KanCare 2.0 Interim Evaluation Report
Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration – KanCare 2.0
January 2019 – September 2022
Final Submission Date: October 20, 2022

Executive Summary

KanCare 2.0 Demonstration Overview

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, with a subsequent one year extension. CMS approved the demonstration renewal titled, "KanCare 2.0" for the period of January 1, 2019, through December 31, 2023.

KanCare is operating concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aging, people with disabilities, and some individuals who are dually eligible).

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services. Building on the success of the previous KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and Children's Health Insurance Program (CHIP) benefits. KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. Services related to social determinants of health include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of independence are tailored to an individual's vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (i.e., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 expands upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care. It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health, and Long Term Services and Supports [LTSS]) through direct interventions, provider referrals, and linkages to community

resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination.

KDHE-DHCF developed the OneCare Kansas (OCK) program that is "offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the 'whole person' across the life span." The focus is on members with certain chronic conditions involving mental health and asthma. Eligible members are invited to opt-in to the program. Care coordination is provided by OCK Partners (OCKPs), who are KanCare providers throughout Kansas that contracted to be OCKPs.

Value-based models and purchasing strategies include provider payment and/or innovative delivery system design methods between MCOs and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs.

KanCare 2.0 includes telehealth solutions in designing, establishing, and maintaining provider networks and expanding the use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring, with a focus on enhancing access to services.

It must be highlighted, much of the interim evaluation measurement period overlapped with the COVID-19 public health emergency (PHE). KanCare 2.0 activities were drastically affected during the onset of the PHE (pandemic). Initially, the MCOs were instructed to pause many activities with members and providers in order to address the public health emergency. For instance, completion of Health Screening Tools (HSTs) was briefly waived. Some changes continued throughout the interim evaluation time period. For example:

- The State obtained an HCBS waiver amendment from CMS, effective January 27, 2020. This amendment remains effective through six months after the end of the public health emergency; the end date is yet to be determined. A couple elements of the amendment that could more directly impact this evaluation of service coordination included
  - suspending the requirement for an HCBS waiver participant to use at least one service every 30 days;
  - allowing telephonic services for case management and monthly monitoring;
  - allowing an extension for reassessments and reevaluations for up to one year past the due date; and,
  - allowing the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- In March 2020 a State moratorium on member face to face visits was implemented, and the MCOs and members needed to re-adjust to telephonic or tele-video visits. The moratorium was lifted in April 2021, with judgement allowed related to the particular case or need, while there were some continued limitations on in-person group meetings (e.g., wrap-around team meetings) and nursing home visits. Through at least January 2022, there was variation in the MCOs' and members' resumption of face-to-face visits, due to continued fluctuations in COVID-19 rates.

Furthermore, the pandemic affected the overall utilization of health care services throughout the state. It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the KanCare 2.0 program outside of the context of the pandemic. Thus, the results presented here should be interpreted with strong caution.

KanCare 2.0 Demonstration Goal and Hypotheses

The KanCare 2.0 demonstration goal is described in Figure ES-1.

KanCare 2.0 Goal	To help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.

Figure ES-1. KanCare 2.0 Demonstration Goal

The four hypotheses of the KanCare 2.0 demonstration are described in Figures ES-2.

KanCare 2.0 Hypothesis 1	Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
KanCare 2.0 Hypothesis 2	Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
KanCare 2.0 Hypothesis 3	Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically: a. Telemedicine will improve access to services such as speech therapy. b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions. c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.
KanCare 2.0 Hypothesis 4	Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.

Figure ES-2. KanCare 2.0 Demonstration Hypotheses

Interim Evaluation of KanCare 2.0 Demonstration

In accordance with the CMS guidelines, the KanCare 2.0 evaluation design for the period of January 1, 2019, through December 31, 2023, was submitted for CMS approval. An updated evaluation design as per CMS guidance and feedback was approved by CMS on February 19, 2020.

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. As the EQRO, KFMC is conducting the required KanCare 2.0 evaluation, and has prepared this interim evaluation report to reflect evaluation progress and present findings to date. Measurement data are provided, as available, for the time period of January 1, 2019,

through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

KanCare 2.0 Demonstration Evaluation Questions

The evaluation questions were developed in alignment with the demonstration's goal and four hypotheses (Figure ES-3).

