Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.17

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Annual Report
Demonstration Year: 5 (1/1/2017-12/31/2017)

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I. Introduction

Pursuant to the KanCare Special Terms and Conditions issued by the Centers for Medicare and Medicaid Services, Number 11-W-00283/7, the State of Kansas, Department of Health and Environment, Division of Health Care Finance, submits this fifth annual report related to Demonstration Year 2017. KanCare is a managed care Medicaid program which serves the State of Kansas through a coordinated approach. The State determined that contracting with multiple managed care organizations will result in the provision of efficient and effective health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS).

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare & Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017.

KanCare is operating concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers, which together provide the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the state into a managed care delivery system to receive state plan and waiver services. This represents an expansion of the state's previous managed care program, which provided services to children, pregnant women, and parents in the state's Medicaid program, as well as carved out managed care entities that separately covered mental health and substance use disorder services. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

This six-year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care; and
- Create a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

The KanCare demonstration will assist the state in its goals to:

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and

- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

II. STC 78(a) – Summary of Quarterly Report Items

Items from the 2017 quarterly reports which are not included in other areas of this annual report, have not already been provided in cumulative annual form, and/or are subject to annualizing are summarized here:

A. Operational Developments/Issues

i. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues; and provider surveys or focused projects to assess and address systemic issues. Annual reviews of the MCOs are discussed elsewhere in this report. Each quarter, the State reports then-current consumer issues, their resolution, and actions taken to prevent further occurrences. Summaries of those issues are included in the state's quarterly STC reports submitted to CMS and posted at www.kancare.ks.gov.

ii. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2017, follows:

MCO	Value Added Service Jan.-Dec 2017	Units YTD	Value YTD
Amerigroup	Adult Dental Care	4,105	$508,242
	Member Incentive Program	20,284	$401,965
	Mail Order OTC	8,152	$148,404
	Total of all Amerigroup VAS	***34,157***	***$1,208,701***
Sunflower	CentAccount Debit Card	77,198	$827,461
	Dental Visits for Adults	7,260	$363,352
	Pharmacy Consultation	9,766	$232,764
	Total of all Sunflower VAS	***160,100***	***$1,912,716***
United	Rewards for Preventive Visits & Health Actions	45,532	$127,324
	Adult Dental Services	2,148	$124,672
	Home Helper Catalog Supplies	2,977	$97,833
	Total of all United VAS	***70,751***	***$787,393***

iii. Enrollment issues: For the calendar year 2017 there were 37 Native Americans who chose to not enroll in KanCare.

The table below represents the enrollment reason categories for calendar year 2017. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	7
KDHE - Administrative Change	237
WEB - Change Assignment	118
KanCare Default - Case Continuity	502
KanCare Default – Morbidity	883
KanCare Default - 90 Day Retro-reattach	535
KanCare Default - Previous Assignment	1560
KanCare Default - Continuity of Plan	3019
AOE – Choice	4765
Choice - Enrollment in KanCare MCO via Medicaid Application	4254
Change - Enrollment Form	1297
Change - Choice	1731
Change - Access to Care – Good Cause Reason	6
Change - Case Continuity – Good Cause Reason	8
Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	43
Total	**18,965**

iv. Grievances and appeals: The following grievance, appeal and state fair hearing data reports activity for all of 2017. The format for reporting these changed starting with quarter ending 6.30.2016. The following tables contain data for the second through fourth quarters of 2016. The tables for the first quarter of 2016 follow those for the second through fourth quarters.

MCOs' Grievance Database
CY17 Annual report

MCO	QOC (non HCBS, non-Trans)	Customer Svcs	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (Reim.)	Trans (No Show)	Trans (Late)	Trans (Safety)	No Driver Avail-able	Trans Other	VAS	Billing/Fin Issues (non Trans)	Other
AMG	36	40	17	51	13	26	65	88	25	18	4	15	16	130	12
SUN	50	93	8	24	27	39	96	69	90	32	5	18	17	41	12
UHC	107	30		20	30	18	60	76	123	28	2	15	13	228	6
Total	193	163	25	95	70	83	221	233	238	78	11	48	46	399	30

**Category Transportation No Driver Available added to report CY2017 3rd qtr.*
**Category Transportation - Other added to report CY2017 4th qtr.*

MCOs' Appeals Database
Members – CY17 annual report

Member Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**
MEDICAL NECESSITY DENIAL				
Criteria Not Met – Durable Medical Equipment	3 93 45	 3 1	1 43 19	2 47 25
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	4 3 123	3 106	1 2 2	 1 15
Criteria Not Met - Medical Procedure (NOS)	14 65 1	 1	7 35	7 29 1
Criteria Not Met - Radiology	21 48	2 	9 15	10 33
Criteria Not Met - Pharmacy	42 241 189	3 19 5	34 126 107	5 96 77
Criteria Not Met - PT/OT/ST	33 1	 	23 	10 1
Criteria Not Met - Dental	2 19 11	 1	 6 	2 13 10
Criteria Not Met or Level of Care - Home Health	8 2	 	3 	5 2
Criteria Not Met - Hospice				
Criteria Not Met - Out of network provider, specialist or specific provider request	1 3	 	1 1	 2
Criteria Not Met – Inpatient Behavioral Health	21 82	 	4 21	17 61
Criteria Not Met – Behavioral Health Outpatient Services and Testing	18 26 39	 1 2	9 10 10	9 15 27
Level of Care - LTSS/HCBS	70 30	15 2	35 8	20 20
Level of Care - WORK				
Level of Care - LTC NF				
Level of Care - Mental Health				
Level of Care – HCBS (change in attendant hours)	10 3	 	5 	5 3

	1			1
Ambulance (include Air and Ground)				
Other- Medical Necessity	4 17 24	 6	 6 4	4 11 14
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	6 5 2	 1 1	 1	6 3 1
Service not covered - Home Health	15		5	10
Service not covered - Pharmacy	3 4 5	 1	2 1 3	1 3 1
Service not covered - Out of Network providers	1			1
Service not covered - OT/PT/Speech	2	1		1
Service not covered – Durable Medical Equipment	6 22		2 12	4 10
Service not covered - Behavioral Health	1 2		 1	1 1
Other - Noncovered service	4 34 35	 20	1 19 4	3 15 11
Lock In	3 2		2 1	1 1
Billing and Financial Issues				
AUTHORIZATION DENIAL				
Late submission by member/provider rep	1 1		 1	1
No authorization submitted	1 2	1 2		
MCO TIMELINESS				
Noncompliance with PA Authorization timeframes				
Noncompliance with resolution of Appeals and issuance of notice				
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **236** **738** **500**	 **24** **28** **145**	 **112** **334** **156**	 **100** **376** **199**

MCO's Appeals Database
Member Appeal Summary – CY17 Annual report

AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Total Number of Appeals Resolved	236 738 500	24 28 145	112 334 156	100 376 199
Percentage Per Category		10% 4% 29%	48% 45% 31%	42% 51% 40%

MCOs' Appeals Database
Providers - CY17 Annual report

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
MEDICAL NECESSITY DENIAL					
Criteria Not Met – Durable Medical Equipment	3 21		3 2	 19	
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	159 137 241		68 68 59	85 69 182	6
Criteria Not Met - Medical Procedure (NOS)	25 21		16 9	9 12	
Criteria Not Met - Radiology	51 23		37 5	14 18	
Criteria Not Met - Pharmacy	101 2		94	7 2	
Criteria Not Met - PT/OT/ST	6		2	4	
Criteria Not Met - Dental	7 31		4 18	3 13	
Criteria Not Met - Vision	164		105	58	1
Criteria Not Met or Level of Care - Home Health	1 2		 2	1	
Criteria Not Met - Hospice	4		2	2	
Criteria Not Met - Out of network provider, specialist or specific provider request	1			1	
Criteria Not Met – Inpatient Behavioral Health	16 28		4 6	11 22	1
Criteria Not Met – Behavioral Health Outpatient Services and Testing	12 10	1	9 7	2 3	

	5	1	3	1	
Level of Care - LTSS/HCBS	4 8		2 3	2 5	
Level of Care - WORK	7			7	
Level of Care - LTC NF	7		2	5	
Level of Care - Mental Health					
Level of Care – HCBS (change in attendant hours)	3		2	1	
Ambulance (include Air and Ground)	11		5	6	
Other-medical necessity	7 16 3		2 9 1	5 7 2	
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	15 10	1 2	9 6	5 2	
Service not covered - Vision	5			5	
Service not covered - Home Health	22 13	 1	9 3	13 6	 3
Service not covered - Pharmacy	9 1	3	3	3 1	
Service not covered - Out of Network providers	1 208	 1	 49	1 125	 33
Service not covered - OT/PT/Speech	2 4		 4	2	
Service not covered – Durable Medical Equipment	16 21 2	2 1	10 5	4 16 1	
Service not covered - Behavioral Health	1 38		1 7	 6	 25
Other- not covered service	80 91 378	13 2	29 42 31	38 49 345	
BILLING AND FINANCIAL ISSUES					
Recoupment	2 11		2	 8	 3
Claim Denied – contained errors	6918 267 983	 6	4140 126 63	2778 141 914	
Claim Denied – by MCO in error	3598 39 83		1459 26 83	2139 13	
PRIOR AUTHORIZATION DENIAL					
Late notification	63 196 1	 5	11 44 1	48 145	4 2
No authorization submitted	94	6	35	53	

	110 224	4	34 80	76 130	10
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**11185** **1266** **2192**	**26** **7** **16**	**5935** **544** **382**	**5213** **712** **1720**	**11** **3** **74**

MCO's Appeals Database
Provider Appeal Summary – CY17 annual report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
1st Level Appeal/Reconsideration*	36914 11217 85619	 4	18095 8876 55656	17350 2341 29959	1469
Resolved at 2nd Appeal Level	2356 1266 2192	1 7 16	996 544 382	1248 712 1720	111 3 74
TOTAL	39270 12483 87811	1 7 20	19091 9420 56038	18598 3053 31679	1580 3 74
Percentage Per Category		>1% >1% >1%	49% 75% 64%	47% 24% 36%	4% >1% >1%

**1st Level Appeal was changed to Reconsideration CY2017 Qtr. 3.*

MCOs' Appeals Database
Provider Appeal Analysis – CY17 Annual report

AMG – Red **SUN – Green** **UHC - Purple**	**Claim Denied- MCO in Error**	**Claim Denied- Provider Mistake or, Incorrect Billing**	**Correctly Billed and Correctly Denied**	**Number Resolved**
MEDICAL NECESSITY DENIAL	2 5	24 38	88 62	114 105
RECOUPMENTS			2	2
NONCOVERED SERVICE DENIAL	48 7	48 18	11 61	107 86
PRIOR AUTHORIZATION DENIAL	30 1	66 18	14 35	110 54
Total	80 13	138 74	113 160	331 247

**This table was added CY2017 Qtr. 4.*

State of Kansas Office of Administrative Fair Hearings
Members – CY17 annual report

AMG-Red SUN-Green UHC-Purple	Withdrawn	Dismissed-Moot MCO Reversed decision	Dismissed – No Internal Appeal	Dismissed -No Adverse Action	Default Dismissal-Appellant did not respond/ appear	Dismissed -Untimely	OAH upheld MCO decision	OAH reversed MCO decision
MEDICAL NECESSITY DENIAL								
Criteria Not Met - Durable Medical Equipment	1	4	1					1 1
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	1							
Criteria Not Met - Medical Procedure (NOS)		4 2	2					
Criteria Not Met - Radiology			1			1	1	
Criteria Not Met - Pharmacy		1 1	1 1			1		
Criteria Not Met - PT/OT/ST	1				1			
Criteria Not Met - Dental		1	2					
Criteria Not Met or Level of Care - Home Health	1	1						
Criteria Not Met - out of network provider, specialist or specific provider request		1						
Criteria Not Met – Behavioral Health Outpatient Services and Testing			1					
Level of Care - LTSS/HCBS	2 3 6	4 1 3		1	1 2		1 2 4	1 1
Level of Care - Mental Health					1		1	
Level of Care – HCBS (change in attendant hours)	2				1		1	
Other- Medical Necessity		1					1	

NONCOVERED SERVICE DENIAL								
Service not covered - Dental	1	**1**						
Service not covered - Pharmacy							**1**	
Service not covered - OT/PT/Speech							**1**	
Service not covered - Durable Medical Equipment		**1**						
Other - Noncovered service		2		2	**1** **1**			
LOCK IN					**1**			
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	**4** **8** **6**	**9** **13** **6**	**1** **8**	**2** **1**	**4** **3** **2**	**2**	**2** **6** **5**	**1** **2** **1**

State of Kansas Office of Administrative Fair Hearings
Providers – CY17 annual report

AMG-Red **SUN-Green** **UHC-Purple**	**Withdrawn**	**Dismissed-Moot MCO Reversed decision**	**Dismissed – No Internal Appeal**	**Dismissed -No Adverse Action**	**Default Dismissal-Appellant did not respond/ appear**	**Dismissed -Untimely**	**OAH upheld MCO decision**	**OAH reversed MCO decision**
MEDICAL NECESSITY DENIAL								
Criteria Not Met - Durable Medical Equipment		1 2					1	
Criteria Not Met - Inpatient Admissions	**2** **5** **36**	1 1 4	1 8			1	**3**	
Criteria Not Met - Medical Procedure (NOS)	**15** **8**	**1**						
Criteria Not Met - Radiology		**1**		**1**				
Criteria Not Met - Pharmacy	**2**	**1** **2**	1 2 5	**7**				
Criteria Not Met - Out of Network providers	**1**							
Criteria Not Met – Behavioral Health		1 2						

Outpatient Services and Testing								
Level of Care - LTSS/HCBS						**1**		
Level of Care - Mental Health							**1**	
Ambulance (include Air and Ground)		2						
Other-medical necessity						1		
NONCOVERED SERVICE DENIAL								
Service not covered - Pharmacy			1					
Service not covered - Out of Network providers	**1**							
Service not covered - Durable Medical Equipment	**1**							
Other- not covered service	**1**	**2**	1 1			**1**		
BILLING AND FINANCIAL ISSUES								
Claim Denied – contained errors	22 75 10	47 22 8	26 21 22	5 3	10 1 2	2 12	**1** **3**	
Claim Denied – by MCO in Error	4	6 6 5	2 2	1		1		
Recoupment	21 9	11	2				**2**	
PRIOR AUTHORIZATION DENIAL								
Late notification							**1**	
No authorization submitted	**5**	3	1					
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**52** **108** **58**	**73** **37** **19**	**33** **27** **36**	**6** **4** **7**	**10** **1** **2**	**5** **14**	**3** **8** **1**	

B. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers January- December 2017:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:25	2.73%	181,639
Sunflower	0:17	1.48%	168,146
United	0:35	0.58%	173,544
HP – Fiscal Agent	0.00	0.00%	15,737

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:28	2.61%	91,550
Sunflower	0:11	1.07%	97,802
United	1:06	0.93%	90,375
HP – Fiscal Agent	0.00	0.0%	16,245

C. Summary of critical incident reporting:

Critical Incidents January-December 2017	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2017
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	1610	1903	1776	1658	**6947**
Pending Resolution	0	0	0	0	**0**
Total Received	1610	1903	1776	1658	**6947**
APS Substantiations*	58	93	114	119	**384**

**The APS Substantiations exclude possible name matches when no date of birth is identified. One adult may be a victim/alleged victim of multiple types of allegations. The information provided is for adults on HCBS programs who were involved in reports assigned for investigation and had substantiations during the quarter noted. An investigation may include more than one allegation.*

D. Safety Net Care Pool: The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to 2017/DY5.

Disproportionate Share Hospital payments continue, as does support for graduate medical education.

Delivery System Reform Incentive Payment (DSRIP) Pool: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continue identifying community partners, creating training for community partners, and working toward reaching the project milestones for DY5. The CMS approved DSRIP annual and semi-annual

payments were made on May 12, 2017 and November 17, 2017 respectively. DSRIP Learning Collaboratives were held on May 8, 2017 and August 25, 2017 with Kansas University, Children's Mercy Hospital, KFMC and the State in attendance. A summary of 2017/DY5 DSRIP payments is attached.

E. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers with that MCO are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

In 2016, the GCRs swung sharply upward in number during May (67), June (62) and July (83), then a sharp overall downward trend from the requests for the remainder of the year. In 2017, the number of requests were far more stable, with the number of requests remaining relatively similar all year. The majority of requests were due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. GCRs filed after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers. In the hopes of reducing the GCR volume, KDHE and the MCOs issued educational materials or information late in 2016, including what could be added to member enrollment packets, to further explain what would be considered "good cause." In 2017, the volume of GCRs remained static, so perhaps the education effort needs further time to help reduce the number of GCR requests.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During 2017, there were six state fair hearings filed for a denied GCR. Two cases were dismissed and three had the denial affirmed. One case was withdrawn, one defaulted, and the remaining three had the decision affirmed. A summary of GCR actions for 2017 is as follows:

Status	2017 Totals
Total GCRs filed	288
Approved	9
Denied	188
Withdrawn (resolved, no need to change)	52
Dismissed (due to inability to contact the member)	39
Pending	0

F. HCBS Waiver Updates:
   i. CMS approved the Autism Waiver renewal on April 1, 2017.
   ii. CMS approved the Severe Emotional Disturbance (SED) waiver renewal on April 1, 2017.

III. STC 78(b) – Total Annual Expenditures

Total annual expenditures for the demonstration population for Demonstration Year 5 (2017), with administrative costs reported separately, are set out in the attached document entitled "KanCare Expenditure & Budget Neutrality – Demonstration Year 5 – 2017."

IV. STC 78(c) – Yearly Enrollment Reports

Yearly enrollment reports for demonstration enrollees for Demonstration Year 5 (2017), including all individuals enrolled in the demonstration, that include the member months, as required to evaluate compliance with the budget neutrality agreement, and the total number of unique enrollees within Demonstration Year 5, are set out in the attached document entitled "KanCare Expenditure & Budget Neutrality – Demonstration Year 5 – 2017."

V. STC 78(d) – Quality Strategy

Kansas has created a broad-based approach to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have an established senior leadership committee jointly responsible for comprehensive oversight and monitoring. Additionally, the KanCare Steering Committee includes the senior leadership, as well as program and quality managers from both agencies, to initiate and review policies or program changes. KDHE continues to refine strategies to monitor and implement the State's KanCare Quality Improvement Strategy (QIS). The QIS is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver.

This approach is guided by information collected from KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from State and Federal agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates. This combined information assists KDHE, KDADs and the MCOs to identify and recommend quality initiatives to monitor and improved services provided to the Kansas Medicaid population.

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, they will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

The State values a collaborative approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures

are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

To support the quality strategy, KDHE staff conduct regular meetings with MCO staff, relevant cross-agency program management staff, and EQRO staff to work on KanCare operational details and ensure that quality activities are occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contact requirements. Included in this work have been reviews, revisions and updates to the QIS, including operational specifications of the performance measures (and pay for performance measures); reporting specifications and templates; LTSS oversight and plan of care review/approval protocols; and KanCare Key Management Activity reporting and follow up. All products are distributed to relevant cross-agency program and financial management staff, and are incorporated into updated QIS and other documents.

Kansas has provided quarterly updates to CMS about the various activities related to HEDIS measurements; CAHPS surveys; Mental Health surveys; Pay for Performance measures; and about specific activities related to MLTSS services, quality measures, and related HCBS waiver amendment application development and submission. State planning for integration of the Managed Care Final Rules related to the Quality Strategy has begun. Performance measures continue to evolve and change based upon analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data and claim encounter data.

As part of its Stakeholder engagement strategy, KDADS and National Association of State Directors of Developmental Disabilities Services (NASDDDS) hosted a Stakeholder Planning/Engagement workday on September 6, 2017. Invitees included self-advocates, providers, CDDOs (Community Developmental Disability Organizations), Disability Rights Center, Kansas Council on Developmental Disabilities (KCDD), Families Together, university partners, MCOs, parents and consumers, as well as State staff. The topics discussed that day were: barriers, development and next steps for residential and day supports, community life engagement, supported employment and systems sustainability.

VI. STC 78(e) – MFP Benchmarks

Kansas's Money Follows the Person (MFP), five-year demonstration grant, serves four HCBS populations: the Frail Elderly (FE), the Physically Disabled (PD), the Traumatic Brain Injured (TBI), and the Intellectually/Developmentally Disabled (I/DD). Kansas stopped taking new admissions to the MFP program 07/01/2017 in preparation of closing out the grant. During calendar year 2017, 137 individuals were transitioned from institutions to their home and community.

Summary of 2017 performance on annual transition benchmarks in the Kansas Money Follows the Person grant follows:

Calendar Year 2017	FE	DD/ICF	PD	TBI
Total Number of annual transition benchmarks achieved	45	16	74	2
Total Number of annual transition benchmarks (revised)	65	37	198	3
Percent Achieved	69.23%	43.24%	37.37%	66.67%

VII. STC 78(f) – HCBS Waiver Waiting Lists

Pursuant to STC 47, the state must report on the status of individuals receiving HCBS Services, including progress regarding waiting lists.

A. Total number of people in nursing facilities, and public ICF/IDDs:

Program	CY 2012	CY 2013	CY 2014	CY 2015	CY2016	CY2017
Nursing Facilities	14,913	14,517	14,565	14,163	12,549	12,897
Public ICF/IDDs	350	344	337	328	322	326

B. Total Number of people on each of the 1915(c) waiting lists:

i. Intellectual/Developmental Disabilities waiver program: 3,697 as of December 31, 2017
ii. Physical Disabilities waiver program: 1,560 as of December 31, 2017

C. Number of people that have moved off the waiting list and the reason:

i. Intellectual/Developmental Disabilities waiver program, as of December 31, 2017:

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	441
Deceased	9
Other	298

ii. Physical Disabilities waiver program, as of December 31, 2017:

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	585
Deceased	41
Other	419

D. Number of people that are new to the waiting list: 617 for I/DD waiver; 1,549 for PD waiver

Calendar Year 2017	FE	DD/ICF	PD	TBI
Total Number of current MFP participants who are re-institutionalized	1	0	4	0
Total Number of current MFP participants	55	22	97	4
Re-institutionalized Percent	1.81%	0.00%	4.12%	0.00%
Post Transition Success Target	80.00%	80.00%	80.00%	80.00%
Percentage of MFP participants maintaining the same level of service after moving to HCBS (post transition success) Percent Achieved	98.18%	100.00%	95.88%	100.00%

(Data source: KAMIS and Eligibility data)

VIII. STC 78(g) – Institutional Days and NF, ICF/IDD Admissions

Included are those admitted from MCOs HCBS delivery system into each institutional setting and those who are not KanCare HCBS recipients admitted from the community into each institutional type specified in STC 47. (See also information at Section VII[A] above, regarding numbers served over years.)

Seven Month Lag 07/01/2016-06/30/2017	Nursing Facilities	Private ICF/IDDs
Days	4,268,923	69,518
Admissions	6,102	34

IX. STC 78(h) – Ombudsman Program

A summary of the KanCare Ombudsman program activities for demonstration year 2017 is attached.

X. STC 78(i) – I/DD Pilot Project

The I/DD Pilot Project concluded effective February 1, 2014, when HCBS I/DD services became a part of the KanCare program.

XI. STC 78(j) – Managed Care Delivery System

A. Project Status, Accomplishments and Administrative Challenges: The initial focus of KanCare implementation was to ensure a successful transition for all populations, with a particular emphasis on populations new to managed care, including the introduction of elderly and people with disabilities to managed care, and the addition of people with developmental disabilities as of February 1, 2014.

   Additional accomplishments in 2017 included the following (about which information has been provided in the quarterly STC reports to CMS):

   i. Regular reporting of key operational data, including to joint legislative committee providing oversight to KanCare and HCBS programs
   ii. Separate and joint critical issues logs
   iii. Regular meetings involving KDHE, KDADS and all three MCOs
   iv. Educational and listening tours related to HCBS waiver activities and 1115 Demonstration renewal
   v. KanCare Advisory Council and external workgroup meetings

B. Utilization Data: Utilization data related to all three KanCare MCOs, separately addressing physical health services, behavioral health, nursing facility, and HCBS services, are collected with data reported by demonstration quarter. These reports are one component of the state's utilization analysis. There is a significant data lag for this report, and KDHE cannot report for 2017 at this time.

   Below is the KanCare Utilization Report for demonstration year 4 (calendar year 2016). A comparison between pre-KanCare measurements and DY 4 data demonstrates a positive trend in the reduced utilization and expense of facility services during the fourth year of KanCare. The chart demonstrates the success of the KanCare program in moving toward its primary goal of controlling Medicaid costs

by emphasizing health, wellness, prevention and early detection. During the first four years of our demonstration program, KanCare has recognized an upward trend in utilization for 6 of the 12 service categories reviewed. As anticipated, the frequency of inpatient visits, and outpatient emergency room treatment have declined, thereby lowering the overall cost of health care. Of greatest significance is a 22% decrease in the annual utilization of inpatient days per 1,000 Members (defined as the total number of inpatient days divided by Member Months and multiplied by 12,000).

The value of this trend is emphasized in the upward movement of those community based, local, outpatient office visits and ancillary services that KanCare has provided to our Members at a greater frequency than before implementation, revealing the relationship between the increase in these services and the reduction in inpatient stays. While member utilization of dental services, home and community based services and transportation services has increased, community based services overall have seen an average increase of 34% in utilization since 2012, and transportation had a 55% increase during this period.

By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state is improving health care quality for our members and reducing the overall cost of Medicaid in Kansas.

KanCare Utilization

		CY 2012	CY 2016	Comparison CY 2016 vs CY 2012	
Type of Service	**Measure Reported**	**Utilization Per/1000**	**Utilization Per/1000**	**Utilization Per/1000**	**% Difference**
Behavioral Health	Claims	4,829	4,447	383	-8%
Dental	Claims	878	920	-42	5%
HCBS	Units	3,212	4,295	-1,083	34%
Inpatient	Days	818	640	178	-22%
Long Term Care	Days	374	386	-12	3%
Outpatient ER	Claims	763	693	70	-9%
Outpatient Non-ER	Claims	1,072	935	136	-13%
Pharmacy	Prescriptions	10,096	9,931	165	-2%
Transportation NEMT	Claims	515	800	-285	55%
Vision	Claims	382	431	-50	13%
Primary Care Physician	Claims	3,616	3,619	-4	0%
FQHC/RHC	Claims	751	855	-104	14%

*Utilization per 1000 formula is Units Reported/Member Months *12,000 - this illustrates the services used per 1000 beneficiaries over a 12 month period.

CY 2016 data extracted from the DSS includes claims with a date of service between 1/1/2016 and 12/31/2015 with a paid date greater than or equal to 1/1/2016; CY 2012 data extracted from the DSS includes claims with a date of service between 1/1/2012 and 12/31/2012 with a paid date greater than or equal to 1/1/2012.

The Utilization Report consists of two Medicaid data sets, one for CY 2016 (1/1/2016 through 12/31/2016) and one for CY 2012 (1/1/2012 through 12/31/2012). The purpose of this report is to compare the 2016 KanCare data to the 2012 Pre-KanCare data to gauge the MCOs' expenditures and the corresponding utilization of services.

C. CAHPS Survey: The Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys are conducted annually by the KanCare Managed Care organizations, and validated by the state's External

Quality Review organization (EQRO) the Kansas Foundation for Medical Care (KFMC). This is the third year the surveys were reviewed by KFMC since the launch of KanCare in January of 2013

CAHPS is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ), and co-developed with National Committee for Quality Assurance (NCQA). The survey measures how well health plans are meeting their member's expectations and goals; to determine which areas of service have the greatest effect on member's overall satisfaction; and to identify areas of opportunity for improvement which could aid plans in increasing the quality of care provided to members.

Detailed specifications are provided by NCQA to be used by health plans in conducting the survey. In order for a health plan's CAHPS survey to be a dependable source of information, it must be administered according to the published CAHPS technical specifications. When administered properly, CAHPS surveys provide information regarding the access, timeliness and/or quality of health care services provided to health care consumers.

The following members were identified for participation in the survey:

- Currently enrolled when the survey was conducted
- Enrolled in the health plan for at least the last six months
- Child population that was 17 years of age or younger as of 12/2017 from both the TXIX and Title XXI plans
- Adult population that was 18 years or older as of 12/2017
- The sample did not include more than one person per household

Amerigroup and United met the sample specifications for the 2017 CAHPS survey. Sunflower State Health Plan did not sample the Title XIX and Title XXI child populations separately as required by the State of Kansas, resulting in insufficient numbers of valid survey responses for those populations in their plan.

Rating of Health Plan: The table below shows the survey responses across all population members who rated their plan with an 8, 9 or 10 on a 0-10 scale (0 being the worst plan and 10 being the best plan)

Rating of Health Plan - 2014 to 2017 (Rating 8+9+10)												
Population	**Program**	**MCO**	**2017**		**2016**		**2015**		**2014**	
			%	**QC**	**%**	**QC**	**%**	**QC**	**%**	**QC**
Adult		**AGP**	76.3%	<50th	75.5%	<50th	71.1%	<25th	72.6%	<50th
		SHP	75.4%	<50th	75.4%	<50th	73.5%	<50th	71.7%	<50th
		UHC	75.2%	<50th	80.2%	>75th	76.9%	>50th	73.3%	<50th
	KanCare Adult		**75.7%**	**<50th**	**76.5%**	**>50th**	**73.4%**	**<50th**	**72.5%**	**<50th**
		AGP	86.1%	>50th	**↓85.2%**	>50th	88.3%	>75th	**	**
	Title XIX	**SHP**	88.9%	>75th	90.1%	>75th	86.5%	>66.67th	86.5%	>50th
		UHC	87.4%	>50th	89.9%	>75th	87.8%	>75th	**	**

General Child	**Title XXI (CHIP)**	**AGP**	89.7%	>75th	87.8%	>66.67th	86.7%	>66.67th	**	**
		SHP	88.9%	>66.67th	92.0%	**>95th**	**↑89.1%**	>75th	84.9%	>50th
		UHC	89.6%	>75th	89.5%	>75th	87.5%	>75th	**	**
	KanCare GC		**88.6%**	**>66.67th**	**88.7%**	**>75th**	**87.6%**	**>75th**	**86.8%**	**>50th**
Children with Chronic Conditions	**Title XIX**	**AGP**								
		SHP	83.7%	<50th	84.6%	>66.67th	82.8%	>66.67th	82.2%	>50th
		UHC	88.4%	>75th	86.1%	>75th	82.0%	<50th	**	**
	Title XXI (CHIP)	**AGP**	91.3%	**>95th**	88.9%	**>95th**	85.5%	**>90th**	**	**
		SHP	86.4%	>66.67th	89.9%	**>95th**	**↑85.9%**	**>90th**	81.4%	>50th
		UHC	88.9%	>75th	86.0%	>75th	88.2%	**>95th**	**	**
	KanCare CCC		**86.6%**	**>75th**	**85.2%**	**>75th**	**83.5%**	**>75th**	**81.1%**	**>50th**

Note: The percentages are for those who responded with either an 8, 9, or 10 on a scale of 0 to 10, where 0 is the worst possible and 10 is the best possible.

*NCQA added percentiles 33.33rd and 66.67th in 2015.

**AGP and UHC did not conduct separate Title XIX and Title XXI surveys in 2014.

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

Rankings above the 90th QC percentile are also highlighted in green.

The purpose of the CAHPS survey is to assess the member's experience with the access, timeliness and quality of the health care available to them through their health plan. Overall the three Kansas MCOs received high marks. The full CAHPS survey results are attached to this report.

D. Annual Summary of Network Adequacy: The MCOs continue to recruit and add providers to their networks. The number of contracting providers under each plan is as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/31/17	# of Unique Providers as of 6/30/17	# of Unique Providers as of 9/30/17	# of Unique Providers as of 12/31/17
Amerigroup	23,758	25,904	25,396	27,107
Sunflower	30,992	31,780	31,506	31,168
UHC	39,881	32,216	30,610	31,247

Gaps in coverage are reported each month by the MCOs by way of Geo Access Reports. Where gaps exist, the plans report their strategy for closing those gaps. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the plans are committed to working with providers in adjacent cities and counties to provide services to members. The current State Required levels of network coverage for HCBS services are met (minimum of two providers/county) except for a few specialties in which there is a shortage of providers available. In these instances, the plans are working with and encouraging contracted providers to extend services to areas without providers. As always, the MCOs are responsible for providing medically necessary services, even if they must authorize members to see non-network providers, make single case agreements with non-network providers or transport members to areas that have network providers available.

The network adequacy reporting from the MCOs remains problematic to analyze due to repetitive and extensive errors with duplication, incorrect types and specialties, incorrect addresses. Each MCO has struggled with correcting their data. While the reports are much improved since previous years, errors remain. KDHE has built a new monitoring tool for feedback and analysis of data trends in the Network Adequacy Report. KDHE performed MCO training sessions with the MCO credentialing and data staff to show how the report should be completed and how to understand the scorecards issued each quarter through the monitoring tool.

The new Managed Care rules have removed enrollment responsibility from MCOs, the State of Kansas added complete provider enrollment duties into the contract with their Fiscal Agent to build a new MMIS system. In that new system, we are building a provider enrollment portal which all Kansas Medicaid providers must use to enroll. The Fiscal Agent will assign specialties and provider types per the enrollment and taxonomy information provided by the provider. Phase one of this system was operational in 2017. This new system will be a solution to one long-standing problem with network adequacy analysis – inaccurate provider data from the MCO reports. With the new system, this will provide standardized provider types, specialties and address information, thus eliminating some of the current errors with the network adequacy reports.

Regarding MCO compliance with provider 24/7 availability, here are the processes, protocols and results from each of the MCOs:

Amerigroup
Amerigroup's contractual agreements with all its PCPs and other Professional providers mandate that, in accordance with regulatory requirements, the provider must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Amerigroup's provider manual, incorporated by reference into provider contracts, also requires that PCPs arrange for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician.

To properly monitor that this access is available from both an appointment availability and after-hours access perspective, Amerigroup Kansas, Inc. engages a vendor to conduct an annual survey of both primary care providers and specialists to ascertain their availability to members. The survey provides the foundation for adjusting provider oversight activities to more fully achieve the best access available for members.

Amerigroup measures compliance of two distinct components in overall member access: (1) appointment availability and (2) after-hours access.

Appointment Availability scored as follows:

- PCPs ranged between 94-97% compliance: 94% for routine care, 94% for urgent care, and 97% for emergent care.
- Specialists' reflect an improvement across all three categories. Urgent care had a slight increase from 98% to 100%. Both urgent care and emergent care reflect more significant

improvements. Urgent care increased compliance from 77% in 2016 to 85% in 2017. Emergent care increased compliance from 89% in 2016 to 96% in 2017.
- Pediatrics shows a decrease in routine care from 96% in 2016 to 91% in 2017. However, both urgent care and emergent care increased from 97% to 99%, and 99% to 100%.
- Behavioral Health compliance is lower than 2016, resulting in an overall 10% decline. Individual scoring ranged between 81%-89% compliance.

Of the noncompliant providers, Specialists comprised the majority at 41%, followed by Behavioral Health at 33%, then PCP's at 20%, and just 5% for Pediatrics. Our follow up to these non-compliant providers will include, but is not limited to:

- Additional education to reiterate the availability standards at recurring Community Mental Health Center (CMHC) meetings.
- Individual provider outreach to reiterate availability standards and evaluate all responses for appropriate action plans.

After-hours compliance showed a slight improvement from 89% to 91% compliance across the two survey groups of PCPs and Pediatric providers.

In 2018, the provider servicing plan will include on-site visits to educate and validate non-compliant practices. We will also capture "best practices" to share with non-compliant practices and other tips/techniques/procedures that drive enhanced compliance. Additionally, where we become aware of new or additional specialty practices, we will engage those providers in contracting to bolster the network.

Sunflower
Office Surveys

Sunflower utilized SPH Analytics, to conduct an annual telephonic survey regarding after-hours access to ensure access standards are being met. The table below details the specific criteria for assessing whether the sample of primary care offices provide acceptable access to after-hours care.

Sunflower Standards and Measurement Methods for PCP After-Hours Access

Access Standard	Performance Goal	Measurement Method	Measurement Frequency
Answering Service: Urgent Request			
Offers to page doctor on call, he/she will call member back	Acceptable response (Pass)	Survey sample of all PCP offices	**Annually**
Offers to telephonically transfer member's call directly to doctor on call	Acceptable response (Pass)	Calls to PCP offices	**Annually**
Only offers to take a message so doctor can call member back next business day	Unacceptable response (Fail)	Calls to PCP offices	**Annually**
Answer Service: Emergency			

Directs member to contact 911 or to go nearest ER	Mandatory Requirement: Answering service must provide emergency service info over the phone (Pass) If service does not offer required info (Fail)	Calls to PCP offices	**Annually**
Refuses to respond to question	Unacceptable response (Fail)	Calls to PCP offices	**Annually**
Answering Machine			
Provides instructions on how to page doctor if situation is urgent	Acceptable response (Pass)	Calls to PCP offices	**Annually**
Instructs member to go to ER or urgent care if situation cannot wait until next business day	Acceptable response (Pass)	Calls to PCP offices	**Annually**
Only provides instructions to leave a message which will be returned the next business day	Unacceptable response (Fail)	Calls to PCP offices	**Annually**
Does message provide instructions to contact 911 or go to nearest ER if member feels situation is emergent?	Mandatory Requirement: Answering machine must provide emergency service info in response to emergency (Pass) If the answering machine does not offer the requirement (Fail)	Calls to PCP offices	**Annually**
No Answer			
Phone rings continuously no options to leave message or instructions on how to access emergent/urgent care	Unacceptable response (Fail)	Calls to PCP offices	**Annually**
Receive a message that the number is no longer in service	**Unacceptable response (Fail)**	**Calls to PCP offices**	**Annually**

The after-hours access for member survey 100% of PCP offices who were successfully contacted were determined have an acceptable method of providing **after-hours** access for members. Of the 375 practitioners in the sample, 333 had a recording or auto attendant; 42 were a live person; and zero unanswered. Of the 333 recording or auto attendant surveys 61 were intercepted by a live person; 161 provided a passing response for urgent and emergent as outlined in Table 5 above. Of the 103 answered by a live person 80 were eligible for survey; 58 provided a passing response for urgent and emergent as outlined in the table above.

CAHPS After-hours Surveys

Sunflower added a custom question, "In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?", to both the Adult and Child CAHPS surveys to further evaluate accessibility of after-hours care. As this is a custom question, no benchmark is available, Sunflower set an internal goal of meeting or exceeding a Summary Rate of 80% of members who responded *always* or *usually* to the question. The results for the

2017 Adult CAHPS survey met Sunflower's goal, with a rate of 85%. The goal was also met for the 2017 Child CAHPS survey, with a rate of 81%.

United

Table 1: Description of Sample

	PCP		Specialist		OB		BH		Total	
	2016	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Sample size	198	277	172	192	72	81	120	146	562	696
Percent (number) contacted	73.2% (145)	87.4% (242)	74.4% (128)	74.5% (143)	90.3% (65)	81.5% (66)	65.8% (79)	72.6% (106)	74.2% (417)	80.0% (557)
Percent (number) completed*	81.4% (118)	74.0% (179)	65.6% (84)	64.1% (123)	69.2% (45)	74.1% (60)	60.8% (48)	57.5% (84)	70.7% (295)	80.1% (446)
After hours calls **	118	179	84	123	45	60	NA	NA	247	362

* Survey completion rates are computed as a percentage of those contacted. **BH providers are not included in after-hours calls; after-hours calls are placed to all other providers who participate in survey.

Table 1 Analysis:

A sample of providers was drawn representing primary care, behavioral health care and high-volume high-impact specialists (Ob-gyn, orthopedics, cardiology, otolaryngology, and oncology/hematology). Providers selected for the sample were those with the highest number of visits as of the time the sample was drawn in April 2017 (primary care >=100 visits YTD). Surveys were conducted from late May through June 2017.

Compared to 2016, a slightly larger sample was drawn (696 compared to 562) and contact rates and survey rates were slightly higher. 80% of the sample was able to be contacted, and 80% of those completed the survey. It should be noted that the survey completion rate is calculated as a percentage of those contacted; therefore, when calculated as a percentage of the entire sample, 64% of the sample were interviewed. Reasons for not being interviewed are outlined in Table 2.

To obtain the estimated intervals to the next available appointment, UHC agents (via a contractor, DialAmerica) ask to speak to the individual who schedules appointments for the practice. They then ask for the date of the first available appointment for a United member (without specifying line of business, e.g., Medicaid) for each category of urgency or visit type (emergency, urgent, routine; and, for PCPs, adult physical and EPSDT). For OB, rather than urgency of care, they ask for the first available appointment based on trimester of pregnancy. To calculate compliance with appointment standards, the theoretical appointment date is subtracted from the date the call was made, and the waiting interval (in days) is computed and compared to the contractual standard (See Tables 3A-B). Average days to appointment are shown in Table 4. For after-hours calls, a second call is made after normal working hours to determine the accessibility of urgent care (Table 5). (Emergency and after-hours calls are not made to BH providers, as it is assumed these urgent situations would be handled by the ER.)

Table 2: Most Common Reasons for Not Being Able to Survey Offices*

	PCP		Specialist		OB-Gyn		BH		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	**198**	**277**	**172**	**192**	**72**	**81**	**120**	**146**	**562**	**696**
Refused to participate	10.1% (20)	12.6% (35)	16.9% (29)	2.6% (5)	16.7% (12)	2.5% (2)	14.2% (17)	2.1% (3)	13.9% (78)	6.5% (45)
Unable to Contact in 3 Attempts	4.5% (9)	5.8% (16)	11.0% (19)	17.2% (33)	6.9% (5)	14.8% (12)	11.7% (14)	7.5% (11)	8.7% (47)	10.3% (72)
Technical Problems	22.2% (44)	6.9% (19)	14.5% (25)	7.8% (15)	9.7% (7)	3.7% (3)	29.2% (35)	19.9% (29)	19.8% (111)	9.5% (66)
Moved, did not update information	3.5% (7)	10.1% (28)	8.7% (15)	8.3% (16)	4.2% (3)	4.9% (4)	5.0% (6)	13.0% (19)	5.5% (31)	9.6% (67)
Total Not Surveyed	40.4% (80)	35.4% (98)	51.2% (88)	35.9% (69)	37.5% (27)	25.9% (21)	60.0% (72)	42.5% (62)	47.5% (267)	35.9% (250)

*Entire sample for each specialty type used as a denominator. The refusal rate is lower when computed as a percent of the entire sample rather than as a percent of those contacted (Table 1).

Table 2 Analysis:

The percentage of providers unreachable for survey dropped to 36% this year compared to nearly half in previous years. The biggest drops were in refusals to participate and technical problems, such as wrong numbers and cell phones, which cannot be called. BH providers had the largest number of cell phone no-contacts, probably representing their more mobile practice patterns (more locations, fewer office staff to schedule appointments). Inability to reach the scheduler remained a persistent problem, accounting for 10% of the sample this year (9% last year). Slight more providers moved to a different practice and did not update contact information, especially among PCPs and BH providers. The sample includes only providers eligible to be interviewed. Those who had retired, gone out of business, dropped out as a UHC provider or were otherwise ineligible were eliminated before the sample was calculated.

Table 3A: Percent of Surveyed Offices in Compliance with State Contractual Appointment Standards

Compliance Rates*	PCP		Specialist**#		OB**		BH		Total	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	**118**	**179**	**84**	**123**	**45**	**60**	**48**	**84**	**295**	**446**
Emergency care	79.7% (94)	74.9% (134)	39.3% (33)	28.5% (35)	NA	NA	NA	NA	62.9% (127)	56.0% (169)
Urgent care	91.5% (108)	86.0% (154)	58.3% (49)	38.2% (47)	NA	NA	56.3% (27)	35.7% (30)	73.6% (184)	59.8% (231)
Routine care	94.1% (111)	96.1% (172)	95.2% (80)	79.7% (98)	NA	NA	83.3% (40)	84.5% (71)	92.4% (231)	88.3% (341)

Adult physical	84.7% (100)	83.2% (149)	NA	NA	NA	NA	NA	NA	84.7% (100)	83.2% (149)
EPSDT/Well Child	90.7% (107)	79.9% (143)	NA	NA	NA	NA	NA	NA	90.7% (107)	79.9% (143)
After hours coverage	70.3% (83)	95.0% (170)	84.5% (71)	96.7% (119)	77.8% (35)	90.0 % (54)	NA	NA	76.5% (189)	77.3% (280)
OB first trimester	NA	NA	NA	NA	93.3% (42)	88.3 % (53)	NA	NA	93.3% (42)	88.3% (53)
OB second trimester	NA	NA	NA	NA	88.9% (40)	75.0 % (45)	NA	NA	88.9% (40)	75.0% (45)
OB third trimester	NA	NA	NA	NA	82.2% (37)	51.7 % (31)	NA	NA	82.2% (37)	51.7% (31)
OB High Risk	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Percentages are based on completed surveys.

**High volume specialists surveyed in were adult and pediatric cardiology, ophthalmology, otolaryngology, orthopedics and pulmonary medicine. Each type was included in each quarter.

Table 3B: Percent of Surveyed Offices in Compliance with NCQA Appointment Standards

Compliance Rates*	**PCP**		**Specialist**#**		**OB****		**BH**		**Total**	
	2016	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
	% (n)		**% (n)**		**% (n)**		**% (n)**		**% (n)**	
Sample Size	**118**	**179**	**84**	**123**	**45**	**60**	**48**	**84**	**295**	**446**
Emergency care	71.2% (84)	74.9% (134)#	39.3% (33)	28.5% (35)#	NA	NA	NA	NA	57.9% (117)	56.0% (169)
Urgent care	57.6% (68)	74.9% (134)	25.0% (21)	28.5% (35)	NA	NA	56.3% (27)	35.7% (30)	46.4% (116)	51.6% (199)
Routine care	93.2% (110)	91.1% (163)	72.6% (61)	59.3% (73)	NA	NA	83.3% (40)	84.5% (71)	84.4% (211)	79.5% (307)
Adult physical	88.1% (104)	87.2% (156)	NA	NA	NA	NA	NA	NA	88.1% (104)	87.2% (156)
EPSDT/Well Child	92.4% (109)	83.8% (150)	NA	NA	NA	NA	NA	NA	92.4% (109)	83.8% (150)
After hours coverage	70.3% (83)	95.0% (170)	NA	NA	NA	NA	NA	NA	70.3% (83)	77.7% (139)
OB first trimester	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
OB second trimester	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
OB third trimester	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
OB High Risk	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Percentages are based on completed surveys.

**High volume specialists surveyed in were adult and pediatric cardiology, ophthalmology, otolaryngology, orthopedics and pulmonary medicine. Each type was included in each quarter.

#NCQA standard for emergency care is "immediate" and for urgent care "same day." Any same-day appointment was counted as satisfying both categories.

Tables 3A and 3B Analysis:

Tables 3A and 3B, shown above, reflect timeliness of appointment access using two sets of standards: those specified in the State contract and those required by the National Committee on Quality Assurance (QI5). As shown in the matrix above, NCQA standards are generally tighter for all except physical exams, where 4 weeks are allowed compared to 3. Appointment timeliness is calculated in whole days as the date of the appointment minus the date the practice was called. Therefore, immediate access can only be evaluated if a same-day appointment is offered, and calls made later in the day with next-day access will appear noncompliant even though they fall within 24 hours. OB access is determined according to trimester of pregnancy rather than emergent, urgent, or routine need, and NCQA standards do not exist for these categories of access. Emergency access for behavioral health is not included because it is assumed that BH emergencies are referred to emergency rooms rather than being treated in office settings.

The process for assessing access is as follows: operators at a third-party vendor, Dial America, call offices on a list provided by the MCO using a pre-arranged script. The script explains the purpose and asks whether this is a good time for the call; if not, a call-back time is arranged (three attempts are made). The scripts ask for the first available appointment date for a United member (Medicaid is not specified) for an emergency, urgent, or routine need. For PCPs, the scripts also ask for a date for an adult physical and EPSDT exam. The operator then asks whether these appointment dates apply to all providers on the list or only certain ones. Dates are adjusted as needed for providers with different availability, though in most cases the appointment times given apply to all providers on the list. It should be noted that not all providers in the practice are assessed in any given call because random sampling means that only certain providers may be in the sample.

Pregnancy access is asked according to trimester of pregnancy, with longer compliance times allowed for earlier stages (three weeks for first trimester, two for second trimester, and one for third trimester). High-risk pregnancy access is also assessed, although no specific standards exist for either the State or NCQA.

Table 4: Average Number of Days Wait for Scheduled Appointment

	PCP (Days)		Specialist (Days)		OB (Days)		BH (Days)	
	2016	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Sample Size	**118**	**179**	**84**	**123**	**45**	**60**	**48**	**84**
Emergency care	1.2	4.6	3.5	17.7	NA	NA	NA	NA
Urgent care	1.7	3.2	4.1	17.1	NA	NA	4.8	5.2
Routine care	3.5	5.7	14.1	23.3	NA	NA	6.6	6.3
Adult physical	16.2	17.5	NA	NA	NA	NA	NA	NA
EPSDT/Well Child	9.9	18.1	NA	NA	NA	NA	NA	NA
OB first trimester	NA	NA	NA	NA	6.4	12.3	NA	NA
OB second trimester	NA	NA	NA	NA	7.2	13.5	NA	NA
OB third trimester	NA	NA	NA	NA	6.8	12.5	NA	NA
OB High Risk	NA	NA	NA	NA	3.4	8.4	NA	NA

Table 4 Analysis:
Table 4 shows access in terms of average days to an appointment based on urgency and specialty type. The generally longer times than in previous years were the result of a small number of physicians with extremely long wait times (up to 3 months in several cases). They occurred across all specialty types. The reasons for these delays are unknown. These data should be interpreted cautiously, as the Table 3 access data are much more reflective of the typical experience.

Table 5: After Hours Compliance

	PCP % (n)		Specialist % (n)		OB % (n)		BH* % (n)		Total % (n)	
	2016	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**	**2016**	**2017**
Sample Size	**118**	**179**	**84**	**123**	**45**	**60**	**48**	**84**	**295**	**362**
Answering service, nurse, physician or message with number to contact	85.6% (101)	95.0% (170)	84.5% (71)	96.7% (119)	77.8% (35)	90.0% (54)	NA	NA	83.8% (207)	94.8% (343)
Answering machine instructing member to go to nearest hospital	1.7% (2)	2.8% (5)	6.0% (5)	2.4% (3)	4.4% (2)	2.4% (6)	NA	NA	3.6% (9)	3.9% (14)
Phone rings continuously with no answer	1.7% (2)	.6% (1)	3.6% (3)	0	0	0	NA	NA	2.0% (5)	0.3% (1)
Other unacceptable (typically, message instructing member to dial 911)	15.3% (18)	1.7% (3)	6.0% (5)	0.8% (1)	17.8% (8)	0	NA	NA	12.6% (31)	1.1% (4)

*BH does not have after-hours compliance calls.

Table 5 Analysis:
After hours calls were placed to all provider types except behavioral health. Across all provider types, 94.8% had an adequate process in place, such as an answering service, nurse, physician, or number to contact. This represents an improvement from previous years. After-hour call-backs to noncompliant providers were made by the quality director on 8/23/17, with the finding that 63 providers initially coded as noncompliant actually were compliant, but the vendor had misinterpreted instructions. The state contract requirements regarding after hours access is as follows: "2.2.5.10 "The CONTRACTOR(S) shall have procedures in place to ensure medically necessary services are available to Members on a 24 hours-per-day,seven (7) days per week basis." Medically necessary services can be carried out by an Emergency Room or Hospital, if needed, after hours. United feels the results may be a little flawed in the fact that most providers do have recorded messages to direct members on where to go for after hour care. United did a spot check on some of these providers and that was our conclusion, however we did not change the outcome

of the audit since it was done by a vendor. We feel that many things could have happened, for example the vendor may not have let the phone ring long enough for the recorded message to pick up. United will be meeting to discuss how to address the drop in compliance and also review the process the vendor has for guided instructions.

Access is generally much higher for PCPs than specialists and follows a similar pattern through the years. About three-quarters of PCPs can provider a same-day appointment for emergencies and urgent care and more than 90% can provide care within the standard (21 days for State, 14 for NCQA) for routine care. Access to specialists is much slower, with 29% able to provide same-day care and 38% care within 48 hours. 59% of specialists were able to provide routine care within 14 days and 79% within 30 days.

Obstetric care was slightly slower this year than last, with only 52% of providers able to schedule an appointment within a week for a patient in the third trimester of pregnancy (in 2016, the number was 82%). 75% could schedule an appointment within two weeks for a member in the second trimester, and 88% within three weeks for a member in the first trimester. It should be noted that these data do not include Family Practitioners and Nurse Midwives who also provide a substantial amount of obstetrical care in the State of Kansas and whose obstetrical access was not assessed separately from other care.

Urgent (within 48 hours) behavioral health care was also less available, with 36% able to provide an appointment compared to 56% last year. It should be noted that the sample size of BH providers this year (n=84) is almost double the size last year (n=48). On the other hand, the large number of providers who were unable to be contacted due to having only cell phones (26 of 146) may have created some bias in the sample.

E. Outcomes of Onsite Reviews: In 2016, the State of Kansas collaborated with its contracted External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC) to conduct the 2016 Balanced Budget Act (BBA) and 2016 Annual State Contract Review in tandem. The State capitalized on the 2016 joint review and associated findings by conducting a follow-up review in 2017. The 2017 State Contract Review served as the final review of the approved KanCare 1115 demonstration waiver contract period in effect from January 1, 2013 through December 31, 2017 through application of the KanCare Quality Improvement Strategy assessment strategies to ensure Federal regulatory and State contractual adherence by the Managed Care Organizations (MCOs). The audit included assessment of the level to which each MCO performs the duties of the contract through operationalization of MCO policies and procedures and the quality of services delivered to providers and members. The 2017 State Contract Review concentrated on follow-up to the 2016 findings in the areas of appeals, clinical and medical records, finance, physician incentive plans, network adequacy, vendor management, credentialing, customer service, care coordination, behavior health records, health risk assessments, health literacy and prevention.

   The 2017 Annual State Contract Review was designed to follow-up on key areas for improvement identified by State subject matter experts during the 2016 Annual State Contract Review. State staff that participated in the 2016 review and documented opportunities for improvement provided focus areas for the 2017 review based upon 2016 findings. The questions were developed to diligently examine provider and member outcomes stemming from each MCO's service delivery model.

The 2017 State Contract Reviews were conducted in the fall of 2017 by scheduling on-site review dates and requesting evidence to demonstrate KanCare contract compliance though on-site demonstrations of technology and management systems. Of interest were:

- Member and provider appeals demonstrating adherence to State-approved policies including systems for tracking notices, vendor data, acknowledgement letters, grievances and State fair hearings.
- Assurance of payment processes to observe the payment floor of 100% for providers.
- Financial reporting to meet accounting program requirements through record retention and software maintenance and insolvency planning.
- MCO management of physician incentive plans and oversight of providers and physician groups and other employment and consulting arrangements established between the MCO and physicians and physician groups.
- Network adequacy standards and management of LTSS, recruitment, panel monitoring and forecasting.
- Quality assurance of vendor service provision, vendor grievances, vendor prior authorizations, and vendor corrective action and performance improvement processes.
- Assessment of provider credentialing and vendor vetting processes, oversight and record maintenance.
- Live demonstrations of member clinical and medical records to demonstrate coordination of care and documentation practices specific to member behavioral health and physical health, including vision services.
- Live electronic file reviews of members initially targeted to receive care coordination.
- Live electronic file reviews of members not automatically assigned to care coordination but assigned based on needs.
- Live electronic file reviews of member identified to benefit from supplemental educational outreach and provision.
- Medical record review of medical screenings and practices for determining who receives health risk assessments specifically related to children with and without special healthcare needs, members with behavioral health needs and non-waiver members and based on claims.
- Live side-by-side listening of customer service calls to verify MCO staff training, use of current policies and desk aids, general responsiveness and courtesy.

The findings for the audit are still under review and rebuttal, but there were no corrective actions required and many positive findings for all three MCOs.

F. Summary of PIPs: Two of the three KanCare MCOs – Amerigroup and United – initiated performance improvement projects (PIP) in July 2013. Sunflower's project planning process extended into late 2013; therefore, interventions were not initiated until January 1, 2014. The current collaborative PIP started in August 2016 focusing upon the HEDIS measure for HPV vaccination.

