Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.18

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Annual Report
Demonstration Year: 6 (1/1/2018-12/31/2018)

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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 sixth annual report related to Demonstration Year 2018. 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 2018 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 2018, follows:

MCO	Value Added Service Jan.- Dec. 2018	Units YTD	Value YTD
Amerigroup	Member Incentive Program	3,596	$1,630,736
	Adult Dental Care	3,811	$498,846
	Mail Order OTC	8,079	$149,896
	Total of All Amerigroup VAS	**16,785**	**$2,425,719**
Sunflower	CentAccount debit card	79,523	$861,477
	Dental visits for adults	5,863	$344,063
	Comprehensive Medication Review	9,862	$250,215
	Total of all Sunflower VAS	**129,647**	**$1,950,149**
United	Additional Vision Services	11,564	$295,432
	Home Helper Catalog Supplies	6,007	$140,234
	Baby Blocks Program and Rewards	1,077	$137,485
	Total of all United VAS	**42,747**	**$900,817**

iii. Enrollment issues: For the calendar year 2018 there were 34 Native Americans who chose to not enroll in KanCare.

The table below represents the enrollment reason categories for calendar year 2018. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Beneficiary placed on Punitive Lock-In	1
Newborn Assignment	11
KDHE - Administrative Change	253
WEB - Change Assignment	96
KanCare Default - Case Continuity	666
KanCare Default – Morbidity	845
KanCare Default - 90 Day Retro-reattach	673
KanCare Default - Previous Assignment	1,569
KanCare Default - Continuity of Plan	2,590
AOE – Choice	4,070
Choice - Enrollment in KanCare MCO via Medicaid Application	6,661
Change - Enrollment Form	1,341
Change - Choice	1,568
Change – Due to Quality of Care – Good Cause Reason	1
Change - Access to Care – Good Cause Reason	71
Change - Case Continuity – Good Cause Reason	2
Change – Due to Treatment not Available in Network – Good Cause	
Assignment Adjustment Due to Eligibility	157
Total	**20,575**

iv. Grievances and appeals: The following grievance, appeal and state fair hearing data reports activity for all of 2018.

MCOs' Member Grievance Database
CY18 Annual report

MCO	AMG		SUN		UHC		Total
	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	
QOC (non HCBS, Non Transportation)	41	12	62	30	126	33	**304**
QOC – Opioids/Pain Management	3	1	6	3	4		**17**
Customer Service	14	10	39	31	31	21	**146**
Member Rights Dignity	7	6	8	5	3	2	**31**
Access to Service or Care	26	20	32	19	26	6	**129**
Non-Covered Services	11	1	6	4	20	4	**46**
Pharmacy	9	2	12	1	29	4	**57**
QOC HCBS Provider		27		41		27	**95**
Value Added Benefits	4	9	12	7	7	3	**42**
Billing/Financial Issues (non-Transportation)	115	45	27	11	179	26	**403**
Transportation – Billing and Reimbursement	14	12	14	6	11	7	**64**

Transportation - No Show	27	25	31	23	21	23	**150**
Transportation - Late	31	15	49	40	60	56	**251**
Transportation - Safety	22	8	27	16	25	22	**120**
No Driver Available	3	2	1	6	2		**14**
Transportation - Other	60	30	65	34	76	43	**308**
MCO Determined Not Applicable			1	2			**3**
Other	7	6	8		6	4	**31**
TOTAL	**394**	**231**	**400**	**279**	**626**	**281**	**2211**

** Quality of Care – Opioids/Pain Management was added CY2018 Qtr. 3*

MCOs' Appeals Database

Members – CY18 annual report

Member 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/LEVEL OF CARE – Criteria Not Met					
Criteria Not Met - Durable Medical Equipment	4 119 63	 2 2	1 49 23	3 68 35	 3
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	15 5 137	8 108	 2	3 5 17	4 10
Criteria Not Met - Medical Procedure (NOS)	39 68 10	1 5 3	21 25 1	15 38 6	2
Criteria Not Met - Radiology	19 101		9 56	10 45	
Criteria Not Met - Pharmacy	77 276 296	 22 14	52 161 162	21 93 102	4 18
Criteria Not Met - PT/OT/ST	25 1		6 	19 1	
Criteria Not Met - Dental	8 9 13		 4 2	8 5 11	
Criteria Not Met or Level of Care - Home Health	10 6	1 	9 2	 2	 2
Criteria Not Met - Out of network provider, specialist or specific provider request	4 2 18	2 1	 7	1 2 8	1 2
Criteria Not Met - Inpatient Behavioral Health	43 13 29	2 2	7 8 3	32 5 23	2 1
Criteria Not Met - Behavioral Health Outpatient Services and Testing	3 11 32		 2 9	3 9 20	 3

Level of Care - LTSS/HCBS	56 22 13	9 1 3	27 7 2	19 14 6	1 2
Level of Care – LTC NF	1			1	
Level of Care - Mental Health	5		1	3	1
Level of Care - HCBS (change in attendant hours)	39 2	4	8 1	25 1	2
Criteria Not Met - Other	1 25 1	1	 15 1	 9	1
NONCOVERED SERVICE					
Service Not Covered - Dental	9 6 2	1		9 5 2	
Service Not Covered - Pharmacy	6 6		1 5	5 1	
Service Not Covered - OT/PT/Speech	2	1		1	
Service Not Covered – Out of Network Providers	1 1		1		1
Service Not Covered - Durable Medical Equipment	39 1	1	22	16 1	
Service Not Covered - Other	6 68	4	2 39	3 25	1
Lock In	3 2 11		3 2 6	 5	
Billing and Financial Issues					
AUTHORIZATION DENIAL					
Late submission by member/provider rep.	3 4	1		2 4	
No authorization submitted	3 3	2 2		1 1	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **331** **815** **651**	 **28** **40** **135**	 **130** **407** **227**	 **155** **368** **246**	 **18** **43**

MCOs' Appeals Database

Member Appeal Summary – CY18 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**
Total Number of Appeals Resolved	331 815 651	28 40 135	130 407 227	155 368 246	18 43
Percentage Per Category		8% 5% 21%	39% 50% 35%	48% 45% 38%	5% 6%

MCOs' Appeals Database

Provider Appeal Summary – CY18 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
Total Number of Appeals Resolved	331 815 651	28 40 135	130 407 227	155 368 246	18 43
Percentage Per Category		8% 5% 21%	39% 50% 35%	48% 45% 38%	5% 6%

MCOs' Reconsideration Database

Providers - CY18 Annual report (reconsiderations resolved)

PROVIDER Reconsideration Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
CLAIM DENIALS					
Hospital Inpatient (Non-Behavioral Health)	2948 3797 3077		902 2123 1405	1469 1503 1672	577 171
Hospital Outpatient (Non-Behavioral Health)	2207 4517 4404		779 2287 2339	1033 1986 2065	395 244
Pharmacy	117		41	58	18
Dental	1 93		 68	1 25	
Vision	399		366	33	
Ambulance (Include Air and Ground)	82 89 411		46 70 261	21 19 150	15
Medical Professional (Physical Health not Otherwise Specified)	14809 4159 30763		6271 3432 19495	6795 716 11268	1743 11
Nursing Facilities - Total	1219 328		523 303	497 25	199
HCBS	2873 3202		1595 2634	920 475	358 93
Hospice	537 518 828		208 489 413	244 27 415	85 2
Home Health	283 16 6		155	105 16 6	23
Behavioral Health Outpatient and Physician	4283 516 6679		2643 289 4900	1248 202 1779	392 25

Behavioral Health Inpatient	119 8 164		34 5 65	66 3 99	19
Out of network provider, specialist or specific provider	114 7466		14 4008	91 3458	9
Radiology	2331 1039 3347		884 691 1980	1299 291 1367	148 57
Laboratory	1702 2269 5657		598 1216 3307	966 964 2350	138 89
PT/OT/ST	289 259 80		158 256 32	101 3 48	30
Durable Medical Equipment	974 1347		391 1042	476 282	107 23
Other	87 13 392		63 11 179	19 2 213	5
Total Claim Payment Disputes	34861 22683 63274		15291 15296 38384	15318 6663 24890	4252 724
BILLING AND FINANCIAL ISSUES					
Recoupment	1024		817	207	
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	1510		941	569	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **34861** **22683** **65808**		 **15292** **15296** **40142**	 **15318** **6663** **25666**	 **4252** **724**

MCOs' Provider Reconsiderations Database

Provider Reconsiderations – Denied Claim Analysis – CY18 Annual report

AMG – Red **SUN – Green** **UHC – Purple**	**Claim Denied-MCO in Error**	**Claim Denied-Provider Error**	**Claim Denied – Correctly Billed and Correctly Denied/Paid**	**Claim Paid – Correctly Billed and Correctly Paid**	**Total**
Provider Reconsiderations					
MCO Reversed Decision on Reconsideration	8334 13519 16376	3521 1775 10470	372 2 4976	38 6562	12265 15296 38384
MCO Upheld Decision on Reconsideration	3604 5860	5810 15 2881	309 4451 9810	2008 2197 23511	11731 6663 42062
Total Claim Payment Disputes	11938 13519 22236	9331 1790 13351	681 4453 14786	2046 2197 30073	23996 21959 80446

MCOs' Appeals Database

Providers - CY18 Annual report (appeals resolved)

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**
CLAIM DENIAL					
Hospital Inpatient (Non-Behavioral Health)	381 400 956	 5 2	72 173 182	260 214 492	49 8 280
Hospital Outpatient (Non-Behavioral Health)	236 707 486	 13	43 362 88	171 307 223	22 25 175
Pharmacy	1 5 1		1 1 1	 4	
Dental	21 40 31	 1	12 28 26	9 12 4	
Vision	73 85 13		2 55 3	71 26 10	 4
Ambulance (Include Air and Ground)	12 18 52		9 8 28	3 10 8	 16
Medical Professional (Physical Health not Otherwise Specified)	855 136 741		305 58 78	461 67 307	89 11 356
Nursing Facilities - Total	118 18 24		59 10 2	44 8 9	15 13
HCBS	234 2		104	98 2	32
Hospice	31 12 2	 1	15 4 1	12 6 1	4 1
Home Health	12 18 137	 2	8 6 25	4 10 54	 58
Behavioral Health Outpatient and Physician	236 136 139	 1	114 28 36	103 108 36	19 66
Behavioral Health Inpatient	16 67		1 15	15 48	 4
Out of network provider, specialist or specific provider	91	1	17	71	2
Radiology	90 187 4	 3	23 81 2	52 98 1	15 5 1

Laboratory	59 79 78	2	10 35 12	47 42 16	2 50
PT/OT/ST	17 19 12		7 15 3	6 3 5	4 1 4
Durable Medical Equipment	140 97 6	4	37 49	89 43 6	14 1
Other	3 40 18	1	1 17 9	2 21 7	 1 2
Total Claim Payment Disputes	2535 2157 2700	32 4	823 962 496	1447 1100 1179	265 63 1021
BILLING AND FINANCIAL ISSUES					
Recoupment	18 22 42		4 15 6	14 23	 7 13
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	719 199 4	3 1 3	282 67 1	326 131	108
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **3272** **2378** **2746**	 **3** **33** **7**	 **1109** **1044** **503**	 **1787** **1231** **1202**	 **373** **70** **1034**

MCOs' Appeals Database
Provider Appeal Summary – CY18 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**
Reconsideration	 34861 22683 65808		 15292 15296 40142	 15318 6663 25666	 4252 724
Resolved at Appeal Level	3272 2378 2746	3 33 7	1109 1044 503	1787 1231 1202	373 70 1034
TOTAL	**38133** **25061** **68554**	**3** **33** **7**	**16401** **16340** **40645**	**17105** **7894** **26868**	**4625** **794** **1034**
Percentage Per Category		<1% <1% <1%	43% 65% 59%	45% 32% 39%	12% 3% 2%

MCOs' Appeals Database

Provider Appeal – Denied Claim Analysis – CY18 Annual report

AMG – Red **SUN – Green** **UHC – Purple**	**Claim Denied-MCO in Error**	**Claim Denied-Provider Error**	**Claim Denied – Correctly Billed and Correctly Denied/Paid**	**Claim Paid – Correctly Billed and Correctly Paid**	**Total**
Provider Appeals					
MCO Reversed Decision on Appeal	491 24 26	247 93 427	72 776 42	12 68	822 962 495
MCO Upheld Decision on Appeal	324 331	726 31	97 989 537	291 80	1438 1100 868
Total Claim Denials	815 24 357	973 124 427	169 1765 579	303 148	2260 2061 1363

State of Kansas Office of Administrative Fair Hearings
Members – CY18 annual report

AMG-Red SUN-Green UHC-Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met															
Durable Medical Equipment	3 7 2	 1 1	 1		3 4 1			 1							
Inpatient Admissions (Non-Behavioral Health)	5 1 2		1		1			1 1 1	 1				2		
Medical Procedure (NOS)	2 3				1 1			 2	1						
Radiology	2							2							
Pharmacy	4 8 8	1 1			1 1			2 7 5	 2						
PT/OT/ST	9				4			5							
Dental	2							2							
Home Health	2				1			1							
Out of network provider, specialist or specific provider request	1														1

Inpatient Behavioral Health	2		1		1										
Behavioral Health Outpatient Services and Testing	1 1		1 1												
LTSS/HCBS	12 5	 2	4 1		5			 2					3		
Level of Care – Mental Health	 2							 2							
Level of Care – HCBS (change in attendant hours)	6		2		3								1		
Criteria Not Met -Other	1		1												
NONCOVERED SERVICE															
Noncovered Service - Dental	1 1								 1				1		
Noncovered Service - Other	2		1					1							
LOCK IN	1									1					
BILLING AND FINANCIAL ISSUES	3					2			1						
TOTAL **AMG-Red** **SUN-Green** **UHC-Purple**	 38 43 18	 1 3 2	 10 4		 15 11 1	 2		 3 24 8	 1 1 4	 1			 7		 1

State of Kansas Office of Administrative Fair Hearings
Providers – CY18 annual report

AMG-Red SUN-Green UHC-Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
CLAIM DENIAL															
Hospital Inpatient (Non-Behavioral Health)	72 37 51	7 20 36	 2 	 	44 3 10	 	10 	8 6 3	2 6 1	 	 	 	 	 	1 1
Hospital Outpatient (Non-Behavioral Health)	1 3 2	 	 1 	 	1 2 1	 	 	 1	 	 	 	 	 	 	
Pharmacy	2 12	 1	 	 	1 1	 	 	 9	 1	 	 	 	1 	 	
Dental	1							1							
Ambulance (Include Air and Ground)	3 1	 	 	 	 1	 	 	2 	1 	 	 	 	 	 	
Medical (Physical Health not Otherwise Specified)	29 9 1	2 2 	 	 	24 1 1	 	 	2 	 6 	 	 	 	 	 	1
Nursing Facilities – Total	8 2	 	 	 	5 1	 	 	2 1	1 	 	 	 	 	 	
HCBS	14 2 2	3 	 	 1	9 1 	 	 	1 1 1	 	 	 	 	 	 	1
Hospice	4						1	1	1				1		
Home Health	1 5 1	 1 	 	 	1 1 	 	 	 1	 	 	 	 	 3 	 	

Behavioral Health Outpatient and Physician	3 11 14	1 5			2 3 7			8 1							1
Behavioral Health Inpatient	1				1										
Radiology	1 22	 10	 2		 1			1 9							
Laboratory	1 2							1 2							
PT/OT/ST	2							2							
Durable Medical Equipment	17 3 3	1 1			13 1 2		1	1 1	1				 1		
Other	1 4 1	1			 3								 1 1		
BILLING AND FINANCIAL ISSUES															
Recoupment	19 1 5	4 1	 2	1	10 3	1		3							
ADMINISTRATIVE DENIALS															
Denials of Authorization (Unauthorized by Members)	2 8	1 4					1	3						1	
TOTAL **AMG-Red** **SUN-Green** **UHC-Purple**	 174 105 105	 19 36 46	 5 2	 1 1	 110 19 25	 1	 12 1	 21 26 25	 6 12 2	 0	 0	 0	 1 6 1	 1	 3 2

MCOs' Grievance Trends
Members – CY18 Annual

Amerigroup CY18 Annual Grievance Trends		
Total # of Resolved Grievances	625	
Top 5 Trends		
Trend 1: Billing and Financial Issues (Non-Transportation)	160	26%
Trend 2: Transportation - Other	90	14%
Trend 3: Quality of Care (non HCBS, non Transportation)	53	8%
Trend 4: Transportation - No Show	52	8%
Trend 5: Access to Service or Care	46	7%

Amerigroup Member Grievances:

- There were 249 transportation grievances in CY2018 which is an increase of 34 (16%) from 215 transportation grievances in CY2017.Transportation grievances account for 40% of Amerigroup's member grievances in CY2018.
- There were 90 member grievances categorized as Transportation – Other which is a significant increase of 75 from CY2017. This category was added to the report in CY2017 Quarter 4.
- Amerigroup's total member grievances is 625 which is a significant increase of 69 (12%) from 556 in CY2017.

Sunflower CY18 Annual Grievance Trends		
Total # of Resolved Grievances	679	
Top 5 Trends		
Trend 1: Transportation - Other	99	15%
Trend 2: Quality of Care (non HCBS, non Transportation)	92	14%
Trend 3: Transportation - Late	89	13%
Trend 4: Customer Service	70	10%
Trend 5: Transportation - No Show	54	8%

Sunflower Member Grievances:

- There were 312 transportation grievances in CY2018 which is an increase of 2 from 310 transportation grievances in CY2017.Transportation grievances account for 46% of Sunflower's member grievances in CY2018.
- There were 99 member grievances categorized as Transportation – Other which is a significant increase of 81 from CY2017. This category was added to the report in CY2017 Quarter 4.
- Sunflower's total member grievances is 679 which is a significant increase of 58 (9%) from 556 in CY2017.

United CY18 Annual Grievance Trends		
Total # of Resolved Grievances	907	
Top 5 Trends		
Trend 1: Billing and Financial Issues (non Transportation)	205	23%
Trend 2: Quality of Care (non HCBS, non Transportation)	159	18%

Trend 3: Transportation - Other	119	13%
Trend 4: Transportation - Late	116	13%
Trend 5: Customer Service	52	6%

United Member Grievances:

- There were 346 transportation grievances in CY2018 which is an increase of 42 (14%) from 304 transportation grievances in CY2017.Transportation grievances account for 38%% of United's member grievances in CY2018.
- There were 119 member grievances categorized as Transportation – Other which is a significant increase of 104 from CY2017. This category was added to the report in CY2017 Quarter 4.
- In CY2018 United had 159 member grievances categorized as Quality of Care (non HCBS, non Transportation) which accounts of 52% of all Quality of Care (non HCBS, non Transportation) members grievances for CY2018.
- United's total member grievances is 907 which is a significant increase of 151 (17%) from 756 in CY2017.

MCO's Reconsideration Trends

Provider – CY18 Annual

Amerigroup CY18 Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	34861	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	14809	42%
Trend 2: Behavioral Health Outpatient and Physician	4283	12%
Trend 3: Hospital Inpatient (Non-Behavioral Health)	2948	8%
Trend 4: HCBS	2873	8%
Trend 5: Radiology	2331	7%

Amerigroup Provider Reconsiderations

- There were 34,861 provider reconsiderations in CY2018 which is an increase of 24,594 from 10,267 provider reconsiderations in CY2017.
- Tracking of provider reconsiderations by categories started in CY2018 Quarter 1.

Sunflower CY18 Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	22683	
Top 5 Trends		
Trend 1: Hospital Outpatient (Non-Behavioral Health)	4517	20%
Trend 2: Medical Professional (Physical Health not Otherwise Specified)	4159	18%
Trend 3: Hospital Inpatient (Non-Behavioral Health)	3797	17%
Trend 4: HCBS	3202	14%
Trend 5: Laboratory	2269	10%

Sunflower Provider Reconsiderations

- There were 22,683 provider reconsiderations in CY2018 which is an increase of 18,331 from 4,352 provider reconsiderations in CY2017.
- Tracking of provider reconsiderations by categories started in CY2018 Quarter 1.

United CY18 Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	65808	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	30763	47%
Trend 2: Out of Network Provider, Specialist or Specific Provider	7466	11%
Trend 3: Behavioral Health Outpatient and Physician	6679	10%
Trend 4: Laboratory	5657	9%
Trend 5: Hospital Outpatient (Non-Behavioral Health)	4404	7%

United Provider Reconsiderations

- There were 65,808 provider reconsiderations in CY2018 which is an increase of 30,095 from 35,713 provider reconsiderations in CY2017.
- Tracking of provider reconsiderations by categories started in CY2018 Quarter 1.

MCOs' Appeals Trends

Member/Provider – CY18 Annual

Amerigroup CY18 Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	331		**Total # of Resolved Provider Appeals**	3272	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	77	23%	Trend 1: Medical Professional (Physical Health not Otherwise Specified)	855	26%
Trend 2: Level of Care - LTSS/HCBS	56	17%	Trend 2: Denials of Authorization (Unauthorized by Members)	719	22%
Trend 3: Criteria Not Met - Inpatient Behavioral Health	43	13%	Trend 3: Hospital Inpatient (Non-Behavioral Health)	381	12%
Trend 4: Criteria Not Met - Medical Procedure (NOS)	39	12%	Trend 4: Hospital Outpatient (Non-Behavioral Health)	236	7%
Trend 5: Level of Care - HCBS)change in attendant hours)	39	12%	Trend 5: Behavioral Health Outpatient and Physician	236	7%

Amerigroup Member Appeals:

- There were 331 member appeals in CY2018 which is a significant increase of 95 (40%) from 236 member appeals in CY2017.

Amerigroup Provider Appeals:

- There were 381 provider appeals categorized as Hospital Inpatient (Non-Behavioral Health) which is a significant increase of 222 from 159 in CY2017.
- There were 236 provider appeals categorized as Hospital Outpatient (Non-Behavioral Health) which is a significant increase of 211 from 25 in CY2017.
- There were 234 provider appeals categorized as HCBS which is a significant increase of 231 from 3 in CY2017.
- There were 3,272 provider appeals in CY2018 which is a significant decrease of 7,913 (70%) from 11,185 provider appeals in CY2017.

Sunflower CY18 Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	815		**Total # of Resolved Provider Appeals**	2378	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	276	34%	Trend 1: Hospital Outpatient (Non-Behavioral Health)	707	30%

Trend 2: Criteria Not Met - Durable Medical Equipment	119	15%	Trend 2: Hospital Inpatient (Non-Behavioral Health)	400	17%
Trend 3: Criteria Not Met - Radiology	101	12%	Trend 3: Denials of Authorization (Unauthorized by Members)	199	8%
Trend 4: Other - Noncovered Services	68	8%	Trend 4: Radiology	187	8%
Trend 5: Criteria Not Met - Medical Procedure (NOS)	68	8%	Trend 5: Medical Professional (Physical Health not Otherwise Specified) / Behavioral Health Outpatient and Physician	136	6%

Sunflower Member Appeals:

- There were 815 member appeals in CY2018 which is a significant increase of 77 (10%) from 738 member appeals in CY2017.

Sunflower Provider Appeals:

- There were 400 provider appeals categorized as Hospital Inpatient (Non-Behavioral Health) which is a significant increase of 263 from 137 in CY2017.
- There were 707 provider appeals categorized as Hospital Outpatient (Non-Behavioral Health) which is a significant increase of 686 from 21 in CY2017.
- There were 136 provider appeals categorized as Behavioral Health Outpatient and Physician which is a significant increase of 125 from 11 in CY2017.
- There were 187 provider appeals categorized as Radiology which is a significant increase of 164 from 23 in CY2017.
- There were 2,378 provider appeals in CY2018 which is a significant increase of 1,112 (88%) from 1,266 provider appeals in CY2017.

United CY18 Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	651		**Total # of Resolved Provider Appeals**	2746	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	296	45%	Trend 1: Hospital Inpatient (Non-Behavioral Health)	956	35%
Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	137	21%	Trend 2: Medical Professional (Physical Health not Otherwise Specified)	741	27%
Trend 3: Criteria Not Met - Durable Medical Equipment	63	10%	Trend 3: Hospital Outpatient (Non-Behavioral Health)	486	18%
Trend 4: Criteria Not Met - Behavioral Health Outpatient Services and Testing	32	5%	Trend 4: Behavioral Health Outpatient and Physician	139	5%
Trend 5: Criteria Not Met - Inpatient Behavioral Health	29	4%	Trend 5: Home Health	137	5%

United Member Appeals:

- There were 296 member appeals categorized as Criteria Not Met - Pharmacy which is a significant increase of 107 from 189 in CY2017.
- There were 651 member appeals in CY2018 which is a significant increase of 151 (23%) from 500 member appeals in CY2017.

United Provider Appeals:

- There were 956 provider appeals categorized as Hospital Inpatient (Non-Behavioral Health) which is a significant increase of 715 from 241 in CY2017.

- There were 137 provider appeals categorized as Home Health which is a significant increase of 122 from 15 in CY2017.
- There were 2,746 provider appeals in CY2018 which is a significant increase of 554 (25%) from 2,192 provider appeals in CY2017.

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY18 Annual

- Amerigroup received 3 Default orders in CY2018
- United Healthcare received 3 Default orders in CY2018

Amerigroup CY18 Annual					
Total # of Member SFH	38		**Total # of Provider SFH**	174	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	1	1%

Sunflower CY18 Annual					
Total # of Member SFH	43		**Total # of Provider SFH**	105	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

United CY18 Annual					
Total # of Member SFH	18		**Total # of Provider SFH**	105	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	1	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 2018:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:34	3.87%	171,793
Sunflower	0:17	1.49%	169,040
United	0:16	0.77%	178,262
DXC – Fiscal Agent	0.05	0.47%	31,572

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	1.29%	110,413
Sunflower	0:22	1.72%	91,339
United	0:10	0.62%	89,788
DXC – Fiscal Agent	0.08	0.45%	36,769

C. Summary of critical incident reporting:

Critical Incidents January-December 2018	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2018
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	2096	1905	1703	1819	**7523**

Pending Resolution	0	0	115	157	**272**
Total Received	2096	1905	1818	1976	**7795**
APS Substantiations*	104	121	112	126	**463**

**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.*

Along with ensuring necessary follow-up and resolution of all reported adverse incidents, additional requirements have been implemented to confirm review and resolutions regarding instances of seclusion, restraint, restrictive intervention, and death followed appropriate policies and procedures. The Kansas Department for Aging and Disability Services (KDADS) implemented enhancements to the AIR system on 9/17/18. These enhancements allow KDADS, KDHE, and MCOs to manage specific critical incidents in accordance with KDADS' AIR Policy.

Upon implementation of enhancements, all the Managed Care Organizations (MCOs) have access to the system. MCOs and KDADS staff may now both read and write information directly into the AIR system. Creating an Adverse Incident Report is forward facing, so anyone from a concerned citizen to an MCO Care Coordinator can report into the AIR system by visiting the KDADS website at www.kdads.ks.gov and selecting Adverse Incident Reporting (AIR) under the quick links. All reports are input into the system electronically. While a system with DCF is being developed to automatically enter determinations into AIR, KDADS requires duplicate reporting for instances of Abuse, Neglect and Exploitation to both DCF and the AIR system. Determinations received from the Kansas Department for Children and Families (DCF) are received by KDADS staff who review the AIR system and attach to an existing report, or manually enter reports that are not already in the AIR system. After reports are received and reviewed and waiver information is verified by KDADS staff in MMIS, MCOs receive notification of assigned reports. MCOs can provide follow-up information within the AIR system and address corrective action plans issued by KDADS as appropriate. To protect member protected health information, MCO access is limited to only their enrolled members. Please note that Kansas is in the process of establishing a memorandum of understanding (MOU) between KDADS and DCF to improve communication, data sharing and leverage resources between the agencies.

As part of the implementation process, KDADS provided MCOs with training on the new AIR system on 9/12/18. As part of implementation of the new KanCare contract, Aetna received a training on 12/19/18 and KDHE presented a summary of the AIR system updates to interested parties on 12/12/18. KDADS will continue to offer further training sessions and refresher sessions as updates occur.

KDADS is planning regular meetings with MCOs to analyze trends and drill down on any specific cases, as appropriate.

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 2018/DY6.

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 DY6. The CMS approved DSRIP annual and semi-annual payments were made on June 28, 2019 and December 20, 2018 respectively. A summary of 2018/DY6 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 2018, the GCRs swung sharply upward in number during May (46) and June (71), gradually reducing after June. July had an unusually large number of approved requests (44) due to a single provider dropping out of a MCO's network. This large provider specializes in traumatic brain injury waiver treatment. The Secretary of the Kansas Department of Health and Environment and the State Medicaid Director opted to approve any good cause request filed for these vulnerable members who expressed a desire for continuity of care with this particular provider. The remaining requests were due largely 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 2018, there were four state fair hearings filed for a denied GCR. Two cases were affirmed, one was withdrawn, and one had a default judgment against the appellant. A summary of GCR actions for 2018 is as follows:

Status	2018 Totals
Total GCRs filed	249
Approved	78

Denied	118
Withdrawn (resolved, no need to change)	29
Dismissed (due to inability to contact the member)	24
Pending	0

F. HCBS Waiver Updates:
   i. CMS approved the Severe Emotional Disturbance (SED) waiver renewal on November 5, 2018.
   ii. CMS approved the Technology Assisted Waiver renewal on August 1, 2018.

III. STC 78(b) – Total Annual Expenditures

Total annual expenditures for the demonstration population for Demonstration Year 6 (2018), with administrative costs reported separately, are set out in the attached document entitled "KanCare Expenditure & Budget Neutrality – Demonstration Year 6 – 2018."

IV. STC 78(c) – Yearly Enrollment Reports

Yearly enrollment reports for demonstration enrollees for Demonstration Year 6 (2018), 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 6, are set out in the attached document entitled "KanCare Expenditure & Budget Neutrality – Demonstration Year 6 – 2018."

V. STC 78(d) – Quality Strategy

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. 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, and public health advocates. This combined information assists KDHE, KDADS and the MCOs to identify and recommend quality initiatives to monitor and improve services provided to the Kansas Medicaid population. The QIS is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration.

