kfmc
HEALTH IMPROVEMENT PARTNERS

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

April 25, 2024

Shirley Norris
Director of Managed Care
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, 2023–2024 Reporting Cycle

Dear Ms. Norris:

Enclosed is the KanCare Annual External Quality Review technical report for the 2023-2024 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 Evaluation, Performance Improvement Project (PIP) Validation, CAHPS 5.1H Survey Validation, Mental Health Consumer Perception Survey, Provider Survey Validation, Review of Compliance with Medicaid and CHIP Managed Care Regulations, Quality Assessment Performance Improvement (QAPI) Review, and Network Adequacy Validation.

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

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

Sincerely,

Beth Nech, MA

Beth Nech, MA
EQRO Senior Manager

Electronic Version: Ryan Gonzales, EQR Audit Manager/Supervisor, KDHE
Christine Osterlund, Deputy Secretary for Agency Integration and Medicaid, KDHE
Ann-Marie Bevel, Waiver Manager, KDHE

Enclosures

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

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

Contract Number: 46100

Submission Date: April 25, 2024

Review Team:
Beth Nech, MA, EQRO Senior Manager
John McNamee, PhD, MA, Senior Health Data Analyst
Alex Fulk, MA, Health Quality Data Analyst
Ghazala Perveen, MBBS, PhD, MPH, Epidemiologist Consultant
Kasey Sorell, MBA, BSN, RN, EQRO Project Lead
Tracy Atkins, MSW, EQRO Project Lead
Tisha Carlson, BS, Quality Review Project Lead
David Athey, B.Eng, Data Engineer
Beckie Archer, Programmer I
Samantha Ferencik, ABD, MA, Quality Research Project Lead
Sudip Nepal, PhD, Health Data Analyst
Lynne Valdivia, MSW, BSN, RN, CCEP, Vice President, Director of Quality Review, and Compliance Officer

Prepared for:

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KanCare

TABLE OF CONTENTS

Appendices

List of Tables and Figures

Report

KanCare Program Annual External Quality Review Technical Report
Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas
2023-2024 Reporting Cycle
Submission Date: April 25, 2024

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 Kansas Medicaid Managed Care program. 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, ABH, or ABHKS) KanCare managed care organization (MCO) contract was effective January 1, 2019. Sunflower Health Plan (Sunflower or SHP) and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare, UHC, or UHCCP) have provided KanCare managed care services since January 2013.

As the EQRO, KFMC evaluated services provided in 2022/2023 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 2023 through April 2024) evaluating activities of each MCO:

- Performance Measure Validation (PMV) and Evaluation, which includes the Information Systems Capability Assessment (ISCA)
- 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 Healthcare Providers and Systems (CAHPS®) Survey Validation[1]
- Provider Survey Validation
- Network Adequacy Validation

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

KFMC completes individual reports for the External Quality Review (EQR) activities noted above throughout the year to provide the State and MCOs timely feedback on program progress. In this Annual Technical Report, summaries are provided for each of these activities, including objectives; technical methods of data collection; descriptions of data obtained; strengths and opportunities for improvement

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

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 (CFR) §438.358. The full reports and appendices of each report provide extensive details by MCO, program, and metrics.) Recommendations and conclusions in the summaries that follow primarily focus on those related directly to improving health care quality, access, and timeliness; additional technical, methodological, and general recommendations to the MCOs are included in the individual reports submitted to the State. The Quality Management Strategy section contains suggestions, based on the EQR findings, for how the State can target goals and objectives in the KanCare Quality Management Strategy (QMS).

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

- EQR Protocol 1: Validation of Performance Improvement Projects
- EQR Protocol 2: Validation of Performance Measures
- EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
- EQR Protocol 4: Validation of Network Adequacy
- EQR Protocol 6: Administration or Validation of Quality of Care Surveys
- EQR Appendix A: Information Systems Capabilities Assessment

On March 11, 2020, the World Health Organization declared Coronavirus Disease 2019 (COVID-19) a global pandemic. Aspects of the pandemic's impact on MCO operations (including service delivery, survey administration, data collection, and performance improvement interventions), member utilization of services, provider resources for care delivery, and performance monitoring continued, to some degree, into this reporting period. More details regarding the potential impact of COVID-19 are described in the individual reports submitted throughout the year.

Each section below contains language regarding the degree to which the previous year's EQRO recommendations have been addressed for that particular activity. Appendix D contains details for this assessment, including definitions for the assessment scale used for all activities. To determine the degree to which previous recommendations were addressed, KFMC assessed activities completed, documentation received, and MCO progress updates received during the 2023-2024 review period for each EQR activity. Additional documentation or information received after the conclusion of the review period will be incorporated into the following year's assessment.

KFMC completed individual reports for each activity included in this annual technical report for the 2023-2024 reporting cycle. These individual reports (submitted to the State throughout this reporting cycle) contain more detail, and additional feedback beyond what is required, than is presented in the following activity summaries. This additional feedback includes suggestions for improvement that have no effect on compliance scores. Appendix A lists the full reports, which are available upon request.

Most EQR-related activities require that findings be tied to access, quality, and timeliness of care. Table I.1 presents an overview of MCO-level strengths and opportunities for improvement identified via the external quality review activities conducted during the 2023-2024 reporting cycle. The "Domain" column indicates how the strengths and opportunities are related to access, quality, or timeliness. The Mental Health Consumer Perception Survey and Network Adequacy Validation activities were conducted at the state level and are not included in the table. It provides a high-level overview of the strengths and

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

opportunities specific to each MCO. Please see the individual activity sections for more detail regarding strengths and opportunities for improvement common among the MCOs.

Table I.1. MCO-Level Strengths and Opportunities for Improvement

MCO		Strengths (S*) and Opportunities (O*)	Domain
Performance Measure Validation			
ABH	S	High performance or notable mentions • Asthma Medication Ratio (51–64 Years) • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis • Cervical Cancer Screening • Controlling High Blood Pressure • Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years) • Well-Child Visits in the First 30 Months of Life (First 15 Months) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	Access, Quality, Timeliness
	O	Low performance • Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Antidepressant Medication Management • Asthma Medication Ratio (5–18 Years) • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications • Hemoglobin A1c Control for Patients with Diabetes – Poor HbA1c Control • Preventive screenings for women and Prenatal and Postpartum Care • Substance use disorder treatment and hospitalization and ED follow-up, total percent of smokers, and discussing smoking and tobacco use cessation strategies • Immunizations for Adolescents and Children • Well-child visits (30 Months to 21 Years) and Child and Adolescent Well-Care Visits • Ambulatory Care – Emergency Department Visits • Use of First-Line Psychosocial Care for Children and Adolescents on Antibiotics	Access, Quality, Timeliness
SHP	S	High performance or notable mentions • Adherence to Antipsychotic Medications for Individuals with Schizophrenia • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months–17 Years) • Childhood Immunization Status — Hepatitis B • Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years) • Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics • Controlling High Blood Pressure • Cervical Cancer Screening • Lead Screening in Children • Prenatal and Postpartum Care, improving rates • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents • Discussing Cessation Strategies and lowest smoking rate of the MCOs	Access, Quality, Timeliness
	O	Low performance • Antidepressant Medication Management • Asthma Medication Ratio (5–18 Years) • Chlamydia Screening in Women • Prenatal and Postpartum Care, relatively low rates • Substance use disorder treatment, advising smokers to quit and discussing tobacco use and smoking cessation medications • Child and adolescent immunizations • Well-child visits and Ambulatory Care — Emergency Department Visits	Access, Quality, Timeliness

* S = Strength: High performance or notable mentions/O = Opportunity: Low performance

Table I.1. MCO-Level Strengths and Opportunities for Improvement			
MCO	**Strengths (S*) and Opportunities (O*)**		**Domain**
Performance Measure Validation (Continued)			
SHP	O	• Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile (Total)	Access, Quality, Timeliness
UHC	S	High performance or notable mentions • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months–17 Years) • Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years) • Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication • Flu Vaccinations for Adults • Percent of Current Smokers • Hemoglobin A1c for Patients with Diabetes • Postpartum Care, improving trend • Total Percent Current Smokers • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile (Total)	Access, Quality, Timeliness
	O	Low performance • Asthma Medication Ratio (5–18 Years) • Ambulatory Care – Emergency Department Visits • Chlamydia Screening in Women (16–20 Years) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition and Counseling for Physical Activity • Initiation and Engagement of Substance Use Disorder Treatment (18–64 Years) and Follow-Up after Emergency Department Visits for Mental Illness (6–17 Years) • Child and Adolescent Immunizations • Controlling High Blood Pressure • Medical Assistance with Smoking and Tobacco Use Cessation – Advising Smokers to Quit and Discussing Cessation Strategies • Postpartum Care, worsening rate • Timeliness of Prenatal Care	Access, Quality, Timeliness
Performance Improvement Project Validation			
ABH	S	Two PIPs were rated High Confidence (95% to 100%) and one was rated Confidence (90% to <95%).	Access, Quality, Timeliness
	O	Two PIPs were rated Low Confidence (80% to <90%).	Access, Quality, Timeliness
SHP	S	One PIP was rated High Confidence (95% to 100%) and one was rated Confidence (90% to <95%).	Access, Quality, Timeliness
	O	Three PIPs received a rating of Low Confidence (80% to <90%).	Access, Quality, Timeliness
UHC	S	The validation rating for two PIPs was High Confidence (95% to 100%); another had a rating of Confidence (90% to <95%).	Access, Quality, Timeliness
	O	Two PIPs rated Low Confidence (80% to <90%).	Access, Quality, Timeliness
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

Table I.1. MCO-Level Strengths and Opportunities for Improvement (Continued)			
MCO		**Strengths (S*) and Opportunities (O*)**	**Domain**
CAHPS Survey Validation			
ABH	S	The following ranks or rates were very high for at least one population* • Ratings of Health Plan, All Health Care, and Specialist Seen Most Often • Getting Care Quickly and Getting Needed Care • How Well Doctors Communicate • Customer Service • Access to Prescription Medicines and Specialized Services • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child *Populations are adult, Medicaid (TXIX) general child (GC), CHIP (TXXI) GC, TXIX children with chronic conditions (CCC), and TXXI CCC.	Access, Quality, Timeliness
	O	Relatively low rates or ranks • Ratings of All Health Care (adult), Personal Doctor (adult), and Specialist Seen Most Often (adult 4-year declining trend) • Getting Care Quickly (adult 4-year declining trend, TXXI GC, and TXIX CCC) and Getting Needed Care (TXIX CCC) • Medical Assistance with Smoking and Tobacco Use Cessation: Smoking and Tobacco Usage, Advising Smokers and Tobacco Users to Quit, and Discussing Cessation Strategies • Flu Vaccinations for Adults 18–64	Access, Quality, Timeliness
SHP	S	The following ranks or rates were very high for at least one population • Ratings of Health Plan and Personal Doctor • Getting Care Quickly and Getting Needed Care • Coordination of Care • How Well Doctors Communicate • Customer Service • Access to Prescription Medicines • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child • Medical Assistance with Smoking and Tobacco Use Cessation – Smoking and Tobacco Usage (rates maintained improving five-year trend)	Access, Quality, Timeliness
	O	Relatively low rates or ranks • Rating of Personal Doctor (adult) and Specialist Seen Most Often (TXXI CCC) • Getting Care Quickly (TXXI CCC, TXIX GC and CCC) • Coordination of Care (adult and TXXI CCC) and Coordination of Care for Children with Chronic Conditions (TXIX CCC and TXXI CCC) • How Well Doctors Communicate (adult) • Access to Specialized Services (TXIX CCC) • Rating of Mental or Emotional Health (TXXI GC and CCC) • Having a Personal Doctor (TXIX CCC)	Access, Quality, Timeliness
UHC	S	The following ranks or rates were very high for at least one population • Ratings of Health Plan, All Health Care, and Personal Doctor • Getting Care Quickly • Coordination of Care • How Well Doctors Communicate • Customer Service • Access to Prescription Medicines and Specialized Services • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child	Access, Quality, Timeliness
	O	Relatively low rates or ranks • Rating of All Health Care (adult and TXXI GC decreasing 5-year trends) • Getting Care Quickly (TXIX GC) and Getting Needed Care (TXXI GC and CCC downward trends) • Coordination of Care (UHC TXIX and TXXI GC)	Access, Quality, Timeliness
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

Table I.1. MCO-Level Strengths and Opportunities for Improvement (Continued)			
MCO		**Strengths (S*) and Opportunities (O*)**	**Domain**
CAHPS Survey Validation (Continued)			
UHC	O	• How Well Doctors Communicate (TXXI GC and CCC) • Coordination of Care for CCC (TXIX and TXXI CCC) • Family-Centered Care: Personal Doctor Who Knows Child (TXXI CCC) • Rating of Mental or Emotional Health (TXXI GC and CCC) • Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit and Discussing Cessation Strategies • Having a Personal Doctor (adults and TXXI GC)	Access, Quality, Timeliness
Provider Satisfaction Survey Validation			
ABH	S	A single survey vendor was used for all MCOs and the same survey processes were used across MCOs.	Quality
	O	The number of completed surveys by the four required provider types were low, impacting generalizability of the results for each provider type (Primary Care Physicians/Providers [PCPs]: 48; Specialists: 24; BH Providers: 159; and HCBS Providers: 166).	Quality
SHP	S	A single survey vendor was used for all MCOs and the same survey processes were used across MCOs.	Quality
	O	The number of completed surveys by the four required provider types were low, impacting generalizability of the results for each provider type (PCPs: 14; Specialists: 17; BH Providers: 40; and HCBS Providers: 53).	Quality
UHC	S	A single survey vendor was used for all MCOs and the same survey processes were used across MCOs.	Quality
	O	The number of completed surveys by the four required provider types were low, impacting generalizability of the results for each provider type (PCPs: 11; Specialists: 10; BH Providers: 105; and HCBS Providers: 135).	Quality
Review of Compliance with Medicaid and CHIP Managed Care Regulations			
ABH	S	All subparts had a compliance score of 92% or above, with one subpart scoring 100% compliant.	Access, Quality, Timeliness
	O	Aetna had the greatest opportunity for improvement, primarily with documentation, within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
SHP	S	All subparts had a compliance score of 96% or above, with two subparts scoring 100% compliant.	Access, Quality, Timeliness
	O	Sunflower had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
UHC	S	All subparts had a compliance score of 96% or above, with two subparts scoring 100% compliant.	Access, Quality, Timeliness
	O	UnitedHealthcare had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
Quality Assessment and Performance Improvement Review			
ABH	S	Aetna's QAPI program evaluation included information on new positions added and team expansion. They also received a score of 100% and award from National Committee for Quality Assurance (NCQA) for Health Equity Accreditation.	Quality
	O	One State requirement was substantially met and two were partially met.	Quality
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

Table I.1. MCO-Level Strengths and Opportunities for Improvement (Continued)			
MCO	**Strengths (S*) and Opportunities (O*)**		**Domain**
Quality Assessment and Performance Improvement Review (Continued)			
SHP	S	In the *2022 QAPI Program Evaluation*, Sunflower included a thorough analysis of their population characteristics, including maps and unique ways of breaking their population into groups (including grouping by product, language, and health care needs).	Quality
	O	Six requirements were partially met, one requirement was minimally met, and two requirements were not met.	Quality
UHC	S	UnitedHealthcare has easy to follow activities for each objective as well as objectives for each goal. QAPI work plans are well laid out and tie back to the QAPI program description and QAPI evaluation.	Quality
	O	Two requirements were substantially met and four requirements were partially met.	Quality
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

Summary of Individual EQR Components

1. Performance Measure Validation and Evaluation

Background/Objectives

KanCare MCOs are required to register with the National Committee for Quality Assurance (NCQA) and undergo an annual NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™, which conveys sufficient integrity to HEDIS data used by consumers and purchasers to compare healthcare organization performance.[3] The State required Aetna, Sunflower, and UnitedHealthcare to report HEDIS Measurement Year (MY) 2022 data through the NCQA data submission portal and undergo an ISCA. Baseline ISCAs were conducted with Sunflower and UnitedHealthcare in 2013 and with Aetna in 2019; all MCOs provided biennial updates in 2023. KFMC also evaluated the MCOs' performance of the Adult and Child Core Set measures to provide an understanding of the strengths and opportunities for improvement related to quality, timeliness, and access to care.

The ISCA/PMV process had four main objectives:

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

The objective of the performance measure evaluation was to provide an understanding of the strengths and opportunities for improvement of MCO performance related to quality, timeliness, and access to care. The evaluation focused on CMS Adult and Child Core Set HEDIS measures and included

- Comparison of the current year rates to
  - Prior year's rates,
  - Statewide aggregate (KanCare) rates, and
  - Quality Compass (QC) percentiles; and
- Analysis of trending across three to five prior years.

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, 2023 Methodologies: PMV and Evaluation.

Performance Measure Validation

In addition to the HEDIS Compliance Audit that NCQA requires of the MCOs, the State requires the EQRO to use an NCQA-Certified HEDIS Compliance Auditor to conduct its PMV. KFMC contracted with MetaStar, Inc.

[3] HEDIS® and NCQA HEDIS Compliance Audit™ are registered trademarks of the National Committee for Quality Assurance.

(MetaStar), an NCQA-Certified HEDIS Compliance Auditor that is independent of the HEDIS Compliance Auditors contracted by the KanCare MCOs. KFMC worked closely with MetaStar and the MCOs throughout the validation process.

Performance Measure Evaluation

MCO data were aggregated for KanCare-level results. This report contains KanCare and MCO results for CMS 2023 (MY 2022) Adult and Child Core Set measures that include rates, rankings, and indicators for notable changes in rates.[4]

- Adult Core Set (Table 1.1): 19 HEDIS measures, including 2 measures derived from the CAHPS surveys. The Plan All-Cause Readmissions (PCR) measure is risk-adjusted and reported according to observed versus expected hospital readmissions.
- Child Core Set (Table 1.2): 17 HEDIS measures.

Ranks are denoted, in order of worst to best performance: <5th, <10th, <25th, <33.33rd, <50th, ≥50th, >66.67th, >75th, >90th, and >95th. For example, a rate ranked <10th will be less than the Quality Compass national 10th percentile but not less than the 5th percentile. Note that, as QC percentiles are based on HEDIS rates from across the nation, some measures with high scores in Kansas may rank very low due to high scores nationwide. Due to the COVID-19 pandemic, NCQA advised caution when evaluating health plan performance with MY 2020 Quality Compass data.

An objective of the KanCare Quality Management Strategy is to improve HEDIS rates that are below the national 75th percentile by at least 10.00% 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 indicate measures that had a "gap-to-goal" percentage change of at least 10.00%. The tables also indicate changes of at least 3.0 percentage points per year (pp/y) averaged across three to five years and, for hybrid and survey measures, statistically significant changes from the prior year and statistically significant trendlines (see Appendix B for additional information).

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[4] Data were available for trending KanCare rates from Sunflower and UnitedHealthcare for measurement years 2017 to 2021, from Aetna for 2019 to 2021, and from Amerigroup Kansas, Inc. (Amerigroup) for 2017 to 2018.

[5] State of Kansas, *KanCare 2.0 Quality Management Strategy*, 12/9/2021, https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-quality-management-strategy-12-09-21.pdf?sfvrsn=bc13511b_8.

Table 1.1. HEDIS Performance Measures (Measurement Year 2022) – Adult Core Set

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

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

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

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AAB *A*	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**								
	– 18–64 Years	47.17	≥50th	47.98 y	≥50th	46.93	≥50th	46.80 c	≥50th
AMM *A*	**Antidepressant Medication Management**								
	– Effective Acute Phase Treatment	53.72	<25th	48.95	**<10th**	54.18	<25th	56.72	<33.33rd
	– Effective Continuation Phase Treatment	37.38	<25th	33.80	<25th	36.45	<25th	40.84	<50th
AMR *A*	**Asthma Medication Ratio**								
	– 19–50 Years	58.03	<50th	55.94	<33.33rd	64.08	>66.67th	54.86	<33.33rd
	– 51–64 Years	59.28 c	<50th	**65.52 bc**	>66.67th	58.14	<50th	57.89	<50th
	– 19–50 and 51–64 Years	58.23	NA	57.21	NA	63.30	NA	55.43	NA
BCS *A*	**Breast Cancer Screening**	45.52	<25th	36.50	**<5th**	49.99	<50th	47.90	<33.33rd
CBP *H*	**Controlling High Blood Pressure**	64.84 d	≥50th	**65.69 ab cd**	>66.67th	**63.99 bc**	≥50th	**64.96 x**	≥50th
CCS *H*	**Cervical Cancer Screening**	60.54	>66.67th	54.74 cd	<50th	61.31 d	>66.67th	63.99	>75th
CHL *A*	**Chlamydia Screening in Women**								
	– 21–24 Years	54.86	<25th	50.74	<25th	54.47	<25th	58.42	<33.33rd
COL *A*	**Colorectal Cancer Screening**	39.99 n	NA	33.50 n	NA	42.12 n	NA	43.05 n	NA
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (18+ Years)**								
	– 7-Day Follow-Up	29.54 n	>66.67th	27.05 n	≥50th	28.77 n	>66.67th	32.07 n	>75th
	– 30-Day Follow-Up	42.72 n	>75th	40.98 n	>66.67th	41.95 n	>66.67th	44.68 n	>75th

* "*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 administrative denominator (Amerigroup 2018; Aetna 2019–2022).

Table 1.1. HEDIS Performance Measures (Measurement Year 2022) – Adult Core Set (Continued)

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

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

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

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
FUH *A*	**Follow Up After Hospitalization for Mental Illness (18–64 Years)**								
	– 7-Day Follow-Up	43.11	>75th	40.89	>75th	44.77	>75th	43.15	>75th
	– 30-Day Follow-Up	64.88	>75th	61.56	>75th	66.63	>75th	65.60	>75th
FUM *A*	**Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years)**								
	– 7-Day Follow-Up	62.59	**>90th**	64.32	**>90th**	63.02	**>90th**	61.04	**>90th**
	– 30-Day Follow-Up	74.10	**>90th**	75.55	**>95th**	75.04	**>90th**	72.30	**>90th**
FVA *C*	**Flu Vaccinations for Adults (18–64 Years)**	46.29 z	>75th	40.15	≥50th	49.60	>75th	**48.30 b**	>75th
HBD *H*	**Hemoglobin A1c Control for Patients with Diabetes**								
	– HbA1c Control (<8%)	52.39 n	≥50th	47.93 n	<33.33rd	48.18 n	<33.33rd	59.61 n	>75th
	– Poor HbA1c Control *(lower rate is better)*	38.78 n	<50th	45.01 n	<25th	40.88 n	<50th	32.12 n	>75th
IET *A*	**Initiation and Engagement of Substance Use Disorder Treatment**								
	Initiation of SUD (18–64 Years)								
	– Alcohol Use Disorder	37.29 n	<25th	38.28 n	<33.33rd	36.40 n	<25th	37.28 n	<25th
	– Opioid Use Disorder	36.95 n	**<5th**	35.36 n	**<5th**	44.05 n	<25th	33.65 n	**<5th**
	– Other Drug Use Disorder	36.89 n	<25th	36.39 n	<25th	37.12 n	<25th	37.03 n	<25th
	– Total	37.01 n	<25th	36.86 n	<25th	37.72 n	<25th	36.53 n	**<10th**
	Engagement of SUD (18–64 Years)								
	– Alcohol Use Disorder	9.91 n	<50th	12.43 n	≥50th	9.32 n	<50th	8.36 n	<33.33rd
	– Opioid Use Disorder	14.69 n	<25th	13.57 n	**<10th**	18.01 n	<25th	13.35 n	**<10th**
	– Other Drug Use Disorder	9.94 n	<50th	10.30 n	<50th	10.08 n	<50th	9.57 n	<50th
	– Total	10.59 n	<33.33rd	11.38 n	<50th	10.79 n	<33.33rd	9.87 n	<25th

* "*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 administrative denominator (Amerigroup 2018; Aetna 2019–2022).

Table 1.1. HEDIS Performance Measures (Measurement Year 2022) – Adult Core Set (Continued)

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

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

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

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
MSC *C*	**Medical Assistance with Smoking and Tobacco Use Cessation** †								
	– Total % Current Smokers *(lower rate and ranking are better)*	27.57	≥50th	32.01	>75th	24.00 d	<50th	**27.20 b**	≥50th
	– Advising Smokers to Quit	**72.44 x**	<50th	71.50	<50th	**74.30 x**	≥50th	**71.51 xz**	<50th
	– Discussing Cessation Medications	50.08	<50th	47.12	<33.33rd	**55.00 x**	>66.67th	48.04	<50th
	– Discussing Cessation Strategies	43.82	<50th	39.79	<25th	53.10	>75th	**38.86 xyz**	<25th
PPC *H*	**Prenatal and Postpartum Care**								
	– Postpartum Care	76.22 d	<50th	74.45	<33.33rd	**72.02 bd**	<25th	**81.75 cdx**	>66.67th
SAA *A*	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia**	61.09	<50th	53.37	<25th	**61.30 b**	<50th	65.52	>66.67th
SSD *A*	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	76.41	<33.33rd	**74.18 x**	<25th	76.68	<33.33rd	77.59	<50th

Risk-Adjusted Measure & Indicators*		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)	9.88	10.93	0.90	10.79	10.84	1.00	10.01	11.10	0.90	9.07	10.77	0.84

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method; "*C*" denotes CAHPS survey measures. "O" means "observed," "E" means "expected," and ratios O/E less than 1.00 indicate better than expected performance.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator (Amerigroup 2018; Aetna 2019–2022).
† Total % Current Smokers is a one-year rate. The other MSC indicators are rolling two-year averages, with the pp change (b, x) being the difference between MY 2022 (2021-2022 average) and MY 2020 (2019-2020 average) and the average rate and rate of change (d, y, z) over four (Aetna) to five (KanCare) years calculated using one-year rates.

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Table 1.2. HEDIS Performance Measures (Measurement Year 2022) – Child Core Set

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

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

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

	Measures & Indicators*	KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AAB *A*	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**								
	– 3mo–17 Years	75.98 bc	≥50th	74.73 bc	≥50th	76.95 bc	>66.67th	75.95 bc	≥50th
ADD *A*	**Follow Up Care for Children Prescribed ADHD Medication**								
	– Initiation Phase	48.94	>75th	45.33	≥50th	49.49	>75th	51.19 b	>75th
	– Continuation & Maintenance Phase	56.80	≥50th	56.27	≥50th	55.66	≥50th	58.54	>66.67th
AMB *A*	**Ambulatory Care – Emergency Department Visits/1000 MM** *(lower is better)*								
	– Ages Less Than 1 Year	1086.51 x	NA	1018.02 x	NA	1139.06 x	NA	1099.62 x	NA
	– Ages 1–9 Years	530.18 x	NA	490.95 x	NA	550.29 x	NA	541.87 x	NA
	– Ages 10–19 Years	394.94	NA	377.12	NA	407.18	NA	397.54	NA
	– Ages 19 Years and Less	490.94 x	NA	463.87 x	NA	509.12 x	NA	495.18 x	NA
AMR *A*	**Asthma Medication Ratio**								
	– Ages 5–11 Years	74.75	<50th	74.94 xy	<50th	78.71 x	≥50th	72.15	<33.33rd
	– Ages 12–18 Years	66.43	<50th	70.09	≥50th	69.75 x	≥50th	62.11	<25th
	– Ages 5–18 Years	70.38	NA	72.44 x	NA	73.76 x	NA	67.02	NA
APM *A*	**Metabolic Monitoring for Children and Adolescents on Antipsychotics**	42.27	>75th	43.33	>75th	42.23	>75th	41.56 x	>66.67th
APP *A*	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)**	72.36 x	>75th	68.12 xy	>75th	75.45	>90th	72.37	>75th
CHL *A*	**Chlamydia Screening in Women (16–20 Years)**	39.92	<25th	38.07	<10th	40.69	<25th	40.63	<25th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator (Amerigroup 2018; Aetna 2019–2022).

Table 1.2. HEDIS Performance Measures (Measurement Year 2022) – Child Core Set (Continued)

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

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

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

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
CIS *H*	**Childhood Immunization Status**								
	– Diphtheria-Tetanus-Acellular Pertussis (DTaP)	66.62 xz	<33.33rd	66.18 xz	<33.33rd	66.91 xz	<33.33rd	66.67 z	<33.33rd
	– Haemophilus Influenzae B (HiB)	80.11 z	<33.33rd	79.32 z	<33.33rd	81.02 xz	<33.33rd	79.81 z	<33.33rd
	– Hepatitis A	82.15 z	≥50th	82.24 z	≥50th	82.00 z	≥50th	82.24	≥50th
	– Hepatitis B	87.55 z	≥50th	85.16 z	<50th	89.29 bz	>66.67th	87.59 z	≥50th
	– Inactivated Poliovirus Vaccine (IPV)	84.76 z	<50th	84.67 z	<50th	84.67 xz	<50th	84.91	<50th
	– Influenza	39.46 wz	<50th	41.85	≥50th	40.15 x	<50th	36.98 wx	<50th
	– Measles-Mumps-Rubella (MMR)	82.88 z	<50th	82.97	<50th	83.21 xz	<50th	82.48	<50th
	– Pneumococcal Conjugate	68.99 z	<50th	68.37 xz	<33.33rd	68.13 xz	<33.33rd	70.32	<50th
	– Rotavirus	67.84 wx	<50th	67.40 xz	<50th	65.94 x	<33.33rd	70.07	≥50th
	– Varicella-Zoster Virus (VZV)	82.84 z	<50th	81.51 z	<33.33rd	83.94	<50th	82.73	<50th
	– Combination 10 (all 10 antigens)	32.01 w	≥50th	33.33	≥50th	31.39	≥50th	31.63 wx	≥50th
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (13–17 Years)**								
	– 7 Days	26.32 n	>75th	25.35 n	>66.67th	27.17 n	>75th	26.19 n	>66.67th
	– 30 Days	41.70 n	>75th	43.66 n	>75th	43.48 n	>75th	38.10 n	>66.67th
FUH *A*	**Follow Up After Hospitalization for Mental Illness (6–17 Years)**								
	– 7 Days	57.83	>75th	54.96	>75th	59.18	>75th	58.76	>75th
	– 30 Days	78.21	>75th	75.54 x	≥50th	78.93	>75th	79.59	>75th
FUM *A*	**Follow Up After Emergency Department Visit for Mental Illness (6–17 Years)**								
	– 7 Days	69.70 x	>75th	67.73 x	>75th	73.85	>75th	66.92 x	>75th
	– 30 Days	82.05 x	>75th	80.45 x	>75th	84.45	>75th	80.83 x	>75th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator (Amerigroup 2018; Aetna 2019–2022).

Table 1.2. HEDIS Performance Measures (Measurement Year 2022) – Child Core Set (Continued)

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

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

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

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
IMA *H*	**Immunizations for Adolescents**					*Administrative*			
	– Human Papillomavirus (HPV)	28.47 wz	<25th	28.71	<25th	30.90 x	<33.33rd	25.79 z	<10th
	– Meningococcal	80.82 d	<50th	81.02 z	<50th	81.90	≥50th	79.56	<50th
	– Tetanus-Diphtheria-Pertussis (Tdap)	82.43 z	<50th	82.97	<50th	83.40	<50th	81.02 z	<33.33rd
	– Combination 1 (Meningococcal, Tdap)	80.40 d	<50th	81.02	≥50th	81.47	≥50th	78.83	<50th
	– Combination 2 (Meningococcal, Tdap, HPV)	28.05 wz	<25th	28.71	<25th	30.47 x	<33.33rd	25.06 z	<25th
LSC *H*	**Lead Screening in Children**	51.67	<33.33rd	51.58	<33.33rd	53.04 b	<33.33rd	50.36	<33.33rd
PPC *H*	**Prenatal and Postpartum Care**								
	– Timeliness of Prenatal Care	80.41 z	<33.33rd	73.48 yz	<25th	75.91 ab	<25th	90.51 x	>75th
W30 *A*	**Well-Child Visits in the First 30 Months of Life**								
	– First 15 Months	59.76	≥50th	58.30 c	<50th	60.83	≥50th	59.85	≥50th
	– 15 Months–30 Months	60.73	<25th	60.82	<25th	61.27 y	<25th	60.14	<25th
WCC *H*	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total)**								
	– BMI percentile	75.20 abd	<50th	75.43 abcd	<50th	68.37 ab	<25th	82.24 abcd	≥50th
	– Counseling for Nutrition	62.56 d	<33.33rd	65.94 abcd	<50th	62.77 d	<33.33rd	59.61	<25th
	– Counseling for Physical Activity	60.26 d	<33.33rd	64.23 abcd	<50th	61.07 bd	<50th	56.20	<25th
WCV *A*	**Child and Adolescent Well-Care Visits**								
	– 3–11 Years	51.96	<33.33rd	49.72	<25th	55.07	<50th	50.61	<25th
	– 12–17 Years	47.19	<50th	44.67	<33.33rd	50.99	≥50th	45.47	<33.33rd
	– 18–21 Years	19.83	<25th	17.94	<25th	22.50	<50th	18.72	<25th
	– 3–21 Years	45.28	<50th	42.92	<25th	48.59	≥50th	43.87	<33.33rd

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator (Amerigroup 2018; Aetna 2019–2022).

Conclusions Drawn from the Data

The MCOs calculated and submitted HEDIS rates for the 2022 measurement year. MetaStar evaluated each area requiring validation to instill confidence that the MCOs' information systems were configured appropriately and that performance measures were calculated correctly. With the exception of stratifications for race and ethnicity, and for Sunflower, an indicator for the Risk of Continued Opioid Use measure, the MCOs' performance measure rates were found to be valid.

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

Performance Measures

The following were considered when determining key strengths (refer to Table 1.1 and Table 1.2): measurement year 2022 rates above the Quality Compass 90th percentile; statistically significant improvements from 2021 (hybrid or survey methods only); at least 10.00% gap-to-goal improvement in rates from 2021, expressed as percentage points (pp) change; improvements averaging at least 3.0 pp/y since 2018 or 2019 (depending on the measure); and statistically significantly improving trends (hybrid or survey methods only) since 2018 or 2019 (depending on the measure).

KanCare

While not all statistically significant trends, the MCOs have generally improved their HEDIS performance rates over the past three to five years. KanCare rates were above the 75th percentile for six Adult and nine Child Core Set measure indicators (see Table 1.1 and Table 1.2). The Follow-Up After Emergency Department Visit for Mental Illness 7-Day and 30-Day Follow-Up (18–64 years) indicators ranked >90th.

Three KanCare rates for Adult Core Set measure indicators had improvements noted in Table 1.1, described below.

- Asthma Medication Ratio (51–64 Years), 2.1 pp/y improving trend from 2018
- Controlling High Blood Pressure, statistically significantly improving trend of 2.3 pp/y from 2018
- Prenatal and Postpartum Care – Postpartum Care, statistically significantly improving trend of 2.7 pp/y from 2018

Six KanCare rates for Child Core Set measure indicators had improvements noted in Table 1.2, as shown below.

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months–17 Years), 8.6 pp increase from 2021 and 3.9 improving trend from 2019
- Immunizations for Adolescents
  - Meningococcal, statistically significantly improving trend of 1.0 pp/y from 2018
  - Combination 1, statistically significantly improving trend of 1.2 pp/y from 2018
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI Percentile, statistically significant 12.9 pp increase from 2021 and statistically significantly improving trend of 2.5 pp/y from 2018
  - Counseling for Nutrition, statistically significantly improving trend of 1.2 pp/y from 2018
  - Counseling for Physical Activity, statistically significantly improving trend of 1.2 pp/y from 2018

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 2022 rates below the Quality Compass 10th percentile; rates statistically significantly worse than in 2021 (hybrid and survey methods only); rates worse by at least 10.00% gap-to-goal from 2021; worsening trends of 3.0 pp/y or more since 2018 or 2019 (depending on the measure); and

statistically significantly worsening trends (hybrid and survey methods only) since 2018 or 2019 (depending on the measure).

KanCare

For KanCare, one Adult Core Set measure indicator was below the 5th percentile (eight Adult and five Child indicators ranked <25th).

The Flu Vaccinations for Adults KanCare Adult Core Set measure had a statistically significantly worsening trend of 2.2 pp/y from 2018 to 2022, as noted in Table 1.1. Medical Assistance with Smoking and Tobacco Use Cessation, Advising Smokers to Quit, had a greater than 10.00% gap-to-goal worsening between averaged 2021-2022 rates and 2019-2020 rates.

Two KanCare child measures had a statistically significantly worsening rate from MY 2021. Four child measures had at least a 10.00% or greater gap-to-goal worsening. Three child measures (13 indicators) had a statistically significantly worsening trend over three to five years, depending on the measure.

- Statistically significantly worsening rate from MY 2021
  - Childhood Immunization Status
  - Immunizations for Adolescents
- At least a 10% gap-to-goal worsening from MY 2021
  - Ambulatory Care – Emergency Department Visits/1000 MM
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
  - Childhood Immunization Status
  - Follow-Up After Emergency Department Visit for Mental Illness, members aged 6-17 years
- Statistically significantly worsening trend over three to five years
  - Childhood Immunization Status
  - Immunizations for Adolescents
  - Prenatal and Postpartum Care

Aetna

Four Adult Core Set measure indicators were below the 10th percentile; 8 more were below the 25th percentile. One Child Core Set measure indicator was below the 10th percentile; seven more were below the 25th percentile.

The following Adult and Child Core Set measure indicators had rates that statistically significantly worsened from the prior year, worsened by 10.00% gap-to-goal or more from 2021 to 2022 (provided in pp), had a worsening trend of at least 3.0 pp/y, or had a statistically significantly worsening trend, from 2019 to 2022, and are noted in Tables 1.1 and 1.2:

- Adult
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis, 3.7 pp/y statistically significantly worsening trend from 2019
  - Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications, 2.6 pp decrease from 2021
- Child
  - Ambulatory Care – Emergency Dept Visits/1000 members (lower is better)
    - Ages Less Than 1 year, increase of 180.5 (visits/1000 members) from 2021
    - Ages 1–9 Years, increase of 70.6 from 2021
    - Ages 19 Years and Less, increase of 55.4 from 2021

- Asthma Medication Ratio
  - Ages 5–11 Years, 5.4 pp decrease from 2021
  - Ages 5–18 Years, 3.7 pp decrease from 2021
- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 6.6 pp decrease from 2021 and 3.4 pp/y worsening trend from 2019
- Childhood Immunization Status
  - DTaP, 4.4 pp decrease from 2021 and 2.5 pp/y statistically significantly worsening trend from 2019
  - Haemophilus Influenzae B (HiB), 2.4 pp/y statistically significantly worsening trend from 2019
  - Hepatitis A, 2.2 pp/y statistically significantly worsening trend from 2019
  - Hepatitis B, 2.3 pp/y statistically significantly worsening trend from 2019
  - Inactivated Poliovirus Vaccine (IPV), 2.2 pp/y statistically significantly worsening trend from 2019
  - Pneumococcal Conjugate, 4.4 pp decrease from 2021 and 2.6 pp/y statistically significantly worsening trend from 2019
  - Rotavirus, 5.4 pp decrease from 2021 and 2.1 pp/y statistically significantly worsening trend from 2019
  - Varicella-Zoster Virus (VZV), 1.8 pp/y statistically significantly worsening trend from 2019
- Follow Up After Hospitalization for Mental Illness (6–17 Years) – 30 Days, 3.1 pp decrease from 2021
- Follow-Up After Emergency Department Visit for Mental Illness (6-17 Years) – 7 Days, 3.6 pp decrease, and 30 Days, 4.2 pp decrease, from 2021
- Immunizations for Adolescents
  - Meningococcal, 2.6 pp/y statistically significantly worsening trend from 2019
- Prenatal and Postpartum Care – Timeliness of Prenatal Care, 3.2 pp/y statistically significantly worsening trend from 2019

Sunflower

No Adult or Child Core Set measure indicators were below the 10th percentile. Nine Adult and four Child Core Set measure indicators were below the 25th percentile.

The following Adult and Child Core Set measures worsened by 10.00% gap-to-goal or more (measured in pp), a worsening trend of at least 3.0 pp/y, or a statistically significantly worsening trend, from 2018 to 2022 depending on the measure, noted in Tables 1.1 and 1.2:

- Adult
  - Medical Assistance with Smoking and Tobacco Use Cessation
    - Advising Smokers to Quit, 2021-2022 average rate decreased 3.5 pp from 2019-2020
    - Discussing Cessation Medications, 2021-2022 average rate decreased 6.2 pp from 2019-2020
- Child
  - Ambulatory Care – Emergency Department Visits/1000 members (lower is better)
    - Ages Less Than 1 Year, increase of 145.6 (visits/1000 members)
    - Ages 1–9 Years, increase of 96.8
    - Ages 19 Years and Less (Total), increase of 64.5

- Asthma Medication Ratio
  - Ages 5–11 Years, 3.1 pp decrease from 2021
  - Ages 12–18 Years, 3.3 pp decrease from 2021
  - Ages 5–18 Years, 3.2 pp decrease from 2021
- Childhood Immunization Status
  - DTaP, 4.4 pp decrease from 2021 and statistically significantly worsening trend of 2.4 pp/y decrease from 2018
  - HiB, 2.2 pp decrease from 2021 and statistically significantly worsening trend of 1.4 pp/y decrease from 2018
  - Hepatitis A, statistically significantly worsening trend of 1.5 pp/y decrease from 2018
  - Hepatitis B, 1.0 pp/y statistically significantly worsening trend from 2018
  - Inactivated Poliovirus Vaccine (IPV), 1.7 pp decrease from 2021 and statistically significantly worsening trend of 1.3 pp/y from 2018
  - Influenza, 6.1 pp decrease from 2021
  - Measles-Mumps-Rubella (MMR), 1.7 pp decrease from 2021 and statistically significantly worsening trend of 1.3 pp/y decrease from 2018
  - Pneumococcal Conjugate, 3.4 pp decrease from 2021 and statistically significantly worsening trend of 2.4 pp/y decrease from 2018
  - Rotavirus, 3.9 pp decrease from 2021
- Immunizations for Adolescents
  - HPV, 7.1 pp decrease from 2021
  - Combination 2, 6.8 pp decrease from 2021
- Well-Child Visits in the First 30 Months of Life (15 Months–30 Months), 3.1 pp/y worsening trend from 2020

UnitedHealthcare

Three Adult Core Set measure indicators were below the 10th percentile; four more were below the 25th percentile. One Child Core Set indicator rate was below the 10th percentile; eight were below the 25th percentile.

The following Adult and Child Core Set measures worsened by 10.00% gap-to-goal or more (measured in pp), had worsening trends of at least 3.0 pp/y, or statistically significantly worsening trends (measured in pp/y), from 2018 to 2022 depending on the measure, noted in Tables 1.1 and 1.2:

- Adult
  - Controlling High Blood Pressure, 4.6 pp decrease from 2021
  - Prenatal and Postpartum Care – Postpartum Care, 3.2 pp decrease from 2021
  - Medical Assistance with Smoking and Tobacco Use Cessation
    - Advising Smokers to Quit, 2021-2022 average 3.1 pp decrease from 2019-2020 and statistically significantly worsening trend of 2.9 pp/y from 2018
    - Discussing Cessation Strategies, 2021-2022 average 6.5 pp decrease from 2019-2020 and statistically significantly worsening trend of 3.7 pp/y from 2018
- Child
  - Ambulatory Care – Emergency Department Visits/1000 members (lower is better)
    - Ages Less Than 1 Year, increase of 172.9 (visits/1000 members)
    - Ages 1–9 Years, increase of 89.1
    - Ages 19 Years and Less (Total), increase of 60.8
  - Metabolic Monitoring for Children and Adolescents on Antipsychotics, 6.1 pp decrease from 2021

- Childhood Immunization Status
  - DTaP, statistically significantly worsening trend of 1.8 pp/y from 2018
  - HiB, statistically significantly worsening trend of 1.3 pp/y from 2018
  - Hepatitis B, statistically significantly worsening trend of 1.0 pp/y from 2018
  - Influenza, statistically significant 8.5 pp decrease from 2021
  - Combination 10, statistically significant 7.1 pp decrease from 2021
- Follow-Up After Emergency Department Visit for Mental Illness (6–17 Years)
  - 7 Days, 6.9 pp decrease from 2021
  - 30 Days, 2.5 pp decrease from 2021
- Immunizations for Adolescents
  - HPV, statistically significantly worsening of 2.2 pp/y from 2019
  - Tdap, statistically significantly worsening trend of 1.3 pp/y from 2018
  - Combination 2, statistically significantly worsening trend of 2.2 pp/y from 2018
- Prenatal and Postpartum Care – Timeliness of Prenatal Care, 3.9 pp decrease from 2021

Technical Strengths

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

Common Among the MCOs

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

Aetna

- Aetna continued to have strong processes in place to ensure accurate and complete receipt and processing of claims, enrollment, and provider data for HEDIS performance measures. All organizational goals for accuracy and timeliness were met for the measurement period.
- Aetna maintained sufficient oversight of its claims processing vendors. A dedicated team ensured that vendor data were received and processed timely and completely.
- Aetna continued to overread all medical record reviews to ensure accuracy and completeness.

Sunflower

- Sunflower successfully added supplemental data from the Kansas Health Information Network (KONZA), an NCQA-certified Data Aggregator Validation organization.
- Sunflower continued to have strong processes in place to ensure accurate and complete receipt and processing of claims, enrollment, and provider data for HEDIS performance measurement. All organizational goals for accuracy and timeliness were met for the measurement period.

UnitedHealthcare

- UnitedHealthcare continued to benefit from the support of its national plan for many aspects of HEDIS performance measure reporting, drawing on the extensive expertise of those within the corporate structure to achieve the goal of accurate and complete measure data.
- UnitedHealthcare used a vendor to conduct medical record abstraction. UnitedHealthcare adequately monitored vendor accuracy and progress and achieved 100 percent accuracy on the medical record re-abstraction.

Technical Opportunities for Improvement

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

Common Among the MCOs

Four issues related to race and ethnicity coding were identified:

- The State Fiscal Agent's crosswalk from Kansas Modular Medicaid System (KMMS) to the 834 enrollment file did not distinguish between N = Not Hispanic or Latino and E = Not specified, which directly impacted the MCOs' ability to accurately stratify HEDIS rates by race and ethnicity.
- Clarification of the meaning of ethnicity code U = Hispanic or Latino Unknown has not been provided to the MCOs.
- Proper interpretation of Health Insurance Portability and Accountability Act (HIPAA) race code descriptions, such as "Black" means "Black, Non-Hispanic," was not provided to users.
- For MY 2022 HEDIS measures and other analyses, MCOs lost data by reading only the first race/ethnicity code from the 834 enrollment file.

Sunflower

- Sunflower self-reported a Risk of Continued Opioid Use (COU) measure error that was identified after the HEDIS data submission to NCQA. The error was due to including duplicate pharmacy records in the member-level data loaded to the NCQA-certified software for HEDIS measure production. The error caused greater than five percent error for the 65+ 15-30 Day sub-component of the measure.

UnitedHealthcare

- UnitedHealthcare did not utilize Kansas-specific data sources such as direct electronic medical record data feeds and aggregated data from Kansas provider groups as supplemental data for HEDIS reporting.
- The quantity billed for Current Procedural Terminology (CPT) code A0425 did not reflect miles traveled on encounters for ambulance service claims; encounters for trips by commercial van appeared to be underreported.

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

Please see Appendix D for MCO responses to the recommendations made as a result of the performance measure validation and evaluation process performed in 2022 (MY 2021).

Recommendations for Quality Improvement

Common Among the MCOs

Technical

1. Review the State Race and Ethnicity HIPAA Crosswalk and update the race and ethnicity data mapping into the HEDIS reporting system to ensure that race and ethnicity are accurately stratified.

Performance Measures

2. The MCOs should review all HEDIS rates below the 75th percentile, as well as those above the 75th percentile with decreasing rates, to look for opportunities for improvement.
3. The MCOs should ensure the following areas are addressed through more focused efforts, such as assessing for health disparities and addressing barriers to associated care, etc.:
    - Initiation and Engagement of Substance Use Disorder Treatment
    - Ambulatory Care – Emergency Dept Visits/1000 members for ages less than 1 year through 19 years
4. Continue or modify existing efforts, identified as partially addressed or in progress, for the previous recommendations noted in Appendix D.

Aetna

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

Technical

1. Aetna should continue with plans to begin capturing multiple race and ethnicity codes when more than one code is included for members in the State 834 enrollment file.

Performance Measures

2. Aetna should prioritize improvement efforts towards the following additional HEDIS measures:
    - Antidepressant Medication Management
    - Breast Cancer Screening
    - Chlamydia Screening in Women
    - Prenatal and Postpartum Care – Timeliness of Prenatal Care
    - Well-Child Visits in the First 30 Months of Life and Adolescent Well-Care Visits for all age groups, including ages 18–21 years; continue focus on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) performance improvement project
    - Medical Assistance with Smoking and Tobacco Use Cessation
        - Discussing Cessation Medications and other Cessation Strategies

Sunflower

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

Technical

1. Sunflower should continue with plans to incorporate each of the race and ethnicity codes submitted for each member in the State 834 enrollment file.

Performance Measures

2. Sunflower should prioritize improvement efforts towards the following additional HEDIS measures:
    - Antidepressant Medication Management
    - Prenatal and Postpartum Care
    - Immunizations – Childhood, Adolescent
    - Well-Child Visits in the First 30 Months of Life (15 Months–30 Months)

Recommendations for Quality Improvement (Continued)

UnitedHealthcare

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

Technical

1. UnitedHealthcare should explore obtaining additional Kansas-specific data sources for supplemental data, such as direct electronic medical record data feeds from Kansas providers and aggregated data.
2. UnitedHealthcare should review provider billing of transportation by ambulance and commercial van.

Performance Measures

3. UnitedHealthcare should prioritize improvement efforts towards the following additional HEDIS measures:
   - Immunizations – Childhood, Adolescent
   - Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Strategies and Advising Smokers to Quit

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2. Performance Improvement Project Validation

Background/Objectives

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

Technical Methods of Data Collection and Analysis

In 2023, regular interagency meetings occurred that included focused PIP discussions among staff from KDHE, KDADS, KFMC, and each of the MCOs. KFMC provided feedback on revised PIP methodologies, interventions, metric specifications, data analysis, and annual progress.

The PIP validations were conducted in accordance with the February 2023 Validating Performance Improvement Projects protocol worksheets and narrative provided by CMS. Evaluation includes review of the MCOs' annual reports submitted for the current and prior years (where applicable), along with their originally submitted approved PIP methodology worksheets. The MCOs' monthly data submitted to KFMC for populating into PIP Action Reports (PARs) along with the corresponding PAR metric specifications were also reviewed.

Description of Data Obtained

Eight of the sixteen PIPs validated during the 2023 to 2024 reporting cycle were based on HEDIS measures. For the various PIPs, sources of data included: claims, encounters, membership data, medical records, laboratory results, and immunizations identified through the Kansas Immunization Registry (KSWebIZ).

Overall Validity and Reliability of PIP

The first rating is determined based on KFMC's level of confidence (High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, Little Confidence: below 80%) that the MCOs 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 PIPs results.

The second rating determines whether the PIPs produced significant evidence of improvement and has, or is on track to, reach the PIP's goal. As an assessment guide, KFMC uses a 12-point system. The MCO rating is based on KFMC's determination of progress made toward the PIP outcome goal, evidence that improvements are attributable to the PIP interventions, and evidence that improvements are sustainable. The net result is the *evaluation score*, which determines the level of overall confidence: High Confidence, 10 to 12 points; Confidence, 7 to 9 points; Low Confidence, 4 to 6 points; and Little Confidence, 3 points or fewer.

The two level of confidence ratings for each of the PIPs evaluated are included in Table 2.1 below.

Table 2.1. MCOs' PIP Topics and Validation Ratings			
PIP Topic	**Validation Status**	**Validation Rating**	**Evidence of Improvement**
Aetna			
EPSDT	Yes	89.9% – Low Confidence	Little Confidence
Pregnancy: Prenatal Care	Yes	80.6% – Low Confidence	Low Confidence
Food Insecurity	Yes	95.6% – High Confidence	Confidence
Long-Term Services & Supports ED Visits	Yes	95.9% – High Confidence	Little Confidence
Influenza Vaccination	Yes	91.6% – Confidence	Little Confidence
Sunflower			
EPSDT	Yes	80.0% – Low Confidence	Little Confidence
Cervical Cancer Screening	Yes	85.1% – Low Confidence	High Confidence
SMD	Yes	96.0% – High Confidence	Little Confidence
Waiver Employment (final year)	Yes	94.5% – Confidence	Little Confidence
Mental Health Services for Foster Care	Yes	83.7% – Low Confidence	Little Confidence
UnitedHealthcare			
EPSDT	Yes	88.8% – Low Confidence	Little Confidence
SMD	Yes	91.8% – Confidence	High Confidence
Advanced Directives	Yes	88.8% – Low Confidence	High Confidence
Housing	Yes	96.4% – High Confidence	High Confidence
AMM	Yes	93.7% – Confidence	High Confidence
All MCOs (Collaborative)			
COVID-19 Vaccination (final year)	Yes	90.8% – Confidence	Confidence

Themes of Recommendations for Quality Improvement

In assessing the EQRO recommendations for the sixteen PIPs, the main themes involved the MCOs' analysis plans, presentations of their data, and accuracy of the results. KFMC recommended for the MCOs to follow the analysis plan from the approved PIP methodology; ensure the described analysis results are accurate, clear; and that the interpretations are supported by the presented data. Another recommendation theme for future annual reports was to make sure the most recent approved technical specifications are being followed throughout the report.

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

Please see Appendix D for information regarding MCO progress on recommendations made in prior years' PIPs.

Aetna

EPSDT PIP

Background/Objectives

Aetna's stated aim for the EPSDT PIP is to "achieve an EPSDT participation rate of 85 percent for ages 0–20 years, over a five-year period." The third year of activity for this PIP was October 1, 2021, to September 30, 2022. Aetna's multifaceted intervention strategy included the six interventions listed below in Table 2.2.

Table 2.2. Aetna's EPSDT PIP Interventions	
PIP Interventions	**Outcome**
Interactive Voice Response (IVR) system calling campaign to remind and educate members/parents/guardians of the importance of EPSDT visits *(Implemented January 2022)*	• 17.7% (17/96) of members received an EPSDT visit within 90 days of IVR contact. • 2.6% (2,113/79,865) of members, aged 0 to 20, with birthdays in January through September 2022, have a land line.
Text Message Campaign to provide educational messages to members/parents/guardians on health-related topics including EPSDT visits *(Implemented January 2022)*	• 13.5% (4,044/29,986) members completed an EPSDT visit within 90 days of receipt of the first text message. • 37.5% (29,985/79,865) of members, aged 0 to 20 years, born in January through September, have an accurate cell phone number. • 28.2% (22,490/79,865) of members, aged 0 to 20 years, born in January through September, completed an EPSDT visit prior to the member's birth month.
Member incentives for completing well-care visits *(Implemented January 2019)*	Results were deemed invalid for measuring intervention effectiveness.
Use of Health Tag reminders on prescriptions filled at CVS pharmacies *(Discontinued March 2022)*	This intervention was never implemented and was discontinued, with State approval, in March 2022.
EPSDT-related webinars to educate providers/office staff on the EPSDT program and recommended screenings *(Implemented January 2022)*	• 127 persons attended, or participated, in the webinar. • 30 attendees responded to the post-webinar survey, 10 of whom were not Aetna staff.
Outreach calls to parents/guardians in Sedgwick County, aged 6-18, who identify as Black or Black non-Hispanic individuals, chose not to identify, or left the question blank on the enrollment form *(Implemented April 2022)*	• 18.3% (32/175) of eligible members completed an EPSDT service within 90 days of a successful outreach call. • 57.3% (2,501/4,362) of eligible members have an accurate phone number. • 7.0% (175/2,501) of eligible members were successfully contacted.

Conclusions Drawn from the Data

Tests for statistically significant differences between remeasurement year (RY) 2 and RY3 Participation Rates were conducted for several subpopulations. There were several key findings:

- For age group 3 to 5, the decrease from 57.9% to 56.4% was statistically significant. No other age groups had statistically significant changes.
- The rate decrease, from 67.3% to 63.5% for members in foster care, was statistically significant.
- Changes were not significant for members receiving Intellectual/Developmental Disability (I/DD) or Serious Emotional Disturbance (SED) Waiver services.

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

- The outreach pilot that was implemented shows promise, as Aetna will expand the staff dedicated to calling members.

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

- Incorrect numerators, denominators, and rates were reported for several process and outcome measures.
- Calculations of totals in a few of the tables were incorrect.
- Expected results of an intervention outcome measure were not reported.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 12 recommendations made to address the opportunities for improvement.

Pregnancy: Prenatal Care PIP

Background/Objectives

Aetna identified two aims for the PIP:

- "The first aim for this PIP is to use member-and provider-focused interventions to increase the median days between Aetna notification of the member's pregnancy and the date of delivery by 3% year over year. The RY2 report data provided a baseline of 187 days and an increase of 3% each year for five years would provide a long-term goal of reaching a median of 219 days between notification and delivery."
- "The second aim for this PIP is to use member- and provider-focused interventions to increase the percent of pregnant women with the initial prenatal visit occurring within the first trimester or within 42 days of enrollment from 42.00 percent (2019) to 75.5 percent by the end of the PIP."

The third year of activity for this PIP was January 1, 2022, to December 31, 2022. The outcomes of Aetna's interventions, based on the 2023 evaluation, are provided in Table 2.3 below.

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

PIP Interventions	Outcome
Texting campaign to female members aged 18–55 years *(Implemented December 2021 through December 2022)*	Results were deemed invalid for measuring intervention effectiveness.
IVR campaign to female members aged 18–55 years *(Implemented December 2021 through December 2022)*	Results were deemed invalid for measuring intervention effectiveness.
Telephonic care management (CM) outreach to newly enrolled members identified as pregnant in the State 834 eligibility file *(Implemented August 2020)*	Results were deemed invalid for measuring intervention effectiveness.
Incentives for providers to notify Aetna of member pregnancy *(Implemented September 2022)*	Results were deemed invalid for measuring intervention effectiveness.

Conclusions Drawn from the Data

Aetna's conclusions were consistent with the data: targeted rates were not achieved.

- The 2022 hybrid Timeliness of Prenatal Care rate (73.5%) was greater than the 2021 rate (72.0%), but below the targeted rate (75.5%) and 2020 baseline rate (77.4%).
- Outcome Measure 2 results showed the initial increase (from 41.0% for 2019 to 45.5% for 2020) was not sustained. The 2022 rate for Outcome Measure 2 was 43.9%.

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

- The analysis completed in 9.2 based on Outcome Measure 2 was thorough and presented well.
- Once all interventions were implemented and data became available, updates were made to interventions that included the combining of two interventions and the addition of a new intervention.

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

- The projected PIP end date and outcome measure were not clearly stated, and the PIP population was not accurately defined.
- Intervention details were missing.

- Reported process and outcome measures did not follow technical specifications, and technical specifications were missing for some PAR measures.
- The PIP outcome measures were not correctly defined or calculated.
- The interpretation of one outcome measure was incorrect, and conclusions were drawn that were not supported by the data.
- There were inconsistencies in the presentation of data between tables; some tables were mislabeled or had missing data.
- For one measure, the denominator criteria was unclear.

Recommendations for Quality Improvement
See Appendix C, *2023 Recommendations: PIP Validation* for details on the 17 recommendations made to address the opportunities for improvement.

Food Insecurity PIP

Background/Objectives

The PIP aim statement is to "use member, provider, and community-facing interventions to reduce food insecurity reported in the annual ABH - Health Care Equity (HCE) screening and the Food Insecurity Screening (FIS) for all targeted members through the end of the PIP."

The third year of activity for this PIP was April 1, 2022, to March 31, 2023. Aetna's plan included the interventions listed in Table 2.4.

Table 2.4. Aetna's Food Insecurity PIP Interventions

PIP Interventions	Outcome
Z-code project with outreach to select providers *(Implemented with provider education webinar in July 2021)*	• Of 2,784,468 claims in 2022, 0.04% (1,054) listed a Z code identifying food insecurity. • Of 130,982 members in 2022, 0.46% (605) had claims with Z codes identifying food insecurity. • Of 345 members in 2022, 15.9% (55) were successfully contacted by CM for outreach within 14 days of CM being notified.
Community Pharmacy Enhanced Service Network (CPESN) program with select pharmacies within the Aetna's network *(Implemented July 2020)*	• Of the 172 members participating in the CPESN program, 8.7% (15) of members were identified as having food insecurity on the HCE assessment. • The percentage of those receiving successful outreach by CM was too low to be reported.
IVR welcome call with CM follow-up as indicated *(Discontinued without implementation)*	Discontinuation of the intervention was approved April 24, 2022.
Member webinar for members with diabetes and other chronic conditions to focus on education and options for healthy eating *(Implemented with initial webinar in 2023 Q1)*	• The link for the educational webinar was sent to 5,560 members. • The number of members completing the survey was too low to report either outcome measure.
Partnership with community providers to provide healthy food resources to communities identified as food deserts *(Implemented 2021 Q2)*	• Over 24,800 Kansans were assisted through community food distribution and food pantries supported by Aetna in 2022.
FIS via Short Message Service (SMS) or IVR *(Implemented 2022 Q3)*	• Of the 769 members in the target areas who were outreached by text and provided a valid response to the first question of the initial survey, 61.1% (470) reported food insecurity. • Of the 695 members in the target areas who were outreached by text and provided a valid response to the second question of the initial survey, 46.3% (322) reported already receiving Supplemental Nutrition Assistance Program (SNAP) or Women, Infants and Children (WIC) benefits.

Conclusions Drawn from the Data

Aetna's presentation and interpretation of the data were clear, organized, and informative.

- **Outcome Measure 1 –** 20.8% (20/96) of members who no longer have food insecurity after self-reporting food insecurity during their initial FIS.
- **Outcome Measure 2 –** 25.6% (23/90) of members who expressed that the food resources and plan assistance provided had helped their food security needs.
- **Outcome Measure 3 –** 10 or fewer members enrolled in Women, Infants and Children (WIC)/ Supplemental Nutrition Assistance Program (SNAP) benefited as a result of intervention.

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

- Aetna's partnership with community providers (Intervention 5) helped provide food to a substantially larger group of people in need in 2022, and ensured recipients had access to culturally appropriate foods.
- The Plan-Do-Study-Act (PDSA) cycles of continuous improvement were detailed.

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

- Non-technical descriptions of the outcome measure were vague.
- Some sections did not follow the instructional guide for the PIP annual report.
- Intervention data were not clearly or correctly presented in multiple instances.
- Data for an outcome measure was incorrectly stated.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 10 recommendations made to address the opportunities for improvement.

Long-Term Services and Supports and Emergency Department Visits PIP

Background/Objectives

Aetna's PIP is to "decrease the use of emergency department visits by HCBS members who are not in long term care for which the member was not subsequently admitted to a higher level of care by 4 visits per 100 members each measurement year over a three-year period." The third year of activity for this PIP was July 1, 2022, to June 30, 2023.

Aetna's interventions target members and their caregivers. Aetna added three interventions to their original five interventions (Table 2.5). One intervention was completed during the prior activity period, and two were discontinued at the end of this activity period.

Table 2.5. Aetna's LTSS ED Visits PIP Interventions

PIP Interventions	Outcome
Intervention 1: Analyze and trend claims data for Emergency Department (ED) use to determine opportunities to decrease utilization of the ED for non-emergent (NE) conditions *(Implemented Quarter 4 2021; Discontinued February 2023)*	One-time intervention was completed in the 2022 annual report.

Table 2.5. Aetna's LTSS ED Visits PIP Interventions (Continued)	
PIP Interventions	**Outcome**
Intervention 2: Text campaign with education for members regarding appropriate use of ED and alternative sites of care *(Implemented July 2021)*	• Process Measure 1 – Percent of members receiving HCBS waiver services who utilized the Nurse Line was 1% or less for all measurement periods. • Process Measure 2 – 10 or fewer members in the PIP population contacted the Nurse Line within 48 hours prior to a NE ED visit in all measurement periods. • Outcome Measure 1 – Percent of members in the PIP population with claims for NE ED visit within 90 days following receipt of text message regarding the Nurse Line was 3% for RY2 and RY3.
Intervention 3: Member education and resources during face-to-face visits with distribution of refrigerator magnets including pertinent phone numbers and information *(Implemented December 2021; Discontinued June 2023)*	• Process Measure 1 – Percent of members on either the physical disability (PD), Frail Elderly (FE), Brain Injury (BI), or I/DD waiver enrolled any time during the measurement period, who indicate magnet was of value was 13% for RY3. • Process Measure 2 – Percent of members on either the PD, FE, BI, or I/DD waiver enrolled any time during the measurement period, who indicate magnet was not of value was 33% for RY2 and 43% for RY3. • Outcome Measure – Percent of members receiving PD, FE, BI, or I/DD waiver services who had a claim for an ED visit with an identified NE primary discharge diagnosis within 6 months of receipt of education and magnet was 8% for RY2 and 9% for RY3.
Intervention 4: Provide education and outreach to primary caregivers for decision making regarding use of ED *(Implemented December 2021; Discontinued June 2023)*	• Process Measure 1 – 10 or fewer HCBS members' primary caregivers indicated the magnet was of value for RY2 and RY3. • Process Measure 2 – 10 or fewer HCBS members' primary caregivers indicated the magnet was not of value for RY2 and RY3. • Outcome Measure 1 – Percent of visits for unique Long-Term Services and Supports (LTSS) members on HCBS waivers any time during the measurement year who have a claim for a NE ED visit without subsequent admission to a higher level of care within 6 months after their primary caregiver received education about the magnet was 7% for RY2 and RY3.
Intervention 5: Service Coordinator outreach to members within 72 hours of notification to Aetna of discharge from ED for NE condition *(Implemented January 2022)*	• Process Measure 1 – Percent of ED visits for NE condition for PIP population that can be identified on the admission, discharge, and transfer (ADT) data feed from KHIN was 49% for RY2 and 50% for RY3. • Process Measure 2 – Average number of days since last service coordinator contact for members in the PIP population who had NE ED visit identified using ADT feed from KHIN was 158 days for RY2 and 139 days for RY3. • Process Measure 3 – Summary of key themes from service coordinator data to better illustrate member justification for using ED versus alternatives found several diagnostic themes. • Outcome Measure 1 – Percent of NE ED visits for the PIP population identified by ADT feed from KHIN in which the member was successfully contacted by the service coordinator within 3 business days following NE ED visit was 52% for RY3.
Intervention 6: Coaching to non-professional caregivers who assist members receiving LTSS using an app provided by Careforth *(Implemented May 2023)*	• Process Measure 1 – Percent of HCBS members that had a non-professional care giver was 41% for baseline, 40% for RY1 and RY2, and 41% for RY3. • Process Measure 2 – 10 or fewer non-professional caregivers referred to Careforth consented to participate in the Careforth program for RY3. • Process Measure 3 – 10 or fewer non-professional caregivers in the Careforth program engaged for RY3.

Table 2.5. Aetna's LTSS ED Visits PIP Interventions (Continued)	
PIP Interventions	**Outcome**
Intervention 7: Addressing member's Social Determinants of Health (SDOH) and loneliness using an app provided by Pyx Heath to decrease ED visits *(Implemented June 2022)*	• Process Measure 1 – Percent of LTSS members referred to Pyx Health who consented to participate in the program was 3% for RY3. • Outcome Measure 1 – Percent of LTSS members on any waiver participating in the Pyx Health program who had an ED visit within 6 months of consenting to participate in the program was 44% in RY3.
Intervention 8: Yearly mailers to HCBS waiver members for condition-specific education Intervention 8: *(Implemented August/September 2023)*	Analysis will be reported in the next annual report.

Conclusions Drawn from the Data

Contrary to the PIP's goal of reducing the number of ED visits per 100 members receiving HCBS services, the rate increased by 7.3 visits per 100 members—from 92.5 from the prior RY2 (July 2020 to June 2021) to 99.9 for the current RY3 (July 2022 to June 2023).

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

- Aetna continues to modify the service coordination outreach process to ensure the proper members receive outreach.
- The three added interventions address barriers experienced in Interventions 3 and 4 and will provide enhanced support to members receiving Long-Term Services and Supports (LTSS), and their caregivers.
- Aetna provided exceptional recommendations for other MCOs to adapt this PIP topic.

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

- Measures were not calculated according to technical specifications.
- Table headings were incorrect.
- There were wording inconsistencies between technical specifications, table labels, and interpretation of results, potentially causing confusion for the reader. Incorrect terminology was used in discussion of process measure results.
- Discrepancies between a process measure and PAR data were not clearly explained.
- Denominators for some outcome measures were incorrect.
- There were inconsistencies between an outcome measure and the alternate outcome measure; rationale was not provided to explain the discrepancy.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 11 recommendations made to address the opportunities for improvement.

Influenza Vaccination PIP

Background/Objectives

Aetna's stated aim for the PIP is to "increase the influenza vaccination rate by 3 pp annually over the baseline year of 2019 for members ages 6 months to 17 years. The long-term goal is to meet Healthy People 2030 goal of increasing the proportion of people who get the flu vaccination every year to 70%." Their fourth year of activity for this PIP was July 1, 2022, through June 30, 2023. Aetna's multifaceted education and outreach interventions are shown in Table 2.6.

Table 2.6. Aetna's Influenza Vaccination PIP Interventions	
PIP Interventions	**Outcome**
Texting Campaign *(Implemented update October 2022)*	• Of 53,495 members who had not received an influenza vaccine prior to the text message, 11% (5,694) received an influenza vaccination within 90 days of receipt of initial SMS/text message by primary contact.
Outreach Calls to Special Populations *(Implemented Mid-December 2021)*	• Of 411 members ages 6 months through 5 years diagnosed with asthma who had not received an influenza vaccination as of December 1st of the measurement year and were successfully outreached by an Aetna National Outreach team member, 4% (16) received an influenza vaccination within 90 days of contact.
CVS Health Tags *(Discontinued January 7, 2022)*	This intervention was discontinued January 2022.
Gaps in Care (GIC) Reports {*Implemented January and February 2022*}	• Of 39,393 members included on the GIC reports, 8% (3,155) received an influenza vaccine within 90 days of the report.
Member Incentives *(Implemented during baseline period [2019–2020]; suspended 2020–2021 due to vendor change; resumed with new vendor in third quarter 2022)*	• Of 17,533 members ages 6 months through 17 years who received an influenza vaccination, 73.8% (12,941) were sent a letter with instructions that outlined how to claim gift card within the measurement year. •
Community Health Promotion Texting Campaign *(Implemented October 2022)*	• Of the 7,227 members receiving a community event text message without an influenza vaccination prior to receiving the text, 14% (989) completed an influenza vaccine within 90 days of the text message; and • Of the 4,784 members not receiving a community event text message without an influenza vaccination prior to the event, 12% (556) completed an influenza vaccine within 90 days of the event.

Conclusions Drawn from the Data

The aim of the PIP, to increase the influenza vaccination rate by 3 pp each year, was not met. The rate for RY3 was 17.8% (12,376/69,552), a decrease of 11.2 pp from baseline (13,982/48,281 or 29.0%). The RY3 rate was 2.2 pp lower than the rate for RY2 (13,718/68,538 or 20.0%). Aetna reported that the decrease in rate between RY2 and RY3 was statistically significant ($p<.001$). Declining influenza vaccination rates were also reported for members under 5 years old and members diagnosed with asthma.

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

- Statistically significant evidence of effectiveness was presented for several interventions.

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

- Conclusions were not supported by the data.
- Measures were not calculated according to technical specifications.
- Discrepancies in PAR data were not clearly explained; the explanations for inconsistencies between intervention measure results and PAR results were incorrect or insufficient.
- For one intervention, the description of the target population was not used consistently throughout the report.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 9 recommendations made to address the opportunities for improvement listed.

Sunflower

EPSDT PIP

Background/Objectives

Sunflower's stated aim for this PIP is to "increase the EPSDT screening rate for KanCare members through a combination of provider, member, and community focus interventions over a five-year period. The effectiveness of the PIP will be measured by the percentage of KanCare members, ages 0 to 20, who receive at least one EPSDT screening within the measurement year (the Participation Rate). The goal is to achieve and maintain an 85% Participation Rate." The activity period for this PIP was January 1, 2022, to December 31, 2022, and included the five interventions listed in Table 2.7.

Table 2.7. Sunflower's EPSDT PIP Interventions

PIP Interventions	Outcome
mPulse text messaging campaign to members aged 6 to 20 years *(Implemented third quarter 2020)*	• Process Measure 1, percentage of members who received EPSDT screening within 90 days of receiving message, 30.2% (5,874/19,452); statistically significant • Process Measure 2, percentage of members who opted out of campaign who received EPSDT screening within 90 days of campaign, 41.6% (35,687/85,691); statistically significant
Warm phone call outreach to members aged 6 to 20 years on the SED waiver *(Implemented second quarter 2020)*	• Process Measure 1, proportion of members in case management on the SED waiver who were successfully called, 22.5% (210/934); statistically significant • Process Measure 2, proportion of members in case management on the SED waiver who completed an EPSDT visit within 90 days of receiving call, 26.6% (111/417)
Provider educational meetings with five targeted providers (selected from providers having 100 to 300 members 6 to 20 years of age) *(Implemented March 2021, October 2022)*	• One-on-one meetings with 5 provider groups in October 2022 • Outcome Measure 1, office visits for members aged 0–20 years that included an EPSDT screening, 50.9% (475/933) • Outcome Measure 2, members, 0–20 years, who received EPSDT services from the provider within 12 months prior to the meeting, 50.3% (509/1,011) • Outcome Measure 3, members, 0–20 years, who received EPSDT services from the provider within 12 months following the March 2022 meeting, 52.6% (514/978)
Foster care partnership *(Implemented second quarter 2020; second quarter 2022)*	• Outcome Measure 1, members, aged 6–20 years, who received an EPSDT screening, 60.2% (2,473/4,105) • Process Measures not available
Internal staff trainings *(Implemented March 2021, August 2022)*	• 169 staff completed training • Average pre-test score 65% • Average post-test score 80% • Average retention score 71%

Conclusions Drawn from the Data

The EPSDT Participation Rates by age group showed increases of about 5 pp and higher from baseline to RY2. (see Figure 2.1)

***Table 44** – Total Population breakdown by age, showing baseline (10/1/2017 to 9/30/2018), RY1 (10/1/2020 to 9/30/2021), and RY2 (10/1/2021 to 9/30/2022), with difference from RY2 vs. RY1 and difference from RY2 to baseline.*

Age Grouping	Baseline (10/1/2017 to 9/30/2018)	RY1 (10/1/2020 to 9/30/2021)	RY2 (10/1/2021 to 9/30/2022)	RY2 from RY1	RY2 from Baseline
Under 1	90.44%	93.50%	92.21%	-1.29%	1.77%
Age 1-2	73.51%	78.33%	78.81%	0.48%	5.30%
Age 3-5	61.46%	63.80%	62.88%	-0.92%	1.42%
Age 6-9	41.50%	47.82%	46.37%	-1.45%	4.87%
Age 10-14	41.95%	49.39%	46.91%	-2.48%	4.96%
Age 15-18	33.16%	41.36%	39.64%	-1.72%	6.48%
Age 19-20	12.36%	17.79%	15.18%	-2.61%	2.82%

Figure 2.1. PIP Population by Age Group and Year

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

- Five interventions were implemented in the activity period, with plans to add an additional intervention in future years.

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

- Annual targets for the Participation Rate were inconsistent with PIP goal and current rates.
- Clarity is needed in tables, as placement of symbols caused confusion as to what was being tested for significance.
- The rationale for discontinuation of an intervention was not clearly explained.
- Conclusions were not supported by the data; some conclusions presented were contradictory between activities, and there were several inconsistencies between the narrative and reported results.
- Multiple sections did not follow the instructional guide for the PIP annual report, some sections were missing, and results were not reported where expected in a few instances.
- Interpretation of the regression analysis was not provided; analysis results and description of statistical tests contained incorrect verbiage.
- Some analysis provided did not correlate with the analysis plan. The analytic plan for the outcome measures needs to mirror the analyses presented.
- Measures were not calculated according to technical specifications; rate changes between remeasurement years for the outcome measure were not explained.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 26 recommendations made to address the opportunities for improvement listed above.

Cervical Cancer Screening PIP

Background/Objectives

Sunflower's stated aim for the Cervical Cancer Screening (CCS) PIP is to "increase the HEDIS® hybrid CCS rate to 59.50% or higher at the end of the PIP. The goal is to demonstrate a 5 pp improvement on the hybrid CCS final HEDIS® rate over the baseline CCS rate." Sunflower's multifaceted intervention approach during the third year of activity, January 2022 to December 2022, of this PIP included the interventions listed below in Table 2.8.

Table 2.8. Sunflower's Cervical Cancer Screening PIP Interventions

PIP Interventions	Outcome
Monthly gap in care reports to providers *(Implemented Fourth quarter 2020, monthly in 2021, and monthly in 2022 starting in April)*	Of 566 members listed on the GIC reports for 2022, • 5.1% (29) had a CCS within 90 days of the report's distribution, and • 9.7% (55) had a CCS within 180 days.

