kfmc
HEALTH IMPROVEMENT PARTNERS

800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org

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Independent Review Organization: External
Expires 06/01/2021

April 28, 2021

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

RE: KanCare Program Annual External Quality Review Technical Report for Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, 2020–2021 Reporting Cycle

Dear Ms. Jurad:

Enclosed is the KanCare Annual External Quality Review technical report for the 2020–2021 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 5.0H Survey Validation, Mental Health Consumer Perception Survey, Provider Satisfaction Survey Validation, Review of Compliance with Medicaid and CHIP Managed Care Regulations, Quality Assessment and 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, lvaldivia@kfmc.org, if you have any questions regarding this report.

Sincerely,

Lynne Valdivia

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

Electronic Version: Shirley Norris, Director of Managed Care

Enclosures

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KanCare Program Annual External Quality Review Technical Report

2020–2021 Reporting Cycle

Contract Number: 46100

Submission Date: April 28, 2021

Review Team: Lynne Valdivia, MSW, BSN, RN, CCEP, Vice President, Director of Quality Review, and Compliance Officer
John McNamee, PhD, MA, Senior Health Data Analyst
Ghazala Perveen, MBBS, PhD, MPH, Epidemiologist Consultant
Jason Orr, MPH, Health Quality Data Analyst
Laura Sanchez, RN, Healthcare Quality Review Analyst
Beth Nech, MA, EQRO Manager
Beckie Archer, Programmer I

Prepared for:

KanCare

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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 or UHC) have provided KanCare managed care services since January 2013.

As the EQRO, KFMC evaluated services provided in 2019/2020 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 2020 through April 2021) 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®[1]) Survey Validation
- Provider Survey Validation
- Network Adequacy Validation

KFMC also conducted the 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

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

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

KFMC used and referenced the following CMS EQR Protocol worksheets and narratives in the completion of these activities:[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 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. The COVID-19 pandemic impacted MCO operations including service delivery, survey administration, data collection, and performance improvement interventions. 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. (2019). CMS External Quality Review Protocols: October 2019. CMS: Baltimore, MD.

Summary of Individual EQR Components

1. ISCA and PMV

Background/Objectives

KanCare MCOs are required to register with National Committee for Quality Assurance (NCQA) and undergo an annual NCQA HEDIS Compliance Audit™ which conveys sufficient integrity to HEDIS® data that it provides a means for consumers and purchasers to compare healthcare organization performance.[3] The State required Aetna, Sunflower, and UnitedHealthcare to report HEDIS 2020 measure data (reflecting calendar year 2019 performance) through the NCQA data submission portal. In addition to the HEDIS Compliance Audit that NCQA requires of the MCOs, the State requires the EQRO to use a HEDIS Certified auditor to conducts its performance measure validation activities. Because 2019 was Aetna's first year as a Kansas MCO (effective January 1, 2019), this was their first performance measure compliance audit.

The performance measure validation objectives were to

- Evaluate the policies, procedures, documentation, and methods the MCO used to calculate the measures;
- Determine the extent to which reported rates were accurate, reliable, free of bias, and in accordance with standards for data collection and analysis;
- Verify measure specifications were consistent with the State's requirements; and
- Ensure re-measurement rates were produced with methods and source data that parallel the baseline rates.

During the performance measure validation and other EQR activities, changes to information systems and processes were captured and included in the activity reports. Baseline Information Systems Capability Assessments (ISCA) were conducted with Sunflower and UnitedHealthcare in 2013 with biennial updates through 2019; Aetna's baseline ISCA was performed in 2019. The MCOs' ISCAs will be updated in 2021.

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 Methodology.

Performance Measure Validation

KFMC contracted with MetaStar, Inc. (MetaStar), an NCQA-licensed organization to perform HEDIS Compliance Audits, to conduct validations during 2020 for a set of performance measures reported by the KanCare MCOs. MetaStar is independent of the HEDIS Certified auditors contracted by the KanCare MCOs. KFMC worked closely with MetaStar and the MCOs throughout the validation process.

Performance Measure Evaluation

HEDIS data for measurement years 2015–2019 were available for Sunflower and UnitedHealthcare and aggregated for KanCare (including Amerigroup for years 2015–2018); 2019 data are baseline rates for Aetna. This report contains KanCare and MCO results for CMS 2020 Adult and Child Core Set measures that include rates, Quality Compass™ (QC) rankings, and indicators for notable changes in rates.[4]

- Adult Core Set (Table 1.1): 18 HEDIS measures, including 2 measures derived from the CAHPS surveys. The Plan All-Cause Readmission measure is risk-adjusted and reported according to observed versus expected hospital readmissions.
- Child Core Set (Table 1.2): 16 HEDIS measures.

[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.

An objective of the KanCare Quality Management Strategy is to improve HEDIS rates that are below the Quality Compass 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).[5] In alignment with this objective, **Table 1.1** and **Table 1.2** include all HEDIS core measures and flags to indicate measures that had a "gap-to-goal" percentage change of 10% or more (based on a performance goal of 100% or 0%, depending on the measure), trendlines indicating average changes of at least 3 percentage points per year (pp/yr), trendlines for hybrid measures with statistically significant average changes since 2015 or 2017 (depending on the measure), and hybrid measures with statistically significant changes from 2018 to 2019.

Table 1.1. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Adult

Measure*	Measure Name & Indicator	KanCare^		Aetna†		Sunflower		UnitedHealthcare	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC
ABA *H*	**Adult BMI Assessment**	88.77 cdx	<50th			87.10 dx	<33.33rd	90.51 cdx	<50th
AMM *A*	**Antidepressant Medication Management**								
	– Effective Acute Phase Treatment	50.97	<33.33rd	47.03	<25th	51.95	<50th	50.34	<25th
	– Effective Continuation Phase Treatment	35.96	<50th	34.16	<25th	37.44	<50th	34.51	<33.33rd
AMR *A*	**Asthma Medication Ratio**								
	– 19–50 Years	54.77	≥50th			59.54 c	>75th	49.43	<33.33rd
	– 19–50 and 51–64 Years	53.68	NA			57.20 c	NA	50.11	NA
BCS *A*	**Breast Cancer Screening**	51.30	<25th			52.50	<25th	50.01	<25th
CBP *H*	**Controlling High Blood Pressure**	54.44 x	<33.33rd	47.45	<10th	54.50	<33.33rd	59.12 x	<50th
CCS *H*	**Cervical Cancer Screening**	57.23 d	<33.33rd	44.28	<10th	59.61 bcd	<50th	63.99	≥50th
CDC *H*	**Comprehensive Diabetes Care**								
	– Poor HbA1c Control (>9.0%) *(lower is better)*	39.01 d	<50th	38.44	<50th	48.42	<25th	29.54 cd	>75th
CHL *A*	**Chlamydia Screening in Women**								
	– 21–24 Years	55.88	<25th	54.68	<25th	56.24	<25th	56.33	<25th
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (18+ years)**								
	– 7-Day Follow-Up	15.22	≥50th	14.05	≥50th	15.81	>66.67th	15.59	≥50th
	– 30-Day Follow-Up	22.23	≥50th	22.16	≥50th	22.44	≥50th	22.06	≥50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures.
^ The KanCare rate is the average of the MCO adult population rates, weighted by MCO.
† Note, 2019 rates are the first HEDIS data submitted by Aetna; therefore, analysis of changes between years is not applicable. Measures ABA, AMR, and BCS were not applicable to Aetna due to the measures' continuous enrollment criteria.
Green indicates Quality Compass (QC) ranks above the 90th percentile or improving performance (marked with "a," "b," "c," or "d"):
[a] Statistically significant improvement in **rate** from prior year (hybrid only); Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).
[b] At least 10% gap-to-goal improvement in **rate** from prior year based on a performance goal of 100% or 0%, depending on the measure.
[c] Average improving trend of at least 3 percentage points per year in rates from 2017 (IET & PCR measures) or 2015 (other measures).
[d] Statistically significant improving trend from 2015 (hybrid and survey methods only); Mantel-Haenszel chi square.
Purple indicates Quality Compass (QC) ranks below the 10th percentile or worsening performance (marked with "x," "y," or "z"):
[x] At least 10% 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 percentage points per year in rates from 2017 (IET & PCR measures) or 2015 (other measures).
[z] Statistically significant worsening trend from 2015 (hybrid or survey methods only); Mantel-Haenszel chi square.
No hybrid rates were statistically significant worse from prior year's rate; Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

[5] *KanCare 2.0 Quality Measure Strategy*. State of Kansas, July 2, 2018, www.kancare.ks.gov/policies-and-reports/quality-measurement/QMS. Accessed March 26, 2021.

Table 1.1. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Adult (cont.)

Measure*	Measure Name & Indicator	KanCare^		Aetna†		Sunflower		UnitedHealthcar	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC
FUH *A*	**Follow Up After Hospitalization For Mental Illness (18–64 years)**								
	– 7-Day Follow-Up	47.67	>75th	47.03	>75th	50.83	**>90th**	44.60	>75th
	– 30-Day Follow-Up	67.38	>75th	63.80	>75th	70.64	**>90th**	66.89	>75th
FUM *A*	**Follow-Up After Emergency Department Visit for Mental Illness (18–64 years)**								
	– 7-Day Follow-Up	60.57	>75th	59.43	>75th	**61.89** b	>75th	59.95	>75th
	– 30-Day Follow-Up	71.76	>75th	69.81	>75th	73.14	>75th	71.94	>75th
FVA *C*	**Flu Vaccinations for Adults Age 18–64**	51.93 d	>75th	47.30	>66.67th	55.04 d	**>90th**	52.19 cd	>75th
IET *A*	**Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment**								
	Initiation of AOD Treatment (18+ years)								
	– Alcohol Abuse or Dependence	43.56 c	≥50th	45.99	>66.67th	44.84 c	>66.67th	40.31	<50th
	– Opioid Abuse or Dependence	37.31	**<10th**	38.53	<25th	39.60	<25th	33.82	**<10th**
	– Other Drug Abuse or Dependence	40.90 c	<50th	42.84	≥50th	**43.33** bc	≥50th	36.86	<25th
	– Total	40.25 c	<33.33rd	41.88	<50th	42.44 c	<50th	36.63	<25th
	Engagement of AOD Treatment (18+ years)								
	– Alcohol Abuse or Dependence	10.84	<50th	10.58	<50th	11.43	≥50th	10.34	<50th
	– Opioid Abuse or Dependence	9.38	<25th	8.23	**<10th**	9.16	<25th	10.40	<25th
	– Other Drug Abuse or Dependence	13.06 c	≥50th	13.48	>66.67th	13.79	>66.67th	11.95	≥50th
	– Total	11.95	<50th	11.90	<50th	12.46	<50th	11.39	<50th
MSC *C*	**Medical Assistance with Smoking and Tobacco Use Cessation**								
	– Total % Current Smokers *(lower rate and QC are better)*	30.03	≥50th	32.28	≥50th	**26.10** b	<50th	32.21	≥50th
	– Advising Smokers to Quit	**78.77** b	≥50th	76.15	<50th	**79.57** b	≥50th	79.83	≥50th
	– Discussing Cessation Medications	54.12 d	<50th	48.09	<25th	**59.34** bcd	>66.67th	53.33 cd	<50th
	– Discussing Cessation Strategies	48.59	≥50th	42.75	<25th	**50.54** b	≥50th	50.83	≥50th
PPC *H*	**Prenatal and Postpartum Care**								
	– Postpartum Care	67.04	<25th	67.64	<25th	62.04	**<10th**	71.53	<33.33rd
SAA *A*	**Adherence to Antipsychotic Medications for Individuals With Schizophrenia**	58.24	<33.33rd	51.30	<25th	54.84	<25th	**69.69** b	>75th
SSD *A*	**Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	80.12	<50th	77.25	<25th	80.57	<50th	82.09	≥50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures

^ The KanCare rate is the average of the MCO adult population rates, weighted by MCO.

† Note, 2019 rates are the first HEDIS data submitted by Aetna; therefore, analysis of changes between years is not applicable.

Green indicates Quality Compass (QC) ranks above the 90th percentile or improving performance (marked with "a," "b," "c," or "d"):

[a] Statistically significant improvement in **rate** from prior year (hybrid only); Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

[b] At least 10% gap-to-goal improvement in **rate** from prior year based on a performance goal of 100% or 0%, depending on the measure..

[c] Average improving trend of at least 3 percentage points per year in rates from 2017 (IET & PCR measures) or 2015 (other measures).

[d] Statistically significant improving trend from 2015 (hybrid and survey methods only); Mantel-Haenszel chi square.

Purple indicates Quality Compass (QC) ranks below the 10th percentile or worsening performance (marked with "x," "y," or "z"):

[x] At least 10% 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 percentage points per year in rates from 2017 (IET & PCR measures) or 2015 (other measures).

[z] Statistically significant worsening trend from 2015 (hybrid or survey methods only); Mantel-Haenszel chi square.

No hybrid rates were statistically significant worse from prior year's rate; Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

Table 1.1. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Adult (cont.)

Risk-Adjusted Measure*	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)	10.83	11.09	0.98				11.28	11.24	1.00	9.90	10.84	0.91

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures. For PCR "O" means "observed," "E" means "expected," and ratios O/E less than 1.00 indicates better than expected performance.
^ The KanCare rate is the average of the MCO adult population rates, weighted by MCO.
† The 2019 denominator for Aetna described less than 150 readmissions, so the Aetna PCR data is suppressed from this reporting.

Table 1.2. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Child

Measure*	Measure Name & Indicator	KanCare^		Aetna†		Sunflower		UnitedHealthcare	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC
ADD *A*	**Follow Up Care for Children Prescribed ADHD Medication**								
	– Initiation Phase	52.81	>75th			53.38	>75th	52.25	>75th
	– Continuation & Maintenance Phase	59.86	>66.67th			62.79	>75th	56.51 xy	≥50th
ADV *A*	**Annual Dental Visit (Total)**	66.68	>75th	66.46	>75th	67.24	>75th	66.28	>75th
AMB *A*	**Ambulatory Care** – Emergency Dept Visits/1000 MM (Total) *(lower is better)*	60.81	≥50th	61.24	≥50th	63.00	≥50th	58.30	≥50th
AMR *A*	**Asthma Medication Ratio**								
	– Ages 5–11 Years	78.36	>66.67th			80.61 c	>75th	76.04	≥50th
	– Ages 12–18 Years	66.65	≥50th			66.71 cx	≥50th	66.58	≥50th
APM *A*	**Metabolic Monitoring for Children and Adolescents on Antipsychotics**	48.08	>75th	45.97	>75th	46.29	>75th	51.67	>75th
APP *A*	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)**	78.25 b	>75th	78.75	>75th	77.67	>75th	78.63 b	>75th
AWC *H*	**Adolescent Well-Care Visits**	56.49 abd	<50th	47.45	<25th	61.31 abcd	≥50th	58.64 x	≥50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures.
^ The KanCare rate is the average of the MCO child population rates, weighted by MCO.
† Note, 2019 rates are the first HEDIS data submitted by Aetna; therefore, analysis of changes between years is not applicable. Measures ADD and AMR were not applicable to Aetna due to the measures' continuous enrollment criteria.
Green indicates Quality Compass (QC) ranks above the 90th percentile or improving performance (marked with "a," "b," "c," or "d"):
[a] Statistically significant improvement in **rate** from prior year (hybrid only); Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).
[b] At least 10% gap-to-goal improvement in **rate** from prior year based on a performance goal of 100% or 0%, depending on the measure..
[c] Average improving trend of at least 3 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
[d] Statistically significant improving trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
Purple indicates Quality Compass (QC) ranks below the 10th percentile or worsening performance (marked with "x," "y," or "z"):
[x] At least 10% 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 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
[z] Statistically significant worsening trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
No hybrid rates were statistically significant worse from prior year's rate; Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

Table 1.2. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Child (cont.)

Measure*	Measure Name & Indicator	KanCare^		Aetna†		Sunflower		UnitedHealthcare	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC
CAP *A*	**Children and Adolescents' Access To PCP**								
	– Ages 12–24 Months	**95.61** b	<50th	95.67	<50th	**96.11** b	≥50th	**95.03** b	<50th
	– Ages 25 Months–6 Years	86.66	<33.33rd	86.70	<33.33rd	87.51	<50th	85.77	<33.33rd
	– Ages 7–11 Years	90.72	<50th			91.90	≥50th	**89.49** x	<50th
	– Ages 12–19 Years	90.43	≥50th			91.20	≥50th	**89.62** x	<50th
CHL *A*	**Chlamydia Screening in Women (16–20 Years)**	40.27	<25th	38.86	<25th	41.11	<25th	40.47	<25th
CIS *H*	**Childhood Immunization Status**								
	– Diphtheria-Tetanus-Acellular Pertussis (DTaP)	76.63 z	<50th	74.93	<33.33rd	**78.10** bz	≥50th	**75.43** b	<50th
	– Haemophilus Influenzae B (HiB)	**87.14** b	<50th	85.75	<33.33rd	**87.83** b	<50th	**86.62** b	<50th
	– Hepatitis A	**88.03** b	≥50th	88.03	≥50th	**89.05** b	>66.67th	**87.10** b	≥50th
	– Hepatitis B	92.06	>66.67th	91.45	≥50th	92.21	>66.67th	**91.97** b	>66.67th
	– Inactivated Poliovirus Vaccine (IPV)	89.31	<50th	90.88	≥50th	**90.27** b	≥50th	88.32	<50th
	– Influenza	44.49 d	<50th	43.30	<33.33rd	44.28	<50th	44.77	<50th
	– Measles-Mumps-Rubella (MMR)	**89.30** b	≥50th	87.46	<33.33rd	**90.27** b	≥50th	**88.56** b	<50th
	– Pneumococcal Conjugate	**78.30** b	≥50th	76.92	<50th	**80.78** b	>66.67th	76.16	<50th
	– Rotavirus	**72.30** b	≥50th	74.64	≥50th	**75.91** ab	>66.67th	68.86	<50th
	– Varicella-Zoster Virus (VZV)	**88.68** b	<50th	86.61	<33.33rd	**89.78** b	≥50th	**87.83** b	<50th
	– Combination 10 (all 10 antigens)	37.10 d	<50th	35.61	<50th	38.69	≥50th	35.77	<50th
FUH *A*	**Follow Up After Hospitalization For Mental Illness (6–17 Years)**								
	– 7 Days	59.89	>75th	58.93	>75th	63.10	**>90th**	**57.46** x	>75th
	– 30 Days	78.57	>75th	76.80	>66.67th	**83.53** b	**>90th**	**75.02** x	≥50th
IMA *H*	**Immunizations for Adolescents**								
	– Human Papillomavirus (HPV)	36.89 cd	<50th	35.28	<33.33rd	36.50 c	<50th	37.47	<50th
	– Meningococcal	**80.49** abcd	<33.33rd	88.56	>66.67th	**82.73** bcd	<50th	**77.37** bcd	<25th
	– Tetanus-Diphtheria-Pertussis (Tdap)	86.56 d	<33.33rd	87.83	<50th	**88.56** bd	<50th	84.43	<25th
	– Combination 1 (Meningococcal, Tdap)	**79.21** abcd	<50th	86.13	≥50th	**81.75** abcd	<50th	75.91 cd	<25th
	– Combination 2 (Meningococcal, Tdap, HPV)	**35.73** ad	<50th	35.04	<50th	35.52 c	<50th	36.01	<50th
PPC *H*	**Prenatal and Postpartum Care**								
	– Timeliness of Prenatal Care	84.28	<33.33rd	82.24	<25th	77.13	<25th	91.73	≥50th

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures.
^ The KanCare rate is the average of the MCO child population rates, weighted by MCO.
† Note, 2019 rates are the first HEDIS data submitted by Aetna; therefore, analysis of changes between years is not applicable. Measure CAP (Ages 7–11 Years and Ages 12–19 Years) was not applicable to Aetna due to the measures' continuous enrollment criteria.
Green indicates Quality Compass (QC) ranks above the 90th percentile or improving performance (marked with "a," "b," "c," or "d"):
a Statistically significant improvement in **rate** from prior year (hybrid only); Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).
b At least 10% gap-to-goal improvement in **rate** from prior year based on a performance goal of 100% or 0%, depending on the measure.
c Average improving trend of at least 3 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
d Statistically significant improving trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
Purple indicates Quality Compass (QC) ranks below the 10th percentile or worsening performance (marked with "x," "y," or "z"):
x At least 10% 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 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
z Statistically significant worsening trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
No hybrid rates were statistically significant worse from prior year's rate; Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

Table 1.2. Aggregated KanCare HEDIS Performance Measures (2019 measurement year) – Child (cont.)

Measure*	Measure Name & Indicator	KanCare^		Aetna†		Sunflower		UnitedHealthcare	
		Rate	QC	Rate	QC	Rate	QC	Rate	QC
W15 *H*	Well-Child Visits in the first 15 Months of Life (6 or more visits)	63.02 [ab]	<33.33rd			59.37 [b]	<25th	66.91 [ab]	<50th
W34 *H*	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	70.70 [d]	<33.33rd	68.61	<33.33rd	68.13 [d]	<25th	74.94 [d]	≥50th
WCC *H*	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
	– BMI percentile (Total)	60.34 [cd]	<10th	52.80	<10th	61.31 [cdx]	<25th	65.21 [cd]	<25th
	– Counseling for Nutrition (Total)	59.57 [d]	<25th	49.15	<10th	60.34 [b]	<25th	66.91 [bcd]	<50th
	– Counseling for Physical Activity (Total)	54.88 [d]	<25th	46.72	<25th	56.45 [b]	<25th	59.61 [cd]	<33.33rd

* "A" denotes an administrative method of data collection was used; "H" denotes a hybrid method; "C" denotes CAHPS survey measures.
^ The KanCare rate is the average of the MCO child population rates, weighted by MCO.
† Note, 2019 rates are the first HEDIS data submitted by Aetna; therefore, analysis of changes between years is not applicable. Measure W15 was not applicable to Aetna due to the measure's continuous enrollment criteria.
Green indicates Quality Compass (QC) ranks above the 90th percentile or improving performance (marked with "a," "b," "c," or "d"):
[a] Statistically significant improvement in **rate** from prior year (hybrid only); Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).
[b] At least 10% gap-to-goal improvement in **rate** from prior year based on a performance goal of 100% or 0%, depending on the measure.
[c] Average improving trend of at least 3 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
[d] Statistically significant improving trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
Purple indicates Quality Compass (QC) ranks below the 10th percentile or worsening performance (marked with "x," "y," or "z"):
[x] At least 10% 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 percentage points per year in rates from 2017 (IMA HPV & Combination 2) or 2015 (other measures).
[z] Statistically significant worsening trend (hybrid only) from 2017 (IMA HPV & Combo 2) or 2015 (other measures); Mantel-Haenszel chi square.
No hybrid rates were statistically significant worse from prior year's rate; Fisher's exact (MCOs) or Pearson's weighted chi square (KanCare).

Conclusions Drawn from the Data

The MCOs calculated and submitted HEDIS rates that were valid for the 2019 measure year. COVID-19 adversely impacted the MCOs' access to certain medical records, but not to the extent that it had a significant impact on measure reporting. Administrative rates were not affected. The impact of COVID-19 on measurement year 2020 performance will be assessed in the upcoming reporting cycle.

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 2019 QC rankings above the 90th percentile; statistically significant improvement from 2018 (hybrid or survey methods only); at least 10% gap-to-goal improvement in rate from 2018 based on a performance goal of 100% or 0% (depending on the measure); improvement of at least 3 pp/yr from 2015 or 2017 (depending on the measure); and statistically significant improving trend (hybrid or survey methods only) from 2015 or 2017 (depending on the measure).

Generally, the KanCare MCOs have improved their HEDIS performance rates over the past three to five years. No KanCare hybrid rates statistically significantly worsened from 2018 to 2019. Rates were above the 75th percentile for five Adult and three Child Core Set measure indicators (see Table 1.1 and Table 1.2).

The following rates for KanCare Adult Core Set measure indicators had improvements noted in Table 1.1; footnoted percentage point (pp) changes from 2018 to 2019 and average (pp/yr) improvements over three or five years are shown below.

- Adult BMI Assessment, 3.2 pp/yr for 2015–2019

- Cervical Cancer Screening, 1.6 pp/yr for 2015–2019
- Comprehensive Diabetes Care – Poor HbA1c Control (>9.0%), 1.7 pp/yr for 2015–2019
- Flu Vaccinations for Adults Age 18–64, 2.1 pp/yr for 2015–2019
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependent Treatment
  - Initiation of AOD – Alcohol Abuse or Dependence (18+), 2.8 pp/yr for 2017–2019
  - Initiation of AOD – Other Drug Abuse or Dependence (18+), 3.3 pp/yr for 2017–2019
  - Initiation of AOD – Total (18+), 2.8 pp/yr for 2017–2019
  - Engagement of AOD – Other Drug Abuse or Dependence (18+), 2.7 pp/yr for 2017–2019
- Medical Assistance with Smoking and Tobacco Use Cessation
  - Advising Smokers to Quit, 2.68 pp
  - Discussing Cessation Medications, 1.8 pp/yr for 2015–2019

The following rates for KanCare Child Core Set measure indicators had improvements noted in Table 1.2; footnoted percentage point (pp) increases from 2018 to 2019 and average (pp/yr) improvements over 3 or 5 years are shown below.

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 4.16 pp
- Adolescent Well-Care Visits, 5.82 pp, 2.2 pp/yr for 2015–2019
- Children and Adolescents' Access to Primary Care Practitioners (12-24 months), 3.04 pp
- Childhood Immunization Status
  - Haemophilus Influenzae B (HiB), 2.1 pp
  - Hepatitis A, 1.79 pp
  - Measles-Mumps-Rubella (MMR), 2.41 pp
  - Pneumococcal Conjugate, 2.68 pp
  - Rotavirus, 3.4 pp
  - Varicella-Zoster Virus (VZV), 2.28 pp
- Immunizations for Adolescents
  - Human Papillomavirus (HPV), 2.6 pp/yr for 2017–2019
  - Meningococcal, 4.85 pp, 4.2 pp/yr for 2015–2019
  - Tetanus-Diphtheria-Pertussis (Tdap), 1.1 pp/yr for 2015–2019
  - Combination 1 (Meningococcal, Tdap), 4.58 pp, 4.3 pp/yr for 2015–2019
  - Combination 2 (Meningococcal, Tdap, HPV), 3.99 pp, 2.4 pp/yr for 2017–2019
- Well-Child Visits in the First 15 Months of Life (6 or More Visits), 8.18 pp
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life, 1.5 pp/yr for 2015–2019
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI percentile (Total) 3.1 pp/yr for 2015–2019
  - Counseling for Nutrition (Total), 2.4 pp/yr for 2015–2019
  - Counseling for Physical Activity (Total), 2.3 pp/yr for 2015–2019

KanCare performance for adult and child measures appear to indicate that primary care, vaccination, and substance use reduction services are increasing in effectiveness.