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 quality strategy, including operational specifications of the performance measures (and pay for performance measures); reporting specifications and templates; LTSS oversight and plan of care review and 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 the updated quality strategy and other documents. Kansas develops quarterly updates for 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. Performance measures continue to evolve and change based upon analysis of HEDIS data and claim encounter data. 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 and KDADS submitted a revised KanCare Quality Management Strategy (QMS) in July 2018 to bring it into compliance with the Medicaid Managed Care Final Rule. Also, KDHE rebid the External Quality Review Organization (EQRO) contract in the Fall of 2018 and recently awarded the contract to the incumbent. The framework of the QMS has been redesigned to look at the KanCare program and the population it serves in a holistic fashion to address all physical, behavioral, functional and social determinants of health and independence needs of the enrolled population. The QMS serves as the launch pad from which the State will continue to build and implement continuous QI principals in key areas of the KanCare program. The State will continue to scale the requirements of the QMS to address and support ongoing system transformation. The revised EQRO contract includes activities specific to accomplishment of the strategies and goals of the QMS, and progress will be monitored and managed during quarterly standing EQRO and State business meetings and as warranted. Regular and consistent cross-agency review of the QMS will highlight progress toward State goals and measures and related contractor progress. The outcome findings will demonstrate areas of compliance and non-compliance with Federal standards and State contract requirements. This systematic review will advance trending year over year for the State to engage contractors in continuous monitoring and improvement activities that ultimately impact the quality of services and reinforce positive change.

As part of its Stakeholder engagement strategy, KDADS has engaged contractors in training on remediation for performance measures in the waivers in August 2018. KDADS has resurrected its Traumatic Brain Injury (TBI) Advisory Board, inviting stakeholders to participate in and advise KDADS in matters surrounding Kansans with TBI. KDADS values stakeholder input as we move forward Kansans with disabilities.

VI. STC 78(e) – MFP Benchmarks

Kansas's Money Follows the Person (MFP), five-year demonstration grant, serve 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.

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 on each of the 1915(c) waiting lists:

i. Intellectual/Developmental Disabilities waiver program: 3,911 as of December 31, 2018
ii. Physical Disabilities waiver program: 1,527 as of December 31, 2018

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

i. Intellectual/Developmental Disabilities waiver program, as of December 31, 2018:

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	323
Deceased	8
Other	316

ii. Physical Disabilities waiver program, as of December 31, 2018:

Reason moved off waiting list	Number of people
Placed on Services (Includes HCBS, MFP, and PACE)	691
Deceased	125
Other	625

C. Number of people that are new to the waiting list: 649 for I/DD waiver; 1,281 for PD waiver
(Data source: Kansas Aging Management Information System (KAMIS) and Medicaid Management Information System (MMIS) Eligibility data)

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

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

Program	CY 2012	CY 2013	CY 2014	CY 2015	CY2016	CY2017	CY2018
Nursing Facilities	14,913	14,517	14,565	14,163	12,549	12,897	13,310
Public ICF/IDDs	350	344	337	328	322	326	316

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 07/01/2017-06/30/2018	Nursing Facilities	Private ICF/IDDs
Days	4,066,456	51,664
Admissions	5,119	43

IX. STC 78(h) – Ombudsman Program

A summary of the KanCare Ombudsman program activities for demonstration year 2018 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 2018 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. Joint critical issues logs which are posted on the Kansas Medical Assistance Programs (KMAP) website for providers to view
   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
   vi. Creation of a CMS approved Quality Management Strategy, which is posted on the KanCare website

B. Utilization Data: One component of the state's analysis of our Medicaid program is a comparison of current service utilization with the Pre-KanCare baseline year (CY 2012). This comparison provides information on shifts and trends in general and specific service areas, including services for both physical and behavioral health care needs, nursing facility and HCBS services, as well as inpatient and outpatient service settings. Refinement of our processes for compiling utilization data has allowed the state to compare utilization for across a spectrum of 17 service types thus allowing us to monitor specific service areas as well as general service types across the entire array of Managed Care services. This process requires an appropriate length of time to pass prior to capturing utilization data for analysis, therefore an analysis of calendar year 2018 data has not been finalized in time for this report.

   The table provided below contains the KanCare Utilization Report for our fifth demonstration year (CY2017). A comparison between pre-KanCare rates (CY 2012) and CY2017 data demonstrates the continuation of a positive trend in reducing the utilization and expense attributed to inpatient facility

services during the fifth year of KanCare, thereby supporting the continued success of our KanCare program's primary goal of controlling Medicaid costs by emphasizing health, wellness, prevention and early detection.

During the first five years of our demonstration program, KanCare has also maintained an upward trend in utilization of community based, local, outpatient office visits and ancillary services by our Members. By providing the MCOs with financial incentives based on outcomes that are tied to meaningful and reliable performance measures, the state is improving health care quality for our Members and reducing the overall cost of Medicaid in Kansas.

KanCare Utilization					
		CY 2012	CY 2017	Comparison CY 2017 vs CY 2012	
Type of Service	Measure Reported	Utilization Per/1000	Utilization Per/1000	Utilization Per/1000	% Difference
Behavioral Health	Claims	4,829	4,577	-253	-5%
Dental	Claims	878	909	31	4%
DME	Claims	460	427	-34	-7%
HCBS	Units	4,187	4,229	42	1%
Independent Laboratory	Claims	807	648	-159	-20%
Inpatient	Days	818	665	-152	-19%
Long Term Care	Days	374	385	12	3%
Medical – Specialty	Claims	1,836	1,414	-421	-23%
Medical – General Practice	Claims	3,615	3,724	109	3%
Outpatient ER	Claims	763	718	-45	-6%
Outpatient ER Ancillary	Claims	1,498	1,591	93	6%
Outpatient Non-ER	Claims	1,072	986	-86	-8%
Pharmacy	Prescriptions	10,096	10,397	300	3%
Targeted Case Mngmt	Claims	793	378	-415	-52%
Transportation NEMT	Claims	515	831	316	61%
Vision	Claims	382	478	96	25%
FQHC/RHC	Claims	751	924	174	23%
Utilization per 1000 formula is (Units Reported/Member Months) x 12,000 - illustrates services used per 1000 beneficiaries over a 12-month period.					
CY 2017 data extracted from DSS includes claims with a date of service between 1/1/2017 and 12/31/2017; paid date greater than or equal to 1/1/2017. CY 2012 data extracted from DSS includes claims with a date of service between 1/1/2012 and 12/31/2012; paid date greater than or equal to 1/1/2012.					
The purpose of this report is to compare the 2017 KanCare data to the 2012 Pre-KanCare data to evaluate MCO expenditures and 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

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).

Table ES-1. Summary Ranges of Scores, Percentages, and Quality Compass Percentiles

	MCO % or Score			Quality Compass Percentile Range		
	Adults	GC	CCC	Adults	GC	CCC
Rating of Health Plan	75%–81%	88%–91%	84%–90%	33th– 90th	50th– **95th**	33rd– **100th**
Rating of All Health Care	74%–76%	85%–91%	84%–95%	33th– 67th	25th– 90th	10th– **100th**
Rating of Personal Doctor	83%–84%	89%–92%	87%–94%	50th– 90th	33th– 90th	10th– **100th**
Rating of Specialist Seen Most Often	81%–84%	88%–96%	81%–93%	33th– 75th	66th– **100th**	**0th**– 90th
Getting Care Quickly	84–87	91–95	92–96	50th– 90th	50th– **95th**	33th– 90th
Getting Needed Care	83–87	89–90	89–93	50th– 90th	75th– **95th**	50th– **100th**
Coordination of Care	82–86	79–86	81–88	25th– 75th	**0th**– 75th	25th– 75th
Health Promotion and Education	71–72	68–75	69–78	25th– 50th	**0th**– 75th	**0th**– 34th
How Well Doctors Communicate	92–94	94–96	95–96	33th– 90th	50th– 90th	50th– 90th
Shared Decision Making	82–83	77–85	85–90	66th– 90th	33rd–**100th**	33th– 90th
Customer Service	87–89	86–91	84–90	33rd– 67th	10th– 90th	NA – 67th
CCC Composites CCC				**CCC**		
Access to Prescription Medicines			93–96	50th– **100th**	*Percentiles strictly greater than 90 th are hightlighted in green; percentiles less than 10 th are highlighted in purple. Quality Compass assigns "NA" if the denominator is less than 100.*	
Access to Specialized Services			77–85	25th– NA		
Coordination of Care for Children with Chronic Conditions			63–77	10th– 75th		
Family-Centered Care: Getting Needed Information			92–93	33th– 75th		
Family-Centered Care: Personal Doctor Who Knows Child			87–92	**5th**– 67th		

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 table below shows the provider growth rate from the 4th Quarter of 2017 to 4th Quarter of 2018. The data in this table is based on the Provider Network Report submitted by each MCO quarterly. The counts represent the unique number of NPIs—or, where NPI is not available—provider name and service locations. This results in counts for the following:

- Providers with a service location in a Kansas county are counted once for each county.
- Providers with a service location in a border area are counted once for each state in which they have a service location that is within 50 miles of the KS border.
- Out of state providers (>50 miles from KS border) are counted once.
- Providers for services provided in the home are counted once for each county in which they are contracted to provide services. *This measure was implemented Q3-2018.

KanCare MCO	# of Unique Provider/ Locations as of 12/31/17	# of Unique Provider/ Locations as of 3/31/18	# of Unique Provider/ Locations as of 6/30/18	# of Unique Provider/ Locations as of 9/30/18*	# of Unique Provider/ Locations as of 12/31/18*	% of change Q42017-Q42018
Amerigroup	27,107	29,066	26,544	33,230	N/A	+23%[a]
Sunflower	31,168	27,441	27,433	30,886	31,998	+3%
UHC	31,247	31,259	30,819	38,196	39,799	+27%

[a] Q4-2017 compared with Q3-2018

The Provider Network reporting from the MCOs was a particular area of emphasis during 2018. KDHE re-designed the Provider Network template, held training with MCOs, and provided quarterly feedback on accuracy and data quality each quarter. We received the first submission of the new Provider Network template on 1/30/19 and completed the data quality analysis of these reports on 2/19/19. We have seen an improvement in the validity of the results. For example, a reduction in the incidence of duplicates and other erroneously included records by 97.3% from Q1-2018 to Q4-2018. Another result is our ability to now compare the Provider Network data with the MCO provider directories using JSON files to compare the two data sets.

Over the last year, the State has also re-designed our GeoAccess standards and reporting. On March 1, 2019, we held a training/presentation for State staff on these new reporting requirements. Our plan is to now train the MCOs and formally publish and implement the documents. The new GeoAccess reporting measures and templates have been designed to continuously evaluate the adequacy of our provider network, identify gaps and assess the appropriateness of the standards. One of the monthly required reports allows the MCOs to describe the strengths of their network as well as the unique initiatives being implemented to engage and retain providers. In addition, an exception process has also been developed which will document when exceptions to the standards have been granted. We have preliminary plans to implement an internal method to validate mapping with a software product.

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:

- Overall compliance is higher than last year, and across all appointment compliance.
- PCP compliance scored as follows: 96% for routine care in 2018 compared to 94% in 2017; 95% for urgent care in 2018 compared to 95% in 2017; and 98% for emergent care in 2018 compared to 97% in 2017.
- Specialist compliance is slightly higher than 2017 at 70%, despite lower appointment compliance with urgent care at 82%, routine care 95%, and emergent care at 85%.
- Pediatrics compliance increased from 89% in 2017 to 96% in 2018 with significant improvement in routine compliance from 91% to 99%.
- Behavioral Health compliance is higher than 2017 in all but one appointment type, resulting in a three percentage point increase in fully compliant providers (57% to 60%). Individual appointment type scoring ranged between 85%-89% compliance.

Historically, non-compliant providers received additional outreach and education to reiterate the standards and evaluate all responses for appropriate action plans.

After-hours compliance showed a slight decrease from 91% to 89% compliance across the two survey groups of PCPs and Pediatric providers. About nine in ten providers are compliant with after-hours standards. The primary reasons for noncompliance are 1) a recorded message that does not offer a live party, and 2) no answer after following prompts.

Sunflower
Office Surveys

Sunflower changed vendors to Morpace in 2018, to conduct the 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 to Sunflower members.

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**

For the after-hours access for member survey, 45% of PCP offices who were successfully contacted were identified as having an acceptable method of providing after-hours access for members. Of the 300 practitioners in the sample, 196 had a recording or auto attendant; 48 provided a live person; 22 had no answer and 34 were unable to be reached. Of the 196 recording or auto attendant surveys, 73% provided a passing response as outlined above. Of the 61 providers who with an automated message with an option to speak to an unspecified live party, 90%(55 providers) provided a live party, while 2% (1 provider) connected to a physician and 8% (5 providers) received no answer at that point.

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 from the member perspective. Since this custom question was added in 2017, it provided 2017 data for comparison with 2018. Sunflower set an internal goal of meeting or exceeding a Summary Rate of 80% of members who responded always or usually to the question for both the Adult and Child survey results. The results for the 2018 Adult CAHPS survey did not met Sunflower's goal, with a rate of 70.3% which was down from 85% in 2017. The goal was met for the 2017 Child CAHPS survey, with a rate of 84.9% which noted improvement from 2017 with a rate of 81%.

United

Table 1: Description of Sample

	PCP		Specialist		OB		BH		Total	
	2017	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Sample size	277	169	192	162	81	133	146	186	696	650
Percent (number) contacted	87.4 % (242)	89.3 % (151)	74.5 % (143)	71.6 % (116)	81.5 % (66)	86.5 % (115)	72.6 % (106)	38.7 % (72)	80.0 % (557)	69.8 % (454)
Percent (number) completed*	74.0 % (179)	74.8 % (113)	64.1 % (123)	59.9 % (97)	74.1 % (60)	72.2 % (96)	57.5 % (84)	26.3 % (49)	80.1 % (446)	78.2 % (355)
**After hours calls ** **	179	151	123	146	60	96	NA	NA	362	393

* 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 2018 (primary care >=100 visits YTD). Surveys were conducted from late May through June 2018.

Compared to 2017, a slightly smaller sample was drawn (650 compared to 696) and contact rates and survey rates were slightly lower. 69.8% of the sample was able to be contacted, and 78.2%

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, 55% 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	
	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	**277**	**169**	**192**	**162**	**81**	**133**	**146**	**186**	**696**	**650**
Refused to participate	12.6% (35)	3.6% (6)	2.6% (5)	3.7% (6)	2.5% (2)	3% (4)	2.1% (3)	0% (0)	6.5% (45)	2.5% (16)
Unable to Contact in 3 Attempts	5.8% (16)	3.6% (6)	17.2% (33)	19.8% (32)	14.8% (12)	8.3% (11)	7.5% (11)	58.1% (108)	10.3% (72)	24.2% (157)
Technical Problems	6.9% (19)	1.2% (2)	7.8% (15)	3.7% (6)	3.7% (3)	0.8% (1)	19.9% (29)	2.2% (4)	9.5% (66)	2% (13)
Moved, did not update information	10.1% (28)	5.3% (9)	8.3% (16)	6.2% (10)	4.9% (4)	4.5% (6)	13.0% (19)	2.7% (5)	9.6% (67)	4.6% (30)
Total Not Surveyed	35.4% (98)	13.6% (23)	35.9% (69)	33.3% (54)	25.9% (21)	16.5% (22)	42.5% (62)	62.9% (117)	35.9% (250)	33.2% (216)

*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 33% 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 24% of the sample this year (10% last year). Slightly less providers moved to a different practice and did not update contact information, especially among 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.

Appointment Wait Time Standards According to State and NCQA Specifications

Compliance Standards of State and NCQA QI5		
Standard	**State of Kansas**	**NCQA**
Emergency	Same day, all providers	Immediate
Urgent	48 hrs, all providers	Same day; 48 hrs, BH
Non-life-threatening emergency	NA	6 hrs, BH
Routine	21 days, PCP; 10 days, BH; 30 days, Specialist	14 days; 10 days, BH
OB	3 wks 1st trimester; 2 wks 2nd trimester; 1 wk 3rd trimester; no specific standard for high risk	NA
Physical/preventive	21 days, adult & EPSDT	4 weeks
After Hours	24/7 PCPs, OBs, Specialists	24/7 PCPs

Table 3A: Percent of Surveyed Offices Who are In Compliance with State Contractual Appointment Standards

Compliance Rates*	PCP		Specialist**#		OB**		BH		Total	
	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	**179**	**113**	**123**	**97**	**60**	**96**	**84**	**49**	**446**	**355**
Emergency care	74.9% (134)	99.1 % (112)	28.5 % (35)	100% (97)	NA	NA	NA	NA	56.0 % (169)	99.5 % (209)
Urgent care	86.0% (154)	99.1 % (112)	38.2 % (47)	100% (97)	NA	NA	35.7 % (30)	83.7 % (41)	59.8 % (231)	96.5 % (250)
Routine care	96.1% (172)	100% (113)	79.7 % (98)	100% (97%)	NA	NA	84.5 % (71)	95.9 % (47)	88.3 % (341)	99.2 % (257)
Adult physical	83.2% (149)	90.3 % (102)	NA	NA	NA	NA	NA	NA	83.2 % (149)	90.3 % (102)
EPSDT/Well Child	79.9% (143)	54.9 % (62)	NA	NA	NA	NA	NA	NA	79.9 % (143)	54.9 % (62)
After hours coverage	95.0% (170)	100% (113)	96.7 % (119)	100% (97)	90.0 % (54)	100 % (96)	NA	NA	77.3 % (280)	100% (306)
OB first trimester	NA	NA	NA	NA	88.3 %	99% (95)	NA	NA	88.3 %	99% (95)

					(53)				(53)	
OB second trimester	NA	NA	NA	NA	75.0 % (45)	100 % (96)	NA	NA	75.0 % (45)	100% (96)
OB third trimester	NA	NA	NA	NA	51.7 % (31)	99% (95)	NA	NA	51.7 % (31)	99% (95)
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**	
	2017	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
	% (n)		**% (n)**		**% (n)**		**% (n)**		**% (n)**	
Sample Size	**179**	**113**	**123**	**97**	**60**	**96**	**84**	**49**	**446**	**355**
Emergency care	74.9% (134)#	99.1% (112)	28.5 % (35)	100 % (97)	NA	NA	NA	NA	56.0 % (169)	99.5 % (209)
Urgent care	74.9% (134)	99.1% (112)	28.5 % (35)	100 % (97)	NA	NA	35.7 % (30)	83.7 % (41)	51.6 % (199)	96.5 % (250)
Routine care	91.1% (163)	100% (113)	59.3 % (73)	100 % (97)	NA	NA	84.5 % (71)	95.9 % (47)	79.5 % (307)	99.2 % (257)
Adult physical	87.2% (156)	90.3% (102)	NA	NA	NA	NA	NA	NA	87.2 % (156)	90.3 % (102)
EPSDT/Well Child	83.8% (150)	54.9% (62)	NA	NA	NA	NA	NA	NA	83.8 % (150)	54.9 % (62)
After hours coverage	95.0% (170)	113 (100%)	NA	NA	NA	NA	NA	NA	77.7 % (139)	100% (113)
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.

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.

Obstetric care improved this year over last, with only 99% of providers able to schedule an appointment within a week for a patient in the third trimester of pregnancy (in 2017, the number was 52%). 100% could schedule an appointment within two weeks for a member in the second trimester, and 99% 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 more available, with 84% able to provide an appointment compared to 36% last year. It should be noted that the sample size of BH providers this year (n=49) is almost half the size last year (n=84). On the other hand, the large number of providers who were unable to be contacted due to having only cell phones may have created some bias in the sample.

Table 4: Average Number of Days Wait for Schedule Appointment

	PCP (Days)		Specialist (Days)		OB (Days)		BH (Days)	
	2017	2018	2017	2018	2017	2018	2017	2018

Sample Size	179	113	123	97	60	96	84	49
Emergency care	4.6	0.58	17.7	1.5	NA	NA	NA	NA
Urgent care	3.2	0.62	17.1	1.8	NA	NA	5.2	2.9
Routine care	5.7	1.5	23.3	18	NA	NA	6.3	9.0
Adult physical	17.5	12.2	NA	NA	NA	NA	NA	NA
EPSDT/Well Child	18.1	12.2	NA	NA	NA	NA	NA	NA
OB first trimester	NA	NA	NA	NA	12.3	9.6	NA	NA
OB second trimester	NA	NA	NA	NA	13.5	8.4	NA	NA
OB third trimester	NA	NA	NA	NA	12.5	7	NA	NA
OB High Risk	NA	NA	NA	NA	8.4	2.4	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)	
	2017	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**	**2017**	**2018**
Sample Size	**179**	**169**	**123**	**162**	**60**	**133**	**84**	**186**	**362**	**464**
Answering service, nurse, physician or message with number to contact	95.0% (170)	89.3% (151)	96.7% (119)	90.1% (146)	90.0% (54)	69.9% (93)	NA	NA	94.8% (343)	84.1% (390)
Answering machine instructing member to go to nearest hospital	2.8% (5)	0% (0)	2.4% (3)	0% (0)	2.4% (6)	0.8% (1)	NA	NA	3.9% (14)	0.2% (1)
Phone rings continuously with no answer	.6% (1)	2.4% (4)	0	0% (1)	0	0% (0)	NA	NA	0.3% (1)	0.9% (4)
Other unacceptable (typically, message instructing member to dial 911)	1.7% (3)	5.3% (9)	0.8% (1)	8.6% (14)	0	0% (2)	NA	NA	1.1% (4)	5% (23)

*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, 84.1% had an adequate process in place, such as an answering service, nurse, physician, or number to contact. This represents an decline from the previous years. The state contract requirements

regarding after-hours access are 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.

E. Outcomes of Onsite Reviews: One activity of the KanCare 1115 renewal process was a readiness review for managed care contractors beginning in January, 2019. KDHE and KDADS worked with a third-party consultant to conduct a joint readiness review in lieu of an annual audit in 2019. The review consisted of a desk audit and on-site, in-person audit by cross-agency subject matter experts who were chosen by state leadership. Team members received in-person training on review tools developed by the consultant to assess the following areas of review:

- Organizational and Administration
- Service Coordination and Covered Services
- Provider Network and Pharmacy
- Financial Management and Program Integrity
- Clinical and Utilization Management
- Claims, IT and WORK/Member Independence

The readiness review provided the state an opportunity to ensure the Managed Care Organizations (MCO) had operable processes and systems for member transitions and service delivery. The level of compliance with the KanCare contract was assessed through material review and interviews with key MCO staff during August 2018 on-site reviews. Follow-up requests and submissions were managed and approved through an automated spreadsheet and document sharing site to address any outstanding inquiries. The review assessed each MCO for:

- A comprehensive understanding of the program requirements and demonstrated ability to operationalize requirements.
- A solid plan for hiring and training staff.
- Evidence that go-live will be seamless to members.
- Clear expectations for the challenges ahead and plans to address barriers.
- A contingency plan for each item not fully demonstrated prior to and during the on-site.

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. These projects were continued in 2018.

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 MCOs also submit an annual report which contains data analysis and summarizes the project's impact. The EQRO reviews and validates these reports for each PIP. 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 2013-2017 (measurements conducted in 2018) 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.

	SFY2017	SFY2018
Total Eligible receiving dental treatment	48,271	48,704
Total Eligible receiving preventative services	121,855	120,084

Value Added Benefits (VAB) are another way in which adult members may access preventive dental services. In 2018, 9,517 members received Dental services as Value added services provided through the MCO's. The value of these services totaled $1,014,178.

I. Pay for Performance Measures

The final results of the KanCare MCOs' performance for the 2017 pay for performance measures (measured in 2018) are detailed in the document attached to this report entitled "KanCare Pay for Performance Measures – Summary of 2017 Performance Outcomes."

Additional performance results are included in the 2018 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, 2018, all three plans are in a sound and solvent financial standing.

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 14, 2018. 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, 2016 and 2017 as well as quarterly reports for each quarter of 2018.

KFMC's annual report for 2018 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 – DY6 2018
IX	KanCare Ombudsman Report – DY6 2018
XI(G)	KanCare Pay for Performance Measures – Summary of 2017 Performance Outcomes
XII	KanCare 2018 Public Forum Summary
XIII	KFMC's KanCare Evaluation Report – DY6 2018

XV. State Contacts(s)

Dr. Lee A. Norman, M.D., Secretary
Christiane Swartz, Deputy Medicaid Director
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Division of Health Care Finance
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XVI. Date Submitted to CMS

March 29, 2019

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 6- YE 2018

DSRIP Payment

Paid dates 1/1/2018 through 12/31/2018*

Provider Names	YE 2017 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	7,839,731	3,519,255	4,320,476
University of Kansas Hospital	18,282,657	8,207,085**	10,075,572
Total	26,122,388	11,726,340	14,396,048

*This included funds from DY4 per CMS

**IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 6 - YE 2018

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

Paid dates 1/1/2018 through 12/31/2018

Hospital Name	YE 2018 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	$ 2,464,138	$ 1,106,152	$ 1,357,986
University of Kansas Hospital	$ 7,392,412	3,318,454*	$ 4,073,958
Total	**$ 9,856,550**	**$ 4,424,606**	**$ 5,431,944**

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 6- YE 2018

Health Care Access Improvement Pool

Paid dates 1/1/2018 through 12/31/2018

Provider Names	YE 2018 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
ASCENSION VIA CHRISTI REHABILITATION HOSPITAL	90,295	40,533	49,762
BOB WILSON MEMORIAL GRANT COUNTY HOSPITAL	145,264	65,209	80,055
CHILDRENS MERCY SOUTH	962,600	432,111	530,489
COFFEYVILLE REGIONAL MEDICAL CENTER INC	308,576	138,520	170,056
GEARY COUNTY HOSPITAL	308,071	138,293	169,778
GREAT BEND REGIONAL HOSPITAL	379,741	170,466	209,275
HAYS MEDICAL CENTER INC*	1,106,374	496,651	609,722
HUTCHINSON REGIONAL MEDICAL CENTER INC	706,624	317,204	389,421
KANSAS HEART HOSPITAL LLC	20,462	9,186	11,277
KANSAS MEDICAL CENTER LLC	29,802	13,378	16,424
KVC PRAIRIE RIDGE PSYCHIATRIC HOSPITAL	2,296	1,030	1,265
LABETTE CO MED	207,875	93,315	114,560
LAWRENCE MEMORIAL HOSPITAL	1,007,329	452,190	555,139
MCPHERSON HOSPITAL INC	191,684	86,047	105,637
MENORAH MEDICAL CENTER	653,888	293,531	360,358
MERCY HOSPITAL FORT SCOTT	252,153	113,192	138,962
MERCY HOSPITAL INC	22,659	10,172	12,487
MIAMI COUNTY MEDICAL CENTER INC	197,127	88,491	108,637
MIDWEST DIVISION OPRMC LLC	3,391,050	1,522,242	1,868,808
MORTON COUNTY HOSPITAL	39,236	17,613	21,623
NEWTON MEDICAL CENTER	597,955	268,422	329,533
OLATHE MEDICAL CENTER INC	1,013,729	455,063	558,666
PRAIRIE VIEW HOSPITAL	11,436	5,134	6,302
PRATT REGIONAL MEDICAL CENTER CORPORTATION	147,316	66,130	81,186
PROVIDENCE MEDICAL CENTER	1,376,358	617,847	758,511
RANSOM MEMORIAL HOSPITAL	255,898	114,873	141,026
SAINT JOHN HOSPITAL	322,146	144,612	177,535
SAINT LUKES CUSHING HOSPITAL	292,235	131,184	161,050
SAINT LUKES SOUTH HOSPITAL INC	237,423	106,579	130,844
SALINA REGIONAL HEALTH CENTER	931,943	418,349	513,594
SALINA SURGICAL HOSPITAL	8,585	3,854	4,731
SHAWNEE MISSION MEDICAL CENTER INC	2,675,480	1,201,023	1,474,457
SOUTH CENTRAL KANSAS REGIONAL MEDICAL CENTER	191,835	86,115	105,720
SOUTHWEST MEDICAL CENTER	377,109	169,284	207,825
ST CATHERINE HOSPITAL	858,819	385,524	473,295
ST FRANCIS HEALTH CENTER	956,268	429,269	526,999
STORMONT VAIL HEALTH CARE INC	4,708,648	2,113,712	2,594,936
SUMNER REGIONAL MEDICAL CENTER	47,622	21,378	26,244
SUSAN B ALLEN MEMORIAL HOSPITAL	451,347	202,610	248,737
TOPEKA HOSPITAL LLC D/B/A THE UNIVERSITY OF KANSAS	961,125	431,449	529,676
VIA CHRISTI HOSPITAL MANHATTAN	1,067,151	479,044	588,107
VIA CHRISTI HOSPITAL PITTSBURG	833,033	373,948	459,084
VIA CHRISTI HOSPITAL WICHITA ST TERESA INC **	483,875	217,212	266,664
VIA CHRISTI HOSPITALS WICHITA INC	7,483,245	3,359,229	4,124,016
WESLEY MEDICAL CENTER	4,612,348	2,070,483	2,541,865
WESTERN PLAINS MEDICAL COMPLEX	481,078	215,956	265,122
Grand Total	41,407,117	18,587,655	22,819,462

*Paid DY5 Q1 & Q2 $418,994

**Paid DY5 Q1 & Q2 $124,552

State Of Kansas
Kansas Department of Health and Environment
Division of Health Care Finance
KanCare Annual Report
Demonstration Year 6
Calendar Year 2018

Population	Unduplicated Beneficiaries by Population	Member Months	Expenditures
Pop 1: ABD/SD Dual	21,378	179,628	$ 44,724,175
Pop 2: ABD/SD Non Dual	36,336	355,558	$ 417,563,307
Pop 3: Adults	70,069	601,035	$ 347,266,234
Pop 4: Children	269,669	2,576,655	$ 646,706,041
Pop 5: DD Waiver	9,516	109,175	$ 497,131,859
Pop 6: LTC	25,768	241,534	$ 938,516,625
Pop 7: MN Dual	3,750	15,394	$ 13,585,933
Pop 8: MN Non Dual	1,985	11,561	$ 26,093,867
Pop 9: Waiver	6,244	53,949	$ 156,993,794
Total	444,715	4,144,489	$ 3,088,581,834

Administration	$ 167,295,916

Overall Unduplicated Beneficiaries	427,907

Notes:
1. CHIP and MCHIP are excluded.
2. Enrollment data is updated through Mar 2019 capitation data.
3. Expenditure data is updated through QE 12 31 2018.