Interactive text messages to members through the mPulse platform *(Implemented Second quarter 2020, Second quarter 2021, Third quarter 2021, Second quarter 2022, Third quarter 2022, and Fourth quarter 2022)*	Percent of members who received a CCS within 90 days of intervention:
	• 1st campaign (April 2022)
	  ○ 6.4% (426/6,670) for member who received text
	  ○ 12.0% (638/5,327) for members who did not receive text
	• 2nd campaign (August 2022)
	  ○ 8.4% (53/628) for member who received text
	  ○ 11.7% (1,118/9,531) for members who did not receive text
	• 3rd campaign (November 2022) (final data not yet available)

Proactive Outreach Management (POM) phone call to members *(Implemented Fourth quarter 2020, Second quarter 2021, Third quarter 2021, Second quarter 2022, Third quarter 2022, and Fourth quarter 2022)*	Percent of members who received a CCS within 90 days of intervention:
	• 1st campaign (April 2022):
	  ○ 5.7% (181/3,181) for members who received call
	  ○ 8.7% (1,096/12,632) for members who did not receive call
	• 2nd campaign (July 2022):
	  ○ 7.4% (221/2,974) for members who received call
	  ○ 10.7% (1,122/10,523) for members who did not receive call
	• 3rd campaign (October 2022):
	  ○ 5.9% (53/892) for members who received call
	  ○ 10.3% (896/8,677) for members who did not receive call

Co-branded member mailers *(Implemented Second quarter 2021)*	Of 90 members who received a co-branded mailer, • 62.2% (56) had a CCS within six months.
Extension for Community Healthcare Outcomes (Project ECHO) webinar for providers and CCCS provider educational lunch and learn *(Implemented Second quarter 2020 and fourth quarter 2021, discontinued August 2022)*	31 people, representing 5 provider groups, attended the December 2021 lunch and learn. Two of the groups had at least one member who received a CCS within six months of the event. Only group-level percentages were reported.
Focused education to members on the I/DD waiver, their mental health provider, and their PCP or obstetrician/gynecologist (OBGYN) *(approved in 2022, not yet implemented)*	Not yet implemented.

Conclusions Drawn from the Data

Sunflower used two types of HEDIS CCS rates to assess progress of the PIP, hybrid rates that are based on claims and medical record review for a sample of members, and administrative rates that are primarily based on claims data (see Figure 2.2). The PIP's original goal was to increase the hybrid CCS

rate by 5 pp from the baseline (MY 2018) rate of 54.50% to 59.50%. Since the goal was exceeded for each of the first three years, Sunflower added a secondary goal, to increase an additional 2 pp annually.

From Sunflower Table 25

CCS Rates by Year (Hybrid)			
Measurement Years 2019 to 2022			
Year	**Rate**	**Den**	**Num**
2019	59.61%	411	245
2020	62.04%	411	255
2021	62.04%	411	255
2022	Not Available		

From Sunflower Table 24

CCS Rates by Year (Administrative)			
Measurement Years 2019 to 2022			
Year	**Rate**	**Den**	**Num**
2019	55.10%	13,499	7,438
2020	51.69%	16,774	8,670
2021	55.30%	19,705	10,896
2022*	55.81%	21,711	12,117

*Data not fully mature

Figure 2.2. Hybrid and Administrative CCS Rates by Year

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

- Sunflower intends to incorporate lessons learned from a discontinued intervention (Intervention 2) to help identify other potential interventions.

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

- Some analysis did not follow the analysis plan; interpretation of statistical significance was missing and interpretation was insufficient or incorrect in a few instances. Several *p*-values were incorrectly calculated which impacted determinations of statistical significance.
- Conclusions were drawn that were not supported by the data.
- The non-technical definition of one measure was missing.
- Table titles, descriptions, and labels were inconsistent with the associated narrative; some tables contained incorrect numerators, denominators, and rates. The data in two tables appeared to have been interchanged.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 17 recommendations made to address the opportunities for improvement.

Diabetes Monitoring for Members with Diabetes and Schizophrenia PIP

Background/Objectives

Sunflower's stated aim for the PIP is "*The use of a multifaceted intervention approach, targeting Sunflower Health Plan members aged 18-64 years who have diagnoses of diabetes and schizophrenia or schizoaffective disorder and providers who serve this population will increase completion of annual Low-density Lipoprotein Cholesterol (LDL-C) and Diabetes Glycated Hemoglobin (HbA1c) testing by 3 pp year over year.*" Sunflower's interventions implemented during the third year of PIP activity (January 1, 2022, through December 31, 2022) are listed below in Table 2.9.

Table 2.9. Sunflower's SMD PIP Interventions	
PIP Interventions	**Outcome**
Warm member phone outreach *(Implemented November 2020)*	• Ten or fewer of 17 successful warm calls resulted in the member completing outstanding HbA1c and LDL-C tests within 90 days.
Gap-in-care reports *(Implemented February 2021)*	• Of the 145 members in RY3 not completing testing for both LDL-C and HbA1c whose provider participates in the GIC email campaign and received a GIC report, 15.2% (22) had both the LDL-C and HbA1c tests identified as completed within 90 days of the PCP receiving the GIC identifying them.
Co-branded letters *(Implemented November 2020)*	• Ten or fewer of 51 co-branded letters resulted in the member completing outstanding HbA1c and LDL-C tests within 90 days.

Conclusions Drawn from the Data

Sunflower reported administrative rates for the HEDIS Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) measure for MY 2019 (baseline) through MY 2022, provided below in Figure 2.3. The goal to increase the rate by 3 pp from the previous year was not achieved. From MY 2021 to MY 2022, the SMD rate increased 0.88 pp, but the MY 2022 rate was 2.06 pp below the baseline. The rate changes were not statistically significant.

Sunflower Table 4

SMD Rates by Year (Administrative)			
Year	**Rate**	**Den**	**Num**
Baseline (1/1/2019-12/31/2019)	65.54%	444	291
RMY1 (1/1/2020-12/31/2020)	62.50%	456	285
RMY2 (1/1/2021-12/31/2021)	62.60%	484	303
RMY3 (1/1/2022-12/31/2022)	63.48%	460	292

Figure 2.3. SMD Administrative Rates (PIP Outcome Measure 1), 2019–2022

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

- The approach for evaluating the effectiveness of the PIP and its interventions was designed well and carried out. This includes measure specifications, data collection, choice of statistical tests, and models for regression analysis.

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

- The results of some statistical tests were improperly interpreted.
- Some conclusions drawn were not supported by the data, root causes for variation of the SMD rates for the Intervention group were not provided, and the description of the pandemic on SMD rates was misplaced.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 7 recommendations made to address the opportunities for improvement.

Waiver Employment PIP

Background/Objectives

Sunflower's stated aim for this PIP is to "increase employment for members 16-64 on the IDD, PD and BI waivers and those KanCare eligible members on the respective waiver and corresponding waiting lists by 2 percentage points year over year for the duration of the PIP by decreasing the barriers identified by providers and members." Sunflower's original plan included five interventions, with some modifications during the PIP. The activity period for this PIP was April 2022 to March 2023. See Table 2.10 for interventions.

Table 2.10. Sunflower's Waiver Employment PIP Interventions

PIP Interventions	Outcome
Sunflower participation in Project SEARCH, serves as Statewide Coordinator *(Implemented August to May 2020/2021 school year through March 2023)*	Of 1,400 members qualifying for the program, 1.3% (18) participated.
Member mailers *(Implemented in December 2020 through March 2023)*	Mailer was sent to 1,134 members (16 to 35 years of age) of the 1,266 on the I/DD and PD waiver waiting lists. • 17 members outreached for additional information following the mailing.
Case management team training *(Implemented March 2021 through March 2023)*	Of the 134 LTSS Case Managers, 131 received training. • Of those surveyed, 89% felt the training was useful, and 94% learned something new.
Member transportation to job fairs and interviews *(Implemented February 2023 through March 2023)*	Ten or fewer eligible members requested transportation.
Provide a value-based payment for providers to incentivize assisting members with disabilities to obtain and maintain employment *(not implemented)*	None of 14 eligible providers were contracted by 3/31/2023.

Conclusions Drawn from the Data

The goal of the PIP is to increase employment for members on the I/DD, PD, and BI waivers or waiting lists by two pp year-over-year. Sunflower's employment rates are below.

PIP Outcome Measure 1 (Employment Rate for I/DD, PD, and BI Waiver Population):

- Baseline rate 11.47%
- RY1 rate 11.76%
- RY2 rate 10.26%
- RY3 rate 10.31%

PIP Outcome Measure 2 (Employment Rate for I/DD and PD Waitlist Population):

- RY1 rate 2.26%
- RY2 rate 2.10%
- RY3 rate 1.97%

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

- All of the previous EQRO recommendations made in the 2022 evaluation were fully addressed in the annual report.
- Sunflower made enhancements throughout this PIP to create sustainable interventions and plans to incorporate several into their standard practices.

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

- Results were not reported where expected in a few occurances, without explanation.
- Table titles, descriptions, and labels were incorrect or did not clearly describe the data; there were instances of tables containing incorrect data.
- Interpretation of results was inadequate in some areas; the narrative contained a description of data that was suppressed in a table.
- Conclusions were drawn that were not supported by the data.

Recommendations for Quality Improvement
See Appendix C, *2023 Recommendations: PIP Validation* for details on the 8 recommendations made to address the opportunities for improvement.

Mental Health Services for Foster Care PIP

Background/Objectives

Sunflower's aim for this PIP is to "increase the outpatient BH treatment access for out-of-home foster care youth ages 3 to 17 across the state for the duration of the PIP. The goal of the PIP will be measured by a 2% increase of foster care members with a BH diagnosis using BH services year-over-year. The increase of services will be met by increasing expedited access and expansion of services available." In the third year of PIP activity (August 1, 2022, through July 31, 2023). Sunflower's interventions targeted members, guardians, and providers. Sunflower's original plan included five interventions. Two interventions were discontinued prior to the current activity year, see details in Table 2.11 below.

Table 2.11. Sunflower's Mental Health Services for Foster Care PIP Interventions

PIP Interventions	Outcome
SED Waiver *(Implemented 2021 Q2)*	For Remeasurement Year 3 (August 2022 to July 2023): • Of the 280 foster care members meeting PIP eligibility criteria who qualify for a Psychiatric Residential Treatment Facility and are placed on the Psychiatric Residential Treatment Facility waitlist, 27.1% (76) received SED waiver services between the date of Prior Authorization Referral and date of admission; and • Of the 26 foster care members meeting PIP eligibility criteria who were discharged from a Psychiatric Residential Treatment Facility, 80.8% (21) received SED waiver services within 30 days of the discharge, and 92.3% (24) received them within 90 days of the discharge.
Parent Management Training, Oregon Model (PMTO) *(Implemented 2020 Q4)*	Of 94 foster care members who utilized the initial Parent Management Training, Oregon Model (PMTO) module from August 2020 to July 2023, 37.2% (35) completed 10 or more modules.
myStrength *(Implemented 2021 Q2)*	The myStrength platform was not used by any PIP-eligible foster care member 13–17 years of age anytime during the duration of the intervention.

Conclusions Drawn from the Data

The PIP outcome measure rate for this annual reporting period (July 1, 2022, to June 30, 2023) was 67.85%, a 7.2% relative decrease (5.3 pp) from the baseline rate (73.15%), as shown in Figure 2.4. As expected, the PIP goal of obtaining an increase of 2 pp from the prior year (to 71.13%) was not met.

Sunflower Table 2

Sunflower PIP Outcome Measurements - Activity 6.2 (during measurement period)					
Measurement Period	Denominator	Numerator	RATE	2% Goal	Goal Met
Baseline 1/1/2019 to 12/31/2019	3,668	2,683	73.15%		
RMY 1 - 8/1/2020 to 7/31/2021	3,399	2,512	73.90%	75.15%	No
RMY 2 – 8/1/2021 to 7/31/2022	3,499	2,489	71.13%	75.90%	No
RMY 3 – 8/1/2022 to 7/31/2023	3,462	2,349	67.85%	73.13%	No

Figure 2.4. PIP Outcome Measurements

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

KFMC did not identify a strength during the validation of this PIP.

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

- Multiple sections did not follow the instructional guide for the PIP annual report, some sections were missing, and results were not reported where expected in a few instances.
- Inconsistent wording was used throughout the report; some activities were not clearly written.
- Some measures were inconsistent with the technical specifications; some technical specifications were unclear.
- Analyses were not clearly or correctly reported.
- Multiple tables displayed incorrect data.
- Conclusions were drawn that were not supported by the data.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 11 recommendations made to address the opportunities for improvement.

UnitedHealthcare

EPSDT PIP

Background/Objectives

UnitedHealthcare's stated aim for this PIP was *"Will the use of targeted interventions towards UHCCP members and providers improve the percentage of UHCCP members ages 0-20 who obtain at least one EPSDT screening during the measurement year? The aim for this PIP is to improve EPSDT screening compliance rates to at least 85% over a five-year period."* The third year of activity for this PIP was January 1, 2022, to December 31, 2022. UnitedHealthcare's multi-faceted intervention approach targets both members and providers. The five interventions listed below in Table 2.12 have been implemented during the PIP.

Table 2.12. UnitedHealthcare's EPSDT PIP Interventions	
PIP Interventions	**Outcome**
Live calls to members who have not completed their EPSDT screening with a warm transfer option to schedule an appointment *(Implemented October 2020; August 2021; May 2022)*	Rates of successful calls: • Members with an accurate phone number who had not completed EPSDT screening, 76.1% (83/109) • Resulting in a warm transfer, 15.7% (13/83) • Resulting in an appointment within 90 days of call, numerator too small to report Percentage of members with accurate phone number who were called and had a claim for EPSDT screening within 90 days of call, 34.9% (38/109)
Mailers to members who did not receive a live call to notify them of the need to complete an annual EPSDT screening *(Implemented October 2020; August 2021; May 2022)*	Percentage of members with EPSDT claim within 90 days of mailer being sent, 15.3% (306/2,000)
EPSDT GIC reports to their Foster Care Coordinator (CC) to assist in EPSDT screening gap closure for members in the foster care system *(Implemented Fourth quarter 2020; quarterly in 2021 and 2022)*	Percentage of members who completed EPSDT screening within 90 days of GIC report distribution • 2020 Q4 to 2021 Q3, ranged from 18.9% (148/782) in 2021 Q1 to 31.9% (500/1,567) in 2021 Q3 • 2021 Q4 to 2022 Q4, ranged from 15.3% (62/406) in 2021 Q4 to 24.3% (103/424) in 2022 Q3 Percentage of members who completed EPSDT screening for the 4 contractors • Baseline (10/1/2019–9/30/2020), ranged from 52.3%–62.9% with an overall rate of 57.9% • Remeasurement Year 1 (10/1/2020–9/30/2021), ranged from 75.7%–81.2% with an overall rate of 77.9% • Remeasurement Year 2 (10/1/2021–9/30/2022), ranged from 71.1%–76.3% with an overall rate of 73.6%
EPSDT GIC reports to providers who do not participate in the provider incentive program, delivered by UHCCP's Clinical Practice Consultants *(Implemented Fourth quarter 2020; quarterly in 2021 and 2022)*	Percentage of targeted provider groups who received GIC reports for members without EPSDT screening • 2020 Q4 to 2021 Q4, ranged from 100.0% in 2020 Q4 (42/42) and 2021 Q1 (61/61) to 93.2% (55/59) 2021 Q4 • 2022 Q1 to 2022 Q4, equaled 100% every quarter in 2022 with denominators ranging from 64 in 2022 Q4 to 81 in 2022 Q2 Proportion of providers responding to survey that report was instrumental/helpful in increasing screening rate • 2020, 44.4% (4/9) • 2021, 50.0% (4/8) • 2022, 45.0% (9/20) Percentage of members who completed EPSDT screening within 90 days of GIC report delivery to provider • 2020 Q4 to 2021 Q3, ranged from 9.0% (1,091/12,110) in 2021 Q3 to 17.3% (2,131/12,332) in 2021 Q2 • 2021 Q4 to 2022 Q4, ranged from 4.0% (460/11,442) in 2021 Q4 to 16.2% (3,017/18,650) in 2022 Q2

Table 2.12. UnitedHealthcare's EPSDT PIP Interventions (Continued)	
PIP Interventions	**Outcome**
Incentive payments to providers for closing EPSDT GIC *(Implemented Fourth quarter 2020; quarterly in 2021 and 2022)*	Percentage of provider groups eligible for the incentive who received incentive for closing screening gaps • 2020, 96.9% (125/129) • 2021, 93.7% (118/126), • 2022, validated data not available at time of report Percentage of members assigned to participating PCP who received EPSDT screening from any provider during calendar year • 2020, 29.7% (14,683/49,396) • 2021, 50.5% (53,125/105,239) • 2022, 48.8% (49,888/102,246)

Conclusions Drawn from the Data

Improvement has been made for all age groups compared to the baseline rates. (see Figure 2.5)

Table 17

EPSDT Screening Rates by Age				
Age Group	**Baseline** (10/1/2018 – 9/30/2019)	**Remeasure Yr1** (10/1/2019 – 9/30/2020)	**Remeasure Yr2** (10/1/2020 – 9/30/2021)	**Remeasure Yr3** (10/1/2021 – 9/30/2022)
Under 1	91.13%	90.85%	93.30%	92.54%
1-2	72.57%	72.53%	75.92%	76.30%
3-5	59.02%	54.47%	61.00%	60.59%
6-9	41.31%	38.04%	43.70%	42.54%
10-14	42.64%	39.13%	45.11%	43.13%
15-18	34.15%	34.16%	38.54%	36.04%
19-20	10.01%	10.95%	16.66%	13.66%
Total	**48.27%**	**45.76%**	**50.01%**	**47.60%**

Figure 2.5. EPSDT Participation Rates by Age Group

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

- RY3 rates were greater than the baseline rates for all age groups reported.

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

- Some analysis provided did not correlate with the analysis plan or was unclearly presented. The recommended analysis for the PIP outcome measure was not reported.
- There continued to be inconsistencies within the annual report narrative regarding components of two interventions, including description of the target population.
- An outcome measure for one intervention did not reflect the description in the narrative.
- Opportunities exist to improve the technical writing.
- It appeared that the historical data regarding when members receive their EPSDT screenings or the differences in Participation Rates among the different age groups were not considered.
- Conclusions were drawn that were not supported by the data.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 15 recommendations made to address the opportunities for improvement.

Improving Diabetes Monitoring for Members with Diabetes and Schizophrenia PIP

Background/Objectives

UnitedHealthcare stated the aim for this PIP is to "employ direct outreach to members and providers to reach or exceed HbA1c and LDL-C testing rates of 66.82% by HEDIS measurement year 2023." The PIP activity period was July 1, 2022, through June 30, 2023. UnitedHealthcare's intervention strategy focuses on employing direct outreach to members and providers to improve testing rates for HbA1c and LDL-C. The following interventions in Table 2.13 have been implemented during this PIP.

Table 2.13. UnitedHealthcare's SMD PIP Interventions

PIP Interventions	Outcome
CM outreach to members on waivers *(Implemented June 2021)*	Of the 48 waiver members in 2022 who received successful outreach from a CM, 43.8% (21) received HbA1c/LDL-C testing within 90 days after the successful outreach.
CM outreach to members in Whole Person Care Program (WPC) *(Implemented June 2021)*	Outcome data not provided in accordance with CMS guidance on small numbers.
Gap in care distribution *(Implemented for PCPs in December 2020)*	Outcome measure results for measurement year 2022 contain inconsistencies and are not trusted.

Conclusions Drawn from the Data

The outcome measure for the PIP is the audited administrative HEDIS SMD measure. The rate for 2022 was 64.9% (277/427). As shown in Figure 2.6, the 2022 rate increased 4.3 pp over the 2021 rate (60.6%) and is 3.2 pp above the baseline rate (61.7%). The 2022 rate is within 2 pp of the target (66.8%).

Table 11

SMD Rates - Total Population			
Measurement Year	**Denominator**	**Numerator**	**Rate**
2019 (Baseline)	397	245	61.71%
2020	434	252	58.06%
2021	452	274	60.62%
2022	427	277	64.87%

Numerator: *Members meeting the denominator criteria who have obtained both an LDL-C test and HbA1c test during the measurement year.*
Denominator: *UHCCP members between the ages of 18-64 as of December 31 of the measurement year with diagnoses of schizophrenia or schizoaffective disorder and diabetes with no more than one gap in enrollment of up to 45 days during the measurement year.*

Figure 2.6. HEDIS SMD Rates

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

- All the previous EQRO recommendations made in the 2022 evaluation were fully addressed in the annual report.

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

- A clear distinction was not made between the PIP population and the denominator population of the PIP outcome measure.

- Multiple sections did not follow the instructional guide for the PIP annual report, some sections were missing, and results were not reported where expected in a few instances.
- UnitedHealthcare did not discuss the inconsistencies between the PAR data and the calculations performed for the annual report.
- Multiple data displayed were incorrect; some results were presented without appropriate interpretation.

Recommendations for Quality Improvement
See Appendix C, *2023 Recommendations: PIP Validation* for details on the 6 recommendations made to address the opportunities for improvement.

Advanced Directives PIP

Background/Objectives

UnitedHealthcare stated the aim for this PIP is, "The use of targeted, culturally competent education to HCBS Waiver members ages 18 and over will lead to 25% of the identified population having an executed Advance Directive (AD) on file with UHCCP by the end of the PIP measurement period. Year one is the baseline year, with a goal for of 3% year-over-year improvement." UnitedHealthcare's multifaceted intervention strategy was developed to provide targeted education and support to members in the HCBS Waiver regarding end-of-life planning. Their six interventions (Table 2.14) focused on the development and provision of educational materials for members, providers, and staff during an activity period of January 1, 2022, to December 31, 2022.

Table 2.14. UnitedHealthcare's Advanced Directives PIP Interventions

PIP Interventions	Outcome
Develop an AD educational form and process to inform, document, store, track, and share *(Completed in 2020)*	No data available
Provide AD training for UHCCP's Community Health Workers (CHW) and (CCs) *(Implemented in 2020)*	Existing staff: • 100% (187/187) June 2020 • 99.5% (193/194) June 2021 • 100% (192/192) June 2022 New staff: • 100% (16/16) June 2020 – May 2021 • 100% (22/22) June 2021 – May 2022 Completed ADs per worker: • 12.2% (8.15/67) 2020 • 14.8% (9.61/65) 2021 • 16% (10.1/63) 2022
Educate providers on the project *(Implemented in 2022)*	KFMC has little confidence that the intervention outcome measure rates were calculated according to its technical specifications.
AD mailer and education for established members on the FE Waiver in Sedgwick County *(Implemented in 2020; discontinued October 2022)*	Newly completed AD on file within 90 days of visit: • 6.3% (8/128) October 2020 – September 2021 • 4.8% (13/270) October 2021 – September 2022 • 7.4% (2/27) October 2022
AD mailer and education for new members on the FE Waiver in Sedgwick (SG) County *(Implemented in 2020; expanded November 2022)*	AD on file within 90 days of enrollment: • 45.1% (64/142) October 2020 – September 2021 (SG County) • 35.9% (56/156) for October 2021 – September 2022 (SG County) • 38% (38/100) November 1, 2022, through December 31, 2022, (statewide)

Table 2.14. UnitedHealthcare's Advanced Directives PIP Interventions (Continued)	
PIP Interventions	**Outcome**
Store completed ADs in UHCCP's CM record for members on the FE Waiver in Sedgwick County and share with member permission *(Implemented in 2020; expanded November 2022)*	ADs on file shared by UHCCP: • 1.3% (2/156) July 2021 (SG County) • 1.1% (2/183) July 2022 (SG County) • 1.6% (3/186) October 31, 2022 (SG County) • <1% (4/832) December 31, 2022 (statewide) ADs on file shared by member: • ≤1% (1/156) July 2021 (SG County) • 83.6% (153/183) July 2022 (SG County) • 87.1% (162/186) October 31, 2022 (SG County) • 90% (749/832) December 31, 2022 (statewide)

Conclusions Drawn from the Data

Over the course of this PIP, the percentage of ADs on file increased, from 12% to 16% in three years, which falls below the goal of 3 pp per year.

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

- All interventions planned for this PIP have been implemented.
- New hire and annual training on ADs are a part of standard practice for CCs.
- AD educational flyer is included in the welcome packet for members newly enrolled in HCBS Waiver services.

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

- Several sections did not follow the instructional guide for the PIP annual report; some sections were missing or insufficient.
- Measures were not calculated according to technical specifications.
- Analytic plans were not detailed enough for correct calculation of measures and updated to reflect current measure specifications.
- Major discrepancies between reported rates and PAR rates were not explained.
- Clarity is needed regarding the definitions of terms in measure specifications and analytic plans, and consistency of terminology in technical writing. Labeling of tables was unclear and technical specifications were ambiguous.
- Root cause analyses were not conducted for poor performing outcome measures.
- Conclusions were drawn that were not supported by the data.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 20 recommendations made to address the opportunities for improvement.

Housing PIP

Background/Objectives

UnitedHealthcare stated their aim for this PIP is to *"assist members in maintaining or obtaining permanent housing through multilevel interventions. The goal is to achieve a Stable Housing rate of 80 percent annually."* The interventions target members, providers, their staff, and community resources.

The interventions listed below in Table 2.15 were conducted during the activity period of September 1, 2022, to August 31, 2023.

Table 2.15. UnitedHealthcare's Housing PIP Interventions

PIP Interventions	Outcome
Staff training on homelessness and housing resources *(Implemented 2020 Q1)*	Of 198 trained CCs and CHWs in Year 3 (August 2022–July 2023), 65.2% (129) referred at least one member to Housing Navigator.
Pilot of Housing Stabilization Funds (HSF) *(Implemented 2020 Q2)*	Of the 56 members awarded Housing Stabilization Funds in Year 3, 92.9% (52) maintained housing for a minimum of 60 days (90 after April 2023)
Housing Bridge pilot to offer 10 units of transitional/permanent housing *(Implemented 2020 Q3)*	• Of the 25 members participating in the Bridge Pilot from August 2020 through July 2023, 60% (15) transitioned to permanent housing. • For the 15 members who transitioned to permanent housing, the 12-month healthcare utilization average increased from $57,742 for the 12 months prior to participation to $73,135 for the 12 months after entering the program, a 1.27-fold increase. Note: Increase was driven by outpatient claims; inpatient and emergency department utilization decreased.
Identify members with housing related needs and connect them with the Whole Person Care (WPC) Team for support *(Implemented August 2022)*	Of the 45 members identified as having housing related needs from SDOH Real Time Offer (RTO) assessments completed from January through June 2023, 26.7% (12) were referred to WPC for support.

Conclusions Drawn from the Data

The Stable Housing rate was 82.8% for the measurement year August 2022 through July 2023. That is, of 93 members identified as homeless or at risk of homelessness who participated in the HSF, Bridge pilot or SDOH Real Time Offer (RTO) interventions, 77 obtained permanent housing or maintained permanent housing within three months of identification. The annual goal, 80%, was met.

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

- UnitedHealthcare identified an additional outcome measure could be added to Intervention 6 to support the measurement of the PIP aim.
- Educational training regarding homelessness was added to staff training curriculum.

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

- Terminology within technical specifications, analytic plans, and reported results was inconsistent, which interferes with the audience's ability to correctly interpret the writing.
- Data in tables were inconsistent.
- One intervention outcome measure was not reported according to the technical specifications.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 6 recommendations made to address the opportunities for improvement.

Antidepressant Medication Management PIP

Background/Objectives

UnitedHealthcare's stated aim for this PIP is to "increase adherence to treatment among adult members who begin treatment for major depression using antidepressant medication by using targeted, culturally competent, and multifaceted education and outreach. The goal is to increase the HEDIS® Antidepressant Medication Management (AMM) Effective Acute Phase Treatment indicator rate ("the AMM acute rate") annually by 3 pp and to ultimately meet or exceed the Quality Compass 75th percentile over a three-year period."

The interventions listed below in Table 2.16 were conducted during the activity period of November 1, 2022, to October 31, 2023.

Table 2.16. UnitedHealthcare's AMM PIP Interventions

PIP Interventions	Outcome
Initial outreach calls to members *(Implemented February 2022)*	• Outcome Measure 1 – 38.1% (188/494) of members during Intervention Year 2 successfully called by Hospitality Assessment Reminder Center staff within 14 days who remained adherent with medication for at least 84 days • Outcome Measure 2 – 28.7% (655/2,283) of members during Intervention Year 2 non-successfully called by Hospitality Assessment Reminder Center staff within 14 days who remained adherent with medication for at least 84 days
Follow-up outreach calls to members *(Implemented February 2022)*	• Outcome Measure 1 – 44.0% (88/200) of members during Intervention Year 2 with successful follow-up calls by Hospitality Assessment Reminder Center staff within 14 days of the successful call in Intervention 1 remained adherent with medication for at least 84 days • Outcome Measure 2 – 34.0% (100/294) of members during Intervention Year 2 with a non-successfully follow-up call within 14 days of the successful call in Intervention 1 remained adherent with medication for at least 84 days
Health Screening Tool completion *(Implemented February 2022)*	• Outcome Measure 1 – 40.7% (148/364) of members during Intervention Year 2, successfully called in Intervention 1 who completed the Health Screening Tool during the call, remained adherent with medication for at least 84 days • Outcome Measure 2 – 30.8% (40/130) of members during Intervention Year 2, successfully called in Intervention 1 who did not complete the Health Screening Tool during the call, remained adherent with medication for at least 84 days

Conclusions Drawn from the Data

The AMM Effective Acute Phase Treatment rate for the first measurement year (MY1; 5/1/2021–4/30/2022) was 56.72%, which was 6.38 pp above the baseline (5/1/2018–4/30/2019) rate, 50.34%. The targeted increase of 3 pp was achieved.

An interim rate for MY2 (5/1/2022–4/30/2023) was reported to be 56.85%. The data cutoff date for this rate was not provided. The previous annual report stated, "As of November 29, 2022, the AMM acute rate was 54.16%." These interim rates estimate the finalized MY2 rates will be 2.7 pp above the MY1 rate. The validity of this estimation depends on the data cutoff date for the interim MY2 rate.

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

- UnitedHealthcare exceeded their targeted rate for MY1 and interim MY2 data showed additional improvement in the AMM Effective Acute Phase Treatment rates.

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

- Several sections did not follow the instructional guide for the PIP annual report; some sections were missing or insufficient.
- Cutoff dates for intervention measures were not provided.
- Statistical tests were incorrect in some sections of the report.
- An intervention outcome measure was not calculated according to the technical specifications.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 5 recommendations made to address the opportunities for improvement.

Collaborative PIP
COVID-19 Performance Improvement Project

Background/Objectives

The MCO's aim for this PIP was stated as, "The COVID-19 Vaccine PIP aimed to increase COVID-19 vaccinations for KanCare members through a combination of provider, member, and community-focused interventions. The effectiveness of the PIP was measured by the percentage of KanCare members who received at least one dose of the COVID-19 vaccine. For adult members (18 and older, not living in a long-term care facility), the goal is to achieve an overall rate of 70%. For youth members (between 5 and 17 years old), the goal was to achieve an overall rate of at least 45%."

The COVID-19 PIP was approved to be discontinued on August 2, 2023 with a final activity period from October 2022 to September 2023. This PIP included three interventions which are listed below in Table 2.17.

Table 2.17. MCOs' Collaborative COVID-19 PIP Interventions

PIP Interventions	Outcome
National Team Member Outreach *(ABH Implemented May 1, 2022)* *(SHP Implemented 2021 Q2 and 2021 Q3)* *(UHCCP Implemented April 2021 and May 2021)*	Results reported by Aetna were not reliable. Sunflower and UnitedHealthcare did not perform activities for this intervention during this measurement period.

Partner with One Care Kansas Providers
(Implemented September 2021 through June 2023)
	• Outcome Measure 1 – Remeasurement Period (RP)5 vaccination rate for members enrolled in OCK:
	  ○ ABH: 62.3% (660/1,059)
	  ○ SHP: 56.7% (775/1,366)
	  ○ UHCCP: 66.3% (745/1,123)
	• Outcome Measure 2 – RP5 vaccination rate for members eligible for, but not enrolled in, OCK:
	  ○ ABH: 47.4% (15,260/32,203)
	  ○ SHP: 45.8% (13,607/29,708)
	  ○ UHCCP: 49.5% (17,391/35,114)

Table 2.17. MCOs' Collaborative COVID-19 PIP Interventions (Continued)	
PIP Interventions	**Outcome**

Community Events
(Implemented June 24, 2023, in Kansas City, KS)
	• Measure 1 – One event was hosted by the MCOs; the total attendance was not reported.
	  ○ 50 Aetna members attended the event.
	• Measure 2 – The percent of unvaccinated KanCare members, living in the event area who received a vaccination was not reported.
	  ○ 4 Aetna members were vaccinated at the event.

Conclusions Drawn from the Data

The MCOs reported the following COVID-19 vaccination rates for RP5 (June 30, 2023):

- All MCOs, all ages 5 or older 34.2% (of 401,706 members)
- All MCOs, stratified by age range
  - 5–17 years 23.9% (217,093; goal = 45%)
  - 18 years or older 46.4% (184,613; goal = 70%)
- All ages 5 or older, stratified by MCO
  - Aetna 34.6% (132,025)
  - Sunflower 34.2% (127,219)
  - UnitedHealthcare 33.9% (142,462)

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

- Through this collaborative PIP, the MCOs were able to gain knowledge from each other.

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

- Conclusions were drawn that were not supported by the data.
- There were incorrect numerators, denominators, and rates for some process and outcome measures. Some denominators were missing.
- Statistical analysis was not provided in an intervention according to the analytic plan.

Recommendations for Quality Improvement

See Appendix C, *2023 Recommendations: PIP Validation* for details on the 6 recommendations made to address the opportunities for improvement.

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3. CAHPS Health Plan 5.1H Survey Validation

Background/Objectives

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

CAHPS surveys are also required for NCQA accreditation of the MCOs. CAHPS data from hundreds of health plans nationwide are submitted to NCQA, who then annually produces the QC 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 2023 CAHPS surveys (measurement year 2022) were conducted by Aetna, Sunflower, and UnitedHealthcare using the CAHPS 5.1H Adult Questionnaire (Medicaid) and CAHPS 5.1H Child Questionnaire (with CCC measure).[6]

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

For the 2023 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 (CSS); Sunflower and UnitedHealthcare contracted with Press Ganey (formerly SPH Analytics). NCQA-certified vendors have ongoing NCQA oversight to ensure adherence to survey requirements. Aetna chose the mixed-mode mail/telephone protocol and Sunflower and UnitedHealthcare chose the mixed-mode mail/telephone/internet protocol. Both protocols include an optional mailing of a prenotification postcard, an initial survey package mailing, mailing of a second survey package to non-respondents, reminder/thank-you postcard mailings after each survey mailing, and telephone follow-up to non-respondents. The survey packages include a cover letter, questionnaire, and postage-paid return envelope addressed to the survey vendor. Regarding telephone follow-up to non-respondents, the protocols specify three to six telephone follow-up attempts spaced at different times of the day and on different days of the week (within a survey, the maximum number of attempts must be the same for all members). For the internet methodology, a link to an online version of the survey is included in the cover letters. Aetna members who called to request a replacement survey were given the option to complete the survey online (two members completed the survey online). All surveys were fielded from February 2023 through May 2023.

The CAHPS tool and survey process have undergone extensive testing for reliability and validity. Detailed

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

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, 2022, with no more than one gap of up to 45 days; enrollment on December 31, 2022; and enrollment when surveyed.
- Members eligible for each survey were
  - **Adults** – Age 18 years and older as of December 31, 2022;
  - **GC Populations** – Age 17 years or younger as of December 31, 2022; and
  - **CCC Populations** – A subset of the GC population identified as "CCC" using HEDIS requirements based on health criteria and specific survey answers.
- Minimum sample sizes were set by NCQA assuming an average 45% response rate for Medicaid product lines and targeting 411 responses were
  - **Adult Sample** – 1,350 adults;
  - **GC Sample** – 1,650 GC children; and
  - **CCC Supplemental Sample** – 1,840 children more likely to have a chronic condition, based on claims and encounter data, drawn from child records not selected for the GC sample. The sample size can be lower than 1,840 if fewer than 1,840 children are available for selection.

None of the populations returned 411 complete and valid surveys. The highest count was 382 (ABH TXIX GC). 2023 response rates ranged from 10.1% to 22.5%.

Conclusions Drawn from the Data Common Among the MCOs

With some exceptions, 2023 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. Declining rates for several metrics, particularly those surrounding coordination of care, are of concern. Additional measures should be taken by MCOs to improve this and other metrics (see Recommendations for Quality Improvement).

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 2019–2023, annual statistical comparisons by question, and annual QC 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, TXIX GC, TXXI GC, TXIX CCC, and TXXI CCC). The ratings are the percentage responding 8, 9, or 10 out of 10.

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Table 3.1. Global Ratings by MCO and Program (Rating 8+9+10) – 2023

Global Rating		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Health Plan	ABH	82.2%	>75th	88.0%	≥50th	86.4%	<50th	85.4%	>75th	87.4%	**>90th**
	SHP	78.0%	≥50th	87.4%	≥50th	89.2%	>66.67th	84.0%	≥50th	**90.1%**	**>95th**
	UHC	79.0%	≥50th	**91.8%**	**>90th**	**90.0%**	>75th	84.1%	≥50th	88.4%	**>90th**
	KanCare	**79.6%**	**≥50th**	**89.1%**		**>66.67th**		**85.0%**		**>66.67th**	
Health Care	ABH	71.1%	**<25th**	**89.8%**	>75th	89.4%	>75th	85.8%	>66.67th	87.3%	>75th
	SHP	78.5%	>75th	85.9%	<50th	87.7%	≥50th	83.3%	<50th	87.9%	>75th
	UHC	73.6%	<50th	88.1%	>66.67th	85.9%	<50th	84.4%	≥50th	↑**89.9%**	**>95th**
	KanCare	**74.5%**	**<50th**	**87.8%**		**≥50th**		**84.9%**		**≥50th**	
Personal Doctor	ABH	84.3%	≥50th	89.3%	<50th	88.1%	<33.33rd	86.2%	<33.33rd	87.8%	<50th
	SHP	↓80.1%	**<25th**	**90.4%**	≥50th	**90.1%**	≥50th	**90.5%**	>75th	87.1%	<50th
	UHC	83.8%	≥50th	**89.5%**	<50th	89.3%	<50th	87.2%	<50th	87.0%	<33.33rd
	KanCare	**82.7%**	**≥50th**	**89.7%**		**≥50th**		**88.0%**		**<50th**	
Specialist	ABH	79.6%	<33.33rd	87.9%		>66.67th		**89.7%**	>75th	↑88%*	
	SHP	80.1%	<33.33rd	85.1%		<50th		87.1%	<50th	84.1%	**<25th**
	UHC	83.2%	≥50th	89%*				83%*		88%*	
	KanCare	**81.1%**	**<50th**	**87.5%**		**≥50th**		**86.3%**		**<50th**	

Note: The KanCare rate for the child surveys is the weighted average of the six subpopulations. The MCO-level General Child ratings of specialist are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: percentages 90% or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold green font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold purple font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.
*Fewer than 100 members responded; NCQA assigns "NA" rather than a QC ranking.

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

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Table 3.2. Composite Scores by MCO and Program – 2023

Composite		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank
Getting Care Quickly	ABH	81.0	<50th	**90.2**	>75th	87*		**90.6**	≥50th	**90.9**	>66.67th
	SHP	85.0	>75th	87.5	≥50th	**91.5**	**>90th**	↓89.2	<50th	**94.0**	**>90th**
	UHC	**90.0**	**>95th**	88*		**91***		**95.9**	**>90th**	**92.7**	>75th
	KanCare	**85.7**	**>75th**	**88.6**		**>66.67th**		**92.1**		**>75th**	
Getting Needed Care	ABH	85.3	>75th	89.2	>75th	87*		85.2	<50th	**↑92.3**	**>95th**
	SHP	84.7	>75th	86.9	>75th	**91.0**	**>95th**	88.3	>66.67th	**91.0**	**>90th**
	UHC	86.2	>75th	89*		86*		87.4	>66.67th	85.6	<50th
	KanCare	**85.4**	**>75th**	**88.3**		**>75th**		**↓87.4**		**>66.67th**	
Coordination of Care	ABH	84.4	<50th	87.6		>75th		83.0	<50th	88*	
	SHP	↓84.7	<50th	83.7		<50th		**91.8**	**>95th**	79.1	**<25th**
	UHC	89.4	**>95th**	79.0		**<25th**		79*		89*	
	KanCare	**86.4**	**≥50th**	**83.1**		**<50th**		**84.7**		**≥50th**	
How Well Doctors Communicate	ABH	**92.7**	≥50th	**95.7**	>75th	95.1	>66.67th	**95.0**	>66.67th	**↑97.8**	**>95th**
	SHP	↓92.2	<50th	**96.0**	>75th	**↑96.8**	**>95th**	**97.7**	**>95th**	**96.5**	>75th
	UHC	**94.1**	>75th	**96.4**	**>95th**	↓94.1	≥50th	**94.7**	≥50th	↓95.5	>66.67th
	KanCare	**93.0**	**≥50th**	**96.0**		**>75th**		**96.0**		**>75th**	
Customer Service	ABH	**90.1**	≥50th	**↑94.9**		**>95th**		**91.5**		>66.67th	
	SHP	**89.6**	≥50th	**92.6**		**>95th**		**90.4**		≥50th	
	UHC	**90.2**	≥50th	**92***				87*			
	KanCare	**89.6**	**<50th**	**↑93.2**		**>95th**		**89.6**		**<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 or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold **green** font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold **purple** font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.
*Fewer than 100 members responded; NCQA assigns "NA" rather than a QC ranking.

Table 3.3 provides scores and rankings for composites specific to the CCC surveys: Access to Prescription Medicines, Access to Specialized Services, Coordination of Care for CCC, 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,
- Flu vaccinations for adults, and
- Smoking and tobacco use and cessation strategies (four questions).

Note that the total percent of adults that are current smokers is reported as a one-year rate and other questions related to tobacco use and cessation strategies are reported as two-year averages in Table 3.6.

Table 3.3. CCC Composite Scores by MCO and Program – 2023

Composite	MCO	Children with Chronic Conditions – Title XIX Score	Title XIX Rank	Title XXI Score	Title XXI Rank
Access to Prescription Medicines	ABH	**93.0**	>75th	**95.1**	**>95th**
	SHP	**93.0**	>75th	**91.2**	≥50th
	UHC	**92.5**	>66.67th	**92.2**	>66.67th
	KanCare	**92.8**		**>75th**	
Access to Specialized Services	ABH	79.5		**>95th**	
	SHP	71.3		<50th	
	UHC	82.0		**>95th**	
	KanCare	77.5		**>95th**	
Coordination of Care for Children with Chronic Conditions	ABH	79.9		>75th	
	SHP	73.2		**<5th**	
	UHC	↓68.9		**<5th**	
	KanCare	73.6		**<10th**	
Family-Centered Care: Getting Needed Information	ABH	**92.1**	≥50th	**95.8**	**>95th**
	SHP	**92.3**	>66.67th	**95.5**	**>95th**
	UHC	**92.4**	>66.67th	**92.9**	>75th
	KanCare	**92.6**		**>75th**	
Family-Centered Care: Personal Doctor Who Knows Child	ABH	**91.7**	≥50th	**93.0**	>75th
	SHP	**89.8**	<33.33rd	**91.1**	≥50th
	UHC	**89.9**	<33.33rd	89.4	**<25th**
	KanCare	**90.5**		**<50th**	

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

Table 3.4. Non-Composite Question Related to Mental or Emotional Health – 2019 to 2023

CAHPS Question		Population	2023	2022	2021	2020	2019
Q30/Q54.	**In general, how would you rate your [your child's] overall mental or emotional health?** *("Excellent" or "Very Good")*	Adult	30.9%	30.2%	30.7%	31.5%	32.0%
		GC	67.6%	66.9%	68.9%	68.1%	↓68.2%
		CCC	35.0%	35.3%	37.1%	38.1%	↓38.0%

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 being based on fewer than 100 responses.
↓Indicates a statistically significant decrease compared to the prior year; $p<.05$.

Table 3.5. Non-Composite Question Related to Having a Personal Doctor – 2019 to 2023

CAHPS Question		Population	2023	2022	2021	2020	2019
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**	84.8%	86.0%	87.2%	86.7%	↑89.1%
		GC	86.3%	86.4%	86.8%	87.5%	↑88.7%
		CCC	**93.3%**	**92.9%**	**93.2%**	**94.3%**	↑**94.7%**

Note: Adult, GC and CCC percentages are combined percentages of MCO populations, weighted by MCO and program population size.
Very High: scores 90 or greater were considered "very high" and are shown in bold **green** font.
↑Indicates a statistically significant increase compared to the prior year; $p<.05$.

Table 3.6. Adult HEDIS Measures Related to Flu Vaccination and Smoking and Tobacco Usage – 2023

Measure	KanCare		Aetna		Sunflower		UnitedHealthcare	
	%	Rank	%	Rank	%	Rank	%	Rank
Flu Vaccination for Adults 18–64 (FVA)	**46.3%**	**>75th**	40.2%	≥50th	49.6%	>75th	48.3%	>75th
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)								
– Total % Current Smokers *(lower is better)*	**27.6%**	**≥50th**	32.0%	**>75th**	24.0%	<50th	27.2%	**≥50th**
– Advising Smokers to Quit	**71.2%**	**<50th**	67.3%	**<25th**	74.3%	≥50th	71.5%	<50th
– Discussing Cessation Medications	**49.5%**	**<50th**	45.2%	**<25th**	55.0%	>66.67th	48.0%	<50th
– Discussing Cessation Strategies	**44.1%**	**<50th**	40.8%	<33.33rd	53.1%	>75th	38.9%	**<25th**

Note: Adult percentages are combined percentages of MCO populations, weighted by MCO and program population size.
Very High: scores 90 or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered "very high" and are shown in bold **green** font.
Relatively Low: KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were "relatively low" and are shown in bold **purple** font (KanCare rank ≥50th and subpopulation rank >75th are in purple if lower is better).
No rates or averages increased or decreased statistically significantly compared to the prior year; $p<.05$.

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

Outcomes

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.

Global Ratings

- **Rating of Health Plan**
  - GC – UHC TXIX (92%, >90th) and UHC TXXI (90%)
  - CCC – ABH TXXI (>90th), SHP TXXI (90%, >95th), and UHC TXXI (>90th)
- **Rating of All Health Care**
  - GC – ABH TXIX (90%)
  - CCC – UHC TXXI (90%, >95th, significantly improved from 2022)
- **Rating of Personal Doctor –** The KanCare GC rate was 90%.
  - GC – SHP TXIX (90%), UHC TXIX (90%), and SHP TXXI (90%)
  - CCC – SHP TXIX (91%)
- **Rating of Specialist Seen Most Often**
  CCC – ABH TXIX (90%, significantly improved from 2022)

Composites

- **Getting Care Quickly** – The KanCare adult and CCC scores ranked >75th, and the KanCare CCC score remained very high (92).
  - Adult – UHC (90, >95th)
  - GC – ABH TXIX (90), SHP TXXI (91, >90th), and UHC TXXI (91)
  - CCC – ABH TXIX (91), UHC TXIX (96, >90th), ABH TXXI (91), SHP TXXI (94, >90th), and UHC TXXI (93)
- **Getting Needed Care** – The KanCare adult and GC ranks were both >75th.
  - GC – SHP TXXI (91, >95th)
  - CCC – ABH TXXI (92, >95th, significantly improved from 2022), and SHP TXXI (91, >90th)
- **Coordination of Care**
  - Adult – UHC (>95th)
  - CCC – SHP TXIX (92, >95th)

- **How Well Doctors Communicate** – The KanCare adult score (93), KanCare GC rate and rank (96, >75th), and the KanCare CCC rate and rank (96, >75th) were very high.
  - Adult – ABH (93), SHP (92), and UHC (94)
  - GC – ABH TXIX (96), SHP TXIX (96), UHC TXIX (96, >95th), ABH TXXI (95), SHP TXXI (97, >95th, a significant increase), and UHC TXXI (94)
  - CCC – ABH TXIX (95), SHP TXIX (98, >95th), UHC TXIX (95), ABH TXXI (98, >95th, a statistically significant increase), SHP TXXI (97), and UHC TXXI (96)
- **Customer Service** – The KanCare adult score (90), the KanCare GC score and rank (93, >95th, a statistically significant increase), and the KanCare CCC score (90) were very high.
  - Adult – ABH (90), SHP (90), and UHC (90)
  - TXIX & TXXI GC – ABH (95, >95th, a statistically significant increase), SHP (93, >95th), and UHC (92)
  - TXIX & TXXI CCC – ABH (92) and SHP (90)

CCC Composites

- **Access to Prescription Medicines** – The KanCare CCC score and rank (93, >75th) were very high.
  - TXIX CCC – ABH (93), SHP (93), and UHC (93)
  - TXXI CCC – ABH (95, >95th), SHP (91), and UHC (92)

  Scores from 2019 to 2023 were all 91 or greater.
- **Access to Specialized Services** – The KanCare CCC rank remained very high (>95th).
  - TXIX & TXXI CCC – ABH (>95th) and UHC (>95th)

  The KanCare CCC score was 78, which indicates room for improvement even with a high ranking.
- **Family-Centered Care: Getting Needed information** – The KanCare CCC rate (93) ranked very high (>75th).
  - TXIX CCC – ABH (92), SHP (92), and UHC (92)
  - TXXI CCC – ABH (96, >95th), SHP (96, >95th), and UHC (93)

  Scores from 2019 to 2023 were all 90 or greater.
- **Family-Centered Care: Personal Doctor Who Knows Child** – The KanCare CCC score (91) was very high.
  - TXIX CCC – ABH (92), SHP (90), and UHC (90)
  - TXXI CCC – ABH (93) and SHP (91)

  Scores from 2020 to 2023 were all 89 or greater.

Non-Composite Questions

- **Smoking and Tobacco Usage** – SHP rates maintained an improving five-year trend (1.6 pp/y).
- **Having a Personal Doctor** – KanCare CCC rate remained very high (93%).
- **Flu Vaccinations for Adults 18–64** – The KanCare ranking was very high (>75th).

Technical

- The Center for the Study of Services (Aetna's vendor) and Press Ganey (Sunflower's and UnitedHealthcare's vendor) are both NCQA-certified survey vendors, with NCQA oversight to ensure survey protocols followed recognized standards.
- The survey process was clearly defined by NCQA and provided comparative information across health plans.
- Each MCO's survey process included an initial mailing of the survey questionnaire, Aetna sent two reminder postcard mailings, and each MCO sent a second mailing of the questionnaire to non-respondents. After the second postcard mailing, telephone outreach to non-respondents was conducted.

- Prior to sending the first survey packet, Aetna sent a postcard notification to all selected members.
- Sunflower and UnitedHealthcare included an internet response option in addition to mail and phone response options. The internet link was included in the cover letters for the questionnaires.
- Aetna made up to six phone attempts to contact non-responding members (the maximum allowed).
- Vendor reports included the timeline for survey implementation.
- Analysis of survey results were clearly presented.
- Each MCO's vendor report included analyses of key drivers for the Rating of Health Plan and recommendations or resources for improving the ratings.

Opportunities for Improvement

Outcomes

Several measures for the KanCare adult and child populations, as well as for each MCO, indicated a need for improvement. Relatively low ranks, that is, below the 50th percentile (for KanCare rates) or the 25th percentile (for MCO ranks) for scores/rates below 90 or 90%, were considered opportunities for improvement. Rates with a statistically significant decrease from 2022 or with decreasing 2019–2023 trendlines were also considered opportunities for improvement.

Global Ratings

- **Rating of All Health Care** – KanCare adult rates ranked <50th.
  - Adult – ABH (<25th)

  Five-year trends were decreasing for KanCare adult (1.1 pp/y), UHC adult (2.2 pp/y), and UHC TXXI GC (1.3 pp/y) rates.
- **Rating of Personal Doctor** – The KanCare CCC rate ranked <50th.
  - Adult – SHP (<25th, the rate decreased significantly to 80%)
- **Rating of Specialist Seen Most Often** – KanCare adult and KanCare CCC scores ranked <50th.
  - CCC – SHP TXXI (<25th)

  The five-year trend for KanCare adult scores (0.9 pp/y) and four-year trend for ABH adult scores (3.2 pp/y) were both declining.

Composites

- **Getting Care Quickly**

  Five-year trends decreased for KanCare GC (1.4 p/y), KanCare CCC (0.9 p/y) population scores.
  The rate for SHP TXIX CCC (89) decreased significantly. The following trends were also decreasing:
  - Adult – ABH adult (1.7 p/y)
  - GC – SHP TXIX (2.0 p/y), UHC TXIX (1.2 p/y), and ABH TXXI (1.7 p/y)
  - CCC – ABH TXIX (1.3 p/y), SHP TXIX (1.4 p/y), and SHP TXXI (0.8 p/y)
- **Getting Needed Care** – The KanCare CCC rate declined significantly from 2022 but increased in rank to >66.67th. There was also a downward trend of 0.9 p/y for KanCare CCC.
  - GC – The UHC TXXI score trend was decreasing (1.7 p/y)
  - CCC – The ABH TXIX and UHC TXXI scores had downward trends (2.5 p/y, 1.6 p/y)
- **Coordination of Care** – The 2023 score for KanCare GC was ranked relatively low (<50th). The rate for SHP adults (85) decreased significantly from 2022.
  - GC – UHC TXIX & TXXI (<25th)
  - CCC – SHP TXXI (<25th)

- **How Well Doctors Communicate** – The ratings given by SHP adults, UHC TXXI GC, and UHC TXXI CCC all decreased significantly from 2022.
  - The 2019 to 2023 scores for UHC TXXI CCC had a decreasing trend (0.5 p/y).

CCC Composites

- **Access to Specialized Services**
  - Trendlines were decreasing for KanCare (1.7 p/y) and SHP TXIX (3.9 p/y)
- **Coordination of Care for Children with Chronic Conditions** – The KanCare CCC score (74, <10th) had not improved over the past 5 years.
  - TXIX & TXXI CCC – SHP (<5th) and UHC (<5th, a significant score decrease from 2022)
- **Family-Centered Care: Personal Doctor Who Knows Child**
  - CCC – UHC TXXI (<25th)

Non-Composite Questions

- **Rating of Mental or Emotional Health** – Only 31% of KanCare adult, 68% of KanCare GC, and 35% of KanCare CCC respondents rated their [their child's] overall mental or emotional health as *excellent* or *very good.* The 2019–2023 trendlines were declining for KanCare CCC (0.9 pp/y), SHP TXXI GC and CCC (1.9 pp/y and 2.9 pp/y), and UHC TXXI GC and CCC (1.9 pp/y and 4.6 pp/y) rates.
- **Medical Assistance with Smoking and Tobacco Use Cessation**
  - **Smoking and Tobacco Usage** – The KanCare rate (28%) was above (worse than) the 50th percentile. The ABH rate (32%) was worse than the 75th percentile.
  - **Advising Smokers and Tobacco Users to Quit** – KanCare and ABH rates ranked relatively low (<50th and <25th, respectively). A decreasing five-year trend was observed for the UHC rate (2.9 pp/y).
  - **Discussing Cessation Medications** – The KanCare rate (50%) ranked <50th and the ABH rate (45%) ranked <25th.
  - **Discussing Cessation Strategies** – The KanCare rate was 44% (<50th). The UHC rate had a decreasing trend (3.7 pp/y).
- **Having a Personal Doctor** – The 2019–2023 trendlines were declining for KanCare adult and GC rates (0.9 pp/y and 0.4 pp/y). There were also downward trends for UHC adults (1.8 pp/y), UHC TXXI GC (1.4 pp/y), and SHP TXIX (0.8 pp/y).
- **Flu Vaccinations for Adults 18–64** – The 2019–2023 trendlines were declining for the KanCare and ABH rates (2.2 pp/y and 2.1 pp/y, respectively).

Technical

- The targeted number of responses (411) was not obtained for any of the 15 survey populations.
- Aetna's sample frames did not meet State requirements when members were selected for the child surveys. After the surveys were fielded, sampled members were correctly reclassified. The number of members in the resulting sample sets were below NCQA requirements for Aetna's TXIX general child and both CCC supplemental samples.

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

All four of the recommendations made in the 2022 CAHPS Health Plan 5.1H Survey Validation report were still in progress. Please see Appendix D for more details.

Recommendations for Quality Improvement

Common Among the MCOs

1. MCOs should conduct root cause analysis to identify the reasons for, and identify next steps to address, the decline in providing urgent and routine care quickly for KanCare members.
2. All MCOs should continue to expand their care coordination efforts, particularly for CCC, including primary care physicians being informed and up to date about the care children receive from other doctors and health providers. Encouraging providers to discuss with the parents and guardians (or the youth themselves) whether their children receive care or services elsewhere, request releases of information, and establish bi-directional ongoing communication with the other providers. 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).
3. 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.
4. 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).
5. MCOs should continue efforts to increase the number of people receiving flu vaccinations yearly.

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4. KanCare Mental Health Consumer Perception Survey

Background/Objectives

Since 2010, KFMC has administered a mental health consumer perception survey to KanCare beneficiaries receiving services, as per the EQR contract with the KDHE and the Kansas Department of Aging and Disability Services (KDADS). Since 2021, KFMC has contracted with Press Ganey, formerly SPH Analytics, to administer the survey. KFMC provided operational oversight; Press Ganey analyzed survey data and produced the analysis.

The survey objectives were to assess the quality of BH services by focusing on the patient's experiences with care.[7] Specific objectives of the survey include the following for adult and child populations.

Adult

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

Child

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

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

For 2023, the survey tool used was a modified version of the Experience of Care and Health Outcomes (ECHO) Survey. The sample included 13,100 KanCare members (5,550 adults and 7,550 children). KFMC created the sample frame from which Press Ganey selected the sample. The survey was administered using a one-wave, mail-only protocol. Adult members and parents or guardians of child members were mailed a survey and cover letter that included an internet option for the survey. A total of 460 adult surveys and 457 child surveys were returned or completed online. Additional details are provided in Appendix B, 2023 Methodologies.

Conclusions Drawn from the Data Common Among the MCOs

Adult Survey Results

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

[7] https://www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html

Table 4.1. Summary Rates of Key Measures – Adult

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

Domain or Question	2023 Rate
Rating of Counseling and Treatment (Q28) (% 8, 9, or 10)	**73.4%**
Rating of Health Plan (Q53) (% 8, 9, or 10)	**80.1%†**
Getting Treatment Quickly (% Always or Usually)	**65.2%**
Q3. Got professional counseling on the phone when needed	49.4%‡
Q5. Saw someone as soon as wanted (when needed right away)	66.0%
Q7. Got appointment as soon as wanted (not counting times needed care right away)	80.2%‡
How Well Clinicians Communicate (% Always or Usually)	**91.2%**
Q11. Clinicians listened carefully to you	92.2%*
Q12. Clinicians explained things	89.5%*
Q13. Clinicians showed respect for what you had to say	92.1%*
Q14. Clinicians spent enough time with you	88.4%*
Q15. Felt safe with clinicians	95.1%^
Q18. Involved as much as you wanted in treatment	89.7%*
Informed about Treatment Options (% Yes)	**49.1%**
Q20. Told about self-help or support groups	41.3%
Q21. Given information about different kinds of counseling or treatment options	57.0%
Perceived Improvement (% Much better or A little better)	**57.5%**
Q31. Your ability to deal with daily problems, compared to one year ago	63.4%
Q32. Your ability to deal with social situations, compared to one year ago	52.8%
Q33. Your ability to accomplish things he/she want to do, compared to one year ago	55.7%
Q34. Rating of your problems or symptoms, compared to one year ago	58.1%
Prescription Medicines (% Yes)	
Q16. Took prescription medicines as part of treatment	85.4%
Q17. Told about side effects of medications	75.6%
Q24. Felt you could refuse a specific type of medicine or treatment	83.7%
Getting Treatment and Information from the Plan (% Not a problem)	**71.3%**
Q43. Problem with getting someone you are happy with since joining this health plan	58.3%‡
Q45. Problem with delays in counseling or treatment while waiting for approval	91.4%
Q46. Problem with getting counseling or treatment needed	74.1%‡
Q48. Problem finding or understanding information in written materials/internet	47.5%
Q50. Problem getting the help needed when calling customer service	64.0%
Q52. Problem with paperwork from health plan	92.2%
Reasons for Counseling or Treatment (% Yes)	
Q54. Counseling was for personal problems, family problems, emotion, or mental illness	94.9%
Q55. Counseling was for alcohol or drug use	11.2%
Non-Domain Question from Key Driver Analysis	
Q10. Seen within 15 minutes of appointment (% Always or Usually)	86.8%^
Q29. Helped by the counseling or treatment you got (% A lot or Somewhat)	83.8%‡
Supplemental Questions (% Strongly Agree or Agree)	
Q64. I am happy with the friendships I have.	81.2%
Q65. I have people with whom I can do enjoyable things.	82.7%

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

Key questions with high rates and questions identified as Power or Retain in the key driver analysis were considered strengths.

- Q10. Seen within 15 minutes of appointment (Retain)
- Q11. Clinicians listened carefully to you (High, Power)
- Q12. Clinicians explained things (Power)
- Q13. Clinicians showed respect for what you had to say (High, Power)
- Q14. Clinicians spent enough time with you (Power)
- Q15. Felt safe with clinicians (High, Retain)
- Q18. Involved as much as you wanted in treatment (Power)
- Q45. Problem with delays in counseling or treatment while waiting for approval (High)
- Q52. Problem with paperwork from health plan (% Not a problem) (High)

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

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

- Q3. Got professional counseling on the phone when needed (Low, Wait)
- Q7. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q20. Told about self-help or support groups (Low)
- Q29. Helped by the counseling or treatment you got (Wait)
- Q32. Your ability to deal with social situations, compared to one year ago (Low)
- Q33. Your ability to accomplish things he/she want to do, compared to one year ago (Low)
- Q43. Problem with getting someone you are happy with since joining this health plan (Wait)
- Q46. Problem with getting counseling or treatment needed (Wait)
- Q48. Problem finding or understanding information in written materials/internet (Low)
- Q53. Rating of Health Plan (Opportunity)

Child Survey Results

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

Table 4.2. Summary Rates of Key Measures – Child

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

Domain or Question	2023 Rate
Rating of Counseling and Treatment (Q29) (% 8, 9, or 10)	**72.9%†**
Rating of Child's Health Plan (Q54) (% 8, 9, or 10)	**85.1%**
Getting Treatment Quickly (% Always or Usually)	**61.4%**
Q3. Got professional counseling on the phone when needed	42.0%
Q5. Saw someone as soon as wanted (when needed right away)	63.8%
Q7. Got appointment as soon as wanted (not counting times needed care right away)	78.3%‡
Q11. Seen within 15 minutes of appointment	88.0%^

Table 4.2. Summary Rates of Key Measures – Child (Continued)	
Categories identified by Press Ganey as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).	
Domain or Question	**2022 Rate**
How Well Clinicians Communicate (% Always or Usually)	**90.8%**
Q12. Clinicians listened carefully to you	90.5%^
Q13. Clinicians explained things	91.4%^
Q14. Clinicians showed respect for what you had to say	93.6%*
Q15. Clinicians spent enough time with you	89.9%^
Q18. Involved as much as you wanted in treatment	88.6%^
Informed About Treatment Options (% Yes)	**70.7%**
Q22. Given information about different kinds of counseling or treatment options	65.6%
Q23. Given information about what you could do to manage your child's condition	75.8%
Getting Treatment and Information from the Plan (% Not a problem)	**72.2%**
Q44. Problem with getting someone your child is happy with since joining this health plan	57.3%†
Q46. Problem with delays in counseling or treatment while waiting for approval	93.8%^
Q47. Problem with getting counseling or treatment child needed	70.8%†
Q49. Problem finding or understanding information in written materials/internet	58.3%
Q51. Problem getting the help needed when calling customer service	57.1%
Q53. Problem with paperwork for child's health plan	96.1%
Perceived Improvement (% Much better or A little better)	**72.1%**
Q30. Helped by the counseling or treatment received (% A lot or Somewhat)	83.3%†
Q32. Child's ability to deal with daily problems, compared to one year ago	75.7%
Q33. Child's ability to deal with social situations, compared to one year ago	69.7%
Q34. Child's ability to accomplish things he/she want to do, compared to one year ago	69.9%
Q35. Rating of your child's problems or symptoms, compared to one year ago	73.2%
Non-Domain Question from Key Driver Analysis (% Always or Usually)	
Q20. Family got the professional help you wanted for your child	84.7%†
Q21. Child had someone to talk to for counseling or treatment when he or she was troubled	83.0%†
Supplemental Questions (% Strongly Agree or Agree)	
Q71. I know people who will listen and understand me when I need to talk	95.7%
Q72. I have people with whom I can do enjoyable things	96.6%

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

Key questions with high rates and questions identified as Power or Retain in the key driver analysis were considered strengths.

- Q11. Child was seen within 15 minutes of appointment (Retain)
- Q12. Clinicians listened carefully to you (Retain)
- Q13. Clinicians explained things (High, Retain)
- Q14. Clinicians showed respect for what you had to say (High, Power)
- Q15. Clinicians spent enough time with you (Retain)
- Q18. Involved as much as you wanted in treatment (Retain)
- Q46. Problem with delays in counseling or treatment while waiting for approval (% Not a problem) (High, Retain)
- Q71. I know people who will listen and understand me when I need to talk (High)
- Q72. I have people with whom I can do enjoyable things (High)

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

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

- Q3. Got professional counseling on the phone when needed (Low)
- Q5. Saw someone as soon as wanted (when needed right away) (Low)
- Q7. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q20. Family got the professional help you wanted for your child (Opportunity)
- Q21. Child had someone to talk to for counseling or treatment when troubled (Opportunity)
- Q29. Rating of Counseling and Treatment (% 8, 9, or 10) (Opportunity)
- Q30. Helped by the counseling or treatment received (Opportunity)
- Q44. Problem with getting someone for your child you are happy with (Low, Opportunity)
- Q47. Problem with getting counseling or treatment child needed (Opportunity)
- Q49. Problem finding or understanding information in written materials/internet (Low)
- Q51. Problem getting the help needed when calling customer service (% Not a problem) (Low)

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

KFMC reviewed the two previous recommendations from KFMC's 2022 report. An update on the extent to which the 2022 recommendations were addressed is currently not available from the State.

Recommendations for Quality Improvement

Recommendations for the State

1. For adult members, continue to monitor and explore methods to increase
   a. Access, quality, and timeliness of treatment;
   b. Member access to information about treatment options and understandability of materials (information about self-help or support groups);
   c. Member perception of their own improvement; and
   d. Member satisfaction with provider.
2. For child members, continue to monitor and explore methods to increase
   a. Access, quality, and timeliness of treatment;
   b. Positive member outcomes including member perceived improvement;
   c. Member satisfaction with provider; and
   d. Accessing and understanding information, including getting needed help from customer service.

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5. Provider Satisfaction Survey Validation

Background/Objectives

The objective of the annual KanCare MCO provider satisfaction survey is to assess how well each MCO is meeting its providers' expectations and needs, identifying strengths and areas for improvement. In July 2021, KDHE executed the KanCare MCO Contract Amendment 14, Section 5.9.11, specifying more detailed provider survey requirements in efforts to improve survey quality and increase consistency across the MCOs. One of the requirements is to submit results that are generalizable to the following four KanCare provider populations: PCPs, specialists, BH providers, and HCBS providers. The MCOs must be in compliance with these requirements for their surveys. All three MCOs contracted with the Center for Applied Research and Evaluation (CARE) at Wichita State University's Community Engagement Institute (WSU-CEI), to develop and conduct the 2023 Provider Satisfaction Survey. The survey vendor developed a combined survey approach and a single survey instrument for the three MCOs. The MCOs' surveys were administered using a single web-based strategy, with email invitations sent to providers for participation. In preparation for the 2023 survey, all three MCOs submitted the Survey Work Plan for State review prior to survey implementation. Three drafts of the MCOs' Survey Work Plan were reviewed, with feedback provided by the State and KFMC. The third draft was approved by the State with emphasis on implementation of KFMC's recommendations prior to, and during, survey implementation. After completion of the survey, all three MCOs submitted the Survey Reports prepared by the survey vendor describing the survey methodology, and analytic results presenting the survey findings.

As the EQRO for the State of Kansas, KFMC completed a validation of the 2023 MCOs' Provider Satisfaction Survey. The objective of KFMC's review described in this report is to validate the methodological soundness of the completed survey.

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

KFMC used the February 2023 Validating Surveys Protocol worksheet and narrative, provided by CMS, to conduct the validation of Provider Surveys. The protocol is comprised of the following eight validation activities:

1. Review survey purpose, objectives, and audience
2. Review the work plan
3. Review the reliability and validity of the survey instrument
4. Review the sampling plan
5. Review the adequacy of the response rate
6. Review the quality assurance plan
7. Review the survey implementation
8. Review the survey data analysis and final report

Conclusions Drawn from the Data

As mentioned above, a combined survey approach was applied for the MCOs' surveys, therefore, validation conclusions are common for all MCOs. The key conclusions are described below:

Common Among the MCOs

- All three MCOs indicated their samples included KanCare network PCPs, specialists, BH clinicians, and HCBS providers.

- The 2023 MCO Provider Satisfaction Surveys did not fulfill the methodological and analytic requirements of State Contract Amendment 14. All three MCOs were unable to provide the results that could be generalizable to their respective KanCare provider networks comprised of the four required provider types, due to the following key issues:
  - Each MCO's survey was implemented by applying a single web-based mode using only email addresses to invite providers to participate in the survey. All three MCOs identified a small proportion of providers with valid emails (Aetna: 2,515; Sunflower: 2,555; and UnitedHealthcare: 3,700); therefore, the sample frames used were not representative of the MCOs' study populations of deduplicated providers (Aetna: 6,133 deduplicated providers; Sunflower: 17,663 deduplicated providers; UnitedHealthcare: 9,847 deduplicated providers).
  - Out of the available email addresses for each MCO, some were for practices/organizations, and some were for individual providers. The email recipient was requested to share the survey link with all providers who work with the MCOs. Thus, the actual number of individual providers eligible to participate, and invited to participate, in the surveys were not known (total and by four provider types).
  - Instead of using the stratified random sampling method and previously calculated statistically significant samples for each of the four provider types, a convenience sampling method was used to identify survey participants for each MCO. An inadequate number of surveys were completed by all four provider types. These numbers were much lower than the needed number of completed surveys to obtain generalizable results for each of the MCOs' KanCare provider networks comprised of the four required provider types (see Tables 5.1-5.3).

Table 5.1. Aetna Provider Satisfaction Survey: Completed Surveys Needed and Completed Surveys Achieved

Provider Type	Providers in Sample Frame	Completed Surveys Needed to Achieve Generalizability	Completed Surveys Achieved Using Convenience Sample
Primary Care	1,503	307	48
Specialist Care	2,398	332	24
BH Care	1,598	310	159
HCBS Care	634	240	166
Total (Approved)	**6,133**	**1,189**	**397**
Nursing Facility			129
Total (surveyed)			526

Table 5.2. Sunflower Provider Satisfaction Survey: Completed Surveys Needed and Completed Surveys Achieved

Provider Type	Providers in Sample Frame	Completed Surveys Needed to Achieve Generalizability	Completed Surveys Achieved Using Convenience Sample
Primary Care	5,395	359	14
Specialist Care	9,598	370	17
BH Care	2,052	324	40
HCBS Care	618	238	53
Total (Approved)	**17,663**	**1,291**	**124**
Nursing Facility			59
Total (surveyed)			183

Table 5.3. UnitedHealthcare Provider Satisfaction Survey: Completed Surveys Needed and Completed Surveys Achieved			
Provider Type	**Providers in Sample Frame**	**Completed Surveys Needed to Achieve Generalizability**	**Completed Surveys Achieved Using Convenience Sample**
Primary Care	1,931	321	11
Specialist Care	2,865	339	10
BH Care	4,493	354	105
HCBS Care	558	228	135
Total (Approved)	**9,847**	**1,242**	**261**
Nursing Facility			45
Total (surveyed)			306

  - All analyses included nursing facility providers. By including nursing facility providers in the analyses, the MCOs' survey results were not aligned with their respective study populations and sample frames comprised of PCPs, specialists, BH providers, and HCBS providers (as per approved Work Plan). Reasons for this deviation from the Work Plan were not provided.
  - Stratified analysis by the four provider types, by survey items, was not done, and weighted data analysis techniques were not applied by all MCOs.
- The above-mentioned methodological issues and concerns were identified by KFMC and the State prior to survey implementation. While providing approval for the Survey Work Plan, the State directed the MCOs to address these concerns during survey implementation to fulfill contractual obligations. All three MCOs did not address these issues and concerns during survey implementation.
- Based on the implemented survey methodology for each survey, non-representativeness of the MCOs' sample frames to their respective study populations, and low number of surveys completed, the overall satisfaction rate with each MCO could only be applied to the providers who completed the survey (Aetna: 526 respondents; Sunflower: 183 respondents; UnitedHealthcare: 306 respondents). The Survey Reports presented the interpretations for most of the results in a manner that could be misinterpreted by the audience as applying to all KanCare providers in each MCO's Network. The MCO reports noted the following interpretations regarding overall satisfaction in the examples below.
  - From Aetna's report, *"Almost half of providers (49 percent) shared that overall they feel satisfied or completely satisfied with Aetna."*
  - From Sunflower's report, *"Two thirds of providers (66 percent) shared that overall they feel satisfied or completely satisfied with Sunflower."*
  - From UnitedHealthcare's report, *"The majority of providers (62 percent) shared that overall they feel satisfied or completely satisfied with United HealthCare."*
  - These results should not be construed as overall satisfaction with the MCOs by all providers in their respective KanCare Provider Network, or even just by all MCOs' providers in the four provider types (PCPs, specialists, BH providers, and HCBS providers).
- The survey findings could not be compared between the MCOs due to the methodological and analytical issues.

Technical Strengths

Common Among the MCOs

- The MCOs contracted with a single survey vendor. The survey vendor applied the same survey administration processes across the MCOs, including the use of a single survey instrument, survey methodology, survey implementation modality, quality assurance procedures, data analysis, and

reporting of the survey. This provided the possibility to compare survey results across the three MCOs.
- The study purpose/objectives for all three surveys were reasonably clear, measurable, and in accordance with State Contract Amendment 14.
- All three surveys were specific to KanCare providers as required by State Contract Amendment 14.
- The survey instrument included appropriate questions to measure the study purpose.
- The survey instrument included only one relative question as required by State Contract Amendment 14. This reduced the issues seen in prior years' surveys due to the possibility of varied understanding and responses when asked about satisfaction compared to other plans they work with, due to differences in the characteristics of the other health plans providers were contracting with.

Opportunities for Improvement

Common Among the MCOs

- Changes were made in the methodology and analyses during the MCOs' survey implementation. The reasons for deviations from the approved Work Plan were not provided.
- Reliability and validity testing for the MCOs' target populations was not conducted by applying methods such as cognitive interviews or focus groups with the targeted survey respondents or the providers with subject matter expertise serving on MCOs' provider committees or advisory groups.
- Only a small proportion of providers/practices identified in the sample frames for the MCOs were eligible to participate in the survey, due to missing email addresses in all three MCOs' provider data files. The number of individual providers with valid email addresses (total, and per provider type) were not determined by the MCOs. Sample frames formulated from the study populations that exclude a major portion of eligible providers (those without email addresses in the MCO's data files) are not representative of the MCOs' study population. A stratified random sampling methodology and statistically significant samples for PCPs, specialists, BH, and HCBS provider populations were not used by the MCOs. Instead, convenience samples were used.
- The surveys were administered using a single web-based strategy, with the email invitation sent only to providers/practices for whom valid email addresses were available. The number of providers (total and by four provider types) who received a survey invitation was not known for each MCO survey.
- There were no established required response rates for the four provider types. The minimum number of completed surveys required for each of the four provider types was not applied for survey implementation by the MCOs.
- Response rates were not calculated for the four provider types.
- None of the MCOs took corrective actions, either with WSU or separately, when inadequate numbers of surveys were completed by all four provider types.
- All analyses presented in MCOs' Survey Reports included nursing facility providers. By including nursing facility providers in the analyses, the results were not aligned with the MCOs' study populations and sample frames comprised of PCPs, specialists, BH providers, and HCBS providers (as per the approved Work Plan).
- Stratified analysis by the four provider types by survey item was not done.
- The survey results were only applicable to survey respondents and were not generalizable to the MCOs' Provider Network of PCPs, specialists, BH providers, and HCBS providers. However, all three Survey Reports presented the interpretations for most of the results in a manner that could be misinterpreted by the readers as applying to all KanCare providers in the MCOs' Network.

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. Please see Appendix D for more details.

There were 15 previous year's recommendations common among the MCOs:

- Three recommendations were fully addressed by all three MCOs,
- Seven recommendations were partially addressed by all three MCOs, and
- Five recommendations were not addressed by all three MCOs.

MCO-specific recommendations were made in the prior year, as well.

- Of the four Aetna-specific recommendations, one was addressed, one was partially addressed, one was not addressed, and one was no longer applicable due to recommended changes made in the 2023 Survey methodology.
- Of the eight Sunflower-specific recommendations, two were addressed, two were partially addressed, two were not addressed, and two were no longer applicable due to recommended changes made in the 2023 Survey methodology.
- Of the eighteen UnitedHealthcare-specific recommendations, five were addressed, nine were partially addressed, and four were not addressed.