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 2019 QC rankings below the 10th percentile; statistically significant worsening from 2018 (hybrid and survey methods only); at least 10% gap-to-goal worsening in rate from 2018 based on a performance goal of 100% or 0% (depending on the measure); worsening trends of 3 pp/yr or more

from 2015 or 2017 (depending on the measure); and statistically significant worsening trends (hybrid and survey methods only) from 2015 or 2017 (depending on the measure).

KanCare

For KanCare, one Adult and one Child Core Set measure indicators were below the 10th percentile (four Adult and three 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; footnoted percentage point (pp) decreases from 2018 to 2019 and average (pp/yr) decreases over three or five years are shown below.

- Adult BMI Assessment, 1.62 pp
- Controlling High Blood Pressure, 4.19 pp
- Childhood Immunization Status – Diphtheria-Tetanus-Acellular Pertussis (DTaP), 0.9 pp/yr for 2015–2019

Aetna

Three adult measure indicators were below the 10th percentile and nine were below the 25th percentile. Two child measure indicators were below the 10th percentile and four were below the 25th percentile.

Sunflower

One adult measure indicator was below the 10th percentile and six were below the 25th percentile. Seven child measure indicators were below the 25th percentile.

The following Adult and Child Core set measures had worsening performance, noted in Tables 1.1 and 1.2; footnoted percentage point (pp) decreases from 2018 to 2019 and average (pp/yr) decreases over three or five years are shown below.

- Adult BMI Assessment, 1.22 pp
- Asthma Medication Ratio – Ages 12–18 Years, 3.08 pp
- Childhood Immunization Status – Diphtheria-Tetanus-Acellular Pertussis (DTaP), 2.2 pp/yr for 2015–2019
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile, 3.9 pp

UnitedHealthcare

One adult measure indicator was below the 10th percentile and six were below the 25th percentile. Five child measure indicators were below the 25th percentile.

The following Adult and Child Core set measure indicators had worsening performance, noted in Tables 1.1 and 1.2; footnoted percentage point (pp) decreases from 2018 to 2019 and average (pp/yr) decreases over three or five years are shown below.

- Adult BMI Assessment, 2.35 pp
- Controlling High Blood Pressure, 5.11 pp
- Follow-Up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase, 7.06 pp, 2.9 pp/yr for 2015–2019
- Adolescent Well-Care Visits, 3.99 pp
- Children and Adolescents' Access to Primary Care Practitioners
  - 7–11 Years, 1.52 pp

  - 12–19 Years, 1.1 pp
- Follow Up After Hospitalization For Mental Illness (6–17 Years)
  - 7-Day Follow-Up, 7.05 pp
  - 30-Day Follow-Up, 4.95 pp

KanCare performance for adult and child measures may indicate that certain preventive services, screenings or assessments, and education—particularly those directed toward youth—may be lacking in effectiveness.

Technical Strengths

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

Common Among the MCOs

- The MCOs were supported by their parent national plans. 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.
- MCOs' staff were fully engaged in the HEDIS reporting process and conducted their own reviews of performance on an ongoing basis. They leveraged their local team members with national plan expertise to ensure performance measure reporting requirements were met.
- No issues were found from the reabstraction of medical records for the two hybrid measures.
- The MCOs calculated and submitted HEDIS rates that were valid for the 2019 measurement year.

Aetna

- Since the plan was new for 2019, Aetna was well supported by its corporate team in many of the shared service areas such as claims processing, enrollment processing, supplemental data configuration, and vendor data acquisition and loading, as well as preparing and integrating data for measure production.
- Aetna's parent corporation implemented a "global end-to-end" tool, used during data preproduction, to provide better data oversight for its regional plans. Aetna could generate their own reports, which fostered ownership and empowered them to evaluate the effectiveness of quality initiatives on an ongoing basis.

Sunflower

- 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

- To prepare for their transition to another vendor's certified HEDIS software, UnitedHealthcare employed a lengthy preparation and testing approach over several months. This preparation included detailed data mapping, parallel data runs, and comparisons to data runs produced by the legacy software. Results of this testing were reviewed by their transition team.

Technical Opportunities for Improvement

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

Aetna

- **Staffing**. Although staffing challenges were mitigated through Aetna's corporate structure for HEDIS 2020, Aetna should continue to build its HEDIS team for the Kansas Medicaid product.
- **Denied Pharmacy Encounters.** Paid pharmacy encounters were included in submissions to the State; however, encounters for denied pharmacy claims were not. Aetna is working toward providing the State with the denied pharmacy encounters for 2020 dates of service.

Sunflower

- **Enrollment Gaps.** KFMC analyzed Sunflower Medicaid Management Information System (MMIS) data and identified a member whose enrollment information seemed to indicate that the member should have been in the denominator for Prenatal and Postpartum Care but was not indicated in member-level detail files from Sunflower as qualifying for the denominator. Sunflower researched the issue and determined that some members' enrollment data needed to be manually updated due to artificial enrollment gaps being created by an add-void sequence in the enrollment data received from the State.
- **Denied Pharmacy Encounters.** Sunflower did not submit encounters for denied pharmacy claims to the Kansas Department of Health and Environment (KDHE) until the fourth quarter of 2020; the MCO should develop a mechanism to track and verify that the denied claims are included in each submission to KDHE moving forward.
- **Denied Dental Encounters.** Analysis by KFMC found no dental encounters in MMIS with a date of denial in 2019. Sunflower confirmed that they had identified an issue post-onsite with a segment of the file related to remaining patient liability. HEDIS rates were not impacted and Sunflower was working with the State to resolve the issue.

UnitedHealthcare

- **Member Months/Benefit Flags.** Mental Health Utilization member months calculations did not match data in MMIS because there wasn't a mental health benefit flag for some non-plan dual eligible members (i.e., dual eligible members who are not enrolled with UnitedHealthcare for their Medicare coverage). Non-plan dual eligible members were also excluded from member-month counts for the Identification of Alcohol and Other Drug Services and Antibiotic Utilization denominators. Analysis by KFMC confirmed that only measures with member-month calculations were impacted. Because of this error, these measures were not calculated according to State requirements and will adversely affect comparisons of 2019 data between MCOs and, potentially, comparisons to subsequent years' HEDIS data.
- **Enrollment Files.** Due to challenges with identifying parent and children in the 834 enrollment file, UnitedHealthcare was working with the State on potentially getting an extract for any child aged 0–2 years to help mitigate this issue.
- **Medicaid IDs.** There were several Medicaid ID changes in UnitedHealthcare's system that were not reflected in the MMIS. UnitedHealthcare researched these and explained that the member experienced a Medicaid ID change in February 2020. KFMC had confirmed there had been no ID change in MMIS (the source of Medicaid ID assignments sent to the MCOs) during that time.
- **Readiness**. In the future, in order to allow for efficient onsite visit discussion, UnitedHealthcare should be mindful that performance measure validation involves the discussion of actions taken as a

result of previous year's recommendations and should be prepared to provide these details during the audit discussion.

- **Documentation**. UnitedHealthcare should consider fully documenting files and processes unique to Kansas and submitting these with Roadmap documentation to minimize questions from auditors reviewing the information, for example, clearly documenting the MCO's process for utilizing the state provider file.

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

Please see Appendix D, Follow-up to Prior Recommendations for MCO responses to the recommendations made as a result of the ISCA and PMV process in 2020 (measure year 2019).

Recommendations for Quality Improvement

Common Among the MCOs

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.
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.
3. The MCOs should work with providers to improve Chlamydia screening in young women.
4. For all measures, the MCOs should work to improve indicator rates that are below the 75th percentile, pursuant to the State's Quality Management Strategy.

Aetna

Performance Measures

Aetna should prioritize improvement efforts towards the following HEDIS measures: Controlling High Blood Pressure, Cervical Cancer Screening, Antidepressant Medication Management, Adolescent Well-Care Visits, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents.

Technical

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.
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.

Sunflower

Performance Measures

Sunflower should prioritize improvement efforts towards the following: Antidepressant Medication Management – Effective Continuation Phase Treatment, Breast Cancer Screening, Comprehensive Diabetes Care – Poor HbA1c Control, Prenatal and Postpartum Care, and Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI percentile (Total).

Recommendations for Quality Improvement (Continued)

Technical

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 in their master data management plan as required by NCQA's ECDS guidelines.
2. Sunflower should compare outputted provider data from Portico with the State's provider data file to ensure consistency between the two sources.
3. Sunflower should resubmit denied dental encounters that were incorrectly submitted to the State.
4. Sunflower should continue to closely monitor enrollment data for members for artificial enrollment gaps and work to develop a permanent solution to curtail this type of occurrence in the future.

UnitedHealthcare

Performance Measures

UnitedHealthcare should prioritize improvement efforts for the following: Controlling High Blood Pressure, Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase, Adolescent Well-Care Visits, and Follow-up After Hospitalization for Mental Illness (6–17 Years) – 7 and 30 Days.

Technical

1. Because UnitedHealthcare submitted Roadmap section 4 versions related to Medical Record Review, one for each entity involved in the process, sometimes the information in these sections conflicted with another. UnitedHealthcare should consolidate responses from each entity into a single section 4 and use different font colors to differentiate the entities providing the response.
2. UnitedHealthcare should expand documentation for Roadmap section 5, attachment 5.6 for electronic clinical data system 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 and standardized data reconciliation procedures.
3. Due to continued challenges with state reporting requirements, UnitedHealthcare should 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.
4. As a result of challenges in obtaining responses to requested items during the review process, UnitedHealthcare should improve its procedures for internal communication related to audit requests and responses.
5. Because it was unclear where formal reconciliations 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.
6. UnitedHealthcare should carefully review all Medicaid ID changes to ensure consistency with MMIS.
7. UnitedHealthcare should ensure the planned update of eligibility processing requirements, to be completed within 24 hours, is implemented.

2. Performance Improvement Project (PIP) 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, to validate the annual PIP results, and to evaluate the overall validity and reliability of the methods and findings.

The following PIPs were included in this 2020–2021 report cycle:

- "Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications" (SSD). (Sunflower – Year 3 [ended December 31, 2019])
- "Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications" (SSD). (UnitedHealthcare – Year 4 [ended June 30, 2020])
- "Increasing compliance with Human Papillomavirus (HPV) vaccination administration in adolescents." (MCO collaborative PIP [ended December 31, 2020]: Aetna [Year 2], Sunflower and UnitedHealthcare [Year 5])
- "Increasing influenza vaccination rates for children ages 6 months to 17 years." (Aetna – Year 1 [July 1, 2019 – June 30, 2020])

Effective with KanCare 2.0, each MCO has been required to have, on an ongoing basis, at least three clinical and two non-clinical State-approved PIPs. The majority of the PIPs, newly developed with KanCare 2.0, will be included in the 2021–2022 reporting cycle. Each PIP has three to five State-approved interventions, designed to enhance the effectiveness and measurable improvement of the PIP's aim. In addition to an annual PIP report, the MCOs submit intervention data on a routine schedule (monthly, quarterly, or semiannually) that is determined by the intervention. KFMC manages the data and creates snapshot reports and dashboards for review and discussion. Modifications or replacement interventions may be made based on individual interventions' successes or lack thereof.

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

In 2020, eight interagency meetings included focused PIP discussions among staff from KDHE, the Kansas Department of Aging and Disability Services (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 CMS Validating PIPs Protocol worksheet and narrative. KFMC completed transition from the CMS 2012 Protocol to the revised October 2019 Protocol during 2020. Evaluation includes review of the MCOs' annual reports submitted for the current and prior years (where applicable), along with their originally submitted methodology worksheets.

The PIPs were based on HEDIS measures except for Aetna's influenza vaccination PIP. 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).

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%. KFMC's use of the word "significant" in this report is used to represent statistical significance.

Evaluation Scores for MCOs' 2020 Annual Progress Reports

- Sunflower's SSD PIP: 99.0%, High Confidence
- UnitedHealthcare's SSD PIP: 96.0%, High Confidence
- MCOs' Collaborative HPV PIP: 91.2%, Confidence
- Aetna's Influenza Vaccination PIP: 89.7%, Low Confidence

Recommendations for Quality Improvement

Common Among the MCOs

There were no specific recommendations for UnitedHealthcare's SSD PIP, Sunflower's SSD PIP, and the MCOs' collaborative HPV PIP, due to conclusion of the PIPs in this report cycle. KFMC recommended the MCOs review and apply the noted opportunities for improvement to continuing and future PIPs.

Aetna
Influenza Vaccination

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 first year of activity was July 1, 2019 through June 30, 2020.

Aetna's plan was to implement five multifaceted interventions focused on education and outreach. Due to multiple internal and external factors, only the first two of the following interventions were conducted during the first measurement year.

- Texting campaign to parents/guardians regarding the importance of influenza vaccinations
- Member incentives for receiving their influenza vaccination
- Community outreach by an Aetna nurse at four community-sponsored immunization events
- Use of HealthTag reminders affixed on prescriptions filled at CVS pharmacies
- Gap in care lists of non-compliant members provided to providers

Conclusions Drawn from the Data

Aetna's baseline influenza vaccination rate for the total PIP population was 25%; see Table 2.1. In the stratified analysis of the rates by age group, children 6 months to 4 years had the highest rate (31%), children 5 to 12 years of age had the second highest rate (24%), and adolescents 13 to 17 years of age had the lowest rate (21%). The difference between the vaccination rates in the three age groups was significant (p<.001).

Table 2.1. Overall Influenza Vaccination Rates (July 1, 2019 to June 30, 2020)				
	6 mo. - 4 Yrs	5 - 12 Yrs	13-17 Yrs	Total
Numerator	2,658	5,119	2,440	10,217
Denominator	8,552	21,089	11,803	41,444
Rate	31.1%	24.3%	20.7%	24.7%

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

- Aetna used Plan-Do-Study-Act cycles with each of their planned interventions to identify areas or steps to adjust, document modifications, identify opportunities for improvement, and report the implementation timeline.
- Aetna included analysis of results stratified by four special needs subgroups (children younger than five years of age, members receiving Severe Emotional Disturbance services, members with Intellectual or Developmental Disability, and members diagnosed with chronic asthma).

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

- As the planned interventions are more fully developed and implemented, additional details should be provided in the annual report for each intervention.
- When reporting results on statistical significance, clarify that the statement of one subgroup having a higher rate than the other two subgroups is not indicating statistical significance, unless additional post hoc bivariate chi-square analyses were conducted.

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

This is the first year for this PIP, so there are no previous recommendations.

Recommendations for Quality Improvement

1. 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.
2. Include analyses and interpretations of results for all process measures.
3. Update the sample Gap in Care report cover letter in Aetna's second annual progress report to reflect the correct PIP member age range, 6 months to 17 years of age.
4. 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.
5. 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.
6. Include information on the number of 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 and assist in determining whether the analytic results indicate the extent of the success of the intervention.
7. Include numbers with the percentages to provide sufficient information to assess whether information was obtained from an adequate number of respondents.
8. Revise the measure calculation to be consistent with the measure denominator description, those identified through KSWebIZ as obtaining the influenza vaccination.

Sunflower
Increasing the Rate of Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications

Background/Objectives
This was Sunflower's third and final progress report, which covered their 2016 baseline measurement and three annual remeasurements (2017, 2018, and 2019).

Sunflower implemented five multifaceted interventions. The first four interventions below were initiated between February and June 2017. The fifth intervention was implemented in September 2019.

- Multiple staff trainings to increase knowledge and awareness
- Referrals to case management (CM) teams for member education and support
- Member education mailers
- Pay-for-performance (P4P) initiative with Community Mental Health Centers (CMHCs)
- Providing diabetes screening compliance status to primary care physicians

Conclusions Drawn from the Data
- Sunflower's diabetes screening remeasurement rates (see Table 2.2) for the total PIP population were significantly higher in 2017 (p<.01), 2018 (p=.01), and 2019 (p<.01) than their 2016 baseline.
- Sunflower's annual goal was a 5% improvement over the prior year's SSD rate. They exceeded their 2017 goal (79.91%) but did not meet the 2018 goal (84.69%) or 2019 goal (83.84%).
- Sunflower's intervention to provide member education and support from CM teams appeared to be the most effective strategy. For members who were successfully contacted by the CM department, the SSD rates were significantly higher compared to the rate of those not contacted in all three intervention years (2019, 71% vs. 54%; 2018, 62% vs. 52%; and 2017, 66% vs. 54%).

Table 2.2. Total Population Diabetes Screening Rates, 2016 to 2019

Year	Screening Rate	N/D*
2019	80.57% ↑	1,385 / 1,719
2018 ^	79.85% ↑	1,248 / 1,563
2017	80.66% ↑	1,305 / 1,618
2016 †	76.10%	1,261 / 1,657

↑ Indicates percentage was statistically significantly higher than in 2016. (p <.05 considered significant)

* N/D = Numerator/Denominator

^ NCQA identified "Trend with Caution" due to specification changes from prior year.

† Baseline Year

Strengths Regarding Quality, Timeliness, and Access to Health Care Services
- Sunflower conducted extensive analyses of their SSD rates during this PIP and provided thorough evaluations of their results.
- A new exploratory data analysis of the member SSD screenings by month was completed in 2019 to look for seasonal trends that may have affected the intervention data. In addition, Sunflower completed additional analysis focused on dual eligibility, alternative coverage, and claims to see if any of the areas had a notable impact on the mailer campaign.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services
- Develop methods to consistently obtain input from members with special health needs and their advocacy groups when developing a PIP.
- Further consider applicable lessons learned regarding the CMHC related P4P initiative when developing or managing other P4P initiatives.

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

All five recommendations in the PIP validation section of the 2019–2020 Annual EQR Technical Report were fully addressed. Please see Appendix D for more details.

UnitedHealthcare
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications

Background/Objectives

This was UnitedHealthcare's fourth and final progress report, which covered their 2016 baseline measurement and three annual remeasurements (2017, 2018, and 2019).

UnitedHealthcare implemented four member-targeted and four provider-targeted interventions to increase the percentage of members in the PIP population who received a glucose or glycosylated hemoglobin (HbA1c) screening test. In 2020, only three of the interventions listed below were active, and outreach was limited due to the COVID-19 pandemic.

- Waiver Management Outreach, Whole Person Care, and Clinical Practice Consultant Outreach (all in effect during 2020)
- Written Communications to Members, Written Communication to Providers, and Provider Education (all not utilized in 2020)
- Behavioral Health Integration (ended in December 2018)
- Visiting Nurse Outreach (only active in 2017)

Conclusions Drawn from the Data

- The annual HEDIS SSD rate significantly improved (p<.001), more than six percentage points, from baseline to 2019 for the "total" PIP population (Medicaid, CHIP, and LTC); see Table 2.3.
- The baseline 2016 SSD rate for the total PIP population was below the QC 25th percentile. Both the 2017 and 2018 SSD remeasurements were greater than the 33.33rd percentile, and the 2019 SSD rate met their improvement benchmark goal and was above the 50th percentile.

Table 2.3. Study Indicator 1 – Annual HEDIS® SSD Rates

	Total	Medicaid + CHIP	LTC	Statistical Test & Significance
Baseline Measure January 1, 2016 – December 31, 2016	**76.03% (866/1139)**	74.28% (722/972)	86.23% (144/167)	
Remeasurement 1 (R1) Period January 1, 2017 – December 31, 2017	**80.05% (1003/1253)**	79.30%↑ (858/1082)	84.80% (145/171)	**Total** – statistically significant increase to baseline, p=.02 **Medicaid + CHIP** – statistically significant increase to baseline; p=.01
Remeasurement 2 (R2) Period January 1, 2018 – December 31, 2018	**80.03% (978/1222)**	78.80%↑ (829/1052)	87.65% (149/170)	**Total** – statistically significant increase to baseline, p=.02 **Medicaid + CHIP** – statistically significant increase to baseline; p=.02
Remeasurement 3 (R3) Period January 1, 2019 – December 31, 2019	**82.43% (1060/1286)**	81.08%↑ (870/1073)	89.20% (190/213)	**Total** – statistically significant increase to baseline; p<.001. **Medicaid + CHIP** – statistically significant increase to baseline; p<.001

↑ Indicates statistically significant increase from the baseline rate to each remeasurement period. (p<.05)
Per NCQA copyright, the total baseline measure is a Certified, Audited Health Plan HEDIS Rate. The other rates, which were calculated using NCQA-certified HEDIS software but were not audited by an NCQA-Certified Auditor, are Unaudited Health Plan HEDIS Rates.

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

- UnitedHealthcare plans to continue assisting members in the SSD measure with obtaining diabetes screenings through Whole Person Care and Waiver Management.
- UnitedHealthcare continues to consider innovative interventions to improve diabetes testing.

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

- Develop methods to consistently obtain input from members with special health needs and their advocacy groups.

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

Of the four recommendations in the PIP validation section of the 2019–2020 Annual EQR Technical Report, one was fully addressed and three were not addressed. Please see Appendix D for more details.

Collaborative PIP
Human Papillomavirus Performance Improvement Project

Background/Objectives

This was the fifth and final progress report for the MCOs' collaborative PIP. UnitedHealthcare and Sunflower conducted the PIP since it was initiated; Aetna joined the PIP in 2019.

The MCOs' multifaceted intervention approach targeted members in the PIP population and providers. Three of the MCOs' interventions listed below (identified by one asterisk [*]), were discontinued prior to 2019. Due to the COVID-19 pandemic, three of the interventions (identified by two asterisks [**]) were not launched in 2020 at the scheduled time.

- Chief Medical Officer Outreach to Primary Care Practitioners (replaced with educational brochure)*
- Community Health Department Initiative, Including Health Fairs (desired results not produced)*
- Provider Educational Brochure (changed to Psychiatric Residential Treatment Facilities [PRTF] packet)*
- Telephone Outreach to Parents/Guardians**
- Unable to Contact by Telephone Written Communication/Mailer**
- Mailing HPV-Specific Information Materials to Non-Compliant Members**
- HPV Professional Conference and/or Webinar Offerings
- Gap in Care Reports to Providers
- Provision of Provider Profiles Which Include Detailed Reports of their Overall Performance
- HPV Information Packet for PRFT and Adolescent Center for Treatment Staff (for use with members)

Conclusions Drawn from the Data

- In the year-over-year comparisons, there were five significantly higher HEDIS HPV vaccine rates (see Table 2.4):
  - Sunflower's and UnitedHealthcare's combined administrative rates: from 2017 to 2018 (p=.04) and 2017 to 2019 (p<.001)
  - UnitedHealthcare's administrative rate: from 2017 to 2018 (p<.01) and 2017 to 2019 (p<.001)
  - Sunflower's hybrid rate: from 2017 to 2018 (p=.03)

- The MCOs met their 5% improvement goal for the HEDIS hybrid vaccine rate from 2017 to 2018. Two other HEDIS administrative HPV vaccine rates were very close to reaching the goal, from 2017 to 2018 (4.9%) and from 2018 to 2019 (4.5%).

Table 2.4. 2017 to 2019 HEDIS Adolescent HPV Vaccine Rates by MCO

	2017		2018		2019	
	N/D*	Rate	N/D*	Rate	N/D*	Rate
	Aetna^					
Admin						
Hybrid					145 / 411	35.28%
	Sunflower					
Admin	1,307 / 4,017	32.54%	1,316 / 4,006	32.85%	1,354 / 3,934	34.42%
Hybrid	128 / 411	31.14%	158 / 411	38.44%↑	150 / 411	36.50%
	UnitedHealthcare					
Admin	1,147 / 3,767	30.45%	1,190 / 3,570	33.33%↑	1,370 / 3,949	34.69% +
Hybrid	141 / 411	34.31%	139 / 411	33.82%	154 / 411	37.47%
	Total†					
Admin	2,454 / 7,784	31.53%	2,506 / 7,576	33.08%↑	2,724 / 7,883	34.56% +
Hybrid	269 / 822	32.73%	297 / 822	36.13%	304 / 822	36.98%

* N/D = Numerator/Denominator
^ First year of operation for ABH of Kansas as a MCO was in 2019. Only the 2019 Hybrid rate was available using their member eligibility.
† Total HPV vaccine rates are for UnitedHealthcare and Sunflower.
↑ Indicates statistically significant increase from the prior year's rate. (p <.05)
\+ Indicates statistically significant increase from 2017 to 2019. (p <.05)

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

- Held collaborative meetings and conducted Plan-Do-Study-Act cycles for continuous quality improvement and to address changes in the interventions due to the COVID-19 pandemic.
- Planning to consider lessons learned from the HPV PIP (e.g., standardize intervention elements) to more effectively identify drivers for success of other PIPs.

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

- Testing for statistical significance should only be performed when the measurement data are comparable.
- Avoid or minimize variance in the implementation of collaborative interventions among MCOs that could affect the ability to make year-over-year comparisons and to assess the impact of the intervention.

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

Of the seven recommendations in the PIP validation section of the 2019–2020 Annual EQR Technical Report, five were fully addressed, one was partially addressed, and one was not addressed. Please see Appendix D for more details.

3. CAHPS Health Plan 5.0H Survey Validation

Background/Objectives

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

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

The 2020 CAHPS surveys (measurement year 2019) were conducted by Aetna, Sunflower, and UnitedHealthcare using the CAHPS 5.0H Adult Questionnaire (Medicaid) and CAHPS 5.0H Child Questionnaire (with CCC measure).[6]

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

For the 2020 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 administered the 2020 CAHPS surveys using a mail-only protocol with three survey mailings; Sunflower and UnitedHealthcare chose the mixed-mode protocol with two survey mailings and telephone follow-up. Aetna's vendor mailed an optional postcard notification prior to the first survey mailing. SPH Analytics also included an online option for Sunflower's members to complete the survey through an Internet link provided in the surveys the members received by mail. Surveys for the MCOs were fielded from February 2020 through May 2020.