   For individual PIPs:

   - Amerigroup chose to improve well-child visit rates in the third, fourth, fifth and sixth years of life.

- 2013-2016 Sunflower chose to increase the rate of initiation and engagement of alcohol and other drug dependence treatment.
- 2013-2016 UnitedHealthcare chose to improve follow-up after hospitalization for mental illness.
- For 2017, both Sunflower and UnitedHealthcare have changed their individual PIP topics to the SSD HEDIS measure – Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication.

Each PIP methodology was reviewed and revised to ensure that clear interventions, outcomes, tracking, and measurement methods were identified. Representatives of each MCO report PIP progress at regularly occurring KanCare interagency meetings. Written updates have also been provided post-implementation of each PIP. The State also created monthly report templates for each MCO to send data showing the progress of each PIP. The EQRO is reviewing and finalizing the reports for each PIP now. The finalized reports will be attached at the end of this annual report submission.

G. Outcomes of Performance Measure Monitoring:

A summary of statewide results (all three KanCare MCOs aggregated) for calendar years 2013-2016 (measurements conducted in 2017) validated by Kansas Foundation for Medical Care. These numbers show the Kansas performance compared to the national 50th percentile on each of the measures, is set out in Table 2 of the attached KFMC report

H. Dental Care:

KanCare and partner agencies continue to emphasize the importance of regular dental care for our members and are committed to maintaining an increased utilization of these important services. Results indicate dental services have been consistently provided over the past two years after significant improvement in 2015.

	SFY2016	SFY2017
Total Eligible receiving dental treatment	**129,752**	**129,564**
Total Eligible receiving preventative services	**122,808**	**121,855**

Value Added Benefits (VAB) are another way in which adult members may access preventive dental services. In 2017, 10,422 members received Dental services as Value added services provided through the MCO's. The value of these services totaled $1,069,648.

I. Pay for Performance Measures

The final results of the KanCare MCOs' performance for the 2016 pay for performance measures (measured in 2017) are detailed in the document attached to this report entitled "KanCare Pay for Performance Measures – Summary of 2016 Performance Outcomes."

Additional performance results are included in the 2017 KanCare annual evaluation report developed by Kansas Foundation for Medical Care and attached to this report.

J. Summary of Plan Financial Performance: As of December 31, 2017, all three plans are in a sound and solvent financial standing. Two of the three plans reported profits in 2017. We are monitoring and working closely with the unprofitable Plan to identify efficiencies that will improve their performance.

Statutory filings for the KanCare health plans can be found on the NAIC's "Company Search for Compliant and Financial Information" website: ***https://eapps.naic.org/cis/.***

XII. Post Award Forum

The KanCare annual public forum, pursuant to STC 15, was conducted on December 19, 2017. A summary of the forum, including comments and issues raised at the forum, is attached.

XIII. Annual Evaluation Report & Revised Evaluation Design

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. In addition, the state submitted a revised KanCare Final Evaluation Design, with revisions as of March, 2015, submitted on April 1, 2015. KFMC has developed and submitted quarterly evaluation reports and annual evaluation reports for all of 2013, 2014, 2015, and 2016 as well as quarterly reports for each quarter of 2017.

KFMC's annual report for 2017 is attached. As with the previous evaluation design reports, the State will review the annual report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIV. Enclosures/Attachments

The following items are attached to and incorporated in this annual report:

Section of Report Where Attachment Noted	Description of Attachment
II(D)	KanCare Safety Net Care Pool Reports (including DSRIP payments)
III/IV	KanCare Expenditure & Budget Neutrality – DY5 2017
IX	KanCare Ombudsman Report – DY5 2017
XI(G)	KanCare Pay for Performance Measures – Summary of 2016 Performance Outcomes
XII	KanCare 2017 Public Forum Summary
XIII	KFMC's KanCare Evaluation Report – DY5 2017

XV. State Contacts(s)

Jeff Andersen, Secretary
Jon Hamdorf, Division Director and Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance

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XVI. Date Submitted to CMS

May 9, 2018

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 5- YE 2017

DSRIP Payment

Paid dates 1/1/2017 through 12/31/2017

Provider Names	YE 2017 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
Children's Mercy Hospital	3,343,750	1,490,413	1,853,337
University of Kansas Hospital	12,365,625	5,538,112*	6,827,513
Total	15,709,375.00	7,028,525	8,680,850
*IGT funds are received from the University of Kansas Hospital			

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 5- YE 2017

Health Care Access Improvement Pool

Paid dates 1/1/2017 through 12/31/2017

Provider Names	YE 2017 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	138,162	62,021	76,141
Children's Mercy Hospital South	944,167	423,837	520,330
Coffey County	43,796	19,660	24,136
Coffeyville Regional Medical Center, Inc.	327,748	147,126	180,622
Cushing Memorial Hospital	393,520	176,651	216,869
Doctors Hospital	9,741	4,373	5,368
Geary Community Hospital	292,820	131,447	161,373
Great Bend Regional Hospital	324,852	145,826	179,026
Hays Medical Center	837,988	376,173	461,815
Hutchinson Hospital Corporation	557,360	250,199	307,161
Kansas Heart Hospital LLC	129,165	57,982	71,183
Kansas Medical Center	94,448	42,398	52,050
Kansas Rehabilitation Hospital	26,192	11,758	14,434
Kansas Surgery & Recovery Center	11,417	5,125	6,292
Labette County Medical Center	222,240	99,764	122,476
Lawrence Memorial Hospital	897,680	402,969	494,711
Memorial Hospital, Inc.	146,690	65,849	80,841
Menorah Medical Center	740,979	332,625	408,354
Mercy Health Center - Ft. Scott	199,364	89,494	109,870
Mercy Hospital, Inc.	27,152	12,189	14,963
Mercy Reg Health Ctr	850,530	381,803	468,727
Miami County Medical Center	179,486	80,571	98,915
Mid-America Rehabilitation Hospital	76,188	34,201	41,987
Morton County Health System	62,635	28,117	34,518
Newton Medical Center	507,933	228,011	279,922
Olathe Medical Center	926,480	415,897	510,583
Overland Park Regional Medical Ctr.	2,753,857	1,236,206	1,517,651
Prairie Ridge	13,226	5,937	7,289
Prairie View Inc.	49,019	22,005	27,014
Pratt Regional Medical Center	164,786	73,972	90,814
Providence Medical Center	1,529,479	686,583	842,896
Ransom Memorial Hospital	274,812	123,363	151,449
Saint Luke's South Hospital, Inc.	219,232	98,413	120,819
Salina Regional Health Center	739,775	332,085	407,690
Salina Surgical Hospital	26,590	11,936	14,654
Shawnee Mission Medical Center, Inc.	3,811,097	1,710,801	2,100,296
South Central KS Reg Medical Ctr	167,722	75,290	92,432
Southwest Medical Center	351,348	157,720	193,628
St. Catherine Hospital	1,023,228	459,327	563,901
St. Francis Health Center	1,956,474	878,261	1,078,213
St. John Hospital	307,628	138,094	169,534
Stormont Vail Regional Health Center	4,145,489	1,860,910	2,284,579
Sumner Regional Medical Center	117,166	52,596	64,570
Susan B. Allen Memorial Hospital	500,208	224,543	275,665
Via Christi Hospital - Pittsburg	698,000	313,332	384,668
Via Christi Hospital St Teresa	249,104	111,823	137,281
Via Christi Regional Medical Center	7,290,477	3,272,695	4,017,782
Via Christi Rehabilitation Center	150,068	67,366	82,702
Wesley Medical Center	4,756,247	2,135,079	2,621,168
Wesley Rehabilitation Hospital	51,345	23,049	28,296
Western Plains Medical Complex	521,664	234,175	287,489
Total	40,836,774.00	18,331,628	22,505,146

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 5 - YE 2017

Large Public Teaching Hospital\Border City Children's Hospital Pool

Paid dates 1/1/2017 through 12/31/2017

Hospital Name	YE 2017 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	$ 2,464,136	$ 1,088,101	$ 1,376,035
University of Kansas Hospital	$ 7,392,412	$ 3,264,304*	$ 4,128,108
Total	**$ 9,856,548**	**$ 4,352,405**	**$ 5,504,143**

*IGT funds are received from the University of Kansas Hospital

DY 5

Start Date: 1/1/2017

End Date: 12/31/2017

	Assistance Total Expenditures	Total Member Months	Administration Total Expenditures
DY5Q1	$726,463,533	1,080,850	$54,815,210
DY5Q2	$722,498,776	1,059,664	$44,833,248
DY5Q3	$754,229,919	1,081,080	$53,900,039
DY5Q4	$761,743,526	1,084,798	$44,845,733
DY5 Total	$2,964,935,754	4,306,392	$198,394,230

UNIQUE ENROLLEES (Updated Annually)			
Pop 1: ABD/SD Dual	20,299	Pop 6: LTC	25,597
Pop 2: ABD/SD Non Dual	34,361	Pop 7: MN Dual	3,266
Pop 3: Adults	70,898	Pop 8: MN Non Dual	2,464
Pop 4: Children	289,392	Pop 9: Waiver	6,121
Pop 5: DD Waiver	9,491		0
		Total:	461,889

OVERALL UNDUPLICATED BENEFICIARIES:	446,427

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
DY5Q1									
Expenditures	$4,291,761	$106,724,314	$79,073,446	$149,773,268	$124,020,026	$215,777,488	$2,345,563	$7,852,460	$36,605,207
Member-Months	22,749	112,724	160,528	670,252	27,125	64,400	4,585	4,519	13,968
PCP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DY5Q2									
Expenditures	$3,972,228	$106,589,716	$78,013,970	$147,477,263	$125,474,937	$214,198,118	$2,152,437	$6,633,583	$37,986,524
Member-Months	21,717	113,071	158,373	651,773	27,311	64,523	4,426	4,005	14,465
PCP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DY5Q3									
Expenditures	$3,952,788	$110,988,585	$82,349,523	$157,558,295	$128,637,815	$223,238,309	$2,135,492	$6,709,236	$38,659,876
Member-Months	21,035	112,933	156,682	678,943	27,309	62,628	4,040	3,810	13,700
PCP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DY5Q4									
Expenditures	$3,762,504	$112,093,415	$83,255,962	$158,749,682	$130,093,720	$227,898,241	$1,957,537	$6,113,686	$37,818,779
Member-Months	20,387	113,324	159,844	679,350	27,400	64,043	3,928	3,505	13,017
PCP	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DY5 Total									
Expenditures	$15,979,281	$436,396,030	$322,692,901	$613,558,508	$508,226,499	$881,112,156	$8,591,029	$27,308,965	$151,070,386
Member-Months	85,888	452,052	635,427	2,680,318	109,145	255,594	16,979	15,839	55,150
DY 5 PMPM	$186	$965	$508	$229	$4,656	$3,447	$506	$1,724	$2,739

KanCare Ombudsman Annual Report - 2017

Kerrie J. Bacon, KanCare Ombudsman

Dashboard

1. Contacts have increased from fourth quarter 2016 to fourth quarter 2017 by 99% (523 to 1040). Contacts in **January 2018** were **464**, which is 59 contacts less than ***all*** of fourth quarter 2016, and almost half of fourth quarter 2017. (This is a comparison of quarter information to one month). Page 2.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2016	**1,130**	846	687	523	
2017	825	835	970	**1,040**	January 2018, 464 contacts
2016 vs. 2017	-27%	-1%	41%	99%	

2. Average days to resolve issues is down from 9 to 7. Percentage of files closed is down from 90% to 83%. The "percent of files closed" is relatively low for Q4/17 in comparison to other quarters in the past year. Because of the high call volume, the Ombudsman's assistant, whose task is to close a certain percentage of cases, was given a lower goal in closing and was prioritized to answering emails coming to the Ombudsman's office (due to the higher contact volume). Page 2.

3. Added Notes History and Email History for the four quarters in 2017 to provide better information on the number of contacts made to the KanCare Ombudsman's office and the work done by the office (emails) to resolve cases. Page 8.

4. Changes in the KanCare Ombudsman's office for 2017. Pages 12-13.
   - KanCare Ombudsman Liaison Training – started in first quarter 2017
   - Revised the KanCare Ombudsman webpages
   - Created the application assistance notebook for enrollees to KanCare
   - Created new volunteer position – Education and Resource Information volunteers

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication and in person during the 2017 year. The number of contacts for the Ombudsman's office received doubled from fourth quarter 2016 to 2017 (523 to 1040); the percent of increase is 99%. Fourth quarter continued the trend of increasing contacts each quarter since the beginning of 2017 ending only 90 contacts short of the highest quarter (Q1, 2016) during the five years of the Ombudsman's office time of operation.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	
2016	**1,130**	846	687	523	
2017	825	835	970	**1,040**	January 2018, 464 contacts
2016 vs. 2017	-27%	-1%	41%	99%	

In the chart below, the "percent of files closed" is relatively low for Q4/17 in comparison to other quarters in the past two years. Because of the high call volume, the Ombudsman's assistant, whose task is to close a certain percentage of cases, was given a lower goal in closing cases and was prioritized to answering emails coming to the Ombudsman's office (due to the higher contact volume). Due to his increased assistance, he is now also receiving direct requests in addition to working the emails.

	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17	Q4/17
Avg. Days to Resolve Issue	7	5	6	4	11	9	9	7
% files resolved in one day or less	50%	56%	54%	52%	34%	44%	34%	45%
% files closed	77%	88%	87%	80%	88%	92%	90%	83%

Outreach by Ombudsman's office

Presentations: (educational, networking, referrals)

- Life Centers of Kansas City (Leavenworth County), January 26, 2017
- Human Trafficking Conference booth; January 27, 2017
- Catholic Charities presentation; February 22, 2017
- POWER Conference booth; February 24, 2017
- Spoke at three Wichita State University (WSU) classes about Ombudsman's office, February 2, 2017; March 6, 2017; March 7, 2017.
- Livable Neighborhoods Task Force meeting (Wyandotte County) February 23, 2017
- Wichita State University Public Health Fair; March 29, 2017
- KanCare Ombudsman Liaison Training Session; Kansas City, March 30, 2017
- Provided quarterly information on the Ombudsman's office at the Robert Bethell HCBS and KanCare Oversight Committee Meeting, April 19, 2017
- Outreach for Ombudsman's office at Franklin County Health Fair, April 26, 2017
- Outreach for Ombudsman's office at Mercy and Truth Medical Missions, April 28, 2017
- Attended Severe Emotional Disturbance Listening Session as outreach; Andover; Monday, May 1, 2017.
- Outreach for Ombudsman's office (six county regional event) at Active Aging Expo; May 3, 2017
- Outreach for Ombudsman's office at Community Connections Celebration event in Osage City, May 5, 2017
- Provided Liaison Training (Community Collaboration/Outreach)
    - Wyandotte Center, April 21, 2017
    - Johnson County CDDO, May 17, 2017
    - Developmental Services of Northwest Kansas (CDDO), Hays, KS, June 21, 2017.
    - Community Health Council of Wyandotte County, Kansas City, KS, June 29, 2017
- Provided testimony on the Ombudsman's office for the KanCare Advisory Council; June 13, 2017
- Attended the KanCare Renewal Listening Session in Topeka, Pittsburg and Wichita as outreach; June 2017.
- Attended the KanCare Consumer Specialized Issues Workgroup and provided several topics for review/discussion; June 20, 2017.
- Presentation on the Ombudsman's office for the Sunflower Advisory Committee; June 26, 2017.
- Mailing by Wichita VISTA volunteer to 38 county local organizations on the Ombudsman's office. Summer 2017

- Third Quarter Public Health Region Meeting in Chanute, KS; July 13, 2017
- 2017 Kansas Conference on Poverty, July 19-20, 2017
- Public Health Quarterly meetings: 8/2017; Hutchinson 8/2, Oakley 8/10, Garden City 8/9, and Topeka 8/29
- Oak Creek Senior Living/Assisted Living Facility, presentation to residents in Topeka, August 16, 2017
- Attended the KanCare Consumer Specialized Issues Workgroup and provided quarterly report for review; August 17, 2017.
- Sedgwick County Developmental Disability Community Council meeting 8/18
- 2017 Midwest Ability Summit in Kansas City, August 19, 2017
- Provided quarterly report on the Ombudsman's office for the Robert Bethell HCBS and KanCare Oversight Committee Meeting, August 23, 2017
- WSU Volunteer Fair 8/28
- Locations Posting KanCare Ombudsman Information: Outreach post about the KanCare Ombudsman office services.
    - 50 + Center, September 2017
    - Olathe Public Library, September 2017
    - Church of Harvest, September 2017
    - First Baptist Church of Olathe, September 2017
    - St. Paul's Catholic Church, September 2017
    - Legacy Christian Church, September 2017
- Public Health Quarterly meetings 9/2017; Beloit-9/6)
- KanCare All MCO Provider outreach meetings, 2 sessions, September 13, 2017
- All MCOs/HCBS Training/Outreach, Olathe, KS; September 20, 2017
- All MCOs/HCBS Training/Outreach, Hays, KS; September 27, 2017
- St. Mary's University, Kansas City, KS; September 28, 2017
- Provided testimony on the Ombudsman's office for the KanCare Advisory Council; October 17, 2017
- KanCare Ombudsman Liaison Training Sessions (educational, networking, referrals, increase capacity)
    - Aledade, Inc. in Salina, KS; July 7, 2017
    - Wyandotte/Leavenworth AAA; July 17, 2017
    - El Centro in Wyandotte County; August 31, 2017
    - Northwestern KS CDDO (DSNWK), in Hill City, KS; Graham Co., Sept. 22, 2017
- 2017 Live Well Age Well, a Johnson County 50+ Clubs Event; Overland Park, KS, October 19, 2017
- Spoke at InterHab Conference, October 25, 2017
- St. Mary's University Career and Graduate School Fair; Kansas City, KS, November 8, 2017

- Governor's Conference November 1st through the 3rd. Maintained booth and interacted with approximately 60 people.
- KanCare Listening Session, Dodge City, November 14, 2017; 2 sessions - approximately 30 people per session.
- KanCare Listening session, Wichita; November 16, 2017; 2 sessions approximately 20 people per session.
- Schlagle High School Health Fair, Kansas City, KS; December 11, 2017
- **KanCare Ombudsman Liaison Training Sessions**: (educational, networking, referrals, increase capacity)
  - RCIL, Emporia, KS, Lyon Co.; October 25, 2017
  - Catholic Charities, Kansas City, Wyandotte Co.; October 30, 2017
  - ECKAAA, Ottawa, KS, Franklin Co.; November 29, 2017

***Publications*:** Outreach, posts and/or articles about the KanCare Ombudsman office services.

- Livable Neighborhoods Neighborhood News (Wyandotte Co. newsletter); January, February, March
- Senior Bluebook; KC, KS and KC, MO; Jan., Feb., March 2017
- Public Health Newsletter; February 2017
- City of Wichita, District 2 (on-line); March 2017
- Livable Neighborhoods Neighborhood E-News (Wyandotte Co. newsletter), April 2017
- May newsletter for Volunteer Commission in Wichita on recruitment
- Wichita State Facebook page Recruitment blurb; May 2017
- ComCare Staff Bulletin; May 2017
- Shepherd's Voice E-Newsletter, June 2017
- Senior Bluebook Magazine; Kansas City, KS and MO; April, May, June 2017
- Senior Bluebook Magazine; Kansas City, KS and Kansas City, MO; July and August 2017
- The Communicator (Wyandotte/Leavenworth AAA Publication), July and August 2017
- Information posted in the newsletters of the:
  - McConnel AFB retirees, August 2017)
- Livable Neighborhood Task Force (Wyandotte Co. Publication); September 2017
- Shepherd's Voice; Kansas City, KS, October 2017
- St. Paul's Catholic Church News Bulletin; Olathe, KS; October 2017
- The Communicator (Wyandotte/Leavenworth, KS); November and December 2017
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey); Oct, Nov, Dec 2017
  - Bel Aire Senior Center; August 2017, updated September 2017
  - Pine Valley Christian Church; September 9, 2017

- Volunteer ICT; posted on their website 9/2017
- St James Church; provided publication information and flyers; Sept. 2017

- Mailed or emailed KanCare Ombudsman flyers to:
  - Atwater Neighborhood Resource Center, Wichita, October
  - Colvin Neighborhood Resource Center, Wichita, October
  - United Methodist Open Door, Wichita, October
  - St. Mark United Methodist Church, Wichita, October
  - Grasslands Estates, Wichita, October
  - Andover Senior Center, Andover, October
  - Northeast Senior Center, Wichita; November
  - Glenville Church, Wichita, November
  - First United Methodist Church, Wichita, November
  - St. Mark's Cathedral Church of God, Wichita, November
  - Fresh Hope, Wichita, November

- Friends and Family Advisory Council which met twice during the 2017.
- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians, consumers and other interested parties during first quarter. Lunch and Learn calls ended during first quarter and people were encouraged to participate in the HCBS bi-weekly (twice/month) calls.

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** has been aiding KanCare members for almost a year and a half (August 2016). Johnson County Satellite office has been answering the phone and meeting with individuals on Wednesdays (10-1), Thursdays (10-4), and Fridays (10-1). Three Education Resource and Information (ERI) volunteers, through St. Mary's college, have been assisting with developing resources for the Ombudsman's office. (see page 13 for more information on ERI volunteer program)
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been open over two years (November 2015), aiding KanCare members. The Southern Kansas Satellite Office is answering the phone and meeting with individuals Monday (12-4), Tuesday (10-2), Thursday (10-12) and Friday (12-4).
- Both Satellite offices are assisting consumers with filling out applications on the phone and in person by appointment.

Data by Ombudsman's Office

The Ombudsman on-line tracker has been updated to include the main Ombudsman office and the two Ombudsman satellite offices covered by volunteers.

The reason for the variance in the numbers in the satellite offices is when volunteers start or end their time with the Ombudsman's office. For example, in Johnson County there were two volunteers for some time, then there were four, then it dropped back to three. You can see the number of calls taken reflected in the number of volunteers available to take those calls. Similar data is reflected in Wichita between first, second and third quarters.

At the end of third quarter we found that the 620 area code numbers, for some reason, had stopped going to the Wichita office. It's not clear when that happened, although if you look at the chart below, it may have been in second quarter. It was fixed by early November which accounts for the increase in numbers for Wichita for fourth quarter.

Contacts by Office	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
Main	432	648	639	759	718
Johnson County	21	28	81	51	62
Wichita	70	149	115	160	260
Total	**523**	**825**	**835**	**970**	**1,040**

Contact Method	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
phone	862	644	507	394	687	701	816	906
email	265	191	174	125	125	127	143	122
letter	2	3	1	0	2	0	0	0
in person	0	8	3	3	11	5	6	8
online	1	0	2	1	0	0	0	0
other	0	0	0	0	0	2	5	4
Total	**1,130**	**846**	**687**	**523**	**825**	**835**	**970**	**1,040**

Caller Type	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**	**Q3/17**	**Q4/17**
Provider	179	110	100	71	117	112	141	122
Consumer	866	601	544	352	630	661	773	862
MCO employee	7	4	10	8	18	9	11	6
Other	78	131	33	92	60	53	45	50
Total	**1,130**	**846**	**687**	**523**	**825**	**835**	**970**	**1,040**

The chart below shows the contact information and the work behind the scenes more clearly. Each time a person contacts the Ombudsman's office it is logged in the Notes History. When the same person contacts the office more than once, it would not necessarily show up under Caller Type or in the Total Contacts. It has been mentioned before that the total count is under represented, due to how the Ombudsman's office keeps track of those who contact the office. If we create a separate file each time a person calls, we would have to pull up several files when the person calls back to catch up on the situation, which is not efficient. The Notes History reflects, for the most part, the calls that are made between the Ombudsman's office and the beneficiary or representative. The information below provides a better understanding of the number of calls that come into the office. Email History is a combination of email contacts and work being done by the Ombudsman's office to assist those who contact the office.

	Q1/17	Q2/17	Q3/17	Q4/17	% incr. Q1 vs. Q4
Notes History (number of notes about contacts made; correlates to number of actual contacts received.	1,388	1,651	1,954	2,122	53%
Email History (all emails; contacts with beneficiaries; also includes office emails regarding assistance on cases)	655	919	1,338	1,490	127%

The most frequent calls regarding home and community-based services (HCBS) waivers in the past four years was regarding the intellectual developmental disability (I/DD) waiver, then nursing facilities were second and the physical disability (PD) waiver was third. The nursing facility calls increased in 2017 due to eligibility issues for people waiting to get on Medicaid who were in a nursing facility or waiting to get in a nursing facility.

Occasionally more than one option can be chosen; for example, when mental health or substance abuse might be included in addition to a waiver or a nursing facility. Waiver information by MCO is located in Appendix A.

WAIVER	2014	2015	2016	2017	Total
PD	79	169	92	154	494
I/DD	83	118	108	200	509
FE	30	62	59	128	279
AUTISM	6	16	6	7	35
SED	10	19	8	18	55
TBI	35	35	26	27	123
TA	26	50	31	27	134
WH	0	0	0	4	4
MFP	10	8	16	3	37
PACE	2	3	0	2	7
MENTAL HEALTH	15	34	23	17	89
SUB USE DIS	1	2	0	0	3
NURSING FACILITY	36	102	121	251	510

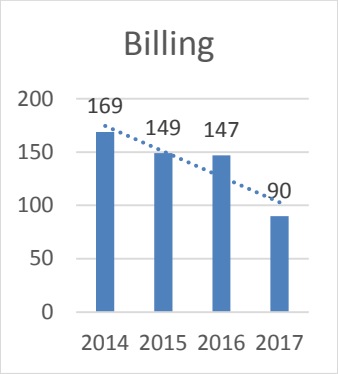
The Issue Categories listed below reflect the past four years in alphabetical order. The top five issues for the total years combined are highlighted. You will note that Other is significantly lower in 2017. The has been helped by the addition of over 20 new categories over the last two years including four new categories in the fourth quarter of 2017. Two categories that have been added in fourth quarter but do not have data yet are Cultural Competency issues and Medicaid Fraud. Issue categories by MCO is located in Appendix A (pages 14-19). There may be multiple issues for a member/contact.

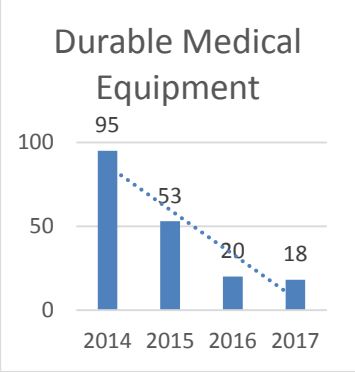
ISSUE CATEGORY	2014	2015	2016	2017
Access to Providers (usually Medical)	54	28	35	51
Abuse / neglect complaints	0	0	0	2
Affordable Care Act Calls	0	0	0	19
Appeals/Fair Hearing questions/issues	0	0	0	44
Background Checks	0	0	0	2
Billing	169	149	147	90
Care Coordinator Issues	52	38	21	34
Change MCO	36	32	24	12
Choice Info on MCO	0	0	0	0
Client Obligation	0	0	0	123
Coding Issues	0	0	0	29
Consumer said Notice not received	0	0	0	1
Cultural Competency	0	0	0	0
Data Requests	0	0	0	8
Dental	45	16	19	29
Division of Assets	0	0	0	14
Durable Medical Equipment	95	53	20	18
Estate Recovery	0	0	0	21
Grievances Questions/Issues	137	153	147	107
Guardianship	21	9	5	11
HCBS Eligibility issues	86	81	109	215
HCBS General Issues	132	180	133	137
HCBS Reduction in hours of service	54	48	23	19
HCBS Waiting List	37	40	26	27
Health Homes	0	25	12	3
Housing Issues	33	14	15	17
Medicaid Application Assistance	0	0	0	441
Medicaid Coding	0	0	0	0
Medicaid Eligibility Issues	438	648	1122	950
Medicaid Fraud	0	0	0	0
Medicaid info (status) update	0	0	0	2
Medicaid Renewal	0	0	0	171
Medical Services	158	94	72	60
Medicare related Issues	0	0	0	37
Medicare Savings Plan Issues	0	0	0	30
Moving to / from Kansas	0	0	0	27
Nursing Facility Issues	60	114	112	110
Pharmacy	92	96	59	43
Questions for Conference Calls/Sessions	35	8	3	0
Respite	0	0	0	0
Social Security Issues	0	0	0	5
Spend Down Issues	0	14	71	107

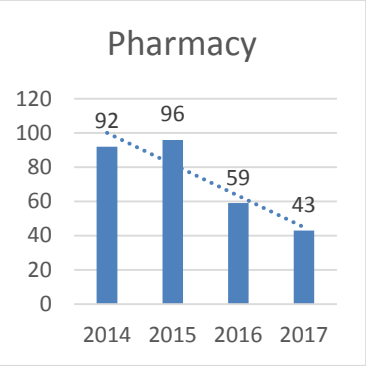
ISSUE CATEGORY	2014	2015	2016	2017
Transportation	52	45	21	34
Working Healthy	0	0	0	5
X-Other	336	585	1342	1019
Z Unspecified	164	89	110	216
Total	2122	2470	3538	4074
Medicaid Eligibility Issues; % to total	21%	26%	32%	23%

Trends in Data

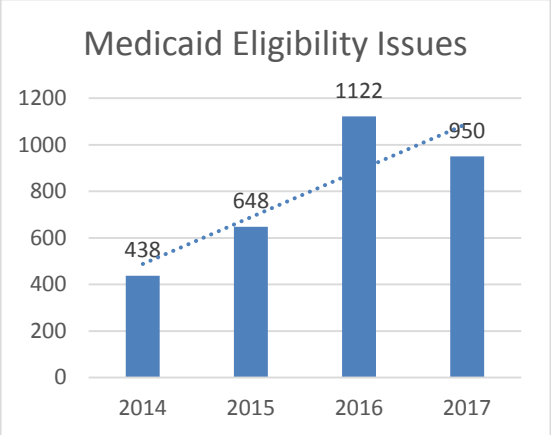
When reviewing the last four years, there are three Issue Categories that have trended down from 2014 to 2017; Billing, Durable Medical Equipment and Pharmacy.

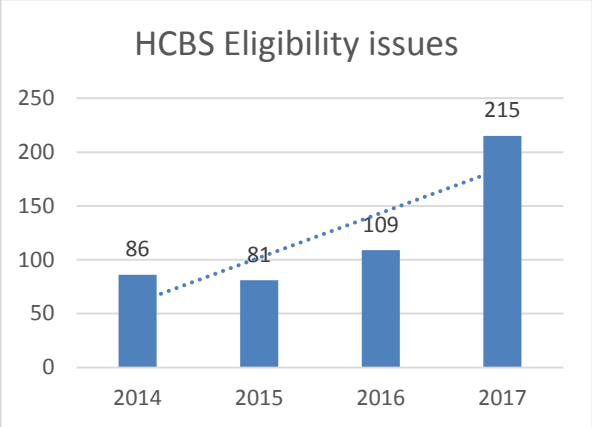






There are two Issue Categories that have trended up from 2014 to 2017; HCBS Eligibility Issues and Medicaid Eligibility Issues. The 2017 number for Medicaid Eligibility is lower. This is due to adding categories that had been represented in the Medicaid Eligibility issue category (Medicaid application assistance, Medicaid information (status) update, Medicaid Renewal). 2017 data represents a clearer picture of true eligibility issues.





Action Taken to Resolve Issues by Ombudsman's Office

The chart on the next page shows action taken by the Ombudsman's office over the past four years. In the action/years that are zero, we added categories during 2016 to provide clearer information regarding the activities of the Ombudsman's office and referral being made. So, some years do not have information recorded. The ***"Resolved"*** section (in gray) explains how cases have been closed. For "Question/Issue Resolved," if a call is returned and the person has already received an answer and does not need help from the Ombudsman's office or the person called to just talk, then it is marked "Resolved" and then closed. The "Used Contacts or Resources" shows when resources are provided; explaining KanCare processes, providing phone numbers, sending information by way of mail or email, or using contacts or resources that are listed in the blue or green categories below. Our offices will contact those offices themselves, with the member, or refer the member to the organization. Once it is resolved this is the section that is used. The "Closed" section is when a person contacts our offices and leaves a message and we are not able to get back in touch with them; either because the number left is a wrong number, there is no voice mail to leave a message and they don't call back, or messages are left and they don't return the call. After a month or so, the case is closed.

"Resources" (in yellow) provided to members can be in many forms: a phone number for an agency, explaining the process for filing a grievance, answering a question about estate recovery, walking someone through the spenddown calculation, offering to mail the Medicaid application, or client obligation explanation, etc. These are just a few examples of the resources provided verbally, mailed and emailed to potential members, members, family, and providers assisting members.

The balance of the Resource Category (in green and blue) shows what action was taken and what contacts were made on behalf of a member, potential member, provider or other caller to resolve an issue and what resources where provided. A few new categories were created during first quarter of 2017. History is not available before then. Often multiple resources are provided to a member/contact.

The green lines are contacts that are typically made by the staff and volunteers of the Ombudsman's office to follow up on a call, email or visit. The blue lines show when contacts have been referred to agencies and/or organizations for further information.

ACTION TAKEN	2014	2015	2016	2017
QUESTION/ISSUE RESOLVED (NO RESOURCES)	208	271	929	417
USED CONTACT OR RESOURCES/ISSUE RESOLVED	463	1127	1356	2494
CLOSED (NO CONTACT)	78	239	841	361
PROVIDED RESOURCES	44	566	815	1330
MAILED/EMAIL RESOURCES	0	0	2	409
KDHE CONTACT	201	390	553	348
DCF CONTACT	40	96	13	14
MCO CONTACT	178	269	171	99
MCO REFERRAL	0	0	0	115
CLEARINGHOUSE CONTACT	0	0	0	571
CLEARINGHOUSE REFERRAL	0	0	2	414
HCBS TEAM CONTACT	97	148	68	105
HCBS TEAM REFERRAL	0	0	0	56
CSP MENTAL HEALTH CONTACT	2	3	2	3
OTHER KDADS CONTACT/REFERRAL	57	162	152	224
STATE OR COMMUNITY AGENCY REFERRAL	45	227	223	278
DISABILITY RIGHTS AND/OR KLS REFERRAL	40	66	27	17
Total	1453	3564	5154	7255

Changes from the past year (Enhancements to the Ombudsman program)

1. ***KanCare Ombudsman Liaison Training – started in first quarter 2017***
   The KanCare Ombudsman Liaison is someone who educates and assists Kansas Medicaid members within their current workplace within their regular hours of operation.
   KanCare Ombudsman Liaison Training is designed to help any staff working within a community organization who deals with Kansas Medicaid consumers to acquire a better understanding of:
   - Basic KanCare programs including Home and Community Based Services;
   - How to assist with Medicaid applications; and
   - Medicaid-related resources.

   There is no fee for this training. It is provided as a service to community organizations for capacity building. For more information go to: www.kancare.ks.gov/kancare-ombudsman-office/liaison-training

2. ***Revised the KanCare Ombudsman webpages*** *(www.kancare.ks.gov/state-ombudsman-office)*
   The Resource Information page was revised reflect the resources and information in the Ombudsman Resource Notebook. This is to assist with the Liaison Training. This way we

could refer community providers to this page after going through it in training and not have to print copies of the notebooks for all participants. It also makes it easier for volunteers and liaisons to find the resources, print them, and refer callers to them if needed.

3. ***Created the application assistance notebook for enrollees to KanCare*.**
The application assistance notebook is printed out and provided to those who come to the satellite offices for application assistance and mailed out to those who are needing help with filing their application. It is found on the Ombudsman website on the resource page, number 12.
It includes:
    - a flow chart for the application process and contact information along the way,
    - application frequently asked questions,
    - application checklist; for enrollee to follow to assist with the initial application process and follow-up, and
    - documentation checklist for KanCare applications (put together from several different checklists, applications and forms.

4. ***Created new volunteer position – Education and Resource Information volunteers.***
St. Mary's College Health Information Management Program requires 120 hours of volunteer work. The Ombudsman Volunteer Coordinator presented information about volunteering in a way that could help them accomplish their goals, learn about KanCare/Medicaid, and assist the Ombudsman's office with developing resources for beneficiaries. One student completed her 120 hours in 4th quarter. Two students started their volunteer time at the end of December and will continue into 1st quarter. These student volunteers complete background checks and the 30-hour volunteer training. An example of the work is at the end of this report; the General Information Fact Sheet for Selecting/Changing an MCO.

Next Steps for Ombudsman's Office

Ombudsman Bill in Legislature

The Ombudsman's office is involved with a bill that will move the office to the Department of Administration as an independent agency. If passed, the changes will take place the beginning of FY 2019.

APPENDIX A – information by Managed Care Organization (MCO)

Amerigroup

Four issue categories have decreased over the last four years for Amerigroup: Billing, Durable Medical Equipment, Medical Services and Pharmacy. There were no significant trends for the Waiver category for the four years for Amerigroup.

ISSUE CATEGORY – Amerigroup	2014	2015	2016	2017
Access to Providers (usually Medical)	20	6	6	14
Abuse / neglect complaints	0	0	0	0
Affordable Care Act Calls	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	0	5
Background Checks	0	0	0	1
Billing	35	31	26	11
Care Coordinator Issues	10	11	9	8
Change MCO	6	8	2	2
Choice Info on MCO	0	0	0	0
Client Obligation	0	0	0	15
Coding Issues	0	0	0	5
Consumer said Notice not received	0	0	0	1
Cultural Competency	0	0	0	0
Data Requests	0	0	0	0
Dental	16	2	2	1
Division of Assets	0	0	0	0
Durable Medical Equipment	37	6	6	2
Estate Recovery	0	0	0	2
Grievances Questions/Issues	13	23	15	18
Guardianship	0	1	0	1
HCBS Eligibility issues	11	15	17	30
HCBS General Issues	25	42	22	32
HCBS Reduction in hours of service	9	8	9	4
HCBS Waiting List	6	8	1	4
Health Homes	0	2	1	2
Housing Issues	4	2	3	2
Medicaid Application Assistance	0	0	0	1
Medicaid Coding	0	0	0	0
Medicaid Eligibility Issues	32	33	51	41
Medicaid Fraud	0	0	0	0
Medicaid info (status) update	0	0	0	0
Medicaid Renewal	0	0	0	22
Medical Services	26	11	13	13
Medicare related Issues	0	0	0	5

ISSUE CATEGORY – Amerigroup	2014	2015	2016	2017
Medicare Savings Plan Issues	0	0	0	1
Moving to / from Kansas	0	0	0	2
Nursing Facility Issues	7	10	4	5
Pharmacy	16	10	7	6
Questions for Conference Calls/Sessions	0	0	0	0
Respite	0	0	0	0
Social Security Issues	0	0	0	0
Spend Down Issues	0	1	8	13
Transportation	18	13	4	5
Working Healthy	0	0	0	0
X-Other	34	53	65	50
Z Unspecified	6	4	4	3
Total	**331**	**300**	**275**	**327**

WAIVER - Amerigroup	2014	2015	2016	2017
PD	19	49	16	36
I/DD	12	23	24	25
FE	5	13	9	19
AUTISM	1	3	1	2
SED	4	3	3	7
TBI	11	11	10	8
TA	6	7	8	9
WH	0	0	0	1
MFP	1	2	0	0
PACE	0	0	0	0
MENTAL HEALTH	4	6	5	4
SUB USE DIS	0	0	0	0
NURSING FACILITY	5	7	3	7

Sunflower

Four issue categories have decreased over the last four years for Sunflower: Billing, Care Coordinators, Durable Medical Equipment and Pharmacy. There were no significant trends for the Waiver category for the four years for Sunflower.

ISSUE CATEGORY - Sunflower	2014	2015	2016	2017
Access to Providers (usually Medical)	12	5	4	12
Abuse / neglect complaints	0	0	0	0
Affordable Care Act Calls	0	0	0	1
Appeals/Fair Hearing questions/issues	0	0	0	2
Background Checks	0	0	0	0
Billing	46	40	30	23
Care Coordinator Issues	32	11	6	10
Change MCO	19	11	5	3
Choice Info on MCO	0	0	0	0
Client Obligation	0	0	0	17
Coding Issues	0	0	0	6
Consumer said Notice not received	0	0	0	0
Cultural Competency	0	0	0	0
Data Requests	0	0	0	0
Dental	11	4	3	3
Division of Assets	0	0	0	0
Durable Medical Equipment	35	23	9	5
Estate Recovery	0	0	0	1
Grievances Questions/Issues	76	66	35	17
Guardianship	3	1	0	1
HCBS Eligibility issues	22	16	15	29
HCBS General Issues	34	44	30	23
HCBS Reduction in hours of service	19	19	4	3
HCBS Waiting List	5	3	1	3
Health Homes	0	5	2	0
Housing Issues	8	2	0	3
Medicaid Application Assistance	0	0	0	6
Medicaid Coding	0	0	0	0
Medicaid Eligibility Issues	30	60	52	49
Medicaid Fraud	0	0	0	0
Medicaid info (status) update	0	0	0	0
Medicaid Renewal	0	0	0	25
Medical Services	53	26	15	14
Medicare related Issues	0	0	0	2
Medicare Savings Plan Issues	0	0	0	1

ISSUE CATEGORY - Sunflower	2014	2015	2016	2017
Moving to / from Kansas	0	0	0	1
Nursing Facility Issues	3	9	10	4
Pharmacy	38	31	13	8
Questions for Conference Calls/Sessions	2	1	0	0
Respite	0	0	0	0
Social Security Issues	0	0	0	1
Spend Down Issues	0	4	8	13
Transportation	11	12	8	9
Working Healthy	0	0	0	0
X-Other	38	55	75	63
Z Unspecified	19	5	1	4
Total	516	453	326	362

WAIVER - Sunflower	2014	2015	2016	2017
PD	27	42	27	31
I/DD	33	27	22	34
FE	11	20	9	18
AUTISM	4	8	1	2
SED	3	5	2	1
TBI	11	7	6	4
TA	10	17	9	5
WH	0	0	0	1
MFP	3	3	4	1
PACE	0	1	0	0
MENTAL HEALTH	3	8	6	2
SUB USE DIS	0	0	0	0
NURSING FACILITY	4	10	15	16

UnitedHealthCare

Four issue categories have decreased over the last four years for UnitedHealthCare: Billing, Durable Medical Equipment, Grievances and Pharmacy. There were no significant trends for the Waiver category for the four years for UnitedHealthCare.

ISSUE CATEGORY – UnitedHealthcare	2014	2015	2016	2017
Access to Providers (usually Medical)	10	8	5	8
Abuse / neglect complaints	0	0	0	1
Affordable Care Act Calls	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	0	5
Background Checks	0	0	0	0
Billing	29	20	13	13
Care Coordinator Issues	6	11	3	9
Change MCO	7	7	7	6
Choice Info on MCO	0	0	0	0
Client Obligation	0	0	0	12
Coding Issues	0	0	0	3
Consumer said Notice not received	0	0	0	0
Cultural Competency	0	0	0	0
Data Requests	0	0	0	0
Dental	5	4	6	6
Division of Assets	0	0	0	1
Durable Medical Equipment	12	9	1	5
Estate Recovery	0	0	0	1
Grievances Questions/Issues	20	24	16	10
Guardianship	3	1	1	1
HCBS Eligibility issues	7	12	12	25
HCBS General Issues	27	28	21	16
HCBS Reduction in hours of service	11	9	4	4
HCBS Waiting List	4	6	4	0
Health Homes	0	5	1	0
Housing Issues	6	4	0	1
Medicaid Application Assistance	0	0	0	4
Medicaid Coding	0	0	0	0
Medicaid Eligibility Issues	23	33	32	42
Medicaid Fraud	0	0	0	0
Medicaid info (status) update	0	0	0	0
Medicaid Renewal	0	0	0	14
Medical Services	21	17	9	8
Medicare related Issues	0	0	0	3
Medicare Savings Plan Issues	0	0	0	1
Moving to / from Kansas	0	0	0	0

ISSUE CATEGORY – UnitedHealthcare	2014	2015	2016	2017
Nursing Facility Issues	2	13	7	7
Pharmacy	13	18	14	4
Questions for Conference Calls/Sessions	0	1	0	0
Respite	0	0	0	0
Social Security Issues	0	0	0	0
Spend Down Issues	0	2	3	9
Transportation	7	11	1	7
Working Healthy	0	0	0	0
X-Other	20	48	67	57
Z Unspecified	4	1	2	10
Total	237	292	229	293

WAIVER	2014	2015	2016	2017
PD	14	37	13	20
I/DD	10	17	14	22
FE	9	10	14	21
AUTISM	0	1	1	1
SED	2	4	1	1
TBI	7	6	3	5
TA	3	6	2	3
WH	0	0	0	0
MFP	3	3	6	0
PACE	0	0	0	0
MENTAL HEALTH	3	6	2	3
SUB USE DIS	1	0	0	0
NURSING FACILITY	2	5	7	16

Amerigroup

Measure	2013	2014 target	2014	Rel change	>50th QC	met/not met	2015 target	2015	Rel change	>50th QC	met/not met	2016 target	2016	Rel change	>50th QC	met/not met
CDC - Hemoglobin A1c (HbA1c) Testing	**84.18%**	88.39%	**85.24%**	1.25%	no	no	89.50%	**84.05%**	-1.39%	no	no	88.25%	86.37%	2.76%	<50th	No
CDC - Eye Exam (retinal) Performed	**48.98%**	51.43%	**51.72%**	5.60%	no	yes	54.31%	**54.93%**	6.19%	yes	yes	57.68%	55.69%	1.38%	≥50th	Yes
CDC - Medical Attention for Nephropathy	**75.26%**	79.02%	**76.72%**	1.95%	no	no	80.56%	**85.94%**	12.01%	no	yes	90.24%	86.48%	0.63%	<10th	No
CDC - HbA1c Control (< 8.0%)	**37.63%**	39.51%	**43.97%**	16.84%	no	yes	46.17%	**49.28%**	12.09%	yes	yes	51.74%	52.15%	5.82%	≥66.66th	Yes
CDC - Blood Pressure Control (<140/90 mm Hg)	**51.40%**	53.97%	**57.65%**	12.15%	no	yes	60.53%	**60.69%**	5.27%	yes	yes	63.72%				
Annual Monitoring for Patients on Persistent Medications	**84.98%**	89.23%	**89.70%**	5.55%	yes	yes	94.19%	**89.20%**	-0.550%	yes	yes	93.66%	88.61%	-0.66%	≥50th	Yes
Well-Child Visits in the First 7 Months of Life	**67.49%**	70.86%	**72.22%**	NA	NA	yes	75.83%	**70.83%**	-1.92%	NA	no					
Preterm Delivery	**11.16%**	10.60%	**11.31%**	-1.36%	NA	no	10.74%	**10.74%**	5.02%	NA	yes					
Follow-up after Hospitalization for Mental Illness (7-day)	**58.77%**	55.83%	**51.09%**	-13.05%	yes	yes	53.64%	**54.31%**	6.30%	yes	yes					
Flu Vaccinations for Adults Ages 18-64	**52.93%**	55.58%	**48.93%**	-7.55%	yes	yes	51.38%	**45.36%**	-7.29%	yes	yes					
Advising Smokers and Tobacco Users to Quit	**77.72%**	81.61%	**73.84%**	-4.99%	no	no	77.53%	**83.44%**	13.00%	yes	yes					
Decreased Number of NF Claims Denied by MCOs			**9.97%**			yes										
Percent of clean claims paid or denied in 20 days							99.25%	**99.30%**	NA	NA	yes	99.25%	**98.71%**	NA	NA	No
Percent of all claims paid or denied in 40 days							98.88%	**99.79%**	NA	NA	yes	98.75%	**99.85%**	NA	NA	Yes
Average turnaround times on HCBS claims							5.3	**6.53**	NA	NA	no					
Average turnaround times on NF claims							5.64	**5.15**	NA	NA	yes					
Annual Dental Visit								**60.15%**	NA	yes	NA	63.16%	62.12%	3.27%	≥66.67th	Yes
Ambulatory Care - ED visits								**67.31%**	NA	yes*	NA	63.94%	55.67	17.29%	≤50th	Yes
Timeliness of Prenatal Care								**65.35%**	NA	no	NA	65.36%	67.13%	2.73%	<10th	yes
Meningococcal Vaccine - age 13								**62.04%**	NA	no	NA	65.14%	66.44%	7.09%	<25th	Yes
Tdap vaccine - age 13								**82.41%**	NA	no	NA	86.53%	80.09%	-2.81%	<25th	No
HPV vaccine - age 13								**13.66%**	NA	no	NA	14.34%	15.23%	11.50%	n/a	Yes
DTaP vaccine - age 2								**75.69%**	NA	no	NA	79.47%	74.01%	-2.22%	<33.33rd	No
IPV vaccine - age 2								**84.49%**	NA	no	NA	88.71%	84.69%	0.23%	<25th	No
MMR vaccine - age 2								**89.35%**	NA	no	NA	93.82%	87.47%	-2.10%	<33.33rd	No
HiB vaccine - age 2								**85.88%**	NA	no	NA	90.17%	83.99%	-2.20%	<25th	No
Hepatitis A vaccine - age 2								**88.89%**	NA	yes	NA	93.33%	84.92%	-4.47%	<50th	No
Hepatitis B vaccine - age 2								**94.21%**	NA	yes	NA	95.00%	90.72%	-3.71%	≥50th	Yes
VZV (chicken pox) vaccine - age 2								**86.57%**	NA	no	NA	90.90%	85.61%	-1.11%	<25th	No
Pneumococcal conjugate vaccine - age 2								**71.53%**	NA	no	NA	75.11%	72.16%	0.88%	<25th	No
Rotavirus vaccine - age 2								**71.06%**	NA	yes	NA	74.61%	69.37%	-2.38%	<50th	No
Influenza vaccine - age 2								**36.57%**	NA	no	NA	38.40%	35.50%	-2.94%	<33.33rd	No
PD-I/DD/SMI populations																
Breast Cancer Screening	**32.36%**	33.98%	**49.29%**	52.32%	NA	yes	51.75%	**50.46%**	2.37%	NA	no					
Cervical Cancer Screening	**47.12%**	49.48%	**51.26%**	8.78%	NA	yes	53.82%	**53.10%**	3.58%	NA	no					
Adult's Access to Preventive/Ambulatory Health Services	**90.46%**		**91.60%**	1.26%	NA	no	95.00%	**94.32%**	-0.21%	NA	no					
CDC - Hemoglobin A1c (HbA1c) Testing	**86.25%**	90.56%	**86.17%**	-0.09%	NA	no	90.48%	**86.79%**	0.72%	NA	no					
CDC - Eye Exam (retinal) performed	**54.38%**	57.10%	**57.45%**	5.65%	NA	yes	60.32%	**58.02%**	1.00%	NA	no					
CDC - Medical Attention for Nephropathy	**80.63%**	84.66%	**77.66%**	-3.68%	NA	no	81.54%	**91.51%**	17.83%	NA	yes					
CDC - HbA1c Control (< 8.0%)	**36.88%**	38.72%	**46.81%**	26.94%	NA	yes	49.15%	**47.17%**	0.77%	NA	no					
CDC - Blood Pressure Control (<140/90 mm Hg)	**58.75%**	61.69%	**62.23%**	5.93%	NA	yes	65.34%	**60.38%**	-2.38%	NA	no					
HCBS population																
Adult's Access to Preventive/Ambulatory Health Services	**90.46%**	94.98%	**94.51%**	-0.30%	NA	no	95.00%	**93.40%**	1.96%	NA	no					
Ambulatory Care - ED Visits	**80.38%**	76.36%	**84.37%**	4.96%	NA	no	80.15%	**82.32%**	-2.43%	NA	no					
Annual Dental Visit	**49.91%**	52.41%	**50.13%**	0.43%	NA	no	52.64%	**52.20%**	4.13%	NA	no					
State Data Sources																
Percent of SUD members whose employment status increased.	**26.82%**	28.16%	**34.47%**	28.53%	NA	yes	**35.34%**	**41.08%**	19.18%	NA	yes	43.1%	**36.9%**	-10.1%	NA	No
Percent of SPMI members whose employment status increased.	**15.10%**	15.86%	**15.94%**	5.56%	NA	yes	16.74%	**16.35%**	2.57%	NA	no	17.17%	**16.24%**	-0.65%	Deemed met	Yes
Percent of SPMI members with increased access to services.	**5.89%**	6.18%	**5.52%**	-6.28%	NA	no	5.796%	**5.25%**	-4.9%	NA	no					
Percent of SED youth members with increased access to services.	**5.46%**	5.73%	**5.19%**	-4.95%	NA	no	5.45%	**5.20%**	0.2%	NA	no					
Utilization of Inpatient Psychiatric Services	**0.34%**	0.32%	**0.33%**	-4.60%	NA	no	0.309%	**0.295%**	10.29%	NA	yes					
Increased Competitive Employment for PD and TBI Members Eligible for WORK Program; Target is change from Apr to Dec	**31^**	33	**38^**	22.58%	NA	yes	35	**33**	-2	NA	no					
Decreased Number of NF Residents Having Falls With Major Injury	**0.53%**	0.50%	**0.52%**	-1.89%	NA	no	0.49%	**0.63%**	21.2%	NA	no					
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	**11.91%**	11.31%	**12.27%**	3.02%	NA	no	11.657%	**11.51%**	6.6%	NA	yes					
Number of Person-Centered Care Homes (PEAK)	**8**	9	**9**	1	NA	**yes**										
% covered services accurately submitted via encounter within 30 days of claim paid date									**2Q met**	NA	0.5			3 Qs met		0.75
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO									0 Q's met	NA	0			2 Qs met		0.5

