Review and Evaluation of the KanCare Quality Management Strategy

2021 - 2024

Introduction

The State of Kansas, as part of the Quality Management Strategy (QMS), began with these hypotheses from the KanCare 2.0 contract.

1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.

2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.

3. The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural areas. Specifically:

    A. Telemedicine will improve access to services such as speech therapy

    B. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.

    C. Telementoring can pair rural healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.

4. Removing payment barriers for services provided in Institutions for Mental Disease (IMDs) for members who have a primary diagnosis of a substance use disorder or co-occurring substance use disorder will result in improved member access to behavioral health services.

The KanCare QMS acted as a roadmap outlining the program's performance measures 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 promote employment and independent living supports.

The State used a combination of nationally recognized measure sets whenever possible, including the National Committee for Quality Assurance (NCQA) HEDIS data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and Mental Health survey data. The State also utilized Kansas Modular Medicaid System (KMMS) claims data; waiver program data; data submitted by the Managed Care Organizations (MCOs); External Quality Review Organization (EQRO) data; Kansas Department for Aging and Disability Services (KDADS) data. The data was collected, presented and discussed in the Bi-Annual Quality Steering Committee meetings.

Kansas contracted with KFMC Health Improvement Partners to provide External Quality Review (EQR) activities. EQR activities are considered a core feature in the State's quality strategy. The State incorporated the EQRO recommendations into the overall QMS. A table which details the State's response to each recommendation in the review, dissemination, and evaluation section of the QMS is available on the state's website. It can be found in Table 9 within the KanCare Quality Management Strategy. https://www.kancare.ks.gov/data-policy/quality-measurement

Summary of Goals, Strategies, and Objectives

Goal 1: Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.

Strategy: Increase the number of providers who qualified for value-based payment rate by 2% year over year (2019-2023).

Objectives:

Objective 1.1: Increase the number of VBPs offered by the MCOs which serve to integrate services

Objective 1.1 was met. The State looked at the number of providers by Tax Identification Number (TIN) who qualified and received incentive/number of projects. The goal was to increase by one project per year, over the course of 2020 to 2024, where one TIN could represent multiple providers. From a baseline in 2020 of 12 projects, 20 projects in 2023, and 28 projects as of July of 2024. The State not only met but exceeded its goal.

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.)

Objective 1.2 was met. All three State of Kansas Medicaid MCOs submitted a cultural competency plan annually that included the necessary elements required in the contract. The State looked at the plans submitted to the State's secure upload site.

Objective 1.3: Increase the number of crisis response claims that occur in the community setting, including in the member's home

Objective 1.3 was not met. From a baseline in 2020 of 14,743 claims, 2023 showed 9,360 claims, and as of July 2024, 2,915 claims. The State looked at the number of claims with a procedure code for crisis intervention services, for age range 0-20, place of service excluding inpatient settings. One reason for the decrease in claims appears to be better education on the use of the crisis intervention services. Additionally, the public health emergency appears to have played a role in the high numbers in 2020. Over the course of the measurement period, data shows that people began returning to office visits vs. utilizing services in the community settings.

Goal 2: Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.

Strategy: Reduce Hospital admissions and the use of crisis services by 25% by the end of three years (2019- 2022), through increased use of employment and ILS services.

Objectives:

Objective 2.1: Improve the process to increase referrals and tracking to employment services for all members who express an interest and need.

Objective 2.1 was met. The State of Kansas created the Employment Specialist Referral Report, which provides the number of members referred by employment specialists to employment services.

The Employment Specialist Referral Report captures data relevant to MCO employment specialist referrals to employment services. These requirements became effective beginning with the January 2022 report period, with initial reporting due at the end of the second quarter, submitting previous quarter's data. As of 8-2024 the total number of members identified grew to 1,033 with 519 members referred to employment services.

Objective 2.2: Implement, support and expand the STEPS pilot program (program begins 07-01-21)

Objective 2.2 was met. Supports and Training for Employing People Successfully (STEPS) is a program through which people with disabilities and/or behavioral health conditions may seek a path to employment without jeopardizing their Social Security benefits or losing medical insurance coverage.