ANNUAL REPORT 2018

KanCare Ombudsman Office

Email: Kerrie.Bacon@ks.gov
Phone: (785) 296-6270
Address: 503 S. Kansas Ave., Topeka, KS 66603
Website: www.kancare.ks.gov/kancare-ombudsman-office/contact-us

I. Table of Contents

Contents

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II. Highlights/Dashboard

A. Introduction

The KanCare Ombudsman Office is providing this 2018 Annual Report to Kansans, Government Organizations, Managed Care Organizations, Providers, KanCare Members and other interested parties to share the activities of this office over the past year/s. We welcome any questions or comments regarding this report. Kerrie Bacon, KanCare Ombudsman.

B. 4,440 initial contacts in 2018 (see page 5)

C. 136 Outreach and Education activities (see page 6 and Appendix A)

D. "Action Taken" includes organizational response to KanCare Ombudsman request for assistance – started in 4th quarter (see page 14)

Q4/2018

Nmbr Referrals	Avg. Days Referred	Referred to	% Responded 0-2 Days	% Responded 3-7 Days	% Responded 8-30 Days	% Responded 31 or More Days
151	3	Clearinghouse	74%	16%	7%	3%
5	2	DCF	80%	0%	20%	0%
2	0	KDADS-Behavior Health	100%	0%	0%	0%
15	3	KDADS-HCBS	73%	13%	13%	0%
-	-	KDADS-Health Occ. Cred.	0%	0%	0%	0%
10	5	KDHE-Eligibility	70%	10%	10%	10%
9	5	KDHE-Program Staff	67%	22%	0%	11%
8	1	KDHE-Provider Contact	88%	13%	0%	0%
3	0	KMAP	100%	0%	0%	0%
1	0	Aetna	100%	0%	0%	0%
9	13	Amerigroup	22%	22%	56%	0%
13	8	Sunflower	62%	23%	8%	8%
6	7	UnitedHealthcare	50%	17%	17%	17%

E. Trends in Data – four charts (see pages 18-19)

F. Changes from last year (Enhancements)-(see pages 19-20)

1. Accessibility Guidelines
2. General Information Fact Sheets
3. Grievance, Appeal and Fair Hearing webpage remodel

III. Introduction

The Centers for Medicare and Medicaid Services Special terms and Conditions (2014), Section 42 for KanCare, provides the KanCare Ombudsman program description and Objectives. This report provides information about the KanCare Ombudsman Office program activities and data collected as the office works to serve Kansans, both beneficiaries and organizations connected to the KanCare program.

IV. Accessibility by Ombudsman's Office

The KanCare Ombudsman office was available to members and potential members of KanCare (Medicaid) by phone, email, written communication, and in person during 2018.

A. Initial Contacts

The number of initial contacts the Ombudsman's office received continues to increase. The initial contacts have been increasing for the last six quarters. 2018 initial contacts are more than double the 2014 and 2015 initial contacts.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
2014	545	474	526	547	2,092
2015	510	462	579	524	2,075
2016	1,130	846	687	523	3,186
2017	825	835	**970**	**1,040**	3,670
2018	**1,214**	**1,059**	**1,088**	**1,124**	4,485

**2013 year does not include emails in the data*

B. Additional Contacts

The KanCare Ombudsman office provides follow up contact with members, providers and organizations as needed. These include requests for follow-up to another organization and their responses, and follow-up contacts to and from the beneficiary. There may be multiple contacts for a member/applicant.

Additional Contacts: Notes History (ongoing contacts with beneficiary to note calls and/or updates with issue/concern)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2017	1,388	1,651	1,954	2,122
2018	2,251	1,892	1,898	1,855

Additional Contacts: Email History (emails with beneficiaries and follow up with agencies, MCOs and providers, to resolve cases)	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2017	655	919	1,338	1,490
2018	1,389	1,252	1,315	1,211

C. Accessibility through the KanCare Ombudsman Volunteer Program

The Kancare Ombudsman Office has two Satellite office; one in Olathe and on in Wichita. Both Satellite offices answer KanCare questions and help with issues as well as assist with filling out KanCare applications on the phone and in person at the offices.

The main means of contact with the two Satellite offices is through the KanCare Ombudsman Toll Free number, which directs calls based on the area code of the caller. The Satellite offices are each covering just under 20 hours per week in serving KanCare beneficiaries.

The Olathe office has one volunteer in training (not listed below) and two volunteer interviews in February. The Satellite offices **current coverage** is listed below. Information on the Satellite office hours and contact information can be found on the Ombudsman web pages on the About/Contact Us page.

	Volunteer Hours	# of Volunteers	# of hours covered/wk.	Area Codes covered
Olathe Satellite Office	T:9am-12pm W:9am-12pm Th: 9am-4pm	3	13.5	913, 785, 816
Wichita Satellite Office	M: 9am-4pm T: 9am-2pm W: 9pm-4:30pm Th: 9am-1pm	3	19.5	316, 620

V. Outreach by Ombudsman's office

The KanCare Ombudsman Office is responsible to help beneficiaries to understand the KanCare system and provide training and outreach to community organizations. The office does this through education, publications and training.

A. Outreach through Collaboration and Education

The KanCare Ombudsman Office provided 66 opportunities for educational outreach during 2018.

B. Outreach through Publications

The KanCare Ombudsman Office provided 55 publications for outreach and education in Kansas during 2018.

C. Outreach through Collaboration and Training

The KanCare Ombudsman Office collaborated and/or trained community partners 15 times during 2018 with 13 of those being Liaison Training. 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:

1. Basic KanCare programs including Home- and Community-Based Services;
2. How to assist with Medicaid applications; and
3. Medicaid-related resources.

For detail on the KanCare Ombudsman Office Outreach, see Appendix A.

VI. Data by Ombudsman's Office

In addition to the contact information in Section IV, the data for the KanCare Ombudsman Office includes data by: region, issues we received calls on, office location, contact method (phone, email, etc.), caller type, program type and action taken to respond to the calls.

A. Data by Region

1. Initial Contacts to KanCare Ombudsman Office by Region

The KanCare Ombudsman's office began pulling data by region in 3rd quarter 2018. See regional map on next page. Most calls are coming from the east side of the state which also ties to the regional location of Medicaid members within the state and population density of Kansas (see #3 on page 7).

Ombudsman Calls by Region	Q3,4 2018
Northeast	802
Southeast	601
Northwest	54
Southwest	75
Out of State	69
Not Identified	2,884
Total	**4,485**

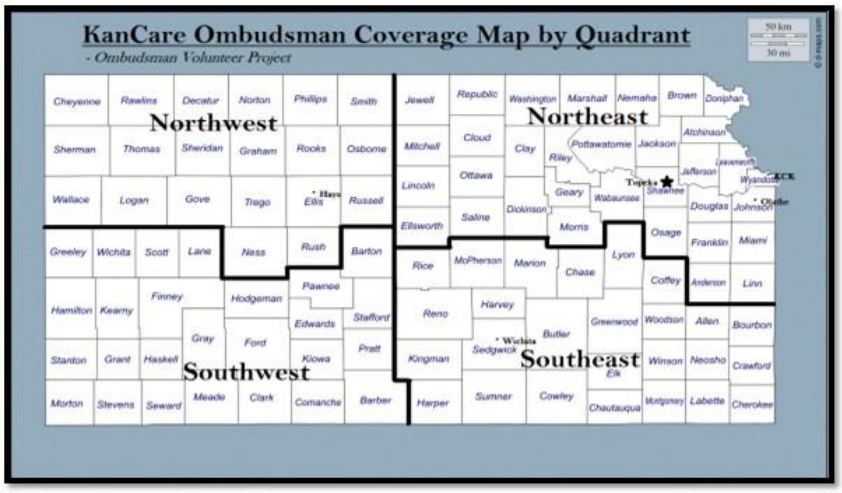
KanCare Members By Region	Total
Northeast	194,798
Southeast	175,370
Northwest	12,488
Southwest	38,023
Total	**420,679**

Data pulled by KDHE 11/20/18

The KanCare Ombudsman map shows the counties included in each region.

- Calls from toll-free Ombudsman line with area codes 785, 913 and 816 (northern regions) go to the Olathe Satellite office.
- Calls from the toll-free Ombudsman line with area codes 316 and 620 (southern regions) go to the Wichita Satellite office.
- All other calls from the toll-free KanCare Ombudsman line go the main (Topeka) office. Calls also come to Topeka to the staffs' direct phone numbers and emails as well as the KanCare Ombudsman general email.

2. KanCare Ombudsman Coverage Map by Region



3. Population Density by KanCare Ombudsman Region

Population Density	Urban	Semi Urban	Densely Settled Rural	Rural	Frontier	Total Counties
NE	5	5	6	15	2	33
SE	1	5	9	7	4	26
NW			1	4	15	20
SW			4	7	15	26
Total	**6**	**10**	**20**	**33**	**36**	**105**

Based on 2015 Census data –Kansas Population Density map using number of people per square mile (ppsm) (www.KCDCinfo.ks.gov):

Frontier - less than 6 ppsm
Rural - 6 to 19.9 ppsm
Densely-Settled Rural - 20 to 39.9 ppsm
Semi-Urban - 40-149.9 ppsm
Urban - 150+ ppsm

B. Data by Issue Category

The top issues for the past five years have centered on Medicaid Eligibility: Medicaid General Issues/questions, Medicaid Eligibility questions, Medicaid Application Assistance, Medicaid Information/Status Update. The second tier of issues are: Other, HCBS General issues, HCBS eligibility issues. The "Other" category has moved from well over 1,000 for two years to around 600 in 2018. During that time there has been a significant increase in the number of calls, so our office sees this as a big improvement. There may be multiple selections for a member/contact. Issue Category information by managed care organization (MCO) is found in Appendix C.

ISSUE CATEGORY	2014	2015	2016	2017	2018
Access to Providers (usually Medical)	54	28	35	51	24
Abuse / neglect complaints	0	0	0	2	29
Affordable Care Act Calls	0	0	0	19	44
Appeals/Fair Hearing questions/issues	0	0	0	44	126
Background Checks	0	0	0	2	5
Billing	169	149	147	90	118
Care Coordinator Issues	52	38	21	34	42
Change MCO	36	32	24	12	61
Choice Info on MCO	0	0	0	0	29
Client Obligation	0	0	0	123	139
Coding Issues	0	0	0	29	73
Consumer said Notice not received	0	0	0	1	50
Cultural Competency	0	0	0	0	5
Data Requests	0	0	0	8	9
Dental	45	16	19	29	32
Division of Assets	0	0	0	14	29
Durable Medical Equipment	95	53	20	18	27
Estate Recovery	0	0	0	21	32
Grievances Questions/Issues	137	153	147	107	98
Guardianship	21	9	5	11	19
HCBS Eligibility issues	86	81	109	216	145
HCBS General Issues	132	180	133	137	180
HCBS Reduction in hours of service	54	48	23	19	14
HCBS Waiting List	37	40	26	27	22
Health Homes	0	25	12	3	2
Help understanding mail	0	0	0	0	62
Housing Issues	33	14	15	17	26
Medicaid Application Assistance	0	0	0	441	638
Medicaid Eligibility Issues	438	648	1122	951	798

ISSUE CATEGORY	2014	2015	2016	2017	2018
Medicaid Fraud	0	0	0	0	12
Medicaid General Issues/questions	0	0	0	0	705
Medicaid info (status) update	0	0	0	4	810
Medicaid Renewal	0	0	0	171	224
Medical Services	158	94	72	60	74
Medicare related Issues	0	0	0	37	98
Medicare Savings Plan Issues	0	0	0	30	81
Moving to / from Kansas	0	0	0	27	70
Nursing Facility Issues	60	114	112	110	86
Pain management issues	0	0	0	0	1
Pharmacy	92	96	59	43	30
Prior authorization issues	0	0	0	0	7
Questions for Conference Calls/Sessions	35	8	3	0	2
Respite	0	0	0	0	2
Social Security Issues	0	0	0	5	58
Spend Down Issues	0	14	71	108	112
Transportation	52	45	21	34	47
Working Healthy	0	0	0	5	26
X-Other	336	585	**1342**	**1018**	**594**
Z Thank you.	28	50	389	1407	2045
Z Unspecified	164	89	110	216	298
(NOT IDENTIFIED)	30	30	63	0	0
ISSUE CATEGORY TOTAL	**2,314**	**2,609**	**4,037**	**5,701**	**8,261**

There may be multiple selections for a member/contact.

C. Data by Office Location

The increase for the Johnson County Satellite office from 2017 to 2018 is due to moving the toll-free number for the Ombudsman's office for numbers with 913, 785 and 816 area code to the Olathe office. Phone calls from these area codes are now directed to the Johnson County Satellite office (Olathe) rather than the Topeka Ombudsman's office.

Contacts by Office	2017	2018
Main	2,764	2,428
Johnson County	222	552
Wichita	684	1,505
Total	**3,670**	**4,485**

D. Data by Contact Method

The number of face-to-face contacts increased over past years. There were several listening sessions during third and fourth quarters of 2018 that the KanCare Ombudsman Office participated in which would account for the increase in face-to-face initial contacts (HCBS listening sessions, KanCare 2.0 listening sessions, Open Enrollment informational meetings, etc.)

Contact Method	2014	2015	2016	2017	2018
Email	463	392	783	517	545
Face-to-Face Meeting	7	7	14	30	58
Letter	13	5	6	2	8
ONLINE	1	0	0	0	0
Other	1	0	6	11	5
Telephone	1,596	1,703	2,413	3,110	3,868
CONTACT METHOD TOTAL	**2,081**	**2,107**	**3,222**	**3,670**	**4,484**

E. Data by Caller Type

The "Other type" category callers tend to be schools, lawyers, students and/or researchers looking for data, and state employees.

CALLER TYPE	2014	2015	2016	2017	2018
Consumer	1,573	1,546	2,372	2,927	3,884
MCO Employee	14	14	31	44	19
Other type	59	145	351	209	212
Provider	418	402	468	492	369
(NOT IDENTIFIED)	17	0	0	0	0
CALLER TYPE TOTAL	**2,064**	**2,107**	**3,222**	**3,672**	**4,484**

F. Data by Program Type

The top program types that we receive calls for are the three waivers (Physical Disability, Intellectual/Developmental Disability, and Frail Elderly) and nursing facility concerns. There may be multiple selections for a member/contact. Program Type information by managed care organization (MCO) is found in Appendix C.

PROGRAM TYPE	2014	2015	2016	2017	2018
PD	79	169	92	154	143
I/DD	83	118	108	200	124
FE	30	62	59	128	110
AUTISM	6	16	6	7	8
SED	10	19	8	18	26
TBI	35	35	26	27	32
TA	26	50	31	27	18
WH	0	0	0	4	20
MFP	10	8	16	3	1
PACE	2	3	0	2	0
MENTAL HEALTH	15	34	23	17	8
SUB USE DIS	1	2	0	0	0
NURSING FACILITY	36	102	121	251	155
PROGRAM TYPE TOTAL	**333**	**618**	**490**	**838**	**645**

VII. Action Taken

This section provides information on:

- The timing of response to beneficiaries by the KanCare Ombudsman Office
- The timing of response to the KanCare Ombudsman Office by organizations assisting the members and the KanCare Ombudsman Office.
- How the KanCare Ombudsman Office resolves contacts: using resources to resolve, resolving without resources, or not able to get a follow up contact and so no resolution.
- The number of beneficiaries that resources were provided to and the number of beneficiaries that had resources mailed or emailed to them.
- The number of beneficiaries that were referred to another organization for assistance.
- The number of beneficiaries that the KanCare Ombudsman Office contacted other organizations to resolve a case (this includes three-way or conference calls with KanCare staff/volunteers, the member or representative, and the organization that we need assistance from.)

A. Responding to Issues

1. Ombudsman Office response to members/applicants (*New Format*)

The Ombudsman Office goal is to respond to a contact within two business days. Even with significant increase in contacts, the KanCare Ombudsman Office has significantly improved the percent of caller contacted in 0-2 days over the last two years.

Quarter yr.	Nmbr. Contacts	Avg. Days To Respond	%Responded 0-2 Days	% Responded in 3-7 Days	% Response 8 or More Days
Q1/2017	827	1	77%	21%	2%
Q2/2017	835	1	80%	19%	1%
Q3/2017	970	2	65%	31%	4%
Q4/2017	1.040	2	69%	22%	9%
Q1/2018	1.213	1	82%	17%	1%
Q2/2018	1.059	1	90%	10%	1%
Q3/2018	1.088	1	87%	12%	1%
Q4/2018	1.124	1	86%	14%	0%

2. Organizational response to Ombudsman requests ***(NEW)***

The KanCare Ombudsman office sends requests for review and assistance to various state and contracting organizations. The following information provides data on the response/resolution response rate for issues that have been referred.

The organization contacted the most by the KanCare Ombudsman Office is the KanCare Clearinghouse. The contacts are done mainly two ways:

- Three way calling with the beneficiary, the staff or volunteer to the Clearinghouse to resolve a question or issue
- Sending an email to our contact at the KanCare Clearinghouse asking for them to review a beneficiary issue.

1.

Q4/2018

Nmbr Referrals	Avg. Days Referred	Referred to	% Responded 0-2 Days	% Responded 3-7 Days	% Responded 8-30 Days	% Responded 31 or More Days
151	3	Clearinghouse	74%	16%	7%	3%
5	2	DCF	80%	0%	20%	0%
2	0	KDADS-Behavior Health	100%	0%	0%	0%
15	3	KDADS-HCBS	73%	13%	13%	0%
-	-	KDADS-Health Occ. Cred.	0%	0%	0%	0%
10	5	KDHE-Eligibility	70%	10%	10%	10%
9	5	KDHE-Program Staff	67%	22%	0%	11%
8	1	KDHE-Provider Contact	88%	13%	0%	0%
3	0	KMAP	100%	0%	0%	0%
1	0	Aetna	100%	0%	0%	0%
9	13	Amerigroup	22%	22%	56%	0%
13	8	Sunflower	62%	23%	8%	8%
6	7	UnitedHealthcare	50%	17%	17%	17%

B. Resolving requests

1. Action Taken by KanCare Ombudsman Office to resolve requests

ACTION TAKEN-Resolution Type	2014	2015	2016	2017	2018
QUESTION/ISSUE RESOLVED (NO RESOURCES)	208	271	929	417	356
USED CONTACT OR RESOURCES/ISSUE RESOLVED	463	1,127	1,356	2,504	3,092
CLOSED (NO CONTACT)	78	239	841	367	483
Total	**749**	**1,637**	**3,126**	**3,288**	**3,931**

There may be multiple selections for a member/contact

2. Additional Help provided by KanCare Ombudsman Office

ACTION TAKEN Additional Help	2014	2015	2016	2017	2018
PROVIDED RESOURCES	44	566	816	1,340	2,321
MAILED/EMAIL RESOURCES	0	0	2	409	533
Total	**44**	**566**	**818**	**1,749**	**2,854**

There may be multiple selections for a member/contact.

3. Referred Beneficiary to an Organization for Assistance/Follow-up

This section has been expanded in 4th quarter to identify groups within the state organizations and the managed care organizations (MCOs) individually for better tracking purposes.

ACTION TAKEN (Old Categories)	2014	2015	2016	2017	Q1-3, 2018
KDHE CONTACT	201	390	553	348	164
DCF CONTACT	40	96	13	14	17
MCO CONTACT	178	269	171	99	71
CLEARINGHOUSE CONTACT	0	0	0	574	526
HCBS TEAM CONTACT	97	148	68	105	49
CSP MENTAL HEALTH CONTACT	2	3	2	3	3

There may be multiple selections for a member/contact.

Action Taken - Refer Caller to Organization (New Categories)	Q4/2018
Clearinghouse	326
KDADS-Behavior Health	2
KDADS-HCBS	18
KDADS-Health Occ. Cred.	1
KDHE	19
KMAP	10
DCF	10
Aetna	11
Amerigroup	19
Sunflower	23
UnitedHealthcare	20
State or Community Agency	142
Disability Rights and/or KLS	9
ACTION TAKEN REFER CALLER TO ORGANIZATION TOTAL	**610**

4. Staff request Assistance from Organization on behalf of beneficiary

This section has been expanded to identify organizations contacted by the KanCare Ombudsman staff for assistance in resolving an issue. There may be multiple selections for a member/contact.

ACTION TAKEN Staff Contact Organization (Old Categories)	2014	2015	2016	2017	Q1-3, 2018
MCO REFERRAL	0	0	0	115	98
CLEARINGHOUSE REFERRAL	0	0	2	415	671
HCBS TEAM REFERRAL	0	0	0	56	35
OTHER KDADS CONTACT/REFERRAL	57	162	152	224	171
STATE OR COMMUNITY AGENCY REFERRAL	45	227	223	279	299
DISABILITY RIGHTS AND/OR KLS REFERRAL	40	66	27	17	11

For information on timeliness of response to request, refer to page 12.

Action Taken Staff Contact Organization (New Categories)	Q4/2018
Clearinghouse	166
KDADS-Behavior Health	3
KDADS-HCBS	17
KDADS-Health Occ. Cred.	1
KDHE-Eligibility	11
KDHE-Program Staff	12
KDHE-Provider Contact	11
KMAP	4
DCF	6
Aetna	1
Amerigroup	11
Sunflower	14
UnitedHealthcare	6
ACTION TAKEN STAFF CONTACT ORGANIZATION TOTAL	**263**

5. Ombudsman Office Resolution of Issues

The average days to close/resolve an issue remained relatively the same from 3rd to 4th quarter. The improvement in 3rd quarter was due to clarification for staff and volunteers to close based on resolution date or if no response, on the date last contacted. Prior to this, cases were closed by many at the end of the quarter when I sent out the reminder to close cases; using the end of quarter date.

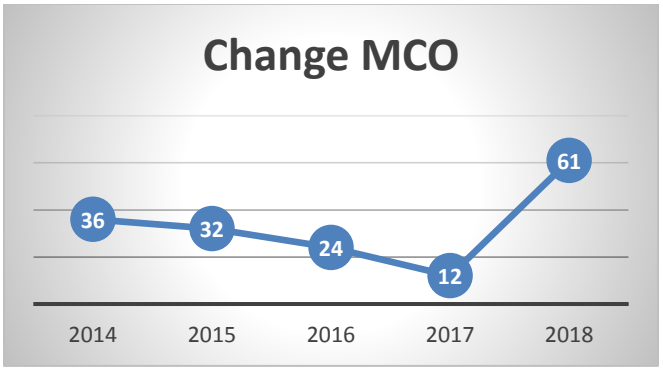
The percent of files closed by the end of the quarter has improved overall from 2017 to 2018; with fourth quarter 2018 at 97%. We have placed an increased emphasis on going back through cases for the quarter and see if they have been resolved and closing them out (for staff and volunteers). In 2017 and prior, the process of going back and reviewing cases to close them was done mostly by one person.

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	Q2/18	Q3/18	Q4/18
Avg. Days to close/resolve Issue	11	9	9	7	8	10	3	4
% files closed/resolved in 0-2 or less					60%	61%	73%	72%
% of files closed/resolved in 3-7 days					17%	13%	17%	18%
% of files closed/resolved in 7-30 days					12%	14%	8%	6%
% of files closed/resolved in greater than 30 days					11%	13%	2%	3%
% files closed	88%	92%	90%	83%	81%	93%	93%	97%

VIII. Trends in Data

A. Changing MCOs

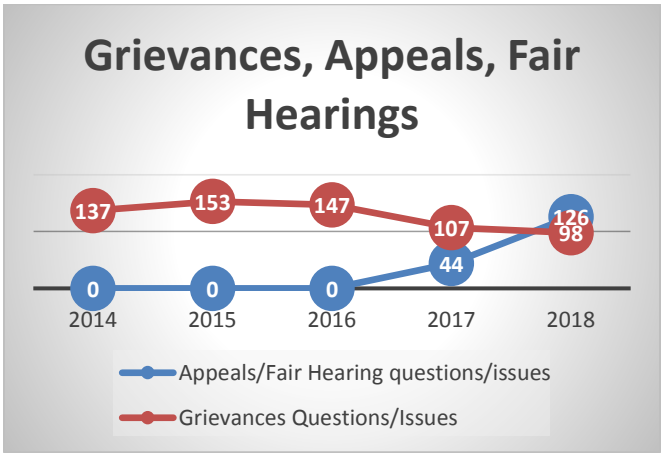
The issue, concern or questions about selecting or changing an MCO increased from 2017 to 2018 after being in a downward trend prior to that. This is probably due, in large part, to the open enrollment for KanCare during 4th quarter. The KanCare Ombudsman Office has a fact sheet that we may provide about changing MCO's in addition to talking with a member about their concerns. The Selecting – changing an MCO fact sheet is also found on the KanCare Ombudsman webpages.



B. Grievances, Appeals, Fair Hearings

This issue was all combined for over three years. Late in 2017, Grievances was pulled out as a separate issue and the data for all three was left in that category for prior years. If you combine the data for 2017 the number is similar to prior years. Combining the data for 2018 shows a significant increase and a higher number of calls regarding appeal and fair hearings during 2018. (151 in 2017 vs. 224 in 2018)

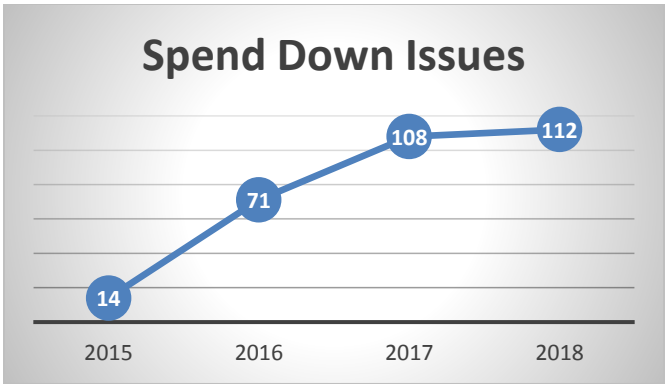
The KanCare Ombudsman Office has multiple documents available for members regarding grievances, appeals and fair hearings for eligibility, managed care organizations (MCO) and fee for service to mail, email or find on the web pages.



C. Spenddown Issues

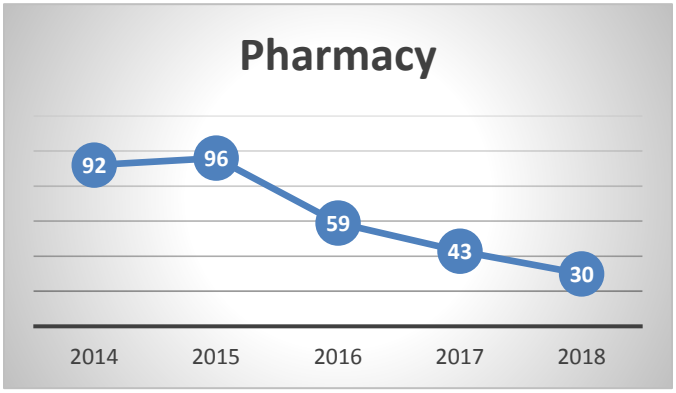
The Spenddown issue has continued to increase as a member concern since the KanCare Ombudsman Office started tracking it in late 2015.

The KanCare Ombudsman Office has a fact sheet that we may provide about the Medicaid spenddown in addition to talking with a member about their concerns. The Spenddown fact sheet also found on the KanCare Ombudsman webpages.



D. Pharmacy

Pharmacy issues continue to decrease since the 2014/2015 high.



IX. Changes from the past year (Enhancements)

A. Created KanCare Ombudsman Accessibility Guidelines

The KanCare Ombudsman Volunteer Coordinator created a 94-page accessibility guideline for use with Word and PowerPoint. The Contents is 4 pages long to enable the user to find the information they need easily. This is part 1 of 2 for completing our goal for cultural competency regarding readability and following the Americans with Disabilities Amendment Act.

This document was emailed to state agency partners and the managed care organizations to assist them with reaching their cultural competency goals.

B. Created and made accessible - General Information Fact Sheets

KanCare Ombudsman General Information Fact Sheets are information pages that provide an overview of Medicaid programs and Medicaid-related programs or topics. Many were created in 2018. If they were already available, they were complete revised to follow the Accessibility Guidelines (noted above.)

The list of General Information Fact Sheets available to members, providers and other interested parties is:

- ADA and Deaf-HH Fact Sheet (see example, Appendix B-page 26)
- Adult Disabled Child Fact Sheet
- Early Detection Works Fact Sheet
- MediKan Fact Sheet
- MSP Extra Help Fact Sheet
- Refugee Immigration Fact Sheet
- Selecting-Changing an MCO Fact Sheet
- SSI vs. SSDI Fact Sheet
- Physical Disability Waiver Fact Sheet
- Frail Elderly Waiver Fact Sheet
- Traumatic Brain Injury Fact Sheet
- Autism Fact Sheet

C. Website: updated the Grievance, Appeal and Fair Hearing section

Changed the format of the website page to reflect the organization the issue is with and then an explanation of what is available for that organization.