* goal is to be below the 50th percentile

Sunflower

Measure	2013	2014 target	2014	Rel change	>50th QC	met/not met	2015 target	2015	Rel change	>50th QC	met/not met	2016 target	2016	Rel change	>50th QC	met/not met
CDC - Hemoglobin A1c (HbA1c) Testing	83.42%	87.59%	84.48%	1.27%	no	no	88.70%	85.62%	1.35%	no	no	89.90%	87.44%	2.13%	≥50th	yes
CDC - Eye Exam (retinal) Performed	48.59%	51.02%	61.42%	26.40%	yes	yes	64.49%	67.92%	10.59%	yes	yes	71.32%	70.70%	4.09%	≥95th	yes
CDC - Medical Attention for Nephropathy	76.45%	80.27%	77.83%	1.80%	no	no	81.72%	92.48%	18.82%	yes	yes	95.00%	87.91%	-4.94%	<25th	no
CDC - HbA1c Control (< 8.0%)	40.96%	43.01%	40.13%	-2.03%	no	no	42.14%	45.58%	13.56%	no	yes	47.86%	53.26%	16.85%	≥66.67th	yes
CDC - Blood Pressure Control (<140/90 mm Hg)	53.23%	55.89%	53.88%	1.22%	no	no	56.57%	56.86%	5.35%	no	yes					
Annual Monitoring for Patients on Persistent Medications	84.18%	88.39%	89.88%	6.77%	yes	yes	94.37%	90.33%	0.50%	yes	yes	94.85%	89.97%	-0.40%	≥75th	yes
Well-Child Visits in the First 7 Months of Life	67.54%	70.92%	68.49%	1.40%	NA	no	71.91%	68.50%	-1.92%	NA	no					
Preterm Delivery	11.51%	10.60%	11.36%	1.31%	NA	no	10.79%	9.76%	14.03%	NA	yes					
Follow-up after Hospitalization for Mental Illness (7-day)	65.13%	61.87%	59.54%	-8.58%	yes	yes	62.52%	67.20%	12.87%	yes	yes					
Flu Vaccinations for Adults Ages 18-64	46.58%	48.91%	46.77%	0.40%	yes	yes	49.11%	44.42%	-5.03%	yes	yes					
Advising Smokers and Tobacco Users to Quit	79.59%	83.57%	78.70%	-1.12%	yes	yes	82.64%	77.44%	-1.60%	yes	yes					
Decreased Number of NF Claims Denied by MCOs			9.51%			yes										
Percent of clean claims paid or denied in 20 days								99.4	NA	NA	yes	99.25	99.27%			yes
Percent of all claims paid or denied in 40 days								99.88	NA	NA	yes	98.75	99.94%			yes
Average turnaround times on HCBS claims							5.61	5.68	NA	NA	no					
Average turnaround times on NF claims							6.76	6.59	NA	NA	yes					
Annual Dental Visit								61.21%	NA	yes	NA	64.27%	63.49%	3.74%	≥75th	yes
Ambulatory Care - ED visits								66.62%	NA	yes*	NA	63.29%	61.63	7.48%	≤50th	yes
Timeliness of Prenatal Care								71.84%	NA	no	NA	71.85%	70.29%	-2.15%	<10th	no
Meningococcal Vaccine - age 13								64.90%	NA	no	NA	68.15%	67.10%	3.38%	<25th	no
Tdap vaccine - age 13								81.74%	NA	no	NA	85.83%	80.49%	-1.53%	<25th	no
HPV vaccine - age 13								18.81%	NA	no	NA	19.75%	21.74%	15.58%		yes
DTaP vaccine - age 2								88.33%	NA	yes	NA	92.75%	77.40%	-12.37%	<50th	no
IPV vaccine - age 2								93.33%	NA	yes	NA	95.00%	89.90%	-3.67%	<50th	no
MMR vaccine - age 2								88.57%	NA	no	NA	93.00%	88.94%	0.42%	<50th	no
HiB vaccine - age 2								89.76%	NA	yes	NA	94.25%	87.98%	-1.98%	<50th	no
Hepatitis A vaccine - age 2								87.86%	NA	yes	NA	92.25%	87.74%	-0.13%	≥66.67th	yes
Hepatitis B vaccine - age 2								93.81%	NA	yes	NA	95.00%	91.35%	-2.63%	≥50th	yes
VZV (chicken pox) vaccine - age 2								88.57%	NA	no	NA	93.00%	87.98%	-0.67%	<33.33rd	no
Pneumococcal conjugate vaccine - age 2								78.81%	NA	yes	NA	82.75%	79.57%	0.96%	≥50th	yes
Rotavirus vaccine - age 2								79.76%	NA	yes	NA	83.75%	72.12%	-9.59%	≥50th	yes
Influenza vaccine - age 2								47.86%	NA	yes	NA	50.25%	40.38%	-15.61%	<50th	no
PD-I/DD/SMI populations																
Breast Cancer Screening	31.30%	32.87%	46.00%	47.00%	NA	yes	48.30%	49.68%		NA	yes					
Cervical Cancer Screening	50.87%	53.41%	48.17%	-5.32%	NA	no	50.58%	50.68%		NA	yes					
Adult's Access to Preventive/Ambulatory Health Services	96.18%	95.00%	95.04%	-1.19%	NA	yes	95.00%	94.87%		NA	no					
CDC - Hemoglobin A1c (HbA1c) Testing	86.54%	90.87%	88.37%	2.11%	NA	no	92.79%	88.37%		NA	no					
CDC - Eye Exam (retinal) performed	56.73%	59.57%	64.53%	13.75%	NA	yes	67.76%	64.53%		NA	no					
CDC - Medical Attention for Nephropathy	80.77%	84.81%	76.74%	-4.98%	NA	no	80.58%	76.74%		NA	no					
CDC - HbA1c Control (< 8.0%)	35.58%	37.36%	45.94%	29.10%	NA	yes	48.24%	45.93%		NA	no					
CDC - Blood Pressure Control (<140/90 mm Hg)	56.73%	59.57%	56.98%	0.43%	NA	no	59.83%	56.98%		NA	no					
HCBS population																
Adult's Access to Preventive/Ambulatory Health Services	93.33%	95.00%	94.40%	1.15%	NA	no?	95.00%	93.97%		NA	no					
Ambulatory Care - ED Visits	78.91%	74.96%	74.98%	-4.97%	NA	no	71.23%	77.33%		NA	no					
Annual Dental Visit	48.85%	51.29%	49.40%	1.14%	NA	no	51.87%	51.65%		NA	no					
State Data Sources																
Percent of SUD members whose employment status increased.	30.64%	32.17%	37.27%	21.64%	NA	yes	39.13%	41.99%	12.68%	NA	yes	44.1	40	Deemed partially met		0.5
Percent of SPMI members whose employment status increased.	16.91%	17.76%	15.49%	-8.40%	NA	no	16.26%	16.11%	4.00%	NA	no	16.91	15.05	Deemed met		Yes
Percent of SPMI members with increased access to services.	6.00%	6.30%	5.57%	-7.17%	NA	no	5.85%	5.34%	-4.9%	NA	no					No
Percent of SED youth members with increased access to services.	5.39%	5.66%	5.29%	-1.86%	NA	no	5.55%	5.28%	-0.2%	NA	no					
Utilization of Inpatient Psychiatric Services	0.29%	0.28%	0.30%	2.74%	NA	no	0.290%	0.269%	11.65%	NA	yes					
Increased Competitive Employment for PD and TBI Members Eligible for WORK Program; Target is change from Apr to Dec	41^	43	44^	7.32%	NA	yes	43	41	0.953488372	NA	no					
Decreased Number of NF Residents Having Falls With Major Injury	0.62%	0.59%	0.56%	-9.68%	NA	yes	0.53%	0.55%	1.8%	NA	no					
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	11.94%	11.34%	12.40%	3.85%	NA	no	11.780%	12.50%	0.8%	NA	no					
Number of Person-Centered Care Homes (PEAK)	8	9	9	1	NA	yes										
% covered services accurately submitted via encounter within 30 days of claim paid date									3 Qs met	NA	0.75			1 Q met		0.25
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO									4 Qs met	NA	Yes			3 Qs met		0.75

* goal is to be below the 50th percentile

UnitedHealthcare

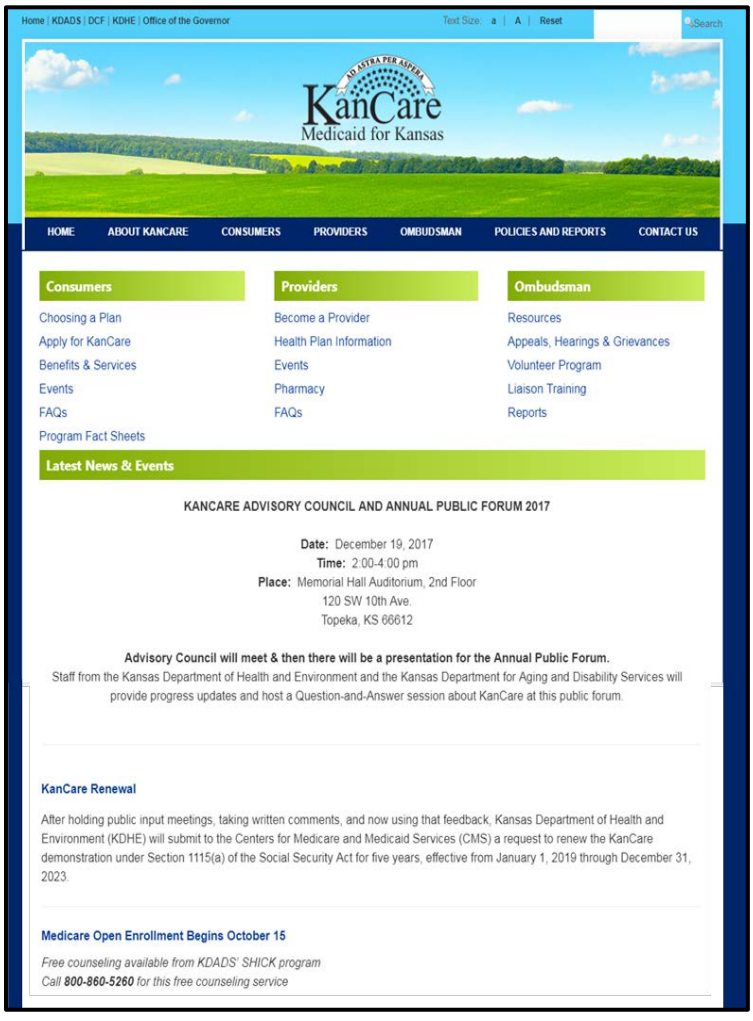
Measure	2013	2014 target	2014	Rel change	>50th QC	met/not met	2015 target	2015	Rel change	>50th QC	met/not met	2016 target	2016	Rel change	>50th QC	met/not met
CDC - Hemoglobin A1c (HbA1c) Testing	**80.17%**	84.18%	**84.57%**	5.49%	no	yes	88.80%	**84.86%**	0.34%	no	no	89.10%	80.97%	-4.58%	<25th	no
CDC - Eye Exam (retinal) Performed	**56.12%**	58.93%	**67.00%**	19.39%	yes	yes	70.35%	**66.29%**	-1.07%	yes	yes	69.60%	68.33%	3.09%	≥90th	yes
CDC - Medical Attention for Nephropathy	**75.29%**	79.05%	**74.57%**	-0.95%	no	no	78.30%	**88.57%**	18.77%	no	yes	93.00%	87.22%	-1.52%	<25th	no
CDC - HbA1c Control (< 8.0%)	**36.70%**	38.54%	**26.29%**	-28.38%	no	no	27.60%	**43.00%**	63.59%	no	yes	45.15%	43.61%	1.42%	<33.33rd	no
CDC - Blood Pressure Control (<140/90 mm Hg)	**56.24%**	59.05%	**37.86%**	-32.69%	no	no	39.75%	**59.43%**	56.98%	no	yes					
Annual Monitoring for Patients on Persistent Medications	**85.78%**	90.07%	**89.59%**	4.44%	yes	yes	94.07%	**91.13%**	1.71%	yes	yes	95.00%	89.98%	-1.26%	≥75th	yes
Well-Child Visits in the First 7 Months of Life	**65.34%**	68.61%	**79.29%**	NA	NA	yes	83.25%	**65.68%**	-17.16%	NA	no					
Preterm Delivery	**10.33%**	9.81%	**9.53%**	7.76%	NA	yes	9.05%	**10.50%**	-15.77%	NA	no					
Follow-up after Hospitalization for Mental Illness (7-day)	**58.27%**	55.36%	**57.82%**	-0.78%	yes	yes	60.71%	**67.73%**	17.14%	yes	yes					
Flu Vaccinations for Adults Ages 18-64	**42.33%**	44.45%	**42.36%**	0.07%	yes	yes	44.48%	**39.80%**	-6.05%	yes	yes					
Advising Smokers and Tobacco Users to Quit	**69.76%**	73.25%	**76.62%**	9.83%	no	yes	80.45%	**77.13%**	0.67%	yes	yes					
Decreased Number of NF Claims Denied by MCOs			**8.93%**			yes										
Percent of clean claims paid or denied in 20 days							99.25%	**99.68**	NA	NA	yes	99.25%	**99.71%**	NA		yes
Percent of all claims paid or denied in 40 days							98.88%	**99.97**	NA	NA	yes	98.75%	**99.99%**	NA		yes
Average turnaround times on HCBS claims							11.36	**9.26**	NA	NA	yes					
Average turnaround times on NF claims							10.15	**8.59**	NA	NA	yes					
Annual Dental Visit								**61.34%**	NA	yes	NA	64.41%	65.72	7.14	≥75th	yes
Ambulatory Care - ED visits								**64.83%**	NA	yes*	NA	68.07%	61.31	5.42%	≤50th	yes
Timeliness of Prenatal Care								**64.72%**	NA	no	NA	64.73%	67.88%	4.89%	<10th	yes
Meningococcal Vaccine - age 13								**62.76%**	NA	no	NA	65.90%	70.80%	12.82%	<25th	yes
Tdap vaccine - age 13								**82.91%**	NA	no	NA	87.06%	84.67%	2.13%	<33.33rd	no
HPV vaccine - age 13								**22.63%**	NA	yes	NA	23.76%	19.37%	-14.39%		no
DTaP vaccine - age 2								**76.40%**	NA	no	NA	80.22%	74.21%	-2.87%	<33.33rd	no
IPV vaccine - age 2								**89.54%**	NA	no	NA	94.02%	90.51%	1.09%	≥50th	yes
MMR vaccine - age 2								**89.29%**	NA	no	NA	93.75%	89.54%	0.27%	<50th	no
HiB vaccine - age 2								**86.86%**	NA	no	NA	91.20%	86.37%	-0.56%	<33.33rd	no
Hepatitis A vaccine - age 2								**87.59%**	NA	yes	NA	91.97%	88.08%	0.56%	≥66.67th	yes
Hepatitis B vaccine - age 2								**91.48%**	NA	yes	NA	95.00%	93.19%	1.86%	≥75th	yes
VZV (chicken pox) vaccine - age 2								**89.54%**	NA	no	NA	94.02%	89.78%	0.27%	<50th	no
Pneumococcal conjugate vaccine - age 2								**76.89%**	NA	no	NA	80.73%	79.08%	2.85%	≥50th	yes
Rotavirus vaccine - age 2								**68.13%**	NA	no	NA	71.54%	72.26%	6.07%	≥50th	yes
Influenza vaccine - age 2								**43.31%**	NA	no	NA	45.48%	38.44%	-11.24%	<33.33rd	no
PD-I/DD/SMI populations																
Breast Cancer Screening	**29.16%**	30.62%	**45.63%**	56.48%	NA	yes	47.91%	**51.86%**	13.64%	NA	yes					
Cervical Cancer Screening	**42.49%**	44.61%	**46.94%**	10.47%	NA	yes	49.29%	**52.88%**	12.66%	NA	yes					
Adult's Access to Preventive/Ambulatory Health Services	**95.92%**	95.00%	**96.15%**	0.24%	NA	yes	95.00%	**95.60%**	-57.00%	NA	yes					
CDC - Hemoglobin A1c (HbA1c) Testing	**83.22%**	87.38%	**85.48%**	2.72%	NA	no	89.75%	**88.31%**	3.31%	NA	no					
CDC - Eye Exam (retinal) performed	**60.71%**	63.75%	**67.74%**	11.59%	NA	yes	71.13%	**71.75%**	5.92%	NA	yes					
CDC - Medical Attention for Nephropathy	**76.16%**	79.97%	**72.18%**	-5.23%	NA	no	75.79%	**89.29%**	23.70%	NA	yes					
CDC - HbA1c Control (< 8.0%)	**39.07%**	41.02%	**25.81%**	-33.95%	NA	no	27.10%	**46.75%**	81.17%	NA	yes					
CDC - Blood Pressure Control (<140/90 mm Hg)	**56.51%**	59.34%	**38.31%**	-32.22%	NA	no	40.23%	**61.36%**	60.19%	NA	yes					
HCBS population																
Adult's Access to Preventive/Ambulatory Health Services	**92.10%**	95.00%	**93.21%**	1.21%	NA	no	95.00%	**94.72%**	1.61%	NA	no					
Ambulatory Care - ED Visits	**72.36%**	68.74%	**73.59%**	1.70%*	NA	no	69.91%	**78.91%**	7.23%	NA	no					
Annual Dental Visit	**49.27%**	51.73%	**46.41%**	-5.81%	NA	no	48.73%	**50.40%**	8.61%	NA	yes					
State Data Sources																
Percent of SUD members whose employment status increased.	**35.20%**	36.96%	**32.98%**	-6.31%	NA	no	34.63%	**42.50%**	28.87%	NA	yes	36.4%	**36.9%**	Deemed partially met		0.5
Percent of SPMI members whose employment status increased.	**14.61%**	15.34%	**15.47%**	5.89%	NA	yes	16.24%	**16.44%**	6.27%	NA	yes	17.27%	**16.35%**	Deemed met		yes
Percent of SPMI members with increased access to services.	**5.91%**	6.21%	**5.63%**	-4.66%	NA	no	5.92%	**5.60%**	-4.9%	NA	no					no
Percent of SED youth members with increased access to services.	**5.28%**	5.54%	**5.02%**	-4.92%	NA	no	5.27%	**5.13%**	2.2%	NA	no					
Utilization of Inpatient Psychiatric Services	**0.36%**	0.34%	**0.31%**	-12.36%	NA	yes	0.296%	**0.298%**	4.56%	NA	no					
Increased Competitive Employment for PD and TBI Members Eligible for WORK Program; Target is change from Apr to Dec	**64^**	67	**68^**	6.25%	NA	yes	14	**14**	1	NA	yes					
Decreased Number of NF Residents Having Falls With Major Injury	**0.49%**	0.47%	**0.51%**	4.08%	NA	no	0.48%	**0.50%**	2.0%	NA	no					
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	**12.11%**	11.50%	**13.40%**	10.65%	NA	no	12.730%	**12.11%**	9.6%	NA	yes					
Number of Person-Centered Care Homes (PEAK)	**8**	9	**9**	1	NA	yes										
% covered services accurately submitted via encounter within 30 days of claim paid date									yes	1 Q met	**0.25**			4 Qs met		Yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO										4 Qs met	**Yes**			4 Qs met		Yes

* goal is to be below the 50th percentile

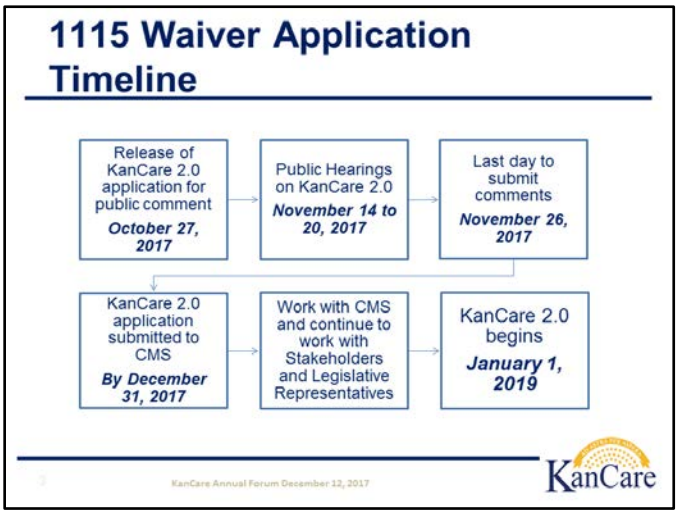
Summary of KanCare Annual Post Award Forum Held 12.19.17

The KanCare Special Terms and Conditions, at item #15, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. … The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC77, associated with the quarter in which the forum was held. The state must also include the summary of its annual report as required in STC78."

Consistent with this provision, Kansas held its 2017 KanCare Public Forum, providing updates and opportunity for input, on Tuesday, December 19, 2016, from 3:00-4:00 pm at the Memorial Hall Auditorium, 2nd Floor, 120 SW 10th Avenue, Topeka, Kansas. The forum was published as a "Latest News and Events" on the face page banner of the www.KanCare.ks.gov website, starting on November 6, 2017. A screen shot of the notice linked from the KanCare website face page banner is as follows:



At the public forum, approximately 20 KanCare program stakeholders (providers, members, and families) attended, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; and staff from the KanCare managed care organizations. A summary of the information presented by state staff is included in the following PowerPoint documents:



KanCare Utilization

- Members have used their Primary Care Physician 19% more with KanCare.
- Members are more likely to attend their appointments; Transportation up 58%.
- Costly inpatient hospital stays have been reduced by 30%.
- Emergency Room use down by 6%.

KanCare Utilization
KanCare vs. Pre-KanCare (2012)

Type of Service	% Utilization Difference
Primary Care Physician	19%
Transporation	58%
Outpatient Non-ER	9%
Inpatient	-30%
Outpatient ER	-6%
Dental	30%
Pharmacy	2%
Vision	17%

As of October 2017

KanCare HCBS Waiver Utilization

- Waiver members have used their Primary Care Physician 19% more with KanCare.
- Members are more likely to attend their appointments; Non-Emergency transportation use up 52%.
- Costly inpatient hospital stays have been reduced by 16%.
- Emergency Room use up by 1%

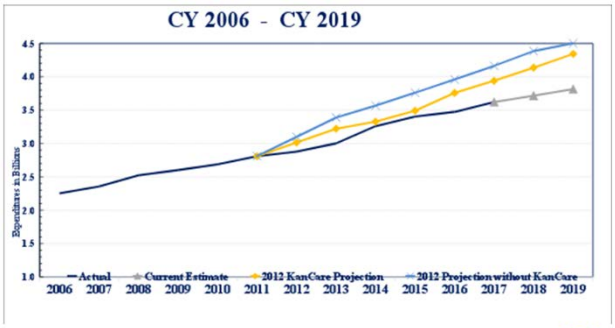
KanCare Utilization In Waiver Population
KanCare vs. Pre-KanCare (2012)

Type of Service	% Utilization Difference
Primary Care Physician	19%
Transporation NEMT	52%
Outpatient Non-ER	6%
Inpatient	-16%
Outpatient ER	1%
Dental	23%
Pharmacy	12%
Vision	27%
HCBS Services	31%

SED, DD, PD, FE, Autism, TA, and TBI

As of October 2017

KanCare Cost Comparison

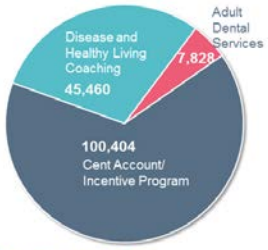


KanCare New Services

at no cost to the State

Top 3 Services by Expenditure

Top 3 Services Accessed by Members



Since the beginning of KanCare, members have been provided more than $18 million dollars in total value of services they did not have access to under old Medicaid at no cost to the state.

KanCare
Calender Year 2017 YTD

CHIP Reauthorization

Current Funds Expire in March 2018

CHIP Reauthorization legislation currently discussed in House and Senate bills

Kansas Medicaid has developed contingency plans if CHIP is reauthorized or if it is not. This plan includes:

- New eligibility category to align with CHIP eligibility
- System changes to support new eligibility determination
- Notification plan for individuals enrolled in CHIP
- Transition from CHIP to Medicaid

KanCare

CHIP Reauthorization

Additional State Expenditures from CHIP not being reauthorized:

SFY 2018 Forecasted budget impact:

SGF: $37,719,937

SFY 2019 Forecasted budget impact:

SGF: $53,355,911

KanCare

Opioid Strategy

5 Key Domains:

1. Opioid Supply Policy
Reduce number of opioids prescribed and in medicine cabinets in Kansas.

2. Opioid Demand Policy
Introduce alternative pain strategies and develop step-down protocols to reduce the number of people needing intensive opioid-based pain management regimens.

3. Opioid Treatment Policy
Expand access to proven treatments for opioid use disorder and dependence.

Opioid Strategy

5 Key Domains:

4. Opioid Prevention Policy
Implement programs to educate on dangers of opioids and on preventive measures to reduce the number of conditions that require intensive pain management.

5. Opioid Enforcement Policy
Work with law enforcement and the Attorney General's office to identify and prosecute illegal sales and trafficking of synthetic and diversion opioids.

Current KanCare Opioid Activities

1. KanCare Prescribing Guidelines
Update KanCare Opioid prescribing guidelines to be reviewed by KDHE leadership and ultimately presented to the Drug Utilization Review (DUR) board in January 2018.
- Led by KDHE Leadership and DHCF,
- Supply-side policy to reduce opioid prescriptions.

2. Kansas Prescription Drug Prevention Workgroup
Grant funded workgroup targeting treatment and recovery activities, with the remainder going to prevention, early intervention and public education.
- Led by Bureau of Health Promotion, and KDADS,
- Treatment and prevention policy directive.

Current KanCare Opioid Activities

(Continued)

3. KanCare 2.0 – 1115 Waiver
Institutions for Mental Diseases (IMD) Exclusion as part of 1115 waiver

4. Other Meetings with key stakeholders
Attorney general (enforcement initiatives), University of Kansas Heart and Stroke Collaborative (PCORI opioid grant proposal), Board of Pharmacy (K-TRACS roadmap),

KanCare Corrective Action Plan (CAP) Update

- Kansas Medicaid Enterprise (KME) is on schedule to complete all tasks by December 2017 as required in the CAP
- KME has met with CMS bi-weekly throughout CY 2017 to obtain CMS support and approval for completing CAP tasks
- Where CMS identified deficiencies, KME is developing operating procedures to better guide staff monitoring tasks
- KME is finalizing system components for real-time reporting of long-term services and supports (LTSS) critical incidents
- KDADS is revising policies for its person-centered planning process to be more member-centric for members receiving home and community-based services (HCBS)

KanCare Corrective Action Plan (CAP) Update (Continued)

CAP Progress by Task Area	
Task Area	**% of Tasks Completed**
Administrative Authority	77%
Person-Centered Planning	82%
Provider Access and Network Adequacy	85%
Participant Protections	79%
Support for Beneficiaries	92%
Stakeholder Engagement Process Development	100%
Overall % of CAP Tasks Complete	**83%**

KanCare Advisory Council and Annual Public Forum

KDADS Update

December 19, 2017

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HCBS November Monthly Summary

HCBS Program	Description of Services	Number of People Eligible to Receive HCBS Services		Number of People on Wait List	Number of Proposed Recipients
		Without MFP	MFP		
Autism	This program provides services to children with Autism to receive early intensive intervention treatment and allow primary caregivers to receive needed support through services.	55			279 (as of 11/30/17)
SED (Serious Emotional Disturbance)	The Home and Community Based Services (HCBS) Serious Emotional Disturbance (SED) Waiver serves as an alternative to inpatient psychiatric treatment for children and youth with mental health disorders.	3,189			
TA (Technology Assisted)	This program serves individuals who are age 0 through 21 years, chronically ill or medically fragile and dependent upon a ventilator or medical device to compensate for the loss of vital bodily function and require substantial and ongoing daily care by a nurse or other qualified caregiver under the supervision of a nurse to avert death or	496			
FE (Frail Elderly)	This program provides an option for Kansas seniors who receive Medicaid and qualify functionally to receive community based services as an alternative to nursing facility care. Services include personal case, household tasks, and health services.	4,817	58		
TBI (Traumatic Brain Injury)	This program is for individuals who have sustained a traumatic brain injury and provides rehabilitative services and the needed assistance after injury to insure that individuals can stay in their homes and be as independent as possible in a safe, healthy environment. The HCBS/TBI program serves individuals 16 years of age and	449	4		
I/DD (Intellectual and Developmental Disabilities)	This program serves individuals age 5 and older who meet the definition of Intellectual disability or having a developmental disability or are eligible for care in an Intermediate Care Facility for people with Mental Retardation (ICF/MR).	8,965	28	3,630	
PD (Physical Disability)	This program serves individuals age 16 and older who meet the criteria for nursing facility placement due to their physical disability, who are determined disabled by social security standards, and who are Medicaid eligible.	5,922	103	1,467	

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2017 Waiver Renewals:

Autism Waiver Renewal:

- KDADS received CMS Approval for the Autism waiver on 6/14/17.
- 60 currently receive services; more children will get services due to transfer of some autism waiver services to the State Plan under the new waiver.

SED Waiver Renewal:

- KDADS received CMS approval for the SED waiver on 4/28/17.
- Currently the CMHC provides all eligibility determinations, plan of care development, and provision of services.
- KDADS is pursuing a contact with third-party assessors to perform side by side assessments to address conflict of interest issues.

3

Waiting List: Current Efforts

I/DD Waiting List

- 8,965 individuals on the HCBS I/DD Program as of 12/15/2017
- Current number of individuals on the Waiting List is 3,630
- 374 people have been offered services for CY 2017
- 200 I/DD Wait list offers were made in August

PD Waiting List

- 5,922 individuals on the HCBS PD Program
- Current number of individuals on the Waiting List is 1,467
- 1,162 people have been offered services for CY 2017
- 300 PD waitlist offers were made in September

The HCBS Monthly Summary is posted on the HCBS page at www.kdads.ks.gov

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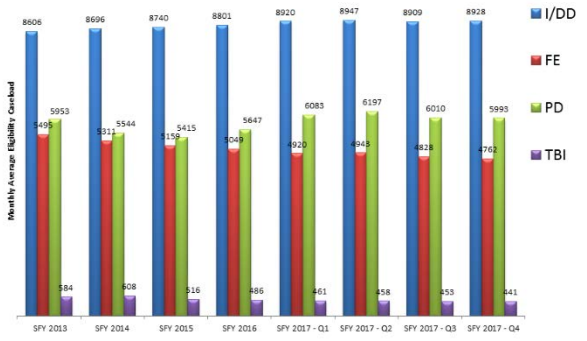
KanCare

Average Monthly Caseload for HCBS



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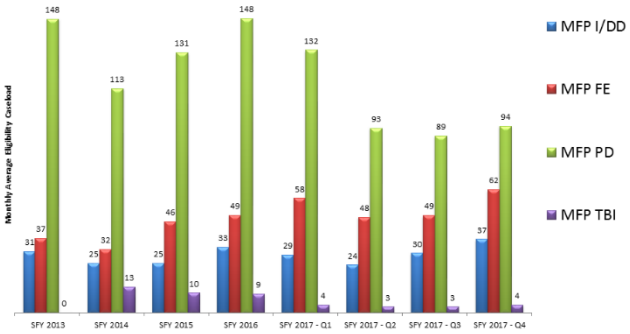
Average Monthly Caseload for HCBS MFP



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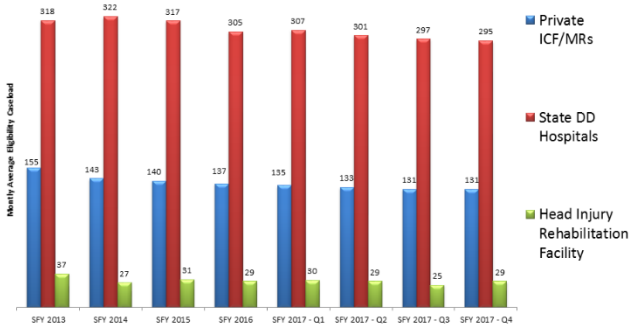
Average Monthly Caseload for State Institutions and Long-Term Care Facilities



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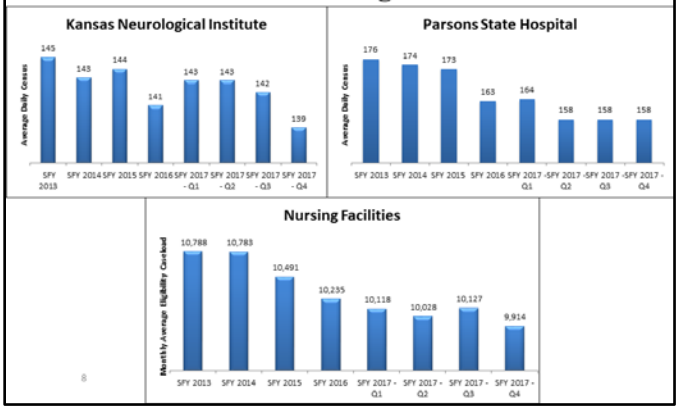
Average Census for State Institutions and Long-Term Care Facilities



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Behavioral Health Initiatives:

Kansas Systems of Care:

- KDADS received a four-year federal grant to create, expand, and sustain trauma-informed care, family-driven and youth-guided SOC approach for addressing the needs of children and youth with SEDs and their families. This will be accomplished through a partnership between KDADS, the Community Engagement Institute and four regional CMHCs.
- For more information, please see: www.kdads.ks.gov/SOC

NFMH Training:

- To address a lack of access to training on mental health for direct service workers, particularly in Nursing Facilities for Mental Health, KDADS has established a grant program to provide funding to support and expand mental health education within Medicaid and/or Medicare certified nursing homes in Kansas.

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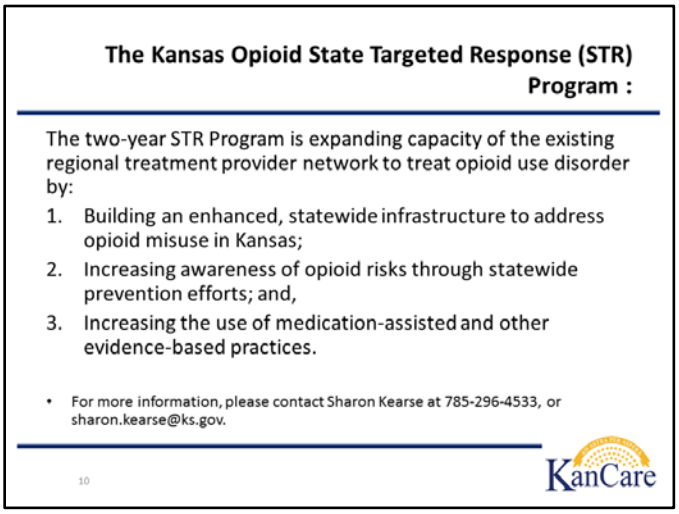
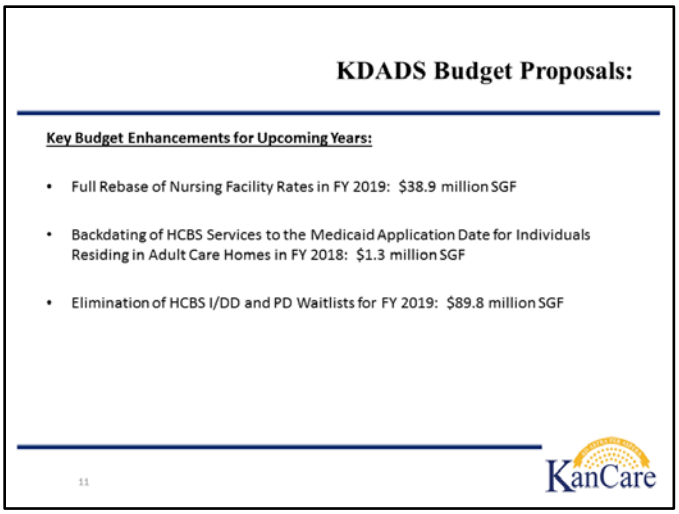
KanCare





After presentation of the update information from both KDHE and KDADS, participants were offered the opportunity to present questions or comments for discussion. Most of the comments and questions were related to the proposed 1115 waiver renewal, including how the proposed work requirement would affect KanCare eligibility. Several stakeholders expressed concern that the requirement would result in KanCare members losing coverage without jobs that provide health insurance. Three stakeholders expressed concern with state HCBS data, stating that it is not consistent with other sources. One commenter expressed a desire for more frequent meetings with stakeholders. One person stated that even if new money was available to significantly reduce HCBS waiting lists, there is not sufficient capacity in the community. He argued that the State needs a plan for developing this capacity. Finally, one person asked for strong permanent language in the proposed new KanCare managed care contracts related to participant self-directed services.

Kansas Foundation for Medical Care, Inc

2947 SW Wanamaker Drive
Topeka, Kansas 66614-4193
Phone 785-273-2552
kfmc.org

March 29, 2018

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: **2017 KanCare Evaluation Annual Report**
Year 5, January – December 2017

Dear Ms. Ross:

Enclosed is the 2017 KanCare Evaluation annual report for Year 5, January – December 2017. If you have questions regarding this information, please contact me, jpanichello@kfmc.org.

Sincerely,

Janice D. Panichello, Ph.D., MPA
Director of Quality Review and Epidemiologist

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE

Enclosures

2017 KanCare Evaluation Annual Report

Year 5, January - December 2017

KFMC Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**March 29, 2018**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review & Epidemiologist** **Lynne Valdivia, BSN, RN, MSW, CCEP, Vice President and Corporate Compliance Officer**

Prepared for:

KanCare

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Year 5, January – December 2017

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2017 KanCare Evaluation Annual Report

Year 5, January – December 2017

2017 KanCare Evaluation Annual Report
Year 5, January-December 2017
March 29, 2018

Background

KanCare is an integrated managed care Medicaid program that is to serve the State of Kansas through a coordinated approach. The goal of KanCare is to provide efficient and effective health care services and ensure coordination of care and integration of physical and behavioral health services with each other and with home and community-based services (HCBS).

In December 2012, the Centers for Medicare & Medicaid Services (CMS) approved the State of Kansas Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare operates concurrently with the State's section 1915(c) HCBS waivers and together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries across Kansas into a managed care delivery system. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

Goals

The KanCare demonstration will assist the State in its goals to:

- **Provide integration and coordination of care** across the whole spectrum of health to include physical health, behavioral health (mental health and substance use disorders) and long-term services and supports (LTSS);
- **Improve the quality of care** Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- **Control Medicaid costs** by emphasizing health, wellness, prevention, and early detection, as well as integration and coordination of care; and
- **Establish long-lasting reforms** that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms, as well.

Hypotheses

The evaluation will test the following KanCare hypotheses:

- By holding managed care organizations (MCOs) to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;

- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health (BH), and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

Performance Objectives

Through the extensive public input and stakeholder consultation process, when designing the comprehensive Medicaid reform plan, the State has identified a number of KanCare performance objectives and outcome goals to be reached through the comprehensive managed care contracts. These objectives include the following:

- Measurably improve healthcare outcomes for members in the areas including: diabetes, coronary artery disease, prenatal care, and BH;
- Improve coordination and integration of physical health care with BH care;
- Support members' desires to live successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

Evaluation Plan

Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is being completed by the Kansas Foundation for Medical Care, Inc. (KFMC), which will subcontract as needed for targeted review. KFMC is the External Quality Review Organization (EQRO) in Kansas. Evaluation criteria are outlined in the comprehensive KanCare Program Medicaid State Quality Strategy and the CMS Special Terms and Conditions document.

To achieve safe, effective, patient-centered, timely, and equitable care, the State is assessing the quality strategy on at least an annual basis and will revise the State Quality Strategy document accordingly. The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, the State Quality Strategy is regularly reviewed, and operational details will be continually evaluated, adjusted, and put into use. Revisions in the State Quality Strategy will be reviewed to determine the need for restructuring the specific measurements in the evaluation design and documented and discussed in the evaluation reports.

The KanCare Evaluation Design, approved by CMS in September 2013, updated in March 2015, includes over 100 performance measures focused on eight major categories with 27 subcategories (see Table 1):

- Quality of Care
- Coordination of Care (and Integration)
- Cost of Care
- Access to Care
- Ombudsman Program
- Efficiency
- Uncompensated Care Cost Pool (UCC)
- Delivery System Reform Incentive Program (DSRIP)

Table 1. Evaluation Design Categories and Subcategories
Quality of Care
(1) Physical Health
(2) Substance Use Disorder Services
(3) Mental Health Services
(4) Healthy Life Expectancy
(5) Home and Community Based Services (HCBS) Waiver Services
(6) Long Term Care: Nursing Facilities
(7) Member Surveys - Quality
(8) Provider Survey
(9) Grievances
(10) Other (Tentative) Studies (specific studies to be determined)
Coordination of Care (and Integration)
(11) Care Management for Members Receiving HCBS Services
(12) Other (Tentative) Study (specific study to be determined)
(13) Care Management for Members with Intellectual/Developmental Disability (I/DD)
(14) Member Survey - Consumer Assessment of Healthcare Providers and Systems (CAHPS)
(15) Member Survey - Mental Health (MH)
(16) Member Survey - Substance Use Disorder (SUD)
(17) Provider Survey
Cost of Care
(18) Costs
Access to Care
(19) Provider Network - GeoAccess
(20) Member Survey - CAHPS
(21) Member Survey - MH
(22) Member Survey - SUD
(23) Provider Survey
(24) Grievances
Ombudsman Program
(25) Calls and Assistance
Efficiency
(26) Systems
(27) Member Surveys
Uncompensated Care Pool
Delivery System Reform Incentive (DSRIP)

Performance measures are evaluated on either a quarterly basis or an annual basis. Due to revisions in reporting requirements, program updates, and changes in Healthcare Effectiveness Data and Information (HEDIS) measure specifications, a few measures were deleted, and several measures in the 2013 KanCare Evaluation Design were added or were slightly revised in 2015.

Data for the performance measures are provided by the Kansas Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) and the Kansas Department for Aging and Disability Services (KDADS). Data sources include State tracking systems and databases, as well as reports from the MCOs providing KanCare/Medicaid services. In calendar year (CY) 2013 through CY2018, the three MCOs are Amerigroup Kansas, Inc. (Amerigroup or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC).

Wherever appropriate, and where data are available, performance measures are analyzed by one or more of the following stratified populations:

- Program - Title XIX/Medicaid and Title XXI/CHIP (Children's Health Insurance Program)
- Age groups - particularly where stratified in HEDIS measures, waivers, and survey populations
- Waiver services
  - Intellectually/Developmentally Disabled (I/DD)
  - Physically Disabled (PD)
  - Traumatic Brain Injury (TBI)
  - Technical Assistance (TA)
  - Serious Emotional Disturbance (SED)
  - Frail Elderly (FE)
  - Money Follows the Person (MFP)
  - Autism
- Providers
- County type (Urban/Semi-Urban, Densely-Settled Rural, Rural/Frontier)
- Those receiving mental health (MH) services
  - Severe and Persistent Mental Illness (SPMI)
  - Serious Mental Illness (SMI)
  - SED (waiver and non-waiver)
- Those receiving treatment for Substance Use Disorder (SUD)
- Those receiving Nursing Facility (NF) services

Annual Evaluation 2017

In the first year of KanCare, baseline data and data criteria were established and defined. For some of the performance measures, baseline data were available pre-KanCare (CY2012 and CY2011). Where pre-KanCare data were not available, baseline data were based on CY2013 data or, for measures that require more than one year of data, CY2013/CY2014.

This fifth annual KanCare Evaluation includes analysis of performance for several measures that have pre-KanCare data, CY2013 through CY2016, and CY2017 available as of March 10, 2018. Data for CY2017 for many of the performance measures are not yet available. A major reason is that data for the entire year cannot be determined accurately until claims for the year, including fourth quarter CY2017 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for 2017 will not be available until July 2018. Some of the HEDIS measures are multi-year measures; for these measures, baseline data for 2013 and 2014 are first reported in the KanCare Annual Evaluation for 2015.

In addition to the measures reviewed annually, there are several measures reviewed quarterly that are briefly summarized in this report. These quarterly measures are analyzed and summarized in detail in

the KanCare Evaluation Quarterly Reports, beginning in Quarter 4 (Q4) CY2013, that are available for public review on the KanCare website, www.kancare.ks.gov.

Quality of Care

Goals, Related Objectives, and Hypotheses for Quality of Care subcategories:

- *Goal: Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes).*
- *Related Objectives: Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; behavioral health.*
  - *Improve coordination and integration of physical health care with behavioral health care.*
  - *Support members successfully in their communities.*
  - *Promote wellness and healthy lifestyles.*
- *Hypotheses:*
  - *By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.*
  - *The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(1) Physical Health

HEDIS Measures

HEDIS are developed, tracked, and reported by the National Committee for Quality Assurance (NCQA). Results for MCOs are compiled annually. The NCQA Quality Compass (QC) annually reports percentiles (ranging from 5th to 95th), that help states identify healthcare service area strengths and opportunities for improvement. HEDIS includes over 100 metrics. The *Physical Health* performance measures include 18 HEDIS measures.

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Adult BMI Assessment (ABA)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- Annual Dental Visit (ADV)
- Adolescent Well-Care Visits (AWC)
- Controlling High Blood Pressure (CBP)
- Comprehensive Diabetes Care (CDC)
- Chlamydia Screening in Women (CHL)
- Appropriate Testing for Children with Pharyngitis (CWP)
- Follow-Up after Hospitalization for Mental Illness (FUH)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
- Annual Monitoring for Patients on Persistent Medications (MPM)
- Medication Management for People with Asthma (MMA)
- Prenatal and Postpartum Care (PPC)
- Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Well-Child Visits in the First 15 Months of Life (W15)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)

The baseline data for most HEDIS and HEDIS-like measures in the KanCare Evaluation Design are HEDIS 2014 (CY2013) administrative and hybrid data from claims and medical record review. (The baselines for multi-year measures are HEDIS 2015, including data from CY2013 and CY2014.) Administrative HEDIS data include all KanCare members from each MCO who met HEDIS eligibility criteria for each measure. Since these measures include all eligible members, KFMC combined the numerators and denominators for the three MCOs to assess the aggregate annual percentages. Hybrid HEDIS data are based on samples of eligible members and include both administrative data and medical record review. As the hybrid HEDIS data are based on samples from each MCO, the aggregate data for hybrid measures were weighted to adjust for any differences in population and sample sizes.

HEDIS results, including comparison of the aggregated rates to QC national percentiles (where available), are summarized in Table 2. Beginning with HEDIS 2015, QC percentile categories were expanded to report the 33.33rd and 66.67th percentiles.

Pre-KanCare data available for some of the HEDIS measures below (CDC, W15, W34, AAP, and PPC) are based on HEDIS data for CY2012 from MCOs (Coventry and UniCare) that provided services to Kansas Medicaid members in 2012. The pre-KanCare and KanCare populations, however, are not directly comparable, as the KanCare populations include members receiving waiver services.

Table 2. Physical Health HEDIS Measures, CY2013 - CY2016

Measure	HEDIS Aggregated Results				Quality Compass ≥50th Percentile^			
	CY2013	CY2014	CY2015	CY2016	CY2013	CY2014	CY2015	CY2016
Adults' Access to Preventive/Ambulatory Health Services (AAP)								
Ages 20-44	85.4%	84.3%	83.7%	**82.6%**	↑	↑	↑	↑
Ages 45-64	92.2%	92.4%	92.3%	**91.3%**	↑	↑	↑	↑
Ages 65 and older	89.5%	88.6%	89.7%	**90.1%**	↑	↑	↑	↑
Total - Ages 20 and older	88.4%	87.5%	87.1%	**86.2%**	↑	↑	↑	↑
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*								
		72.2%	77.6%	**80.9%**		↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*								
	47.3%	51.5%	48.2%	**52.1%**	↓	↓	↓	↓
Comprehensive Diabetes Care (CDC)								
HbA1c Testing *(CMS Core Quality Measure)*	83.1%	84.8%	84.9%	**85.8%**	↓	↓	↓	↓
Eye Exam (Retinal)	50.1%	58.6%	62.5%	**64.4%**	↓	↑	↑	↑
Medical Attention for Nephropathy	75.8%	76.8%	89.2%	**87.2%**	↓	↓	↓	↓
HbA1c Control (<8.0%)	39.0%	39.3%	46.6%	**51.0%**	↓	↓	↓	↑
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	54.4%	52.9%	45.4%	**41.1%**	↓	↓	↓	↓
Blood Pressure Control (<140/90)	53.1%	52.6%	58.8%	**57.9%**	↓	↓	↓	↓
Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH) *(CMS Core Quality Measure)*								
	61.0%	56.2%	62.8%	**64.4%**	↑	↑	↑	↑
Annual Monitoring for Patients on Persistent Medications (MPM) *(CMS Core Quality Measure)*								
	84.9%	89.7%	90.2%	**89.5%**	↓	↑	↑	↑

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Table 2. Physical Health HEDIS Measures, CY2013 - CY2016 (Continued)

Measure	HEDIS Aggregated Results				Quality Compass ≥50th Percentile^			
	CY2013	CY2014	CY2015	CY2016	CY2013	CY2014	CY2015	CY2016
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents *(CMS Core Quality Measure)*								
Weight Assessment/BMI for Children and Adolescents (WCC)								
Ages 3-11	33.7%	44.3%	48.9%	**55.5%**	↓	↓	↓	↓
Ages 12-17	36.6%	47.3%	48.1%	**56.9%**	↓	↓	↓	↓
Total – Ages 3-17	34.7%	45.3%	48.6%	**56.0%**	↓	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)								
Ages 3-11	47.4%	50.8%	50.6%	**55.4%**	↓	↓	↓	↓
Ages 12-17	46.0%	47.0%	45.7%	**53.1%**	↓	↓	↓	↓
Total – Ages 3-17	46.9%	49.5%	49.1%	**54.7%**	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)								
Ages 3-11	39.6%	43.5%	43.3%	**47.9%**	↓	↓	↓	↓
Ages 12-17	53.1%	50.6%	48.3%	**58.6%**	↓	↓	↓	↓
Total – Ages 3-17	44.0%	45.8%	44.9%	**51.5%**	↓	↓	↓	↓
Annual Dental Visit (ADV)								
Ages 2-3	40.8%	41.2%	42.8%	**45.8%**	↑	↑	↑	↑
Ages 4-6	66.3%	65.7%	66.2%	**69.2%**	↑	↑	↑	↑
Ages 7-10	70.7%	70.1%	70.4%	**72.7%**	↑	↑	↑	↑
Ages 11-14	62.8%	62.8%	63.2%	**66.4%**	↑	↑	↑	↑
Ages 15-18	53.9%	53.5%	54.1%	**57.2%**	↑	↑	↑	↑
Ages 19-21	31.5%	30.2%	34.7%	**33.1%**	↓	↓	↑	↓
Total - Ages 2-21	60.3%	60.0%	60.9%	**63.7%**	↑	↑	↑	↑
Appropriate Testing for Children with Pharyngitis (CWP)								
	51.6%	52.2%	55.1%	**61.2%**	↓	↓	↓	↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)								
	71.9%	73.5%	76.3%	**79.2%**	↓	↓	↓	↓
Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure in 2013-2017)*								
5-11 years of age		27.4%	29.1%	**31.7%**		↑	↑	↑
12-18 years of age		24.1%	26.6%	**31.9%**		↑	↑	↑
19-50 years of age		39.6%	38.3%	**41.4%**		↑	↑	↑
51-64 years of age		53.0%	55.1%	**60.1%**		↑	↑	↑
Total - Ages 5-64		28.1%	29.9%	**33.7%**		↓	↓	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD) *(CMS Core Quality Measure)*								
Initiation Phase		48.0%	50.7%	**52.2%**		↑	↑	↑
Continuation & Maintenance Phase		54.8%	61.2%	**61.4%**		↑	↑	↑
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*								
Ages 16-20	42.4%	41.0%	41.3%	**41.0%**	↓	↓	↓	↓
Ages 21-24	55.6%	54.5%	53.5%	**52.8%**	↓	↓	↓	↓
Total – Ages 16-24	46.1%	45.4%	45.8%	**45.3%**	↓	↓	↓	↓
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*								
Prenatal Care	71.4%	70.4%	67.4%	**68.4%**	↓	↓	↓	↓
Postpartum Care	60.3%	55.8%	57.5%	**58.0%**	↓	↓	↓	↓

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Table 2. Physical Health HEDIS Measures, CY2013 - CY2016 (Continued)								
Measure	HEDIS Aggregated Results				Quality Compass ≥50th Percentile^			
	CY2013	CY2014	CY2015	CY2016	CY2013	CY2014	CY2015	CY2016
Initiation in Treatment for Alcohol or other Drug Dependence (IET) *(CMS Core Quality Measure)*								
Ages 13-17	49.0%	50.8%	46.4%	**50.2%**	↑	↑	↑	↑
Ages 18 and older	40.9%	41.3%	37.7%	**40.1%**	↑	↑	↓	↓
Total – Ages 13 and older	42.1%	42.6%	38.9%	**41.4%**	↑	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence (IET) *(CMC Core Quality Measure)*								
Ages 13-17	32.5%	31.0%	26.8%	**27.5%**	↑	↑	↑	↑
Ages 18 and older	12.2%	12.1%	10.7%	**12.4%**	↑	↑	↑	↑
Total – Ages 13 and older	15.2%	14.8%	12.9%	**14.3%**	↑	↑	↑	↑
Adolescent Well Care Visits (AWC) ***(CMS Core Quality Measure)***								
	43.6%	46.7%	46.8%	**47.7%**	↓	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) *(CMS Core Quality Measure)*								
	63.4%	65.9%	64.8%	**67.3%**	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*								
0 visits		4.2%	3.0%	**3.4%**		↑*	↑*	↑*
1 visit		4.4%	3.3%	**3.5%**		↑*	↑*	↑*
2 visits		6.0%	4.8%	**4.8%**		↑*	↑*	↑*
3 visits		7.1%	6.5%	**5.5%**		↑*	↑*	↑*
4 visits		12.3%	9.1%	**8.6%**		↑	↓	↓
5 visits		16.8%	14.5%	**15.5%**		↓	↓	↓
6 or more visits		49.3%	58.7%	**58.6%**		↓	↓	↓

^↑Signifies Quality Compass ranking >50th percentile; ↓Signifies Quality Compass ranking <50th percentile
* HEDIS rates greater than 50th percentile that indicate poor performance

Adults' Access to Preventive/Ambulatory Health Services (AAP)
Population: Ages 20-44; 45-65; 65 and older; Medicaid
Analysis: Annual comparison to CY2013 baseline, trending over time
This measure tracks annual preventive/ambulatory visits. In each of the age ranges, the aggregate HEDIS results for CY2013 through CY2016 were above the QC 50th percentile; for ages 45-64 the results were again above the QC 75th percentile. Pre-KanCare data were available for ages 20-44 and ages 45-64.

- **Ages 20-44 - 82.6%,** lower than in CY2013-CY2015 (83.7%-85.4%), but **>66.67th** QC.
- **Ages 45-64 - 91.3%**, comparable to the three prior years (92.2%-92.4%) and **>75th** QC percentile in all four years. In CY2012, the aggregate pre-KanCare percentage was lower at 87.8%.
- **Ages 65 and older - 90.1%**, comparable to CY2013-CY2015 (88.6%-89.7%) and **>66.67th** QC. (Pre-KanCare data were not reported by the MCOs for CY2012 for those ages 65 and older.)
- **Total – Ages 20 and older - 86.2%**, slightly lower than in the three previous years (87.1%-88.4%), but **>75th** QC.

Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*
Data for this measure are based on aggregate weighted hybrid HEDIS data.
Population: Medicaid and CHIP combined populations age 18 and older
Analysis: Annual comparison to baseline reported in CY2014 and trending over time

The aggregate rate based on hybrid data for CY2016 was **80.9%** (**<33.33rd** QC), 4.2%-12.0% higher than the prior two years.

Controlling High Blood Pressure (CBP) *(CMS Core Quality Measure)*
Population: Medicaid
Analysis: Annual comparison to CY2013 baseline, trending over time
The aggregate rate based on weighted hybrid data for CY2016 was **52.1%** (**<50th QC**), 1.3%-10.3% higher than the three prior years. MCO rates ranged from 47.7% (Amerigroup; <25th QC) to 55.5% (Sunflower; <50th QC).

Comprehensive Diabetes Care (CDC) (*HbA1c Testing and HbA1c Poor Control [>9.0%] are CMS Core Quality Measures)*
This measure is a composite HEDIS measure composed of eight metrics, each reported by MCOs based on hybrid data.
Population: Ages 18-75; Medicaid
Analysis: Pre-KanCare compared to KanCare and trending over time

- **HbA1c Testing** (P4P 2014-2016) **-** The aggregate rate for CY2016 was **85.8%,** higher than the four previous years, but again **<50th QC**. Sunflower's rate in CY2016 (87.4%) was >50th QC, UnitedHealthcare's rate (81.0%) was <25th QC, and Amerigroup rate (86.4%) was <50th QC.
- **HbA1c Poor Control (>9.0%)** - For this metric, the goal is to have a lower rate and higher QC percentile. The aggregate rate for CY2016 was **41.1%**, 9.5% to 24.4% lower than the previous three years and **<50th QC**. Amerigroup's rate (39.1%) and Sunflower's rate (40.2%) were both >50th QC; UnitedHealthcare's rate (47.5%) was <33.33rd QC.
- **HbA1c Control (<8.0%)** (P4P 2014-2017) - The aggregate rate for CY2016 was **51.0%**, 9.6%-30.9% higher than the three prior years and **>50th QC** for the first time in four years. Amerigroup's rate (52.2%) and Sunflower's rate (53.3%) were both >66.67th QC; UnitedHealthcare's rate (43.61) was <33.33rd QC.
- **Eye Exam (Retinal)** (P4P 2014-2016) - The aggregate rate for CY2016 was **64.4%**, **>75th QC**, and 3.1% higher than in CY2015 but 28.6% higher than in CY2013. Sunflower's rate (70.7%) was >95th QC, UnitedHealthcare's rate (68.3%) was >90th QC, and Amerigroup's rate (55.7%) was >50th QC.
- **Medical Attention for Nephropathy** (P4P 2014-2016) - The aggregate rate for CY2016 was **87.2%**, **<25th QC**. The CY2016 aggregate rate was 2.2% lower than in CY2015 but was 15.1% higher than in CY2013.
- **Blood Pressure Control (<140/90)** (P4P 2014-2016) - The aggregate rate for CY2016 was **57.9%**, **<50th** QC. UnitedHealthcare's rate (62.8%) was 5.6% higher than in 2015 and >50th QC. Amerigroup's rate (58.8%) was <50th QC, and Sunflower's rate (54.9%) was <33.33rd QC.

Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH) (P4P 2014-2015) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time
The aggregate rate based on administrative data for CY2016 was **64.4%**, **>75th QC**, and higher than the prior three years. Amerigroup's rate (55.3%) was >66.67th QC, Sunflower's rate (68.6%) was >90th QC, and UnitedHealthcare's rate (69.3%) was >95th QC.