Recommendations for Quality Improvement

Common Among the MCOs

1. Ensure all the requirements of the State Contract Amendment 14, Section 5.9.11 regarding Provider Satisfaction Survey are fulfilled.
2. Implement the survey methodology and analytic plan approved by the State prior to the survey implementation or obtain written approval from the State for any revisions. Document, in the Survey Report, the rationale for revisions to the survey methodology during survey implementation.
3. Conduct reliability and validity testing of the Survey Instrument with the target population of the survey, such as the MCOs' provider advisory committees. Access these groups to identify potential reasons for non-participation in the survey and suggestions for improvement.

Common Among the MCOs

4. Ensure generalizability of the survey findings to the intended study population:
    - Include only PCPs, specialists, BH providers, and HCBS providers (i.e., the four required provider types) in the study population and sample frame. Ensure the sample frame planned and used is representative of the study population. This could be achieved by substantially increasing email data completeness in the provider network files to substantially improve the sample frame numbers and adding other modes of identifying eligible providers.
    - Apply stratified random sampling methodology (a type of probability sampling appropriate for meeting State Contract Amendment 14 requirements). Calculate the sample sizes needed using clearly described sample size calculation parameters. These calculated sample sizes would be the required minimum number of completed surveys by the four provider types. Ensure using and achieving these calculated sample sizes during survey implementation. Establish minimum required response rates to be achieved for the four required provider types.

Recommendations for Quality Improvement

Common Among the MCOs (Continued)

- Plan, implement, and report steps to increase the number of completed surveys or improve the response rate by each of the four provider types, such as: multi-modal strategy instead of single mode (e.g., mail, phone, and web-based) for notifications, surveying, and reminders; increasing the duration of survey; frequency and number of reminders; updating and correcting provider contact information prior to survey and throughout the survey – resending survey after researching and finding new contact information; asking the providers the issues related to their non-participation and taking steps to address these issues, and determining the reason for a large number of ineligible surveys.
- Plan, apply, and report corrective actions implemented during fielding of the survey if the number of completed surveys is less than the minimum expected number by provider type, such as extending the survey cut-off date, or completing an extra provider phone follow-up for the provider types with low numbers of completed surveys.

5. Design and implement an analysis plan with appropriate statistical tests (if applicable) to obtain survey results generalizable to the MCO's KanCare Network of PCPs, specialists, BH providers, and HCBS providers populations.
   - All respondents identified through the "Other, specify" response option, who cannot be classified in one of the four required provider types, should be excluded from the survey analysis.
   - Calculate and report response rates in addition to the completed responses; also, conduct and report non-response analysis.
   - Conduct and report stratified analyses of all survey items for the four provider types.
   - Create and use sampling weights in the analyses.
   - Include numerator and denominator counts in the data tables presented in the Survey Report.
   - Include numerators and denominators used for analyzing data for each survey item (overall and stratified analyses results).
   - Use and report caution in interpretation of the results when results are based on small numbers.

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

Background/Objectives

The Medicaid and CHIP Managed Care Regulations require performance of independent, external reviews of the quality, timeliness of, and access to care and services provided to Medicaid and CHIP beneficiaries by MCOs.[8] 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, and Aetna since January 2019. KFMC reviewed MCO compliance with the Medicaid and CHIP Managed Care regulations updated May 6, 2016, and November 13, 2020.

The current review period is 2022-2024, with KFMC conducting approximately one-half of the review in Years 1 (2022) and 2 (2023) for Sunflower and UnitedHealthcare, along with needed follow-up in Years 2 (2023) and 3 (2024). KFMC completed most of the full regulatory compliance review for Aetna in Year 1 (2022). Needed follow-up was conducted in Year 2 (2023) and will be completed again in Year 3 (2024). KFMC's compliance review results for the Year 2 (2023) review is included in this *2023-2024 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 February 2023, 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 CMS.

The protocol involves completion of the following five activities:

- Activity 1: Establish Compliance Thresholds
- Activity 2: Perform Preliminary Review (Pre-Site Visit)
- Activity 3: Conduct Managed Care Organization Site Visit
- Activity 4: Compile and Analyze Findings (Post-Site Visit)
- 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, manuals, and other materials related to the federal regulations, and case files for Coordination and Continuity of Care, Provider Selection, and Grievances and Appeals.

The following Medicaid Managed Care Regulatory Provisions were reviewed in Years 1 and 2 for the MCOs:

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

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

The regulatory areas were divided and categorized by year reviewed per MCO within the three-year review period (2022–2024), as displayed in Table 6.1.

Table 6.1. Standards Reviewed Timeframe (2022-2024)

Regulatory Standard	Reviewed by the EQRO					
	RC* 2022 – 2023			RC* 2023 – 2024		
	ABH	SHP	UHC	ABH	SHP	UHC
Subpart B – State Responsibilities						
§438.56 Disenrollment: Requirements and Limitations	X				X	X
Subpart C – Enrollee Rights and Protections						
§438.100 Enrollee Rights	X				X	X
§438.114 Emergency and Poststabilization Services	X				X	X
Subpart D – MCO, PIHP, and PAHP Standards						
§438.206 Availability of Services	X	X	X			
§438.207: Assurances of Adequate Capacity and Services	X	X	X			
§438.208 Coordination and Continuity of Care	X	X	X	X^		
§438.210 Coverage and Authorization of Services	X				X	X
§438.214 Provider Selection	X	X	X			
§438.224 Confidentiality	X	X	X			
§438.228 Grievance and Appeal Systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	X				X	X
§438.402 General Requirements	X	X	X			
§438.404 Notice of Adverse Benefit Determination	X				X	X
§438.406 Handling of Grievances and Appeals	X				X	X
§438.408 Resolution and Notification	X				X	X
§438.410 Expedited Resolution of Appeals	X				X	X
§438.414 Information about the Grievance and Appeal System to Providers and Subcontractors	X				X	X
§438.416 Recordkeeping Requirements	X				X	X
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	X				X	X
§438.424 Effectuation of Reversed Appeal Resolutions	X				X	X
§438.230 Sub-contractual Relationships and Delegation	X	X	X			
§438.236 Practice Guidelines	X	X	X			
§438.242 Health Information Systems	X				X	X
Subpart E – Quality Measurement and Improvement						
§438.330 Quality Assessment and Performance Improvement Program	X	X	X			

*Reporting Cycle (RC)
^ Additional Nursing Facility case review was completed for Aetna in Year 2 (2023).

KFMC utilized the five-point rating compliance scoring (Fully Met, Substantially Met, Partially Met, Minimally Met, and Not Met) as defined in the EQR Protocol 3; results were compiled into a tabular format for reporting on each regulatory category. The individual MCO *2022* and *2023 Review of Compliance with Medicaid and CHIP Managed Care Regulations* reports contain more detail and are available upon request.

KFMC applied a point system to calculate the overall compliance score for each regulatory component, subpart, and overall MCO compliance. Each component earns a compliance score in the following way: Fully Met receives four points; Substantially Met receives three points; Partially Met receives two points; Minimally Met receives one point; and Not Met receives zero points. The Compliance Score for each regulation is a percentage found by dividing the numerator (the total number of points earned by the

components within that regulation) by the denominator (the total number of points possible for components within that regulation).

Conclusions Drawn from the Data

Compliance

Common Among the MCOs, Years 1 and 2 Reviews – 2022 and 2023

For the areas reviewed for the MCOs in Years 1 and 2, all three had the greatest opportunity for improvement in §438.214 *Provider Selection,* §438.228 *Grievance and Appeal Systems* (requires compliance with Subpart F Grievance and Appeal System), and §438.416 *Recordkeeping Requirements*.

Aetna, Years 1 and 2 Reviews – 2022 and 2023

KFMC reviewed all regulatory areas in Subparts B, C, D, and E in Year 1. Due to errors in Aetna's Nursing Facility case list selection for the Year 1 case review, it was determined that 12 of 20 cases could not be reviewed and follow-up to case review within §438.208 *Coordination and Continuity of Care* would occur in the Year 2 Compliance Review. From the Year 1 and Year 2 combined LTSS – Nursing Facility record review, there were no changes to the Year 1 (2022) overall compliance rating of 94% for the federal regulatory requirements.

Overall, Aetna was 94% compliant with the federal regulatory requirements. Subpart B Disenrollment: Requirements and Limitations is not included because the requirements are not applicable to the health plan. Subpart E Quality Measurement and Improvement; External Quality Review scored the highest (100% Fully Met). Table 6.2 summarizes the Compliance Review findings for Years 1 and 2.

Table 6.2. Summary of 2022 and 2023 Compliance Reviews – Aetna

Federal Regulations	Component Compliance*						
	Components	FM* (4 Points)	SM* (3 Points)	PM* (2 Points)	MM* (1 Point)	NM* (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee Rights^ǂ §438.10 Information Requirements^ §438.3(j) Standard Contract Requirements: Advance Directives	24	(18/24)	(6/24)	(0/24)	(0/24)	(0/24)	94% (90/96)
§438.114 Emergency and Post-stabilization Services‡	5	(2/5)	(3/5)	(0/5)	(0/5)	(0/5)	85% (17/20)
SUBPART C TOTAL	**29**	**(20/29)**	**(9/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**92% (107/116)**

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
ǂ Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.2. Summary of 2022 and 2023 Compliance Reviews – Aetna (Continued)							
Federal Regulations	**Component Compliance***						
	Components	**FM* (4 Points)**	**SM* (3 Points)**	**PM* (2 Points)**	**MM* (1 Point)**	**NM* (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.206 Availability of Services†	17	(15/17)	(1/17)	(1/17)	(0/17)	(0/17)	96% (65/68)
§438.207 Assurances of Adequate Capacity and Services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.208 Coordination and Continuity of Care‡	11	(8/11)	(1/11)	(2/11)	(0/11)	(0/11)	89% (39/44)
§438.210 Coverage and Authorization of Services†	13	(11/13)	(2/13)	(0/13)	(0/13)	(0/13)	96% (50/52)
§438.214 Provider Selection†	5	(2/5)	(0/5)	(3/5)	(0/5)	(0/5)	70% (14/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228 Grievance and Appeal Systems^† (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General Requirements†	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and Adequate Notice of Adverse Benefit Determination†	9	(7/9)	(2/9)	(0/9)	(0/9)	(0/9)	94% (34/36)
§438.406 Handling of Grievances and Appeals†	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.408 Resolution and Notification†	15	(10/15)	(3/15)	(2/15)	(0/15)	(0/15)	88% (53/60)
§438.410 Expedited Resolution of Appeals†	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	83% (10/12)
§438.414 Information about Grievance and Appeal System to Providers and Subcontractors^† §438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.2. Summary of 2022 and 2023 Compliance Reviews – Aetna							
Federal Regulations	**Component Compliance***						
	Components	**FM* (4 Points)**	**SM* (3 Points)**	**PM* (2 Points)**	**MM* (1 Point)**	**NM* (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.416 Recordkeeping Requirements‡	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending‡	4	(3/4)	(1/4)	(0/4)	(0/4)	(0/4)	94% (15/16)
§438.424 Effectuation of Reversed Appeal Resolutions‡	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual Relationships and Delegation‡	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice Guidelines‡	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health Information Systems‡	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(97/119)**	**(13/119)**	**(9/119)**	**(0/119)**	**(0/119)**	**93% (445/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality Assessment and Performance Improvement Program‡	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
OVERALL COMPLIANCE	**162**	**(131/162)**	**(22/162)**	**(9/162)**	**(0/162)**	**(0/162)**	**94% (608/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
ǂ Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Of the individual regulatory areas reviewed within Subparts C, D, and E, Aetna had the greatest opportunity for improvement, primarily with documentation, within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.

Sunflower, Years 1 and 2 Reviews – 2022 and 2023

Overall, Sunflower was 97% compliant with the federal regulatory requirements reviewed in Years 1 and 2. Subpart B Disenrollment: Requirements and Limitations is not included because the requirements are not applicable to the health plan. Subpart C – Enrollee Rights and Protections and Subpart E Quality Measurement and Improvement; External Quality Review scored the highest (100% Fully Met). Table 6.3 summarizes the compliance scores for those regulatory areas reviewed for Sunflower.

Table 6.3. Summary of 2022 and 2023 Compliance Reviews – Sunflower							
Federal Regulations	**Component Compliance***						
	Components	**FM* (4 Points)**	**SM* (3 Points)**	**PM* (2 Points)**	**MM* (1 Point)**	**NM* (0 Points)**	**Compliance Score***
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee Rights^ §438.10 Information Requirements^ §438.3(j) Standard Contract Requirements: Advance Directives	24	(24/24)	(0/24)	(0/24)	(0/24)	(0/24)	100% (96/96)
§438.114 Emergency and Post-stabilization Services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(29/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**100% (116/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.206 Availability of Services†	17	(16/17)	(1/17)	(0/17)	(0/17)	(0/17)	99% (67/68)
§438.207 Assurances of Adequate Capacity and Services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.208 Coordination and Continuity of Care†	11	(9/11)	(0/11)	(2/11)	(0/11)	(0/11)	91% (40/44)
§438.210 Coverage and Authorization of Services	13	(12/13)	(1/13)	(0/13)	(0/13)	(0/13)	98% (51/52)
§438.214 Provider Selection†	5	(3/5)	(1/5)	(1/5)	(0/5)	(0/5)	85% (17/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228(a-b) Grievance and Appeal Systems^ (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General Requirements‡	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and Adequate Notice of Adverse Benefit Determination	9	(6/9)	(3/9)	(0/9)	(0/9)	(0/9)	92% (33/36)
§438.406 Handling of Grievances and Appeals	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§438.408 Resolution and Notification	15	(12/15)	(3/15)	(0/15)	(0/15)	(0/15)	95% (57/60)
§438.410 Expedited Resolution of Appeals	3	(2/3)	(1/3)	(0/3)	(0/3)	(0/3)	92% (11/12)

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component documentation reviewed in Year 1 (2022) and case review completed in Year 2 (2023)

Table 6.3. Summary of 2022 and 2023 Compliance Reviews – Sunflower							
Federal Regulations	**Component Compliance***						
	Components	**FM* (4 Points)**	**SM* (3 Points)**	**PM* (2 Points)**	**MM* (1 Point)**	**NM* (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.414 Information about Grievance and Appeal System to Providers and Subcontractors^ §438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.416 Recordkeeping Requirements	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.424 Effectuation of Reversed Appeal Resolutions	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual Relationships and Delegation†	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice Guidelines†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health Information Systems	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(102/119)**	**(13/119)**	**(4/119)**	**(0/119)**	**(0/119)**	**96% (455/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality Assessment and Performance Improvement Program†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
Overall Compliance	**162**	**(145/162)**	**(13/162)**	**(4/162)**	**(0/162)**	**(0/162)**	**97% (627/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component documentation reviewed in Year 1 (2022) and case review completed in Year 2 (2023)

Of the individual regulatory areas reviewed within Subparts C, D, and F, Sunflower had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.

UnitedHealthcare, Years 1 and 2 Reviews – 2022 and 2023

Overall, UnitedHealthcare was 97% compliant with the federal regulatory requirements reviewed in Years 1 and 2. Subpart B Disenrollment: Requirements and Limitations is not included because the requirements are not applicable to the health plan. Subpart C – Enrollee Rights and Protections and Subpart E Quality Measurement and Improvement; External Quality Review scored the highest (100% Fully Met). Table 6.4 summarizes the compliance scores for those regulatory areas reviewed for UnitedHealthcare.

Table 6.4. Summary of 2022 and 2023 Compliance Reviews – UnitedHealthcare

Federal Regulations	Component Compliance*						
	Components	FM* (4 Points)	SM* (3 Points)	PM* (2 Points)	MM* (1 Point)	NM* (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee Rights^ §438.10 Information Requirements^ §438.3(j) Standard Contract Requirements: Advance Directives	24	(24/24)	(0/24)	(0/24)	(0/24)	(0/24)	100% (96/96)
§438.114 Emergency and Post-stabilization Services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(29/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**100% (116/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.206 Availability of Services†	17	(15/17)	(1/17)	(1/17)	(0/17)	(0/17)	96% (65/68)
§438.207 Assurances of Adequate Capacity and Services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.208 Coordination and Continuity of Care†	11	(8/11)	(1/11)	(2/11)	(0/11)	(0/11)	89% (39/44)
§438.210 Coverage and Authorization of Services	13	(12/13)	(1/13)	(0/13)	(0/13)	(0/13)	98% (51/52)
§438.214 Provider Selection†	5	(2/5)	(2/5)	(1/5)	(0/5)	(0/5)	80% (16/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228(a-b) Grievance and Appeal Systems^ (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General Requirements‡	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and Adequate Notice of Adverse Benefit Determination	9	(7/9)	(2/9)	(0/9)	(0/9)	(0/9)	94% (34/36)

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component documentation reviewed in Year 1 (2022) and case review completed in Year 2 (2023)

Table 6.4. Summary of 2022 and 2023 Compliance Reviews – UnitedHealthcare							
Federal Regulations	**Component Compliance***						
	Components	**FM* (4 Points)**	**SM* (3 Points)**	**PM* (2 Points)**	**MM* (1 Point)**	**NM* (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.406 Handling of Grievances and Appeals	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§438.408 Resolution and Notification	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
§438.410 Expedited Resolution of Appeals	3	(3/3)	(0/3)	(0/3)	(0/3)	(0/3)	100% (12/12)
§438.414 Information about Grievance and Appeal System to Providers and Subcontractors^ §438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities: Enrollee Handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.416 Recordkeeping Requirements	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.424 Effectuation of Reversed Appeal Resolutions	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual Relationships and Delegation†	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice Guidelines†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health Information Systems	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(104/119)**	**(11/119)**	**(4/119)**	**(0/119)**	**(0/119)**	**96% (457/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality Assessment and Performance Improvement Program†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
Overall Compliance	**162**	**(147/162)**	**(11/162)**	**(4/162)**	**(0/162)**	**(0/162)**	**97% (629/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component documentation reviewed in Year 1 (2022) and case review completed in Year 2 (2023)

Of the individual regulatory areas reviewed within Subparts C, D, and F, UnitedHealthcare had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.

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

Common Among the MCOs

- It is evident that the MCOs' staff care about their members. For example, Aetna staff take the time to have personal conversations with their members; Sunflower staff listen to their members' needs and work to implement programs to meet those needs; and UnitedHealthcare staff continually advocate for their members.
- The MCOs are forward thinking and innovative related to aspects of the members' care and service delivery. For example:
  - Aetna's innovations included culturally sensitive food bank food choices, focus on the foster care population, work force initiatives, collaboration with diverse community partners, and utilizing technology.
  - Sunflowers's innovations included Pro Football Hall of Fame Event – April 2023 String Youth, Strong Communities, distribution of 21,000 bottles of water in 22 counties, local community engagement [i.e., clinics, recreation centers, schools, daycares, food banks, and libraries], employee donations to local charities, Farmer's Markets, Direct Support Professionals Social Media Campaign, Value Based Contract for Competitive Employment –I/DD, State I/DD Sequential Intercept Model for persons with I/DD, Start Smart for Your Baby program, and Project ECHO.
  - UnitedHealthcare's innovations included partnership with the Boys and Girls Club, back to school fairs, health fairs, lobby sits, community baby showers, Job Resource fair, and Value Added Benefits presentations to Health Department, and the doula program and coverage of doula services.

Aetna

As a result of KFMC's 2022 and 2023 Compliance Reviews for Aetna, the following strengths were identified:

- Aetna held a Women's Health gap day on a Saturday and women were able to get a mammogram and cervical cancer screening. A second day was added because of the large turnout.
- There are collaborative agreements between smaller independent BH providers and the Community Mental Health Centers to reduce ED use.
- Aetna assigned an Outreach Coordinator as a women's health specialist to focus on care gaps related to specific HEDIS measures, and the Quality Practice Liaison position was created within Aetna to work with providers on quality improvement.

Sunflower

- For outreach to rural providers, Sunflower had a provider breakfast in Hays, Kansas. They also developed a Rural Health Advising Committee where providers give feedback on how to better serve members and barriers they face. Sunflower staff stated it is important to meet providers where they are.
- Sunflower had a regional pilot training on conscious anti-racism that Sunflower leaders attended.
- Customer Service Representatives have access to Central Point, a centralized library where all the state specific processes and policies are housed. This allows staff easy access to information to answer questions from customers in real time.

UnitedHealthcare

- UnitedHealthcare has Learn Source and the Care Management University that have trainings available on health equity, diversity and inclusion, health equity university training (different badges that can be earned), trauma informed care, motivational interviewing, and many other topics.

- UnitedHealthcare implemented the Care Bridge program. It is an example of UnitedHealthcare going above and beyond to ensure that members can access after-hours guidance through the use of a tablet.
- Maestro was described by UnitedHealthcare as a resource for members to easily find procedures, coverage, policies, and benefits. It was described as a decision tree with a built-in algorithm that the members can use to get applicable information by answering a series of questions.

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

The following are the opportunities identified from the 2023 review. For the opportunities identified from the 2022 review, see the KFMC 2022-2023 KanCare Program Annual External Quality Review Technical Report.

Common Among the MCOs

There were no common opportunities for improving Quality, Timeliness, and Access to Health Care Services.

Aetna

As a result of KFMC'S 2022 and 2023 Compliance Reviews, Aetna needs to follow-up on KFMC's case review findings related to *Coordination and Continuity of Care – Care and Coordination of Services for all MCO, PIHP, and PAHP Enrollees:* Aetna was provided a "Case Review Detail" document that outlined findings that need addressed. (§438.208[b][1] and [b][3])

Sunflower

As a result of KFMC's 2023 Compliance Review for Sunflower, follow-up to KFMC's 2023 case review findings is needed related to:

- *Handling of Grievance and Appeals – Special Requirements*: Revise Sunflower policy and procedure to include language that the information must be supplied sufficiently in advance of the appeal resolution. (§438.406[b][5])
- *Resolution and Notification: Grievances and Appeals – Specific Timeframes-Standard Resolution of Appeals* (§438.408[b][2]) and *Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution* (§438.410[c][2]): Review appeal case review finding to ensure appeal was processed correctly.

UnitedHealthcare

There were no opportunities for improvement identified specific to quality, access, or timeliness for UnitedHealthcare in the Year 3 review. Please see the Technical Opportunities for Improvement below.

Technical Strengths

Common Among the MCOs

Each MCO had staff who are knowledgeable.

Detail on MCO-specific technical strengths can be found in the individual reports, which are available upon request.

Technical Opportunities for Improvement

The following are the opportunities identified from the 2023 review. For the opportunities identified from the 2022 review, see the KFMC 2022-2023 KanCare Program Annual External Quality Review Technical Report.

Common Among the MCOs

As a result of KFMC'S 2022 and 2023 Compliance Reviews for the MCOs, each of the three MCOs need to follow-up on KFMC's case review findings related to *Record Keeping Requirements* (grievance case review): The MCOs were provided a "Case Review Detail" document that outlined findings that needed addressed. (§438.416[b][2-3])

Aetna

There were no additional Technical opportunities beyond those that were common to all MCOs during KFMC's 2023 Compliance Review for Aetna.

Sunflower

As a result of KFMC's 2023 Compliance Review for Sunflower, the following opportunities emerged:

- *Timely and Adequate Notice of Adverse Benefit Determination (Content of Notice)* (§438.404[b][6]), *Notice of Adverse Action* §438.210[c] and *Resolution and Notification: Grievance and Appeals – Content of Notice of Appeal Resolution* §438.408[e][2][ii-iii]: Re-educate staff to double check that the correct appeal resolution letter was sent to the member.
- *General Requirements - Filing Requirements (Authority to File)* (§438.402[c][1][ii] and State Contract sections 4.2.1.16.2 and 4.4.2.1.15.7, *Notice of Adverse Action* §438.210[c], *Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice* §438.404[b][3], and *Record Keeping Requirements* §438.416[b][6]):
  - Determine who filed the grievance and ensure all areas of the system are consistent. The internal system should include the name of who submitted the appeal.
  - Re-educate staff on most appropriate selection for who submitted the appeal and the requestor in True Care should be congruent with Prime (§438.402[c][1][ii]).
- *Resolution and Notification: Grievance and Appeals – Specific Timeframes-Standards Resolution of Appeals* (§438.408[c][2][ii]) and *Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution* (§438.410[c][2][iii]): Update the *Member Handbook* language to include the member's right to file a grievance if they disagree with the decision to extend the timeframe.

UnitedHealthcare

As a result of KFMC's 2023 Compliance Review for UnitedHealthcare, the following opportunities emerged:

- *Handling of Grievances and Appeals (Special requirements)*: Re-educate staff on the timeframe requirements of sending the written acknowledgement for provider appeals (§438.406[b][1]).
- Follow-up to KFMC's 2023 grievance case review findings related to *General Requirements: Filing Requirements (Authority to File)* (§438.402[c][1][ii] and State Contract section 4.2.1.16.2 and 4.4.2.1.15.7, *Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice* §438.404[b][3], and *Record Keeping Requirements* §438.416[b][6]: Determine the name of the person that filed the grievance, determine their relationship to the member, document the name in the system, and ensure the system consistently reflects who filed the grievance and submitted the appeal.
- *Record Keeping Requirements*: Re-educate staff that information entered in the internal UHC database should be double checked prior to finalization. Also, develop policy and procedure related to appropriate use of abbreviations and educate staff. If one already exists, re-educate staff on the policy (§438.416[b]).
- *Handling of Grievances and Appeals (Special requirements)*: Revise the *Provider Manual* to inform members of the grievance/appeal acknowledgement process and timeframes (§438.406[b][1]).

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

Between June 2023 and September 2023, KFMC obtained from each MCO a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2020–2022 that were still in progress or less than fully addressed. KFMC provided each MCO with suggestions on how to bring outstanding recommendations into full compliance and each MCO was given the opportunity to respond on their progress. The following summaries include the 2020–2022 reviews.

Aetna

There are 55 recommendations included in Appendix D, *Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed*. KFMC noted:

- Twenty-four moved to fully addressed in 2023;
- Eight were partially addressed;
- Twelve were not addressed; and
- Eleven continue to be in progress.

Sunflower

There are 15 recommendations included in Appendix D. KFMC noted:

- Eight moved to fully addressed in 2023 (includes one recommendation where one of three components is unable to be addressed);
- Five were partially addressed;
- One was not addressed; and
- One continues to be in progress.

UnitedHealthcare

There are 24 recommendations included in Appendix D. KFMC noted:

- Four moved to fully addressed in 2023;
- Ten were partially addressed;
- One was not able to be fully addressed by UnitedHealthcare;
- Five were not addressed; and
- Four continue to be in progress.

Recommendations for Quality Improvement

A recommendation indicates where an MCO change is needed to be in full compliance with the stated regulation. See Appendix C, *2023 Recommendations: Compliance Review* for details.

Aetna

Year 2 Follow-up Review – 2023

Based on the areas identified for improvement, one recommendation continued to apply, and KFMC made 1 additional recommendation and amended 3 recommendations from 2022 related to Coordination and Continuity of Care.

Sunflower

Year 2 Review – 2023

Based on the areas identified for improvement, KFMC made 12 recommendations related to Grievance, Appeal, and Notice of Adverse Benefit Determination.

Recommendations for Quality Improvement (Continued)

UnitedHealthcare

Year 2 Review – 2023

- Based on the areas identified for improvement, KFMC made 8 recommendations related to Grievance, Appeal, and Notice of Adverse Benefit Determination.

Summary of Two-Year Compliance Review

Table 6.5 details a summary of the MCOs' overall two-year Compliance Review results for Subparts C, D, and E. Subpart B – Disenrollment: Requirements and Limitations is not included because for regulation §438.56 *Disenrollment: Requirements and Limitations*, the State, through its fiscal agent, is responsible for disenrollment, and the MCOs are not able to disenroll members. Therefore, these requirements are not applicable to the health plans.

Table 6.5. Summary of 2022 and 2023 Compliance Review Results

Federal Regulation	Compliance Score		
	ABH	SHP	UHC
Subpart C – Enrollee Rights and Protections			
§438.100 Enrollee Rights	94%	100%	100%
§438.114 Emergency and Poststabilization Services	85%	100%	100%
Subpart C Total	**92%**	**100%**	**100%**
Subpart D – MCO, PIHP and PAHP Standards			
§438.206 Availability of Services	96%	99%	96%
§438.207 Assurances of Adequate Capacity and Services	100%	100%	100%
§438.208 Coordination and Continuity of Care	89%	91%	89%
§438.210 Coverage and Authorization of Services	96%	98%	98%
§438.214 Provider Selection	70%	85%	80%
§438.224 Confidentiality	100%	100%	100%
§438.228 Grievance and Appeal Systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	75%	75%	75%
§438.402 General Requirements	95%	95%	95%
§438.404 Notice of Adverse Benefit Determination	94%	92%	94%
§438.406 Handling of Grievances and Appeals	100%	88%	88%
§438.408 Resolution and Notification	88%	95%	100%
§438.410 Expedited Resolution of Appeals	83%	92%	100%
§438.414 Information about the Grievance and Appeal System to Providers and Subcontractors	100%	100%	100%
§438.416 Recordkeeping Requirements	75%	50%	75%
§438.420 Continuation of Benefits While Appeal and State Fair Hearing are Pending	94%	100%	100%
§438.424 Effectuation of Reversed Appeal Resolutions	100%	100%	100%
§438.230 Sub-contractual Relationships and Delegation	100%	100%	100%
§438.236 Practice Guidelines	100%	100%	100%
§438.242 Health Information Systems	100%	100%	100%
Subpart D Total	**93%**	**96%**	**96%**
Subpart E – Quality Measurement and Improvement; External Quality Review			
§438.330 Quality Assessment and Performance Improvement Program	100%	100%	100%
Subpart E Total	**100%**	**100%**	**100%**
OVERALL COMPLIANCE	**94%**	**97%**	**97%**

7. Quality Assessment and Performance Improvement Review

Background/Objectives

The QAPI approach is continuous, systematic, comprehensive, and data-driven. Implementing this approach allows organizations to improve on identified challenges as well as plan for future opportunities.[9] KFMC's objectives were to review completeness of each MCO's 2023 QAPI design, examine strengths, identify opportunities for improvement, and provide recommendations for improvement. Sunflower and UnitedHealthcare have provided KanCare managed care services since January 2013, and Aetna since January 2019.

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

The MCOs, in the administration of their QAPI programs, must comply with State Contract sections *5.2.2 Disenrollment*, *5.9. Quality Assessment and Performance Improvement*, *5.16.1 Reports and Audits* letter B, and *5.17.2 Contractor(s) Key Personnel* letter C, number 10.

For this review, KFMC assessed the MCO's QAPI evaluation, program description, work plans, and additional supporting documents submitted from the MCOs for compliance with the contract elements. See Appendix B, *2023 Methodologies: QAPI Review* for a detailed list of the documents reviewed.

Annually, the MCOs are to complete the *QAPI Checklist* (see Appendix B for more detail). It is to accompany the QAPI work plan that is submitted November 30 of each year.

Conclusions Drawn from the Data

Of the 30 total requirements from the *QAPI Checklist* (Appendix B), KFMC identified the MCOs were less than fully compliant for 11 requirements, with the following ratings: substantially met (ABH – 1 and UHC – 2); partially met (ABH – 2; SHP – 6; and UHC – 4); minimally met (SHP – 1); and not met (SHP – 2). See table 7.1 for a display of the requirements and ratings that were less than fully met.

Table 7.1. 2023 QAPI Review – Requirements Less Than Fully Met, All MCOs

State Contract Requirement	Description	MCO	Rating*
5.9.1 General Requirements, letter E	Mechanisms to detect both underutilization and overutilization of services	SHP	PM
5.9.1 General Requirements, letter F	Mechanisms to compare services and supports received with those in the Member's treatment/ service plan for individuals enrolled in LTSS Waivers	SHP	PM
5.9.1 General Requirements, letter G	Mechanisms to identify Members who are enrolled in LTSS Waivers but who are not receiving any Waiver services	ABH	PM
5.9.1 General Requirements, letter N, number 6	Annual Evaluation Process	SHP	PM
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter A	Use of the State specified guiding principles	SHP	MM
		UHC	PM

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

[9] QAPI Description and Background. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition. Updated September 20, 2016. Accessed May 19, 2020.

Table 7.1. 2023 QAPI Review – Requirements Less Than Fully Met, All MCOs (Continued)			
State Contract Requirement	**Description**	**MCO**	**Rating***
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter B	Use of the State specified goals	SHP	NM
		UHC	SM
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter C	Use of the State specified objectives	ABH	PM
		UHC	PM
		SHP	NM
5.9.4 Performance Measures, letters A-B	Comply with the requirements in the QMS regarding performance measures for medical, BH and LTSS	ABH	SM
		UHC	SM
5.9.7 National Committee for Quality Assurance Accreditation	NCQA Accreditation and LTSS Distinction	SHP	PM
		UHC	PM
5.9.8 Healthcare Effectiveness Data and Information Set and CAHPS	HEDIS General Requirements	SHP	PM
		UHC	PM
5.16.1 Reports and Audits, letter B	SHP review and oversight of data collection and ensuring complete and accurate data from participating providers	SHP	PM
* FM = Fully Met (96% - 100%), SM = Substantially Met (75% - 95%), PM = Partially Met (50% - 74%), MM = Minimally Met (25% - 49%), and NM = Not Met (0% - 24%).			

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

The following sections contain opportunities for the MCOs to make improvements that both impact and do not impact the compliance ratings. Recommendations are indicated where an opportunity for improvement impacts the compliance rating (the MCO compliance is less than fully met regarding CFR *§438.330 Quality Assessment and Performance Improvement Program* and/or State Contract requirement), and addressing the recommendation is required. A suggested enhancement indicates where an MCO change would improve or clarify language related to the regulatory requirement and/or State Contract requirement but is not yet required and does not impact the compliance rating for the current review. Unaddressed suggested enhancements could result in a recommendation in the next review (these are indicated below with an asterisk).

Common Among the MCOs

Section 5.2.2 Disenrollment

5.2.2(B)(2) [Fully Met]: *Contractor Responsibilities: The Contractor(s) is also required to track the reason for the disenrollments for the Contractor(s)' Quality Assessment and Performance Improvement (QAPI) process.*

- Aetna [Fully Met]: There was discussion of "reason for disenrollment" in the *2023 QAPI Program Description* and there was an activity to address this requirement in the *2023 QAPI Work Plans.* Therefore, this requirement is fully met. However, there was no description of tracking the reason for disenrollment in the *2022 QAPI Program Evaluation*. *
- Sunflower [Fully Met]: There was discussion of how Sunflower's Quality Program monitors, tracks, and reviews member enrollment and disenrollment patterns in the *2022 QAPI Program Evaluation*, as well as an activity in the QAPI work plan dated November 30, 2023; therefore, this requirement is fully met. In the *2022 QAPI Program Description*, there was no evidence of monitoring, tracking, and reviewing trends of reason for disenrollment.*

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

- UnitedHealthcare [Fully Met]: The activity "Review and Discuss Enrollment & Disenrollment Reports" was included in the *2023 QAPI Work Plans*; therefore, this requirement is fully met. The *QAPI Checklist* UHC submitted, under the heading "UHC Notes," detailed enrollment/disenrollment is reviewed quarterly at the Service Quality Improvement Sub-committee (SQIS) meeting. In the *2022 QAPI Evaluation*, there was no mention of tracking the reason for disenrollment or of the SQIS meeting where this is reviewed. The *2023 QAPI Program Description* included information that quarterly the SQIS reviews member experience data, associated barriers, and interventions. It also detailed the responsibilities of the SQIS; however, information on tracking the reason for disenrollment was not included. If activities of Committee Meetings are used to provide evidence of compliance with the State's QAPI requirements, they should be referenced in the QAPI documents, as applicable.*

Section 5.9.1 General Requirements

5.9.1(N)(6): *Develop an annual evaluation process to be completed within the first quarter of each new year from which findings and recommendation will be used to shape the annual QAPI program description and QAPI workplan. The QAPI evaluation should assess the extent to which the CONTRACTOR(S) met its goals and objectives and should include recommendations for continuous quality and service improvement.*

- Aetna [Fully Met]:
  - The *2023 QAPI Work Plans* included an activity related to the annual QAPI program evaluation, therefore, the requirement is fully met.
  - The *2023 QAPI Program Description* detailed information related to the annual evaluation process.
  - Aetna described how they met their internally identified goals and objectives throughout the *2022 QAPI Program Evaluation*. Measures included findings and recommendations for continuous quality and service improvement that were partially used to shape the *2023 QAPI Program Description* and *2023 QAPI Work Plans*. The *2022 QAPI Program Evaluation* recommendations for improvement are referred to in a variety of ways (e.g., opportunity, description of monitor, opportunities for improvement, intervention, areas for consideration, recommended program changes, strategy, action plan, etc.). Using a consistent term would better help the reader identify the recommendations made. Also, it is not always clear which recommendations for improvement were selected for implementation in the next year, as not all of them were displayed in a table with "Yes" or "No" to identify whether they were selected for implementation. Additionally, some of the recommendations detailed in the *2022 QAPI Program Evaluation* table with a "Yes" that they were selected for implementation in the next year were not always included in the *2023 QAPI Program Description* or *2023 QAPI Work Plans*.*
- Sunflower [Partially Met]:
  - The *2023 QAPI Work Plans* included an activity related to the annual QAPI program evaluation; therefore, the requirement is fully met. However, the SHP internal Quality Program objectives were not included.
  - The *2023 QAPI Program Description* detailed information related to the annual evaluation process. Some of the SHP internal Quality Program objectives were included in the section "Scope"; however, they were not referred to as "objectives." Rather, some were included in a bulleted list that detailed what is included in SHP's Quality Program. Also, they were not

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consistently worded. SHP should clearly identify the internal objectives in the QAPI program description, and the objectives should be consistent between documents.*
    - The *2022 QAPI Program Evaluation* clearly detailed SHP's internal Quality Program objectives, but it did not include overall goals for SHP. It described how SHP met their department goals and objectives, and measures included findings and recommendations for continuous quality and service improvement. Also, the evaluation clearly identified the priorities and recommendations to be implemented in the 2023 QI [Quality Improvement] Program, and it stated they are addressed in the *2023 QI Program Description* and *Work Plan*. However, upon review, the priorities and recommendations were minimally used to shape the *2023 QAPI Program Description* and *2023 QAPI Work Plans*, as they were not always included.*
- UnitedHealthcare [Fully Met]:
    - The *2023 QAPI Work Plans* included an activity related to the annual QAPI evaluation; therefore, the requirement is fully met. The *2023 QAPI Program Description* also detailed information related to the annual evaluation process. The *2022 QAPI Evaluation* included findings and recommendations that were partially used to shape the *2023 QAPI Program Description* and *2023 QAPI Work Plans*, as some of the recommendations detailed in the *2022 QAPI Evaluation* were not always included in the *2023 QAPI Program Description* or *2023 QAPI Work Plans*. For example, related to PIPs, there were recommendations made in the *2022 QAPI Evaluation* that were identified to be implemented in the next year; however, in the *2023 QAPI Work Plan*, there was a very broad level activity for completing each PIP and the specific recommendations were not included. Also, the activities were not detailed in the *2023 QAPI Work Plans* and *2023 Program Description* related to the HEDIS goals that were identified in the findings of the *2022 QAPI Evaluation*.*
    - Throughout the *2022 QAPI Evaluation*, UHC described how they met their internally identified goals and objectives. Measures included findings and recommendations for continuous quality and service improvement. The findings and recommendations from the QAPI evaluation that are selected for implementation in the next year should be included in the next QAPI program description.*

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

- *5.9.3(A)*: *Adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors* (see the State Contract for principles A.1-A.11).
    - Aetna [Fully Met]: The guiding principles were included in the *2023 QAPI Work Plans* and *2023 QAPI Program Description*. The *2022 QAPI Program Evaluation*, section "QAPI Goals and Objectives" includes, in the narrative, the State guiding principles A.1-A.11; however, the title of the section does not reflect this.
    - Sunflower [Minimally Met]: The *2022 QAPI Program Evaluation* and *2023 QAPI Program Description* included information on the guiding principles as listed in section 5.9.3(A) of the State Contract. However, guiding principles (A)(2), (A)(4-5), (A)(7), and (A)(10-11) were not included in the *2023 QAPI Work Plans*. Also, related to guiding principle (A)(8), there was detail on a transparent and collaborative environment with members, but it did not include providers and other stakeholders. In the QAPI work plan dated November 30, 2023, SHP added

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"Integration and infusion of State identified guiding principles" to column D "Objective" (row 76). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement.

- UnitedHealthcare [Partially Met]: The *2022 QAPI Evaluation* and *2023 QAPI Program Description* included information on the State guiding principles. The *2023 QAPI Work Plans* included information on all of the State guiding principles except (A)(2), (A)(10), and (A)(11).

- *5.9.3(B)*: *Adopt, at a minimum, the following goals within its QAPI program* (see the State Contract for goals B.1-B.6).
  - Aetna [Fully Met]:
    - Goals 5.9.3.B.1-6 were included in the *2023 QAPI Work Plans*.
    - The *2022 QAPI Program Evaluation* incorporated State Contract goals 5.9.3.B.1-5; however, goal 5.9.3.B.6 was not included.* (Also applies to 5.9.1[N][6])
    - In the *2023 QAPI Program Description*, footnote 17 associated with the section "QAPI Program Guiding Principles, Goals, and Objectives," should also reference, "B.1-6 and C.1-7" of the State Contract.
  - Sunflower [Not Met]: There were no clear SHP internal goals listed in the *2022 QAPI Program Evaluation* and *2023 QAPI Work Plans*. Also, the goals, as listed in section 5.9.3(B) of the State Contract, were not included in any of the QAPI documents. In the QAPI work plan dated November 30, 2023, SHP added "Incorporation of the State identified goals" to column D "Objective" (row 77). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement and none of the goals were included. Rather, it detailed the State Contract requirement. The *2023 QAPI Program Description* identified one primary SHP goal that stated, "… to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings and aimed at improving the quality of care and services delivered." That goal was not included in the *2023 QAPI Work Plans*. The *2023 QAPI Program Description* included department specific goals. It also included several statements regarding Sunflower's Quality Program goals; however, none were listed other than the goal previously stated.*
  - UnitedHealthcare [Substantially Met]:
    - The State-identified goals, as listed in section 5.9.3(B) of the State Contract, should be included in the UHC QAPI program documents. The UHC internal goals/objectives address most of the State Contract identified goals, however, the following were not included:
      - UHC Internal Goal A, Objective that states, "Support medically complex and fragile members through person-centered complex case management programs that improve the member experience" applies to State Contract requirement 5.9.3(B)(1). However, it is missing the part of the State Contract goal related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports." (UHC *2023 QAPI Work Plan* row 8, Objectives Tab).*
      - UHC Internal Goal B, Objective that states, "Monitor the adequacy of the contracted network through analysis of access, availability, and out-of-network (OON) data and adjust the practitioner network, as appropriate, to meet diverse population needs" applies to State Contract requirement 5.9.3(B)(6). However, it is missing the part of the goal related to "…adopt innovative and strategic partnerships with its Participating

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Providers to improve the delivery of quality care and service to all Members." * (UHC *2023 QAPI Work Plan* row 16, Objectives Tab)

- UHC's internal goals are consistent throughout all three documents except for Goal B where part of the language was inconsistent. The *2023 QAPI Work Plan* states, "B. Improve the member and practitioner experience"; the *2022 QAPI Evaluation* states, "B. Evaluated the member and practitioner experience"; and the *2023 QAPI Program Description* states, "B. Improve the member experience." Goal B in the QAPI program description needs to be revised.*
- The *2023 QAPI Work Plans* outline the "Goals"; however, in the *2022 QAPI Evaluation* and *2023 Program Description* they were referred to as "Program Objectives." For consistency, the language needs to be revised.*

- *5.9.3(C)*: *Adopt, at a minimum, the following objectives to meet the established QAPI goals* (see the State Contract for objectives C.1-C.7).
  - Aetna [Partially Met]: The objectives, as listed in section 5.9.3(C) of the State Contract, are included in the *2022 QAPI Program Evaluation* and the *2023 QAPI Program Description*. However, objectives C.2 and C.4 were not included in the *2023 QAPI Work Plans*.
  - Sunflower [Not Met]: The following was noted related to the State-specified objectives:
    - Objectives (A)(8) and (C)(1-7) were not included in the *2023 QAPI Work Plans*. In the QAPI work plan dated November 30, 2023, SHP added "State identified seven objectives to meet established QAPI goals" to column D "Objective" (row 78). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement.
    - Objective (C)(2) was substantially included, and (C)(3) was partially included in the *2022 QAPI Program Evaluation* and *2023 QAPI Program Description*. Related to (C)(2-3), SHP's internal objective in the *2022 QAPI Program Evaluation* stated, "To allocate personnel and resources necessary to: support the quality improvement program, including data analysis and reporting." The *2023 QAPI Program Description* stated, "Allocation of personnel and resources necessary to: support the Quality Program, including data analysis and reporting." Both are missing the part of the State Contract goal related to collection of data ([C][2]) and making information actionable and implementing interventions to demonstrate improved results ([C][3]). Also, SHP's internal objectives are not called objectives in the *2023 QAPI Program Description*.*
    - Objectives (C)(1), (C)(4), and (C)(7) were not included in the *2022 QAPI Program Evaluation* and *2023 QAPI Program Description*.*
    - Objectives (A)(8) and (C)(5-6) were not included in the *2023 QAPI Program Description*.*
    - Objectives (A)(8) and (C)(5-6) were partially included in the *2022 QAPI Program Evaluation*.* SHP's internal objectives state:
      - Related to (A)(8), "To seek input and work with members, providers, and community resources to improve quality of care provided to members." However, it is missing the part of the State Contract goal related to development of a transparent and collaborative environment and it does not include other stakeholders.
      - Related to (C)(5), "To oversee peer review procedures that will address deviations in medical management and health care practices and devise action plans to improve services." However, it is missing the part of the State Contract goal related to

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mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered.
    - Related to (C)(6), "To seek input and work with members, providers, and community resources to improve quality of care provided to members." However, it is missing the part of the State Contract goal related to adopting strategies to collect and integrate experience of care and satisfaction data from caregivers and other network partners into the QAPI program.
- UnitedHealthcare [Partially Met]:
    - UHC's internal objectives were included throughout all three documents. However, the "Objectives" detailed in QAPI documents should be consistent. UHC's "Program Objectives" detailed in the *2022 QAPI Evaluation* were nearly consistent with those outlined in the *2022 QAPI Work Plans* and *2022 QAPI Program Description.* The *2022 QAPI Evaluation* did not include the list of specific health outcomes to be improved that were detailed in the *2022 QAPI Work Plan* and the *2022 QAPI Program Description* (Goal A, Objective 7). Also, between the *2022 QAPI Work Plan* and the *2022 QAPI Program Description* the list of three health outcomes to be improved were not consistent by one outcome, "Reduction of COVID-19 spread and hospitalizations" versus "promotion of maternal care," respectively. Lastly, the *2022 QAPI Evaluation* and *2022 QAPI Program Description* did not include the "Objectives" detailed below that were outlined in the *2022 QAPI Work Plans*. In the *2022 QAPI Evaluation*, the "Program Objectives" detailed should be consistent with those outlined in the *2023 QAPI Work Plans* and *2023 QAPI Program Description*. If there are changes in the objectives from one year to the next, the changes should be identified.
        - Goal C, Objective 3, "Participate in state-required PIPS for EPSDT, AMM, Advance Directives (LTSS), Housing/Homelessness, SMD, and COVID-19 (Collaborative)."
        - Goal D, Objective 4 "Close gaps in care through evidence-based member engagement programs targeted to specific linguistic and cultural populations."
    - The objectives, as listed in section 5.9.3(C) of the State Contract, should be used in the UHC QAPI program documents. UHC did not include, in their program objectives, the following State-specified objectives:
        - 5.9.3(C)(1-3), (C)(5), and (C)(7) were not included in the *2022 QAPI Evaluation*, *2023 QAPI Program Description*, and *2023 QAPI Work Plans*.*
        - 5.9.3(C)(4) was not included in the *2022 QAPI Evaluation* or the *2024 QAPI Work Plans*.*
        - 5.9.3(C)(6) was not included in the *2023 QAPI Program Description*.*
        - 5.9.3(C)(7) was not included in the *2022 QAPI Evaluation* or *2023 QAPI Program Description*.*

Section 5.9.4 Performance Measures

5.9.4(A-B): *Comply with the requirements in the QMS regarding performance measures for medical, Behavioral Health and LTSS.*

- Aetna [Substantially Met]: ABH included assessment of all State required performance measures in the *2022 QAPI Program Evaluation* and *2023 QAPI Program Description*. The *2023 QAPI Work Plans* included information on multiple performance measures; however, the measures *Breast Cancer Screening (BCS-AD)* and *Chlamydia Screening in Women ages 16 to 24 (CHL)* were not included.

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

- Sunflower [Fully Met]: SHP included assessment of all performance measures in the *2023 QAPI Work Plans* and *2022 QAPI Program Evaluation*, therefore, this measure is fully met. However, in the *2023 QAPI Program Description*, there was no mention of the measures *Breast Cancer Screening (BCS-AD)* and *Chlamydia Screening in Women ages 16 to 24 (CHL)*.*
- UnitedHealthcare [Substantially Met]: UHC included assessment of all performance measures in the QAPI documents except for the *Breast Cancer Screening (BCS-AD)* measure in the *2023 QAPI Program Description* and *2023 QAPI Work Plans*.*

Aetna

Section 5.9.1 General Requirements

- *5.9.1(A)* [Fully Met]: *The State's QMS: The CONTRACTOR(S) shall comply with the State's QMS. The QMS includes, among other things, details on the State's expectations and requirements for quality activities and timeliness. The QMS is reviewed annually, at a minimum, and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The CONTRACTOR(S) shall comply with any revisions to the QMS.*
  - In the *2023 QAPI Work Plans*, rows 126 and 129-131 are the KanCare 2.0 QMS Goals but they are listed as "Activities" in the work plan.

- *5.9.1(G)* [Partially Met]: *Develop and implement mechanisms to identify Members who are enrolled in LTSS Waivers but who are not receiving any Waiver services.*
  - There was minimal information included related to the "LTSS Participation Rate" in the *2022 Long Term Support Services and Supports Program Evaluation* and *2022 QAPI Program Evaluation.* There was an exact citation of 5.9.1.(G) in the *2023 QAPI Program Description*. However, in the aforementioned documents, there was no description provided of the process to identify members enrolled in LTSS Waivers but not receiving any waiver services.* Lastly, there were no activities to address this requirement in the *2023 QAPI Work Plans*. Therefore, this requirement is partially met. The QAPI documents should outline how the health plan addresses this requirement.

Sunflower

Section 5.9.1 General Requirements

5.9.1(E) [Partially Met]: *Develop and implement mechanisms to detect both underutilization and overutilization of services.*

- The *2022 QAPI Program Evaluation* and *2023 QAPI Program Description* describe mechanisms that SHP uses to detect both underutilization and overutilization of services. In the QAPI work plan dated November 30, 2023, SHP added the "Objective," "Detection of underutilization and overutilization of services" (row 91); however, column E "Activity" does not include an activity that SHP completes to detect utilization of services. Rather, it includes the State Contract and Federal regulatory requirement. Therefore, this requirement is partially met.

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

- The *2023 QAPI Program Description* included how SHP implements mechanisms to compare services and supports received with those set forth in the member's treatment/service plan for individuals

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

enrolled in LTSS Waivers. The *2022 QAPI Program Evaluation* included information on the *2021 Sunflower Annual LTSS Member Satisfaction Survey*; however, it did not address mechanisms used to compare services and supports received with those in the member's treatment/service plan.* In the QAPI work plan dated November 30, 2023, SHP added the "Objective," "For members receiving LTSS, mechanisms used to compare services and supports received with those in the member's treatment/service plan" (rows 103 and 105). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it included the State Contract and Federal regulatory requirement. Therefore, this requirement is partially met.

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

- The *2023 QAPI Program Description* thoroughly described how SHP staff review members' utilization of services for those enrolled in LTSS Waiver services and how they identify and address those members who are not receiving any waiver services. Additionally, the *2023 QAPI Work Plans* included activities to measure and analyze member participation for each LTSS program; therefore, this requirement is fully met. The *2022 QAPI Program Evaluation* detailed information that SHP analyzes and reports on key indicators of clinical and non-clinical outcomes that include "LTSS Reporting." However, it does not include detail on mechanisms to identify members enrolled in LTSS Waivers but not receiving any services.*

5.9.1(L) [Fully Met]: *Report to the State on the results of efforts to support community integration for Members using LTSS.*

- The *2023 QAPI Program Description* and *2023 QAPI Work Plans* included detail on how SHP supports community integration for members using LTSS, therefore this requirement is fully met. In the *2023 QAPI Checklist*, SHP identified the two items below in the *2023 QAPI Program Evaluation* as evidence of compliance with this requirement. However, neither section included detail on community integration for members using LTSS.*
  - Section "Long Term Support Services Advisory Committee" that included information on the representatives, meeting in-person, and LTSS Advisory responsibilities.
  - Section "Population Characteristics - Member Demographics and Service Area" that included details on enhancing CM and coordination, disease prevention, management services, member incentives offered, and member participation and feedback.

<u>Section 5.9.7 National Committee for Quality Assurance Accreditation</u>

5.9.7 [Partially Met]: *Contractor shall indicate whether they have achieved National Committee for Quality Assurance (NCQA) accreditation and LTSS Distinction for its Kansas Medicaid line of business, including the level of accreditation achieved.*

- SHP included information on NCQA Accreditation in the *2022 QAPI Program Evaluation* and *2023 QAPI Program Description*. In the QAPI work plan dated November 30, 2023, SHP added "NCQA Accreditation" to column D "Objective" (row 82). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement.

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

Section 5.9.8 Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers & Systems

5.9.8 [Partially Met]: *HEDIS General Requirements.*

- The following HEDIS requirements were not addressed in the *2023 QAPI Work Plans* or *2023 QAPI Program Description*:*
  - *Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)*. [Objective 4.5]
  - *HbA1c good control (<8.0%) for Members with diabetes* [Objective 5.1]
- The following HEDIS requirements were not addressed in the *2022 QAPI Program Evaluation*, *2023 QAPI Work Plans,* and the *2023 QAPI Program Description*:*
  - *Well-Child Visits first 15 months (effective 2020 name changed from W15 to W30)* [Objective 5.2a]
  - *Well-Child Visits 15-30 months (15-30-month period & name change in 2020)* [Objective 5.2b]
  - *Child and Adolescent Well-Care Visits (WCV) ages 3-11* [Objective 5.3a]
  - *Child and Adolescent Well-Care Visits (WCV) ages 12-17* [Objective 5.3b]
  - *Child and Adolescent Well-Care Visits (WCV) ages 18-21* [Objective 5.3c]

In the QAPI work plan dated November 30, 2023, SHP added "Healthcare Effectiveness Data and Information Set (HEDIS) data collection and reporting for population-specific HEDIS measures" to column D "Objective" (row 83). However, column E "Activity" did not include the State required HEDIS measures that are to be reported in the QAPI work plan. Rather, it detailed the State Contract requirement.

Section 5.9.10 Member Satisfaction Surveys

5.9.10(F) [Fully Met]: *Member Satisfaction Survey conducted with the KanCare Substance Use Disorder* [SUD] *population and annual summary.*

- In SHP's *2023 QAPI Checklist*, they advised they submitted the collaborative *2022 SUD Member Satisfaction Survey Report* to the State on June 30, 2023. However, information on this was not included in the *2023 QAPI Program Description*.*

Section 5.16.1 Reports and Audits

5.16.1(B) [Partially Met]: *Ensure that data received from Participating Providers is accurate and complete.*

- The *2022 QAPI Program Evaluation* and *2023 QAPI Program Description* included information on this requirement. In the *2023 QAPI Work Plan* dated November 30, 2023, SHP added "Data received from Participating Providers" to column D "Objectives" (row 97). However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement.

UnitedHealthcare

Section 5.9.1 General Requirements

5.9.1(A) [Fully Met]: *The State's QMS: The CONTRACTOR(S) shall comply with the State's QMS. The QMS includes, among other things, details on the State's expectations and requirements for quality activities and timeliness. The QMS is reviewed annually, at a minimum, and may be revised based on such review.*

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The CONTRACTOR(S) shall comply with any revisions to the QMS.

- The *2023 QAPI Work Plans* included the activity "Review State QMS annually, including compliance of the QMS"; therefore, this requirement is fully met. However, the *2022 QAPI Evaluation* and *2023 Program Description* did not include details of how UHC complies with the State QMS. In the *2023 Program Description*, within the list of "Responsibilities of the QMC," oversight and approval of the *QI* [Quality Improvement] *PHM PD* [Population Health Management Program Description], *QI PHM WP* [Work Plan], and *QI PHM Eval* [Evaluation] was listed. However, showing evidence of compliance with the State QMS requires more than listing these items in the program description. Also, the *QAPI Checklist* UHC submitted detailed the QMC Minutes as evidence of this requirement. KFMC reviewed the meeting minutes; they did not detail the QMS being incorporated into the QAPI program description or program evaluation (see the bullets below for the information included). If activities of Committee Meetings are used to provide evidence of compliance with the State's QAPI requirements, they should be referenced in the QAPI documents, as applicable.*
    - Quarter 1 (Q) 2023: The Director of Clinical Quality discussed the QI PHM PD, QI PHM PE, and QI PHM WP. There was also discussion of the 2022 QAPI report recommendations related to the QMS.
    - Q2 and Q3 2023: The Director of Clinical Quality addressed the QI Work Plan.
    - Q4 2023: The Director of Clinical Quality discussed the QMS and QI Work Plan. Related to the QMS, it states, "The QMS has been incorporated into the health plan QI Work Plan to ensure all factors are being met and that the state can easily located all the information that is required."

Section 5.9.7 National Committee for Quality Assurance Accreditation

5.9.7 [Partially Met]: *Contractor shall indicate whether they have achieved National Committee for Quality Assurance (NCQA) accreditation and LTSS Distinction for its Kansas Medicaid line of business, including the level of accreditation achieved.*

- UHC's *2023 QAPI Work Plans* did not include an activity for NCQA Accreditation and LTSS Distinction.

Section 5.9.8 Healthcare Effectiveness Data and Information Set and Consumer Assessment of Healthcare Providers & Systems

5.9.8 [Partially Met]: *HEDIS General Requirements.*

- In the *2023 QAPI Work Plans*, "Objectives" tab, row 13, column J detailed the HEDIS measures that UHC focused on in 2023. The measure *Chlamydia Screening in Women ages 16 to 24 (CHL)* was listed, but the measure *Breast Cancer Screening (BCS-AD)* was not. Also, State QMS Goal 4, Objective 4.5 was included in the list; however, Goal 5, required Objectives 5.1, 5.2a, 5.2b, 5.3a, 5.3b, and 5.3c were not. HEDIS measures were briefly mentioned in the *2023 QAPI Program Description*; however, there was no discussion on how UHC planned to approach HEDIS measure collection and improvement efforts. Also, the State required HEDIS measures that are to be reported in the QAPI program description were not included. All of the HEDIS requirements are outlined in the *2022 QAPI Evaluation*; however, the Well-Child visits are not evaluated by the age group specified in the HEDIS measures, instead, UHC uses "0-20."*

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

Section 5.9.9 Adverse Incident Reporting and Management System

5.9.9 [Fully Met]: *Adverse Incident Reporting and Management System General Requirements.*

- The *2022 QAPI Evaluation* thoroughly discussed adverse incident reporting in section "B. Monitoring of Quality of Care and Adverse Events." The *2023 QAPI Work Plans* included activities related to review of National Quality of Care reports and National Critical Incident reports. The National Quality of Care reports detailed information on quality-of-care reporting, which applies to adverse incidents.
- The *2023 QAPI Program Description* included a "Quality of Care" section; however, it did not include information on how UHC integrates data from the Adverse Incident Reporting and Management System and how the information will be used along with grievance data to improve the care and services delivered, decrease incidents of abuse, neglect, and exploitation, and prevent future incidents.*

Section 5.9.10 Member Satisfaction Surveys

5.9.10(F) [Fully Met]: *Member Satisfaction Survey conducted with the KanCare Substance Use Disorder population and annual summary.*

- The *2023 QAPI Work Plans* included information on the KanCare SUD survey and annual summary, therefore, this requirement is fully met. There was no discussion of this requirement in the *2022 QAPI Evaluation* and *2023 QAPI Program Description*. In the *QAPI Checklist* UHC submitted, areas of the *2022 QAPI Evaluation* and *2023 QAPI Program Description* were identified as to where information on this requirement could be found. However, upon review, information specifically pertaining to the annual SUD survey and summary was not included.*

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

Common Among the MCOs

- The MCOs collaborate across departments to maximize quality assessment and coordinate quality improvement.
- The MCOs are forward thinking and innovative, and staff are very knowledgeable.

Aetna

- Aetna's QAPI program evaluation included information on:
  - New positions added and team expansion.
  - A score of 100% and award from NCQA for Health Equity Accreditation.
- Aetna continues to make improvements to the QAPI program and required reporting.

Sunflower

- In the *2022 QAPI Program Evaluation*, Sunflower included a thorough analysis of their population characteristics, including maps and unique ways of breaking their population into groups (including grouping by product, language, and health care needs).
- Sunflower identified their plan strengths, accomplishments, and opportunities for improvement.

UnitedHealthcare

- UnitedHealthcare keeps thorough committee notes.
- UnitedHealthcare has easy to follow activities for each objective as well as objectives for each goal.

* If the information is not included in the specified QAPI document beginning with the documents submitted in calendar year 2024, it will result in a recommendation being made and a potential change in the overall compliance rating.

- UnitedHealthcare's work plans are well laid out and tie back to the QAPI program description and QAPI evaluation.
- Related to NCQA Accreditation, UnitedHealthcare achieved 4 Stars for the annual star rating in 2022.

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

Prior to the writing of this report, the MCOs had the opportunity to provide updates to recommendations made in prior years that were still in progress or less than fully addressed (via the KFMC progress tracking tool). The findings are summarized below and are also detailed in Appendix D, *Degree to Which the Previous Years' EQRO Recommendations Have Been Addressed*.

Aetna, Sunflower, and UnitedHealthcare

In 2023, the following was noted:

- For Aetna, two prior recommendations were partially addressed;
- For Sunflower, one prior recommendation was fully addressed, two were partially addressed, and two were not addressed; and
- For UnitedHealthcare, two prior recommendations were fully addressed, two were partially addressed, and one was not addressed.

Recommendations for Quality Improvement

Common Among the MCOs

In 2023, there were no recommendations that were common to all MCOs.

Aetna, Sunflower, and UnitedHealthcare

Based on the areas identified for improvement, KFMC made 3 recommendations for Aetna, 21 recommendations for Sunflower, and 10 recommendations for UnitedHealthcare (see Appendix C, *2023 Recommendations: QAPI Review*).

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8. Network Adequacy Validation

Background/Objectives

KanCare MCOs must maintain sufficient provider networks to deliver timely and accessible care to their members across the continuum of services. The contracts between the KDHE and the KanCare MCOs specify requirements for provider access and availability, including after-hours access, appointment availability, and geo-access standards.[10] In 2023, KFMC validated data and methods used to assess and report, or to reflect (i.e., provider directory), MCO network adequacy. KFMC used and referenced Protocol 4: Validation of Network Adequacy of the EQR Protocols, provided by the CMS, revised February 2023.[11]

During Activity One of the EQR Protocol, KFMC met with KDHE to define the scope of the validation for 2023. Findings and recommendations from past EQR network validation reports were considered when defining the scope of activities, as were the Network Validation Protocol, other EQR activities, and the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, Proposed Rule.[12] Since 2020, KFMC's primary network validation activity has been after-hours access monitoring. KFMC's access monitoring has involved using MCO provider network reports, online provider directory reports, MCO online directories through their websites, and contacting providers after regular office-hours to assess after-hours access. Repeated data-related KFMC recommendations for the MCOs have included,

- improve the classification of provider type, specialty, and Primary Care Provider (PCP) status in the provider databases,
- standardize data fields shared between databases (e.g., provider name and address fields) so providers may be uniquely distinguished, and
- provide the most up-to-date provider directory information to members (e.g., correct phone, currently practicing providers).

As noted, KFMC has identified areas for improvement regarding provider directory information. Also, the Medicaid and CHIP Managed Care Access, Finance, and Quality, Proposed Rule, if finalized, requires online provider directories to be validated to ensure accurate, up-to-date information. The proposed rule stipulates the verification of four pieces of data: active network status, street address, telephone number, and whether the provider is accepting new enrollees. CMS states in the proposed rule:

> "We believe these are the most critical pieces of information that enrollees rely on when seeking network provider information. Inaccuracies in this information can have a tremendously detrimental effect on enrollees' ability to access care since finding providers that are not in the managed care plan's network, have inaccurate addresses and phone numbers, or finding providers that are not accepting new patients listed in a plan's directory can delay their ability to contact a network provider and ultimately, receive care."

[10] KanCare Network Adequacy Standards. Updated September 22, 2022. Kansas Department of Health and Environment, Division of Health Care Finance. https://kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/final-geoaccess-standards-with-hcbs-standards.pdf

[11] CMS External Quality Review (EQR) Protocols. February 2023. OMB Control No. 0938-0786. Expires: December 31, 2025. Centers for Medicare and Medicaid Services. Department of Health and Human Services. USA. https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf (Accessed March 04, 2023).

[12] The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, Proposed Rule. Centers for Medicare & Medicaid Services. May 3, 2023. https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

KFMC's other repeated recommendations pertain to provider network reports. The Information Systems Capabilities Assessments for each MCO identifies specific provider data file transfer processes between the State and MCO. In general, the State sends each MCO a provider network (PRN) file daily and monthly, consisting of new providers and demographic updates for existing providers. The MCOs' systems ingest the State data into their provider network files and update the online provider directories. The assumption is that the MCO's provider data in the State's system, the MCO's Provider Network Report, and the MCO's Provider Directory Report should match. Additionally, the number of providers in the Provider Network Report should match with the Mapped Provider Count report. KDHE and KFMC agreed it was important to focus validation efforts on the data sources used in the various network adequacy reports before validating the methods used for calculating specific network adequacy indicators. If the data sources have validity concerns, the network adequacy indicator rates will have validity concerns no matter how accurate the calculations.

Finally, as a pre-cursor to future, more in-depth validation of the MCOs' Annual Timeliness Reports, KFMC and KDHE agreed that a review of the MCOs' methodologies and reported findings would be added to this year's validation activities.

Primary and Secondary Objectives

This study had a primary objective of determining the accuracy of online provider directory information for a stratified random sample for each MCO. Provider types assessed were primary care providers, specialists, behavioral health providers, and OB/GYNs presumed to be active in winter 2023. Secondary objectives were to

- Determine the percent of data that is matching between the MCO provider network files and the Kansas Modular Medicaid System (KMMS) provider data,
- Determine the percent of matching information by comparing the MCO provider network files to their provider directory files,
- Assess provider counts in geo-access network reports by comparing them to MCO provider network files, and
- Review methodologies for appointment and after-hours studies and geo-access mapping.

Technical Methods of Data Collection and Analysis

Data Sources

- MCO reports related to the provider networks were accessed through the KanCare Report Administration website. One annual and four quarterly sets of MCO reports were used:
  - MCO Annual Timeliness Reports – Excel files including the methodology, compliance rates, and improvement activities regarding the MCO's annual audit of network providers' compliance with during office-hours access, appointment availability, and after-hours access requirements.
  - Online Provider Directory Files (Directory Files) – Excel files listing providers in the MCO's online provider directory
  - Network Adequacy (Provider Network Reports) – Excel files listing providers who were participating, non-participating, and previously participating in the MCO's network.
  - Mapped Provider Count Reports – Excel files including the numbers of distinct providers and distinct locations by provider specialty types in the MCO's network.
  - Geo-Mapping Reports, Adult and Pediatric Maps – PDF documents identifying geographical coverage of providers throughout the state for specific provider types.
- MCO provider directories were accessed by KFMC through their websites for verification of information obtained through calls.

- Provider information housed by the State was accessed through KMMS and its reporting warehouse tables. KFMC receives and archives KMMS warehouse tables from the State's fiscal agent.

Directory Validation Calls

The primary method for validation of the MCOs' online provider directories was to call a random sample of 1,290 phone numbers and have the call recipient confirm basic directory information. For practice-level information (e.g., practice name, address, and phone number), a single call made on behalf of all providers at that location sufficed for confirming the directory information. Therefore, phone numbers from the provider directories were selected to be called only once. To keep call times short and to not overburden the call respondent, one directory record associated with the phone number was selected for validation of practioner-level data (e.g., the individual provides services at that location and is in the MCO's network). The MCO from whose directory the record was chosen was considered the *primary MCO* for the call. If a corresponding record (same phone number, person, and location) was listed in another MCO's directory file, the call would include partial validation of the record for this *secondary MCO*. Additional details related to creating the sampling frame and selecting the samples are contained in Appendix B (Sampling Strategy for Network Validation Calls).

KFMC's caller tracked findings from each call within an information system including specific elements from the objectives, requirements, and standards described throughout. Calls were categorized according to the result of the call (e.g., reached intended provider, reached answering machine, no answer). An inter-rater reliability system was used to settle any conflicting dispositions between KFMC's caller and quality reviewer. See **Error! Reference source not found.** for additional details regarding call monitoring and data analysis.

Standards for Directory Validation

The following standards were created by KFMC to assess directory record outcomes:

- **Fully Met** – Records where calls to the listed telephone number to assess valid active network status, street addresses, telephone number, and acceptance of new enrollees was confirmed by speaking with an individual representing the provider.
- **Substantially Met** – Records where calls to the listed telephone number allowed KFMC's caller to have an opportunity to verify all of the elements under assessment by speaking with an individual representing the provider. The provider was confirmed to be practicing at the telephone number provided in the directory but one of the other three elements was incorrect.
- **Partially Met** – Records where calls to the listed telephone number resulted in KFMC's caller not having an opportunity to verify all four pieces of data or where two or more pieces of data were incorrect. Partial verification may have occurred when a voice mail confirmed we had reached the correct practice and provider, but no respondent was available to answer further questions. This category also includes instances where a respondent confirmed some information but then ended the call.
- **Minimally Met** – Records where calls to the listed telephone number reached a voice message that only provided the practice or provider name and either one (but not both) was incorrect.
- **Not Met** – Records where calls to the listed telephone number clearly failed to satisfy all four components. This includes calls that resulted in either a No Answer or Confirmed Wrong Number. Confirmed Wrong Numbers are categorized as such, when either an individual or a voice recording identifies an incorrect business name or individual as the party reached. In several instances, the recording or person reached indicated that the telephone number dialed was for the billing department and explicitly stated that this was the incorrect number for scheduling. This category

also includes instances when voice recordings were reached that provided no information whatsoever (did not state practice, provider name, etc.).

Comparison of Provider Network Reports to Provider Directory Files

Comparisons were made between the fourth quarter 2023 Online Provider Directory Files and Provider Network Reports to assess the completeness and consistency of the data. To facilitate the State's monitoring of the MCO provider networks, KDHE directed the MCOs to also include the provider's KMMS ID in the files containing the records of their Online Provider Directory in addition to its inclusion in their Network Adequacy Reports, as previously mentioned. The KMMS ID can be split into two parts, the first 10 digits which represent the specific provider and the last 4 digits which represent the provider's specific service location. These first 10 digits of the KMMS ID will be referenced as the *base ID* within the remainder of this report. Provider type and NPI were also included in both files and used to compare the files' contents.

A full description of the methodology for the analysis is provided in Appendix B (Comparison of Provider Network Reports and Online Provider Directory Files).

Review of MCO Access Monitoring Methodologies

Each MCO conducted annual monitoring to assess provider compliance with State contractual appointment standards and after-hours access. The monitoring occurred through a provider office appointment availability survey and a provider after-hours access survey. KFMC assessed the MCOs' methodologies, considering the State's specific template questions and EQR Protocol 4. KFMC also referenced EQR Protocol 6, Administration or Validation of Quality of Care Surveys, when assessing the survey methodologies and results. e each MCOs' access monitoring occurred by telephone.

Comparisons were made between sample size, compliance rates-sampled, unsuccessful attempts, compliance rates-completed, days or hours to appointment, and after-hours access compliance to determine potential inconsistencies within each MCO's Annual Timeliness Report. Comparisons were also assessed among the MCOs' reports to identify differences in methods that could impact the State's interpretation of the reports.

Specific Geo-Mapping methodologies were not evaluated at this time, since the method of mapping provider data used standardized software. Rather, reliability and validity of the source data is a potential issue. Therefore, KFMC decided to start with the Assessment of Geo-Access Network Reports activity to identify potential areas that could impact the data used by the geo-mapping software.

Assessment of Geo-Access Network Reports

This year's review compared the number of PCPs in Kansas serving adult and pediatric members identified in the MCOs' fourth quarter 2023 Mapped Provider Counts, Geo-Access Maps, and Provider Network Reports. To identify distinct providers, NPI and KMMS identifiers were obtained from the Network Report for this review. The KMMS identifier Base ID provides the distinct provider ID and the full KMMS ID provides the distinct location ID at the end of the identifier.

Comparisons were completed by population density groupings of urban/semi-urban and densely-settled rural/rural/frontier, and statewide. Out-of-state PCPs were not included in the review, as the Provider Network Reports included PCPs in non-border states and the counts in the Geo-Access Maps only included PCPs in border states. Also, comparisons with other provider types were not completed at this

time, due to previously identified inconsistencies with provider type classifications that could affect count comparisons.

The total number of PCPs were also identified from the Online Provider Directory Files (for comparison to the Provider Network Reports). The Directory Files did not indicate whether adult or pediatric members, or both, were served. Instead, the age range served by provider was noted in the directories, with wide variations identified among the providers.

Description of Data Obtained

Directory Validation Calls

Calls occurred from December 7, 2023, through February 20, 2024. After calling was completed, a dataset was created for analysis that combined fields from the sample frame with additional fields from the call tracking system. The additional fields described call placement (e.g., caller name, date), provider type, specific findings, and disposition of the inter-rater review. Summary tables were created that included counts of records and levels of evaluation criteria met, as well as descriptive statistics such as percentages of totals within each category as well as numbers and percentages by contact type (e.g., all records leading to answering machine recordings) to provide context.

Findings are first presented in terms of contact type, then according to the level of quality.

Call Results by Contact Type

The distribution of results by contact type, provider type, and MCO for calls are displayed in Table 8.1. Of the 1,290 calls, less than half reached the intended provider's office (620 calls, 48% of calls). A small portion of the calls resulted in reaching an unidentified voice recording (38 calls, 3% of calls). Many calls led to either a wrong number (509 calls, 39% of calls) or no answer (123 calls, 10% of calls).

Table 8.1. Calls to Providers by Provider and Contact Type

Contact Type	Aetna		Sunflower		UnitedHealthcare		KanCare	
Provider Type	Records	%	Records	%	Records	%	Records	%
Intended Provider or Intended Provider's Voice Recording	**159**		**182**		**279**		**620**	
Behavioral Health	29	18%	28	15%	39	14%	96	15%
Specialist	58	36%	84	46%	109	39%	251	40%
OB/GYN	19	12%	19	10%	34	12%	72	12%
PCP	53	33%	51	28%	97	35%	201	32%
Voice Recording with No Information	**16**		**12**		**10**		**38**	
Behavioral Health	3	19%	6	50%	3	30%	12	32%
Specialist	7	44%	3	25%	7	70%	17	45%
OB/GYN	1	6%	3	25%	0	0%	4	11%
PCP	5	31%	0	0%	0	0%	5	13%
Wrong Number	**214**		**183**		**112**		**509**	
Behavioral Health	34	16%	26	14%	24	21%	84	17%
Specialist	67	31%	50	27%	24	21%	141	28%
OB/GYN	35	16%	30	16%	20	18%	85	17%
PCP	78	36%	77	42%	44	39%	199	39%
No Answer	**41**		**53**		**29**		**123**	
Behavioral Health	4	10%	10	19%	4	14%	18	15%
Specialist	18	44%	13	25%	10	34%	41	33%
OB/GYN	5	12%	8	15%	6	21%	19	15%
PCP	14	34%	22	42%	9	31%	45	37%

These results indicate that each MCO has room for significant improvement regarding the basic validity of their online directories. UnitedHealthcare has a higher proportion of calls reaching the intended providers, but still less than half, while Aetna and Sunflower have around a quarter of their online directories reaching the correct provider. Of particular concern are those records pertaining to OB/GYN providers which had the lowest ratio of telephone numbers that reached the intended provider for Aetna and Sunflower and the second lowest ratio for UnitedHealthcare. These incorrect telephone numbers to critical providers create an additional barrier for members and thus have the potential to perpetuate negative health outcomes for some of the most vulnerable populations in Kansas (e.g., people of color who need to visit an OB/GYN). To provide additional context for the findings given above, the following sections will break-down these results by KFMC's standards for directory validation.

The distribution of results by provider type, quality rating, and MCO are displayed in Table 8.2.