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, 2019, with no more than one gap of up to 45 days; enrollment on December 31, 2019, and when surveyed. Members eligible for each survey were:
  - **Adults** – Age 18 years and older as of December 31, 2019;
  - **GC Populations** – Age 17 years and younger as of December 31, 2019;

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

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

The COVID-19 pandemic probably contributed to lower-than-expected response rates. Fewer than 411 surveys, the targeted number of responses, were completed for two-thirds of the populations surveyed. However, the pandemic appeared to have little impact on global ratings and composite scores.

The MCOs provided the State and KFMC copies of the vendor reports and cross-tabular tables that included response, non-response, and ineligible response counts for each of the CAHPS survey questions by population. KFMC used and referenced the CMS Validating Surveys protocol worksheet and narrative to evaluate the technical methods and results from the MCO CAHPS reports. The CAHPS vendors' general findings and recommendations appeared appropriate. Statistical tests and key driver analyses conducted by the vendors were also appropriate for the survey.

An error by UnitedHealthcare's vendor caused seven TXIX and seven TXXI respondents to be misclassified as CCC or non-CCC in the child reports. The UHC CCC populations were reidentified and rates recalculated for KFMC's validation report to the State. Recalculation changed rates less than 1 percentage point and did not impact the general findings or recommendations made by the vendor for the child populations. Adult and general child rates were not affected.

KFMC's analyses in the CAHPS validation reports provide the State with annual comparisons of member satisfaction with services provided by each MCO, by MCO subpopulations, and in aggregate that help identify areas of strength and those where additional focus may be warranted.

Annual changes from the prior year were statistically tested (using Fisher's exact) for each survey question (by MCO and by population) for years 2016 to 2020. KFMC also calculated aggregated annual percentages (weighted by population) for all survey questions and tested for statistically significant differences between consecutive years (using chi square). A statistical test (Mantel-Haenszel chi square) for trends over five years (2016–2020) were conducted to determine if the slope of the trend line on a graph was statistically significantly different from horizontal.

KFMC compared results with Quality Compass national percentiles for health maintenance organizations for the year the survey was conducted (vendor reports included the prior year's percentiles, as vendor reports were provided to MCOs before the current year's Quality Compass was available). MCO and KanCare rates were ranked using the QC 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 $>95^{th}$.

For identifying areas of strength and opportunities for improvement, rates were classified as *"very high"* or *"relatively low."* Percentages 90% or greater and scores 90 or greater were considered *very high.* KanCare rates above the 75^{th} percentile and subpopulation rates above the 90^{th} percentile also were

considered *very high*. KanCare percentages less than 90% and scores less than 90 that were also less than the 50th percentile were classified as *relatively low*. MCO program rates below the 25th percentile also were classified as *relatively low.* A "significant change" means the differences in rates was statistically significant with probability *p* less than 0.05.

Conclusions Drawn from the Data Common Among the MCOs

With few exceptions, 2020 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 2016–2020, annual statistical comparisons by question, and annual Quality Compass rankings for composites, ratings, and questions.

In this summary report, Table 3.1 displays Health Plan, Health Care, Personal Doctor, and Specialist Seen Most Often ratings, and QC rankings by 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) – 2020

Global Rating		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	%	QC	%	QC	%	QC	%	QC	%	QC
Health Plan	ABH	76.1%	<33.33rd	89.1%	>66.67th	88.0%	≥50th	85.2%	≥50th	84.8%	<50th
	SHP	80.5%	≥50th	89.5%	>75th	**90.4%**	>75th	87.4%	>66.67th	**91.0%**	**>95th**
	UHC	82.5%	>75th	**91.0%**	>75th	89.7%	>75th	88.0%	>75th	88.3%	>75th
	KanCare	**80.1%**	**≥50th**	**89.9%**	**>75th**			**87.3%**	**>66.67th**		
Health Care	ABH	76.6%	<50th	87.8%	<50th	87.8%	<50th	84.1%	<25th	84.2%	<25th
	SHP	78.0%	≥50th	89.0%	≥50th	89.3%	≥50th	87.9%	<50th	**90.2%**	>66.67th
	UHC	79.9%	>75th	**90.0%**	>66.67th	**92.4%**	**>90th**	**↑90.7%**	>75th	**90.9%**	>75th
	KanCare	**78.4%**	**>66.67th**	**89.2%**	**≥50th**			**88.1%**	**<50th**		
Personal Doctor	ABH	86.1%	>66.67th	**92.1%**	>66.67th	89.9%	<33.33rd	88.5%	<25th	85.8%	<25th
	SHP	84.3%	≥50th	**90.5%**	<50th	88.9%	<25th	**90.4%**	<50th	**90.6%**	≥50th
	UHC	88.4%	**>90th**	**92.3%**	>66.67th	88.8%	<25th	**91.0%**	≥50th	**90.8%**	≥50th
	KanCare	**86.3%**	**>66.67th**	**91.2%**	**≥50th**			**90.0%**	**<50th**		
Specialist*	ABH	**90.3%**	**>90th**	86.1%	<33.33rd			**90.1%**	>75th	**91.5%**	>75th
	SHP	81.8%	<33.33rd	89.2%	>75th			89.7%	>75th	87.0%	<33.33rd
	UHC	87.8%	>75th	86.7%	<50th			89.3%	≥50th	89.3%	>66.67th
	KanCare	**86.3%**	**>66.67th**	**87.4%**	**≥50th**			**89.6%**	**>75th**		

Note: The KanCare rate for the child surveys is the weighted average of the six subpopulations.
*The MCO-level 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 (QC) rankings above the 75th percentile, and subpopulation QC rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare QC rankings below the 50th percentile and subpopulation QC 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, Personal Doctor, 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.

Table 3.2. Composite Scores by MCO and Program – 2020

Composite		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	Score	QC	Score	QC	Score	QC	Score	QC	Score	QC
Getting Care Quickly	ABH	87.6	**>90th**	**92.1**	≥50th	**92.3**	≥50th	**95.1**	≥50th	**92.1**	<50th
	SHP	87.6	**>90th**	**95.4**	**>90th**	**90.4**	<50th	**96.4**	>75th	**95.7**	>66.67th
	UHC	88.4	**>95th**	**93.4**	>66.67th	**94.0**	>75th	**94.9**	≥50th	**97.2**	**>90th**
	KanCare	**87.9**	**>90th**		**93.5**	**>75th**			**95.5**	>66.67th	
Getting Needed Care	ABH	88.9	**>90th**	87.0	≥50th	84.9	<50th	**92.2**	**>90th**	**91.8**	>75th
	SHP	86.1	>66.67th	**90.3**	>75th	**90.3**	>75th	88.9	≥50th	**93.5**	**>95th**
	UHC	89.2	**>90th**	85.5	<50th	**90.9**	>75th	**91.8**	>75th	**91.7**	>75th
	KanCare	**88.0**	**>75th**		**87.9**	**≥50th**			**91.1**	**>75th**	
Coordination of Care	ABH	89.4	>75th	85.3	<50th	83.2	**<25th**	86.7	≥50th	82.5	**<25th**
	SHP	83.7	<50th	83.7	**<25th**	81.1	**<25th**	83.3	**<25th**	83.1	**<25th**
	UHC	**↑90.8**	**>90th**	84^	NA^	85.6	<50th	81.5	**<25th**	82.9	**<25th**
	KanCare	**↑87.9**	>66.67th		**84.2**	**<33.33rd**			**83.6**	**<25th**	
How Well Doctors Communicate	ABH	**92.0**	<33.33rd	**97.3**	>75th	**95.8**	≥50th	**96.1**	≥50th	**96.2**	≥50th
	SHP	**91.9**	**<25th**	**96.7**	>75th	**97.0**	>75th	**97.4**	**>90th**	**↑97.6**	**>90th**
	UHC	**↑95.0**	>75th	**95.3**	<50th	**95.9**	≥50th	**96.6**	≥50th	**97.4**	**>90th**
	KanCare	**93.1**	**<50th**		**↑96.3**	**≥50th**			**↑96.8**	**>66.67th**	
Customer Service*	ABH	89.5	<50th		**90.4**	>66.67th		87.2	**<5th**	89.5	<50th
	SHP	**91.7**	>75th		**↓86.5**	**<25th**		89.0	<50th	**91.7**	>75th
	UHC	89.6	≥50th		**92.5**	>75th		**93.0**	**>95th**	89.6	≥50th
	KanCare	**90.3**	**≥50th**		**89.7**	**≥50th**			**90.0**	**<50th**	

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 (QC) rankings above the 75th percentile, and subpopulation QC rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare QC 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 QC ranking was not assigned (NA).

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

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 – 2020

Composite		Children with Chronic Conditions			
		Title XIX		Title XXI	
	MCO	Score	QC	Score	QC
Access to Prescription Medicines	ABH	**93.3**	>66.67th	**94.9**	>75th
	SHP	**95.7**	**>90th**	**96.2**	**>90th**
	UHC	**94.5**	>75th	**97.2**	**>95th**
KanCare			**↑94.9**	**>75th**	
Access to Specialized Services*	ABH		82.6	>75th	
	SHP		81.8	>75th	
	UHC		85.0	**>95th**	
KanCare			**83.2**	**>95th**	
Coordination of Care for Children with Chronic Conditions	ABH	71.9	<25th	77.3	<50th
	SHP	73.4	<33.33rd	75.8	<50th
	UHC	72^	NA^	78^	NA^
KanCare			**↓73.2**	**<33.33rd**	
Family-Centered Care: Getting Needed Information	ABH	**93.7**	≥50th	**93.3**	<50th
	SHP	**96.3**	**>90th**	**95.6**	>75th
	UHC	**95.2**	>75th	**95.0**	>75th
KanCare			**↑95.1**	**>75th**	
Family-Centered Care: Personal Doctor Who Knows Child	ABH	**90.1**	<33.33rd	**91.9**	≥50th
	SHP	**92.7**	>66.67th	**92.5**	≥50th
	UHC	89.7	<25th	**92.0**	≥50th
KanCare			**↑91.1**	**<33.33rd**	

Note: The KanCare score is the weighted average of the six subpopulation scores.
* The Access to Specialized Services 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 (QC) rankings above the 75th percentile, and subpopulation QC rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare QC 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; $p<.05$.
^ Denominator was less than 100; therefore, a QC rank was not assigned (NA).

Table 3.4. Non-Composite Question Related to Mental or Emotional Health – 2016 to 2020

CAHPS Question		Population	2020	2019	2018*	2017*	2016*
Q30/Q54.	**In general, how would you rate your [your child's] overall mental or emotional health?** *("Excellent" or "Very Good")*	Adult	31.5%	32.0%	34.9%	**↓32.3%**	35.8%
		GC	68.1%	**↓68.2%**	72.7%	74.5%	74.4%
		CCC	38.1%	**↓38.0%**	**↓41.2%**	46.2%	**↑45.1%**

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 2016 to 2018.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.

Table 3.5. Non-Composite Question Related to Having a Personal Doctor – 2016 to 2020

CAHPS Question		Population	2020	2019	2018*	2017*	2016*
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**	86.7%	**↑89.1%**	83.6%	84.3%	83.5%
		GC	87.5%	**↑88.7%**	86.9%	87.4%	88.2%
		CCC	94.3%	**↑94.7%**	93.3%	94.5%	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 2016 to 2018.
↑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 – 2020

Measure	KanCare		Aetna		Sunflower		UnitedHealthcare	
	Percent	QC	Percent	QC	Percent	QC	Percent	QC
Flu Vaccination for Adults 18–64 (FVA)	**51.9%**	**>75th**	47.3%	>66.67th	55.0%	**>90th**	52.2%	>75th
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)								
– Total % Current Smokers *(lower is better)*	**30.0%**	**≥50th**	32.3%	≥50th	26.1%	<50th	32.2%	≥50th
– Advising Smokers to Quit	**78.8%**	**≥50th**	76.2%	<50th	80%*	NA*	79.8%	≥50th
– Discussing Cessation Medications	**54.1%**	**<50th**	48.1%	<25th	59%*	NA*	53.3%	<50th
– Discussing Cessation Strategies	**48.6%**	**≥50th**	42.7%	<25th	51%*	NA*	50.8%	≥50th

Note: There were no statistically significant increases or decreases compared to the prior year; $p<.05$.
Rankings above the Quality Compass (QC) national 90th percentile are highlighted in green.
* Indicates the number of responses was less than 100; therefore, a QC rank 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 SHP TXXI CCC rate (91%, >95th) were very high. Rates increased each year since 2016 for the KanCare, SHP, and UHC adult populations. The average increase in the KanCare adult rate was 1.0 percentage points per year.
- **Rating of All Health Care –** Five trend lines showed significant improvement from 2016 to 2020 (KanCare adult and CCC, SHP TXXI GC, and UHC adult and TXXI CCC). The UHC TXIX CCC rate increased 5 percentage points from 2019. The UHC TXIX GC rate was very high (92%, >90th).
- **Rating of Personal Doctor –** Rates were very high for KanCare GC (91%), KanCare CCC (90%) and UHC adult (>90th); each of the three rates were the highest rate for the population from 2016 to 2020. The KanCare adult rate increased each year since 2016; the average increase was 1.3 pp/yr.
- **Rating of Specialist Seen Most Often –** Rates were very high for KanCare CCC (90%, >75th) and ABH adult (90%, >90th). The KanCare adult, KanCare CCC, and UHC adult rates have been increasing since 2016 (averaging 1.4 pp/yr, 0.7 pp/yr, and 2.8 pp/yr, respectively), and the three 2020 rates were the highest in the 5-year period.

Composites

- **Getting Care Quickly –** All adult scores were above the 90th percentile (>95th for UHC). All child scores were 90 or greater, including KanCare GC (94, >75th), KanCare CCC (95, >90th), SHP TXIX GC (95, >90th), and UHC TXXI CCC (97, >90th). The KanCare adult, GC, and CCC rates each had an increasing 5-year trendline.
- **Getting Needed Care –** Rates were very high for KanCare adult (>75th), KanCare CCC (91, >75th), ABH adult (>90th), UHC adult (>90th), ABH TXIX CCC (92, >90th), and SHP TXXI CCC (93, >95th).
- **Coordination of Care –** A significant increase in the KanCare adult Coordination of Care score (5 pp) was driven by a significant increase of 13 percentage points in the UHC adult score (91, >90th).
- **How Well Doctors Communicate –** The scores were 90 or greater from 2016 to 2020 for all populations, including KanCare adult (93), KanCare GC (96), KanCare CCC (97), SHP TXIX CCC (97, >90th), SHP TXXI CCC (98 , >90th), and UHC TXXI CCC (97, >90th). The 2016–2020 trendlines were increasing for KanCare GC (0.4 p/yr), SHP TXXI CCC (0.8 p/yr), KanCare CCC (0.5 p/yr), SHP TXIX CCC

(1.0 p/yr), and UHC TXXI CCC (0.3 p/yr). Increases from 2019 were significant for KanCare GC, KanCare CCC, UHC adult, and SHP TXXI CCC.

- **Customer Service –** Scores were 90 for KanCare adult, GC, and CCC populations. The UHC CCC (TXIX and TXXI combined) score was also very high (93, >95th).

CCC Composites

- **Access to Prescription Medicines –** All scores from 2016 to 2020 have been greater than 91, and the 2020 score has been the greatest in those five years for KanCare (95, >75th), SHP TXIX (96, >90th), SHP TXXI (96, >90th), and UHC TXXI (97, >95th).
- **Access to Specialized Services –** The KanCare and UHC (TXIX and TXXI combined) scores ranked >95th. The 5-year average increase in KanCare CCC scores was 0.7 p/yr.
- **Family-Centered Care: Getting Needed information –** All scores from 2016 to 2020 were 90 or greater. The 5-year trendlines were increasing for KanCare (0.8 p/yr) and SHP TXIX (1.6 p/yr), and the 2020 scores were the highest: 95 (>75th) for KanCare and 96 (>90th) for SHP TXIX.
- **Family-Centered Care: Personal Doctor Who Knows Child –** The 2020 KanCare score (91) was significantly higher than in 2019.

Non-Composite Questions

- **Having a Personal Doctor –** KanCare CCC had a very high rate (94%).

Notable Improvements in Quality, Timeliness, and Access to Health Care Services

Common Among the MCOs

- **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications** – While the 2020 rate continues to be relatively low (54%), it was the highest rate in five years. Increases across 2016 to 2020 were statistically significant for KanCare, SHP, and UHC adult rates. Increases averaged 1.8 pp/yr for KanCare, 3.0 pp/yr for SHP, and 3.6 pp/yr for UHC.
- **Flu Vaccinations for Adults 18–64** – KanCare (52%, >75th) and SHP (>90th) rates are very high based on percentile rankings. The average increases from 2016 to 2020 were 2.1 pp/yr for KanCare and SHP rates and 3.7 pp/yr for UHC rates.

Sunflower

- **Medical Assistance with Smoking and Tobacco Use Cessation** – From 2019 to 2020, Sunflower rates improved by over 8 percentage points for questions about advising smokers and tobacco users to quit (Q33) and discussing cessation strategies (Q34 and Q35); correspondingly, the percentage of respondents who smoked or used tobacco (Q32) decreased (improved) by 4 percentage points. The changes are not statistically significant, so the results should be interpreted with caution.

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

Several measures for the KanCare adult and child populations, as well as for each MCO, indicated a need for some improvement. Rates with a statistically significant decrease from 2019 and decreasing 2016–2020 trendlines were also considered opportunities for improvement.

Common Among the MCO

Global Ratings

- **Rating of All Health Care** – The 2020 KanCare CCC rate was 88% and ranked <50th. Rates were 84% and ranked <25th for ABH TXIX CCC and ABH TXXI CCC.
- **Rating of Personal Doctor** – The rates ranked <25th for SHP TXXI GC (89%), UHC TXXI GC (89%), ABH TXIX CCC (89%), and ABH TXXI CCC (86%).

Composites

- **Coordination of Care** – The 2020 scores for coordination of care for KanCare GC (84, <33.33rd) and KanCare CCC (83, <25th) populations indicated that they could be further improved. Scores ranked <25th for SHP TXIX GC (84), ABH TXXI GC (83), SHP TXXI GC (81), SHP TXIX CCC (83), UHC TXIX CCC (82), ABH TXXI CCC (83), SHP TXXI CCC (83), and UHC TXXI CCC (83).
- **Customer Service** – Two rates with TXIX and TXXI combined were relatively low. The SHP GC rate (87, <25th) was significantly less than the 2019 rate (90; >75th). The ABH CCC rate (87) ranked <5th.

CCC Composites

- **Coordination of Care for Children with Chronic Conditions** – The KanCare CCC rate (73, <33.33rd) was the lowest score from 2016 to 2020 and significantly less than the score in 2019 (77). The ABH TXIX rate also was relatively low (72, <25th).

Non-Composite Questions

- **Rating of Mental or Emotional Health** – This continues to be an area with opportunities for improvement. The 2016–2020 trendlines are declining for KanCare adult, GC, and CCC rates. Only 32% of KanCare adult, 68% of KanCare GC, and 38% of KanCare CCC respondents rated their [their child's] overall mental or emotional health as *excellent* or *very good.*
- **Medical Assistance with Smoking and Tobacco Use Cessation**
  - **Discussing Cessation Medications** – The KanCare rate (54%) ranked <50th, even after increasing from 2016 to 2020 at an average of 1.8 percentage points per year. The ABH rate (48%, <25th) was also relatively low. This is an identified missed opportunity, since 79% of providers advised members who smoke or use tobacco to quit.
  - **Discussing Cessation Strategies** – The ABH rate (43%, <25th) was relatively low. Although the KanCare rate (49%) ranked ≥50th, it was 30 percentage points less than the KanCare rate for advising smoking cessation, indicating a missed opportunity to also discuss strategies for cessation while advising the member to quit.

Technical Strengths

The following are areas of strength for KanCare related to survey administration and reporting.

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, providing some assurance through ongoing NCQA oversight that survey protocols follow recognized standards.
- Each MCO's survey process included two reminder post cards and, for non-responders, second mailings of the survey questionnaires and telephone outreach (Sunflower and UnitedHealthcare) or a third questionnaire mailing (Aetna).
- The survey process was clearly defined by NCQA and provided comparative information across health plans.
- 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.

Sunflower

- Sunflower's vendor included an internet response option in addition to mail and phone response options.

Sunflower and UnitedHealthcare

- Sunflower and UnitedHealthcare included supplemental questions that provided additional assessment of member satisfaction in areas of particular MCO interest. Most questions were asked in two or more years, allowing comparison of progress over time.

Technical Opportunities for Improvement

The following are opportunities for improving survey administration and reporting.

Common Among the MCOs

- Vendor reports did not include margins of error or confidence intervals. Both help the reports' audience assess the generalizability of the survey.

Sunflower and UnitedHealthcare

- SPH Analytics, the survey vendor for Sunflower and UnitedHealthcare, is under probation with NCQA due to lack of internal controls and discrepancies in the vendor's data collection processes specific to CAHPS. NCQA indicated reported rates and results were not impacted.

UnitedHealthcare

- UnitedHealthcare's vendor reports did not include sample frame counts.

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

EQRO and MCO updates on the seven recommendations common to all MCOs made in the prior year's review are shown in Appendix D. Three recommendations were completed, substantial progress was made on two recommendations, and activities for improvement were in progress for two recommendations. There were no MCO-specific prior recommendations.

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 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).
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).

Sunflower and UnitedHealthcare

Sunflower and UnitedHealthcare should monitor NCQA updates regarding SPH Analytics' probationary status.

4. 2020 Mental Health Consumer Perception Survey

Background/Objectives

Since 2010, KFMC has administered the Mental Health Consumer Perception Survey to KanCare beneficiaries receiving services, as per contracts with KDHE and KDADS. In 2020, KFMC contracted with Vital Research, LLC to administer the survey. KFMC provided operational oversight, analyzed survey data, and produced this report.

The survey objectives were to

- Determine strengths and weaknesses in consumer perception of access to care, quality and appropriateness of services, and effectiveness of services;
- Describe consumer perception of their participation in planning their treatment;
- Describe the healthcare access, quality, and outcomes for KanCare adult and youth members who have received mental health services; and
- Compare 2020 survey results to prior years (2013 to 2019).

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

The Mental Health Statistics Improvement Program (MHSIP) survey tools (Youth Services Survey for Families and Adult Consumer Survey) are nationally standardized surveys, having been tested and determined to be valid and reliable. Since 2010, KFMC has used survey instruments that were adapted at the State's request to better assess services provided to members. As a result, Kansas MHSIP survey results may not be directly comparable to results from similar surveys conducted in other states.

Members eligible to receive the survey were "Adults" (ages 18 or older) and "Youth" (ages 17 or younger, family responding) who were enrolled in KanCare on the date of sample selection and who had received one or more mental health services through one of the three MCOs between March 1, 2020, and August 31, 2020. KFMC identified 18,444 Adult members and 26,817 Youth members who met the criteria. The enrollment and demographic data (such as member name, age, phone number, and mailing address) for determining survey sample frames were obtained from the October 2020 Medicaid Enrollment file.

The number of surveys to be mailed was calculated by dividing the minimum number of responses required by the expected raw response rate, which was estimated using prior years' rates. 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 Youth (379) populations. To reduce potential bias caused by differing response rates, a random sample stratified by age group was selected from the Adult members. A simple random sample of Youth members was selected. Surveys were mailed to 7,844 KanCare members, representing 4,043 Youth members and 3,801 Adult members (744 for ages 45 or older; 1,838 for ages 25–44; and 1,219 for ages 18–24).

The survey methodology employed a mail-only distribution process consisting of a three-wave mail protocol, with one questionnaire mailing and two reminder postcards. The tasks and timeframes employed were based on the standard NCQA protocol for administering surveys. Survey packets were mailed from October 13 to October 22, 2020. Reminder postcards were mailed to non-respondents from October 22 to November 3, 2020, and November 6 to November 13, 2020. Surveys were re-mailed as requested by members from October 13 through December 11, 2020. The Adult mental health survey

questionnaire was mailed to the adult members, and the Youth survey questionnaire was mailed to the parents or guardians of youth members.

Of the 7,844 members mailed the survey, 835 complete and valid surveys were received (Adult: 407; Youth: 428), exceeding the minimum required number of survey responses (Adult: 396; Youth: 379). The 2020 response rate for the Adult population was calculated to be 11.4%, and the response rate for the Youth population was 11.3%. The overall survey response rate was 11.3%. Youth survey response rates in 2020 (11.3%) were higher than 2019 (10.0%), while Adult survey response rates in 2020 (11.4%) were lower than 2019 (12.0%).

Analysis included tests for statistically significant differences between 2020 and each prior year, eight-year linear trends from the start of the KanCare program in 2013, and five-year linear trends from 2016.

Bias Analysis

To judge the impact of non-response bias on the survey results, demographic information from the Kansas MMIS was tabulated and analyzed for the sample frames and survey response groups of each survey subgroup. Also, to provide context, demographic information for all KanCare adults and youth (mental health consumers and non-consumers) was reviewed. Demographic categories included sex, age range, race, ethnicity, county type, and MCO. For Youth members, no significant differences in representation were seen between any demographic strata or across MCOs. For Adult members, significant differences were seen for several strata and across MCOs (Age groups 25–44 and 45+, County, and Race), although the unequal representation had minimal impact on survey conclusions.

Conclusions Drawn from the Data Common Among the MCOs

The Adult and Child survey questions were grouped into the service domains listed in Table 1. Domain rates for 2020 are also provided in Table 1.