Overall Care Coordination Among KanCare 2.0 Members	1. Did the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improve quality of care, health and cost outcomes? 2. Did the OneCare Kansas program that implements comprehensive and intense method of care coordination improve the quality of care, health and cost outcomes?
KanCare 2.0 Hypothesis 1	1. Did the Value-Based Provider Incentive Program increase integration and reduce silos between physical and behavioral health services provided to KanCare members? 2. Did the Value-Based Provider Incentive Program for integration between physical and behavioral health services improve quality of care, health, and cost outcomes?
KanCare 2.0 Hypothesis 2	1. Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community improve their independence and health outcomes?
KanCare 2.0 Hypothesis 3	1. Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas? 2. Did use of the tele-monitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas? 3. Evaluation question related to telementoring: Data sources for describing the baseline and five-year status of the use of telementoring to pair rural and semi-urban healthcare providers with remote specialists are currently not known; therefore, the related evaluation question and design will be developed later. 4. Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?
KanCare 2.0 Hypothesis 4	1. Did removing payment barriers for services provided in IMDs for KanCare members improve members' access to substance use disorder (SUD) treatment services. (As per CMS guidance, evaluation of Hypothesis 4 was conducted as a part of the SUD Demonstration Evaluation).

Figure ES-3. KanCare 2.0 Demonstration Evaluation Questions

KanCare 2.0 Demonstration Interim Evaluation Results

The interim evaluation included the assessment of performance measures for the KanCare 2.0 Service Coordination Strategy, OCK program, Hypothesis 3, and the monitoring of overall KanCare 2.0 performance measure during 2019–2021.

The performance outcome data are not currently available for the evaluation of KanCare 2.0 Hypothesis 1 and Hypothesis 2. Therefore, the evaluation of these hypotheses will be conducted as part of the summative evaluation of KanCare 2.0.

Per CMS recommendation, KanCare 2.0 Hypothesis 4 evaluation results are included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration.

As noted earlier, the interim evaluation includes the time period that encompasses the onset and continuation of the COVID-19 public health emergency (PHE). The PHE was a very strong confounding variable that impacted almost all aspects of the evaluation. As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits (e.g., CHIP members turning 19 years old and 60 days after delivery for women receiving benefits due to pregnancy). Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the homogeneity of the population changed (impacting statewide outcome measures). Also, many types of health care utilization decreased during this time period due to stay-at-home and isolation processes, while telehealth for applicable services was implemented statewide.

Thus, the results presented here should be interpreted with caution. Where feasible, adjustments were made to the analytic plans to account for the pandemic's impact on measurement outcomes. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of KanCare 2.0 efforts.

a. Evaluation of the KanCare 2.0 Service Coordination Strategy

To examine whether the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improves quality of care, and health and cost outcomes, the evaluation methodology included assessment of the performance measures in the following comparison populations.

- **Intervention Group:** Members who had a Health Risk Assessment (HRA) and Person Centered Service Plan (PCSP) during 2019 to 2021
- **Comparison Group 1:** Intervention Group members from 2016 to 2018 (pre-intervention period).
- **Comparison Group 2:**
  - Members who had a Health Screen Assessment (HSA) that met an HRA threshold and received traditional care (i.e., did not receive a PCSP).
  - Members who had an HSA total score from 18 to 22 and did not meet an HRA threshold and received traditional care.

Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the service coordination strategy was effective. However, as previously noted, the COVID-19 pandemic impeded the MCOs' abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time. The performance measures examined are listed in Figure ES-4.

Measure 1	Adults' Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure 2	Annual Dental Visit (ADV)
Measure 3	Adolescent Well-Care Visit (AWC)
Measure 4	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/ Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
Measure 5	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
Measure 6	Emergency Department Visits (Overall)

Figure ES-4. Performance Outcome Measures KanCare 2.0 Service Coordination Strategy Evaluation

Since all HCBS waiver participants are eligible for service coordination, they represent a higher percentage of members participating in service coordination than non-HCBS participants. Examples of non-HCBS participants in service coordination may include members with behavioral health needs or complex/chronic conditions, members in nursing or residential facilities, hospitals or members in foster care. The ratio of HCBS waiver participants to non-HCBS participants was different between the intervention and control groups: 82% of the 23,807 members in the Intervention Group were members receiving HCBS services compared to 26% of the 26,712 members in Control Group 2. Of the 4,366 non–HCBS recipients in the Intervention Group, 77% were from one MCO; the reason for this difference is unknown.