Objective 2.3: Increase the use of community integration codes, supportive housing, Operation Community Integration (OCI)

Objective 2.3 was met. The State looked at the number of claims with a procedure code for community support services. The claim count for 2020 was 1,046, increasing to 1,959 in 2023, and as of July 2024, the claim count is 2,032.

Objective 2.4: Increase the average utilization of Value Added Benefits (VABs) per member per year

Objective 2.4 was met. The average utilization of VABs per member/per year in 2020 was 0.68. In 2023 there was an increase to an average of 2.01, and as of July 2024, an average of 1.26. The State looked at the VAB data submitted by the MCOs in the KanCare Report Administration (KRA).

Objective 2.5: Each MCO will implement a Performance Improvement Project (PIP) that addresses Social Determinants of Health (SDOH)

Objective 2.5 was met. Each MCO carried out a PIP focusing on SDOH. The detailed EQRO evaluation of each PIP is included in the 2023-2024 Annual EQR Technical Report.

> Aetna Better Health of Kansas developed a PIP on "Reducing food insecurity." The EQRO determined there was confidence that this PIP was achieved.
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> Sunflower Health Plan developed a PIP on "Improving access to mental health services for children in foster care." The EQRO determined there was little confidence that this PIP was achieved.
>
> United Healthcare Community Plan developed a PIP to "Provide housing resources for members who are homeless or at-risk of homelessness." The EQRO determined there was high confidence that this PIP was achieved.

Objective 2.6: Increase the rate of completed health screens

Objective 2.6 was not met. In 2020 the rate reported was 7.09%, dropping to 4.60% in 2023. The State received the health screen data on a template submitted by the MCOs through the State's KanCare Report Administration (KRA) site. The State then moved to a system generated report that compiled data submitted by the MCOs. A partial explanation of the drop in numbers is the difference between the way the data was compiled in each report.

Objective 2.7: Increase the rate of members enrolled into OCK by 10% year over year

Objective 2.7 was met. In 2020 the numbers of members enrolled on OneCare Kansas (OCK) was 921, increasing to 5,347 in 2023, however the OneCare Kansas program has been discontinued by the State.

Objective 2.8: Increase percent of those enrolled in OCK that received a claim for care coordination by 10% year over year

Objective 2.8 was not met. In 2020 the percent of those enrolled in OneCare Kansas that received a claim for care coordination was 52%, decreasing to 37% in 2023. The OneCare Kansas program has been discontinued by the State.

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

Objective 2.9 was not met. The State looked at claims that had a Z code identifying members with employment, housing, legal, food or health access needs. The claim count in 2020 was 34,144 and dropped to 30,331 in 2023. The State believes that better provider education and incentives would help increase the use of Z codes on claims. The State will continue to monitor the use of Z codes on claims without filtering to a specific subset.

Goal 3: The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural areas.

Specifically:

A. Telemedicine will improve access to services such as speech therapy

B. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions

C. Telementoring can pair rural healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.

Strategy: Improve access to services by increasing the availability of telehealth services 2018-2023 (expecting a higher increase in 2020 than in subsequent years due to approval of additional procedure codes).

Objectives:

Objective 3.1: Annually increase claims for speech therapy via telehealth

Objective 3.1 was not met. In 2020 the number of claims for speech therapy via telehealth was 8,184, dropping to 845 in 2023. The State opened the use of speech therapy codes via telehealth during the public health emergency. Telehealth services for speech therapy dramatically increased during this time. An explanation for the decrease in claims is members returned to the office setting as restrictions related to the public health emergency decreased. As a result, utilization of these services via telehealth declined.

Objective 3.2: Annually increase claims for wellness monitoring via telehealth

Objective 3.2 was not met. The State looked at claims with wellness monitoring, maintenance monitoring and evaluation and management procedure codes. In 2020 the number of claims for

wellness monitoring via telehealth was 109,100, dropping to 33,860 in 2023. An explanation for the decrease in claims is that as the restrictions related to the public health emergency decreased, members returned to the office setting. As a result, utilization of these services via telehealth declined.