Table 8.2. Quality Ratings Results of Sampled Directory Records

Provider Type	Aetna		Sunflower		UnitedHealthcare		KanCare	
Quality Rating	Records	%	Records	%	Records	%	Records	%
Behavioral Health	**70**		**70**		**70**		**210**	
Fully Met	7	10%	6	9%	7	10%	20	10%
Substantially Met	4	6%	2	3%	4	6%	10	5%
Partially Met	18	26%	17	24%	26	37%	61	29%
Minimally Met	0	0%	3	4%	2	3%	5	2%
Not Met	41	59%	42	60%	31	44%	114	54%
Specialists	**150**		**150**		**150**		**450**	
Fully Met	22	15%	37	25%	47	31%	106	24%
Substantially Met	13	9%	21	14%	18	12%	52	12%
Partially Met	17	11%	23	15%	34	23%	74	16%
Minimally Met	6	4%	3	2%	10	7%	19	4%
Not Met	92	61%	66	44%	41	27%	199	44%
OB/GYN	**60**		**60**		**60**		**180**	
Fully Met	5	8%	8	13%	12	20%	25	14%
Substantially Met	6	10%	1	2%	6	10%	13	7%
Partially Met	8	13%	10	17%	13	22%	31	17%
Minimally Met	0	0%	0	0%	3	5%	3	2%
Not Met	41	68%	41	68%	26	43%	108	60%
PCPs	**150**		**150**		**150**		**450**	
Fully Met	17	11%	16	11%	34	23%	67	15%
Substantially Met	14	9%	8	5%	16	11%	38	8%
Partially Met	18	12%	24	16%	43	29%	85	19%
Minimally Met	4	3%	3	2%	4	3%	11	2%
Not Met	97	65%	99	66%	53	35%	249	55%

Directory Records Having Fully Met Standards

Records deemed Fully Met had associated calls made that reached a live respondent and clearly satisfied the access and quality standards of the study. In other words, these are records associated with calls in which successful validation of all four pieces of data was achieved.

Of the 1,290 calls made, 218 (17%) of the corresponding records were categorized as Fully Met. Records with Aetna as the primary MCO accounted for 23% (51 out of 218) of the total number of records that achieved this standard. Sunflower's records consisted of 31% (67 out of 218) and UnitedHealthcare had the largest percentage of the total number of records categorized as Fully Met at 46% (100 out of 218).

Directory Records Having Substantially Met Standards

Records deemed Substantially Met had associated calls made that reached a live respondent who was able to confirm telephone number and two other elements under assessment. Substantially Met records accounted for 113 (9%) out of 1,290 total records. No records deemed Substantially Met had associated calls that resulted in voice recordings.

Directory Records Having Partially Met Standards

Records deemed Partially Met represent calls where some information was either not confirmed or where the provider office disconnected the call before all questions were asked. All in all, there were 251 out of 1,290 (19%) records having Partially Met standards. In 31 (12% of 251) cases, a person affiliated with the provider or practice indicated that KFMC's caller had reached the correct number but failed to confirm additional information. Oftentimes some of the four components could not be assessed due to answering machines only providing partial information. A total of 183 records (73%) resulted in reaching an answering machine with incomplete information. Partially Met standards also include records where KFMC's caller reached a person who represented the provider or practice but only two of the four elements was verified to be correct (37 records, 15%).

Directory Records Having Minimally Met Standards

Records deemed Minimally Met had associated calls made that lacked substantial information. For all records in this category, KFMC's caller was only able to reach and assess voice messages. Additionally, these voice messages indicated either an incorrect practice or provider had been reached. Of the total 1,290 records, 38 (3%) fell into this category.

Directory Records Having Not Met Standards

Records deemed Not Met had associated calls made that indicated major inaccuracies. Of the total number of records, 670 (52%) were Not Met. Of these 670 records, 123 of the associated calls (18% of Not Met records) were not answered, were disconnected, had a busy signal, or otherwise did not lead to reaching a person or answering machine recording on behalf of the provider. KFMC's caller reached a wrong number for 509 (76%) records. KFMC's caller reached an answering machine that did not provide information for the practice group or provider for 38 (6%) records.

Validating Specialty and PCP Status

For directory records that indicated a provider type of either specialty or PCP, an attempt was made to confirm that the provider in question was practicing as a PCP or as the specialty type listed in the provider directory files (see Table 8.3). Overall, 281 calls (31% of 900 calls) resulted in a confirmation that the correct specialty was listed in the provider directory file. Calls that reached only a voice recording did not offer the ability to assess specialty match rate and were considered incorrect. Note that this validation did not impact the categorization of calls in the previous sections.

Table 8.3. Specialty Match Rate of Sampled Directory Records

Provider Type	Aetna		Sunflower		UnitedHealthcare		KanCare	
	Records	%	Records	%	Records	%	Records	%
Specialists	**150**		**150**		**150**		**450**	
Correct Specialty	32	21%	59	39%	68	45%	159	35%
PCPs	**150**		**150**		**150**		**450**	
Correct Specialty	36	24%	29	19%	57	38%	122	27%
Total	**300**		**300**		**300**		**900**	
Correct Specialty	68	23%	88	29%	125	42%	281	31%

Findings of Comparison of Provider Network Reports to KMMS

The intent of this validation activity was to assess the accuracy and completeness of the MCOs' Provider Network Reports by comparing them against the State's provider data housed in the Kansas Modular Medicaid System (KMMS). Data expected by KFMC to be comparable included provider names and addresses, provider types and specialties, affiliation of practitioner with group practices, and network contracting status. January 2024 Provider Network Report records were compared to the KMMS reporting warehouse records (as of February 29, 2024).

Initial Observations

While reviewing the Provider Network Reports and preparing their records for analysis, the following observations were made.

The State instructed MCOs to separately report three sets of providers. The first were *participating providers* or those providers in the network during the calendar year. The second were *non-participating providers* or non-network providers who submitted claims with dates of service in two consecutive quarters, including providers with single case agreements. Finally, there were *previously terminated providers* or those former participating providers.

Aetna did not appear to have separated participating and previously terminated providers in its report. All of Aetna's records reported January 1, 2019, as the effective date for all records and did not have populated end dates. For these dates to be correct, Aetna's provider network would need to have remained unchanged since their KanCare contract began. Only one record was reported in Aetna's table of previously terminated providers. UnitedHealthcare's report included non-participating group providers; however, no practitioners within those groups were listed as non-participating providers.

KMMS IDs were not fully populated for Sunflower and UnitedHealthcare providers. All Aetna records contained a KMMS ID. National Provider Identifiers (NPIs) were mostly populated by each MCO. For records with a KMMS ID and an NPI, the pairing of the KMMS ID to the NPI was consistent with the KMMS Provider NPIs cross walk table. However, there were inconsistencies noted within the NPI and KMMS ID fields (see Appendix B for details).

Matching Records using KMMS ID

Counts of January 2024 Provider Network Report records for participating providers that matched on KMMS ID, stratified by MCO and provider enrollment type, are shown in Table 8.4. The number and percentage of those records not matched to KMMS on KMMS ID, name, and address fields and the number and percentage of records matched to KMMS are also shown.

Table 8.4. Records in Provider Network Reports Matched to KMMS on KMMS ID

	Individuals		Groups and Facilities	
Aetna	**N**	**%**	**N**	**%**
Records in January 2024 Files	100,431	100%	74,142	100%
Excluded (Not matched on KMMS ID, name and address)	1,875	2%	6,102	8%
Records Matched To KMMS	98,556	98%	68,040	92%
Sunflower	**N**	**%**	**N**	**%**
Records in January 2024 Files	81,817	100%	51,081	100%
Excluded	50,415	62%	10,212	20%
Records Matched To KMMS	49,111	38%	40,869	80%

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.
Excluded Records: See Appendix B, Tables B.3 and B.5, for a breakdown by the steps in which records were excluded.

Table 8.4. Records in Provider Network Reports Matched to KMMS on KMMS ID (Continued)				
	Individuals		Groups and Facilities	
UnitedHealthcare	**N**	**%**	**N**	**%**
Records in January 2024 Files	102,030	100%	65,216	100%
Excluded	52,994	52%	58,007	89%
Records Matched To KMMS	49,036	48%	7,209	11%

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.
Excluded Records: See Appendix B, Tables B.3 and B.5, for a breakdown by the steps in which records were excluded.

Not matching on names was the most frequent cause of records not matching for Aetna's records. For both Sunflower and UnitedHealthcare, the most frequent cause of records not matching was missing KMMS ID.

Matching Records using NPI

Counts of January 2024 Provider Network Report records for participating providers that matched using NPI, stratified by MCO and provider enrollment type, are shown in Table 8.5. The number and percentage of those records not matched to KMMS using NPI (i.e., excluded records), name, and address fields and the number and percentage of records matched to KMMS are also shown.

Table 8.5. Records in Provider Network Reports Matched to KMMS using NPI				
	Individuals		Groups and Facilities	
Aetna	**N**	**%**	**N**	**%**
Participating Provider Records in January 2024 Files	100,431	100%	74,142	100%
Excluded (Not matched using NPI, name, and address)	1,474	1%	4,267	6%
Records Matched to KMMS on Name and Address	**98,957**	**99%**	**69,875**	**94%**
Full Matches (Full matches on Name and Address)	93,117	94%	16,708	24%
Full+Partial (1 full match, 1 partial match)	5,786	6%	47,443	68%
Partial Matches (Partial matches on both)	54	<1%	5,724	8%
Sunflower	**N**	**%**	**N**	**%**
Participating Provider Records in January 2024 Files	81,817	100%	51,081	100%
Excluded	26,435	32%	7,527	15%
Records Matched to KMMS on Name and Address	**55,382**	**68%**	**43,554**	**85%**
Full Matches	52,814	95%	5,206	12%
Full+Partial	2,541	5%	34,579	79%
Partial Matches	27	<1%	3,769	9%
UnitedHealthcare	**N**	**%**	**N**	**%**
Participating Provider Records in January 2024 Files	102,030	100%	65,216	100%
Excluded	30,420	30%	25,472	39%
Records Matched to KMMS on Name and Address	**71,610**	**70%**	**39,744**	**61%**
Full Matches	68,215	95%	5,075	13%
Full+Partial	3,365	5%	28,214	71%
Partial Matches	30	<1%	6,455	16%

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.
Excluded Records: See Appendix B, Tables B.4 and B.6 for a breakdown by the steps in which records were excluded.

Not matching on names was the most frequent cause of records not matching for Aetna's records. Not matching on address was the most frequent cause of records not matching for Sunflower's and UnitedHealthcare's records. Each MCO had some records without a match to the KMMS Providers table: 14 (<1%) for Aetna; 1,264 (2%) for Sunflower; and 6,433 (6%) for UnitedHealthcare. This indicates that there are NPIs within the MCOs' databases that are not present in the KMMS Providers table.

Not matching on address was the primary reason records did not match using NPI. The number of records not matched underscores the need for KMMS IDs for this type of analysis.

Additional analysis was conducted on the records for participating providers that matched to KMMS using NPI (referred to as *records studied*). The accuracy of the provider type and provider addresses have direct implications to both the provider directories and the Mapped Provider Count Reports. While interpreting these statistics, keep in mind that matching to KMMS using NPI can match a record from the provider network file to multiple KMMS records. Since matching using NPI returns multiple matches, the problems may be understated.

Frequently seen cases of unmatched provider types included

- Advanced practice nurses and mid-level practitioners (per KMMS) listed as physicians by MCOs,
- Physicians listed as advanced practice nurses and mid-level practitioners by MCOs,
- Mental health providers listed as physicians by MCOs (and vice versa), and
- Advanced practice nurses listed as home health agencies, dentists, and chiropractors by MCOs.

Note, the studied records not matched to at least one record with a matching service location address had addresses matched to another type of address (mail to, pay to, etc.). Also, keep in mind the percentage of records that did not match to any address using NPI (see Table 8.5 above).

The KMMS Contracts table provides effective beginning and ending dates for service locations contracted with an MCO as a participating or non-participating provider. The records studied for each MCO were matched to this table and subsequently stratified into four non-overlapping categories for records pertaining to individuals and records pertaining to groups and facilities.

Provider Network Report and Online Provider Directory File Comparisons

The intent of this validation activity was to assess the accuracy and completeness of the MCOs' Online Provider Directory Files by comparing them against the active participating providers in the Provider Network Reports. At a minimum, KFMC expected that providers included in the Online Provider Directory would be included in the Network Report. Comparisons were made between the directory files and network reports for the fourth quarter of 2023.

Following are key observations; additional findings and details are provided in Appendix B (Comparison of Provider Network Reports and Online Provider Directory Files).

Overall Observations

Many of the differences observed were due to the nature of the reports. The Online Directory File's main purpose is to populate the MCOs' directories. For example, the directories may limit the non-Kansas providers included. The business name may not be as appropriate for the member as the DBA [Doing Business As] or the address name. The websites may query both practitioner and practice information from the same record. In contrast, the Provider Network Reports are driven by the State's needs.

As noted above, the Participating Providers tab of the network reports contained a Termination Date field indicating providers who ended network participation during the year. This field was not populated by Aetna. Address data were standardized in the Aetna and UnitedHealthcare network reports and directory files but were not between the Sunflower network report and directory file.

The network reports populated the Business Name field (for groups and facilities) or the First, Middle, and Last Name fields (for individuals). For the directory files, there was a lack of consistency in which name fields were populated for individuals and groups and facilities. The majority of directory records had all name fields populated. Details are provided in the MCO-specific sections of Appendix B.

With few exceptions, NPI was populated in both the network reports and the directory files.

Considerably more out-of-state providers were in the network reports than in the directory files, although it is expected that members residing near the Kansas border can access providers in neighboring states within 50 miles of the Kansas border.

Table 8.6 compares counts of distinct identifiers (NPI, base ID, and KMMS ID) between the network reports and the directory files for each MCO. Counts for all records provided are shown first and counts for providers with Kansas addresses are shown second. Both sets break out counts for PCPs.

Table 8.6. Counts of Distinct Identifiers

As Provided	Aetna		Sunflower		UnitedHealthcare	
Description	**Directory File**	**Network Rpt**	**Directory File**	**Network Rpt**	**Directory File**	**Network Rpt**
Total Records	171,641	174,573	139,127	111,882	93,269	148,942
Distinct NPIs	21,199	29,231	18,688	21,723	13,990	28,153
– PCPs	2,866	5,586	2,364	3,684	2,786	4,961
– serving Adult		4,413		3,157		4,905
– serving Pediatric		5,574		3,621		4,957
Distinct Base IDs	19,898	25,719	13,340	13,144	12,296	17,677
– as PCPs	2,911	4,916	1,985	1,948	2,631	3,899
– serving Adult		3,854		1,606		3,844
– serving Pediatric		4,905		1,917		3,896
Distinct KMMS IDs	23,147	30,868	14,380	15,451	13,227	19,628
– as PCPs	3,389	6,641	2,062	2,183	2,697	4,206
– serving Adult		5,488		1,839		4,151
– serving Pediatric		6,629		2,151		4,203
Kansas Only Providers	**Aetna**		**Sunflower**		**UnitedHealthcare**	
Description	**Directory File**	**Network Rpt**	**Directory File**	**Network Rpt**	**Directory File**	**Network Rpt**
Total Records	171,312	152,792	117,226	98,375	91,484	109,932
Distinct NPIs	21,057	24,645	16,304	17,441	13,987	21,905
– PCPs	2,866	4,480	1,948	2,868	2,786	4,220
– serving Adult		3,657		2,509		4,174
– serving Pediatric		4,476		2,810		4,216
Distinct Base IDs	19,800	21,552	11,737	10,193	12,293	15,199
– as PCPs	2,911	3,906	1,656	1,365	2,631	3,434
– serving Adult		3,141		1,157		3,387
– serving Pediatric		3,902		1,337		3,431
Distinct KMMS IDs	23,027	25,858	12,705	12,342	13,224	16,934
– as PCPs	3,389	5,228	1,725	1,559	2,697	3,699
– serving Adult		4,408		1,350		3,652
– serving Pediatric		5,224		1,531		3,696

Source: MCO Online Provider Directory Files (directory files) and Provider Network Reports (network reports) for 2023 Q4. Providers of services to adults or pediatric members, or both, are not indicated in directory files; ages served are inconsistent
Note: All network report counts based upon non-terminated providers. Directory file does not contain a termination date and therefore all contained are considered non-terminated.

NPIs

NPI was a well-populated field. All records in Aetna's and Sunflower's directory files had NPI populated; fewer than 100 distinct names (combined name fields) did not have an NPI in UnitedHealthcare's

directory file. In the network reports, only one distinct name in the ABH report was missing the NPI; fewer than 60 distinct names did not have an NPI in the SHP and UHC reports.

Inclusion of non-Kansas providers in the directory files varied by MCO. There was a wide variation of out-of-state NPIs between the MCO directories—213 for Aetna, approximately 4,700 for Sunflower and only 4 for UnitedHealthcare. There were considerably more out-of-state NPIs in the network reports than in the directory files for Aetna and UnitedHealthcare—approximately 4,500 for Aetna and 6,300 for UnitedHealthcare. Sunflower had 500 fewer NPIs for out of state providers in the network report as compared to the provider directory. The majority of out-of-state NPIs were for border-state providers.

The directory files did not have a field indicating whether a PCP served adult or pediatric patients but did have a field for ages served. The field, when populated, contained a wide range of ages; KFMC did not attempt to map these records to adult, pediatric, or both. In the network reports, most PCPs were designated as serving both adult and pediatric patients.

As expected, the majority of NPIs in the MCOs' directory files (between 70% and 96%) were also in the network reports. It is notable that fewer NPIs (between 50% and 67%) in the network reports had a match in the directory files.

Base IDs
Because the base ID (first 10 characters of the KMMS ID) designates a provider, it would be expected that counts of distinct base IDs would be comparable to distinct NPIs. However, KMMS ID is not well-populated for Sunflower and UnitedHealthcare (see Appendix B, Tables B.3 and B.5).

Comparing KMMS IDs
The full KMMS ID contains a location identifier and providers can practice at multiple locations, thus a higher number of distinct KMMS IDs versus base IDs would be expected. This was true for all MCOs in both the directory files and the network reports. However, there were records in all files with the same KMMS ID on records with different addresses.

Comparing Provider Types
KFMC analyzed the NPI and KMMS ID (both base ID and full ID) by the provider types in the MCO directory files and network reports. In Appendix B, Tables B.8, B.9, B.11, B.12, B.14, and B.15 show the counts of distinct NPIs, base IDs, and KMMS IDs based on the provider types in the network report and by the provider types in the directory files. Different provider types are used in the network reports and the directory files for each of the MCOs, so a direct comparison was not possible. Distinct counts are provided as well as how many of the identifiers were included in the other file.

Several examples of directory records misclassifying the provider's type and specialty were verified using KMMS and the NPPES NPI Registry.[13]

Review of MCO Access Monitoring Methodologies

Each MCO conducted appointment availability and after-hours access surveys in the third and fourth quarters of 2023 and submitted their methodology and results on KDHE's reporting template. The MCOs varied on the level of detail provided in the survey methodology and explanation of variances. However,

[13] NPPES NPI Registry (a federal government website managed by the Centers for Medicaid and Medicare Services) https://npiregistry.cms.hhs.gov/search

all MCOs need to provide more detail. Appendix B (Findings of Review of MCO Access Monitoring Methodologies) provides findings specific to individual MCOs.

In a couple cases, references would be made to sending the entire provider network to the vendor, but no counts were reported. Other information needed for both surveys included sample frame counts, provider file data sources, number of providers excluded from the survey, definition of provider (i.e., sampling at the individual practitioner, or group practice level), and survey questions.

It wasn't clear how PCPs for adults and pediatrics were categorized for the sub-reporting. It appeared to occur a couple ways, by only including pediatricians in the pediatrics category having no overlap with the adult PCP category, or by having anyone that serves adults or pediatrics being in each category as appropriate, with overlap between the two.

The "Median Number of Days Wait for Scheduled Appointment," ranged widely by MCO for routine care appointments. Aetna and UnitedHealthcare were more similar for emergency care and urgent care appointments. The data appear to be inconsistent and calculated using different technical specifications. The median number of days for an appointment were reported as follows:

- Appointment with a PCP
  - Emergency Care: Aetna (.04), UnitedHealthcare (.04), Sunflower (30)
  - Urgent Care: Aetna (.08), UnitedHealthcare (.04), Sunflower (30)
  - Routine Care: Aetna (1), UnitedHealthcare (9.51), Sunflower (47)
- Appointment with a Mental Health Provider
  - Emergency Care: Aetna (.25), UnitedHealthcare (.53), Sunflower (21)
  - Urgent Care: Aetna (1), UnitedHealthcare (.86), Sunflower (21)
  - Routine: Aetna (2), UnitedHealthcare (9.91), Sunflower (31)

Sunflower reported, "Regarding the 'Days or Hours Appointment' tab - The wait times are inflated due to the use of the median point in the data. The averages calculated were much lower due to the ability of our providers to see walk in patients. Perhaps it would be best to see both the median and average measures with an explanation provided on the deviation. We could also look at addressing the outliers by eliminating the five lowest and five highest values, the continuing to utilize median." In 2022, Sunflower reported using the provider's third available appointment time, instead of their first or second available. Sunflower indicated the first available appointment could be a cancellation that day, or a slot held for urgent needs, that may not represent "average accessibility." UnitedHealthcare's "Access & Availability Guideline" survey questions asked for the first available appointment. Aetna's questions were not provided.

A few observations were noted in the non-compliant and compliant response options that suggest potential opportunities for further discussion about MCO surveyor training, quality assurance, data entry, etc. Among the unsuccessful attempts calls, the majority were classified as technical, such as "vendor hold times, being asked to call back later, or data inaccuracy." Sunflower's after-hours access results showed only 1 of the 330 calls were non-compliant (a "no answer"). However, a very high percentage of calls during the appointment availability survey were unsuccessful attempts, 81.4% (6,096), suggesting some inconsistency in the sample process or reporting of results for the after-hours survey. Of the 910 after-hours calls completed by UnitedHealthcare, 99.3% compliance was reported, with providers either having an answering service or an answering machine instructing callers to go to the nearest hospital. Based on past experience, KFMC finds it very unusual to have such a high

compliance rate and that these two response categories would be the only ones used among 910 providers.

For PCPs, where 24/7 hour member access to be able to speak with someone "on call" for their provider is needed, 293 (42.3%) of the 692 after-hours calls were answered by an answering machine, making it important to ensure the message is correct. Of the answering machine responses, 192 (65.5%) had messages directing the caller to the nearest hospital, and 101 (34.5%) had messages with "no issues." The definition of "no issues" was not identified and is highly open to varying interpretation by the surveyor even with some instructions.

Assessment of Geo-Access Network Reports

Distinct provider and location counts, by population density groupings (densely-settled rural/rural/ frontier, and semi-urban/urban), are shown in Table 8.7. The MCOs' January 2024 Adult and Pediatric GeoAccess Maps provide third quarter 2023 counts of distinct providers and distinct locations. The statewide distinct provider and location counts for third quarter 2023 were reported in each MCO's January 2024 Mapped Provider Count Report. It was unclear how the MCOs identified distinct provider counts, such as by group practice or individual practitioner. Also, it is not clear what identifiers were used in the process (e.g., NPI, KMMS ID, or name and address). Methods used by MCOs to determine adult and pediatric PCPs (e.g., age ranges served, provider type/specialty, PCP specific flag) were also unknown. For comparison, corresponding counts were calculated from the January 2024 Provider Network Report for fourth quarter 2023.

Initial Observations

Aetna's distinct PCP provider and location counts from the Provider Network Report were higher overall than their Geo Access Map counts. This suggests some potential underreporting and an opportunity to explore reasons for the discrepancies. Aetna's network report contained cases where both a physician group practice and its individual practitioners were listed as PCPs; the groups and practitioners with different KMMS IDs may partially explain why counts from the network reports where higher.

Sunflower's Network Report had lower distinct provider counts than the Geo Access Maps. However, this was likely because Sunflower's Provider Network Reports did not have the KMMS IDs fully populated.

UnitedHealthcare's Network Report NPIs and Distinct Base IDs were more consistent with the Geo Access Maps' distinct provider counts across the population densities than the other MCOs. However, the Network Report distinct location counts were substantially higher than the Geo Access Maps distinct location counts, similar to Aetna's patterns regarding distinct locations. UnitedHealthcare also lists both groups and individuals in a group in the network reports.

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Table 8.7. Distinct Identifiers by Geographic Regions for Kansas PCPs						
Kansas PCPs	Aetna		Sunflower		UnitedHealthcare	
	Geo Access Maps	Network Report	Geo Access Maps	Network Report	Geo Access Maps	Network Report
Distinct Providers against Distinct NPIs						
Densely-settled Rural/Rural/frontier						
– Adult	805	1,336	1,424	1,389	1,435	1,639
– Pediatric	838	1,423	1,483	1,437	1,469	1,646
Semi-Urban/Urban						
– Adult	1,860	2,756	2,232	1,626	2,621	2,918
– Pediatric	2,308	3,531	2,674	1,898	2,848	2,956
Statewide						
`– Adult	2,770	3,657	3,618	2,509	3702	4,174
– Pediatric	3,331	4,476	4,343	2,810	3951	4,216
Distinct Providers against Distinct Base IDs						
Densely-settled Rural/Rural/Frontier						
– Adult	805	1,043	1,424	539	1,435	1,272
– Pediatric	838	1,116	1,483	548	1,469	1,278
Semi-Urban/Urban						
– Adult	1,860	2,452	2,232	733	2,621	2,341
– Pediatric	2,308	3,181	2,674	904	2,848	2,380
Statewide						
– Adult	2,770	3,141	3,618	1,157	3702	3,387
– Pediatric	3,331	3,902	4,313	1,337	3951	3,431
Distinct Locations against Distinct KMMS IDs						
Densely-settled Rural/Rural/Frontier						
– Adult	352	1,441	432	645	449	1,430
– Pediatric	356	1,526	436	654	454	1,436
Semi-Urban/Urban						
– Adult	597	3,272	629	813	735	2,444
– Pediatric	609	4,042	650	985	743	2,483
Statewide						
– Adult	1,120	4,408	1,258	1,350	1184	3,652
– Pediatric	1,138	5,224	1,300	1,531	1197	3,696

Data Source: January 2024 reports – Provider Network Reports, Mapped Provider Counts Reports, Adult and Pediatric Maps. Provider Network Reports records were limited to participating providers as of 12/31/2023. Providers serving adult and pediatric members were counted in both strata.

Study Limitations

The provider directory records validated through phone calls were limited to records for individual practitioners. Records for hospitals, nursing facilities, clinics, home health agencies, HCBS providers, and other organizations were excluded. Mid-level practitioners were also excluded because they were not readily classifiable as primary care, behavioral health, OB/GYN, or specialty providers.

Because the number of individuals listed for a phone number varied widely, the study results were not intended to be generalized at the practice or practitioner levels. Within a provider type's sample frame, each phone number had an equal probability of being selected but an individual in a large practice would be less likely to be selected than an individual in a practice with fewer practitioners. Since its sample frame was very small, the OB/GYN sample was selected before the PCP and Specialist samples; consequently, multi-specialty practices were more likely to be selected for the OB/GYN sample than the PCP or Specialty samples.

The comparison of Provider Network Reports to KMMS tables identified discrepancies within the data; it did not determine which values are correct. KMMS IDs were insufficiently populated for directly joining provider network records with KMMS tables. NPIs are specific to people or businesses, but not to service locations. Therefore, joining provider network records to KMMS records using NPI returned results for multiple service locations even after restricting records on names and addresses. Consequently, issues identified through NPIs may be understated.

Similar to issues in comparing Provider Network Reports and KMMS tables, discrepancies were identified from comparisons of the Provider Network Reports and Online Directory files. NPIs were consistently populated between files, but KMMS IDs were not for two of the MCOs. Issues identified through base IDs may be underreported.

The file structure and content needed for supporting online provider directories differed from that needed for monitoring adequacy of provider networks. Consequently, data were often not directly comparable.

Conclusions Drawn from the Data Common Among the MCOs

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

- The State and MCOs continue working towards improving the accuracy of the provider directory files. The State also 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

Directory Validation Calls

- The main finding of this validation activity was that the majority of directory records for contracted providers were either incorrect or outdated. Only 17% of the records analyzed were categorized as Fully Met, and only 9% were categorized as Substantially Met. Almost three quarters of records (74%) displayed minor or major issues leading to Partially Met (19%), Minimally Met (3%), or Not Met (52%) categorizations. Stratification of records by provider type revealed that certain provider types had slightly more accurate records than others, but none had more than about a third that fully or substantially met standards.
- The quality of voice recordings limited the ability to verify basic information about practices and providers. Some recordings simply stated that KFMC's caller had reached a telephone number's voice mail without providing either a practice or provider name.

Comparison of Provider Network Reports to KMMS

- Missing KMMS ID was the primary reason records did not match using KMMS ID. Aetna's records were not missing any KMMS IDs for participating individual or group and facility providers. For individual providers, Sunflower's and UnitedHealthcare's records were missing 61% and 49% of KMMS IDs, respectively. For group and facility providers, Sunflower's and UnitedHealthcare's records were missing 15% and 85% of KMMS IDs, respectively.
- For individuals in a group practice, the NPI and KMMS ID of the group were frequently provided; the identifiers for the individual would be better for looking up records in KMMS.
- For matching using NPIs, about 1% of records for individuals and 6% of records for groups and facilities could not be matched to KMMS for Aetna. About 30% of records for individuals could not be matched to KMMS for Sunflower and UnitedHealthcare. About 15% and 39% of records for

groups and facilities could not be matched to KMMS for Sunflower and UnitedHealthcare, respectively.
- Of the network report records matched to KMMS using NPI, 2% to 6% did not match the provider type in KMMS. The addresses on 1% to 2% of network report records did not match to a service location address in KMMS. Finally, there were several instances where records for participating providers were not matched to KMMS Contracts table records that indicated the provider was contracted as a participating or non-participating provider.
- There were NPIs present in the Provider Network Reports that were not present in the KMMS NPI-to-provider crosswalk table.

Comparison of Provider Network Reports and Online Provider Directory Files
- KMMS IDs were not sufficiently populated.
- Group KMMS IDs were attributed to individuals.
- Lack of data standardization between the files excluded the possibility of matching records by provider types and addresses.
- The directory files contained provider records with misclassified provider type and specialty.

Review of MCO Access Monitoring Methodologies
- Gaps in methodologic detail made it difficult to fully evaluate the methodology and interpret the survey results. Information gaps included, sample frame counts by specialty type, sampling data sources, definition of provider in the sample (i.e., group practice, individual practitioner, or both), survey questions, counts for providers excluded from the survey, method for identifying strata for access indicators when providers overlap the adult and pediatric categories.
- Only one or two categories were used for the majority of response options, indicating survey callers may not be capturing data as intended. It was not clear whether the MCOs have procedure manuals for the surveyors or quality control procedures for survey oversight, such as inter-rater reliability.
- The response options for answering machines were open to varying interpretation without detailed instructions, (e.g., "answering machine message with no issues").
- There were potential variations in survey methodologies among the MCOs that can lead to different, or potentially invalid results, and misinterpretation of findings, (e.g., the calculation method for Median Number of Days Wait for Scheduled Appointment, and use of potentially different survey questions).

Assessment of Geo-Access Network Reports
- The identifiers used for the provider counts (e.g., NPI, KMMS ID, or name and address) could not be determined.
- Methods used to determine adult and pediatric PCPs (e.g., age ranges served, provider type/specialty, PCP specific flag) could not be determined.
- Counts from the provider network reports did not support counts from the geo-access network reports.

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

- **Recommendation:** KanCare MCOs should use findings from KFMC's annual Primary Care Provider After-Hours Access Monitoring report
- **KFMC Response:** All MCOs *partially addressed* this recommendation. Due to the 2023 change in scope for KFMC's network adequacy validation activities, after-hours access monitoring was not completed to assess improvement in previously non-compliant providers. However, each MCO

continued to conduct their own annual after-hours annual compliance surveys and to address issues with non-compliance.
  - Aetna reported Provider Relations followed-up with all non-compliant providers from their 2022 survey. However, they did not indicate how many, if any, were included in their 2023 survey sample for reassessment.
  - Sunflower reported various stages of follow-up with non-compliant providers, including follow-up surveys. It appears follow-up occurred with around two-thirds of the non-compliant providers, and the remainder, who were PCPs, may have been included in the next full survey.
  - UnitedHealthcare reported reaching out to all provider groups after the 2022 survey and a little less than half of the non-compliant providers were included in the 2023 survey.
- **Recommendation:** KanCare MCOs should continue to provide training and technical assistance to providers on how to adequately implement standards on after-hours availability requirements.
  KFMC Response: All MCOs *fully addressed* this recommendation. Follow-up regarding the after-hours survey noted above included education and technical assistance regarding after-hours access standards. All MCOs reported plans for continued outreach and education to providers regarding all access standards.
- **Recommendation:** KanCare MCOs should continue to seek ways to help improve the classification of provider type, specialty, and PCP status in the provider databases.
  KFMC Response: This recommendation is *in progress.* The MCOs have completed some follow-up after the annual timeliness surveys to correct provider information in the system. UnitedHealthcare is working to increase data flow between systems to ensure data transfer of corrected provider information between teams.
- KFMC determined the State-related recommendations (i.e., continuing to review and work with the MCOs on provider databases, and working with KFMC to design 2023 network adequacy validation design) were *fully addressed*.

Recommendations for Quality Improvement

Recommendations for the State

1. As intended, the State should continue to review and work with the MCOs on accuracy of the various provider databases.

Recommendations for the KanCare MCOs

2. KanCare MCOs should inform providers that all pre-recorded messages must be high-quality, informative, and provide callers with certainty that they have reached the practice whose number they dialed. A member should, at minimum, have a means for leaving a message and should be told when to expect a return call.
3. KanCare MCOs should use findings from KFMC's Network Adequacy Validation report to work with providers to improve the accuracy (of names, in particular) and timely updating of directory files.
4. KanCare MCOs should validate their provider data (e.g., NPIs, provider types, and specialties) against the State's records.
5. Sunflower and UnitedHealthcare should prioritize populating KMMS IDs for participating individual, group, and facility providers.
6. Aetna should populate effective and end date fields in its network reports.

Recommendations for Quality Improvement

Recommendations for the KanCare MCOs (Continued)

7. For individuals in a group practice, KanCare MCOs should provide the NPI and KMMS ID of the individual, not the group.
8. Additional methodological detail is needed for the appointment availability and after-hours access provider surveys in all MCO Annual Timeliness Reports. See details under opportunities for improvement.
9. The MCOs should review and enhance their survey caller training and procedure manual specificity, regarding categorization of survey responses and unsuccessful attempt reasons. Review, and improve if needed, surveyor oversight, including inter-rater reliability testing.
10. The State, MCOs, and EQRO should review and discuss the potential variations in survey methodologies that could affect the measures and MCO comparisons, with the State making final determinations regarding methodological changes.

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9. Quality Management Strategy

The KanCare QMS, submitted to CMS on December 9, 2021, includes goals and objectives to improve "performance of our managed care partners and improving the quality of care our KanCare members receive."[14] The EQR activities KFMC completed in the last year, related to goals and objectives in the QMS, are described below in Table 9.1. Additionally, and in accordance with CFR §438.364(a)(4), suggestions for how the State can improve the quality strategy to better support improvement of the quality, timeliness, and access to health care services provided through the KanCare program are listed below.

The State and KFMC developed a QAPI Checklist of MCO requirements, which was implemented during the 2022 QAPI Review KFMC conducted. One item on the QAPI Checklist (#2), requires MCO compliance with the State QMS. See the previous report section, QAPI Review, and Appendix B, 2023 Methodologies: QAPI Review, for more details. Elements of the EQR related to specific goals and objectives of the KanCare QMS are described below.

Table 9.1. KanCare Quality Management Strategy and EQR Activities
Goal #1: Improve the delivery of holistic, integrated, person centered, and culturally appropriate care to all members
Objective 1.2: MCOs will annually submit a cultural competency plan which includes robust elements of a health equity strategy along with all elements required in the contract (5.5.4.B.)
For this objective, the review of the MCO's policies for cultural competency to assess compliance with CFR §438.206(c)(2) Access and Cultural Considerations is also part of the Compliance Review. Each MCO submitted their cultural competency plan for review in the 2022 review; all MCOs were fully compliant with the specified regulation. The case review portion of the Compliance Review assessed MCO and provider member records for compliance with State and federal regulations related to care coordination. One requirement was for the MCO to document primary language and other cultural considerations in the *Service Plan.* KFMC reviewed this element in 2022 and made recommendations to include this information. Two MCOs addressed this recommendation in 2023, and one is still in progress. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of this report for more details.
Goal #2: Increasing employment and independent living supports to increase independence and health outcomes
Objective 2.2: Implement, support and expand the Supports and Training for Employing People Successful (STEPS) pilot program (program begins 07/01/21)

Sunflower's Waiver Employment PIP included an intervention to provide mailed resources to community members to meet employment goals. This was the final year for the PIP.
• The originally planned mailer was replaced with a mailer about the STEPS program.
  ○ The mailer was sent to 1,134 members (16 to 35 years of age) of the 1,266 on the I/DD and PD waiver waiting lists.
  ○ 17 members requested additional information following the mailing.
• See Objective 2.5, and the Performance Improvement Project Validation section of this report for more details.

[14] *KanCare Quality Management Strategy*. State of Kansas, December 9, 2021, www.kancare.ks.gov/quality-measurement/QMS. Accessed April 5, 2023.

Table 9.1. KanCare Quality Management Strategy and EQRO Activities (Continued)
Objective 2.5: Each MCO will implement a Performance Improvement Project (PIP) that addresses SDOH [social determinants of health]

KFMC validated the following PIPs related to the social determinants of health:
• Aetna Food Insecurity, validation rating of 95.6% (High Confidence)
  ○ All five active interventions were implemented.
  ○ 20.8% (20/96) of members reported no longer having food insecurity after self-reporting food insecurity during their initial screen
• Sunflower Waiver Employment
  ○ The validation rating was 94.5% (Confidence)
  ○ Four of five interventions were implemented.
• UnitedHealthcare Housing, validation rating of 96.4% (High Confidence)
  ○ All four interventions were implemented.
  ○ Of 93 members identified as homeless or at risk of homelessness who participated in the Housing Stabilization Fund (HSF), Bridge pilot or SDOH ROT interventions, 77 obtained permanent housing or maintained permanent housing within three months of identification.
For more details, see the Performance Improvement Project Validation section of this report.

Objective 2.6: Increase the rate of completed health screens
As part of the Compliance Review, KFMC reviewed MCO and provider records related to care coordination. Across all MCOs, the number of members with a completed health screen needed to increase in 2021 and 2022. This remains true for 2023. A workgroup comprised of the State, KFMC, and MCOs revised the health screen tool. The MCOs were in the process of implementing the revised tool during the 2022 reporting cycle. KFMC continues to follow up with the MCOs to ensure screening outreach attempts are documented and received updates during the 2023 reporting cycle. • Aetna and Sunflower fully addressed the recommendation by providing work flow and process documentation. • UnitedHealthcare partially addressed the recommendation by providing a detailed narrative response, but no process or work flow.
Objective 2.9 Increase the rate of claims that use of Z codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs
Aetna's Food Insecurity PIP included an intervention regarding Z-code outreach to providers. • A provider education webinar became available July 2021. • See Goal #2, Objective 2.5, and the Performance Improvement Project Validation section of this report for more details.
Goal #4: Removing payment barriers for services provided in Institutions for Mental Diseases (IMD's) for KanCare members will result in improved beneficiary access to Substance Use Disorder (SUD) treatment service specialists
Objective 4.3: Increase peer support utilization for BH services by 10% year over year
In 2023, KFMC administered the ECHO Survey to KanCare adults and children who had utilized mental health services. Of the adult respondents to the survey, 41.3% were told about self-help or support groups (Q20). For more details, please refer to the 2023 KanCare Mental Health Consumer Perception Survey section of this report.
Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)
The PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2022) – Adult Core Set.
Objective 4.6: Develop and implement direct testing or secret shopping activities for provider network validation
KFMC conducted provider network validation calls as part of the 2023 Network Adequacy Validation. For more detail within this report, please see the Network Adequacy Validation section.

Table 9.1. KanCare Quality Management Strategy and EQRO Activities (Continued)
Goal #5: Improve overall health and safety for KanCare members
State QMS Strategy: All MCOs are expected to achieve the National HEDIS 75th Quality Compass percentile for all reported HEDIS data. For HEDIS measures falling below the 75th percentile, the State strategy is aimed at reducing annually, by 10%, the gap between the baseline rate and 100%. Each measure that shows improvement equal to or greater than the performance target is considered achieved. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI. **Objective 5.1:** HbA1c good control (<8.0%) for members with diabetes **Objective 5.2a:** Well-Child Visits first 15 months (effective 2020, W15 became an indicator of W30) **Objective 5.2b:** Well-Child Visits 15–30 months (15-30-month period & name change in 2020) **Objective 5.3a:** Child and Adolescent Well-Care Visits (WCV) ages 3–11 **Objective 5.3b:** Child and Adolescent Well-Care Visits (WCV) ages 12–17 **Objective 5.3c:** Child and Adolescent Well-Care Visits (WCV) ages 18–21
Objective 5.7: Increase rates of selected Adult and Child Core measures by 5% annually: • Breast Cancer Screening (BCS-AD) • Chlamydia Screening in Women (CHL) ages 16 to 24
The PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2022) – Adult Core Set and Table 1.2. HEDIS Performance Measures (Measurement Year 2022) – Child Core Set.

EQRO Suggestions for the State

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

End of written report

Appendix A

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

List of KFMC EQR Technical Reports

Below is a list of reports on the required and optional EQR activities described in 42 CFR 438.358 that have been submitted by KFMC to the Kansas Department of Health and Environment during the 2023 –2024 reporting cycle.

PMV

- Aetna — *2023 Validation and Evaluation of HEDIS MY 2022 Performance Measures of Aetna,* December 11, 2023
- Sunflower — *2023 Validation and Evaluation of HEDIS MY 2022 Performance Measures of Sunflower,* December 11, 2023
- UnitedHealthcare — *2023 Validation and Evaluation of HEDIS MY 2022 Performance Measures of UnitedHealthcare,* December 11, 2023

Performance Improvement Project Validation

- **Aetna**
  - *2023 Evaluation of Aetna,* ***EPSDT*** *PIP (*October 1, 2021, to September 30, 2022), July 6, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Aetna,* ***Pregnancy: Prenatal Care*** *PIP (*January 1, 2022, to December 31, 2022), August 22, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Aetna,* ***Food Insecurity*** *PIP (*April 1, 2022, to March 31, 2023), September 6, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Aetna,* ***LTSS-Emergency Department Visits*** *PIP (*July 1, 2022, to June 30, 2023), November 20, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Aetna,* ***Influenza Vaccination*** *PIP (*July 1, 2022, to June 30, 2023), January 29, 2024; Year 4 PIP evaluation
- **Sunflower**
  - *2023 Evaluation of Sunflower,* ***EPSDT*** PIP *(January 1, 2022, to December 31, 2022),* July 11, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Sunflower,* ***Cervical Cancer Screening*** PIP *(January 1, 2022, to December 31, 2022),* July 31, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Sunflower,* ***Diabetics Monitoring for People with Diabetes and Schizophrenia (SMD)*** PIP *(January 1, 2022, to December 31, 2022),* December 20, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Sunflower,* ***Waiver Employment*** PIP *(April 1, 2022, to March 31, 2023),* August 16, 2023; Year 3 PIP evaluation
  - *2023 Evaluation of Sunflower,* ***Mental Health Services for Foster Care*** PIP *(August 1, 2022, to July 31, 2023),* December 20, 2023; Year 3 (Final year) PIP evaluation

- **UnitedHealthcare**
  - *2023 Evaluation of UnitedHealthcare,* ***EPSDT*** PIP *(January 1, 2022, to December 31, 2022),* July 13, 2023**;** Year 3 PIP evaluation
  - *2023 Evaluation of UnitedHealthcare,* ***Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD)*** PIP, *(July 1, 2022, to June 30, 2023),* October 4, 2023**;** Year 3 PIP evaluation
  - *2023 Evaluation of UnitedHealthcare,* ***Advanced Directives*** PIP *(January 1, 2022, to December 31, 2022),* May 15, 2023**;** Year 3 PIP evaluation
  - *2023 Evaluation of UnitedHealthcare,* ***Housing*** PIP *(September 1, 2022, to August 31, 2023),* December 13, 2023**;** Year 3 PIP evaluation
  - *2023 Evaluation of UnitedHealthcare,* ***Antidepressant Medication Management (AMM)*** PIP *(November 1, 2022, to October 31, 2023),* April 2, 2024**;** Year 2 PIP evaluation
- **Collaborative PIP**
  - *2023 Evaluation of Aetna, Sunflower, and UnitedHealthcare,* ***COVID-19 Collaborative*** PIP *(October 1, 2022, to September 30, 2023),* March 20, 2024; Year 2 PIP evaluation

CAHPS Health Plan 5.1H Survey Validation

- Aetna
  Sunflower
  UnitedHealthcare — *2023 CAHPS Health Plan 5.1H Survey Validation – Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas,* March 21, 2024. The 2023 CAHPS surveys were conducted by each MCO from February through May 2023.

Mental Health Consumer Perception Survey

- KanCare — *2023 KanCare Mental Health Consumer Perception Survey,* February 29, 2024.

Provider Survey Validation

- Aetna — *2023 Provider Satisfaction Survey Validaton*, April 22, 2024. The Aetna survey was administered by the Center for Applied Research and Evaluation (CARE) at Wichita State University's Community Engagement Institute (WSU-CEI).
- Sunflower — *2023 Provider Satisfaction Survey Validaton*, April 22, 2024. The Sunflower survey was administered by the Center for Applied Research and Evaluation (CARE) at Wichita State University's Community Engagement Institute (WSU-CEI).
- UnitedHealthcare — *2023 Provider Satisfaction Survey Validaton*, April 22, 2024. The UnitedHealthcare survey was administered by the Center for Applied Research and Evaluation (CARE) at Wichita State University's Community Engagement Institute (WSU-CEI).

Review of Compliance with Medicaid and CHIP Managed Care Regulations

- Aetna — *2023 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna,* March 5, 2024.
- Sunflower — *2023 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower,* February 15, 2024.
- UnitedHealthcare — *2023 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare,* February 20, 2024 (Revised).

Quality Assessment and Performance Improvement Review

- Aetna — *2023 QAPI Review*, February 5, 2024.
- Sunflower — *2023 QAPI Review*, March 21, 2024.
- UnitedHealthcare — *2023 QAPI Review*, February 29, 2024.

Network Adequacy Validation

- KanCare — *2023 Network Adequacy Validation,* April 24, 2024.

Appendix B

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

2023 Methodologies

The following project methodologies are included in Appendix B:

- PMV and Evaluation
- MH Consumer Perception Survey
- QAPI Review
- Network Adequacy Validation

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

Performance Measure Validation Methods

MetaStar performed validation of the HEDIS MY 2022 performance measures according to CMS Protocol 2 (Validation of Performance Measures), (the Protocol).[1]

Common Among the MCOs

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

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

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

As part of the PMV process and with approval from the State, the HEDIS Postpartum Care indicator of the Prenatal and Postpartum Care (PPC) measure and the BMI Percentile indicator of the HEDIS Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure were reabstracted by MetaStar (30 records per measure for each MCO). MetaStar provided a randomly selected list of cases to the MCOs, and the MCOs provided the medical records for the reabstraction. MetaStar performed the reabstractions prior to the on-site interviews.

Prior to the virtual onsite, KFMC requested member-level files for 25 measures in order to conduct validations, such as comparing figures in the MCO's Information Data Submission System (IDSS) to what resided in the KMMS. The measures requested are used by the State and KFMC for evaluation of the KanCare 2.0 and SUD 1500 Demonstration projects and for the pay-for-performance incentive program. The validations serve three purposes:

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

From the set of all member-level tables, the uniqueness of the Medicaid ID was tested (that is, verifying a Medicaid ID appeared only once per denominator). Within each MCO's records, the relationship between the Medicaid ID and MCO-defined identifiers was examined by checking for Medicaid IDs

[1] Centers for Medicare & Medicaid Services, *CMS External Quality Review (EQR) Protocols*, February 2023, OMB Control No. 0938-0786, Expires December 31, 2025.

associated with multiple MCO-defined identifiers, and vice versa. For records showing the members' names and dates of birth, comparison to the names and dates of birth in KMMS were made. Race and ethnicity codes in KMMS were compared to values from the member-level table for PPC and WCC. The stratified rates for PPC and WCC were determined to be inconsistent with KMMS. Examples of screen shots from KMMS showing members' race and ethnicity were provided to the MCOs during the onsite visits. Following the onsite visits, the MCOs provided corresponding screen shots from their systems and from the 834 files. See section Findings Related to Race and Ethnicity for further discussion.

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

- Measures with December 31, 2021, anchor date
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Annual Dental Visit (ADV)
  - Cervical Cancer Screening (CCS)
  - Chlamydia Screening in Women (CHL)
  - Use of Opioids from Multiple Providers (UOP)
  - Child and Adolescent Well-Care Visits (WCV)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Measures anchored on the second birthday
  - Childhood Immunization Status (CIS)
  - Lead Screening in Children (LSC)
- Measures anchored on the thirteenth birthday
  - Immunizations for Adolescents (IMA)

The eligible population criteria for CIS and LSC are the same. KFMC verified that the two measures had the same populations for each MCO. CIS and IMA denominator criteria were then applied to KMMS demographic and MCO-assignment tables to estimate the denominators. Discrepancies between the member-level tables' denominators and the KMMS-derived denominators were consistent with prior years' findings.

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

KFMC calculated rates for four HEDIS measures from KMMS data and compared results to the MCOs' rates for measurement years 2019 through 2022. For AAP, ADV, and WCV, corresponding rates were within two percentage points for 2022, comparable to prior years. The differences between KFMC-calculated rates and MCO rates were greater for the PPC indicators (not all of the data available to the MCOs for these rates are from claims that are submitted as encounters); however, the differences were relatively consistent between MCOs and between years.

Performance Measure Evaluation Methods

KFMC analyzed data for all HEDIS measures that are CMS Adult or Child Core Set measures to identify strengths and opportunities for improving access, timeliness, and quality of healthcare.

Common Among the MCOs

HEDIS measures may be classified by methods of data collection:

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

For some measures for which either administrative or hybrid rates may be submitted to NCQA, the State required the hybrid methodology but allowed the MCOs to choose either method for the others. Numerator and denominator specifications for the HEDIS measures can be found in the *HEDIS Measurement Year 2022, Volume 2: Technical Specifications for Health Plans.*

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 HEDIS rates to national percentiles for all Medicaid and Children Health Insurance Program health plans made available through NCQA's Quality Compass®. 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 $>95^{th}$. Note that, as QC percentiles are based on HEDIS rates from across the nation, some measures with high scores in Kansas may have very low QC rankings due to high scores nationwide. Due to the COVID-19 pandemic, NCQA advises caution when using MY 2020 data for rate comparisons.

Changes in MCO and KanCare rates and rankings across years 2018 to 2022 were assessed. Amerigroup was included in KanCare aggregations for 2018. Aetna data was included in KanCare rates beginning in 2019, where available (for some measures, Aetna had few or no members meeting continuous eligibility criteria).

For hybrid and CAHPS measures, annual changes between rates and the prior year's rates were tested for statistical significance using Fisher's exact for MCO rates and a weighted Pearson chi-square test for KanCare rates. Within this report, a *significant change* means the differences in rates was statistically

significant with probability (*p*) less than 0.05. Note, statistical tests on administrative rates with very large denominators may report very small changes as statistically significant.

Changes in rates between 2021 and 2022 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 10.00% or more as a threshold. The formula for the gap-to-goal percentage change is:

(2021 Rate – 2020 Rate) / (Goal Rate – 2020 Rate), where Goal Rate is 100% or 0%.

Slopes of trend lines were calculated using the ordinary least-squares method. Depending on data availability, three to five years were trended for KanCare, Aetna, Sunflower, and UnitedHealthcare. The slopes provide the *average rate of change* across the trending period in pp/y. The slopes were tested to see if they were statistically significantly different from horizontal (i.e., significantly different from 0 pp/y) using Mantel-Haenszel chi-square (*p* less than 0.05 was considered significant). Average rates of change of at least 3.0 pp/y were also noted.

Findings Related to Race and Ethnicity

The conversion from the Medicaid Management Information System (MMIS) to KMMS in April 2022 included changing code sets and table structures for race and ethnicity. Review of analyses reported by MCOs in annual PIP reports suggested there were issues with the new codes or their interpretation. Comparison of HEDIS member-level detail tables to KMMS data showed inconsistencies in the stratification of 2022 HEDIS rates by race and ethnicity. In response, KFMC reviewed documentation from the State and compared race and ethnicity coding of specific members from Medicaid Management Information System, KMMS, and MCO systems as part of the 2023 ISCA/PMV.

Federal Policy

Two federal policies guide the collection and reporting of race and ethnicity coding for Medicaid reporting. The primary policy is the 1997 revision of the Statistical Policy Directive No. 15.[2] This policy of the Office of Management and Budget (OMB) specifies five minimum race categories and two minimum ethnicity categories (see inset). The policy encourages collection of additional categories provided they may be aggregated into these minimum categories. Also, whenever feasible, race and ethnicity should be collected separately, with ethnicity collected first, and respondents should be allowed to select multiple races.

OMB Minimum Race Categories
A=American Indian or Alaska Native
B=Black
P=Native Hawaiian or Pacific Islander
S=Asian
W=White

OMB Minimum Ethnicity Categories
H=Hispanic or Latino
N=Not Hispanic or Latino

The second policy is the Department of Health and Human Services (HHS) guidance on data collection standards.[3] The HHS guidance specifies the collection of additional race and ethnicity categories that aggregate into the OMB minimum categories. The additional codes subdivided the Asian, Native

[2] Office of Management and Budget. *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity*. Federal Register; Volume 62; No. 210; October 30, 1997.

[3] Department of Health and Human Services (2011). *HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status*. Available at: https://aspe.hhs.gov/reports/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-disability. Downloaded October 17, 2023.

Hawaiian or Pacific Islander, and Hispanic or Latino categories. Other OMB policy requirements that were previously incorporated into HHS policy were retained.

By August 2013, the additional race and ethnicity codes were incorporated into KanCare member applications. Additional revisions to the applications were completed as part of updates to Kansas's alternative single streamlined online and paper applications that were approved by CMS in July 2020.[4]

Pre-conversion

Race and ethnicity were captured on the Kansas Medical Assistance Program (KMAP) application forms during enrollment and stored in the Kansas Eligibility Enforcement System. The race and ethnicity sections of the current online and paper applications are shown in Figures B1 and B2. Except for the "Other" race, the categories on the online form conform to the HHS guidelines. The paper version also has a few deviations. Most importantly, the paper version does not have an option for the member to indicate non-Hispanic ethnicity.

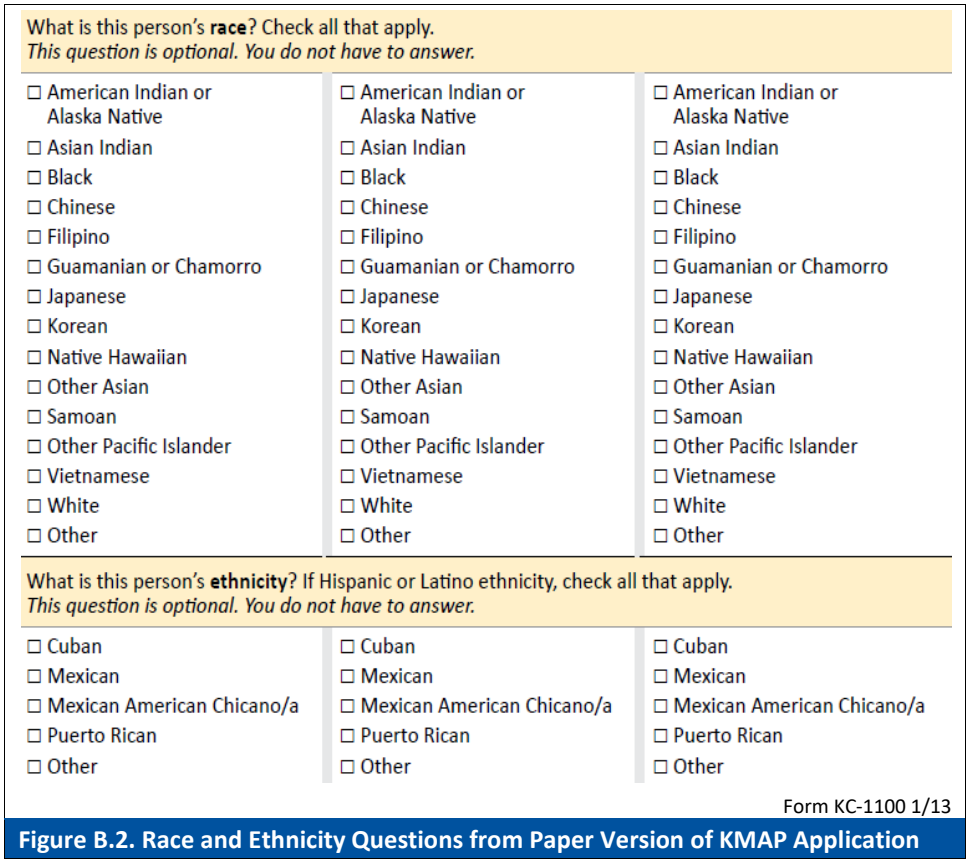
Figure B.1. Race and Ethnicity Questions from Online Version of KMAP Application

The race and ethnicity codes were submitted to the MCOs on the 834 enrollment files as a single element with the two codes delimited by a carat (^). The MCOs' claims systems displayed the codes in separate race and ethnicity fields.

[4] KS – Submission Package – KS2019MS0006O – (KS-19-0023) – Eligibility. Downloaded 10/12/2023 from https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html.

Post-conversion

The KMMS system went live in April 2022. Although members have the option of marking multiple ethnic groups on the application, only one ethnicity code is stored on the member's demographic record in the case management module of KMMS (the module from which the 834 files are derived). Up to five race codes are stored in a child table of the case management module. The race codes are stored without a hierarchical order or designation of primary race.



What is this person's **race**? Check all that apply.
This question is optional. You do not have to answer.

☐ American Indian or Alaska Native	☐ American Indian or Alaska Native	☐ American Indian or Alaska Native
☐ Asian Indian	☐ Asian Indian	☐ Asian Indian
☐ Black	☐ Black	☐ Black
☐ Chinese	☐ Chinese	☐ Chinese
☐ Filipino	☐ Filipino	☐ Filipino
☐ Guamanian or Chamorro	☐ Guamanian or Chamorro	☐ Guamanian or Chamorro
☐ Japanese	☐ Japanese	☐ Japanese
☐ Korean	☐ Korean	☐ Korean
☐ Native Hawaiian	☐ Native Hawaiian	☐ Native Hawaiian
☐ Other Asian	☐ Other Asian	☐ Other Asian
☐ Samoan	☐ Samoan	☐ Samoan
☐ Other Pacific Islander	☐ Other Pacific Islander	☐ Other Pacific Islander
☐ Vietnamese	☐ Vietnamese	☐ Vietnamese
☐ White	☐ White	☐ White
☐ Other	☐ Other	☐ Other

What is this person's **ethnicity**? If Hispanic or Latino ethnicity, check all that apply.
This question is optional. You do not have to answer.

☐ Cuban	☐ Cuban	☐ Cuban
☐ Mexican	☐ Mexican	☐ Mexican
☐ Mexican American Chicano/a	☐ Mexican American Chicano/a	☐ Mexican American Chicano/a
☐ Puerto Rican	☐ Puerto Rican	☐ Puerto Rican
☐ Other	☐ Other	☐ Other

Form KC-1100 1/13

Figure B.2. Race and Ethnicity Questions from Paper Version of KMAP Application

Through 2022, each MCO only stored the first code on the segment. The description of that race/ethnicity was displayed in claims management front-end systems in one of two fields, race or ethnicity. Consequently, only one race/ethnicity was mapped into the HEDIS systems to stratify MY 2022 results by race and ethnicity.

During 2023, the MCOs began storing all race/ethnicity codes on the 834 enrollment segments so that they will be available for stratifying MY 2023 HEDIS measures.

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For submission to the MCOs via the 834 enrollment files, the HHS categories were crosswalked into a "HIPAA" code set (see Figure B3). The most frequently used categories (White and Black or African American) were subdivided into categories indicating both race and ethnicity. For example, both HIPAA codes C=Caucasian and O=White (Non-Hispanic) were used to indicate members with White race, depending on whether the member had an ethnicity code indicating Hispanic ethnicity (codes U, C, A, M, or P) or not (codes N or E). Race codes within the OMB category S=Asian were collapsed into A=Asian or Pacific Islander; codes within OMB category P=Native Hawaiian or Pacific Islander were collapsed into J=Native Hawaiian and P=Pacific Islander. OMB category A=American Indian or Alaska Native mapped directly into I=American Indian or Alaskan Native.

Race and Ethnicity HIPAA Crosswalk

MMIS code	MMIS Description	Ethnicity codes	HIPAA code	HIPAA description
01	White	N, E	O	White (Non-Hispanic)
01	White	U, C, A, M, P	C	Caucasian
04	Other Asian		A	Asian or Pacific Islander
05	American Indian		I	American Indian or Alaskan Native
06	Filipino		A	Asian or Pacific Islander
07	Black or African American	N, E	N	Black (Non-Hispanic)
07	Black or African American	U, C, A, M, P	B	Black
09	Chinese		A	Asian or Pacific Islander
10	Cambodian		A	Asian or Pacific Islander
11	Japanese		A	Asian or Pacific Islander
12	Korean		A	Asian or Pacific Islander
13	Samoan		P	Pacific Islander
14	Asian Indian		A	Asian or Pacific Islander
15	Native Hawaiian		J	Native Hawaiian
16	Guamanian or Chamorro		P	Pacific Islander
17	Laotian		A	Asian or Pacific Islander
18	Vietnamese		A	Asian or Pacific Islander
19	Other		E	Other Race or Ethnicity
20	Unknown		7	Not Provided
21	Other Pacific Islander		P	Pacific Islander
		U, C, A, M, P	H	Hispanic

Ethnicity Code Descriptions:
N = Not of Hispanic, Latino/a, or Spanish origin; C = Cuban; M=Mexican, Mexican American, Chicano/a; P = Puerto Rican
A = Hispanic, Latino/a, or Spanish origin; E = Not Specified; U = Hispanic or Latino Unknown

Source: Gainwell Technologies. *KMMS KanCare Guide Code Tables*, Version 1.54, August 10, 2023, Page 147.

Figure B3. Race and Ethnicity Code Crosswalk

Ethnicity codes within the OMB category Hispanic or Latino were mapped to H=Hispanic. Two non-OMB codes used in KMMS were also crosswalked (Other race into E=Other Race or Ethnicity and Unknown race into 7=Not Provided).

Although not shown on the crosswalk, specific cases were observed where ethnicities N=Not of Hispanic, Latino/a, or Spanish origin and E=Not Specified were mapped into 7=Not Provided.

Currently, the 834 enrollment files can convey one ethnicity and five race HIPAA codes on the race/ethnicity segment. Examples observed while comparing screen shots from KMMS and 834 segments from MCOs are shown in Figure B4. The first two and last two examples indicate that the codes on the 834 segments are not placed in a consistent order.

Example	MMIS Race(s)	MMIS Ethnicity	834 Codes
1	01 = White	N = Not Hispanic or Latino	O^7
2	01 = White	N = Not Hispanic or Latino	7^O
3	01 = White	M = Mexican	H^C
4	07 = Black or African American	N = Not Hispanic	N^7
5	07 = Black or African American	A = Another Hispanic or Latino	H^B
6	05 = American Indian	M = Mexican	H^I
7	05 = American Indian	N = Not Hispanic or Latino	I^7
8	20 = Unknown	M = Mexican	7^H
9	07 = Black or African American 01 = White	U = Hispanic or Latino Unknown	B^C^H
10	01 = White 05 = American Indian 06 = Filipino	M = Mexican	A^C^I^H
11	01 = White, 07 = Black or African American, 05 = American Indian	M = Mexican	C^B^I^H

Figure B4. Race and Ethnicity Code Crosswalk Examples

Issues

The crosswalk did not distinguish between N = Not Hispanic or Latino (i.e., the member indicated Not Hispanic or Latino on the online form) and E = Not Specified (i.e., the member opted not to mark any box). This directly impacts stratified HEDIS rates since the two codes would be placed into different HEDIS stratum.

The meaning of the ethnicity code U=Hispanic or Latino Unknown is unclear. The crosswalk table suggests it means "the member is known to be Hispanic or Latino, but we don't know if they are Mexican, Cuban, Puerto Rican, or Other." However, the description "we don't know if the member is Hispanic or Latino" was found to be more consistent with cross-tabular counts comparing March 2022 Medicaid Management Information System data to April 2022 KMMS.

The MCOs' user-interface screens viewed at the onsite visits displayed the HIPAA descriptions provided in the crosswalk table, which do not accurately describe the data. The applications did not indicate to the users that "Caucasian" and "Black" meant "White (Hispanic)" and "Black (Hispanic)." Furthermore, none of the MCOs used codes for Caucasian or Black to indicate Hispanic or Latino ethnicity in the HEDIS systems for MY 2022, which indicates there was insufficient documentation or training for back-end users.

The benefits of subdividing White into White (Non-Hispanic) and Caucasian were frequently lost when the MCOs read only one code into their systems. In Example 1, the first code of "O^7" indicates the member was White and Not Hispanic or Latino. However, if the member had been coded "7^O" like in Example 2, the MCO would only know the member was Not Hispanic or Latino.

Due to these issues, the MCOs' rates for HEDIS measures stratified by race and ethnicity were not valid.

Findings Related to Encounters Validation

The quantity billed for Current Procedural Terminology code A0425 by UnitedHealthcare did not reflect miles traveled on encounters for ambulance service claims; encounters for trips by commercial van appeared to be underreported.

Comparisons between MCOs of transportation claims found two inconsistencies. First, UnitedHealthcare was not capturing the number of miles traveled for trips by ambulance (procedure codes A0426–A0425). That is, for almost 100% of UHC-paid claims for ambulance service, the quantity billed on service lines with procedure code A0425 indicated only one mile was travelled; the percentage for the other two MCOs was less than 15%. Second, UnitedHealthcare paid less than 200 trips by commercial van (codes T2003 and T2005) in the last two years; the other two MCOs each had over 50,000 trips.

Findings Related to Performance Measure Validation and Evaluation

Prior to submitting the performance measure validation and evaluation reports to the State, draft reports were provided to the State and to each MCO for feedback regarding any errors or omissions.

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

Survey Instruments

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

The adult survey instrument used in 2021 was a version adapted by the vendor from the originally developed ECHO questionnaire. In 2022, the original ECHO survey tool was used, which added 25 questions to the adult survey. Trending is not available from 2021 to 2022 for the questions added to the 2022 tool.

KFMC contracted with Press Ganey (formally SPH Analytics) to administer the Kansas ECHO Survey. Press Ganey is a certified CAHPS® vendor with experience administering the ECHO Survey since its development.[2] Press Ganey also processed and analyzed the data and provided the final reports upon which this summary report is based. KFMC created the sample frames and provided them to Press Ganey.

Survey Population and Sampling Process

Members eligible to receive the survey were adult (ages 18 or older) and child (ages 17 or younger, family responding) populations enrolled in KanCare and residing in Kansas on the date of sample selection (June 15, 2023), continuously enrolled during the measurement period (June 1, 2022, through May 31, 2023), and who had received one or more mental health or substance use disorder services through one of the three MCOs during the measurement period.[3] See Table A-1 for the method of identifying mental health and substance use disorder services. A total of 28,029 adult members and 35,805 child members met the criteria. The sample frames were pulled from the June 2023 Medicaid Enrollment file, which included enrollment and demographic data (such as member name, age, phone number, and mailing address).

After receiving the sample frame files from KFMC, Press Ganey implemented a process of deduplication of the sample frames. The sample frames were deduplicated to one record per household. To improve response rates, members whose household received the most recent Sunflower Health Plan ECHO Survey (also administered by Press Ganey) were then removed. The resulting files included 16,682 eligible adult and 18,660 eligible child members.

[1] https://www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html
[2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ)
[3] Age is calculated as of May 31, 2023. "Continuous enrollment" allows one gap of up to 45 days during the measurement period but requires enrollment on May 31, 2023.

The minimum number of survey responses required to obtain a 95% confidence level with a 5% margin of error was calculated for the adult (382) and child (382) populations. Samples were selected for the adult and child populations using simple random sampling. Surveys were mailed to 13,100 KanCare members, representing 5,550 adult and 7,550 child members.

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

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

Survey Protocol

The survey methodology employed a mail-only distribution process consisting of a one-wave mail protocol. A survey with a cover letter and postage-paid return envelope was mailed to each adult in the sample and to the parent or guardian of each child in the sample. The cover letter provided an internet Uniform Resource Locator (URL), username, and password, so the member (or parent/guardian) could take the survey online, if desired. The tasks and timeframes employed were based on the standard National Committee for Quality Assurance (NCQA) protocol for administering surveys. Surveys were mailed August 09, 2023.

The cover letters for the 2023 Adult and Child ECHO Surveys included language in both English and Spanish; all mailed surveys were in English.

Survey Response Rates

A total of 917 valid surveys were returned: 460 adult surveys and 457 child surveys. Of the adult surveys received, 400 were completed by mail, and 60 were completed via the URL provided (59 in English, 1 in Spanish). For the child surveys, 360 were received by mail and 97 surveys were completed online (87 in English, 10 in Spanish). The adjusted response rates for the adult and child populations were 8.8% and 6.4%, respectively. A total of 791 surveys were undeliverable (343 adult and 448 child).

Data Processing and Analysis

Press Ganey processed all completed surveys and analyzed the results.

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

Impact of the COVID-19 Pandemic

The pandemic did not impact the administration of this survey. However, the pandemic has affected mental health and access to services, both of which are factors in determining who was eligible to be surveyed. Comparing survey results between years should therefore be done with caution.

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Quality Assessment and Performance Improvement Review

MCO Documents Reviewed

For this review, KFMC assessed the following documents submitted from the MCOs for compliance with the State Contract QAPI elements:

- Common to the MCOs:
  - *2022 Member Satisfaction Survey – A Collaborative Point in Time Convenience Survey of Member Using Substance Use Disorder (SUD) Services* (Aetna, Sunflower, and UnitedHealthcare)
  - Follow-up to previous KFMC recommendations (Aetna – 2022; Sunflower – 2021 and 2022; and UnitedHealthcare – 2019 and 2022)
- Aetna:
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement Program Evaluation January – December 2022* (hereafter referred to as *2022 QAPI Program Evaluation*)
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement 2023 Program Description* (hereafter referred to as *2023 QAPI Program Description*)
  - *2023 Aetna QAPI Work Plans* dated May 31 and November 30, 2023 (hereafter referred to as *2023 QAPI Work Plans*)
  - *Aetna Annual Assessment of Network Adequacy 2022 – Monitor and improve access to non-behavioral health behavioral healthcare services*
  - *Aetna Better Health of Kansas CHIP Child Population 2023 (MY 2022)* CAHPS® *5.1H Medicaid with CCC Measure Member Experience Survey*
  - *Aetna Better Health of Kansas Adult Population 2023 (MY2022)* CAHPS® *5.1H Medicaid Member Experience Survey*
  - *Aetna Better Health of Kansas Child Population 2023 (MY2022)* CAHPS® *5.1H Medicaid with CCC Measure Member Experience Survey*
  - *Aetna 2022 Long Term Services and Supports Program Evaluation*
  - *2023 MCO Provider Satisfaction Survey Aetna November 2023*
  - *Annual Assessment of Network Adequacy 2022 – Monitor and improve access to non-behavioral health and behavioral healthcare services Provider Engagement March 5, 2023*
  - *Aetna Better Health of Kansas 2023 QAPI Checklist*
- Sunflower:
  - *Sunflower Health Plan 2022 Quality Improvement Program Evaluation, Report Period January 1, 2022 – December 31, 2022* (hereafter referred to as *2022 QAPI Program Evaluation*)
  - *Sunflower Health Plan 2023 Quality Program Description* (hereafter referred to as *2023 QAPI Program Description*)
  - *Sunflower Health Plan 2023 QAPI Work Plans* dated May 31 and November 30, 2023 (hereafter referred to as *2023 QAPI Work Plans*)
  - *Sunflower Health Plan 2023 QAPI Checklist*
- UnitedHealthcare:
  - *2022 Quality Improvement & Population Health Management Annual Evaluation Report – UnitedHealthcare Plan of Midwest, Inc. (UnitedHealthcare Community Plan of Kansas) [Date Completed: March 9, 2023, QMC* [Quality Management Committee] *Committee Approval: March 27, 2023]* (hereafter referred to as the *2022 QAPI Evaluation*)
  - *2023 UnitedHealthcare QAPI Work Plans* dated May 31 and November 30, 2023 (hereafter referred to as *2023 QAPI Work Plans*)

- *QIPD2023 Quality Improvement and Population Health Management Program Description UnitedHealthcare Plan of Midwest, Inc. (UnitedHealthcare Community Plan of Kansas)* dated March 2023 (hereafter referred to as *2023 QAPI Program Description*)
- *Population Health Management Annual Attachment - UnitedHealthcare of the Midwest, Inc. (UnitedHealthcare Community Plan of Kansas*) dated January 6, 2023
- *My Community Connections SDOH Monthly Report Kansas C&S UnitedHealthcare (Duals and Non-Duals) – Issue 2 | July - 2022 | VOLUME 1* and *Issue 3 | August - 2022 | VOLUME 1*
- *UnitedHealthcare Community Plan of Kansas Long-Term Services & Support Care Management Program Evaluation* dated May 2023
- *UnitedHealthcare Community Plan of Kansas Long-Term Services & Support Care Management Program Description* dated March 13, 2023
- *Healthcare Quality and UM* [Utilization Management] *Committee (HQUM) – UHC Community Plan of Kansas Meeting Minutes* (Quarters 1-4, 2023)
- *Quality Management Committee (QMC) – UHC Community Plan of Kansas Meeting Minutes* (Quarters 1-4, 2023)
- *Service Quality Improvement Sub-Committee (SQIS) – UHC Community Plan of Kansas Meeting Minutes* (Quarters 1-4, 2023)
- *UnitedHealthcare 2022 Complex Case Management (CCM) Satisfaction Survey*
- *UnitedHealthcare 2022 Health First Steps (HFS) Satisfaction Survey*
- *2023 MCO Provider Satisfaction Survey UnitedHealthcare November 2023*
- *UnitedHealthcare Attachment A – PHM Program and Services*
- *UnitedHealthcare Community Plan of Kansas C&S Care Model Program Description* dated January 2023
- *Attachment B: National & Regional Committees*
- *Attachment 2 – 2022 Segmentation Worksheet UnitedHealthcare Community Plan of Kansas*
- *UnitedHealthcare National Quality of Care Reports* dated July 1, through December 31, 2022, and January 1 through June 30, 2023
- *2022 UnitedHealthcare QAPI Work Plans* dated May 31 and November 30, 2022 (hereafter referred to as *2022 QAPI Work Plans*)
- *UnitedHealthcare Community Plan of Kansas 2023 QAPI Checklist*
- *UnitedHealthcare Community Plan of Kansas Quality Improvement and Population Health Management Program Description* dated March 2022 (hereafter referred to as *2022 QAPI Program Description*)

Required QAPI Reporting Elements from the KanCare Quality Management Strategy (QMS)

From the January 2022 KanCare QMS, the State advised (May 6, 2022) the MCOs are to report on the following elements in their QAPI Program Description and QAPI Program Evaluation:

- Objective 4.5: Achieve the National HEDIS® 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)
- Objective 5.1: HbA1c good control (<8.0%) for members with diabetes
- Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)
- Objective 5.2b: Well-Child Visits 15-30 months (15-30-month period & name change in 2020)
- Objective 5.3a Child and Adolescent Well-Care Visits (WCV) ages 3-11
- Objective 5.3b Child and Adolescent Well-Care Visits (WCV) ages 12-17
- Objective 5.3c Child and Adolescent Well-Care Visits (WCV) ages 18-21

Per the State, "All MCOs are expected to achieve the HEDIS 75th QC percentile for all reported HEDIS data. HEDIS measures falling below the 75th percentile the State has devised the following strategy aimed at reducing annually, by 10%, the gap between the baseline rate and 100%. For example, if the baseline rate was 55%, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5%. Each measure that shows improvement equal to or greater than the performance target is considered achieved. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI."

MCO QAPI Requirements

In 2023, the State and KFMC met on April 11 and 17, and May 15, to discuss the items on the *QAPI Checklist* and determine what changes needed to be made to the requirements for the MCOs. On June 22, 2023, the State and KFMC met with the MCOs, presented the changes, and provided the new *QAPI Checklist* (included in this appendix, see page B-16). The State informed the MCOs of the expectation that the *QAPI Checklist* changes are to be incorporated, by the MCO, into the QAPI documents as follows:

- *2023 QAPI Work Plan* due from the MCOs November 30, 2023: The State determined there was not enough time for the MCOs to make the changes to the *2023 QAPI Work Plan* that was due May 31, 2023. Therefore, if the required items were not included in the QAPI work plan dated November 30, 2023, it would result in non-compliance and a recommendation would be made.
- *2023 QAPI Evaluation* (due from the MCOs April 29, 2024) and *2024 QAPI Program Description* (due from the MCOs August 31, 2024): The State determined there was not enough time for the MCOs to make the changes to the *2022 QAPI Evaluation* due April 29, 2023, and the *2023 QAPI Program Description* due August 31, 2023. Therefore, if the required items are not included in the *2022 QAPI Evaluation* (reviewed in the 2023 review) and *2023 QAPI Program Description* (reviewed in the 2023 review), it will result in suggested enhancements being made with the notation that if the items are not included in the *2023 QAPI Evaluation* and *2024 QAPI Program Description* (reviewed in the 2024 review), it will result in recommendations being made.