Table 4.1. 2020 Mental Health Survey Domain Results – Adults (18+ Years) and Youth (0-17 Years)

Domain	KanCare Adults			KanCare Youth		
	Rate*	95% CI^	N/D†	Rate	95% CI	N/D
General Satisfaction	93.4%	90.6%–95.5%	371/397	90.3%	87.0%–92.8%	374/414
Service Access	89.8%	86.4%–92.4%	353/393	88.4%	84.9%–91.2%	362/410
Participation in Treatment Planning	85.2%	81.2%–88.5%	312/366	95.7%	93.2%–97.3%	390/408
Cultural Sensitivity				97.2%	94.9%–98.6%	346/356
Service Quality and Appropriateness	93.4%	90.4%–95.5%	356/381			
Outcomes	78.9%	74.4%–82.8%	286/362	84.3%	80.5%–87.6%	341/405
Improved Functioning	76.9%	72.4%–80.9%	292/379	82.7%	78.8%–86.1%	335/406
Social Connectedness	77.1%	72.6%–81.1%	291/377	89.8%	86.5%–92.4%	369/411
Crisis Management	86.8%	82.6%–90.1%	271/312	84.2%	79.4%–88.0%	236/281

* KanCare rates are weighted averages of MCO rates to compensate for unequal MCO survey response rates.
^ The modified-Wald (Agresti–Coull) method was used for the 95% confidence intervals (CI).
† N/D shows the unweighted numerators and denominators for each rate.

Adult domain rates for General Satisfaction and Service Quality and Appropriateness were higher than in 2019. The domains with the lowest positive response rates in 2020 were also the three domains with the lowest positive response rates in 2019 (Outcomes, Improved Functioning, and Social Connectedness). Nearly all domains showed improvement from the 2019 Adult survey; Social Connectedness declined since the past survey.

The Youth domains with the highest rates in 2020 were also the domains with the highest rates in 2019 (Cultural Sensitivity and Participation in Treatment Planning). As in 2019, the lowest positive response rates were for questions in the Improved Functioning, Outcomes, and Crisis Management domains. Nearly all domains showed improvement from the 2019 Youth survey; Cultural Sensitivity had no change from the past survey.

Of Adult members who reported on paid employment, 18.7% indicated they are doing what they want to do for a paid job (8.4% are not), 40.5% indicated they want a paid job but do not have one, and 32.4% do not have a paid job and do not want one.

Of the 835 complete and valid surveys received, all but one had at least one comment. Altogether there were 1,507 comments. Comment themes of provider, service quality and appropriateness, and general satisfaction had the highest counts of positive comments for both Adult and Youth. Comment themes of service access, service quality and appropriateness, and provider operations had the most statements categorized as areas for improvement for both Adult and Youth.

The COVID-19 pandemic impacted four areas related to the mental health survey: the mode of healthcare delivery, survey administration, survey response rates, and reporting of survey results. There were no statistically significant decreases in perceptions on service timeliness, adequacy, or quality or in perceived health outcomes from 2019 to 2020. All domains showed improvement from 2019 except for the Adult survey Social Connectedness domain, which worsened. It is likely that the worsening within the Social Connectedness domain may have been due, in part, to stay-at-home orders and restrictions placed on gatherings. Similarly, there were some small changes in responses to the question on employment. Those having paid work decreased in 2020 (18.7% paid doing what they want to do and 8.4% paid but not doing what they want to do) from 2019 (21.5% paid doing what they want to do and 10.9% paid but not doing what they want to do). Conversely, those responding that they did not have a paid job but wanted one increased from 2019 (35.1%) to 2020 (40.5%). It may be likely that these decreases in occupation (a net decrease of 5.3%) and increase in desire for paid employment may be due to the economic downturn from the pandemic.

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

- The following 2020 domain rates were at or above 90%:
  - General Satisfaction – Adult (93.4%) and Youth (90.3%)
  - Participation in Treatment Planning – Youth (95.7%)
  - Service Quality and Appropriateness – Adult (93.4%)
  - Cultural Sensitivity – Youth (97.2%)
- The following 2020 questions for Adult and Youth survey domains had rates at or above 90%:
  - General Satisfaction domain Adult survey questions related to liking the services received, still getting services from current mental health providers, and recommending mental health providers to friends or family
  - Youth questions in the General Satisfaction domain related to overall satisfaction, staff helping no matter what, and services received were right for the member and their family
  - Service Access domain questions for both Adults and Youth related to convenience of location of services and availability of services at times that were good for the member

  - Participation in Treatment Planning Adult questions related to their comfort in asking questions about treatment and medication, and Youth questions related to parents and guardians being able to help choose the child's service and treatment goals and to participate in the child's treatment
  - Service Quality and Appropriateness questions specific to Adults related to being given information about rights, mental health providers encouraging members to take responsibility, respecting member wishes regarding sharing information about treatment, and sensitivity to cultural background
  - Cultural Sensitivity questions specific to Youth related to mental health providers treating members with respect (including religious/spiritual beliefs), speaking in a way the member understood, and sensitivity to cultural/ethnic background
  - Social Connectedness domain Youth questions regarding the member knowing people who will listen to and understand them, having people they can talk with about the child's problems, and having people with whom they can do enjoyable things
- The following significant positive trends are evidence of improvement in domain rates and survey question positive response rates:
  - For Adults, the General Satisfaction, Service Access, Service Quality and Appropriateness, and Crisis Management domains displayed statistically significant positive trends from 2016 to 2020. Except for the Crisis Management domain, each of these also had significant positive eight-year trends.
  - There was a significant positive eight-year trend for the Youth Participation in Treatment Planning domain.
  - For Youth, the Service Access and Participation in Treatment Planning domains displayed significant positive five- and eight-year trends.
- The following positive trends for non-domain questions were significant:
  - Five-year trend for "*My mental health providers spoke with me in a way I understood*"
  - Five- and eight-year trends for *"Medication for emotional/behavioral problems was available timely"*

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

- The following 2020 domain rates were below 80%:
  - Outcomes – Adult (79%)
  - Improved Functioning – Adult (77.0%)
  - Social Connectedness – Adult (77.1%)
- The following 2020 rates for Adult and Youth survey domain questions were below 80%:
  - Service Quality and Appropriateness – Adult only
    - "*I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).*" (78.6%; eight-year negative trend)
  - Outcomes – Adult and Youth
    - "*I am better able to deal with crisis.*" (Adult 74.7%; eight-year negative trend)
    - "*I do better in social situations.*" (Adult 66.7%; eight-year negative trend)
    - "*My symptoms are not bothering me as much.*" (Adult 66.6%, also in Improved Functioning)
    - "*My child is better able to cope when things go wrong.*" (Youth 73.8%, also in Improved Functioning)
    - "*I am satisfied with our family life right now.*" (Youth 78.8%)

  - Improved Functioning – Adult and Youth
    - "*I am better able to take care of my needs.*" (Adult 79.7%)
    - "*I am better able to handle things when they go wrong.*" (Adult 67.2%)
    - "*I am better able to do things that I want to do.*" (Adult 76.3%)
    - "*My symptoms are not bothering me as much.*" (Adult 66.6%, also in Outcomes)
    - "*My child is better able to cope when things go wrong.*" (Youth 73.8%, also in Outcomes)
  - Social Connectedness – Adult
    - "*I feel I belong in my community.*" (70.3%)
- "*My child is doing better in school and/or work*," (Youth) had an eight-year negative trend (Outcomes and Improved Functioning domains)
- 40.5% of Adult respondents indicated they want a paid job but do not have one (Employment non-domain question)

Technical Opportunity for Improvement

- A large number of surveys (467) were returned as undeliverable by the United States Postal Service.

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

Of note, question level rates increased at least 2.5 percentage points (pp) for these areas included in 2019 recommendations:

- Recommendation 1, *"For Adult members, explore methods to increase positive results and mitigate trends among the following: [eight items listed]"*
  - *Ability to see a psychiatrist when wanted* increased 2.7 pp (Service Access)
  - *Members feeling like they decided their treatment goals* increased 3.8 pp (Participation in Treatment Planning)
  - *Encourage mental health providers to review medication side effects* increased 2.8 pp (Service Quality and Appropriateness)
  - *Sensitivity to cultural backgrounds* increased 3.6 pp (Service Quality and Appropriateness)
  - *Ability to deal with crisis* increased 2.6 pp (Outcomes)
  - *Doing better at school and/or work* increased 7.8 pp (Outcomes)
  - *Crisis services helped* increased 2.9 pp (Crisis Management)
- Recommendation 2, *"For Youth members, explore methods to increase positive results and mitigate trends among the following: [six items listed]"*
  - *Fostering relationships with peers and others* increased 4.6 pp (Outcomes and Improved Functioning)
  - *Doing well in school* increased 2.6 pp (Outcomes and Improved Functioning)
  - *Satisfaction with family life right now* increased 2.5 pp (Outcomes)
  - *Enjoyment of social activities* increased 2.6 pp (Social Connectedness)

Please see Appendix D, Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed, for more details.

Recommendations for Quality Improvement

1. For Adult members, continue monitoring and explore methods to improve or continue improvement regarding
   a. Increasing promotion of consumer-run programs and monitor member engagement to prevent further decline of peer participation activities (Service Quality and Appropriateness);
   b. Members being better able to deal with crisis and handle things going wrong (Outcomes and Improved Functioning);

Recommendations for Quality Improvement (Continued)

c. Members doing better in social situations (Outcomes);
d. Members' symptoms not bothering them as much (Outcomes and Improved Functioning);
e. Social connectedness for members, especially ways to foster a sense of community belonging (Social Connectedness); and
f. Helping members who want a paid job to obtain paid employment (Employment non-domain question).

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) and
   b. Youth members being better able to cope when things go wrong (Outcomes and Improved Functioning).
3. As KDADS continues to develop a comprehensive crisis response model, evaluate availability and usage of crisis services to determine program successes and areas for improvement.

Technical Recommendation

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

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5. Provider Satisfaction Survey Validation

Background/Objectives

KFMC completed a validation of the 2020 Provider Satisfaction Surveys conducted by Aetna, Sunflower, and UnitedHealthcare. The objectives of the Provider Satisfaction Surveys were to assess how well each plan is 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.

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 the Centers for Medicare & Medicaid Services (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. Surveys for the MCOs were fielded from September 2020 through December 2020. All three MCOs used a dual-mode methodology, including mail and internet modalities. Sunflower and Aetna also used a phone follow-up component. The Aetna survey applied simple random sampling methodology to draw a sample of 1,500 providers (primary care providers (PCPs), specialists and BH clinicians) and achieved a total of 122 complete surveys. Sunflower noted a sample of 2,000 providers (PCPs, specialists and BH clinicians) was drawn, although the type of sampling methodology was not indicated. The Sunflower survey achieved a total of 171 complete surveys. The UnitedHealthcare survey report noted 46 surveys were completed without providing information on the type of sampling methodology applied or size of the sample drawn. The overall response rates for the Aetna, Sunflower and UnitedHealthcare surveys were 8.1%, 8.6%, and 2%, respectively.

Aetna reported significant delays occurred in the survey process this year due to managing provider response delays caused by the COVID-19 pandemic. Sunflower noted COVID-19 impacted the 2020 response rates, and they were lower than in typical years (348 surveys were completed in 2019).

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

Aetna

- The Overall satisfaction rate with Aetna was 54% among its KanCare network PCPs, Specialists, and BH Clinicians (the identified survey sample composition). However, a strong caution had to be applied to make this conclusion due to the low response rate, the low number of completed surveys, and the application of unweighted data analysis techniques.

Sunflower

- The Overall Satisfaction Rate with Sunflower was 66% among its KanCare network PCPs, Specialists, and BH Clinicians (survey sample composition). However, a strong caution had to be applied to make this conclusion due to a low response rate, low number of completed surveys, and the application of unweighted data analyses techniques.

UnitedHealthcare

- The Kansas survey findings were based on a very low response rate and a very low number of complete surveys; therefore, results could not be representative of and generalizable to the study population. However, the national UnitedHealthcare *Overall Satisfaction Rate* was 39%, with a Kansas rate of 25%. With the Kansas rate, caution has to be applied due to a very low number of completed surveys.

Technical Strengths

Common Among the MCOs

- Question categories seem to be organized appropriately and in accordance with different service areas as indicated by the survey instruments for the three MCOs.
- Multi-mode survey methodology including a mail questionnaire with an internet option was used by the three MCOs. Two MCOs also applied a component of follow-up telephone calls to non-respondents (Aetna and Sunflower). Aetna sent two mail questionnaires to all providers in the sample. Sunflower mailed an initial postcard to providers.
- Detailed and varied analyses using statistical procedures with graphical presentation of the results were done for the surveys of two MCOs (Aetna and Sunflower).
- The statement for using caution while interpreting results due to insufficient sample size was included in the Survey Reports of the MCOs.
- Benchmarking to 2019 SPH Analytics Medicaid Book of Business was applied for the surveys of two MCOs (Aetna and Sunflower). The third MCO reported national results of their survey in addition to Kansas specific results (UnitedHealthcare).

Aetna

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

- Aetna used educational Web forums to encourage providers to complete the survey.
- The use of a simple random sampling method to draw the survey sample of providers helps to reduce the risk of biased results.
- The tables that displayed statistical significance testing highlighted not only the 2020 survey data but also comparisons to indicate whether the 2020 survey data exceeded or was below a comparison benchmark score.

Sunflower

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

- The total number of valid surveys for each survey component (mail, internet and telephone follow-up), and by provider type (PCPs, Specialists and BH Clinicians) for each survey component were documented in the Survey Report.
- An appropriate method of response rate calculation was applied to assess the overall response rate.
- The analyses were conducted for two provider groups (physical health provider and BH Clinicians).

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.

Opportunities for Improvement

Common Among the MCOs

- The survey reports did not provide information regarding reliability and validity testing of the survey instruments for the MCOs.
- A majority of the survey questions for Aetna and Sunflower were relative questions. Aetna's survey instrument included 49 relative questions (out of 64 questions); and Sunflower's survey instrument included 33 relative questions (out of 53 questions).
- The survey samples of Aetna and Sunflower were not in alignment with their provider network compositions, thus limiting the samples' representation to their provider network. The study population and sample composition was not described for UnitedHealthcare, thus it was not feasible to assess the sample's representation of the study population.
- The survey samples of the MCOs did not include HCBS providers. The survey sample for UnitedHealthcare did not include BH clinicians, and the survey sample for Sunflower included a considerably low number of BH clinicians with very few completing the survey.
- 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 (PCPs, specialists, BH clinicians, and HCBS providers) by survey samples, low response rates, low number of completed surveys with even lower numbers of individual question responses, and use of unweighted analysis technique.
- The sampling method used to draw the survey sample was not mentioned in the Survey Reports for Sunflower and UnitedHealthcare.
- The overall response rates were low for the MCOs (Aetna: 8.1%; Sunflower: 8.6%; and UnitedHealthcare: 2%). The number of completed surveys was considerably low for the MCOs (Aetna: 122; Sunflower: 171; and UnitedHealthcare: 46).
- It was not feasible to assess the adequacy of sample sizes of the MCOs, as information on all crucial aspects of sample size calculation (population size, confidence level, standard deviation, expected response rate) was not provided in their survey reports.
- There was no required response rate or required number of returned surveys established for the MCOs. 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.
- The response rate calculation method was not described for Aetna and UnitedHealthcare.
- The analysis of survey responses was not weighted to improve generalization of the results to the study populations.
- Information regarding non-response analysis was not provided in the survey reports.
- Due to unavailability of the information on crucial aspects of the survey methodology, assessment of the appropriateness of the survey methodology was not feasible.
- Corrective steps were not applied during the course of the survey administration to improve the response rate and number of completed surveys.
- The results for the composites and global ratings shown in the survey reports for Aetna and Sunflower included the percentages and denominators, whereas numerators were not shown. The results presented in the survey report for UnitedHealthcare only showed the number of returned surveys and percentages for the individual questions, without including their numerators and denominators. The percentages based on a small number of responses could be inaccurately interpreted if denominators are not shown.
- Demographic segmental analyses were conducted for Aetna and Sunflower; however, neither MCO

included the denominators. Due to unavailability of these data, assessment of the generalizability of these results was not feasible. UnitedHealthcare results were not stratified by practice specialty.
- The footnotes for the tables presenting data for the MCOs did not include statements related to the statistical test significance level and limitations due to insufficient sample size; lack of this technical information on individual tables could lead users to interpret results inaccurately.
- Survey results for Aetna and Sunflower were compared to the SPH Analytics Aggregate Book of Business benchmarks; however, neither MCO included discussion on the similarities and differences between the respondents of their 2020 Survey and the 2019 SPH Analytics Aggregate Book of Business to indicate the comparison was appropriate.
- The survey reports for the MCOs did not mention whether quality management processes were applied. Although SPH Analytics has a quality management program in place and its documents indicated quality management steps were applied, the survey reports for Aetna and Sunflower did not reference these documents.

Aetna

Following are the areas for improvement for the Aetna survey in addition to those described for all MCOs:
- The low overall response rate (8.1%) and low number of completed surveys (122) indicated the sample size of 1,500 providers was not sufficient.
- A considerably small number of PCPs completed the surveys (23 respondents indicated Primary care as their Area of Medicine), thus the results could not be generalizable to their network PCPs.
- Aetna noted a high amount of bad address/bad phone numbers contributed to the low response rate, although no details were provided and no corrective actions were taken.

Sunflower

Following are the areas for improvement for the Sunflower survey in addition to those described for all MCOs:
- It was not clear whether a probability sampling method was applied to help avoid the risk of biased results.
- It was not clear how sample sizes of the three provider categories were determined (total sample size: 2,000 providers; PCPs: 1,031 providers; Specialists: 923 providers; and BH Clinicians: 46). The number of BH Clinicians in the sample was very low.
- The overall response rate (8.6%) and number of completed surveys (171) were low. The total number of completed surveys for the individual provider categories were considerably low (61 PCPs, 105 specialists, and 5 BH clinicians).

UnitedHealthcare

Following are the areas for improvement for the UnitedHealthcare survey in addition to those described for all MCOs:
- It was not clear whether the respondents of the survey were KanCare providers.
- Telephone follow-up and other steps were not applied to ensure collection of a sufficient number of completed surveys and an adequate response rate.
- The overall response rate (2%) and number of completed surveys (46) were very low.
- The results based on less than 30 responses were not marked to be interpreted with caution.
- The Kansas respondents were much less satisfied than the UHC national respondents (range of 10-25 percentage points less across 35 questions). It was not clear whether Kansas providers were actually substantially less satisfied or if this was the reflection of the very low response rate.

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 13 previous year's recommendations common across the MCOs, Aetna and Sunflower partially addressed five recommendations, minimally addressed one recommendation, and did not address seven recommendations; UnitedHealthcare did not address the 13 recommendations. In addition to common recommendations across the MCOs, additional recommendations were made to each MCO (Aetna: 5; Sunflower: 4; and UnitedHealthcare: 3). Out of five additional Aetna recommendations, they are in the process of addressing two recommendations (in progress), minimally addressed one recommendation and did not address two recommendations. Out of four additional Sunflower recommendations, they are in the process of addressing one recommendation, and did not address three recommendations. UnitedHealthcare did not address any of their three additional recommendations. Please see Appendix D for more details.

Recommendations for Quality Improvement

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, 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.
   - 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.
   - Include an adequate number of KanCare providers by provider type (PCPs, specialists, BH clinicians, and HCBS providers) in the survey sample.
   - Weight the analysis by provider type.
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, and updated/correct contact information for tracking and contacting the providers.
   - 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.
3. Ensure data analysis results are appropriately interpreted:
   - Document statistical testing performed to clearly indicate validity of the results. Indicate when response rates are too low.
   - 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.
   - Interpret the results within the context of the study population represented by the survey sample.
   - Ensure tables include numerator and denominator counts for each question, significance level used for statistical testing, and indication if the results are not based on an adequate number of respondents to be considered valid with application of caution for interpretation of results.

Recommendations for Quality Improvement (Continued)

- Limitations related to the survey methodology, response rate, and number of valid surveys should be considered in the interpretation of the results.
- Conduct non-response analysis.

4. Include a detailed description of the contents of the survey design and administration in the Survey Report and accompanying documents:
   - Describe the procedures applied to ensure the validity and reliability of the survey instrument.
   - 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.
   - Describe the survey administration tasks in detail.
   - Describe the quality procedures applied during each step of the survey implementation and data analysis with reference to the vendor's quality management plan.
   - Describe any changes made to the study design during the survey implementation and their reasons.
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.

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. Consider using stratified random sampling to draw a sample in alignment with the Aetna KanCare provider network composition. Consider a sample size greater than 1,500 providers.
3. Determine the reason for such a large number of ineligible surveys and take steps to address identified issues.

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. Consider using stratified random sampling to draw a sample in alignment with the Sunflower provider network composition.
3. Determine the reason for such a large number of ineligible surveys and take steps to address identified issues.

UnitedHealthcare

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

1. Consider using stratified random sampling to draw a sample in alignment with the UnitedHealthcare KanCare provider network composition.
2. Include a phone follow-up component to the multi-mode methodology; send second questionnaire to the non-respondents.

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

Background/Objectives

The Medicaid and CHIP Managed Care Regulations[7] require performance of independent, external reviews of the quality and timeliness of, and access to care and services provided to Medicaid beneficiaries by MCOs. The objective of KFMC's 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.

The process was updated in 2019 to spread the review of regulations over the three-year period, with KFMC conducting approximately one third of the review each year, along with needed follow-up. Since Aetna's MCO contract was effective January 1, 2019, KFMC completed most of their full regulatory compliance review in 2019. KFMC's compliance review reports for the 2019 review were submitted in August 2020 and are included in this annual EQR Technical report. KFMC's 2020 regulatory compliance reviews will be individually reported in 2021 and included in the spring 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. In addition, KFMC compiled findings in a worksheet based on the EQR Protocol 3 documentation and reporting tool template developed by the 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 Site 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 regulation, and case files for coordination of care, grievances, appeals, and provider credentialing.

The following Medicaid Managed Care Regulatory Provisions were reviewed:

- Subpart C – Enrollee Rights and Protections (Aetna only)
- Subpart D – Quality Assessment and Performance Improvement
- Subpart E – Quality Measurement and Improvement
- Subpart F – Grievance System

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

KFMC utilized the levels of compliance as defined in the EQR Protocol 3 and results were compiled into a tabular format for reporting on each category. Please refer to the individual MCO 2019 Review of Compliance with Medicaid and CHIP Managed Care Regulations reports for more detail.

Conclusions Drawn from the Data Common Among the MCOs

Compliance

Common Among the MCOs

For each of the MCOs, Subpart F, Grievance System, had the greatest opportunity for improvement.

Aetna

Overall, Aetna was 71% fully compliant with federal regulatory requirements (See Table 6.1). Subpart E, Quality Measurement and Improvement, scored the highest (86% fully met), and Subpart F, Grievance System, had the greatest opportunity for improvement (60% fully met). The only individual requirement that was minimally met pertained to documentation and communication of the Member's right to be provided, upon request and free of charge, reasonable access to all information relevant to the Member's Adverse Benefit Determination. No requirements were rated not met.

Table 6.1. Summary of Compliance Review – Aetna

Federal Regulations	Component Compliance*					
	FM	SM	PM	MM	NM	Components
Overall Compliance^	**71% (110/156)**	**9% (14/156)**	**20% (31/156)**	**1% (1/156)**	**0%**	**156**

* Number and percent of regulatory components that were: FM = Fully Met (100%), SM = Substantially Met (75% - 99%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).
^ Aetna's Overall Compliance is for Subparts C, D, E, and F; percentages may add up to more than 100% due to rounding.

Of the individual regulatory areas within Subparts C, D, E, and F, Aetna had the greatest opportunity for improvement, primarily with documentation, in the following:

- §438.114 Emergency and Poststabilization Services [Subpart C]
- §438.214 Provider Selection [Subpart D]
- §438.224 Confidentiality [Subpart D]
- §438.228 Grievance Systems [Subpart D]
- §438.404 Timely and Adequate Notice of Adverse Benefit Determination [Subpart F]
- §438.406 Handling of Grievances and Appeals [Subpart F]
- §438.408 Resolution and Notification [Subpart F]
- §438.414 Information about Grievance and Appeal System to Providers/Subcontractors [Subpart F]

Sunflower

Overall, Sunflower was 83% fully compliant with federal regulatory requirements (See Table 6.2). Subpart E, Quality Measurement and Improvement, scored the highest (100% fully met), and Subpart F, Grievance System, had the greatest opportunity for improvement (60% fully met). No requirements were rated not met or minimally met.

Table 6.2. Summary of Compliance Review – Sunflower						
Federal Regulations	**Component Compliance***					
	FM	**SM**	**PM**	**MM**	**NM**	**Components**
Overall Compliance^	**83% (52/63)**	**11% (7/63)**	**6% (4/63)**	**0%**	**0%**	**63**
* Number and percent of regulatory components that were: FM = Fully Met (100%), SM = Substantially Met (75% - 99%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%). ^ Sunflower's Overall Compliance is for Subparts D, E, and F; percentages may add up to more than 100% due to rounding.						

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

- §438.214 Provider Selection [Subpart D]
- §438.402 General Requirements [Subpart F]

UnitedHealthcare

Overall, UnitedHealthcare was 86% fully compliant with federal regulatory requirements (See Table 6.3). Subpart E scored the highest (100% fully met), and Subpart F had the greatest opportunity for improvement (60% fully met). There were no requirements that were not met or minimally met.

Table 6.3. Summary of Compliance Review – UnitedHealthcare						
Federal Regulations	**Component Compliance***					
	FM	**SM**	**PM**	**MM**	**NM**	**Components**
Overall Compliance^	**86% (54/63)**	**10% (6/63)**	**5% (3/63)**	**0%**	**0%**	**63**
* Number and percent of regulatory components that were: FM = Fully Met (100%), SM = Substantially Met (75% - 99%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%). ^ UnitedHealthcare's Overall Compliance is for Subparts D, E, and F; percentages may add up to more than 100% due to rounding.						

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

- §438.214 Provider Selection [Subpart D]
- §438.402 General Requirements [Subpart F]

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

Common Among the MCO

The MCOs are forward-looking, innovative, and have a proactive approach to improvement. Throughout the 2019 review cycle, each MCO was organized and responsive.

Aetna

- Aetna is able to directly access a number of hospital data systems.
- Aetna communicates with providers when discrepancies are found between the provider application and KMAP file. Aetna will encourage the provider to make sure the State has updated information.
- Aetna trains staff on Charting the Life Course, which includes educating staff about the member's power regarding care decisions and development of life goals. Aetna partnered with University of Missouri – Kansas City to train community providers and expand the focus beyond the member's medical needs to their entire life needs.
- Aetna developed the Care Unify population health platform to facilitate real-time quality assessment and improvement.