Annual Monitoring for Patients on Persistent Medications (MPM) (P4P 2014-2016) *(CMS Core Quality Measure)*
Population: Medicaid, Age 18 and older
Analysis: Annual comparison to CY2013 baseline, trending over time
The aggregate rate based on administrative data for CY2016 was **89.5%**, comparable to the prior three years (89.7%-90.2%), and **>66.67th QC**.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations, ages 3-17.
Analysis: Annual comparison to CY2013 baseline and trending over time

- **Weight Assessment/BMI**
  The aggregate weighted hybrid HEDIS rates for reporting BMI (Body Mass Index) have increased from CY2013 to CY2016 but have remained below the QC 25th percentile.
  - **Ages 3-11** – **55.5%** in CY2016; **<25th QC** but 13.4%–64.6% higher than the three prior years (33.7%-48.9%).
  - **Ages 12-17** – **56.9%** in CY2016; **<25th QC** but 18.3%–55.6% higher than the three prior years (36.6%-48.1%).
  - **Total – Ages 3-17** – **56.0%** in CY2016; **<25th QC** but 15.3%–61.6% higher than the three prior years (34.7%-48.6%).
- **Counseling for Nutrition**
  The CY2016 aggregate weighted hybrid HEDIS rates in CY2016 in total were higher and by age group than the three prior years but continued to be below the QC 25th percentile.
  - **Ages 3-11** – **55.4% (<25th QC**) in CY2016; 9.1%–16.9% higher than the three prior years (47.4%-50.8%).
  - **Ages 12-17** – **53.1%** (**<25th QC**) in CY2016; 13.0%–16.1% higher than the three prior years (45.7%-47.0%).
  - **Total – Ages 3-17** – **54.7%** (**<25th QC**) in CY2016; 10.4%–16.6% higher than the three prior years (46.9%-49.5%).
- **Counseling for Physical Activity**
  The aggregate weighted hybrid HEDIS rate for each age strata (ages 3–11; ages 12–17; and ages 3–17) were below the QC 50th percentile in CY2013 through CY2016.
  - **Ages 3–11**: **47.9%** (**<33.33rd QC** percentile) in CY2016; 10.2%–20.9% higher than the three prior years (39.6%-43.5%).
  - **Ages 12–17**: **58.6%** (**<50th QC** percentile) in CY2016; 10.3%–21.2% higher than the three prior years (48.3%-53.1%).
  - **Total (Ages 3–17): 51.5%** (**<33.33rd QC** percentile) in CY2016; 12.4%–17.0% higher than the three prior years (44.0%–45.8%).

Annual Dental Visit (ADV) (P4P 2016 and 2017 for Ages 2-20)
Population: Medicaid and CHIP combined populations, Ages 2–3; Ages 4–6; Ages 7–10; Ages 11–14; Ages 15–18; Ages 19–21; Total (Ages 2–20)
Analysis: Annual comparison to CY2013 baseline and trending over time
In CY2016, aggregate administrative HEDIS rates for each age range increased and were >66.67th QC, except ages 19-20, which was <50th QC. The total rate for ages 2–20 (63.7%) was >75th QC.

- **Ages 2–3**: **45.8%** in CY2016 (**>66.67th QC**), 6.9%–12.2% higher than the three prior years.
- **Ages 4–6**: **69.2%** in CY2016 (**>66.67th QC**), 4.3–5.3% higher than the previous three years (65.7%-66.3%).

- **Ages 7–10**: **72.7%** in CY2016 (**>75th QC**), 2.8–3.7% higher than the three prior years (70.1%–70.7%).
- **Ages 11–14**: **66.4%** in CY2016 (**>66.67th QC**), 5.1–5.9% higher than the three prior years (62.8%-63.2%).
- **Ages 15–18**: **57.2%** in CY2016 (**>66.67th QC**), 5.8–6.9% higher than the three prior years (53.5%-54.1%).
- **Ages 19–20**: **33.1%** in CY2016 (**<50th QC** percentile). The 2016 rate was 4.6% lower than in 2015.
- **Total (Ages 2–20):** 63.7% in CY2016 (**>75th QC** percentile), 4.6% to 6.3% higher than the three prior years (60.0%-60.9%).

Appropriate Testing for Children with Pharyngitis (CWP)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to 2013 baseline and trending over time
The aggregate rate based on administrative data for CY2016 was **61.2%, <25th QC**, but 11.1%-18.6% higher than the previous three years.

Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure 2013–2017)*
Data are based on aggregated weighted administrative HEDIS data. QC percentiles are based on 75% compliance by age group and in total.
Population: Ages 5-11, 12-18, 19-50, 51-65; Medicaid and CHIP combined populations
Analysis: Annual comparison to baselines reported in CY2014 and trending over time

- **Ages 5-11** – **31.7%** in CY2016 (**>50th QC**), 8.9%-15.8% higher than the prior two years.
- **Ages 12-18** – **31.9%** in CY2016 (**>66.67th QC**), 20.1%-32.8% higher than the prior two years.
- **Ages 19-50** – **41.4%** in CY2016 (**>66.67th QC**),4.6%-8.1% higher than the prior two years.
- **Ages 51-64** – **60.1%** in CY2016 (**>75th QC**), 9.1%-13.5% higher than the prior two years
- **Total (Ages 5-64)** – **33.7%** in CY2016 (**>50th QC**),12.6%-20.1% higher than the prior two years.

Follow-Up Care for Children Prescribed ADHD Medication (ADD) *(CMS Core Quality Measure)*
Data are based on aggregate weighted administrative HEDIS data.
Population: Ages 6-12; Medicaid and CHIP combined populations; Children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)
Analysis: Annual comparison to baselines reported in CY2014 and trending over time

- **Initiation Phase** – The aggregate weighted rate in CY2016 was **52.2%**, **>75th QC**. UnitedHealthcare's rate (58.2%) was >90th QC; Sunflower's rate (53.5%) was >75th QC, and Amerigroup's rate (45.1%) was >50th QC.
- **Continuation & Maintenance Phase** – The aggregate weighted rate in CY2016 was **61.4%** and **>50th QC**. UnitedHealthcare's rate (71.0%) was >90th QC, Sunflower's rate (62.0%) was >66.67th QC, and Amerigroup's rate (52.3%) was <50th QC.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)

- Population: Medicaid and CHIP combined populations
- Analysis: Annual comparison to CY2013 baseline and trending over time
- The aggregate rate based on administrative data for CY2016 was **79.2%** (**<25th QC** percentile) but 3.7%-10.2% higher than the three prior years (71.9%-76.3%).

Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
The CY2016 aggregate and individual MCO rates continued to be below the 25th QC.

- **Ages 16-20** – The aggregate rate in CY2016 was **41.0%, <10th QC**. Rates have decreased 0.6% to 3.2% for the last four years.
- **Ages 21-24** – The aggregate rate in CY2016 was **52.8%** (**<25th QC**). The 2016 rate was 1.4% lower than in 2015 and 3.2% lower than in 2013.
- **Total – Ages 16-24** – The CY2016 aggregate rate was **45.3%** (**<25th QC**). MCO rates ranged from 44.4% (Sunflower, <10th QC) to 45.2% (UnitedHealthcare, <25th QC).

Prenatal and Postpartum Care (PPC) (P4P – Prenatal Care 2016 - 2018) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time

- **Prenatal Care** - The aggregate rate based on weighted hybrid data for CY2016 was **68.4%, <10th QC**. Rates for all three MCOs in 2016, which ranged from 67.1% to 70.3% were all <10th QC. The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 57.9%.
- **Postpartum Care** - The aggregate rate based on weighted hybrid data for CY2016 was **58.0%, <25th** QC. UnitedHealthcare's rate (61.3%) was <50th QC; Amerigroup's rate (58.6%) and Sunflower's rate (54.1%) were both <25th QC.

Initiation and Engagement in Treatment for Alcohol or Other Drug Dependence (IET) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time

- **Initiation in Treatment**
  - **Ages 13-17** - The aggregate rate based on administrative data for CY2016 was **50.2%** (**>75th QC**). UnitedHealthcare's rate (58.0%) was >90th QC; Amerigroup's rate (47.3%) was >66.67th QC; and Sunflower's rate (45.5%) was >50th QC.
  - **Age 18 and older** - The aggregate rate based on administrative data for CY2016 was **40.1%** (**<50th QC**), 6.4% higher than in CY2015 but 2%-2.7% lower than in 2013 and 2014. UnitedHealthcare's rate, however was 47.8%, >75th QC, and 31.3% higher than in 2015. Sunflower's rate (38.2%) was <50th QC, and Amerigroup's rate (35.6%) was <33.33rd QC.
  - **Total – Age 13 and older** - The aggregate rate based on administrative data for CY2016 was **41.1%** (**>50th** QC).
- **Engagement in Treatment**
  - **Ages 13-17** - The aggregate rate based on administrative data for CY2016 was **27.5%**, **>90th QC**. UnitedHealthcare's rate (31.4%) was >95th QC; Amerigroup's rate (26.5%) was >90th QC, and Sunflower's rate (24.6%) was >75th QC.
  - **Age 18 and older** - The aggregate rate based on administrative data was only **12.4%** in CY2016, which was **>50th QC**. MCO rates ranged from 11.9% to 13.3%.
  - **Total – Ages 13 and older** - The aggregate rate based on administrative data for CY2016 was **14.3%** (**>50th QC**).

Adolescent Well Care Visits (AWC) *(CMS Core Quality Measure)*
Population: Ages 12-21; Medicaid and CHIP combined populations
Analysis: Annual comparison to CY 2013 baseline and trending over time
The aggregate rate based on administrative data for CY2016 was **47.7%** (**<50th QC**), 1.9%-9.4% higher than the three prior years.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) (P4P in 2017 and 2018) *(CMS Core Quality Measure)*
Population: Ages 3-6; Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time
The aggregate rate based on administrative data for CY2016 was **67.3%, <33.33rd QC**, but 2.2%-6.2% higher than the three prior years.

Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*
This metric tracks the number of well-child visits after hospital discharge post-delivery. QC percentiles must be interpreted differently from those above; being above the 75th percentile for "0 visits," for example is not a positive result, whereas being above the 75th percentile for "6 or more visits" would be a positive result. Data are based on aggregated weighted administrative HEDIS data.
Population: Age through 15 months; Medicaid and CHIP combined populations
Analysis: Annual administrative rates compared to baselines reported in CY2014 and trending over time

- **0 visits** – **3.4%** in CY2016 (**>75th QC**), which for this metric means poorer rates compared to nationally); prior two years were 3.1%-4.4%.
- **1 visit** – **3.5%** in CY2016 (**>75th QC**), which for this metric means poorer rates compared to nationally); prior two years were 3.3%-4.4%.
- **2 visits** – **4.8%** in CY2016 (**>75th QC**), which for this metric means poorer rates compared to nationally); prior two years were 4.8%-6.0%.
- **3 visits** – **5.5%** in CY2016 (**>50th QC**); prior two years were 6.5%-7.1%.
- **4 visits** – **8.6%** in CY2016 (**<50th QC**), prior two years were 9.1%-12.3%.
- **5 visits** – **15.5%** in CY2016 (**<50th QC**), higher than in 2015 (14.5%) and lower than in 2014 (16.8%).
- **6 or more visits** – **58.6%** in CY2016 (**<50th QC**), comparable to 2015 (58.7%) and higher than in 2014 (40.3%; 25th QC).

Additional P4P Physical Health Measures

Well-Child Visits, Four Visits within the First Seven Months of Life (P4P 2014-2015)
For this P4P measure, the MCOs reported the percentage of children who had four or more well-child visits within the first seven months (post-discharge after birth). This measure is HEDIS-like, in that the HEDIS criteria and software for Well-Child Visits within the first 15 months of Life (W15) was adapted to include well-child visits only within the first seven months to allow annual calendar year assessment of progress. Now that multiple years of MCO data are available, progress in completing well-child visits in these first months will be assessed through the Well-Child Visits in the First 15 Months of Life (W15) HEDIS measure.
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to 2013 baseline, trending over time
In CY2015, 67.6% of 4,471 infant members born in January through May 2015 had four or more well-child visits by the time they were seven months of age. This was a 6.2% decrease compared to CY2014 (72.1% of 6,442) and comparable to CY2013 (66.9% of 5,824).

Preterm Delivery (P4P 2014-2015)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to 2013 baseline, trending over time
Preterm delivery rates in 2013 to Medicaid and CHIP members were the baseline data. Each MCO uses unique systems for tracking preterm delivery. Because of differences in tracking methods and criteria, the preterm delivery rates should not be compared to preterm birth rates reported in vital statistics records of the State or other agencies. In 2015, MCO preterm delivery rates ranged from 9.8% (Sunflower) to 10.7% (Amerigroup). UnitedHealthcare's preterm delivery rate, which had the largest improvement of the three MCOs from 2013 (10.3%) to 2014 (9.5%), increased to 10.5% in 2015.

(2) Substance Use Disorder (SUD) Services

The following performance measures are based on National Outcome Measurement System (NOMS) measures for members who are receiving SUD services, including improvement in living arrangements, reduction in number of arrests, reduction in drug and alcohol use, attendance at self-help meetings, and employment status. Each of these measures is tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following SUD measures, members may be included in more than one quarter of data (or may be counted more than once in a quarter), as they may be discharged from SUD treatment in one month, but re-enter treatment later in the quarter or year. The denominators in the tables below represent the number of times members were discharged from SUD treatment during the quarter. The actual number of individual members who received SUD services each year is not reported.

The number and percent of members receiving SUD services whose living arrangements improved
The denominator for this performance measure is the number of KanCare members (annual quarterly average) who were discharged from SUD services during the measurement period and whose living arrangement details were collected by KDADS in the Kansas Client Placement Criteria (KCPC) state tracking system. The numerator is the number of members with stable living situations at time of discharge from SUD services (see Table 3).

Table 3. Number and Percent of Members Receiving SUD Services who were in Stable Living Situations at Discharge - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare members in stable living situations at discharge	199	218	189	183	190	133
Denominator: Number of KanCare members discharged from SUD services during the reporting period	201	220	190	185	196	138
Percent of KanCare members in stable living situations at discharge from SUD services	99.0%	99.1%	99.3%	98.9%	96.9%	96.4%

The percentages of members in stable living conditions at time of discharge from SUD services were consistently high throughout CY2012 through CY2017. The high rate, over 96% in each quarter of the five-year period, is attributed by KDADS staff to the nature of treatment (active participation and attendance) in conjunction with the time of data collection (on day of discharge from treatment).

The number and percent of members receiving SUD services whose criminal justice involvement improved

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (annual quarterly average). The numerator is the number of members who reported no arrests in the 30 days prior to discharge (see Table 4).

Quarterly rates of those without arrests were over 98% for each quarter of CY2012 through CY2017. This equates to about 1 to 4 arrests per quarter.

Table 4. Number and Percent of Members Receiving SUD Services whose Criminal Justice Involvement Decreased - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of members without arrests at time of discharge from SUD services	199	219	188	183	193	137
Denominator: Number of members discharged from SUD services during the reporting period	201	220	190	185	196	138
Percent of members without arrests during reporting period	99.0%	99.3%	98.9%	98.9%	98.5%	99.3%

The number and percent of members receiving SUD services whose drug and/or alcohol use decreased

The denominator for this measure is the number of members (annual quarterly average) who were discharged from SUD services during the measurement period and whose substance use information was collected in the KCPC at discharge from SUD treatment (see Table 5). The numerator is the number of members who reported at discharge no use of alcohol and other drugs for the prior 30 days.

Table 5. Number and Percent of Members Receiving SUD Services with Decreased Drug and/or Alcohol Use - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of members discharged from SUD services who were abstinent from alcohol and other drugs	191	207	181	173	178	126
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	190	185	196	138
Percent of members abstinent from alcohol and other drugs at time of discharge from SUD services	95.3%	94.2%	95.5%	93.5%	90.8%	91.3%

The quarterly percentages of decreased use of alcohol and other drugs were reported to be above 90% in each quarter of CY2012 through CY2017.

The number and percent of members receiving SUD services whose attendance of self-help meetings increased

The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (annual quarterly average) and whose attendance at self-help programs was collected in KCPC at both admission and discharge from SUD treatment services (see Table 6). The numerator is the number of members who reported attendance at self-help programs prior to discharge from SUD services.

Table 6. Number and Percent of Members Receiving SUD Services Attending Self-Help Programs - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare members attending self-help programs	121	93	85	73	71	57
Denominator: Number of KanCare members discharged from SUD services during quarter	201	220	190	185	182	138
Percent of KanCare members attending self-help programs	59.9%	42.3%	44.5%	39.5%	39.0%	41.3%

The average annual quarterly percentage of attendance of self-help programs has decreased overall since CY2012. The annual quarterly average in CY2016 (39.0%) was the lowest in the six-year period CY2012 to CY2017. Attendance increased in CY2017 to a percentage of 41.3%.

The number and percent of members receiving SUD services whose employment status was improved or maintained (P4P 2014-2016)

The denominator for this measure is the number of members, ages 18 and older at admission to SUD services, (annual quarterly average) who were discharged from SUD services during the measurement period and whose employment status was collected in the KCPC database at discharge from SUD services (see Table 7). The numerator is the number of members who reported at discharge from SUD services that they were employed full-time or part-time.

The annual quarterly average of KanCare members discharged from SUD treatment who are employed has continued the trend upward. There has been a 13.9 percentage point increase (43.7% relative increase) from CY2013 to CY2017. The only change in this trend occurred in CY2016 where it decreased by 4.7 percent points. In CY2017 the measure increased by 7.4 percentage points to 45.7%, a one-year relative increase of 19.3%.

It should be noted there are two types of SUD treatment services: outpatient/reintegration and intermediate/residential. In outpatient/reintegration, working is allowed or encouraged, while in intermediate/residential treatment employment is not permitted. This is a possible factor in the low percentage employed at discharge from SUD treatment.

Table 7. Number and Percent of Members Discharged from SUD Services who were Employed - Annual Quarterly Average, CY2012 - CY2017						
	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare members employed (full-time or part-time)	60	70	80	86	75	63
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	229	206	196	138
Percent of members employed at discharge from SUD services	29.7%	31.8%	34.9%	41.8%	38.3%	45.7%

(3) Mental Health Services

The following performance measures are based on NOMS for members who are receiving MH services, including adults with SPMI and youth experiencing SED. Measures focus on increased access to services for SPMI adults and SED youth, improvement in housing status for homeless adults, improvement or maintenance of residential status for youth, gain or maintenance of employment status for SPMI adults, improvement in Child Behavior Checklist (CBCL) Competence scores, and reduction in inpatient psychiatric services. Each of these measures is tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following measures, members may be included in more than one quarter of data, as housing and employment status may change throughout the year. Members may also have more than one inpatient admission during the year.

The number and percent of adults with SPMI with access to services (P4P 2014-2015)
The denominator for this measure is the number of KanCare adult members at the beginning of each quarterly measurement period (see Table 8). The numerator is the number of KanCare adults with SPMI based on assessments and reporting by Community Mental Health Centers (CMHCs) who continue to be eligible to receive services in the measurement period.

Table 8. Number and Percent of KanCare Adults with SPMI - Annual Quarterly Average, CY2012 - CY2017						
	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare adults with SPMI	8,051	5,745	7,515	7,389	6,933	6,594
Denominator: Number of KanCare adults	123,656	126,305	134,843	136,989	143,108	135,187
Percent of KanCare adults with SPMI	6.5%	4.5%	5.6%	5.4%	4.8%	4.9%
Adult access rate per 10,000	651.1	454.9	557.3	539.4	484.5	487.8

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data, which allows more accurate trend analysis. The period between CY2015 and CY2017 has stayed relatively stable.

The number and percent of youth experiencing SED who had increased access to services (P4P 2014-2015)
The denominator for this measure is the number of KanCare youth members at the beginning of each measurement period (see Table 9). The numerator is the number of KanCare youth experiencing SED based on assessments and reporting by CMHCs for each measurement period.

Table 9. Number and Percent of KanCare Youth Experiencing SED - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of SED youth	14,937	11,984	14,782	14,834	15,206	14,063
Denominator: Number of KanCare youth	267,788	274,326	285,753	284,830	294,494	261,152
Percent of SED youth	5.6%	4.4%	5.2%	5.2%	5.2%	5.4%
SED rate per 10,000	557.8	436.9	517.3	520.8	516.3	538.5

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies and improved processes that have resulted in increased and more complete reporting of this data that allow more accurate trend analysis. The improved reporting processes demonstrate the percentage of youth identified as SED has been stable and consistent from CY2014–CY2017.

The number and percent of youth experiencing SED who experienced improvement in their residential status
The denominator for this measure is the number of KanCare SED youth with unstable living arrangements at the beginning of each quarterly measurement period. The numerator for this measure is the number of KanCare SED youth with improved housing status at the end of the quarterly measurement period (see Table 10).

Table 10. Number and Percent of SED Youth who Experienced Improvement in their Residential Status - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare SED youth with improved housing status at end of quarter	208	177	142	168	542	518
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of quarter	254	219	174	198	607	575
Percent of SED youth with improved housing status	81.7%	80.6%	81.3%	84.9%	89.3%	90.1%

The annual quarterly average percentage of SED youth with improved housing status in CY2015 (84.9%) was higher than in the CY2012 (81.7%), CY 2013 (80.6%), and CY2014 (81.3%). The trend continued in CY2016 and CY2017, reaching a quarterly average of improved housing of 90.1%.

There was a reporting methodology change for CY2016 and CY2017. The measure now considers whether youth improved their unstable housing status by quarter end or maintained a foster home status. This results in the number of both youth and housing status measured to increase.

The number and percent of youth experiencing SED who maintained their residential status
The denominator for this measure is the number of KanCare SED youth with stable living arrangements at the beginning of the measurement period. The numerator is the number of KanCare SED youth who maintained a stable living arrangement at the end of the measurement period (see Table 11).

Table 11. Number and Percent of SED Youth who Maintained their Residential Status - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare SED youth who maintained a stable living arrangement at end of quarter	5,284	4,554	3,293	4,279	4,407	4,501
Denominator: Number of KanCare SED youth with stable living arrangements at beginning of quarter	5,568	4,612	3,316	4,328	4,482	4,575
Percent of SED youth that maintained residential status	94.9%	98.7%	99.3%	98.9%	98.3%	98.4%

The annual quarterly average from CY2013 to CY2017 maintained a high percentage above 98%.

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)
The denominator is the number of youth with prior competence scores within clinical range (score of 40 or less). The numerator is the number of youth with improvement in their most recent competence score (see Table 12).

Table 12. Number and Percent of KanCare SED/CBS Youth with Improvement in Their Child Behavior Checklist (CBCL) Scores, CY2012 - CY2017

	Pre-KanCare		KanCare									
	CY2012		CY2013		CY2014		CY2015		CY2016		CY2017	
	S1	S2	S1	S2*	S1	S2	S1	S2	S1	S2	S1	S2
Numerator: Number of KanCare SED/CBS youth with increased total competence score	1313	1170	1466		912	785	958	886	686	506	628	554
Denominator: Number of KanCare SED/CBS youth with prior competence score less than 40	2,490	2,207	2,796		1,705	1,513	1,804	1,666	1,297	1,860	2,160	2,221
Percent of KanCare SED/CBS youth with improvement in their most recent CBCL competence score	52.7%	53.0%	52.4%		53.5%	51.9%	53.1%	53.2%	52.9%	27.2%	29.1%	24.9%

* No data available

The numbers of SED/CBS (Community-Based Services) youth with prior competence scores of 40 or less decreased each year from CY2012 to CY2015. The percentage with improvement in their most recent CBCL score has been relatively comparable in each of these testing periods. In the period from CY2016 S2 to CY2017 S2, the percent with improved CBCL scores decreased. This may in part be attributed to changes in the reporting methodology that now capture more members in the denominator. The increase in the denominator may be resulting in a decrease in the metric to under 30%.

The number and percent of KanCare members, diagnosed with SPMI, who were competitively employed (P4P 2014-2016)
The denominator for this measure is the number of KanCare adults with SPMI in each measurement period, and the numerator is the number of adults with SPMI who are competitively employed during the measurement period and whose employment status is reported by the CMHC providing services to the members (see Table 13).

Table 13. Number and Percent of KanCare Adults Diagnosed with an SPMI who were Competitively Employed - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare SPMI adults competitively employed	481	382	610	628	567	524
Denominator: Number of KanCare SPMI adults	3,596	3,100	3,900	3,854	3,562	3,367
Percent of SPMI adults competitively employed	13.4%	12.3%	15.6%	16.3%	15.9%	15.6%

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data that allows more accurate trend analysis. The percentage has been consistently stable from CY2014 to CY2017 between 15.6% and 16.3%.

The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of the reporting period
The denominator for this measure is the number of KanCare homeless adults with SPMI at the beginning of each quarter. The numerator is the number of KanCare adults with SPMI with improvement in their housing status by the end of the quarter for CY2012 to CY2017 (see Table 14).

Table 14. Number and Percent of Members with SPMI Homeless at the Beginning of the Reporting Period that were Housed at the end of the Reporting Period - Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare adults with SPMI homeless at the beginning of quarter housed at the end of the quarter	69	58	35	46	35	28
Denominator: Number of KanCare adults with SPMI homeless at the beginning of the quarter	150	100	70	104	104	112
Percentage of adults with SPMI who were homeless at the beginning of the quarter housed by the end of the quarter	45.7%	58.0%	49.1%	44.2%	33.7%	25.0%

The annual quarterly average number of adults with SPMI who were homeless at the start of each quarter decreased from an average of 150 in CY2012 to 100 in CY2013 to 70 in CY2014, increased to an annual quarterly average of 104 in CY2015 and CY2016 and then to 112 in CY2017. Compared to CY2012 (45.7%), the average annual quarterly average of those who were housed at the end of each quarter was higher in CY2013 (58.0%) and CY2014 (49.1%) but dropped in CY2015 to 44.2% and continued to decrease in CY2016 (33.7%) and CY2017 (25.0%).

The number and percent of members utilizing inpatient mental health services (P4P 2014-2015)
The denominator for this measure is the number of KanCare eligible members at the end of each quarter. The numerator is the number of KanCare members admitted to an inpatient MH facility during each quarter (see Table 15). Rates are reported per 10,000.

Table 15. Number and Percent of KanCare Members Utilizing Inpatient Services Annual Quarterly Average, CY2012 - CY2017

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Numerator: Number of KanCare members with an inpatient mental health admission during the quarter	1,560	1,298	1,306	1,020	975	999
Denominator: Number of KanCare members	391,444	406,731	418,610	413,145	437,602	396,339
Percent of members utilizing inpatient mental health services	0.4%	0.3%	0.3%	0.2%	0.2%	0.3%
Rate per 10,000	39.9	31.9	31.2	24.7	22.3	25.2

The annual quarterly average rate (per 10,000) of inpatient admissions decreased from CY2012 to CY2015. A statewide change in screening policy as of October 2015 no longer requires inpatient screens to be completed by CMHC personnel at non-CMHC locations. Since the policy change, the rate per 10,000 has maintained a range between 22.3 and 25.2.

(4) Healthy Life Expectancy

Health Literacy

CAHPS

Survey questions for this performance measure are based on questions in the CAHPS surveys, which are conducted nationally. All three MCOs are contractually required by the State to conduct CAHPS surveys and submit results to the NCQA; annual results from MCOs are ranked nationally in the NCQA Quality Compass (QC). The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. Specifically, the survey aims to measure how well MCOs are meeting their members' expectations and goals, to determine which areas of service have the greatest effect on members' overall satisfaction, and to identify areas of opportunity for improvement that could aid the MCOs in increasing the quality of provided care.

The State directed each of the MCOs to conduct separate valid surveys from five populations: Adults, General Child (GC) – Title XIX/Medicaid (TXIX), GC – Title XXI/CHIP (TXXI), Children with Chronic Conditions (CCC) – TXIX, and CCC – TXXI. With NCQA approval, each MCO added supplemental

questions to their surveys: Amerigroup added 11 questions to the adult survey and one to the child surveys; Sunflower added nine questions to the adult survey and seven to the child surveys; and UnitedHealthcare added 12 questions to the adult and child surveys.

The analysis below is based on the percentage of positive responses as reported in the CAHPS surveys. Table 16 shows percentages of positive responses for CAHPS questions related to physical health. (See Table 23 for questions related to quality of care, Table 30 for questions related to coordination of care, Table 42 for questions related to access to care, and Table 49 for an efficiency-related question.)

Questions on child surveys only:

In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?

Aggregated positive rates for the GC and CCC populations were higher in 2017 than the previous years (2014–2016). Quality Compass rankings for this question are provided only for the CCC population.

- **GC**: **90.6%** in 2017; 89.3%–90.0% in 2014–2016
- **CCC**: **93.2**% in 2017 (**>75th QC**); 90.9%–91.9% in 2014–2016
  UnitedHealthcare rates in 2017 were >95th QC (96.2% TXIX; 95.1% TXXI); from 2016 to 2017, UnitedHealthcare's CCC TXIX rate increased significantly from 89.7% (<25th QC) in 2016 to 96.2% in 2017 (p<.01). Amerigroup's CCC TXXI rate (63.7%) was >90th QC.

In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?

Aggregated positive rates for the GC and CCC populations were higher in 2017 than the previous years (2014–2016). (Quality Compass rankings for this question are not available for this question.)

- **GC**: **94.5%** in 2017; 91.1%–92.5% in 2014–2016
- **CCC**: **94.0**% in 2017; 92.1%–92.8% in 2014–2016

Table 16. Healthy Life Expectancy - CAHPS Survey

Question	Pop	Weighted % Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Child Surveys only									
In the last 6 months…									
How often did you have your questions answered by your child's doctors or other health providers?	GC	89.6%	89.3%	90.0%	**90.6%**				
	CCC	90.9%	91.9%	91.1%	**93.2%**	↑	↑	↑	↑
How often did your child's personal doctor explain things in a way that was easy for your child to understand?	GC	91.1%	91.4%	92.5%	**94.5%**				
	CCC	92.4%	92.1%	92.8%	**94.0%**				
In the last six months, did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?	Adult	71.6%	68.0%	70.1%	**70.8%**	↓	↓	↓	↓
	GC	70.7%	67.1%	67.3%	**68.4%**	↓	↓	↓	↓
	CCC	73.3%	71.6%	71.4%	**73.8%**	↓	↓	↓	↓

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Table 16. Healthy Life Expectancy - CAHPS Survey (Continued)

Question	Pop	Weighted % Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Adult and Child Surveys									
In the last six months, did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?	Adult	71.6%	68.0%	70.1%	**70.8%**	↓	↓	↓	↓
	GC	70.7%	67.1%	67.3%	**68.4%**	↓	↓	↓	↓
	CCC	73.3%	71.6%	71.4%	**73.8%**	↓	↓	↓	↓
In the last six months, did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?	Adult	53.5%	52.9%	50.2%	**54.0%**				
	GC	31.9%	33.3%	33.2%	**32.7%**				
	CCC	51.3%	50.7%	53.2%	**53.0%**				
Did you and a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?	Adult	93.3%	91.0%	93.3%	**93.1%**		↓	↑	↑
	GC	98.3%	94.8%	96.6%	**94.5%**		↑	↑	↑
	CCC	98.2%	96.7%	97.8%	**96.8%**		↑	↑	↑
Did you and a doctor or other health provider talk about the reasons you might <u>not</u> want (your child) to take a medicine?	Adult	73.1%	72.3%	68.9%	**69.2%**		↑	↑	↑
	GC	77.4%	68.0%	69.5%	**68.6%**		↑	↑	↑
	CCC	81.5%	76.8%	74.8%	**74.4%**		↑	↓	↑
When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (your child)?	Adult	75.9%	79.5%	79.4%	**75.8%**	↓	↑	↑	↓
	GC	77.7%	80.0%	80.8%	**80.7%**	↑	↑	↑	↑
	CCC	83.5%	86.0%	83.7%	**85.7%**	↑	↑	↓	↑
In the last six months, how often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?	Adult	91.9%	91.8%	93.0%	**93.0%**	↑	↑	↑	↑
	GC	95.5%	94.9%	95.2%	**96.2%**	↑	↑	↑	↑
	CCC	95.3%	95.6%	95.1%	**96.9%**	↑	↑	↓	↑
In the last six months, how often did your (child's) personal doctor listen carefully to you?	Adult	89.7%	91.2%	91.5%	**92.5%**	↓	↑	↑	↑
	GC	95.7%	95.2%	94.5%	**96.4%**	↑	↑	↓	↑
	CCC	94.4%	94.9%	94.7%	**96.6%**	↑	↑	↑	↑
Questions on Adult Survey only									
Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?	**Adult**	47.5%	46.5%	43.7%	**48.8%**		↑	↑	↑
Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	**Adult**	37.6%	33.5%	32.2%	**33.2%**	↑*	↑*	↑*	↑*
In the last 6 months…									
How often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	**Adult**	75.7%	76.2%	79.5%	**80.0%**	↓	↓	↑	↑
How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	**Adult**	48.3%	43.2%	46.1%	**51.3%**	↑	↓	↓	↑
How often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?	**Adult**	38.6%	37.5%	44.4%	**48.4%**	↓	↓	↑	↑

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
*≥50th Quality Compass percentile for this metric represent poor performance compared to national rates

Questions on both adult and child surveys:

In the last 6 months:

Did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?

Overall scores were slightly higher in 2017 but continue to be low compared to national scores, particularly for the CCC population whose 2017 score of 73.8% was below the 5th QC. All but one subgroup in 2017 were below the 50th QC. Results for the aggregate rates for the adult and child surveys were comparable across KanCare and pre-KanCare years:

- **Adults**: **70.8%** in 2017 (**<25th QC**); 68.0%–71.6% in 2014–2016; 70.0% in 2012
- **GC**: **68.4%** in 2017 (**<25th QC**); 67.1%–70.7% in 2014–2016; 68.9% in 2012
- **CCC**: **73.8**% in 2017 (**<5th QC**); 71.4%–73.3% in 2014–2016.

Did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?

Over half of the adult survey respondents in CY2014 through CY2016 (50.2%–54.0%) and CCC survey respondents (50.7%–53.2%) indicated they had talked with a provider about starting or stopping a medication in the previous six months, while closer to one-third of the GC survey respondents talked with a provider about starting or stopping a prescription medication (31.9%– 33.3%).

If yes:

- **How much did a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?**
  Over 91% of the Adults (in 2017 and 2016), over 92% of GC (in 2014–2017), and over 94% of CCC (in 2014–2017) surveyed responded positively.
  - **Adult**s: **93.1%** in 2017 (**>50th QC**); 91.0%–93.3% in 2014–2016
  - **GC**: **94.5%** in 2017 (**>66.67th QC**); 94.8%–98.3% in 2014–2016
    Amerigroup's TXXI rate (96.3%) was >90th QC in 2017.
  - **CCC**: **96.8**% in 2017 (**>50th QC**); 96.7%–98.2% in 2014–2016
- **How much did a doctor or other health provider talk about the reasons you might <u>not</u> want (your child) to take a medicine?**
  Discussions with providers related to reasons a member might not want (or might not want their child) to take a medicine have consistently been lower than the percent of providers reported to have discussed reasons to take a medicine. Kansas rates, however, ranked above the 50th QC or higher compared to national responses to this question.
  - **Adult**s: **69.2%** in 2017 (**>50th QC**); 68.9%–73.1% in 2014–2016
  - **GC**: **68.6%** in 2017 (**>66.67th QC**); 68.0%–77.4% in 2014–2016
    Amerigroup's GC TXIX and TXXI rates [both 73.0%] were >95th QC in 2017.
  - **CCC**: **74.4**% in 2017 (**>50th QC**); 74.8%–81.5% in 2014–2016
- **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
  Kansas child survey rates ranked above the 50th QC or higher compared to national responses to this question; the adult survey positive response percentage in 2017 was below the 25th QC.
  - **Adult**s: **75.8%** in 2017 (**<25th QC**); 75.9%–79.5% in 2014–2016
  - **GC**: **80.7%** in 2017 (**>50th QC**); 77.7%–80.8% in 2014–2016
    UnitedHealthcare's TXXI rate [84.8%] in 2017 was >95th QC).
  - **CCC**: **85.7**% in 2017 (**>50th QC**); 83.5%–86.0% in 2014–2016
    UnitedHealthcare's TXIX and TXXI rates (89.9% and 88.5%, respectively) were >95th QC in 2017.

How often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?
All MCO and subgroup percentages in 2017 were above 90% positive.

- **Adult**s: **93.0%** in 2017 (**>66.67th QC**); 91.8%–93.0% in 2014–2016
- **GC**: **96.2%** in 2017 (**>75th QC**); 94.9%–95.2% in 2014–2016
  UnitedHealthcare's TXXI rate, 97.7%, was >95th QC and significantly higher (*p*<.01) than in 2016 [93.9%, <50th QC]).
- **CCC**: **96.9**% in 2017 (**>75th QC**); 95.1%–95.6% in 2014–2016
  UnitedHealthcare's TXIX and TXXI rates (98.5% and 99.5%, respectively) were >95th QC in 2017 and significantly higher than in 2016 (*p*=.02 and *p*=.03, respectively). Amerigroup's TXXI rate (97.3%) was >90th QC in 2017.

How often did your (child's) personal doctor listen carefully to you?
All MCO adult and child subgroup percentages in 2017 were above 91% positive and were higher than the previous years (2014–2016). All MCO child survey subgroup percentages were above 95% positive in 2017.

- **Adult**s: **92.5%** in 2017 (**>50th QC**); 89.7%–91.5% in 2014–2016
- **GC**: **96.4%** in 2017 (**>75th QC**); 94.5%–95.7% in 2014–2016
  Sunflower's TXIX rate, 97.2%, was >90th QC and significantly higher (*p*<.001) than in 2016 (92.8%; <25th QC). UnitedHealthcare's TXIX rate in 2017, 98.1%, was >95th QC and significantly higher (*p*=.02) than in 2016 (94.3%; <50th QC).
- **CCC**: **96.6**% in 2017 (**>75th QC**); 94.4%–94.9% in 2014–2016
  UnitedHealthcare's TXIX and TXXI rates (98.1% and 98.0%, respectively) were >95th QC; UnitedHealthcare's TXIX rate in 2017 was significantly higher (*p*<.01) than in 2016 (93.5%; <33.33rd QC).

Questions on adult survey only:
Have you had either a flu shot or flu spray in the nose since July 1, [previous year]? (P4P 2014-2015) *(CMS Core Quality Measure)*

Adults: **49.3%** in 2017 (**>90th QC**); 43.7%–47.5% in 2014–2016
Sunflower's rate in 2017 (60.4%) was >95th QC and significantly higher (*p*=.003) than in 2016 (44.2%; >75th QC). Amerigroup's rate in 2017 (48.2%) was >90th QC. UnitedHealthcare's rate was 40.5% (>50th QC).

Smoking Cessation *(CMS Core Set measure)*
Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?

Adults: **33.2%** in 2017 (**>50th QC**); 43.7%–47.5% in 2014–2016
(>50th QC for this metric is signifies a higher rate of smokers in Kansas.)

Members who responded "every day" or "some days" were asked the following questions:
In the last 6 months:
How often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan? (P4P 2014-2015)
Adults: 80.0% in 2017 (**>66.67th QC**); 75.7%–79.5% in 2014–2016
Amerigroup's rate (82.5%) and Sunflower's rate (83.8%) were >90th QC in 2017. UnitedHealthcare's rate (70.8%) was <25th QC.

How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.
Adults: **51.3%** in 2017 (**>66.67th QC**); 43.2%–48.3% in 2014–2016
Amerigroup's rate (52.3%) was >75th QC; Sunflower's rate (50.0%) was >50th QC; and UnitedHealthcare's rate (43.4%) was <25th QC.

How often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.
Adults: **48.4%** in 2017 (**>66.67th QC**); 37.5%–44.4% in 2014–2016
Amerigroup's rate (50.9%) was >75th QC, Sunflower's rate (48.1%) was >66.67th QC, and UnitedHealthcare's rate (45.1%) was >50th QC.

HEDIS – Healthy Life Expectancy

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
Population: Members diagnosed with diabetes and schizophrenia
Analysis: Annual comparison to CY2013 baseline and trending over time
The aggregate rate based on administrative data for CY2016 was **58.1%**, **<10th QC**, and 11.1% lower than in CY2015. MCO rates ranged from 56.1% (Amerigroup; <5th QC) to 62.9% (UnitedHealthcare; <25th QC).

Healthy Life Expectancy for persons with SMI, I/DD, and PD

The following measures are described as "HEDIS-like" in that HEDIS criteria are used for each performance measure, but the HEDIS programming is adapted to include only those populations that meet eligibility criteria and are also I/DD, PD, or SMI. Each of these measures was a P4P measure for the MCOs in 2014 and 2015; though no longer P4P, the State has directed the MCOs to continue to report these rates separately for the HCBS population to allow continued tracking of progress in improving these rates (see Table 17).

Table 17. HEDIS-Like Measures - PD, I/DD, SMI Populations, CY2013 - CY2016

	CY2013	CY2014	CY2015	CY2016
Breast cancer screening*	31.0%	47.0%*	50.5%*	51.6%*
Cervical cancer screening*	47.0%	48.8%*	52.1%*	51.8%*
Adults' access to preventive/ambulatory health services	95.6%	95.2%	94.9%	95.3%*
Comprehensive diabetes care				
HbA1c testing	84.4%	86.5%	87.6%	86.2%
Eye exam (retinal) performed	58.7%	63.7%	66.5%	67.3%
Medical attention for nephropathy	77.8%	75.2%	90.8%	87.6%
HbA1c Control (<8.0%)	38.1%	38.0%	46.5%	52.8%^
Blood pressure control (<140/90)	57.0%	51.0%	60.2%	52.1%^

* Multi-year measure - CY2016, for example, includes members who were screened in CY2015 or CY2016.
^Aggregated rate for Amerigroup and Sunflower. UnitedHealthcare data reported for 2016 was reported based on administrative data, and metric requires medical record review to assess blood pressure control.

Preventive Ambulatory Health Services (P4P 2014-2015)
In CY2013 through CY2016, over 94.5% of adult PD, I/DD, SMI members (ages 20-65) were reported to have had an ambulatory preventive care visit during the year. Rates for this subpopulation were higher than rates for all eligible KanCare members in CY2013 (95.6% for PD-I/DD-SMI adults, compared to 88.4% for all KanCare adult members); in CY2014 (95.2% for PD-I/DD-SMI, compared to 87.5% for all KanCare adult members); in CY2015 (94.9% for PD-I/DD-SMI, compared to 87.1% for all KanCare adult members); and in CY2016 (**95.3%** for PD-I/DD-SMI, compared to 86.2% for all KanCare adult members).

Breast Cancer Screening (P4P 2014-2015) *(CMS Core Quality Measure)*
The breast cancer screening rates reported for the PD, I/DD, SMI population in CY2015 (50.5%) and in CY2016 (**51.6%**) were higher than the aggregated CY2015 and CY2016 HEDIS rates for the eligible KanCare population (45.0% and 46.5%, respectively; both rates **<10th** QC percentile). The breast cancer screening HEDIS measure has multi-year eligibility criteria. The numerators for CY2014, CY2015, and CY2016 include two years of data for members (PD, I/DD, and SMI women ages 52–74) who had mammograms. The numerator for CY2013 includes only one year of data due to 2013 being the first year the MCOs began providing services in Kansas. Due to the multi-year HEDIS criteria, data for 2015 were the first HEDIS data reported by the three MCOs.

Cervical Cancer Screening (P4P 2014-2015) *(CMS Core Quality Measure)*
In CY2016, the aggregated rate based on MCO reported rates for the PD-I/DD-SMI population (**51.8%**) was lower than the aggregated HEDIS rate for all eligible KanCare women (54.8%; <33.33rd QC). The cervical cancer screening measure, as with the breast cancer screening measure, is a multi-year measure. The cervical cancer screening rate reported for the CY2015 PD, I/DD, SMI population (52.1%) was comparable to the aggregated CY2015 HEDIS rate for the eligible KanCare population (51.6%).

Comprehensive Diabetes Care (P4P 2014-2015)
In CY2014 and CY2015, the following metrics of the Comprehensive Diabetes Care (CDC) HEDIS measure were P4P for all eligible KanCare members with diabetes and were separate P4P measures for those with diabetes in the PD-I/DD-SMI combined populations. P4P rates were based on hybrid HEDIS rates, which include medical record review. The hybrid method is particularly necessary for metrics such as Blood Pressure Control (<140/90) and HbA1c Control (<8.0%), while other metrics such as Eye Exam and HbA1c Testing can be accurately reported based on submitted claims. For the CY2014 and CY2015 P4P rates, MCOs oversampled eligible members or separately sampled PD-I/DD-SMI members eligible for the CDC HEDIS measure. MCOs were directed to continue to report CDC rates for PD-I/DD-SMI members in CY2016 and CY2017. In CY2016, UnitedHealthcare's rates reported for the PD-I/DD-SMI metrics were based only on administrative (claims) data. The rate reported by UnitedHealthcare for the Blood Pressure Control metric was 0.21%, based on 2 of 932, compared to the 61.4% rate based on hybrid data for CY2015, and, for the HbA1c Control (<8.0%) metric, was reported as 12.1%, compared to 46.8% in CY2015. Consequently, rates reported for CY2016 below and in Table 17 for these two metrics are based only on rates reported by Amerigroup and Sunflower.

- **HbA1c testing** - *(CMS Core Quality Measure)* In CY2014 to CY2016, MCO aggregated rates for the PD-I/DD-SMI members were slightly higher than the rates for all eligible KanCare adult members: CY2016 – **86.2%** for the PD-I/DD-SMI members, compared to 85.8% for all KanCare eligible adults; CY2015 – 87.6% for PD-I/DD-SMI, compared to 84.9% for all KanCare adult members; CY2014 – 86.5% for PD-I/DD-SMI, compared to 84.8% for all KanCare adult members; and CY2013 – 84.4% for PD-I/DD-SMI adults, compared to 83.1% for all KanCare adult members.

- **Eye exam (retinal)** – The aggregated rate for PD-I/DD-SMI members was higher in CY2016 (**67.3%**) than the three prior years: CY2015 (66.5%), CY2014 (63.7%), and CY2013 (58.7%). Rates for PD-I/DD-SMI members were also higher each year than rates for all eligible KanCare members in each of these years: CY2016 (64.4%), CY2015 (62.5%), CY2014 (58.6%), and in CY2013 (50.1%).
- **Medical attention for nephropathy** – Rates for the PD-I/DD-SMI population and for all eligible KanCare members greatly increased in CY2015 compared to the two previous years. The CY2015 rate for the PD-I/DD-SMI population (90.8%) was 20.7% higher than in CY2014 (75.2%) and was higher than the rate for all eligible KanCare members (89.2%). In CY2016, the aggregated rates decreased slightly for both the PD-I/DD-SMI members (**87.6%**) and for all eligible KanCare members (87.2%).
- **HbA1c control <8.0%** - Rates for HbA1c control have generally increased each year from CY2013 to CY2016 for the PD-I/DD-SMI members and for all eligible KanCare members. Rates in CY2013–CY2015 have been comparable, but slightly lower, for the PD-I/DD-SMI populations (38.1%–46.5%), compared to all eligible members (39.0%–46.6%). As noted above, the CY2016 rate for the PD-I/DD-SMI population is based on aggregated hybrid rates of Amerigroup and Sunflower (**52.8%**), which is comparable to the aggregated rates of Amerigroup's and Sunflower's total eligible population (52.7%).
- **Blood pressure control <140/90** - The CY2015 rate for PD-I/DD-SMI members (60.2%) was 18% higher than in CY2014 (51.0%) and higher than the rate for all eligible KanCare members (58.8%). In CY2014 and CY2013, the blood pressure control rates for PD-I/DD-SMI members were lower than rates for all eligible KanCare members in CY2014 (51.0% for PD-I/DD-SMI; 52.9% for all KanCare adult members) and in CY2013 (54.0% for PD-I/DD-SMI adults; 54.4% for all KanCare adult members). As noted above, the CY2016 rate for the PD-I/DD-SMI population is based on aggregated hybrid rates of Amerigroup and Sunflower (**52.1%**), which is lower than the aggregated rates of Amerigroup's and Sunflower's total eligible population (56.8%).

(5) Home and Community Based Services (HCBS) Waiver Services

The populations for the following performance measures are members who are receiving HCBS services (includes I/DD, PD, FE, TBI, TA, SED, Autism, and MFP).

The number and percent of KanCare members receiving PD or TBI waiver services who are eligible for the WORK program who have increased competitive employment (P4P 2014-2015)
This measure compares the number of members receiving PD, TBI, or I/DD waiver services who are enrolled in Working Healthy and receiving services through the Work Opportunities Reward Kansans (WORK) program. The work program provides personal services and other services to assist employed persons with disabilities (including PD, TBI, and I/DD) eligible for Working Healthy.

For the P4P measure, progress was measured based on enrollment as of April each year (after MCO open enrollment is completed), compared to enrollment as of December of the same year for PD and TBI Waiver members. In assessing progress, exceptions were allowed for members who had moved out of state, who aged out of the program, who were hospitalized (or had a decline in health that impacted employment), were deceased during the year, or graduated to full-time employment. For the P4P metrics in 2014 and 2015 (that included PD and TBI waiver members): there were 143 PD and 16 TBI Waiver members participating in the WORK program as of April 2014, with 10 additional members participating during the year; and, in 2015, there were 72 PD and 15 TBI Waiver members participating in the WORK program as of April, with one additional TBI member participating during the year

In 2017, there were 142 PD, 15 TBI, and 125 I/DD Waiver members participating in the WORK program as of April, with six additional PD, TBI, and I/DD Waiver members participating during the year.

Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment. Percentages reported by KDADS are summarized in Table 18.

Table 18. Percent of HCBS Waiver Participants Whose Service Plans Address Their Assessed Needs and Capabilities, CY2013 - CY2016

Waiver	CY2013	CY2014	CY2015	CY2016
Intellectual/Developmental Disability (I/DD)	99%	78%	48%	68%
Physical Disability (PD)	86%	87%	59%	76%
Frail Elderly (FE)	87%	86%	61%	77%
Traumatic Brain Injury (TBI)	72%	73%	45%	72%
Technical Assistance (TA)	96%	96%	59%	73%
Serious Emotional Disturbance (SED)	92%	90%	97%	94%
Autism	59%	68%	46%	36%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. The 2017 HCBS quality data will be finalized in May 2018.

Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan. Percentages reported by KDADS are summarized in Table 19.

Table 19. Percent of HCBS Waiver Participants who Received Services in the Type, Scope, Amount, Duration, and Frequency Specified in Their Service Plan, CY2013 - CY2016

Waiver	CY2013	CY2014	CY2015	CY2016
Intellectual/Developmental Disability (I/DD)	98%	92%	68%	77%
Physical Disability (PD)	85%	95%	72%	81%
Frail Elderly (FE)	87%	92%	72%	83%
Traumatic Brain Injury (TBI)	70%	87%	56%	72%
Technical Assistance (TA)	100%	98%	74%	80%
Serious Emotional Disturbance (SED)	13%	93%	98%	90%
Autism	50%	86%	49%	38%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 19, SED Waiver service plans had the most complete

documentation of services received, as identified in member service plans. The 2017 HCBS quality data will be finalized in May 2018.

(6) Long-Term Care: Nursing Facilities

Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO (P4P 2014)
The denominator for this measure is the number of NF claims, and the numerator is the number of these claims that were denied in the calendar year (see Table 20). Due to claims lag, data for 2017 will be reported in the 2018 annual report.

Table 20. Nursing Facility Claims Denials, CY2012 - CY2016

	CY2012	CY2013	CY2014	CY2015	CY2016
Total number of nursing facility claims	555,652	337,767	368,242	361,293	323,794
Number of nursing facility claims denied	63,976	45,475	38,339	47,645	43,340
Percent of nursing facility claims denied	11.5%	13.5%	10.4%	13.2%	13.4%

The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013, and then decreased to 10.4% in CY2014. The denial rates in CY2015 (13.2%) and CY2016 (13.4%) were comparable to CY2013.

Percentage of NF members who had a fall with a major injury (P4P 2014-2015)
The denominator for this measure is the number of NF members in KanCare, and the numerator is the number of these members that had falls that resulted in a major injury during the year (see Table 21).

Table 21. Nursing Facility Major Injury Falls, CY2012 - CY2017

	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017
Nursing facility KanCare members	46,794	46,114	43,589	42,301	37,138	38,690
Number of nursing facility major injury falls	288	246	232	236	202	214
Percent of nursing facility Kancare members with major injury falls	0.62%	0.53%	0.53%	0.56%	0.54%	0.55%

The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013 and CY2014. There were 74 fewer falls in CY2017 than in CY2012. MCOs have been encouraged by the State to work together and with State agencies to ensure nursing facilities throughout Kansas are continuing to implement fall prevention practices.

Percentage of members discharged from a NF who had a hospital admission within 30 days (P4P 2014-2015)
The denominator for this measure is the number KanCare members discharged from a NF. The numerator is the number of these members who had hospital admissions within 30 days of being discharged from the NF (see Table 22).

Table 22. Hospital Admissions After Nursing Facility Discharge, CY2012 - CY2017 Q2						
	CY2012	CY2013	CY2014	CY2015	CY2016	CY2017 Q1-Q2
Number of nursing facility discharges	2,130	2,086	2,268	2,210	1,958	1,035
Number of hospital admissions after nursing facility discharge	153	250	288	266	260	130
Percent of hospital admissions after nursing facility discharge	7.18%	11.98%	12.70%	12.04%	13.28%	12.56%

The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and increased again in CY2014 to 12.70%. In CY2015, the percentage decreased to 12.04% and increased to 13.28% in CY2016. During the first two quarters of CY2017, the percentage decreased to 12.56%. Data for CY2017 are limited to the first six months of the year due to the time lag for submitting and processing claims.

Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network (P4P 2014)
PEAK program data are used to identify nursing facilities designated as Person-Centered Care Homes, along with MCO provider files to verify inclusion in the network. PEAK program data are reported on a fiscal year basis, based on the State fiscal year that begins July 1.

- By the end of FY2013 (June 2013) there were eight nursing facilities recognized as PEAK: five Level 5 homes, one Level 4 home, and two Level 3 homes.
- By the end of FY2014 (June 2014), there were nine nursing facilities recognized as PEAK: six Level 5 homes, one Level 4 home, and two Level 3 homes.
- By the end of FY2015 (June 2015), there were 10 nursing facilities recognized as PEAK: four Level 5 homes, three Level 4 homes, and three Level 3 homes.
- By the end of FY2016 (June 2016), there were 15 nursing facilities recognized as PEAK: four Level 5 homes, five Level 4 homes, and six Level 3 home.
- By the end of FY2017 (June 2017), there were 17 nursing facilities recognized as PEAK: six Level 5 homes, seven Level 4 homes, and four Level 3 homes.

(7) Member Survey – Quality

CAHPS Survey

CAHPS questions related to quality of care include the following questions focused on patient perceptions of provider treatment. Four of the questions are “rating” questions where survey respondents were asked to rate their (or their child’s) personal doctor, health care, health plan, and the specialist seen most frequently. Rating was based on a scale from zero to 10, with 10 being the “best possible” and zero the “worst possible.” Positive response for these rating questions below follow the NCQA standard of combining results for selections of “9” or “10” (and separate results for selections of “8,” “9,” or “10”), and then weighted by MCO population for aggregating the results. Results for the ratings questions and two additional questions are provided in Table 23.