QAPI Compliance Rating

The 2023 compliance rating was determined by the following:

- If the requirement was included in at least one of the QAPI documents, and fully met, it is considered compliant for the 2023 review.
- If the requirement is expected to be in the QAPI work plan (per the expectations outlined in the *QAPI Checklist*), it must be included and fully met for the requirement to be compliant.

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QAPI Checklist

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
1.	Tracking the reason for disenrollment	5.2.2 Disenrollment – second Letter B, Number 2	**1. Is there evidence in the MCO QAPI Program that they are monitoring and reviewing disenrollment trends?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
2.	MCO Compliance with the State's QMS	5.9.1 General Requirements – Letter A	**1. Does the MCO acknowledge its intent to abide by the requirements of the State's QMS?** **2. Is there evidence that the QMS is reviewed at least annually, including the MCO's compliance of the State QMS?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
3.	Collected and reported performance measure data for members receiving LTSS	• 5.9.1 General Requirements – Letter D • CFR §438.330(b)(2) and (c)(1)(i-ii)	**1. Is there evidence that the MCO collects and reports performance measurement data, including performance measures for Members receiving LTSS related to:** • Quality of life • Rebalancing (definition and/or examples) Long-term Services and	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Supports (LTSS) Rebalancing Toolkit Fact Sheet | CMS • Community integration activities Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
4.	Detection of underutilization and overutilization of services	• 5.9.1 General Requirements – Letter E • CFR §438.330(b)(3)	**1. Is there evidence that the MCO has a mechanism to detect both underutilization and overutilization of services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
5.	For members receiving LTSS, mechanisms used to compare services and supports received with those in the member's treatment/service plan	• 5.9.1 General Requirements – Letter F • CFR §438.330(b)(5)(i)	**1. Is there evidence that the MCO has a mechanism to compare services and supports received with those set forth in the Member's treatment/service plan for individuals enrolled in LTSS Waivers (Home and Community Based Services)?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
6.	Mechanisms to ID members enrolled in LTSS waivers but not receiving waiver services	5.9.1 General Requirements – Letter G	**1. Is there evidence that the MCO has a mechanism to identify Members who are enrolled in LTSS Waivers but who are not receiving any waiver services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
7.	Mechanisms to ID and address BH service needs and ensure Members receive the approved BH services	5.9.1 General Requirements – Letter H	**1. Is there evidence that the MCO has a mechanism to identify BH service needs of Members?** **2. Is there evidence that the MCO ensures that Members receive approved BH services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
8.	For Members receiving SCHN, mechanisms to assess quality and appropriateness of care	• 5.9.1 General Requirements – Letter I • CFR §438.330(b)(4)	**1. Is there evidence that the MCO has a mechanism to assess quality and appropriateness of care for Members receiving SHCN?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
9.	For members receiving LTSS, mechanisms to assess the quality and appropriateness of care, including assessment of care between settings	• 5.9.1 General Requirements – Letter J • CFR §438.330(b)(5)(i)	**1. Is there evidence that the MCO has a mechanism in place to assess the quality and appropriateness of care for members that receive LTSS?** **2. Is there evidence that the MCO has a mechanism to assess the quality and appropriateness of care between settings for LTSS services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • Member Survey for members receiving LTSS services • Credentialling and peer review of providers • Readmission rate of LTSS members	
10.	Adverse/Critical Incidents	• 5.9.1 General Requirements – Letter K • CFR §438.330(b)(5)(ii)	**1. Is there evidence that the MCO participates in efforts to prevent, detect, and remediate critical incidents, including identifying, tracking, and reviewing critical incidents to address potential and actual quality of care and/or health and safety issues?**	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: Report in the QAPI documents how the MCO tracks critical incidents and addresses issues identified.	
11.	For members receiving LTSS, results of efforts to support community integration reported to the State	5.9.1 General Requirements – Letter L	**1. Does the MCO report in the QAPI Evaluation (or LTSS Program Evaluation), at a minimum, the efforts to support community integration from Members using LTSS?** Documents Expected at a Minimum: QAPI Evaluation and/or LTSS Program Evaluation, QAPI Program Description and/or LTSS Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: Detail MCO activities that support community integration specifically for those members using LTSS.	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
12.	Evaluation of the impact and effectiveness of the MCO's QAPI	5.9.1 General Requirements – Letter M	**1. Is there evidence that the MCO has a process to evaluate the impact and effectiveness of the QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • In the MCO QAPI Evaluation, include details of the impact and effectiveness of the QAPI program. • In the QAPI Program Description, MCO detail a process to evaluate the impact and effectiveness of its QAPI program. • In the QAPI Work Plan, MCO detail activity/ activities to evaluate the impact and effectiveness of its QAPI program.	
13.	Structure and staffing for QAPI	5.9.1 General Requirements – Letter N.1-4 (N4: Related NCQA Quality Improvement Committee Responsibilities, see related NCQA Annual Evaluation Guidelines and Program Description Requirements)	Review for evidence of the following: **1. The MCO has a QAPI unit within its organizational structure that is separate and distinct.** **2. The MCO employs sufficient, qualified staff and utilizes appropriate resources to achieve quality Outcomes.** **3. The MCO ensures the Chief Medical Officer (CMO) is responsible for oversight of the QAPI program.**	

QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
			e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		4. The MCO has an established Quality Committee Structure from the Board of Directors down to the local health plan that includes committees to address: **a. Quality management/quality improvement** **b. Service** **c. Delegation oversight** **d. Credentialing/recredentialing** **e. Peer review** **f. Member Advisory** **g. Subcommittees to address children or other special populations, as appropriate.** **5. All committees have a charter outlining the role, responsibility, membership and meeting frequency** **6. Membership of committees includes an appropriate mix of community Providers, Members and caregivers reflective of the services delivered and populations served.** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • QAPI Program Description to include a description of the QAPI organization	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			structure, including descriptions of the committees. • QAPI Evaluation to include any challenges or successes with the committees and staffing within the MCO. • QAPI Work Plan to include the committees and meeting timeframes/frequency. • The MCO to include a description of the various committees with their roles, responsibilities, membership, and meeting frequency.	
14.	Annual MCO QAPI work plan	• 5.9.1 General Requirements – Letter N.5 • Related NCQA QI Committee Responsibilities • Related NCQA QAPI Work Plan and Annual Evaluation Guidelines	**1. Is a current work plan(s) included in the submission?** **2. Does the work plan(s) include QAPI activities and a timeline for completion?** <u>Document Expected at a Minimum</u>: QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: The State/KFMC would not expect to see details of the QAPI Work Plan in the QAPI Program Description or QAPI Evaluation. The State expects the MCO to show whether the activity has been completed or continues to be in progress.	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
15.	Annual MCO QAPI evaluation	• 5.9.1 General Requirements – Letter N.6 • CFR §438.330(e)(1-2) • See related NCQA QAPI Work Plan Guidelines and NCQA Annual Evaluation Guidelines	**1. Is a current evaluation included in the submission?** **2. Is there evidence that the evaluation includes findings and recommendations that were used to shape the annual QAPI program description and QAPI Work Plan?** **3. Does the evaluation assess the extent that the MCO met its goals and objectives?** **4. Does the evaluation include recommendations for continuous quality and service improvement?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: Completion of the QAPI Evaluation should be included in the QAPI Program Description and should include the elements listed. The opportunities, as identified in the QAPI Evaluation, should be addressed in the subsequent year's QAPI Program Description and QAPI Work Plan.	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
16.	Integration and infusion of State identified guiding principles	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letter A.1-11 A. The CONTRACTOR(S) shall adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors: 1. Promote an organizational culture focused on continuous quality improvement, innovation, and service excellence at all levels of quality program design and implementation. 2. Empower staff excellence through hiring those who are Medicaid experienced and knowledgeable and investing in their development through relevant ongoing training, education, and mentorship. 3. Harness data from information systems and engage data analytic approaches to produce actionable information, which is consistent, timely, valid, and reliable and supports evidence-based decision making. 4. Utilize Rapid-Cycle Process Improvement methods to quickly identify, analyze and resolve operational inefficiency, improve the quality of care and improve the Member and Provider experience. 5. Focus on achieving year-over-year quantitative and qualitative improvements.	**1. Is there evidence of the Guiding Principles as listed in the State Contract, in at least one of the QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • The guiding principles do not need to be word for word or listed as guiding principles in the QAPI documents. This could be evidenced by the MCOs description of their QAPI programs throughout the documents. • The guiding principles should be consistent through all QAPI documents.	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		6. Implement a system of measurement and monitoring to assure the health, safety, and welfare of Members. 7. Pursue innovative approaches, including the use of telehealth, e-visits and alternative payment arrangements, to expand access to quality care and services. 8. Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members. 9. Maximize the quality of life of all Members by addressing Social Determinants of Health and Independence and through delivery of culturally appropriate, integrated, holistic, evidenced based care and services. 10. Promote the highest level of independence, dignity, productivity and community inclusion or preservation and maintenance of dignity, privacy and individuality based on Member and representative choice, rights and goals of care. 11. Use person-centered models to collaborate with Members, caregivers, and family to achieve the highest level of Member self-actualization and success.		

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
17.	Incorporation of the State identified goals	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letter B.1-6 B. The CONTRACTOR(S) shall adopt, at a minimum, the following goals within its QAPI program. The CONTRACTOR(S) shall respond to how these goals will be incorporated into its QAPI program and into those of its delegates and Subcontractors: 1. The CONTRACTOR(S) shall develop performance measurement and performance improvement strategies to maximize health Outcomes and the quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports. 2. The CONTRACTOR(S) shall promote the highest level of Member independence, productivity, Wellness and functional ability in the most integrated and least restrictive setting through harnessing data to monitor and ensure the delivery of holistic, integrated, person-centered, and culturally appropriate care to all KanCare populations. 3. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Members, family	**1. Is there evidence the MCO's goals include the specified goals in the State Contract?** **2. Are the goals consistent through all QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • Within the MCO's listed goals, the goals as listed in the State contract need to be included. • The goals do not need to be word for word and the MCO can include more, MCO specific goals. • The goals should be consistent through all QAPI documents.	

QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
			e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
	members of Members, caregivers and other stakeholders in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance. 4. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Providers, community-based organizations, Subcontractors and other network partners in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance. 5. The CONTRACTOR(S) shall use innovative strategies to improve access to and availability of services through the development of strong collaborative partnerships with Providers, Subcontractors and other network partners. 6. The CONTRACTOR(S) shall employ strategies to evaluate the ongoing efficiency and effectiveness of its Participating Providers and adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and services to all Members.		

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
18.	State identified seven objectives to meet established QAPI goals	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letters A.8 and C.1-7 A. Adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors: 8. Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members. C. Respond to how it will incorporate the following objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals: 1. Collect complete and accurate data on Members and Providers regarding service processes and Outcomes furnished through robust collection, analysis and reporting of data. 2. Maintain staff with the capacity and capability to provide and describe Kansas specific data at every level of collection, analysis, and reporting by the Plan, as well as, Participating Providers and vendors. 3. Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.	**1. Is there evidence the MCO's objectives include the specified objectives in the State Contract?** **2. Are the objectives consistent through all QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • Within the MCO's listed objectives, the objectives, as listed in the State contract, need to be included. • The objectives do not need to be word for word and the MCO can include more MCO specific objectives. • The objectives should be consistent through all QAPI documents.	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		4. Deploy Rapid-cycle Quality Improvement principles throughout the organization. 5. Develop strong Provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered. 6. Adopt strategies to collect and integrate experience of care and satisfaction data from Members, caregivers, Participating Providers, and other network partners into the QAPI program. 7. Drive collaboration and innovation internally, across business units and externally with Members, caregivers, Participating Providers, stakeholders and community- based entities.		
19.	Performance Measures	• 5.9.4 Performance Measures – General Requirements and letters A-B • CFR §438.330(c)(2) • See related NCQA Data Collection Requirements • NCQA Requirements for MCO Practitioner/Provider Contracts Goal 5: Objective 5.7 State required Medicaid Child Core Measure Sets to be reported in the QAPI Program Description and QAPI Evaluation: • *Breast Cancer Screening (BCS-AD)*	**1. Is there evidence the MCO uses performance measure data in a rapid-cycle fashion to improve the integration of physical, behavioral, and LTSS service delivery and improve access and availability of LTSS and Behavioral Health Providers?** **2. Is there evidence the MCO uses data to improve the quality of care and services delivered to all populations?** **3. Does the MCO report in the QAPI Program Description and QAPI Evaluation, the State required Medicaid**	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		• *Chlamydia Screening in Women ages 16 to 24 (CHL)*	**Child Core Measure Sets (i.e., Breast Cancer Screening and Chlamydia Screening in Women ages 16 to 24)?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
20.	Clinical and Non-clinical PIPs	• 5.9.1 General Requirements – Letters B.1-2 and C • 5.9.5 Performance Improvement Projects – General Requirements and A-J • CFR §438.330(a)(1-2) and (b)(1)	**1. Is there evidence the MCO incorporates the PIPs and results into the QAPI program?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: For the QAPI Review, the MCO should incorporate the PIPs and results into the QAPI Program Description and have activities that address the PIPs in the QAPI Work Plan.	
21.	Peer Review Process and Peer Review Committee	• 5.9.6 Peer Review – General Requirements and Letter A • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO has a Peer Review process and incorporates the data to improve the delivery of care and services?** **2. Is there evidence the MCO has a Peer Review Committee, chaired by the CMO or physician designee?**	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: The MCO should have the process detailed in the QAPI documents.	
22.	NCQA Accreditation	• 5.9.7 National Committee for Quality Assurance Accreditation – General Requirements and Letters A-B • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO is NCQA accredited?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • MCO include language detailing they have a goal to maintain NCQA status. • Include the level of NCQA accreditation. • Include when the next NCQA accreditation will occur.	
23.	HEDIS data collection and reporting for population-specific HEDIS measures	• 5.9.8 HEDIS and CAHPS – General Requirements and Letters A-G • Related NCQA Data Collection and Quality Improvement (BH) • State QMS, Goal 4, Objective 4.5 and Goal 5, Objectives 5.1, 5.2a, 5.2b, 5.3a, 5.3b, and 5.3c	**1. Is there evidence the MCO incorporates HEDIS measures in their QAPI program?** **2. Are the required HEDIS measures evaluated in the QAPI program?**	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		State required HEDIS measures that the state requires be reported in the QAPI Program Description and QAPI Evaluation: • Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET) • Objective 5.1: HbA1c good control (<8.0%) for members with diabetes • Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30) • Objective 5.2b: Well-Child Visits 15-30 months (15-30 -month period & name change in 2020) • Objective 5.3a Child and Adolescent Well-Care Visits (WCV) ages 3-11 • Objective 5.3b Child and Adolescent Well-Care Visits (WCV) ages 12-17 • Objective 5.3c Child and Adolescent Well-Care Visits (WCV) ages 18-21	Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: In QAPI documents, include HEDIS reporting and ongoing analysis of the HEDIS data.	
24.	CAHPS Surveys	• 5.9.8 HEDIS and CAHPS – Letter G • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO incorporates the results from CAHPS Surveys in their QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			NOTES – How the MCO can show compliance: Details on the MCOs administration of the CAHPS survey each year.	
25.	Adverse incident reporting, investigation, follow up, and data collection, analysis, tracking, and trending	• 5.9.9 Adverse Incident Reporting and Management System General Requirements – Letters A-F • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence that the MCO integrates data from the Adverse Incident Reporting and Management System, addressing how information will be used along with grievance data to improve the care and services delivered by network Providers, decrease incidents of abuse, neglect and exploitation, and prevent future incidents?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
26.	Member Satisfaction Survey Methodology, Survey, results, and incorporation into the QAPI program to improve care for members	• 5.9.10 Member Satisfaction Surveys – Letters A-E • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO conducts Member satisfaction surveys and incorporates the results in to the QAPI program to improve care for Members?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
27.	Member satisfaction survey conducted with the KanCare SUD population and annual summary	• 5.9.10 Member Satisfaction Surveys – Letter F.1-2 (Amendment 14) • Related NCQA Data Collection and Quality Improvement (BH)	**1. Did the MCO administer the annual SUD Survey (Section 5.9.10.F)?** **2. If yes to #1, did the MCO submit the annual summary results to the State? (Section 5.9.10.F.2)** **3. Is there evidence the MCO incorporates the results of Member satisfaction surveys conducted with the KanCare SUD population and annual summary into the QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: In QAPI documents, the MCO should include information detailing they have completed the survey. It would not be an expectation for the MCO to include information on what has been done to meet each of the contract requirements (Amendment 14).	
28.	Provider Satisfaction Survey methodology, survey results report, and incorporation into the MCO QAPI program	• 5.9.11 Provider Satisfaction Surveys – Letters A-E (Amendment 14) • Related NCQA Data Collection and Quality Improvement (BH)	**1. Did the MCO complete the Provider Satisfaction Survey Methodology?** **2. If yes, did they submit it to the State for approval?** **3. Did the MCO administer the Provider Satisfaction Survey?**	

	QAPI Requirement	State QMS, State Contract Section and/or Code of Federal Regulations (CFR) §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			4. If yes to #3, did the MCO submit the summary results to the State? **5. Is there evidence the MCO incorporates the Provider satisfaction survey(s) methodology and results into the QAPI program to improve care for Members and the MCO service to its Participating Providers?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
29.	Data received from Participating Providers	5.16.1 Reports and Audits – Letter B	**1. Is there evidence that the MCO ensures that data received from Participating Providers is accurate, complete, and timely?** Document Expected at a Minimum: QAPI Work Plan NOTES – How the MCO can show compliance: MCO activity in the QAPI Work Plan to verify the accuracy, completeness, and timeliness of the reports prior to submission to the State.	
30.	Information on the Quality Management Director that is exclusively dedicated to the KanCare program	5.17.2 CONTRACTOR(S) Key Personnel – Letter C.10	**1. Does the QAPI Program Description include information on the QM Director that is exclusively dedicated to the KanCare program?** Document Expected at a Minimum: QAPI Program Description	

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Network Adequacy Validation

Sampling Strategy for Network Validation Calls

KFMC staff obtained and analyzed each MCO's *Online Provider Directory* file from the third quarter of 2023 that contained a listing of participating providers as of September 30, 2023. To simplify the data collection processes and reduce the potential for the results to over-represent larger practices with multiple providers at the same phone number, the focus in 2023 was on unique phone numbers using provider directory data. This approach could capture the same provider practicing at different locations with different phone numbers. This aligns with the purpose of simulating what a KanCare member would experience, since they would typically call the phone number in the directory associated with a specific location.

For each phone number, one directory record was randomly selected (from a combined listing of the three MCOs' directory files) to represent the phone number. The MCO from whose directory the record was chosen was considered the *primary MCO* for the call. If a corresponding record (same phone number, person, and location) was listed in another MCO's directory file, the call would include partial validation of the record for this *secondary MCO*.

Sample Determination

For each MCO, a sample of 430 phone numbers was randomly selected from the sample frame: 70 Behavioral Health, 150 Specialists, 60 OB/GYN, and 150 PCP providers. In all, 1,290 records were selected, which was an increase from the number of calls made for prior year's validation of after-hours access (976). The sample size within each provider grouping was determined using the following logic. Since each member should be receiving primary care, a relatively large sample size was warranted. OB/GYNs is a subcategory of primary care providers that was broken out for separate review, so a smaller sample was selected. The Specialist stratum contains a diverse group of provider types and specialties, so a relatively large sample was selected. The Behavioral Health providers are a less diverse group and received a smaller sample size.

Sample Frame Determination

Sample frames of distinct phone numbers were created from the MCOs' provider directory files. As an initial step, the directory records were classified into the four sample categories based on the provider types and specialties listed within the provider directory files:

- **Behavioral Health –** Behavioral Health Providers, Mental Health, and Mental Health Provider types
- **OB/GYN –** Obstetrician/Gynecologist, Obstetrics, and Obstetrics & Gynecology specialties
- **PCP** – The following providers, if not classified as OB/GYN or Exclusions (see below):
  - Physician and Specialist provider types with specialty of Family Practice, Family Practitioner, General Internist, General Pediatrician, General Practice, General Practitioner, Internal Medicine, Pediatrics, Preventative Medicine
  - Physician provider type flagged with IsPCP = "Y" in Aetna and Sunflower directory files, or Primary Care Providers type in the UnitedHealthcare directory file
- **Specialist –** The following providers, if not classified as PCP, OB/GYN or Exclusions:
  - Audiologist, Chiropractor, Dental Providers, Dentist, General Dentist, Nutritionist, Optometrist, Physician, Primary Care, PT/OT/ST, Specialist, Therapist, Vision, Vision - Retail, Vision Providers types

- **Exclusions –** The following specialties excluded records from being classified as PCP or Specialist:
  - Federally Qualified Health Care Agency
  - Rural Health Clinic
  - Indian Health Services Clinic
  - Advanced Registered Nurse Practitioner, Certified Registered Nurse Anesthetist, Family Nurse Practitioner, Nurse Practitioner, Pediatric Nurse Practitioner, Physician Assistant, or Psychiatric Nurse Practitioner
  - Screening Brief Intervention and Referral for Treatment specialty
  - Durable Medical Equipment specialty

After classification, the Behavioral Health, OB/BYN, Specialist, and PCP records were cleaned and deduplicated along these steps:

1. Deduplicate to keep one provider type and specialty code per practitioner per service location.
2. Remove records with missing phone numbers.
3. Remove records with addresses not in Kansas.
4. Deduplicate on key fields (NPI, Last Name, First Name, Middle Name, Business Name, Group Affiliation, Phone Number, MCO, and Address fields) prioritizing records indicating the provider is accepting new patients.
5. Set aside records with missing first name (i.e., directory records at a group or practice level).
6. For the retained records that do not carry the name of the group or practice, determine, if possible, the group or practice name by matching the record to the directory files on address fields. If multiple matches are obtained, deduplicate as in Step 4.
7. Assign to each cleaned record a random number.
8. For each phone number, select the record with the minimum random value. This step determines the phone number's primary MCO.
9. Sort the records selected in Step 8 by MCO and the random number. Select for each MCO the records to be called by identifying the given number of records with the lowest random values.
10. Identify secondary MCOs for the call by matching to the other MCOs' directories on Phone Number, NPI, City, and Street Address. If records matched on the street number but not the complete street address, then the records were manually reviewed. Many of these were considered matching after abbreviations and misspellings were taken into account.

    Record counts at several stages of constructing the sample frames and selecting of sample are displayed in Table B.2.

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Table B.2. Record Counts During Sample Selection				
	Aetna	**Sunflower**	**UnitedHealthcare**	**KanCare**
Records in Online Directory Files	**190,872**	**126,055**	**52,708**	**369,635**
Records for Provider Types Assessed	**147,599**	**73,749**	**28,640**	**249,988**
Behavioral Health	58,750	14,525	11,064	84,339
Specialists	58,332	18,470	12,820	89,622
OB/GYN	3,173	2,837	742	6,752
PCP	27,344	37,917	4,014	69,275
Records After Deduplication and Cleaning	**44,053**	**16,154**	**17,429**	**77,636**
Behavioral Health	17,427	3,218	9,001	29,646
Specialists	17,195	5,695	4,656	27,546
OB/GYN	1,612	810	645	3,067
PCP	7,819	6,431	3,127	17,377
Records for Individuals (Practitioners)	**41,596**	**12,455**	**17,346**	**71,397**
Behavioral Health	16,680	3,164	8,999	28,843
Specialists	16,721	5,015	4,577	26,313
OB/GYN	1,509	810	645	2,964
PCP	6,686	3,466	3,125	13,277
Records for Individuals with Group Info	**41,594**	**9,714**	**17,346**	**68,654**
Behavioral Health	16,680	2,144	8,999	27,823
Specialists	16,719	4,389	4,577	25,685
OB/GYN	1,509	553	645	2,707
PCP	6,686	2,628	3,125	12,439
Sample Frame of Phone Numbers	**2,220**	**1,282**	**2,528**	**6,030**
Behavioral Health	691	360	1,284	2,335
Specialists	881	508	667	2,056
OB/GYN	151	63	75	289
PCP	497	351	502	1,350
Sampled Records (Calls Completed)	**430**	**430**	**430**	**1,290**
Behavioral Health	70	70	70	210
Specialists	150	150	150	450
OB/GYN	60	60	60	180
PCP	150	150	150	450

Source: MCO Online Provider Directory Files for third quarter of 2023.

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Directory Validation Call Procedures

Application Overview – Provider Network Access Monitoring

For each directory record selected for a validation call, key data fields from the MCOs' Online Provider Directory Files were loaded into KFMC's *Provider Network Access Monitoring* application with one record created for each sample record. Each record was assigned a unique sequence number.

Additional fields for each record within the application were organized into three sections:

- **Header** – provider information uploaded to application, caller username, and date fields
- **Call Form** – fields for the caller to record results of call
- **Quality Review** – fields for inter-rater review

Header

The header section included the basic information for each record uploaded from the directory samples: phone number, provider ID, provider name, group name, provider category, provider specialty, address, primary MCO, and any secondary MCOs. For each associated MCO, the header also indicated whether provider was flagged in its directory as a PCP and whether the provider was flagged in its directory as accepting new patients. Additionally, hours of operation for the primary MCO were included. On the first save of the call record, call date and caller were automatically populated with the date and timestamp and user ID, respectively, which were unchanged if the data entry fields were subsequently modified.

Call Form

The data entry section of each record consisted of questions and response options for phone number, street address, in network, accepting new patients, and for PCPs and Specialists, whether the provider was practicing as a PCP or Specialist at that phone number and location. The options for phone number were *Yes* and *No*; the other questions had the additional options of *Don't Know* and *Not Applicable*. The data entry section also included online directory look-up fields for each MCO with whom the provider was associated, for caller use based on certain call conditions.

Question 1 – Phone

The person answering the call was asked if the phone number was correct for the provider and practice group. Choices were *Yes, the provider was at that number*, or *No, the provider was not at the number*. Fields were available to record a corrected group name and phone number, if provided.

Question 2 – Specialty or PCP

This question was only asked for the providers in the PCP and Specialist samples. For PCPs, the person answering the call was asked if the provider was providing PCP services; for specialists, the inquiry was about providing services for the specialty listed on the sampled record. Response options were *Yes*, *No*, and *Don't Know*.

Question 3 – Address

The person answering the call was asked if the caller had reached the location at the street address on the record. Response options were *Yes* and *No*; a field was provided to record a different address, if provided.

Question 4 – New Patients
The person answering the call was asked if the provider was accepting new patients at the address. Response options were *Yes*, *No*, *Don't Know*, and *Not Applicable*.

Question 5 – In Network
Separate question/response options were provided for each associated MCO. The person answering the call was asked to confirm that the provider was in-network for the MCO. Response options were *Yes*, *No*, *Don't Know*, and *Not Applicable*.

Wrong Number
A checkbox was provided and checked if the person answering the call stated the provider was not at the number dialed. The box was also checked when voice recordings indicated that the incorrect practice and provider had been reached.

No Answer
A checkbox was provided and checked if no one answered the call. This checkbox was also used when it appeared the number that was dialed was reaching a fax machine.

Voice Message – Group and Provider Names
Two dropdown lists were provided, with the options Yes, No, and Unknown. These fields were used when a voice mail or person answered but did not allow the caller to ask the questions. They indicate if the response confirmed the associated practice group name or the provider name.

Information Provided By
A field was available to record the name of the person who answered the phone, if one was provided.

Comments
This field provided analyst comments from the sample selection process as well as additional information from the caller or persons who reviewed the calls.

MCO Online Provider Directory Confirmation
If the person answering a call answered *No* to one of the questions, the caller performed a directory look-up in the online provider directory for the associated MCOs. Fields were available to record a different practice group name, phone number, or address; dropdown lists were used to record if the online directory look-up confirmed the data in the record header (third quarter MCO provider directory), different information provided by the person answering the call, or neither (new data). Checkboxes were used to record if the provider was not found in the online directory or was found (assumed to be in-network). A field was provided to record if the online directory indicated the provider was or was not accepting new patients, and, for the sampled PCPs and Specialists, if the provider was so listed in the online directory.

A checkbox was available for the caller to signal a request for special review of the recorded results by the Quality Reviewer.

Quality Review
The quality review section was reserved for use by the Quality Reviewer and, when necessary, Secondary Reviewer. The disposition of the review (*Agree*, *Disagree*, *Resolved*) was selected from a drop-down menu. The Quality Reviewer's rationale for this disposition was recorded in a free text field. The review date was automatically populated when a disposition was selected.

Directory Validation Call Procedures

Place and Record Call

Calls were placed to the provider's phone number in the record header using *Zoom Phone* via Zoom Video Communications, Inc. Each call was recorded to the cloud and then downloaded locally to be accessible to the *Provider Network Access Monitoring* application. Recordings were renamed using the record's sequence number and accessible via a link on the data entry form.

Address Call Objectives

The caller's goal for each call was to determine, from a member's perspective, the accuracy of information available in the MCOs' provider directories. The caller followed a script in all calls in which a person was reached. In these cases, the caller asked the person to verify the phone number, physical address, accepting new patients status, and in-network status of the provider; for specialists and PCPs, the person was asked to verify those services were being offered by the provider at that address. When a recording was reached, the caller noted if the provider group or provider name were identified on the recording.

Complete Call Form

The data entry section of each record was updated with findings from the call. When indicated, online directory look-up fields were populated. The completed fields provided context to the quality of responses, such as whether incorrect numbers were identified, more accurate numbers were provided, or the provider was practicing at an address different from the location sampled.

Quality Review of Completed Call Records

KFMC staff members made calls to providers, and a sample of completed calls underwent inter-rater review by the Quality Reviewer. Each review included a disposition (*Agree, Resolved* or *Disagree*) and comments on rationale for the disposition. The Quality Reviewer reviewed the first twenty completed calls. Feedback was provided to the caller, and several improvements to the process and call form were made. Thereafter, the Quality Reviewer selected over one-half of completed records for inter-rater review.

Upon a quality review disposition of *Agree*, the call was considered appropriately marked and no further action was taken. For a quality review disposition of *Disagree*, certain aspects of the call record were perceived by the reviewer as missing necessary marks, inappropriately marked, or possessing other inaccuracies that may affect analysis of the call. The caller was given the opportunity to review the comments of the reviewer and make any changes to the record to address the comments. If the reviewer agreed with changes made, this was recorded in the reviewer comments and the disposition was changed to *Resolved*.

Analysis of Directory Validation Call Activity

Reports were run from the *Provider Network Access Monitoring* application to assist with inter-rater review selection and assess the overall status of the progress and completion of calls. Records within the application were exported into an Excel spreadsheet for analysis. These data were analyzed using descriptive statistics.

Classification by Access and Quality Standards

For interpretation and reporting, records were assessed according to perceived member access and the degree to which the providers' office confirmed the information in the provider directory file. Records were categorized according to four ratings of quality: *Fully Met*, *Substantially Met, Partially Met*,

Minimally Met, and *Not Met*. Each of the four ratings were mutually exclusive by the criteria included below.

Records Rated as Fully Met

Records included within these counts clearly met criteria of success for accurate directory information. All calls within this level of achievement were confirmed with a live person representing the provider. Each of these calls resulted in confirmation of all four components of assessment (directory phone, address, acceptance of new patients, and correct in-network status).

Records Rated as Substantially Met

Records included within these counts were perceived to have minor issues pertaining to no more than one of the four components under assessment. All records within this level of achievement were confirmed with a live person representing the provider.

Records Rated as Partially Met

Records included within these counts were perceived to have clear issues. This group was divided into three subcategories:

- Reached a person representing the provider that verified either the practice or the provider was at the location and telephone number listed in the directory. However, either the provider or practice name was incorrect.
- Reached an incomplete recording that confirmed either the practice or the provider was at the location and telephone number listed in the directory (but not both), and
- Reached a person representing the provider who did not know or did not confirm two or more of the four components. Failure to confirm all elements was sometimes due to lack of knowledge on the part of the respondent and sometimes due to intentional hang-ups.

Records Rated as Minimally Met

Records included within these counts lacked substantial information critical to assessing the four elements. All records within this level of achievement represent instances where only voice messages were able to be reached and assessed. These voice messages did not provide all information necessary for full assessment. Additionally, all records in this level of achievement had associated voice messages that indicated either an incorrect practice or provider (but not both) had been reached. Many messages that indicated an incorrect practice name did not mention the provider in question.

Records Rated as Not Met

Records included within these counts clearly failed to satisfy the four components. This group contained three subcategories:

- Reached a voice recording having no instructions or information resulting in the ability to confirm any of the four components or the ability to determine if the correct group practice or provider had been reached.
- Reached a person or voice recording that indicated a wrong number had been reached. Wrong numbers are categorized as such, when either an individual or a voice recording identifies an incorrect business name or individual as the party reached. In instances where callers reached a voice recording that indicated the practice in question had been permanently closed, these records were classified as *Wrong number*.
- Calls were regarded as *No answer* if one or more of the following outcomes were present: there was no answer after the line rang for at least 30 seconds, a message was reached that indicated the phone number was no longer in service, the call either disconnected or the phone stopped ringing, or another reason beyond those indicated previously.

Comparison of Provider Network Reports to KMMS

The intent of this validation activity was to assess the accuracy and completeness of the MCOs' Provider Network Reports by comparing them against the State's provider data housed in the Kansas Modular Medicaid System (KMMS). Data expected to be comparable included provider names and addresses, provider types and specialties, affiliation of practitioner with group practices, and network contracting status. The analysis conducted is exploratory and will be used for planning future Provider Network Validation activities.

To facilitate the State's monitoring of the MCO provider networks, KDHE directed the MCOs to include the provider's KMMS ID (also called the provider location ID or service location ID) in the Network Adequacy Reports. The KMMS ID is a unique identifier for records in the KMMS Providers table from the State. The original analytic plan was based on comparing October 2023 Provider Network Report files to KMMS Provider tables. However, the KMMS ID was considered insufficiently populated for this activity, and the analysis was delayed until the January 2024 reports were available.

Two archived sets of KMMS reporting warehouse files were available for this analysis: tables as of December 31, 2023, and as of February 29, 2024. Results are based February 2024 records (the latest KMMS data available was used to maximize the number of records matched; effective and end dates within KMMS tables may restrict data at time of analysis).

Initial Observations

While reviewing the Provider Network Reports and preparing their records for analysis, the following observations were made.

The State instructed MCOs to separately report three sets of providers:

- **Participating –** providers in the network during the calendar year
- **Non-participating –** non-network providers who submitted claims with dates of service in two consecutive quarters, including providers with single case agreements
- **Previously Terminated –** former participating providers

Aetna did not appear to have separated participating and previously terminated providers in its report. All of Aetna's records reported January 1, 2019, as the effective date for all records and did not have populated end dates. For these dates to be correct, Aetna's provider network would need to have been unchanged since their KanCare contract began. Only one record was reported in Aetna's table of previously terminated providers.

UnitedHealthcare's report included non-participating group providers; however, no practitioners within those groups were listed as non-participating providers.

Providers are assigned a KMMS ID at the time of enrollment in Kansas Medicaid and are enrolled as either individuals or businesses. These are subdivided into six enrollment types:

- **Individual Providers** – individuals, individuals in group practices, and other (rendering, prescribing, and ordering) providers
- **Business Providers** – group practices, facilities, and atypical providers

The two types of providers are distinguishable in the Provider Network Reports and in KMMS by the name fields. For individual providers, the first, last, and middle names are populated; the business name and doing business as (DBA) name fields are populated for business providers.

KMMS IDs were not fully populated for Sunflower and UnitedHealthcare providers. All Aetna records contained a KMMS ID. National Provider Identifiers (NPIs) were mostly populated by each MCO. For records with a KMMS ID and an NPI, the pairing of the KMMS ID to the NPI was consistent with the KMMS Provider NPIs cross walk table. However, there were inconsistencies noted within the NPI and KMMS ID fields:

- For individuals in a group, the group's KMMS ID was frequently populated (allowing comparison of information specific to the group, such as the business name and address, but not information specific to the individual, such as their name, provider type, or specialty).
- Sunflower's report had records with the same NPI but different addresses that had the same KMMS ID. Individuals are assigned a single NPI, but an individual's KMMS IDs indicate the specific service locations at which they practice.
- Each MCO's Provider Network Reports had KMMS IDs associated with multiple provider types (in KMMS, each provider type is assigned a separate identifier).

Following the State's instructions, providers with multiple specialties had multiple rows in the Provider Network Reports—one per specialty with the other fields duplicated. For providers offering services at the member's home (e.g., home health agencies and HCBS providers), the MCOs were instructed to indicate the service area using the street address field (e.g., "Serving Wyandotte County"), thus creating one record per county with the other fields duplicated. Many providers offering services at home had multiple specialties in the Provider Network Reports (one record per specialty per county served).

Analytic Plan

Two methods were used to match the provider network files to the KMMS tables, the first was based on KMMS ID and the second on NPI. Separate results are presented for individual and business providers. The basic steps were the same for both methods. In these steps, the KMMS ID will refer to the identifier contained within the provider network files. The corresponding identifier in the KMMS tables is referred to as the *service location ID* (or *provider location ID*).

1. Load the MCOs' Provider Network Reports (January version) into a single *provider network file*.
2. Basic data cleaning included converting text to upper case and adding a unique record identifier.
3. Divide the file into a file of individual providers (a.k.a., practitioners) and a file of group and facility providers based on name fields. If the Business Name field was populated, the record was placed in the group and facility file. Records without business names had the First Name field populated, and these records were placed in the individual file.
4. Remove records with missing KMMS ID (first method) or NPI (second method). The file for individuals did not have missing NPIs.
5. Obtain the service location IDs corresponding to the provider network file record.
   a. For KMMS IDs – the service location ID is the KMMS ID.
   b. For NPIs – crosswalk the NPIs to service location IDs using the KMMS Provider NPIs table. An NPI may match to multiple service location IDs (NPIs no longer effective are included at this stage). NPIs not matched to a service location were excluded from further analysis.
6. Obtain the enrollment type code for the service location from the KMMS Provider record with the service location ID. For individuals enrolled in a group practice, both the individual's and the group's service location ID are needed. For records in the file of individual providers (Step 2),

   a. If the enrollment type indicates the KMMS ID or NPI is that of the individual, then obtain the service location ID for the group from the KMMS Affiliations crosswalk table.
   b. If the group's KMMS ID or NPI was provided, the Affiliations table will provide the service location IDs for individuals enrolled in the group. There is generally more than one individual in the group, and the service location ID for a particular member of the group cannot be discerned without further information. At this step, obtain the service location IDs for all enrollees in the group.
7. Service locations may have multiple addresses stored in KMMS (e.g., service location, pay to, and deliver to). The address fields from in the provider network files will be compared to each address available for the service location ID. Later analysis will determine the percentage of provider records matched to a service location address. See Matching Addresses for details.
8. Records for individuals will be matched on last name, first name, and middle initial. The business names within the provider network file will be compared to the business name, DBA name, and address names from corresponding KMMS records identified through the service location IDs. See Matching Names for details.
9. Conduct additional analyses, focusing on participating provider records matched to KMMS using NPI.

Matching Addresses

This section provides details to Step 7 of the analytic plan. The first part explains how address information was obtained from KMMS and cleaned in preparation for comparing to provider network file addresses. The second part details the algorithm for matching addresses.

Creating the Table of Addresses

The resulting *Table of Addresses* included these fields:

- KMMS ID and Service Location IDs – primary keys for the KMMS Providers table
- Enrollment Type Code – indicates whether the provider was enrolled as a group (G), facility (F), individual (I), individual in a group (IG) or an ordering, rendering, or prescribing (O) provider
- Address Service Location ID – the service location id that was matched to the Address table
- Address Name
- Address Type – contact (C), service location (S), mailing (M), delivery (D), medical record requests (MR), pay to (P), etc.
- Address Lines 1 and 2
- City, State, and ZIP code – stored in separate fields, 5-digits for ZIP code
- Primary Address Number – determined from Street Address Lines 1 and 2
- Address Effective Date, End Date, and End Year

The Table of Addresses was created as follows:

1. Create a list of distinct pairs of service location IDs and enrollment type codes from file resulting from Steps 1–6 above.
2. The address information corresponding to each KMMS ID is queried in four stages.
   a. Join the records from Step 1 to the Providers table on service location ID. Obtain the location name (rename to "Address Name"), address type (all will be "C"), street address lines, city, state, first 5 digits of the ZIP code, and effective and end dates.
   b. Inner join the records from Step 1 to the Address table on service location id. Obtain the address name, address type (none are "C"), street address lines, city, state, first 5 digits of the ZIP code,

and effective and end dates. Records are not expected for individuals in groups—address records were found one individual in a group.

c. Inner join the records from Step 1 to the Affiliations table on service location id to obtain the parent service location ID (this is the group's service location ID for individuals in a group). Inner join with the Address table to obtain the same fields as in Step 2b.
d. Combine the three sets of addresses into one file.

3. Clean the address fields:
   a. Convert Address Lines 1 and 2 to upper case. Retain only alphanumeric characters and spaces.
   b. Convert city, state, and address name to uppercase. Retain alphabetic characters and spaces.
   c. Set the End Year field to the year of the address end date (9999 for current records).
   d. Determine the *primary address number* (aka, street number or house number). If the first character of Address Line 1 is numeric, then use the leading number of Line 1 as the primary address number. Otherwise, if the first character of the second address line is numeric, use the first number of Line 2 as the primary address number and interchange the contents of Line 1 and Line 2 (this interchanging often moves post office box numbers to the second line and the street address to the first line).
4. Deduplicate to keep one record per combination of KMMS ID, address service location ID, address name, address Lines 1 and 2, city, state, ZIP, and year of the address ending date. In the process, create flags indicating the address types used by the combination.

Criteria for Matching Addresses

Records that had the same city or 5-digit ZIP code, street address or post office box number, and state were considered to have a *full match*. Records matching on state and city or 5-digit ZIP code, but not street address were said to have a *partial match* if they had the same primary address number (a.k.a., house number, see Step 3d above) or if the street address from the provider network file indicated a county in which the services were provided at a member's home (the county names were not required to match, only that services were being provided to a county). Before making comparisons, the relevant fields were converted to upper case and all non-alphanumeric characters including spaces were removed.

The Provider Network Reports have a single field for the street address, but the KMMS Provider tables includes a second street address line (frequently a suite number). Street addresses were considered to be a full match if any of the following were true (in the examples, the street address from the provider network file is listed first and the two address lines from KMMS are separated with a dash):

- Provider file address matched either line from KMMS
  - 100 Main St and 100 Main St – Suite A
  - PO Box 234 and 100 Main Street – PO Box 234
  - 100 Main St and 100 Main St – (missing)
- Primary address numbers were equal and the provider file address contained the first line from KMMS
  - 200 Broadway Avenue and 200 Broadway Ave – Suite A
- Primary address numbers were equal and the provider file address was found in both lines from KMMS combined
  - 100 Main St Suite A and 100 Main St – Suite A

Notes: Matching on ZIP codes was added to handle abbreviations in city names (e.g., Cottonwood Falls and Cottonwood Fls) and locations for which the Postal Service allows different names to be used for

the city (e.g., some ZIP codes in Shawnee and Mission, KS, may use Shawnee Mission for the city). Also, the matching criteria on street addresses will not usually catch differences caused by abbreviations (e.g., 100 W Main and 100 West Main, or 200 SW First Street and 200 SW 1st Street).

Matching Names

This section provides details to Step 8 of the analytic plan. Name information was obtained from KMMS and cleaned in preparation for comparing to provider network file names, first for individuals and second for groups and facilities. The third part details matching records on names.

Table of Individual Names

The *Table of Individual Names* included the following fields:

- Provider Location ID and Service Location ID – primary keys for the KMMS Providers table
- Enrollment Type Code – indicates whether the provider was enrolled as an individual (I), individual in a group (IG) or an ordering, rendering, or prescribing (O) provider
- First – first name of the individual
- Middle – middle name or initial of the individual
- Last – last name of the individual
- Cleaned Name fields (last, first, middle initial, first initial)

The Table of Individual Names was created as follows:

1. Create a list of distinct pairs of service location IDs and enrollment type codes from file resulting from Steps 1–6 above.
2. Inner join the list to the KMMS Provider table on service location ID to obtain the individual's first, last, and middle names.
3. Perform an initial cleaning of the name fields:
    a. Convert first, last, and middle name fields to uppercase. Retain only alpha characters, removing spaces for first and last names (so "Jones-Smith" and "Jones Smith," "Mc Donald" and "McDonald," or "Mary Jane" and "Maryjane" would be considered the same).
    b. Create a new column for the middle initial, collect only the first letter of the middle name, and convert to upper case.
    c. Create a new column for the first initial, collect only the first letter of the first name, and convert to upper case.

Table of Business Names

The *Table of Business Names* was created in a similar fashion as the Table of Individual Names except for the name fields used for comparison (business name, doing business as name, and the address name). Before comparisons, spaces and non-alphabetic characters were removed and text converted to uppercase.

Criteria for Matching Names.

The process for matching names of individuals was slightly different from the process for group and facility names.

- For both types of providers,
    - Records were paired using service location ID,
    - Comparisons were made using the cleaned name fields, and

  - Names were considered to be the same if one was contained within the other (e.g., "Deb" and "Deborah", "Jones" and "Smith Jones", "McDonald" and "McDonald Jr," or "Big Clinic" and "Big Clinic, LLC").
- For individuals, two records were said to have a *full match* on names if the first names were the same and the last names were the same. Records that did not match on first and last name had a *partial match* on names if they had the same first name and middle initial, last name and middle initial, or last name and first initial. Note that paired records that both had missing initials were considered to be matching on middle initial.
- For groups and facilities, the business name from the provider file was compared to the business name, the doing business as (DBA) name from the KMMS Providers table, and the address names from the Table of Addresses. Records were paired on service location ID. Matching on business name was deemed a *full match*. If the business name in the provider network file matched the DBA name or an address name from KMMS, the records had a *partial match*.

Results for Individual Providers

Counts of January 2024 Provider Network Report records for individual providers, stratified by MCO and network participation status, are shown in Tables C1 and C2. The number and percentage of those records not matched to KMMS on KMMS ID or NPI, name, and address fields (by the steps in which they were excluded) and the number and percentage of records matched to KMMS are also shown. The following are general observations:

- Missing a KMMS ID was the primary reason records did not match using KMMS ID. For records with a KMMS ID, 90% or more of the records matched to KMMS (95% to 98% for participating individuals).
- Not matching on address was the primary reason records did not match using NPI. The number of records not matched underscores the need for KMMS IDs for this type of analysis.
- For records matching to KMMS using NPI, 94% to 96% had full matches on both name and addresses.
- The No Match to KMMS Provider Table row of Table B.3 shows that KMMS IDs for all but 33 records for individual providers in the provider network file were identified as provider location IDs in the February 2024 KMMS Providers table (310 records for individual providers and 119 records for groups and facilities were not found in the December 2023 KMMS Providers table).

Table B.3. Provider Network Records Matched to KMMS on KMMS ID – Individuals

	Participating		Non-Participating		Terminated	
Aetna	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	100,431	100%	11,764	100%	1	100%
Excluded – Missing KMMS ID	0	0%	0	0%	0	0%
Excluded – No Match to KMMS Provider Table	14	<1%	4	<1%	0	0%
Excluded – Matched Neither Name or Addresses	17	<1%	0	0%	0	0%
Excluded – Matched Name but not Address	190	<1%	19	<1%	0	0%
Excluded – Matched Address but not Name	1,654	2%	168	1%	0	0%
Records Matched To KMMS	98,556	98%	11,573	98%	1	100%

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.

Table B.3. Provider Network Records Matched to KMMS on KMMS ID – Individuals (Continued)						
	Participating		Non-Participating		Terminated	
Sunflower	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	81,817	100%	25,803	100%	50,883	100%
Excluded – Missing KMMS ID	49,883	61%	0	0%	40,988	81%
Excluded – No Match to KMMS Provider Table	3	<1%	1	<1%	6	<1%
Excluded – No Match on Name or Addresses	1	<1%	1	<1%	4	<1%
Excluded – Matched Name but not Address	218	<1%	225	1%	104	<1%
Excluded – Matched Address but not Name	310	<1%	247	1%	152	<1%
Records Matched To KMMS	31,402	38%	25,329	98%	9,629	19%
UnitedHealthcare	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	102,030	100%	0		53,492	100%
Excluded – Missing KMMS ID	50,249	49%	0		45,779	86%
Excluded – No Match to KMMS Provider Table	5	<1%	0		0	0%
Excluded – No Match on Name or Addresses	14	<1%	0		5	<1%
Excluded – Matched Name but not Address	2,254	2%	0		718	1%
Excluded – Matched Address but not Name	472	<1%	0		76	<1%
Records Matched To KMMS	49,036	48%	0		6,914	13%
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.						

Of Aetna's records for participating individual providers, 98% matched to KMMS records on KMMS ID and 99% were matched using NPI. For non-participating providers, 98% of records matched to KMMS on KMMS ID and 99% matched using NPI. Not matching on names was the most frequent cause of records not matching for Aetna's records.

Of Sunflower's records for participating individual providers, 38% matched on KMMS ID (low rates driven by missing KMMS ID), and 68% of records matched using NPI (30% did not match on address and 2% had NPIs not found in KMMS). Non-participating individual providers had a 98% match rate on both KMMS ID and NPI.

For UnitedHealthcare's records for participating individuals, 48% matched to KMMS record on KMMS ID (49% were missing a KMMS ID, and 2% did not match on addresses). Using NPIs, 70% of records for individuals participating in UnitedHealthcare's network matched to KMMS (23% did not match on address, and 6% had NPIs not found in KMMS). UnitedHealthcare's Provider Network Report did not list any non-participating individual providers.

Table B.4. Provider Network Records Matched to KMMS Using NPI – Individuals						
	Participating		Non-Participating		Terminated	
Aetna	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	100,431	100%	11,764	100%	1	100%
Excluded – No Match to KMMS Provider Table	14	<1%	4	<1%	0	0%
Excluded – Matched Neither Name or Addresses	1	<1%	0	0%	0	0%
Excluded – Matched Name but not Address	283	<1%	17	<1%	0	0%
Excluded – Matched Address but not Name	1,176	1%	138	1%	0	0%
Records Matched to KMMS on Name and Address	**98,957**	**99%**	**11,605**	**99%**	**1**	**100%**
Full Matches (Full matches on Name and Address)	93,117	94%	11,033	95%	1	100%
Full+Partial (1 full match, 1 partial match)	5,786	6%	569	5%	0	0%
Partial Matches (Partial matches on both)	54	<1%	3	<1%	0	0%
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.						

Table B.4. Provider Network Records Matched to KMMS Using NPI – Individuals (Continued)						
	Participating		Non-Participating		Terminated	
Sunflower	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	81,817	100%	25,803	100%	50,883	100%
Excluded – No Match to KMMS Provider Table	1,264	2%	1	<1%	3,148	6%
Excluded – Matched Neither Name or Addresses	233	<1%	1	<1%	188	<1%
Excluded – Matched Name but not Address	24,438	30%	225	1%	14,374	28%
Excluded – Matched Address but not Name	500	1%	233	1%	401	1%
Records Matched to KMMS on Name and Address	**55,382**	**68%**	**25,343**	**98%**	**32,772**	**64%**
Full Matches	52,814	95%	24,380	96%	30,916	94%
Full+Partial	2,541	5%	957	4%	1,830	6%
Partial Matches	27	<1%	6	<1%	26	<1%
UnitedHealthcare	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	102,030	100%	0		53,492	100%
Excluded – No Match to KMMS Provider Table	6,433	6%	0		10,782	20%
Excluded – Matched Neither Name or Addresses	234	<1%	0		232	<1%
Excluded – Matched Name but not Address	23,064	23%	0		18,382	34%
Excluded – Matched Address but not Name	689	1%	0		259	0%
Records Matched to KMMS on Name and Address	**71,610**	**70%**	**0**		**23,837**	**45%**
Full Matches	68,215	95%	0		22,453	94%
Full+Partial	3,365	5%	0		1,374	6%
Partial Matches	30	<1%	0		10	<1%

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.

Additional Statistics for Records Matched Using NPI – Individuals

Additional analysis was conducted on the records for individual participating providers that matched to KMMS using NPI (referred to as *records studied*). While interpreting these statistics, keep in mind that matching to KMMS using NPI can match a record from the provider network file to multiple KMMS records.

KMMS Enrollment Types

Of 98,957 records studied for Aetna,

- 99% (98,232) matched using NPI to at least one record for an individual in a group,
- 21% (21,062) matched to at least one record for an individual, and
- 2% (2,243) matched to at least one record for a rendering, prescribing, or ordering provider.

Of 55,382 records studied for Sunflower,

- 98% (54,293) matched using NPI to at least one record for an individual in a group,
- 29% (15,895) matched to at least one record for an individual, and
- 1% (765) matched to at least one record for a rendering, prescribing, or ordering provider.

Of 71,610 records studied for UnitedHealthcare,

- 98% (70,505) matched using NPI to at least one record for an individual in a group,
- 22% (15,581) matched to at least one record for an individual, and
- 2% (1,651) matched to at least one record for a rendering, prescribing, or ordering provider.

The above percentages do not indicate issues with the MCO provider network tables. They do highlight the limitations of relying on NPI to identify a specific service location record.

KMMS IDs

Of 98,957 records studied for Aetna with populated KMMS ID,

- 86% (85,075) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

Of 31,415 records studied for Sunflower with populated KMMS ID,

- >99% (31,399) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

Of 49,225 records studied for UnitedHealthcare with populated KMMS ID,

- >99% (49,194) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

Aetna's lower percentage is driven by their providing the group's NPI and KMMS ID for individuals in the group.

Provider Types and Service Locations

Of 98,957 records studied for Aetna,

- >99% (98,944) matched to at least one record matching provider type using NPI, and
- >99% (98,848) matched to at least one record with a matching service location address using NPI.

Of 55,382 records studied for Sunflower,

- 95% (52,873) matched to at least one record matching provider type using NPI, and
- 97% (53,547) matched to at least one record with a matching service location address using NPI.

Of 71,610 records studied for UnitedHealthcare,

- 99% (71,228) matched to at least one record matching provider type using NPI, and
- 97% (69,535) matched NPI to at least one record with a matching service location address using.

The accuracy of the provider type and provider addresses have direct implications to both the provider directories and the Mapped Provider Count Reports. Since matching using NPI returns multiple matches, the problems may be understated.

Frequently seen cases of unmatched provider types included

- Advanced practice nurses and mid-level practitioners (per KMMS) listed as physicians by MCOs,
- Physicians listed as advanced practice nurses and mid-level practitioners by MCOs,
- Mental health providers listed as physicians by MCOs (and vice versa), and
- Advanced practice nurses listed as home health agencies, dentists, and chiropractors by MCOs.

Note, the studied records not matched to at least one record with a matching service location address had addresses matched to another type of address (mail to, pay to, etc.). Also, keep in mind the percentage of records that did not match to any address using NPI (see Table B.4.).

KMMS Contracts Table

The KMMS Contracts table provides effective beginning and ending dates for service locations contracted with an MCO as a participating or non-participating provider. The records studied for each MCO were matched to this table and subsequently stratified into four non-overlapping categories.

Of 98,957 records studied for Aetna,

- 93% (91,569) matched to at least one service location contracted as a participating provider in 2023,

- 7% (7,288) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- <1% (73) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (27) did not match to any Contracts table records.

Of 55,382 records studied for Sunflower,
- 86% (47,868) matched to at least one service location contracted as a participating provider in 2023,
- 11% (6,349) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- 2% (1,088) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (77) did not match to any Contracts table records.

Of 71,610 records studied for UnitedHealthcare,
- 95% (68,260) matched to at least one service location contracted as a participating provider in 2023,
- 4% (2,812) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- 1% (464) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (74) did not match to any Contracts table records.

Results for Group and Facility Providers

Tables B.5 and B.6 display counts of January 2024 Provider Network Report records for groups and facilities, stratified by MCO and network participation status. The number and percentage of those records not matched to KMMS using KMMS ID or NPI, name, and address fields (by the steps in which they were excluded) and the number and percentage of records matched to KMMS are also shown. Results were similar to results for individual provider records. The following are general observations:
- Missing KMMS ID was the primary reason records did not match using KMMS ID.
- The percent of records for groups and facilities with a KMMS ID that matched to KMMS was lower than the corresponding percent of records for individual providers.
- For matching with NPI, the reasons for not matching to KMMS was more varied. The main contributing factors included records with NPIs not found in KMMS, records not matching on name, and records not matching on address (depending on the MCO and participation status).
- For records matching to KMMS using NPI, the percent of full matches on both name and addresses was also lower than the percent for the corresponding individual provider records (values ranged from 12% to 24%).

Table B.5. Provider Network Records Matched to KMMS on KMMS ID – Groups and Facilities

	Participating		Non-Participating		Terminated	
Aetna	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	74,142	100%	5,155	100%	0	
Excluded – Missing KMMS ID	0	0%	0	0%	0	
Excluded – Matched Neither Name or Addresses	8	<1%	0	0%	0	
Excluded – Matched Name but not Address	12	<1%	0	0%	0	
Excluded – Matched Address but not Name	6,082	8%	880	17%	0	
Records Matched To KMMS	68,040	92%	4,275	83%	0	

Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.

Table B.5. Provider Network Records Matched to KMMS on KMMS ID – Groups and Facilities (Continued)						
	Participating		Non-Participating		Terminated	
Sunflower	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	51,081	100%	769	100%	3,826	100%
Excluded – Missing KMMS ID	7,675	15%	0	0%	3,082	81%
Excluded – Matched Neither Name or Addresses	57	<1%	0	0%	1	<1%
Excluded – Matched Name but not Address	191	<1%	4	1%	16	<1%
Excluded – Matched Address but not Name	2,289	4%	49	6%	247	6%
Records Matched To KMMS	40,869	80%	716	93%	480	13%
UnitedHealthcare	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	65,216	100%	2,501	100%	13,717	100%
Excluded – Missing KMMS ID	55,154	85%	0	0%	13,372	97%
Excluded – Matched Neither Name or Addresses	314	<1%	28	1%	12	<1%
Excluded – Matched Name but not Address	868	1%	3	<1%	52	<1%
Excluded – Matched Address but not Name	1,671	3%	1,387	55%	57	<1%
Records Matched To KMMS	7,209	11%	1,083	43%	224	2%
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 2/29/2024.						

For Aetna's participating group and facility records, 92% matched KMMS records on KMMS ID, and 94% matched using NPI. Not matching on name was the only substantial factor for non-matching of records. For non-participating provider records, the percentages were 83% and 90%, respectively. A factor for more records matching using NPI than when using KMMS ID is that NPI is a less specific identifier than KMMS ID. An NPI may represent multiple service locations, which provides more KMMS records to compare the MCO's record against and increases the probability of having a false positive result.

For Sunflower's participating group and facility records, 80% matched KMMS records on KMMS ID, and 85% matched using NPI. Missing identifiers and not matching on name were the primary reasons records did not match. For non-participating provider records, the percentages of matches were 93% and 95%, respectively, with non-matching on names being the primary cause of non-matching of records.

For UnitedHealthcare's participating group and facility records, 11% matched KMMS records (85% were missing KMMS ID, 3% did not match on name) on KMMS ID, and 61% (14% had NPIs not found in KMMS, non-matching names and addresses were also factors). For non-participating provider records, the percentages were 43% and 75%, respectively, with non-matching on names being the primary cause of non-matching of records.

Table B.6. Provider Network Records Matched to KMMS Using NPI – Groups and Facilities						
	Participating		Non-Participating		Terminated	
Aetna	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	74,142	100%	5,155	100%	0	
Excluded – Missing NPI	29	<1%	0	0%	0	
Excluded – No Match to KMMS Provider Table	22	<1%	192	4%	0	
Excluded – Matched Neither Name or Addresses	3	<1%	0	0%	0	
Excluded – Matched Name but not Address	12	<1%	0	0%	0	
Excluded – Matched Address but not Name	4,201	6%	345	7%	0	
Records Matched to KMMS on Name and Address	**69,875**	**94%**	**4,618**	**90%**	**0**	
Full Matches (Full matches on Name and Address)	16,708	24%	3,065	66%	0	
Full+Partial (1 full match, 1 partial match)	47,443	68%	1,491	32%	0	
Partial Matches (Partial matches on both)	5,724	8%	62	1%	0	
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 12/31/2023.						

Table B.6. Provider Network Records Matched to KMMS Using NPI – Groups and Facilities (Continued)						
	Participating		Non-Participating		Terminated	
Sunflower	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	51,081	100%	769	100%	3,826	100%
Excluded – Missing NPI	2,126	4%	0	0%	472	12%
Excluded – No Match to KMMS Provider Table	500	1%	0	0%	385	10%
Excluded – Matched Neither Name or Addresses	598	1%	0	0%	206	5%
Excluded – Matched Name but not Address	1,987	4%	4	1%	509	13%
Excluded – Matched Address but not Name	2,316	5%	37	5%	574	15%
Records Matched to KMMS on Name and Address	**43,554**	**85%**	**728**	**95%**	**1,680**	**44%**
Full Matches	5,206	12%	234	32%	1,061	63%
Full+Partial	34,579	79%	492	68%	585	35%
Partial Matches	3,769	9%	2	<1%	34	2%
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 12/31/2023.						
UnitedHealthcare	**N**	**%**	**N**	**%**	**N**	**%**
Records in January 2024 Files	65,216	100%	2,501	100%	13,717	100%
Excluded – Missing NPI	675	1%	0	0%	340	2%
Excluded – No Match to KMMS Provider Table	8,970	14%	0	0%	1,781	13%
Excluded – Matched Neither Name or Addresses	3,725	6%	5	<1%	238	2%
Excluded – Matched Name but not Address	8,618	13%	3	<1%	1,244	9%
Excluded – Matched Address but not Name	3,484	5%	628	25%	1,158	8%
Records Matched to KMMS on Name and Address	**39,744**	**61%**	**1,865**	**75%**	**8,956**	**65%**
Full Matches	5,075	13%	840	45%	306	3%
Full+Partial	28,214	71%	1,022	55%	6,742	75%
Partial Matches	6,455	16%	3	<1%	1,908	21%
Source: MCO Provider Network Reports for 10/1/2023 to 12/31/2023 submitted by 1/30/2024 and Kansas Modular Medicaid System reporting warehouse tables as of 12/31/2023.						

Additional Statistics for Records Matched Using NPI – Groups and Facilities

In this section, *records studied* refers to MCO records for participating groups and facilities that matched to KMMS using NPI.

KMMS Enrollment Types

Of 69,875 records studied for Aetna,

- 28% (19,371) matched to at least one record for a group using NPI, and
- 81% (56,653) matched to at least one record for a facility.

Of 43,554 records studied for Sunflower,

- 8% (3,334) matched to at least one record for a group using NPI, and
- 99% (43,070) matched to at least one record for a facility.

Of 39,744 records studied for UnitedHealthcare,

- 12% (4,817) matched to at least one record for a group using NPI, and
- 94% (37,341) matched to at least one record for a facility.

The number of studied records matched group and facility records shows limitations of relying on NPI for identifying service locations. The number of group and the number of facility providers records in the Provider Network Reports could not be determined from the data provided. Therefore, stratified rates (e.g., the percent of facility providers matched to a facility enrollment type) could not be calculated.

KMMS IDs

Of 69,872 records studied for Aetna with populated KMMS ID,

- 97% (68,026) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

Of 41,443 records studied for Sunflower with populated KMMS ID,

- 99% (40,872) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

Of 8,020 records studied for UnitedHealthcare with populated KMMS ID,

- 96% (7,679) matched to KMMS records with that KMMS ID as the Provider Location ID using NPI.

These statistics may show discrepancies between NPIs used by the MCOs and NPIs registered in KMMS. The analysis did not limit KMMS Provider NPI records to primary NPI or exclude NPI records no longer effective.

Provider Types and Service Locations

Of 69,875 records studied for Aetna,

- 98% (68,684) matched to at least one record matching provider type using NPI, and
- >99% (69,843) matched to at least one record with a service location address.

Of 43,554 records studied for Sunflower,

- 98% (42,528) matched to at least one record matching provider type using NPI, and
- 99% (43,203) matched to at least one record with a service location address.

Of 39,744 records studied for UnitedHealthcare,

- 94% (37,448) matched to at least one record matching provider type using NPI, and
- 98% (39,098) matched to at least one record with a service location address.

The accuracy of the provider type and provider addresses have direct implications to both the provider directories and the Mapped Provider Count Reports. Since matching using NPI returns multiple matches, the problems may be understated.

KMMS Contracts Table

The KMMS Contracts table provides effective beginning and ending dates for service locations contracted with an MCO as a participating or non-participating provider. The records were stratified into four non-overlapping categories.

Of 69,875 records studied for Aetna,

- 98% (68,602) matched to at least one service location contracted as a participating provider in 2023,
- 1% (1,043) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- <1% (53) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (177) did not match to any Contracts table records.

Of 43,554 records studied for Sunflower,

- 93% (40,518) matched to at least one service location contracted as a participating provider in 2023,

- 6% (2,654) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- 1% (293) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (89) did not match to any Contracts table records.

Of 39,744 records studied for UnitedHealthcare,

- 98% (38,934) matched to at least one service location contracted as a participating provider in 2023,
- 1% (272) matched to at least one service location contracted as a non-participating provider in 2023 and to no service locations contracted as a participating provider in 2023,
- 1% (488) matched to at least one service location with a contract ending before 2023 and to no service locations contracted as a participating or non-participating provider in 2023, and
- <1% (50) did not match to any Contracts table records.

Limitations

- Comparing Provider Network Report records to KMMS records identifies areas with discrepancies. The activity does not establish which records had correct information.
- KMMS IDs were insufficiently populated for directly joining provider network records with KMMS tables.
- NPIs are specific to people or businesses, but not to service locations. Therefore, joining provider network records to KMMS records using NPI returned results for multiple service locations even after restricting records on names and addresses. Consequently, issues identified through NPIs may be understated.
- The matching rates presented in Tables B.2–B.5 include cases where the KMMS data were outside of their effectiveness date range (i.e., no longer current), which was intentionally done so use of out-of-date data could be studied later.

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Comparison of Provider Network Reports and Online Provider Directory Files

The intent of this validation activity was to assess the accuracy of the MCOs' Online Provider Directory Files, which are files reported to the State consisting of the data used by the MCOs in their online provider directories, and the consistency between those files and the Provider Network Reports.

Background

The MCOs' provider databases are updated from the State's provider network (PRN) files, which are provided to the MCOs monthly and supplemented with daily updates. In their updated Information Security Capabilities Assessment responses and during the virtual Performance Measure Validation on-site meetings in September 2023, the MCOs stated that PRN files were used to update their provider data.

The PRN files include names, specialties, service locations, provider types, NPIs, and KMMS IDs. KFMC expected that the providers in the MCOs' Online Provider Directory Files would be included in the MCOs' Provider Network Reports.

The State-assigned 14-character KMMS ID (aka, provider location ID) uniquely identifies a provider and the services offered at a service location in KMMS records. Although exceptions are found in KMMS, the first 10 characters should be the same for all of a provider's service locations. Those 10 characters are referred to as the provider's base ID.

The data dictionaries provided with the directory files included a column to explain null values. This was only populated by Sunflower. They explained that when the KMMS ID is null, "the provider's location does not match the location on the PRN with the KMAP ID. This may be an additional location for the provider."

The Network Adequacy Reports contained a Termination Date on the Participating Providers tab for providers who stopped participating in the network during the reporting year. Populated dates ran through the end of December 2023. Those records were excluded from the analysis.

Analysis

KFMC compared the fourth quarter 2023 directory files and the Participating Providers tab in the network reports submitted by the MCOs in January 2024. The analysis concentrated on the numbers of distinct identifiers in the files—NPI, KMMS ID, and base ID. Some records were missing the NPI, KMMS ID, or both.

As noted in Appendix C, Initial Observations, none of the records on the Participating Providers tab of Aetna's network report contained a termination date. The difference in the count of distinct NPIs in Aetna's network report is approximately 2,700 more than the count in UnitedHealthcare's network report, which does exclude records with termination dates.

There were considerably more distinct NPIs in the network reports than in the directory files. Provider NPI was well-populated in both the directory files and network reports so this would not account for the difference. The Aetna files had KMMS ID populated on most records; this was not the case for Sunflower and UnitedHealthcare (see MCO-specific results below).

A comparison of adult and pediatric providers between the files could not be made as the directory files did not contain a field indicating whether the provider accepted adult or pediatric members. The field is included in the network reports; the directory files contain an Ages Served field but, when populated, it

contained a wide variety of age ranges. On PCP records in the network report, Sunflower did not populate the Adult or Pediatric field for 178 distinct NPIs (77 distinct KMMS IDs).

Because the base ID identifies an individual practitioner, group, or facility, as does the NPI, it would be expected that the count of distinct values would be comparable between the network reports and directory files. Groups and facilities may use the same or different NPIs for service locations or lines of business, so there was not an exact one-to-one match between NPIs and base IDs. A large number of individual providers' records for Sunflower and UnitedHealthcare did not have a KMMS ID populated, which is consistent with differences between distinct base ID and distinct NPI counts.

Aetna Better Health of Kansas

In the Provider Network Report and in the KMMS Provider tables, first and last names are only populated for individual providers, and the business name is only populated for groups and facilities. However, in Aetna's directory file, Business Name field was always populated, and First Name was populated on all but 725 records (except for a few, the provider type was pharmacy). On records with First Name populated, the Last Name and Business Name entries were the same on 166,933 records and different on 3,982 records; these records included 663 distinct business names. Because a spot check of these records indicated the associated NPIs were individual, rather than organizational, NPIs, these records were counted as individuals. The majority of these had specialties of general dentistry, optometry, and general ophthalmology. For purposes of the analysis presented in Table B.7, records with populated First Name were assumed to represent an individual; otherwise, they were considered a group or facility record.

Table B.7. Record Counts by Distinct Provider Identifiers – Aetna

	Individuals			Groups and Facilities		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	100,431	170,915		74,142	725	
Distinct NPIs	24,753	20,493	18,942	4,478	706	604
Distinct Base IDs	23,467	19,613	17,821	2,883	314	253
Distinct KMMS IDs	25,017	22,442	18,840	7,599	720	599
Distinct Names	24,675	20,569		3,329	376	
– missing NPI	0	0		1	0	
– missing KMMS ID	0	11		0	3	
Distinct Base ID and NPI pairs	29,109	24,598	21,720	4,499	703	596
Distinct KMMS ID and NPI pairs	35,975	31,776	25,868	7,613	720	599
Kansas Only	**Individuals**			**Groups and Facilities**		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	84,779	170,658		68,013	654	
Distinct NPIs	20,602	20,422	18,705	4,043	635	578
Distinct Base IDs	19,502	19,567	17,536	2,611	261	231
Distinct KMMS IDs	20,809	22,392	18,374	6,511	650	573
Distinct Names	20,546	20,497		3,016	318	
– missing NPI	0	0		1	0	
– missing KMMS ID	0	8		0	2	
Distinct Base ID and NPI pairs	24,143	24,486	21,432	4,063	633	570
Distinct KMMS ID and NPI pairs	29,595	31,663	25,824	6,523	650	573

Note: Records for individuals were distinguished from groups and facilities based on the name fields populated.

Aetna's directory file contained duplicates of behavioral health providers (4,438 distinct NPIs)—one set had a provider type of "Mental Health" and the second had "Mental Health Providers."

There were approximately 4,000 more distinct individual names in the network report than in the directory file. Restricting to providers with Kansas addresses reduced the difference to less than 100 records.

In Aetna's directory file, the groups, in which the individual practices, are captured in the Group Affiliations field. This field contained a comma delimited list of all the groups in which the individual practices. The network files are laid out with the individuals and each of their affiliated groups on separate records. This explains the ten-fold difference in the groups and facilities counts.

The majority of individuals' NPIs (92%), base IDs (91%), and KMMS IDs (82%) in the directory file were also in the network report as individuals. For groups or facilities, the percentage of matches from the directory file were slightly fewer, but that could be due to the issue with Business Names in the directory file.

Of the 21,199 distinct NPIs in Aetna's directory file, 212 were for out-of-state providers. The majority of these were in Missouri (158) and Oklahoma (12); 20 were providers in non-border states. Of the 29,231 distinct NPIs in the network report, 7,539 were for out-of-state providers. The majority of these were in Missouri (6,057), Nebraska (408), Colorado (401), and Oklahoma (553); 23 were located in non-border states. In the network report, except for four NPIs, out-of-state providers that were flagged as PCPs were limited to border states. The majority of out-of-state providers in the network report were physicians and advance practice nurses in Missouri.

Counts of distinct identifiers by provider types in the network report are provided in Table B.8. Counts by provider types in the directory file are in Table B.9. The stratified counts did not take matching by provider type into consideration. Due to the differences in provider types between the two files, a direct provider type comparison could not be made. Aetna included advance practice nurses and mid-level practitioners with provider type of physician in their directory file.

The network report included records for hospitals, ambulatory surgical centers, custodial care facilities, rehabilitation facilities, home health agencies, hospices, public health agencies, case managers, HCBS providers, and clinics that were not included in the directory file. There was also a large number of advance practice nurses, mental health providers, and physicians without a matching record in the directory file (see Table B.8).

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Table B.8. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – Aetna Provider Network Report						
Provider Network Report Provider Types	**NPI**	**Also in Directory File**	**Base ID**	**Also in Directory File**	**KMMS ID**	**Also in Directory File**
01 – Hospital	224	1	191	93	239	16
02 – Ambulatory Surgical Center	60	4	59	7	60	4
03 – Custodial Care Facility	259	0	225	16	262	0
04 – Rehabilitation Facility	3	0	3	0	3	0
05 – Home Health Agency	91	0	84	19	125	1
06 – Hospice	81	0	77	12	90	2
08 – Clinic	343	3	143	101	364	70
09 – Advance Practice Nurse	6,212	4,763	5,973	4,644	6,899	5,113
10 – Mid-Level Practitioner	1,319	1,095	1,340	1,139	1,671	1,349
11 – Mental Health Provider	5,902	4,230	5,448	4,063	6,404	4,254
13 – Public Health Agency	87	1	83	8	89	2
14 – Podiatrist	73	46	74	58	139	77
15 – Chiropractor	22	0	18	2	20	1
17 – Therapist	1,247	929	1,056	872	1,208	950
18 – Optometrist	309	262	309	148	353	120
19 – Optician	4	3	4	4	6	5
20 – Audiologist	156	111	153	108	212	130
21 – Case Manager (Targeted)	55	0	54	5	65	1
22 – Hearing Aid Dealer	5	1	4	1	8	1
23 – Nutritionist	124	106	128	109	152	128
24 – Pharmacy	711	594	296	232	720	567
25 – DME/Medical Supply Dealer	299	108	193	94	385	91
26 – Transportation Provider	107	1	101	22	172	13
27 – Dentist	382	256	384	161	433	134
28 – Laboratory	294	1	227	97	329	11
29 – X-Ray Clinic	221	1	197	91	234	9
30 – Renal Dialysis Center	45	0	22	1	45	0
31 – Physician	11,053	7,176	10,038	7,068	12,628	7,689
32 – Non-Physician	1	0	1	0	1	0
42 – Teaching Institution	1	1	1	1	1	0
54 – Screening Providers	7	0	7	0	18	0
55 – HCBS	695	122	637	144	966	129
56 – Work	28	0	28	1	54	0
Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.						

The directory file had identifiers for dentists, mental health providers, and physicians that were not included in the network report. Table B.9 includes 494 NPIs (2,420 records) for Primary Care provider type. These records had specialties of ophthalmology and optometry. In the directory file specialists (based on specialty code) were included in the physician provider type records; the specialist provider type primarily consisted of ophthalmologists, optometrists, pediatric dentists, and oral surgeons.

Table B.9. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – Aetna Provider Directory						
Provider Directory Provider Types	**NPI**	**Also in Network Report**	**Base ID**	**Also in Network Report**	**KMMS ID**	**Also in Network Report**
Pharmacy	692	594	304	244	691	575
Clinic	3	3	3	3	7	7
Dentist	76	36	77	41	97	54
DME/Medical Supply Dealer	1	1	1	1	1	1
General Dentist	404	209	311	141	339	115
Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.						

Table B.9. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – Aetna Provider Directory (Continued)						
Provider Directory Provider Types	**NPI**	**Also in Network Report**	**Base ID**	**Also in Network Report**	**KMMS ID**	**Also in Network Report**
HCBS	2	2	2	2	2	2
Hospice	1	0	1	0	1	0
Mental Health Provider	4,438	4,234	4,294	4,047	4,561	4,195
Physician	14,053	13,263	13,686	12,690	16,180	13,292
Primary Care	494	278	322	126	389	116
PT/OT/ST	1,005	924	947	856	1,042	928
Specialist	153	103	111	59	136	67
Unknown	4	2	3	2	3	2
Vision	81	56	83	61	103	73
Vision – Retail	1	0	2	0	2	0
Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.						