1. Eligibility (Clearinghouse)
    - Grievance
    - Fair Hearing
2. Managed Care Organizations
    - Grievance
    - Appeals
    - Fair Hearing
3. Fee for Service
    - Grievance
    - Fair Hearing

X. Appendix A – Outreach by Ombudsman's office

A. Outreach through Collaboration and Education

- Participated in Friends and Family Advisory Council meeting: (January 9, 2018)
- Staffed booth at the Wichita State Volunteer Fair on January 22, 2018 – approximately 450 attendees
- Indian Creek Library (Olathe, KS) (February 2, 2018)
- Participated in KanCare Long Term Care meeting: (February 8, 2018)
- Provided written testimony to Bob Bethell KanCare Oversight Committee: (February 16, 2018)
- Participated in KanCare Advisory Workgroup meeting (February 21, 2018)
- Keeler Women's Center (Kansas City, KS) (February 28, 2018)
- Staffed booth and networked with other organizations at the Wichita State Health Fair on February 28, 2018 – approximately 450 attendees
- Staffed booth at the Wichita State POWER Conference on March 2, 2018 – approximately 200 attendees
- Provided resources at the KCDHH Deaf and Hard of Hearing Day at the Capital (Topeka, KS) (March 6, 2018)
- Participated in KanCare Long-Term Care meeting: (March 8, 2018)
- Attended the Quarterly VISTA Training and shared about the Ombudsman on March 8, 2018 – approximately 20 attendees
- Attended the TA HCBS Wavier Listening Session (Olathe, KS) (March 13, 2018)
- Provided information at the KanCare Advisory Council Meeting: (March 27, 2018)
- Displayed resources at the Wichita State Health Professions Career Day March 28, 2018 – approximately 75 attendees
- Provided KanCare Ombudsman information at KDHE Eligibility Training (Topeka, KS) (March 29, 2018)
- Life Patterns, HCBS Provider Event (Topeka, KS) (March 31, 2018)
- Mid-Kansas Community Action Program: Sent brochures and outreach/recruitment flyers to administrative assistant. Put Ombudsman brochures and outreach/recruitment flyers in the mail on April 11, 2018.
- E.C. Tyree Clinic: Mailed brochures and outreach flyer to hang up in their office.
- Garden City Eligibility Worker: Mailed KanCare brochures, and outreach/recruitment flyers to KanCare Eligibility Worker, for her to hang in her office, and pass on to Genesis Family Health Center.
- Salina Eligibility Worker: Mailed outreach/recruitment flyers to KanCare Eligibility worker, for her to hang in her office, and pass on to Salina Family Healthcare Center.

- Wichita Eligibility Worker: Mailed KanCare brochures, and outreach/recruitment flyers to KanCare Eligibility Worker Sandra, for her to hang in her office.
- Kansas City Eligibility Worker: Mailed KanCare brochures, and outreach/recruitment flyers for KanCare Eligibility Worker, for her to hang in her office, and pass on to Vibrant Health Wyandotte.
- Tabled at the Governors Public Health Conference on April 4, 2018 to help with outreach efforts to providers and other organizations that assist Medicaid consumers.
    - Approximately 300 attendees.
- Tabled in the Community Resource area of the Via Christi Medical Mission at Home: Day of Free Healthcare on April 14, 2018, to recruit possible volunteers and perform outreach to consumers.
    - Approximately 235 consumers and 900 volunteers attended the event.
- Presented first quarter report and written testimony at the Robert Bethel Home and Community Based Services/HCBS and KanCare Oversight Committee; April 23, 2018.
- Kickapoo Nation 18th Annual Health Fair, Horton, April 17, 2018
- Legacy Christian Church Annual Global Vision Night; Overland Park, KS; April 29, 2018
- 2018 Employment First Summit; Topeka, KS; May 30 & 31, 2018
- Presented first quarter report to the KanCare Advisory Council; May 30, 2018.
- Presentation to Resource Center for Independent Living (RCIL) regarding Ombudsman's office, June 14, 2018.
- Positive Aging Day; Wichita, KS; June 26, 2018
- Shared information with Long Term Care Committee on KanCare Ombudsman's office through first quarter report and updates, April 12, 2018, May-written only due to on-line meeting, June 14, 2018.
- Performed outreach to approximately 100 providers and consumers regarding the Ombudsman's Office and our services at the KDHE Wichita Open Enrollment Forum on October 1, 2018
- Open Enrollment Education Meetings for Members and Providers; Topeka, KS; October 1, 2018
- Performed outreach to approximately 30 providers and consumers regarding the Ombudsman's Office and our services at the KDHE Dodge City Open Enrollment Forum on October 2, 2018.
- Attended and provided assistance as needed at Olathe MCO Open Enrollment, October 2,2018
- Performed outreach to approximately 30 providers and consumers regarding the Ombudsman's Office and our services at the KDHE Pittsburg Open Enrollment Forum on October 3, 2018.

- Tabled at the Kansas Public Health Association Conference on October 2, 2018 to 231 attendees regarding the Ombudsman Office's services and our liaison training opportunities.
- Vending table at the Olathe MCO provider training; October 4, 2018
- Presented at the Andover Senior Center on October 5, 2018 to approximately 30 seniors regarding our volunteer opportunities and services.
- Presented at the Andover Senior Center on October 5, 2018 to approximately 30 seniors regarding our volunteer opportunities and services.
- Presented at the Derby Senior Center on October 11, 2018 to approximately 10 seniors regarding our volunteer opportunities and services.
- Spoke to Shaunna Millar's Social Welfare Policy Class at Wichita State on October 11, 2018 about the Ombudsman Office's internship opportunities to approximately 35 students.
- Presented at the Derby Senior Center on October 11, 2018 to approximately 10 seniors regarding our volunteer opportunities and services.
- Spoke to Sonja Armbruster's US Healthcare Administration class at Wichita State on October 11, 2018 about the Ombudsman Office's internship opportunities to approximately 50 students.
- Shared information regarding our upcoming liaison training in Wichita to approximately 20 attendees at the United Way Emergency Assistance Network Meeting on October 16, 2018.
- Attended the Sedgwick County CDDO Community Council Meeting on October 19, 2018 and shared information about the Ombudsman Office to the approximately 40 attendees.
- Tabled at the Healthier Lyon County Health Fest to approximately 200 attendees regarding the Ombudsman Office on October 20, 2018.
- Attended a question and answer session with the United Methodist Open Door staff regarding KanCare, and how the Ombudsman Office can assist them and their clients on October 22, 2018.
- Spoke to Hana Shahin's Introduction to Community Psychology Class at Wichita State on October 23, 2018 about the Ombudsman Office's internship opportunities to approximately 25 students.
- Vending table at the 2018 NAMI Conference; Topeka, KS; October 12-13, 2018.
- Overview of Protected Income Limit and Client Obligation for Big Tent Coalition, Topeka, October 11, 2018
- Presentation on KanCare; Norton, KS Senior Center; Norton, KS; October 19, 2018
- Vending table at the Live Well/Age Well; Overland Park, KS; October 29, 2018
- Provided monthly reports to the KanCare Long Term Care Workgroup meeting; Oct. 11, Nov. 8, Dec 13, 2018

- Provided written report to Bob Bethell HCBS KanCare Oversight Joint Committee, Nov. 8-9, 2018
- Participated in Kansas Meaningful Measures Committee meeting; Nov. 16, 2018
- Vending table at Hearing Loss Summit; Overland Park, KS; November 17, 2018
- Overview of KanCare Ombudsman's office with KanCare Inspector General, Sara Fertig; Topeka; November 28, 2018
- Vending table at the Heartland Conference; Kansas City, KS; December 6 and 7, 2018
- Presented at the Butler County Aging Network Meeting about the Ombudsman Office and our services; El Dorado; Dec. 6, 2018
- Overview of KanCare Ombudsman's office for Aetna Member Advocate team; Dec. 12, 2018
- Presented at the Disability Advocates 4 Action (organization) about the Ombudsman Office and our services; Wichita; Dec. 12, 2018
- Provided written report for KanCare Advisory Council meeting and open forum; Dec. 14, 2018
- Project Eagle Presentation on KanCare for those with non-US Citizen, status; Kansas City, KS; December 14, 2018

B. Outreach through Publications

- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (Jan, Feb, March 2018)
- Library Main Administration to be distributed to all Wichita libraries; January 18, January 23, and January 30, 2018
- New Spring Church; January 23, 2018
  River Community Church; January 23, 2018
- Tabernacle Bible Church; January23, 2018
- Reflection Ridge Retirement Community; January11, 2018
- Holiday Retirement; January 30, 2018
- Presbyterian Manors; January 30, 2018
- Future Healthcare Professionals at WSU; February 28,2018
- Summit Church; February 27, 2018
- Midway Baptist Church; February 27, 2018
- Calvary Baptist Church; February 27, 2018
- Healthcare Sciences Program at NU; March 7, 2018
- HEALTH Organization at WSU; March 13, 2018
- Oxford Grand Retirement Community; March 15, 2018
- Submitted ombudsman outreach advertisement to the Community Health Worker newsletter; March 21, 2018
- Shepherd's Voice; Kansas City, KS; March 2018
- Livable Neighborhoods Task Force; Kansas City, KS; March 2018

- Olathe Public Library (Johnson Co.) (April, May, June 2018)
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (April, May, June 2018)
- Labette Center for Mental Health Service: Emailed newsletter info and photo to be posted on Facebook and in their community newsletter. April 2018
- South Central Mental Health Counseling Center: Emailed outreach advertisements on April 9, 2018. They are posting our website link on their online resources page and forwarding the information to each office to post on their news boards.
- Nazarene Nursing Program – e-newsletter (Counties: Johnson, Douglas and Wyandotte) (June 2018)
- Johnson County Community College – flyer posted (Counties: Johnson) (June 2018)
- Johnson County Library – Shawnee – flyer posted (Johnson County) (June 2018)
- Johnson County Library – Corinth – e newsletter -(located in Prairie Village) (Johnson County) (June 2018)
- Olathe Family YMCA – flyer
- First Christian Church of Olathe – e-newsletter; Counties: Johnson (August 2018)
- Second Baptist Church of Olathe – Flyer posted; Counties: Johnson (August 2018)
- Statewide Community Health Workers monthly newsletter, September
- Shepherd's Voice; Kansas City, KS (July, August 2018)
- Livable Neighborhoods Task Force; Kansas City, KS (July, August 2018)
- Golden Years Newspaper; Counties: Franklin, Osage, Anderson, Linn, Coffey (July, Aug, Sept 2018)
- Olathe Public Library; Olathe, KS (July, August, September 2018)
- Christ Church Anglican – e-newsletter (Counties: Johnson) (October 2018)
- Shepherd's Voice (Kansas City, KS) (October 2018)
- Livable Neighborhoods Task Force (Kansas City, KS) (October and November 2018)
- Hung 51 recruitment fliers advertising the Ombudsman Office's internship opportunities in and around Wichita State's campus and buildings on October 15-10, 2018.
- Hung a recruitment flier in the common area of the Wichita Public Library Westlink Branch on October 20, 2018
- Aquatics Center of Leawood – Flyer posted (Counties: Johnson) (November 2018)
- Olathe Community Center – Flyer posted (Counties: Johnson) (December 2018)

- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (Oct., Nov., Dec. 2018)
- Olathe Public Library (Olathe, KS) (Oct., Nov., Dec. 2018)
- Sent recruitment and outreach information to Butler County Department on Aging to be included in their quarterly newsletter (Nov 2018)
- Delivered a volunteer flier to be hung in the common area of Oxford Villa Active Senior Apartments on November 28, 2018 and put in their resident newsletter.
- Delivered a volunteer flier to be hung in the common area of Reflection Ridge Retirement Community on November 28, 2018 and put in their resident newsletter.
- Delivered a volunteer flier to be hung in the common area of Grassland Estates on November 28, 2018 and put in their resident newsletter.
- Delivered a volunteer flier to be hung in the common area of Park West Plaza Retirement Community on November 28, 2018 and put in their resident newsletter.
- Left an invitation for staff at Country Acres Senior Residences to the Sedgwick County Liaison Training on November 28, 2018. Also delivered a volunteer flier to be hung in the common area and put in their resident newsletter.
- Left an invitation for staff at Via Christi Village to the Sedgwick County Liaison Training on November 28, 2018. Also delivered a volunteer flier to be hung in the common area and put in their resident newsletter.
- Left an invitation for staff at Finch Hollow Senior Residences to the Sedgwick County Liaison Training on November 28, 2018. Also delivered a volunteer flier to be hung in the common area and put in their resident newsletter.
- Left an invitation for staff at Woodlake Senior Residences to the Sedgwick County Liaison Training on November 28, 2018. Also delivered a volunteer flier to be hung in the common area and put in their resident newsletter.

C. Outreach through Collaboration and Training

- Kansas Commission on the Deaf and Hard of Hearing (Topeka, KS) – working to bring ASL volunteers to our volunteer offices (February 2018)
- Refugee and Immigration Department of Catholic Charities (Wyandotte, Co.) – working to increase ability to direct and assist refugees and immigrants in accessing medical assistance programs in Kansas

Liaison Trainings with Community Partners

- Liaison Training, Community Empowerment Institute, Wichita, June 1, 2018
- Liaison Training, Labette County, Southeast Kansas Independent Living (SKIL), June 12, 2018
- Liaison Training, Lawrence, KS, June 15, 2018
- Conducted liaison training in Geary Co.; Junction City, KS (July 9, 2018)

- Conducted liaison training in *Ford County* at the Southwest Kansas Area Agency on Aging, July 10, 2018
- Conducted liaison training in *Rice County*, sponsored by the Rice County Council on Aging, August 12, 2018
- Conducted liaison training in Sedgwick County at the Wichita downtown Senior Center, August 24, 2018.
- Conducted liaison trainings in Cowley County, Arkansas City Senior Center. on September 12, 2018
- Conducted liaison trainings in *Finney County* at the Finney County Health Department, September 24, 2018.
- Smith Co. (Smith Center, KS) (October 18, 2018)
- Wyandotte Co. (Kansas City, KS) (November 7, 2018)
- Johnson Co. (Olathe, KS) (December 11, 2018)
- Sedgwick County at the Community Engagement Institute on December 3, 2018.

KanCare General Information Fact Sheet

Americans with Disability Amendment Act Fact Sheet
Accommodations and Auxiliary Services for Deaf and Hard of Hearing

XI. Appendix B

A. General Information

Passed by Congress in 1990, the Americans with Disabilities Act (ADA) is the nation's first comprehensive civil rights law addressing the needs of people with disabilities, prohibiting discrimination in employment, public services, public accommodations, and telecommunications.[1] The ADA Amendments Act of 2008 (ADAAA) was enacted on September 25, 2008, and became effective on January 1, 2009. The law made several significant changes to the definition of "disability" under the Americans with Disabilities Act (ADA). It also directed the U.S. Equal Employment Opportunity Commission (EEOC) to amend its ADA regulations to reflect the changes made by the ADAAA.[2]

B. The Justice Department's ADA Rulemaking History

The Department originally published its ADA title II (state and local government) and title III (businesses, medical offices, entertainment, etc.) regulations on July 26, 1991, including the 1991 ADA Accessibility Guidelines (1991 Standards). The original law required Title II entities to provide auxiliary aides and services for people with disabilities.

On September 15, 2010 the Department published final regulations revising the Department's ADA regulations, including the adoption of updated ADA Standards for Accessible Design (2010 Standards). The revised final rules went into effect on March 15, 2011. Compliance with the 2010 Standards was required on March 15, 2012, except that compliance with the requirements in the 2010 Standards with respect to existing swimming pools was subsequently extended to January 31, 2013. (77 FR 30174 (May 21, 2012)).

On July 15, 2016, Attorney General Loretta Lynch signed a final rule revising the ADA title II and III regulations to implement the requirements of the ADA Amendments Act of 2008. The final rule was published in the Federal Register on August 11, 2016, and took effect 60 days after publication, on October 11, 2016. Congress enacted the ADA Amendments Act to

clarify the meaning and interpretation of the ADA definition of "disability" to ensure that the definition of disability would be broadly construed and applied without extensive analysis.

The title III regulation was again revised on November 21, 2016, when Attorney General Loretta Lynch signed a final rule that further clarified a public accommodation's obligation to provide appropriate auxiliary aids and services for people with disabilities. The final rule provides that public accommodations that own, operate, or lease movie theaters are required to provide closed movie captioning and audio description whenever showing a digital movie that is produced, distributed, or otherwise made available with these features. The final rule was published in the Federal Register on December 2, 2016, and took effect 45 days after publication, on January 17, 2017. [3]

C. Technical Assistance

The Department of Justice operates a toll-free ADA Information Line to provide information and materials to the public about the requirements of the ADA. ADA Specialists, who assist callers in understanding how the ADA applies to their situation, are available on Monday, Tuesday, Wednesday, and Friday from 9:30 a.m. until 5:30 p.m. (Eastern Time) and on Thursday from 12:30 p.m. until 5:30 p.m. (Eastern Time). Calls are confidential. To get answers to technical questions, obtain general ADA information, order free ADA materials, or ask about filing a complaint, please call: 800-514-0301 (voice); 800-514-0383 (TTY).[4]

D. Kansas Commission for the Deaf and Hard of Hearing (KCDHH)

KCDHH maintains a listing of persons qualified in various types of interpreting, as supported by K.S.A. 75-5393(b) (11), which KCDHH through its Executive Director provides for a program of regulation and certification of interpreters for the deaf, hard of hearing and speech-impaired individuals. The KCDHH administers the statewide registration of all interpreters in place of a certification system, of which either system is made available by K.S.A. 75-4355b, et seq.[5] KCDHH staff can answer questions about where to find other kinds of accommodations if someone asks for a service other than interpreters, like CART, audio loop. They may also be able to suggest providers in the area. Contact 785-368-8034 or VP 785-246-5077.

E. Better Understanding of Accessibility

While accessibility is often used to describe facilities or amenities to assist people with disabilities, as in "wheelchair accessible", the term can extend to Braille signage, website design, sign language interpreters, and so on.[6]

The ADA requires that title II entities (state and local governments) and title III entities (businesses and nonprofit organizations that serve the public) communicate effectively with people who have communication disabilities. The goal is to ensure that communication with people with these disabilities is equally effective as communication with people without disabilities.

- The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication.

- The goal is to ensure that communication with people with disabilities is as effective as communication with people without disabilities.[7]

- The rules apply to communicating with the person who is receiving the covered entity's goods or services as well as with that person's parent, spouse, or companion in appropriate circumstances. [8]

- Since people communicate differently, it is the responsibility of the individual who is Deaf/HH to let businesses/agencies know the specific accommodation they are requesting. Requests for accommodation should give a business/agency a reasonable amount of time to provide the accommodation. Requests for accommodations made in writing are easier to track.[9]

F. Auxiliary Aids and Services

The ADA uses the term "auxiliary aids and services" ("aids and services") to refer to the ways to communicate with people who have communication disabilities.

- For people who are deaf, have hearing loss, or are deaf-blind, this includes providing a qualified notetaker; a qualified sign language interpreter, oral interpreter, cued-speech interpreter, or tactile interpreter; real-time captioning; written materials; or a printed script of a stock speech (such as given on a museum or historic house tour). A "qualified" interpreter means someone who can interpret effectively, accurately, and impartially, both receptively (i.e., understanding what the person with the disability is saying) and expressively (i.e., having the skill needed to convey information back to that person) using any necessary specialized vocabulary.
- For people who have speech disabilities, this may include providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly), especially if the person will be speaking at length, such as giving testimony in court, or communicating with someone who uses a communication board. In some situations, keeping paper and pencil on hand so the person can write out words that staff cannot understand may provide effective communication. Staff should always listen attentively and not be afraid or embarrassed to ask the person to repeat a word or phrase they do not understand.

In addition, aids and services include a wide variety of technologies including:

- assistive listening systems and devices
- open captioning, closed captioning, real-time captioning, and closed caption decoders and devices
- telephone handset amplifiers, hearing-aid compatible telephones, text telephones (TTYs), videophones, captioned telephones, and other voice, text, and video-based telecommunications products
- Real time captioning (also known as computer-assisted real-time transcription, or CART)
- Video relay service (VRS)
- Video remote interpreting (VRI)[10]

G. For More Information:

- Kansas Commission for Deaf and Hard of Hearing (KCDHH) - For additional information and/or to make a request for appropriate forms, documents or interpreter assistance, please contact KCDHH at 785-368-8034 or VP 785-246-5077 or website at: http://www.dcf.ks.gov/services/RS/Pages/KCDHH.aspx

- Effective Communication; ADA requirements from the U.S. Department of Justice/Civil Rights Division: https://www.ada.gov/effective-comm.htm (Very informative)

- Fact Sheet from the Office for Civil Rights: Your Rights under the ADA https://www.hhs.gov/sites/default/files/ocr/civilrights/resources/factsheets/ada.pdf

- Deaf Rights: What you need to know: https://www.huffingtonpost.com/lydia-l-callis/deaf-rights-what-you-need-to-know_b_5688351.html

Note: This guide is informational only and is not intended to be legal advice. Also, the laws addressed in this guide change frequently based on different courts' interpretations of them.

H. References

1. The ADA of 1990; U.S. Equal Employment Opportunity Commission; https://www.eeoc.gov/eeoc/history/35th/1990s/ada.html

2. Fact Sheet on the EEOC's Final Regulations Implementing the ADAAA; U.S. Equal Employment Opportunity Commission; https://www.eeoc.gov/laws/regulations/adaaa_fact_sheet.cfm

3. The Americans with Disabilities Act of 1990 and Revised ADA Regulations Implementing Title II and Title III; United States Department of Justice Civil Rights Division; https://www.ada.gov/2010_regs.htm

4. ADA Information Line; United States Department of Justice Civil Rights Division; https://www.ada.gov/infoline.htm

5. Overview of KCDHH Interpreter Registration; Kansas Department for Children and Families; http://www.dcf.ks.gov/services/RS/Pages/KCDHH/KQAS.aspx

6. Askdefine/extensive definition of accessible*;* https://accessible.askdefine.com/

7. Effective Communication; *U.S. Department of Justice, Civil Rights Division, Disability Rights Section;* https://www.ada.gov/effective-comm.htm

8. Effective Communication, Overview; *U.S. Department of Justice, Civil Rights Division, Disability Rights Section;* https://www.ada.gov/effective-comm.htm

9. Americans with Disabilities Act – Effective Communication for the Deaf and People who are Hard of Hearing; p.2; Disability Law Center, Utah's Protection and Advocacy Center; http://www.ccano.org/wp-content/uploads/2015/01/ADA-Effective-Communication-for-Deaf-and-Hard-of-Hearing.pdf

10. Effective Communication, Auxiliary Aids and Services; *U.S. Department of Justice, Civil Rights Division, Disability Rights Section;* https://www.ada.gov/effective-comm.htm

XII. Appendix C – Data by MCO

A. Amerigroup

ISSUE CATEGORY	2014	2015	2016	2017	2018
Access to Providers (usually Medical)	20	6	6	14	4
Abuse / neglect complaints	0	0	0	0	4
Affordable Care Act Calls	0	0	0	0	1
Appeals/Fair Hearing questions/issues	0	0	0	5	10
Background Checks	0	0	0	1	1
Billing	35	31	26	11	24
Care Coordinator Issues	10	11	9	8	15
Change MCO	6	8	2	2	29
Choice Info on MCO	0	0	0	0	14
Client Obligation	0	0	0	15	26
Coding Issues	0	0	0	5	12
Consumer said Notice not received	0	0	0	1	8
Cultural Competency	0	0	0	0	1
Data Requests	0	0	0	0	1
Dental	16	2	2	1	3
Division of Assets	0	0	0	0	0
Durable Medical Equipment	37	6	6	2	12
Estate Recovery	0	0	0	2	2
Grievances Questions/Issues	13	23	15	18	15
Guardianship	0	1	0	1	0
HCBS Eligibility issues	11	15	17	30	16
HCBS General Issues	25	42	22	32	29
HCBS Reduction in hours of service	9	8	9	4	9
HCBS Waiting List	6	8	1	4	1
Health Homes	0	2	1	2	0
Help understanding mail	0	0	0	0	6
Housing Issues	4	2	3	2	4
Medicaid Application Assistance	0	0	0	1	10
Medicaid Coding	0	0	0	0	0
Medicaid Eligibility Issues	32	33	51	41	44
Medicaid Fraud	0	0	0	0	1
Medicaid General Issues/questions	0	0	0	0	43
Medicaid info (status) update	0	0	0	0	32
Medicaid Renewal	0	0	0	22	23
Medical Services	26	11	13	13	12
Medicare related Issues	0	0	0	5	7
Medicare Savings Plan Issues	0	0	0	1	2
Moving to / from Kansas	0	0	0	2	0
Nursing Facility Issues	7	10	4	5	6
Pain management issues	0	0	0	0	0
Pharmacy	16	10	7	6	4
Prior authorization issues	0	0	0	0	1
Questions for Conference Calls/Sessions	0	0	0	0	0
Respite	0	0	0	0	0
Social Security Issues	0	0	0	0	4

ISSUE CATEGORY	2014	2015	2016	2017	2018
Spend Down Issues	0	1	8	13	11
Transportation	18	13	4	5	11
Working Healthy	0	0	0	0	2
X-Other	34	53	65	50	41
Z Thank you.	2	3	24	93	179
Z Unspecified	6	4	4	3	7
(NOT IDENTIFIED)	3	7	7	0	0
ISSUE CATEGORY TOTAL	**333**	**303**	**299**	**420**	**687**

PROGRAM TYPE	2014	2015	2016	2017	2018
PD	19	49	16	36	24
I/DD	12	23	24	25	20
FE	5	13	9	19	25
AUTISM	1	3	1	2	1
SED	4	3	3	7	8
TBI	11	11	10	8	10
TA	6	7	8	9	3
WH	0	0	0	1	2
MFP	1	2	0	0	0
PACE	0	0	0	0	0
MENTAL HEALTH	4	6	5	4	1
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	5	7	3	7	10
PROGRAM TYPE TOTAL	**68**	**124**	**79**	**118**	**104**

B. Sunflower

ISSUE CATEGORY	2014	2015	2016	2017	2018
Access to Providers (usually Medical)	12	5	4	12	13
Abuse / neglect complaints	0	0	0	0	3
Affordable Care Act Calls	0	0	0	1	1
Appeals/Fair Hearing questions/issues	0	0	0	2	9
Background Checks	0	0	0	0	1
Billing	46	40	30	23	22
Care Coordinator Issues	32	11	6	10	6
Change MCO	19	11	5	3	9
Choice Info on MCO	0	0	0	0	1
Client Obligation	0	0	0	17	13
Coding Issues	0	0	0	6	15
Consumer said Notice not received	0	0	0	0	10
Cultural Competency	0	0	0	0	0
Data Requests	0	0	0	0	0
Dental	11	4	3	3	8
Division of Assets	0	0	0	0	1
Durable Medical Equipment	35	23	9	5	4
Estate Recovery	0	0	0	1	0
Grievances Questions/Issues	76	66	35	17	16
Guardianship	3	1	0	1	3
HCBS Eligibility issues	22	16	15	29	24
HCBS General Issues	34	44	30	23	32
HCBS Reduction in hours of service	19	19	4	3	2
HCBS Waiting List	5	3	1	3	1
Health Homes	0	5	2	0	0
Help understanding mail	0	0	0	0	6
Housing Issues	8	2	0	3	3
Medicaid Application Assistance	0	0	0	6	5
Medicaid Coding	0	0	0	0	0
Medicaid Eligibility Issues	30	60	52	49	42
Medicaid Fraud	0	0	0	0	2
Medicaid General Issues	0	0	0	0	46
Medicaid info (status) update	0	0	0	0	26
Medicaid Renewal	0	0	0	25	17
Medical Services	53	26	15	14	11
Medicare related Issues	0	0	0	2	8
Medicare Savings Plan Issues	0	0	0	1	7
Moving to / from Kansas	0	0	0	1	1
Nursing Facility Issues	3	9	10	4	4
Pain management issues	0	0	0	0	0
Pharmacy	38	31	13	8	7
Prior authorization issues	0	0	0	0	3
Questions for Conference Calls/Sessions	2	1	0	0	0
Respite	0	0	0	0	0
Social Security Issues	0	0	0	1	2
Spend Down Issues	0	4	8	13	7
Transportation	11	12	8	9	6

ISSUE CATEGORY	2014	2015	2016	2017	2018
Working Healthy	0	0	0	0	3
X-Other	38	55	75	63	40
Z Thank you.	6	14	32	109	165
Z Unspecified	19	5	1	4	7
(NOT IDENTIFIED)	6	0	1	0	0
ISSUE CATEGORY TOTAL	**522**	**467**	**358**	**471**	**612**

PROGRAM TYPE	2014	2015	2016	2017	2018
PD	27	42	27	31	31
I/DD	33	27	22	34	15
FE	11	20	9	18	9
AUTISM	4	8	1	2	1
SED	3	5	2	1	2
TBI	11	7	6	4	7
TA	10	17	9	5	2
WH	0	0	0	1	3
MFP	3	3	4	1	1
PACE	0	1	0	0	0
MENTAL HEALTH	3	8	6	2	0
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	4	10	15	16	8
28PROGRAM TYPE TOTAL	109	148	101	115	79

C. UnitedHealthcare

ISSUE CATEGORY	2014	2015	2016	2017	2018
Access to Providers (usually Medical)	10	8	5	8	0
Abuse / neglect complaints	0	0	0	1	3
Affordable Care Act Calls	0	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	0	5	13
Background Checks	0	0	0	0	0
Billing	29	20	13	13	20
Care Coordinator Issues	6	11	3	9	15
Change MCO	7	7	7	6	6
Choice Info on MCO	0	0	0	0	2
Client Obligation	0	0	0	12	23
Coding Issues	0	0	0	3	6
Consumer said Notice not received	0	0	0	0	3
Cultural Competency	0	0	0	0	0
Data Requests	0	0	0	0	1
Dental	5	4	6	6	3
Division of Assets	0	0	0	1	1
Durable Medical Equipment	12	9	1	5	1
Estate Recovery	0	0	0	1	0
Grievances Questions/Issues	20	24	16	10	10
Guardianship	3	1	1	1	1
HCBS Eligibility issues	7	12	12	25	17
HCBS General Issues	27	28	21	16	34
HCBS Reduction in hours of service	11	9	4	4	1
HCBS Waiting List	4	6	4	0	3
Health Homes	0	5	1	0	0
Help understanding mail	0	0	0	0	12
Housing Issues	6	4	0	1	1
Medicaid Application Assistance	0	0	0	4	15
Medicaid Coding	0	0	0	0	0
Medicaid Eligibility Issues	23	33	32	42	44
Medicaid Fraud	0	0	0	0	1
Medicaid General Issues/questions	0	0	0	0	39
Medicaid info (status) update	0	0	0	0	19
Medicaid Renewal	0	0	0	14	19
Medical Services	21	17	9	8	18
Medicare related Issues	0	0	0	3	2
Medicare Savings Plan Issues	0	0	0	1	7
Moving to / from Kansas	0	0	0	0	2
Nursing Facility Issues	2	13	7	7	9
Pain management issues	0	0	0	0	1
Pharmacy	13	18	14	4	8
Prior authorization issues	0	0	0	0	1
Questions for Conference Calls/Sessions	0	1	0	0	0
Respite	0	0	0	0	1
Social Security Issues	0	0	0	0	2
Spend Down Issues	0	2	3	9	20
Transportation	7	11	1	7	10