A lack of standardization of the HST, HRA, Needs Assessment and PCSP variable fields, in the datasets provided by the MCOs, created limitations in compiling the Intervention and Comparison Groups needed for the interim evaluation measurement period. Through a contract amendment, the HST and HRA have been standardized, with implementation of the standardized tools occurring in early 2022.

Key Results and Conclusions

- Assessment results support the assertion that KanCare 2.0 Service Coordination Strategy had a positive impact on rates of the following measure:
  - Outpatient or Professional Claims (for diabetic retinopathy, influenza, pneumonia or shingles)
- While improvements were not seen in the other measures, no conclusions can be determined due to the changes in healthcare utilization during the pandemic.
- The MCOs' challenges in implementing the strategy as intended (e.g., contacting members, completing screenings and needs assessments) and the impacts of the COVID-19 pandemic must be considered before judging the success or failure of the strategy.

Figure ES-5. Key Conclusions from KanCare 2.0 Service Coordination Strategy Evaluation Results

The main findings related to the outcome measures are summarized below:

- The results for one measure (Outpatient or Professional Claims, for diabetic retinopathy, influenza, pneumonia or shingles) supports the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on its rates. It should be noted, instead of improving, this measure's rates increased for both the Intervention Group and Comparison Group 2. Since the Intervention Group's rates changed less, relative to Comparison Group 2, the Intervention Group's performance was deemed better under the circumstances.
- The 2019–2021 rates for ED Visits, Observation Stays, or Inpatient Admissions (for diabetic ketoacidosis/hyperglycemia, acute severe asthma, hypertensive crisis, fall injuries, SUD, or mental health issues), Annual Dental Visits, and Adolescent Well-Care Visits, worsened for both groups from 2016–2018, with the Intervention Group having poorer performance than Comparison Group 2.
- The relative improvements in both groups were about the same for the Access to Preventive/ Ambulatory Health Services and Emergency Department Visits (overall) measures.

Opportunities for Improvement

- It was not clear from the MCOs' data whether all members eligible for participation in the Service Coordination Strategy received an HRA and Needs Assessment, along with a PCSP if applicable.

Recommendations

- As the State completes the PHE winding down period, review and improve the steps applied by the three MCOs to ensure all members eligible for participation in the Service Coordination Strategy receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate during the remaining years of the KanCare 2.0 demonstration. Application of the Service Coordination Strategy to all eligible members will assist in achieving its impact on the performance outcomes.

b. Evaluation of the OneCare Kansas Program

Quantitative Evaluation of OCK Program

KDHE-DHCF developed the OneCare Kansas (OCK) program that is offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the 'whole person' across the life span. The focus is on members with certain chronic conditions involving mental health and asthma. Initially, eligibility was limited to members diagnosed with Severe Bipolar Disorder, Paranoid Schizophrenia, or Asthma (plus one other qualifying health condition). Effective April 1, 2021, qualifying diagnoses were expanded to additional severe mental illnesses and/or expanded types of asthma which increased the eligible population. Eligible members are invited to opt-in to the program. Care coordination is provided by contracted providers, OCK Partners (OCKPs), including primarily Community Mental Health Centers, as well as Federally Qualified Health Centers, individual primary care practices, providers who serve individuals with developmental disabilities, and other community-based mental health providers (CBMH). As of April 1, 2022, OCK had 3,272 enrolled members.

To examine whether the OCK program (that implements comprehensive and an intense method of care coordination) improves the quality of care, health and cost outcomes, the evaluation assessment of the performance outcome measures in the following comparison populations.

- **Intervention Group –** KanCare 2.0 members eligible for participation in OCK who were enrolled in

the program for at least 3 months of the measurement year (2020 and 2021).

- **Comparison Group 1 –** Members of Intervention Group with their outcome data abstracted for the pre-intervention period (2016–2019).
- **Comparison Group 2 –** KanCare 2.0 members who met OCK eligibility criteria based on MMIS encounter data but did not enter into OCK and received traditional care (2020–2021).

Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the program was effective. However, the COVID-19 pandemic presented challenges for the MCOs' and OCKPs' implementation and ongoing administration of OCK, for much of the intervention period. While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

The performance outcome measures examined are listed in Figure ES-6.