Objective 3.3: Annually increase number billed claims for specialists providing care via telehealth to frontier, densely-settled rural, and rural counties

Objective 3.3 was not met. The State looked at claims from members in rural counties with a telehealth procedure code. In 2020 the number of claims was 194,934, dropping to 59,698 in 2023. An explanation for the decrease in claims is that as the restrictions related to the public health emergency decreased members returned to the office setting. As a result, utilization of these services via telehealth declined.

Goal 4: Removing payment barriers for services provided in Institutions for Mental Disease (IMDs) for members who have a primary diagnosis of a substance use disorder or cooccurring substance use disorder will result in improved member access to behavioral health services.

Strategy: Decrease use of emergency room and hospital stays by increasing utilization of residential and outpatient BH services by 5% year over year (2019-2023).

To analyze the strategy of decreasing the use of emergency room and hospital stays by increasing the utilization of residential and outpatient behavioral health services, the State looked at claims for IMD providers, with residential SUD service codes, and compared it to the count of hospital claims where the member had a behavioral health service. The number of hospital claims for members who had behavior health services decreased year over year.

Objectives:

Objective 4.1: Implement, support, and expand IMD exclusion waiver for SUD

Objective 4.1 was partially met. The State has been in the process of expanding IMD exclusion waiver for SUD during this Quality Management Strategy reporting period. There are no current numbers to report.

Objective 4.2: Implement, support, and expand IMD exclusion waiver for MH

Objective 4.2 was partially met. The State has been in the process of expanding IMD exclusion waiver for SMH during this Quality Management Strategy reporting period. There are no current numbers to report.

Objective 4.3: Increase peer support utilization for BH services by 10% year over year

Objective 4.3 was not met. The State looked at claims with a procedure code for mental health and SUD peer support services. In 2020 the number of claims with a peer support services code was 43,556, dropping to 26,123 in 2023. During the bi-annual Quality Steering Committee meeting there was discussion on the methodology used to pull the data for this objective. There has also been a shift to new billing procedures for the CCBHCs which may have an impact. The State is working with its partners to take a deeper look at the data pulls.

Objective 4.4: Reduction in use of antipsychotic medications in nursing homes < or = 12%

Objective 4.4 is not met. The aggregate rate for 2019 was 12.04% and the rate for 2022 was 13.97% (a lower percent is better). None of the MCOs met the target goal.

Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)

Objective 4.5 was not met. The aggregate rate for 2020 was 44.51% and the rate for 2022 was 36.16%. This number did not fall within the 75th percentile.

Objective 4.6: Develop and implement direct testing or secret shopping activities for provider network validation

Objective 4.6 was met. The State received from each MCO a project that validated their provider network.

Objective 4.7: Increase the rate of members who indicated a desire to be discharged from a NF or NFMH facility to a community setting who were discharged within 90 days

Objective 4.7 was not met. The aggregate rate for 2019 was 57.81% and the rate for 2022 was 57.12%. The State did not make progress in the rate of members discharged from a NF or NFMH facility to community settings.

Goal 5: Improve overall health and safety for KanCare members.

Strategy: All MCOs are expected to achieve the National HEDIS 75th Quality Compass (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 26 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. (2019-2023).

Objectives:

The following objectives use HEDIS measures. All MCOs were expected to achieve the National HEDIS 75th Quality Compass (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%. 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.

Objective 5.1: HbA1c good control (<8.0%) for members with diabetes

Objective 5.1 was not met. The aggregate rate for 2020 was 53.91%, for 2022 the rate was 51.91%, and the rate for 2023 was 52.39%. The State saw little change in the rate of good control for members with diabetes.

Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)

Objective 5.2a was not met. The aggregate rate for 2020 was 55.10%, for 2022 the rate was 59.76% and the rate for 2023 was 59.76%. While this is an improvement, it fell short of the State's goal.

Objective 5.2b: Well-Child Visits 15-30 months (15-30-month period & name change in 2020)

Objective 5.2b not met. The aggregate rate for 2020 was 65.27% and the rate for 2023 was 60.73%. The reported rate is not within the 75th percentile.