Sunflower Health Plan

Sunflower's Provider Network Report populated the Termination Date field to indicate providers who were no longer participating in the network; their records were excluded from analysis.

The Online Provider Directory File had both First Name and Business Name fields populated on 92% of the records. On approximately 500 records, the first and last names formed the business name, which generally indicates a solo practitioner; these were counted as individuals. On almost 11,000 records, First Name was empty, and Business Name was populated; these were counted among the groups and facilities. For purposes of the analysis presented in Table B.10, records were classified as group or facility when the First Name field was empty; otherwise, it was counted as an individual.

Table B.10. Record Counts by Distinct Provider Identifiers – Sunflower						
	Individuals			**Groups and Facilities**		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	61,106	128,392		50,776	10,735	
Distinct NPIs	17,909	15,893	11,213	3,826	3,128	1,766
Distinct Base IDs	11,311	12,527	5,939	1,845	905	626
Distinct KMMS IDs	11,567	13,072	5,982	3,901	1,419	894
Distinct Names	17,901	15,910		3,105	5,088	
– missing NPI	0	0		34	0	
– missing KMMS ID	10,556	10,590		1,077	4,190	
Distinct Base ID and NPI pairs	11,312	12,529	5,940	3,081	1,194	873
Distinct KMMS ID and NPI pairs	11,567	13,072	5,982	3,901	1,419	894
Kansas Only	**Individuals**			**Groups and Facilities**		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	49,952	108,879		48,423	8,347	
Distinct NPIs	14,192	13,790	9,207	3,261	2,831	1,602
Distinct Base IDs	8,549	10,985	4,631	1,656	843	575
Distinct KMMS IDs	8,775	11,494	4,664	3,584	1,321	822
Distinct Names	14,189	13,803		2,765	4,093	
– missing NPI	0	0		33	0	
– missing KMMS ID	8,536	9,118		882	3,235	
Distinct Base ID and NPI pairs	8,550	10,987	4,632	2,796	1,104	804
Distinct KMMS ID and NPI pairs	8,775	11,494	4,664	3,584	1,321	822
Note: Records for individuals were distinguished from groups and facilities based on the name fields populated. Records include providers participating in the networks as of December 31, 2023.						

There were approximately 2,000 more distinct individual names in the network report than in the directory file; within Kansas, the difference was only 400.

There were 2,000 fewer distinct business names in the network report than in the directory file. The difference may be explained by the way the Business Name fields were populated. The directions for the Online Provider Directory Files from the State indicates the Business Name field should contain the office or service provider name if the provider is not an individual. For large groups or facilities with multiple service locations, the service location names may differ from the business name of the group or facility. Sunflower populated the directory file with the service location name and the network reports with the business name of the group or facility.

To illustrate issues with attributing names, NPIs, and KMMS IDs to individuals or to groups and facilities, in the network report, 81 records had business name that contained "Children's Mercy". Provider types were hospitals, home health agencies, therapists, pharmacies, DME/Medical Suppliers, transportation, laboratories, x-ray clinic, HCBS, renal dialysis, and Mental Health Provider (8 distinct business names, 12 distinct NPIs, and one base ID when populated). In the directory file, 53 records had a business name that contained variations of "Children's Mercy"; 18 of these records also populated the First Name and Last Name fields (11 distinct individual names). The records with a first name were counted as individuals in Table B.10; the remaining 35 records had 23 distinct business names, counted as groups and facilities. Of the 11 individuals, 7 had a KMMS ID (all had NPI). Of the 23 distinct business names (10 distinct NPIs), 3 had a KMMS ID. Of the business names, 14 distinct names (18 records) had a common NPI. The NPI was on an additional 18 records (6 distinct names) that did not include "Children's Mercy" in the Business Name field, none of which contained a KMMS ID—two of these had a "Last Name, First Name" in the Business Name field and another was for a provider group. The provider group name populated the Business Name field of an additional 2,148 records with first and last names also provided. The provider group was not included in the network report.

There appeared to be significant standardization of names and addresses in the network report, which was consistent with data from the State PRN file being used; names and addresses were not standardized in the directory file. A larger number of records for individuals did not have the KMMS ID field populated in either the directory file or the network report. As noted above, Sunflower's directory file's data dictionary noted that these records had addresses that did not match those provided for certain KMMS IDs in the State PRN file.

The provider's NPI field was populated on most records. The match rate for individuals' NPIs between the two files was between 60% and 70%. For individuals' KMMS ID, which were less populated, the match rate was approximately 50% between the files. For groups and facilities, the difference between the two files was greater. Approximately 56% of the NPIs in the directory file had a match to a group/facility's NPI in the network report; only 46% of the NPIs in the network report had a match to a group/facility's NPI in the directory file. For group/facilities' base IDs, 69% in the directory file had a match in the network report; however, only 34% of the base IDs in the network report had a match in the directory file.

Of the 18,688 distinct NPIs in Sunflower's directory file, 4,737 were for out-of-state providers. The majority of these were in the border states—Missouri (3,556), Oklahoma (601), Nebraska (313), and Colorado (175); 180 were providers in non-border states. Of the 21,723 distinct NPIs in the network report, 5,948 were for out-of-state providers. The majority of these were in Missouri (3,937), Nebraska

(391), Colorado (294), and Oklahoma (653); 748 were located in non-border states. In the network report, most out-of-state providers that were flagged as PCPs were in border states. However, distinct NPIs for PCPs were also in non-border states, primarily provider types advance practice nurse (36) and physician (17) in Virginia as well as physician provider type (46) in Tennessee.

Counts of distinct identifiers by provider types in the network report are provided in Table B.11; counts by provider types in the directory file are provided in Table B.12. The stratified counts did not take matching by provider type into consideration. Due to the differences in provider types between the two files, a direct provider type comparison could not be made.

Table B.11. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – Sunflower Provider Network Report

Network Report Provider Type	NPI	Also in Directory File	Base ID	Also in Directory File	KMMS ID	Also in Directory File
01 – Hospital	346	193	168	85	194	75
02 – Ambulatory Surgical Center	86	11	56	1	57	0
03 – Custodial Care Facility	373	262	247	199	289	228
04 – Rehabilitation Facility	13	1	3	0	3	0
05 – Home Health Agency	197	31	102	33	120	8
06 – Hospice	92	2	75	9	86	0
08 – Clinic	414	53	147	50	342	0
09 – Advance Practice Nurse	4,633	2,836	2,819	1,550	2,879	1,556
10 – Mid-Level Practitioner	1,024	925	604	518	618	524
11 – Mental Health Provider	3,804	2,157	2,420	1,054	2,878	1,133
12 – Local Education Agency	1	0	1	0	1	0
13 – Public Health Agency	107	92	94	78	97	79
14 – Podiatrist	47	1	23	0	25	0
15 – Chiropractor	16	12	13	10	14	10
17 – Therapist	1,038	765	678	421	708	399
18 – Optometrist	477	444	449	411	465	427
19 – Optician	1	1	1	0	1	0
20 – Audiologist	81	71	44	34	45	34
21 – Case Manager (Targeted)	122	80	82	63	103	63
22 – Hearing Aid Dealer	7	1	4	0	7	0
23 – Nutritionist	101	3	75	3	75	2
24 – Pharmacy	697	678	296	143	676	152
25 – DME/Medical Supply Dealer	430	305	207	135	309	204
26 – Transportation Provider	143	40	97	35	116	1
27 – Dentist	478	437	422	97	451	105
28 – Laboratory	335	129	173	61	219	45
29 – X-Ray Clinic	211	158	148	73	159	67
30 – Renal Dialysis Center	144	2	29	1	65	0
31 – Physician	7,342	4,416	4,416	2,239	4,479	2,246
32 – Non-Physician	1	1	1	1	1	1
42 – Teaching Institution	1	1	1	1	1	1
45 – QMB	21	13	21	9	21	0
54 – Screening Providers	7	1	7	4	7	0
55 – HCBS	846	283	678	130	815	13
56 – Work	33	13	29	13	29	0

Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.

Provider type and specialty were not populated for 14 individual's NPIs and 11 business's NPIs in the directory file. Unlike Aetna's directory file, Sunflower's directory file did contain provider identifiers for groups and facilities. However, there were a considerable number of hospitals, ambulatory care centers,

home health agencies, and clinics in the network report that did not have a provider identifier match in the directory file. There were also many advance practice nurses, mental health providers, and physicians that were in one file without a match in the other file.

Table B.12. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – Sunflower Provider Directory

Provider Directory Provider Types	NPI	Also in Network Report	Base ID	Also in Network Report	KMMS ID	Also in Network Report
NULL (no value)	25	12	0	0	0	0
Advance Practice Nurse	3,701	2,756	3,152	1,495	3,229	1,504
Ambulatory Surgical Center	10	7	0	0	0	0
Audiologist	112	68	104	34	106	34
Case Manager (Targeted)	78	78	60	60	64	63
Chiropractor	16	12	12	10	12	10
Clinic	8	4	0	0	0	0
Custodial Care Facility	365	359	198	196	232	229
Dentist	715	460	132	97	157	105
DME/Medical Supply Dealer	413	373	140	134	338	242
HCBS	56	53	26	25	108	102
Home Health Agency	21	17	0	0	0	0
Hospital	187	182	74	72	81	75
Laboratory	3	1	1	0	1	0
Mental Health Provider	3,204	2,052	2,427	1,003	2,594	1,012
Mid-Level Practitioner	1,256	912	1,058	489	1,110	495
Nutritionist	3	2	2	2	2	2
Optometrist	632	452	553	412	698	427
Pharmacy	681	679	79	78	115	90
Physician	6,766	4,249	4,604	2,058	4,748	2,059
Public Health Agency	94	93	79	79	80	79
Rehabilitation Facility	7	4	5	5	6	4
Therapist	807	599	660	345	690	338
Transportation Provider	32	32	1	1	1	1
Work	1	1	0	0	0	0
X-Ray Clinic	9	7	6	6	14	13

Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.

The differences between NPI matches based on provider types illustrate inconsistencies with how providers are classified (see Tables B.11 and B.12). As an example, a distinct NPI had 12 records, and one business name, in Sunflower's network report and 16 records with 10 business names in its directory file. In the network report, 8 of the records were for acute care hospitals; 2 records are for therapists, 1 was for a laboratory, and one was for an x-ray clinic. In the directory file, the NPI was on 7 acute care hospitals (5 names) and 9 general practice physician (6 names) records. One name matches between the two provider types in the directory. The NPI had 8 addresses in the network report and 13 addresses in the provider directory. Neither file had KMMS ID populated for these records.

UnitedHealthcare Community Plan of Kansas

UnitedHealthcare's Provider Network Report populated the Termination Date field to indicate providers who were no longer participating in the network; their records were excluded from analysis.

In the Online Provider Directory File, 45,820 records had First Name field empty and either Last Name or Business Name fields populated; these records were considered businesses. An additional 1,299 records had First Name and Business Name empty; the business name was in the Last Name field. These were primarily pharmacies and were also counted as businesses. First Name was not empty on 47,449

records. Of these, 438 had Business Name, First Name and Last Name populated. For purposes of the analysis provided in Table B.13, records with First Name populated were considered individuals; records with First Name empty were counted as facilities or groups.

The PCP flag was not populated in UnitedHealthcare's Online Provider Directory File. Instead, UnitedHealthcare used provider type of "Primary Care Providers" to designate PCPs.

Table B.13. Record Counts by Distinct Provider Identifiers – UnitedHealthcare

	Individuals			Groups and Facilities		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	85,218	47,449		63,724	45,820	
Distinct NPIs	23,698	11,411	11,215	4,456	2,580	2,281
Distinct Base IDs	16,218	10,741	8,569	1,459	1,556	1,126
Distinct KMMS IDs	16,550	10,858	8,419	3,078	2,370	1,596
Distinct Names	23,659	11,435		3,235	2,109	
– missing NPI	0	31		52	55	
– missing KMMS ID	13,458	929		1,621	300	
Distinct Base ID and NPI pairs	16,218	10,739	8,569	2,547	2,362	1,785
Distinct KMMS ID and NPI pairs	16,550	10,856	8,419	3,079	2,362	1,594
Kansas Only	**Individuals**			**Groups and Facilities**		
Description	**Network Rpt**	**Directory File**	**In Both**	**Network Rpt**	**Directory File**	**In Both**
Total Records	60,330	47,449		49,602	44,035	
Distinct NPIs	19,003	11,411	11,203	2,903	2,577	2,271
Distinct Base IDs	13,910	10,741	8,485	1,289	1,553	1,121
Distinct KMMS IDs	14,208	10,858	8,333	2,726	2,367	1,584
Distinct Names	18,981	11,435		2,820	2,105	
– missing a NPI	0	31		51	55	
– missing a KMMS ID	9,262	929		1,325	299	
Distinct Base ID and NPI pairs	13,910	10,739	8,485	2,226	2,359	1,775
Distinct KMMS ID and NPI pairs	14,208	10,856	8,333	2,726	2,359	1,583

Note: Records for individuals are distinguished from groups and facilities based on how the name fields are populated. Records included providers participating in the networks as of December 31, 2023.

The directory file contained 30,417 records for individuals and 26,243 records for groups and facilities that were exact duplicates of other records. The duplicate records were included in the Total Records counts.

Of the 13,990 distinct NPIs in UnitedHealthcare's directory file, only four were for out-of-state providers (1,785 records). Three NPIs were for HCBS providers; two were in Missouri and one in Idaho. Multiple specialties were attributed to each HCBS provider resulting in several hundred records for each. The fourth NPI was classified a Specialist (DME), having two records without KMMS ID and erroneous state code for Kentucky (the city, county, and ZIP code were for Kansas). The UnitedHealthcare directory file did not include any border state PCP providers.

The majority of individuals' NPIs (98%), base IDs (80%), and KMMS IDs (77%) in the directory file were also found in the network report. For groups or facilities, the percentage of matches from the directory file were slightly fewer, but still between approximately 67% to 88%. Conversely, for groups and facilities, approximately 50% of the NPIs and KMMS IDs in the network report were not found in the directory file. For facilities and groups, 14% of the distinct names in the directory file did not have KMMS ID populated, with a rate of 50% in the network report.

Of the 28,153 distinct NPIs in the network report, 9,523 were for out-of-state providers. The majority of these were in Missouri (6,060), Nebraska (699), Colorado (242), and Oklahoma (402); 2,452 were located in non-border states. In the network report, out-of-state providers flagged as PCPs were limited to border states. The majority of out-of-state provider NPIs were physicians and advance practice nurses in Missouri.

Counts of distinct identifiers by provider types in the network report are provided in Table B.14, and Table B.15 provides counts by provider types in the directory file. The stratified counts did not take matching by provider type into consideration. Due to the differences in provider types between the two files, a direct provider type comparison could not be made.

The network report included NPIs for a large number of advance practice nurses, mid-level practitioners, physicians, and laboratories that were not included in the directory file (see Table B.14)—this provides and explanation for there being approximately 7,500 more distinct individual names and 700 more group and facility names for Kansas providers in the network report than in the directory file.

Table B.14. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – UnitedHealthcare Provider Network Report

Provider Network Report Provider Types	NPI	Also in Directory File	Base ID	Also in Directory File	KMMS ID	Also in Directory File
01 – Hospital	225	130	159	127	177	101
02 – Ambulatory Surgical Center	59	48	52	45	53	45
03 – Custodial Care Facility	298	291	234	233	274	250
04 – Rehabilitation Facility	17	12	10	10	12	9
05 – Home Health Agency	160	126	66	65	75	51
06 – Hospice	95	70	68	61	75	58
08 – Clinic	340	189	138	124	301	139
09 – Advance Practice Nurse	5,286	1,972	4,155	1,663	4,208	1,638
10 – Mid-Level Practitioner	1,170	645	925	575	942	564
11 – Mental Health Provider	5,651	3,710	2,844	2,128	3,145	2,076
13 – Public Health Agency	106	13	90	33	96	6
14 – Podiatrist	60	39	44	33	44	32
17 – Therapist	1,443	844	1,034	736	1,101	700
18 – Optometrist	521	369	456	351	480	321
19 – Optician	16	11	11	7	11	6
20 – Audiologist	138	83	114	78	117	76
21 – Case Manager (Targeted)	24	21	12	9	13	6
22 – Hearing Aid Dealer	1	1	1	1	1	0
23 – Nutritionist	119	59	97	55	97	55
24 – Pharmacy	879	624	287	231	670	473
25 – DME/Medical Supply Dealer	362	236	170	143	253	82
26 – Transportation Provider	97	63	66	52	69	38
27 – Dentist	408	297	355	266	383	257
28 – Laboratory	1,248	142	220	138	300	111
29 – X-Ray Clinic	250	147	172	137	199	110
30 – Renal Dialysis Center	132	49	33	27	64	48
31 – Physician	9,906	3,692	6,718	3,064	6,967	3,006
54 – Screening Providers	2	0	0	0	0	0
55 – HCBS	563	534	175	168	221	156
56 – Work	21	21	15	15	15	4

Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.

Although classified differently by provider type, most of the NPIs in the directory file were found in the network report (see Table B.15). UnitedHealthcare's primary care providers included physicians, nurse practitioners, FQHCs, OB-GYNs, RHCs, pediatricians, and physician assistants. Ambulatory surgical centers, home health agencies, health departments, hospice, laboratories, rehabilitation and physical therapy were classified as ancillary providers.

Table B.15. Distinct NPIs, Base IDs, and KMMS IDs by Provider Types – UnitedHealthcare Provider Directory

Provider Directory Provider Types	NPI	Also in Network Report	Base ID	Also in Network Report	KMMS ID	Also in Network Report
Ancillary Providers	468	369	358	267	408	275
Behavioral Health Facilities	104	83	87	57	95	40
Behavioral Health Providers	4,185	4,144	3,787	2,408	3,887	2,374
Clinic/Multispecialty Clinic	11	11	11	11	11	11
Convenience Care Clinics	2	1	2	1	2	1
Dental Providers	297	297	286	266	288	257
Home and Community Based Service Providers	430	406	368	203	427	169
Hospitals	142	126	124	121	130	103
Long Term Care Providers	792	689	639	394	740	398
Pharmacy	627	624	247	233	614	504
Primary Care Providers	2,786	2,739	2,631	2,395	2,697	2,382
Specialists	4,395	4,243	4,138	3,547	4,157	3,502
Urgent Care Centers	22	17	16	11	18	10
Vision Providers	425	423	414	400	414	367

Note: Records were matched only on the identifier, not on the provider types as they differed between the two files.

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Review of MCO Access Monitoring Methodologies

Aetna's Annual Timeliness Report

Aetna submitted their Annual Timeliness Report on October 31, 2023. Appointment availability survey calls occurred between August 23 and September 13, 2023, during provider office-hours of 9 a.m. to 5 p.m. on weekdays. The dates and times of day or week were not reported for the after-hours survey. It is assumed the after-hours survey occurred during the same August to September time period.

Appointment Availability

Regarding the sample for appointment availability access monitoring, they stated, "1,807 unique provider telephone numbers were included in the sample, which represented ALL available unique phone numbers in the Kansas provider universe." However, they also reported a subgroup of specialty types (PCPs, oncologists, obstetrician/gynecologists, and behavioral health) were included and other specialties were excluded. The data source and calculation for determining the 1,807 unique provider telephone numbers was unclear. For instance, assuming a unique provider location would generally have a unique provider telephone number, the Aetna Mapped Provider Count Report for the corresponding time-period reported at least 2,990 unique provider locations for the subgroup of specialty types to be included in the survey. There were likely more, but KFMC only counted adult and pediatric specialists one time for the same specialty, understanding providers may serve both and be duplicated between the subcategories. The Mapped Provider Count Report also had over 9,000 unique locations for ALL Aetna providers included in the geo-maps. A potential reason for the smaller number (1,807) in Aetna's Annual Timeliness Report is they noted, "provider offices that did not have a phone number populated were excluded." It was not clear what data source was being referenced for phone numbers, or what Aetna did about the providers without a documented phone number in their system. Aetna should report the number of provider offices excluded from the survey, as being unable to be reached. If Aetna was unable to identify the provider phone number, a member would not have access to the provider information through the provider directory either.

In addition to questions regarding follow-up from the previous year, the KDHE report template asks how many of the non-compliant providers from the prior year were included in the survey sample this year. Aetna reported their Provider Relations Representatives contacted 100% of the 1,539 non-compliant providers (by 12/31/2022) and they were given the Access and Appointment Availability requirements. However, they do not indicate how many of the 1,539 non-compliant providers in 2022 were included in the 2023 survey.

Tables 2.1.a, Provider Sample in Compliance with State Contractual Appointment Standards, provided results for the following provider types: PCP (overall, adult and pediatric), Specialist, MH, SUD, and OB. It isn't clear what provider types are within the "Specialist" provider stratum, other than oncologists, since it was previously noted other specialties were excluded. Information is needed regarding how Aetna determined the categorization of providers with overlapping specialties, such as those providing both adult and pediatric PCP services, or MH and SUD services.

Table 3, Most Common Reasons for Not Being Able to Survey Offices, reports 1,807 providers were contacted, 535 surveys were completed, and 1,272 surveys were not completed; however, 1,291 total providers were not surveyed. The discrepancy is under the Specialist column where 223 surveys were not completed but 242 providers were not surveyed. While the numbers and percentages may be incorrect, the majority (over 86%) of reasons for unsuccessful attempts were due to the caller being

unable to contact the provider after three attempts, and incorrect phone numbers was close to 12%. The Other category was used to capture phone number changes and reaching business or government entities, which would seem to fit with incorrect phone numbers.

Tables 4.2.a., 4.2.b, and 4.2.c., Offices Surveyed in Compliance with State Contractual Appointment Standards reported Aetna members' median number of days wait for a routine care visit with a PCP was one day, six days for a specialist, and two days for a mental health provider. Aetna's results were noticeably lower compared to the other MCOs, suggesting an area for further review among the MCOs to ensure consistent instruction and methodologies for comparison and interpretation purposes.

After-Hours Access
For after-hours calls, a random sample of 502 unique telephone numbers were selected for outreach. The proportions by specialty were a little different than the appointment availability sample, with the after-hours sample having 125 PCPs, 123 specialist, 44 OBs, 210 BH providers. Of the 502 calls completed, 43.2% were compliant. Of the 217 compliant, 52.9% were answered by answering machines, with half of those having instructions to go to the nearest hospital.

Of the 134 non-compliant calls, 88.9% were due to the phone ringing continuously, disconnecting, or quitting ringing. Incorrect and fax machine numbers were the remaining non-compliant calls.

Sunflower Annual Timeliness Report

More methodological detail was needed in Sunflower's Annual Timeliness Report submitted November 14, 2023; distinctions between the appointment availability survey and the after-hours access survey were needed. The time-period for the After-Hours Survey was not reported, nor was the time of day and week when calls were completed. The sample related template questions were not fully answered. Sunflower noted, "We used a Confidence Interval of 95% +/- 5%, which is generally accepted by NCQA. The entire network was sent to the vendor. The vendor chooses the sample based on the goals provided per provider type. Kansas' goal for 2023 is to reach 90% of providers passing all appointment standards." They also stated, "exclusions are any provider that a member can't make an appointment with: Hospitalists, Anesthesiologists." It appears these statements applied to the appointment availability survey. Sunflower provided no detail regarding the number of providers in its entire network or the vendor's processes in determining sample selection or provider exclusions, leading to potential misinterpretations. Sunflower identified samples of 336 (PCP), 160 (Pediatric), 422 (Specialist), 93 (OB/GYN), and 382 (BH) providers. It is possible the vendor began calling by provider type until they were able to survey the number of providers per sample. However, it could also be interpreted they were supposed to call providers until they reached enough providers to get to 90% compliance rates per provider type, although, 90% compliance rates weren't attained. It appeared 7,489 providers were attempted to be contacted, with 1,393 surveys completed. Among the MCOs, Sunflower was able to collect the most provider information regarding technical issues, incorrect phone numbers, providers having moved with no updated information, etc.

Appointment Availability
Tables 2.1.a and 2.1.b, Provider Sample in Compliance with State Contractual Appointment Standards of the report template is intended to represent compliance among all providers eligible for the survey, since providers that are not able to answer the survey (for various reasons) may also not be accessible to a member for assistance. Sunflower's Table 2.1.a, did not include percentages to reflect denominators of "surveys completed" plus "total surveys not completed"; only counts of compliant providers among the completed surveys were included.

Table 3, Most Common Reasons for Not Being Able to Survey Offices of the report template, Row 9 "Survey Not Completed" should equal the Total Not Surveyed. However, Sunflower reports "–1393" in the Total for Row 9, instead of "6,096." The number of providers contacted was reported as "0" instead of "7,489." Among the 6,096 providers called but not surveyed, 70.1% were not called because of technical or other problems; the descriptions for these categories were brief, including "vendor hold times, being asked to call back later, or data inaccuracy." Almost all remaining reasons, 29.3%, were related to data inaccuracies, including incorrect phone numbers, and the provider having moved with no updated information.

Regarding Tables 4.1.a and 4.1.b, Offices Surveyed in Compliance with State Contractual Appointment Standards, Sunflower did not identify the numbers surveyed for the adult PCP and pediatric PCP providers and did not provide percentages associated with the compliance numbers.
Sunflower's 2022 Annual Timeliness Report noted the health plan "considers the third appointment availability to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect available urgent appointments or appointments available due to cancellations for a given day, which may not represent average accessibility." It is not clear whether Sunflower's compliance rates in 2023 are based on third available or average appointment availability. The survey questions were not included for review. However, median numbers of days wait for scheduled appointments reported by Sunflower in Tables 4.2.a–4.2.c are noticeably longer than those reported by the other MCOs, suggesting Sunflower may be measuring these indicators differently and more reasonably from the members' viewpoint.

After-Hours Access
Sunflower reported completing 330 After-Hours PCP calls, stating, "After hours audits were completed based on the PCP audit volume. This allows us to have a full picture of how the PCP meets the needs of our members." However, 496 PCPs were surveyed for the appointment availability calls. Also, in the Sunflower Annual Timeliness Report, under After-Hours Calls Definitions on the Sample Size sheet, Sunflower noted successful and unsuccessful attempts are included. In Table 5, After-Hours Access Compliance, only 1 of the 330 calls was non-compliant (a "no answer") The very high percentage of calls during the appointment availability survey that were unsuccessful attempts, 81.4% (6,096), suggests some inconsistency in the sample process or reporting of results for the After-Hours survey.

Improvement Activities noted survey completion for 2024. Sunflower did not address the provider populations to be included, as PCPs were the only population included in 2023.

UnitedHealthcare's Annual Timeliness Report

UnitedHealthcare submitted their Annual Timeliness Report on October 30, 2023, including an attachment "Access & Availability Program Guidelines 2023." The guidelines provide details regarding provider file formats, survey questions, call response outcome codes, acceptable responses, and sample sizes. Some instructions depended on whether the sampling method occurred by provider location or by practitioner. It wasn't clear from UnitedHealthcare's documentation in the reporting template whether they sampled by provider location or by practitioner.

UnitedHealthcare stated, "Based on previous years' survey data, an anticipated frequency of 85% was used to estimate the sample size. Confidence limits of +- 5% were estimated to allow for reasonably precise results while keeping sample sizes manageable. The following providers were in the sample frame by provider type: PCP – 4121, Specialists – 1310, OB – 497, BH – 821, SUD – 80.

The same samples were used for the appointment availability and after-hours access surveys. The samples by provider type were comprise of the following: PCP – 237, Specialists – 215, OB – 178, MH – 200, SUD – 80, for a total of 910 providers. For the after-hours survey, the MH and SUD provider populations were combined into 280 providers in Behavioral Health.

Appointment Availability

Regarding Table 3, Most Common Reasons for Not Being Able to Survey Offices, of the 107 surveys not completed, the majority were "moved, no updated information" (29%); "other" (39.3%) including "PCP: Provider Retired (4), Provider is a specialist (3), Provider is CMO or Trainer and does not see patients (5) Specialists: Provider Retired (2), Provider does not take Medicaid (2) OB: Provider is a specialist (4), Provider does not take Medicaid (17) MH: Provider is a specialist (4), Provider not accepting new patients (1)"; and "technical problems" (17.8%) including "Provider is unable to bring up appt calendar without a members name/DOB (PCP - 11, OBGYN - 2), Provider is unable to see appointment availability without a referral (specialists - 6)."

In all areas except "Routine Care" for MH (89.5%) and "OB 2nd Trimester" (96.7%), provider compliance with contractual appointment standards rates were 99.0% or above (Annual Timeliness Report Tables 4.1.a, 4.1.b). The UnitedHealthcare Access & Availability Program Guidelines' routine and urgent care appointment availability questions for PCPs and High Volume and High Impact Specialists ask providers for the next available appointment. Table 4.1.a showed the PCP (Adults) and PCP (Peds) sizes were similar—182 providers serving adults compared to 201 providers serving pediatric members. The overall number of PCPs is 201 and it is not clear how UnitedHealthcare identified the adult and pediatric subcategories.

After Hours Access

Of the 910 after-hours calls completed, UnitedHealthcare reported 99.3% compliance with access standards. Of the 904 compliant calls, 68% (615 calls) were responded to by a provider answering service, and the remaining 32% (289) were responded to by an answering machine with instructions to go to the nearest hospital. Based on past experience, KFMC finds it very unusual these two response categories would be the only ones used among 910 providers. Quality assurance steps are important, such as inter-rater reliability to ensure surveyors are accurately collecting and consistently entering data as intended.

Also, it wasn't clear how the UnitedHealthcare Access & Availability Program Guidelines were implemented pertaining to acceptable answering machine messages. The Guidelines state for "After Hours Calls (All Provider Types)" it is acceptable if "the answering machine provides instructions directing the member to the nearest hospital." However, under "24/7 Accessibility, Physician Coverage," the UnitedHealthcare Guidelines state,

> *"Primary Care Physicians (PCPs) must provide coverage to members 24 hours/seven (7) days a week. Offices must have a phone message or answering service available to members after office hours that instruct the member how to contact the physician for urgent or emergency conditions (There may be circumstances identified by the health plan where a practitioner in a service area with limited back-up may be given latitude with these requirements)….Unacceptable call responses are as follows:*
>
> *i. The answering machine states the office is closed and directs the member to call 911. No alternative mode is provided to contact a live person in the event of a non-life-threatening emergency."*

Appendix C

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

2023 Recommendations

The following project recommendations are included in Appendix C:

- PIP Validation
- Compliance Review
- QAPI Review

2023 PIP Recommendations	
Aetna	
EPSDT	
Activity 5	1. Update Activity 5 to align technical specifications and analytic plans with analysis to be reported in Activity 8.2. 2. Following the transition to a new vendor, the intervention technical specifications and analysis plan should be updated to be consistent with any changes made in the data collection.
Activity 8	3. Verify the numerators for Outcome Measure 2 and Process Measure 2 are calculated according to their technical specifications. 4. Verify calculated values displayed in tables are correct. 5. Ensure descriptions of the intent of measures are clear and accurate. 6. Verify measurement periods are consistent with available data. 7. Report the measures as they were defined in the methodology or redefine the measures to be consistent with the data reported. 8. When a table contains multiple rows of data and a total, the total should be the actual sum of the row values. If it is not, an explanation for the discrepancy should be provided. 9. In the next annual report, update the measure technical specifications and the analysis plan to be consistent with any changes made following the November 2022 transition of vendors. 10. In the next annual report, provide the results for Outcome Measure 4d for RY3, or provide an explanation for its omission. 11. Because this intervention is geared toward provider education, exclude Aetna staff from the reported survey results or report their responses separately.
General	12. Consistently refer to the PIP outcome measure as the “Participation Rate.”
Pregnancy: Prenatal Care	
Activity 5	1. Provide details of the incentive payment structure in the next annual report.
Activity 8	2. Use standard language of reporting measure as defined or provide an explanation for deviation. 3. Include technical specifications for all reported measures, including PAR measures not completely defined in Activity 5. 4. Use consistent terminology for defining measures and describing measure results. 5. If numerators are suppressed, suppress percentages instead of reporting them as 0%. 6. Provide discussion concerning the cause of Table 9’s large changes in denominator. 7. Provide dates for events that affect interpretation of the data. 8. Create or modify PAR measures to correspond with changes to interventions’ processes or goals. 9. Write table titles that match the reported data. 10. Revise PARs to reflect the current population targeted for Intervention 4 and include historic data.

2023 PIP Recommendations	
Aetna	
Pregnancy: Prenatal Care (Continued)	
General	11. Update the aim statement to indicate more clearly the projected PIP end date and the second aim's baseline rate and outcome measure. 12. Define the PIP population in Activity 3 as "female members with a pregnancy during the activity period." 13. In Activity 6.1, repeat the aim statement and provide non-technical descriptions for each of the PIP's outcome measures. In Activity 6.2 provide complete technical specifications for each of the PIP's outcome measures, in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. 14. Review, and revise as needed, the technical specifications for PIP Outcome Measure 1 (Median Days from Notification to Delivery). 15. In Activity 9.2, discuss the impact of the policy changes that extended Medicaid coverage. 16. Reevaluate the success of the PIP and its interventions based on revised measurements. 17. Ensure conclusions drawn are supported by the data.
Food Insecurity	
Activity 5	1. Update the denominator statements for Process Measure 7 and Outcome Measure 1 to reflect the intended measurements.
Activity 8	2. Mention that the Z59.4 diagnosis code became non-billable on October 1, 2022, when codes Z59.41 and Z59.48 became effective. 3. Define and consistently use a notation for the group diagnosis codes identifying food insecurity. 4. Ensure table titles reflect the data presented. 5. Update Tables 2 and 3 headers to appropriately match the data that is included. Include a notation when changes occurred within the criteria used to pull data for the table. 6. Provide appropriate reasons for inconsistencies between PAR and intervention measures. 7. Follow the CMS cell suppression policy throughout the report. 8. Correct the headers in Figures 19–23 and 26 to match the data presented.
General	9. In Activity 6.1, repeat the aim statement and provide non-technical descriptions for each of the PIP outcome measures in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. 10. Ensure conclusions are supported by the data.
Long-Term Services and Supports and Emergency Department Visits	
Activity 5	1. For clarity, revise the technical specifications and analytic plans for measures ABH_ED_2a, ABH_ED_2b, ABH_ED_3a, and ABH_ED_4a to remove discrepancies between metric descriptions and numerator and denominator statements. 2. Specify the method for calculating annual rates for measures defined using PAR technical specifications. 3. Continue to update the technical specifications and analytic plans for Intervention 8 as the details become known.

2023 PIP Recommendations	
Aetna	
Long-Term Services and Supports and Emergency Department Visits (Continued)	
Activity 8	4. Verify the denominators for the Outcome Measure 1 and Alternate Outcome Measure for Intervention 2. Provide an explanation for any discrepancies. 5. Reevaluate causes of discrepancies between Process Measure 2 (ABH_ED_2a) data reported in Tables 4 and 7. 6. Include the full question from the text survey evaluating Intervention 3 & 4 in Activity 5.3. Update the technical specifications, analytic plan, and presentation of results for Process Measures 1 and 2 to reflect the responses more clearly to the question. 7. Ensure Intervention 4 rates were calculated according to the technical specifications and that wording related to measures is consistent between Activities 5.3 and 8. 8. Verify the terms *median* and *mean* are being used correctly. Clarify technical specifications and reporting of results where *average* refers to a measure of central tendency other than the arithmetic mean. 9. Calculate Outcome Measure 1 for Intervention 5 according to its technical specifications. 10. Specify the method for calculating annual rates in the analytic plans for measures defined using PAR technical specifications for monthly rates. 11. Update the heading of tables for Intervention 7 to better describe the data they contain.
General	There were no additional recommendations made for this PIP.
Influenza Vaccination	
Activity 5	1. Revise Activity 5.2 to clearly indicate the target population for Intervention 2.
Activity 8	2. Provide appropriate explanations for inconsistencies between PAR and annual report results. 3. Calculate measures according to the technical specifications, or clearly indicate how and why they deviated from the specifications. 4. Submit necessary updates for approval to properly correct the error found in technical specifications of the Process Measure ABH_Influ_2a so annual report and PAR measures are calculated the same. 5. Review the technical specifications for Intervention 5 measures; following the PIP Update process if changes are warranted.
General	6. Reevaluate the effectiveness of outreach calls to children diagnosed with asthma (Intervention 2). 7. Continue to report evidence of effectiveness of the PIP to supplement the results of the PIP outcome measure. 8. Ensure that interpretations of analysis results are supported by the data. 9. Investigate the completeness of the claim and immunization registry data. The goal would be to determine the extent to which influenza vaccinations are not being reported to KSWebIZ or billed by providers.

2023 PIP Recommendations	
Sunflower	
EPSDT	
Activity 5	1. If an intervention goal is added, it should be included in intervention measures. 2. Intervention descriptions should be consistent with responses to "Follow-up to Previous Recommendations."
Activity 8	3. When citing limitations to a successful intervention, provide a clear description of those limitations. 4. Correctly label tables and data columns. 5. Ensure the conclusions are supported by the analytic results. 6. Provide an explanation for the large difference in denominators for Process Measure 1 between RY1 and RY2 and between points 2 and points 3. 7. Use consistent and standard statistical nomenclature when reporting results so that the interpretation is clear (*p*-values and odds). 8. Ensure that the interpretation of the analytic results is supported by the evidence. 9. Compare the (combined) EPSDT screening rate of members attributed to the participating provider groups to the control group to analyze the impact of the intervention. 10. Ensure that numerator and denominator columns are properly labeled. 11. Verify the accuracy of the pre- and post-training score rates and the percentage point change. 12. Report the measures as defined in the methodology or update the methodology to reflect what was reported in Activity 8.2.
General	13. Update the annual targeted rates for the PIP outcome measure. 14. Include qualifications of each PIP role and all staff involved in the PIP in future reports. 15. Use consistent abbreviations and acronyms throughout the report (RY1, RY2, RMY 1, RMY 2). 16. Ensure analysis results described in the report narrative are consistent with the data presented in tables. 17. Accurately describe data being tested or measured and how the results are being interpreted. 18. Ensure all data and statistical interpretations are verified for accuracy and clarity in future reports. 19. For the statistical testing, report rounded *p*-values for values from 0.01 through 0.99 and using ranges otherwise. 20. Redesign tables in Activities 8.2 and 9.1 to improve the clarity of the contents and purpose so that the reader can more readily understand the data and test results that are presented. 21. Provide a detailed analytic comparison of the baseline to remeasurement EPSDT Participation Rates in Activity 9.1 and a less technical interpretation of the results in Activity 9.3. 22. Review technical writing in Activities 8.2 and 9.1 of statistical results for clarity, accuracy, and correct interpretation. 23. Results and analysis specific to an intervention's process and outcome measures should be provided in Activity 8.2, rather than in Activity 9. Analysis against a control group is described in intervention methodologies. This analysis is presented in Activity 9 and should be described in Activity 7. 24. Provide a description of how Sunflower intends to meet the PIP outcome goal, EPSDT Participation Rate greater than 85% (e.g., annual rate improvement targets).

2023 PIP Recommendations	
Sunflower	
EPSDT (Continued)	
	25. Provide an interpretation of the rate change from RY 1 to RY 2 in Activity 10.1. 26. Include a summary of the impact of the interventions on the PIP outcome measure, including their impact on achieving the PIP Goal of an 85% Participation Rate, in Activity 10.1.
Cervical Cancer Screening	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. In Activity 8.2, provide data, comparisons, and significance testing of CCS closure rates between initiative and the non-initiative groups consistent with the analytic plans described in Activities 5 for Interventions 1, 2, and 3. 2. Ensure that the interpretation of the analytic results is supported by the evidence. 3. Update the analytic plan in Activity 5.1.d, redefining the control group criteria and adjusting for any impacts on analysis and trending due to requested changes to the intervention. 4. Ensure all calculations are correct. 5. Ensure that the evidence is properly labeled. 6. Suppress data in accordance with the CMS cell suppression policy, including suppressing in a way that the suppressed data cannot be reconstructed. 7. Ensure table titles and labels align with the contents of the table.
General	8. For the statistical testing, report rounded *p*-values for values from 0.01 through 0.99 and report ranges otherwise. 9. Revise the contents of Activity 6 in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. 10. Reference the *Conducting Performance Improvement Project Worksheet Instructional Guide* for ways to judiciously reduce the reporting of exploratory analysis and year-over-year trending analysis. 11. Clarify the data cutoff dates for the CCS administrative and hybrid rates in Activity 7. 12. Ensure that counts, rates, and *p*-values are calculated correctly. 13. In the listing of staff participating in the PIP, include title, qualifications, and responsibilities. 14. Provide an early indication of the PIP's effectiveness based on the administrative CCS rate. 15. Include interpretations of statistical significance in addition to rejection/non-rejection of the null hypothesis in Activities 8.2 and 9. 16. Ensure the content of the data tables are correct and match the narrative content. 17. Provide correct interpretations of statistical results that will be meaningful to the reader.

2023 PIP Recommendations	
***Sunflower* (Continued)**	
Diabetes Monitoring for Members with Diabetes and Schizophrenia	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. Interpret statistical test results that are not statistically significant as being inconclusive. 2. As requested by the State, follow CMS cell suppression guidelines for reporting of small numbers. 3. Since receipt of emails is not tracked, update measure definitions in Activity 5.2.c and the corresponding narrative to reflect emails being sent as the trigger event.
General	4. Provide the current aim statement in Activity 2, rather than just the original statement and descriptions of revisions. 5. In Activity 3, clarify that the continuous enrollment criterion applies to the PIP outcome measures and not the PIP population or interventions' measures. 6. Ensure conclusions are supported by the data. 7. Explain factors that affect comparability of rates (e.g., timing of interventions, characteristics of members within strata).
Waiver Employment	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. Provide possible explanations for substantial changes in denominator sizes. 2. Per CMS cell suppression policy, avoid reporting suppressed values in the narrative or other tables. 3. Provide a warning to the reader, margin of error, or *p*-value when comparing rates with small denominators. 4. Report rates or percentages for measures with defined numerators and denominators (or provide rationale for not doing so). 5. Use table titles and headings that clearly describe the data. 6. Verify calculations are correct.
General	7. For Activity 9.1, follow the analytic plan presented in Activity 7, or provide rationale for the deviations. 8. Ensure conclusions drawn are supported by the data.
Mental Health Services for Foster Care	
Activity 5	1. Review the guidance outlined in the *Conducting Performance Improvement Project Worksheet Instructional Guide* when writing annual reports to ensure required elements are included in PIP annual reports.
Activity 8	2. Interpret each intervention's effectiveness based upon the measures' results. 3. Review data tables for clarity and accuracy. 4. Provide complete technical specifications for all reported measures. 5. Provide interpretation of the intervention's success or failure based upon the measure results. 6. Follow the CMS cell suppression policy when reporting small counts, including counts in report tables and narrative. Consider aggregating data across multiple measurement periods or strata. 7. Report measures in accordance with the technical specifications and analytic plans in Activity 5 or provide an explanation for the deviations. Update Activity 5 as needed.

2023 PIP Recommendations	
Sunflower	
Mental Health Services for Foster Care (Continued)	
General	8. Refer to the *Conducting PIP Worksheet Instructional Guide* for the information on providing follow-up to each EQRO recommendation made in previous years' PIP annual validation reports as outlined in Activity 10.2. 9. For clarity, word the aim statement the same throughout the report. 10. Submit changes to the technical specifications for measures, including changes to code listings, for review by the State and KFMC using the PIP Update process. 11. Conclusions should be drawn that are supported by the data.
UnitedHealthcare	
EPSDT	
Activity 5	1. The Outcome Measure 1 denominator should be updated to reflect the age range targeted in the intervention.
Activity 8	2. Revise the analysis plan (Activity 5.1.d) to indicate the percentage of live call-referred appointments that resulted in an EPSDT claim within 90 days will be calculated using multi-year measurement periods. 3. The 2021 annual PIP report stated that the 2021 Q4 rate was based on partial data due to claims lag. Those reported values and the ones seen in the 2022 annual PIP report were the same. Please verify that those values were updated according to the same claims lag allowance as the other quarters. 4. UnitedHealthcare stated in Activity 5.3.c that their goal is to see an increase of 3 pp quarter-over-quarter in the number of foster care members who complete their annual EPSDT screening, but in Activity 8.2, that their goal is an increase of 3 pp year-over-year with corresponding quarterly data. Although both have the same meaning, the same terminology should be used in every location. 5. Clarify the analytic plan in Activity 5.3 to explain how foster care members assigned to multiple or no foster care contractors are handled in Outcome Measure 1 calculations. 6. Clarify the description of providers targeted for Intervention 4 (GIC reports to providers not participating in the incentive program) and refer to them consistently throughout the report. 7. Ensure consistency when using abbreviations and acronyms (Since CP-PCPi is an acronym for Community Plan Primary Care Provider Incentive, replace occurrences of "CP-PCPi Incentive" with either "CP-PCP Incentive" or "CP-PCPi.) 8. Replace the use of "in the EPSDT measure" with a clearer statement that will indicate whether the member component is based on those members missing closures concerning their annual EPSDT screenings or if it is based on the members who should receive an annual EPSDT screening and may or may not already done so.

2023 PIP Recommendations	
UnitedHealthcare	
EPSDT (Continued)	
General	9. The Outcome Measure 1 denominator for Intervention 5 should be updated to reflect the age range targeted in the intervention. 10. Update the analytic plan in Activity 7.2 to reflect the analysis reported in Activity 9.1 (control group, trending by age). 11. Update the analytic plan to include testing for key drivers influencing changes in Participation Rates that includes participation in interventions as factors. 12. Ensure that the interpretation of the impact of the interventions is supported by the evidence, and ensure appropriate conclusions are drawn. 13. Consistently refer to the PIP outcome measure as the "Participation Rate." 14. In future annual reports, refer to historical data regarding when members receive their EPSDT screenings or the differences in Participation Rates among the different age groups. 15. Revise the analysis plan (Activity 5.1.d) to indicate the percentage of live call-referred appointments that resulted in an EPSDT claim within 90 days will be calculated using multi-year measurement periods.
Improving Diabetes Monitoring for Members with Diabetes and Schizophrenia	
Activity 5	1. Include a summary of activities conducted in previous activity periods under the subheading of "Completed in Prior Activity Periods", per the *Conducting Performance Improvement Project Worksheet Instructional Guide.*
Activity 8	2. Provide explanations for inconsistencies between PAR and annual report results. 3. Verify the conflicting counts of the number of members listed on the GIC report.
General	4. Restate the PIP population (Activity 3) in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. 5. Correctly calculate and report the *p*-values resulting from chi-square tests. 6. For exploratory analyses presented in Activity 9.3, include interpretations of how results relate to the evaluation of the PIP or to the potential for improving interventions.
Advanced Directives	
Activity 5	1. Revise the Outcome Measure's technical specifications for clarity and to reduce technical writing problems. 2. Provide additional detail to the analytic plans so that measures are calculated according to specifications and results can be more easily interpreted. 3. Define terms not readily understood by the intended audience that are used in measure specifications and analytic plans. Use consistent terminology for technical writing. 4. Inform the reader that FE Waiver eligibility begins at age 65. 5. Update process measure technical specifications to reflect the expanded intervention population and add directions to the analytic plan for reporting statewide and Sedgwick County rates.

2023 PIP Recommendations	
UnitedHealthcare	
Advanced Directives (Continued)	
	6. Rewrite the technical specifications and analytic plans for the intervention outcome measure to reflect rates intended to be reported. 7. Revise the technical specifications for Process Measure 2 to improve clarity. 8. Add technical specifications for Process Measure 4 to Activity 5.6.c.
Activity 8	9. Verify that data in narrative agrees with data in tables. 10. Be consistent between the technical specifications for the AD training outcome measure and how results are calculated and reported. 11. Revise the column headings in the report tables for the AD training results so they are clear and appropriate based on the content of the columns. 12. Refer to the *Conducting Performance Improvement Project Worksheet Instructional Guide* for direction related to reporting of discontinued measures. The technical specifications and reported analysis are expected to be consistent. 13. Conduct and report results of root cause analysis for underperforming measure results. 14. Continue to report rates for Sedgwick County. 15. When rates differ significantly between those provided in the annual report and in PAR Snapshots for the same measure, provide an explanation for the difference. 16. Use a date for the measurement period of point-in-time measures.
General	17. Incorporate recommendations for improving the writing of the annual report into next year's report. 18. Include qualifications of each PIP role and all staff involved in the PIP in future reports. 19. Reassess the analytic plan for the PIP outcome measure—changes to the regression model and stratified analysis are warranted. 20. Review the *Conducting Performance Improvement Project Worksheet Instructional Guide* for guidance on the content and organization for the 2023 annual report, including follow-up to prior recommendations.
Housing	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. Correct or explain the inconsistency between Tables 2, 4, and 6 in the count of CCs and CHWs who scored 80% or better on the post-training test for Year 3. 2. For clarity, provide rationale for any deviations from the technical specifications. 3. Report intervention process and outcome measures according to the technical specification and analytic plan or explain how and why deviations were made. 4. Use consistent terminology within the technical specifications, analytic plans, and reporting of results. 5. Follow through with developing the additional outcome measure for Intervention 6 that was discussed in Activity 5.6.c. Submit the technical specification for review using the PIP Update process.

2023 PIP Recommendations	
UnitedHealthcare	
Housing (Continued)	
General	6. Use consistent technical terminology throughout the report where writing relates to technical specifications, analytic plans, and measure results.
Antidepressant Medication Management	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. Provide cutoff dates of the intervention measures; mature data may then be reported in subsequent annual reports. 2. Determine and report the denominator for Outcome Measure 2 consistent with the methodology in Activity 5.1.c.
General	3. Include a non-technical description of the PIP outcome measure in Activity 6.1. 4. Verify chi-square and Fisher's exact statistical tests are correctly performed. 5. In Activity 10.1, provide a discussion, in layman's terms, of the interventions and their impact on the PIP outcome measure.
Collaborative	
COVID-19 Vaccine	
Activity 5	There were no Activity 5 recommendations made for this PIP.
Activity 8	1. Ensure measure results are calculated correctly and clearly reported. 2. In Activity 8.2, provide analysis in accordance with the analysis plans of Activity 5, or explain the reasons for deviating from the plans. 3. Ensure measure results are calculated correctly and clearly reported. 4. Incorporate KSWebIZ into analysis related to vaccinations. 5. In Activity 8.2, provide analysis in accordance with the analysis plans of Activity 5, or explain the reasons for deviating from the plans.
General	6. Report results clearly and accurately.

Regulatory Area	2023 Compliance Review Recommendations
Common Among the MCOs	
2023 Review Recommendations	
In 2023, there were no recommendations that were common to all MCOs.	
Aetna	
2022/2023 Review Recommendations*	
Subpart D – MCO, PIHP and PAHP Standards: Coordination and Continuity of Care	
Case Review related to §438.208(b)(1) Coordination and Continuity of Care	1. Review the internal Aetna process to ensure the following required elements are documented in the Service Plan or a separate specified location (State Contract 5.4.4.1 *Plans of Service*) [2022 Recommendation 14]: a. Any services authorized including a detailed description of the amount, scope, and duration of services needed to help meet identified needs or to achieve goals. (State Contract 5.4.4.1.D.3) b. The pharmacy and number. (State Contract 5.4.4.1.D.9) c. Primary language being included. (State Contract 5.4.4.1.D.10) d. Eligibility start and end date. (State Contract 5.4.4.1.D.17) e. Developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting. (State Contract 5.4.4.1.F) f. Member's preferred method of receiving a copy of their service plan (paper or electronic). (State Contract 5.4.4.1.I)
	2. Review the internal Aetna process to ensure the Service Plan has the following completed (State Contract 5.4.4.1 *Plans of Service* and 5.4.4.2 *Person Centered Service Planning*) [2022 Recommendation 15]: a. Signed and approved. (State Contract 5.4.4.1.G and 5.4.4.2.C) b. Signed by the member, their MCO service coordinator, community service coordinator, and any providers that were present during the development of the Plan of Service. (State Contract 5.4.4.1.G.2) c. Signatures being obtained from, at a minimum, the service coordinator, the community service coordinator, and member prior to implementation unless an extraordinary circumstance prevented signatures from being obtained. (State Contract 5.4.4.1.G.3) d. **The medication list with date and dosages. (State Contract 5.4.4.1.D.8)** e. **Dates of next service coordination contact (State Contract 5.4.4.1.D.13)** f. **Date of annual reassessment (State Contract 5.4.4.1.D.14)** g. **Reviewed during every contact with the member and updated with new signatures as needed. (State Contract 5.4.4.1.H)**
	3. Aetna should educate providers on the following (2022 Recommendation 16): a. Providers should have contact with other service providers. b. The provider should acknowledge test results. c. The provider should have follow-up of all results and inform the member of the results. d. **Follow-up, next steps or plans for each encounter should be documented by the provider.**

* 2022 Recommendations Applicable to the 2023 Review (amendments to the recommendations are in bold).

Regulatory Area	2023 Compliance Review Recommendations
***Aetna* (Continued)**	
2022/2023 Review Recommendations*	
Subpart D – MCO, PIHP and PAHP Standards: Coordination and Continuity of Care (Continued)	
Case Review related to §438.208(b)(1) Coordination and Continuity of Care	4. Aetna should review the following cases and determine appropriate follow-up, if needed (e.g., MCO follow-up regarding the specific case or general provider education) [2022 Recommendation 18]. KFMC provided Aetna details for each member in a separate, secure document: a. 2022 Sample Selection: LTSS – NF Member 7 b. **2023 Sample Selection: LTSS – NF Members 4 and 9**
2023 Review Recommendations	
Case Review Related to §438.208(b)(3) Coordination and Continuity of Care	5. Re-educate staff that health screen should be completed or an attempt to contact the member should be made within 90 days of enrollment or every other year.
Sunflower	
2023 Review Recommendations	
Subpart F – Grievance and Appeal System	
Grievance Case Review related to §438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.2.1.16.2; §438.210(c) Notice of Adverse Action; §438.404(b)(3) Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice; and §438.416(b)(6) Recordkeeping Requirements	1. For the identified cases, review the internal system documentation and determine who filed the grievance and ensure all areas of the internal system are consistent. KFMC provided Sunflower details for the members in a separate, secure document (Members 11, 17, and 19).
Appeal Case Review related to §438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.2.1.16.2 and 4.4.2.1.15.7; §438.404(b)(3) Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice; and §438.416(b)(6) Recordkeeping Requirements	2. For the identified case, the name of the individual submitting the appeal should be identified in the internal system. KFMC provided Sunflower details for the member in a separate, secure document (Member 23).

* 2022 Recommendations Applicable to the 2023 Review (amendments to the recommendations are in bold).

Regulatory Area	2023 Compliance Review Recommendations
***Sunflower* (Continued)**	
2023 Review Recommendations	
Subpart F – Grievance and Appeal System (Continued)	
Appeal Case Review related to §438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.4.2.1.15.7)	3. Re-educate staff on the most appropriate selection to choose for who submitted the appeal (Members 6 and 23). KFMC provided Sunflower details for the members in a separate, secure document (Members 6 and 23).
	4. Re-educate staff that the requestor in TruCare should be congruent with PRIME. KFMC provided Sunflower details for the members in a separate, secure document (Members 7 and 9).
Appeal Case Review related to §438.404(b)(6) Timely and Adequate Notice of Adverse Benefit Determination (Content of Notice); §438.210(c) Notice of Adverse Action; and §438.408(e)(2)(ii-iii) Resolution and Notification: Grievances and Appeals – Content of Notice of Appeal Resolution	5. Re-educate staff to double check that the correct appeal resolution letter was sent to the member (Member 30).
§438.406(b)(5) Handling of Grievances and Appeals: Special Requirements (Member's request of case file during appeal)	6. In Sunflower policy and procedure *KS.QI.11 Appeal and Grievance System Description*, section "Member Requests for Appeal Documents," specify that if members make a request for documentation, the information must be supplied sufficiently in advance of the appeal resolution.
Appeal Care Review related to §438.408(b)(2) Resolution and Notification: Grievances and Appeals – Specific Timeframes-Standard Resolution of Appeals; §438.410(c)(2) Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution	7. Review this case and advise if the appeal should have been processed since Sunflower identified that an Authorized Representative form was not needed to review this appeal (Member 5).
§438.408(c)(2)(ii) Resolution and Notification: Grievances and Appeals (Extension of timeframes: Requirements following extension) and §438.410(c)(2)(iii) Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution	8. Update language in the *Member Handbook*, in the section "Appeals Basics" to include language detailing the member has the right to file a grievance if he or she disagrees with the decision to extend the timeframes not at the request of the member.

Regulatory Area	2023 Compliance Review Recommendations
***Sunflower* (Continued)**	
2023 Review Recommendations	
Subpart F – Grievance and Appeal System (Continued)	
Grievance Case Review related to §438.416(b)(2) Record Keeping Requirements	9. Sunflower should review the cases identified to determine the correct grievance date and address as appropriate to ensure the grievance date is consistent throughout the internal system and grievance acknowledgement/resolution letters (e.g., changes to the internal system to capture the accurate date and/or staff education). KFMC provided Sunflower details for the members in a separate, secure document (Members 5, 7, 9, 13, 14, 16, and 23-25).
	10. Grievance receipt date, subcontractor review date, and grievance resolution date needs to be clear in the internal Sunflower system (Members 11 and 12).
Grievance Case Review related to §438.416(b)(3) Record keeping Requirements	11. Provide evidence of the dates the grievance was reviewed to make a determination (Members 11, 12, 19, 22-24, 26, 27, 29, and 30).
Appeal Case Review related to §438.416(b)(2) Recordkeeping Requirements	12. For the identified case, review the internal system documentation and determine and identify the date the appeal was filed (Member 23).
UnitedHealthcare	
2023 Review Recommendations	
Subpart F – Grievance and Appeal System	
§438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.2.1.16.2; §438.404(b)(3) Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice; and §438.416(b)(6): Recordkeeping Requirements	1. Review the cases identified to determine the name of the person that filed the grievance and address as appropriate to ensure the system consistently reflects who filed the grievance (e.g., staff education). KFMC provided UHC details for the members in a secure separate document. (Members 16, 21, 22, 29, and 30)
§438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.2.1.16.2; §438.404(b)(3) Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice	2. Review who filed the grievance and determine their relationship to the member and ensure it is documented in the internal system. (Member 30)
§438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File) and State Contract 4.4.2.1.15.7; §438.404(b)(3) Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice	3. For the identified cases, review internal system documentation and determine who submitted the appeal and ensure all areas of the internal system are consistent. (Members 7, 13, 18, and 19)

Regulatory Area	2023 Compliance Review Recommendations
***UnitedHealthcare* (Continued)**	
2023 Review Recommendations	
Subpart F – Grievance and Appeal System (Continued)	
§438.406(b)(1) Handling of Grievances and Appeals (Special requirements)	4. In the UHC *2023 Care Provider Manual*, sections "Member grievance" and "Member appeals," page 105, where the grievance and appeal process is explained, add language to inform members of the grievance/appeal acknowledgement process and timeframe. (State Contract section 5.2 "Provider Grievance Process," subsection 5.2.1.4 and section 5.4.7 "Provider Appeals Process," subsection 5.4.7.1.5)
	5. For provider appeals, re-educate staff that the health plan is to send written acknowledgement of an appeal receipt within ten (10) calendar days of the date the health plan received the appeal request. (Member 27)
Case Review related to §438.416(b)(2) Recordkeeping Requirements	6. UHC should review the cases identified to determine the correct grievance date and address as appropriate to ensure the grievance date is consistent throughout the internal system and grievance acknowledgement letter (e.g., changes to the internal system to capture the accurate date and/or staff education). KFMC provided UHC details for the members in a secure separate document (Members 29 and 30).
Grievance issues not related to an element on the review tool for §438.416(b) Recordkeeping Requirements	7. Re-educate staff that information entered in the internal UHC database should be double checked prior to finalization (Members 6, 13, and 19). KFMC provided UHC details for the members in a secure separate document.
	8. Develop a policy and procedure outlining the appropriate use of abbreviations with an approved abbreviation list and educate staff. If such policy and procedure exists, re-educate staff on importance to use only approved abbreviations in documentation.

State Contract Area and QAPI Checklist Requirement	2023 QAPI Review Recommendations
Common Among the MCOs	
In 2023, there were no recommendations that were common to all MCOs.	
Aetna	
5.9.1 General Requirements, letter G (QAPI Checklist Requirement 6)	1. Include activities in future QAPI work plans to address mechanisms to identify members enrolled in LTSS Waivers but not receiving waiver services.
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter C (QAPI Checklist Requirement 18) and *5.9.1 General Requirements*, letter N, number 6 (QAPI Checklist Requirement 15)	2. In future QAPI work plans, State Contract-specified objectives C.2 and C.4 of section 5.9.3(C) should be included to demonstrate how the QAPI program addresses them.
5.9.4 Performance Measures – General Requirements, letters A-B (QAPI Checklist Requirement 19)	3. In future QAPI work plans, include information on the following measures: a. *Breast Cancer Screening (BCS-AD)* b. *Chlamydia Screening in Women ages 16 to 24 (CHL)*
Sunflower	
5.9.1 General Requirements, letter E (QAPI Checklist Requirement 4)	1. In future QAPI work plans, include an activity that SHP completes to achieve detection of underutilization and overutilization of services.
5.9.1 General Requirements, letter F (QAPI Checklist Requirement 5)	2. In future QAPI work plans, include an activity that SHP completes to develop and implement mechanisms used to compare services and supports received with those in the member's treatment/service plan.
5.9.1 General Requirements, letter N, number 6 (QAPI Checklist Requirement 15)	3. In future QAPI work plans, include the SHP internal Quality Program objectives that are detailed in the *2022 QAPI Program Evaluation*.
	4. Include in future QAPI work plans, the priorities and recommendations that were selected for implementation in the prior year QAPI program evaluation.
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter A *Guiding Principles* (QAPI Checklist Requirement 16)	5. In future QAPI work plans, include State Contract-specified guiding principles (A)(2), (A)(4-5), (A)(7), and (A)(10-11) of section 5.9.3(A) to demonstrate how the QAPI program addresses them.
	6. In future QAPI work plans, for guiding principle 5.9.3(A)(8), include detail on a transparent and collaborative environment with providers and other stakeholders.
	7. In future QAPI work plans, include an activity that SHP completes for integration and infusion of the State identified guiding principles.

State Contract Area and QAPI Checklist Requirement	2023 QAPI Review Recommendations
***Sunflower* (Continued)**	
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter B *Goals* (QAPI Checklist Requirement 17)	8. In future QAPI work plans, include State Contract-specified goals (B)(1-6) of section 5.9.3(B) to demonstrate how the QAPI program addresses them.
	9. In future QAPI work plans, clearly state QAPI program goals and use them consistently.
	10. In future QAPI work plans, use the term "goals" as defined in the State Contract, section 5.9.3(B).
	11. In future QAPI work plans, use the term "goals" consistently.
	12. In future QAPI work plans, for the SHP objective "Incorporation of the State identified goals" in column D, include an activity that SHP completes to achieve this requirement.
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter C, *Objectives* (QAPI Checklist Requirement 18)	13. In future QAPI work plans, include State Contract-specified objectives (C)(1-7) of section 5.9.3(C) to demonstrate how the QAPI program addresses them.
	14. In future QAPI work plans, clearly state QAPI program objectives and use them consistently.
	15. In future QAPI work plans, use the term "objectives," as defined in the State Contract, section 5.9.3(C).
	16. In future QAPI work plans, use the terms "objectives" and "activities" consistently. (State Contract, section 5.9.3[C])
	17. In future QAPI work plans, for the SHP objective "State identified seven objectives to meet established QAPI goals," in column D, include an activity that SHP completes to achieve this requirement.
5.9.7 National Committee for Quality Assurance Accreditation – General Requirements (QAPI Checklist Requirement 22)	18. In future QAPI work plans, for the SHP Objective "NCQA Accreditation" in column D, include activities related to SHP's NCQA Accreditation, the level of accreditation, and/or when the next accreditation will occur.
5.9.8 HEDIS and CAHPS – General Requirements (QAPI Checklist Requirement 23)	19. In future QAPI work plans, include information on the following identified HEDIS requirements: a. *Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET).* [QMS Objective 4.5] b. *HbA1c good control (<8.0%) for Members with diabetes* [QMS Objective 5.1] c. *Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)* [QMS Objective 5.2a] d. *Well-Child Visits 15-30 months (15-30-month period & name change in 2020)* [QMS Objective 5.2b] e. *Child and Adolescent Well-Care Visits (WCV) ages 3-11* [QMS Objective 5.3a] f. *Child and Adolescent Well-Care Visits (WCV) ages 12-17* [QMS Objective 5.3b] g. *Child and Adolescent Well-Care Visits (WCV) ages 18-21* [QMS Objective 5.3c]

State Contract Area and QAPI Checklist Requirement	2023 QAPI Review Recommendations
***Sunflower* (Continued)**	
5.9.8 HEDIS and CAHPS – General Requirements (QAPI Checklist Requirement 23)	20. In future QAPI work plans, for the SHP Objective "Healthcare Effectiveness Data and Information Set (HEDIS) data collection and reporting for population-specific HEDIS measures," include the State QMS required HEDIS measures Goal 4, Objective 4.5 and Goal 5, Objectives 5.1, 5.2a-b, and 5.3a-c.
5.16.1 Reports and Audits, letter B (QAPI Checklist Requirement 29)	21. In future QAPI work plans, for the SHP Objective "Data received from Participating Providers" in column D, include an activity that SHP completes to ensure that data received from Participating Providers is accurate and complete.
UnitedHealthcare	
5.2.2 Disenrollment, letter B, number 2 and *5.9.1 General Requirements*, letter A (QAPI Checklist Requirements 1 and 2)	1. In future QAPI documents, reference, as applicable, committee meeting activities that are used to provide evidence of compliance with the State's QAPI requirements.
5.9.1 General Requirements, letter N, number 6 (QAPI Checklist Requirement 15)	2. In future QAPI work plans, in the column "Comments/Status/Previous Issue Update," include the QAPI evaluation recommendations that will be implemented that year and/or include a new activity row within the work plan. 3. In future QAPI work plans, describe activities that UHC will do to improve HEDIS goals that are identified in the prior year QAPI evaluation.
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter A *Guiding Principles* (QAPI Checklist Requirement 16)	4. In future QAPI work plans, State Contract-specified guiding principles (A)(2), (A)(10), and (A)(11) of section 5.9.3(A) should be included to demonstrate how the QAPI program addresses them.
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter B *Goals*, numbers 1 and 6 (QAPI Checklist Requirement 17)	5. In future QAPI work plans, incorporate the following missing elements of the State Contract-specified goals of section 5.9.3(B) to demonstrate how the QAPI program addresses them: a. Add to UHC internal Goal A, row 8 Objective, the part of the State-specified goal(s) related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports." (State Contract, section 5.9.3[B][1]) b. Add to UHC Internal Goal B, row 16 Objective, the part of the State-specified goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members." (State Contract, section 5.9.3[B][6])
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter C, *Objectives* (QAPI Checklist Requirement 18)	6. In future QAPI documents, ensure that UHC "Program Objectives" are consistent across the documents. 7. In future QAPI work plans, in the UHC "Program Objectives," State Contract-specified objectives (C)(1-5) and (C)(7) of section 5.9.3(C) should be included to demonstrate how the QAPI program addresses them.

State Contract Area and QAPI Checklist Requirement	2023 QAPI Review Recommendations
***UnitedHealthcare* (Continued)**	
5.9.4 Performance Measures – General Requirements, letters A-B (QAPI Checklist Requirement 19)	8. In future QAPI work plans, include information on the measure *Breast Cancer Screening (BCS-AD)*.
5.9.7 National Committee for Quality Assurance Accreditation – General Requirements (QAPI Checklist Requirement 22)	9. In future QAPI work plans, include information on NCQA Accreditation and LTSS Distinction.
5.9.8 HEDIS and CAHPS – General Requirements (QAPI Checklist Requirement 23)	10. In future QAPI work plans, include information on how UHC addresses the HEDIS measure *Breast Cancer Screening (BCS-AD)* and State QMS, Goal 5, Objectives 5.1, 5.2a-b, and 5.3a-c.

Appendix D

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

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

Based on documentation provided for review, the completion status of previous recommendations was scored using the following scale:

- Fully Addressed – Documentation clearly indicated all aspects of the recommendation were applied.
- Substantially Addressed – Most parts of the recommendation were applied; some issues remain.
- Partially Addressed – Some parts of the recommendation were applied; issues remain.
- Not Addressed – Documentation did not indicate any part of the recommendation was applied.
- In Progress – Review indicated efforts to meet the recommendation are active.
- No Longer (or Not) Applicable – Changing circumstances rendered the recommendation not applicable.
- Not Assessable – KFMC could not determine the completion status of the recommendation.