ISSUE CATEGORY	2014	2015	2016	2017	2018
Working Healthy	0	0	0	0	2
X-Other	20	48	67	57	25
Z Thank you.	1	3	31	96	175
Z Unspecified	4	1	2	10	3
(NOT IDENTIFIED)	2	1	4	0	0
ISSUE CATEGORY TOTAL	**238**	**295**	**260**	**389**	**599**

PROGRAM TYPE	2014	2015	2016	2017	2018
PD	14	37	13	20	24
I/DD	10	17	14	22	13
FE	9	10	14	21	13
AUTISM	0	1	1	1	0
SED	2	4	1	1	6
TBI	7	6	3	5	5
TA	3	6	2	3	3
WH	0	0	0	0	4
MFP	3	3	6	0	0
PACE	0	0	0	0	0
MENTAL HEALTH	3	6	2	3	2
SUB USE DIS	1	0	0	0	0
NURSING FACILITY	2	5	7	16	12
PROGRAM TYPE TOTAL	**54**	**95**	**63**	**92**	**82**

KanCare Pay for Performance Measures – Summary of 2017 Performance Outcomes

Amerigroup

Amerigroup									
Measure	**2013 rate**	**2014 rate**	**met/not met**	**2015 rate**	**met/not met**	**2016 rate**	**met/not met**	**2017 rate**	**met/not met**
CDC - HbA1c Control (< 8.0%)	37.63%	43.97%	yes	49.28%	yes	52.15%	yes	54.89%	yes
Annual Dental Visit				60.15%	n/a	62.12%	yes	64.02%	yes
Timeliness of Prenatal Care				65.35%	n/a	67.13%	yes	72.26%	yes
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	11.91%	12.27%	no	11.51%	yes			13.85%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q1				99.88%	yes	77.23%	no	94.74%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q2				96.75%	yes	97.71%	yes	35.84%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q3				74.19%	no	99.35%	yes	76.62%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q4				76.90%	no	95.93%	yes	68.85%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q1				94.44%	no	85.21%	no	84.44%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q2				57.73%	no	97.43%	yes	91.54%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q3				65.92%	no	101.79%	yes	87.40%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q4				65.48%	no	76.61%	no	81.48%	no
NEW MEASURES - 2017						**Baseline**			
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)						4.67%	n/a	4.78%	no
Cervical Cancer Screening (CCS)						51.64%	n/a	54.50%	no
Childhood Immunization Status (CIS) - Combination 10						23.20%	n/a	26.03%	no
Immunizations for Adolescents (IMA) - Combination 2						14.12%	n/a	29.20%	yes
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						68.29%	n/a	72.51%	yes/50%
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication								15.62%	yes
Residents of a NF or NFMH discharged to a community setting								60.42%	yes
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date								85.04%	yes
				2015 Portion Met	54.0%	*2016 Portion Met*	54.6%	*2017 Portion Met*	53.6%
				2015 Portion Unmet	46.0%	*2016 Portion Unmet*	45.4%	*2017 Portion Unmet*	46.4%
					100.0%		100.0%		100.0%

KanCare Pay for Performance Measures – Summary of 2017 Performance Outcomes

Sunflower

Sunflower									
Measure	**2013 Rate**	**2014 Rate**	**met/not met**	**2015 Rate**	**met/not met**	**2016 Rate**	**met/not met**	**2017 Rate**	**met/not met**
CDC - HbA1c Control (< 8.0%)	40.96%	40.13%	no	45.58%	yes	53.26%	yes	54.99%	yes
Annual Dental Visit				61.21%	n/a	63.49%	yes	65.15%	yes
Timeliness of Prenatal Care				71.84%	n/a	70.29%	no	67.64%	no
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	11.94%	12.40%	no	12.50%	no			12.93%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q1				95.68%	yes	84.31%	no	91.96%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q2				96.15%	yes	92.09%	no	93.27%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q3				96.61%	yes	96.66%	yes	84.31%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q4				93.69%	no	88.51%	no	86.06%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q1				97.61%	yes	95.42%	no	96.54%	no
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q2				97.52%	yes	98.27%	yes	99.06%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q3				97.93%	yes	104.76%	yes	103.55%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q4				98.98%	yes	99.43%	yes	101.36%	yes
NEW MEASURES - 2017									
Use of Multiple Concurrent Antipsychotics in children and Adolescents (APC)						4.81%	n/a	4.64%	yes
Cervical Cancer Screening (CCS)						49.15%	n/a	56.20%	no
Childhood Immunization Status (CIS) - Combination 10						31.01%	n/a	38.44%	yes
Immunizations for Adolescents (IMA) - Combination 2						17.79%	n/a	29.93%	yes
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						63.22%	n/a	66.18%	no
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication								14.19%	yes
Residents of a NF or NFMH discharged to a community setting								62.95%	yes
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date								96.59%	yes
				2015 Portion Met	52.2%	*2016 Portion Met*	46.4%	*2017 Portion Met*	62.5%
				2015 Portion Unmet	47.9%	*2016 Portion Unmet*	53.6%	*2017 Portion Unmet*	37.5%
					100.0%		100.0%		100.0%

KanCare Pay for Performance Measures – Summary of 2017 Performance Outcomes

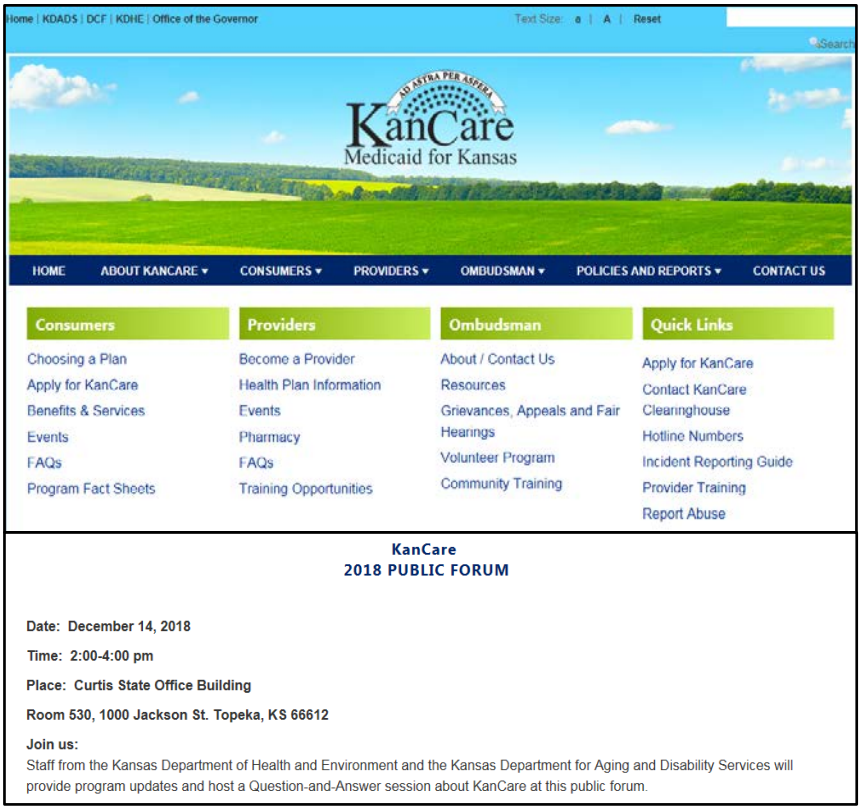
UnitedHealthcare

UnitedHealthcare									
Measure	**2013 rate**	**2014 rate**	**met/not met**	**2015 Rate**	**Met/Not Met**	**2016 Rate**	**Met/Not Met**	**2017 rate**	**Met/Not Met**
CDC - HbA1c Control (< 8.0%)	36.70%	26.29%	no	43.00%	yes	43.61%	no	55.01%	yes
Annual Dental Visit				61.34%	n/a	65.72%	yes	65.26%	yes
Timeliness of Prenatal Care				64.72%	n/a	67.88%	yes	68.37%	no
Decreased Percentage of Members Discharged from a NF Having Hospital Admission Within 30 Days	12.11%	13.40%	no	12.11%	yes			11.70%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q1				84.36%	no	95.61%	yes	96.53%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q2				92.45%	no	97.39%	yes	95.84%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q3				95.07%	no	97.92%	yes	95.86%	no
% covered services accurately submitted via encounter within 30 days of claim paid date - Q4				97.01%	yes	97.38%	yes	99.30%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q1				95.86%	yes	100.36%	yes	98.74%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q2				96.43%	yes	99.96%	yes	98.96%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q3				97.70%	yes	100.51%	yes	98.74%	yes
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO - Q4				98.36%	yes	100.73%	yes	100.08%	yes
NEW MEASURES - 2017									
Use of Multiple Concurrent Antipsychotics in children and Adolescents (APC)						4.85%	n/a	2.99%	yes
Cervical Cancer Screening (CCS)						66.58%	n/a	64.96%	yes
Childhood Immunization Status (CIS) - Combination 10						31.39%	n/a	35.04%	yes 50%
Immunizations for Adolescents (IMA) - Combination 2						17.27%	n/a	31.87%	yes
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						71.28%	n/a	74.85%	yes
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication								14.12%	yes
Residents of a NF or NFMH discharged to a community setting								55.90%	yes
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date								95.06%	yes
				2015 Portion Met	61.06%	*2016 Portion Met*	60.00%	*2017 Portion Met*	76.8%
				2015 Portion Unmet	38.95%	*2016 Portion Unmet*	40.00%	*2017 Portion Unmet*	23.2%
					100.01%		100.00%		100.0%

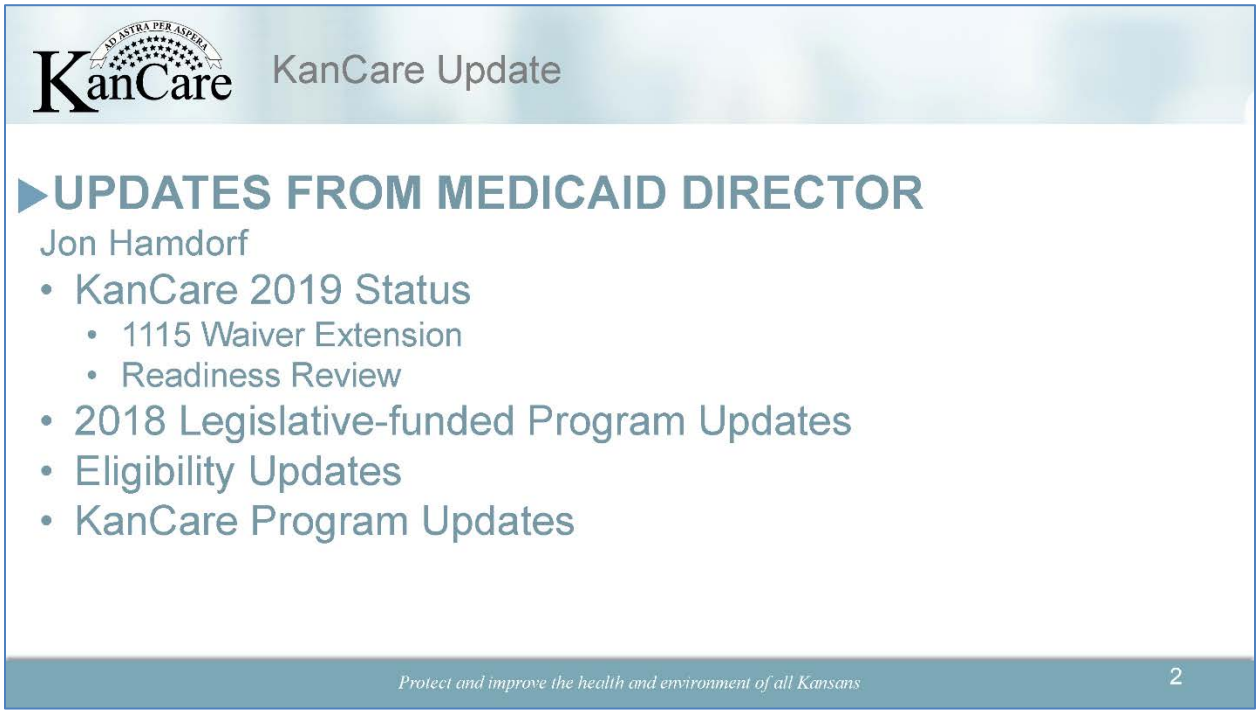
Summary of KanCare Annual Post Award Forum Held 12.14.18

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 2018 KanCare Public Forum, providing updates and opportunity for input, on Tuesday, December 14, 2016, from 2:00-4:00 pm at the Curtis State Office Building, Room 530, 1000 Jackson St., Topeka, Kansas. The forum was published on the face page of the www.KanCare.ks.gov website, starting on October 17, 2018. A screen shot of the notice from the KanCare website face page is as follows:



At the public forum, approximately 40 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 Update

1115 WAIVER EXTENSION

- December Approval
  - Budget Neutrality completed
  - STCs finalized
  - IMD Exclusion for SUD – Implementation Plan
  - All other programs with July 1, 2019,or later date

KanCare Update

READINESS REVIEW

- Go-live date: January 1, 2019
- Finishing readiness review reports for CMS
- Continuity of Care Policy
  - 90-day plan of care hold
  - Provider payments without contract for new MCOs
  - Prior Authorization suspension (limited time/services)
- Post go-live phone support in January
- Prior authorizations and single provider credentialing form (HB 2026)

KanCare Update

▶LEGISLATIVE-FUNDED PROGRAMS

Program	Status	Engagement With Stakeholders/Associations	Risks	ETA
OneCare Kansas (Health Homes)	Draft Policy to review with Steering Committee. Systems estimate for MMIS	Steering committee2 meeting December 20	Systems / Data Development Timing (Quarter)	TBD
Reinstatement post incarceration	Positions hired. Contract completed with Appriss	Coordination with DOC	DCF Funding	January 2019
Mid Year Rate Adjustment	Completed	Completed	None	Completed
Juvenile Crisis Centers	Working with DCF on RFI / RFP	tbd	Medicaid payments Medical Necessity	Spring / Summer 2019

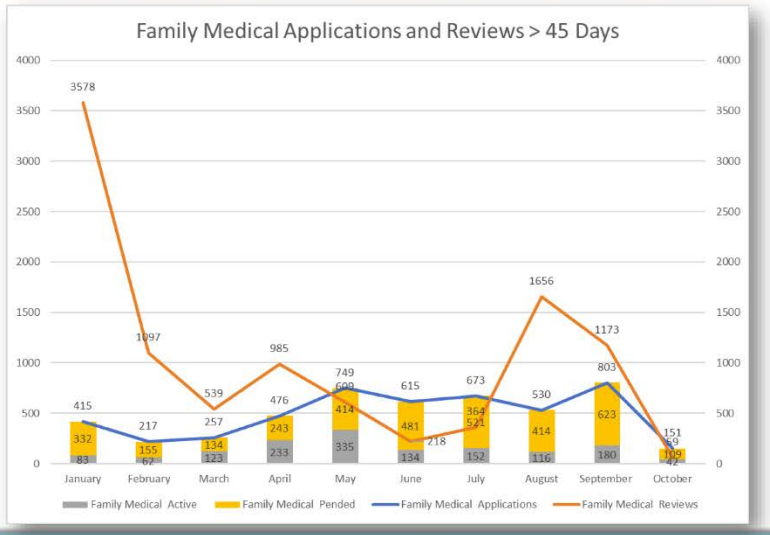
KanCare Update

▶LEGISLATIVE-FUNDED PROGRAMS

Issues/Challenges

- Telehealth Bill
  - All providers/services?
  - Follow CMS guidance for now
- Juvenile Crisis Center Bill
  - Payment for covered and medically necessary services (use of federal matching funds and SGF)
  - Discharge, recidivism, transient population
  - Non-Medicaid population

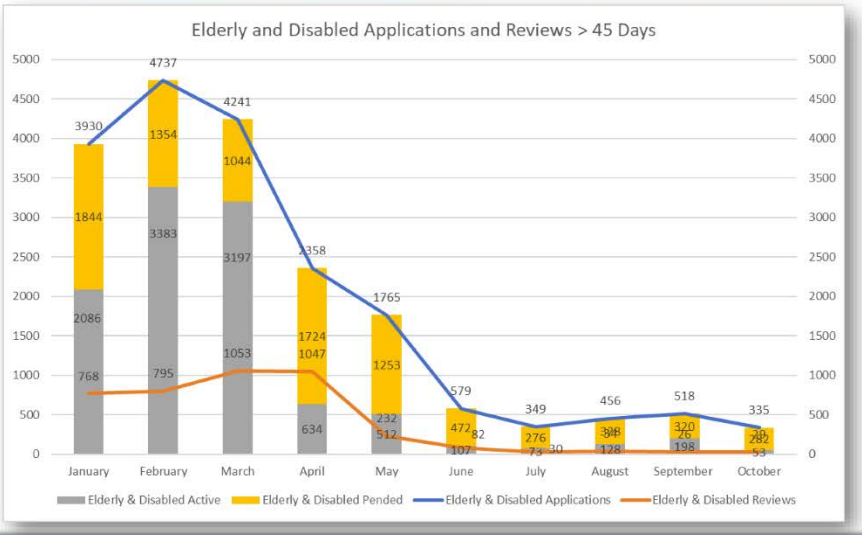
KanCare Update



Protect and improve the health and environment of all Kansans

7

KanCare Update



Protect and improve the health and environment of all Kansans

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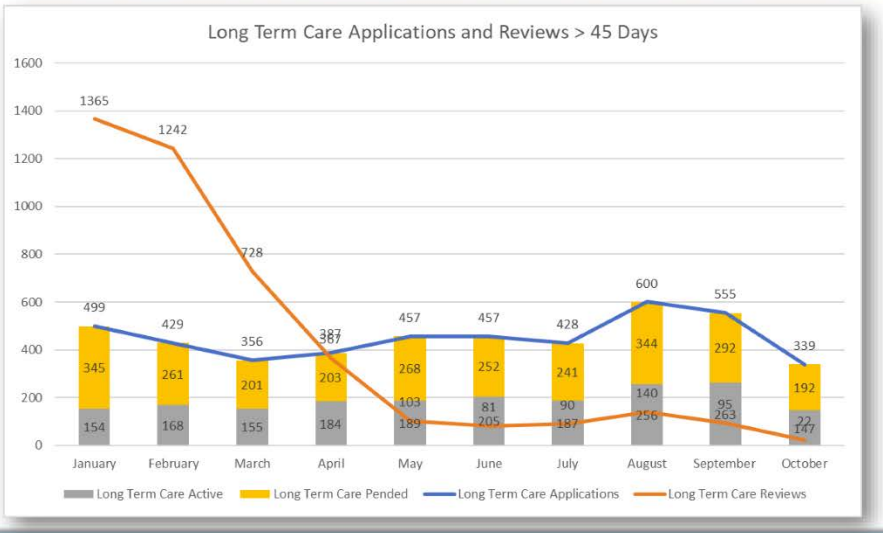
KanCare Update



KanCare Update

Liquidated Damages

LD Daily Calculation

Year-Month	Evaluation Date	SLA 1 - ED&LTC App LD Amt	SLA 2 - Await Dis LD Amt	SLA 3 - FM App LD Amt	SLA 4 - PW 7 Day LD Amt	SLA 5 - PW 30 Day LD Amt	SLA 6 - Reviews LD Amt	SLA 7-CM LD Amt	All SLA LD Amt
2018-10	10/18/2018	$7,900	$0	$6,350	$3,700	$350	$13,750	$300	$32,350
	10/19/2018	$5,750	$0	$4,850	$1,150	$50	$11,900	$300	$24,000
	10/23/2018	$8,650	$0	$8,900	$1,400	$50	$7,750	$300	$27,050
	10/24/2018	$6,800	$0	$3,600	$1,300	$0	$4,500	$300	$16,500
	10/25/2018	$5,650	$0	$1,450	$1,650	$50	$3,500	$300	$12,600
	10/26/2018	$5,500	$0	$1,300	$400	$50	$3,400	$300	$10,950
	10/30/2018	$4,500	$0	$50	$100	$50	$0	$0	$4,700
	10/31/2018	$1,950	$0	$0	$0	$0	$0	$0	$1,950

KanCare Update

KANCARE PROGRAM UPDATES

KanCare Utilization

- Members are more likely to attend their appointments; Transportation up 60% compared to pre-KanCare levels
- Costly inpatient hospital stays have been reduced by 19%
- Emergency Room use down by 8%
- All metrics use number of claims as basis of measurement, with exception of Inpatient (Days) and Pharmacy (prescriptions)

KanCare Utilization

Types of Service	KanCare (2017) vs. Pre-KanCare (2012)	2017 vs. 2016
Primary Care Physician	3%	3%
Transportation NEMT	60%	3%
Outpatient Non-ER	-8%	6%
Inpatient	-19%	4%
Outpatient ER	-8%	6%
Dental	-1%	-6%
Pharmacy	3%	5%
Long Term Care	2%	2%
Vision	13%	-1%
HCBS Services	2%	0%

KanCare Update

KANCARE PROGRAM UPDATES

KanCare Utilization

- Primary Care utilization is up by 21% vs. 2012, up 1% to previous year
- Inpatient hospital stays have decreased by 12% compared to 2012
- ER visits have decreased by 21%
- Dental services have increased by 34%
- All metrics use units as measurement

HCBS Waiver Utilization

Type of Service	KanCare (2017) vs. Pre-KanCare (2012)	2017 vs. 2016
Primary Care Physician	21%	1%
Transportation NEMT	113%	1%
Outpatient Non-ER	-12%	2%
Inpatient	-12%	3%
Outpatient ER	-21%	3%
Dental	34%	-6%
Pharmacy	10%	5%
Vision	21%	1%
HCBS Services	2%	0%

MCO Financial Update

KanCare
MCO Profit and Loss per NAIC Filings
June 30, 2018 Compared to June 30, 2017

MCOs owe HIPF in 2018
- Fee is based on 2017 revenues, payable in 2018
- Statutory reporting expenses the entire annual fee in Q1 of 2018
- GP rates have been restated by the State by allocating HIPF proportionately

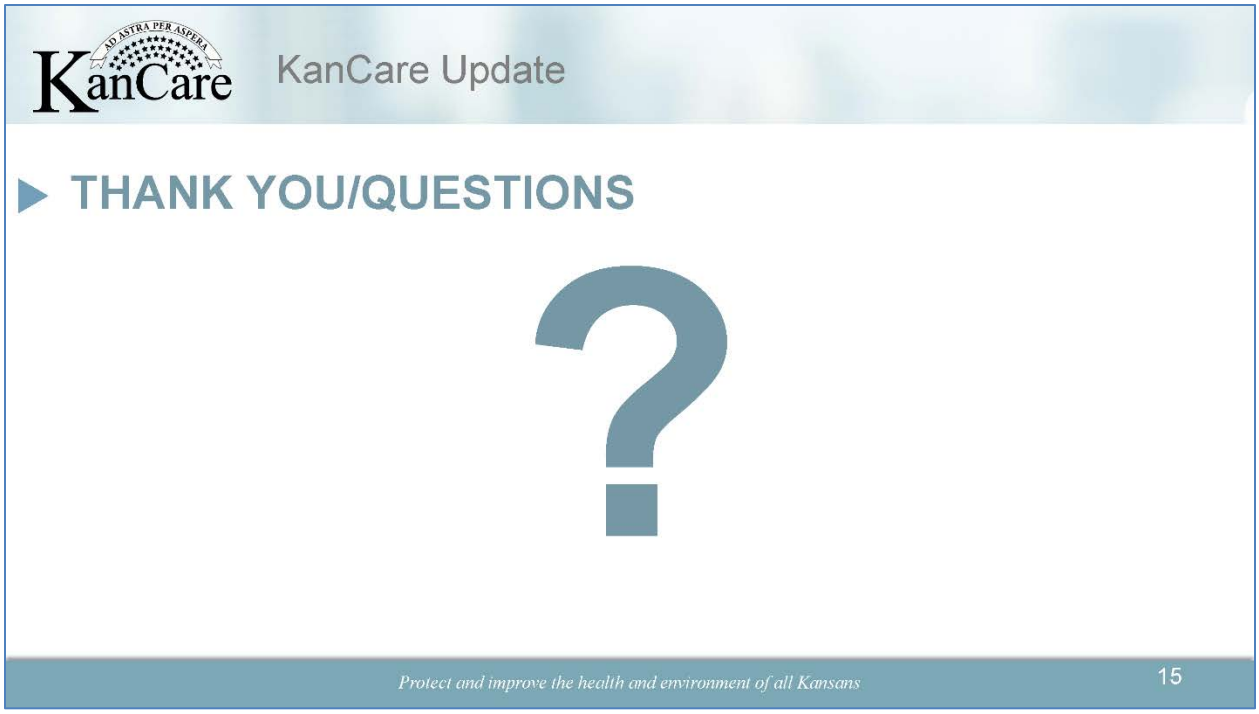
	Amerigroup	Sunflower	United	Total
Total Revenues	$534,051,202	$675,305,514	$554,542,315	$1,763,899,031
Total hospital and medical	$468,333,186	$551,480,552	$455,766,541	$1,475,580,279
Claims adjustments, General Admin., Increase in reserves	$82,739,070	$117,066,487	$88,117,997	$287,923,554
Net underwriting gain or (loss)	($17,021,054)	$6,758,475	$10,657,777	395,198
Net income or (loss) after capital gains tax and before all other federal income taxes	($15,273,900)	$7,937,673	$10,657,777	3,321,550
Federal and foreign income tax/(benefit)	$183,636	$4,497,639	$8,210,752	$12,892,027
Add Back Change to Reserves	$0	$0	$0	$0
Adjusted Net income (loss) - Through June 30, 2018	($15,457,536)	$3,440,034	$2,447,025	($9,570,477)
GP before income tax	**-2.9%**	**1.2%**	**1.9%**	**0.2%**
HIPF (Q3-Q4 booked in Q1)	7,669,000	4,116,162	4,783,868	16,569,030
Adj'd net income before income tax	(7,604,900)	12,053,835	15,441,645	19,890,580
GP before income tax and wo extra HIPF	**-1.42%**	**1.78%**	**2.78%**	**1.13%**

KanCare Update

CORRECTIVE ACTION PLAN - MLTSS

CAP PROGRESS BY TASK AREA	
Task Area	**% of Tasks Complete**
Administrative Authority	100%
Person-Centered Planning	100%
Provider Access and Network Adequacy	100%
Participant Protections	100%
Support for Beneficiaries	100%
Stakeholder Engagement Process Development	100%
Overall % of CAP Tasks Complete	100%

Corrective Action Plan Completed October 2018



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 a well-child examinations that resulted in a rate reduction. Director Hamdorf explained that the consequences of the policy were unintended, and he had directed KDHE staff to reverse the policy and correct the rate reduction retroactively back to November 1, 2018. He also stated he had recommended to Governor-elect Kelly's transition team that they consider a rate increase for pediatric services; however, the projection for that was about $11 million. One parent complained that he had not received notice of the education meetings held in September and October to explain the transition from Amerigroup to Aetna Better Health of Kansas.

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

March 27, 2019

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

RE: **2018 KanCare Evaluation Annual Report**
Year 6, January – December 2018

Dear Ms. Ross:

Enclosed is the 2018 KanCare Evaluation annual report for Year 6, January – December 2018. If you have questions regarding this information, please contact me, lsanchez@kfmc.org.

Sincerely,

Laura Sanchez, RN

Laura Sanchez, RN
Healthcare Quality Review Analyst

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE
Amy Swanson, Quality Manager, KDHE

Enclosures

Kansas Foundation for Medical Care, Inc

URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

2018 KanCare Evaluation Annual Report

Year 6, January - December 2018

KFMC Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**March 27, 2019**
Review Team:	**Laura Sanchez, RN, Project Manager** **Tracy Atkins, LMSW, Project Manager** **Lynne Valdivia, MSW, BSN, RN, CCEP, Vice President, Director of Quality Review, and Compliance Officer**

Prepared for:

KanCare

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Year 6, January – December 2018

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Year 6, January – December 2018

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2018 KanCare Evaluation Annual Report

Year 6, January – December 2018

2018 KanCare Evaluation Annual Report
Year 6, January–December 2018
March 27, 2019

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 (PH), behavioral health (BH, includes mental health [MH] and substance use disorders [SUD]) 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 PH, 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 PH 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 Survey – Quality
(8) Provider Survey
(9) Grievances
(10) Other Study – HCBS CAHPS Survey
Coordination of Care (and Integration)
(11) Care Management for Members Receiving HCBS Services
(12) Other Study – HCBS CAHPS Survey
(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 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. From calendar year (CY) 2013 through CY2018, the three MCOs were Amerigroup Kansas, Inc. (Amerigroup or AGP), Sunflower Health Plan (Sunflower or SHP), 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)
  - Autism
- Providers
- County type (Urban/Semi-Urban, Densely-Settled Rural, Rural/Frontier)
- Those receiving 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 2018

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 (2012 and 2011). Where pre-KanCare data were not available, baseline data were based on 2013 data or, for measures that require more than one year of data, 2013/2014.

This sixth annual KanCare Evaluation includes analysis of performance through calendar year (CY) 2018. However, 2018 data 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 CY2018 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for the CY2018 measurement year will not be available until July 2019. Some of the HEDIS measures are multi-year measures; for these measures, baseline data for CY2013 and CY2014 are first reported in the KanCare Annual Evaluation for

2015. Some measures are based on surveys that ask the respondent to consider a previous time-period (e.g., past six months) when answering questions. The year reported with survey data reflects the year the survey was completed.

Comparisons are provided across KanCare years and with pre-KanCare rates when possible. HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results are tracked and reported by the National Committee for Quality Assurance (NCQA); results for MCOs are compiled annually. The NCQA Quality Compass (QC) annually reports national averages and percentiles (5th, 10th, 25th, 33.33rd, 50th, 66.67th, 75th, 90th, and 95th) that provide benchmarks for MCO comparisons, helping identify healthcare service area strengths and opportunities for improvement. Beginning with HEDIS 2015, the 33.33rd and 66.67th percentiles were included in QC, which must be considered when comparing 2014 QC rankings to later rankings.

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 Quarter 4 [Q4] CY2013) that are available for public review on the KanCare website, www.kancare.ks.gov.