Objective 5.3a: Child and Adolescent Well-Care Visits (WCV) ages 3-11

Objective 5.3a was not met. The aggregate rate for 2020 was 48.41% and the rate for 2023 was 51.98%. The reported rate is not within the 75th percentile.

Objective 5.3b: Child and Adolescent Well-Care Visits (WCV) ages 12-17

Objective 5.3b was not met. The aggregate rate for 2020 was 46.14% and the rate for 2023 was 47.19%. The reported rate is not within the 75th percentile.

Objective 5.3c: Child and Adolescent Well-Care Visits (WCV) ages 18-21

Objective 5.3.c was not met. The aggregate rate for 2020 was 23.90% and the rate for 2023 was 19.83%. The reported rate is not within the 75th percentile.

Objective 5.4: Increase the percentage of members who feel their long-term services meet their current needs and goals to 85% over the next three years

Objective 5.4 was not met. The State looked at the NCI-AD Survey results to track the percentage of this objective. In 2020 the percentage of members who felt their long-term services meets their current needs was 71%, it increased to 77% by 2023. While there was an increase, the number fell short of the State's goal.

Objective 5.5: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous level of care determination for all waivers will increase by 20% annually until an 87% compliance rate is reached. (not applicable for SED)

Objective 5.5 was partially met, while the numbers have moved up and down across the board, not all the percentages reached the 87% compliance rate.

The State looked at the percentages of waiver participants received their annual level of care evaluation within 12 months of the pervious, many of the percentages have increased, other waiver percentage numbers have remained steady, a few of the waiver percentages have reached 90% or higher.

Objective 5.6: Number of waiver participants whose service plans were developed according to the processes in the approved waiver for all waivers will increase by 20% annually until an 87% compliance rate is reached

Objective 5.6 was partially met. While the numbers have increased year over year, not all increased by 20% annually, and none of the percentages are at the 87% compliance rate.

The State looked at the number of waiver participants whose service plans were developed according to the process in the approved waiver. The percentages have increased across the board, year over year, but have yet to meet the 87% compliance rate.

Objective 5.7: Increase rates of selected Adult and Child Core measures by 5% annually

Objective 5.7 was not met. Both selected screening measure rates, Breast Cancer Screening and Chlamydia Screening in Women, decreased during the reporting period.

For Breast Cancer Screening (BCS-AD) the aggregate data for 2020 was 48% and the rate for 2023 was 45.52%. This did not meet the target goal.

For Chlamydia Screening in Women (CHL) ages 16-24 the aggregate data for 2020 was 42% and the rate for 2023 was 39.92%.

The QMS utilized measurable consistent goals and objectives as continuous quality improvement metrics. The goals for the QMS are the same goals that were used in the State's KanCare 2.0 contract with the MCOs. This allowed for a focused approach by the MCOs to work towards achieving these goals and objectives.

The State will continue with a selected number of goals and objectives from this report period and will include new goals and objectives that better align with the new KanCare 3.0 contract in the next QMS.

Quality Management Strategy Goals and Objectives

Goals and Objective Descriptions		Data Source	Baseline (2020)	Performance Target (2023)
Goal 1: Improve the Delivery of Holistic, Integrated, Person Centered, and Culturally Appropriate Care to all members				
1.1	Increase the number of VBPs offered by the MCOs which serve to integrate services	MCO	12 projects	20 projects
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.)	Annual Contract Review	Submitted	Submitted
1.3	Increase the number of crisis response claims that occur in the community setting, including in the member's home	KMMS	14,743 claims	9,360 claims
Goal 2: Increasing Employment and independent living supports to increase independence and health outcomes				
2.1	Improve the process to increase referrals and tracking to employment services for all members who express an interest and need	KRA	1240 members *tracking began in 2022	896 members
2.2	Implement, support and expand the STEPS pilot program (program begins 07-01-21)	EQRO	N/A	Program was enacted
2.3	Increase the use of community integration codes, supportive housing, Operation Community Integration (OCI)	KMMS	1,046 claims	1,959 claims
2.4	Increase the average utilization of Value Added Benefits (VABs) per member per year	KRA	0.68 avg utilization	2.01 avg utilization
2.5	Each MCO will implement a Performance Improvement Project (PIP) that addresses SDOH	PIP Annual Report	Submitted	Submitted
2.6	Increase the rate of completed health screens	KRA	7.09%	4.60%
2.7	Increase the rate of members enrolled into OCK by 10% year over year	KRA	921 members	5,347 members
2.8	Increase percent of those enrolled in OCK that received a claim for care coordination by 10% year over year	KRA	52%	37%
2.9	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	KMMS	34,144 claims	30,331 claims