Table 23. Member Survey (CAHPS) - Quality of Care Questions, CY2014 - CY2017									
Question	Pop	Weighted % Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Using any number from 0 to 10, where 0 is the worst rating possible and 10 is the best rating possible:									
What number would you use to rate all your (your child's) health care in the last 6 months? *(Rating 8, 9, or 10)*	**Adult**	73.5%	73.9%	74.2%	**74.5%**	↑	↑	↑	↑
	GC	87.5%	85.7%	87.7%	**89.2%**	↑	↑	↑	↑
	CCC	84.8%	84.5%	84.9%	**87.0%**	↑	↑	↑	↑
What number would you use to rate all your (your child's) health care in the last 6 months? *(Rating 9 or 10)*	**Adult**	52.8%	50.9%	53.9%	**55.8%**	↑	↓	↑	↑
	GC	68.6%	68.9%	70.7%	**72.2%**	↑	↑	↑	↑
	CCC	65.2%	64.8%	66.2%	**67.7%**	↑	↑	↑	↓
What number would you use to rate your (your child's) health plan? *(Rating 8, 9, or 10)*	**Adult**	72.5%	73.4%	76.5%	**75.7%**	↓	↓	↑	↓
	GC	86.8%	87.6%	88.7%	**88.6%**	↑	↑	↑	↑
	CCC	81.1%	83.5%	85.2%	**86.6%**	↑	↑	↑	↑
What number would you use to rate your (your child's) health plan? *(Rating 9 or 10)*	**Adult**	54.6%	57.6%	60.9%	**58.0%**	↓	↓	↑	↓
	GC	71.0%	72.1%	73.8%	**74.3%**	↑	↑	↑	↑
	CCC	63.3%	66.8%	67.4%	**69.9%**	↓	↑	↑	↑
What number would you use to rate your (your child's) personal doctor? *(Rating 8, 9, or 10)*	**Adult**	79.6%	81.5%	80.5%	**83.0%**	↑	↑	↓	↑
	GC	88.5%	87.9%	88.7%	**90.6%**	↑	↓	↑	↑
	CCC	87.7%	87.7%	87.9%	**89.2%**	↑	↑	↓	↑
What number would you use to rate your (your child's) personal doctor? *(Rating 9 or 10)*	**Adult**	64.4%	67.4%	67.5%	**67.4%**	↑	↑	↑	↑
	GC	73.4%	72.5%	75.9%	**76.6%**	↓	↓	↑	↑
	CCC	71.8%	72.9%	74.3%	**74.4%**	↓	↓	↓	↓
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? *(Rating 8, 9, or 10)*	**Adult**	80.0%	80.3%	80.6%	**82.7%**	↓	↓	↓	↑
	GC	85.6%	82.9%	87.9%	**88.3%**	↑	↓	↑	↑
	CCC	85.5%	83.9%	87.0%	**86.7%**	↓	↓	↑	↑
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? *(Rating 9 or 10)*	**Adult**	64.8%	66.1%	66.5%	**69.8%**	↓	↑	↑	↑
	GC	69.6%	69.3%	73.0%	**74.7%**	↓	↓	↑	↑
	CCC	68.5%	67.8%	73.0%	**73.2%**	↓	↓	↑	↑
In the last 6 months…									
How often did your (your child's) personal doctor show respect for what you had to say?	**Adult**	91.9%	92.5%	93.4%	**93.3%**	↑	↑	↑	↑
	GC	96.7%	96.0%	96.0%	**97.3%**	↑	↑	↑	↑
	CCC	94.4%	95.8%	95.6%	**97.2%**	↓	↑	↓	↑
How often did your (your child's) personal doctor spend enough time with you (your child)?	**Adult**	89.0%	89.4%	89.7%	**91.2%**	↑	↑	↑	↑
	GC	90.4%	89.7%	91.0%	**92.3%**	↑	↑	↑	↑
	CCC	90.6%	91.3%	91.4%	**93.1%**	↓	↓	↑	↑

^↑Signifies Quality Compass ranking >50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Rating of health care *(scale of 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible)*
Rating of 8, 9, or 10:

- **Adult**s: **74.5%** in 2017 (**>50th QC**); 73.5%–74.2% in 2014–2016
- **GC**: **89.2%** in 2017 (**>75th QC**); 85.7%–87.7% in 2014–2016
- **CCC**: **87.0%** in 2017 (**>66.67th QC**); 84.5%–84.9% in 2014–2016
  Amerigroup's rate for TXIX (87.2%; >66.67th QC) was significantly higher (*p*<.01) than in 2016 (82.2%).

Rating of 9 or 10:

- **Adults**: **55.8%** in 2017 (**>50th QC**); 50.9%–53.9% in 2014–2016
- **GC**: **72.2%** in 2017 (**>66.67th QC**); 68.6%–70.7% in 2014–2016
- **CCC**: **67.7**% in 2017 (**<50th QC**); 64.8%–66.2% in 2014–2016
  Amerigroup's rate for TXIX (69.2%; >50th QC) was the highest of the six subgroups and was a significant increase (*p*<.01) compared to 2016 (62.8%; <25th QC).

Rating of health plan *(scale of 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible)*
Rating of 8, 9, or 10:

- **Adults**: **75.7%** in 2017 (**<50th QC**); 72.5%–76.5% in 2014–2016
- **GC**: **88.6%** in 2017 (**>66.67th QC**); 86.8%–88.7% in 2014–2016
- **CCC**: **86.6**% in 2017 (**>75th QC**); 81.1%–85.2% in 2014–2016
  Amerigroup's TXXI rate (91.3%) was >95th QC.

Rating of 9 or 10:

- **Adults**: **58.0%** in 2017 (**<50th QC**); 54.6%–60.9% in 2014–2016
- **GC**: **74.3%** in 2017 (**>66.67th QC**); 71.0%–73.8% in 2014–2016
- **CCC**: **69.9**% in 2017 (**>50th QC**); 63.3%–67.4% in 2014–2016

Rating of personal doctor *(scale of 0 to 10, where 0 is the worst possible and 10 is the best possible)*
Rating of 8, 9, or 10:

- **Adults**: **83.0%** in 2017 (**>50th QC**); 79.6%–81.5% in 2014–2016
- **GC**: **90.6%** in 2017 (**>66.67th QC**); 87.9%–88.7% in 2014–2016
  UnitedHealthcare's TXXI rate (92.6%) was >95th QC and significantly higher (*p*<.01) than in 2016 (88.7%; >50th QC). Amerigroup's TXIX rate (90.7%; >66.67th QC) was significantly higher (*p*=.04) than in 2016 (87.5%; <50th QC).
- **CCC**: **89.2**% in 2017 (**>50th QC**); 87.7%–87.9% in 2014–2016

Rating of 9 or 10:

- **Adults**: **67.4%** in 2017 (**>50th QC**); 64.4%–67.5% in 2014–2016
- **GC**: **76.6%** in 2017 (**>50th QC**); 72.5%–75.9% in 2014–2016
  UnitedHealthcare's TXXI rate (77.6%) was >50th QC and significantly higher (*p*<.01) than in 2016 (70.3%; <25th QC).
- **CCC**: **74.4**% in 2017 (**<50th QC**); 71.8%–74.3% in 2014–2016.

Rating of specialist seen most often *(scale of 0 to 10, where 0 is the worst possible and 10 is the best possible)*
Rating of 8, 9, or 10:

- **Adult**s: **82.7%** in 2017 (**>50th QC**); 80.0%–80.6% in 2014–2016;
- **GC**: **88.3%** in 2017 (**>50th QC**); 82.9%–87.9% in 2014–2016
- **CCC**: **86.7**% in 2017 (**>50th QC**); 83.9%–87.0% in 2014–2016

Rating of 9 or 10:

- **Adults**: **69.8%** in 2017 (**>66.67th** QC**);** 64.8%–66.5% in 2014–2016
- **GC**: **74.7%** in 2017 (**>50th QC**); 69.3%–73.0% in 2014–2016
  Amerigroup's TXIX rate (80.5%) was >90th QC and significantly higher (*p*=.03) than in 2016 (70.0%; <50th QC).
- **CCC**: **73.2**% in 2017 (**>50th QC**); 67.8%–73.0% in 2014–2016

Doctor respected member's comments.
Rates were higher than 93% for all subgroups in 2017:

- **Adults**: **93.3%** in 2017 (**>50th QC**); 91.9%–93.4% in 2014–2016
- **GC**: **97.3%** in 2017 (**>75th QC**); 96.0%–96.7% in 2014–2016
  UnitedHealthcare's TXIX rate (99.3%) was >95th QC and significantly higher (*p*<.01) than in 2016 (95.0%; <33.33rd QC); their TXXI rate (98.0%) was >90th QC. Sunflower's TXIX rate (97.5%; >75th QC) was significantly higher (*p*=.02) than in 2016 (93.9%).
- **CCC**: **97.2**% in 2017 (**>75th QC**); 94.4%–95.8% in 2014–2016
  UnitedHealthcare's TXIX rate (99.6%) was >95th QC in 2017 and significantly higher (*p*<.001) than in 2016 (94.1%; <25th QC). UnitedHealthcare's TXXI rate (98.5%) was also >95th QC in 2017.

Doctor spent enough time with the member.

- **Adults**: **91.2%** in 2017 (**>75th QC**); 89.0%–89.7% in 2014–2016
- **GC**: **92.3%** in 2017 (**>75th QC**); 89.7%–91.0% in 2014–2016
  UnitedHealthcare's TXXI rate in 2017 (94.6%) was >95th QC.
- **CCC**: **93.1**% in 2017 (**>75th QC**); 90.6%–91.4% in 2014–2016
  UnitedHealthcare's TXIX and TXXI rates (95.4% for each) were >95th QC in 2017.

Mental Health Survey

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2017 of a random sample of KanCare members who received one or more MH services in the prior six-month period. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past seven years, were used for this project.

Questions were the same in 2011 through 2017, with the following additional questions added at the request of the State

- A question added in 2017 related to whether the (adult) member is doing what he/she wants to for paid work;
- Three questions added to the youth survey in 2016 related to whether the parent/guardian feels the child's mental health provider believes the child can grow, change, and recover; talks to them in an encouraging way; and encourages the child's growth and success
- Three questions added to the adult survey in 2015 on smoking cessation; and
- A question on whether medication was available timely added in 2013.

In 2017, the survey was mailed to 11,770 KanCare members and the following were completed: 415 General Adult, 503 General Youth, 386 SED Waiver Youth, and 27 SED Waiver young adult surveys. Results were also stratified by whether the member completed the survey or whether a family member/guardian completed the survey for a child (age <18).

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

Table 24 shows rates of positive responses for questions related to quality of care. (See Table 31 for questions related to coordination of care, Table 42 for questions related to access to care, and Table 50 for an efficiency-related question.)

The quality-related questions in Table 24 focus on the following:

Understandable communication from provider with member

- Rates for all five survey subgroups in the 7-year period were 92.9% or above.
- For the General Adult population, there was a significant increase in positive responses in 2017 (94.8%) compared to 2016 (90.0%; *p*=.02) and a higher percentage of positive responses in 2017 than in five of six prior years.
- The General Youth rate in 2017 was 97.7%; rates over the 7-year period ranged from 96.7% in 2011 to 98.8% in 2015.
- The SED Waiver youth and young adults rate in 2017 was 97.9%.
- The General Youth (ages 12–17), youth responding, rate in 2017 was 94.7%.
- For the SED Waiver youth (ages 12–17), youth responding, rates were above 90% for the 7-year period. The 7-year positive trend from 2011 (92.1%) to 2017 (95.8%) was significant (*p*=.03).

If given other choices, the member would still get services from their most recent mental health provider.

Positive responses from adults were higher in 2017 (89.0%) than in five of six prior years (2016 – 85.0%; 2015 – 88.4%; 2014 – 89.4%; 2013 – 88.3%; 2012 – 84.4%; 2011 – 88.3%).

Member choice of treatment goals.

- In 2017, the percentage of members who indicated they had a choice of treatment goals ranged from 83.2% (General Adult) to 94.3% (SED Waiver youth and young adults).
- General Adults - 83.2% in 2017; over the 7-year period, rates ranged from 77.0% (2012) to 85.1% (2015).
- General Youth and SED Waiver youth and young adults - Rates have been above 90% each year from 2011 to 2017.
- General Youth (ages 12–17), youth responding - The 2017 rate (90.5%) was higher than in five of six prior years.
- SED Waiver youth (ages 12–17), youth responding, also had a higher percentage of positive responses in 2017 (88.4%) than in five of the six prior years.

Table 24. Mental Health Survey - Quality-Related Questions

	Year	Rate	N/D	95% CI	*p*-value	Trend 7-Yr
My (my child's) mental health providers spoke with me in a way that I understood.	**General Adult (Age 18+)**					
	2017	**94.8%**	381 / 402	92.1% – 96.6%	.02↑	
	2016	90.0%	266 / 295	86.0% – 92.9%		
	2015	95.3%	368 / 386	92.7% – 97.1%		
	2014	93.6%	765 / 817	91.7% – 95.1%		
	2013	94.3%	1,002/1,063	92.8% – 95.6%		
	2012	91.5%	257 / 281	87.6% – 94.2%		
	2011	93.4%	282 / 302	89.9% – 95.7%		
	General Youth (Ages 12-17), Youth Responding					
	2017	**94.7%**	212 / 224	90.8% – 97.0%		
	2016	94.4%	148 / 157	89.5% – 97.2%		
	2015	93.9%	137 / 146	88.6% – 96.9%		
	2014	95.5%	290 / 303	92.5% – 97.4%		
	2013	96.3%	495 / 515	94.2% – 97.7%		
	2012	98.0%	97 / 99	92.5% – 99.9%		
	2011	97.0%	131 / 135	92.4% – 99.1%		
	SED Waiver Youth (Ages 12-17), Youth Responding					
	2017	**95.8%**	186 / 194	91.8% – 98.0%		.03↑
	2016	95.5%	158 / 165	91.0% – 97.9%		
	2015	97.4%	147 / 151	93.3% – 99.2%		
	2014	96.9%	183 / 189	93.2% – 98.7%		
	2013	93.8%	213 / 227	89.8% – 96.3%		
	2012	92.0%	126 / 137	86.1% – 95.6%		
	2011	92.1%	116 / 126	85.9% – 95.8%		
	General Youth (Ages 0-17), Family Responding					
	2017	**97.7%**	476 / 487	95.9% – 98.8%		
	2016	97.5%	323 / 331	95.1% – 98.8%		
	2015	98.8%	324 / 328	96.9% – 99.7%		
	2014	97.5%	766 / 786	96.1% – 98.4%		
	2013	97.3%	950 / 981	96.1% – 98.2%		
	2012	97.8%	262 / 268	95.1% – 99.1%		
	2011	96.7%	327 / 338	94.2% – 98.2%		
	SED Waiver Youth and Young Adult, Family/Member Responding					
	2017	**97.9%**	400 / 408	96.0% – 99.0%		
	2016	98.0%	324 / 331	95.8% – 99.1%		
	2015	97.9%	329 / 336	95.7% – 99.1%		
	2014	98.2%	414 / 422	96.4% – 99.2%		
	2013	97.4%	476 / 488	95.5% – 98.5%		
	2012	97.8%	314 / 321	95.5% – 99.0%		
	2011	97.2%	278 / 286	94.4% – 98.6%		
If I had other choices, I would still get services from my mental health providers.	**General Adult (Age 18+)**					
	2017	**89.0%**	345 / 388	85.5% – 91.8%		
	2016	85.0%	246 / 289	80.4% – 88.7%		
	2015	88.4%	336 / 380	84.8% – 91.3%		
	2014	89.4%	720 / 805	87.1% – 91.4%		
	2013	88.3%	911/1,034	86.2% – 90.1%		
	2012	84.4%	232 / 275	79.6% – 88.2%		
	2011	88.3%	263 / 298	84.1% – 91.5%		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

	Year	Rate	N/D	95% CI	*p*-value	7-Yr Trend
As a result of services I received, I am better able to deal with crisis.	**General Adult (Age 18+)**					
	2017	**77.2%**	285 / 369	72.7% – 81.2%	.02↑	
	2016	69.2%	192 / 277	63.6% – 74.4%		
	2015	79.3%	279 / 352	74.8% – 83.3%		
	2014	78.7%	602 / 765	75.7% – 81.5%		
	2013	79.1%	780 / 987	76.4% – 81.5%		
	2012	71.4%	182 / 255	65.5% – 76.6%		
	2011	80.4%	221 / 275	75.2% – 84.6%		
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**General Adult (Age 18+)**					
	2017	**83.2%**	311 / 374	79.1% – 86.7%		
	2016	78.6%	219 / 278	73.4% – 83.0%		
	2015	85.1%	303 / 356	81.1% – 88.5%		
	2014	84.0%	655 / 780	81.3% – 86.5%		
	2013	81.8%	809 / 989	79.3% – 84.1%		
	2012	77.0%	198 / 257	71.5% – 81.8%		
	2011	83.7%	237 / 283	79.0% – 87.6%		
	General Youth (Ages 12-17), Youth Responding					
	2017	**90.5%**	198 / 219	85.8% – 93.8%		
	2016	84.6%	128 / 151	77.9% – 89.5%		
	2015	91.0%	127 / 140	84.9% – 94.8%		
	2014	84.1%	255 / 302	79.5% – 87.8%	.03↑	
	2013	88.8%	448 / 509	85.6% – 91.4%		
	2012	81.6%	80 / 98	72.7% – 88.1%	.03↑	
	2011	86.8%	112 / 129	79.8% – 91.7%		
	SED Waiver Youth (Ages 12-17), Youth Responding					
	2017	**88.4%**	166 / 188	83.0% – 92.3%		.01↑
	2016	86.8%	140 / 161	80.6% – 91.2%		
	2015	92.3%	135 / 146	86.7% – 95.7%		
	2014	86.9%	169 / 194	81.4% – 91.0%		
	2013	82.2%	183 / 222	76.7% – 86.7%		
	2012	81.3%	109 / 134	73.9% – 87.1%		
	2011	83.5%	101 / 121	75.8% – 89.1%		
	General Youth (Ages 0-17), Family Responding					
	2017	**92.9%**	436 / 469	90.2% – 94.9%		
	2016	92.5%	288 / 311	89.0% – 95.0%		
	2015	92.7%	289 / 312	89.2% – 95.1%		
	2014	92.2%	689 / 750	90.0% – 93.9%		
	2013	90.5%	847 / 937	88.4% – 92.2%		
	2012	91.6%	229 / 250	87.4% – 94.5%		
	2011	90.7%	294 / 324	87.1% – 93.5%		
	SED Waiver Youth and Young Adult, Family/Member Responding					
	2017	**94.3%**	376 / 397	91.5% – 96.2%		
	2016	94.3%	301 / 318	91.2% – 96.4%		
	2015	95.0%	310 / 327	92.1% – 97.0%		
	2014	95.8%	395 / 412	93.3% – 97.4%		
	2013	93.1%	451 / 483	90.5% – 95.1%		
	2012	96.1%	303 / 315	93.3% – 97.8%		
	2011	93.8%	264 / 281	90.2% – 96.1%		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	7-Yr Trend
As a result of services I received, I am better able to control my life.	**General Adult (Age 18+)**						
	2017		**82.0%**	316 / 385	77.9% – 85.6%	.02↑	
	2016		74.8%	213 / 284	69.4% – 79.5%		
	2015		83.8%	309 / 369	79.7% – 87.2%		
	2014		84.9%	669 / 788	82.2% – 87.2%		
	2013		83.0%	851/1,025	80.6% – 85.2%		
	2012		76.4%	204 / 267	70.9% – 81.1%		
	2011		86.5%	250 / 289	82.1% – 90.0%		
As a result of services I received, I am better at handling daily life.	**General Youth (Ages 12-17), Youth Responding**						
	2017		**86.0%**	191 / 222	80.8% – 90.0%		
	2016		85.3%	131 / 154	78.8% – 90.1%		
	2015		87.0%	127 / 146	80.5% – 91.6%		
	2014		86.0%	260 / 302	81.6% – 89.5%		
	2013		88.6%	450 / 510	85.3% – 91.2%		
	2012		88.8%	87 / 98	80.8% – 93.8%		
	2011		83.1%	108 / 130	75.6% – 88.6%		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2017		**85.5%**	164 / 192	79.8% – 89.9%		
	2016		85.9%	140 / 163	79.7% – 90.5%		
	2015		83.0%	124 / 149	76.1% – 88.2%		
	2014		84.1%	158 / 187	78.1% – 88.7%		
	2013		79.6%	176 / 221	73.8% – 84.3%		
	2012		82.4%	112 / 136	75.0% – 87.9%		
	2011		90.1%	109 / 121	83.3% – 94.4%		
As a result of services my child and/or family received, my child is better at handling daily life.	**General Youth (Ages 0-17), Family Responding**						
	2017		**82.9%**	397 / 478	79.3% – 86.0%		
	2016		77.8%	252 / 324	72.9% – 82.0%		
	2015		82.0%	265 / 323	77.4% – 85.8%		
	2014		79.6%	606 / 764	76.6% – 82.3%		
	2013		82.1%	772 / 948	79.5% – 84.4%		
	2012		81.0%	205 / 253	75.7% – 85.4%		
	2011		79.4%	258 / 325	74.6% – 83.4%		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2017		**74.0%**	294 / 397	69.5% – 78.1%		
	2016		75.9%	243 / 323	70.9% – 80.2%		
	2015		71.5%	233 / 326	66.4% – 76.1%		
	2014		72.0%	297 / 407	67.4% – 76.1%		
	2013		74.4%	355 / 477	70.3% – 78.1%		
	2012		75.6%	241 / 319	70.6% – 80.0%		
	2011		79.2%	227 / 286	74.2% – 83.5%		
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**General Adult (Age 18+)**						
	2017		**86.7%**	328 / 378	82.9% – 89.8%		
	2016		82.7%	230 / 278	77.8% – 86.7%		
	2015		86.3%	315 / 365	82.4% – 89.5%		
	2014		86.8%	675 / 778	84.2% – 89.0%		
	2013		87.6%	891/1,020	85.4% – 89.4%		
	2012		81.6%	213 / 261	76.4% – 85.9%		
	2011		89.3%	258 / 289	85.1% – 92.4%		

Table 24. Mental Health Survey - Quality-Related Questions (Continued)

	Year	Rate	N/D	95% CI	*p*-value	7-Yr Trend
As a result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.	**General Adult (Age 18+)**					
	2017	**77.1%**	294 / 381	72.6% – 81.1%	.02↑	
	2016	69.3%	195 / 280	63.6% – 74.4%		
	2015	78.9%	290 / 368	74.4% – 82.8%		
	2014	74.3%	581 / 782	71.1% – 77.3%		
	2013	77.7%	786/1,012	75.0% – 80.2%		
	2012	70.1%	185 / 264	64.3% – 75.3%	.04↑	
	2011	82.4%	238 / 289	77.5% – 86.3%		
	General Youth (Ages 0-17), Family Responding					
	2017	**82.9%**	393 / 474	79.2% – 86.0%		
	2016	80.7%	255 / 317	76.0% – 84.7%		
	2015	84.5%	268 / 317	80.1% – 88.1%		
	2014	80.7%	606 / 751	77.8% – 83.4%		
	2013	84.3%	780 / 930	81.8% – 86.5%		
	2012	85.0%	215 / 253	80.0% – 88.9%		
	2011	84.1%	264 / 314	79.6% – 87.7%		
	SED Waiver Youth and Young Adult, Family/Member Responding					
	2017	**73.4%**	290 / 395	68.8% – 77.5%		
	2016	73.5%	231 / 316	68.3% – 78.1%		
	2015	69.9%	227 / 324	64.7% – 74.7%		
	2014	71.1%	290 / 405	66.6% – 75.3%		
	2013	73.5%	349 / 475	69.4% – 77.3%		
	2012	72.3%	229 / 317	67.1% – 76.9%		
	2011	76.5%	210 / 275	71.1% – 81.1%		
I felt comfortable asking questions about my treatment and medication.	**General Adult (Age 18+)**					
	2017	**91.2%**	360 / 395	87.9% – 93.6%	.03↑	
	2016	85.9%	245 / 285	81.3% – 89.5%		
	2015	94.5%	358 / 379	91.7% – 96.4%		
	2014	90.7%	733 / 808	88.5% – 92.5%		
	2013	91.1%	959/1,052	89.2% – 92.7%		
	2012	87.5%	244 / 279	83.0% – 90.9%		
	2011	93.6%	278 / 297	90.2% – 95.9%		
I have people I am comfortable talking with about my child's problems.	**General Youth (Ages 0-17), Family Responding**					
	2017	**91.6%**	431 / 470	88.8% – 93.8%		
	2016	91.5%	289 / 316	87.9% – 94.2%		
	2015	92.5%	300 / 324	89.0% – 94.9%		
	2014	90.4%	688 / 761	88.1% – 92.3%		
	2013	91.6%	871 / 954	89.7% – 93.2%		
	2012	93.1%	244 / 262	89.3% – 95.7%		
	2011	92.6%	301 / 325	89.2% – 95.0%		
	SED Waiver Youth and Young Adult, Family/Member Responding					
	2017	**89.0%**	360 / 404	85.6% – 91.7%		
	2016	89.9%	289 / 322	86.1% – 92.8%		
	2015	87.7%	288 / 328	83.7% – 90.9%		
	2014	88.0%	366 / 417	84.5% – 90.8%		
	2013	89.1%	423 / 475	85.9% – 91.6%		
	2012	87.5%	281 / 321	83.4% – 90.7%		
	2011	89.4%	254 / 284	85.3% – 92.5%		

Better ability to deal with crisis, as a direct result of services provided.
For the General Adult population, there was a significant increase in positive response in 2017 (77.2%) compared to 2016 (69.2%; *p*=.02); positive response rates in 2017 were lower in 2017 than in four of six prior years. (2015 – 79.3%; 2014 – 78.7%; 2013 – 79.1%; 2012 – 71.4%; 2011 – 80.4%)

Better control of daily life due to services provided.
- General Adults - there was a significant increase in positive responses in 2017 (82.0%) compared to 2016 (74.8%; *p*=.02); rates have ranged from 74.8% (2016) to 86.5% (2011).
- General Youth - Rates ranged from 77.8% in 2016 to 82.9% in 2017; the 2017 rate is the highest of the 7-year period.
- SED Waiver youth and young adults - 74.0% in 2017; over the 7-year period, rates ranged from 71.5% in 2015 to 79.2% in 2011.
- SED Waiver youth (ages 12–17), youth responding - 85.5% in 2017; over the 7-year period, rates ranged from 79.6% in 2013 to 90.1% in 2011.
- General Youth (ages 12–17), youth responding, the 2017 rate was 86.0%; over the 7-year period, rates ranged from 83.1% (2011) to 88.8% (2012).

Assistance in obtaining information to assist members in managing their health.
The 2017 rate for the General Adult population (86.7%) increased to a rate comparable to 2015 (86.3%) and 2014 (86.8%).

Better able to do things the member wants to do, as a direct result of services provided.
For the General Adult population, there was a significant increase in positive response in 2017 (77.1%) compared to 2016 (69.3%; *p*=.02) and 2012 (70.1%; *p*=.04). Rates for SED Waiver youth/young adult were also relatively low, ranging from 69.9% in 2015 to 76.5% in 2011. General Youth rates ranged from 80.7% in 2016 and 2014 to 85.0% in 2012.

Comfort in asking questions about treatment, medication, and/or children's problems.
- General Adults - Rates have been 90% positive or higher in five of the seven years. (2017 – 91.2%; 2016 – 85.9%; 2015 – 94.5%; 2014 – 90.7%; 2013 – 91.1%; 2012 – 87.5%; 2011 – 93.6%)
- General Youth – Rates have been above 90% each year from 2011 to 2017.
- The 2017 rate for SED Waiver youth and young adults, was 89.0%; rates were generally comparable over the 7-year period, ranging from 87.5% in 2012 to 89.9% in 2016.

SUD Consumer Survey

In 2011 and 2012, ValueOptions-Kansas (VO) conducted satisfaction surveys of members who accessed SUD treatment services. The survey consisted of 30 questions administered in 2012 by mail and through face-to-face interviews at provider locations. The VO survey was administered to 629 individuals, including Medicaid members and others receiving SUD services.

In 2017, Amerigroup, Sunflower, and UnitedHealthcare administered the survey to a total of 252 KanCare members (compared to 342 in in 2016, 193 in 2015, and 238 in 2014). The survey was a convenience survey administered in May through August through face-to-face interviews, mail, telephone, and provider-initiated at time of visit/treatment. The age range in 2017 was 14 to 67, including 30 under age 18 and nine older than age 60. The average age for the 2017 survey was 33.8, comparable to 2016 (33.9), 2015 (32), 2014 (33.7) and 2012 (31.8); the median age in 2017 was 32. The demographics differed somewhat in that 31.8% of the 2017 survey respondents were males, compared to 44.8% in 2015, 43.9% in 2014, and 61.6% for the 2012 VO survey.

The 2012 results are reported for the SUD survey questions in this report; however, due to the difference in numbers of survey respondents and the additional non-Medicaid members surveyed in 2012, comparisons cannot be directly made with survey results in 2014 to 2017. SUD survey questions related to quality of care follow and are summarized in Table 25.

Table 25. SUD Survey - Quality-Related Questions, CY2014 - CY2017

	CY2014	CY2015	CY2016	CY2017
Overall, how would you rate the quality of service you have received from your counselor? *(Percentage of "Very good" or "Good" responses)*	**94.3%**	**93.2%**	**93.3%**	**88.2%**
How well does your counselor involve you in decisions about your care? *(Percentage of "Very good" or "Good" responses)*	**92.0%**	**88.4%**	**92.6%**	**87.4%**
Since beginning treatment, in general are you feeling much better, better, about the same, or worse? *(Percentage of "Much better" or "Better" responses)*	**87.1%**	**92.6%**	**88.9%**	**84.0%**

Overall, how would you rate the quality of service you have received from your counselor?
In 2017, 88.2% of members surveyed rated the quality of service as very good or good, lower than the three prior years (93.2%-94.3%) and pre-KanCare (2012 - 95.3%).

How would you rate your counselor on involving you in decisions about your care?
In 2017, 87.4% of the members surveyed rated counselor involvement of members in decisions about their care as very good or good, which was lower than the three prior years (88.4%-92.6%) and lower than pre-KanCare. (2012 – 93.5%; 2011 – 96.7%).

Since beginning treatment, in general are you feeling much better, better, about the same, or worse?
In 2017, 84.0% of the members surveyed responded they were feeling much better or better since beginning treatment, lower than the three prior years (87.1%-92.6%) and pre-KanCare 2012 (98.8%).

(8) Provider Survey

For provider surveys in 2014 and subsequent years in KanCare, the MCOs were directed to include three questions related to quality, timeliness, and access. These three questions and response options are to be worded identically on each of the MCOs' surveys to allow comparison and ability to better assess the overall program and trends over time.

Two of the MCOs, Sunflower and UnitedHealthcare, administer separate surveys to their BH providers. The MCOs were asked to include these three questions on their BH surveys as well.

The surveys also differed in the numbers of survey responses. For the three questions reviewed in this report, in 2017 Amerigroup had 272 to 365 provider responses; Sunflower had 167 to 182 general provider survey responses and only 33 to 34 BH survey responses; and UnitedHealthcare had only 74 to 75 general provider responses and 156 to 158 BH survey responses.

Unlike other sections of the KanCare Evaluation Report where data for the three MCOs are aggregated, data for the provider survey responses are reported separately by MCO. This is due in part to the separate surveying of BH providers and to the possibility that the same providers may have responded to two or three of the MCO surveys. The primary reason, however, is that the three questions are MCO-specific related to provider perceptions of each MCO's unique preauthorization processes, availability of specialists, and commitment to quality of care.

In this section, results are reported for the quality-related question. The provider survey results for the timeliness-related question are in Section 17 and Section 23 for the access-related question results.

Providers were asked, "**Please rate your satisfaction with (MCO name's) demonstration of their commitment to high quality of care for their members."** (See Table 26 for survey results by individual MCO.

Amerigroup
Amerigroup conducts one survey for both physical health providers and BH providers. In 2017, 65.2% of 365 providers surveyed reported they were very or somewhat satisfied, higher than the three previous years (2016 – 60.9%; 2015 – 62.8%; and 2014 – 50.9%). The percentage of providers responding very or somewhat dissatisfied was correspondingly lower in 2017 (11.5%) than in the three previous years (16.3% in 2016; 13.8% in 2015, and 18.8% in 2014).

Sunflower
Sunflower conducts a general survey of physical health providers and a separate survey by Cenpatico of BH providers.

- **Sunflower general provider survey –** In 2017, 51.1% of 182 providers surveyed reported they were very or somewhat satisfied, a higher rate than in 2016 (50.8%), 2015 (47.1%) and 2014 (37.5%). The percentage of providers responding they were very or somewhat dissatisfied decreased each year from 17.6% in 2014 to 11.9% in 2015 to 10.3% in 2016 to 9.9% in 2017.

Table 26. Provider Satisfaction with MCO's Commitment to High Quality of Care for Their Members, CY2014 - CY2017

MCO Provider Survey Type	2014	2015	2016	2017
	Very or Somewhat Satisfied			
Amerigroup*	50.9%	62.8%	60.9%	65.2%
Sunflower *(General Provider)*	37.5%	47.1%	50.8%	51.1%
Cenpatico *(Behavioral Health)*	**	51.6%	48.8%	35.3%
UnitedHealthcare *(General Provider)*	^	44.7%	40.3%	41.3%
Optum *(Behavioral Health)*	54.7%	59.4%	55.9%	53.2%
	Neither Satisfied nor			
Amerigroup*	30.4%	23.4%	22.8%	23.3%
Sunflower *(General Provider)*	45.0%	41.0%	38.9%	39.0%
Cenpatico *(Behavioral Health)*	**	41.3%	44.2%	44.1%
UnitedHealthcare *(General Provider)*	^	40.8%	44.4%	38.7%
Optum *(Behavioral Health)*	36.9%	34.7%	35.2%	38.0%
	Very or Somewhat Dissatisfied			
Amerigroup*	18.8%	13.8%	16.3%	11.5%
Sunflower *(General Provider)*	17.6%	11.9%	10.3%	9.9%
Cenpatico *(Behavioral Health)*	**	7.2%	7.0%	20.6%
UnitedHealthcare *(General Provider)*	^	14.5%	15.3%	20.0%
Optum *(Behavioral Health)*	8.4%	5.9%	9.0%	8.9%
	Total Responses			
Amerigroup*	283	427	215	365
Sunflower *(General Provider)*	251	293	311	182
Cenpatico *(Behavioral Health)*	**	126	172	34
UnitedHealthcare *(General Provider)*	^	76	72	75
Optum *(Behavioral Health)*	84	101	145	158

*Amerigroup includes Behavioral Health Providers in their General Provider Survey.
**Question was not asked in Cenpatico survey in 2014.
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."

- **Sunflower (Cenpatico) BH provider survey –** In 2017, only 34 BH providers were surveyed, down from 126 to 172 in 2015 and 2016; this should be taken into consideration when assessing any annual differences in responses. In 2017, 35.3% of 34 BH providers were very or somewhat satisfied, down from 48.8% in 2016 and 51.6% in 2015. The percentage of BH providers reporting they were very or somewhat dissatisfied was 20.6% in 2017, up from 7.0% in 2016 and 7.2% in 2015. This question was not asked in the 2014 BH survey. As directed by the State, this question was added to the 2015 survey.

UnitedHealthcare
UnitedHealthcare conducts an annual survey of physical health providers and a separate BH provider survey through Optum.

- **UnitedHealthcare general provider survey** – In 2017, 41.3% of 75 providers surveyed were very or somewhat satisfied, compared to 40.3% in 2016 and 44.7% in 2015. The percentage very or somewhat dissatisfied (20.0%) was higher than in 2016 (15.3%) and 2015 (14.5%). In 2014, UnitedHealthcare surveyed 66 providers, but, due to a typographical error in the survey instrument, the results cannot be compared.
- **UnitedHealthcare (Optum) BH provider survey –** In 2017, 53.2% of 158 BH providers surveyed were very or somewhat satisfied, compared to 55.9% in 2016, 59.4% in 2015, and 54.7% in 2014. The percentage of BH providers responding they were very or somewhat dissatisfied was 8.9%, compared to 9.0% in 2016, 5.9% in 2015, and 8.4% in 2014.

(9) Grievances – Reported Quarterly

Compare/track number of grievances related to quality over time, by population type.
Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KDHE KanCare website for public review.

(10) Other (Tentative) Studies (Specific studies to be determined)

The focus and topics for "other studies" to be conducted and reported in the 2018 KanCare Evaluation Annual report are planned to be focused on network adequacy and member perceptions of the quality of HCBS services received.

Coordination of Care (and Integration)

Goals, Related Objectives, and Hypotheses for Coordination of Care subcategories:

- *Goal: Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders, and LTSS.*
- *Related Objectives:*
  - *Improve coordination and integration of physical healthcare with behavioral healthcare.*
  - *Support members successfully in their communities.*
- *Hypothesis:*
  - *The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.*

(11) Care Management for Members Receiving HCBS Services

The population for the following performance measures is members who are receiving HCBS waiver services, including Intellectual/Developmental Disability (I/DD), PD, TA, TBI, Autism, FE, and MFP.

The number and percent of KanCare member waiver participants with documented change in needs whose service plans were revised, as needed, to address the change

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants with documented change in needs whose service plans were revised, as needed, to address the change (see Table 27). These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. The 2017 HCBS quality data will be finalized in May 2018

Table 27. Percent of HCBS Waiver Participants with Documented Change in Needs Whose Service Plans were Revised, as Needed, to Address the Change, CY2013 - CY2016

Waiver	CY2013	CY2014	CY2015	CY2016
Intellectual/Developmental Disability (I/DD) Waiver	97%	23%	28%	28%
Physical Disability (PD) Waiver	75%	39%	53%	65%
Frail Elderly (FE) Waiver	78%	38%	54%	65%
Traumatic Brain Injury (TBI) Waiver	53%	38%	38%	67%
Technical Assistance (TA) Waiver	92%	42%	75%	60%
Serious Emotional Disturbance (SED) Waiver	85%	86%	88%	83%
Autism Waiver	45%	11%	11%	16%

The number and percent of KanCare member waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs

The denominator for this measure is the number and percent of waiver participants who had assessments, and the numerator is the number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs (see Table 28).

Table 28. Percent of Waiver Participants who had Assessments Completed by the MCO that Included Physical, Behavioral, and Functional Components to Determine the Member's Needs, CY2014 - CY2016

Waiver	CY2014	CY2015	CY2016
Intellectual/Developmental Disability (I/DD) Waiver	78%	58%	82%
Physical Disability (PD) Waiver	87%	66%	83%
Frail Elderly (FE) Waiver	87%	70%	86%
Traumatic Brain Injury (TBI) Waiver	71%	65%	86%
Technical Assistance (TA) Waiver	95%	75%	87%
Serious Emotional Disturbance (SED) Waiver	92%	54%	71%
Autism Waiver	68%	48%	60%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. The 2017 HCBS quality data will be finalized in May 2018.

HCBS HEDIS-like Measures

For the following HCBS HEDIS-like performance measures were P4P in CY2014 and CY2015; though no longer P4P, the State has directed the MCOs to continue to report these rates separately for the HCBS population to allow continued tracking of progress in improving these rates (see Table 29). Note: In CY2014 and CY2015, members with dual eligibility, i.e., enrolled in both Medicare and Medicaid, were excluded to ensure consistency in reporting these P4P measures, as one of the MCOs (UnitedHealthcare) was at that time excluding dual-eligible members from their HEDIS reporting. Beginning with CY2017, MCOs were directed by the State to include dual-eligible members when calculating HEDIS rates.)

Table 29. HEDIS-Like Measures - HCBS Populations, CY2013 - CY2016

	CY2013	CY2014	CY2015	CY2016
Adults' access to preventive/ambulatory health services	**92.0%**	**93.1%**	**94.0%**	**94.1%**
Annual Dental Visits	**49.4%**	**49.0%**	**51.6%**	**51.6%**
Decrease in number of Emergency Department Visits* *(Visits/1000 member months)*	**77.58**	**78.06**	**79.64**	**71.55**

* The goal for this measure is to decrease the rate.

Increased preventive care – Increase in the number of primary care visits (P4P 2014-2015)
This measure is based on the HEDIS Adults' Access to Preventive/Ambulatory Health Services (AAP) measure
Population: HCBS
Analysis: Annual comparison to baseline, trending over time
The percentage of HCBS members who had an annual preventive health visit increased from 92.0% in CY2013 to 93.1% in CY2014, to 94.0% in CY2015, and again in CY2016 to **94.1%.** The rates for the HCBS member subpopulation were 4% to 8% higher than the rates for all KanCare adult members in all three years (88.4% in CY2013, 87.5% in CY2014, 87.1% in CY2015, and 86.2% in CY2016).

Increase in Annual Dental Visits (P4P 2014-2015)
This measure is based on the HEDIS Annual Dental Visit (ADV) measure
Population: HCBS (ages 2-21)
Analysis: Annual comparison to 2013 baseline, trending over time
The percentage of HCBS members who had an annual dental visit in CY2016 and CY2015 was **51.6%**, both years higher than in CY2014 (49.0%) and CY2013 (49.4%). The annual dental visit rates for HCBS members were 15% to 19% lower than the HEDIS rates for the overall KanCare population in each of the four years – CY2016 (63.7%), CY2015 (60.9%), CY2014 (60.0%) and CY2013 (60.3%).

Decrease in number of Emergency Department Visits (P4P 2014-2015) *(CMS Core Quality Measure)*
This measure is based on the HEDIS Ambulatory Care – Emergency Department Visits (AMB) measure. As per HEDIS criteria, this metric is reported as a rate based on visits per 1,000 member-months.

Population: HCBS
Analysis: Annual comparison to 2013 baseline, trending over time
The emergency department (ED) visit rate (per 1,000 member-months) for the HCBS population were lower in CY2016 (**71.55**) than the three previous years (77.58 in 2013, 78.06 in 2014, and 79.64 in 2015). ED visit rates reported by MCOs for CY2016 for the HCBS population ranged from 62.54 (Amerigroup) to 76.3 (UnitedHealthcare) and 76.7 (Sunflower). The rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (65.17 in CY2013, 64.19 in CY2014, 66.31 in CY2015, and 59.53 in CY2016).

(12) Other (Tentative) Study (Specific study to be determined)

The focus and topics for "other studies" to be conducted and reported in the 2018 KanCare Evaluation Annual report are planned to be focused on network adequacy and member perceptions of the quality of HCBS services received.

(13) Care Management for members with I/DD

Measures in this section pertain to the completed I/DD pilot project conducted in CY2013 through January 2014. Data provided by KDADS for this section were described and reviewed in the 2013 and 2014 KanCare Evaluation Reports.

(14) Member Survey – CAHPS

CAHPS questions related to coordination of care (see Table 30) include the following questions focused on perception of care and treatment in the Medicaid and CHIP populations. Additional detail on the CAHPS survey In CY2017 can be found in Section 4 of this report in the Health Literacy section.

Questions on child surveys only (pre-KanCare results for CY2012 were not available for these questions):
In the last 6 months:
Did your child get care from more than one kind of health care provider or use more than one kind of health care service?

- **GC**: **21.6%** in 2017; 21.9%–24.5% in 2014–2016
- **CCC**: **45.7**% in 2017; 45.3%–48.0% in 2014–2016
  Those responding their child received care from more than one kind of health care provider or health care service were asked:
  - **Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**
    - **GC**: **56.0%** in 2017; 55.2%–56.7% in 2014–2016
      (QC rankings are only reported by NCQA for the CCC survey populations.)
    - **CCC**: **56.9**% in 2017 (**<25th QC**); 57.6%–58.2% in 2014–2016
      MCO CCC subgroup rates in 2017 ranged from 52.4% (<5th QC) to 58.8% (no QC due to less than 100 survey responses).

Table 30. Member Survey - CAHPS Coordination of Care Questions									
Question	Pop	% Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Child Surveys only									
Did your child get care from more than one kind of health care provider or use more than one kind of health care service?	GC	22.3%	24.5%	21.9%	**21.6%**				
	CCC	46.2%	48.0%	45.3%	**45.7%**				
Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	GC	56.7%	56.4%	55.2%	**56.0%**				
	CCC	57.9%	58.2%	57.6%	**56.9%**	↓	↓	↓	↓
Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?	GC	10.4%	11.2%	10.2%	**9.2%**				
	CCC	16.6%	17.3%	16.8%	**16.6%**				
Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	GC	91.1%	92.5%	94.5%	**92.6%**				
	CCC	96.5%	93.1%	94.9%	**95.3%**	↑			↑
Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?	GC	24.5%	28.6%	26.7%	**24.9%**				
	CCC	77.2%	76.8%	74.8%	**73.7%**				
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	GC	92.9%	92.4%	91.6%	**92.7%**				
	CCC	92.3%	92.4%	92.1%	**92.6%**	↓	↓	↓	↓
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life?	GC	92.5%	88.8%	89.6%	**91.2%**				
	CCC	90.3%	89.1%	89.2%	**90.1%**	↑	↓	↓	↑
In the last 6 months, did you get or refill any prescription medicines for your child?	GC	50.8%	53.0%	50.3%	**50.5%**				
	CCC	86.5%	86.0%	84.0%	**86.2%**				
How often was it easy to get prescription medicines for your child through his or her health plan?	GC	95.2%	93.1%	94.4%	**94.3%**				
	CCC	94.7%	93.2%	94.4%	**94.7%**	↑	↑	↑	↑
Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?	GC	56.7%	59.5%	54.1%	**59.7%**				
	CCC	57.6%	59.7%	57.0%	**59.5%**	↓	↑	↓	↓

^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

Table 30. Member Survey - CAHPS Coordination of Care Questions (Continued)									
Question	Pop	% Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Adult and Child Surveys									
In the last 6 months…									
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	87.6%	88.1%	87.2%	**88.0%**	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	**93.4%**	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	**94.1%**	↑	↑	↑	↑
Did you (your child) get care from a doctor or other health provider besides your (his or her) personal doctor?	Adult	62.0%	61.4%	60.9%	**65.3%**				
	GC	39.5%	44.1%	39.6%	**42.0%**				
	CCC	58.3%	60.7%	58.6%	**58.7%**				
How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?	Adult	83.0%	82.7%	85.0%	**84.6%**	↑	↑	↑	↑
	GC	81.9%	82.3%	81.5%	**83.3%**	↑	↑	↓	↑
	CCC	80.5%	83.3%	80.5%	**80.6%**	↓	↑	↓	↓
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	43.0%	46.5%	44.3%	**46.8%**				
	GC	17.9%	19.4%	17.9%	**18.7%**				
	CCC	38.4%	39.5%	39.8%	**39.8%**				
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	84.8%	81.7%	86.2%	**82.9%**	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	**86.4%**	↑	↑	↓	↑
	CCC	85.3%	83.3%	86.0%	**87.1%**	↑	↑	↑	↑
^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile									

Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?

- **GC**: **24.9%** in 2017; 24.5%–28.6% in 2014–2016
- **CCC**: **73.7**% in 2017; 74.8%–77.2% in 2014–2016

  Those responding their child had a medical, behavioral, or other health condition that lasted more than three months were asked:
  - **Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?**
    - **GC**: **92.7%** in 2017; 91.6%–92.9% in 2014–2016
      (QC rankings are only reported by NCQA for the CCC survey populations.)
    - **CCC**: **92.6**% in 2017 (**<50th QC**); 92.1%–92.4% in 2014–2016
      MCO CCC subgroup rates in 2017 ranged from 52.4% (<5th QC) to 58.8% (no QC due to less than 100 survey responses).
  - **Does your child's personal doctor understand how your child's medical, behavioral, or other health conditions affect your family's day-to-day life?**
    - **GC**: **56.0%** in 2017; 55.2%–56.7% in 2014–2016
      (QC rankings are only reported by NCQA for the CCC survey populations.)
    - **CCC**: **56.9**% in 2017 (**<25th QC**); 57.6%–58.2% in 2014–2016
      MCO CCC subgroup rates in 2017 ranged from 52.4% (<5th QC) to 58.8% (no QC due to less than 100 survey responses).

In the last 6 months:

Did you get or refill any prescription medicines for your child?

- **GC**: **50,5%** in 2017; 50.3%–53.0% in 2014–2016
- **CCC**: **86.2**% in 2017; 84.0%–86.5% in 2014–2016
  Those responding they got or refilled a prescription for their child in the last 6 months were asked:
  - **Was it easy to get prescription medicines for your child through his or her health plan?**
    - **GC**: **94.3%** in 2017; 93.1%–95.2% in 2014–2016
      All MCO GC subgroup rates in 2014 to 2017 have been above 91%. In 2017, MCO GC subgroup rates ranged from 92.0% to 95.8%. (QC rankings are only reported by NCQA for the CCC survey populations.)
    - **CCC**: **94.7**% in 2017 (**>95th QC**); 93.2%–94.7% in 2014–2016
      All MCO CCC subgroup rates in 2014 to 2017 have been above 91%. In 2017, MCO CCC subgroup rates ranged from 93.1% to 96.4%. Rates for three MCO CCC subgroups in 2017 were >95th QC: UnitedHealthcare TXXI (96.4%), UnitedHealthcare TXIX (96.2%), and Sunflower TXXI (94.6%). Rates for two MCO CCC subgroups were >90th QC and 94.4%: Amerigroup TXXI and Sunflower TXIX. Amerigroup's CCC TXIX rate in 2017 (93.1%) was >75th QC.
  - **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
    - **GC**: **59.7%** in 2017; 54.1%–59.5% in 2014–2016
      (QC rankings are only reported by NCQA for the CCC survey populations.)
    - **CCC**: **59.5**% in 2017 (**<50th QC**); 57.6%–59.7% in 2014–2016
      MCO CCC subgroup rates in 2017 (ranging from 57.0%–59.1%) were <50th QC or lower, with the exception of Sunflower TXIX (64.2%; >66.67th QC) and Amerigroup TXXI (61.0%; >50th QC).

In the last 6 months:

Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?

- **GC**: **9.2%** in 2017; 10.2%–11.2% in 2014–2016
- **CCC**: **16.6**% in 2017; 16.6%–17.3% in 2014–2016
  Those responding they needed their child's doctor's or other health providers to contact a school or daycare center about their child's health were asked:
  - **Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?**
    - **GC**: **92.6%** in 2017; 91.1%–94.5% in 2014–2016
      (QC rankings are reported only for CCC for this question.)
    - **CCC**: **95.3**% in 2017 (**>75th QC**); 93.1%–96.5% in 2014–2016
      QC rankings are only available for MCO subgroups with 100 or more responses reported in the survey. Amerigroup's TXIX survey population was the only subgroup with over 100 survey responses in 2017 (94.8%; >66.67th QC).

Questions on both adult and child surveys:

In the last 6 months:

How often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?

- **Adul**ts: **88.0%** in 2017 (**>75th** QC); 87.2%–88.1% in 2014–2016; Rates for each of the MCOs were >75th QC in 2017, 2016, and 2015.

- **GC**: **93.4%** in 2017 (**>75th** QC); 92.0%–93.4% in 2014–2016
  Rates for all MCO GC subgroups were above the 50th QC or higher and over 90% positive in 2017. UnitedHealthcare's TXIX rate (94.6%) and TXXI rate (95.4%) were >95th QC.
- **CCC**: **94.1**% in 2017 (**>75th** QC); 91.9%–93.0% in 2014–2016
  Rates for all MCO CCC subgroups were above 91% in 2017.UnitedHealthcare's TXXI rate (97.3%) in 2017 was >95th QC and significantly higher (*p*<.01) than in 2016 (92.1%; >50th QC); their TXIX rate (94.7%) in 2017 was >90th QC. Amerigroup's TXIX rate (94.3%; >75th QC) was significantly higher (*p*<.01) than in 2016 (89.9%; <50th QC).

In the last 6 months:
Did you (your child) get care from a doctor or other health provider besides your (child's) personal doctor?

- **Adults**: **62.3%** in 2017; 60.9%–62.0% in 2014–2016
- **GC**: **42.0%** in 2017; 39.5%–44.1% in 2014–2016
- **CCC**: **58.7**% in 2017; 58.3%–60.7% in 2014–2016
  Those who responded they received care from a provider other than their personal doctor in the last 6 months were asked:
  - **How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?**
    - **Adults**: **84.6%** in 2017 (**>50th QC**); 82.7%–85.0% in 2014–2016
      Sunflower's rate (90.0%) was >95th QC; Amerigroup's rate (82.4%) was <50th QC, and UnitedHealthcare's rate (80.0%) was <25th QC.
    - **GC**: **83.3%** in 2017 (**>50th QC**); 81.5%–82.3% in 2014–2016
    - **CCC**: **80.6**% in 2017 (**<25th QC**); 80.5%–83.3% in 2014–2016
      Amerigroup's and UnitedHealthcare's rates for CCC TXIX and TXXI were <25th QC, ranging from 78.7% to 80.3%. Sunflower's CCC TXIX rate (83.0%) was >50th QC; their CCC TXXI rate (81.2%) was <33.33rd QC.

In the last 6 months:
Did you make any appointments (for your child) to see a specialist?

- **Adult**s: **46.8%** in 2017; 43.0%–46.5% in 2014–2016
- **GC**: **18.7%** in 2017; 17.9%–19.4% in 2014–2016
- **CCC**: **39.8**% in 2017; 38.4%–39.8% in 2014–2016
  Those who responded they had made an appointment to see a specialist were asked:
  - **How often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    - **Adults**: **82.9%** in 2017 (**>66.67th QC**); 81.7%–86.2% in 2014–2016
    - **GC**: **86.4%** in 2017 (**>75th QC**); 79.8%–84.6% in 2014–2016
      UnitedHealthcare's TXXI rate in 2017 (90.2%) was >95th QC and significantly higher (*p*<.01) than in 2016 (78.0%; <50th QC). Sunflower's TXIX rate in 2017 (86.4%; >75th QC) was significantly higher (*p*=.04) than in 2016 (74.0%).
    - **CCC**: **87.1**% in 2017 (**>75th QC**); 83.3%–86.0% in 2014–2016
      UnitedHealthcare's TXIX rate in 2017 (89.5%) was >90th QC.

(15) Member Survey – Mental Health

The MH Surveys conducted in 2011 through 2017 are described above in Section 7 "Member Survey – Quality." The questions in Table 31 are related to the perception of care coordination for members receiving MH services.

Table 31. Mental Health Survey - Questions Related to Coordination of Care

	Year	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**						
	2017	**83.9%**	335 / 399	79.9% – 87.2%			
	2016	80.7%	235 / 290	75.8% – 84.9%			
	2015	84.9%	325 / 383	81.0% – 88.2%			
	2014	86.5%	704 / 814	84.0% – 88.7%			
	2013	86.0%	917/1,066	83.8% – 87.9%			
	2012	78.8%	219 / 278	73.6% – 83.2%			
	2011	91.3%	274 / 300	87.6% – 94.1%	<.01↓		
	General Youth (Ages 12–17), Youth Responding						
	2017	**84.3%**	187 / 222	78.9% – 88.5%			
	2016	83.1%	126 / 152	76.3% – 88.3%			
	2015	87.5%	126 / 144	81.0% – 92.1%			
	2014	83.8%	260 / 309	79.2% – 87.5%			
	2013	82.8%	427 / 518	79.1% – 86.0%			
	2012	85.0%	85 / 100	76.6% – 90.8%			
	2011	85.1%	114 / 134	78.0% – 90.2%			
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2017	**83.0%**	160 / 193	77.0% – 87.7%		<.01↑	.03↑
	2016	79.3%	127 / 161	72.3% – 84.9%			
	2015	81.5%	123 / 151	74.6% – 86.9%			
	2014	74.8%	138 / 184	68.0% – 80.5%			
	2013	71.8%	165 / 229	65.7% – 77.2%	<.01↑		
	2012	76.3%	103 / 135	68.4% – 82.7%			
	2011	77.6%	97 / 125	69.5% – 84.1%			
My family got as much help as we needed for my child.	**General Youth (Ages 0-17), Family Responding**						
	2017	**83.5%**	405 / 485	79.9% – 86.5%			
	2016	82.2%	264 / 320	77.6% – 86.0%			
	2015	86.3%	278 / 322	82.1% – 89.6%			
	2014	79.7%	609 / 766	76.7% – 82.4%			
	2013	83.2%	799 / 966	80.7% – 85.4%			
	2012	82.9%	213 / 257	77.8% – 87.0%			
	2011	84.2%	278 / 330	79.9% – 87.8%			
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2017	**79.3%**	319 / 403	75.0% – 83.0%			
	2016	77.6%	253 / 325	72.7% – 81.8%			
	2015	78.9%	260 / 330	74.2% – 83.0%			
	2014	76.4%	318 / 413	72.0% – 80.2%			
	2013	75.2%	363 / 482	71.1% – 78.8%			
	2012	77.3%	248 / 321	72.4% – 81.6%			
	2011	77.4%	220 / 284	72.2% – 81.9%			

Table 31. Mental Health Survey - Questions Related to Coordination of Care (Continued)							
	Year	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
	General Adult (Age 18+)						
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**2017**	**80.7%**	274 / 340	76.2% – 84.6%			
	2016	78.7%	207 / 264	73.3% – 83.2%			
	2015	80.4%	278 / 346	75.9% – 84.3%			
	2014	82.3%	589 / 716	79.4% – 84.9%			
	2013	83.4%	802 / 962	80.9% – 85.6%			
	2012	76.7%	191 / 249	71.1% – 81.5%			
	2011	82.3%	214 / 260	77.2% – 86.5%			

Perception that the members were able to access all of the services they thought they needed

- For SED Waiver youth and young adults, the 2017 rate (79.3%) was higher than in each of the six prior years (ranging from 75.2%–78.9%). The 2017 rate for SED Waiver Youth and Young Adults in Urban counties (70.4%) was significantly lower compared to other county types (83.9%; $p<.01$ [Semi-Urban 81.5%; Densely-Settled Rural 85.6%; Rural and Frontier 84.6%]).
- For General Youth, (ages 12–17), youth responding, the 2017 positive response percentage was 84.3%, and over the 7-year period, ranged from 82.8% in 2013 to 87.5% in 2015.
- The 2017 General Adult rate (83.9%) was significantly lower than the 2011 rate (91.3%; $p<.01$), with only the 2016 (80.7%) rate and 2012 rate (78.8%) lower.
- The 2017 SED Waiver youth (ages 12–17), youth responding, rate (83.0%) was the highest rate in the 7-year period. The 7-year positive trend from 2011 (77.6%) to 2017 (83.0%) and from 2013 (71.8%) to 2017 (83.0%) was significant ($p=.03$ and $p<.01$, respectively).
- For General Youth, the 2017 rate was 83.5%; rates ranged from 79.7% (2014) to 86.3% (2015).

Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)

The General Adult positive response percentage in 2017 was 80.7% and, over the 7-year period, ranged from 76.7% (2012) to 83.4% (2013).

(16) Member Survey – SUD

Section 7 provides background on the SUD survey conducted by the three MCOs in CY2014 through CY2017. Questions related to perceptions of care coordination include the following questions (see Table 32):

Has your counselor requested a release of information for this other substance abuse counselor who you saw?

- In 2017, 36.7% (84 of 229) of members who responded indicated they had received services in the past year from a substance abuse counselor in addition to their current counselor, compared to 44.3% (136) of 30 in 2016, 34.8% (63 of 181 surveyed) in 2015, and 35.7% (70 of 196) surveyed in 2014.
- Of the 84 who received services from more than on substance use counselor, 70 responded to the follow-up question asking if their counselor requested a release of information from the other counselor. Of the 70, 57 (81.4%) indicated their counselor requested a release of information, comparable to 2016 (82.4%) and 2015 (85.1%) and higher than in 2014 (60.3%).

Table 32. SUD Survey - Questions Related to Coordination of Care, CY2014 - CY2017				
	CY2014	CY2015	CY2016	CY2017
In the last year, have you received services from any other substance use counselor in addition to your current counselor? *(Percentage of "Yes" responses)*	35.7%	34.8%	44.3%	36.7%
If yes to previous question: Has your current counselor asked you to sign a "release of information" form to share details about your visit(s) with the other substance use counselor who you saw? *(Percent of "Yes" responses)*	60.3%	85.1%	82.4%	81.4%
Thinking about the coordination of all your health care, do you have a primary care provider or medical doctor?* *(Percentage of "Yes" responses)*	64.9%	64.4%	66.4%	65.6%
If yes to previous question: Has your counselor asked you to sign a "release of information" form to allow him/her to discuss your treatment with your primary care provider or medical doctor? *(Percentage of "Yes" responses)*	52.5%	69.8%	70.4%	65.8%
*Denominator for question includes "Don't know/No opinion" responses in addition to "Yes" and "No" responses.				

Has your counselor requested a release of information for and discussed your treatment with your medical doctor?

- In 2017, 2.4% (6) of 250 members responding indicated they did not know if they have a primary care provider (PCP), compared to 4.0% (14 of 327) in 2016, 3.1% (6 of 191) in 2015, and 7.1% (15 of 211) in 2014. In 2017, 65.6% (164 of 250) indicated they have a PCP, comparable to 66.4% in 2016, 64.4% in 2015, and 64.9% in 2014.
- Of those who indicated they have a PCP, 65.8% (77 of 117) in 2017 reported their counselor requested a release of information to allow discussion of the member's treatment with their PCP, lower than 70.4% in 2016 and 69.8% in 2015 and higher than in 2014 (52.5%).

(17) Provider Survey

Background information and comments on the 2017 Provider Survey are described in Section 8. In this section, results are reported for satisfaction with the preauthorization process. The provider survey results for the quality-related question are in Section 8, and results for the access-related question are in Section 23.

Providers were asked, "**Please rate your satisfaction with obtaining precertification and/or authorization for (MCO's) members**." Table 33 provides the available survey results by individual MCO.

Amerigroup

In 2017, 62.5% of 309 providers surveyed reported they were very satisfied or satisfied with Amerigroup precertification and/or authorization, comparable to 2015 (61.2%) and higher than in 2016 (51.7%), 2014 (53.3%), and 2013 (40.7%). The percentage very dissatisfied or dissatisfied was lower in 2017 (19.1%) than the four prior years (28.7% in w016; 20.7% in 2015; 22.8% in 2014; and 42.6% in 2013).

Sunflower

- **Sunflower general provider survey** – In 2017, 42.5% of 179 providers surveyed reported they were very satisfied or satisfied, lower than in 2016 (46.1%) and higher than in 2015 (39.8%) and 2014 (38.2%). The percentage very dissatisfied or somewhat dissatisfied was comparable in 2017 (23.5%) and 2015 (23.8%), higher than in 2016 (15.7%) and lower than in 2014 (29.0%). No comparison can be made with the 2013 general provider survey results since Sunflower's 2013 survey questions were asked of providers only in comparison to other MCOs.
- **Sunflower (Cenpatico) BH provider survey** – The number of BH providers surveyed ranged from 33 in 2017 to 293 in 2016, which should be taken into consideration when assessing annual changes in satisfaction rates. In 2017, 57.6% of the 33 BH providers surveyed indicated they were very or somewhat satisfied with Cenpatico precertification/preauthorization, higher than in 2016 (32.3% of 167) and 2015 (42.5% of 127) and lower than in 2014 (63.4%of 52). The percentage dissatisfied or very dissatisfied was lower in 2017 (6.1%) and 2016 (9.0%) than in 2015 (13.4%) and 2014 (9.6%).

Table 33. Provider Satisfaction with Obtaining Precertification and/or Authorization for Their Members, CY2014 - CY2017

MCO Provider Survey Type	2014	2015	2016	2017
	Very or Somewhat Satisfied			
Amerigroup*	53.3%	61.2%	51.7%	62.5%
Sunflower *(General Provider)*	38.2%	39.8%	46.1%	42.5%
Cenpatico *(Behavioral Health)*	63.4%	42.5%	32.3%	57.6%
UnitedHealthcare *(General Provider)*	^	50.0%	41.7%	44.0%
Optum *(Behavioral Health)*	52.3%	58.4%	51.4%	52.9%
	Neither Satisfied nor Dissatisfied			
Amerigroup*	23.9%	18.1%	19.7%	18.4%
Sunflower *(General Provider)*	32.8%	36.4%	38.2%	34.1%
Cenpatico *(Behavioral Health)*	26.9%	44.1%	58.7%	36.4%
UnitedHealthcare *(General Provider)*	^	27.6%	33.3%	26.7%
Optum *(Behavioral Health)*	34.5%	36.6%	39.7%	40.8%
	Very or Somewhat Dissatisfied			
Amerigroup*	22.8%	20.7%	28.7%	19.1%
Sunflower *(General Provider)*	29.0%	23.8%	15.7%	23.5%
Cenpatico *(Behavioral Health)*	9.6%	13.4%	9.0%	6.1%
UnitedHealthcare *(General Provider)*	^	22.4%	25.0%	29.3%
Optum *(Behavioral Health)*	13.1%	5.0%	8.9%	6.4%
	Total Responses			
Amerigroup*	272	397	178	309
Sunflower *(General Provider)*	241	269	293	179
Cenpatico *(Behavioral Health)*	52	127	167	33
UnitedHealthcare *(General Provider)*	66	76	72	75
Optum *(Behavioral Health)*	84	101	146	157

*Amerigroup includes Behavioral Health Providers in their General Provider Survey
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."

UnitedHealthcare

- **UnitedHealthcare general provider survey –** In 2017, 44.0% of 75 providers surveyed were very or somewhat satisfied, comparable to 41.7% in 2016 and lower than in 2015 (50.0%). The percentage of providers reporting they were very or somewhat dissatisfied was higher in 2017 (29.3%) than in 2016 (25.0%) and 2015 (22.4%).
- **UnitedHealthcare (Optum) BH provider survey** – In 2017, 52.9% of 157 BH providers were very or somewhat satisfied, comparable to 2016 (51.4%) and 2014 (52.3%) and lower than in 2015 (58.4%). In 2017, 6.4% reported they were very or somewhat dissatisfied, compared to 8.9% in 2016, 5.0% in 2015, and 13.1% in 2014.

Cost of Care

Goals, Related Objectives, and Hypotheses for Costs subcategory:

- *Goal: Control Medicaid costs by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care*
  Related Objectives:
  - *Promote wellness and healthy lifestyles*
  - *Lower the overall cost of health care.*
- *Hypothesis: By holding MCOs to outcomes and performance measures, and typing measures to meaningful financial incentives, the state will improve health care quality and reduce costs.*

(18) Costs

Population: KanCare Members by Medicaid Eligibility Group (MEG)
Analysis: Pre-KanCare compared to KanCare and trending over time beginning in DY2

Comparison of Pre-KanCare and KanCare Service Utilization

Table 34 shows a comparison of the annual number of services used by those eligible for Medicaid services pre-KanCare in CY2012 with services used by KanCare members in CY2016.

Table 34. Comparison of Pre-KanCare (2012) and KanCare (2016) Service Utilization

Type of Service	% Utilization Difference
Non-Emergency Transportation	55%
Home & Community-Based Services	34%
Vision	13%
Dental	5%
Primary Care Physician	0%
Inpatient	-22%
Outpatient, Non-Emergency Room	-13%
Outpatient Emergency Room	-9%
Pharmacy	-2%

Services with increased utilization in CY2016 compared to CY2012 were Dental (5% increase), Home and Community-Based Services (34% increase), Vision (13% increase), and Non-Emergency Transportation (55% increase)

Inpatient Hospitalization decreased 22% in CY2016 compared to CY2012, and Emergency Room Outpatient Visits decreased by 9%. Decreases in utilization of these services are a positive outcome, reflecting increased access of treatment from the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays.KDHE reported that, due to increased member months in CY2016 from eligibility reconfiguration, utilization services fluctuated in comparison to last year's report, but a positive utilization trend continues to improve in comparison to CY 2012.

Per Member Per Month (PMPM) Average Annual Service Expenditures

Per member per month (PMPM) is the annual average monthly cost to provide care. "Cost to provide care" is based on encounters, i.e., payments to providers who have submitted claims for services, including fee-for-service (FFS) claims. FFS claims were included due to claims paid as fee-for-service for KanCare members due to eligibility reconfiguration and reprocessing of applications in a timely manner.

Table 35 shows the PMPM for CY2013, CY2014, CY2015, and CY2016 in total and by comparison groups.

Due to "claims lag," i.e., the time allowed for providers to submit claims and the time allowed for the MCOs to process the claims, a certain portion of service costs in one year will be reflected in the PMPM the following year. As shown in Table 35, CY2013 would appear to have lower PMPM when, in actuality, the differences are likely due to CY2013 being the first year of KanCare, and some of the service costs in CY2013 were paid in CY2014. On the same note, some of the costs for services received in CY2014 were paid in CY2015 and years following.

Overall, the PMPM average annual service expenditures have increased year over year.

The five comparison population groups in the PMPM analysis above consist of:

- Children & Families: CHIP, M-CHIP (Medicaid-CHIP program), Foster Care, TAF (Temporary Assistance for Families), and PLE (Poverty Level Eligible);
- Waiver Services: Autism, TA, SED, TBI, and I/DD waiver populations;
- Long Term Care: Child in Institutions, FE Waiver, PD Waiver, Nursing Facility, and ICF/MR (intermediate care facility for persons with mental retardation);
- Persons with Disabilities: SSI (Supplemental Security Income) Aged, Blind, and Disabled and Medically Needy Aged Blind and Disabled;
- Pregnant Women
- Other: Refugees, Breast & Cervical Cancer, and members participating in the WORK and Working Disabled programs.

Table 35. Per Member Per Month (PMPM) Service Expenditures by Medicaid Eligibility Group, CY2013 - CY2016

Comparison Groups	CY2013	CY2014	CY2015	CY2016
Children & Families	174	200	214	221
Waiver Services	2,995	3,148	3,565	3,598
Long Term Care	2,049	2,346	2,598	2,731
Persons with Disabilities	623	676	696	797
Pregnant Women	379	404	323	321
Other	516	762	813	847
Total	450	488	518	529

Access to Care

Goals, Related Objectives, and Hypotheses for Access to Care subcategories:

- *Goal: Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.*
- *Related Objectives:*
  - *Measurably improve health outcomes for members.*
  - *Support members successfully in their communities.*
  - *Promote wellness and healthy lifestyles.*
  - *Improve coordination and integration of physical health care with behavioral health care.*
  - *Lower the overall cost of health care.*
- *Hypothesis: The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(19) Provider Network – GeoAccess

Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy, occupational therapy, x-ray, and lab], and pharmacy)
KFMC reviewed the GeoAccess reports, maps, Network Adequacy reports, and other data to identify the percent of counties where specific provider types are not available from at least one MCO. KFMC also reviewed GeoAccess maps showing provider access by provider type for CY2012-CY2017.

In March 2018, KDHE staff provided MCO staff with training on how the quarterly Network Adequacy Reports are to be completed. KDHE staff echoed observations made each year by KFMC related to the number of duplicates, errors, and incomplete entries in these reports. KDHE provided clear guidelines as to how data should be reported and directed the MCOs to make corrections based on these guidelines. KDHE will be providing each MCO with feedback each quarter as to their progress in presenting accurate representation of network adequacy.

KDHE will also be reviewing the GeoAccess reports also submitted quarterly. At this point in time, it is unclear what, if any, impact there is to the GeoAccess reports from the errors and duplications in the Network Adequacy Report

Additional guidance has also been provided to MCO staff related to reporting the numbers and locations of primary care providers. Due to potential corrections currently being implemented in the reporting processes, the number of primary care and internal medicine providers and locations were excluded from Table 36, which summarizes counts reported in the GeoAccess reports for 2017 compared to 2016.

The GeoAccess reports include access to services by county and county type, number of members in each county by MCO, and percentage of each county within prescribed mileage ranges, depending on the type of service. Percentages of access in each county are based on the number and location of providers and the number of members in the county. For OB/GYN, Sunflower correctly reports much fewer members compared to other provider types, as availability needs to be based on the number of female members in each county. Amerigroup and UnitedHealthcare, however, report the same number of members for OB/GYN in each county as the number of members in other specialties.

Table 37 reports the number of counties (and whether the county is urban or non-urban) where each MCO reported that, as of December 2017, 100% of the members in the county had no access to particular provider types.

As shown in the table, there are some specialties, particularly in rural and frontier counties, where the number of counties without access is comparable for all three MCOs. Each year, the numbers of counties where no access to a provider specialty were available from any MCO has decreased.

Corrections later this year to the Network Adequacy and GeoAccess reports are anticipated to provide more accurate counts for provider specialty availability that will be reported in next year's KanCare Evaluation Annual Report. Of the 105 counties in Kansas, 16 are "Urban" or "Semi-Urban" and 89 are non-urban (21 "Densely-Settled Rural," 32 "Rural," and 36 "Frontier").

Table 36. Providers and Provider Locations by MCO and by Provider Type, CY2017 compared to CY2016*						
Provider Type	Number of Providers/ Number of Locations			Difference from 2016 to 2017		
	AGP	SSHP	UHC	AGP	SSHP	UHC
Physicians						
Allergy	**135/ 154**	44 / 32	38 / 35	+96 / +132	+2 / +2	-8 / -10
Cardiology	338 / 168	358/ 208	**419 / 242**	-7 / -16	+23 / +30	-17 / -41
Dermatology	**148 / 176**	46 / 50	76 / 74	+108 / +131	+2 / +13	-3 / -6
Gastroenterology	**519 / 428**	123 / 79	123 / 164	+408 / +371	+7 / +4	-10 / -18
General Surgery	**479 / 312**	352 / 242	350 / 273	+148 / +131	+6 / +18	-24 / -40
Hematology/Oncology	214 / 120	120 / 70	**247 / 151**	-3 / +9	+15 / +17	-18 / -54
Neonatology	**97 / 47**	67 / 19	63 / 32	+28 / +36	-7 / -1	-9 / -1
Nephrology	**112** / 56	62/ 53	104 **/ 99**	+20 / +21	-9 / +3	-3 / +23
Neurology	263 / 129	**289** / 132	273 **/ 150**	+57 / +25	+23 / +8	-33 / -75
Neurosurgery	91 / 54	**117 / 59**	87 / 57	+18 / +17	+30 / +7	-11 / -36
OB/GYN	**638 / 438**	379 / 218	456 / 286	+256 / +253	-12 / -1	-28 / -5
Ophthalmology	**242 / 308**	139 / 159	156 / 136	+113 / +104	+3 / -9	-29 / -24
Orthopedics	**352 / 238**	262 / 163	303 / 201	+131 / +131	-3 / +13	-27 / -45
Otolaryngology	**203 / 186**	100 / 62	109 / 89	+110 / +124	-4 / 0	+6 / -2
Physical Medicine/Rehab	**103 / 122**	71 / 57	84 / 75	+48 / +81	-1 / -4	-6 / -6
Plastic & Reconstructive Surgery	**158 / 164**	45 / 38	49 / 37	+121 / +134	+2 / +2	-11 / -24
Podiatry	**449 / 425**	40 / 48	75 / 111	+412 / +395	+2 / +7	-35 / -38
Psychiatrist	**499 / 357**	346 / 224	351 / 304	+24 / -8	-167 / -13	+16 / +8
Pulmonary Disease	**240 / 185**	106 / 91	131 / 106	+101 / +119	-13 / -9	-10 / -21
Urology	**204 / 188**	86 / 80	122 / 101	+104 / +131	-14 / +8	-37 / -35
Hospital						
Hospitals	86 / 125	**166 / 166**	147 / 151	-161 / -108	0 / 0	-2 / -1
Eye Care - Optometry						
Eye Care - Optometry	**552 / 563**	454 / 399	404 / 325	+151 / +146	+4 / -46	-144 / -161
Dental						
Dental Primary Care	380 / 280	**424 / 336**	410 / 289	-15 / -6	+19/ +51	+14 / +5
Ancillary Services						
Physical Therapy	**608 / 442**	587 / 313	449 / 229	+114 / +74	+51 / +12	+29 / +5
Occupational Therapy	**446 / 390**	235 / 200	231 / 162	-57 / +46	+11 / +8	+24 / +4
X-ray	**218 / 252**	181 / 204	147 / 151	-59 / -9	+2 / +18	-2 / -1
Lab	187 / 219	**220 / 236**	149 / 166	-100 / -57	-6 / -7	-3 / +10
Pharmacy						
Retail Pharmacy	642 / 639	**820 /803**	658 / 653	0 / 0	+242 / +79	-41 / -32

Blue font represents the highest number of providers and locations reported.

*Excluding Primary Care and Internal Medicine Providers due to reporting process revisions and updates being implemented in 2018.

Urban and Semi-Urban Counties

MCOs reported 69.3% of KanCare members in 2016 (273,640) and in 2017 (270,678) were residents of Urban or Semi-Urban Counties. In CY2012 - CY2014, KanCare members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types. In CY2016 there were three provider types where Semi-Urban counties did not have access through at least one MCO: Allergy – Montgomery County; Neonatology – Saline County; and Plastic & Reconstructive Surgery – Geary, Montgomery, and Riley Counties.

Based on the GeoAccess reports, provider types were available in CY2017 in Urban and Semi-Urban counties by at least one MCO. Provider types available from only one MCO include:

- Allergy – Montgomery County;
- Dermatology – Montgomery County;
- Plastic & Reconstructive Surgery – Geary, Montgomery, and Riley Counties; and
- Podiatry – Riley County.

Frontier, Rural, and Densely-Settled Rural (Non-Urban) Counties

In CY2016 and CY2017, 30.7% of KanCare members were residents of Frontier, Rural, or Densely-Settled Rural counties (119,752 in CY2017 and 121,327 in CY2016).

In CY2016, there were seven provider types where one or more county had no access through any of the three MCOs in 2016. In CY2017, there were only two provider types that MCOs reported had no access within the county from any MCOs:

- Neonatology: Cheyenne, Decatur, Gove, Logan, Ness, Norton, Rawlins, Sheridan, Sherman, Thomas, Trego, Wallace, and Wichita Counties; and
- Nephrology – Cheyenne and Rawlins Counties.

Including counties where over 95% of the members do not have access to particular provider types adds the following counties:

- Neonatology – Reno, Graham, and Greeley Counties; and
- Nephrology – Sherman County.

In Table 38, the number and percentage of members without access to provider types are listed by provider types. (Not included in the table are provider types, such as PCP, Internal Medicine, and Behavioral Health that have 100% access, based on distance standards.)

Table 37. Counties with no Provider Access by MCO and County Type, CY2017									
Provider type	Number of Counties with 0% Access (of 105 Counties)								
	Urban & Semi-Urban			Non-Urban			Counties with 0% access from all 3 MCOs' providers		
	AGP	SSHP	UHC	AGP	SSHP	UHC	Urban	Non-Urban	# members no access
Physicians									
Primary Care Provider	-	-	-	-	-	-	-	-	-
Allergy	-	2	1	-	3	4	-	-	-
Cardiology	-	1	-	-	-	-	-	-	-
Dermatology	-	2	1	-	12	-	-	-	-
Gastroenterology	-	-	-	-	24	8	-	-	-
General Surgery	-	-	-	-	-	-	-	-	-
Hematology/Oncology	-	2	-	-	14	-	-	-	-
Internal Medicine	-	-	-	-	-	-	-	-	-
Neonatology	-	3	3	14	20	42	-	13	5,073
Nephrology	-	-	1	2	4	3	-	2	562
Neurology	-	-	-	-	-	3	-	-	-
Neurosurgery	-	3	1	-	2	9	-	-	-
OB/GYN	-	-	-	-	7	-	-	-	-
Ophthalmology	-	-	-	-	-	-	-	-	-
Orthopedics	-	-	-	-	-	1	-	-	-
Otolaryngology	-	-	-	-	-	1	-	-	-
Physical Medicine/Rehab	-	1	-	-	5	33	-	-	-
Plastic & Reconstructive Surgery	-	5	4	-	17	18	-	-	-
Podiatry	-	2	1	-	18	4	-	-	-
Psychiatrist	-	-	-	-	8	-	-	-	-
Pulmonary Disease	-	1	-	-	15	1	-	-	-
Urology	-	-	-	-	3	3	-	-	-
Hospital									
Hospitals	-	-	-	-	-	-	-	-	-
Eye Care - Optometry									
Eye Care - Optometry	-	-	-	-	1	3	-	-	-
Dental									
Dental Primary Care	-	-	-	6	-	7	-	-	-
Ancillary Services									
Physical Therapy	-	-	-	-	-	-	-	-	-
Occupational Therapy	-	-	-	-	4	4	-	-	-
X-ray	-	-	-	-	-	-	-	-	-
Lab	-	-	-	-	-	-	-	-	-
Pharmacy									
Retail Pharmacy	-	-	-	-	-	-	-	-	-

Table 38. Number and Percentage of Members not Within Access Distance by Provider Type and MCO, CY2017					
Provider type	AGP	SSHP	UHC	Total	% of all members
Neonatology	7,655	29,882	30,357	67,894	**17.5%**
Plastic/Reconstructive Surgery	83	23,767	19,257	43,108	**11.1%**
Physical Medicine	333	9,358	17,645	27,336	**7.0%**
Allergy	83	10,142	8,866	19,092	**4.9%**
Neurosurgery	2,621	10,000	6,138	18,759	**4.8%**
Podiatry	-	15,348	2,876	18,224	**4.7%**
Gastroenterology	-	12,264	5,767	18,031	**4.6%**
Dermatology	83	13,360	3,243	16,686	**4.3%**
Pulmonary Disease	-	9,176	3,742	12,918	**3.3%**
Hematology/Oncology	250	10,380	477	11,107	**2.9%**
Nephrology	2,532	4,193	4,321	11,046	**2.8%**
Dental	4,312	784	4,000	9,096	**2.3%**
Cardiology	83	7,452	271	7,806	**2.0%**
OB/GYN	167	2,284	3,386	5,837	**1.5%**
Psychiatrist	583	4,185	1,240	6,008	**1.5%**
Occupational Therapy	122	1,720	2,422	4,264	**1.1%**
Retail Pharmacy	750	1,566	1,431	3,746	**1.0%**
Otolaryngology	-	649	2,777	3,426	**0.9%**
Lab	488	2,000	686	3,174	**0.8%**
X-ray	325	1,995	686	3,006	**0.8%**
Urology	-	1,179	1,365	2,544	**0.7%**
Optometry	284	425	1,857	2,566	**0.7%**
Neurology	83	987	1,270	2,340	**0.6%**
Hospitals	1,300	403	686	2,390	**0.6%**
Opthalmology	-	111	1,812	1,923	**0.5%**
Orthopedics	-	618	418	1,036	**0.3%**
Physical Therapy	122	55	40	217	**0.1%**

Average distance to a behavioral health provider

Average distance to one, two, three, four, and five BH providers by county type and by MCO in CY2017 are described below. While other provider types are reported by Urban/Semi-Urban and by Densely-Settled Rural/Rural/Frontier, access to behavioral health providers is reported for Densely Settle Rural separately from Rural/Frontier Counties. (Note: Amerigroup's reported populations in the GeoAccess Report for Densely-Settled Rural + Rural/Frontier adds up to 548 fewer than the Amerigroup reported for these rural county types combined.)

As of December 2017, the MCOs reported the following number of BH providers and number of locations of the providers:

- Amerigroup – 2,374 providers at 908 locations reported for 2017 (431 fewer providers at 69 fewer locations)

- Sunflower – 3,408 providers at 935 locations (304 more providers at 60 more locations than reported in 2016)
- UnitedHealthcare – 3,065 providers at 932 locations in 2017 (7 additional providers at 2 additional locations, compared to 2016)

Urban/Semi-Urban – Access standard is one provider within 30 miles.

- Amerigroup – 83,318 members in Urban/Semi-Urban counties (797 fewer than reported in 2016). The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.8 miles; to two providers was 1.6 miles; and to one provider was 1.2 miles.
- Sunflower – 91,989 members in Urban/Semi-Urban counties (6,865 fewer than reported in 2016). The average distance to "the 5th closest provider was 2.1 miles; to the "4th closest" provider was 2.0 miles; to the "3rd closest" provider was 1.9 miles; to the "2nd closest" provider was 1.7 miles; and to "the 1st closest" provider was 1.4 miles.
- UnitedHealthcare– 95,371 members in Urban/Semi-Urban counties (4,681 more members than in 2016). The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.9 miles; to two providers was 1.7 miles; and to one provider was 1.4 miles.

Densely-Settled Rural – Access standard is one provider within 45 miles

- Amerigroup – 25,185 members in Densely-Settled Rural counties (707 fewer than in 2016). The average distance to a choice of five providers was reported as 4.7 miles; to four providers was 4.5 miles; to three providers was 3.9 miles; to two providers was 3.5 miles; and to one provider was 2.8 miles.
- Sunflower – 23,567 members in Densely-Settled Rural counties (2,267 fewer than reported in 2016). The average distance to "the 5th closest provider was 5.9 miles; to the "4th closest" provider was 5.7 miles; to the "3rd closest" provider was 5.3 miles; to the "2nd closest" provider was 4.7 miles; and to "the 1st closest" provider was 3.9 miles.
- UnitedHealthcare – 25,449 members in Densely-Settled Rural counties (1,383 more than in 2016). The average distance to a choice of five providers was 4.4 miles; to four providers was 4.3 miles; to three providers was 4.2 miles; to two providers was 4.0 miles; and to one provider was 3.3 miles.

Rural/Frontier - Access standard is one provider within 60 miles

- Amerigroup – 14,906 members in Rural/Frontier counties (106 more than in 2016). The average distance to a choice of five providers was 18.3 miles; to four providers was 16.7 miles; to three providers was 14.9 miles; to two providers was 12.6 miles; and to one provider was 9.7 miles.
- Sunflower – 15,178 members in Rural/Frontier counties (1,318 fewer than reported in 2016). The average distance to "the 5th closest provider was 21.2 miles; to the "4th closest" provider was 19.3 miles; to the "3rd closest" provider was 18.7 miles; to the "2nd closest" provider was 16.0 miles; and to "the 1st closest" provider was 11.7 miles.
- UnitedHealthcare – 14,919 members in Rural/Frontier counties (1,523 more than in 2016). The average distance to a choice of five providers was 12.8 miles; to four providers was 11.9 miles; to three providers was 11.2 miles; to two providers was 10.3 miles; and to one provider was 9.2 miles.

Percent of counties covered within access standards for behavioral health

BH providers were available to members of all three MCOs within the State access standards for each county type.

Urban/Semi-Urban - The access standard for Urban and Semi-Urban counties is within 30 miles. Based on the MCO GeoAccess reports, this access standard was met each year CY2012 to CY2017 for 100% of the 16 Urban and Semi-Urban counties in Kansas.

Densely-Settled Rural - The access standard for Densely-Settled Rural counties is within 45 miles. Based on the GeoAccess maps and data, this access standard was met in CY2017 and each year CY2012 to CY2016 for 100% of the 21 Densely-Settled Rural counties in Kansas, as reported by the three MCOs.

Rural/Frontier - The access standard for Rural and Frontier counties is a distance of 60 miles. Based on the GeoAccess maps and data, this access standard was met in CY2017 and each year CY2012 to CY2016 for 100% of the 32 Rural counties and 36 Frontier counties in Kansas, as reported by Amerigroup, Sunflower, and UnitedHealthcare.

Home and Community Based Services (HCBS) - Counties with access to at least two providers by provider type and services

Table 39 provides information reported by the three MCOs indicating the number of counties that have at least two service providers and the number of counties that have at least one service provider for each HCBS provider type. The baseline for this measure is CY2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review. Information on the counties without access or limited access is not yet reported through GeoAccess mapping, and reports do not yet include names of counties that have less than two providers or no providers available. Future plans, however, include mapping of HCBS service access. Beginning this fall, MCOs will be required to include in their quarterly Network Adequacy reports specific counties and HCBS services for which each MCO has contracts in place with specific HCBS providers.

As indicated in Table 39, 7 of the 27 HCBS services were reported to be available in CY2017 from at least two service providers in all 105 counties for members of all three MCOs: Specialized medical care/medical respite, Assistive services, Attendant care services (Direct), Home-delivered meals, Personal emergency response (installation), Personal emergency response (rental), and Personal services.

Of the remaining 20 Home and Community Based Services:

- Adult Day Care
  - Amerigroup - Services were available from at least two providers in **83** counties, down from 102 counties in CY2015 and CY2016. At least one service provider was reported to be available in **101** of the 105 counties.
  - Sunflower - Services were available from at least two providers in only **49** counties in 2017, down from 50 in 2016 and 52 in 2015. At least one service provider was available in **79** counties, two fewer than in 2016.
  - UnitedHealthcare - Services were available from at least two providers in only **44** counties in 2017, down from 47 counties in CY2016 and CY2015. At least one provider was available in **66** counties, down from 58 in CY2016 and 72 in CY2015.

Table 39. Number of Counties with Access to Home and Community Based Services (HCBS) CY2017 Compared to CY2016*

Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Speech therapy - Autism Waiver	^	^	12	28↑	2	2
Speech therapy - TBI waiver	36↓	44↓	50	105	11↑	28
Behavior therapy - TBI waiver	100↓	101↓	105	105	54↓	105
Cognitive therapy - TBI waiver	101↓	101↓	105	105	22↓	54↓
Occupational therapy - TBI waiver	29↓	51↓	105	105	14↑	33
Physical therapy - TBI waiver	16↓	43↓	105	105	30	52↓
Adult day care	83↓	101↓	49↓	79↓	44↓	66↓
Intermittent intensive medical care	101↑	105↑	95↑	105	105	105
Home modification	101↑	101	105	105	105	105
Health maintenance monitoring	54↓	100↓	96↑	105	105	105
Specialized medical care/medical respite	105	105	105	105	105	105
Assistive services	105	105	105	105	105	105
Assistive technology	101↓	102↓	105	105	105	105
Attendant care services (Direct)	105	105	105	105	105	105
Comprehensive support (Direct)	43↓	50↓	105	105	105	105
Financial management services (FMS)	103↓	103↓	105	105	105	105
Home telehealth	89↓	102↓	105	105	105	105
Home-delivered meals (HDM)	105	105	105	105	105	105
Long-term community care attendant	103↓	103↓	105	105	105	105
Medication reminder	102↓	103↓	105	105	105	105
Nursing evaluation visit	102↓	103↓	105	105	105	105
Personal emergency response (installation)	105	105	105	105	105	105
Personal emergency response (rental)	105	105	105	105	105	105
Personal services	105	105	105	105	105	105
Sleep cycle support	37↓	37↓	105	105	105	105
Transitional living skills	101↓	103↓	105	105	105	105
Wellness monitoring	105	105	103↓	105	105	105

* Arrows indicate whether the number of counties with access to the service increased or decreased compared to CY2016.

^Amerigroup reported "With the implementation of policy E2015-040, developmental speech therapy services are covered under the Medicaid State Plan and not under the Autism Waiver. Per guidance in that policy, providers of developmental speech-language pathology services are not independently enrolled."

- Intermittent Intensive Medical Care
  - Amerigroup – In 2017, Amerigroup reported **101** counties had access to at least two service providers, 24 more than In CY2016 and CY2015. In CY2017, Amerigroup reported all **105** counties had a least one service provider, compared to 102 in CY2016 and CY2015.
  - Sunflower reported in CY2017 at least two service providers are available in **95** counties, one more than in CY2016 and CY2015. Sunflower reported in CY2013 to CY2017 that all **105** counties had at least one service provider.

  - UnitedHealthcare reported in CY2013 through CY2017 there were at least two service providers available in all **105** counties.
- Speech Therapy (Autism Waiver)
  - Amerigroup – In 2017, Amerigroup reported, "*With the implementation of policy E2015-040, developmental speech therapy services are covered under the Medicaid State Plan and not under the Autism Waiver. Per guidance in that policy, providers of developmental speech-language pathology services are not independently enrolled*." In CY2016, Amerigroup reported this service to be available from two providers in only 7 counties (and no additional counties with availability of one provider).
  - Sunflower - In CY2017 (and CY2015 and CY2016), Sunflower reported that in only **12** counties there were two or more providers available for specialized speech therapy for those on the Autism Waive. At least one service provider was reported to be available in **28** counties in CY2017, one fewer than in 2016 but the same as in CY2014 and CY2015.
  - UnitedHealthcare – Each year from CY2013–CY2017, UnitedHealthcare has reported that these specialized services were only available from one or two providers in only **2** counties.
- Speech Therapy – TBI Waiver
  - Amerigroup – In CY2017, Amerigroup reported at least two providers were available in **36** counties and at least one provider available in 44 counties. In CY2013 to CY2016, Amerigroup reported at least two providers were available in all **105** counties (which may have been due to including availability from speech therapists who had not completed training in the specialized speech therapy for those with TBI).
  - Sunflower – In CY2017 (and CY2015 and CY2016), Sunflower reported that at least two providers were available in **50** counties and that at least one provider was available in all **105** counties.
  - UnitedHealthcare reported that at least two providers were available in CY2017 in **11** counties, up from 9 counties in CY2016 and 4 counties in CY2015. At least one provider was reported to be available in **28** counties in CY2016 and CY2017, up from 10 counties in CY2015.
- Behavior Therapy – TBI Waiver
  - Amerigroup reported that at least two providers were available in **100** counties and at least one provider available in **101** counties, down from 105 in prior years.
  - Sunflower again reported that at least two providers were available in all **105** counties for this specialized behavior therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in **54** counties, down from 72 counties in 2016 and up from 18 counties in CY2015. At least one provider was reported to be available in all **105** counties in CY2017 and CY2016, up from 43 counties in CY2015.
- Cognitive Therapy – TBI Waiver
  - In CY2017, Amerigroup reported at least one or two providers were available in **101** counties, down from 105 counties as reported in CY2013–CY2016.
  - In CY2013 to CY2017, Sunflower reported that at least two providers were available in all **105** counties for this specialized cognitive therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in **22** counties in CY2017, down from 26 counties in CY2016 and up from 18 counties in CY2015. At least one provider was reported to be available in **54** counties, down from 55 counties in CY2016 and up from 43 counties in CY2015.

- Occupational Therapy – TBI Waiver
  - Amerigroup – In CY2017, Amerigroup reported at least two providers were available in **29** counties and at least one provider available in **51** counties. In CY2013 to CY2016, Amerigroup reported at least two providers were available in all 105 counties (which may have been due to including availability from occupational therapists who had not completed training in the occupational therapy for those with TBI).
  - In CY2013 to CY2017, Sunflower reported that at least two providers were available in all **105** counties for this specialized occupational therapy for those with TBI.
  - UnitedHealthcare reported that in CY2017, at least two providers were available in **14** counties, up from 12 counties in CY2016 and 11 counties in CY2013 to CY2015. In CY2016 and CY2017, UnitedHealthcare reported that at least one provider was available in **33** counties, up from 19 counties in CY2015.
- Physical Therapy – TBI Waiver
  - Amerigroup – In CY2017, Amerigroup reported at least two providers were available in **16** counties and at least one provider available in 43 counties. In CY2013 to CY2016, Amerigroup reported at least two providers were available in all **105** counties (which may have been due to including availability from physical therapists who had not completed training in the specialized physical therapy for those with TBI).
  - Sunflower reported that at least two providers were available in all **105** counties in CY2013 to CY2017 for this specialized physical therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in **30** counties in CY2016 and CY2017, up from 23 counties in CY2015. At least one provider was reported to be available in **52** counties in CY2017, down from 55 counties in CY2016 and higher than 40 counties in CY2015.
- Health Maintenance Monitoring
  - Amerigroup – In CY2017, Amerigroup reported that at least two service providers were available in **54** counties, down from 69 counties in CY2015 and CY2016. Amerigroup reported at least one provider was available in **100** counties, down from 103 the four previous years.
  - Sunflower – In CY2017, Sunflower reported two or more providers were available in 96 counties, one more than was reported available in CY2015 and CY2016. Sunflower reported at least one provider was available in **105** counties (all five years).
  - UnitedHealthcare – In CY2013–CY2017, UnitedHealthcare reported that at least two service providers were available in all 105 counties.
- Home Modification
  - In 2017, Amerigroup reported at least two providers were available in **101** counties, up from 27 in CY2016 and 14 in CY2015. In CY2016 and CY2017, Amerigroup reported 101 counties had at least one service provider, down from 102 in CY2015.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Assistive Technology
  - In 2017, Amerigroup reported at least two providers were available in **101** counties, down from 105 the four previous years. Assistive Technology was not available from at least one provider in three counties in CY2017.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.

- Comprehensive Support (Direct)
  - In 2017, Amerigroup reported at least two providers were available in only **43** counties, down from 105 the four previous years. In 2017, Amerigroup reported at least one provider was available in **50** counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Financial Management Services
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from 105 the four previous years. In 2017, Financial Management Services were not available from at least one provider in two counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Home Telehealth
  - In 2017, Amerigroup reported at least two providers were available in **89** counties, down from 105 the four previous years. In 2017, Amerigroup reported at least one provider was available in **102** counties, three fewer than in CY2016 and CY2015.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Long-term Community Care Attendant
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from **105** the four previous years. Long-Term Community Care Attendants were not available from at least one provider in two counties in CY2017.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Medication Reminder
  - In 2017, Amerigroup reported at least two providers were available in **102** counties, down from 105 the four previous years. In 2017, Amerigroup reported at least one provider was available in **103** counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Nursing Evaluation Visit
  - In 2017, Amerigroup reported at least two providers were available in **102** counties, down from 105 the four previous years. In 2017, Amerigroup reported at least one provider was available in **103** counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Sleep Cycle Support
  - In 2017, Amerigroup reported at least two providers were available in only **37** counties, down from 105 the four previous years. Sleep Cycle Support was not available from at least one provider in **68** counties in CY2017.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Transitional Living Skills
  - In 2017, Amerigroup reported at least two providers were available in **101** counties, down from 105 the four previous years. Transitional Living Skills providers were not available in two counties in CY2017.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.

- Wellness Monitoring
  - In 2017, Sunflower reported at least two providers were available in **103** counties, down from 105 the four previous years. In 2017, Sunflower reported at least one provider was available in **105** counties.
  - In CY2013 to CY2017, Amerigroup and UnitedHealthcare reported at least two service providers were available in all **105** counties.

As discussed in the 2013 and 2014 KanCare Evaluation Annual Reports, there is a wide gap in reporting of availability of the TBI-related services that indicates potential discrepancies in reporting by the MCOs and/or differences in defining the criteria required for service providers for these specialized services.

There is no indication in the report again this year as to which specific counties do not have at least two services available. The provider network adequacy reports indicate specific providers, but do not separately provide a list of counties that have access to no providers (or less than two providers).

Population – The HCBS reports do not indicate whether members needing these services are residents of the counties where there are no providers or less than two providers. If this information was provided by each MCO, members, program managers, and reviewers could more easily identify counties where services may be provided by one of the other MCOs, and alternatively whether none of the MCOs have providers in the particular county (and in neighboring counties). The MCO GeoAccess reports provide information on the total number of members in each county; however, the reports do not indicate whether members in sparsely populated counties are in need of services that are not commonly needed or available.

I/DD Provider Services

I/DD provider services by county availability are listed in Table 40. Services reported in 2017 to be available from at least two I/DD providers by all three MCOs in CY2017 included only Medical Alert Rental.

Services not available from at least two I/DD providers by all three MCOs in all 105 Kansas counties include:

- Supported Employment Services
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in only **37** counties, down from 51 in CY2016, and from at least one provider in **82** counties (up from 81 in CY2016).
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in **98** counties and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available from at least two I/DD providers in only **24** counties in CY2017, one more than in CY2016, and from at least one provider in **73** counties, up from 48 reported in CY2016.
- Wellness Monitoring
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in **99** counties, up from 92 counties in CY2016, and from at least one provider in **104** counties, one less than in CY2016.
  - Sunflower reported this service to be available in CY2017 from at least two I/DD providers in **102** counties, up from 95 counties in CY2016, and from at least one provider in all **105** counties, up from 102 counties in CY2016.

- UnitedHealthcare reported this service to be available from at least two I/DD providers in only **62** counties in CY2017, down from 80 counties in CY2016, and from at least one provider in **85** counties in CY2017, down from all 105 counties in CY2016.

Table 40. Number of Counties with Access to at Least Two I/DD Providers, by MCO, CY2017

Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Targeted Case Management	**104**↓	**104**↓	105	105	105	105
Medical Alert Rental	105*	105	**105**↑	105	105*	105
Residential Support	**103**↓	**103**↓	105	105	**100**↓	105
Supportive Home Care	**103**↓	**103**↓	105	105	**81**↓	105
Sleep Cycle Support	**103**↓	**103**↓	105	105	105	105
Supported Employment Services	**37**↓	**82**↑	98	105	**24**↓	**73**↑
Personal Assistant Services	**103**↓	**103**↓	105	105	105	105
Assistive Services	**102**↓	**102**↓	105	105	105	105
Respite Care (Overnight)	**103**↓	**103**↓	105	105	105	105
Wellness Monitoring	**99**↑	**104**↓	**102**↑	**105**↑	**62**↓	**85**↓
Day Support	**103**↓	**103**↓	105	105	**59**	**97**
Financial Management Services (FMS)*	**103**↓	**103**↓	105	105	105	105
Specialized Medical Care - RN	101	**101**↓	104	105	105	105
Specialized Medical Care - LPN	**102**↑	**102**↓	104	105	105	105

* Provider specialty not specific to I/DD

- Targeted Case Management
  - In 2017, Amerigroup reported at least two providers were available in **104** counties, down from 105 in CY2016; Targeted Case Management was not available in CY2017 in one county from at least one provider.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Sleep Cycle Support
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from 105 in CY2016; Sleep Cycle Support was not available from at least one provider in CY2017 in two counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Respite Care (Overnight)
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from 105 in CY2016; Overnight Respite Care was not available from at least one provider in CY2017 in two counties.
  - In CY2016 and CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.

- Assistive Services
  - In 2017, Amerigroup reported at least two providers were available in **102** counties, down from 104 in CY2016; Assistive Services were not available from at least one provider in CY2017 in three counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Personal Assistant Services
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from 105 in CY2016; Personal Assistant Services were reported as not available from at least one provider in CY2017 in two counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Financial Management Services
  - In 2017, Amerigroup reported at least two providers were available in **103** counties, down from 105 in CY2016; Financial Management Services were reported as not available from at least one provider in CY2017 in two counties.
  - In CY2013 to CY2017, Sunflower and UnitedHealthcare reported that at least two service providers were available in all **105** counties.
- Residential Support
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in **103** counties, down from 105 in CY2016; Residential Support was reported as not available in two counties in CY2017.
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in all **105** counties.
  - UnitedHealthcare reported this service to be available from at least two I/DD providers in 100 counties in CY2017, five fewer than in CY2016, and from at least one provider in all **105** counties.
- Supportive Home Care
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in **103** counties, down from 105 in CY2016; Supportive Home Care was reported as not available in two counties in CY2017.
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in all **105** counties.
  - UnitedHealthcare reported this service to be available from at least two I/DD providers in **81** counties, down from 103 counties in CY2017, and from at least one provider in all **105** counties.
- Day Support
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in **103** counties, down from 105 in CY2016; Day Support was reported as not available in two counties in CY2017.
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in all **105** counties.
  - UnitedHealthcare reported this service to be available from at least two I/DD providers in **59** counties in CY2017, one more than in CY2016, and from at least one provider in **97** counties.

- Specialized Medical Care - RN
  - Amerigroup reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in **101** counties; Specialized Medical Care – RN was reported as not available in four counties in CY2017, four fewer than in CY2016.
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in **104** counties and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in all **105** counties.
- Specialized Medical Care - LPN
  - Amerigroup reported this service to be available in CY2017 from at least two I/DD providers in **102** counties, one more than in CY2016; Specialized Medical Care – LPN was reported as not available in three counties in CY2017, two fewer than in CY2016.
  - Sunflower reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in **104** counties and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available in CY2016 and CY2017 from at least two I/DD providers in all **105** counties.

Provider Open/Closed Panel Report
The MCOs submit monthly Network Adequacy reports that include a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. This is primarily populated for PCP types. Beginning in 2018, major revisions are being made in the timely reporting of open/closed panels not only for PCPs, but for other provider types as well.

In previous years, KFMC recommended that, due to a high frequency of duplicate entries (including exact duplicates, address variations for the same address, P.O. Box address and street address in a small town, etc.), the MCOs should review this report and remove duplicate entries. At MCO training in March 2018, KDHE staff provided examples of continued duplicate entries and provided each MCO a quarterly summary report listing the number of duplicate and presumed duplicate entries in their most recent Network Adequacy quarterly report, along with the number of entries with missing data, missing and multiple values related to open/closed panel reporting, and a summary of outliers and other issues MCOs are to follow up on. MCOs were directed to make corrections and modify their reporting to more accurately identify the number of providers by specialty and location, as well as to more consistently and accurately update open/closed panel status of providers. After submission of their Network Adequacy report each quarter, KDHE will be providing each MCO summary reports tracking progress and identifying additional corrections and modifications needed to improve accuracy of network adequacy reporting.

Provider After-Hour Access (24 hours per day/7 days per week)
The MCOs are required by the State to ensure 24/7 access is available to members. No tracking report templates, however, are required of the MCOs by the State for tracking this. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards.

Amerigroup
In 2016 and 2017, Amerigroup's After-Hours Access survey was of PCPs and pediatricians. Amerigroup provided a PowerPoint document and an email summary of survey results for 2017 compared to 2016. The 2017 survey was conducted October 5–13, 2017. Calls were made between 5pm and 9pm on weekdays.

Review of the descriptions of the survey sampling, methodology, survey conclusions, and comparisons to 2016 survey results raised several questions about the conclusions reached for the survey outcomes:

- Morpace described the selected sample as a "'random sample' quota of n=200 and that, after the quota was filled, Morpace "*census-dialed all remaining noncompliant providers from 2016*."
  - Morpace reported they dialed 300 phone numbers and had 200 "*completed*." If the purpose of the survey is to see how many of the providers were accessible after hours, how many of these additional 100 phone dials were wrong numbers from the online provider directory?
  - Morpace reported that 116 providers who were non-compliant in 2016 were contacted, with 24 of the 116 added after the 200 "random sample quota" was reached. The remaining 92 providers appear to have been part of the "random sample" of 200 providers contacted. In their January 2018 GeoAccess report, Amerigroup reported their network included 2,765 providers at 828 locations. It seems unlikely (though not impossible) that a random sample of 2,765 providers would result in selection of 92 of the 116 non-compliant providers from 2016 (of the 200 randomly selected); the 92 providers composed 4% of the total PCPs and 46% of the 200 providers randomly selected.
- After the survey was conducted, Morpace extrapolated the After-Hours Access survey data to remaining providers who shared the same phone number. The number of providers on which the "fully compliant" percentages were based was reported as 826 (rather than the 200 plus 24 providers described as the "random sample" plus 24 non-compliant providers from 2016 not randomly selected). Morpace reported that 91% of the 826 extrapolated providers were fully compliant and compared the results to 89% in 2016.
  - Morpace gave an example that if three providers shared the same number, the results for the one phone call would be attributed to all three providers. Morpace reported, "*Because of this extrapolation, the total number of providers after extrapolation is greater than the actual number of surveys conducted*." It appears, then, that the survey results are not based on the "random sample" of 200 (or 224) providers. It also was not clear whether there was a limit to the extrapolation by practice; if a large PCP practice, for example, had 15 PCPs, with 12 not in the "random sample," were the results extrapolated to include all 15 PCPs in the practice?
  - Morpace included counts and percentages of compliance results for the 116 non-compliant providers from 2016 contacted again in 2017, as well as counts and percentages for the 826 "extrapolated" providers; but, no counts or percentages of compliance were provided for the actual "random sample" of 200+24 providers. (The heading on the summary compliance counts and percentages refer to these as "Random Sample.")
  - Morpace reported 73 (9% of the 826 "total providers") were noncompliant in 2017: 72 were reported as having a recorded message that did not provide a way to reach a live party, and **1** provider was noncompliant due to "*no answer/no answer after following prompts*." Of the 116 providers who were non-compliant in 2016, 31 (27%) were again reported to have been noncompliant. Of the 31, however, **6** were reported to be noncompliant due to "*no answer/no answer after following prompts*." As only 1 of the "total providers" was reported to be non-compliant due to "*no-answer/no after following prompts*," it appears, then, that the 116 of 224 providers surveyed in the "random sample" may not have been included in "total providers" percentages. Excluding any or all of the 116 would inflate the compliance percentage reported for the extrapolated counts and introduce bias.

Sunflower

Sunflower reported they conducted an after-hours access survey in 2017, but that, as of March 2018, results of that survey are still under review by Sunflower and are not yet available for release.

UnitedHealthcare

UnitedHealthcare's After-Hours Survey was conducted in 2016 and 2017 by DialAmerica. The 2017 survey was conducted in May through June.

In 2017, 696 providers (and, in 2016, 562) providers were selected by random sample. Of the 696, 557 (80.0%) were able to be contacted, and 446 of the 557 completed an appointment availability survey. For the After-Hours Access survey, DialAmerica completed after-hours calls to 362 of the 557 providers (179 PCPs, 123 Specialists, and 60 Obstetricians) and in 2016 295 (118 PCPs, 84 Specialists, and 45 Obstetricians). BH providers were excluded from after-hours calls as the vendor "*assumed these urgent situations would be handled by the ER*." Of 362 providers, 343 (94.8%) were reported to have had an "*answering service, nurse, physician, or message with number to contact*"; 3.9% (14) were reported to have an "*answering machine instructing member to go to the nearest hospital*"; 0.3% (1) had "*phone rings continuously with no answer*"; and 1.1% (4) had "*other unacceptable, typically, message instructing member to dial 911*."

Compliance rates were higher in 2017 (94.8%) compared to 2016 (83.8%). In August 2017, the quality director contacted providers identified as non-compliant.

CAHPS supplemental questions related to after-hours access

Each of the three MCOs includes a supplemental question (and initial skip question) in their CAHPS surveys addressing after-hours appointment access. Sunflower and UnitedHealthcare included the questions in their adult and child surveys; Amerigroup included the questions only in their adult CAHPS survey.

Amerigroup asked in their adult survey:
In the last six months, if you called your doctor's office after office hours for an urgent need, how many minutes did you usually have to wait between making a call to the office and speaking to the doctor or doctor's representative?

- In CY2017, 26.2% (128 of 475) of adult survey respondents indicated they called after hours for an urgent need, compared to 24.4% (of 499) in CY2016.
- In CY2017, 67.2% of adults who called their doctor's office after hours said their wait to speak to a doctor or doctor's representative was less than 20 minutes, compared to 71.2% In CY2016
- The CY2017 rate of respondents reporting a wait over 60 minutes increased to 15.6% (of 128 respondents), compared to 8.3% (of 132) in CY2016, 17.4% in CY2015, and 13.8% in CY2014.

UnitedHealthcare asked in their adult survey (and a similar question in the child surveys):
In the last 6 months, did you call a doctor's office or clinic after hours to get help for yourself?

Those who responded positively were asked:
In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted?

- **Adults** – In CY2017, 12.4% of adults surveyed called their doctor's office or clinic after hours, compared to 11.0% in CY2016. Of the 51 who indicated they called their provider after hours, 74.5% in CY2017, and 69.2% in CY2016, said they always or usually got the help they wanted; 11.8% in CY2017 and 15.4% in CY2016 said they never got the help they wanted.
- **GC survey population** - In CY2017, 9.0% of GC survey respondents called their doctor's office or clinic after hours, comparable to 8.9% in CY2016. Of those who indicated they called their provider after hours, 91.9% in CY2017 and 87.0% in CY2016 said they always or usually get the

help they wanted, and 2.9% in CY2017 and 2.8% in CY2016 (compared to 14.4% in CY2015) said they never got the help they wanted.

- **CCC survey population** – In CY2017 12.7% (and in CY2016, 10.0%) of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours in CY2017 90.3%, up from 80.0% in CY2016, said they always or usually got the help they wanted, and none of the respondents in CY2017, compared to 4.2% in CY2016 and to 8.8% in CY2015, said they never got the help they wanted.

Sunflower asked in their adult survey (and a similar question in the child surveys):
In the past 6 months, did you phone your personal doctor's office after regular office hours to get help or advice for yourself?

Those who responded positively were asked:
In the last 6 months, when you phoned after regular office hours, how often did you get the help or advice you needed?

- **Adults** – In CY2017, 12.4% of adults (compared to 14.0% in CY2016) called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 74.5% in CY2017 and 75.0% in CY2016 said they always or usually got the help or advice they needed and 11.8% in CY2017 and 15.0% in CY2016 said they never got the help or advice they needed.
- **GC survey population** - In CY2017, 9.3% (of 1,021) of GC survey respondents, compared to 13.6% in CY2016, called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 81.8% in CY2017 and 83.1% in CY2016 said they always or usually got the help they wanted; 8.0% in CY2017, compared to 9.9% in CY2016 and 6.8% in CY2015, said they never got the help they wanted.
- **CCC survey population** – In CY2017, 12.7% (and in CY2016 16.7%) of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours, 82.5% in CY2017, and 87.2% in CY2016, said they always or usually got the help they needed and 7.2% in CY2017, and 4.7% in CY2016 and CY2015, said they never got the help they wanted.

Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first, second, third trimester and high risk)
The MCOs are required by the State to ensure that in-office wait time requirements are met. No tracking report templates, however, (as per the 24/7 access above) are required of the MCOs by the State for tracking these measures. Amerigroup and UnitedHealthcare reported emergent, urgent, and routine appointment access. UnitedHealthcare also reported appointment access for prenatal care by trimester and high risk. Survey results to date have not yet included in-office wait times.

Amerigroup
Amerigroup's Appointment Availability Survey was administered October 5-24, 2017. The vendor, Morpace, used a Computer-Assisted Telephone Interviewing methodology. Interviewers used a prepared script that identified Amerigroup during the call. Calls were placed on weekdays during normal business hours.

Appointment types assessed for availability were:

- PCPs and Pediatricians: Routine, Urgent, and Emergent Care
- Specialists: Routine, Urgent, and Emergent Care. Results for Specialists were reported by High Volume and by High Impact. Morpace reported these categories were not mutually exclusive. The actual number and survey results for specialists were not reported in total. Specialties included

OB/GYN, but appointment availability specifically for prenatal care (or for appointment availability by trimester or high-risk pregnancy were not reported in the summary data available to KFMC.
- Behavioral Health – Urgent care, Emergent (but non-life-threatening) Care, Mental Health follow-up after hospital discharge, Initial Visit Routine Care, and Follow-up Routine Care.