At the approval of the State, Amerigroup submitted some limited data for CY2018 due to their contract ending December 31, 2018; therefore, some results previously reported cannot be determined for CY2018. Through the remainder of the report, where applicable, this will be referred to as Amerigroup data was not available.

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

The *Physical Health* performance measures include the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (AAP)
- Annual Dental Visit (ADV)
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

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

HEDIS results, including comparison of the aggregated rates to QC national percentiles (where available), are summarized in Table 2. 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 measures that have specification changes from the previous year can potentially cause trending impacts and are reported by NCQA as *"Trend with Caution"* or *"Break in Trending."* Four of the measures in Table 2 were identified for CY2017 as having a possible trending impact:

- *"Trend with Caution"*: Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- *"Break in Trending"*:
  - Medication Management for People with Asthma (MMA)
  - Follow Up After Hospitalization for Mental Illness (FUH)
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)

Pre-KanCare data available for some of the HEDIS measures (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 – CY2017

Measure	HEDIS Aggregated Results					Quality Compass ≥50th Percentile				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Adults' Access to Preventive/Ambulatory Health Services (AAP)										
Ages 20–44	85.4%	84.3%	83.7%	82.6%	**83.6%**	↑	↑	↑	↑	↑
Ages 45–64	92.2%	92.4%	92.3%	91.3%	**90.7%**	↑	↑	↑	↑	↑
Ages 65 and older	89.5%	88.6%	89.7%	90.1%	**90.9%**	↑	↑	↑	↑	↑
Total – Ages 20 and older	88.4%	87.5%	87.1%	86.2%	**86.7%**	↑	↑	↑	↑	↑
Annual Dental Visit (ADV)										
Ages 2–3	40.8%	41.2%	42.8%	45.8%	**46.6%**	↑	↑	↑	↑	↑
Ages 4–6	66.3%	65.7%	66.2%	69.2%	**70.7%**	↑	↑	↑	↑	↑
Ages 7–10	70.7%	70.1%	70.4%	72.7%	**73.7%**	↑	↑	↑	↑	↑
Ages 11–14	62.8%	62.8%	63.2%	66.4%	**67.7%**	↑	↑	↑	↑	↑
Ages 15–18	53.9%	53.5%	54.1%	57.2%	**58.7%**	↑	↑	↑	↑	↑
Ages 19–20	31.5%	30.2%	34.7%	33.1%	**33.9%**	↓	↓	↑	↓	↓
Total – Ages 2–20	60.3%	60.0%	60.9%	63.7%	**64.8%**	↑	↑	↑	↑	↑
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%	**43.6%**	↑	↑	↑	↑	*
Ages 18 and older	40.9%	41.3%	37.7%	40.1%	**34.7%**	↑	↑	↓	↓	*
Total – Ages 13 and older	42.1%	42.6%	38.9%	41.4%	**35.8%**	↑	↑	↑	↑	*
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%	**23.6%**	↑	↑	↑	↑	*
Ages 18 and older	12.2%	12.1%	10.7%	12.4%	**10.4%**	↑	↑	↑	↑	*
Total – Ages 13 and older	15.2%	14.8%	12.9%	14.3%	**12.0%**	↑	↑	↑	↑	*
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*										
Prenatal Care	71.4%	70.4%	67.4%	68.4%	**69.3%**	↓	↓	↓	↓	↓
Postpartum Care	58.5%	55.8%	57.5%	58.0%	**61.1%**	↓	↓	↓	↓	↓
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*										
Ages 16–20	42.4%	41.0%	41.3%	41.0%	**39.6%**	↓	↓	↓	↓	↓
Ages 21–24	55.6%	54.5%	53.5%	52.8%	**54.5%**	↓	↓	↓	↓	↓
Total – Ages 16–24	46.1%	45.4%	45.8%	45.3%	**45.1%**	↓	↓	↓	↓	↓
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*										
		72.2%	77.6%	80.9%	**86.5%**		↓	↓	↓	↓
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%	**64.3%**	↓	↓	↓	↓	↓
Ages 12–17	36.6%	47.3%	48.1%	56.9%	**65.6%**	↓	↓	↓	↓	↓
Total – Ages 3–17	34.7%	45.3%	48.6%	56.0%	**64.7%**	↓	↓	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)										
Ages 3–11	47.4%	50.8%	50.6%	55.4%	**60.6%**	↓	↓	↓	↓	↓
Ages 12–17	46.0%	47.0%	45.7%	53.1%	**56.7%**	↓	↓	↓	↓	↓
Total – Ages 3–17	46.9%	49.5%	49.1%	54.7%	**59.2%**	↓	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)										
Ages 3–11	39.6%	43.5%	43.3%	47.9%	**51.9%**	↓	↓	↓	↓	↓
Ages 12–17	53.1%	50.6%	48.3%	58.6%	**57.8%**	↓	↓	↓	↓	↓
Total – Ages 3–17	44.0%	45.8%	44.9%	51.5%	**53.9%**	↓	↓	↓	↓	↓
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%	**59.0%**	↑	↑	↑	↑	*
Follow-Up Care for Children Prescribed ADHD Medication (ADD)^ *(CMS Core Quality Measure)*										
Initiation Phase		48.0%	50.7%	52.2%	**49.5%**		↑	↑	↑	^
Continuation & Maintenance Phase		54.8%	61.2%	61.4%	**57.5%**		↑	↑	↑	^

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
* Quality Compass identified "Break in Trending" due to specification changes from prior year
^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

Table 2. Physical Health HEDIS Measures, CY2013 – CY2017 (Continued)										
Measure	HEDIS Aggregated Results					Quality Compass ≥50th Percentile				
	2013	2014	2015	2016	2017	2013	2014	2015	2016	2017
Adolescent Well Care Visits (AWC) *(CMS Core Quality Measure)*										
	43.6%	46.7%	46.8%	47.7%	**53.3%**	↓	↓	↓	↓	↓
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%	**71.0%**	↓	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*										
0 visits		4.2%	3.0%	3.4%	**2.9%**		↑†	↑†	↑†	↑†
1 visit		4.4%	3.3%	3.5%	**3.4%**		↑†	↑†	↑†	↑†
2 visits		6.0%	4.8%	4.8%	**4.1%**		↑†	↑†	↑†	↑†
3 visits		7.1%	6.5%	5.5%	**6.5%**		↑†	↑‡	↑†	↑†
4 visits		12.3%	9.1%	8.6%	**8.0%**		↑	↓	↓	↓
5 visits		16.8%	14.5%	15.5%	**14.4%**		↓	↓	↓	↓
6 or more visits		49.3%	58.7%	58.6%	**60.7%**		↓	↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*										
	47.3%	51.5%	48.2%	52.1%	**53.6%**	↓	↓	↓	↓	↓
Comprehensive Diabetes Care (CDC)										
HbA1c Testing *(CMS Core Quality Measure)*	83.1%	84.8%	84.9%	85.8%	**86.2%**	↓	↓	↓	↓	↓
Eye Exam (Retinal)	50.1%	58.6%	62.5%	64.4%	**62.4%**	↓	↑	↑	↑	↑
Medical Attention for Nephropathy	75.8%	76.8%	89.2%	87.2%	**88.8%**	↓	↓	↓	↓	↓
HbA1c Control (<8.0%)	39.0%	39.3%	46.6%	51.0%	**55.0%**	↓	↓	↓	↑	↑
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	54.4%	52.9%	45.4%	41.1%	**35.3%**	↓	↓	↓	↓	↓
Blood Pressure Control (<140/90)	53.1%	52.6%	58.8%	57.9%	**61.1%**	↓	↓	↓	↓	↓
Appropriate Testing for Children with Pharyngitis (CWP)										
	51.6%	52.2%	55.1%	61.2%	**68.6%**	↓	↓	↓	↓	↓
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%	**38.0%**		↑	↑	↑	↑
12–18 years of age		24.1%	26.6%	31.9%	**36.4%**		↑	↑	↑	↑
19–50 years of age		39.6%	38.3%	41.4%	**46.6%**		↑	↑	↑	↑
51–64 years of age		53.0%	55.1%	60.1%	**60.2%**		↑	↑	↑	↑
Total – Ages 5–64		28.1%	29.9%	33.7%	**39.2%**		↓	↓	↑	↑
Annual Monitoring for Patients on Persistent Medications (MPM)* *(CMS Core Quality Measure)*										
	84.9%	89.7%	90.2%	89.5%	**90.0%**	↓	↑	↑	↑	*
Appropriate Treatment for Children with Upper Respiratory Infection (URI)										
	71.9%	73.5%	76.3%	79.2%	**81.9%**	↓	↓	↓	↓	↓

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
* Quality Compass identified "Break in Trending" due to specification changes from prior year
† 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. The aggregate administrative HEDIS results for CY2013 through CY2017 were above the QC 75th percentile for age groups 20–44, 45–64, and 20 and older. Pre-KanCare data were available for ages 20–44 and ages 45–64.

- **Ages 20–44** – **83.6%** (**>75th QC**) in CY2017; the rates fluctuated over the five-year period (82.6% [CY2016] – 85.4% [CY2013]).
- **Ages 45–64** – **90.7%** in CY2017, lower than the prior four years (ranging from 91.3% [CY2016] to 92.4% [CY2014]) and **>75th QC** percentile in all five years. In CY2012, the aggregate pre-KanCare percentage was lower at 87.8%.
- **Ages 65 and older** – **90.9%** (**>66.67th QC**) in CY2017, comparable to CY2016 (90.1%) and higher than CY2013–CY2015 (88.6%–89.7%). (Pre-KanCare data were not reported by the MCOs for CY2012 for those ages 65 and older.)

- **Total – Ages 20 and older** – **86.7%** (**>75th QC**) in CY2017, the rates fluctuated over the five-year period (ranging from 86.2% [CY2016] to 88.4% [CY2013]).

Annual Dental Visit (ADV) (Pay for Performance [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; and Total (Ages 2–20)
Analysis: Annual comparison to CY2013 baseline and trending over time
In CY2017, aggregate administrative HEDIS rates for each age range increased and were >66.67th QC, except ages 19–20, which was <33.33rd QC. Also, the CY2017 rates were higher than the previous four years for all age ranges except 19 to 20. Following are the 2017 rates in bold, with the range of rates from the previous four years provided after the semicolon.

- **Ages 2–3**: **46.6%** (**>66.67th QC**); 40.8% (CY2013)–45.8% (CY2016)
- **Ages 4–6**: **70.7%** (**>66.67th QC**); 65.7% (CY2014)–69.2% (CY2016)
- **Ages 7–10**: **73.7%** (**>75th QC**); 70.1% (CY2014)–72.7% (CY2016)
- **Ages 11–14**: **67.7%** (**>66.67th QC**); 62.8% (CY2013)–66.4% (CY2016)
- **Ages 15–18**: **58.7%** (**>66.67th QC**); 53.5% (CY2014)–57.2% (CY2016)
- **Ages 19–20**: **33.9%** (**<33.33rd QC**); 30.2% (CY2014)–34.7% (CY2015)
- **Total (Ages 2–20)**: **64.8%** (**>75th QC**); 60.0% (CY2014)–63.7% (CY2016)

Initiation and Engagement in Treatment for Alcohol or Other Drug Dependence (IET) *(CMS Core Quality Measure)*
Population: Medicaid and CHIP combined populations
Analysis: Aggregate rate based on administrative data for CY2017, trending over time (except CY2017 when a *"break in trending"* was reported by NCQA, as previously stated).

- **Initiation in Treatment**
  - **Ages 13–17** – **43.6%** (**≥50th QC**)
  - **Age 18 and older** – **34.7%** (**<25th QC**)
  - **Total – Age 13 and older** – **35.8%** (**<25th QC**)
- **Engagement in Treatment**
  - **Ages 13–17** – **23.6%**, (**>75th QC**)
  - **Age 18 and older** – Only **10.4%** (**<33.33rd QC**)
  - **Total – Ages 13 and older** – **12.0%** (**<50th QC**)

Prenatal and Postpartum Care (PPC) (P4P – Prenatal Care 2016 – 2017) *(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 CY2017 was **69.3%, <10th QC**. Rates for the previous four years ranged from 67.4% (CY2015) to 71.4% (CY2013). 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 CY2017 was **61.1%** (**<33.33rd QC)**. Rates for the previous four years ranged from 55.8% (2014) to 58.5% (2013). The MCO rates were: UnitedHealthcare – 65.0%, <50th QC; Amerigroup – 59.6%, <33.33rd QC; Sunflower – 57.7%, <25th QC.

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 CY2017 the administrative aggregate and individual MCO rates continued to be below the 25th QC.

- **Ages 16–20** – The aggregate rate in CY2017 was **39.6%** (**<10th QC)** and was lower than the prior four years (ranging from 41.0% [CY2014] to 42.4% [CY2013]).
- **Ages 21–24** – The aggregate rate in CY2017 was **54.5%** (**<25th QC**) and the rates fluctuated over the last five years (ranging from 52.8% [CY2016] to 55.6% [CY2013]).
- **Total – Ages 16–24** – The CY2017 aggregate rate was **45.1%** (**<10th 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 ages 18 and older
Analysis: Annual comparison to baseline reported in CY2014 and trending over time
The aggregate rate based on hybrid data for CY2017 was **86.5%** (**<50th QC**), higher than the previous three years (72.2% [CY2014] to 80.9% [CY2016]).

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/Body Mass Index (BMI)**
  The aggregate weighted hybrid HEDIS rates for reporting BMI have increased from CY2013 to CY2017 but ages 3–11 and ages 3–17 have remained below the QC 25th percentile. For all three populations, the CY2017 rate (in bold below) was higher than the four prior years (ranges are detailed below after the semicolon).
  - **Ages 3–11** – **64.3%** (**<25th QC)**; 33.7% (CY2013)–55.5% (CY2016)
  - **Ages 12–17** – **65.6%** (**<33.33rd QC**); 36.6% (CY2013)–56.9% (CY2016)
  - **Total – Ages 3–17** – **64.7%** (**<25th QC**); 34.7% (CY2013)–56.0% (CY2016)
- **Counseling for Nutrition**
  The CY2017 aggregate weighted hybrid HEDIS rates (in bold below) in total and by age group were higher than the four prior years (ranges are detailed after the semicolon below). However, ages 3–11 and ages 3–17 continued to be below the QC 25th percentile.
  - **Ages 3–11** – **60.6% (<25th QC**); 47.4% (CY2013)–55.4% (CY2016)
  - **Ages 12–17** – **56.7%** (**<33.33rd QC**); 45.7% (CY2015)–53.1% (CY2016)
  - **Total – Ages 3–17** – **59.2%** (**<25th QC**); 46.9% (CY2013)–54.7% (CY2016)
- **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 CY2017.
  - **Ages 3–11: 51.9%** (**<33.33rd QC**) in CY2017 and higher than the prior four years (ranging from 39.6% [CY2013] to 47.9% [CY2016]).
  - **Ages 12–17: 57.8%** (**<33.33rd QC**) in CY2017; the rates fluctuated over the five-year period (ranging from 48.3% [CY2015] to 58.6% [CY2016]).
  - **Total (Ages 3–17): 53.9%** (**<33.33rd QC**) in CY2017 and higher than the prior four years (ranging from 44.0% [CY2013] to 51.5% [CY2016]).

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 (except CY2017 when a *"break in trending"* was reported by NCQA, as previously stated)

The aggregate rate based on administrative data for CY2017 was **59.0%**, **>90th QC.** The MCO rates were: Amerigroup – (57.6%); Sunflower – (59.7%); UnitedHealthcare – (59.5%); and all were >90th QC.

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 (except CY2017 when a *"trend with caution"* was reported by NCQA, as previously stated)

- **Initiation Phase** – The aggregate weighted rate in CY2017 was **49.5%** (**>66.67th QC)**. The MCOs rates were: UnitedHealthcare – 53.7% (>75th QC); Sunflower – 52.8% (>75th QC), and Amerigroup – 41.2% (<50th QC).
- **Continuation & Maintenance Phase** – The aggregate weighted rate in CY2017 was **57.5%** (**≥50th QC**). The MCOs rates were: UnitedHealthcare – 64.1% (>75th QC); Sunflower – 62.5% (>66.67th QC); and Amerigroup – 45.4% (<25th QC).

Adolescent Well Care Visits (AWC) *(CMS Core Quality Measure)*
Population: Ages 12–21; Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
The aggregate rate for CY2017 was **53.3%** (**<50th QC**), higher than the prior four years (ranging from 43.6% [CY2013] to 47.7% [CY2016]).

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) (P4P in 2017) *(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 CY2017 was **71.0%** (**<50th QC)**, higher than the prior four years (ranging from 63.4% [CY2013] to 67.3% [CY2016]).

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 for 2017 (in bold below) compared to baselines reported in CY2014 and trending over time

- **0 visits** – **2.9%** (**>75th QC**), lower than the prior three years (ranging from 3.0% [CY2015] to 4.2% [CY2013])
- **1 visit** – **3.4%** (**>75th QC**)

- **2 visits** – **4.1%** (**>75th QC**), lower than the prior three years (4.8% [CY2015 and CY2016] and 6.0% [CY2013])
- **3 visits** – **6.5%** (**>75th QC**)
- **4 visits** – **8.0%** (**<50th QC**), lower than the prior three years (ranging from 8.6% [CY2016] to 12.3% [CY2014])
- **5 visits** – **14.4%** (**<50th QC**), lower than the prior three years (ranging from 14.5% [CY2015] to 16.8% [CY2014])
- **6 or more visits** – **60.7%** (**<33.33rd QC**), an improvement from the prior three years (ranging from 49.3% [CY2014] to 58.7% [CY2015])

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 CY2017 was **53.6%** (**<50th QC**), higher than the prior four years (ranging from 47.3% [CY2013] to 52.1% [CY2016]).

Comprehensive Diabetes Care (CDC), *HbA1c* (Hemoglobin A1c) *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. However, in CY2017, different data collection methods were reported by the MCOs for the *"Eye Exam measurement."* The total aggregated rate for the CY2017 *"Eye Exam"* measurement is based on a combination of Hybrid and Administrative 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 CY2017 was **86.2%,** higher than the prior four years (ranging from 83.1% [CY2013] to 85.8% [CY2016]), but again **<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 CY2017 was **35.3%**, lower than the prior four years (ranging from 41.4% [CY2016] to 54.4% [CY2013]) and **>50th QC**.
- **HbA1c Control (<8.0%)** (P4P 2014–2017) – For this metric, the goal is to have a higher rate and higher QC percentile. The aggregate rate for CY2017 was **55.0%**, higher than the prior four years (ranging from 39.0% [CY2013] to 51.0% [CY2016]) and **>66.67th QC** for the first time in five years.
- **Eye Exam (Retinal)** (P4P 2014–2016) – The aggregate rate for CY2017 was **62.4%** (**>66.67th QC**). **Medical Attention for Nephropathy** (P4P 2014–2016) – The aggregate rate for CY2017 was **88.8%** (**<33.33rd QC**). The prior four years ranged from 75.8% (CY2013) to 89.2% (CY2015).

Blood Pressure Control (<140/90) (P4P 2014–2015) – The aggregate rate for CY2017 was **61.1%** (**<50th** QC), higher than the previous four years (52.6% [CY2014] to 58.8% [CY2015]).

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 CY2017 was **68.6%** (**<25th QC**), and higher than the prior four years (ranging from 51.6% [CY2013] to 61.2% [CY2016]).

Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure 2013–2017)*
Data are based on aggregated weighted administrative HEDIS data.
Population: Ages 5–11, ages 12–18, ages 19–50, and ages 51–65; Medicaid and CHIP combined populations
Analysis: Annual comparison to baselines reported in CY2014 and trending over time
The CY2017 rates (in bold below) for each population were higher than the prior three years (ranges are detailed below after the semicolon):

- **Ages 5–11 – 38.0%** (**>75th QC**); 27.4% (CY2014) to 31.7% (CY2016)
- **Ages 12–18 – 36.4%** (**>75th QC**); 24.1% (CY2014) to 31.9% (CY2016)
- **Ages 19–50 – 46.6%** (**>75th QC**); 38.3% (CY2015) to 41.4% (CY2016)
- **Ages 51–64 – 60.2%** (**>75th QC**); 53.0% (CY2014) to 60.1% (CY2016)
- **Total (Ages 5–64) – 39.2%** (**≥50th QC**); 28.1% (CY2014) to 33.7% (CY2016)

Annual Monitoring for Patients on Persistent Medications (MPM) (P4P 2014–2016) *(CMS Core Quality Measure)*
Population: Medicaid, Ages 18 and older
Analysis: Annual comparison to CY2013 baseline, trending over time (except CY2017 when a *"break in trending"* was reported by NCQA, as previously stated)
The aggregate rate based on administrative data for CY2017 was **90.0%** (**>66.67th 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 CY2017 was **81.9%** (**<25th QC**) and higher than the prior four years (ranging from 71.9% [CY2013] to 79.2% [CY2016]).

(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 an annual quarterly average and includes those whose living arrangement details were collected by KDADS in the Kansas Client Placement Criteria (KCPC) state tracking system (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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare members in stable living situations at discharge	199	218	189	183	190	133	143
Denominator: Number of KanCare members discharged from SUD services during the reporting period	201	220	190	185	196	138	146
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%	97.9%

The percentages of members in stable living conditions at time of discharge from SUD services were consistently high from CY2012 through CY2018. The high rate, over 96% in each quarter of the six-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 performance measure is an annual quarterly average and the numerator is based on the 30 days prior to discharge (see Table 4).

The annual quarterly average of those without arrests was over 98% for each quarter of CY2012 through CY2018 and has remained fairly constant. This equates to about 1 to 4 arrests per quarter. The rate for CY2018 (99.3%) is the same as in CY2013 and CY2017.

Table 4. Number and Percent of Members Receiving SUD Services whose Criminal Justice Involvement Decreased – Annual Quarterly Average, CY2012 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of members without arrests at time of discharge from SUD services	199	219	188	183	193	137	145
Denominator: Number of members discharged from SUD services during the reporting period	201	220	190	185	196	138	146
Percent of members without arrests during reporting period	99.0%	99.3%	98.9%	98.9%	98.5%	99.3%	99.3%

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

The denominator for this performance measure is an annual quarterly average and includes those whose substance use information was collected in the KCPC at discharge from SUD treatment (see Table 5). The numerator is based on the 30 days prior to discharge.

The annual quarterly average of decreased use of alcohol and other drugs were reported to be above 90% in each quarter of CY2012 through CY2018. The highest rate of the seven years was 95.5% in CY2014.

Table 5. Number and Percent of Members Receiving SUD Services with Decreased Drug and/or Alcohol Use – Annual Quarterly Average, CY2012 – CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of members discharged from SUD services who were abstinent from alcohol and other drugs	191	207	181	173	178	126	136
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	190	185	196	138	146
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%	93.4%

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

The denominator for this performance measure is an annual quarterly average and includes those whose attendance at self-help programs was collected in KCPC at both admission and discharge from SUD treatment services (see Table 6). The numerator includes those who reported attendance prior to discharge from SUD services.

Table 6. Number and Percent of Members Receiving SUD Services Attending Self-Help Programs – Annual Quarterly Average, CY2012 – CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare members attending self-help programs	121	93	85	73	71	57	66
Denominator: Number of KanCare members discharged from SUD services during quarter	201	220	190	185	182	138	146
Percent of KanCare members attending self-help programs	59.9%	42.3%	44.5%	39.5%	39.0%	41.3%	45.2%

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 seven-year period CY2012 to CY2018. Attendance increased in CY2018 to a percentage of 45.2% and it is the highest rate since 2013; but, lower than in CY2012 pre-KanCare (59.9%).

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

The denominator for this performance measure is the number of members, ages 18 and older at admission to SUD services, annual quarterly average, and whose employment status was collected in

the KCPC database at discharge from SUD services (see Table 7). The numerator is employment reported by members at discharge from SUD services.

Table 7. Number and Percent of Members Discharged from SUD Services who were Employed – Annual Quarterly Average, CY2012 – CY2018

	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare members employed (full-time or part-time)	60	70	80	86	75	63	72
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	229	206	196	138	146
Percent of members employed at discharge from SUD services	29.7%	31.8%	34.9%	41.8%	38.3%	45.7%	49.1%

The annual quarterly average of KanCare members discharged from SUD treatment who are employed has continued the trend upward. There has been a 17.3 percentage point increase (54.4% relative increase) from CY2013 to CY2018. From CY2017 to CY2018 the measure increased by 3.4 percentage points to 49.1%, a one-year relative increase of 7.4%.

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.

(3) Mental Health Services

The following performance measures are based on NOMS for members who are receiving MH services. Measures focus on increased access to services for adults with SPMI and youth experiencing SED, improvement in housing status for adults who are homeless, improvement or maintenance of residential status for youth, gain or maintenance of employment status for adults with SPMI, 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 is measured from the beginning of each quarterly measurement period (see Table 8). The numerator is based on assessments and reporting by Community Mental Health Centers (CMHCs) of members 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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare adults with SPMI	8,051	5,745	7,515	7,389	6,933	6,594	6,423
Denominator: Number of KanCare adults	123,656	126,305	134,843	136,989	143,108	135,187	125,361
Percent of KanCare adults with SPMI	6.5%	4.5%	5.6%	5.4%	4.8%	4.9%	5.1%
Adult access rate per 10,000	651.1	454.9	557.3	539.4	484.5	487.8	512.4

Tracking for this performance 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 CY2018 has stayed relatively stable.

The number and percent of youth experiencing SED who had increased access to services (P4P 2014–2015)
The denominator is measured from the beginning of each measurement period (see Table 9). The numerator is 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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of SED youth	14,937	11,984	14,782	14,834	15,206	14,063	13,819
Denominator: Number of KanCare youth	267,788	274,326	285,753	284,830	294,494	261,152	230,062
Percent of SED youth	5.6%	4.4%	5.2%	5.2%	5.2%	5.4%	6.0%
SED rate per 10,000	557.8	436.9	517.3	520.8	516.3	538.5	600.7

Tracking for this performance 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, and the CY2018 rate (6.0%) is the highest since pre-KanCare (4.4% [2013] to 6.0% [2018]).

The number and percent of youth experiencing SED who experienced improvement in their residential status
The denominator is measured from the beginning of each quarterly measurement period. The numerator is measured 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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare SED youth with improved housing status at end of quarter	208	177	142	168	542	518	374
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of quarter	254	219	174	198	607	575	437
Percent of SED youth with improved housing status	81.7%	80.6%	81.3%	84.9%	89.3%	90.1%	85.5%

The annual quarterly average percentage of SED youth with improved housing status in CY2015 was higher than in CY2012 through CY2014. The increasing trend continued in CY2016 and CY2017, reaching a quarterly average of improved housing of 90.1%. However, in CY2018, the average percentage decreased to 85.5%.

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
Table 11 details, the numerator and denominator for this performance measure. The annual quarterly average from CY2013 to CY2018 maintained a high percentage above 98%.

Table 11. Number and Percent of SED Youth who Maintained their Residential Status – Annual Quarterly Average, CY2012 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
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	3,557
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	3,621
Percent of SED youth that maintained residential status	94.9%	98.7%	99.3%	98.9%	98.3%	98.4%	98.2%

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)
Table 12 details, the numbers of youth receiving SED/CBS (Community-Based Services) with prior competence scores of 40 or less decreased from Score 1 to Score 2 each year from CY2012, CY2014, CY2015, and CY2018. The percentage with improvement in their most recent CBCL score was relatively comparable from CY2012 through CY2015, with a decrease beginning with Score 2 CY2016.

Table 12. Number and Percent of KanCare SED/CBS Youth with Improvement in Their Child Behavior Checklist (CBCL) Scores, CY2012 – CY2018														
	Pre-KanCare		KanCare											
	2012		2013		2014		2015		2016		2017		2018	
	S1	S2	S1	S2*	S1	S2	S1	S2	S1	S2	S1	S2	S1	S2
Numerator: Number of KanCare SED/CBS youth with increased total competence score	1,313	1,170	1,466		912	785	958	886	686	506	628	554	341	345
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	1,420	1,395
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%	24.0%	24.7%
* No data available														

The number and percent of KanCare Adults, diagnosed with SPMI, who were competitively employed (P4P 2014–2016)

The denominator for this performance measure is from each measurement period. The numerator is based on the measurement period and adults with SPMI 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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare SPMI adults competitively employed	481	382	610	628	577	524	502
Denominator: Number of KanCare SPMI adults	3,596	3,100	3,900	3,854	3,631	3,367	3,256
Percent of SPMI adults competitively employed	13.4%	12.3%	15.6%	16.3%	15.9%	15.6%	15.4%

Tracking for this performance 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 CY2018 between 15.4% 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

Table 14 displays the numerator and denominator for the annual quarterly average. 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.

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 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
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	24
Denominator: Number of KanCare adults with SPMI homeless at the beginning of the quarter	150	100	70	104	104	112	94
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%	25.5%

The annual quarterly average number of adults with SPMI who were homeless at the start of each quarter was less in CY2013 through CY2018 (70 [CY2014] to 112 [CY2017]) than in CY2012 (150). Compared to CY2012 (45.7%), the annual quarterly average of those who were housed by the end of each quarter was higher in CY2013 (58.0%) and CY2014 (49.1%) but dropped in CY2015 through CY2018.

The number and percent of members utilizing inpatient mental health services (P4P 2014–2015)
The numerator and denominator for this performance measure are displayed in Table 15. The denominator includes eligible members at the end of each quarter. Rates are reported per 10,000.

Table 15. Number and Percent of KanCare Members Utilizing Inpatient Services – Annual Quarterly Average, CY2012 – CY2018							
	Pre-KanCare	KanCare					
	2012	2013	2014	2015	2016	2017	2018
Numerator: Number of KanCare members with an inpatient mental health admission during the quarter	1,560	1,298	1,306	1,020	975	999	866
Denominator: Number of KanCare members	391,444	406,731	418,610	413,145	437,602	396,339	355,423
Percent of members utilizing inpatient mental health services	0.4%	0.3%	0.3%	0.2%	0.2%	0.3%	0.2%
Rate per 10,000	39.9	31.9	31.2	24.7	22.3	25.2	24.4

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

Consumer Assessment of Healthcare Providers and Systems (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 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.

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 24 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 48 for a question related to efficiency.)