Goals and Objective Descriptions		Data Source	Baseline (2020)	Performance Target (2023)
Goal 3: Increase Telehealth usage through Speech Therapy, monitoring health indicators, pair rural healthcare providers with remote specialists				
3.1	Annually increase claims for speech therapy via telehealth	KMMS	8,184 claims	845 claims
3.2	Annually increase claims for wellness monitoring via telehealth	KMMS	109,100 claims	33,860 claims
3.2	Annually increase number billed claims for specialists providing care via telehealth to frontier, densely-settled rural, and rural counties.	KMMS	194,934 claims	59,698 claims
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				
4	Decrease use of emergency room and hospital stays by increasing utilization of residential and outpatient BH services by 5% year over year	KMMS	39,762 claims	21,594 claims
4.1	Implement, support, and expand IMD exclusion waiver for SUD	KDADS	In progress	In progress
4.2	Implement, support, and expand IMD exclusion waiver for MH	KDADS	In progress	In progress
4.3	Increase peer support utilization for BH services by 10% year over year	KMMS	43,556 claims	26,123 claims
4.4	Reduction in use of antipsychotic medications in nursing homes < or = 12%	MDS	12.04%	13.97%
4.5	Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)	HEDIS	44.51%	36.16%
4.6	Develop and implement direct testing or secret shopping activities for provider network validation	MCO	Submitted	Submitted
4.7	Increase the rate of members who indicated a desire to be discharged from a NF or NFMH facility to a community setting who were discharged within 90 days	MDS	57.81%	57.12%
Goal 5: Improve overall health and safety for KanCare members				
5.1	HbA1c good control (<8.0%) for members with diabetes	HEDIS	53.91%	52.39%
5.2a	Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)	HEDIS	55.10%	59.76%
5.2b	Well-Child Visits 15-30 months (15-30-month period & name change in 2020)	HEDIS	65.27%	60.73A%
5.3a	Child and Adolescent Well-Care Visits (WCV) ages 3-11	HEDIS	48.41%	51.98%
5.3b	Child and Adolescent Well-Care Visits (WCV) ages 12-17	HEDIS	46.14%	47.19%
5.3c	Child and Adolescent Well-Care Visits (WCV) ages 18-21	HEDIS	23.90%	19.83%A
5.4	Increase the percentage of members who feel their long-term services meet their current needs and goals to 85% over the next three years	NCI-AD	71%	77%

Goals and Objective Descriptions		Data Source	Baseline (2020)	Performance Target (2023)
5.5	Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous level of care determination for all waivers will increase by 20% annually until an 87% compliance rate is reached. (not applicable for SED)	KDADS Quality review report	PD: 66% FE: 70% IDD: 97% BI: 57% TA: 99% AU: 100%	PD: 57% FE: 58% IDD: 99% BI: 49% TA: 100% AU: 100%
5.6	Number of waiver participants whose service plans were developed according to the processes in the approved waiver for all waivers will increase by 20% annually until an 87% compliance rate is reached	KDADS Quality review report	PD: 43% FE: 41% IDD: 36% BI: 28% TA: 29% AU: 14% SED: 34%	PD: 83% FE: 82% IDD: 76% BI: 65% TA: 77% AU: 73% SED: 62%
5.7	Increase rates of selected Adult and Child Core measures by 5% annually	KRA		
		BCS-AD	48%	45.52%
		CHL	42%	39.92%