Performance Measure Validation and Evaluation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Common Among the MCOs		
Performance Recommendations		
1.	The MCOs should prioritize improvement efforts towards the following HEDIS measures: • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment • Metabolic Monitoring for Children and Adolescents on Antipsychotics • Breast Cancer Screening • Chlamydia Screening in Women • Ambulatory Care – Emergency Dept Visits/1000 member-months (MM) for ages less than 1 year through 19 years	See MCO sections below
2.	For all measures, the MCOs should work to improve indicator rates that are below the Quality Compass national 75th percentile, pursuant to the State's Quality Management Strategy. **KFMC Update:** For the 2021 measurement year, Aetna had three Adult Core Set and six Child Core Set measure indicators with rates above the 75th percentile; in 2022, the count was unchanged for both Adult and Child Core Set measure indicators. Six Adult and nine Child Core Set measure indicators rates below the 75th percentile in MY 2021 improved their ranking in MY 2022. For MY 2021, Sunflower had six Adult Core Set and eight Child Core Set measure indicators rates above the 75th percentile; for MY 2022, seven Adult and nine Child Core Set measure indicators rates were above the 75th percentile. Five Adult and seven Child Core Set measure indicators rates below the 75th percentile in MY 2021 improved their ranking for MY 2022. UnitedHealthcare had eight Adult and seven Child Core Set measure indicators rates that ranked above the 75th percentile for MY 2021; for MY 2022, ten Adult Core Set indicators had rates above the 75th percentile, but the count was unchanged for Child Core Set measure indicators. Rates below the 75th percentile in MY 2021 increased their ranking for four Adult and four Child Core Set measure indicators for MY 2022.	In Progress

Performance Measure Validation and Evaluation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna		
Technical Recommendations		
1.	Aetna should continue to monitor for the completeness of the race and ethnicity data provided in the State enrollment files and explore additional data sources for members who declined to provide the information during KanCare enrollment, or whose race and ethnicity category is unknown. **KFMC Update:** Aetna Better Health monitored the completeness of race and ethnicity data. While Aetna Better Health has identified additional sources, they only used the KMMS race and ethnicity data as a data source.	Fully Addressed
Performance Recommendations		
2.	Aetna should prioritize improvement efforts towards the following HEDIS rates: • **Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence** **KFMC Update:** Aetna is addressing follow-up after emergency department visits through a variety of direct and indirect approaches. In addition to programs begun last year, they have added a pilot project this year. This measure had a break in trending due to significant changes in the measure between MYs 2021 and 2022. ○ 7-Day Follow-Up: 27.1% rate ranked ≥50th ○ 30-Day Follow-up: 41.0% rate ranked >66.67th • **Initiation and Engagement of Alcohol and Other drug Abuse or Dependence Treatment, now Initiation and Engagement of Substance Use Disorder (SUD) Treatment** **KFMC Update:** In addition to the programs started in the prior year, Aetna have begun a telehealth pilot project. NCQA advised a break in trending between MYs 2021 and 2022 due to major changes in the indicators. However, rates and ranks continue to be low. ○ Engagement of SUD Treatment ▪ Total: 11.4% ranked <50th ○ Initiation of SUD Treatment ▪ Total: 36.9% ranked <25th ▪ Opioid Abuse or Dependence: 35.4% ranked <5th	In Progress In Progress

Performance Measure Validation and Evaluation

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna	
Performance Recommendations (Continued)	
• **Childhood Immunization Status and Immunizations for Adolescents, particularly HPV for adolescents; continue influenza vaccination performance improvement efforts** **KFMC Update:** Aetna is addressing immunization rates through various strategies. Childhood vaccination rates worsened for all but two antigens; adolescent vaccination rates improved for two of three antigens. The HPV rank decreased from <50th to <25th. ○ Childhood Immunizations – Combination 10: 33.3%, 1.5 pp increase, ranked ≥50th ▪ Influenza: 41.9%, 1.0 pp increase, ranked <50th ○ Adolescent Immunizations – Combination 2: 28.7%, 5.8 pp decrease, ranked <25th ▪ HPV: 28.7%, 6.3 pp decrease	In Progress
• **Metabolic Monitoring for Children and Adolescents on Antipsychotics** **KFMC Update:** The rate (43.3%) decreased 1.6 pp from MY 2021, and the rank remained >75th. Aetna is implementing a new value-based strategy with Community Mental Health Centers. While opportunity for improvement remains, since the rank has remained greater than the 75th percentile since 2018, KFMC considers this recommendation to be Fully Addressed for the purpose of this evaluation.	Fully Addressed
• **Well-Child Visits in the First 30 Months of Life and Child and Adolescent Well-Care Visits for all age groups, including 18-21 years; continue focus on EPSDT performance improvement project** **KFMC Response:** Aetna has implemented a variety of strategies to improve well-child visit rates, with increases for members below the age of three (W30) but decreases for members older than 30 months (WCV). Aetna has a related PIP. ○ First 15 Months: 58.3%, 2.4 pp increase, improving trend of 4.4 pp/y from 2020 to 2022, but ranked <50th ○ 15 Months–30 Months: 60.8%, 1.9 pp increase, but ranked <25th ○ 3–11 Years: 49.7%, 1.2 pp decrease, ranked <25th ○ 12–17 Years: 44.7%, 1.0 pp decrease, ranked <33.33rd ○ 18–21 Years: 17.9%, 1.7 pp decrease, ranked <25th	In Progress

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna	
Performance Recommendations (Continued)	
• **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications and Other Cessation Strategies** **KFMC Update:** KFMC compared the 2021-2022 average rates to the 2019-2020 average rates for the indicators other than percentage of current smokers and tobacco users. ○ Total % Current Smokers: 32.0%, no change from 2021, although the rank worsened to >75th (lower rank is better). ○ Discussing Cessation Medications: 47.1%, 0.23 pp increase, ranked <33rd (<25th in 2019-2020) ○ Discussing Cessation Strategies: 39.8%, 4.0 pp decrease, ranked <25th (<33.33rd in 2019-2020) ○ Advising Smokers to Quit: 71.5%, 1.8 pp decrease, ranked <50th (unchanged from 2019-2020)	In Progress
• **Cervical Cancer Screening** **KFMC Update:** Cervical Cancer Screening rate, 54.7%, ranked <50th, an improvement from <33.33rd in MY 2021. It had an average improving trend of 3.6 pp/y from 2019 to 2022.	In Progress
• **Chlamydia Screening in Women** **KFMC Update:** The rates for Chlamydia screening remained below the 10th percentile. ○ Age 16 to 20: 38.1%, 0.5 pp increase, rank <5th ○ Age 20 to 24: 50.7%, 1.3 pp decrease, rank <10th	In Progress
• **Breast Cancer Screening** **KFMC Update:** The rate, 36.5%, for Breast Cancer Screening remained below the 5th percentile.	In Progress
• **Prenatal and Postpartum Care** **KFMC Update:** Aetna has been conducting a related PIP; however, strong evidence of the effectiveness and sustainability of the interventions has not been shown. Aetna plans to continue provider incentives and started member incentives in 2023. The Postpartum Care indicator remained below the 33.33rd percentile, had an approximate 1.0 pp improvement from MY 2021, but a statistically significantly worsening trend of 3.2 pp/y from 2019 to 2022. Timeliness of Prenatal Care improved 1.5 pp from MY 2021 and ranked below the 25th percentile, which was an improvement from the 2021 ranking of below the 10th percentile.	In Progress

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna		
Performance Recommendations (Continued)		
	• **Ambulatory Care – Emergency Department Visits /1000 Members (Ages <1 through 19 Years)** **KFMC Update:** Visits for all age groups increased in MY 2022. Rates were previously reported as visits for 1000 member months; the measure was modified to report visits per 1000 members. The three-year trend has been increasing, with the largest increase for members less than one year of age (average of 166.8 more visits per 1000 members per year).	In Progress
	• **Adherence to Antipsychotic Medications for Individuals with Schizophrenia** **KFMC Update:** The rate decreased almost 1.0 pp from MY 2021; the rank improved from below the 25th percentile to below the 33.33rd percentile, indicating national performance worsened more than Aetna's performance. Aetna is implementing a value-based strategy with Community Mental Health Centers.	In Progress
	• **Flu Vaccinations for Adults** **KFMC Update:** The rate was equal to or greater than the 50th percentile but decreased 1.9 pp from 2021.	Partially Addressed
Sunflower		
Technical Recommendations		
1.	Sunflower should analyze the completeness of member race and ethnicity data and continue to explore additional data sources to supplement the race and ethnicity data captured from the State 834 enrollment files. **KFMC Update:** Sunflower Health Plan analyzed the completeness of race and ethnicity data. Sunflower Health Plan only used the KMMS race and ethnicity data as a data source, but additional sources were explored.	Fully Addressed

Performance Measure Validation and Evaluation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower (Continued)		
Performance Recommendations		
2.	Sunflower should prioritize improvement efforts towards the following HEDIS rates: • **Antidepressant Medication Management – Effective Continuation Phase Treatment** **KFMC Update:** There was a 1.0 pp decrease in the rate, and the ranking remained <25th. Sunflower's response appeared to include the same efforts as provided in the previous year. • **Chlamydia Screening in Women** **KFMC Update:** Sunflower continues to address chlamydia screening. There were no statistically significant changes or trends. ○ 16–20 years: 40.7%; 0.3 pp increase; <25th percentile; 0.7 pp/y improving trend ○ 21–24 years: 54.5%; 1.7 pp increase; <25th percentile; 0.7 pp/y worsening trend • **Breast Cancer Screening** **KFMC Update:** Sunflower continues a variety of strategies to improve women's health, including breast cancer screening. There has been minimal improvement in the breast cancer screening rates over the last several years. ○ 50.0%; 0.2 pp increase; <50th percentile; 0.4 pp/y worsening trend • **Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence** **KFMC Response:** Both the 7-Day and 30-Day rates ranked above the 66.67th percentile, an improvement from MY 2021. NCQA advised a break in trending due to significant changes in the measure. ○ 7 Days: 28.8% ○ 30 Days: 42.0%	Partially Addressed In Progress In Progress In Progress

Performance Measure Validation and Evaluation

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower	
Performance Recommendations (Continued)	
• **Ambulatory Care – Emergency Dept Visits/1000 MM for ages less than 1 year through 19 years** **KFMC Update:** Visits for all age groups increased in MY 2022. Rates are expressed as visits per 1000 members (rates previously reported as visits per 1000 member-months were converted for comparison). The three-year trend has been increasing, with the largest increase in the group of members under one year old (average of 205.9 more visits per 1000 members per year). ○ Age <1: 1139.1, an increase of 145.6 visits per 1000 members from 2021 ○ Age 1 through 9: 550.3, an increase of 96.9 visits per 1000 members from 2021 ○ Age 10 through 19: 407.2, an increase of 31.5 visits per 1000 members from 2021 ○ Total: 509.1, an increase of 64.5 visits per 1000 members from 2021	Partially Addressed
• **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment** **KFMC Update:** Sunflower continues various strategies to address this measure. NCQA advised a break in trending between MY 2021 and 2022 due to major changes in the indicators; the measure was also renamed to Initiation and Engagement of Substance Use Disorder Treatment. All indicators for Initiation of SUD Treatment ranked <25th. All indicators for Engagement of SUD Treatment were less than the 50th percentile; Engagement for Opioid Use Disorder ranked <25th. ○ Initiation of SUD (18–64 Years) Total: 37.7%, ranked <25th ○ Initiation for Opioid Use Disorder: 44.4%, ranked <25th ○ Engagement of SUD (18+ Years) Total: 10.8%, ranked <33.33rd	In Progress
• **Comprehensive Diabetes Care – Poor HbA1c Control** **KFMC Response:** The indicators for the Comprehensive Diabetes Care measure were separated out into their own measures for MY 2022. Poor HbA1c Control is now an indicator for the measure Hemoglobin A1c Control for Patients with Diabetes (HBD). The MY 2022 rate for Poor HbA1c Control was 40.9% and ranked <50th.	In Progress

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower	
Performance Recommendations (Continued)	
• **Follow-Up After Hospitalization for Mental Illness** **KFMC Update:** Sunflower continues to address follow-up after hospitalizations for mental illness through various strategies and the rates continued to rank greater than the 75th percentile. While the rates have slightly decreased and there has been an average worsening per year, these decreases have not been statistically significant. Since Sunflower is meeting the KanCare expectations for HEDIS rates to rank greater than the 75th percentile, KFMC considers this recommendation fully addressed. ○ Ages 18–64 Years ▪ Within 7 days: 44.8%; 1.1 pp decrease; 1.7 pp/y average worsening ▪ Within 30 days: 66.6%; 1.4 pp decrease; 0.6 pp/y average worsening ○ Ages 6–17 Years ▪ Within 7 days: 59.2%; 0.5 pp decrease; 0.4 pp/y average worsening ▪ Within 30 days: 78.9%; 0.5 pp decrease; 0.3 pp/y average worsening	Fully Addressed
• **Prenatal and Postpartum Care** **KFMC Update:** The ranking for the rates of both indicators improved from less than the 10th percentile to less than the 25th percentile. Due to the level of improvement efforts and the gap-to-goal improvement from 2021, KFMC considers this recommendation to be substantially addressed. However, KFMC does not consider it Fully Addressed since the rates, although improved, are less than the 25th percentile. ○ Prenatal Care: 75.9%, an increase of 7.1 pp and 22.6% gap-to-goal improvement ○ Postpartum Care: 72.0%, an increase of 5.1 pp and 15.4% gap-to-goal improvement	Substantially Addressed
• **Continue existing improvement efforts for Child and Adolescent Well-Care Visits** **KFMC Update:** The rate decreased for all three age categories, with the largest decrease in the 12 to 17 age group. Sunflower have implemented a variety of improvement efforts, including adding it to P4P. The average change (pp/y) is from 2020 to 2022. ○ 3–11 Years: 55.1%, ranked <50th, 1.1 pp decrease, 2.2 pp/y improvement ○ 12–17 Years: 51.0%, ranked ≥50th, 1.4 pp decrease, 1.1 pp/y improvement ○ 18–21 Years: 22.5%, ranked <50th, 1.1 pp decrease, 1.8 pp/y worsening ○ 3–21 Years: 48.6%, ranked ≥50th, 2.0 pp decrease, 0.5 pp/y improvement	In Progress

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower	
Performance Recommendations (Continued)	
• **Immunizations – Childhood, Adolescent (HPV)** **KFMC Update:** Childhood immunization rates decreased for all but one antigen (Hepatitis B); for all of these except Hepatitis A and Varicella-Zoster, the decrease was greater than 10% gap-to-goal. The rate for four of the ten antigens ranked <33.33rd. The Immunization for Adolescents vaccination rate for HPV (31.0%) decreased 7.1 pp from MY 2021, and the rank fell from ≥ 50th to <33.33rd.	In Progress
• **Metabolic Monitoring for Children and Adolescents on Antipsychotics** **KFMC Update:** While the rate warrants improvement, for the purpose of this review and to be in alignment with the State Quality Management Strategy, the rate has ranked greater than the 75th percentile since 2018, and the annual decrease and average worsening trend were not statistically significant. Therefore, KFMC is considering this recommendation to be fully addressed. ○ 42.2%, 2.4 pp decrease, average 1.5 pp/y worsening	Fully Addressed
• **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Medications and Advising Smokers to Quit** **KFMC Update:** Total % Current Smokers had a statistically significant improving trend of 1.6 pp/y. KFMC compared the 2019-2020 rates to the 2021-2022 rates for the indicators other than the percentage of current smokers and tobacco users. Since the recommendation was focused on discussing cessation medications and advising smokers to quit, and both had decreases, KFMC considers this recommendation to still be in progress. KFMC acknowledges the gains made in discussing cessation strategies (>75th) and the improving trend for the percent of current smokers and tobacco users. ○ Total % Current Smokers, (lower is better) 24.0%, 0.7 pp lower than 2021 ○ Advising Smokers to Quit, 74.3%, ranked ≥50th, worsened 15.7% gap-to-goal (3.5 pp) from 2019-2020 ○ Discussing Cessation Medications, 55.0%, rank decreased from >75th to >66.67th, worsened 16.1% gap-to-goal (6.2 pp) from 2019-2020 ○ Discussing Cessation Strategies, 53.1%, rank improved from >50th to >75th, increased 3.9 pp from 2019-2020	In Progress

Performance Measure Validation and Evaluation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare		
Technical Recommendations		
1.	From the 2021 report, UnitedHealthcare should carefully review the Roadmap and ISCA responses prior to submission to ensure that where the questions are similar, the responses are consistent. **KFMC Update:** While most ISCA responses were consistent with the Roadmap responses, there were a few questions that had inconsistent responses.	Partially Addressed
2.	UnitedHealthcare should analyze the completeness of member race and ethnicity data and continue to explore additional data sources to supplement the race and ethnicity data captured from the State 834 enrollment files. **KFMC Update:** UHC analyzed the completeness of race and ethnicity data. UHC used the KMMS race and ethnicity data as the primary source for race and ethnicity data. UHC also derived member ethnicity using member language to enhance data completeness.	Fully Addressed
Performance Recommendations		
3.	UnitedHealthcare should prioritize improvements efforts for the following HEDIS rates: • **Breast Cancer Screening** **KFMC Response:** There was a slight increase (1.2 pp) in the breast cancer screening rate from 2021. The ranking did not change from the 33.33rd percentile. • **Chlamydia Screening in Women** **KFMC Update:** UnitedHealthcare implemented a variety of improvement strategies. ○ 16–20 years, 40.6% (<25th), a 1.1 pp decrease from 2021 (41.7%, <25th) ○ 21–24 years, 58.4% (<33.33rd), a 2.2 pp increase from 2021 (56.2%, <33.33rd) • **Metabolic Monitoring for Children and Adolescents on Antipsychotics** **KFMC Update:** UnitedHealthcare has implemented a variety of improvement strategies. The total rate, 41.6%, decreased 6.1 pp from the previous year (47.6%), and the rank decreased from >75th to >66.67th.	In Progress In progress In Progress

Performance Measure Validation and Evaluation

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment** **KFMC Update:** Additional efforts specific to the topic have been implemented. Due to changes in the definitions of the measures, NCQA recommended a break in trending for the measure. ○ Initiation of SUD Treatment ▪ Alcohol: 37.3%, <25th ▪ Opioid: 33.7%, <5th ▪ Other drug: 37.0%, <25th ▪ Total: 36.5%, <10th ○ Engagement of SUD Treatment ▪ Alcohol: 8.4%, <33.33rd ▪ Opioids: 13.4%, <10th ▪ Other drug: 9.6%, <50th ▪ Total: 9.9%, <25th	In Progress
• **Antidepressant Medication Management** **KFMC Update:** There were small increases in the rates and rankings, and both indicators had improving trends. UnitedHealthcare has implemented a variety of targeted improvement strategies and is conducting a related PIP. ○ Effective Acute Phase Treatment: 56.7%, increased 1.9 pp, improved 2.3 pp/y from 2018; rank improved from <25th to <33.33rd ○ Effective Continuation Phase Treatment: 40.8%, increased 2.4 pp, improved 2.4 pp/y from 2018; rank improved from <25th to <50th	Substantially Addressed
• **Well-Child Visits in the First 30 Months of Life** **KFMC Update:** UnitedHealthcare implemented several improvement efforts. ○ First 15 Months: 59.9%, a 2.8 pp increase; rank remained ≥50th ○ 15–30 Months: 60.1%, a 1.1 pp increase; rank remained <25th	In Progress

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Continue existing improvement efforts for Child and Adolescent Well-Care Visits** **KFMC Update:** Ages 18–21 continued to have the lowest rate. HEDIS Roadmap indicates EPSDT Outreach Live Calls are conducted. ○ Ages 3–11: 50.6%, a 1.2 pp decrease; rank decreased from <33.33rd to <25th ○ Ages 12–17: 45.5%, a 2.6 pp decrease; rank decreased from <50th to <33.33rd ○ Ages 18–21: 18.7%, a 2.2 pp decrease; rank decreased from <33.33rd to <25th ○ Total: 43.9%, decreased 2.7 pp; rank decreased from <50th to <33.33rd	In Progress
• **Continue existing improvement efforts for Medical Assistance with Smoking and Tobacco Use Cessation** **KFMC Update:** KFMC compared the 2021-2022 average rates to the 2019-2020 average rates for the indicators other than percentage of current smokers and tobacco users. All indicators, with the exception of percentage of current smokers and tobacco users, worsened from 2019-2020. ○ Total % Current Smokers: 27.2%, decreased 5.6 pp, ranking improved from >75th to ≥50th (lower rate and ranking are better) ○ Advising Smokers to Quit: 71.5%, decreased 12.2% gap-to-goal (3.1 pp) from 2019-2020, ranked <50th, and had a statistically significantly worsening trend of 2.9 pp/y from 2018 ○ Discussing Cessation Medications: 48.0%, decreased 2.4 pp from 2019-2020, ranked <50th ○ Discussing Cessation Strategies: 38.9%, decreased 11.9% gap-to-goal (6.5 pp) from 2019-2020, statistically significantly worsening trend of 3.7 pp/y from 2018, rank decreased from <50th to <25th	In Progress
• **Follow-Up After Hospitalization for Mental Illness (18 to 64 Years)** **KFMC Update:** UnitedHealthcare has multiple strategies in place to address follow-up after hospitalization for mental illness. The rates for members 18–64 Years have ranked >75th since 2018 and remained stable. While opportunity for improvement remains, KFMC considers this recommendation fully addressed due to the rates being above the Quality Compass 75th percentile. ○ 7-Day Follow-Up: 43.2%, 0.4 pp decrease from 2021 ○ 30-Day Follow-Up: 65.6%, 0.1 pp increase from 2021	Fully Addressed

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence** **KFMC Update:** UnitedHealthcare's response makes comparisons to the prior year's Quality Compass rankings. However, as noted below, the rates were above the 75th percentile. While there is further opportunity for improvement, for the purpose of this review, KFMC considers the recommendation fully addressed since the 75th percentile requirement by the State has been met. Due to changes in the measure definition, NCQA recommended a break in trending for this measure. ○ Age 18+, 7-Day Follow-Up: 32.1% ○ Age 18+, 30-Day Follow-Up: 44.7%	Fully Addressed
• **Ambulatory Care – Emergency Dept Visits/1000 MM for ages less than 1 year through 19 years** **KFMC Update:** Rates are expressed as visits per 1000 members (rates previously reported as visits per 1000 member-months were converted for comparison). Due to this change, Quality Compass rankings were not available for MY 2022. Three of four indicators had a greater than 10.0% gap-to-goal worsening; all indicators had a worsening trend, with the greatest increase in the less than one year group. ○ Ages Less than 1 Year: 1099.6, an increase of 172.9 visits/1000 members (18.7% gap-to-goal) ○ Ages 1–9 Years: 541.9, an increase of 89.1 visits/1000 members (19.7% gap-to-goal) ○ Ages 19 Years and Less: 495.2, an increase of 60.8 visits/1000 members (14.0% gap-to-goal)	In Progress

Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Immunizations – Childhood, Adolescent, and Adult** **KFMC Update:** UnitedHealthcare continued improvement efforts. Flu Vaccinations for Adults, 48.3%, increased 5.8 pp from 2021, and its rank improved to >75th from >66.67th in 2021. Two Childhood Immunization indicators worsened more than 10.0% gap-to-goal from 2021. Three antigens had statistically significantly worsening trends from 2018. Only three antigens were above the 50th percentile (Hepatitis A, Hepatitis B, and Rotavirus). o Influenza, 37.0% rate, <50th, 8.5 pp decrease from 2021 (15.6% gap-to-goal) o Combination 10, 31.6%, ≥50th, statistically significant 7.1 pp decrease from 2021 (11.6% gap-to-goal) o DTaP, 66.7%, decreased 1.8 pp/y, ranked <33.33rd o HiB, 79.8%, decreased 1.3 pp/y, ranked <33.33rd o Hepatitis B, 87.6%, decreased 1.0 pp/y, ranked ≥50th For Immunizations for Adolescents, all indicators were below the 50th percentile: o HPV, 25.8%, ranked <10th, decreased 5.8 pp from 2021, with a statistically significant worsening trend of 2.2 pp/y from 2018 o Tdap, 81.0%, ranked <33.33rd, had a statistically significantly worsening trend of 1.3 pp/y o Meningococcal, 79.6%, <50th, 0.5 pp increase from 2021 o Combination 1, 78.8%, <50th, 1.0 increase from 2021 o Combination 2, 25.1%, <25th, 6.1 pp decrease from 2021, and worsening trend of 2.2 pp/y from 2018	In Progress

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna PIP – EPSDT		
1.	In the next annual report, explain the discrepancy involving the CPT-4 codes used in the PIP outcome measure analysis. The impact of the discrepancy on the results should be provided and prior reported measurements corrected, if needed. **Aetna Response:** Aetna reviewed the technical specifications and removed CPT code 99212 from the query and from the specification document. To avoid confusion, all references to specifications point the reader back to the technical specifications in Appendix A. **KFMC Response:** Current and prior rates were calculated using the approved technical specifications for the PIP outcome measure.	Fully Addressed
2.	Provide an interpretation of all analysis results. **Aetna Response:** This was added to 9.3 for this report. **KFMC Response:** Aetna discussed the data provided in Activity 9.1 in Activity 9.3. This included comparison of measure years, special populations, and efficacy of the interventions. Activity 9.3 also interpreted the exploratory data and listed future changes that are planned or in progress.	Fully Addressed
3.	The differences KFMC noted in Aetna's documentation of the CPT-4 codes, identified for the member incentive intervention, should be explained in the next annual report. **Aetna Response:** Aetna reviewed the technical specifications and removed CPT code 99212 from the query and from the specification document. To avoid confusion, all references to specifications point the reader back to the technical specifications in Appendix A. Also discussed in 8.1 **KFMC Response:** As Aetna explained, the erroneous code was removed.	Fully Addressed
4.	Details should be provided in the next annual report to clarify if the same webinar content Aetna planned to post to their website will be used by the vendor, EventBrite, when they host webinars in 2022, and also if the webinar will be offered quarterly. **Aetna Response:** The details on the provider webinar were clarified in Activity 5.5. and in Activity 8.1. EventBrite is the platform Aetna uses to offer the webinars to the providers and office staff, however, EventBrite does not host the webinar. Aetna hosts the webinar internally and invitations to attend are sent through Teams. **KFMC Response:** Aetna clarified how they use EventBrite in the intervention and stated the same webinar is conducted quarterly.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna PIP – EPSDT (Continued)		
5.	Ensure the most recent technical specifications for the PIP outcome measure are being used and provided in the annual report. **Aetna Response:** This was noted, and the most recent technical specifications have been attached for this annual report. **KFMC Response:** Technical specifications were included in the annual report.	Fully Addressed
Aetna PIP – Pregnancy: Prenatal Care		
1.	Revise the analytic plan for the texting campaign and IVR campaigns to indicate the 90-day claims run-out period only applies to claims-dependent measures. **Aetna Response:** Complete **KFMC Response:** Aetna clarified that the 90-day claims runout only applies to the verification of a prenatal visit in the first trimester or within 42 days of enrollment for new members.	Fully Addressed
2.	Update the aim statements to indicate more clearly the baseline rates and performance goals. **Aetna Response:** Complete **KFMC Response:** A baseline and performance goal was provided for each aim of the PIP.	Fully Addressed
3.	Define the PIP population as female members with a pregnancy during the activity period. **Aetna Response:** Complete **KFMC Response:** Activity 3 was not updated as recommended.	Not Addressed
4.	Provide complete specifications for outcome measures and separate specifications for administrative and hybrid Timeliness of Prenatal Care measures. **Aetna Response:** Complete **KFMC Response:** Not all specifications were contained in Activity 6.2 (or placed elsewhere with a reference in Activity 6.2). Provide a citation to NCQA documentation for HEDIS measures. A technical definition is needed for "notification date" for Outcome Measure 1.	Partially Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***Aetna PIP – Pregnancy: Prenatal Care* (Continued)**		
5.	Incorporate monthly tracking of the administrative Timeliness of Prenatal Care indicator in the analysis plan for the PIP outcome measures. **Aetna Response:** Complete **KFMC Response:** The recommendation was based on Aetna's statement in Activity 6.2, "The modified, unaudited measure to monitor performance will be used throughout the PIP and serve to provide monthly and quarterly monitoring of progress." Monthly monitoring of Outcome Measure 2 was not added to Activity 7.2. Instead, plans were added to stratify Outcome Measure 2 rates.	Not Addressed
6.	Provide more details to the plans for analyzing the PIP outcome measures to assess the effectiveness of PIP as a whole and the effectiveness of interventions individually. **Aetna Response:** Complete **KFMC Response:** Additional details were included and consistent with the analysis presented.	Fully Addressed
7.	Provide a detailed interpretation, in layman's terms, of the data analysis results. **Aetna Response:** Complete **KFMC Response:** The details were appropriate for the intended audience.	Fully Addressed
Aetna PIP – Food Insecurity		
1.	Conduct analysis according to the analytic plans, which may need to be revised for clarity and technical precision, or explain why analysis deviated from the plans. **Aetna Response:** Complete **KFMC Response:** No issues were cited in the current report.	Fully Addressed
2.	Follow the analytic plan for the CPESN intervention described in the methodology (testing for statistical significance) or provide an explanation for not doing so. **Aetna Response:** Complete **KFMC Response:** Aetna removed statistical significance testing from the CPESN intervention's analytic plan. The revised plan was followed.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna PIP – Food Insecurity (Continued)		
3.	Ensure non-technical descriptions, outcome measures, and data analysis are consistent. **Aetna Response:** Complete **KFMC Response**: No issues were cited in the current report.	Fully Addressed
4.	Provide documentation for staff who are participating in the PIP according to the *Conducting Performance Improvement Project Worksheet Instructional Guide*. **Aetna Response:** Complete **KFMC Response:** While all staff were listed, their qualifications were not included, as instructed in the *Conducting PIP Worksheet Instructional Guide*.	Partially Addressed
5.	Ensure analysis results described in the report narrative are consistent with the data presented. **Aetna Response:** Complete **KFMC Response:** The figure was not included in the current report; similar issues were not cited.	Fully Addressed
Aetna PIP – LTSS-Emergency Department Visits		
1.	Aetna should state the revised aim statement and then discuss changes from the prior version. **Aetna Response:** Fully addressed per recommendation for activity 2 **KFMC Response:** Revisions to Activity 2 were appropriate.	Fully Addressed
2.	In describing the proposed revision to the PIP goals for the outcome measure, Aetna should clearly indicate whether a relative change or absolute change (percentage point change) is intended. Stating the targeted rate would also improve clarity. **Aetna Response:** Addressed by the new aim for the PIP **KFMC Response:** Revisions to the goal were appropriate.	Fully Addressed
3.	Present the proposal for changes to the PIP goals to the State and KFMC for review and discussion. Goal changes need the State's approval. **Aetna Response:** Fully addressed and goals approved on 5/5/2023 **KFMC Response:** The proposed changes were reviewed and discussed by the State and KFMC.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna PIP – LTSS-Emergency Department Visits (Continued)		
4.	The anchor date should be removed from the PIP population definition. **Aetna Response:** Fully addressed in section 2.1 **KFMC Response:** The anchor date was removed.	Fully Addressed
5.	Aetna should ensure International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes are consistent in narrative and Appendices. **Aetna Response:** Fully addressed **KFMC Response:** Specific ICD codes were not specified in the narrative. All ICD code statements directed the reader to an appendix in the annual report.	Fully Addressed
6.	Provide a summary of the opportunities for improving the PIP in the report. **Aetna Response:** Fully addressed **KFMC Response:** Aetna provided a detailed summary of opportunities to further strengthen the PIP.	Fully Addressed
7.	Remove the sentence, "Clarifications have been added to the specifications for the outcome measure," from the definition of the PIP outcome measure. **Aetna Response:** Fully addressed **KFMC Response:** The sentence was removed.	Fully Addressed
Aetna PIP – Influenza Vaccination		
1.	Precisely define the PIP population (i.e., the population for whom improvement is intended). Separately define the denominator of the PIP's outcome measure. **Aetna Response:** Fully addressed **KFMC Response:** The PIP population was defined as directed and the denominator population was stated separately in Activity 6.	Fully Addressed
2.	Revert the date on which age is based back to January 1 for the PIP outcome measure. **Aetna Response:** Fully addressed **KFMC Response:** The age was reverted to January 1.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Aetna PIP – Influenza Vaccination (Continued)		
3.	Clarify age ranges throughout the report. **Aetna Response:** Fully addressed **KFMC Response:** Age ranges were clarified throughout the report.	Fully Addressed
4.	Ensure that interpretations of analysis results are supported by the data (e.g., relationship between declining flu vaccination rates and COVID-19 prevalence rates). **Aetna Response:** Fully addressed **KFMC Response:** Statements not supported by the data were made in multiple activities.	Not Addressed
5.	Label tables and describe populations consistently and accurately (e.g., age ranges). **Aetna Response:** Fully addressed **KFMC Response:** Specific instances were corrected. However, the title of Figure 10 and years labels in Tables 9 and 10 did not match the data.	Partially Addressed
6.	Review the *Conducting Performance Improvement Project Worksheet Instructional Guide* for guidance on the content for all activities. **Aetna Response:** Fully addressed **KFMC Response:** Content was appropriate.	Fully Addressed
7.	Include the insights resulting from the analysis of the texting campaign as a predictor for receiving a flu vaccination. **Aetna Response:** Fully addressed **KFMC Response:** This analysis was not reported in Activity 9 this year.	Not Applicable
Sunflower PIP – EPSDT		
1.	Establish a goal for post-training test scores or for the percentage point increase between pre-training to post-training test scores for the staff training on the importance of EPSDT screenings. **Sunflower Response:** Opposed to a percentage point increase between pre and post-test scores, Sunflower added training goals that set a standard post-training score and a standard retention score. This ensures a high standard is met post training, rather than just increasing upon a pre score. **KFMC Response:** The goal for post-training test scoring overall rate was set to 94%.	Fully addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower PIP – EPSDT (Continued)		
2.	In the 2022 annual report, describe the one-on-one provider intervention activities completed and any changes in the implementation of the intervention. **Sunflower Response:** Activity 5.3.a has been expanded to elaborate on the intervention activities and changes have been documented in 8.1.3. **KFMC Response:** Details of the provider intervention activities were clearly explained in Activity 5.3.a.	Fully Addressed
3.	Ensure analyses for process and outcome measures are conducted according to the approved methodology's measure specifications and analytic plans or provide rationale and details of changes. **Sunflower Response:** This annual report realigns to approved methodology and any deviation has been explained in the narrative. **KFMC Response:** The measures were reported as defined.	Fully Addressed
4.	Ensure analysis results described in the report narrative are consistent with the data presented in tables. **Sunflower Response:** This has been reviewed and confirmed. **KFMC Response:** This year's report has several examples of statistics being presented and misinterpreted. For example, on two occasions, Sunflower "accepted" the null hypothesis, and subsequently stated that the rates were different from each other. The null hypothesis is that there is no difference between the rates.	Partially Addressed
5.	Accurately describe data being tested or measured and how the results are being interpreted. **Sunflower Response:** This annual report should accurately describe results and interpretation of results. **KFMC Response:** The results of the logistic regression were presented but never discussed or interpreted. The output from Python was copied into the report, but no description of the analysis or the results was provided.	Partially Addressed
6.	Ensure all data and statistical interpretations are verified for accuracy and clarity in future reports. **Sunflower Response:** Sunflower utilized a Centene statistician, and the statistical analysis and interpretation was reviewed by Centene's healthcare and clinical analytics. **KFMC Response:** Some of the data presented were not accurate. Analysis did not show an understanding of the difference between the null hypothesis and the alternative hypothesis.	Partially Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower PIP – Cervical Cancer Screening		
1.	Ensure the content of the data tables are correct and match the narrative content (e.g., ensure prior year's data are not being inadvertently reported as current year's data). **Sunflower Response:** Sunflower identified a need for technical specifications to be written for all data tables within the PIP annual report. This will ensure the table content is labeled correctly and future reporting aligns and is consistent year over year. Additionally, we added remeasurement periods and included historically reported data to ensure easy comparison and appropriate titling. **KFMC Response:** Activity 8.2 contains incorrect rate and *p*-value calculations along with mislabeled data tables. Data for mPulse and POM interventions were interchanged in cross-tabulation tables in Activity 9.1.	Not Addressed
2.	Provide correct interpretations of statistical results that will be meaningful to the reader (e.g., interpretation rate differences using odds ratios). **Sunflower Response:** Reviewed with statistician and will include statistical results that are meaningful to the reader as applicable. **KFMC Response:** The narrative presenting statistical test results contained interpretation errors in Activities 8.2 and 9.1. In Activity 9.3, a discussion of results in terms of rates and differences in rates would be more readily understood by the intended audience than the interpretation given in terms of odds and odds ratios.	Not Addressed
3.	Determine which are the most relevant statistical tests to report and do not include statistical tests that do not provide meaningful results (e.g., proportions tests). **Sunflower Response:** Reviewed by the statistician and will only provide statistical tests that add substance and value to the annual report. **KFMC Response:** The statistical tests chosen were appropriate for the data and hypotheses being tested.	Fully Addressed
4.	Include in the analysis plans for regression analysis, testing for correlation between the variables (e.g., age and region) and goodness of fit of the model. **Sunflower Response:** Reviewed with statistician and have included regression analysis planning for testing correlation between variables and fit of the model. **KFMC Response:** This was provided and presented in tabular form with a good explanation of the results.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***Sunflower PIP – Cervical Cancer Screening* (Continued)**		
5.	Change the focus of logistic regression from determining the relationship between the CCS rate and demographic and clinical characteristics to determining which interventions were most effective. **Sunflower Response:** Reviewed with statistician and have included intervention correlation and regression analysis. **KFMC Response:** The interventions were tested, and a test of multicollinearity was performed finding only weak correlations between interventions.	Fully Addressed
6.	Ensure statements of success of the PIP are supported by the data presented. **Sunflower Response:** The overall goal of the PIP, to increase the hybrid HEDIS rate by 5 percentage points by PIPs (Performance Improvement Projects) end and has been surpassed. Additional detail will be paid to any other accounting of success, ensuring it aligns with the data presented. **KFMC Response:** Statements of success were supported by the data in Activities 9.3 and 10.1.	Fully Addressed
Sunflower PIP – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		
1.	Ensure consistency of data reported in multiple tables. **Sunflower Response:** Fully addressed: Tables have been reviewed and data accuracy has been ensured so that contradictory data does not exist. **KFMC Response:** Data in tables were consistent.	Fully Addressed
2.	Revise the analytic plans to improve readers' understanding of the analytic results by providing additional detail and proper placement of reported results. **Sunflower Response:** Fully addressed: The analytic plan was revised for this annual reporting period and adjusted within this annual report. **KFMC Response:** Analytic plans were revised as recommended.	Fully Addressed
3.	To ensure that conclusions are supported by the data, test for statistical significance. **Sunflower Response:** Fully addressed: The analytic plan was revised for this annual reporting period and statistical significance was tested where applicable. **KFMC Response:** Statistical testing was enhanced and appropriate for the data.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower PIP – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) (Continued)		
4.	Clarify the race/ethnicity categories in the presentation of results. **Sunflower Response:** Fully addressed: Ethnicity definitions were collapsed as appropriate, and this variable was only included as part of the regression analysis. **KFMC Response:** Descriptions of categories clearly reflected the race/ethnicity of the members within each stratum.	Fully Addressed
5.	Do not include as key drivers or results data resulting from small sample sizes. **Sunflower Response:** Fully addressed: Results documented in Activity 10 are resulting from larger sample sizes, where a chi square can be performed and considered a valid finding for determination of results. **KFMC Response:** Key drivers included in the regression analysis appeared to be sufficiently populated.	Fully Addressed
Sunflower PIP – Waiver Employment		
1.	Follow the analysis plan in the approved methodology for the PIP outcome measures—unemployment rates were not presented, and no data were submitted for 2020 to determine whether a two percent increase year-over-year was achieved between 2020 and 2021. **Sunflower Response:** The analytic plan was revised for this annual report due to the data availability and possible analysis that could be produced. Unemployment rates have been presented by remeasurement year, to include the 2-percentage point increase goal and actual. **KFMC Response:** The revised analytic plan was appropriate.	Fully Addressed
2.	To describe the PIP population more accurately, Sunflower should remove the criteria related to interventions' targeted memberships and outcome measure denominators. **Sunflower Response:** This has been removed. **KFMC Response:** Sunflower removed this detail from Activity 3.	Fully Addressed
3.	In future annual reports, details from prior activity periods should be provided for the interventions using a brief summary for each year. Also, include details of the intervention to reflect the plan at the beginning of the activity year. **Sunflower Response:** This has been included in this annual report. **KFMC Response:** Sunflower provided details of prior activity periods and the plan at the beginning of the activity year.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Sunflower PIP – Waiver Employment (Continued)		
4.	All elements included in an intervention PDSA cycle should reflect the continuous improvement activity for the period of time covered in the annual report. **Sunflower Response:** Noted for future reference. PDSA cycles will ensure proper reference in this and future annual reports. **KFMC Response:** Sunflower included a PDSA for only the current activity year.	Fully Addressed
5.	The technical specifications and the analytic plan for the Project SEARCH outcome measure should be followed from the approved PIP methodology. **Sunflower Response:** This has been provided in this annual report in 8.2.1. **KFMC Response:** Sunflower identified the measurement period of 4/1/2020 to 3/31/2021 as the baseline.	Fully Addressed
6.	The analytic plan from the approved PIP methodology should be followed and the outcome measure reported (percentage of case managers eligible for the training who completed the training). **Sunflower Response:** Where data was available, it was reported according to an analytic plan. All data tables provide the approved methodology, where data was not collected, this has been noted. **KFMC Response:** Sunflower made appropriate changes to the reported data.	Fully Addressed
7.	In the next annual report, data should be provided using the measure Sunflower defines for the STEPS mailing. **Sunflower Response:** The measure has been updated. **KFMC Response:** Sunflower provided data for all three measurement periods with notations identifying the type of mailer.	Fully Addressed
Sunflower PIP – Mental Health for Foster Care		
1.	Follow the CMS cell suppression guidelines when reporting statistics based on small counts, including report tables and narrative. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Although the report indicated values 1 to 10 would be suppressed, they were not in Table 8, 10, and 11.	Not Addressed
2.	Reassess the PIP's aim, goal, measures, and interventions and modify the PIP to bring the interventions into alignment with the aim statement. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Reassessment resulted in the PIP being replaced with a similar PIP.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***Sunflower PIP – Mental Health for Foster Care* (Continued)**		
3.	Provide complete technical specifications for all measures being reported. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Technical specifications were provided.	Fully Addressed
4.	Redesign of the PIP outcome measure results is needed to make it clear that the goal is a 2% relative increase from the prior year's rate. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** The table displaying the PIP outcome measure results was redesigned. The goal was clearly shown to be an annual increase of 2 percentage points. A reason for changing from relative to percentage point increases was not provided.	Fully Addressed
5.	Conclusions should be drawn that are supported by the data. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Conclusions in Activity 9.1 were not supported by the data.	Not Addressed
6.	Define intervention measures in the activities they are reported in. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Definitions were provided as recommended.	Fully Addressed
7.	For tables, use titles and row and column labels that describe the data. Add footnotes for clarification, if needed. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Titles, row, and column labels reflected the data, except for the title of Table 8.	Partially Addressed
8.	If reporting tests for statistical significance, describe the type of test, the data tested, and the test results. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** The name of the test and *p*-values were provided.	Fully Addressed
9.	Refer to the *Conducting PIP Worksheet Instructional Guide* for the information that should be included in each activity, as well as provide follow-up to each EQRO recommendation made in previous years' PIP annual validation reports in the appropriate activity. **Sunflower Response:** An MCO response was not provided. **KFMC Response:** Activity 10.1 was consistent with the instructional guide, but 10.2 did not address key components.	Partially Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – EPSDT		
1.	Update the analytic plan to guide the analysis to be conducted. **UnitedHealthcare Response:** UHCCP addressed this recommendation in Activity 7.2. **KFMC Response:** Individual tests of Chi-square were not performed for all variables. They also did not describe the control group and the trending by age. The purpose of the demographic analysis continues to be misstated.	Partially Addressed
2.	Evaluate the relative effectiveness of the different interventions on the PIP outcome measure; use logistic regression to account for members receiving multiple interventions and to control differences in age ranges. **UnitedHealthcare Response:** UHCCP provided a logistic regression analysis in Activity 9.1. **KFMC Response:** Logistic regression for multiple interventions was not performed. Logistic regression was used to test the effect of demographic variables on having a screening.	Not Addressed
3.	Clarify the description of providers targeted for GIC reports to providers not participating in the incentive program and refer to them consistently throughout the report. **UnitedHealthcare Response:** UHCCP provided information about this change in Activity 8.1. UHCCP updated the verbiage throughout the report that pertains to Intervention 4 and providers who did not participate in the incentive program, to provide more standardization and clarity for the reader. **KFMC Response:** While UnitedHealthcare attempted to clarify which providers were being targeted, they did not address the usage issues cited in 8.2 and continued to use the undefined phrase "in the EPSDT measure." It is still unclear if the provider group would receive a GIC report if they had 50 or more members within the 0 to 20 age group or if the provider group would receive a GIC report if they had 50 or more members that have not completed their annual EPSDT screening.	Not Addressed
4.	The data presented for the provider incentive program intervention should be consistent with the definition of Outcome Measure 1 in the technical specifications or the measure should be modified. **UnitedHealthcare Response:** UHCCP has verified that the information in Table 16 for Intervention 5, Outcome Measure 1, is consistent with the definition of Outcome Measure 1 in the methodology. **KFMC Response:** UnitedHealthcare changed the denominator description appropriately in their Table 16.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD)		
1.	Review the analytic plan for statistical testing of differences in SMD rates between demographic groups and the presentation of analytic results to ensure the intended analysis is conducted and clearly interpreted. **UnitedHealthcare Response:** UHCCP reviewed the plan in Activity 7.2 prior to writing narrative analysis in Activity 9.1 and believes the two activities are in alignment. **KFMC Response:** The activities were in alignment. The analysis was clearly presented.	Fully Addressed
2.	In the next annual report, document activities according to the *Conducting Performance Improvement Project Worksheet Instructional Guide* for the Care Management outreach interventions to members on waivers and members in WPC. **UnitedHealthcare Response:** UHCCP referenced the Conducting Performance Improvement Project Worksheet Instructional Guide when writing this annual report, including guidance for Activity 8.2. Additional description of the activity was provided in this annual report. **KFMC Response:** The summary provided in Activity 8.1 was appropriate for the intervention changes. No PDSA was needed.	Fully Addressed
3..	When numerators or denominators fall below the threshold for reporting results of the care management outreach to members in WPC, still provide an interpretation of the extent to which the intervention was or was not successful, any lessons learned from less than optimal performance, and any follow-up activities to improve performance. **UnitedHealthcare Response:** As noted in Activity 8, values for intervention 2 continue to fall below reporting thresholds for most metrics. UHCCP reported on one of four metrics by combining the call campaigns between years. See Activity 8.2 for additional details. UHCCP reports that the process was followed and noted no barriers to conducting the intervention. Due to the small values within the data, a full interpretation of the extent to which the intervention was successful cannot fully be based on the actual data outcomes. However, UHCCP reports that the data seen within the unreported metrics has a wide variance in outcomes. This is not surprising considering the small amount of data. UHCCP expects that values in the next annual report may be large enough to report when the data from the third year is combined with the first two years of data. See Activity 10.4 for additional analysis. **KFMC Response:** UnitedHealthcare's response was sufficient.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) (Continued)		
4.	Explain the difference in denominators between the annual report and the PAR for the process measure. **UnitedHealthcare Response**: UHCCP provided additional details in Activity 8.2 about why differences may be seen in data between the PAR data and data within this annual report. Caution is warranted when comparing the data sets. **KFMC Response:** UnitedHealthcare provided a reasonable explanation to why there was a difference between denominators of the annual report and PAR measures.	Fully Addressed
5.	Ensure consistency of the results in the annual report between the narrative and data tables for the GIC distribution intervention. **UnitedHealthcare Response:** UHCCP conducted multiple reviews of the narrative and data tables in Activity 8 for the GIC intervention. **KFMC Response:** No inconsistencies between the narrative and data tables were found.	Fully Addressed
6.	Ensure the analysis and narrative related to process and outcome measures are consistent with the measures' technical specifications. **UnitedHealthcare Response:** UHCCP has made note in the analysis that caution is advised in comparing PAR and annual report data. Details can be found in Activity 8.2. UHCCP reviewed the specifications before writing the analysis in this report. **KFMC Response:** UnitedHealthcare provided a reasonable explanation to why there was a difference between denominators of the annual report and PAR measures.	Fully Addressed
UnitedHealthcare PIP – Advanced Directives		
1.	Update the analytic plan to reflect current analytic needs. **UnitedHealthcare Response:** UHCCP has a new Quality lead for the AD PIP that is connecting with KFMC about updating analytic plans for all UHCCP PIPs. **KFMC Response:** Correspondence between the new Quality Lead and KFMC's Senior Health Data Analyst resulted in improvements to the logistic regression reported in Activity 9.1. The report would have benefited from upgrading of other areas of analysis.	Partially Addressed
2.	Ensure analysis results described in the annual report and presented in tables are verified for accuracy. **UnitedHealthcare Response:** Tables and commentary have been reviewed for accuracy and alignment. Language both within and outside of the tables has been updated to provide more clarity and accuracy. **KFMC Response:** Issues of data accuracy were not cited for the current report.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***UnitedHealthcare PIP – Advanced Directives* (Continued)**		
3.	In the 2022 annual report, align year over year improvement goals (currently 3 percentage points per year) with the PIP outcome goal of having an AD on file with UnitedHealthcare for 50% of members in LTC by the end of the PIP. **UnitedHealthcare Response:** UHCCP requested and was granted approval to reduce the AIM target goal from 50% to 25% after discovering errors in how outcomes had previously been reported. **KFMC Response:** During the approval process for the request to change the outcome goal from 50% to 25%, the annual 3 percentage point goal was discussed and considered appropriate.	Fully Addressed
4.	Be consistent between the technical specifications for the AD training process measures and how they are calculated and reported. **UnitedHealthcare Response:** UHCCP has aligned these items. **KFMC Response:** This was not an issue in the current report.	Fully Addressed
5.	The analysis plan should be followed when calculating measures for the established members. **UnitedHealthcare Response:** UHCCP has reviewed the analysis plan and has followed this plan when calculating measures for established members. **KFMC Response:** The process measure was calculated incorrectly based on numerator and denominator definitions in Activity 5.4.	Not addressed
6.	Update the analysis plan for interventions to include reporting of measurements of the full intervention population and of the Sedgwick County FE waiver pilot group once the intervention is expanded beyond the pilot group. **UnitedHealthcare Response:** This has been incorporated by creating separate tables for Intervention #5 for Sedgwick County and for Statewide intervention for FE Waiver members. Intervention #4 has been discontinued effective 10/31/2022. **KFMC Response:** The changes addressed the recommendation.	Fully Addressed
UnitedHealthcare PIP – Housing		
1.	Determine goals for the PIP outcome measures in the aim statement. **UnitedHealthcare Response:** UHCCP met with KFMC and KDHE to discuss a new PIP aim and outcome measure. UHCCP submitted a new aim statement and outcome measure and received an approval on April 19, 2023. The new PIP aim statement and outcome measure are stated in this report. **KFMC Response:** The aim statement was revised appropriately.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – Housing (Continued)		
2.	Report PIP outcome measure results according to the technical specifications and analytic plans or explain how and why deviations were made. **UnitedHealthcare Response:** Please see activity 6.2 and 7 for technical specification and analytic plans. Please note that a short description on technical specification for 2, 3 and 6 are added since those intervention feed the outcomes for the PIP (activity 6.2). Also, we realized that there is a need to develop a new outcome measure for intervention 6 to support the data collection feeds into the aim of this PIP. **KFMC Response:** A new outcome measure replaced the measures reported in the prior years. The analysis reported in Activity 9.1 was consistent with the technical specifications and analytic plan.	Fully Addressed
3.	Provide technical specifications for ad hoc measures. **UnitedHealthcare Response:** UHCCP team believes that measures used for the demographic analysis are defined in activity 9.1. **KFMC Response:** With the additional detail provided in Activity 9.1, the specifications were sufficiently complete.	Fully Addressed
4.	Interpret measure results consistent with the statistical analysis. **UnitedHealthcare Response:** UHCCP team believes that statistic analysis and consistent interpretation are stated in 9.1. **KFMC Response:** No issues were cited this year.	Fully Addressed
5.	Interpret the extent to which the PIP outcome measures indicate the overall effectiveness of the interventions toward realizing the goals of the PIP. **UnitedHealthcare Response:** The UHCCP team believes that narrative and the analysis presented in activity 9.3 supports the conclusion that the PIP is effective based on the outcome measure of the PIP as defined in activity 6.2. However, it also describes challenges and the need to define a new outcome measure for intervention 6. **KFMC Response:** This year, Activity 9.3 contained the required content.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – AMM		
1.	Acknowledge that the baseline AMM acute rate was pre-pandemic and correctly state the baseline time periods. **UHCCP Response:** The baseline intake period is from 5/1/2018 – 4/30/2019. UHCCP has reviewed the report to reflect this baseline date range throughout. **KFMC Response:** Updates to the report met the recommendation.	Fully Addressed
2.	Submit substantive changes to measure specifications for review through the PIP update process. **UHCCP Response:** UHCCP has noted this recommendation. No substantive changes were made to the interventions from the previous annual report. Minor changes, as noted in Activity 8.1, were made to interchangeable terms and systems used for documenting calls but UHCCP does not consider these changes substantive changes to the intent or design of the interventions. **KFMC Response:** No changes made during this activity period warranted review through the update process.	Fully Addressed
3.	Use terminology consistently throughout the narrative and the measures specifications. **UHCCP Response:** The originally approved methodology included and used the terms "contact" and "call" interchangeably throughout the document. KFMC's analysis in the previous annual report indicated this may be unclear. In response to this feedback, UHCCP decided to adjust language within this report to include the term "call". This adjustment does not alter the original intent of the metrics, nor does it impact how UHCCP is pulling or reporting data. **KFMC Response:** UnitedHealthcare used the term "call" consistently throughout the report.	Fully Addressed
4.	If interventions target the same population, use the same population definitions. **UHCCP Response:** Updated description was included in Activity 5.3.a to more clearly indicate the intervention #3 population was the same as intervention #1. **KFMC Response:** This was clearly stated in Activity 5.3.a.	Fully Addressed
5.	Refer to the implementation guide for directions on documenting PDSA and non-PDSA changes. **UHCCP Response:** UHCCP referred to instructional guide. **KFMC Response:** No PDSA cycles were included in this report, nor were they needed.	Fully Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
UnitedHealthcare PIP – AMM (Continued)		
6.	Do not label a process measure as "interim" without explaining why the data are not complete. **UHCCP Response:** Interim label was removed from process measures 1 and 2 (intervention #1) and from process measure 1 (intervention #3). Interim label applies to process measure 3 (intervention #1) and explanation can be found in Activity 8.2. **KFMC Response:** Explanations were provided for data labelled as "interim."	Fully Addressed
7.	In Activity 10.1, provide a discussion, in layman's terms, of the interventions and their impact on the PIP outcome measure. **UHCCP Response:** UHCCP provided analysis of the interventions in Activity 10.1. **KFMC Response:** Statistical information was included in Activity 10.1 (interpretation of statistical information should be included in Activity 9). An overall reflection of interventions and the impact was not provided.	Partially Addressed
8.	Determine and report adherence for the outcome measures consistent with the methodology in Activity 5.1.d. **UnitedHealthcare Response:** UHCCP reviewed methodology language and reports results accordingly. **KFMC Response:** The calculation for the denominator for Outcome Measure 1 denominator was consistent with the methodology in Activity 5.1.d.	Fully Addressed
9.	Analyses of the impact of changing the method of identifying the populations for interventions should be completed and reviewed before decisions are made to change the methods. Report results that may be of interest to other managed care organizations interested in adapting the PIP in the next annual report. **UHCCP Response:** UHCCP conducted a review of using HEDIS® data as a source for population identification at the intervention level. It was discovered that the HEDIS® data would identify the population of interest for the outcome measure. However, the lag from the time a member first begins their antidepressant medication and the time the member shows up within the HEDIS® data set was too great for UHCCP to make a meaningful impact through the use of interventions defined within this PIP. The decision was made to continue with the current plan for member identification for interventions. **KFMC Response:** The issue was reassessed and reported in Activity 10.3.	Fully Addressed
Collaborative COVID-19		
1.	Continue PIP activities until a decision on continuation or discontinuation of the PIP is received from the State. **Collaborative Response:** NA, This PIP has been discontinued. **KFMC Response:** While the PIP was discontinued, a decision to discontinue it was not made until August 2, 2023. This left time in the activity year for the interventions to continue as planned.	Partially Addressed

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Collaborative COVID-19 (Continued)		
2.	Determine goals specific to age ranges 6 months to 4 years, 5 to 11 years, and 12 to 17 years. Stratify PIP outcome measure results by age range. **Collaborative Response:** Goals established for youth in annual report as requested. **KFMC Response:** The MCOs established a goal of 45% for members aged 5 to 17 years.	Fully Addressed
3.	Provide complete technical specifications for the PIP outcome measure in Activity 6.2 and detail analytic plans for the PIP outcome measure in Activity 7.2. **Collaborative Response:** More detail was provided by all MCO's on how data is extracted. Analytic plans in 7.2 were updated to address validity concerns. **KFMC Response:** The activities were sufficiently detailed.	Fully Addressed
4.	Remove chi-square testing for statistically significant differences between measurement periods from the analytic plan, Activity 7.2. **Collaborative Response:** Removed chi-squares in favor of logistic regressions after restructuring the data. Analytic plans in 7.2 were updated to address validity concerns. **KFMC Response:** The recommendation was followed.	Fully Addressed
5.	Report results clearly and accurately. **Collaborative Response:** This report updated with results to address validity concerns and make sure information is clear and defined accurately. **KFMC Response:** Issues cited in the prior report were addressed, but clarity and accuracy remained an issue.	Partially Addressed
6.	When partnering with its parent company for member outreach and education, the MCOs should ensure that the data needed for reporting by the local plan will be available and provided. **Collaborative Response:** Addressed and defined barriers in the report on member outreach and education, details given on any changes, but this PIP has been discontinued. **KFMC Response:** Partnering with the parent companies did not occur in this activity period.	Not Applicable

CAHPS Health Plan 5.1H Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
Common Among All MCOs		
1.	All MCOs should continue to expand their care coordination efforts, particularly for children with chronic conditions, including primary care physicians being informed and up to date about the care children receive from other doctors and health providers. Encouraging providers to discuss with the parents and guardians (or the youth themselves) whether their children receive care or services elsewhere, request releases of information, and establish bi-directional ongoing communication with the other providers. The MCOs could assist providers in identifying members' other sources of care, for the provider to use in flagging medical records as prompts for initiation of coordination of care discussions (e.g., similar to gap-in-care communications). **KFMC 2023 Update:** The KanCare adult rate decreased again in 2023 with the rank now being above average ≥50th. The KanCare GC score saw no improvement from 2022 and still ranks below the national average (<50th). The score for the Coordination of Care for Children with Chronic Conditions composite decreased and now ranks below the 10th percentile.	In Progress
2.	MCOs should further review their processes for encouraging providers to assess and respond to members' mental health and emotional health issues, and for encouraging members to access mental health or substance use disorder services. **KFMC 2023 Update**: The KanCare adult and GC percentages of respondents indicating their [their child's] mental or emotional health was excellent or very good marginally improved in 2023. The KanCare CCC percentage declined by an average of 0.9 percentage points per year since 2019. Issues with improvement in these metrics should no longer be attributed to the COVID-19 pandemic.	In Progress
3.	MCOs should continue efforts to reduce smoking and tobacco use and to promote cessation. Consider methods to address providers' missed opportunities to discuss cessation medications and other strategies while advising smoking cessation (e.g., MCO supplying communication materials and identifying resources for providers to use, or for referrals). **KFMC 2023 Update**: There was a notable (but not significant) decline in the percentage of KanCare adults indicating they smoke or use tobacco every day or some days, driven mostly by a decrease of over 5 percentage points in this measure for UnitedHealthcare. However, the two-year rolling averages for the other three metrics continued to decline, indicating that providers might require additional incentives or increased awareness to increase those metrics.	In Progress
4.	MCOs should continue efforts to increase the number of people receiving flu vaccinations yearly. **KFMC 2023 Update:** Vaccination rates for flu improved in 2023, achieving a very high ranking (>75th). That said, since national rates are low, there is still a marked amount of room for improvement.	In Progress

KanCare Mental Health Consumer Perception Survey

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
Common Among the MCOs		
1.	For adult members, monitor and explore methods to improve or continue improvement regarding a. Access, quality, and timeliness of treatment; b. Members getting information about treatment options (information about self-help or support groups); c. Improved outcomes including member perceived improvement; and d. Member satisfaction with provider. **KFMC Response:** KFMC did not receive an update from the State for the 2022 recommendations.	Not Assessable
2.	For child members, monitor and explore methods to improve or continue improvement regarding e. Access, quality, and timeliness of treatment; f. Improved outcomes including member perceived improvement; g. Member satisfaction with provider; and h. Accessing and understanding information, including getting needed help from customer service **KFMC Response:** KFMC did not receive an update from the State for the 2022 recommendations.	Not Assessable

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
Common Among the MCOs		
1.	**Describe in detail the survey methodology and analysis plan in the Work Plan**	
•	The survey methodology described in the Work Plan should include a clearly defined intended study population and its size; a clearly defined appropriate sampling frame and its size; clearly defined sampling methodology (probability sampling; type of probability sampling); and clearly described parameters used in the sample size calculation (population size, margin of error, confidence level, standard deviation, response rate) **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare clearly described the composition and size of their study populations for the 2023 Survey; the Work Plans for the three MCOs noted the total number of unduplicated providers in the sample frames were the same as the study population (Aetna: 6,133 unduplicated providers; Sunflower: 17,663 deduplicated providers; UnitedHealthcare: 9,847 deduplicated providers). The Work Plans for the three MCOs also noted applying a single web-based modality using only an email strategy to send the survey invitations; all providers for whom email addresses were not available were not included in the survey. The Work Plans noted the number of valid emails were available for providers/practices (Aetna: 2,515 emails; Sunflower: 2,555 emails; UnitedHealthcare: 3,700 emails). Some of these email addresses were for the individual providers, whereas some were for practices with more than one provider. The total number of all the individual providers with available email addresses, including those with practice's emails available, was not determined. Also, the total numbers for the four provider types with email addresses were not provided. The Work Plans for all three MCOs did not discuss their sample frames being non-representative of their study populations due to the exclusion of a large proportion of providers (all without valid emails). Thus, all relevant information regarding the sample frames was not provided. The Work Plans presented the calculation of the statistically significant sample sizes for the four provider types by applying stratified random sampling method. The sample sizes were calculated using the parameters of 5% margin of error, 95% confidence level, 50% response distribution, and the population sizes of the provider types as identified in the study populations. These sample sizes were the number of completed needed to provide generalizable results. The Work Plans noted, instead of using the stratified random sampling method and calculated statistically significant samples for each of the four provider types, a convenience sampling method was used to identify survey participants. The number of providers, total and by four provider types, who received email invitations to participate in the survey were not provided by the three MCOs.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	The Analysis Plan should be described in detail. **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare described the analysis plans in their 2023 Survey Work Plans.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***Common Among the MCOs* (Continued)**		
•	Describe any deviation made from the survey methodology and analysis plan as described in the Work Plan and the reasons for such deviation in the Survey Report **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare made several deviations from their approved Work Plans during the survey implementation. These include: providers were allowed to complete the survey for multiple MCOs; the surveys were also completed by nursing facility providers; and these respondents were not excluded from survey analysis and results. The processes for applying these changes, and the reasons for these deviations from the Work Plans were not provided in the Survey Reports.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Include survey quality procedures for all steps of survey implementation; if a quality assurance plan is provided by the survey vendor than review the plan and if it shows any deficiencies in quality management steps, then a plan to address these deficiencies should be included in the Work Plan. **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare described the quality control procedures for the steps of survey implementation.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare
2.	**Ensure generalizability of the survey findings to the intended study population**	
•	Apply stratified sampling methodology using the parameters of sample size calculation, including margin of error, power, confidence level, response rate to obtain sufficient sample sizes for the four provider types (PCPs, specialists, BH clinicians, HCBS providers) for achieving adequate number of completed surveys. The key principles for generalizability of survey results to the study population, survey response rate and statistical requirements needed for the application of the statistical test of significance (such as t-test) as described in the scientific literature should be taken into account to obtain survey results generalizable to the survey population. **KFMC Response:** The Survey Reports for all three MCOs presented the calculation of the statistically significant sample sizes for the four provider types by applying stratified random sampling method. The sample sizes were calculated using the parameters of 5% margin of error, 95% confidence level, 50% response distribution and the population sizes of the provider types as identified in the study population. These sample sizes were the number of completed surveys needed to provide generalizable results. However, instead of using the stratified random sampling and these samples, a convenience sampling method was used to identify survey participants. Only providers/practices with email addresses were invited to participate in the survey. The statistically significant sample sizes of four provider types as required by State Contract Amendment 14 were not achieved by all three MCOs. The number of surveys completed by four provider types were low. The MCOs' study populations were composed of PCPs, specialists, BH providers, and HCBS providers, however, the analyses also included the nursing facility providers completing the surveys. Thus, the provider types included in the analyses were not in alignment with the MCOs' study populations. The survey results for all three MCOs were not generalizable to their respective study populations formulated from their KanCare Provider Network of PCPs, specialists, BH, and HCBS providers.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
Common Among the MCOs **(Continued)**		
•	Establish a minimum accepted response rate and number of complete surveys for each of the four provider types; and consider them in the sample size calculation to have a sufficient sample size for achieving adequate number of completed surveys. **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare did not establish the minimum required response rate for their surveys. The minimum required number of completed surveys for four provider types were calculated, however these numbers were not achieved.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Apply steps to attain a designated number of surveys completed by four provider types to ensure generalizability of the results to these provider types (PCPs, specialists, BH clinicians, HCBS providers). **KFMC Response:** The minimum required number of completed surveys by different provider types was calculated by all three MCOs. The specific steps such as making an attempt to obtain additional email addresses or remedial steps during survey implementation were not applied to attain required number of completed surveys from four required provider types to ensure generalizability of the results to these provider populations. The number of surveys completed by each of the four provider types was very low; and the survey results could not be generalizable to these four provider populations of the MCOs' KanCare Provider Network.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Create and use sampling weights in the analyses to obtain survey results that could be generalizable to the study population. **KFMC Response:** Aetna, Sunflower, and UnitedHealthcare did not create sampling weights for analysis and generalizing results to their study populations.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
3.	**Apply steps to improve response rate of the survey**	
•	Apply additional corrective actions during survey fielding if the number of completed surveys is not meeting the minimum expected response rate, such as researching bad addresses or phone numbers to determine new addresses/numbers for a remailing or follow-up phone calls or extending the duration of the survey. **KFMC Response:** After receiving a low number of completed surveys for each of the four provider types, no corrective actions were implemented during fielding of the survey to achieve more completed surveys by each of the four provider types.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare

Provider Satisfaction Survey Validation

	Follow-Up to Previous Recommendations (2022)	2023 Completion Status
***Common Among the MCOs* (Continued)**		
4. •	**Ensure data analysis results are appropriately interpreted:** Provide the interpretation of the analysis results and ensure interpretation is based on the provider population included in the survey sample. **KFMC Response:** The Survey Reports for all three MCOs provided the interpretation of the analysis results for the total number of respondents. However, the Reports presented the interpretations for most of these results in a manner that could be misinterpreted by the readers as applying to all KanCare providers of the MCOs' Networks and being generalizable to MCOs' KanCare Provider Network of PCPs, specialists, BH providers, and HCBS providers. Stratified analyses for all survey items by the four provider types were not conducted by the MCOs.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Conduct non-response analysis. **KFMC Response:** The three MCOs did not apply non-response analyses of the 2023 Survey data.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
5. •	**Include a detailed description of the contents of the survey design and administration in the Survey Report and accompanying documents:** Include detailed information on all aspects of survey methodology in the Survey Report or include references in the Survey Report to other submitted documents. **KFMC Response:** The Survey Reports and Work Plans for all three MCOs did not provide information on all aspects of the survey methodology (see KFMC responses above). During survey implementation, providers were asked to complete the surveys for multiple MCOs. The process to obtain surveys for more than one MCO per provider was not clearly described. The criteria applied to select providers to request for completing more than one MCO survey, the number of providers who were asked to complete surveys for multiple MCOs, and the number of respondents who completed multiple surveys was not noted.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
***Common Among the MCOs* (Continued)**		
•	Include in survey methodology: a clearly defined intended study population and its size; a clearly defined appropriate sampling frame and its size; and a clear description of the parameters (population size, margin of error, power, confidence level, standard deviation, response rate) used in the sample size calculation. The write-up should include the description of the sampling method used for the survey. **KFMC Response:** The final 2023 Survey Reports for the MCOs did not describe the crucial information for the survey methodology. Only those providers/ practices from the sample frame for whom email addresses were available were invited to participate in the survey. The crucial information related to the sample frame – the number of individual providers for whom email addresses were available (total and by four provider types i.e., providers eligible for the survey) was not provided. The sampling method used was noted, however, the number of providers invited to participate in the survey (survey sample) was not described.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Include survey quality procedures for all steps of survey implementation; if a quality assurance plan is provided by the vendor, the Survey Report needs to address whether the plan was implemented in full. **KFMC Response:** The 2023 Survey Report provided this information. The Survey Report noted the survey performance was audited. To address underperformance, sampling review, additional recruitment, and data scrubbing was done. The Report should provide more details regarding the quality assurance steps.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare
•	In the Survey Report, describe any changes made to the study design described in the Work Plan during the implementation of the survey along with the reasons for making these changes. **KFMC Response:** The 2023 MCOs' Survey Report provided some information on the changes made to the study design described in the Work Plan. However, the reasons for making these changes were not provided.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
Aetna		
The recommendations below are in addition to the "Common Among the MCOs" recommendations.		
•	Use the criterium applied for counting the internet and phone surveys as a "completed survey" for revising the criterium used for counting a mail survey. The criterium to count a mail survey as a "completed survey" with one or very few questions answered is not appropriate. Such criterium should be based on responses available to an adequate number of the survey questions. **KFMC Response:** The 2023 Survey only had an internet survey mode; therefore, this recommendation was no longer applicable.	No Longer Applicable
•	Include survey implementation steps in Work Plan to improve the response rate of the survey or number of returned surveys by each of the four provider types, such as updating and correcting contact information of the providers (mail, phone and email); using additional methods to inform and encourage participation; collecting data over an adequate duration; sending frequent reminder notices to the providers; and determining the reason for a large number of ineligible surveys. These steps will assist in further increasing the number of completed surveys. **KFMC Response:** Aetna staff provided advanced survey notice to providers. WSU sent weekly email reminders. Aetna and WSU's response to KFMC's draft report noted "Aetna sent several thousand emails to providers to promote taking the survey." Aetna's frequency and number of emails per provider, and the timeframe for the emails were unclear.	Partially Addressed
•	Mention a caution in interpretation of the results in the footnotes of the tables and graphs when results are based on small numbers. **KFMC Response:** The Aetna Survey Report did not include any write-up regarding the implications of small number of surveys completed by four required types of providers participating in the survey. The caution was not included in the footnotes of the tables and graphs and in the write-up for the interpretation of the survey results. Due to methodological issues and a low number of completed surveys, the survey results could not be applied to the study population and could not be generalizable to Aetna's KanCare Provider Network of PCPs, specialists, BH providers, and HCBS providers. The Survey Report presented the interpretations for most of the results in a manner that could be misinterpreted by readers as applying to all KanCare providers of the Aetna Network. The results should not be construed as the satisfaction with Aetna services by all providers in Aetna's KanCare Provider Network, or even just by all of Aetna's providers in the four provider types (PCPs, specialists, BH, and HCBS). It is highly suggested to include this information in the write-up and all tables and graphs presenting data in the Survey Report to assist in correct interpretation of the data.	Not Addressed
•	Include numerator and denominator counts in the data tables presented in Survey Report. **KFMC Response:** The numerator and denominator counts for the rates calculated for the survey items were only included in the data tables presented in the Aetna Survey Reports.	Fully Addressed

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
Sunflower		
The recommendations below are in addition to the "Common Among the MCOs" recommendations.		
•	Revise the six Network Providers/Coordination of Care questions to remove the phrasing that makes the provider answer relative to the other health plans they work with. **KFMC Response:** Sunflower used an updated survey instrument. This updated survey instrument included only one relative question as required by the State Contract Amendment 14. All other questions included in the instrument were specific to Sunflower and its KanCare Provider Network and not relative to other MCOs, other insurance plans, or other products.	Fully Addressed
•	Conduct validity testing of the updated survey instrument. **KFMC Response:** The content validity of the survey questions was determined only through the discussions between MCO staff working on the Provider Satisfaction Survey project. The internal consistency was calculated by developing Cronbach's Alpha scores for six scales to measure overall provider experience satisfaction. The reliability and validity testing for the target population was not conducted by applying the methods such as cognitive interviews or focus groups with the targeted survey respondents or the providers with subject matter expertise serving on MCO provider committees or advisory groups.	Partially Addressed
•	Strengthen further the selected sample by sampling a higher number of specialists, BH clinicians and HCBS providers. **KFMC Response:** Only those providers/practices from the sample frame for whom email addresses were available were invited to participate in the survey (convenient sample). The Survey Report noted only 2,555 valid emails were available. Some email addresses were for organizations/practices; thus, it was not known how many individual providers were reached through these emails (total and by four provider types). A convenience sampling method was used. The statistically significant sample sizes of PCPs, specialists, BH providers, and HCBS providers as required by State Contract Amendment 14 were not achieved.	Not Addressed
•	Revise the criterium to count a mail survey as a "completed survey." The criterium to count a survey as a "completed survey" with one or very few questions answered is not appropriate. **KFMC Response:** The 2023 Survey only had an internet survey mode; therefore, this recommendation was no longer applicable.	No Longer Applicable
•	Apply the same criteria to count a survey as a "completed survey" for all the components of the multi-mode survey strategy (mail, internet, telephone follow-up). **KFMC Response**: The 2023 Survey only had an internet survey mode; therefore, this recommendation was no longer applicable.	No Longer Applicable

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
***Sunflower* (Continued)**		
•	The Contract Amendment 14, Section 5.9.11 noted that the stratified results by each group, PCPs, specialists, HCBS and BH providers, should be included in the Survey Report. Conduct stratified analyses by four provider types and add HCBS provider response option to the Area of Medicine question of the survey instrument. **KFMC Response:** The stratified analysis by four provider types was not conducted.	Partially Addressed
•	Mention a caution in interpretation of the results in the footnotes of the tables and graphs when results are based on small numbers. **KFMC Response:** The Sunflower Survey Report did not include any write-up regarding the implications of small number of surveys completed by four required types of the providers participating in the survey. The caution was not included in the footnotes of the tables and graphs and in the write-up for the interpretation of the survey results. Due to methodological issues and a low number of completed surveys, the survey results could not be applied to the study population and could not be generalizable to Sunflower's KanCare Provider Network of PCPs, specialists, BH providers, and HCBS providers. The Survey Report presented the interpretations for most of the results in a manner that could be misinterpreted by readers as applying to all KanCare providers of the Sunflower Network. The results should not be construed as the satisfaction with Sunflower services by all providers in Sunflower's KanCare Provider Network, or even just by all of Sunflower's providers in the four provider types (PCPs, specialists, BH, and HCBS). It is highly suggested to include this information in the write-up and all tables and graphs presenting data in the Survey Report to assist in correct interpretation of the data.	Not Addressed
•	Include numerator and denominator counts in the data tables presented in Survey Report. **KFMC Response:** The numerator and denominator counts for the overall rates for 183 respondents calculated for the survey items were included in the data tables presented in the Sunflower Survey Report.	Fully Addressed

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
UnitedHealthcare		
The recommendations below are in addition to the "Common Among the MCOs" recommendations.		
•	Submit Work Plan prior to the implementation of the survey for the State's approval. **KFMC Response:** UnitedHealthcare submitted the Work Plan for its 2023 Provider Satisfaction Survey prior to the implementation of the survey for State approval. The Work plan was submitted on August 31, 2023.	Fully Addressed
•	Specify minimum required number of completed surveys for the four provider types (PCPS, specialists, BH clinicians and HCBS providers); specify minimum response rates. **KFMC Response:** The number of completed surveys for the four provider types, needed to provide generalizable results (statistically significant samples), were calculated using the stratified random sampling method and presented in the Work Plan. However, the Work Plan noted a convenience sampling method would be used to identify survey participants. The minimum response rates for four provider types were not specified.	Partially Addressed
•	Describe the survey administration tasks in detail. **KFMC Response:** The Survey Report did not describe all items required by State Contract Amendment 14, such as a timeline for each step, handling of inaccurate email addresses, and number of providers invited to participate in the survey.	Partially Addressed
•	Include the information in the Survey Report regarding reliability and validity testing of the survey instrument for the target study population (UnitedHealthcare eligible providers) and more specifically, UnitedHealthcare KanCare providers, including PCPs, specialists, BH clinicians and HCBS providers. **KFMC Response:** The content validity of the survey questions was determined only through the discussions between MCO staff working on the Provider Satisfaction Survey project. The internal consistency was calculated by developing Cronbach's Alpha scores for six scales to measure overall provider experience satisfaction. The reliability and validity testing for the target population was not conducted by applying the methods such as cognitive interviews or focus groups with the targeted survey respondents or the providers with subject matter expertise serving on MCO provider committees or advisory groups.	Partially Addressed
•	Ensure the study population for the UnitedHealthcare Kansas Provider Satisfaction Survey is composed of all KanCare providers in the UnitedHealthcare KanCare Provider Network. **KFMC Response:** The 2023 Survey conducted by UnitedHealthcare was a KanCare-specific survey. The study population was comprised of PCPs, specialists, BH providers, and HCBS providers participating in UnitedHealthcare's KanCare Provider Network.	Fully Addressed

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
***UnitedHealthcare* (Continued)**		
•	Include in the study population the four provider types including PCPs, specialists, BH clinicians and HCBS providers. **KFMC Response:** The study population of the survey was comprised of all PCPs, specialists, BH providers, and HCBS providers in UnitedHealthcare's KanCare Provider Network.	Fully Addressed
•	Ensure the compositions of the sample frame and selected sample are in alignment with the composition of the study population of the UnitedHealthcare Kansas Provider Satisfaction Survey (KanCare providers including four required provider types). **KFMC Response:** The composition of UnitedHealthcare Survey's initial sample frame and samples were in alignment with the composition of the study population (KanCare providers including four required provider types). However, the sample frame used to invite survey participants was comprised of a small proportion of providers/practices with valid email addresses only. All providers without email addresses in UnitedHealthcare's provider data files were excluded. The sample frame with exclusion of a larger proportion of providers without valid email addresses was non-representative of the study population. Also, the results presented in the Survey Report included nursing facility providers. Thus, the types of providers included in the analyses and results were not in alignment with the study population and sample frame composition.	Not Addressed
•	Determine the reason for such a large number of non-respondents and address the issues, such as ensuring provider contact information (mail, phone, and email) is updated for accuracy at the time of survey implementation. **KFMC Response:** The reasons for such a large number of non-respondents were not determined. The Survey Report only noted that some of the providers informed the vendor they did not want to participate in the survey; however, any reason from these providers was not cited in the Report. No steps were taken to ensure accurate email addresses were available.	Not Addressed
•	Implement steps to improve the provider response rate, such as adding a follow-up telephone survey component to the survey methodology. Further strengthen the survey methodology by verifying the contact information of the providers selected in the sample at the time of survey implementation, researching bad mail and email addresses to resend undeliverable surveys or complete further outreach, reminder phone calls, determining the reason for ineligible surveys, and appropriate timings for fielding the survey (data collection over an adequate duration). **KFMC Response:** UnitedHealthcare staff provided advanced survey notice to providers and three reminder emails during survey fielding. WSU sent weekly reminder emails. No other steps were noted to increase the response rate and number of completed surveys.	Partially Addressed

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
UnitedHealthcare (Continued)		
•	Ensure survey results are focused on provider responses specific to KanCare. **KFMC Response:** The Survey was KanCare-specific, and the results were focused on provider satisfaction specific to KanCare.	Fully Addressed
•	Conduct analyses to provide results by each of the four provider types as required by Contract Amendment 14. **KFMC Response**: The stratified analysis by four provider types was not done.	Not Addressed
•	Document statistical tests (e.g., t-test) performed per question and composite to clearly indicate the validity of the results. **KFMC Response:** The Survey Report documented analysis procedures, including statistical tests. However, these analyses focused on the calculation and assessment of the overall rates for the respondents who completed the surveys. The stratified analyses using statistical tests for each survey item for four provider types were not conducted as per State Contract Amendment 14 requirement.	Partially Addressed
•	Ensure the analytic result for each question is based on a valid numerator and denominator. **KFMC Response:** The analyses focused on the calculation and assessment of the overall rates for 306 survey respondents and were based on valid numerators and denominators. It should be noted the number of surveys completed by each of the four provider types was very low; and the survey results could not be generalizable to these four provider populations of UnitedHealthcare's KanCare Provider Network. Also, the required stratified analysis for each survey item for the four provider types were not conducted.	Partially Addressed
•	Ensure tables and figures presenting survey results provide adequate information, such as numerator and denominator counts for each question, indication if the results are not based on an adequate number of respondents to be considered valid and should be interpreted with caution, and significance level used for statistical testing. **KFMC Response:** The numerator and denominator counts for the overall rates for the survey respondents were included in the data tables presented in the UnitedHealthcare Survey Report. The Survey Report did not include any write-up regarding the implications of the small number of surveys completed by four required types of the providers participating in the survey. The caution was not included in the footnotes of the tables and graphs and in the write-up for the interpretation of the survey results. Due to methodological issues and a low number of completed surveys, the survey results could not be applied to the study population and could not be generalizable to UnitedHealthcare's KanCare Provider Network for the four provider types. The interpretations for most of the results are presented in a manner that could be misinterpreted by the readers as applying to all KanCare providers of the UnitedHealthcare Network.	Partially Addressed

Provider Satisfaction Survey Validation

Follow-Up to Previous Recommendations (2022)		2023 Completion Status
UnitedHealthcare (Continued)		
•	Describe the survey administration tasks in detail in the Survey Report, along with a timeline for the application of all of the steps for the dual-mode strategy. **KFMC Response:** The Survey Report and Work Plan did not provide information on all aspects of survey administration (see KFMC responses above). The timeline for the application of all of the survey administration steps was not described in the Survey Report. During survey implementation, providers were asked to complete the surveys for multiple MCOs. The process to obtain more than one MCO survey from the providers was not clearly described. The criteria applied to select providers to request for completing more than one MCO survey, the number of providers who were asked to complete surveys for multiple MCOs, and the number of respondents who completed multiple surveys was not noted.	Partially Addressed
•	Document analysis procedures, including statistical test statistics used for the comparative analyses. **KFMC Response:** The Survey Report documented analysis procedures, including statistical tests for the assessment of overall rates for the survey respondents. The stratified analyses for each survey item for the four provider types were not conducted.	Partially Addressed
•	Present survey results for each of the four provider types as required by the Contract Amendment 14. **KFMC Response:** The stratified analyses for all survey items by the four provider types were not conducted.	Not Addressed
•	Include numerators and denominators for each question in the tables presenting survey results. **KFMC Response:** The numerator and denominator counts for the overall rates were included in the data tables presented in the UnitedHealthcare Survey Report.	Fully Addressed

Compliance Review

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Common Among the MCOs					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards					
1.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: Elements documented in the Service Plan **Aetna**: • Review the internal Aetna process to ensure the following required elements are documented in the Service Plan or a separate specified location (State Contract, Section 5.4.4.1 *Plans of Service*) [2022 Recommendation 14]: a. Any services authorized including a detailed description of the amount, scope, and duration of services needed to help meet identified needs or to achieve goals. (LTSS – NF cases; State Contract 5.4.4.1.D.3) b. The pharmacy and number. (BH, LTSS – HCBS, and Special Health Care Needs [SHCN] – Title V cases; State Contract 5.4.4.1.D.9) c. Primary language being included. (LTSS – NF cases; State Contract 5.4.4.1.D.10) d. Eligibility start and end date. (Physical Health [PH], LTSS – NF, and SHCN – Title V cases; State Contract 5.4.4.1.D.17) e. Developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting. (PH cases; State Contract 5.4.4.1.F) f. Member's preferred method of receiving a copy of their service plan (paper or electronic). (PH, BH, SHCN –TA Waiver and Title V, and LTSS – HCBS and NF cases; State Contract 5.4.4.1.I) **KFMC 2023 Update:** ABH submitted the document *Care Plan Development and Updating- Enhanced Version ICM and LTSS* that fully addressed the following: • Letter a: Items 20-22, 24-27, 33-34. KS LTSS Service Plan, items 24, 26, 27, 36. • Letter b: Page 4, item 1, lists Pharmacy in the care team participation. • Letter c: Page 7, item 7, has a field for spoken language and written language. • Letter e: Page 1, section "Signatures on Service Plan Letters:" • Letter f: Page 7, item 7, has a field for preferred method of receiving the service plan. Letter d: In Progress, as ABH submitted an IT [Information Technology] ticket to add a field for the eligibility start and end dates to the Service Plan. For this element to be fully addressed, ABH needs to submit evidence of the finalized Service Plan to demonstrate the changes made.	ABH/SHP/UHC Not Yet Reviewed	ABH/SHP/ UHC New	ABH/UHC In Progress SHP Partially Addressed

Follow-Up to Previous Recommendations	Completion Status			
	2020	2021	2022	2023
Common Among the MCOs (Continued)				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
Sunflower: • Review the internal Sunflower process to ensure the following required elements are documented in the Service Plan or a separate specified location (State Contract, Section 5.4.4.1 *Plans of Service*) [2022 Recommendation 1]: a. Description of the member's goals, strategies to meet goals and desired health, functional and quality of life outcomes. For youth members, inclusion of their family's goals and strategies shall be incorporated into the Plan of Service. (PH and SHCN – TA – Waiver; State Contract 5.4.4.1.D.1) b. Member's identified strengths, preferences, and any identified needs including psycho-social needs and needs related to social determinants of health and independence such as housing or financial assistance. (PH and SHCN – TA Waiver; State Contract 5.4.4.1.D.2) c. Risk factors, including a member's understanding of risk factors and potential adverse consequences, member's plans to respond to adverse consequences, and additional measures in place to minimize them, when needed. (PH, SHCN – TA Waiver, and SHCN – Title V; State Contract 5.4.4.1.D.4) d. Level of Service Coordination (All six case review categories; State Contract 5.4.4.1.D.5) e. Medication list with date and dosages (All six case review categories; State Contract 5.4.4.1.D.8) f. Pharmacy and number (All six case review categories; State Contract 5.4.4.1.D.9) g. Primary language (SHCN – Title V; State Contract 5.4.4.1.D.10) h. Date of next Service Coordination (All six case review categories; State Contract 5.4.4.1.D.13) i. Date of annual reassessment (All six case review categories; State Contract 5.4.4.1.D.14) j. Patient liability and/or client obligation information including information about providers to whom the member has paid (All six case review categories; State Contract 5.4.4.1.D.16) k. Any specialized communication needs including interpreters or special devices required by the member. This includes an identification of any reading challenges. (SHCN – TA Waiver; State Contract 5.4.4.1.D.18) l. Member's physical environment and any modifications necessary to ensure the member's health and safety. (PH; State Contract 5.4.4.1.D.20) m. Service coordinator name and direct contact information along with appropriate off-hours contact information. (All six case review categories; State Contract 5.4.4.1.D.22) n. Member given a choice of paper or electronic Plan of Service prior to development of the plan. A completed Plan of Service must be provided to the member prior to services beginning. (All six case review categories; State Contract 5.4.4.1.I)				

Follow-Up to Previous Recommendations	Completion Status			
	2020	2021	2022	2023
Common Among the MCOs (Continued)				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
Sunflower (Continued): **KFMC 2023 Update**: In letters a-n below, the documents detailed were provided by SHP. a. Kansas Department for Aging and Disability Services approved *Personal Interest Inventory (PII)/Support Plan* and *CC.CM.02 Care Coordination Care Management Policy* demonstrated how member's goals are made and where they are in the Service Plan. b. Health Risk Assessments (HRAs), PII/Support Plan, TA Waiver specific needs assessment, and *CC.CM.02 Care Coordination Care Management Policy* demonstrated the member's strengths, preferences, and needs are assessed and documented appropriately. c. HRAs, *CC.CM.02 Care Coordination Care Management Policy*, and *LTSS WP_PCSP* [Person-Centered Service Plan] policy demonstrated that members are assessed for risk factors, their understanding of risk factors and potential adverse consequences, member's plans to respond to adverse consequences, and additional measures in place to minimize them, when needed. d. From KFMC's inquiry about the expectations of the service plan including the level of service coordination, on September 20, 2023, KDHE confirmed section 5.4.5 of the State Contract is on hold based on State policy *M2019-078 Prohibiting Implementation of New Eligibility or Programmatic Changes Before 7-1-2019* (KDHE provided). Therefore, letter d is no longer applicable. However, the *CC.CM.02 Care Coordination Care Management Policy* and *LTSS_WP_PCSP* policy described their levels of service coordination and how it is determined. e. HRAs (examples), the PII/Support Plan, the *CC.CM.02 Care Coordination Care Management Policy*, and the *Nursing Facility Work Process* demonstrated how SHP obtains and documents the member's medication list and consistently updates it, and where in SHP's record the medication list is documented. f. The PCSP demonstrated where the member's preferred pharmacy and contact information is documented. g. HRA examples demonstrated when primary language of the member is asked and documented. h. LTSS – NF: SHP stated, "A note template is being developed to document that the next visit is to occur in the following calendar year." For all of the other review categories, SHP provided the Work Process *CC.CM.02*, and an example of the note in the Care Plan to demonstrate how the date of next service coordination is documented. In order for this element to be fully addressed, SHP needs to submit the note template that documents the next service coordination date.				