- Aetna's security procedures do not allow the opening of email attachments on company cell phones. Supervisors verify the appropriate access of protected health information (PHI) by staff, and they are notified when staff are accessing a lot of PHI.

Sunflower

- Sunflower information technology staff created auto-fill tools for field staff to ensure information captured is consistent and to reduce error.
- There is a trial check run review for claims to identify system issues and ensure timely payment of claims.
- Physicians are able to do home visits for home-bound members, with the option of the visiting physician becoming the member's PCP. Sunflower intends to expand this program.
- The "Centers of Excellence" educational opportunities allow for comparison against other Centene plans to improve Sunflower Health Plan performance. Local managers and directors participate on national Centers of Excellence teams and bring best and promising practices to the local plan.
- Quality Assurance committees are local, with participation from local providers.
- Sunflower Health Plan has an integrated medical record system.

UnitedHealthcare

- UnitedHealthcare has an innovative approach to implementation of pilot projects.
- There is collaboration with diverse partners and participation in community workgroups.
- The MCO formed a non-profit for a Medicaid Insights Transparency Initiative.
- The HCBS tableau dashboard allows for the ability to pull data and identify opportunities to address regarding utilization and patient care.
- UnitedHealthcare's experience and approach to cultural competency appears robust.

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

Common Among the MCOs

As a result of the 2019 Compliance Reviews, five main areas of opportunity common to the MCOs emerged: Information for Enrollees and Enrollee Rights; Availability, Access, and Coverage of Services; Coordination and Continuity of Care; Provider Selection; and Grievance, Appeal, and Notice of Adverse Benefit Determination.

- Information for Enrollees and Enrollee Rights: Opportunities for improvement related to this area included updates to member materials, *Member Handbook,* MCO policies, and/or *Provider Manual* regarding medical records.
- Availability, Access, and Coverage of Services: For this area, opportunities for improvement included updates to MCO policies, *Member Handbook,* and/or *Provider Manual* related to members' right to a second opinion.
- Coordination and Continuity of Care: Opportunities for improvement from this area pertained to provider education regarding coordination of services, follow-up to KFMC's case review findings, and updates to MCO policies, *Member Handbook,* and/or *Provider Manual* related to care coordination processes.
- Provider Selection: Opportunities for improvement emerged for this area regarding follow-up to KFMC's case review findings and updates to MCO policies, *Member Handbook,* and/or *Provider Manual* regarding provider credentialing and recredentialing.
- Grievance, Appeal, and Notice of Adverse Benefit Determination: For this area, opportunities for improvement included updates to MCO policies, *Member Handbook,* and/or *Provider Manual*

related to information provided to members, grievance system processes, and clarification for providers regarding the grievance, appeal, and/or state fair hearing process.

Aetna

- Information for Enrollees and Enrollee Rights: Opportunities for improvement were related to member enrollment materials and education for potential members regarding member rights, benefits, plan features, enrollment, disenrollment, advance directives, provider network, provider selection, service authorization, and medical records.
- Availability, Access, and Coverage of Services: For this area, opportunities for improvement included updates to MCO policies and procedures, *Member Handbook,* and/or *Provider Manual* related to types of services covered and service access, prior authorization requirements, service availability, and member cultural considerations.
- Coordination and Continuity of Care: In this area, opportunities pertained to policy and procedure updates, including staff education and information for members regarding the care coordination process.
- Grievance, Appeal, and Notice of Adverse Benefit Determination: Opportunities emerged in this area regarding follow-up to KFMC's case review findings and updates to policies, procedures, and member communications related to grievance, appeal, and state fair hearings. Recommendations included updates regarding processes, timeframes, member rights and responsibilities, and provider and staff education.

Sunflower

- Information for Enrollees and Enrollee Rights: Opportunities for improvement included updates to policy and procedure regarding dissemination of medical necessity criteria to members.
- Availability, Access, and Coverage of Services: In this area, there were opportunities for policy and procedure updates regarding telemedicine and cultural competency.
- Coordination and Continuity of Care: Opportunities for improvement pertained to policy and procedure updates regarding dually eligible members in care management.

UnitedHealthcare

- Information for Enrollees and Enrollee Rights: Opportunities for improvement were related to policy and procedure updates regarding medical records retention timeframes.
- Availability, Access, and Coverage of Services: In this area, there were opportunities for policy and procedure updates regarding documentation of vendor selection.

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

Aetna

Because Aetna's MCO contract began January 1, 2019, there are no prior recommendations.

Sunflower

There were 15 follow-up recommendations from the 2018 Sunflower Compliance Review report.

- Two were fully complete.
- Two were not complete.
- One was no longer applicable.
- Ten recommendations were added to the 2020 review, as those topics were included in year 2 of the updated review cycle (See Background/Objectives).

See Appendix D, Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed, for details.

UnitedHealthcare

There were 13 follow-up recommendations from the 2018 UnitedHealthcare Compliance Review report.

- One was fully complete.
- Four were not complete.
- Two were no longer applicable.
- Six recommendations were added to the 2020 review, as those topics were included in year 2 of the updated review cycle (See Background/Objectives).

See Appendix D, Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed, for details.

Recommendations for Quality Improvement

Recommendations are specific for each MCO regarding the opportunities for improvement identified. Refer to Appendix C for 2019 recommendations for Aetna, Sunflower, and UnitedHealthcare.

Aetna

Based on the areas identified for improvement, KFMC made 79 recommendations.

- 16 for Information for Enrollees and Enrollee Rights
- 12 for Availability, Access, and Coverage of Services
- 7 for Coordination and Continuity of Care
- 5 for Provider Selection
- 39 for Grievance, Appeal, and Notice of Adverse Benefit Determination

Sunflower

Based on the areas identified for improvement, KFMC made 16 recommendations.

- 2 for Information for Enrollees and Enrollee Rights
- 2 for Availability, Access, and Coverage of Services
- 3 for Coordination and Continuity of Care
- 6 for Provider Selection
- 3 for Grievance, Appeal, and Notice of Adverse Benefit Determination

UnitedHealthcare

Based on the areas identified for improvement, KFMC made 14 recommendations.

- 1 for Information for Enrollees and Enrollee Rights
- 2 for Availability, Access, and Coverage of Services
- 3 for Coordination and Continuity of Care
- 6 for Provider Selection
- 2 for Grievance, Appeal, and Notice of Adverse Benefit Determination

7. Quality Assessment and Performance Improvement (QAPI) 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. The State's Quality Management Strategy (QMS) aligns with QAPI program requirements outlined in the KanCare 2.0 contract, which requires MCO QAPI programs to:

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

KFMC's objectives were to review completeness of each MCO's 2020 QAPI design, examining strengths, identifying opportunities for improvement, and providing recommendations for improvement. The KanCare MCO contract was effective January 1, 2013, and re-awarded January 1, 2019 for both Sunflower and UnitedHealthcare. Aetna's KanCare MCO contract was effective January 1, 2019.

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

KFMC assessed the MCO QAPI program against the State contract requirements (see Table 7.1) and annual QAPI evaluations. State contract Section 5.9.1, Letter N, Number 6 stipulates the following:

- MCOs must complete an annual evaluation in Q1 of each new year;
- Findings and recommendations from the annual evaluation must shape the annual QAPI Program Description and annual QAPI Workplan; and
- 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, 2020 QAPI Review – Summary of Compliance, for a comprehensive list of annual QAPI evaluation requirements from all three sources (State, Federal, NCQA).

In addition to KFMC's 2019 QAPI review findings, the following items were reviewed for this report:

Aetna

- Aetna Quality Assessment Performance Improvement Program Description – 2019, 2020 (*Program Description*)

- Aetna QAPI Workplan – 2019, 2020 (*Workplan*)
- Aetna Quality Assessment and Performance Improvement Program Evaluation January – December 2019 (*Evaluation*)

Sunflower

- Sunflower Health Plan Quality Assessment and Performance Improvement Program Description – 2019, 2020 (*Program Description*)
- Sunflower Health Plan Medicaid QAPI Work Plan – 2019, 2020 (*Workplan*)
- Annual Quality Program Evaluation Sunflower Health Plan 2019 (*Evaluation*)

UnitedHealthcare

- UnitedHealthcare Community Plan KS Quality Improvement Program Description March 2019 (*Program Description*)
- 2019 C_S QI Work Plan Kansas CS (*Workplan*)
- UnitedHealthcare Community Plan (KS) Community & State 2019 Quality Improvement Evaluation March 2019 (*Evaluation*)
- UnitedHealthcare Community Plan (KS) Community & State 2019 Quality Improvement Program Description March 2019 (*Program Description*)
- 2020 KS QAPI Work Plan (*Workplan*)

Conclusions Drawn from the Data 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. 2020 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 Quarter 1	Fully Met	Fully Met	Fully Met
	Recommendations/findings from 2019 *Evaluation* are used to shape 2020 *Program Description* and *Workplan*	Partially Met	Partially Met	Partially Met
Annual Evaluation includes:	Completed and ongoing quality improvement (QI) activities outlined in 2019 *Program Description* and *Workplan*	Substantially Met	Substantially Met	Substantially Met
	Trending of QI results over time, including trending and outcomes for PIPs	Not Applicable*	Fully Met	Fully Met
	Comparison against performance objectives defined in *Program Description*	Fully Met	Fully Met	Fully Met
	Assessment of performance measures	Fully Met	Fully Met	Fully 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 includes:	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

- Practitioner profile interface to improve provider quality of care
- Inclusion of detailed Logic Model in QAPI documentation

Sunflower

- Identifying their plan strengths and accomplishments, included receiving a "Commendable" status during the annual NCQA reassessment

UnitedHealthcare

- Identifying their plan strengths and accomplishments, included receiving a "Commendable" status during the annual NCQA reassessment

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

Common Among the MCOs

The MCOs were generally compliant with the annual QAPI evaluation requirements as stipulated in the State contract, federal regulations, and NCQA requirements. KFMC identified the following opportunities for improvement for each MCO's QAPI program.

Aetna

- Aetna's *Evaluation* of their 2019 QAPI assessed most of the opportunities for improvement included in the 2019 *Program Description* and *Workplan,* except for:
  - Establish standards and perform audit functions for medical records documentation
- The opportunities for improvement identified in the 2019 *Evaluation* generally connect to the 2020 *Program Description* and *Workplan*. However, there were opportunities for improvement identified in the 2019 *Evaluation* that were not included in either the 2020 *Program Description* or 2020 *Workplan.* Examples include:
  - Engage and educate providers regarding authorization request requirements
  - Improving quality of communication and coordination between primary care and specialists
  - Incentives for high risk providers regarding notifying ABH of pregnant members
  - Increase awareness of appointment availability standards
  - Reconstruction of the LTSS service plan to meet State requirements
- The *Evaluation* of 2019 lists administrative results for unaudited and uncertified HEDIS measures, as HEDIS results were not available at the time of evaluation. The 2020 Program Description outlines responsibilities for the Quality Management Department, and one of these is to monitor 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 *Workplan* includes general activities related to HEDIS

(annual HEDIS training to staff and compare findings to previous year), but the *Workplan* lacks detailed interventions to address unmet goals regarding performance measures.

Sunflower

- Sunflower's *Evaluation* of their 2019 QAPI program assessed most of the opportunities for improvement included in the 2019 *Program Description* and *Workplan,* except for:
  - Increase medication management for people with asthma. Asthma is mentioned in the goals related to disease management programs, but this specific goal is not included, nor is it reported in the HEDIS measures
  - Provider and Member Quality Improvement Communications Plan
  - Assessment of Online Physician Directory
- The opportunities for improvement identified in the 2019 *Evaluation* generally connect to the 2020 *Program Description* and *Workplan*. However, there were opportunities for improvement identified in the 2019 *Evaluation* that were not included in either the 2020 *Program Description* or 2020 *Workplan.* Examples include:
  - Member Survey Opportunities for Improvement
  - Provider Survey Opportunities for Improvement
  - Continuity of Care between medical and behavioral healthcare
  - Appropriate diagnosis, treatment, and referral of BH disorders
  - Treatment access and follow-up for member with coexisting medical and BH disorders

UnitedHealthcare

- UnitedHealthcare's *Evaluation* of their 2019 QAPI program assessed most of the opportunities for improvement included in the 2019 *Program Description* and *Workplan.* Examples include:
  - Confirm member notification of PCP terminations within 30 calendar days of termination
  - Confirm member notification of continuity of care for SPC/PCP termination
  - Review and discuss marketing and NPS scores
  - Member Services Call Volume Update
  - EPSDT Promotion
- The opportunities for improvement identified in the 2019 *Evaluation* generally connect to the 2020 *Program Description* and *Workplan*. However, there were opportunities for improvement identified in the 2019 *Evaluation* that were not included in either the 2020 *Program Description* or 2020 *Workplan.*
  - The *Evaluation* reported most of the grievances regarding access issues were related to non-emergent transportation. Neither the *Program Description* nor *Workplan* describe how this opportunity for improvement will be addressed.
- KFMC was unable to assess whether all recommendations and findings from the 2019 *Evaluation* were used to shape the 2020 *Program Description* or *Workplan,* as not all findings were reported in the *Evaluation.* Some findings were reported in documentation separate from the QAPI *Evaluation*. For example:
  - 2019 Continuity and Coordination of Care report
  - 2019 Continuity and Coordination of Behavioral Health and Medical Care report
  - 2019 Population Health Management (PHM) Evaluation
  - Evaluation of national and health plan QI committee structure

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

Aetna

There were ten recommendations from KFMC's 2019 Review of Aetna's QAPI program documents. Aetna provided updates to prior recommendations, and KFMC determined

- seven moved to fully complete in 2020,
- one moved from partially complete to substantially complete, and
- two were still in progress.

Sunflower

There were seven recommendations from KFMC's 2019 Review of Sunflower's QAPI program documents. Sunflower provided updates to prior recommendations, and KFMC determined

- two moved to fully complete in 2020, and
- five were still in progress.

UnitedHealthcare

There were twelve recommendations from KFMC's 2019 Review of UnitedHealthcare's QAPI program documents. UnitedHealthcare provided updates to prior recommendations, and KFMC determined

- five moved to fully complete in 2020, and
- seven were still in progress.

Recommendations for Quality Improvement

Common Among the MCOs

1. Include assessment of all interventions outlined in the *Program Description* and/or *Workplan* in the annual *Evaluation.*
2. Address all opportunities for improvement and proposed interventions identified in the *Evaluation* in the subsequent year's *Program Description* and/or *Workplan*.

Aetna

1. In the 2021 *Workplan*, include interventions to address unmet performance measurement goals.

Sunflower

There were no recommendations for Sunflower beyond those under Common Among MCOs.

UnitedHealthcare

1. For all areas evaluated as part of the QAPI program, report findings in the annual *Evaluation.* For example, include high level results from the Continuity and Coordination of Care report in the annual QAPI *Evaluation* report.

8. Network Adequacy Validation

Background/Objectives

Managed care organizations (MCOs) contracted under the State of Kansas KanCare program must maintain sufficient provider networks to provide adequate access to covered services for all KanCare members. KDHE contracted with KFMC to begin provider network validation activities, while awaiting the CMS release of an EQR protocol for Validation of Network Adequacy. KFMC and KDHE devised an initial network validation activity to be conducted by KFMC: primary care provider (PCP) after-hours access monitoring.

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 2020 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 the MCOs. For each provider in the study contacted after hours by phone, the caller aimed to address specific objectives:

- Verify the accuracy of the provider phone number sourced from MCO provider directory.
- Categorize the call by result (*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.
- 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

Provider network reports and provider directory databases—each as of June 30, 2020—were obtained from each MCO. Dataset identification fields (e.g., name, address, phone) were cleaned; cleaning methods differed by MCO due to different conventions within identifying fields. Distinct counts of providers were obtained in each file using unique identifiers—National Program Identifier (NPI) and Kansas Medical Assistance Program identifier (KMAP ID)—and other identifying fields that were present. Unique PCP records were obtained from the cleaned 2020 Q2 provider network files, deduplicated by multiple methods, and merged with matching records in the 2020 Q2 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 1,334 PCP records.

Each distinct provider from the sample was included in a "record," which contained information on the provider and results from calls placed to the provider. KFMC's caller tracked findings from each call within an information system, including specific elements from the objectives and requirements described above. Calls were categorized according to the result of the call (e.g., reached intended provider, received answering machine, no answer). A quality reviewer performed inter-rater quality review for a proportion of calls, and a second reviewer was available to settle any conflicting dispositions between caller and quality reviewer.

Survey results were analyzed using descriptive statistics, and percentages were stratified by category. Results for each record were then assessed according to perceived member access or answering machine message quality. Records not possessing clear 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 to be "not met."

Description of Data Obtained

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 according to perceived member access or answering machine message quality. Summary tables were created that included counts of records meeting evaluation criteria and 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) to provide context.

Conclusions Drawn from the Data Common Among the MCOs

Findings from the study indicated 54% of sampled PCP records (719/1,334) were considered to be fully or substantially meeting KanCare requirements and the study's performance standards. A subset of sampled records (200/1,334; 15%) had minor issues, such as incomplete recordings or respondents unable to tell members when or if a provider could be contacted. Another subset of records (258/1,334; 19%) clearly did not meet requirements. Of those not met, 60% (155/258) were due to poor answering machine recordings, with no or unclear instructions, and 40% (103/258) were where the respondent indicated the provider could not be contacted after hours.

Some data quality or provider unavailability issues presented a barrier to concluding success or failure with relation to the KanCare requirements and study's performance standards. Calls for 4% of PCP records (52/1,334) were completed successfully, but the content of the call did not lead to conclusive evaluation against the requirements or standards, such as when the responding operator was unable to locate the provider in a hospital directory. Call attempts for 8% of sampled PCP records (105/1,334) were not answered, connected to a non-working number, disconnected, or otherwise did not lead to reaching a respondent or answering machine on behalf of the provider, which were also considered inconclusive. Inconclusive results were not evaluated according to the KanCare requirements or study standards as changes such as a provider leaving a practice may have occurred between receipt of provider data and completing the after-hours call.

Finally, inaccurate or outdated provider information were flagged when identified but did not count against PCP availability. Due to timing of call placement following receipt of provider contact information, it was unable to be determined whether the data was inaccurate or outdated upon receipt or if changes were made within provider practices after the 2020 Q2 data submission. For instance, some calls placed to providers led to a person or recording that indicated the phone number was incorrect. Additionally, some respondents told the KFMC caller that the listed provider was no longer practicing at that location.

In lieu of a contractual requirement from the State that obligates MCOs include specific availability terms or conditions in their PCP contracts, a written definition for after-hours non-emergent service availability may be needed to objectively evaluate after-hours availability. With almost one in every five PCP records determined to be non-compliant, KanCare MCOs and the Kansas health care system should take steps to address the issues related to the after-hours availability of providers.

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

- The State and MCOs continued to improve network data in 2020, and the State remains committed to continuing to work with the MCOs on improving data quality and reporting.

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.

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

This is the first year for network adequacy validation activities to be performed for KanCare, so there are no previous recommendations.

Recommendations for Quality Improvement

1. Review after-hours access study data provided by KFMC, through the State, that highlight specific provider issues, follow-up with the providers and report to the State on any internal policy changes and actions taken with providers.
2. 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.
3. 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.

Recommendations for Quality Improvement with Respect to Policy

1. The State should consider targeting one or more objectives in the Quality Management Strategy toward 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.
2. 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.

End of written report

Appendix A

KanCare Program Annual External Quality Review Technical Report

(2020–2021) 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 State during the 2020 –2021 reporting cycle.

ISCA and PMV

KFMC contracted with MetaStar, Inc. (an organization licensed by NCQA to perform HEDIS Compliance Audits) to conduct the PMV and ISCA follow-up of Aetna, Sunflower, and UnitedHealthcare.

ISCA: The ISCA is conducted biennially with the next ISCA scheduled for 2021. Follow-up to recommendations made during the 2019 ISCA was performed during the 2019 measure year (2020 calendar year) Performance Measure Validation.

PMV: Performance measures reported by each MCO were validated according to the 2019 CMS EQR Protocol 2, Validation of Performance Measures Reported by the MCO. Specifications for these measures can be found in the *HEDIS 2020 Volume 2, Technical Specifications for Health Plans.* All HEDIS measures were subject to validation.

- Aetna — *2019 ISCA Follow-up to Recommendations and 2020 Validation of Performance Measures for CY2019 of Aetna,* November 20, 2020.
- Sunflower — *2019 ISCA Follow-up to Recommendations and 2020 Validation of Performance Measures for CY2019 HEDIS of Sunflower,* November 20, 2020.
- UnitedHealthcare — *2019 ISCA Follow-up to recommendations and 2020 Validation of Performance Measures for CY2019 HEDIS of UnitedHealthcare,* November 20, 2020.

Performance Improvement Project Validation

- Aetna — *2020 PIP Annual Evaluation of Aetna, "Influenza Vaccination" (*July 1, 2019 to June 30, 2020), January 15, 2021; Year 1 PIP evaluation.
- Sunflower — *Evaluation of 2020 Sunflower SSD PIP, "Increasing the Rate of Diabetic Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications" Final Report (January 1, 2019 to December 31, 2019),* December 18, 2020; Year 3 PIP evaluation.
- UnitedHealthcare — *Evaluation of 2020 UnitedHealthcare SSD PIP, "Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medication" Final Report (January 1, 2020 to June 30, 2020),* October 6, 2020**;** Year 4 PIP evaluation.
- Collaborative HPV — *2020 Human Papillomavirus (HPV) Collaborative PIP Evaluation Final Report,* April 8, 2021; Year 5 PIP evaluation for Sunflower and UnitedHealthcare, and year 2 for Aetna.

CAHPS Health Plan 5.0H Survey Validation

KFMC completed a validation of the 2020 CAHPS surveys conducted by Aetna, Sunflower, and UnitedHealthcare.

- Aetna
  Sunflower
  UnitedHealthcare — *2020 CAHPS Health Plan 5.0H Survey Validation – Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas,* April 1, 2021. KFMC's validation of the 2020 CAHPS surveys conducted by each MCO from February through May 2020, includes separate survey results by MCO and subpopulation for adults, general child (GC) Title XIX/Medicaid (TXIX) members, GC Title XXI/CHIP (TXXI) members, Children with Chronic Conditions (CCC) TXIX members, and CCC TXXI members.

Mental Health Consumer Perception Survey

In 2020, KFMC contracted with Vital Research, LLC to administer the survey. KFMC provided operational oversight, analyzed survey data, and produced the written report. The Mental Health Statistics Improvement Program (MHSIP) survey tools (Youth Services Survey for Families and Adult Consumer Survey) are nationally standardized surveys. The survey was administered from October 13, 2020, to December 11, 2020.

- KanCare — *2020 Kansas Medicaid Mental Health Consumer Perception Survey,* March 18, 2021

Provider Satisfaction Survey Validation

KFMC completed a validation of the Provider Satisfaction Surveys conducted by the three MCOs conducted in 2020.

- Aetna — *2020 Provider Survey Validaton*, April 2, 2021. Aetna's survey was conducted from November 2020 through December 2020 by the vendor, SPH Analytics.

- Sunflower — *2020 Provider Survey Validaton*, April 2, 2021. The Sunflower survey was conducted from October 2020 through December 2020 by the vendor SPH Analytics.

- UnitedHealthcare — *2020 Provider Survey Validaton,* April 2, 2021. The UnitedHealthcare survey was conducted from September 2020 through November 2020. UnitedHealthcare partnered with Escalent to conduct this survey.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

A full review of MCO compliance with federal standards is required every three years and may be completed over the course of the three years. KFMC completed a full review for Aetna, as their MCO contract came into effect on January 1, 2019. Since KFMC completed full Sunflower and UnitedHealthcare regulatory compliance reviews in 2013 and 2016, with follow-up in the interim years, it was determined the 2019 review would involve around one-third of the review, with the remaining thirds occurring in the following two years along with needed follow-up.

- Aetna — *2019 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower,* August 5, 2020.

- Sunflower *2019 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower*, August 5, 2020.

- UnitedHealthcare *2019 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare,* August 5, 2020.

Quality Assessment and Performance Improvement Review

KFMC evaluated the completeness of each MCO's 2020 QAPI design, examining strengths, opportunities for improvement, and providing recommendations for improvement. KFMC assessed MCO QAPI programs against the State contract requirements in Section 5.9 of their KanCare 2.0 contract, "Quality Assessment and Performance Improvement," and annual MCO QAPI evaluations.

- Aetna *2020 QAPI Review*, April 28, 2021.

- Sunflower *2020 QAPI Review*, April 28, 2021.

- UnitedHealthcare *2020 QAPI Review,* April 28, 2021.

Network Adequacy Validation

KDHE contracted with KFMC to begin provider network validation activities, while awaiting the CMS release of an EQR protocol for Validation of Network Adequacy. KFMC and KDHE devised an initial network validation activity to be conducted by KFMC: primary care provider (PCP) after-hours access monitoring.

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 primary care providers (PCPs) presumed to be active in fall 2020 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 information available from MCOs.

- *Primary Care Provider After-Hours Access Monitoring,* April 2021.

Appendix B

KanCare Program Annual External Quality Review Technical Report

(2020–2021) Reporting Cycle

Performance Measure Validation 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 CY 2019 HEDIS performance measures according to the 2012 Centers for Medicare & Medicaid Services (CMS) protocol, "*External Quality Review (EQR) Protocol 2: Validation of Performance Measures Reported by the MCO*," (the Protocol).

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, two measures, the Timeliness of Prenatal Care indicator of Prenatal and Postpartum Care and Adolescent Well Care Visits, 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 visits, KFMC requested member-level files for 21 measures to validate MCO data against data residing in the State's Medicaid Management Information Systems (MMIS) reporting database. The following analysis was conducted for each MCO, and MCO-level results were compared against each other:

- Member enrollment with the MCO on the measures anchor date was verified for nine measures.
- Names and dates of birth were compared for consistency across records.
- Member-level files for Childhood Immunization Status, Immunizations for Adolescents, and Prenatal and Postpartum Care were compared to files of members meeting denominator criteria calculated from MMIS using HEDIS specifications.
- Monthly enrollment counts from the MMIS tables, stratified by age and gender, were compared to corresponding counts the MCOs reported for Mental Health Utilization.
- Inclusion of members with dual eligibility was verified for Cervical Cancer Screening and Comprehensive Diabetes Care.
- Impact of unsubmitted denied pharmacy encounters for Sunflower and Aetna was assessed.