Measure 1	Adults' Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure 2	Annual Dental Visit (ADV)
Measure 3	Adolescent Well-Care Visit (AWC)
Measure 4	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/ Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
Measure 5	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
Measure 6	Emergency Department Visits (Overall)

Figure ES-6. Performance Outcome Measures for OCK Program Evaluation

Key Results and Conclusions

- Results support the assertion that OCK had a positive impact on rates of the following measures:
  - Adults' Access to Preventive/Ambulatory Health Services
  - Adolescent Well-Care Visits
  - Annual Dental Visit – had a positive impact on Annual Dental Visits rates, but less definitively.
- There is potential for the other measures to improve during the remainder of the demonstration, as multiple measures showed relative improvements but were not statistically significant.
- While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy is not possible at this time.

Figure ES-7. Key Conclusions from OneCare Kansas Program Evaluation Results

Qualitative Evaluation of OCK Program

Information from the OCK Learning Collaborative meetings summary reports from April 2020 through March 2022 was abstracted for qualitative evaluation. Information was also abstracted from the OCK Program's June 2021 online survey of OCK partners (OCKPs), six regional virtual meetings with OCKPs in

July 2021, and a virtual polling session in March 2022. The six items examined are listed in Figure ES-8.

Item 1	Learning needs identified and discussed by the OCK Learning Collaborative participants
Item 2	Factors that facilitated the OCK implementation to achieve its goals, April 2020–March 2022
Item 3	Barriers/challenges seen in the implementation of the OCK program
Item 4	Observations related to the OneCare Kansas program success in achieving its goals
Item 5	Assistance needed by the OCK Partners from Partners' Network and State/MCO Implementation Team to assure quality services
Item 6	Recommendations and Potential Next Steps for the OCK program

Figure ES-8. Qualitative Items for OneCare Kansas Program Evaluation

Key Results and Conclusions

- Identified key factors that facilitated OCK implementation include the availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic code expansion.
- Key themes of identified barriers and challenges in OCK implementation included
  - Issues with program structure, including labor and time-intensive processes and unclear expectations
  - Access to member information, financial concerns, member enrollment, roster and engagement, opt-in/opt-out process, collaborations with partners/providers, staffing, and access to care in rural areas
- Key observations regarding OCK program successes included the following:
  - Improved care coordination
  - Improved support of members and increase in member trust and engagement
  - Increased partner collaboration
  - Sharing information about the program with community partners
- One learning need theme, identified by Learning Collaborative participants, that did not appear to be addressed pertained to trainings on OCK focused conditions, such as asthma, behavioral health, motivational interviewing and health literacy.
- OCK partners emphasized a need of continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges.
- OCK partners made the following key recommendations and suggestions for potential next steps.
  - Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.
  - Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
  - Improve program processes and systems.

- Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
- Identification of the opportunities to obtain hospital data and provision of organizational data.

Opportunities for Improvement

- Review of the MCOs' data files indicated the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from encounters (using the State's OCK program eligibility criteria), and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.
- Potential unmet OCK partners' learning needs include topics specific to working with OCK members, such as asthma, behavioral health, motivational interviewing, and health literacy.

Recommendations

- Ensure standardization of the MCOs' processes to determine members' eligibility for the OCK program, per the State's criteria.
- Determine OCK partners' continued learning needs specific to working with OCK members and their diagnoses, and provide related Learning Collaborative training or other resources.

c. Evaluation of KanCare 2.0 Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs

Each of the three MCOs designed a value-based provider incentive program (VBPs) to address KanCare 2.0 Hypothesis 1:

- Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers.
- Sunflower Health Plan VBP – Behavioral Health Project.
- UnitedHealthcare VBP – Pediatric Care Network Project.

The three MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects. The evaluation of Hypothesis 1 will be conducted as a part of summative evaluation of KanCare 2.0.

d. Evaluation of KanCare 2.0 Hypothesis – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities

Outcome measures data for the evaluation of Hypothesis 2 were not collected by two MCOs as a part of their Health Risk Assessment (HRA) tool. In 2021, the State and MCOs revised the HST to include the questions required for data collection of the Hypothesis 2 evaluation measures. The HST was then incorporated by each MCO into their health assessment processes, and each of the MCOs started using this standardized HST for all members in 2022 (Sunflower Health Plan started in January 2022, UnitedHealthcare started in March 2022, and Aetna started in May 2022). As the standardized HST was not fully implemented until May 2022, data for Hypothesis 2 outcome measures are not currently available. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

e. Evaluation of KanCare 2.0 Hypothesis 3 – Use of Telehealth Services

The evaluation of Hypothesis 3, comprised of quantitative and qualitative components, examined whether the use of telehealth services (telemedicine, telemonitoring, and telementoring) enhanced access to care for KanCare members living in rural and semi-urban areas.