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 have only had small changes from 2014 to 2017), and the 2018 rates were lower than 2017. Quality Compass rankings for this question are provided only for the CCC population. The 2018 rates are in bold below and the ranges for previous rates (noted after the semicolon) are provided with the time-periods where the highest and lowest rates occur.

- **GC: 89.3%** in 2018; 89.3%–90.6% in 2014–2017
- **CCC: 92.4%** in 2018 **(≥50th QC**); 90.9%–93.0% in 2014–2017
  UnitedHealthcare's 2018 TXIX rate (92.2%; ≥50th QC) was significantly lower (*p*=.04) than the prior year's rate (96.2%; >95th 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 2018 than the previous years (2014–2017). (Quality Compass rankings are not available for this question.)

- **GC: 94.6%** in 2018; 91.1%–94.4% in 2014–2017
- **CCC: 94.7%** in 2018; 92.1%–93.6% in 2014–2017

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Table 16. Healthy Life Expectancy – CAHPS Survey, CY2014 – CY2018

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
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%	**89.3%**					
	CCC	90.9%	91.9%	91.1%	93.0%	**92.4%**	↑	↑	↑	↑	↑
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%	94.4%	**94.6%**					
	CCC	92.4%	92.1%	92.8%	93.6%	**94.7%**					
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%	**71.8%**	↓	↓	↓	↓	↓
	GC	70.7%	67.1%	67.3%	70.2%	**72.1%**	↓	↓	↓	↓	↓
	CCC	73.3%	71.6%	71.4%	74.4%	**77.1%**	↓	↓	↓	↓	↓
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%	**52.6%**					
	GC	31.9%	33.3%	33.1%	34.2%	**33.9%**					
	CCC	51.3%	50.7%	53.1%	53.2%	**52.2%**					
Did you and a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?	Adult	*	91.0%	93.3%	93.1%	**93.6%**		↓	↑	↑	↑
	GC	98.3%	94.8%	96.6%	93.8%	**94.4%**		↑	↑	↑	↑
	CCC	98.2%	96.7%	97.8%	96.4%	**96.3%**		↑	↑	↑	↓
Did you and a doctor or other health provider talk about the reasons you might not want (your child) to take a medicine?	Adult	*	72.3%	68.9%	69.2%	**71.5%**		↑	↑	↑	↑
	GC	77.4%	68.0%	69.5%	67.9%	**69.3%**		↑	↑	↑	↑
	CCC	81.5%	76.8%	74.8%	73.8%	**74.7%**		↑	↓	↑	↑
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%	**81.7%**	↓	↑	↑	↓	↑
	GC	77.7%	80.0%	80.8%	80.7%	**82.9%**	↑	↑	↑	↑	↑
	CCC	83.5%	86.0%	82.5%	85.9%	**87.3%**	↑	↑	↓	↑	↑

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile
* Answer choices changed from "A lot, Some, A little, Not all" in 2014 to "Yes, No" in 2015.

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Questions on Adult and Child Surveys											
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%	**92.4%**	↑	↑	↑	↑	↑
	GC	95.5%	94.9%	95.2%	95.8%	**96.6%**	↑	↑	↑	↑	↑
	CCC	95.3%	95.6%	95.1%	96.6%	**96.7%**	↑	↑	↓	↑	↑
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%	**93.3%**	↓	↑	↑	↑	↑
	GC	95.7%	95.2%	94.5%	96.8%	**96.3%**	↑	↑	↓	↑	↑
	CCC	94.4%	94.9%	94.7%	96.6%	**96.2%**	↑	↑	↑	↑	↑
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%	**50.5%**		↑	↑	↑	↑
Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	Adult	37.5%	33.5%	32.2%	33.2%	**31.9%**	↑^	↑^	↑^	↑^	↑^
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%	**78.8%**	↓	↓	↑	↑	↑
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%	51.2%	**52.2%**	↑	↓	↓	↑	↑
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.	Adult	38.6%	37.5%	44.4%	48.4%	**46.0%**	↓	↓	↑	↑	↑

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile.
* Answer choices changed from "A lot, Some, A little, Not all" in 2014 to "Yes, No" in 2015.
^ ≥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 improved in 2018 but continue to be low compared to national scores. All but one subgroup in 2018 was below the 50th QC. Results for the aggregate rates for the adult and child surveys were comparable across KanCare years:

- **Adults**: **71.8%** in 2018 (**<33.33rd QC**); 68.0%–71.6% in 2014–2017
- **GC**: **72.1%** in 2018 (**<50th QC**); 67.1%–70.7% in 2014–2017; **CCC**: **77.1%** in 2018 (**<25th QC**); 71.4%–74.4% in 2014–2017

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 2014 through 2017 (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, and closer to one-third of the GC survey respondents (31.9%–34.2%) indicated this. However, in 2018 there were small decreases in the rates compared to 2017 for all three respondent groups.

If yes:

- **How much did a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?**
  The QC percentile threshold increased for the adult population in 2018 but decreased for CCC.
  - **Adults: 93.6%** in 2018 (**>66.67th QC**); 91.0%–93.3% in 2015–2017 (<33.33rd to ≥50th QC)
  - **GC: 94.4%** in 2018 (**>75th QC**); 93.8%–96.6% in 2015–2017
  - **CCC: 96.3%** in 2018 (**<50th QC**); 96.4%–97.8% in 2015–2017 (≥50th to >75th QC)
- **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.
  - **Adults: 71.5%** in 2018 **(>66.67th QC**); 68.9%–72.3% in 2015–2017
  - **GC: 69.3%** in 2018 (**>75th QC**); 67.9%–69.5% in 2015–2017
  - **CCC: 74.7%** in 2018 (**≥50th QC**); 73.8%–76.8% in 2015–2017
- **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
  Kansas child survey rates and adult survey rates all improved in 2018 and the QC percentile thresholds increased compared to 2017.
  - **Adults: 81.7%** in 2018 (**>75th QC**); 75.8%–79.5% in 2014–2017
  - **GC: 82.9%** in 2018 (**>75th QC**); 77.7%–80.8% in 2014–2017
    Sunflower's TXIX rate (86.0%) in 2018 was >95th QC.
  - **CCC: 87.3%** in 2018 (**>75th QC**); 82.5%–86.0% in 2014–2017

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 positive percentages in 2018 were over 90%.

- **Adults: 92.4%** in 2018 (**<50th QC**); 91.8%–93.0% in 2014–2017
- **GC: 96.6%** in 2018 (**>75th QC**); 94.9%–95.8% in 2014–2017

- **CCC: 96.7%** in 2018 (**>66.67th QC**); 95.1%–96.6% in 2014–2017

How often did your (child's) personal doctor listen carefully to you?
All MCO adult and child subgroup percentages in 2018 remained above 91% positive. Although the QC percentile thresholds decreased for the child surveys in 2018, the subgroup survey rates were above 95%.

- **Adults: 93.3%** in 2018 (**>66.67th QC**); 89.7%–92.5% in 2014–2017; rate has steadily increased since 2014.
- **GC: 96.3%** in 2018 (**>66.67th QC**); 94.5%–96.8% in 2014–2017.
- **CCC: 96.2%** in 2018 (**≥50th QC**); 94.4%–96.6% in 2014–2017.

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: 50.5% in 2018 (**>90th QC**); 43.7%–48.8% in 2014–2017
Amerigroup's rate (54.6%) and Sunflower's rate (51.8%) were both >95th QC and UnitedHealthcare's rate (45.4%) was >75th QC.

Smoking Cessation *(CMS Core Quality Measure)*
Do you now smoke cigarettes or use tobacco: every day or some days, or not at all?
Adults: in 2018, **31.9%** (**≥50th QC**) reported they smoke; 32.2%–37.5% in 2014–2017
Although UnitedHealthcare's 2018 rate (35.7%) decreased compared to 2014 (40.6%), their rates and QC percentile ranking have been higher than the other two MCOs. (≥50th QC for this metric 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: 78.8%** in 2018 (**≥50th QC**); 75.7%–80.0% in 2014–2017
> In comparison to 2017, UnitedHealthcare's 2018 rate and percentile ranking increased whereas Amerigroup's and Sunflower's 2018 rate and QC percentile decreased.
> Amerigroup's rate (80.6%) was >66.67th QC, Sunflower's rate (77.1%) was <50th QC, and UnitedHealthcare's rate (78.6%) was <50th 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: 52.2% in 2018 (**≥50th QC**); 43.2%–51.2% in 2014–2017
Amerigroup's rate (50.0%) was <50th QC; Sunflower's rate (54.3%) and UnitedHealthcare's rate (52.1%) were both ≥50th 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: 46.0% in 2018 (**≥50th QC**); 37.5%–48.4% in 2014–2017; the overall rate and QC percentile decreased compared to 2017. UnitedHealthcare's and Amerigroup's 2018 rate and QC percentile also decreased, whereas Sunflower's rate and percentile threshold increased.

Amerigroup's rate (45.7%) was ≥50th QC, Sunflower's rate (51.4%) was >75th QC, and UnitedHealthcare's rate (41.1%) was <33.33rd 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 CY2017 was **63.7%, <25th QC**, and 9.7% (relative) higher than in CY2016. MCO rates were 59.3% (Sunflower; <10th QC), 68.2% (Amerigroup; <50th QC), and 63.2% (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 an MCO P4P measure 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 – CY2017

	2013	2014	2015	2016	2017
Breast cancer screening*	31.0%	47.0%*	50.5%*	51.6%*	52.1%
Cervical cancer screening*	47.0%	48.8%*	52.1%*	51.8%*	50.9%
Adults' access to preventive/ambulatory health services	95.6%	95.2%	94.9%	95.3%*	94.5%
Comprehensive diabetes care					
HbA1c testing	84.4%	86.5%	87.6%	86.2%	85.0%
Eye exam (retinal) performed	58.7%	63.7%	66.5%	67.3%	66.8%
Medical attention for nephropathy	77.8%	75.2%	90.8%	87.6%	89.3%
HbA1c Control (<8.0%)	38.1%	38.0%	46.5%	52.8%^	56.7%^
Blood pressure control (<140/90)	57.0%	51.0%	60.2%	52.1%^	62.5%^

* Multi-year measure - Includes members who were screened within 27 month time period ending in CY2017.
^ Aggregated rate for Amerigroup and Sunflower. UnitedHealthcare data reported for 2016 and 2017 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 CY2017, 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 (94.5% [CY2017] to 95.6% [CY2013]) were higher than rates for all eligible KanCare members (86.7% [CY2017] to 88.4% [CY2013]).

Breast Cancer Screening (P4P 2014–2015) *(CMS Core Quality Measure)*
The breast cancer screening rate reported for the PD, I/DD, SMI population in CY2017 was 52.1%. The rates for CY2015–CY2017 were higher (50.5% [CY2015] to 47.0% [CY2017]) than the aggregated HEDIS rates for the eligible KanCare population (45.0% [CY2015] to 52.17.0% [CY2017], all rates <10th QC). The breast cancer screening HEDIS measure has multi-year eligibility criteria. The numerators for CY2014–CY2017 include 27 months of data each measurement year 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 CY2017, the aggregated rate based on MCO reported rates for the PD–I/DD–SMI population (50.9%) was lower than the aggregated HEDIS rate for all eligible KanCare women (58.3%; <50th QC). The cervical cancer screening measure, as with the breast cancer screening measure, is a multi-year measure. The cervical cancer screening rates reported for the CY2013 and CY2015 PD, I/DD, SMI population (47.0% and 52.1%, respectively) were comparable to the aggregated CY2013 and CY2015 HEDIS rates for the eligible KanCare population (49.0% and 51.6%, respectively).

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-like measure. MCOs were directed to continue to report CDC rates for PD–I/DD–SMI members in CY2016 and CY2017. UnitedHealthcare's rates reported for the PD–I/DD–SMI metrics for these two years were based only on administrative (claims) data. Therefore, aggregated rates reported for CY2016 and CY2017 in Table 17 for these two metrics are based only on data reported by Amerigroup and Sunflower.

- **HbA1c testing** – *(CMS Core Quality Measure)* In CY2017, the MCO aggregated rates (85.0%) for the PD–I/DD–SMI members was slightly lower than the rate for all eligible KanCare adult members (86.2%). In CY2014 to CY2016, MCO aggregated rates for the PD–I/DD–SMI members (CY2014 – 86.5%; CY2015 – 87.6%; and CY2016 – 86.2%) were slightly higher than the rates for all eligible KanCare adult members (CY2014 – 84.8%; CY2015 – 84.9%; and CY2016 – 85.8%).
- **Eye exam (retinal)** – The aggregated rate for PD–I/DD–SMI members was lower in CY2017 (66.8%- than in CY2016 (67.3%) and comparable to CY2015 (66.5%). Rates for PD–I/DD–SMI members were also higher each year (ranging from 58.7% [CY2013] to 67.3% [CY2016]) than rates for all eligible KanCare members (ranging from 50.1% [CY2013] to 64.4 [CY2016]).
- **Medical attention for nephropathy** – Rates for the PD–I/DD–SMI population and all eligible KanCare members had small increases from CY2016 to CY2017. However, the CY2017 rate for the PD–I/DD–SMI population (89.3%) was 14.8% (relative percent) higher than in CY2013 (77.8%) and was higher than the CY2017 rate for all eligible KanCare members (88.8%). The HEDIS-like rates for the PD–I/DD–SMI population have been more comparable to the all eligible KanCare members since CY2015.
- **HbA1c control <8.0%** – Rates for HbA1c control have generally increased each year from CY2013 to CY2017 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% [CY2013]–46.5% [CY2015]), compared to all eligible members (39.0% [CY2013]–46.6% [CY2015]). As noted above, the CY2016 and CY2017 rates for the PD–I/DD–SMI population are based on an aggregated hybrid rate of Amerigroup and Sunflower (56.7%), which is comparable to the aggregated rate of their total eligible population (52.7%).
- **Blood pressure control <140/90** – The CY2017 rate for the PD–I/DD–SMI members had a large increase (62.5%) compared to CY2016 (52.1%); however, the rate in CY2015 was 60.2%. The blood

pressure control rates have been higher for the PD–I/DD–SMI members (57.0% [CY2013]; 62.5% [CY2017] than the rates for the total eligible population 53.1% [CY2013]; 61.1% [CY2017], although the annual rates have varied more in the HEDIS-like population. As noted above, the CY2017 rate for the PD–I/DD–SMI population is based on an aggregated hybrid rate of Amerigroup and Sunflower (62.5%), which is higher than their total eligible population aggregated rate (56.8%).

Immunizations for Adolescents – Combination 2
(meningococcal conjugate vaccine [1 dose], tetanus, diphtheria toxoids and acellular pertussis [Tdap 1]; and human papillomavirus [HPV, vaccine series])
This is the MCOs' first year of providing HEDIS-like rates for the immunizations for adolescents measure (IMA). The CY2017 MCO aggregate rate (25.3%) for the PD–I/DD–SMI population is lower than the reported HEDIS measure for all eligible KanCare members (30.3%).

Childhood Immunizations – Combination 10
(diphtheria, tetanus, and acellular pertussis [DTaP, 4]; polio [IPV, 3]; measles, mumps, and rubella [MMR, 1], haemophilus influenza type B [HiB, 3]; hepatitis B [HepB, 3]; chicken pox [VZV, 1];
pneumococcal conjugate [PCV, 4]; hepatitis A [HepA, 1]; rotavirus [RV, 2–3]; and influenza [flu])
This is the first year (CY2017) the MCOs have provided their HEDIS-like rates for the childhood immunizations measure (CIS). The HEDIS measure is for children who turn two years of age during the measurement year. Therefore, there are very few eligible children in the HEDIS-like population (PD–I/DD–SMI) for this measure. Two of the four eligible members were up-to-date with all of their childhood immunizations.

(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, and Autism).

The number of KanCare members receiving PD or TBI waiver services who are participating in the WORK program. (P4P 2014–2015)
This performance 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 2018, data was provided for how many waiver members moved to the WORK program, but not whether the number of hours of competitive employment were increased. The number of members participating in the WORK program in 2018 (150 PD, 16 TBI, and 135 I/DD) was fairly consistent with 2017. There were 142 PD, 15 TBI, and 125 I/DD Waiver members participating in the WORK program as of April 2017, with six additional PD, TBI, and I/DD Waiver members participating during the year.

Previously, 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.

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

The denominator for this performance 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 – CY2017

Waiver	2013	2014	2015	2016	2017
Intellectual/Developmental Disability (I/DD)	99%	78%	48%	68%	77%
Physical Disability (PD)	86%	87%	59%	76%	84%
Frail Elderly (FE)	87%	86%	61%	77%	81%
Traumatic Brain Injury (TBI)	72%	73%	45%	72%	77%
Technical Assistance (TA)	96%	96%	59%	73%	83%
Serious Emotional Disturbance (SED)	92%	90%	97%	94%	92%
Autism	59%	68%	46%	36%	37%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 18, SED Waiver participants had the highest percentage for service plans addressing their assessed needs and capabilities. Members receiving Autism waiver services have the lowest rates.

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 performance 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 – CY2017

Waiver	2013	2014	2015	2016	2017
Intellectual/Developmental Disability (I/DD)	98%	92%	68%	77%	81%
Physical Disability (PD)	85%	95%	72%	81%	86%
Frail Elderly (FE)	87%	92%	72%	83%	86%
Traumatic Brain Injury (TBI)	70%	87%	56%	72%	77%
Technical Assistance (TA)	100%	98%	74%	80%	83%
Serious Emotional Disturbance (SED)	13%	93%	98%	90%	94%
Autism	50%	86%	49%	38%	37%

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. Members receiving Autism Waiver services have the lowest rates.

(6) Long-Term Care: Nursing Facilities

Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO (P4P 2014)
The numerator is the number of denied NF claims in the calendar year (see Table 20). Due to claims lag, data for 2018 is not currently reported.

Table 20. Nursing Facility Claims Denials, CY2012 – CY2017

	2012	2013	2014	2015	2016	2017
Denominator: Total number of nursing facility claims	555,652	337,767	368,242	361,293	323,794	320,540
Numerator: Number of nursing facility claims denied	63,976	45,475	38,339	47,645	43,340	32,270
Percent of nursing facility claims denied	11.5%	13.5%	10.4%	13.2%	13.4%	10.1%

The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013; CY2015 and CY2016 had similar rates. However, in CY2017, the percentage of denied NF claims (10.1%) was lower than the prior five years and comparable to CY2014 (10.4%).

Percentage of NF members who had a fall with a major injury (P4P 2014–2015)
Table 21 details the numerator and denominator for the performance measure. 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; the rate has remained consistent since CY2013. There were 75 fewer falls in CY2018 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.

Table 21. Nursing Facility Major Injury Falls, CY2012 – CY2018

	2012	2013	2014	2015	2016	2017	2018
Denominator: Nursing facility KanCare members	46,794	46,114	43,589	42,301	37,138	38,690	39,278
Numerator: Number of nursing facility major injury falls	288	246	232	236	202	214	213
Percent of nursing facility Kancare members with major injury falls	0.62%	0.53%	0.53%	0.56%	0.54%	0.55%	0.54%

Percentage of members discharged from a NF who had a hospital admission within 30 days (P4P 2014–2018)
Table 22 details the numerator and denominator for this performance measure. The numerator includes admissions within 30 days of being discharged from the NF.

Table 22. Hospital Admissions After Nursing Facility Discharge, CY2012 – CY2017

	2012	2013	2014	2015	2016	2017
Denominator: Number of nursing facility discharges	2,130	2,086	2,268	2,210	1,958	1,987
Numerator: Number of hospital admissions after nursing facility discharge	153	250	288	266	260	254
Percent of hospital admissions after nursing facility discharge	7.18%	11.98%	12.70%	12.04%	13.28%	12.78%

The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased in CY2013 to 11.98% from 7.18% in CY2012 (pre-KanCare) and has fluctuated each year thereafter. CY2017 had 143 fewer discharges and 101 more hospital admissions after NF discharge compared to CY2012.

Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network (P4P 2014)
Peak 2.0 is a Medicaid pay-for-performance program offered by KDADS. The Kansas State University Center on Aging administers the program on behalf of KDADS. The goal of the program is to improve the quality of life for residents living in Kansas nursing facilities. The program is designed to reward organizational change through the adoption of person-centered care practices. Facilities enrolled in the program engage in a variety of opportunities including education, action planning, consultation, exposure, recognition and mentoring activities. All facilities enrolled in the program are not considered a *"PEAK Home."* There are foundation levels. Person-Centered Care Homes in the PEAK program are homes that have achieved Level 3 through 5.

PEAK Person-Centered Care Homes are evaluated at the end of a fiscal year and are awarded Levels 3–5 for the next fiscal year. The evaluation covers a retrospective period, the award is prospective. For example, the evaluations are conducted at the end of a fiscal year (spring). The homes that earned PEAK Person-Centered Home status are awarded levels 3 through 5 for the next state fiscal year.

Level 4 and 5 homes are evaluated every other year; therefore, the award and PEAK Person-Centered Care Home designation is for two years. At the bi-annual review, a Level 4 or 5 home could be moved to Level 3 or lower.

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. Table 23 details the number of PEAK Person-Centered Care Homes from FY2013 to FY2018. The number of Person-Centered Care Homes increased from 8 in FY2013 to 17 by June of FY2017, and by June of FY2018, decreased to 13.

Table 23. Nursing Facilities Designated as PEAK Person-Centered Care Homes at the end of the Fiscal Year, FY2013 – FY2018*

	2013	2014	2015	2016	2017	2018
Number of Nursing Homes	**8**	**9**	**10**	**15**	**17**	**13**
Number of Level 5 homes	5	6	4	4	6	5
Number of Level 4 homes	1	1	3	5	7	6
Number of Level 3 homes	2	2	3	6	4	2

* The start of the fiscal year is July 1.

(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 24. Adults consistently report lower ratings than GC and CCC, with GC respondents generally providing the higher score overall.

Table 24. Member Survey (CAHPS) – Quality of Care Questions, CY2014 – CY2018

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
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%	74.1%	74.5%	**74.7%**	↑	↑	↑	↑	↓
	GC	87.5%	85.7%	87.7%	88.5%	**88.3%**	↑	↑	↑	↑	↑
	CCC	84.8%	84.5%	84.9%	87.1%	**86.9%**	↑	↑	↑	↑	↑
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%	**55.3%**	↑	↓	↑	↑	↑
	GC	68.6%	68.9%	70.7%	71.8%	**71.4%**	↑	↑	↑	↑	↑
	CCC	65.2%	64.8%	66.2%	67.9%	**66.4%**	↑	↑	↑	↓	↓
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%	**77.8%**	↓	↓	↑	↓	↑
	GC	86.8%	87.6%	88.7%	87.7%	**88.5%**	↑	↑	↑	↑	↑
	CCC	81.1%	83.5%	85.2%	86.0%	**85.4%**	↑	↑	↑	↑	↑
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%	**61.8%**	↓	↓	↑	↓	↑
	GC	71.0%	72.1%	73.8%	74.0%	**74.7%**	↑	↑	↑	↑	↑
	CCC	63.3%	66.8%	67.4%	69.9%	**69.7%**	↓	↑	↑	↑	↑
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%	**83.4%**	↑	↑	↓	↑	↑
	GC	88.5%	87.9%	88.7%	90.5%	**90.3%**	↑	↓	↑	↑	↑
	CCC	87.7%	87.7%	87.9%	89.4%	**88.9%**	↑	↑	↓	↑	↓
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%	**69.4%**	↑	↑	↑	↑	↑
	GC	73.4%	72.5%	75.9%	77.4%	**76.5%**	↓	↓	↑	↑	↑
	CCC	71.8%	72.9%	74.3%	74.6%	**75.4%**	↓	↓	↓	↓	↓
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%	**82.4%**	↓	↓	↓	↑	↓
	GC	85.6%	82.9%	87.9%	88.5%	**90.7%**	↑	↓	↑	↑	↑
	CCC	85.5%	83.9%	87.0%	86.9%	**85.9%**	↓	↓	↑	↑	↓
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%	66.4%	69.8%	**69.3%**	↓	↑	↑	↑	↑
	GC	69.6%	69.3%	73.0%	75.7%	**77.6%**	↓	↓	↑	↑	↑
	CCC	68.5%	67.8%	73.0%	73.5%	**72.8%**	↓	↓	↑	↑	↓
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%	**94.0%**	↑	↑	↑	↑	↑
	GC	96.7%	96.0%	96.0%	97.6%	**96.8%**	↑	↑	↑	↑	↑
	CCC	94.4%	95.8%	95.6%	97.2%	**96.5%**	↓	↑	↓	↑	↑
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%	**90.3%**	↑	↑	↑	↑	↑
	GC	90.4%	89.7%	91.0%	92.0%	**91.4%**	↑	↑	↑	↑	↑
	CCC	90.6%	91.3%	91.4%	92.9%	**93.3%**	↓	↓	↑	↑	↑

↑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:

- **Adults: 74.7%** in 2018 **(<50th QC**); 73.5%–74.5% in 2014–2017
- **GC: 88.3%** in 2018 **(≥50th QC**); 85.7%–88.5% in 2014–2017
- **CCC: 86.9%** in 2018 (**≥50th QC**); 84.5%–87.1% in 2014–2017
  UnitedHealthcare's rate for TXXI (94.9%; >95th QC) was significantly higher (*p*=.03) than in 2017 (87.9%; >75th). Sunflower's TXXI 2018 rate (90.0%) was >95th QC.

Rating of 9 or 10:

- **Adults: 55.3%** in 2018 (**≥50th QC**); 50.9%–55.8% in 2014–2017
- **GC: 71.4%** in 2018 (**≥50th QC**); 68.6%–71.8% in 2014–2017
- **CCC: 66.4**% in 2018 (**<50th QC**); 64.8%–67.9% in 2014–2017

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: 77.8%** in 2018 (**≥50th QC**); 72.5%–76.5% in 2014–2017
- **GC: 88.5%** in 2018 (**>66.67th QC**); 86.8%–88.7% in 2014–2017
  Amerigroup's 2018 TXXI rate (91.1%) was >90th QC.
- **CCC: 85.4**% in 2018 (**≥50th QC**); 81.1%–86.0% in 2014–2017
  UnitedHealthcare's 2018 TXXI rate (90.4%) was >95th QC.

Rating of 9 or 10:

- **Adults: 61.8%** in 2018 (**≥50th QC**); 54.6%–60.9% in 2014–2017
  Sunflower's rate (65.7%; >75th QC) was significantly higher (*p*=.02) than in 2017 (58.5%).
  UnitedHealthcare's rate (62.5%; ≥50th QC) was significantly higher (*p*=.04) than in 2017 (55.7%).
- **GC: 74.7%** in 2018 (**>66.67th QC**); 71.0%–74.0% in 2014–2017
  Sunflower's 2018 TXXI rate (78.6%) was >90th QC.
- **CCC: 69.7%** in 2018 (**≥50th QC**); 63.3%–69.9% in 2014–2017

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: 83.4%** in 2018 (**>66.67th QC**); 79.6%–83.0% in 2014–2017
- **GC: 90.3%** in 2018 **(≥50th QC**); 87.9%–90.5% in 2014–2017
- **CCC: 88.9%** in 2018 **(<33.33rd QC**); 87.7%–89.4% in 2014–2017

UnitedHealthcare's TXXI rate (94.5%) was >95th QC.

Rating of 9 or 10:

- **Adults: 69.4%** in 2018 (**>66.67th QC**); 64.4%–67.5% in 2014–2017
- **GC: 76.5%** in 2018 (**≥50th QC**); 72.5%–77.4% in 2014–2017
  Amerigroup's TXXI rate (77.1%) was ≥50th QC and significantly higher (*p*=.02) than in 2017 (72.3%; <25th QC).
- **CCC: 75.4%** in 2018 (**<50th QC**); 71.8%–74.6% in 2014–2017
  Amerigroup's TXXI rate (78.7%) was >66.67th QC and significantly higher (*p*=.01) than in 2017 (68.2%; <5th QC).

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:

- **Adults: 82.4%** in 2018 (**<50th QC**); 80.0%–82.7% in 2014–2017
- **GC: 90.7%** in 2018 (**>75th QC**); 82.9%–88.5% in 2014–2017
  Although not a significant difference in rates, Sunflower's QC ranking improved from >66.67th (89.4%) in 2017 to >95th (95.7%) in 2018.
- **CCC: 85.9%** in 2018 (<**50th QC**); 83.9%–87.0% in 2014–2017

Rating of 9 or 10:

- **Adults: 69.3%** in 2018 (**≥50th** QC); 64.8%–69.8% in 2014–2017
- **GC: 77.6%** in 2018 (**>75th QC**); 69.3%–75.7% in 2014–2017
  Amerigroup's TXXI rate (79.9%) was >90th QC.
  Sunflower's TXIX rate (81.0%) was >95th QC.
- **CCC: 72.8%** in 2018 (**<50th QC**); 67.8%–73.5% in 2014–2017

Doctor respected member's comments.
Rates were higher than 94% for all subgroups in 2018:

- **Adults: 94.0%** in 2018 (**>66.67th QC**); 91.9%–93.4% in 2014–2017
- **GC: 96.8%** in 2018 (**≥50th QC**); 96.0%–97.6% in 2014–2017
  UnitedHealthcare's TXIX rate (96.1%) was <50th QC and significantly lower (p=.02) than in 2017 (99.3%; >95th QC).
- **CCC: 96.5%** in 2018 (**≥50th QC**); 94.4%–97.2% in 2014–2017
  UnitedHealthcare's TXIX rate (95.6%) was <25th QC and significantly lower (p<.01) than in 2017 (99.6%; >95th QC).

Doctor spent enough time with the member.

- **Adults: 90.3%** in 2018 (**≥50th QC**); 89.0%–91.2% in 2014–2017
- **GC: 91.4%** in 2018 (**>66.67th QC**); 89.7%–92.0% in 2014–2017
- **CCC: 93.3%** in 2018 **(>66.67th QC);** 90.6%–92.9% in 2014–2017

Mental Health Survey

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2018 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 for Families and Adult Consumer Survey tools, as modified over the past eight years, were used for this project.

Questions were the same in 2011 through 2018, with the exception of the following questions that were added and some later removed (in 2018), at the State's request:

- In 2018, in the adult survey tool, questions (previously added in 2015) related to smoking cessation were removed. In the youth survey tool, the section for youth ages 12 and older to complete (to capture youth perceptions of care received) and questions related to providers' interaction with youth were removed.
- A question was added in 2017 related to whether the (adult) member is doing what he/she wants to for paid work.