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

Aetna

For the medical record review and reabstraction process, Aetna had only 12 Adolescent Well-Care Visits records meeting selection criteria (i.e., the information about the visit meeting numerator criteria was obtained from a medical record and not from administrative data). The difference was made up by re-abstracting 18 Postpartum Care indicator records.

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 2020, 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®[1] (QC). MCO and KanCare rates were ranked using the QC percentiles. The ranks are denoted, in order of worst to best performance: <5th, <10th, <25th, <33.33rd, <50th, ≥50th, >66.67th, >75th, >90th, and >95th. Note that, as QC rankings are based on national percentiles, some measures with high scores in Kansas may have very low QC rankings due to high scores nationwide. For example, a rate of 87 for one metric may rank <10th, while the same rate for another metric may rank >90th.

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

Aetna

Because Aetna became an MCO contractor in January 2019, HEDIS data for prior measurement years were not available. Aetna's 2019 measurement rates serve as baseline rates for future year analyses.

KanCare, Sunflower, and UnitedHealthcare

Changes in MCO and KanCare rates and QC rankings across years 2015 to 2019 were assessed. Amerigroup was included in KanCare aggregations from 2015–2018. Aetna data was included in KanCare rates for 2019, where available (for some measures, Aetna had few or no members meeting continuous eligibility criteria). Rates calculated by aggregating only Sunflower and UnitedHealthcare results were not assessed for changes across years and are not discussed within this report.

For each hybrid measure, annual changes between rates and the prior year's rates were tested for statistical significance using Fisher's exact or Pearson chi square. Within this report, a "significant change" means the differences in rates was statistically significant with probability (*p*) less than 0.05. Note, statistical tests on administrative rates with very large denominators may report very small changes as statistically significant.

Changes in rates between 2018 and 2019 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

(2019 Rate – 2018 Rate)/(Goal Rate – 2018 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. 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., not significantly different from 0 pp/yr) using Mantel-Haenszel chi square ($p < .05$ considered significant).

Appendix C

KanCare Program Annual External Quality Review Technical Report

(2020 – 2021 Reporting Cycle)

2019 Compliance Review Recommendations

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
Information for Enrollees and Enrollee Rights	
§438.10(c)(6)(v): Information Requirements: Basic rules (Information provided electronically):	1. 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.
§438.10(e)(2): Information Requirements: Information for potential enrollees:	2. Develop a policy for implementation regarding education for potential members addressing member rights, member benefits, and plan features.
§438.10(e)(2)(vi): Information Requirements: Information for potential enrollees (Formulary):	3. 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.
§438.10(e)(2)(viii) and related provision §438.68(a–e) Network Adequacy Standards (as it relates to Information Requirements for potential enrollees):	4. 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.
§438.10(e)(2)(x): Information Requirements: Information for potential enrollees (Quality and performance indicators):	5. 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*]
§438.10(f)(2): Information Requirements: General requirement (Member disenrollment):	6. 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)."
§438.10(g)(2)(i) and (ii)(A–B): Information Requirements: Information for enrollees of MCOs – Enrollee Handbook (Provided benefits):	7. 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.
§438.10(g)(2)(v-vi): Information Requirements: Information for enrollees of MCOs – Enrollee Handbook (Provided benefits):	8. 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."

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
§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:	9. In policy *4500.70 Advance Directives,* include the elements of the referenced State contract as well as reference the State legal authority.
	10. In the 2020 follow-up review, provide the contract agreements with the advance directive language.
	11. 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.
§438.10(h)(3–4): Information Requirements: Information for all enrollees of MCOs – Provider Directory:	12. Maintain a Provider Directory online that is up-to-date.
	13. 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."
§438.100(b)(2)(iv–vi): Enrollee Rights: Specific Rights (Basic requirement):	14. 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."
§438.224: Confidentiality (Medical records and other identifying information):	15. 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.
	16. 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*.]
Availability, Access, and Coverage of Services	
§438.114(d)(1-3): Emergency and Postabilization Services: Additional rules for emergency services (payment):	17. 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)*

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
§438.114(e): Emergency and Postabilization Services: Additional rules for emergency services (Pre-approval):	18. 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)*
§438.206(b)(2) Availability of Services: Delivery Network (Maintains and monitors a network of appropriate providers):	19. 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."
	20. 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."
	21. 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.
§438.206(b)(3) Availability of Services: Delivery Network (Second opinion):	22. 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.
§438.206(c)(1)(iii) Furnishing of Services: Timely Access (Evening and weekend appointment availability):	23. In the *Provider Manual* and related documentation, describe how evening and weekend appointment access standards are met.
§438.206(c)(2) Access and Cultural Considerations:	24. 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."
	25. 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."
	26. In the *Member Handbook*, include language that indicates members may choose their PCP based on cultural preference.
§438.210(d)(3): Coverage and Authorization of Services: Timeframe for decisions (Covered outpatient drug decisions):	27. 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.*

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
§438.330(b)(5)(i-ii): Quality Assessment and Performance Improvement Program: Basic elements (Assess quality and appropriateness for LTSS):	28. In the *ISC 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*.]
Coordination and Continuity of Care	
§438.208(a)(1): Coordination and Continuity of Care: Basic requirement:	29. In the 2020 follow-up, provide KFMC demonstration of the HSTs, HRAs, PCSPs 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.
§438.208(a)(3): Coordination and Continuity of Care: Basic requirement (Dually eligible enrollees):	30. 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."
§438.208(b)(2): Coordination and Continuity of Care: Care and coordination of services (Care Transition):	31. Ensure all appropriate Kansas staff are familiar with Aetna policy *7000.40 Member Transition* and that processes are being followed.
Case Review Related to §438.208 Coordination and Continuity of Care:	32. Aetna should reference the various documents by title in their Desktop document that represent compliance with the Health Screening, Health Risk Assessment, Needs Assessments, PCSP, and Plan of Service requirements and provide links or report templates in the policy and procedure documents.
	33. 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.
	34. 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).
	35. 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.
Provider Selection	
§438.214(c) and Related Provision §438.12(a-b): Provider Selection: Nondiscrimination (General rules):	36. 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.
	37. 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)*.

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection:	38. 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 NPDB check results beyond the checklist noting completion for providers 1, 2, 4,and 13). Skygen should provide documentation indicating the state's Board of Healing Art's sanction reason for Provider 5 was reviewed.
	39. 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.
	40. In the 2020 follow-up review, Aetna should provide credentialing documentation for cases 12, 13, and 15, or rationale for credentialing not needed.
	Grievance, Appeal, and Notice of Adverse Benefit Determination
§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file):	41. 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."
	42. 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.
	43. 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)
§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file):	44. 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.
§438.402(c)(3)(ii): General Requirements: Filing requirements (Procedures):	45. On page 67 of the *Member Handbook*, include "The Member or Member's Authorized Representative may submit an Appeal either orally or in writing."
§438.404(a): Timely and Adequate Notice of Adverse Benefit Determination: Notice:	46. 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.
	47. In policy *7100.05 Prior Authorization*, add the following to the first full paragraph on page 22 after the sentence beginning "A NOA sent to a member must be…": "The NOA 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."

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
§438.404(b)(2): Timely and Adequate Notice of Adverse Benefit Determination: Content of notice (Reasons for the adverse benefit determination):	48. 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."
	49. 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."
	50. Add this requirement to the "*Member Rights*" section in the *Member Handbook*, and all other documentation that includes the list of member rights.
§438.404(c)(1): Timely and Adequate Notice of Adverse Benefit Determination: Timing of notice:	51. Include these specific timeframes in Aetna policy *3100.70 Member Appeals.*
§438.404(c)(2): Timely and Adequate Notice of Adverse Benefit Determination: Timing of notice (Denial of payment):	52. 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."
§438.406(b)(1): Handling of Grievances and Appeals: Special Requirements (Acknowledge receipt):	53. 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."
§438.406(b)(2): Handling of Grievances and Appeals: Special Requirements (Grievances and appeals decisions):	54. 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."
	55. 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**

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
	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."
	56. 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.
§438.408(d)(1): Resolution and Notification: Grievances and Appeals (Format of notice: Grievances):	57. 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."
§438.408(d)(2)(i): Resolution and Notification: Grievances and Appeals (Format of notice: Appeals):	58. 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."
§438.408(f)(3): Resolution and Notification: Grievances and Appeals (Requirements for State Fair Hearings):	59. 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."
§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):	60. 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."*
	61. 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*.

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Aetna	
Case Review Related to §438.210 and Subpart F Grievance System:	62. 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).
	63. Aetna should follow up regarding Member 29 to ensure the grievance was resolved and communicated in the member's parent/guardian language preference.
	64. 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.
	65. Re-educate staff to capture who filed the appeal and whether the appeal was written or verbal.
	66. In the tracking system, include receipt of verbal or written appeal and note who made the appeal.
	67. In the Acknowledgement Letter, note who made the appeal.
	68. In the Appeal Decision Letter: Note who made the appeal and include date of appeal resolution.
	69. Include documentation of the Appointment of Representative Form (whether it was received or not).
	70. 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).
	71. 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).
	72. 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.
	73. For the 2020 Follow-Up Review, provide screenshots showing whether the grievances were filed in orally or in writing.
	74. Resolve expedited appeals within required timeframe.
	75. Send appeal acknowledgement letters for all appeals received and appeal decision letters for all resolved appeals.
	76. Re-educate staff to capture date of appeal resolution in the notice of appeal resolution.
	77. Re-educate staff to capture results of resolution process in notice of appeal resolution.
	78. Review Members 13, 24, 25, and 29 to verify resolution of appeal and whether resolution letters were sent.
	79. For the 2020 follow-up review, provide letter of disposition.

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Sunflower	
Information for Enrollees and Enrollee Rights	
§438.224: Confidentiality (Medical records retention):	1. 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*.)
§438.236(c): Practice Guidelines (Dissemination of guidelines):	2. 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."
Availability, Access, and Coverage of Services	
§438.206(b)(3) Availability of Services: Delivery Network (Second opinion):	3. 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.
§438.206(c)(2) Access and Cultural Considerations:	4. 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. Additionally, include the expanded language in Sunflower policy and procedure *KS.CONT.11: Telemedicine-Telehealth.*
Coordination and Continuity of Care	
§438.208(a)(3): Coordination and Continuity of Care: Basic requirement (Dually eligible enrollees):	5. 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.
Case Review Related to §438.208 Coordination and Continuity of Care:	6. Sunflower should review the specific cases and more current information to determine whether follow-up with the members and/or providers are needed. 7. 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.
Provider Selection	
§438.214(c) and Related Provision §438.12(a-b): Provider Selection: Nondiscrimination (General rules):	8. In the *QAPI Program Description*, revise the *Credentialing Committee* section to reflect the Committee will continue to be chaired by Sunflower's Medical Director.

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
Sunflower	
Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection:	9. 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).
	10. Sunflower should recheck the list of OIG Excluded Individuals/Entities using the provider's current name (Provider 20) and ensure all alternative names are checked going forward.
	11. In the 2020 follow-up review, Sunflower should provide evidence of the date of written notification to the provider regarding the credentialing decision.
	12. Sunflower should ensure the names/alternate names of all owners, managers, and Board members are checked against the exclusion databases/lists.
	13. 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.
	Grievance, Appeal, and Notice of Adverse Benefit Determination
§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file):	14. 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)
§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file):	15. 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.
§438.402(c)(3)(i): General Requirements: Filing requirements (Procedures):	16. 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.

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
UnitedHealthcare	
Information for Enrollees and Enrollee Rights	
§438.224: Confidentiality (Medical records retention):	1. 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.
Availability, Access, and Coverage of Services	
§438.206(b)(3) Availability of Services: Delivery Network (Second opinion):	2. 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."
§438.206(c)(1)(vi) Furnishing of Services (Timely Access):	3. 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.
Coordination and Continuity of Care	
Case Review Related to §438.208 Coordination and Continuity of Care:	4. UnitedHealthcare should review the specific cases and more current information to determine whether follow-up with the members and/or providers is needed.
	5. 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.
	6. Encourage and remind providers to follow-up and document test/procedure results and member notification, as well as follow-up regarding referrals and consultations.
Provider Selection	
§438.214(c): Provider Selection: (Non-discrimination):	7. 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.
§438.214(e) and Related Provision §438.12(a-b): Provider Selection: (State requirements):	8. 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.
Credentialing/Recredentialing Case Review Related to §438.214 Provider Selection:	9. KFMC recommends UnitedHealthcare review files or obtain an attestation to correctness of the submitted information from Provider 1.
	10. 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,

Compliance Review

Regulatory Area	*2019 Compliance Review Recommendations*
UnitedHealthcare	
	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.
	11. UnitedHealthcare should ensure the names/alternate names of all owners, managers, and Board members are checked against the exclusion databases/lists.
	12. UnitedHealthcare should provide the credentialing file for Provider 1, with rationale for denying the credentialing in Missouri and approving in Kansas.
	Grievance, Appeal, and Notice of Adverse Benefit Determination
§438.402(c)(1)(i): General Requirements: Filing requirements (Authority to file):	13. 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)
§438.402(c)(1)(ii): General Requirements: Filing requirements (Authority to file):	14. 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.

Appendix D

KanCare Program Annual External Quality Review Technical Report

(2020 – 2021 Reporting Cycle)

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

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
Common Among the MCOs		
Performance Recommendations		
1.	All MCOs should continue and expand their care coordination efforts and enhance service access for adult and child behavioral health services, due to low performance in Adult Antidepressant Medication Management, Adult Initiation and Engagement of Treatment for Alcohol or Other Drug Abuse and Use of Multiple Concurrent Antipsychotics in Children and Adolescents. **KFMC Update:** Kansas's service coordination strategy associated with the KanCare program (health screenings, health risk assessments, plans of care, etc.) has influenced the health and well-being of Medicaid beneficiaries. The State's Section 1115 Substance Use Disorder (SUD) Demonstration, approved by CMS in mid-2020 incorporates Kansas policy changes such as expanding service delivery by institutions for mental disease (IMDs) and allows for medication-assisted treatment (MAT). Sunflower has utilized a monthly letter campaign for members within the Antidepressant Medication Management (AMM) population and has reviewed care alerts for assigned members and addressed gaps through Depression Disease Management and collaboration with local public health departments and prescribers in late 2019. Sunflower referred members to LifeShare in 2019 and also held trainings with behavioral health and physical health staff that included discussion of antipsychotic medications, among other topics. UnitedHealthcare was approved in late 2020 to conduct a PIP focused on a subset of the AMM acute phase population; the PIP is still in the planning stage as of this Annual Technical Report.	Substantial Progress
2.	All MCOs should improve service utilization, access and care coordination for adolescent and adult women, particularly in the areas of Breast Cancer Screening, Chlamydia Screening, and Prenatal and Postpartum Care (Postpartum Care had the lowest rate). **KFMC Update:** Kansas policy changes for KanCare have influenced the health and well-being of Medicaid beneficiaries. Aetna was approved in late 2019 to conduct a PIP focused on pregnant members with aims to improve the Prenatal and Postpartum Care (PPC) – Timeliness of Care indicator; PIP interventions were initiated in late 2020. UnitedHealthcare was approved in mid-2019 to conduct a PIP focused on prenatal and postpartum care; PIP interventions were initiated in early 2020. Sunflower initiated additional interventions in 2019, that continued through 2020, for Prenatal and Postpartum Care (PPC), such as telephonic outreach to new mothers, perinatal Smart Start mailers, and incentives programs. Sunflower had a special focus on Breast Cancer Screenings (BCS) in 2019 and deployed interventions such as Provider Profiles, member education, member engagement reminders, and Medical Management outreach. UnitedHealthcare has also maintained two value-added benefits programs for prenatal and postpartum care (as indicated in 2019 QAPI): first trimester incentive and Healthy First Steps Reward Program.	In Progress

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
Common Among the MCOs		
Performance Recommendations		
3.	All MCOs should encourage providers to improve and expand communication between providers and members to encourage utilization of key child and adolescent preventive services with an emphasis on their importance for healthy development. MCOs should prioritize addressing low performance in Well-Child Visits, Weight Assessment and Counseling for Nutrition and Physical Activity, Childhood Immunization Status, and Immunizations for Adolescents (HPV has the lowest rate of three antigens). **KFMC Update:** Kansas policy changes for KanCare have influenced the health and well-being of Medicaid beneficiaries. KanCare MCOs and the State designed a collaborative PIP focused on Human Papillomavirus (HPV) vaccination in 2015. This PIP was concluded in 2021 and a final report will be submitted later in Spring 2021. The KanCare rates for Well-Child Visits in the first 15 Months of Life (6 or more visits) (W15) and Adolescent Well-Care Visits (AWC) displayed 10% or greater gap-to-goal improvements from measurement year 2018 that were also statistically significant. Multiple rates for Childhood Immunization Status (CIS) displayed 10% or greater gap-to-goal improvements from measurement year 2018: Haemophilus Influenzae B (HiB), Hepatitis A, Measles-Mumps-Rubella (MMR), Pneumococcal Conjugate, Rotavirus, and Varicella-Zoster Virus (VZV). Two rates for Immunizations for Adolescents (IMA) displayed 10% or greater gap-to-goal improvements from measurement year 2018 that were also statistically significant: Meningococcal and Combination 1; Combination 2 displayed a 10% or greater gap-to-goal improvement. Lastly, the MCOs each have a PIP focused on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) that was approved in mid-2019 with interventions starting by January 2020. Sunflower promoted the perinatal Smart Start program which included well-child visits, among other activities, and also utilized Proactive Outreach Management (POM) calls to parents of newborns to remind them of scheduling for well-child visits (AWC/W15/W34) and immunizations (CIS/IMA). Sunflower also engaged network physicians in 2019 with Pay for Performance incentives to ensure member completion of infant and adolescent immunizations (CIS/IMA).	Substantial Progress
4.	While rates for Children and Adolescents' Access to PCP remain greater than 85% in all age groups, monitor and assess potential need for intervention due to measure year 2018 decreases. All MCO's rates ranked <25th QC for children 12–24 months old. **KFMC Update:** The KanCare rate for Children and Adolescents' Access to PCP (CAP) – Ages 12–24 Months displayed a 10% or greater gap-to-goal improvement from measurement year 2018. The 2019 ranks for Ages 12–24 Months were <50th or better for all MCOs.	Substantial Progress

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
Common Among the MCOs		
Performance Recommendations		
5.	MCOs should continue to increase efforts and options to reduce smoking and tobacco use and to promote cessation. Consider coordinated efforts between MCOs to encourage providers to routinely give smoking and tobacco use cessation advice and to discuss medications and other methods to assist members with cessation. **KFMC Update:** The KanCare rate for Medical Assistance with Smoking and Tobacco Use Cessation (MSC) – Advising Smokers to Quit displayed a 10% or greater gap-to-goal improvement from measurement year 2018. From 2019 to 2020, Sunflower rates improved by over 8 percentage points for questions about advising smokers and tobacco users to quit and discussing cessation strategies; correspondingly, the percentage of respondents who smoked or used tobacco decreased (improved) by 4 percentage points. The changes are not statistically significant, so the results should be interpreted with caution.	In Progress
6.	MCOs should continue to increase efforts to ensure members receive a flu shot annually. Influenza has the lowest rate of the antigens for Childhood Immunization Status. **KFMC Update:** The increase in KanCare childhood influenza vaccination rates from 2018 to 2019 was statistically significant. Though Aetna was not included in the prior year's Annual Technical Report evaluation, the MCO was approved in mid-2019 to conduct a PIP focused on child and adolescent influenza vaccination; interventions were initiated in 2020.	In Progress
7.	When implementing these recommendations, MCOs should frequently assess their impact and determine if more targeted interventions are needed. Consider analyzing data to determine variation in rates by certain demographics. **KFMC Update**: MCOs routinely compare HEDIS rates to prior years; Sunflower and UnitedHealthcare also report performance according to NCQA Quality Compass (QC) benchmarks. Sunflower reviews specific performance and describes targeted interventions to address gaps. Prioritized process measures for interventions included within MCO PIPs are monitored monthly.	In Progress

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
Aetna		
Technical Recommendations		
1.	Aetna should continue to evaluate baseline performance measures and utilize regional and national quality improvement team knowledge and resources as it grows its own unique program. **Response:** Aetna utilized the corporate QI team as a resource as it prepared for the first year of HEDIS reporting.	Addressed
2.	Aetna should continue to explore supplemental data sources beyond the immunization registry, such as lab results files, electronic medical records (EMR) feeds, or other sources that may augment HEDIS rates. As with any supplemental data source, be sure to reach out to your HEDIS Auditor if questions arise as you identify potential supplemental data sources, since NCQA requirements for supplemental data are continuing to evolve. **Response:** Aetna implemented new supplemental data sources, including lab result files from Quest and LabCorp, as well as Continuity of Care Document data from Athena EMR.	Addressed
3.	Due to some timeliness issues with SkyGen's encounter data file submissions, which were identified through Aetna's vendor monitoring procedures, the managed care organization (MCO) required a corrective action plan (CAP) from the vendor. Aetna should continue close oversight of this vendor to ensure the CAP has been followed, and that timeliness of encounter submissions does not become an issue again. **Response:** Aetna continued its close oversight of its vendor, SkyGen, throughout 2019 utilizing weekly and monthly monitoring of encounter data files.	Addressed
4.	As Aetna prepares to produce performance measure rates for measurement year 2019, the MCO should ensure that all dual eligible members are included in the rates submitted for reporting. **Response:** Aetna ensured that performance measures for measurement year 2019 included all dual eligible members.	Addressed

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
Sunflower		
Technical Recommendations		
1.	Sunflower should work with its corporate team to ensure Roadmap sections and attachments for supplemental data are complete and specific to source. **Response:** Sunflower ensured that the Roadmap section 5 files for supplemental data were complete and specific to the supplemental data source.	Addressed
2.	Explore capabilities in TruCare to upload paper versions of health risk assessments (HRAs) until they can auto-upload from tablets/laptops. **Response:** Sunflower was able to ensure retention of hard-copy health risk assessments (HRA)s by scanning them and storing the images in the TruCare case management application.	Addressed
3.	It was discussed during the onsite that Sunflower did not retain hard copies of health risk assessments that had been entered into TruCare. Sunflower should implement mechanisms to scan or store the hard copy assessment forms for audit purposes. **Response:** Sunflower was able to ensure retention of hard-copy health risk assessments (HRA)s by scanning them and storing the images in the TruCare case management application.	Addressed
4.	Because no acknowledgement of receipt is received from vendors related to the MCO's provision of enrollment files, Sunflower should consider working with the vendors to obtain verification that the files were received. **Response:** Sunflower monitored its ancillary vendors' receipt of the MCO's enrollment files through the automated email notification that the file transfer was successful, or whether there was an issue or failure. There were no failures noted in 2019. In addition, Sunflower reviewed enrollment file receipt during its quarterly delegation oversight meetings, and each vendor provided details related to enrollment file processing including number of files received, processed, and turn-around time.	Addressed
Performance Recommendations		
5.	Sunflower should address low rates for Comprehensive Diabetes Care – Poor HbA1c Control and Adherence to Antipsychotic Medications for Individuals with Schizophrenia. **KFMC Update**: Sunflower was approved in 2016 to conduct a PIP focused on Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) and the PIP continued through December 2019 before being replaced in 2020 by a PIP focused on Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD). The SSD PIP population showed statistically significant improvement for HbA1c screening from 2016 to 2017 and maintained performance for 2018–2019, likely to continue through the SMD PIP. Both populations may have also benefitted in antipsychotic medication adherence. The remaining HEDIS sub-populations for the Comprehensive Diabetes Care (CDC) – Poor HbA1c Control and Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA) may have benefitted somewhat from Sunflower's PIP activities.	In Progress

ISCA and PMV

	Follow-Up to Prior Recommendations (2019)	*Status*
UnitedHealthcare		
Technical Recommendations		
1.	Due to change in methodology, the measurement year 2018 Timeliness of Prenatal Care indicator of the Prenatal and Postpartum Care measure should not be trended with prior years' rates. **Response:** Analysis conducted by KFMC, including results within the Annual Technical Reports, breaks trending of Timeliness of Prenatal Care between 2017 and 2018 for KanCare and UnitedHealthcare.	Not Addressed
2.	Because March Vision and SkyGen vendors did not meet performance expectations periodically during 2018, UnitedHealthcare should continue its rigorous monitoring of these vendors' data. **Response:** UnitedHealthcare assigned a vendor manager for March Vision and SkyGen Dental that reports directly to the MCO's Chief Operating Officer; held monthly joint operating committee meetings with both March Vision and SkyGen Dental, where a review of their monthly scorecard was conducted; conducted bi-weekly encounter reviews and weekly touch points with March Vision and SkyGen Dental; and performed an annual audit of each delegated provider.	Addressed

Performance Improvement Projects (PIPs)