- **Telemedicine:** connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.
- **Telemonitoring:** technologies that measure health indicators of patients in their homes and transmit the data to an overseeing Provider.
- **Telementoring:** technologies to connect community providers with specialists for consultations, grand rounds, education, and to fully extend the range of care available within a community practice.

Quantitative Evaluation of KanCare 2.0 Hypothesis 3

The use of telemedicine services and use of telemonitoring services were examined for the period of January 2018 through December 2021, with cross-year comparisons. The members who received telehealth strategies (telemedicine and telemonitoring strategies) constituted the Intervention Group. The evaluation measures regarding telemedicine services are listed in Figure ES-9.

Measure 1	Percentage of telemedicine services received by the members living in the rural or semi-urban (Non-Urban) areas
Measure 2	Number of receiving sites for telemedicine services in the rural and semi-urban (Non-Urban) areas
Measure 3	Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services
Measure 4 & Measure 5	Speech Therapy Analysis; Individual Psychotherapy Analysis; Family and Group Psychotherapy Analysis; and Community Psychiatric Supportive Treatment Analysis: • Measure 4: Number of paid claims with selected procedure codes • Measure 5: Number of members with selected diagnosis per 1,000 members • Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80 • Percentage of KanCare members with diagnosis in category F80 who received speech therapy • Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis • Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy • Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis • Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy • Percentage of KanCare members receiving community psychiatric supportive treatment

Figure ES-9. Performance Outcome Measures for the Evaluation of Use of Telemedicine Services

The evaluation measures regarding telemonitoring are listed in Figure ES-10.

Measure 1	Percentage of members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
Measure 2	Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas
Measure 3	Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services

Figure ES-10. Performance Outcome Measures for the Evaluation of Use of Telemonitoring Services

Key Results and Conclusions

Use of Telemedicine Services

- Results for all measures examined support the assertion that the use of telemedicine services increased among KanCare 2.0 members (Non-Urban and Urban).
- The ability of these results to show improvement was overshadowed by the impact of the COVID-19 PHE. It should be noted, the increases in usage were higher among Urban members compared to Non-Urban members in these years. These increases corresponded to the onset of the PHE and may be due to changes related to the provision of services by providers and their usage by members made during these years.
- It should also be noted, though still above the pre-COVID-19 PHE years, usage of telemedicine services among members started showing decline in 2021 compared to 2020.
- Thus, the results seen should be interpreted with caution. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.

Figure ES-11. Key Conclusions Based on the Use of Telemedicine Services Evaluation Results (Hypothesis 3 Component)

Other main findings are summarized below:

- Telemedicine services for Non-Urban members were used most frequently for Mental, Behavioral and Neurodevelopmental Disorders throughout the time period, specifically Mood [affective] disorders ranked first.
- Analysis related to speech therapy supports the assertion that telehealth enhanced access to care for KanCare members.

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Use of Telemonitoring Services

- Results for all telemonitoring evaluation measures support the assertion of increased use of telemonitoring services among Non-Urban KanCare 2.0 members
  - Percentage of members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
  - Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas
  - Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services

Figure ES-12. Key Conclusions Based on the Use of Telemonitoring Services Evaluation Results (Hypothesis 3 Component)

The main finding related to the outcome measures is summarized below:

- The three telemonitoring evaluation measures showed low utilization of telemonitoring services. However, all three showed an improvement in counts/percentages from 2019 to 2020 and 2021. These improvements corresponded to the onset of the pandemic and may be due to its impact.

Qualitative Evaluation of Hypothesis 3

Use of Telementoring Services

The data sources are not currently available to describe the status of the use of Telementoring; therefore, quantitative evaluation was not conducted. The focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri, using the Project ECHO (Extension for Community Healthcare Outcomes) Model.

Key Results and Conclusions

- From March 2019 through November 2021, there were twelve Project ECHO series comprised of fifty-one sessions, with an average of 42 participants per session. Following are the Project ECHO topics.
  - Behavioral health (3 of the 4 series focused on Substance Use Disorders)
  - Social Determinants of Health
  - Intellectual and Developmental Disabilities
  - Foster Care
  - Aging
  - Cancer
  - Care Coordination
  - Preventive Health
- The sessions were attended by providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. Participants were from non-urban and urban counties.
- Evaluation results (obtained after each session by the Project ECHO host) indicated participants' knowledge of the topic improved, and they obtained helpful skills and techniques to improve professional practice.