Morpace reported 1,762 phone numbers were dialed. Of these, 611 (35%) completed surveys, 41% were contacted but did not complete the survey, and 429 (24%) had inaccurate phone numbers. Inaccurate phone numbers were categorized as:
- Wrong phone number/Doctor not at number listed (169; 39% of 429)
- Wrong specialty/script did not apply (71; 17%)
- Fax-Modem/Non-working (70; 16%)
- "Generic Disposition Code" (59; 14%)
- Hospital-based provider (27; 6%)
- Stuck in phone tree loop (20; 5%)
- Doesn't take Amerigroup (13; 3%)

As they did in the After-Hours Survey, Morpace referred to the 611 completed surveys as a "random sample," but reported results only for an "extrapolated" number based on the number of providers at each practice who were the same provider type as the provider in the actual random sample. Morpace referred to this survey as a "group" survey. The example given was that if four PCPs were at a particular phone number, one survey was completed. "*Interviewers asked for the next available appointment for different scenarios with **any** of the PCPs confirmed at the phone number. That is, individual appointment availability was **not** assessed*." Results were then reported based only on an extrapolated sample of 1,737 providers (656 PCPs, 383 High volume specialists, 324 High impact specialists, 106 Behavioral Health Prescribers, 320 Behavioral Health Non-Prescribers, and 272 Pediatrics). Results were not reported for the 611 providers in the actual random sample. A chart was provided showing the number of providers by provider type, but the number added up to 731 instead of 611.

Morpace reported 74% of the extrapolated providers were fully compliant in 2017. Morpace reported 77% of providers in 2016 were fully compliant; however, no information was provided as to how many providers had been surveyed in 2016, nor whether the 2016 survey was also an extrapolated "random sample."

Morpace also resurveyed 221 providers in 2017 who had been non-compliant in 2016. Of the 221, 36% were again reported as non-compliant. Results by provider type for the 221 providers added up to 264, (which may possibly be due to the specialty categories not being mutually exclusive).
- Behavioral Health Non-Prescribers – 56% (37 of 66) were again non-compliant;
- Behavioral Health Prescribers – 33% (5 of 15) were again non-compliant;
- Specialists – 31% (26 or 84) of High Volume and 28% (12 of 43) of High Impact were non-compliant;
- PCPs – 24% (11 of 45) were again non-compliant; and
- Pediatrics – 9% (1 of 11) again non-compliant.

Sunflower

Sunflower reported they conducted an appointment access survey in 2017, but that, as of March 2018, results of that survey are still under review by Sunflower with the vendor and are not yet available.

UnitedHealthcare

UnitedHealthcare's Appointment Availability survey was conducted in 2016 and 2017 (May and June) by DialAmerica. In 2017, 696 providers (and, in 2016, 562) providers were selected by random sample. Of the 696, 557 (80.0%) were able to be contacted, and 446 (64.1% of the sample) completed an appointment availability survey, including 179 PCPs, 60 Obstetricians, 84 BH, and 123 high-volume/high-impact specialists (OB/GYN, orthopedics, cardiology, oncology/hematology, and otolaryngology).

DialAmerica calls were not made using a "secret shopper" methodology. Interviewers asked for the first available appointment for a UnitedHealthcare member for each appointment category (emergency, urgent, routine; for PCPs, adult physical and EPSDT; and for obstetricians the first available appointment based on pregnancy trimester).

Requests for appointment availability for more than one provider at a practice were limited to only those providers who had been selected by random sample; appointment availability for one provider in a practice was not assumed to apply to multiple providers, including other providers in the practice in the random sample. Survey results, including counts and percentages, were reported by provider type and appointment type for providers in the sample; results were not extrapolated to multiple providers.

Of the 250 providers in the sample who were not surveyed, 72 (10.3%) were "unable to contact in 3 attempts"; 67 (9.6%) "moved, did not update information"; 66 (9.5%) had "technical problems" (described as including wrong numbers and cell phones "which cannot be called"); and 45 (6.5%) "refused to participate."

The UnitedHealthcare report included the numbers and percentages of providers in the random sample contacted in 2017 and 2016 who were in compliance with State contractual standards (see Table 41).

Table 41. UnitedHealthcare Appointment Availability Survey Results - 2016 and 2017 Provider Compliance to State Contractual Appointment Availability Standards

Appointment Type	PCP		Specialists		Obstetricians		BH		Total*	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Emergency care	79.7%	74.9%	39.3%	28.5%					62.9%	56.0%
Urgent care	91.5%	86.0%	**58.3%**	**38.2%↓**			**56.3%**	**35.7%↓**	**73.6%**	**59.8%↓**
Routine care	94.1%	96.1%	**95.2%**	**79.7%↓**			83.3%	84.5%	92.4%	88.3%
Adult physical	84.7%	83.2%							84.7%	83.2%
EPSDT/Well child	**90.7%**	**79.9%↓**							**90.7%**	**79.9%↓**
OB first trimester					93.3%	88.3%			93.3%	88.3%
OB second trimester					88.9%	75.0%			88.9%	75.0%
OB third trimester					**82.2%**	**51.7%↓**			**82.2%**	**51.7%↓**

* Denominator for total excludes provider types reported to be not applicable for the appointment type.
Shaded areas = Not Applicable

CAHPS supplemental questions related to appointment availability

Sunflower added the following questions related to appointment availability to their adult survey:

- **In the last 6 months, how many days did you usually have to wait between making an appointment and actually seeing a provider for a non-urgent problem or health condition?** In 2017, 75.3% reported they were able to see a provider for a non-urgent problem within seven days or less, down from 78.2% in 2016.

- **In the last 6 months, not counting the times you needed health care right away from the specialist you saw most often, how many days did you usually have to wait between making an appointment and actually seeing the specialist?**
  In 2017, 64.0% of adults surveyed reported they were able to see a specialist within 7 days or less, compared to 65.2% in 2016.

- **In the last 6 months, which of the following contributed to the problems you experienced seeing a specialist?**
  Of the 566 responding in 2017, 213 indicated they did not have a problem seeing a specialist and 120 reported they had not seen a specialist in the last 6 months. Of the remaining 169, 47.9% reported, "Appointment times were not available soon enough."

Sunflower added the following questions to their child surveys:

- **In the last 6 months, not counting the times your child needed health care right away, how many days did you usually have to wait between making an appointment and your child actually seeing a health provider?**
  GC survey respondents had slightly higher percentages reporting they were able to see a provider within seven days for a non-urgent problem (87.9%–88.1%) compared to CCC survey respondents (84.0%–85.6%); 2016 rates were higher for all GC and CCC subgroups (GC – 93.2%; CCC 89.0%–91.1%).

- **In the last 6 months, how many days did you usually have to wait between making an initial appointment for your child with a specialist and actually seeing the specialist for a non-urgent problem or health condition?**
  GC survey respondents had higher percentages reporting they were able to see a specialist within seven days for a non-urgent problem or health condition (68.9%–70.9%) compared to CCC survey respondents (56.9%–59.0%).

- **In the last 6 months, which of the following contributed to the problems you experienced seeing a specialist?**
  Of the 278 responding in 2017, 54% responded "Scheduling an appointment as soon as my child needed," and 15.1% responded "Getting the referral in a timely manner."

UnitedHealthcare added the following question to their adult and child surveys:

- **Adult survey: In the last 6 months, if you needed to see a mental health specialist, how often was it easy to get an appointment within two weeks?**
  In 2017, 61.5% of 195 adults said it was "always" or "usually" easy to get an appointment "as soon as needed," compared to 51.4% in 2016.
- **Child survey: In the last 6 months, if your child needed to see a mental health specialist, how often was it easy to get an appointment as soon as your child needed?**
  75.6% to 84.2% of the child survey respondents in 2017 reported they "always" or "usually" were able to get an appointment with a mental health specialist as soon as needed.

(20) Member Survey – CAHPS

Additional detail on the CAHPS survey In CY2017 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to access of care include the questions in Table 42.

Table 42. Member Survey - CAHPS Access to Care Questions, 2014 - 2017										
Question	Pop	Weighted % Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Adult and Child Surveys									
In the last six months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?	Adult	45.2%	45.7%	44.0%	**46.3%**				
	GC	35.1%	37.9%	35.7%	**36.5%**				
	CCC	43.6%	47.4%	43.1%	**45.3%**				
In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	Adult	88.1%	87.2%	86.2%	**88.5%**	↑	↑	↑	↑
	GC	94.1%	93.2%	93.7%	**94.7%**	↑	↑	↑	↑
	CCC	95.0%	93.9%	95.1%	**96.6%**	↑	↑	↑	↑
In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?	Adult	75.8%	77.1%	76.3%	**75.3%**				
	GC	70.8%	68.9%	69.5%	**67.6%**				
	CCC	80.0%	78.7%	77.3%	**77.5%**				
In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	Adult	82.9%	82.7%	82.5%	**84.6%**	↑	↑	↑	↑
	GC	90.6%	89.7%	90.0%	**90.7%**	↑	↑	↑	↑
	CCC	92.2%	92.4%	92.2%	**93.6%**	↓	↑	↑	↑
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	87.6%	88.1%	87.2%	**88.0%**	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	**93.4%**	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	**94.1%**	↑	↑	↑	↑
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	43.0%	46.5%	44.3%	**46.8%**				
	GC	17.9%	19.4%	17.9%	**18.7%**				
	CCC	38.4%	39.5%	39.8%	**39.8%**				
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	84.8%	81.7%	86.2%	**82.9%**	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	**86.4%**	↑	↑	↓	↑
	CCC	85.3%	83.3%	86.0%	**87.1%**	↑	↑	↑	↑
^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile									

Questions on both adult and child surveys:

In the last 6 months:

Did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?

- **Adult**s: **46.3%** in 2017; 44.0%–45.7% in 2014–2016;
- **GC**: **36.5%** in 2017; 35.1%–37.9% in 2014–2016
- **CCC**: **45.3**% in 2017; 43.1%–47.4% in 2014–2016.

Those who responded they had needed care right away at a clinic, ER, or doctor's office in the previous 6 months were asked:

When you needed care right away, how often did you get care as soon as you thought you needed?

- **Adults**: **88.5%** in 2017 (**>75th QC**); 86.2%–88.1% in 2014–2016;
  UnitedHealthcare's rate (91.8%) was >95th QC and significantly higher (*p*=.04) than in 2016 (85.0%; >50th QC); Sunflower's rate (87.7%) was >75th QC; and Amerigroup's rate (86.8%) was >66.67th QC.
- **GC**: **94.7%** in 2017 (**>75th QC**); 93.2%–94.1% in 2014–2016
  Rates for all MCO GC subgroups were above 91% in 2014, 2015, 2016, and 2017. Sunflower's TXXI rate (96.2%) and UnitedHealthcare's TXIX rate (96.2%) were >90th QC in 2017.
- **CCC**: **96.6**% in 2017 (**>90th QC**); 93.9%–95.1% in 2014–2016
  Rates for all MCO GC subgroups were above 92% in 2014, 2015, 2016, and 2017. UnitedHealthcare's TXIX rate (99.3%) was >95th QC in 2017 and significantly higher (*p*=.03) than in 2016 (94.8%; >75th QC). Amerigroup's TXXI rate (97.4%) was also >95th QC in 2017.

In the last 6 months:

How often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?

- **Adul**ts: **88.0%** in 2017 (**>75th QC**); 87.2%–88.1% in 2014–2016; Rates for each of the MCOs were >75th QC in 2017, 2016, and 2015.
- **GC**: **93.4%** in 2017 (**>75th QC**); 92.0%–93.4% in 2014–2016
  Rates for all MCO GC subgroups were above the 50th QC or higher and over 90% positive in 2017. UnitedHealthcare's TXIX rate (94.6%) and TXXI rate (95.4%) were >95th QC.
- **CCC**: **94.1**% in 2017 (**>75th QC**); 91.9%–93.0% in 2014–2016
  Rates for all MCO CCC subgroups were above 91% in 2017.UnitedHealthcare's TXXI rate (97.3%) in 2017 was >95th QC and significantly higher (*p*<.01) than in 2016 (92.1%; >50th QC); their TXIX rate (94.7%) in 2017 was >90th QC. Amerigroup's TXIX rate (94.3%; >75th QC) was significantly higher (*p*<.01) than in 2016 (89.9%; <50th QC).

In the last 6 months:

Did you make any appointments for a <u>check-up or routine care</u> (for your child) at a doctor's office or clinic?

- **Adult**s: **75.3%** in 2017; 75.8%–77.1% in 2014–2016
- **GC**: **67.6%** in 2017; 68.9%–70.8% in 2014–2016
- **CCC**: **77.5**% in 2017; 77.3%–80.2% in 2014–2016
  Those who responded they made an appointment for a check-up or routine care were asked:
  Not counting the times you needed care right away, how often did you get an appointment for (your child) for a <u>check-up or routine care</u> at a doctor's office or clinic as soon as you thought you needed?
  - **Adults**: **84.6%** in 2017 (**>75th QC**); 82.5%–82.9% in 2014–2016
    Sunflower's rate (88.1%) in 2017 was >95th QC; UnitedHealthcare's rate (83.5%) was >75th QC; and Amerigroup's rate (81.6%) was >66.67th QC.
  - **GC**: **90.7%** in 2017 (**>66.67th QC**); 89.7%–90.6% in 2014–2016
    UnitedHealthcare's TXXI rate (93.0%) in 2017 was >90th QC.
  - **CCC**: **93.6**% in 2017 (**>66.67th QC**); 92.2%–92.4% in 2014–2016
    All of the MCO CCC subgroup rates in 2017 were above 91% positive, with all rates above the 50th QC or higher. UnitedHealthcare's TXIX rate (94.9%) and Amerigroup's TXXI rate (94.9%) were >90th QC in 2017.

In the last 6 months:
Did you make any appointments (for your child) to see a specialist?

- **Adult**s: **46.8%** in 2017; 43.0%–46.5% in 2014–2016
- **GC**: **18.7%** in 2017; 17.9%–19.4% in 2014–2016
- **CCC**: **39.8**% in 2017; 38.4%–39.8% in 2014–2016
  Those who responded they had made an appointment to see a specialist were asked:
  How often did you get an appointment (for your child) to see a specialist as soon as you needed?
  - **Adults**: **82.9%** in 2017 (**>66.67th** QC); 81.7%–86.2% in 2014–2016
  - **GC**: **86.4%** in 2017 (**>75th** QC); 79.8%–84.6% in 2014–2016
    UnitedHealthcare's TXXI rate in 2017 (90.2%) was >95th QC and significantly higher (p<.01) than in 2016 (78.0%; <50th QC). Sunflower's TXIX rate in 2017 (86.4%; >75th QC) was significantly higher (p=.04) than in 2016 (74.0%).
  - **CCC**: **87.1**% in 2017 (**>75th** QC); 83.3%–86.0% in 2014–2016
    UnitedHealthcare's TXIX rate in 2017 (89.5%) was >90th QC.

(21) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2017 are described above in Section 7 "Member Survey – Quality." Questions and survey results related to member perceptions of access to MH services are listed in Table 43 and are described below:

Provider availability as often as member felt it was necessary
General Adults: Results in 2017 (86.3%) were generally comparable to the six previous years. (2016 – 84.0%; 2015 – 87.2%; 2014 – 87.9%; 2013 – 88.2%; 2012 – 85.3%; 2011 – 88.8%)

Ability to get services during a crisis

- Rates in 2017 were 80.6% for SED Waiver youth and young adults and 86.3% for General Youth.
- The General Adult population had a lower percentage of positive responses in 2017 (83.5%) than in four of the six prior years. (2016 – 80.7%, 2015 – 85.0%, 2014 – 86.0%, 2013 – 85.4%, 2012 – 79.2%, 2011 – 83.9%)
- For the SED Waiver youth and young adults, the 2017 rate (80.6%) was the second highest rate in the 7-year period.

Services were available at times that were good for the member

- General Adult positive response results increased from 87.4% in 2016 to 91.9% in 2017.
- General Youth positive response results increased from 83.9% in 2016 to 87.4% in 2017.
- General Youth (ages 12-17), youth responding: Rates were generally comparable each year. (2017–87.5%; 2016–90.4%; 2015–88.5%; 2014–87.5%; 201388.7%; 2012–83.0%; 2011–89.5%)
- SED Waiver Youth and Young Adults: The rate in 2017 (87.9%) was higher than in five of six prior years. (2016 – 84.1%; 2015 – 84.5%; 2014 – 85.2%; 2013 – 85.1%; 2012 – 88.6%; 2011 – 85.4%)
- SED Waiver Youth, youth responding, had a higher percentage of positive responses in 2017 (88.8%) than each of the six prior years (ranging from 82.2% in 2012 to 86.0% in 2014).

Table 43. Mental Health Survey - Access-Related Questions

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
I was able to see a psychiatrist when I wanted to.								
			General Adult (Age 18+)					
	2017		**81.3%**	295 / 363	77.0% – 85.0%	.02↑		
	2016		73.6%	195 / 265	67.9% – 78.5%			
	2015		83.4%	291 / 349	79.2% – 87.0%			
	2014		80.5%	598 / 744	77.5% – 83.2%			
	2013		82.3%	807 / 981	79.8% – 84.6%			
	2012		70.8%	187 / 264	65.1% – 76.0%	<.01↑		
	2011		82.1%	225 / 274	77.1% – 86.2%			
I was able to get all the services I thought I needed.								
			General Adult (Age 18+)					
	2017		**83.9%**	335 / 399	79.9% – 87.2%			
	2016		80.7%	235 / 290	75.8% – 84.9%			
	2015		84.9%	325 / 383	81.0% – 88.2%			
	2014		86.5%	704 / 814	84.0% – 88.7%			
	2013		86.0%	917/1,066	83.8% – 87.9%			
	2012		78.8%	219 / 278	73.6% – 83.2%			
	2011		91.3%	274 / 300	87.6% – 94.1%	<.01↓		
			General Youth (Ages 12-17), Youth Responding					
	2017		**84.3%**	187 / 222	78.9% – 88.5%			
	2016		83.1%	126 / 152	76.3% – 88.3%			
	2015		87.5%	126 / 144	81.0% – 92.1%			
	2014		83.8%	260 / 309	79.2% – 87.5%			
	2013		82.8%	427 / 518	79.1% – 86.0%			
	2012		85.0%	85 / 100	76.6% – 90.8%			
	2011		85.1%	114 / 134	78.0% – 90.2%			
			SED Waiver Youth (Ages 12-17), Youth Responding					
	2017		**83.0%**	160 / 193	77.0% – 87.7%		<.01 ↑	.03↑
	2016		79.3%	127 / 161	72.3% – 84.9%			
	2015		81.5%	123 / 151	74.6% – 86.9%			
	2014		74.8%	138 / 184	68.0% – 80.5%			
	2013		71.8%	165 / 229	65.7% – 77.2%	<.01↑		
	2012		76.3%	103 / 135	68.4% – 82.7%			
	2011		77.6%	97 / 125	69.5% – 84.1%			
My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)								
			General Youth (Ages 0-17), Family Responding					
	2017		**83.5%**	405 / 485	79.9% – 86.5%			
	2016		82.2%	264 / 320	77.6% – 86.0%			
	2015		86.3%	278 / 322	82.1% – 89.6%			
	2014		79.7%	609 / 766	76.7% – 82.4%			
	2013		83.2%	799 / 966	80.7% – 85.4%			
	2012		82.9%	213 / 257	77.8% – 87.0%			
	2011		84.2%	278 / 330	79.9% – 87.8%			
			SED Waiver Youth and Young Adult, Family/Member Responding					
	2017		**79.3%**	319 / 403	75.0% – 83.0%			
	2016		77.6%	253 / 325	72.7% – 81.8%			
	2015		78.9%	260 / 330	74.2% – 83.0%			
	2014		76.4%	318 / 413	72.0% – 80.2%			
	2013		75.2%	363 / 482	71.1% – 78.8%			
	2012		77.3%	248 / 321	72.4% – 81.6%			
	2011		77.4%	220 / 284	72.2% – 81.9%			

Table 43. Mental Health Survey - Access-Related Questions (Continued)

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
My mental health providers were willing to see me as often as I felt it was necessary.	**General Adult (Age 18+)**							
	2017		**86.3%**	341 / 395	82.6% – 89.4%			
	2016		84.0%	243 / 289	79.3% – 87.8%			
	2015		87.2%	332 / 381	83.4% – 90.2%			
	2014		87.9%	706 / 804	85.5% – 90.0%			
	2013		88.2%	927/1,051	86.2% – 90.1%			
	2012		85.3%	233 / 273	80.6% – 89.1%			
	2011		88.8%	262 / 295	84.7% – 92.0%			
Services were available at times that were good for me (convenient for us/me).	**General Adult (Age 18+)**							
	2017		**91.9%**	367 / 399	88.8% – 94.3%			
	2016		87.4%	258 / 294	83.1% – 90.8%			
	2015		90.0%	343 / 381	86.6% – 92.7%			
	2014		89.8%	733 / 817	87.5% – 91.7%			
	2013		92.1%	985/1,071	90.4% – 93.6%			
	2012		87.7%	242 / 276	83.2% – 91.1%			
	2011		92.3%	277 / 300	88.7% – 94.9%			
	General Youth (Ages 0-17), Family Responding							
	2017		**87.4%**	428 / 489	84.2% – 90.1%			
	2016		83.9%	276 / 328	79.6% – 87.5%			
	2015		90.9%	297 / 327	87.2% – 93.6%			
	2014		86.9%	682 / 783	84.4% – 89.1%			
	2013		88.7%	871 / 983	86.5% – 90.5%			
	2012		88.0%	235 / 267	83.5% – 91.4%			
	2011		85.9%	287 / 334	81.8% – 89.3%			
	General Youth (Ages 12-17), Youth Responding							
	2017		**87.5%**	194 / 222	82.4% – 91.2%			
	2016		90.4%	141 / 156	84.6% – 94.2%			
	2015		88.5%	130 / 147	82.2% – 92.8%			
	2014		87.5%	271 / 308	83.3% – 90.7%			
	2013		88.7%	455 / 513	85.5% – 91.3%			
	2012		83.0%	83 / 100	74.4% – 89.2%			
	2011		89.5%	119 / 133	83.0% – 93.7%			
	SED Waiver Youth and Young Adult, Family/Member Responding							
	2017		**87.9%**	357 / 407	84.3% – 90.7%			
	2016		84.1%	275 / 328	79.7% – 87.7%			
	2015		84.5%	283 / 336	80.2% – 88.0%			
	2014		85.2%	356 / 418	81.5% – 88.3%			
	2013		85.1%	415 / 487	81.6% – 88.0%			
	2012		88.6%	287 / 324	84.7% – 91.7%			
	2011		85.4%	243 / 285	80.8% – 89.0%			
	SED Waiver Youth (Ages 12-17), Youth Responding							
	2017		**88.8%**	174 / 196	83.5% – 92.5%			
	2016		84.4%	139 / 164	78.0% – 89.2%			
	2015		85.7%	131 / 153	79.3% – 90.4%			
	2014		86.0%	167 / 194	80.3% – 90.2%			
	2013		82.6%	187 / 226	77.2% – 87.0%			
	2012		82.2%	111 / 135	74.8% – 87.8%			
	2011		83.7%	103 / 123	76.1% – 89.3%			

Table 43. Mental Health Survey - Access-Related Questions (Continued)

	Year (0% – 100%)	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
During a crisis, I was able to get the services I needed.	**General Adult (Age 18+)**						
	2017	**83.5%**	277 / 332	79.1% – 87.1%			
	2016	80.7%	196 / 242	75.3% – 85.2%			
	2015	85.0%	265 / 312	80.6% – 88.5%			
	2014	86.0%	586 / 682	83.2% – 88.4%			
	2013	85.4%	742 / 870	82.9% – 87.6%			
	2012	79.2%	183 / 231	73.5% – 84.0%			
	2011	83.9%	209 / 249	78.8% – 88.0%			
During a crisis, my family was able to get the services we needed.	**General Youth (Ages 0-17), Family Responding**						
	2017	**86.3%**	285 / 330	82.1% – 89.6%			
	2016	83.8%	209 / 248	78.7% – 87.9%			
	2015	84.6%	197 / 233	79.3% – 88.7%			
	2014	83.4%	457 / 548	80.1% – 86.3%			
	2013	86.2%	604 / 706	83.5% – 88.6%			
	2012	87.4%	173 / 198	82.0% – 91.4%			
	2011	89.5%	204 / 228	84.8% – 92.9%			
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2017	**80.6%**	270 / 334	76.0% – 84.5%			
	2016	78.0%	205 / 260	72.6% – 82.7%			
	2015	78.3%	213 / 272	73.0% – 82.8%			
	2014	81.5%	276 / 338	76.9% – 85.3%			
	2013	76.4%	299 / 390	71.9% – 80.3%			
	2012	79.1%	197 / 249	73.6% – 83.7%			
	2011	80.0%	173 / 216	74.2% – 84.8%			
Medication available timely*	**General Adult (Age 18+)**						
	2017	**91.0%**	310 / 341	87.5% – 93.6%			
	2016	92.9%	237 / 255	89.0% – 95.5%			
	2015	90.3%	296 / 328	86.5% – 93.1%			
	2014	92.7%	661 / 713	90.5% – 94.4%			
	2013	91.8%	827 / 903	89.8% – 93.4%			
	Question introduced in 2013¶						
	General Youth (Ages 0–17), Family Responding						
	2017	**95.6%**	263 / 275	92.4% – 97.6%		<.01↑	
	2016	83.7%	171 / 204	78.0% – 88.2%	<.001↑		
	2015	88.0%	198 / 225	83.0% – 91.6%	<.01↑		
	2014	85.3%	408 / 478	81.8% – 88.2%	<.001↑		
	2013	86.1%	537 / 622	83.1% – 88.6%	<.001↑		
	Question introduced in 2013¶						
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2017	**97.1%**	333 / 343	94.7% – 98.5%		<.01↑	
	2016	94.5%	262 / 278	91.1% – 96.7%			
	2015	93.3%	275 / 294	89.8% – 95.7%	.02↑		
	2014	94.8%	356 / 376	92.0% – 96.7%			
	2013	90.9%	379 / 416	87.8% – 93.3%	<.001↑		
	Question introduced in 2013‡						

*Not asked in 2012 and 2011

Table 43. Mental Health Survey - Access-Related Questions (Continued)

	Year 0% 100%	Rate	N/D	95% CI	*p*-value	Trend 5-Year	Trend 7-Year
	General Adult (Age 18+)						
My mental health providers returned my calls in 24 hours.	**2017**	**85.9%**	303 / 353	81.8% – 89.2%	.04↑		
	2016	79.6%	213 / 267	74.4% – 84.1%			
	2015	84.4%	292 / 346	80.2% – 87.9%			
	2014	83.3%	618 / 742	80.5% – 85.8%			
	2013	84.4%	840 / 995	82.0% – 86.5%			
	2012	80.8%	202 / 250	75.4% – 85.2%			
	2011	88.1%	251 / 285	83.8% – 91.4%			

Ability to see a psychiatrist when the member wanted to

The positive response rate for the General Adult population was significantly higher in 2017 (81.3%) compared to 2016 (73.6%; *p*=.02) and 2012 (70.8%; *p*<.01). (2015 – 83.4%; 2014 – 80.5%; 2013 – 82.3%; 2011 – 82.1%)

Ability to get all the services the members thought they needed

- The 2017 General Adult rate (83.9%) was significantly lower than the 2011 rate (91.3%; *p*<.01), with only the 2016 (80.7%) rate and 2012 rate (78.8%) lower.
- For General Youth, the 2017 rate (83.5%) was higher than the 2016 rate (82.2%) but lower than in 2015 (86.3%).
- For General Youth (ages 12–17), youth responding, the 2017 rate (84.3%) was higher than the 2016 rate (83.1%), but lower than in 2015 (87.5%), which was the highest of the 7-year period.
- For SED Waiver Youth (ages 12-17), youth responding, the 2017 rate (83.0%) was the highest rate in the 7-year period. The trends from 2011 to 2017 and since the implementation of KanCare in 2013 showed statistically significant increases (*p*=.03, 2011 to 2017 and *p*<.01, 2011 to 2013). (2017 – 83.0%;2016 – 79.3%; 2015 – 81.5%; 2014 – 74.8%; 2013 – 71.8%; 2012 – 76.3%; 2011 – 77.6%)
- For SED Waiver youth and young adults, the 2017 rate (79.3%) was higher than in each of the six prior years (ranging from 75.2% in 2013 to 78.9% in 2015). The 2017 percentage of positive responses from Urban SED Waiver Youth and Young Adults was significantly lower (70.4%) compared to other county types (83.9%; *p*<.01[Semi-Urban 81.5%; Densely-Settled Rural 85.6%; Rural and Frontier 84.6%]).

Timely availability of medication

- From 2013 to 2017 the General Adult population rates for medication availability have been above 90%.
- General Youth positive rate significantly increased in 2017 to 95.6% from 83.7% in 2016 (*p*<.001); 88.0% in 2015 (*p*<.01); 85.3% in 2014 (*p*<.001); and 86.1% in 2013 (*p*<.001). It also had a significant trending increase in positive response percentages since the implementation of KanCare in 2013. (2013 – 86.1%; 2014 – 85.3%; 2015 – 88.0%; 2016 – 83.7%; 2017 – 95.6%; [*p*=<.01, 2013 to 2017])
- SED Waiver youth and young adult responses have also been over 90% positive over the five-year period, ranging from 90.9% in 2013 to 97.1% in 2017. Positive responses significantly increased in 2017 to 97.1% from 93.3% in 2015 (*p*=.02) and 90.9% in 2013 (*p*<.001). Also, it had significant trending increases in positive response percentages since the implementation of KanCare in 2013. (2013 – 90.9%; 2014 – 94.8%; 2015 – 93.3%; 2016 – 94.5%; 2017 – 97.1%; [*p*=<.01, 2013 to 2017])

- General Youth and SED Waiver Youth and Young Adult positive responses are the highest they have been since 2013.

Provider return of calls within 24 hours
General Adults: In 2017, 85.9% responded positively, higher than in five of six prior years, and a significant increase compared to 2016 (79.6%) (p=.04). The 2017 percentage of positive responses from members in Urban counties was significantly lower (79.9%) than responses from other county types (90.8%; p<.001 [Semi-Urban 90.0%; Densely-Settled Rural 89.8%; Rural and Frontier 93.7%])

(22) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2017. Questions related to perceptions of access to care for members receiving SUD services follow (see Table 44).

Table 44. SUD Survey - Access-Related Questions, CY2014 - CY2017

	CY2014	CY2015	CY2016	CY2017
Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? *(Percent of "Yes" responses)*	**92.1%** (186/202)	**87.7%** (157 / 179)	**84.4%** (270 / 320)	**84.0%** (205 / 244)
In the last year, did you need to see your counselor right away for an urgent problem? *(Percent of "Yes" responses)*	**28.5%** (57 / 200)	**25.7%** (47 / 183)	**28.4%** (92 / 324)	**29.2%** (69 / 236)
If yes:				
How satisfied are you with the time it took you to see someone? *(Percent of "Very satisfied" and "Satisfied" responses)*	**98.2%** (56 / 57)	**79.07%** (34 / 43)	**94.1%** (79 / 84)	**90.5%** (57 / 63)
Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? *(Percent of ">48 hours" responses)*	**10.9%** (6 / 55)	**19%** (8 / 42)	**16%** (12 / 75)	**10.0%** (6 / 60)
Is the distance you travel to your counselor a problem or not a problem? *(Percent of "Not a Problem" responses)*	**89.1%** (180 / 202)	**88%** (161 / 183)	**87.9%** (275 / 313)	**85.0%** (199 / 234)
Were you placed on a waiting list? *(Percent of "Yes" responses)*	**12.2%** (25 / 205)	**15.6%** (28 / 180)	**21.2%** (69 / 326)	**15.2%** (35 / 230)
If you were placed on a waiting list, how long was the wait? *(Percent of "3 weeks or longer" responses)*	**26.1%** (6 / 23)	**46.2%** (12 / 26)	**42.1%** (24 / 57)	**45.2%** (14 / 31)

Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted?
In 2017, 84.0% of members indicated they got an appointment as soon as they wanted. Prior years ranged from 84.4%–92.1%. MCO rates in 2017 ranged from 81.3% (Amerigroup) to 85.9% (UnitedHealthcare).

For urgent problems, how satisfied are you with the time it took you to see someone?
In 2017, 29.2% of the members surveyed indicated in the past year they had needed to see their counselor right away for an urgent problem, up from to 25.7%–28.5% in 2014–2016 and 26% in 2012. Of the 69 members who reported needing to see a counselor right away for an urgent problem, 63 responded to the follow-up question related to satisfaction with the wait time to see someone; 90.5% of the 63 members indicated in 2017 they were very satisfied or satisfied with the wait time.

For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?
Of the 69 members who reported in 2017 needing to see a counselor right away for an urgent problem, 60 provided a response related to the length of the wait time.

- In 2017, **10.0%** (6 of 60) had to wait more than 48 hours to see a counselor, down from 16% in 2016 and 19% in 2015.
- In 2017, **55.0%** (33) of the 60 members were seen within 24 hours, compared to 64.0% in 2016, 54.8% in 2015, and 58.2% in 2014.

Is the distance you travel to your counselor a problem or not a problem?
In 2017, **85%** (199 of 234) of members surveyed reported travel distance was not a problem, 3%-4% lower than the three prior years and 5.5% lower than in 2012.

Were you placed on a waiting list?
In 2017, **15.2%** (35 of 230) of the members surveyed reported they were placed on a waiting list. The number and percentage of members placed on a waiting list increased from 11.7% in 2012 to 12.2% (25 of 205) in 2014 to 15.6% (28 of 180) in 2015 to 21.2% (69 of 326) in 2016

If you were placed on a waiting list, how long was the wait?

- In 2017, 31 of 35 members who reported they were placed on a waiting list responded. Of these, 45.2% (14) indicated their wait was three weeks or longer and 16.1% (5) reported waiting one week or less.
- In 2016, 57 of 69 members who reported they were placed on a waiting list responded. Of these, 42.1% (24) indicated their wait was three weeks or longer, and 38.6% (22) reported waiting one week or less.
- In 2015, 26 of the 28 members placed on a waiting list responded. Of these, 46.2% (12) indicated their wait was three weeks or longer, and 23.1% (6) reported they waited one week or less.
- In 2014, 23 of the 25 members that indicated they were put on a waiting list responded. Of these, 26.1% (6) indicated their wait was three weeks or longer, and 34.7% (8) waited one week or less.

(23) Provider Survey

Background information and comments on the Provider Survey are described in Section 8 above. In this section, results are reported for satisfaction with the availability of specialists. The provider survey results for the quality-related question are in Section 8, and results for the preauthorization-related question are in Section 17.

Providers were asked, "**Please rate your satisfaction with availability of specialists**." Table 45-provides the available survey results by individual MCO.

Amerigroup
In 2017, **56.9%** of 272 providers surveyed were very or somewhat satisfied, comparable to 59.4% in 2016 and 59.5% in 2015 and higher than 45.9% in 2014. The percentage of providers very or somewhat dissatisfied with availability of specialists was 17.6%, lower than in 2016 (21.9%) and slightly higher than in 2015 (16.8%) and 2014 (17.1%).

Sunflower

- **Sunflower general provider survey** – In 2017, **41.9%** of 167 providers surveyed were very or somewhat satisfied with the availability of specialists, comparable to 2016 (39.8%) and 2014 (40.7%) and lower than in 2015 (52.9%). The percentage of providers very or somewhat dissatisfied with availability of specialists was 9.6% in 2017, comparable to 8.4% in 2016 and lower than 16.2% in 2015 and 15.0% in 2014.
- **Sunflower (Cenpatico) BH provider survey** – In 2017, **48.5%** of 33 BH providers surveyed were very or somewhat satisfied with availability of specialists, an increase compared to 28.1% in 2016 of BH and 27.4% in 2015. Sunflower reported in 2017 none of the 33 BH providers responded they were dissatisfied or very dissatisfied with availability of specialists.

Table 45. Provider Satisfaction with Availability of Specialists, CY2014 - CY2017

MCO Provider Survey Type	2014	2015	2016	2017
	Very or Somewhat Satisfied			
Amerigroup[#]	45.9%	59.5%	59.4%	56.3%
Sunflower *(General Provider)*	40.7%	52.9%	39.8%	41.9%
Cenpatico *(Behavioral Health)*	**	27.4%	28.1%	48.5%
UnitedHealthcare *(General Provider)*	^	45.2%	43.7%	40.5%
Optum *(Behavioral Health)*	32.1%	38.6%	44.1%	41.0%
	Neither Satisfied nor Dissatisfied			
Amerigroup[#]	37.0%	23.7%	18.8%	26.1%
Sunflower *(General Provider)*	44.2%	30.9%	51.7%	48.5%
Cenpatico *(Behavioral Health)*	**	65.3%	64.7%	51.5%
UnitedHealthcare *(General Provider)*	^	32.9%	39.4%	37.8%
Optum *(Behavioral Health)*	54.8%	55.4%	44.1%	49.4%
	Very or Somewhat Dissatisfied			
Amerigroup[#]	17.1%	16.8%	21.9%	17.6%
Sunflower *(General Provider)*	15.0%	16.2%	8.4%	9.6%
Cenpatico *(Behavioral Health)*	**	7.3%	7.2%	0%
UnitedHealthcare *(General Provider)*	^	21.9%	16.9%	21.6%
Optum *(Behavioral Health)*	13.1%	5.9%	11.7%	9.6%
	Total Responses			
Amerigroup[#]	257	333	160	272
Sunflower *(General Provider)*	226	259	261	167
Cenpatico *(Behavioral Health)*	**	124	167	33
UnitedHealthcare *(General Provider)*	63	73	71	74
Optum *(Behavioral Health)*	84	101	145	156

#Amerigroup includes Behavioral Health Providers in their General Survey
**Question was not asked in Cenpatico survey in 2014.
^UnitedHealthcare results for 2014 cannot be determined due to a typographical error in the survey instrument that included "Somewhat satisfied" twice and excluded "Somewhat dissatisfied."

UnitedHealthcare

- **UnitedHealthcare general provider survey** – In 2017, **40.5%** of the 74 providers surveyed were very or somewhat satisfied, lower than in 2016 (43.7%) and 2015 (45.2%). 21.6% of the providers surveyed in 2017 were very or somewhat dissatisfied, higher than in 2016 (16.9%) and comparable to 2015 (21.9%). (2014 survey results are not available due to a typographical error on the survey instrument.)
- **UnitedHealthcare (Optum) BH provider survey** – In 2017, **41.0%** of 156 BH providers were very or somewhat satisfied, lower than 44.1% in 2016 and higher than 38.6% in 2015 and 32.1% in 2014. The percentage of BH providers reporting they were very or somewhat dissatisfied was 9.6% in 2017, lower than 11.7% in 2016 and 13.1% in 2014 and higher than 5.9% in 2015.

Efficiency

(24) Grievances – Reported Quarterly

Compare/track number of access-related grievances over time, by population type.
Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(25) Calls and Assistance – Reported Quarterly

- **Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office.**
- **Track number and type of assistance provided by the Ombudsman's Office.**
  The types of assistance and numbers of contacts provided to KanCare members by the Ombudsman's Office are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(26) Systems

Data for the following measures are reported for the KanCare population and stratified by HCBS waiver I/DD, PD, TBI, and FE, and by MH – members who had a MH visit during the year. HEDIS data reported for ED visits and Inpatient Discharges are also reported for the KanCare population based on data submitted to KDHE by the three MCOs. The HCBS and MH stratified data differ somewhat from the HEDIS data, primarily due to inclusion or exclusion of members with dual coverage through Medicare or through private insurance (in addition to Medicaid eligibility).

Emergency Department (ED) Visits
Population: KanCare (all members) and stratified by TBI, FE, I/DD, PD, and MH
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2016 compared to rates in CY2012 pre-KanCare.

As noted above, reported rates can differ a great deal depending on whether members with dual eligibility are excluded or included. Rates of ED visits per 1,000 member-months excluding dual-eligible members were lower for all KanCare members and were higher for each of the waiver populations (see Table 46 and Table 47). Dual-eligible members in 2016 composed approximately 11% of the overall KanCare population and approximately 71% of the HCBS population of TBI, FE, I/DD, and PD members. The percentage of dual members varied, too, by waiver type: FE–94% dual, PD–69% dual, I/DD–58% dual, and TBI–56% dual.

While there are differences in the numbers and rates of ED visits for the TBI, FE, I/DD, PD, and MH members in CY2012 through CY2016 when including dual eligible members and excluding dual-eligible members, no differences were noted in ED usage patterns based on dual eligibility. The summaries that follow are based on data that include members with dual eligibility.

Table 46. HCBS and MH Emergency Department (ED) Visits, Including Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2016					
	CY2012	CY2013	CY2014	CY2015	CY2016
All KanCare Members					
ED Visits	326,831	307,575	356,652	369,262	365,363
Members	463,285	467,632	481,950	490,441	498,611
Member-Months	4,592,675	4,655,420	4,918,690	5,005,417	5,160,959
Visits per 1,000 member months	**71.16**	**66.07**	**72.51**	**73.77**	**70.79**
Waiver Members					
Traumatic Brain Injury (TBI)					
ED Visits	1,452	1,202	1,295	1,109	931
Members	744	748	694	590	577
Member-Months	6,596	7,406	6,667	5,991	5,608
Visits per 1,000 member months	**220.13**	**162.30**	**194.24**	**185.11**	**166.01**
Frail Elderly (FE)					
ED Visits	6,199	3,945	4,232	4,000	4,006
Members	7,341	6,899	6,879	6,683	6,272
Member-Months	68,631	64,328	62,984	61,240	58,785
Visits per 1,000 member months	**90.32**	**61.33**	**67.19**	**65.32**	**68.15**
Intellectual/Developmental Disability (I/DD)					
ED Visits	5,601	4,218	4,894	5,008	5,266
Members	9,037	9,084	9,123	9,141	9,257
Member-Months	103,258	103,575	104,737	105,222	106,514
Visits per 1,000 member months	**54.24**	**40.72**	**46.73**	**47.59**	**49.44**
Physical Disability (PD)					
ED Visits	12,424	8,089	8,483	8,367	9,528
Members	6,984	6,340	6,166	6,368	6,905
Member-Months	75,087	68,468	64,782	66,098	71,236
Visits per 1,000 member months	**165.46**	**118.14**	**130.95**	**126.58**	**133.75**
Total - TBI, FE, I/DD, PD					
ED Visits	25,676	17,454	18,904	18,484	19,731
Members	24,106	23,071	22,862	22,782	23,011
Member-Months	253,572	243,777	239,170	238,551	242,143
Visits per 1,000 member months	**101.26**	**71.60**	**79.04**	**77.48**	**81.48**
Mental Health (MH)					
ED Visits	113,755	108,503	136,237	150,513	151,554
Members	89,020	90,979	99,696	107,728	114,822
Member-Months	939,152	959,909	1,058,918	1,160,450	1,269,478
Visits per 1,000 member months	**121.13**	**113.03**	**128.66**	**129.70**	**119.38**

Table 47. HCBS and MH Emergency Department (ED) Visits, Excluding Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2016					
	CY2012	CY2013	CY2014	CY2015	CY2016
All KanCare Members - Excluding Dual-Eligible					
ED Visits	271,689	254,076	295,969	308,455	306,465
Members	405,448	411,120	425,636	435,122	445,132
Member-Months	4,026,589	4,100,783	4,361,384	4,463,500	4,633,272
Visits per 1,000 member months	**67.47**	**61.96**	**67.86**	**69.11**	**66.14**
Waiver Members - Excluding Dual-Eligible					
Traumatic Brain Injury (TBI)					
ED Visits	797	579	680	588	530
Members	303	305	281	242	251
Member-Months	2,727	3,081	2,662	2,467	2,361
Visits per 1,000 member months	**292.26**	**187.93**	**255.45**	**238.35**	**224.48**
Frail Elderly (FE)					
ED Visits	296	194	225	277	292
Members	263	251	307	323	381
Member-Months	2,515	2,293	2,800	3,157	3,645
Visits per 1,000 member months	**117.69**	**84.61**	**80.36**	**87.74**	**80.11**
Intellectual/Developmental Disability (I/DD)					
ED Visits	2,372	1,613	1,819	1,980	2,294
Members	4,255	3,392	3,530	3,664	3,870
Member-Months	46,812	37,633	39,583	41,461	43,791
Visits per 1,000 member months	**50.67**	**42.86**	**45.95**	**47.76**	**52.39**
Physical Disability (PD)					
ED Visits	4,419	2,683	2,938	3,230	3,874
Members	2,215	1,623	1,624	1,776	2,156
Member-Months	22,999	17,161	16,767	18,223	21,622
Visits per 1,000 member months	**192.14**	**156.34**	**175.23**	**177.25**	**179.17**
Total - TBI, FE, I/DD, PD					
ED Visits	7,884	5,069	5,662	6,075	6,990
Members	7,036	5,571	5,742	6,005	6,658
Member-Months	75,053	60,168	61,812	65,308	71,419
Visits per 1,000 member months	**105.05**	**84.25**	**91.60**	**93.02**	**97.87**
Mental Health (MH)					
ED Visits	78,317	74,166	95,035	106,950	110,631
Members	64,107	66,170	73,903	81,135	90,132
Member-Months	672,690	692,989	780,539	871,817	995,816
Visits per 1,000 member months	**116.42**	**107.02**	**121.76**	**122.67**	**111.10**

ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2016 compared to rates in CY2012 pre-KanCare. All rates below are based on number of ED visits per 1,000 member-months during the calendar year.

- **KanCare Population**: The ED rate in CY2016 (**70.79**) was lower than the rate in CY2012 (71.16), CY2014 (72.51), and CY2015 (73.77).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2016, compared to the other waiver populations. The ED visit rate in CY2016 (**166.01**) was lower than in CY2015 (185.11), CY2014 (194.24) and CY2012 (220.13). The CY2016 rate was a relative decrease of 24.6% compared to CY2012.
- **PD** – PD members also had high rates of ED visits, **133.75** in CY2016. The CY2016 rate was higher than in CY2015 (126.58) but lower than in CY2012 (165.46), a relative decrease of 19.2% compared to CY2012.
- **MH** –ED visit rates for SMI members have also been higher each year than the overall KanCare member rates, as well as those of FE and I/DD members. The rate in CY2016 (**119.38**) was lower than in CY2015 (129.0), CY2014 (128.66), and CY2012 (121.03).
- **I/DD** – I/DD member ED rates were lower than those of PD, FE, TBI, and MH members each of the five years. The CY2016 rate (**49.44**) was lower than in CY2012 (54.24) but higher than the rates in CY2013–CY2015.
- **FE** – FE member ED rates were lower than those of PD, FE, TBI, and MH members each of the five years. The CY2016 rate (**68.15**) was lower than in CY2012 (90.32) but higher than the rates in CY2013–CY2015.

ED visit rates for the KanCare population, in HEDIS data reported by the MCOs for all KanCare members, were also lower in CY2016 (**59.53** ED visits/1,000 member-months) compared to previous years (64.19–66.31), with a 10.2% relative decrease in ED visits from CY2015 to CY2016. A direct comparison cannot be made, however, with HEDIS rates for ED visits (reported as Ambulatory Care, ED Visits [AMB]), as the HEDIS rates exclude ED visits that result in inpatient admissions, while the data reported for HCBS and MH include all ED visits whether or not they resulted in an inpatient admission.

Inpatient Hospitalizations

Population: KanCare (all members) and stratified by TBI, FE, I/DD, and PD**.**
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
Data reported below and in Table 48 for HCBS (TBI, FE, I/DD, and PD) and all members are based on inpatient admissions per 1,000 member-months. Overall inpatient admission rates were lower in CY2016 than the four prior years. HEDIS data for inpatient utilization also showed lower rates in CY2016 than the three previous years and a 22.2% relative decrease in rates from CY2015 to CY2016. HEDIS rates, however, are based instead on inpatient discharges, so are not directly comparable. While overall inpatient rates decreased, inpatient rates for TBI, FE, and I/DD were higher in CY2016 than in CY015 and higher than CY2012 (pre-KanCare).

- **KanCare Population**: The inpatient rate for KanCare members in CY2016 (**14.51**) was lower than the rates from the previous four years (ranged from 15.29–15.74).
- **TBI** – The TBI member inpatient admission rate in CY2016 (50.46) was higher than the four previous years (45.37–49.74).
- **FE** – The FE inpatient admission rate in CY2016 (**51.10**) was higher than CY2015 (50.54), CY2013 (48.91), and CY2012 (47.27)..
- **I/DD** – I/DD member inpatient admission rates have been much lower than those of PD, FE, and TBI members each year. Rates, however, have increased each year from 12.36 in CY2012 to **14.73** in CY2016.

- **PD** – The PD inpatient admission rate in CY2016 (**54.55**) was higher than CY2015 (53.54), CY2013 (50.58), and CY2012 (53.84). PD inpatient admission rates have been higher each year than those of TBI, FE, and I/DD members.

Inpatient Readmissions within 30 days of inpatient discharge

Population: KanCare (all members), and stratified by I/DD, PD, TBI, and FE.

Analysis: Comparison of baseline CY2012 to annual measurement and trending over time. Inpatient readmission rates decreased in 2016 for TBI and FE members, increased for PD and I/DD members, and was relatively stable for the overall KanCare population. All rates below are based on total readmissions per 1,000 member-months each year.

- **KanCare** – The readmission rates for all KanCare members in CY2013–CY2016 have been slightly lower than the CY2012 rate (1.59). Rates have increased each year from 1.45 in CY2013 to **1.54** in CY2016.
- **TBI** – TBI member readmission rates decreased from 13.02 in CY2015 to **9.99** in CY2016. The CY2016 rate, however, is higher than the rates in CY2012 (8.64), CY2013 (7.02), and CY2014 (6.90).
- **PD** – The readmission rate for PD members in CY2016 (**11.09**) was higher than the four previous years and higher than the readmission rates of TBI, FE, and I/DD members.
- **FE** – The FE member readmission rate in CY2016 (**7.93**) was higher than in CY2012 (7.29) and CY2013 (7.23), but lower than in CY2014 (8.05) and CY2015 (8.25).
- **I/DD** – The I/DD member readmission rate was also higher in CY2016 (**2.04**) but have consistently been lower each year compared to those of PD, FE, and TBI members and have been only slightly higher than the readmission rates for all KanCare members.

Table 48. HCBS and MH Inpatient Admissions and Readmissions within 30 days of Discharge, CY2012 - CY2016

		Inpatient Admissions		Readmissions after Discharge	
Year	Members	Admits	Rate/1,000 member-months	Readmits	Rate/1,000 member-months
Total - All KanCare Members					
2012	463,285	71,310	**15.53**	7,306	**1.59**
2013	467,632	71,867	**15.44**	6,763	**1.45**
2014	481,950	77,407	**15.74**	7,435	**1.51**
2015	490,441	76,518	**15.29**	7,630	**1.52**
2016	498,611	74,870	**14.51**	7,929	**1.54**
Waiver Members					
Traumatic Brain Injury (TBI)					
2012	744	308	**46.69**	57	**8.64**
2013	748	336	**45.37**	52	**7.02**
2014	694	302	**45.30**	46	**6.90**
2015	590	298	**49.74**	78	**13.02**
2016	577	283	**50.46**	56	**9.99**
Frail Elderly (FE)					
2012	7,341	3,244	**47.27**	500	**7.29**
2013	6,899	3,146	**48.91**	465	**7.23**
2014	6,879	3,303	**52.44**	507	**8.05**
2015	6,683	3,095	**50.54**	505	**8.25**
2016	6,272	3,004	**51.10**	466	**7.93**
Intellectual/Developmental Disability (I/DD)					
2012	9,037	1,276	**12.36**	143	**1.38**
2013	9,084	1,287	**12.43**	148	**1.43**
2014	9,123	1,377	**13.15**	183	**1.75**
2015	9,141	1,519	**14.44**	176	**1.67**
2016	9,257	1,569	**14.73**	217	**2.04**
Physical Disability (PD)					
2012	6,984	4,043	**53.84**	698	**9.30**
2013	6,340	3,463	**50.58**	605	**8.84**
2014	6,166	3,606	**55.66**	699	**10.79**
2015	6,368	3,539	**53.54**	652	**9.86**
2016	6,905	3,886	**54.55**	790	**11.09**
Total Waiver Populations (TBI, FE, I/DD, and PD)					
2012	24,106	8,871	**34.98**	1,398	**5.51**
2013	23,071	8,232	**33.77**	1,270	**5.21**
2014	22,862	8,588	**35.91**	1,435	**6.00**
2015	22,782	8,451	**35.43**	1,411	**5.91**
2016	23,011	8,742	**36.10**	1,529	**6.31**

Quantify system design innovations implemented by KanCare such as: Person-Centered Medical Homes, Electronic Health Record use, Use of Telehealth, and Electronic Referral Systems

System design innovations for improved health care provision throughout Kansas, such as patient-centered medical homes, electronic health record use, use of telehealth, and electronic referral systems, are reported in the KanCare Evaluation Annual Reports. The summary that follows is an update on 2017 activities.

To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC researches and summarizes the various related initiatives occurring in Kansas that have the potential to affect a broad KanCare population. KFMC collects the following information about the other initiatives, as available, to help determine overlap with KanCare initiatives:

- Consumer and provider populations impacted,
- Coverage by location/region,
- Available post-KanCare performance measure data, and
- Start dates and current stage of the initiative.

Health Homes

The Health Homes program for KanCare members with SMI continued to provide care coordination services through June 30, 2016, when the program was discontinued. Care Coordination and Targeted Case Management services are available through MCOs and CMHCs.

Patient Centered Medical Homes

- Blue Cross/Blue Shield of Kansas (BCBSKS)
  BCBSKS has a Quality-Based Reimbursement Program (QBRP) that allows their contracting providers to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSKS and their patients.
  - *Coverage by location/region:* Kansas, excluding metro Kansas City
  - *Start dates and current stage of the initiative*: Since 2011, BCBSKS has incentivized a number of provider-based quality improvement initiatives such as Electronic Health Record (EHR) adoption, electronic prescribing, participation in a Health Information Exchange (HIE), and Patient Centered Medical Home (PCMH). These incentives change each year and continued in 2017.
- Children's Mercy Hospital & Clinics (CMH) DSRIP - Expansion of Patient Centered Medical Homes and Neighborhoods
  - *Consumer and provider populations impacted:* Children and youth with medical complexity (CYMC) and their siblings.
  - *Coverage by location/region:* Four practices in Northeast Kansas
  - *Start dates and current stage of the initiative*: The project started January 1, 2015. The four practices are in active stages of modifying their processes, per the PCMH model, in preparation for NCQA certification. One practice became PCMH-recognized by NCQA in 2016.

Other Practice Redesign Initiatives

- Kansas Healthcare Collaborative – Practice Transformation Network
  The Kansas Healthcare Collaborative (KHC), a quality organization founded by the Kansas Medical Society and the Kansas Hospital Association, is the lead organization in Kansas for the Practice Transformation Network (PTN). The PTN involves group practices, health care systems, and others joining forces to collectively share quality improvement expertise and best practices to reach new

levels of coordination, continuity, and integration of care. KHC provides coaching and assistance to clinician practices preparing for clinical and operational practice transformation from a fee-for-service payment model to performance-based payment.
  - *Consumer and provider populations impacted:* Primary care practices, health care systems, and the consumers they serve.
  - *Coverage by location/region:* More than 1,190 Kansas clinicians and 111 clinics are participating in this effort.
  - *Start date of the initiative*: The grant was awarded September 29, 2015, and the project is ongoing.
- The University of Kansas Hospital (UKHS) – Kansas Heart and Stroke Collaborative (KHSC)
  The KHSC is an innovative care delivery and payment model to improve rural Kansans' heart health and stroke outcomes and reduce total cost of care. The grant program is funded by the Centers for Medicare and Medicaid Services Innovation. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information exchange, "big data" analysis, and population health management. The program includes the following objectives:
  - Develop shared clinical guidelines for moving patients to the next level of care.
  - Provide care coordination and management.
  - Deliver more telemedicine resources.
  - Leverage electronic health information exchanges.
  - Establish standards and procedures to increase efficiency and economics of scale.
  - Design and deploy payment models to support rural providers.
  - Create a forum for sharing best practices and regional care strategies.
    - *Consumer and provider populations impacted:* All consumers of participating providers. *Coverage by location/region:* As noted in UKHS's 2016 annual report, "*The collaborative has expanded from its original 13 healthcare participants in 12 northwest Kansas communities to 38 hospitals in 37 Kansas counties*."
    - *Start date and current stage of the initiative*: The initiative started September 1, 2014, and extended through August 31, 2017.
    - *Outcomes/Performance Measurement Results*: In 2017, KHSC reported this model was improving quality, outcomes and lowering costs. Next steps were to move into a Medicare Shared Savings Program as an Accountable Care Organization (ACO); this was part of KHSC's sustainability plan.
- ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. As of January 1, 2018, there were 13 ACOs in Kansas; this is an increase from 9 in CY2016.
- Kansas Association for the Medically Underserved – Health Center Controlled Network (HCCN)
  The HCCN is a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiency through the redesign of practices to integrate services and optimize patient outcomes. Redesign includes a focus on health information technology systems, integration of electronic health record systems, Meaningful Use (MU) attestation, and quality improvement.
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.