	Follow-Up to Previous Recommendations (2019)	*Status*
MCO Collaborative PIP – HPV		
1.	The MCOs should include, with their findings, the interpretations and lessons learned regarding comparisons among measurement years and among MCOs. **Response:** The MCOs addressed lessons learned from conducting this PIP and also provided interpretations for the results of the HPV vaccine rates.	Fully Addressed
2.	Provide more detailed information regarding criteria used and rationale for determining who receives an intervention when 100% are not included. **Response:** The MCOs provided the following response in their annual report: *"The MCOs had determined member outreach interventions would follow a new approach in 2021. To have a more effective comparison of individual interventions and to standardize the outreach among the MCOs, the methodology for member outreach interventions was to be modified to include one control group, consisting of members who will not have received any outreach, and each outreach intervention (member letters, outreach phone calls, and member brochures) would be administered to a de-duplicated, randomized selection of members across the state. Details of randomization and comparison for study were under development for implementation by 2nd Quarter 2021. Sampling details and rationale would have been included in the 2021 Annual Report. This PIP was discontinued as of 12/31/2020, therefore this recommendation will be taken into consideration when writing future PIPs."*	Fully Addressed
3.	Evaluate the impact on the measurement of members receiving a dose of the HPV vaccine within 90 days after successful telephone outreach when they are calling parents/guardians six months prior to the member's birthday. Depending on the impact study, the MCOs may determine they want to review outcomes within 90 days after the successful call and again to review completion of the vaccination series by the 13th birthday for those with successful calls six months prior. **Response:** In the annual report the MCOs evaluated the Impact of members receiving a dose of the HPV vaccine within 90 days after successful telephone outreach.	Fully Addressed
4.	Evaluate the different elements of the "unable to reach" letter process, such as wording of the letter, and requiring the parent/guardian to call the MCO. Currently, the only outcome measure is the "*number of members who received a dose of the HPV Vaccine within 90 days of the Phone response call to the "Did Not Contact" letter."* Consider also evaluating the number of members with a letter sent that received a vaccination after receipt of the letter, without having called the MCO; this would help evaluate the effectiveness of the letter, or whether requiring a response phone call is impacting a low follow-up vaccination rate. **Response:** The MCOs stated in the annual report, *"During the 2020 PIP year, it was determined that a standardized "Did Not Reach" letter should be utilized that included information related to the HPV vaccination as well as contact information for the members assigned MCO. This was to be implemented during 2021 with evaluation in the 2021 Annual Report; however, this PIP was discontinued as of 12/31/2020."*	Fully Addressed

Performance Improvement Projects (PIPs)

	Follow-Up to Previous Recommendations (2019)	***Status***
MCO Collaborative PIP – HPV		
5.	Provide specific information regarding the method used for determining which providers are sent (mail, fax, secure email) or hand-delivered a Gap in Care report and when the information is sent. **Response:** The MCOs did not provide details in their report for how they determined which electronic method to use in distribution of their Gap in Care reports. In 2020, reports were not distributed in-person due to the COVID-19 pandemic.	Not Addressed
6.	Since the MCOs routinely use the Gap in Care reports (in-person, mail, and portal) as an intervention for their PIPs, it is recommended they work to identify a method for measuring whether the Gap in Care reports are being accessed through their portals. **Response:** The MCOs provided the following response in their report: "*Throughout 2020, the MCOs were unable to identify a method to evaluate whether Gaps in Care reports were being accessed through the Provider Portals. The MCOs planned to continue looking into this request throughout 2021, but with the PIP concluding 12/31/2020, this did not occur in time for Annual Report submission. The recommendation will be taken into consideration when developing future PIPs*."	Partially Addressed
7.	Since the Provider Profile reports appear to focus on a wide range of preventive measures and other performance, consider ways to focus on the HPV vaccination rates in the Provider Profile reports, for PIP purposes. **Response:** The MCOs provided the following response in their report: "*The MCOs had planned to combine the Gaps in Care reports and Provider Profile reports into a single intervention in 2021 in order to improve consistency amongst the information providers receive from the three MCOs. However, with the HPV PIP concluding 12/31/2020, this intervention adjustment did not occur. The recommendation will be taken into consideration when developing future PIPs*."	Fully Addressed

Performance Improvement Projects (PIPs)

	Follow-Up to Previous Recommendations (2019)	***Status***
Sunflower PIP – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
1.	Provide an explanation in the 2019 annual report for why the SSD measure denominator has been much larger than the population identified for the spring mailers, which has been reported as sent to the entire PIP population. **Response:** Sunflower explained in the 2019 report that members continued to be identified and added to the SSD denominator during the measurement year and not every SSD member will have been identified by the time of the spring mailer.	Fully Addressed
2.	In the 2019 annual report, include the definition of a successful contact for a mailer ("*delivered to an address and not returned*") to reflect the current measurement. **Response:** Sunflower provided a definition for received mailer, "*mailer was not returned to Sunflower's office*" and also for did not receive mailer, "*mailer was returned to Sunflower's office*."	Fully Addressed
3.	Revise the time period in the numerator for the spring and August mailer intervention from "measurement year" to "90 days after member mailer sent" to reflect the current measurement. **Response:** Sunflower modified the numerator description as recommended (in the 90 days after the mailer was sent) for both "received mailer" and "did not receive mailer."	Fully Addressed
4.	Specify in the 2019 annual report the number of attendees for each staff training, content of the trainings, and who the audiences were. **Response:** Sunflower provided more details of the training in the 2019 final report that clarified the content, timeframes, and staff who participated.	Fully Addressed
5.	While activities for this PIP ended in 2019, Sunflower initiated a new intervention in September 2019 with primary care physicians to provide them the diabetes screening compliance status of their assigned/attributed members. This intervention was added as part of Sunflower's transition to their new SMD PIP. However, Sunflower should continue monitoring the SSD rate to determine whether changes are needed to sustain improvements achieved during the PIP. **Response:** Sunflower did not indicate in the annual report if they would continue to monitor the SSD rate; however, the 2020 SSD rate (reflecting 2019 performance) was 81% and in 2019 the rate was 80%. Therefore, this recommendation is considered fully addressed. Their comments mentioned using lessons learned from the SSD PIP for their new PIP including: "*Since these are similar populations, Sunflower is able to review the type of interventions that worked within the SSD project for potential application with the SMD project. Due to the success within the SSD study, member outreach by phone or in person is an intervention that will be incorporated into the SMD study."*	Fully Addressed

Performance Improvement Projects (PIPs)

	Follow-Up to Previous Recommendations (2019)	***Status***
UnitedHealthcare PIP – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic		
1.	Fully update the definition for PIP eligibility with any changes in the HEDIS technical specifications. Clarify whether the additional diagnosis of schizoaffective disorder was included when determining members eligible for the interventions. **Response:** UnitedHealthcare did not address this recommendation. However, KFMC verified the list of diagnosis codes did not change when schizoaffective disorder was added to the measure description between measurement years 2017 and 2018.	Not Addressed
2.	Report the number of times the provider portal (if possible, more specifically the Gap-in-Care reports through the provider portal), is accessed in total and by tax identification number during the measurement year. **Response:** UnitedHealthcare did not provide any data in their annual report regarding the provider portal; however, the level of activity for this intervention was impacted by the COVID-19 pandemic.	Not Addressed
3.	If a similar intervention is used in future PIPs, the paired member, prescriber and primary care provider mailings should occur earlier in the year to allow enough time to fully evaluate their effectiveness. Consider ways to improve this intervention to increase effectiveness. **Response:** UnitedHealthcare did not comment on this recommendation in their 2020 Supplemental Report.	Not Addressed
4.	In the 2019 final report for the SSD PIP, an overall summary and assessment of this PIP should be provided, including the following: • Key outcome results (including statistical evidence of any observed improvement that might reasonably have resulted from the interventions); • Drivers for the success; • Foreseen sustainability of the outcomes; • Aspects of the PIP that will be incorporated into standard practice within the MCO; and • Lessons learned applicable to their new SMD PIP. **Response:** UnitedHealthcare provided an overall summary and assessment of the SSD PIP with comments addressing these items.	Fully Addressed

CAHPS Health Plan 5.0H Validation

	Follow-Up to Previous Recommendations (2019)	Status
Common Among Sunflower and UnitedHealthcare		
1.	For the child surveys, each MCO should continue complying with NCQA CCC survey protocols to ensure adequate numbers of complete surveys in each subgroup to obtain generalizable results that meet NCQA requirements. **KFMC Update:** Each MCO complied with NCQA CCC survey protocols related to sampling and sample sizes. The MCOs oversampled for both the general child and CCC supplemental samples.	Completed
2.	All MCOs should continue and expand their care coordination efforts, particularly for children with chronic conditions, to promote improvement of MCO and provider assistance in coordinating the child's care among different providers and services. Consider obtaining feedback from members (e.g., through supplemental CAHPS questions, patient and family advisory committees, focus groups) to better understand their expectations regarding CCC coordination of care, the type of assistance, if any, they want, and how the MCO and providers can improve. **KFMC Update:** Coordination of Care composite scores increased from 2019 to 2020 for KanCare adult, GC, and CCC populations. The 2016–2020 trendlines are increasing. However, the Coordination of Care for Children with Chronic Conditions composite score for 2020 decreased from the 2019 score for the KanCare CCC population. Efforts by the State and MCOs during 2019 and 2020 to improve coordination of care included the following: • Revising and expanding health risk assessments • Development of the OneCare Kansas program—a comprehensive and intense method of care coordination for Kansas Medicaid members who qualify. OneCare Kansas integrates and coordinates all services and supports with the goal of treating the *"whole person"* across the lifespan. To be eligible, members must have either a diagnosis of paranoid schizophrenia, severe bipolar disorder, major depressive disorder or asthma with a risk of developing one of 10 listed comorbidities (diabetes, hypertension, kidney disease, cardiovascular disease, COPD, metabolic syndrome, mental illness, substance use disorder, morbid obesity, tobacco use, or exposure to second hand smoke).* • Initiating Performance Improvement Projects (PIPs) – Several PIPs include aspects of case management outreach, including Aetna's PIPs for prenatal care and for decreasing non-emergent use of emergency department visits by members in the Home and Community Based Services program who are not in long-term care, and Sunflower's and UnitedHealthcare's PIPs for diabetes monitoring for people with diabetes and schizophrenia. • Training Providers – Sunflower's and UnitedHealthcare's websites host provider training webcasts and other resources for improving coordination of care. * https://www.kancare.ks.gov/consumers/onecare-ks-members/eligibility-for-onecare-kansas. Diagnosis of major depressive disorder was added April 1, 2021.	Substantial Progress

CAHPS Health Plan 5.0H Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among Sunflower and UnitedHealthcare		
3.	MCOs should encourage providers to improve and expand communications between providers and members regarding illness prevention. Both MCOs should consider methods to evaluate the effectiveness of provider communications, trainings and education to help determine whether changes to the improvement efforts are needed prior to 2020. **KFMC Update:** Several PIPs include sending providers lists of members due, or overdue, for preventive services, such as cervical cancer screenings, diabetes screenings, and immunizations.	Completed
4.	MCOs should increase efforts to promote Shared Decision Making between providers and the members. **KFMC Update:** The Shared Decision Making composite was removed from CAHPS by NCQA, which prevented assessment of this recommendation using CAHPS scores. Sunflower and UnitedHealthcare's websites indicated provider training was completed, or available online, that included aspects of member-provider communications related to the Shared Decision Making composite.	Completed
5.	MCOs should further review their processes for encouraging providers to assess and respond to members' mental health and emotional health issues, and for encouraging members to access mental health or substance use disorder services. **KFMC Update:** The decline of Rating of Mental or Emotional Health rates indicates a continued need for improvement. Statewide improvement efforts related to mental or emotional health include expanding authorization of telemedicine. In August 2019, CMS approved the implementation plan for Kansas's Section 1115 Substance Use Disorder (SUD) Demonstration, which will indirectly affect mental or emotional health of members with SUD. Sunflower also initiated a PIP for increasing access to mental health services for members in foster care. Their multifaceted intervention approach is targeting members, guardians and provider needs. Provider training material was available on the MCOs' websites, such as UnitedHealthcare's *"Behavioral Health Toolkit for Medical Providers."*	In Progress

CAHPS Health Plan 5.0H Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among Sunflower and UnitedHealthcare		
6.	MCOs should continue to increase efforts and options to reduce smoking and tobacco use and to promote cessation. Consider coordinated efforts between MCOs to encourage providers to routinely give smoking and tobacco use cessation advice and to discuss medications and other methods to assist members with cessation. **KFMC Update**: Responses to the four questions related to smoking, tobacco use, and cessation strategies indicated improvement from 2019 to 2020. Comparisons to Quality Compass percentiles showed continuing opportunities for improvement. From 2019 to 2020, Sunflower rates improved by over 8 percentage points for questions about advising smokers and tobacco users to quit and discussing cessation strategies; correspondingly, the percentage of respondents who smoked or used tobacco decreased (improved) by 4 percentage points. The changes are not statistically significant, so the results should be interpreted with caution.	In Progress
7.	MCOs should continue to increase efforts to ensure members receive a flu shot annually. Consider obtaining feedback from members and providers (e.g., additional survey questions, focus groups, patient and family advisory councils, provider advisory groups) regarding barriers to annual flu vaccinations. Assess whether more targeted interventions are needed; consider analyzing data to determine variation in rates by certain demographics. **KFMC Update**: The 2020 Flu Vaccinations for Adults 18–64 rate for KanCare (52%) ranked >75th. The average increase from 2016 to 2020 in KanCare rates was 2.1 percentage points per year. Aetna initiated a PIP to improve influenza vaccination rates for their members ages 6 months to 17 years, including members with severe emotional disturbance, intellectual/developmental disabilities, and those with chronic asthma. This PIP may indirectly improve the vaccination rates for adults (parents and guardians may receive a vaccination with their child, and children may continue to receive annual flu vaccinations as they cross into adulthood).	Substantial Progress

Mental Health Consumer Perception Survey

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
Recommendations for Quality Improvement		
1.	**For Adult members, explore methods to increase positive results and mitigate trends among the following:** a. Involvement in peer- or consumer-led programming (Service Quality and Appropriateness). b. Increasing effectiveness of crisis services (Crisis Management and Outcomes). c. Coordinate services to provide housing stability (Outcomes). d. Enhancing feelings of control; independence; social and community connections; and doing better in school and/or work (Outcomes, Improved Functioning, and Social Connectedness). e. Reducing symptoms (Outcomes and Improved Functioning). f. Ability to see a psychiatrist when wanted, in conjunction with other MCO Access Monitoring (Service Access). g. Members feeling like they decided their treatment goals (Participation in Treatment Planning). h. Explore methods to help members obtain employment when wanted. **KDADS Response:** In 2020, the Kansas Department for Aging and Disability Services has focused on creating a comprehensive crisis response model in accordance with SAMHSA's National Guidelines for Behavioral Health Crisis Care Best Practices. These efforts include improving statewide and regional crisis call service, planning for mobile behavioral health crisis capacity for youth and adults, and expanding the number of crisis receiving and stabilization facilities in the state. These facilities will increase access to psychiatric care, licensed clinicians and peer support and ensure coordinated connection to ongoing care.	Ongoing
2.	**For Youth members, explore methods to increase positive results and mitigate trends among the following:** a. Interpersonal relationships at home, with peers, and others (Outcomes, Improved Functioning, and Social Connectedness). b. Doing better in school and/or work (Outcomes and Improved Functioning). c. Coping strategies (Outcomes and Improved Functioning). d. Satisfaction with family life right now (Outcomes). e. Availability of crisis services (Crisis Management). f. For both Adults and Youth, continue expanding availability of providers and services, including psychiatrists, crisis services, and options for services at different times of day and on weekends. **KDADS Response:** The Kansas Department for Aging and Disability Services has also worked on expanding the statewide System of Care through the Kansans Together initiative. This collaborative work has aimed to improve behavioral health outcome for children and youth with mental health needs. Kansans Together is guided by the principles that youth services in Kansas should be family driven, youth guided, trauma-informed, culturally and linguistically competent, and community-based.	Ongoing

Mental Health Consumer Perception Survey

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
	KDADS has also continued support of the Youth Leaders in Kansas (YLinK) program. YLinK supports youth with serious emotional disturbance by providing an array of services aimed at improving family and peer relationships, community engagement, education or employment support and self-advocacy skills.	
Technical Recommendations		
3.	**For future survey administration, explore alternative data sources to determine if better quality contact data exist for the survey populations.** **KFMC Response:** An alternative data source was not determined.	Ongoing

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
1.	**Revise Survey Instrument** All MCOs should include questions with same language in the survey instrument to provide comparative results to assess how well the plans are meeting their providers' expectations and needs, and to identify common and unique strengths and opportunities for improvement across the MCOs. **KFMC Response:** MCOs did not provide a 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.
2.	**Ensure alignment of survey methodology with the purpose/objective of the survey** Ensure the study population, sampling frame and selected survey sample are in alignment with the intended purpose of the survey. **Aetna Response:** "*Aetna feels the survey methodology conducted by SPH meets the purpose of the study. In the 2020 survey Aetna opened the survey to all provider types as we felt this was the appropriate decision to include all Medicaid provider types. As you are aware in 2019 only PCPs were sampled.*" **KFMC Response:** The 2020 Survey study populations for the Aetna and Sunflower surveys were comprised of their Provider Networks including the Primary Care Physicians (PCPs), Specialists, Behavioral Health (BH) Clinicians and HCBS providers; however, their survey samples only included the PCPs, Specialists and BH Clinicians and excluded the HCBS providers. The intended purpose of the survey described by both MCOs is directed towards the assessment of the satisfaction of their network's providers with the MCOs' services; therefore, alignment of the study population, sampling frame and sample of the survey with the composition of MCOs' provider networks is essential. UnitedHealthcare did not provide a response. UnitedHealthcare did not address this recommendation or provide the information in the 2020 Survey Report.	**Partially Addressed:** Aetna and Sunflower. **Not Addressed:** UnitedHealthcare.
3.	**Ensure generalizability of the survey findings to the intended study population** Ensure generalizability of the survey findings to the intended study population by applying robust probability sampling method, alignment of the sampling frame and selected sample with the composition of the study population, sufficient sample size, and achieving an adequate response rate and number of completed surveys. **Aetna Response:** "*In 2019 only, PCPs were selected for the sample and in 2020 it was increased to include all providers in our network. Going forward to the 2021 review we will be discussing with SPH how to better address the alignment of the sample size in relationship to the network to provide the best sample population.*"	**Partially Addressed**: Aetna **In Progress:** Sunflower. **Not Addressed:** UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	Status
Common Among the MCOs		
	Sunflower Response: "*Sunflower Health Plan is currently working to include LTSS/HCBS category as a Provider Type in our 2020 Access Survey. A separate script with distinctive questions around LTSS/HCBS providers will be developed and submitted to the State of Kansas for approval. Additionally, Sunflower Health Plan will explore ways to increase Behavior Health provider in the Provider Satisfaction Survey sample. These actions will help achieve a statistically significant survey sample for both HCBS and Behavioral Health provider populations in the surveys.*" **KFMC Response:** Aetna applied simple random sampling; the composition of the survey sample was not in complete alignment with the study population's composition due to the exclusion of HCBS providers, although Aetna mentioned they are working on it. Aetna did not address other aspects of the recommendation. Sunflower's 2020 Survey Report did not mention the sampling method used to draw the survey sample; the composition of the survey sample was not in complete alignment with the study population's composition due to the exclusion of HCBS providers and inclusion of a small number of BH Clinicians, although Sunflower mentioned they are working on it. Sunflower did not address other aspects of the recommendation. UnitedHealthcare did not provide a response. UnitedHealthcare's 2020 Survey Report did not describe the sampling methodology. The information regarding the composition of the survey's study population, sampling frame and sample was not provided. Other aspects of the recommendation were also not addressed. UnitedHealthcare has had low number of completed surveys for multiple years with no improvement.	
4.	Ensure an adequate number of completed surveys to achieve a valid number of respondents for the individual questions of the survey. **Aetna Response:** "*For the 2020 survey Aetna utilized the addresses registered with KDHE in their provider file. We expect an improvement in in the bad address file and upon receipt of the file we will work with the provider to update their address to the state system, so it reflects correct. SPH recommends a sample size of 1500 providers to qualify to meet the survey.*" **Sunflower Response:** "*Steps will be taken to improve the response rate and number of completed surveys, such as* ○ *Exam reason for such a large number of ineligible surveys.* ○ *Identify and mitigate the issues for low return of complete surveys by providers.* ○ *Plan to use a two-wave mail and internet component methodology.* ○ *Sending a second questionnaire to non-respondents.* ○ *A minimum accepted response rate will be defined to calculate a sufficient sample size to further increasing the number of complete surveys.* ○ *Take steps to ensure provider contact information (mail, phone, and email) is updated for accuracy.* ○ *Ensure appropriate timings for fielding.*"	**Not Addressed:** Aetna, Sunflower and UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
	KFMC Response: A response was not provided by the UnitedHealthcare. All three MCOs had considerably low overall number of completed surveys (Aetna: 122; Sunflower: 171; and UnitedHealthcare: 46) and low overall response rates (Aetna: 8.1%; Sunflower 8.6%; and UnitedHealthcare: 2%) for their 2020 Surveys. None of the MCOs included numerators and denominators for the individual questions in the tables presenting the survey results in their Survey Reports; therefore, it was not feasible to assess whether the percentages calculated for the individual questions were valid.	
5.	Ensure inclusion of an adequate number of KanCare providers by provider type (including BH clinicians and HCBS providers) in the survey sample to achieve an adequate number of complete surveys to generalize the results to these segments of the MCO's provider network. **Aetna Response:** "*In 2019 only, PCPs were selected for the sample and in 2020 it was increased to include all providers in our network. Going forward to the 2021 review we will be discussing with SPH how to better address the alignment of the sample size in relationship to the network to provide the best sample population.*" **Sunflower Response:** "*Sunflower Health Plan is currently working to include LTSS/HCBS category as a Provider Type in our 2020 Access Survey. A separate script with distinctive questions around LTSS/HCBS providers will be developed and submitted to the State of Kansas for approval. Additionally, Sunflower Health Plan will explore ways to increase Behavior Health provider in the Provider Satisfaction Survey sample. These actions will help achieve a statistically significant survey sample for both HCBS and Behavioral Health provider populations in the surveys".* **KFMC Response:** Aetna's and Sunflower's 2020 Survey samples were comprised of KanCare providers; the HCBS providers were not included in the survey samples for both MCOs; Sunflower's survey sample included a low number of BH Clinicians with very few of them that completed the surveys (5 providers); and for Aetna's Survey, a considerably small number of PCPs and Specialists completed the surveys. Due to exclusion of the HCBS providers and an inadequate number of surveys completed by the provider types included in the survey samples (PCPs, Specialists and BH Clinicians), Aetna's and Sunflower's survey results were not generalizable to their provider networks and the provider segments. UnitedHealthcare did not provide a response. UnitedHealthcare's 2020 Survey Report did not mention whether the providers surveyed were KanCare providers or not. The study population and the survey sample composition were not described in the Survey Report. A demographic profile of the survey respondents presented in the Survey Report did not include BH Clinicians and HCBS provider categories.	**Partially Addressed**: Aetna and Sunflower. **Not Addressed:** UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	***Status***
Common Among the MCOs		
6.	**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. Further strengthen the survey methodology by ensuring frequent reminder notices/ follow-up, appropriate timings for fielding the survey, data collection over an adequate duration, and updated/correct contact information for tracking and contacting the providers. **Aetna Response:** *"In 2020 SPH did do a second round of mailings to the 1500 Survey targets. In addition, for the 2020 survey Aetna did take additional steps though educational Web forums such as our bi-weekly Executive calls, open to all providers, Aetna encouraged providers to complete the survey. We are looking at other methods for 2021 as well, such as posting a banner on our Provider Homepage, having our Provider Network Representatives include a by line on their Emails to providers during the survey period encouraging them to respond and also within our Provider Monthly Newsletter."* **Sunflower Response:** "*Steps will be taken to improve the response rate and number of completed surveys, such as* ○ *Exam reason for such a large number of ineligible surveys.* ○ *Identify and mitigate the issues for low return of complete surveys by providers.* ○ *Plan to use a two-wave mail and internet component methodology.* ○ *Sending a second questionnaire to non-respondents.* ○ *A minimum accepted response rate will be defined to calculate a sufficient sample size to further increasing the number of complete surveys.* ○ *Take steps to ensure provider contact information (mail, phone, and email) is updated for accuracy.* ○ *Ensure appropriate timings for fielding."* **KFMC Response:** Aetna used multi-mode methodology for their 2020 Survey, which included two-wave mail survey with internet and phone follow-up components. For the 2020 Survey, some of the recommended steps were applied by Aetna to improve the response rate. Sunflower used multi-mode methodology for 2020 Survey, which included one-wave mail survey with internet and phone follow-up components. For their 2020 Survey, some of the recommended steps were applied by Sunflower to improve the response rate. UnitedHealthcare did not provide a response. UnitedHealthcare used dual-mode methodology for 2020 Survey, which included one-wave mail survey with internet component; the telephone follow-up component was not included to the survey methodology; and the Survey Report did not mention the application of any other step described in the recommendation.	**Partially Addressed**: Aetna and Sunflower. **Not Addressed:** UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
	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. **Aetna Response:** "*No corrections implemented during fielding but high amount of bad address/ bad phone numbers which both contributed to the low response rate.*" **KFMC Response:** Sunflower and UnitedHealthcare did not provide a response. After receiving a considerably low number of completed surveys for their 2020 Surveys, all three MCOs did not apply corrective actions during fielding of the survey.	**Not Addressed**: Aetna, Sunflower and UnitedHealthcare.
7.	**Ensure data analysis results are appropriately interpreted** Ensure data analysis results are appropriately interpreted by documenting statistical testing performed per question and composite and clearly indicate when a finding is not statistically significant versus when response rates are too low. Limitations should be considered in the interpretation of the survey findings. **Aetna Response:** *"Aetna is currently awaiting the final report from SPH which should include the following:* ○ *Sample Methodology* ○ *Benchmark Comparisons* ○ *Composite Analysis* ○ *Segmentation Analysis* ○ *Correlation Analysis* ○ *Technical Notes* *Upon Receipt of this information we will provide additional information."* **KFMC Response:** This information (see Aetna's response) was not included in Aetna's final 2020 Survey Report. Sunflower and UnitedHealthcare did not provide a response. All three MCOs did not mention in their 2020 survey reports the statistical tests used for the data analyses. All three MCOs did not indicate when a finding was not statistically significant versus when not valid due to low response rate. All three MCOs did not consider the limitations related to the survey sample composition, insufficient sample size, low response rate and low number of complete surveys in the interpretation of the survey findings.	**Not Addressed:** Aetna, Sunflower and UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
8.	**Include detailed description of the contents of the survey design and administration in the survey report and accompanying documents** The sampling methodology description should include a clearly defined intended study population and its size; a clearly defined appropriate sampling frame and its size; and clearly described parameters (margin of error, confidence level, response rate) used in the sample size calculation. **Aetna Response:** "*The final Report should include the content information above as was provided in the 2019 Final Report.*" **KFMC Response:** This information (see Aetna's response) was not included in Aetna's final 2020 Survey Report. Aetna provided an accompanying document that only described the intended study population, whereas rest of the information mentioned in the recommendation was either lacking or not clearly defined. Sunflower did not provide a response. The recommended information was not provided in Sunflower's 2020 Survey Report. Sunflower provided information to KFMC that only described the intended study population, whereas rest of the information mentioned in the recommendation was either lacking or not clearly defined. UnitedHealthcare did not provide a response. The recommended information was not provided in UnitedHealthcare's 2020 Survey Report.	**Minimally Addressed:** Aetna and sunflower. **Not Addressed:** UnitedHealthcare.
9.	The survey administration tasks should be described in detail. **Aetna Response**: "*The final Report should include the content information above as was provided in the 2019 Final Report.*" **KFMC Response:** Aetna mentioned in its response (see above) that Aetna's final 2020 Survey Report will provide this information; however, the final Survey Report did not describe detailed survey administration tasks. Sunflower and UnitedHealthcare did not provide a response. The recommended information was not provided in Sunflower's and UnitedHealthcare's final 2020 Survey Reports.	**Not Addressed:** Aetna, Sunflower and UnitedHealthcare.
10.	The survey quality procedures applied for different steps of survey implementation should be included in the survey report with reference to the SPH QMP, which should be provided along with the survey report. **Aetna Response:** "*The final Report should include the content information above as was provided in the 2019 Final Report.*"	**Partially Addressed:** Aetna and Sunflower. **Not Addressed:** UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
	KFMC Response: Aetna provided to KFMC the SPH Analytics POPEngage Quality Management Program (SPH QMP) document. SPH QMP described quality management protocol and mentioned audits were conducted; Aetna's final 2020 Survey Report did not reference the SPH QMP or mention whether quality procedures were applied. Sunflower provided SPH Analytics Quality Assurance Plan (SPH QAP) document to KFMC. SPH QAP described quality management protocol and mentioned procedures were conducted; however, Sunflower's 2020 Survey Report did not reference the SPH QAP or mention whether quality procedures were applied. UnitedHealthcare did not provide a response. UnitedHealthcare's 2020 Survey Report did not mention application of quality management procedures and did not provide any reference to vendor's quality assurance procedures. UnitedHealthcare did not provide its survey vendor's quality management document to KFMC.	
11.	Any changes made to the study design during the implementation of the survey along with the reasons for making these changes should be described. **Aetna Response:** "*The final Report should include the content information above as was provided in the 2019 Final Report.*" **KFMC Response:** Aetna's final 2020 Survey Report did not provide this information. Sunflower and UnitedHealthcare did not provide a response. The recommended information was not provided in Sunflower's and UnitedHealthcare's final 2020 Survey Reports.	**Not Addressed:** Aetna, Sunflower and UnitedHealthcare.
12.	The survey report should reference all accompanying documents, particularly those including detailed methodologic descriptions. **Aetna Response:** "*The final Report should include the content information above as was provided in the 2019 Final Report.*" **KFMC Response:** Aetna's final 2020 Survey Report did not provide reference to the accompanying quality management document provided by the SPH Analytics (SPH QMP document). The final 2020 Survey Report did not include reference to any other document with regard to its survey methodology. Sunflower did not provide a response**.** Sunflower's 2020 Survey Report did not provide reference to the accompanying quality management document provided by the SPH Analytics (SPH QAP document). The 2020 Survey Report did not include reference to any other document with regard to its survey methodology. UnitedHealthcare did not provide a response. The recommended information was not provided in the 2020 Survey Report.	**Not Addressed:** Aetna, Sunflower and UnitedHealthcare.