Recommendations

- Continue to expand the use of telementoring, ensuring all MCOs develop and implement plans for this.

Telehealth Provider Survey

Qualitative information was also collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of providers' telehealth experiences, perceptions regarding telehealth and access to care, and to identify providers' recommendations regarding telehealth. The survey was conducted in August and September 2022.

Key Results and Conclusions

Seventy-three providers from urban and non-urban counties completed the survey, with the majority from behavioral health care providers. Other respondents were from primary care, specialty health care and home and community based services. The key points based on the survey results are summarized below:

- Most respondents "strongly agree" or "agree" that telehealth has improved access to care for KanCare members. It expands their ability to see clients/patients over a greater geographic distance, and it is important to the success of their organization. About two-thirds of the respondents "strongly agree" or "agree" that telehealth increases their ability to see more clients/patients, it fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and it improves the quality of care for clients/patients.
- Most respondents noted being "very comfortable" or "moderately comfortable" delivering telehealth services.
- Most of the survey respondents "strongly agree" or "agree" clients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.
- Three-fourths of respondents noted the effectiveness of services delivered by telehealth is "about the same" or "better" than services delivered in-person.
- Following are key barriers in providing telehealth services, identified by survey respondents, with the first two bullets being the most frequently noted.
    - Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access).
    - Lack of client familiarity or comfort with using telehealth services.
    - Lack of reliable internet for providers; and
    - Do not consider telehealth services as effective as in-person services.
- Following are key recommendations (themes) by survey respondents.
    - Provide consistency in application of rules and systems.
    - Increase and improve technology and resources for the members and providers.
    - Continued coverage by insurance companies.
    - Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.
    - Increase reimbursement rate for telehealth services.
    - Ensure opportunities for telehealth services are available for all members.

  - Provide trainings for providers, including easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational questions.
  - Telehealth is a valuable source for members and providers.
- Only 6% of respondents indicated their usage of telehealth visits would decrease in the future, with 50% anticipating the number of telehealth visits for KanCare members will "Increase somewhat."

Opportunities for Improvement

- KanCare 2.0 Hypothesis 3's focus is to enhance access to care for KanCare members living in rural and semi-urban areas. The results for the evaluation of telemonitoring service usage showed low utilization of the telemonitoring services. Although, some increases were seen in 2020 and 2021 among Non-Urban and Urban members, the increases seen were higher for Urban members than the Non-Urban members. Similarly, the increases seen in the telemedicine service usage were higher for the Urban members.
- Though still above pre-pandemic years, the results for the measures assessing the telemedicine and telemonitoring usage started showing a decline in 2021 compared to 2020, which may indicate the increases are due to COVID–19 pandemic.
- The focus of KanCare 2.0 Hypothesis 3, related to telementoring, is to pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. A data warehouse is not in place to collect detailed information on telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

Recommendations

- Ensure application of the strategies to improve the usage of telemedicine and telemonitoring services among Non-Urban members to increase their access to appropriate care.
- Ensure increased provision and utilization of telementoring sessions to increase the capacity of rural and semi-urban healthcare providers for the treatment of chronic, complex conditions among Non-Urban members.
- Assist the University partners and Health Plans providing telementoring sessions in developing a standardized evaluation component to assess the impact of these sessions in improving the capacity of providers in rural and semi-urban areas.
- Develop a data warehouse to collect the information on the telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

f. The Evaluation of KanCare 2.0 Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with SUD

A separate report is prepared describing the results for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

h. Monitoring of the Overall KanCare 2.0 Performance Measures

The Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey, National Core Indicators (NCI) survey, and National Core

Indicators—Aging and Disabilities (NCI-AD) Survey measures related to the areas for improvement from the prior evaluation of the KanCare Demonstration (2013–2018) were assessed. The measures examined are listed in Figure ES-13.