Follow-Up to Previous Recommendations	Completion Status			
	2020	2021	2022	2023
Common Among the MCOs (Continued)				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
i. LTSS-NF: SHP stated, "A note template is being developed to document that the next visit is to occur in the following calendar year." For PH/SHCN-Title V and BH, no explanation of how the date of annual reassessment is documented in the member's record. For LTSS-HCBS and SHCN-TA Waiver, the *PCSP Work Process* documents how often the annual or semi-annual assessment is completed for each waiver. For this element to be fully addressed, SHP needs to submit the note template that documents the next annual reassessment date. j. For PH, BH, SHCN-Title V, and LTSS-NF, no explanation of how patient liability and/or client obligation information is documented in the member's record. For LTSS-HCBS and SHCN-TA Waiver, the PCSP (in the document *KFMC Continuity of Care Response*) demonstrated how it is documented if a member has a client obligation. For this recommendation to be fully addressed, SHP needs to provide documentation and explanation for PH, BH, SHCN-Title V, and LTSS-NF of how patient liability and/or client obligation information is documented (i.e., screenshots of the KMAP system and SHP system). k. PII/Support Plan (in the *KFMC Continuity of Care Response*, PP. 13 and 40), demonstrated how the communication needs of the member is documented in the plan. l. HRA examples (see *CCMA.HRA* and *KS HRA KA*) demonstrated how the member's physical environment is assessed and documented and how any modification needs are assessed. m. SHP provided a brief explanation of how the service coordinator name and direct contact information is documented for the member, however, the referenced letter in the explanation for BH was not provided, therefore, it is partially addressed. For all other categories, SHP provided a *Member welcome letter, KFMC Continuity of Care Response,* and *Supporting documents for LTSS-NF Feedback* that showed examples of how the member is given their service coordinator name and contact information, as well as off-hours contact information. For this recommendation to be fully addressed, SHP needs to provide the letter referenced for BH. n. SHP provided a brief explanation of how choice is given to the member for the member's preference for a paper or electronic Plan of Service and that the completed Plan of Service was provided to the member prior to services beginning, however, for the PH, BH, and SHCN-Title V categories, evidence of documentation was not provided, therefore, it is partially addressed. All other review categories are fully addressed as SHP provided the *PCSP Work Process*, section "E. Providing a Finalized Person Centered Service Plan" which covers how the member will be provided the final PCSP. For this recommendation to be fully addressed, SHP needs to provide evidence of how the member's preference for paper or electronic Plan of Service is documented in the member record (i.e., screenshots of the internal system showing the field where preference is documented).				

Follow-Up to Previous Recommendations	Completion Status			
	2020	2021	2022	2023
Common Among the MCOs (Continued)				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
<u>UnitedHealthcare</u>: • Review the internal UnitedHealthcare process to ensure the following required elements are documented in the Service Plan or a separate specified location (State Contract, section 5.4.4.1 *Plans of Service*) [2022 Recommendation 2]: a. The level of service coordination. (All six case review categories; State Contract 5.4.4.1.D.5) b. The medication list with date and dosages. (All six case review categories; State Contract 5.4.4.1D.8) c. The pharmacy and number. (All six case review categories; State Contract 5.4.4.1.D.9) d. Primary language. (LTSS – NF cases; State Contract 5.4.4.1.D.10) e. Dates of next service coordination (All six case review categories; State Contract 5.4.4.1.D.13) f. Date of annual reassessment. (All six case review categories; State contract 5.4.4.1.D.14) g. The service coordinator name and direct contact information along with appropriate off-hours contact information. (All six case review categories; State Contract 5.4.4.1.D.22) h. Developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting. (SHCN – TA Waiver cases; State Contract 5.4.4.1.F) **KFMC 2023 Update:** For letter a, KFMC inquired with the State about the expectations of the service plan including the level of service coordination. On September 20, 2023, KDHE provided KFMC confirmation that section 5.4.5 of the State Contract is on hold based on State *Policy M2019-078 Prohibiting Implementation of New Eligibility or Programmatic Changes Before 7-1-2019*. KDHE provided the referenced policy. Therefore, letter a is no longer applicable. For letters b-g, UHC reports that they are "reviewing the most appropriate location to document this requirement, as this impacts multiple care coordination populations." For letter h, UHC needs to submit the referenced processes that align with this requirement. Also, provide documentation of the date this was reinforced with UHC staff and what method was used.				

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Common Among the MCOs (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
2.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: Education to providers: **Aetna**: • Aetna should educate providers on the following (2022 Recommendation 16): a. Ask if the member received services elsewhere. (PH, BH, and SHCN – Title V) b. Providers should have contact with other service providers. (PH, BH, LTSS – HCBS, SHCN – TA Waiver and Title V) c. The provider should acknowledge test results. (PH, BH, and SHCN – TA Waiver) d. Follow-up should be documented by the provider. (BH) e. The provider should have follow-up of all results and inform the member of the results. (PH, BH, and SHCN – TA Waiver) f. Providers need to include evidence that that the referral took place. (BH) g. Providers need to include in consult or referral notes that the consult occurred. (PH) h. In the record, there needs to be evidence of continuity of care in the provider setting. (SHCN – TA Waiver and Title V) **KFMC 2023 Update:** ABH provided a Provider Bulletin that covers all the education in the recommendation. The bulletin is being reviewed internally and then will go through the KDHE approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved bulletin. **Sunflower**: • Sunflower should educate providers on the following (2022 Recommendation 4): a. Ask if the member received services elsewhere. (PH) b. Providers should have contact with other service providers. (PH) c. The provider should acknowledge test results. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) d. Follow-up of all results should be documented by the provider. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) e. The provider should have follow-up of all results and inform the member of the results. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) f. Providers need to include evidence that that the consult services took place. (PH, BH, LTSS – HCBS, and SHCN – TA Waiver) g. Consult or referral notes should be included in the record. (PH, BH, SHCN – TA Waiver, and SHCN – Title V)	ABH/SHP/UHC Not Yet Reviewed	ABH/SHP/ UHC New	ABH/SHP/ UHC In Progress

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Common Among the MCOs (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
	KFMC 2023 Update: SHP provided their *2023 Medicaid Provider Orientation* that included (slide 30) a summarization of how providers can facilitate coordination of care, including referrals. However, the list does not include all of the specific areas identified in this recommendation (a-g), and SHP reported that new slides are being developed to be included in the presentation. SHP needs to provide the approved revised Medicaid Provider Orientation that addresses letters a-g. **UnitedHealthcare**: • UnitedHealthcare should educate providers on the following (2022 Recommendation 5): a. Ask if the member received services elsewhere. (PH and BH) b. Providers should have contact with other service providers. (PH and BH) c. The provider should acknowledge test results. (BH) d. Follow-up of all results should be documented by the provider. (PH and BH) e. The provider should have follow-up of all results and inform the member of the results. (PH and BH) f. Providers need to include evidence that that the referral took place. (PH, BH, LTSS – NF, and SHCH – Title V) g. Consult or referral notes should be included in the record. (PH and LTSS – NF) **KFMC 2023 Update:** UHC reported that they "will send out communication to providers reminding them of this requirement" for all elements of this recommendation. For this recommendation to be fully addressed, UHC needs to send to KFMC, for review, education materials that were used, the date/s the communication was sent to providers, and what method was used to send the communication.				
3.	Case Review related to §438.208(b)(3) Coordination and Continuity of Care: Health Screening Tool (HST) outreach attempts **Aetna**: • In the 2023 follow-up review, provide the process for documenting all HST outreach attempts. (2022 Recommendation 20) **KFMC 2023 Update:** ABH provided the document *Desktop: Initial Health Screening Tool (HST) Outreach Process/HRQ (Health Risk Questionnaire) Outreach Process* which outlines how HST outreach attempts are to be documented.	ABH/SHP/UHC Not Yet Reviewed	ABH/SHP/ UHC New	ABH/SHP Fully Addressed UHC Partially Addressed	

	Follow-Up to Previous Recommendations	Completion Status 2020	2021	2022	2023
Common Among the MCOs (Continued)					
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
	Sunflower: • In the 2023 follow-up review, provide the process for documenting all Health Screen Tool outreach attempts. (2022 Recommendation 6) **KFMC 2023 Update**: SHP provided the document *KS.WP.CM.32 Health Risk Screening Tool Work Process,* which outlines the process of completing the Health Risk Screen Tools and HRAs, including outreach attempts and methods and running reports.				
	UnitedHealthcare: • In the 2023 follow-up review, provide the process for documenting all HST outreach attempts. (2022 Recommendation 7) **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For this recommendation to be fully addressed, UHC needs to provide documentation (i.e., policy and procedure, Standard Operating Procedures (SOPs), screenshots of the Community Care system, HST or of the IVR vendor system that captures all contact attempts mentioned by UHC).				
4.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: **Aetna**: • In the 2023 follow-up review, provide the "Disclosure of Ownership and Controlling Interest and Management Statement" for Providers 1 through 15. (2022 Recommendation 24) **KFMC 2023 Update:** ABH provided an explanation of how the Disclosure of Ownership and Controlling Interest is collected and reviewed, however, the attachments that ABH referred to could not be found in the ABH file upload. The only case that details the Disclosure of Ownership form is Provider 3 (PP. 94-108). For this recommendation to be fully addressed, ABH needs to show how the Disclosure of Ownership and Controlling Interest and Management Statement is verified/assessed for credentialing. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During	Not Yet Reviewed	New	ABH/UHC Partially Addressed SHP Fully Addressed (2 cases) and Unable to Address (1 case)	

Follow-Up to Previous Recommendations	Completion Status			
	2020	2021	2022	2023
Common Among the MCOs (Continued)				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where' [MCO NAME] provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing." **Sunflower**: • In the 2023 follow-up review, provide the Disclosure of Ownership and Controlling Interest and Management Statement for Providers 4, 10, and 11. (2022 Recommendation 9) **KFMC 2023 Update**: SHP provided the Disclosure of Ownership and Controlling Interest and Management Statement for Providers 4 and 10. SHP is not able to obtain the form for Provider 11. **UnitedHealthcare**: • In the 2023 follow-up review, provide documentation of the "Disclosure of Ownership and Controlling Interest and Management Statement" for all reviewed providers. (2022 Recommendation 13) **KFMC 2023 Update:** UHC provided a thorough explanation, however, no evidence was submitted of UHC verifying the Disclosure of Ownership had been completed. For this recommendation to be fully addressed, UHC needs to provide documentation on how they would verify the Disclosure of Ownership was completed through KMAP. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where 'UHC provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing."				

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Common Among the MCOs (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
5.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: Disclosure of Ownership and Controlling Interest and Management Statement **Aetna**: • In the 2023 follow-up review, provide the Disclosure of Ownership and Controlling Interest and Management statement for Providers 2, 3, 7, 8, and 10-14. (2022 Recommendation 32) **KFMC 2023 Update:** ABH provided a brief explanation but did not specify for what provider/s the explanation was for. Also, there were no documents submitted as evidence. For this recommendation to be fully addressed, ABH needs to show how the Disclosure of Ownership and Controlling Interest and Management Statement is verified/assessed for credentialing. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where' [MCO NAME] provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing." **Sunflower**: • In the 2023 follow-up review, provide Disclosure of Ownership and Control Interest for Providers 2, 3, 5, 7, and 12. (2022 Recommendation 11) **KFMC 2023 Update**: SHP provided the Disclosure of Ownership and Control Interest for Providers 2, 3, 5, 7, and 12. **UnitedHealthcare**: • In the 2023 follow-up review, provide the Disclosure of Ownership and Controlling Interest for Providers 1, 2, 3, 4, 6, 8, 12, 14, and 15. (2022 Recommendation 17)	ABH/SHP/UHC Not Yet Reviewed	ABH/SHP/ UHC New	ABH Not Addressed SHP Fully Addressed UHC Partially Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Common Among the MCOs (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
	KFMC 2023 Update: UHC provided a thorough explanation, however, no evidence was submitted of UHC verifying the Disclosure of Ownership had been completed. For this recommendation to be fully addressed, UHC needs to provide documentation on how they would verify the Disclosure of Ownership was completed through KMAP. 9/29/2023 response from the State pertaining the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where 'UHC provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing."				
Aetna					
2020 Recommendations: Subpart D – MCO, PIHP and PAHP Standards					
1.	Case Review Related to §438.208 Coordination and Continuity of Care: • For future case review requests, ensure all outreach attempts to members for health screenings are included with submitted documentation. KFMC will ensure this is an included element of the request. (2020 Recommendation 6) **KFMC 2022 Update:** Documentation of HST outreach attempts was not provided in records reviewed by KFMC. **KFMC 2023 Update:** ABH provided a screenshot of the system that will track outreach attempts to members.	New	In Progress		Fully Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna					
	2022 Recommendations: Subpart B – State Responsibilities				
2.	§438.56(c)(1) Disenrollment: Requirements and Limitations – Disenrollment Requested by the Enrollee: • In Aetna policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* include the following (2022 Recommendation 1): a. Regulatory language stating members may request disenrollment for cause, at any time. b. The additional three reasons to disenroll for cause that are detailed in the *Member Handbook*: "If you no longer qualify for Medicaid under one of the eligible categories; If you transfer to an eligibility category that is not included in the benefits; and Renewing your insurance." **KFMC 2023 Update:** ABH provided policy *4500.86 Member Disenrollment/Disruptive Member Transfer* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress	
3.	§438.56(c)(1) Disenrollment: Requirements and Limitations – Disenrollment Requested by the Enrollee: • In the *Member Handbook*, section "Disenroll from Aetna Better Health of Kansas," include the regulatory language stating members may request disenrollment for cause, at any time. (2022 Recommendation 2) **KFMC 2023 Update:** ABH provided the updated online *Member Handbook* and stated their printed 2024 manual will be updated with the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed	
4.	§438.56(d)(2)(iv) Disenrollment: Requirements and Limitations – Procedures for Disenrollment-Cause for Disenrollment: • Include in policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* the regulatory language that states, "For enrollees that use Medicaid Managed Long Term Services and Supports, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO, PIHP, or PAHP and, as a result, would experience a disruption in their residence or employment." (2022 Recommendation 3) **KFMC 2023 Update:** ABH provided policy *4500.86 Member Disenrollment/Disruptive Member Transfer* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart C – Enrollee Rights and Protections					
5.	§438.10(f)(1) Information Requirements: Information for all Enrollees of MCO's – General Requirements: • For consistency with the *Member Handbook* and the *Member Notification for Provider Terminations Desktop Process*, in policy and procedure *7000.40 Member Transition,* section "Policy," sub-section "Notification of Practitioner or Provider Group Termination Requirements," include the word "written" to identify written notice of termination is provided to members affected by the termination of a practitioner or practice group in the statements below. (2022 Recommendation 4) a. "Health plan notifies members affected by the termination of a practitioner or practice group in general, family, or internal medicine or pediatrics **at least ten (10) calendar days prior** to the effective termination date [bold in original]." (P. 1) b. "If a practitioner notifies the health plan of termination **less than ten (10) days prior** to the effective date, the health plan notifies the affected members as soon as possible, but **no later than ten (10) calendar days after** receipt of the notification [bold in original]." (P. 2) **KFMC 2023 Update:** ABH provided policy *7000.40 Member Transition – Kansas Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress
6.	§438.10(f)(1) Information Requirements: Information for all Enrollees of MCO's – General Requirements: • Provide consistency between the *Member Notification for Provider Terminations Desktop Process* and policy and procedure *7000.40 Member Transition,* as the policy and procedure details member notification will be sent in "at least ten (10) calendar days prior to the effective termination date" or "no later than ten (10) calendar days after receipt of the notification" and the Desktop Process details "Members will be notified no more than 15 calendar days from the date of issuance." (2022 Recommendation 5) **KFMC 2023 Update:** ABH provided policy *7000.40 Member Transition – Kansas Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart C – Enrollee Rights and Protections (Continued)					
7.	§438.10(g)(2)(v) Information Requirements: Information for Enrollees of MCOs – Enrollee Handbook (after-hours and emergency coverage) and related provision §438.114(a) Emergency and Poststabilization Services: Definitions: • Add the regulatory definition for post-stabilization services to the *Provider Manual*. (State Contract, Section 5.8.3.4 *Emergency and Post-Stabilization Services*, letter E) (2022 Recommendation 6) **KFMC 2023 Update:** ABH provided a link to the updated 2023 *Provider Manual* that includes the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed	
8.	§438.3(j)(3) Standard Contract Requirements: Advance Directives (related provision to §438.10[g][2][xii] Information Requirements: Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities – Enrollee Handbook): • In the *Member Handbook*, add a statement that Aetna will provide members with written information on advance directive policies and a description of applicable state law. (State Contract, Section 5.10.7 *Member Handbook Requirements*, letter E, number 17) (2022 Recommendation 7) **KFMC 2023 Update:** ABH provided the updated online *Member Handbook* that included the recommended regulatory language, and they stated the 2024 printed manual will be updated with the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed	
9.	§422.128(b)(1)(i) Information on Advance Directives; §417.436(d)(1)(i)(A) Rules for Enrollees: Advance Directives; and §489.102(a)(1)(i) Requirements for Providers (related provision to §438.10[g][2][xii] Information Requirements: Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities – Enrollee Handbook and §438.3[j] Standard Contract Requirements: Advance Directives): • Add to Aetna policy and procedure *7800.70 Advance Directives Corporate Policy,* section "Focus/Disposition: Scope," fourth bullet, the words "in state law." It would read, "Members are notified of any changes as soon as possible but no later than ninety (90) days after the effective date of the change in state law." (2022 Recommendation 8) **KFMC 2023 Update:** ABH provided policy *7500.90 Advance Directives Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart C – Enrollee Rights and Protections (Continued)					
10.	§422.128(b)(1)(i) Information on Advance Directives; §417.436(d)(1)(i)(A) Rules for Enrollees: Advance Directives; and §489.102(a)(1)(i) Requirements for Providers (related provision to §438.10[g][2][xii] Information Requirements: Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities – Enrollee Handbook and §438.3[j] Standard Contract Requirements: Advance Directives): • Add to Aetna policies and procedures *4500.70 Advance Directives* and *7800.70 Advance Directives Amendment* or *7800.70 Advance Directives Corporate Policy* the regulatory language that states, "Providers may contract with other entities to furnish this information but remain legally responsible for the ensuring that the requirements of this section are met." (State Contract, Section 5.10.2 *Advance Directives*, letter B, number 1) (2022 Recommendation 9) **KFMC 2023 Update:** ABH provided policy *7500.90 Advance Directives Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress
11.	§438.114(d)(2) Emergency and Post-stabilization Services: Additional Rules for Emergency Services (payment): • Add to the *Provider Manual,* "Chapter 5: Covered and Non-Covered Services," section "Emergency Services," the regulatory language that states, "An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition to stabilize the patient." (2022 Recommendation 10) **KFMC 2023 Update:** ABH provided a link to the updated 2023 *Provider Manual* that includes the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards					
12.	§438.114(e) Emergency and Poststabilization Services: Coverage and Payment – Poststabilization Care Services and related provisions §422.113(c)(2)(iv) and (3) Special Rules for Ambulance Services, Emergency and Urgently Needed Services, and Maintenance and Post-stabilization Care Services: Maintenance Care and Post-stabilization Care Services – *MA Organization Financial Responsibility and End of Responsibility*: • Add to the *Provider Manual*, section "Post-stabilization Services," the regulatory language that the MCO "Must limit charges to enrollees for post-stabilization care services to an amount no greater than what the organization would charge the enrollee if he or she had obtained the services through the MA organization. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission." (2022 Recommendation 11) **KFMC 2023 Update:** ABH provided the link to the updated 2023 *Provider Manual* that includes the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed	
13.	§438.206(b)(3) Availability of Services: Delivery Network (second opinion): • In the *Member Handbook*, section "Getting a second opinion," add the language "in- or out-of-network" to the paragraph, "You can get a second opinion from another provider when your PCP or a specialist says you need surgery or other treatment. A second opinion is available at no charge to you. Your PCP can recommend a provider. You can also call Member Services at 1-855-221-5656, (TTY: 711)." (2022 Recommendation 12) **KFMC 2023 Update:** ABH provided the updated online *Member Handbook* and stated the printed manual will be updated for the 2024 version with the recommended regulatory language.	Not Yet Reviewed	New	Fully Addressed	
14.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Review the cases identified as nursing facility cases where there was no evidence submitted that they resided in a nursing facility and advise what kind of service someone would receive from a nursing facility if they did not reside there (Members 3, 5, 11, 13, 15, 16, and 20). (2022 Recommendation 13) **KFMC 2023 Update:** During the 2023 review year, ABH submitted case files for NFs and KFMC was able to complete the review.	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
15.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Review the internal Aetna process to ensure the Service Plan has the following completed (State Contract, Section 5.4.4.1 *Plans of Service* and 5.4.4.2 Person Centered Service Planning) [2022 Recommendation 15]: a. Signed and approved. (PH, and SHCN – Title V cases; State Contract 5.4.4.1.G and 5.4.4.2.C) b. Signed by the Member, their MCO service coordinator, community service coordinator, and any providers that were present during the development of the Plan of Service. (PH and SHCN – Title V cases; State Contract 5.4.4.1.G.2) c. Signatures being obtained from, at a minimum, the service coordinator, the community service coordinator, and Member prior to implementation unless an extraordinary circumstance prevented signatures from being obtained. (PH cases; State Contract 5.4.4.1.G.3) d. Signed by the Member, guardian, or legal representative, the MCO service coordinator, the community service coordinator, and all providers listed on the PCSP. (PH and SHCN – Title V; State Contract 5.4.4.2.C.2) e. Distributed to all attendees within 14 days of the development of the plan. (SHCN – Title V cases; State Contract 5.4.4.2.H) **KFMC 2023 Update:** a-d. Fully addressed: PP. 1-2, section "Signatures on Service Plan Letters," outlines the requirements of signatures on the Service Plan. e. Partially addressed: P. 2, section "Signatures on Service Plan Letters," subsection "LTSS" states, "**Service Plan Letter** must be sent to/shared with the member/legal representative and PCP (at minimum). It must also be shared with any ICT member of the member's choosing." However, no time frame was stated. For this element to be fully addressed, ABH needs to provide evidence that the Service Plan is distributed within 14 days of the development of the plan.	Not Yet Reviewed	New	Partially Addressed
16.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Aetna should review the case identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (PH Title 19 Member 9) (2022 Recommendation 17) **KFMC 2023 Update:** ABH provided a brief explanation of outreach for PH Title 19 Member 9, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence of either follow-up done with the member and/or outreach/education done with the provider.	Not Yet Reviewed	New	Not Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
17.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Aetna should review the case and determine appropriate follow-up, if needed (e.g., MCO follow-up regarding the specific case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (LTSS – NF Member 7) (2022 Recommendation 18) **KFMC 2023 Update:** ABH provided a brief explanation of outreach for LTSS – NF Member 7, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence of either follow-up done with the member and/or outreach/education done with the case management staff.	Not Yet Reviewed	New	Not Addressed	
18.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Aetna should review the case identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (SHCN – Title V Member 20) (2022 Recommendation 19) **KFMC 2023 Update:** ABH provided a brief explanation of outreach for SHCN – Title V Member 20, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence (i.e., documentation such as case management notes) of the parent declining services.	Not Yet Reviewed	New	Not Addressed	
19.	§438.210(d)(1)(i-ii) Coverage and Authorization of Services: Standard Authorization Decisions (Also applies to Subpart F §438.404[c][3] Timely and Adequate Notice of Adverse Benefit Determination: Timing of Notice [Standard Service Authorization Decisions]): • In Aetna policy and procedure *7100.05 Prior Authorization,* section "Extension of Decision Times for Non-urgent Pre-service Decisions," second paragraph, change the time frame of "fifteen (15) for NOA [Notice of Action] additional calendar days" to "fourteen (14) calendar days" to be consistent with the regulation and State Contract Attachment D section 4.3.3.2.1 that details "fourteen (14) calendar days." (2022 Recommendation 21) **KFMC 2023 Update:** ABH submitted policy amendment *7200.03 UM timeliness Standards and Decision Notification Amendment* that includes the recommended regulatory language. ABH reported, currently, this policy amendment is under internal review; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy.	Not Yet Reviewed	New	In Progress	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
20.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide explanation of the delay in the provider notification for Providers 6 and 13. (2022 Recommendation 22) **KFMC 2023 Update:** For Providers 6 and 13, ABH provided an explanation of the delay in the provider notification.	Not Yet Reviewed	New		Fully Addressed
21.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide an explanation of why "NA" [Not Applicable] is checked on the credentialing checklist instead of "Yes" since the credentialing application indicated the providers had hospital privileges for Providers 2, 5, 6, 7, 10, 11, 12 and 14. (2022 Recommendation 23) **KFMC 2023 Update:** For Providers 2, 5, 6, 7, 10, 11, 12 and 14, ABH provided an acceptable explanation of why N/A is checked on the credentialing checklist.	Not Yet Reviewed	New		Fully Addressed
22.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the National Plan and Provider Enumeration System (NPPES) check that was completed on Providers 1, 2, 4-7, 9, 12, 13, and 15. (2022 Recommendation 25) **KFMC 2023 Update:** For Providers, 1, 2, 4, 6, 7, 9, 12, 13, and 15, ABH provided the NPPES check that was completed. The document provided for Provider 5 was blank; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that the NPPES was completed for Provider 5 (the document needs to have the provider's name on it).	Not Yet Reviewed	New		Partially Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
23.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the Social Security Administration's Death Master File check that was completed for Providers 1, 2, and 4-15. (2022 Recommendation 26) **KFMC 2023 Update:** ABH provided the document *Desktop Name: SS Death Master File Report Processing.* It states, "To define the process in which contracted providers identified as deceased on the Social Security Death Master File Report are researched and terminated in Aetna systems."	Not Yet Reviewed	New	Fully Addressed	
24.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) to any person with an ownership or control interest or who is an agent or managing employee of the provider check that was completed for Providers 2, 4-9, 12, 13, and 15. (2022 Recommendation 27) **KFMC 2023 Update:** For Providers, 2, 4, 7, 8, 9, 12, and 15, ABH provided the OIG LEIE check that was completed. The documents provided for Providers 5 and 6 were blank, and Provider 13 was not provided; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that the OIG LEIE check was completed for Providers 5, 6, and 13 (the document needs to have the provider's name on it).	Not Yet Reviewed	New	Partially Addressed	
25.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the General Services Administration's System for Awards Management (GSA–SAM) check that was completed for Providers 5, 7, 9, 12, and 15. (2022 Recommendation 28) **KFMC 2023 Update:** For Providers, 7, 9, 12, and 15, ABH provided the GSA-SAM check that was completed. The document provided for Provider 5 was blank; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that GSA-SAM check was completed for Provider 5 (the document needs to have the provider's name on it).	Not Yet Reviewed	New	Partially Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
26.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide detail regarding the significant delay between when the credentialing was approved and when the provider was notified by letter for Providers 7, 11, and 12. (2022 Recommendation 29) **KFMC 2023 Update:** For Providers 7, 11, and 12, ABH provided an explanation of the significant delay between when the credentialling was approved and when the provider was notified, however, no evidence was provided to support the reported update. For this recommendation to be fully addressed, ABH needs to provide documentation of the update (i.e., a process flow or work process of the automation).	Not Yet Reviewed	New		Partially Addressed
27.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the notification to the provider of the credentialing decision for Provider 1. (2022 Recommendation 30) **KFMC 2023 Update:** The file provided was for Individual Provider 1, but the file needed is Institutional Provider 1. For this recommendation to be fully addressed, ABH needs to provide the notification to the provider of the credentialling decision for Institutional Provider 1.	Not Yet Reviewed	New		Not Addressed
28.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the attestation of correctness for Provider 2. (2022 Recommendation 31) **KFMC 2023 Update:** ABH stated the evidence for the attestation of correctness is in the uploaded attachments, however, the attachments were not found. For this recommendation to be fully addressed, ABH needs to provide the attachments for Institutional Provider 2.	Not Yet Reviewed	New		Not Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
29.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the NPPES check that was completed for Providers 2, 3, 7, 8, 10, 11, 13, and 14. (2022 Recommendation 33) **KFMC 2023 Update:** The files provided were for the Individual Providers, but the files needed are Institutional Providers 2, 3, 7, 8, 10, 11, 13, and 14. For this recommendation to be fully addressed, ABH needs to provide the notification to the provider of the credentialling decision for Institutional Providers 2, 3, 7, 8, 10, 11, 13, and 14.	Not Yet Reviewed	New	Not Addressed	
30.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the OIG LEIE to any person with an ownership or control interest or who is an agent or managing employee of the provider check that was completed for Provider 2. (2022 Recommendation 34) **KFMC 2023 Update:** The file provided was for Individual Provider 2, but the file needed is Institutional Provider 2. For this recommendation to be fully addressed, ABH needs to provide the OIG LEIE for Institutional Provider 2.	Not Yet Reviewed	New	Not Addressed	
31.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the GSA-SAM check that was completed for Providers 2, 3, 7, 8, 10, 11 and 14. (2022 Recommendation 35) **KFMC 2023 Update:** The files provided were for Individual Providers 2, 3, 7, 8, 10, 11 and 14, but the files needed are Institutional Providers 2, 3, 7, 8, 10, 11 and 14. For this recommendation to be fully addressed, ABH needs to provide the GSA-SAM check for Institutional Providers 2, 3, 7, 8, 10, 11, and 14.	Not Yet Reviewed	New	Not Addressed	
32.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide documentation of Malpractice insurance/professional liability insurance for Providers 1-4. (2022 Recommendation 36) **KFMC 2023 Update:** The files provided were for Individual Providers 1-4, but the files needed are Institutional Providers 1-4. For this recommendation to be fully addressed, ABH needs to provide documentation of malpractice insurance/professional liability insurance for Institutional Providers 1-4.	Not Yet Reviewed	New	Not Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
33.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the general/comprehensive liability insurance for Provider 3. (2022 Recommendation 37) **KFMC 2023 Update:** ABH provided an explanation of why the general/comprehensive liability insurance was not provided for Institutional Provider 3. The explanation addressed the recommendation.	Not Yet Reviewed	New	Fully Addressed	
34.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, for initial credentialing files, provide the date of receipt of the application for Providers 1, 4, 9 and 15. (2022 Recommendation 38) **KFMC 2023 Update:** The files provided were for Individual Providers 1, 4, 9 and 15, but the files needed are for the Institutional Providers 1, 4, 9 and 15. For this recommendation to be fully addressed, ABH needs to provide documentation of the date of receipt of the application for Institutional Providers 1, 4, 9, and 15.	Not Yet Reviewed	New	Not Addressed	
35.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, for Provider 2, review the file and provide detail on whether the pharmacy license was current at the time of recredentialing. (2022 Recommendation 39) **KFMC 2023 Update:** ABH provided documentation demonstrating that the pharmacy license was current at the time of recredentialing.	Not Yet Reviewed	New	Fully Addressed	
36.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide a copy of the insurance policy for Provider 11. (2022 Recommendation 40) **KFMC 2023 Update:** The file provided was for Individual Provider 11, but the file needed is Institutional Provider 11. For this recommendation to be fully addressed, ABH needs to provide a copy of the insurance policy for Institutional Provider 11.	Not Yet Reviewed	New	Not Addressed	

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
37.	§438.214(e) Provider Selection: State Requirements: • Credentialing decisions should be communicated to the provider within 60 days of the completed application being received. (Individual Health Care Professional Providers 6 and 13) [2022 Recommendation 41] **KFMC 2023 Update:** ABH provided the Approval letters for Individual Health Care Professional Providers 6 and 13; however, there was no explanation as to why the credentialling decision was communicated outside of the 60-day timeframe. For this recommendation to be fully addressed, ABH needs to provide evidence and remediation (i.e., staff education) as to why it took longer than 60 days to communicate the decision.	Not Yet Reviewed	New	Partially Addressed	
	2022 Recommendations: Subpart F – Grievance and Appeal System				
38.	§438.402(c)(1)(i)(B)(3) General Requirements: Filing Requirements – Authority to file-External Medical Review and §438.408(f)(1)(ii) Resolution and Notification: Grievance and Appeals – Availability-External Medical Review: • Related to External Independent Third-Party Review (EITPR), in the documents below and any additional applicable documents, include the regulatory language that EITPR review will be of no cost to the member (2022 Recommendation 42): a. Aetna policies and procedures *3600.38 Provider Appeals and Reconsiderations, 3100.90 Enrollee Complaint/Grievance,* and *3100.70 Enrollee Appeals* b. *Provider Manual* c. *Member Handbook* **KFMC 2023 Update:** ABH provided the following documents with the recommended regulatory language: • Policy *6300.38 Provider Appeals and Reconsiderations*, section, "External Independent Third Party Review (EITPR)" [P.3]. • Policy *3100.90 Enrollee Complaint/Grievance*, section, "External Independent Third Party Review (EITPR)" [P.3]. • Policy *3100.70 Enrollee Appeals*, section, "External Independent Third Party Review (EITPR)" [P.3]. • *Provider Manual*, "Chapter 18: Appeal and Grievance System" (P.127). • *Member Handbook*, "Grievance, Appeals and State Fair Hearings" (P.77).	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)					
39.	§438.406(b)(1) Handling of Grievances and Appeals: Special Requirements (Acknowledgement of verbal or written Grievance): • Grievance Acknowledgement letters should be sent within 10 calendar days of receipt (Member 10). (2022 Recommendation 43) **KFMC 2023 Update:** ABH provided policy *3100.90 Enrollee Complaint & Grievance*. Section "Acknowledgement of Grievances," second bullet (P.11) states, "All written enrollee grievances are acknowledged in writing within five (5) calendar days of receipt. For grievances resolved the same day of receipt, the grievance will be acknowledged in the Grievance Resolution Letter."	Not Yet Reviewed	New	Fully Addressed	
40.	Appeal Case Review related to §438.406(b)(1) Recordkeeping Requirements: • Educate staff that Appeal Acknowledgement letters sent to members regarding their appeal request are to be sent within five calendar days (Member 18). (2022 Recommendation 44) **KFMC 2023 Update:** ABH provided policy *3100.70 Enrollee Appeals*. The second bullet from the top (P.12) states, "Aetna Better Health will acknowledge the receipt of standard appeals in writing within five (5) calendar days after receiving an appeal request." In addition, on 4/4/2023, ABH educated staff during a "Team Huddle."	Not Yet Reviewed	New	Fully Addressed	
41.	§438.408(c)(2) Resolution and Notification: Grievances and Appeals – Extension of Timeframes-Requirements Following Extension and §438.410(c)(2) Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution: • In the *Provider Manual*, related to Aetna extending the timeframes not at the request of the member, in the sections "Member Grievance Process," sub-section "Standard Grievances" and "Member Appeal Process – Standard Appeals," add the following regulatory language (2022 Recommendation 45): a. Make reasonable efforts to give the enrollee prompt oral notice of the delay. b. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision. **KFMC 2023 Update:** ABH added the recommended regulatory language to the *Provider Manual*, "Chapter 18: Appeal and Grievance System," sections "Member Grievance Process: Standard Grievances" and "Member Appeal Process: Standard Appeals" (PP.128-129).	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)					
42.	§438.408(c)(2) Resolution and Notification: Grievances and Appeals – Extension of Timeframes-Requirements Following Extension and §438.410(c)(2) Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution: • In the *Member Handbook*, related to Aetna extending the timeframes not at the request of the member, in the section "Grievance Extension" and the section "Appeals," subsection "If we need more information," add the following regulatory language (2022 Recommendation 46): a. Make reasonable efforts to give the enrollee prompt oral notice of the delay. b. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe. Specific to the section "Appeals," subsection "If we need more information," inform the enrollee of the right to file a grievance if he or she disagrees with that decision. **KFMC 2023 Update:** ABH submitted the request to add the recommended regulatory language to the *Member Handbook*. For this recommendation to be fully addressed, ABH needs to provide the updated approved *Member Handbook*.	Not Yet Reviewed	New	In Progress	
43.	§438.408(d)(1) Resolution and Notification: Grievances and Appeals – Format of Notice-Grievances: • Grievance resolution letters to members should be sent within 3 calendar days following the date of grievance resolution (Members 2-5 and 8). (2022 Recommendation 47) **KFMC 2023 Update:** ABH provided policy *3100.90 Enrollee Complaint & Grievance*. Section "Grievance Resolution and Notification," third paragraph (P. 12) states, "Grievances will be resolved and resolution notice sent within the following time frames and the enrollee will be notified orally the same day as resolution for expedited grievances and in writing within three (3) calendar days of resolution for all grievances, unless an extension of time is warranted." In addition, on 4/4/2023, staff education was completed during a "Team Huddle."	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)					
44.	Appeal Case Review related to §438.408(d)(2)(ii) Resolution and Notification: Grievances and Appeals – Format of Notice-Appeals: • For notice of an expedited resolution, Aetna should make reasonable effort to provide verbal notice to the member and document the date of the contact/attempted contact in the internal Aetna system (Members 1, 3, 4, 8, 9, and 14). (2022 Recommendation 48) **KFMC 2023 Update:** ABH provided policy *3100.70 Enrollee Appeals*. Section "Timeframe for Resolving – Expedited Appeals," third paragraph, last sentence (P. 17), states, "Aetna Better Health will make reasonable effort to communicate expedited decisions orally, followed by an electronic or written notification within seventy-two (72) hours of receipt of the expedited request." In addition, on 4/4/2023, ABH provided staff education during a "Team Huddle."	Not Yet Reviewed	New	Fully Addressed	
45.	Appeal Case Review related to §438.408(e)(1) Resolution and Notification: Grievance and Appeals – Content and Notice of Appeal Resolution: • Include the date of completion in the written notice of resolution for each level of the appeal (Members 1-30). (2022 Recommendation 49) **KFMC 2023 Update:** ABH provided member letter templates for the written notice of resolution that include the date of completion; however, the letters need KDHE approval before finalizing. For this recommendation to be fully addressed, ABH needs to provide the final approved letter templates.	Not Yet Reviewed	New	In Progress	
46.	§438.416(b) Recordkeeping Requirements: • In Aetna policy and procedure *3100.90 Enrollee Complaint/Grievance,* section "Investigation and Documentation," first paragraph, add to the list of bulleted items following the statement, "In addition, the system maintains for all grievance types," the regulatory language "Name of the covered person for whom the appeal or grievance was filed." It would read, "In addition the system maintains for all grievance types: The name of the covered person for whom the appeal or grievance was filed." (2022 Recommendation 50) **KFMC 2023 Update:** ABH provided policy *3100.90 Enrollee Complaint & Grievance* and the recommended regulatory language was added (P.11).	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)					
47.	Grievance Case Review related to §438.416(b)(3) Recordkeeping Requirements: • For all grievances entered into the Aetna internal grievance system, next to the field "Reviewer" (e.g., Grievance System Manager or Medical Director) Aetna should populate the field "Hearing/Review Date/Time" to be compliant with the regulatory requirement (date captured for each review or, if applicable, review meeting), as the notes detailed in the "General Notes" and "Resolution Notes" field do not always provide enough information to determine the date of each grievance review (Member 20). (2022 Recommendation 51) **KFMC 2023 Update:** ABH provided screenshots of their internal grievance system to demonstrate the change made of inclusion of the resolution date.	Not Yet Reviewed	New	Fully Addressed	
48.	Appeal issues not related to an element on the review tool for §438.416(b) Recordkeeping Requirements: • Review the internal Aetna appeal system and ensure the appeal decision date is consistent in each area/field (Member 8). (2022 Recommendation 52) **KFMC 2023 Update:** ABH provided policy *3100.98 Documentation of Mail Times* that describes the process for documenting mail date and time, as well as validation steps. Further, on 4/4/2023, during a "Team Huddle," ABH provided staff education on the policy to ensure consistency of the appeal decision date in each area.	Not Yet Reviewed	New	Fully Addressed	
49.	Appeal issues not related to an element on the review tool for §438.416(b) Recordkeeping Requirements: • Review the internal Aetna appeal system and ensure the date on the acknowledgement letter and in the internal Aetna system match (Member 10). (2022 Recommendation 53) **KFMC 2023 Update:** ABH provided policy *3100.98 Documentation of Mail Times* that describes the process for documenting mail date and time, as well as validation steps. Further, on 4/4/2023, during a "Team Huddle," ABH provided staff education on the policy to ensure consistency of the appeal decision date in each area.	Not Yet Reviewed	New	Fully Addressed	

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
Aetna (Continued)					
	2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)				
50.	§438.420(a)(i-ii) Continuation of Benefits While the MCO Appeal and the State Fair Hearing are Pending: Definition: • Related to continuation of benefits for Non-HCBS Waiver and HCBS Waiver services, complete the following (2022 Recommendation 54): a. Add distinction to the Aetna appeal resolution letters, between continuation of benefits for Non-HCBS Waiver and HCBS Waiver services. b. In the section "Continuation of Benefits" in the *Provider Manual*, include language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*. c. In Aetna policy and procedure *3100.70 Enrollee Appeals,* section "Request for Continued Benefits During Appeals Process," include language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook.* **KFMC 2023 Update:** a. Not Addressed: ABH did not provide an updated Appeal Resolution Letter Template to demonstrate the recommended regulatory language had been added. For this to be fully addressed, ABH needs to provide an approved updated letter template that has a distinction between continuation of benefits for Non-HCBS Waiver and HCBS Waiver services. b. Fully Addressed: ABH provided an updated *Provider Manual* that includes language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*. c. Fully Addressed: ABH provided policy *3100.70 Enrollee Appeals*. Section "Request for Continued Benefits During Appeals Process," (PP.12-13) includes language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*.	Not Yet Reviewed		New	Partially Addressed
Sunflower					
	2021 Recommendations: Subpart C – Enrollee Rights and Protections				
1.	§438.10(g)(2)(xi) Information for Enrollees of MCOs, PIHPs, PAHPs, and PCCM Entities – Enrollee Handbook: Right to File Grievances and Appeals: To the *Member Handbook*, add language that clearly states members have "the right to file grievances and appeals." (2021 Recommendation 2)	Not Yet Reviewed	New	Not Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
Sunflower					
	2021 Recommendations: Subpart C – Enrollee Rights and Protections (Continued)				
	KFMC 2022 Update: KFMC was unable to find the recommended language in the *Member Handbook.* **KFMC 2023 Update**: Language is in the 2023 Sunflower *Member Handbook* (P. 53), section "Member Rights & Responsibilities," subsection, "Sunflower Members Have the Following Rights:" bullet 9, "To file grievances and appeals about Sunflower or the care it provides. To receive a response in a reasonable period of time."				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
2.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: For ease of reference for members and providers, for any applicable elements listed above (see Common to the MCOs recommendation 1) that are not included in the Service Plan or PCSP, make a reference in the Service Plan/PCSP indicating where the information can be located. (2022 Recommendation 2) **KFMC 2023 Update**: See the "KFMC 2023 Update" in "Common to the MCOs" Recommendation 1.	Not Yet Reviewed		New	Partially Addressed
3.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: Review the internal Sunflower process to ensure that the PCSP documents the following (2022 Recommendation 3): a. Distributed to all attendees within fourteen (14) days of the development of the plan (LTSS – HCBS cases; State contract 5.4.4.2.H). b. Signed and approved. (PH and LTSS – HCBS cases; State Contract 5.4.4.2.C) c. Signed by the member, guardian, or legal representative, the MCO service coordinator, the community service coordinator, and all providers listed on the PCSP. (PH and LTSS – HCBS cases; State Contract, 5.4.4.2.C.2) d. Signed by the service coordinator, the community service coordinator, and member prior to implementation. (PH and LTSS – HCBS cases; State Contract, 5.4.4.1.C.3) **KFMC 2023 Update**: a. The SHP *PCSP Work Process* (P. 13) details the member is given the finalized plan and the Care Manager confirms receipt of the plan, however, no timeframe is listed. This element is In Progress. For this element to be fully addressed, SHP needs to submit the approved revised process that reflects specific distribution of the plan within 14 days of development. b-d. For LTSS – HCBS, SHP submitted the *PCSP Work Process* that describes the member signature requirements (PP. 8-12). For PH, SHP explained how the verbal consent of the member is obtained, but no SHP internal process was submitted, therefore, these elements are partially addressed.	Not Yet Reviewed		New	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Sunflower (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
4.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: Sunflower should review the cases identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Sunflower details for each member in a separate and secure document (2022 Recommendation 5): a. PH TXIX: Members 1, 2, 4, 5, 7, 9, 10, 13, 15, and 17; PH TXXI: Members 1, 3, 4, 5, 6, 8, 9, 10, 11, and 14 b. BH TXIX: Members 8, 9, and 16; TXXI Members 2, 5, 7, 8, 9, 10, 11, and 14 c. LTSS – HCBS Members 6, 9, and 11 d. LTSS – NF Members 2 and 10 e. SHCN – Title V Member 22 **KFMC 2023 Update**: Overall, in the update provided, SHP addressed most of the members noted in the recommendation, however, no documentation was provided. The following members were not addressed and/or the explanation did not adequately address the recommendation: PH TXIX Member 9; BH TXIX Member 8; BH TXXI Members 2, 7, 8, and 9; LTSS – HCBS Member 9; and SHCN – Title V Member 22. SHP reports they are in progress of addressing the issues identified for PH TXXI Member 8 and LTSS – NF Member 10. For this recommendation to be fully addressed, SHP needs to provide documentation of the outreach attempts (i.e., screenshots of the system that tracks texts or mailers sent with date stamps), provide staff and provider education materials, and address the concerns made for those members not adequately addressed. KFMC provided SHP a sperate document via the SFTP for detailed explanation of the cases.	Not Yet Reviewed	New	Partially Addressed
5.	Case Review Related to §438.208(b)(3) Coordination and Continuity of Care: A health screen should be completed or an attempt to contact the member within 90 days of enrollment or every other year (PH, BH, LTSS – NF, and SHCN – Title V). (2022 Recommendation 7) **KFMC 2023 Update**: SHP provided the document *KS.WP.CM.32 Health Risk Screening Tool Work Process.* Section "Purpose" states, "Sunflower's plan to conduct initial Health Screenings for: New Sunflower Medicaid Members within ninety (90) days of enrollment," and "The CONTRACTOR(S) must complete the Health Screen via telephone or in person at least every other year."	Not Yet Reviewed	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
Sunflower (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
6.	Case Review Related to §438.208(b)(3) Coordination and Continuity of Care: For eligible members, Sunflower should include documentation of the need for a yearly Health Screen Tool reassessment (PH, BH). (2022 Recommendation 8) **KFMC 2023 Update**: SHP provided the document *KS.WP.CM.32 Health Risk Screening Tool Work Process* which states, "The CONTRACTOR(S) shall update the Health Screen at least annually through phone assessment, PCP, or claims data. The CONTRACTOR(S) must complete the Health Screen via telephone or in person at least every other year. The CONTRACTOR(S) may only complete the Health Screen via claims data every other year."	Not Yet Reviewed	New		Fully Addressed
7.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: In the 2023 follow-up review, provide notification of credentialing decision letter for Providers 1, 8, and 14. (2022 Recommendation 10) **KFMC 2023 Update**: SHP provided explanation of why the notification of credentialing decision letter was not sent to the listed Institutional providers and stated that SHP processes have been updated to send notification of approval. For this recommendation to be fully addressed, SHP needs to provide documentation of the process change (i.e., the written work process, a policy and procedure, and/or the email template for notification of approval of recredentialing).	Not Yet Reviewed	New		Partially Addressed
8.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: In the 2023 follow-up review, provide malpractice insurance for Provider 2. (2022 Recommendation 12) **KFMC 2023 Update**: SHP provided the malpractice insurance for Provider 2.	Not Yet Reviewed	New		Fully Addressed
9.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: In the 2023 follow-up review, provide State Uniform HCBS Supplemental Form for Provider 3. (2022 Recommendation 13) **KFMC 2023 Update**: SHP did not provide the document to KFMC, and it was not noted as a missing document when KFMC confirmed the number of uploaded documents (KFMC SFTP), therefore, this recommendation is not addressed, as KFMC was unable to review the State Uniform HCBS Supplemental Form for Provider 3.	Not Yet Reviewed	New		Not Addressed

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
Sunflower (Continued)					
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
10.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: In the 2023 follow-up review, for Provider 12, provide the recredentialing application and signed attestation of correctness. (2022 Recommendation 14) **KFMC 2023 Update**: SHP provided the recredentialing application and signed attestation of correctness for Provider 12.	Not Yet Reviewed		New	Fully Addressed
UnitedHealthcare					
	2020 Recommendation: Subpart D – MCO, PIHP and PAHP Standards				
1.	Case Review Related to §438.208 Coordination and Continuity of Care: Findings from case review conducted. • With future record requests, include member services' documentation of all outreach attempts for health screenings for members in the request; KFMC will ensure this is included as a request element. (2020 Recommendation 24) **KFMC 2022 Update:** Documentation of HST outreach attempts was not provided in records reviewed by KFMC. **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For a fully addressed rating, UHC will need to provide documentation (i.e., screenshots of the Community Care or HST that is mentioned).	New	Substantially Addressed	In Progress	Partially Addressed
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
2.	Case Review Related to §438.208 Coordination and Continuity of Care: Case review that included review of health screens. • Identify and implement strategies to increase health screens of members in the BH and PH populations. (2020 Recommendation 25) **KFMC 2022 Update:** UHC did provide documentation outlining the remediation plan to increase the completion of health screens of members, however completion rates remain low, therefore KFMC will continue to monitor this recommendation. **KFMC 2023 Update:** According to UHC's narrative, good progress is being made towards this recommendation being fully addressed. For this recommendation to be fully addressed, UHC needs to submit documents providing evidence of their increase in HST completion (i.e., a screenshot of the spreadsheet document with clear labeling). The documentation submitted was not clearly labeled; therefore, KFMC could not verify what the numbers submitted signified.	New	In Progress		Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
UnitedHealthcare (Continued)					
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
3.	§438.206(b)(3) Availability of Services: Delivery Network (Second Opinion): • In the *Member Handbook*, section "Getting a Second Opinion," revise the last sentence that details an out-of-network second opinion is at *no more cost* to the member than if the service was provided in-network. For example, the sentence would read, "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." (2022 Recommendation 1) **KFMC 2023 Update:** UHC revised the *Member Handbook*, section "Getting a Second Opinion," so the last sentence reads, "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."	Not Yet Reviewed	New	Fully Addressed	
4.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: • For ease of reference for members and providers, for any applicable elements listed above (2022 Recommendation 2) that are not included in the Service Plan or PCSP, make a reference in the Service Plan/PCSP indicating where the information can be located. (2022 Recommendation 3) **KFMC 2023 Update:** UHC's Summer 2023 update stated they are in the process of updating the PCSP document. Upon completion, UHC needs to provide documentation of when the changes were made and provide a template PCSP reflecting the changes.	Not Yet Reviewed	New	In Progress	
5.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: • Review the internal UnitedHealthcare process to ensure the PCSP is distributed to all attendees within fourteen (14) days of the development of the plan. (BH, LTSS – NF, and SHCN – TA Waiver cases; State Contract 5.4.4.2.H) (2022 Recommendation 4) **KFMC 2023 Update:** UHC's Summer 2023 update states that their processes and procedures align with the recommendation, however, no policies and procedures or SOPs were provided. For this recommendation to be fully addressed, UHC needs to submit documents (i.e., policies and procedures, training documents, SOPs etc.) for KFMC to review.	Not Yet Reviewed	New	Not Addressed	

	Follow-Up to Previous Recommendations	Completion Status 2020	2021	2022	2023
UnitedHealthcare (Continued)					
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
6.	Case Review Related to §438.208(b)(1) Coordination and Continuity of Care: • UnitedHealthcare should review the cases identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided United details for the following cases in a secure separate document (2022 Recommendation 6): a. PH TXIX Members 3, 4, 5, 8, 9, 18, and 20; PH TXXI Members 2, 4, 5, 12, 18, and 20 b. BH TXIX Members 1, 3, 6, 11, 12, 13, 16, and 17; Replacement cases 4 and 5; BH TXXI Members 1, 2, 3, 4, 5, 8, 13, 14, 15, 19, and 20; Replacement cases 2, 3, 5 and 6 c. LTSS – HCBS Members 12 and 18 d. LTSS – NF Members 5, 6, 10, and 15 e. SHCN – TA Waiver Members 17 and 18 f. SHCN – Title V Members 1, 6, 10, 16, 28, 30, 31, 32, 34, and 35 **KFMC 2023 Update:** The original secure document, as referenced in the recommendation was uploaded by KFMC to the KFMC SFTP site on 2/14/2023, along with an email notification from KFMC to UHC, however no receipt confirmation was received from UHC. On 9/20/2023, the secure document was reuploaded by KFMC for UHC's reference along with the original email informing them of the upload.	Not Yet Reviewed	New	Not Addressed
7.	Case Review Related to §438.208(b)(3) Coordination and Continuity of Care: • A health screen should be completed or an attempt to contact the member within 90 days of enrollment or every other year (PH, BH, LTSS – NF, and SHCN – Title V) (2022 Recommendation 8) **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For this recommendation to be fully addressed, UHC needs to provide documentation (i.e., policy/procedure, SOPs, screenshots of the Community Care system, HST, or of the IVR vendor system that captures all contact attempts mentioned by UHC).	Not Yet Reviewed	New	Partially Addressed
8.	Case Review Related to §438.208(b)(3) Coordination and Continuity of Care: • For eligible members, UnitedHealthcare should include documentation of the need for a yearly HST reassessment (PH). (2022 Recommendation 9) **KFMC 2023 Update:** UHC provided a thorough explanation on how the need for a yearly HST reassessment is documented, however, for this recommendation to be fully addressed, UHC needs to submit documentation to support how they are addressing the recommendation (i.e., screenshots of the IVR system, policy & procedure, or SOP that demonstrates the process).	Not Yet Reviewed	New	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
UnitedHealthcare (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards					
9.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide evidence of provider notification of the credentialing decision for Provider 4 (10/19/2022 replacement sample selection). (2022 Recommendation 10) **KFMC 2023 Update:** UHC reported they are unable to get a copy of the credentialling decision notification letter that was sent to the provider due to an issue with internal copies of letters not saving to the credentialing cycles. For this recommendation to be fully addressed, UHC will need to provide evidence that the letter notification to the provider of the credentialling decision was sent. This evidence could be a screenshot of UHC's system with documentation of the date the notification was sent.	Not Yet Reviewed	New	UHC Unable to Fully Address	
10.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide explanation of delay in provider notification (provider notified >60 days) for Provider 7 (6/14/2022 original sample selection). (2022 Recommendation 11) **KFMC 2023 Update:** For Provider 7, from the documentation UHC submitted, the initial application date is detailed as 7/6/2021, with most verification happening on 10/5/2021. UHC states the credentialing process was delayed due to the provider not providing admitting privileges at a participating hospital. That information was received on 11/5/2021, with the credentialing decision being made by UHC the same day. In order for this recommendation to be fully addressed, UHC needs to provide explanation of why there was more than 60 days between receiving the initial application (7/6/2021) and sending the email requesting additional information (11/3/2021).	Not Yet Reviewed	New	Partially Addressed	
11.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the signed attestation to correctness for Provider 2 (11/28/2022 replacement sample selection). (2022 Recommendation 12) **KFMC 2023 Update:** UHC provided the signed attestation to correctness for Provider 2.	Not Yet Reviewed	New	Fully Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
UnitedHealthcare (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
12.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide documentation that the Master Death File was checked on all providers (Providers 1-8, 6/14/2022 original sample selection; Providers 9-15, 10/19/2022 replacement sample selection). (2022 Recommendation 14) **KFMC 2023 Update:** UHC provided the Social Security Death Mast File Database Cleanse SOP and explained how it is used to verify contracted providers are not deceased.	Not Yet Reviewed	New	Fully Addressed	
13.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide an explanation of why there would be a span of six months between credentialing dates (Provider 5, 6/14/2022 original sample selection). (2022 Recommendation 15) **KFMC 2023 Update:** UHC's explanation stated they were compliant because there was no more than 36 months between credentialing and recredentialing dates. However, since providers are recredentialed every 36 months, it is not clear why a provider would be initially credentialed and then recredentialed within a short time period of six months. UHC will need to provide KFMC explanation of the reason.	Not Yet Reviewed	New	Partially Addressed	
14.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide the signed attestation of correctness for Providers 3, 7, 10, and 14. (2022 Recommendation 16) **KFMC 2023 Update:** UHC provided the attestations for the Individual Health Care Professional cases, not the Institutional Health Care Professional cases. For this recommendation to be fully addressed, UHC will need to provide the signed attestation of correctness for Institutional Health Care Providers 3, 7, 10, and 14.	Not Yet Reviewed	New	Not Addressed	

	Follow-Up to Previous Recommendations	Completion Status			
		2020	2021	2022	2023
UnitedHealthcare (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
15.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide evidence of the following, for Institutional Health Care Professional 14 (2022 Recommendations 18a-c): a. NPPES, OIG/LEIE and GSA-SAM being checked. (Also applies to §438.214[d]) (2022 Recommendations 18a and 20) b. Entity that credentialed the provider, Medicare/Medicaid Program participation, and that all information used for credentialing was less than 180 days old. c. Review the file completeness, as there were only four documents submitted (DEA certificate, commercial liability insurance, proof of Kansas permit and licensure) and it is unknown if the provider was being credentialed or recredentialed or who completed it. **KFMC 2023 Update:** The documents provided for Institutional Health Care Professional 14 did not include an Aperture checklist during the 2022 Review of UHC. For this recommendation to be fully addressed, UHC needs to provide evidence that the items listed in the recommendation were verified by UHC.	Not Yet Reviewed	New	Not Addressed	
16.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider Selection: • In the 2023 follow-up review, provide evidence of the malpractice insurance for Providers 6, 7, 14 and 15. (2022 Recommendation 19) **KFMC 2023 Update:** The Health Care Professionals that are referenced in UHC's response are the Individual Health Care Professional files, not the Institutional Health Care Professional files that are referenced in the recommendation.	Not Yet Reviewed	New	Not Addressed	

Follow-Up to Previous Recommendations		Completion Status			
		2020	2021	2022	2023
UnitedHealthcare (Continued)					
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)					
17.	§438.214(e) Provider Selection – State Requirements: • Credentialing decisions should be communicated to the provider within 60 days of the completed application being received. (Provider 7, 6/14/2022 original sample selection). (2022 Recommendation 21) **KFMC 2023 Update:** For Provider 7, from the documentation UHC submitted, the initial application date is detailed as 7/6/2021, with most verification happening on 10/5/2021. UHC states the credentialing process was delayed due to the provider not providing admitting privileges at a participating hospital. That information was received on 11/5/2021, with the credentialing decision being made by UHC the same day. For this recommendation to be fully addressed, UHC needs to provide explanation why there was more than 60 days between receiving the initial application (7/6/2021) and sending the email requesting additional information (11/3/2021).	Not Yet Reviewed	New	Partially Addressed
2022 Recommendations: Subpart F – Grievance and Appeal System					
18.	§438.402(c)(1)(i)(B) General Requirements: Filing Requirements (Authority to File - External Medical Review): • Add the regulatory language related to external medical review in the United policy *UCSMM 07.12 Appeal Process and Record Documentation*, table column "State/Federal Medicaid Rules." (2022 Recommendation 22) **KFMC 2023 Update:** UHC reports they are currently working with their Corporate Administration on making the change to fully address this recommendation.	Not Yet Reviewed	New	In Progress
19.	§438.402(c)(1)(ii) General Requirements: Filing Requirements (Authority to File): • In the *Grievance and Appeal Process Letter Attachment*, add language clarifying an Authorized Representative can file a grievance on behalf of the member. (2022 Recommendation 23) **KFMC 2023 Update:** UHC provided the updated *Grievance and Appeal Process Letter Attachment* with the clarifying language that an Authorized Representative can file a grievance on behalf of the member.	Not Yet Reviewed	New	Fully Addressed

Quality Assessment and Performance Improvement Review

Follow-Up to Previous Recommendations		Completion Status				
		2019	2020	2021	2022	2023
Common Among the MCOs						
	2022 Recommendation					

1.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors:
	• ABH – Incorporate the State-specified goals listed in the State Contract section 5.9.3(B) in the QAPI program documents.
	• SHP and UHC – In future QAPI documents, incorporate the State-specified goals listed in the State Contract section 5.9.3(B) to demonstrate how the QAPI program addresses them.
	
	KFMC Update:
	• ABH 2023 Review: The State-specified goals were incorporated into the *2023 QAPI Work Plan* (dated November 30, 2023) and the *2023 QAPI Program Description.* The *2022 QAPI Program Evaluation* included goals 5.9.3(B)(1-5) but did not include goal 5.9.3(B)(6).
	• SHP 2023 Review: The QAPI documents do not include the State Contract-specified goals and the one SHP goal included in the program description was not included in the other documents.
	• UHC 2023 Review: The *2023 QAPI Work Plans* did not include the following requirements of the State-specified goals listed in the State Contract section 5.9.3(B) to demonstrate how the QAPI program addresses them:
	  ○ UHC internal Goal A, row 8 Objective (work plan) states, "Support medically complex and fragile members through person-centered complex case management programs that improve the member experience." However, it is missing the part of the State Contract goal related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports."
	  ○ UHC Internal Goal B, row 16 Objective (work plan) states, "Monitor the adequacy of the contracted network through analysis of access, availability, and OON data and adjust the practitioner network, as appropriate, to meet diverse population needs." However, it is missing the part of the State Contract goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members."
				Not Yet Reviewed	New	ABH Partially Addressed
						
						SHP/UHC Not Addressed

Follow-Up to Previous Recommendations		Completion Status				
		2019	2020	2021	2022	2023
Aetna						
	2022 Recommendation					
1.	5.9.1(N)(6) General Requirements – Structure and Staffing: Develop an annual evaluation process: • Ensure that the goals are consistent between the QAPI evaluation, work plans, and program description. **KFMC Update:** • 2023 Review: The goals continue to not be consistent across the three QAPI documents, as the *2023 QAPI Work Plan* (dated November 30, 2023) and *2023 QAPI Program Description* included the goals listed in the State Contract section 5.9.3(B)(1-6). The *2022 QAPI Program Evaluation* included goals 5.9.3(B)(1-5) but did not include goal 5.9.3(B)(6).	Not Yet Reviewed			New	Partially Addressed
Sunflower						
	2021 Recommendation					
1.	5.16.1(B) Reports and Audits – Steps Contractor must take to ensure that data received from Participating Providers is accurate and complete: • 2021: In future QAPI work plans, program descriptions, and evaluations, include information related to MCO's review of all reports submitted to the State. • 2022: Include information in the QAPI documents on review and oversight of data collection, ensuring complete and accurate data from participating providers, and Sunflower's review of all reports submitted to the State. **KFMC Update:** • 2022 Review: Information related to review of all reports for timeliness, accuracy, and completeness prior to submission to the State (State Contract, section 5.16.1[B]) was not added to the *2021 QAPI Evaluation, 2022 QAPI Work Plans,* or *2022 QAPI Program Description*. • 2023 Review: In 2023, the State determined the MCO is not required to include this information in the QAPI evaluation or program description. However, it is required to be in the QAPI work plan. In the *2023 QAPI Work Plans*, SHP added a row "Data received from Participating Providers." However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement. Therefore, this is partially addressed.	Not Yet Reviewed		New	Not Addressed	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status				
		2019	2020	2021	2022	2023
Sunflower (Continued)						
	2022 Recommendations					
2.	5.9.1(A) General Requirements – The State's QMS: The Contractor shall comply with the State's QMS. • In future QAPI documents, include information on how SHP complies with the State QMS. **KFMC Update**: • 2023 Review: Sunflower added language to the *2022 QAPI Evaluation, 2023 QAPI Work Plans,* and the *2023 QAPI Program Description* related to how they comply with the State QMS.	Not Yet Reviewed			New	Fully Addressed
3.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt through which the Contractor shall meet the established QAPI goals and incorporate the objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals: • In future QAPI documents, use the State-specified objectives listed in the State Contract section 5.9.3(C) to demonstrate how the QAPI program addresses them. **KFMC Update:** • 2023 Review: The QAPI documents do not include the State Contract-specified objectives listed in State Contract section 5.9.3(C).	Not Yet Reviewed			New	Not Addressed
4.	5.9.10(F) Contractor to annually conduct a member satisfaction survey with the KanCare SUD population and incorporate questions, as needed, into their survey instrument as instructed by KDADS or KDHE: • In future QAPI documents, include the KanCare SUD population and annual summary. **KFMC Update**: • 2023 Review: The 2022 QAPI Evaluation included information on the KanCare SUD Survey. In the *2023 QAPI Work Plans*, SHP added a line that addressed the SUD survey. The 2023 QAPI Program Description did not include information on the SUD survey.	Not Yet Reviewed			New	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status				
		2019	2020	2021	2022	2023
UnitedHealthcare						
	2019 Recommendation					
1.	5.9.11(A) QMS requirements: • Address QMS requirements for providers surveys, including providing a work plan to the State that contains a timeline, barrier analysis, and intervention(s) to address results. **KFMC Update:** • 2020 Review: UHC is developing a policy and procedure to address this recommendation. • 2021 Review: UHC provided documentation that adequately addressed the timeline; however, it did not include barrier analysis, nor intervention(s) to address results as recommended. • 2022 Review: UHC advised they follow the survey template as provided by the State. The survey and results are conducted by all three Kansas MCO's simultaneously with an approved KDHE Survey instrument. Upon State feedback, UHC will "address and make recommendations related to the substance abuse survey tool and any recommendations related to program interventions…" Through the 2022 Provider Survey Validation process, KFMC learned the joint-MCO provider survey tool has not yet been implemented. This recommendation status continues to be In Progress. • 2023 Review: In 2023, UHC and the other two MCOs completed the joint Provider Survey.	New	In Progress			Fully Addressed
	2022 Recommendations					
2.	5.9.1(A) General Requirements – The State's QMS: The Contractor will comply with the State's QMS. • In future QAPI documents, include information on how UHC complies with the State QMS. **KFMC Update:** • 2023 Review: The *2023 QAPI Work Plans* included the activity "Review State QMS annually, including compliance of the QMS." The *2022 QAPI Evaluation* and *2023 Program Description* did not include details of how UHC complies with the State QMS. In the *2023 Program Description*, within the list of "Responsibilities of the QMC," oversight and approval of the QI PHM PD, QI PHM WP, and QI PHM Eval was listed. However, showing evidence of compliance with the State QMS requires more than listing these items in the program description.	Not Yet Reviewed			New	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status				
		2019	2020	2021	2022	2023
UnitedHealthcare						
	2022 Recommendations (Continued)					
3.	5.9.1(I) General Requirements –The Contractor will develop and implement mechanisms to assess the quality and appropriateness of care furnished to Members with special health care needs: • In future QAPI documents, include mechanisms to assess quality and appropriateness of care for Members receiving SHCN. **KFMC Update:** • 2023 Review: UHC added to the *2023 QAPI Work Plan*, LTSS Tab, row 4, "Review case management files against policies & procedures for compliance." The "Crosswalk description" column details the State contractual requirement.	Not Yet Reviewed			New	Fully Addressed
4.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt through which the Contractor shall meet the established QAPI goals and incorporate the objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals: • In future QAPI documents, use the State-specified objectives listed in the State Contract section 5.9.3(C) to demonstrate how the QAPI program addresses them. **KFMC Update:** • 2023 Review: In the QAPI documents, UHC did not include in their program objectives the following State-specified objectives listed in the State Contract section 5.9.3(C): ○ 5.9.3(C)(1-3), (C)(5), and (C)(7) were not included in the *2022 QAPI Evaluation*, *2023 QAPI Program Description*, and *2023 QAPI Work Plans*. ○ 5.9.3(C)(4) was not included in the *2022 QAPI Evaluation* or the *2024 QAPI Work Plans*. ○ 5.9.3(C)(6) was not included in the *2023 QAPI Program Description*. ○ 5.9.3(C)(7) was not included in the *2022 QAPI Evaluation* or *2023 QAPI Program Description*.	Not Yet Reviewed			New	Partially Addressed

Appendix E

KanCare Program Annual External Quality Review Technical Report

2023–2024 Reporting Cycle

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
AD	Advanced Directives
ADHD	Attention Deficit Hyperactivity Disorder
Aetna, ABH, or ABHKS	Aetna Better Health of Kansas
AHRQ	Agency for Healthcare Research and Quality
ADT	Admission, Discharge, and Transfer
AMM	Antidepressant Medication Management (HEDIS measure)
BH	Behavioral Health
BI	Brain Injury
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CC	Care Coordinator
CCC	Children with Chronic Conditions
CCS	Cervical Cancer Screening (HEDIS measure)
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program (Title XXI)
CHW	Community Health Worker
CM	Care Management
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPESN	Community Pharmacy Enhanced Service Network
CP-PCPi	Community Plan Primary Care Provider Incentive
CPT	Current Procedural Terminology
CSS	Center for the Study of Services
DTaP	Diptheria, Tetanus, and Acellular Pertussis Vaccine
ECHO	Experience of Care and Health Outcomes (ECHO Survey)
ECHO	Extension for Community Healthcare Outcomes (Project ECHO)
ED	Emergency Department
EITPR	External Independent Third-Party Review
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FE	Frail Elderly
FIS	Food Insecurity Screening
FM	Fully Met
GC	General Child CAHPS survey population
GIC	Gaps in Care
GSA-SAM	Government Services Administration's System for Award Management
HbA1c	Glycated Hemoglobin
HCBS	Home and Community-Based Services

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
HCE	Health Care Equity
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HiB	Haemophilus Influenzae B
HIPAA	Health Insurance Portability and Accountability Act
HPV	Human Papillomavirus
HRA	Health Risk Assessment
HSF	Housing Stabilization Fund
HST	Health Screening Tool
I/DD	Intellectual/Developmental Disability
IDSS	Information Data Submission System
IPV	Inactivated Poliovirus Vaccine
ISCA	Information Systems Capabilities Assessment
IVR	Interactive Voice Response
KDADS	Kansas Department for Aging and Disability Services
KFMC	KFMC Health Improvement Partners
KHIN or KONZA	Kansas Health Information Network
KMAP	Kansas Medical Assistance Program
KMMS	Kansas Modular Medicaid System
KSWebIZ	Kansas Immunization Registry
LDL-C	Low-density Lipoprotein Cholesterol
LEIE	List of Excluded Individuals/Entities
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MetaStar	MetaStar, Inc.
MH	Mental Health
MM	Member-Months (Performance Measure Validation)
MM	Minimally Met (Compliance Review)
MMIS	Medicaid Management Information Systems
MMR	Measles-Mumps-Rubella
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NE	Non-Emergent
NF	Nursing Facility
NM	Not Met
NPI	National Program Identifier
NPPES	National Plan & Provider Enumeration System
OBGYN	Obstetrician/Gynecologist
OIG	Office of the Inspector General
OMB	Office of Management and Budget

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
PAHP	Prepaid Ambulatory Health Plan
PARs	PIP Action Report
PCP	Primary Care Physician/Provider
PCSP	Person-Centered Service Plan
PD	Physical Disability
PDSA	Plan-Do-Study-Act
PH	Physical Health
PHM PD	Population Health Management Program Description
PIHP	Prepaid Inpatient Health Plan
PII	Personal Interest Inventory
PIP	Performance Improvement Project
PM	Partially Met
PMTO	Parent Management Training, Oregon Model
PMV	Performance Measure Validation
POM	Proactive Outreach Management
pp	Percentage Points
pp/y	Percentage Points Per Year
PPC	Prenatal and Postpartum Care (HEDIS measure)
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QC	Quality Compass (NCQA)
QI	Quality Improvement
QMC	Quality Management Committee
QMS	Quality Management Strategy
RC	Reporting Cycle
RP	Remeasurement Period
RTO	Real Time Offer
RY	Remeasurement Year
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SHCN	Special Health Care Needs
SM	Substantially Met
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia
SMS	Short Message Service
SNAP	Supplemental Nutrition Assistance Program
SOP	Standard Operating Procedure
SQIS	Service Quality Improvement Sub-committee
STEPS	Supports and Training for Employing People Successfully
SUD	Substance Use Disorder
Sunflower or SHP	Sunflower Health Plan

List of Abbreviations and Acronyms	
Abbreviation/Acronym	***Description***
TA	Technical Assistance
Tdap	Tetanus, Diptheria toxoids, and Pertussis Vaccine
TXIX	Title XIX Grants to States for medical assistance programs (Medicaid)
TXXI	Title XXI State Child Health Insurance Programs (CHIP)
UnitedHealthcare, UHC, or UHCCP	UnitedHealthcare Community Plan of Kansas
VZV	Varicella-Zoster Virus
WCC	Weight Assessment and Counseling for Nutrition and Physical Activitiy for Children and Adolescents (HEDIS measure)
WIC	Women, Infants and Children
WP	Work Plan
WPC	Whole Person Care Program
Yr	Year