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
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. **Aetna Response:** "*There is only one question in the survey that asks the provider to answer in relationship to the other health plans. This question was left in the survey and serves the sole purpose to our health plan as a snapshot in time of how our health plan is perceived in the market by the providers. The survey results are the area of importance we focus on related to the survey. Improvement in all functional areas is the focus of our organization."* **KFMC Response:** The questions in the "Demographics and Overall Satisfaction" categories of Aetna's 2020 Survey questionnaire were non-relative, whereas the questions in remaining seven categories (forty-nine 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**
2.	Consider using stratified random sampling to draw a sample in alignment with the Aetna provider network composition. **Aetna Response:** "*We will need to discuss this issue further with SPH to determine the effect on the random sample performed but Aetna does recognize input for rural and urban providers is important for the survey."* **KFMC** Response**:** Not addressed for 2020 Survey; however, as mentioned in the its response, Aetna will be discussing this recommendation with the Survey vendor (SPH Analytics).	**In Progress**
3.	Determine the reason for such a large number of ineligible surveys and take steps to address identified issues. **Aetna Response:** "*For the 2020 survey Aetna utilized the addresses registered with KDHE in their provider file. We expect an improvement in in the bad address file and upon receipt of the file we will work with the provider to update their address to the state system, so it reflects correct. SPH recommends a sample size of 1500 providers to qualify to meet the survey."* **KFMC Response:** Aetna noted that a high amount of bad addresses and bad phone numbers contributed to the low response rate. Aetna did not provide details regarding the number of bad address and phone numbers. Aetna used the addresses registered in the KDHE file for 2020 Survey and reported activities will be done in future.	**Minimally Addressed**

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
Aetna		
4.	Interpretation of the study results should reflect the study population represented by the sample and respondents. **Aetna Response:** "*Aetna is currently awaiting the final report from SPH which should include the following:* ○ *Sample Methodology* ○ *Benchmark Comparisons* ○ *Composite Analysis* ○ *Segmentation Analysis* ○ *Correlation Analysis* ○ *Technical Notes* *Upon Receipt of this information we will provide additional information."* **KFMC Response:** This information was not included in the final 2020 Survey Report. The interpretations of the survey results presented in the final 2020 Survey Report did not reflect the survey sample and respondents.	**Not Addressed**
5.	Develop and report timelines for implementing each step in the action plans Aetna develops in response to provider survey responses. **Aetna Response:** "*Imbedded below is the Survey Action Plan Template that will be used to monitor the 2020 Provider Satisfaction Survey and include solutions to help drive the increase in satisfaction scores for the 2021 survey. We will meet monthly starting in January and report out quarterly our activities. All functional areas within the health plan will meet and develop action plans based on the 2020 survey questions. From an action plan perspective, the first 3 quarters are the most impactful to help drive scores in each survey year as surveys are usually administered in the end or the 3rd quarter or start of the 4th quarter of the year."* **KFMC Response:** Aetna provided the Survey Action Plan Template to KFMC imbedded in the document providing responses to the recommendations made by KFMC in the 2019 Survey Validation Report; Aetna mentioned its plan to use this template to monitor the 2020 Survey (see response).	**In Progress**

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
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. **KFMC Response:** Sunflower did not provide a response.	**Not Addressed**
2.	The selected stratified sample should further be strengthened by sampling a higher number of specialists, and more importantly ensuring an adequate number of BH providers, thus helping to further the representativeness of the sample to all types of the providers in the study population (Sunflower network providers). **Sunflower Response:** "*Sunflower Health Plan will explore ways to increase Behavior Health provider in the Provider Satisfaction Survey sample. These actions will help achieve a statistically significant survey sample for both HCBS and Behavioral Health provider populations in the surveys.*" **KFMC Response:** The 2020 Survey did not address the recommendation, although Sunflower mentioned they are working on it.	**In Progress**
3.	Determine the reason for such a large number of ineligible surveys and take steps to address identified issues. **Sunflower Response:** "*Steps will be taken to improve the response rate and number of completed surveys, such as:* ○ *Exam reason for such a large number of ineligible surveys.* ○ *Identify and mitigate the issues for low return of complete surveys by providers.* ○ *Plan to use a two-wave mail and internet component methodology.* ○ *Sending a second questionnaire to non-respondents.* ○ *A minimum accepted response rate will be defined to calculate a sufficient sample size to further increasing the number of complete surveys.* ○ *Take steps to ensure provider contact information (mail, phone, and email) is updated for accuracy.* ○ *Ensure appropriate timings for fielding."* **KFMC Response:** This recommendation was not addressed in 2020 Survey; Sunflower informed KFMC that they will address it in 2021 survey.	**Not Addressed**
4.	Interpretation of the study results should reflect the study population represented by the sample and respondents. **KFMC Response:** Sunflower did not provide a response. The interpretations of the survey results presented in the 2020 Survey Report did not reflect the survey sample and respondents.	**Not Addressed**

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2019)	*Status*
UnitedHealthcare		
The recommendations below are in addition to the "Common Among the MCOs" recommendations.		
1.	Consider using stratified random sampling method to draw a sample in alignment with the UnitedHealthcare KanCare provider network composition. **KFMC Response:** UnitedHealthcare did not provide a response. UnitedHealthcare's 2020 Survey Report did not mention the composition of the survey study population and sampling method used to draw the survey sample.	**Not Addressed**
2.	Use a multi-mode survey methodology including a two-wave mail survey accompanied with an internet option component and a phone follow-up component. **KFMC Response:** UnitedHealthcare did not provide a response. For 2020 survey, UnitedHealthcare applied dual-mode methodology including one-wave mail survey with internet option. Telephone follow-up component was not applied. The overall response rate (2%) and number of completed surveys (46) were very low for 2020 Survey.	**Not Addressed**
3.	Ensure the analytic result for each question is based on a valid denominator. Findings based on inadequate numerators and denominators are not valid and can provide inaccurate interpretations. **KFMC Response:** UnitedHealthcare did not provide a response. The overall number of complete surveys for 2020 survey were very low (46 completed surveys). UnitedHealthcare noted in the Survey Report, "*Attributes receiving fewer than 30 responses should be treated with caution."* However, the tables included in the 2020 Survey Report showing the results only included the percentages for the individual questions without including their numerator and denominator counts. Also, tables did not incorporate the notation showing if the percentages were based on fewer than 30 responses. Due to unavailability of the information on the crucial aspects, it was not feasible to assess the validity of the results for the individual questions.	**Not Addressed**

Compliance Review

Regulatory Area	Follow-Up to Previous Recommendations (2018)	Status
Sunflower		
§438.206(c)(1)(iii) Furnishing of Services – Timely Access (24 hours/7 days per week):	1. For consistency with the other MCOs, SHP explore ways for their Primary Care Providers (PCPs) to provide 24/7 coverage directly. **KFMC Response:** SHP provided documentation to address this recommendation.	Fully Complete
§438.207(a) [was §438.206(b)(1)(iv)] Availability of Services (Providers not accepting new patients):	2. For the SHP Network Adequacy Report: SHP continue to review how providers are classified and make corrections as necessary.	Added to 2020 Review
	3. For the SHP Network Adequacy Report: SHP incorporate corrections in the Network Adequacy Report into the GeoAccess Report to ensure mapping of access correctly reflects network adequacy.	Added to 2020 Review
§438.207(a) [was §438.206(b)(1)(v)] Availability of Services (Geographic location of providers and Medicaid enrollees):	4. Continue, at the State's request, to make changes to the Network Adequacy Report to detail whether Psychiatry and Serious Emotional Disturbance (SED) Waiver providers treat adults, pediatric, or both.	Added to 2020 Review
	5. Continue to make efforts to identify providers who are providing services to KanCare members in other MCO networks, contact those providers to reach agreements to bring them in-network to provide services to SHP members, and, if a network agreement cannot be reached, ensure timely access of members to providers in other MCO networks through a single case agreement.	Added to 2020 Review
	6. Continue to review and correct Network Adequacy and GeoAccess Reports to ensure physician extenders are reported correctly (SHP lists *"physician extenders – Advanced Practice Registered Nurses and Physician Assistant*" in the Network Adequacy Reports as physician specialists).	Added to 2020 Review
	7. For the SHP GeoAccess document *"GEOQS013118"*: • Continue to recruit providers in counties that do not currently meet the access standards, focusing recruiting efforts on specialties of particular need for SHP members in these counties.	Added to 2020 Review
	8. For the SHP GeoAccess document *"GEOQS013118"*: • In the 2018 follow-up review, provide the most current two reports of the bi-monthly audit of the data in the Network Adequacy Report completed by the Data Management team.	Added to 2020 Review
§438.208(b)(1) Coordination and Continuity of Care (Ongoing source of primary care):	9. Review the SHP quarterly provider meetings, orientations, workshops, and physical and behavioral health cases to ensure 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 Response:** SHP provided documentation to address this recommendation.	Fully Complete
	10. Review the SHP quarterly provider meetings, orientations, workshops, and physical and behavioral health cases to ensure:	Not Complete

Compliance Review

Regulatory Area	*Follow-Up to Previous Recommendations (2018)*	*Status*
Sunflower		
	• That providers continue to be made aware and that they continue to develop processes to ensure effective follow-up required when referrals are ordered, to ensure the referral is made, and documentation occurs of communication with the specialist regarding the results of the referral and changes in the treatment plan. **KFMC Response:** This regulation remains substantially met; KFMC had not received updated documentation as of the 2019 report.	
§438.214(b)(1) Provider Selection – Credentialing and Recredentialing Requirements:	11. Review credentialing/recredentialing applications to verify SHP is using the most current State identified *"Kansas Organizational Provider Credentialing/Recredentialing Application"* and all HCBS provider credentialing/recredentialing applications include the HCBS Supplemental Form. **KFMC Response:** This recommendation is no longer applicable. Currently, applications are submitted to the State (not the MCO) using the standardized form.	No Longer Applicable
§438.214(b)(2) Provider Selection (MCO must follow documented process for credentialing/recredentialing):	12. Provider Credentialing/Recredentialing 2016 Case Review: In the 2018 follow-up review, include the letter to the provider for evidence of written communication to the provider. (Institutional Provider 5) **KFMC Response:** This regulation remains partially met; KFMC had not received updated documentation as of the 2019 report.	Not Complete
§438.230(b)(3) Sub-contractual Relationships and Delegation – Specific Conditions (MCO monitors subcontractor's performance): Delegated Vendor Oversight (DVO) Meeting Minutes and Scorecards:	13. In the 2018 follow-up review, submit the following: • For DVO Meeting Minutes, submit an example (if applicable) of DVO Meeting Minutes that detail the changes made to capture an update on the status of a requested line/category to be added to the scorecard and, if it could not be added, the reason should be detailed.	Added to 2020 Review
	14. 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.).	Added to 2020 Review
	15. Provide detail in the scorecard on how the year-to-date eligibility statistics are calculated.	Added to 2020 Review

Compliance Review

Regulatory Area	Follow-Up to Prior Previous Recommendations (2018)	Status
UnitedHealthcare		
§438.207 [was §438.206(b)(1)(iv)] Availability of Services (Delivery Network):	1. For the "PVRLST" data source that was implemented: UnitedHealthcare continue monitoring to ensure network adequacy reporting does not have classifications errors and ensure consistency in how providers are classified continues to improve.	Added to 2020 Review
	2. For the "PVRLST" data source that was implemented: UnitedHealthcare incorporate corrections in the Network Adequacy Report into the GeoAccess Report to ensure mapping of access correctly reflects network adequacy.	Added to 2020 Review
	3. Continue to recruit providers in counties that do not currently meet the standards and where the other two Managed Care Organizations (MCOs) have a much higher number of providers in more counties, focusing recruitment efforts on specialties of particular need for UnitedHealthcare members in these counties and on specialties where distance to access is now greatest.	Added to 2020 Review
	4. Continue to make efforts to identify providers who are providing services to KanCare members in other MCO networks; contact those providers to reach agreements to bring them in-network to provide services to UnitedHealthcare members; and, if a network agreement cannot be reached, ensure timely access of members to providers in other MCO networks through a single case agreement.	Added to 2020 Review
§438.207 [was §438.206(b)(1)(v) Availability of Services – Delivery Network (Geographic location of providers and Medicaid enrollees)]:	5. Review the Network Adequacy report and any other applicable reports (e.g., GeoAccess) to verify the MCOs have implemented the State's reporting requirements of identifying whether the provider services (psychiatry availability) are for adults, pediatric, or both. Also, that SED services are classified as available for adults, pediatric, or both (requirements beginning with the October 2018 report submitted for Quarter 3 [July – September 2018]).	Added to 2020 Review
	6. Review the revised Network Adequacy Quarterly Report for the newly added county level information (beginning October 2018) and assess whether the State should consider requiring MCOs to include in GeoAccess mapping the availability of each HCBS service. At a minimum, a list of counties with limited access to specific HCBS services (reported, as of 2018, by counts and not by county names). **KFMC Response:** This recommendation is no longer applicable due to changing State reporting requirements.	No Longer Applicable
§438.208(b)(1) Coordination and Continuity of Care (Ongoing source of primary care):	7. Review UnitedHealthcare's results for the most recent two quarters of the "*National PCP MRR Scoring Tool*" (sections "*Problem Evaluation and Management*," numbers 6 and 9, and "*Problem Evaluation and Management-cont'd*," numbers 2 and 10). **KFMC Response:** UHC provided documentation to address this recommendation.	Fully Complete

Compliance Review

Regulatory Area	Follow-Up to Prior Previous Recommendations (2018)	Status
UnitedHealthcare		
	8. Review physical and behavioral health files to verify: • 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. • 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; • There is evidence of providers assisting members with referrals and coordination of care; • There is detailed documentation of follow-up from previous concerns, and documentation in progress notes of all appointments/services members have received from their provider since the last visit; and • If there is no documentation of the aforementioned, there is evidence of UnitedHealthcare educating (e.g., site visit and/or letters) or taking corrective action with the provider for the lack of documentation in the record. **KFMC Response:** This regulation remains substantially met; KFMC had not received updated documentation as of the 2019 report.	Not Complete
§438.214(b)(1) Provider Selection – Credentialing and Recredentialing Requirements:	9. Review provider credentialing/recredentialing cases for the most current version of the "*Kansas Joint Credentialing Application.*" **KFMC Response:** This recommendation is no longer applicable. Currently, applications are submitted to the State (not the MCO) using the standardized form.	No Longer Applicable
§438.214(b)(2) Provider Selection:	10. The internal process should be reviewed, and/or additional quality checks and process monitoring should be completed: • When requesting disclosure of alternate provider and facility names and when checking all names against the Office of Inspector General (OIG) List of Excluded Individuals and Entities Exclusions Database (LEIE) during the credentialing/recredentialing process. • In checking all names of owners, controlling interests, and managing employees noted on DOO forms against the OIG LEIE Exclusions Database. **KFMC Response:** This regulation remains substantially met; KFMC had not received updated documentation as of the 2019 report.	Not Complete
§438.214(e) Provider Selection – State Requirements:	11. Related to State Contract Section 2.2.4.1.6 (Recredentialing to occur every three years) and 2.2.4.1.7 (Timeframe requirements for credentialing of all service providers applying for network provider status): To ensure credentialing and recredentialing is being completed in the required timeframe: • Review provider credentialing and recredentialing files.	Not Complete

Compliance Review

Regulatory Area	*Follow-Up to Prior Previous Recommendations (2018)*	*Status*
UnitedHealthcare		
	• Review the *"Community Plan 2018 NCC ScoreCard,"* months August – December 2018. **KFMC Response:** This regulation remains substantially met; KFMC had not received updated documentation as of the 2019 report.	
§438.214(e) Provider Selection:	12. In the 2018 follow-up 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 requirement 2.2.4.1.5 (conflict free case management); or, if the State *"Final Form Policy"* has not been issued and UnitedHealthcare has updated the policy to incorporate the provision, it should be submitted for review. **KFMC Response:** This regulation remains substantially met; KFMC had not received updated documentation as of the 2019 report.	Not Complete
§438.408(e)(2)(i–iii) Resolution and Notification: Grievances and Appeals – Content of Notice of Appeal Resolution (Right to State Fair Hearing):	13. For appeal case review, the EQRO should ensure the appeal disposition (resolution) letters include the *"Member Grievance and Appeals Process"* document (when appropriate).	Added to 2020 Review

Quality Assessment and Performance Improvement (QAPI) Review

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
1.	5.9.1(G) Mechanisms to identify LTSS Members not receiving any services: • Include a description of the process to identify members enrolled in LTSS waivers but not receiving any waiver services. **KFMC Response:** • ABH and UHC provided documentation to address this recommendation. • SHP indicated this update will be made to the 2021 QAPI documentation.	ABH – Fully Complete SHP – In Progress UHC - Fully Complete
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 Response:** • ABH and UHC provided documentation to address this recommendation. • SHP indicated this update will be made to the 2021 QAPI documentation.	ABH – Fully Complete SHP – In Progress UHC - Fully Complete
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 Response:** • ABH and SHP provided documentation to address this recommendation. • UHC indicated updates to the Member Handbook and Member web Portal will be made to address this recommendation.	ABH – Fully Complete SHP – Fully Complete UHC – In Progress

Quality Assessment and Performance Improvement (QAPI) Review

	Follow-Up to Previous Recommendations (2019)	*Status*
Common Among the MCOs		
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 Response:** • ABH did not provide an update on this recommendation. • SHP indicated this update will be made to the 2021 QAPI documentation. • UHC is developing a policy and procedure to address this recommendation.	ABH – In Progress SHP – In Progress UHC– In Progress
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 Response**: • ABH provided policy *CRCMGT-002 Corporate Records Management Program,* which mentions the *Aetna Records Retention Schedule*. KFMC would like a copy of the retention schedule, as the aforementioned policy does not contain retention time periods. • SHP indicated this update will be made to the 2021 QAPI documentation. • UHC indicated a policy was submitted to address this recommendation; KFMC has not received the policy at the time of reporting.	ABH – Substantially Complete SHP – In Progress UHC – In Progress

Quality Assessment and Performance Improvement (QAPI) Review

	Follow-Up to Previous Recommendations (2019)	*Status*
Aetna		
1.	QAPI General Recommendation: • Within each section of the Program Description, include references to all associated supplemental documents. **KFMC Response:** ABH provided documentation to address this recommendation.	Fully Complete
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 Response:** ABH indicated they were in the process of updating the *ISC Program Description*, which includes this information.	In Progress
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 Response:** ABH provided documentation to address this recommendation.	Fully Complete
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 Response:** ABH provided documentation to address this recommendation.	Fully Complete
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 Response:** ABH provided documentation to address this recommendation.	Fully Complete

Quality Assessment and Performance Improvement (QAPI) Review

	Follow-Up to Previous Recommendations (2019)	*Status*
Sunflower		
1.	5.9.6(A)(6) Peer Review Committee: • Provide policy documentation that decisions made by the Peer Review Committee are not overturned 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 Response:** SHP provided documentation to address this recommendation.	Fully Complete
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 Response:** SHP indicated this update will be made to the 2021 QAPI documentation.	In Progress

Quality Assessment and Performance Improvement (QAPI) Review

	Follow-Up to Prior Recommendations (2019)	*Status*
UnitedHealthcare		
1.	QAPI General Recommendation: • Include references to all associated supplemental documents within each section of the Program Description. **KFMC Response:** UHC indicated this update will be made to the 2021 QAPI documentation.	In Progress
2.	5.9.3(A)(2): Staff training and development: • Expand on the descriptions of staff training and development. **KFMC Response:** UHC provided documentation to address this recommendation.	Fully Complete
3.	5.9.3(B)(1): Promotion of member employment: • Describe how member employment is promoted. **KFMC Response:** UHC provided documentation to address this recommendation.	Fully Complete
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 Response:** UHC indicated an update will be made to policy *KSAD-0004 Provider Data Accuracy* to include a reference to QAPI documentation.	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 Response:** UHC indicated an update will be made to policy to include requested language.	In Progress
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 Response:** UHC provided documentation to address this recommendation.	Fully Complete
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 Response:** UHC is developing a policy and procedure to address this recommendation.	In Progress

Appendix E

KanCare Program Annual External Quality Review Technical Report

(2020 – 2021 Reporting Cycle)

List of Abbreviations

List of Abbreviations	
Abbreviation	**Description**
ABH	Aetna Better Health of Kansas (Aetna)
AGP	Amerigroup Kansas, Inc. (Amerigroup)
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS measure)
AOD	Alcohol and Other Drugs
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Children and Adolescents' Access to PCP
CCC	Children with Chronic Conditions
CCS	Cervical Cancer Screening (HEDIS measure)
CDC	Comprehensive Diabetes Care
CHIP	Children's Health Insurance Program (Title XXI)
CHIPRA	Children's Health Insurance Program Reauthorization Act
CM	Case Management
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CPC	Clinical Practice Consultants
CY	Calendar Year
DOO	Disclosure of Ownership
DTaP	Diptheria, Tetanus, and Acellular Pertussis Vaccine
DVO	Delegated Vendor Oversight
EQR	External Quality Review
EQRO	External Quality Review Organization
GC	General Child CAHPS survey population
HbA1c	Glycosylated Hemoglobin
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HiB	Haemophilus Influenzae Type B Vaccine
HPV	Human Papillomavirus
I/DD	Intellectual/Developmental Disability
IMA	Immunizations for Adolescents (HEDIS measure)
IPV	Inactivated Polio Vaccine
ISC	Integrated Service Coordination
ISCA	Information Systems Capabilities Assessment
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KSWebIZ	Kansas immunization registry
KFMC	KFMC Health Improvement Partners
LEIE	List of Excluded Individuals and Entities
LTC	Long-term Care

List of Abbreviations	
Abbreviation	**Description**
MCO	Managed Care Organization
MHSIP	Mental Health Statistics Improvement Program
MMIS	Medicaid Management Information Systems
MMR	Measles, Mumps, and Rubella Vaccine
MTM	Medication Therapy Management
MY	Measurement Year
NA	Not Available
NCC	National Call Center
NCQA	National Committee for Quality Assurance
NOA	Notice of Action
OIG	Office of the Inspector General
P4P	Pay-for-Performance
PCP	Primary Care Provider
PHI	Protected Health Information
PIP	Performance Improvement Project
PMV	Performance Measure Validation
PRTF	Psychiatric Residential Treatment Facilities
Q	Question
QAPI	Quality Assessment and Performance Improvement
QC	Quality Compass (NCQA)
SED	Serious Emotional Disturbance
SSD	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS measure)
SHP	Sunflower Health Plan of Kansas (Sunflower)
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)
UHC	UnitedHealthcare Community Plan of Kansas (UnitedHealthcare)
VZV	Varicella Zoster Vaccine (Chicken Pox Vaccine)
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (HEDIS measure)