HEDIS Measures	Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care Postpartum Care Comprehensive Diabetes Care Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Control (<8.0%) Poor Control HbA1c (>9.0%) Eye Exam Performed for Patients with Diabetes (EED)
CAHPS Survey Measures	Medical Assistance with Smoking and Tobacco Use Cessation (MSC) Advising Smokers and Tobacco Users to Quit Discussing Cessation Medications Discussing Cessation Strategies
NCI Survey Measures	Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability (I/DD) Waiver Service Can see and communicate with their family when they want (if not living with family) Has friends (may be staff or family) and can see them when wants Able to go out and do the things they like to do in the community as often as they want Services and Supports help person live a good life Decides or has input in deciding how to spend free time Decides or has input in deciding daily schedule
NCI -AD Survey Measures	Social and Community Engagement Among Adults and Seniors Participating in the FE, PD, and BI Waiver Programs to Receive LTSS Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person) Percentage of people who are able to do things they enjoy outside of home as much as they want to Percentage of people whose services help them live a better life Percentage of people who like how they spend their time during the day Proportion of people who get up and go to bed when they want to Percentage of people who can eat their meals when they want to

Figure ES-13. Performance Measures for the Overall Monitoring of KanCare 2.0

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Key Results and Conclusions

- Results for following measures support the assertion that an improvement was seen in the overall performance of KanCare 2.0.
  - HEDIS Measure improvement
    - Postpartum Care
  - NCI Survey Measures–improvement
    - Able to go out and do the things they like to do in the community as often as they want
    - Services and Supports help person live a good life
  - NCI Survey Measures–high percentages (≥80%) though no improvement
    - Can see and communicate with their family when they want (if not living with family)
    - Decides or has input in deciding how to spend free time
    - Decides or has input in deciding daily schedule
  - NCI-AD Survey Measures–improvement
    - Percentage of people whose services help them live a better life
  - NCI-AD Survey Measures–high percentages (≥80%) though no improvement
    - Always able to see or talk to friends and family when they want to
    - Get up and go to bed when they want to
    - Can eat their meals when they want to
- Results for the following measures did not support the assertion that an improvement was seen in the overall performance of KanCare 2.0.
  - HEDIS Measure
    - Timeliness of Prenatal Care
    - Hemoglobin A1c Control for Patients with Diabetes (HBD)
    - HbA1c Control (<8.0%)
    - Poor Control HbA1c (>9.0%)
    - Eye Exam Performed for Patients with Diabetes (EED)
  - CAHPS Survey Measures
    - Medical Assistance with Smoking and Tobacco Use Cessation (MSC)
    - Advising Smokers and Tobacco Users to Quit
    - Discussing Cessation Medications
    - Discussing Cessation Strategies
  - NCI-AD Survey Measures
    - Has friends (may be staff or family) and can see them when wants
  - NCI-AD Survey Measures
    - Able to do things they enjoy outside of home as much as they want to
    - Like how they spend their time during the day

Figure ES-14. Key Conclusions Based on the Monitoring of Overall KanCare 2.0 Performance Measures

The results for one HEDIS measure, two NCI Survey measures, and one NCI-AD Survey measure supported the assertion that an improvement was seen in the overall performance of KanCare 2.0.

The main findings related to the outcome measures are summarized below:

HEDIS Measures

- The Prenatal and Postpartum Care (PPC) measure includes Timeliness of Prenatal Care and Postpartum Care. An improvement in the Postpartum Care rate and its QC ranking was seen from Measurement year (MY) 2019 to MY 2020. The QC ranking for Postpartum Care rate also increased from <25th to <50th percentile.
- The rest of the HEDIS measures did not show improvement from 2019 to 2020.
- A statistically significant decline in the Timeliness of Prenatal Care rate was seen in MY 2020 from MY 2019, with rates for both years below 33.33rd percentile.
- The Eye Exam Performed for Patients with Diabetes (EED) rate had a statistically significant declining trend from My 2016 to MY 2020.
- However, the QC rankings increased to >75th for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

CAHPS Survey Measures

- The three indicators of the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure — Advising Smokers and Tobacco Users to Quit; Discussing Cessation Medications; and Discussing Cessation Strategies — did not show improvement (with some declines), and had QC rankings less than the 50th percentile, suggesting a need for improvement.

Kansas NCI Survey Measures for Social and Community Engagement (2016–2017, 2017–2018, and 2018–2019)

- The percentage of members whose services and supports help them live a good life, was 90% or above in all three years.
- The percentages for three out of six measures—Can see and communicate with their family when they want (if not living with family); Decides or has input in deciding how to spend free time; and Decides or has input in deciding daily schedule—were above 80% in all three years.
- The percentage of members with the ability to go out and do things they like in the community increased from 79% to 85% in the most recent year.
- The percentage of members with the ability to see friends when they want declined from 83% in 2016-17 to 78% in 2017-18 and 2018-19.