  - *Coverage by location/region:* Locations of participating safety net clinics include: Atchison, Dodge City, Garden City, Great Bend, Halstead, Hays, Hoxie, Hutchinson, Junction City, Lawrence, Liberal, Manhattan, Newton, Salina, Topeka, Ulysses, Victoria, Wichita, and Winfield.
- As mentioned in previous KanCare evaluation reports, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created provisions to promote the Meaningful Use (MU) of health information technology. Through the Office of the National Coordinator for Health Information Technology Regional Extension Center program, KFMC provided support to more than 1,600 Eligible Professionals (EPs) and 95 Eligible Hospitals (EHs) across the state to achieve MU. The Regional Extension Center program was sunset on April 7, 2016.

  KFMC, through funding by KDHE-DHCF, is providing technical assistance to Medicaid providers, including assisting them with health information technology (HIT) security risk assessments and meaningful use of an EHR between February 2014 and September 2017. A new contract has recently been awarded to KFMC and HIT technical assistance continues with Kansas Medicaid providers.

Health Information Exchange (HIE)

Increasing HIE capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of healthcare providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), have continued to expand their capabilities and to offer services to a wider audience.

Telehealth and Telemedicine

Telehealth is a broad scope of remote healthcare services, including long-distance clinical healthcare, patient and professional health-related education, and health administration activities. Telehealth refers to a broader scope of remote healthcare services, while telemedicine refers specifically to remote clinical services using interactive televideo, including use of digital stethoscopes, otoscope cameras, general exam cameras, and intra-oral scopes.

The University of Kansas Center for Telemedicine & Telehealth (KUCTT) include the following:

- Heartland Telehealth Resource Center, as well as telemedicine services
  - *Consumer and provider populations impacted:* KU Center for Telemedicine and Telehealth has conducted thousands of clinical consultations for Kansans and hosted hundreds of educational events for health professionals, teachers, students and the public. Many hospitals and clinics across the state are equipped with video conferencing systems that allow providers to collaborate with KUCTT for specialty clinical consults. The KUCTT has provided clinical telemedicine consults to patients across Kansas in more than 30 medical specialties.
  - *Coverage by location/region:* More than 100 sites throughout Kansas
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 1991
- Project ECHO – Extension for Community Healthcare Outcomes
  - *Consumer and provider populations impacted:* UKHS joined forces with CMH for the first local Project ECHO, focusing on treating epilepsy. Project ECHO has expanded beyond this initial joint project. It provides collaborative provider education, linking interdisciplinary specialty teams with multiple primary clinics. Increases access for patients in rural and underserved communities. Topics have included airways, Epilepsy; Pediatric Psychopharmacology; Asthma;

ADHD; Back-to-school; Pain Management; Opioid Addiction; Healthy Lifestyles Pediatric Obesity.
    - *Coverage by location/region:* There are five ECHO Hubs in Kansas and registrant participant sites throughout Kansas.
    - *Start date and current stage of the initiative*: This is an ongoing service provided since 2015
- Telehealth Rocks – Rural Outreach for the Children of Kansas
    - *Consumer and provider populations impacted:* Connecting children and families with developmental and behavioral specialists through telemedicine.
    - *Coverage by location/region:* Serving nine counties in southeast Kansas.
    - *Start date and current stage of the initiative*: This is an ongoing service provided since 2017
- Telehealth Rocks Schools
    - *Consumer and provider populations impacted:* Extends telemedicine into the school setting to assist children and families with developmental and behavioral concerns.
    - *Coverage by location/region:* Serving 11 counties and 19 school settings in southeast and south-central Kansas.
    - *Start date and current stage of the initiative*: This is an ongoing service provided since 2016

Timely resolution of grievances and **Compare/track number of access-related grievances over time, by population type –** Reported Quarterly
Timely resolution of grievances is analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

Comparisons and tracking of access-related grievances over time and by population are reported in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. KDHE updated grievance reporting processes and provided training to MCO staff to ensure more accurate and uniform quarterly reporting of member grievances.

Timeliness of claims processing – Reported Quarterly
Timeliness of processing clean claims, non-clean claims, and all claims is reported and analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. Included in this measure are the numbers of claims received each month, the number of claims processed within contractually required timeframes, and analysis of trends over time for turnaround times for processing clean claims. In 2017, KDHE updated reporting templates; and, at the State's direction, MCOs updated their reporting of timeliness of claims processing that now provides more comparable reporting from each MCO based on more uniform reporting criteria.

(27) Member Surveys

CAHPS Survey

Additional detail on the CAHPS survey In CY2017 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to efficiency include the following questions listed in Table 49.

Table 49. Member Survey - CAHPS									
Question	Pop	% Positive Responses				Quality Compass ≥50th Percentile^			
		2014	2015	2016	2017	2014	2015	2016	2017
Questions on Adult and Child Surveys									
In the last 6 months, did you get information or help from your (child's) health plan's customer service?	Adult	33.1%	33.2%	32.6%	**31.4%**				
	GC	24.7%	27.3%	28.9%	**26.2%**				
	CCC	28.3%	31.1%	30.2%	**28.0%**				
In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?	Adult	80.0%	84.2%	83.8%	**83.0%**	↓	↑	↑	↑
	GC	86.7%	85.4%	84.5%	**84.6%**	↑	↑	↑	↑
	CCC	84.8%	84.4%	82.9%	**83.4%**	↑	↑	↓	↓
^↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile									

Questions on both adult and child surveys:
In the last 6 months, did you get information or help from your (child's) health plan's customer service?
Similar to the previous three years, less than one-third of members in 2017 reported contacting customer service at their MCO for information or help.

- **Adult**s: **31.4%** in 2017; 32.6%–33.2% in 2014–2016
- **GC**: **26.2%** in 2017; 24.7%–28.9% in 2014–2016
- **CCC**: **28.0**% in 2017; 28.3%–31.1% in 2014–2016.
  Those who responded they received information or help from customer service from their MCO in the previous 6 months were asked:
  - **In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?**
    While less than one-third of members contacted their MCO's customer service, over 82% found the information provided helpful.
    - **Adults**: **83.0%** in 2017 (**>50th QC**); 80.0%–84.2% in 2014–2016
      Sunflower's rate (86.7%) was >90th QC, UnitedHealthcare's rate (82.4%) was >50th QC, and Amerigroup's rate (79.5%) was <25th QC in 2017.
    - **GC**: **84.6%** in 2017 (**>66.67th QC**); 84.5%–86.7% in 2014–2016
      UnitedHealthcare's TXXI rate (88.0%) in 2017 was >90th QC).
    - **CCC**: **83.4**% in 2017 (**<33.33rd QC**); 82.9%–84.8% in 2014–2016

Mental Health Survey

The MH Surveys conducted in CY2011 through CY2017 are described above in Section 7 "Member Survey – Quality."

From 2016 to 2017, the percentage of members responding positively to the question, "**My mental health providers returned my calls in 24 hours**," increased significantly from 79.6% in 2016 to 85.9% in 2017 (p=.04) and was higher than the five previous years (see Table 50). The 2017 percentage of positive responses from members in Urban counties (79.9%) was significantly lower than responses from other county types (90.8%; p<.001 [Semi-Urban 90.0%; Densely-Settled Rural 89.8%; Rural and Frontier 93.7%]).

Table 50. Mental Health Survey - Efficiency-Related Questions						
	Year	0% 100%	Rate	N/D	95% CI	*p*-value
	General Adult (Age 18+)					
My mental health providers returned my calls in 24 hours.	**2017**		**85.9%**	303 / 353	81.8% – 89.2%	.04↑
	2016		79.6%	213 / 267	74.4% – 84.1%	
	2015		84.4%	292 / 346	80.2% – 87.9%	
	2014		83.3%	618 / 742	80.5% – 85.8%	
	2013		84.4%	840 / 995	82.0% – 86.5%	
	2012		80.8%	202 / 250	75.4% – 85.2%	
	2011		88.1%	251 / 285	83.8% – 91.4%	

SUD Survey

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014-2017. The question that follows is related to perception of efficiency for members receiving SUD services (see Table 51).

Table 51. SUD Survey - Efficiency-Related Question, CY2014 - CY2017				
	CY2014	CY2015	CY2016	CY2017
How well does your counselor communicate with you? *(Percent of "Very well" or "Well" responses)*	**93.9%**	**93.2%**	**92.1%**	**87.3%**

How would you rate your counselor on communicating clearly with you?
Of the 245 surveyed in CY2017, 214 (87.3%) rated their counselor as communicating very well or well, 5–7% lower than the three prior years. Results varied by MCO, however (Amerigroup – 91.4%; Sunflower – 89.7%; UnitedHealthcare – 78.5%).

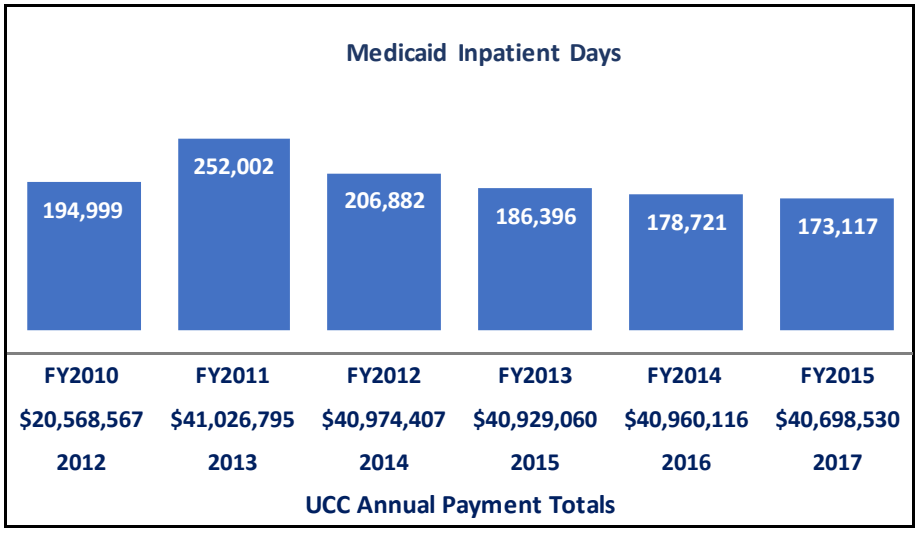
Uncompensated Care Cost (UCC) Pool

Number of Medicaid Days for Uncompensated Care Cost Pool hospitals compared to UCC Pool Payments
The UCC Pool permits payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals. The UCC Pool funding is based on historical costs. For instance, the UCC Pool funding for CY2016 is based on costs of care during FY2014, and funding for CY2017 is based on costs of care during FY2015.

There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, to 178,721 in CY2016, and to 173,117 in CY2017.

UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool

payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116 and decreased to $40,598,530 in CY2017.



Delivery System Reform Incentive Program (DSRIP)

The DSRIP program aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals are to work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas, which was launched in 2015, includes two major hospitals, Children's Mercy Hospital and Clinics (CMH) and the University of Kansas Hospital (UKHS). The two hospital systems are major medical service providers to Kansas and Missouri residents. CMH projects include *Improving Coordinated Care for Medically Complex Patients (Beacon Program)* and *Expansion of Patient-Centered Medical Homes and Neighborhoods (PCMH)*. UKHS projects include STOP Sepsis (*Standard Techniques, Operations, and Procedures for Sepsis)* and SPARCC (*Supporting Personal Accountability and Resiliency for Chronic Conditions).*

KFMC, the External Quality Review Organization (EQRO) for the Medicaid program (KanCare) for the State of Kansas, reviewed annual reports for activities completed in CY2015 and CY2016 submitted to the KDHE by CMH and UKHS. The major focus of the DSRIP Evaluation is to assess the progress in meeting overall goals of each project, along with providing an independent evaluation of progress in meeting each of the metrics delineated in levels one through four of the DSRIP project proposals approved by CMS in February 2015.

The University of Kansas Hospital System

STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis

In 2017, STOP Sepsis training was provided to 860 participants, bringing the total to 1,488 staff from hospitals, nursing facilities, emergency medical services (EMS), and other healthcare providers. As of December 2017, an additional 14 Kansas facilities agreed to share sepsis data, increasing the number of partner facilities tracking and reporting sepsis data to 47. In 2017, the STOP Sepsis project added 66 community partners, bringing the total to 213.

While 213 community partners would appear to exceed UKHS's target of 185, the 185 target community partners initially included 143 NFs. Enlisting NFs to participate in a project that includes additional data tracking activities has been a challenge. As of December 2017, however, there are now 57 partner NFs. In 2017, UKHS provided training specific to NFs to 340 NF staff from 17 facilities. UKHS also developed and implemented in 2017 a new database tool for NFs for tracking and reporting sepsis data. The NF and hospital database is now set up in REDCap, which project partners have found more user-friendly than the previous database and has provided UKHS staff more efficient and expanded reporting of sepsis data from multiple types of partnering facilities.

UKHS has also partnered with the technology company Redivus Health on a mobile app to assist providers in recognizing and diagnosing sepsis. Pilot testing of the app in 2017 includes participation from NF and hospital partners.

Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)

The SPARCC program focuses on building heart failure (HF) patients' ability to care for themselves and be resilient in the face of their chronic condition. The program also includes caregivers, who benefit as well from the skills learned through the training.

As of June 2017, 199 patients and caregivers have participated in SPARCC training. An additional 27 patients participated in one or more SPARCC sessions in the second half of 2018, for a total in 2016 and 2017 of 226. The number of community partners increased from 87 in 2016 to 103 by the first half of 2017. Of 228 individuals throughout Kansas who have been trained as SPARCC facilitators, 70 have facilitated at least one patient education group. One SPARCC facilitator training was held in 2017, which drew participants from 28 facilities across the state, 16 facilities that were participating for the first time. UKHS has also been successful in developing 13 training videos for SPARCC facilitators they can now access through the YouTube website.

Positive outcomes of the program are reflected through improved scores assessing quality of life and depression. The program also emphasizes the need of HF patients to monitor their weight, blood pressure, and blood glucose levels in those who also have diabetes.

Children's Mercy Hospital and Clinics

Improving Coordinated Care for Medically Complex Patients (Beacon Program)

The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013 and reported in December 2014 that 63 Beacon patients were from Kansas. In 2015 there were 56 Kansas Beacon patients (38 CYMC and 18 siblings). In 2016, the number increased to 92 Kansas Beacon patients (65 CYMC and 27 siblings); and, as of December 31, 2017, there were 108 "active" Kansas Beacon patients (73 CYMC, 17 siblings, and 18 consults). There were, however, at least 136 Kansas

children and adolescents who received Beacon services at some point in 2017, including 86 CYMC and 32 siblings in addition to the 18 consults.

The number of Kansas Beacon patients has grown in the last two years but has continued to be lower than initially forecast, as the Beacon program has continued to encounter barriers in increasing referrals for consultations, technicalities related to providing telehealth services, and underestimation of the number of Beacon patients transitioning from the program. Beacon continues to conduct outreach to providers throughout Kansas. In 2017, Beacon focused on establishing telehealth locations throughout Kansas and development of resource guides for county-specific services in addition to those available statewide and nationally. As of December 2017, resource guides were completed for 88 counties. Beacon has also updated and expanded a variety of additional online resources to address needs of Beacon children, families, and PCPs providing local services to children with complex medical needs.

Expansion of Patient-Centered Medical Homes and Neighborhoods

CMH is promoting the PCMH model to transform the way pediatric primary care is organized and delivered in Kansas. Components of the PCMH DSRIP project include increasing access to effective and efficient primary care services and increasing the use of population health management through health information technology. CMH is partnering with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. The participating practices will deliver improved care that meets the Triple Aim.

CMH continues to actively work with the four practices; they met or exceeded all measurement targets in 2017, except for the PCMH recognition target that was out of their control. One practice achieved NCQA PCMH recognition in 2016. Two practices were intending to submit their applications for recognition in 2017; however, there were substantial NCQA related extenuating circumstances. CMH and the practices continue to make progress in their implementation of the other transformation processes. The fourth practice continues to work towards implementing PCMH standards, although they do not plan to apply for PCMH recognition. Two practices are implementing new electronic medical records (EMRs) that will provide enhanced reporting capabilities.

CMH continues to provide routine educational webinars and the online message board is being used as a forum for the practices to communicate with each other. The addition of a Collaborative Service Agreement from Children's Mercy Hospital allows for enhanced communication and collaboration for these practices and practices from around the region. CMH also implemented the Community Engagement Resource Application (CERA), containing detailed information about various community agencies and organizations that address various social determinants of health. This application contains over 800 community resources and was accessed over 11,000 times in 2017.

Conclusions

Metrics in this annual evaluation are from the KanCare Evaluation Design approved by CMS. Data in this evaluation report are from a number of sources, including:

- **HEDIS** data for CY2016 (reported in CY2017) compared to HEDIS data for CY2013–CY2015 for 19 HEDIS measures (60 metrics, including subparts). Data are aggregated, weighted MCO annual HEDIS data, with individual MCO HEDIS data reported where results differed greatly by MCO or where annual rates significantly increased. NCQA Quality Compass rankings were also included in

the analysis to allow national comparison to Kansas rates. HEDIS-like data were also reported by the MCOs for several HEDIS metrics that were P4P in CY2014–CY2015 for three metrics for the HCBS population and eight metrics for the combined PD-I/DD-SMI population.

- **National Outcome Measurement System (NOMS)** – KDADS provided data and analysis of NOMS metrics related to members receiving SUD, SED, SPMI, and NF services.
- **HCBS services and service plans** – KDADS provided comparison data on services and ongoing service plan updates by waiver type.
- **Mental Health Survey** results for surveys completed in CY2017 by adults, youth, and SED youth and young adults who received mental health services in the prior six-month time-period. Results for CY2017 were compared to results pre-KanCare (CY2011 and CY2012) and prior KanCare years CY2013–CY2016. Results were included for 26 questions by subgroup.
- **CAHPS** aggregated MCO data for separate surveys completed in CY2017 of adults, general child Title XIX, general child Title XXI, Title XIX children with chronic conditions, and Title XXI children with chronic conditions, and compared to aggregated rates from survey results in CY2014–CY2016, national Quality Compass rankings. Results are also reported by MCO where outcomes differed greatly or significantly changed. Included in the annual evaluation are 20 questions asked of all five subgroups, 22 asked only on the four child surveys, 5 questions asked only on the Adult surveys, and 5 MCO supplemental questions.
- **Provider Surveys** – Results for three questions each MCO has been required to include in their annual provider surveys related to satisfaction with availability of specialists, overall quality, and the MCO's preauthorization process.
- **SUD Survey** – Results for 15 questions in the annual convenience survey conducted by the MCOs of members receiving SUD treatment services.
- **GeoAccess** – Analysis of provider availability as reported by MCOs quarterly related to network availability of provider types by specialty, including HCBS and I/DD service providers.
- **Costs** Update provided by KDHE finance staff on service utilization and PMPM (per member per month) costs by Medicaid eligibility group.
- **Emergency Department, Inpatient, and Readmissions** – Annual comparison (2012–2016) of ED visits, inpatient hospitalizations, and readmissions (rate per 1,000 member-months) for the total KanCare population and Waiver populations (TBI, FE, PD, and I/DD).
- **DSRIP** – Update on the third year of implementation of statewide projects being conducted by the University of Kansas Hospital System (STOP Sepsis and SPARCC [program for heart failure patients and their caretakers]) and Children's Mercy Hospitals and Clinics (Beacon program and PCMH expansion).
- **UCC –** Update on uncompensated care funding for hospitals in Kansas providing services to Medicaid and uninsured individuals.

Results for each of the above data sources are summarized below:

HEDIS measures

CMS Core Health Care Quality Measures – KanCare results ≥50th QC in CY2016

- ***Flu Vaccinations for Adults*** (FVA): >90th QC (49.3%)
- ***Follow-up (within 7 days) after Hospitalization for Mental Illness*** (FUH): >75th QC (64.4%)
- ***Annual Monitoring for Patients on Persistent Medications*** (MPM): (89.5%) >66.67th QC
- ***Follow-up for Children Prescribed ADHD Medication*** (ADD)
  - Initiation Phase – >75th QC (52.2%)
  - Continuation Phase – >50th QC (61.4%)

- ***Initiation and Engagement in Treatment for Alcohol or other Drug Dependence*** (IET)
  - Initiation in Treatment
    - Ages 13–17 (50.2%): >75th QC
    - Total – Ages 13 and older (41.1%): >50th QC
  - Engagement in Treatment
    - Ages 13–17 (27.5%): >90th QC
    - Total – Ages 13 and older (14.3%) and Ages 18 and older (12.4%): >50th QC
- ***Medical Assistance with Smoking and Tobacco Use Cessation*** (MSC)
  - Advised to Quit: >66.67th QC (80.0%)
  - Medication recommended or discussed: >66.67th QC (51.3%)
  - Methods other than medication discussed: >66.67th QC (48.4%)

CMS Core Health Care Quality Measures – KanCare results <50th QC in CY2016

- ***Prenatal and Postpartum Care*** (PPC)
  - Prenatal Care (68.4%): <10th QC
  - Postpartum Care (58.0%): <25th QC
- ***Controlling High Blood Pressure*** (CBP): <50th QC (52.1%)
- ***Comprehensive Diabetes Care*** (CDC)
  - HbA1c Testing: <50th QC (85.8%)
  - HbA1c Poor Control (>9.0%): <50th QC (41.1%)
- ***Adolescent Well-Care Visits*** (ADW): (47.7%) <50th QC
- ***Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*** (W34): (67.3%) <33.33rd QC
- ***Well Child Visits in the First 15 Months of Life*** (W15)
  - 4 visits (8.6%), 5 visits (15.5%), 6 or more visits (58.6%): <50th QC
  - 0 visits (3.4%), 1 visit (3.5%), 2 visits (4.8%): >75th QC
- ***Adult BMI Assessment*** (ABA): <33.33rd QC (80.9%)
- ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** (WCC)
  - Weight Assessment/BMI: <25th QC (Total – Ages 3-17: 56.0%; Ages 3-11: 55.5%; Ages 12-17: 56.9%)
  - Counseling for Nutrition for Children/Adolescents: <25th QC (Total – Ages 3-17: 54.7%; Ages 3-11: 55.4%; Ages 12-17: 53.1%)
  - Counseling for Physical Activity for Children/Adolescents
    - Ages 12–17: <50th QC (58.6%)
    - Total – Ages 3-17 (51.5%) and Ages 3–11 (47.9%): <33.33rd QC
- ***Chlamydia Screening in Women*** (CHL)
  - Total – Ages 16-24 (45.3%) and Ages 21–24 (52.8%): <25th QC
  - Ages 16–20 (41.0%): <10th QC
- ***Breast Cancer Screening***: (46.5%) <10th QC
- ***Cervical Cancer Screening***: (54.8%) <33.33rd QC
- ***Initiation and Engagement in Treatment for Alcohol or other Drug Dependence*** (IET): Initiation in Treatment – Ages 18 and Older (40.1%): <50th QC

Additional HEDIS measures – KanCare results ≥50th QC in CY2016

- ***Adults' Access to Preventive/Ambulatory Health Services*** (AAP)
  - Total - Ages 20 and older (86.2%) and Ages 45–64 (91.3%): >75th QC
  - Ages 20-44 (82.6%) and Ages 65 and older (90.1%): >66.67th QC

- ***Annual Dental Visit*** (ADV)
  - Total –Ages 2-20 (63.7%) and Ages 7–10 (72.7%): >75th QC
  - Ages 2–3 (45.8%), Ages 4–6 (69.2%), Ages 11–14 (66.4%), Ages 15–18 (57.2%): >66.67th QC
- ***Comprehensive Diabetes Care*** (CDC)
  - HbA1c Control (<8.0%): (51.0%) >50th QC
  - Eye Exam (Retinal): (64.4%) >75th QC
- ***Medication Management for People with Asthma***
  - Total–Ages 5-64 (33.7%) and Ages 5–11 (31.7%): >50th QC
  - Ages 51–64: (60.1%) >75th QC
  - Ages 12–18 (31.9%) and Ages 19–50 (41.4%): >66.67th QC

Additional HEDIS measures – KanCare results ≤50th QC in CY2016

- ***Comprehensive Diabetes Care*** (CDC)
  - Medical Attention for Nephropathy: (87.2%)<25th QC
  - Blood Pressure Control (<140/90): (57.9%) <50th QC
- ***Diabetes Monitoring for People with Diabetes and Schizophrenia*** (SMD) - (58.1%) <10th QC
- ***Annual Dental Visit*** (ADV) – Ages 19–20: (33.1%) <50th QC
- ***Appropriate Testing for Children with Pharyngitis*** (CWP): (61.2%) <25th QC
- ***Appropriate Treatment for Children with Upper Respiratory Infection***: (79.2%) <25th QC

HEDIS-like Measures

The following measures are HEDIS-like in that HEDIS criteria were limited to the combined **SMI, I/DD, and PD** member populations:

- Rates in CY2016 for ***Preventive Ambulatory Health Services*** (AAP), ***Cervical Cancer Screening*** (CCS), ***Breast Cancer Screening*** (BCS), ***HbA1c Testing*** (CDC), ***Eye Exam (retinal)*** (CDC), and ***Medical Attention for Nephropathy*** (CDC) for the PD-I/DD-SMI populations were comparable to rates in CY2013–CY2015.
  - Rates that were **higher** in the PD-I/DD-SMI population compared to the rate for the total KanCare population in CY2016 were:
    - ***Breast Cancer Screening***: 51.6% compared to 46.5%;
    - ***Preventive Ambulatory Health Services***: 95.3% compared to 86.2%; and
    - ***Eye Exam (retinal):*** 67.3% compared to 64.4%.
  - Rates that were **lower** in the PD-I/DD-SMI population compared to the rate for the total KanCare population in CY2016 were:
    - ***Cervical Cancer Screening***: 51.8% compared to 54.8% and
    - ***Blood Pressure Control (<140/90)*** (CDC): 52.1% compared to 56.8%.
  - Rates that were **comparable** in the PD-I/DD-SMI population compared to the rate for the total KanCare population in CY2016 were the following Comprehensive Diabetes Management metrics:
    - ***HbA1c Testing***: 86.2% compared to 85.8%;
    - ***HbA1c Control (<8.0%)*****:** 52.8% compared to 52.7%; and
    - ***Medical attention for Nephropathy***: 87.6% compared to 87.2%

The following HEDIS-like measures apply to members receiving **HCBS waiver services (I/DD, PD, TA, TBI, Autism, SED, FE, and MFP)**:

- ***Increase in the number of primary care visits*** – The CY2016 rate (94.1%) was comparable to those of the three previous years and higher than the rate for all KanCare adult members (86.2%).

- ***Increase in annual dental visits*:** The CY2016 rate (51.6%) was again in CY2016 lower than the rate for all KanCare members (63.7%).
- The CY2016 rate for ***Decrease in number of emergency department visits*** (71.55/1,000 visitor months) was lower than the rate in the three previous years (ranged from 77.58–79.64) and was again higher than the HEDIS rate for the overall KanCare population (59.53)

SUD Services

- From CY2013 to CY2017, there has been a 13.9 percentage point increase (43.7% relative increase) in the annual quarterly employment average for KanCare members completing SUD treatment. From CY2016 to CY2017, the annual quarterly average of employment increased by 7.4 percentage points to 45.7%, a one-year relative increase of 19.3%.
- Attendance of self-help programs decreased from 44.5% in CY2014 to 39.5% in CY2015 to 39.0% in CY2016 and increased in CY2017 to 41.3%, lower all four years than in CY2012 pre-KanCare (59.9%).
- Three of the five SUD measures (stable living arrangements at time of discharge from SUD services, decreased arrests, and decreased use of alcohol and/or other drugs) have had consistently high success rates (over 90%) pre-KanCare (CY2012) and in KanCare (CY2013-CY2017).

Mental Health Services

- The percentage has been consistently stable between CY2014 and CY2017 between 15.6% and 16.3%.
- The percentages of SPMI adults and SED youth with access to services are based on the number of members assessed as having SED (youth) and SPMI (adults). In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data, which allows more accurate trend analysis. The period between CY2015 and CY2017 has stayed relatively stable.
- Compared to CY2012 (45.7%; 69 of 150), the average annual quarterly average of those homeless at the beginning of the quarter who were housed at the end of each quarter was higher in CY2013 (58.0%; 58 of 100) and CY2014 (49.1%; 35 of 70) but dropped in CY2015 to 44.2% (46 of 104) and continued to decrease in CY2016 (33.7%; 35 of 104) and CY2017 (25.0%; 28 of 112).
- The annual quarterly average percentage of SED youth with improved housing status has been increasing each year from 80.6% in CY2013 to 90.1% in CY2017. The annual quarterly average from CY2013 to CY2017 maintained a high percentage above 98%.

HCBS Waiver Services

- WORK employment program – In 2017, there were 142 PD, 15 TBI, and 125 I/DD Waiver members participating in the WORK program as of April, with six additional PD, TBI, and I/DD Waiver members participating during the year.
- The 2017 HCBS quality data will be finalized in May 2018.

Nursing Facilities (NF)

- The percentages of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to rates 0.06%-0.9% lower in CY2013–CY2017. In CY2017, there were 74 fewer falls than in CY2012.
- The percentage of NF Medicaid members readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and to 12.70% in CY2014. In CY2015, the percentage decreased to 12.04%, then increased to 13.28% in CY2016. During the first two quarters of CY2017, the percentage decreased to 12.56%.

- The percentage of NF claims denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013, and then decreased to 10.4% in CY2014. The denial rates in CY2015 (13.2%) and CY2016 (13.4%) were comparable to CY2013.
- PEAK – The number of Person-Centered Care Homes increased from 8 in FY2013 to 17 by June of FY2017.

Member Survey – Mental Health

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2017 of a random sample of KanCare members who received one or more MH services in the prior six-month period. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past seven years, were used for this project.

Questions were the same in 2011 through 2017, with the following additional questions added at the request of the State

- A question added in 2017 related to whether the (adult) member is doing what he/she wants to for paid work;
- Three questions added to the youth survey in 2016 related to whether the parent/guardian feels the child's mental health provider believes the child can grow, change, and recover; talks to them in an encouraging way; and encourages the child's growth and success
- Three questions added to the adult survey in 2015 on smoking cessation; and
- A question on whether medication was available timely added in 2013.

In 2017, the survey was mailed to 11,770 KanCare members and the following were completed: 415 General Adult, 503 General Youth, 386 SED Waiver Youth, and 27 SED Waiver young adult surveys. Results were also stratified by whether the member completed the survey or whether a family member/guardian completed the survey for a child (age <18).

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

Responses related to quality of care were generally very positive (over 80%) in 2017 with the exception of the General Adult population related to being better able to deal with crisis and better able to do things they want to do (77.2% and 77.1%, respectively) and SED Waiver Youth and Young Adults related to being better at handling daily life (74.0%) and better able to do things he or she wants to do (73.4%).

Survey questions with >90% satisfaction in 2017 included:

- Mental health provider spoke in a way the member understood (all survey subgroups)
- Member determining or helping determine treatment goals (General Youth, General Youth [youth responding, ages 12–17], SED Waiver Youth and Young Adult)
- I have people I am comfortable talking with about my child's problems (General Youth)
- Member felt comfortable asking questions about treatment and medication (Adults)
- Services available at a convenient times (Adults)
- Medication available timely (Adults, General Youth, SED Waiver Youth and Young Adults)

There were a number of significant increases in 2017 compared to 2016, compared to other previous years, and trends over the 5-year KanCare years (2013—207) and 7-years (pre-KanCare 2011 and 2012

in addition to KanCare years). Examples of some of the significant increases this year by survey population include:

- Able to see a psychiatrist when wanted to (Adults: 2017: 81.3%, 2016: 73.6%; *p*=.02)
- Better able to control life (Adults – 2017: 82.0%, 2016: 74.8%; *p*=.02)
- As a result of services received, member is better able to deal with a crisis (Adults–2017: 77.2%, 2016: 69.2%; *p*=.02)
- As a result of services received, member is better able to do things he or she wants to do (Adults–2017: 77.1%, 2016: 69.3%; *p*=.02)
- Able to get all the services member thought needed (SED Waiver, youth responding, ages 12-17: significant increase 5-year trend and 7-year trend)
- Mental health providers returned calls in 24 hours (Adults– 2017: 85.9%, 2016: 79.6%; *p*=.04)
- Medication available timely (General Youth–2017: 95.6%, significantly higher than each year 2013–2016; *p*<.001; and 5-year trend; *p*<.01; SED Wavier Youth and Young Adult–5-year trend; *p*<.01)

KFMC also analyzed survey results to identify service issues that may differ by county type. Members in Urban counties, for example, were under-represented in the following:

- Provider return of calls within 24 hours: General Adult population – The 2017 percentage of positive responses from members in Urban counties was significantly lower (79.9%) than responses from other county types (90.8%; *p*<.001 [Semi-Urban 90.0%; Densely-Settled Rural 89.8%; Rural and Frontier 93.7%])
- Ability to get all the services the members thought they needed: SED Waiver Youth and Young Adults – The 2017 percentage of positive responses from Urban SED Waiver Youth and Young Adults was significantly lower (70.4%) compared to other county types (83.9%; *p*<.01[Semi-Urban 81.5%; Densely-Settled Rural 85.6%; Rural and Frontier 84.6%]).

Member Survey – CAHPS

Overall, the CAHPS questions had high positive responses again in CY2017. A number of questions have had >90% positive response in 2017 and previous years, as well as high Quality Compass (QC) rankings compared to national rates. Examples include:

- Doctor spent enough time with the member (**Adults** 91.2%, >75th QC; **GC** 92.3%, >75th QC; **CCC** 93.1%, >75th QC)
- Doctor talked about reasons to take a medicine (**Adult** 93.1%, >50th QC; **GC** 94.5%, >66.67th QC; **CCC** 96.8%, >50th QC)
- Child's doctors and other health providers answered parents' questions (GC 90.6%; CCC 93.2%)
- Child's personal doctor explained things in a way that was easy for the child to understand (**GC** 94.5%; **CCC** 94.0%)
- Personal doctor listened carefully (**Adult** 92.5%, >50th QC; **GC** 96.4%, >75th QC; **CCC** 96.6%, >75th QC)
- Personal doctor explained things in a way that was easy to understand (**Adult** 93.0%,>66.67th QC; **GC** 96.2%, >75th QC; **CCC** 96.9%, >75th QC)
- Doctor respected member's comments (**Adult** 93.3%, >50th QC; **GC** 97.3%, >75th QC; **CCC** 97.2%, >75th QC)

Members' ratings of their health care, health plan, personal doctor, and specialist seen most often also continued to be highly positive in 2017. The following are based on members' rating responses of 8, 9, or 10 (where 0 is the worst and 10 is the best) in 2017. In each of these, ratings were higher from parents/guardians related to the care their children received, compared to ratings of adults of their own care received.

- **Health Care**: **Adults** 74.5%, >50th QC; **GC** 89.2%, >75th QC; **CCC** 87.0%, >66.67th QC

- **Health Plan: Adults** 75.7%, <50th QC; **GC** 88.6%, >66.67th QC; **CCC** 86.6%, >75th QC
- **Personal Doctor**: **Adults** 83.0%, >50th QC; **GC** 90.6%, >66.67th QC; **CCC** 89.2%, >50th QC
- **Specialist seen most often**: **Adults** 82.7%, >50th QC; **GC** 88.3%, >50th QC; **CCC** 86.7%, >50th QC

Members also indicated high satisfaction with timely access to healthcare services. Examples in 2017 include:

- When needed care right away, received care as soon as needed (**Adults** 88.5%, >75th QC; **GC** 94.7%, >75th QC; **CCC** 96.6%, >90th QC)
- For a check-up or routine care, how often got an appointment as soon as needed (**Adults** 84.6%, >75th QC; **GC** 90.7%, >66.67th QC; **CCC** 93.6%, >66.67h QC)
- Easy to get care, tests, or treatment needed (**Adults** 88.0%, >75th QC; **GC** 93.4%, >75th QC; **CCC** 94.1%, >75th QC)
- Appointment to see a specialist as soon as needed (**Adults** 82.9%, >66.67th QC; **GC** 86.4%, >75th QC; **CCC** 87.1%, >75th QC)
- Easy to get prescription for child (**GC** 94.3%; **CCC** 94.7%, >95th QC)

In 2017, 62.3% of adults, 58.7% of parents/guardians of children with chronic conditions (CCC), and 42.0% parents/guardians of children in the "general child" (GC) population, indicated care was received from a doctor or health provider other than their personal doctor in the previous six months. Those responding positively were then asked, "How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?" Positive response percentages for Adults (84.6%) and GC (83.3%) were >50th QC. For children with chronic conditions, who would seem likely to have a greater need for coordination of care, 80.6% responded positively, which was <25th QC, demonstrating an opportunity for improvement.

Additional opportunities for improvement, particularly for children with chronic conditions include the following:

- "In the last six months, did you and (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?" Results for each survey population have been lower than the national average each year since CY2012. In CY2017, the rate for CCC (73.8%) was <5th QC. Rates for the Adult (70.8%) and GC (68.4%) survey populations were <25th QC in CY2017.
- While over 92% of parents/guardians surveyed in 2017 responded positively that their child's personal doctor understands how the child's medical, behavioral, or other health conditions affect the child's day-to-day life, only 56.0% of GC and 56.9% of CCC responded positively that the child's personal doctor understands how the child's medical, behavioral, or other health conditions affect the family's day-to-day life. (CCC <25th QC; GC does not receive a QC ranking)

Provider Survey

Provider survey sample sizes ranged greatly from as few as 33 (Sunflower/Cenpatico BH survey) to 365 (Amerigroup). Sunflower and UnitedHealthcare have separate surveys for general provider and for BH providers.

- The percentage of surveyed providers in 2017 who were very or somewhat satisfied with "obtaining precertification and/or authorization for (MCO's) members," ranged from 42.5%–62.5% and for very or somewhat dissatisfied ranged from 6.1%–29.3%.
- The percentages of providers very or somewhat satisfied with availability of specialists in 2017 ranged from 40.5%–56.3%. The percentage very or somewhat dissatisfied" ranged from 0–21.6%.

- For the question on "provider satisfaction with MCO's commitment to high quality of care for its members," responses in 2017 for very or somewhat satisfied ranged from 35.3%– 65.2%. For very or somewhat dissatisfied, responses in 2017 ranged from 8.9%–20.6%.

Member Survey SUD

The SUD surveys in 2012 (pre-KanCare) and in 2014 to 2017 were convenience samples of members contacted in person, by mail, and by phone. The surveys included 252 members in 2017, 342 members in 2016, 193 members in 2015, 238 in 2014, and 629 in 2012.

Several rates were lower in 2017 than in the previous years (2014–2016 and pre-KanCare 2012):

- 88.2% rated the quality of services as very good or good, compared to 93.2%–94.3% in 2014–2016 and 95.3% in 2012.
- 84.0% reported they were feeling much better or better since beginning treatment, down from 88.9% in 2016, 92.6% in CY2015, 87.1% in CY2014, and 98.8% in 2012.
- 84.0% of members surveyed said they were able to get an appointment for their first visit as soon as they wanted, compared to 84.4% in 2016, 87.7% in 2015, and 92.1% in 2014.
- 87.3% rated their counselor as communicating very well or well in communicating clearly with them, down from 92.1% in 2016, 93.2% in 2015, and 93.9% in 2014.
- 85.0% indicated the distance traveled to their counselor was not a problem, down from 87.9%–89.1% in 2014–2016.
- 87.4% rated counselor involvement of the member in decision making as very good or good, down from 88.4%–92.6% in 2014–2016 and 93.5% in 2012.

Other SUD survey results in 2017 included:

- 29.2% indicated they had an urgent problem. Of those who reported needing an urgent visit, 90.5% were satisfied with the time it took to see someone; and, 10.0% reported they waited more than 48 hours for an urgent visit, down from 16.0% in 2016, 19.0% in 2015 and 10.9% in 2014.
- Of 230 surveyed in 2017, 35 (15.2%) reported they were placed on a waiting list for an appointment, compared to 21.2% in 2016, 15.6% in 2015, and 12.2% in 2014. Of those placed on a waiting list, 45.2% (14 of 31) reported their wait to be three weeks or more, compared to 42.1% (24 of 57) in 2016, 46.2% (12 of 26) in 2015, and 26.1% (6 of 23) in 2014.
- Of the 65.6% who indicated they have a PCP, 65.8% reported their counselor requested a release of information to allow discussion of the member's treatment with their PCP, lower than 70.4% in 2016 and 69.8% in 2015 and higher than in 2014 (52.5%).
- 36.7% reported they received services from another counselor within the last year; 81.4% of these members reported they were asked to sign a release to share details with the other counselor.

Network Adequacy

GeoAccess

Extensive efforts are underway in 2018 to improve the network adequacy reporting. KDHE analyzed a recent quarterly report for each MCO and provided training to MCO staff, as well as a report showing each MCO the number of potential duplicates and reporting errors. KFMC will be analyzing MCOs' future quarterly network adequacy reports to provide updates on their progress in correcting errors and in updating provider data, including whether provider panels are open, closed, or only treating KanCare members who are already patients in the practice. KDHE is also planning to review the MCOs' GeoAccess quarterly reports and will be working with the MCOs to ensure mapping and availability of services by county are accurately modeled and reported. Although this annual report includes tables

summarizing provider availability by county, KFMC anticipates that the 2018 annual evaluation will likely provide much more accurate results due to the changes underway in 2017.
Based on the MCO GeoAccess reports for the fourth quarter of CY2017, access to certain specialties in all counties by any MCO has greatly increased compared to CY2015 and CY2016. There were only two specialties that had no provider access from any of the three MCOs: Nephrology – in two Frontier counties and Neonatology–in 11 Frontier counties and 2 Rural counties.

The number of HCBS counties with less than two providers per county and with less than one provider per county has increased in 2017 compared to 2016. The HCBS provider access reports continued in 2017 to not list or map the counties with no or limited access. The number of TBI and Autism Waiver therapy providers continued to differ widely by MCO, with one MCO reporting access to two or more providers in all 105 counties compared to the other MCOs reporting only 16 to 30 counties with access to two or more providers. HCBS services with the lowest availability by county from all three MCOs were:

- **Adult Day Care** – (Amerigroup: 83 counties with 2 or more providers, 101 counties with at least one; Sunflower: 49 counties with 2 or more, 79 counties with at least one; UnitedHealthcare: 44 counties with 2 or more; 66 counties with at least one)
- **Speech Therapy – TBI Waiver** (Amerigroup: 36 counties with 2 or more providers, 44 counties with at least one; Sunflower: 50 counties with 2 or more, 105 counties with at least one; UnitedHealthcare: 11 counties with 2 or more; 28 counties with at least one)
- **Speech Therapy** – Autism Waiver (Sunflower: 12 counties with 2 or more providers, 28 with counties with at least one provider; UnitedHealthcare: 2 counties with 2 or more providers; Amerigroup: no count provided, citing "*developmental speech therapy services are covered under the Medicaid State Plan and not under the Autism Waiver*.")

The updated guidelines for the Network Adequacy quarterly report include major revisions in the reporting of HCBS provider availability. At the March 2018 training, MCOs were instructed to report each county and each service each HCBS provider is currently providing or are available to provide services.

After-Hours Access and Appointment Availability

Each of the MCOs conducted surveys to assess compliance of providers with availability to provide members assistance after office hours and to assess availability of timely appointments by appointment type (routine, urgent, and emergent; and, for pregnancy, by trimester and high risk).

- Amerigroup conducted an after-hours access survey of PCPs and pediatricians and a survey of PCPs, pediatricians, specialists, and BH providers to assess availability of routine, urgent, and emergent appointments. Providers who were non-compliant in 2016 were contacted again in 2017. Although Amerigroup referred to those contacted as being a "random sample," results were reported only for an "extrapolated" number of providers. If, for example one PCP from the sample who is in a practice with six PCPs not in the sample, availability of each type of appointment by any one of the 7 PCPs in the practice was counted as available for all 7 and reported as such. The appointment availability survey did not include availability of obstetric appointments by trimester and high risk.
- Sunflower reported they conducted after-hours and appointment availability surveys in 2017, but that the results of the survey were still being reviewed with the vendor and were not yet available.
- UnitedHealthcare conducted after-hours access and appointment availability surveys for each of the appointment types, including, in addition to routine, urgent, and emergent by provider type, obstetric appointments by trimester. Noncompliant providers from 2016 were contacted, and the quality director contacted providers noncompliant in 2017 for after-hours access after the survey

was completed. Survey results were reported for providers in the random sample (i.e., survey results were not extrapolated values).

Emergency Department Visits

ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2016 compared to rates in CY2012 pre-KanCare. Rates described below are based on ED visits per 1,000 member-months.

- **KanCare Population**: The ED rate in CY2016 (**70.79**) was lower than the rate in CY2012 (71.16), CY2014 (72.51), and CY2015 (73.77).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2016, compared to the other waiver populations. The ED visit rate in CY2016 (166.01) was lower than in CY2015 (185.11), CY2014 (194.24) and CY2012 (220.13). The CY2016 rate was a relative decrease of 24.6% compared to CY2012.
- **PD**: PD members also had high rates of ED visits, 133.75 in CY2016. The CY2016 rate was higher than in CY2015 (126.58) but lower than in CY2012 (165.46), a relative decrease of 19.2% compared to CY2012.
- **MH:** ED visit rates for SMI members have also been higher each year than the overall KanCare member rates. The rate in CY2016 (119.38) was lower than in CY2015 (129.0), CY2014 (128.66), and CY2012 (121.03).
- **I/DD:** I/DD member ED rates were lower than those of PD, FE, TBI, and MH members each of the five years. The CY2016 rate (49.44) was lower than in CY2012 (54.24) but higher than the rates in CY2013–CY2015.
- **FE:** FE member ED rates were lower than those of PD, FE, TBI, and MH members each of the five years. The CY2016 rate (68.15) was lower than in CY2012 (90.32) but higher than the rates in CY2013–CY2015.

Inpatient Hospitalizations

Inpatient admission rates were lower in CY2016 than the four prior years; rates for TBI, FE, and I/DD, however, were higher in CY2016 than in CY015 and higher than CY2012 (pre-KanCare). Rates described below are based on inpatient admission visits per 1,000 member-months.

- **KanCare**: The inpatient rate for KanCare members in CY2016 (**14.51**) was lower than the rates from the previous four years (ranged from 15.29–15.74).
- **TBI**: The TBI member inpatient admission rate in CY2016 (50.46) was higher than the four previous years (45.37–49.74).
- **PD**: The PD inpatient admission rate in CY2016 (**54.55**) was higher than CY2015 (53.54), CY2013 (50.58), and CY2012 (53.84).
- **FE**: The FE inpatient admission rate in CY2016 (**51.10**) was higher than CY2015 (50.54), CY2013 (48.91), and CY2012 (47.27).
- **I/DD**: I/DD member inpatient admission rates have been much lower than those of PD, FE, and TBI members each year. Rates, however, have increased each year from 12.36 in CY2012 to **14.73** in CY2016.

Inpatient Readmissions within 30 days of inpatient discharge

Overall inpatient admission rates were lower in CY2016 than the four prior years. While overall inpatient rates decreased, inpatient rates for TBI, FE, and I/DD were higher in CY2016 than in CY015 and higher than CY2012 (pre-KanCare).Rates described below are based on inpatient readmissions per 1,000 member-months.

- **KanCare**: Overall readmission rates for KanCare members from CY2013 to CY2016 have increased slightly each year, from 1.45 in CY2013 to **1.54** in CY2016, but have been lower than in CY2012 (1.59).
- **TBI:** TBI member readmission rate decreased from 13.02 in CY2015 to **9.99** in CY2016. The CY2016 rate, however, is higher than the rates in CY2012 (8.64), CY2013 (7.02), and CY2014 (6.90).
- **PD**: The readmission rate for PD members in CY2016 (11.09) was higher than the four previous years and higher than the TBI, FE, and I/DD members' readmission rates.
- **FE:** The FE member readmission rate in CY2016 (**7.93**) was higher than in CY2012 (7.29) and CY2013 (7.23) but lower than in CY2014 (8.05) and CY2015 (8.25).
- **I/DD:** The I/DD member readmission rate was also higher in CY2016 (**2.04**) but have consistently been lower each year compared to those of PD, FE, and TBI members and have been only slightly higher than the readmission rates for all KanCare members.

Uncompensated Care Cost Pool (UCC)

There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, to 178,721 in CY2016, and to 173,117 in CY2017. UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116 and decreased to $40,598,530 in CY2017.

Delivery System Reform Incentive Program (DSRIP)

The University of Kansas Hospital

- **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**
  In 2017, STOP Sepsis training was provided to 860 participants, bringing the total to 1,488 staff from hospitals, nursing facilities, emergency medical services (EMS), and other healthcare providers. In 2017, the STOP Sepsis project added 66 community partners, bringing the total to 213. UKHS provided training specific to NFs to 340 NF staff from 17 facilities in 2017. UKHS also developed and implemented in 2017 a new database tool for NFs for tracking and reporting sepsis data. UKHS has also partnered with the technology company Redivus Health on a mobile app to assist providers in recognizing and diagnosing sepsis. Pilot testing of the app in 2017 includes participation from NF and hospital partners.
- **Supporting Personal Accountability and resiliency for Chronic Conditions (SPARCC)**
  The SPARCC program focuses on building heart failure (HF) patients' ability to care for themselves and be resilient in the face of their chronic condition. The program also includes caregivers, who benefit as well from the skills learned through the training. As of December 2017, 228 individuals throughout Kansas have been trained s SPARCC facilitators and 226 patients and caregivers have participated in SPARCC training. The number of Kansas community partners increased from 87 in 2016 to 103 by the first half of 2017. UKHS has also been successful in developing 13 training videos for SPARCC facilitators they can now access through the YouTube website.

Children's Mercy Hospital and Clinics

- **Improving Coordinated Care for Medically Complex Patients (Beacon Program)**
  The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013. CMH reported there were 63 Kansas Beacon patients in 2014, 56 in 2015, 92 in

2016, and 108 in 2017 (including 18 consults for children in rural Kansas communities). In 2017, Beacon focused on establishing telehealth locations throughout Kansas and development of resource guides for county-specific services in addition to those available statewide and nationally. As of December 2017, resource guides were completed for 88 counties. Beacon has also updated and expanded a variety of additional online resources to address needs of Beacon children, families, and PCPs providing local services to children with complex medical needs.

- **Expansion of Patient Centered Medical Homes and Neighborhoods**
  CMH continues to actively work with the four practices; they met or exceeded all measurement targets in 2017, except for the PCMH recognition target that was out of their control. One practice achieved NCQA PCMH recognition in 2016. Two practices were intending to submit their applications for recognition in 2017; however, there were substantial NCQA related extenuating circumstances. The fourth practice continues to work towards implementing PCMH standards, although they do not plan to apply for PCMH recognition. Two practices are implementing new electronic medical records (EMRs) that will provide enhanced reporting capabilities. CMH implemented the Community Engagement Resource Application (CERA), containing detailed information about various community agencies and organizations that address various social determinants of health. This application contains over 800 community resources and was accessed over 11,000 times in 2017.

Recommendations

1. MCOs should pay particular attention to improving results for HEDIS measures that have been identified by CMS as core quality measures, particularly where results were below the 25th Quality Compass percentile in 2017, including:
   - Prenatal and Postpartum Care (PPC): Prenatal Care <10th QC; Postpartum Care <10th QC
   - Chlamydia Screening in Women (CHL): Ages 16-20 <10th QC; Ages 21-24 <25th QC
   - Breast Cancer Screening (BCS) <10th QC
   - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): Weight Assessment/BMI <25th QC; Counseling for Nutrition <25th QC
2. MCOs should ensure their surveys have an adequate number of participants to achieve meaningful and generalizable results wherever possible.
3. MCOs should report counts (including numerators and denominators) and percentages/rates for those in the randomly selected sample, and not just report results that were extrapolated. In contacting practices, appointment availability should be based on the provider in the random sample and not based on availability from any of many providers in the practice.
4. MCOs should follow up with all providers identified as non-compliant in after-hours access and appointment availability, with priority attention to those who have been non-compliant in more than one year.
5. MCOs should include in their appointment availability surveys not only routine, urgent, and emergent appointment access, but also, where applicable, pregnancy-related appointments by trimester and high risk.
6. The State should consider requiring MCOs to include in GeoAccess mapping of availability of each HCBS service. At a minimum, a list of counties with limited access to specific HCBS services (reported, as of 2017, by counts and not by county names).

Appendix A

2017 KanCare Evaluation Annual Report

Year 5, January – December 2017

List of Related Acronyms

Kansas Foundation for Medical Care, Inc.

List of Related Acronyms	
Acronym	**Description**
ACO	Accountable Care Organization
ADHD	Attention Deficit Hyperactivity Disorder
AGP	Amerigroup Kansas, Inc. (Amerigroup)
BCBSKS	Blue Cross/Blue Shield of Kansas
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist Competence T-Scores
CBS	Community-Based Services
CCC	Children with Chronic Conditions (CAHPS survey population)
CHIP	Children's Health Insurance Program (Title XXI)
CMH	Children's Mercy Hospital and Clinics
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
CYMC	Children and Youth with Medical Complexity
DSRIP	Delivery System Reform Incentive Program
ECHO	Extension for Community Healthcare Outcomes
ED	Emergency Department
EHR	Electronic Health Record
EQRO	External Quality Review Organization
FE	Frail Elderly (Waiver)
GC	General Child - CAHPS Survey Population
HbA1c	Hemoglobin A1c (Glycated hemoglobin)
HCBS	Home and Community-Based Services
HCCN	Health Center Controlled Network
HEDIS	Healthcare Effectiveness Data and Information Set
HF	Heart failure
HIE	Health Information Exchange
HIT	Health information technology
HITECH	Health Information Technology for Economic and Clinical Health Act
I/DD	Intellectual/Developmental Disability (Waiver)
KCPC	Kansas Client Placement Criteria (tracking system)
KDADS	Kansas Department for Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Healthcare Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KHC	Kansas Healthcare Collaborative
KHSC	Kansas Heart and Stroke Collaborative

List of Related Acronyms	
Acronym	**Description**
KUCTT	University of Kansas Center for Telemedicine & Telehealth
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
MH	Mental Health
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NOMS	National Outcome Measurement System
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Provider
PD	Physically Disabled (Waiver)
PEAK	Promoting Excellent Alternatives in Kansas (Person-Centered Care Homes)
PMPM	Per member per month
PTN	Patient Transformation Network
Q	Quarter
QC	Quality Compass
S	Score
SED	Serious Emotional Disturbance (Waiver)
SMI	Serious Mental Illness
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions
SPMI	Severe and Persistent Mental Illness
SSHP	Sunflower State Health Plan of Kansas
SSI	Supplemental Security Income
STOP Sepsis	Standard Techniques, Operations, and Procedures Sepsis Awareness Program
SUD	Substance Use Disorder
TA	Technical Assistance (Waiver)
TBI	Traumatic Brain Injury (Waiver)
TXIX	Title XIX/Medicaid
TXXI	Title XXI/CHIP, Children's Health Insurance Program
UCC	Uncompensated Care Cost Pool
UHC	UnitedHealthcare Community Plan of Kansas (UnitedHealthcare)
UKHS	The University of Kansas Hospital System
VO	ValueOptions - Kansas
WebIZ	Kansas Statewide Immunization Information System
WORK	Work Opportunities Reward Kansas program