Kansas NCI-AD Survey Measures for Social and Community Engagement (2018–2019, and 2019–2020):

- The percentages for three out of six measures—Percentage of people whose services help them live a better life; Proportion of people who get up and go to bed when they want to; and Percentage of people who can eat their meals when they want to— were above 90% in both years.
- The percentage of members with the ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in recent year.
- The percentages for the measure assessing members' ability to do things they enjoy outside of home as much as they want remained same in both years.
- The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

Recommendations

- Review and ensure strategies are applied by the MCOs and health care providers to improve provision of timely prenatal care, comprehensive diabetes care, and medical assistance for smoking and tobacco use cessation to KanCare 2.0 members.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve the social wellbeing of members receiving I/DD waiver services. Ensure the PCSPs of these members include the provision of assistance for them to engage socially, with friends and family, when they want.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve social and community engagement among adults and senior members obtain long term services and supports through the Frail Elderly, Physical Disability and Brain Injury waiver programs. Ensure the PCSPs of these members include provision of assistance for them to engage in activities of their interest outside their home when they want and to decide their daily activities.

Interpretations, and Policy Implication and Interactions with Other State Initiatives

KFMC will address the policy implications and interactions with other state initiatives in the summative KanCare 2.0 evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. KanCare 2.0 activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency. As a result, many of the projects that would have provided data for this evaluation were on hold for a considerable amount of time. Also, the Service Coordination Strategy could not be fully administered as designed, during much of the evaluation time period, due to limitations in face-to-face visits.

Lessons Learned and Recommendations for States

There were a few lessons learned as a result of this interim evaluation. These lessons learned are also recommendations to State Medicaid agencies for future demonstrations, as well as for the State of Kansas for the remainder of KanCare 2.0.

- There were additional delays in the implementation of KanCare 2.0 strategies that appeared unrelated to the delays due to the COVID-19 pandemic, such as the MCOs' Value Based Provider Incentive Program delays. These delays will impact the ability to evaluate the efficacy of the KanCare 2.0 program, as a whole. KFMC recommends State Medicaid agencies evaluate MCO delays to determine whether they are unavoidable or whether stronger enforcement of timelines is warranted.
- Some of the programs that began (or were intended to begin) during the evaluation timeframe proved to be more time-intensive to implement than anticipated. KFMC recommends State

Medicaid agencies and MCOs explore ways to accelerate the time to implementation of the programs, as designed. This will help to ensure adequate time is allowed for fully conducting the strategy activities, collecting data, and fully testing the hypotheses.

- Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative KanCare 2.0 evaluation report.

Summary of Opportunities for Improvement and Recommendations

- **MCO care coordination assessment:** As the public health emergency completes its winding down period, all members eligible for participation in the Service Coordination Strategy should receive the appropriate assessments.
- **OneCare Kansas capacity and provider training:** The State should ensure the MCOs have a standardized process to determine member eligibility for OCK. The State and MCOs should continue to support the OCK Learning Collaborative, and address providers' training needs regarding working with OCK members (e.g., motivational interviewing, health literacy) and specific diagnoses.
- **Increase telemedicine and telemonitoring utilization:** The State and MCOs should review and implement, as feasible, the provider recommendations for how to improve telehealth services. The State and MCOs should also seek ways to increase the use of telemonitoring services.
- **Improve telementoring opportunities and capacity:** The State should ensure all MCOs develop and implement plans to increase telementoring opportunities targeted towards providers in rural and semi-urban areas of the state, as well as continue to support current telementoring efforts. Standardized methods should also be developed and implemented to collect information on telementoring opportunities across the state and to evaluate the impact for KanCare 2.0 providers, especially those in rural and semi-urban parts of Kansas.
- **Strategies to improve quality and timeliness of care:** The MCOs should evaluate their Quality Assurance and Performance Improvement Programs to ensure they and contracted providers are developing and applying strategies to improve identified KanCare 2.0 performance measures (prenatal, comprehensive diabetes care, medical assistance for smoking and tobacco use cessation).
- **Strategies to improve member social and community engagement:** As the public health emergency completes its winding down period, the State should ensure the MCOs are working through their own care management processes (specifically using the PCSP), as well as with contracted providers, to improve social and community engagement for members on waiver services (I/DD, FE, PD, and BI).