- Three questions were 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.
- A question on whether medication was available timely added in 2013.

In 2018, the survey was mailed to 8,339 KanCare members and 754 (339 Adult and 415 Youth) were completed. Results are reported for the subgroups Adults (members ages 18 or older) and Youth (members ages 17 or younger) who received mental health services. The reported results for *"Youth"* reflect family member responses for members age 17 or younger.

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (2011 and 2012) to KanCare (2013 to 2018).

Table 25 shows rates of positive responses for questions related to quality of care. (See Table 31 for questions related to coordination of care, Table 43 for questions related to access to care, and Table 49 for an efficiency-related question.)

The quality-related questions in Table 25 focus on the following:

Understandable communication from provider with member

- For Adult members, the rate in 2018 was 93.3%; positive responses have been 90% or above in each of the seven previous years.
- The Youth rate in 2018 was 98.1%; rates ranged from 96.7% (2011) to 98.8% (2015), with no statistically significant differences.

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

Adult members had a lower percentage of positive responses in 2018 (86.1%) than in five of seven prior years (84.4% [2012] to 89.4% [2014]), although differences were not statistically significant.

Better ability to deal with crisis, as a direct result of services provided.

For Adult members, there was a significant increase in 2018 to 78.6% from 69.2% in 2016 ($p<.01$). All other years ranged from 71.4% [2012] to 80.4% [2011].

Member choice of treatment goals.

- In 2018, the percentage of Adult members who indicated they had a choice of treatment goals was 80.6%, and as in previous years, Adult members had a lower positive response percentage than the Youth subgroup (92.8%).
- The Youth rate in 2018 was 92.8% and annual rates have ranged from 90.5% to 92.9% since 2011.

Better control of daily life due to services provided.

- The rate for Adult members significantly increased to 82.0% in 2018 from 74.8% in 2016 ($p=.03$). All other years ranged from 76.4% [2012] to 86.5% [2011].
- For Youth, the rate in 2018 was 79.6%, with no statistically significant differences.

Table 25. Mental Health Survey – Quality-Related Questions

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Yr	Trend 8-Yr
My (my child's) mental health providers spoke with me in a way that I understood.	**Adults (Age 18+)**							
	2018		**93.3%**	308 / 330	90.0% – 95.6%		.45	.96
	2017		94.8%	381 / 402	92.1% – 96.6%	.38		
	2016		90.0%	266 / 295	86.0% – 92.9%	.13		
	2015		95.3%	368 / 386	92.7% – 97.1%	.24		
	2014		93.6%	765 / 817	91.7% – 95.1%	.82		
	2013		94.3%	1,002/1,063	92.8% – 95.6%	.48		
	2012		91.5%	257 / 281	87.6% – 94.2%	.40		
	2011		93.4%	282 / 302	89.9% – 95.7%	.96		
	Youth (Ages 0–17), Family Responding							
	2018		**98.1%**	399 / 407	96.2% – 99.1%		.39	.24
	2017		97.7%	476 / 487	95.9% – 98.8%	.68		
	2016		97.5%	323 / 331	95.1% – 98.8%	.54		
	2015		98.8%	324 / 328	96.9% – 99.7%	.43		
	2014		97.5%	766 / 786	96.1% – 98.4%	.51		
	2013		97.3%	950 / 981	96.1% – 98.2%	.38		
	2012		97.8%	262 / 268	95.1% – 99.1%	.75		
	2011		96.7%	327 / 338	94.2% – 98.2%	.24		
If I had other choices, I would still get services from my mental health providers.	**Adults (Age 18+)**							
	2018		**86.1%**	273 / 318	81.9% – 89.5%		.25	.75
	2017		89.0%	345 / 388	85.5% – 91.8%	.25		
	2016		85.0%	246 / 289	80.4% – 88.7%	.71		
	2015		88.4%	336 / 380	84.8% – 91.3%	.36		
	2014		89.4%	720 / 805	87.1% – 91.4%	.11		
	2013		88.3%	911/1,034	86.2% – 90.1%	.29		
	2012		84.4%	232 / 275	79.6% – 88.2%	.55		
	2011		88.3%	263 / 298	84.1% – 91.5%	.43		
As a direct result of the services I received, I am better able to deal with crisis.	**Adults (Age 18+)**							
	2018		**78.6%**	242 / 308	73.7% – 82.9%		.19	.45
	2017		77.2%	285 / 369	72.7% – 81.2%	.66		
	2016		69.2%	192 / 277	63.6% – 74.4%	**<.01 +**		
	2015		79.3%	279 / 352	74.8% – 83.3%	.83		
	2014		78.7%	602 / 765	75.7% – 81.5%	.98		
	2013		79.1%	780 / 987	76.4% – 81.5%	.87		
	2012		71.4%	182 / 255	65.5% – 76.6%	.05		
	2011		80.4%	221 / 275	75.2% – 84.6%	.61		
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**Adults (Age 18+)**							
	2018		**80.6%**	250 / 311	75.8% – 84.6%		.55	.98
	2017		83.2%	311 / 374	79.1% – 86.7%	.37		
	2016		78.6%	219 / 278	73.4% – 83.0%	.54		
	2015		85.1%	303 / 356	81.1% – 88.5%	.12		
	2014		84.0%	655 / 780	81.3% – 86.5%	.17		
	2013		81.8%	809 / 989	79.3% – 84.1%	.63		
	2012		77.0%	198 / 257	71.5% – 81.8%	.30		
	2011		83.7%	237 / 283	79.0% – 87.6%	.32		
	Youth (Ages 0–17), Family Responding							
	2018		**92.8%**	360 / 388	89.7% – 95.0%		.10	.08
	2017		92.9%	436 / 469	90.2% – 94.9%	.96		
	2016		92.5%	288 / 311	89.0% – 95.0%	.88		
	2015		92.7%	289 / 312	89.2% – 95.1%	.96		
	2014		92.2%	689 / 750	90.0% – 93.9%	.72		
	2013		90.5%	847 / 937	88.4% – 92.2%	.18		
	2012		91.6%	229 / 250	87.4% – 94.5%	.58		
	2011		90.7%	294 / 324	87.1% – 93.5%	.32		

Table 25. Mental Health Survey – Quality-Related Questions (Continued)

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Yr	Trend 8-Yr
As a direct result of the services I received, I am better able to control my life.	**Adults (Age 18+)**							
	2018		**82.0%**	263 / 321	77.4% – 85.8%		.11	.21
	2017		82.0%	316 / 385	77.9% – 85.6%	.99		
	2016		74.8%	213 / 284	69.4% – 79.5%	**.03 +**		
	2015		83.8%	309 / 369	79.7% – 87.2%	.53		
	2014		84.9%	669 / 788	82.2% – 87.2%	.23		
	2013		83.0%	851/1,025	80.6% – 85.2%	.68		
	2012		76.4%	204 / 267	70.9% – 81.1%	.09		
	2011		86.5%	250 / 289	82.1% – 90.0%	.13		
As a direct result of the services my child and/or family received, my child is better at handling daily life.	**Youth (Ages 0–17), Family Responding**							
	2018		**79.6%**	314 / 396	75.3% – 83.2%		.64	.94
	2017		82.9%	397 / 478	79.3% – 86.0%	.21		
	2016		77.8%	252 / 324	72.9% – 82.0%	.56		
	2015		82.0%	265 / 323	77.4% – 85.8%	.41		
	2014		79.6%	606 / 764	76.6% – 82.3%	.99		
	2013		82.1%	772 / 948	79.5% – 84.4%	.28		
	2012		81.0%	205 / 253	75.7% – 85.4%	.65		
	2011		79.4%	258 / 325	74.6% – 83.4%	.96		
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**Adults (Age 18+)**							
	2018		**87.0%**	269 / 310	82.8% – 90.3%		.41	.58
	2017		86.7%	328 / 378	82.9% – 89.8%	.91		
	2016		82.7%	230 / 278	77.8% – 86.7%	.14		
	2015		86.3%	315 / 365	82.4% – 89.5%	.80		
	2014		86.8%	675 / 778	84.2% – 89.0%	.92		
	2013		87.6%	891/1,020	85.4% – 89.4%	.80		
	2012		81.6%	213 / 261	76.4% – 85.9%	.08		
	2011		89.3%	258 / 289	85.1% – 92.4%	.39		
As a direct 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.	**Adults (Age 18+)**							
	2018		**80.6%**	251 / 312	75.9% – 84.6%		.71	.97
	2017		77.1%	294 / 381	72.6% – 81.1%	.26		
	2016		69.3%	195 / 280	63.6% – 74.4%	**<.01 +**		
	2015		78.9%	290 / 368	74.4% – 82.8%	.58		
	2014		74.3%	581 / 782	71.1% – 77.3%	**.03 +**		
	2013		77.7%	786/1,012	75.0% – 80.2%	.27		
	2012		70.1%	185 / 264	64.3% – 75.3%	**<.01 +**		
	2011		82.4%	238 / 289	77.5% – 86.3%	.59		
	Youth (Ages 0–17), Family Responding							
	2018		**80.0%**	310 / 388	75.7% – 83.7%		.18	.07
	2017		82.9%	393 / 474	79.2% – 86.0%	.27		
	2016		80.7%	255 / 317	76.0% – 84.7%	.81		
	2015		84.5%	268 / 317	80.1% – 88.1%	.12		
	2014		80.7%	606 / 751	77.8% – 83.4%	.75		
	2013		84.3%	780 / 930	81.8% – 86.5%	.06		
	2012		85.0%	215 / 253	80.0% – 88.9%	.11		
	2011		84.1%	264 / 314	79.6% – 87.7%	.16		

Table 25. Mental Health Survey – Quality-Related Questions (Continued)							
	Year 0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Yr	Trend 8-Yr
I felt comfortable asking questions about my treatment and medication.	**Adults (Age 18+)**						
	2018	**89.8%**	294 / 328	86.0% – 92.6%		.34	.35
	2017	91.2%	360 / 395	87.9% – 93.6%	.53		
	2016	85.9%	245 / 285	81.3% – 89.5%	.14		
	2015	94.5%	358 / 379	91.7% – 96.4%	**.02 -**		
	2014	90.7%	733 / 808	88.5% – 92.5%	.63		
	2013	91.1%	959/1,052	89.2% – 92.7%	.46		
	2012	87.5%	244 / 279	83.0% – 90.9%	.37		
	2011	93.6%	278 / 297	90.2% – 95.9%	.08		
I have people I am comfortable talking with about my child's problems.	**Youth (Ages 0–17), Family Responding**						
	2018	**91.9%**	374 / 407	88.8% – 94.2%		.69	.73
	2017	91.6%	431 / 470	88.8% – 93.8%	.90		
	2016	91.5%	289 / 316	87.9% – 94.2%	.87		
	2015	92.5%	300 / 324	89.0% – 94.9%	.77		
	2014	90.4%	688 / 761	88.1% – 92.3%	.41		
	2013	91.6%	871 / 954	89.7% – 93.2%	.88		
	2012	93.1%	244 / 262	89.3% – 95.7%	.55		
	2011	92.6%	301 / 325	89.2% – 95.0%	.71		

Received help from provider in obtaining information to assist in managing their health.
For Adult members, the rate in 2018 (87.0%) was higher than in five of seven years (81.6% [2012] to 89.3% [2011]) and was comparable to 2013 (87.6%).

Better able to do things the member wants to do, as a direct result of services provided.

- Adult member positive responses significantly increased in 2018 to 80.6% from 69.3% in 2016 ($p<.01$), 74.3% in 2014 ($p=.03$), and 70.1% in 2012 ($p<.01$).
- Youth had a lower percentage of positive response in 2018 (80.0%) than in each of the seven previous years; although, there were no statistically significant differences. Rates prior to 2018 ranged from 80.7% [2016 and 2014] to 85.0% [2012].

Comfort in asking questions about treatment, medication, and/or children's problems.

- For Adult members feeling comfortable asking questions about their treatment and medication, there was a significant decrease in positive responses from 2015 (94.5%) compared to 2018 (89.8%; $p=.02$) and a greater than 90% positive response in five of seven prior years.
- For Youth family respondents feeling like they have people they are comfortable talking with about their child's problems, the rate in 2018 was 91.9%; rates have consistently been greater than 90% since 2011 (90.4% [2014] to 93.1% [2012]).

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 SUD survey was not

conducted in 2018. 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 ranged from 31.8 (2012) to 33.9 (2016) 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.

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.

From CY2013 to CY2017, two of the MCOs, Sunflower and UnitedHealthcare, administered separate surveys to their BH providers. However, in September 2018, Cenpatico was transitioned to Sunflower; therefore, a separate survey was not conducted in 2018. The MCOs were asked to include these three questions on their BH surveys as well.

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. 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 PH and BH providers. In CY2018, **70.6%** of 303 providers surveyed reported they were very or somewhat satisfied, higher than the four previous years (50.9% [CY2014] – 65.2% [CY2017]). The percentage of providers responding very or somewhat dissatisfied was correspondingly lower in CY2018 (10.6%) than in the four previous years (11.5% [CY2017] –18.8%[CY2014]).

Sunflower

In CY2018, Sunflower conducted one survey for both PH and BH providers. In CY2018, **54.6**% of 174 providers surveyed reported they were very or somewhat satisfied, a higher rate than in the four previous years (51.1% [CY2017] to 37.5% [CY2014]); trend with caution due to changes in survey methods. The percentage of providers responding they were very or somewhat dissatisfied decreased each year from CY2014 (17.6%) to CY2017 (9.9%) and increased to 13.8% in CY2018.

Table 26. Provider Satisfaction with MCO's Commitment to High Quality of Care for Their Members, CY2014 – CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	50.9%	62.8%	60.9%	65.2%	**70.6%**
Sunflower *(General Provider)*	37.5%	47.1%	50.8%	51.1%	**54.6%**
Cenpatico *(Behavioral Health)*	†	51.6%	48.8%	35.3%	‡
UnitedHealthcare *(General Provider)*	^	44.7%	40.3%	41.3%	**61.5%**
Optum *(Behavioral Health)*	54.7%	59.4%	55.9%	53.2%	**49.3%**
	Neither Satisfied nor Dissatisfied				
Amerigroup*	30.4%	23.4%	22.8%	23.3%	**18.8%**
Sunflower *(General Provider)*	45.0%	41.0%	38.9%	39.0%	**31.6%**
Cenpatico *(Behavioral Health)*	†	41.3%	44.2%	44.1%	‡
UnitedHealthcare *(General Provider)*	^	40.8%	44.4%	38.7%	**30.8%**
Optum *(Behavioral Health)*	36.9%	34.7%	35.2%	38.0%	**39.2%**
	Very or Somewhat Dissatisfied				
Amerigroup*	18.8%	13.8%	16.3%	11.5%	**10.6%**
Sunflower *(General Provider)*	17.6%	11.9%	10.3%	9.9%	**13.8%**
Cenpatico *(Behavioral Health)*	†	7.2%	7.0%	20.6%	‡
UnitedHealthcare *(General Provider)*	^	14.5%	15.3%	20.0%	**7.7%**
Optum *(Behavioral Health)*	8.4%	5.9%	9.0%	8.9%	**11.5%**
	Total Responses				
Amerigroup*	283	427	215	365	**303**
Sunflower *(General Provider)*	251	293	311	182	**174**
Cenpatico *(Behavioral Health)*	†	126	172	34	‡
UnitedHealthcare *(General Provider)*	^	76	72	75	**26**
Optum *(Behavioral Health)*	84	101	145	158	**148**

*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."
†Question was not asked in Cenpatico survey in 2014.
‡Cenpatico Behavioral Health transitioned to Sunflower September 1, 2018; therefore, no data is vailable.

UnitedHealthcare

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

- **UnitedHealthcare general provider survey** – In CY2018, **61.5%** of 26 providers surveyed were very or somewhat satisfied, higher than the three previous years (ranging from 40.3% [CY2016] to 44.7% [CY2015]); although the lower denominator in CY2018 could be impacting this. The percentage very or somewhat dissatisfied (7.7%) was lower than the three previous years (CY2017 – 20.0%; CY2016 – 15.3%; CY2015 – 14.5%). Results from 2014 cannot be compared due to a typographical error in the survey instrument.

- **UnitedHealthcare (Optum) BH provider survey** – In CY2018, **49.3%** of 148 BH providers surveyed reported they were very or somewhat satisfied, a lower rate than the previous four years, ranging from 53.2% (CY2017) to 59.4% (CY2015). The percentage of BH providers responding they were very or somewhat dissatisfied was 11.5%, a higher rate than in the four previous years, ranging from 5.9% (CY2015) to 9.0% (CY2016).

(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 Study: HCBS CAHPS Survey

The CAHPS HCBS Survey was developed by CMS for state Medicaid programs to utilize as part of their ongoing quality improvement efforts. The survey was designed to be administered across a wide range of adults with various physical, cognitive, developmental, mental health, and intellectual disabilities. KFMC secured the services of Vital Research (VR) to administer the first-year completion of this survey, based on their experience of conducting the survey in other states.

A stratified random sample of 1,200 members was drawn from 18,609 KanCare members to ensure completion of 400 in-person survey interviews. The survey population included members who receive services and supports from the FE, I/DD, PD, and TBI waiver programs. The survey contains the following seven parts:

- A cognitive screen with three questions to determine survey participant eligibility.
- Nine identification questions to determine what types of assistance the survey participant receives in his/her home or community.
- A core set of 69 questions that asks the participant about services he/she receives from personal assistants, behavioral health staff, homemakers, transportation services, targeted case managers (for I/DD Waiver), MCO Care Coordinator, as well as other questions such as about personal safety and community inclusion. Questions are focused towards service quality, care coordination, access and timeliness of services.
- *"About You"* section with 15 general questions, such as physical and mental health self-ratings, primary language spoken at home, and other background items.
- Supplemental Employment Module that contains 21 questions about the participant's employment status, whether he/she has a job coach, their experience with this job coach, etc.
- Three Supplemental Access Questions regarding waiver recipients' access to medical care.

Data collection of the face-to-face interviews began on January 31, 2019 and is currently ongoing. The survey analysis results will be provided in the Overall KanCare Evaluation report.

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 populations included in the following performance measures are members who are receiving HCBS waiver services, including I/DD, PD, TA, TBI, Autism, and FE.

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 performance 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. As shown in Table 27, when there was a documented change in needs, the Technical Assistance and SED Waiver participants had the highest percentage of service plans that were revised, as needed, to address the change.

Table 27. Percent of HCBS Waiver Participants with Documented Change in Needs Whose Service Plans were Revised, as Needed, to Address the Change, CY2013 – CY2017

Waiver	2013	2014	2015	2016	2017
Intellectual/Developmental Disability (I/DD) Waiver	97%	23%	28%	28%	60%
Physical Disability (PD) Waiver	75%	39%	53%	65%	62%
Frail Elderly (FE) Waiver	78%	38%	54%	65%	67%
Traumatic Brain Injury (TBI) Waiver	53%	38%	38%	67%	57%
Technical Assistance (TA) Waiver	92%	42%	75%	60%	83%
Serious Emotional Disturbance (SED) Waiver	85%	86%	88%	83%	83%
Autism Waiver	45%	11%	11%	16%	22%

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 performance measure is the number of waiver participants who had assessments, and the numerator is the number 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 – CY2017				
Waiver	**2014**	**2015**	**2016**	**2017**
Intellectual/Developmental Disability (I/DD) Waiver	78%	58%	82%	92%
Physical Disability (PD) Waiver	87%	66%	83%	92%
Frail Elderly (FE) Waiver	87%	70%	86%	89%
Traumatic Brain Injury (TBI) Waiver	71%	65%	86%	89%
Technical Assistance (TA) Waiver	95%	75%	87%	95%
Serious Emotional Disturbance (SED) Waiver	92%	54%	71%	68%
Autism Waiver	68%	48%	60%	69%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver type. As shown in Table 28, Technical Assistance Waiver participants had the highest percentage of assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.

HCBS HEDIS-like Measures

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 – CY2017					
	2013	**2014**	**2015**	**2016**	**2017**
Adults' Access to Preventive/Ambulatory Health Services	92.0%	93.1%	94.0%	94.1%	95.1%
Annual Dental Visits	49.4%	49.0%	51.6%	51.6%	53.2%
Decrease in Number of Emergency Department Visits* *(Visits/1000 member months)*	77.58	78.06	79.64	71.55	75.90
* 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 CY2017 percentage (95.1%) of HCBS members who had an annual preventive health visit was higher than the prior four years (ranging 92.0%–94.1%). The rates for the HCBS member subpopulation from CY2013 to CY2017 were higher than the corresponding rates for all KanCare adult members in each of the five years (CY2013 [88.4%]; CY2014 [87.5%]; CY2015 [87.1%]; CY2016 [86.2%]; and CY2017 [86.7%]).

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 CY2017 percentage (53.2%) of HCBS members who had an annual dental visit was higher than the prior four years (ranging 49.0%–51.6%). The annual dental visit rates for HCBS members were 9.3 to 12.1 percentage points lower than the HEDIS rates for the overall KanCare population in each of the five years (CY2013 [60.3%]; CY2014 [60.0%]; CY2015 [60.9%]; CY2016 [63.7%]; and CY2017 [64.8%]).

Decrease in number of Emergency Department Visits (P4P 2014–2015)
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 was higher in CY2017 (75.90) than in CY2016 (71.55) but lower than CY2013–CY2015 (77.58; 78.06; and 79.64, respectively). CY2017 ED visit rates reported by MCOs for the HCBS population were 58.57 – Amerigroup, 63.97 – UnitedHealthcare, and 64.64 – Sunflower. The ED rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (CY2013 [65.17]; CY2014 [64.19]; CY2015 [66.31]; CY2016 [59.53]; and CY2017 [62.42]).

(12) Other Study: HCBS CAHPS Survey

The CAHPS HCBS survey previously discussed (see Section 10) includes Coordination of Care related questions, including Targeted Case Management services for the I/DD Waiver members and MCO Care Coordinator services for all survey participants.

(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 2018 CAHPS survey can be found in Section 4 of this report in the Health Literacy section.

Pre-KanCare results for 2012 are not available for child survey questions. Also, the following Coordination of Care for Children with Chronic Conditions questions only have NCQA reported Quality Compass rankings for the CCC survey populations.
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: 24.6%** in 2018; 21.9%–24.5% in 2014–2017

- **CCC: 50.4%** in 2018; 45.3%–48.0% in 2014–2017
  The CCC rate was significantly higher (p=.03) compared to the 2017 rate (47.4%).
  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: 55.7%** in 2018; 54.2%–56.7% in 2014–2017
    - **CCC: 56.9%** in 2018 (**<25th QC**); 57.2%–58.2% in 2014–2017
      Sunflower's TXIX rate (54.7%) in 2018 was <10th QC.

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

- **GC: 28.8%** in 2018; 24.5%–28.6% in 2014–2017
- **CCC: 75.4%** in 2018; 74.8%–77.2% in 2014–2017
  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: 93.8%** in 2018; 91.6%–92.9% in 2014–2017
    - **CCC: 94.1%** in 2018 (**≥50th QC**); 92.1%–92.4% in 2014–2017
      The rate was significantly higher (p=.03) compared to the 2017 rate (92.3%; <50th QC).
  - **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: 91.7%** in 2018; 88.8%–92.5% in 2014–2017
    - **CCC: 90.9%** in 2018 (**≥50th QC**); 89.1%–90.3% in 2014–2017
      Sunflower's 2018 TXIX rate (90.5%; ≥50th QC) was significantly higher (p=.04) than the prior year's rate (85.7%; <25th QC).

Table 30. Member Survey – CAHPS Coordination of Care Questions, CY2014 – CY2018

Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
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%	23.9%	**24.6%**					
	CCC	46.2%	48.0%	45.3%	47.4%	**50.4%**					
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%	54.2%	56.7%	**55.7%**					
	CCC	57.9%	58.2%	57.5%	57.2%	**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%	10.4%	**12.1%**					
	CCC	16.6%	17.3%	16.7%	17.5%	**17.6%**					
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%	91.4%	**92.2%**					
	CCC	96.5%	93.1%	94.9%	94.6%	**93.2%**	↑			↑	↓

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

Table 30. Member Survey – CAHPS Coordination of Care Questions, CY2014 – CY2018 (Continued)											
Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
Questions on Adult and Child Surveys											
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%	27.0%	**28.8%**					
	CCC	77.2%	76.8%	74.8%	74.6%	**75.4%**					
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%	92.8%	**93.8%**					
	CCC	92.3%	92.4%	92.1%	92.3%	**94.1%**	↓	↓	↓	↓	↑
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%	91.0%	**91.7%**					
	CCC	90.3%	89.1%	89.2%	89.6%	**90.9%**	↑	↓	↓	↑	↑
In the last 6 months, did you get or refill any prescription medicines for your child?	GC	50.8%	53.0%	50.3%	52.6%	**52.3%**					
	CCC	86.5%	86.0%	84.1%	86.2%	**84.8%**					
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%	93.4%	**93.5%**					
	CCC	94.7%	93.2%	94.4%	94.6%	**93.6%**	↑	↑	↑	↑	↑
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%	60.0%	**61.0%**					
	CCC	57.6%	59.7%	57.0%	60.4%	**63.2%**	↓	↑	↓	↑	↑
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%	87.1%	88.0%	**87.1%**	↑	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	93.0%	**93.7%**	↑	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	93.6%	**93.2%**	↑	↑	↑	↑	↑
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%	**60.6%**					
	GC	39.5%	44.1%	39.6%	43.3%	**45.8%**					
	CCC	58.3%	60.7%	59.1%	59.3%	**63.3%**					
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%	**83.8%**	↑	↑	↑	↑	↑
	GC	81.9%	82.3%	81.5%	84.9%	**81.4%**	↑	↑	↓	↑	↓
	CCC	80.5%	83.3%	80.5%	81.0%	**82.9%**	↓	↑	↓	↓	↓
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%	**45.3%**					
	GC	17.9%	19.4%	17.9%	19.5%	**21.4%**					
	CCC	38.4%	39.5%	39.8%	40.7%	**43.2%**					
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%	**83.1%**	↑	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	87.6%	**85.2%**	↑	↑	↓	↑	↑
	CCC	85.3%	83.3%	86.0%	87.0%	**86.2%**	↑	↑	↑	↑	↑
↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile											

In the last 6 months:
Did you get or refill any prescription medicines for your child?

- **GC: 52.3%** in 2018; 50.3%–53.0% in 2014–2017
- **CCC: 84.8%** in 2018; 84.1%–86.5% in 2014–2017
  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: 93.5%** in 2018; 93.1%–95.2% in 2014–2017
      All MCO GC subgroup rates in 2014 to 2018 have been above 91%. In 2018, MCO GC subgroup rates ranged from 92.2% to 96.6%.
    - **CCC: 93.6%** in 2018 (**>66.67th QC**); 93.2%–94.7% in 2014–2017
      All MCO CCC subgroup rates in 2014 to 2018 have been above 91%. In 2018, MCO CCC subgroup rates ranged from 93.0% to 95.7%. Sunflower's TXXI rate (95.7%) has ranked >95th QC for two consecutive years.
  - **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
    - **GC: 61.0%** in 2018; 54.1%–60.0% in 2014–2017
    - **CCC: 63.2%** in 2018 (**≥50th QC**); 57.0%–60.4% in 2014–2017
      Amerigroup's 2018 TXIX rate (64.6%; >75th QC) was significantly higher (*p*=.03) than the prior year's rate (58.9%; <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: 12.1%** in 2018; 10.2%–11.2% in 2014–2017
- **CCC: 17.6%** in 2018; 16.6%–17.5% in 2014–2017
  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: 92.2%** in 2018; 91.1%–94.5% in 2014–2017
    - **CCC: 93.2%** in 2018 (**<50th QC**); 93.1%–96.5% in 2014–2017

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?

- **Adults: 87.1%** in 2018 **(≥50th QC**); 87.1%–88.1% in 2014–2017
- **GC: 93.7%** in 2018 (**>75th QC**); 92.0%–93.4% in 2014–2017
  Rates for all MCO GC subgroups were above the 50th QC or higher and over 91% positive in 2018. UnitedHealthcare's TXIX rate (95.1%) was >95th QC.
- **CCC: 93.2%** in 2018 (**≥50th QC**); 91.9%–93.6% in 2014–2017
  Rates for all MCO CCC subgroups were above 92% in 2018.

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: 60.6%** in 2018; 60.9%–65.3% in 2014–2017
- **GC: 45.8%** in 2018; 39.5%–44.1% in 2014–2017

- **CCC: 63.3%** in 2018; 58.3%–60.7% in 2014–2017
  The overall CCC rate (63.3%) and Sunflower's TXIX rate (67.8%) were both significantly higher (*p*=.01; *p*<.01, respectively) than in 2017 (59.3% and 59.1%, respectively).
  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: 83.8%** in 2018 (**≥50th QC**); 82.7%–85.0% in 2014–2017
    - **GC: 81.4%** in 2018 (**<33.33rd QC**); 81.5%–84.9% in 2014–2017
      The overall GC rate was significantly lower (*p*=.02) than in 2017 (84.9%; >66.67th QC). UnitedHealthcare's TXIX rate (74.6%; <5th QC) was also significantly lower (*p*<.01) than in 2017 (88.1%; >75th QC).
    - **CCC: 82.9%** in 2018 (**<50th QC**); 80.5%–83.3% in 2014–2017

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

- **Adults: 45.3%** in 2018; 43.0%–46.8% in 2014–2017
  Sunflower's rate (40.9%) was significantly lower *(p*<.01) than the 2017 rate (49.9%).
- **GC: 21.4%** in 2018; 17.9%–19.5% in 2014–2017
- **CCC: 43.2%** in 2018; 38.4%–40.7% in 2014–2017
  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: 83.1%** in 2018 (**>66.67th QC**); 81.7%–86.2% in 2014–2017
    - **GC: 85.2%** in 2018 (**>66.67th QC**); 79.8%–87.6% in 2014–2017
      Amerigroup's TXXI rate in 2018 (87.3%) was >90th QC and significantly higher (*p*=.03) than in 2017 (78.7%; <50th QC).
    - **CCC: 86.2%** in 2018 (**≥50th QC**); 83.3%–87.0% in 2014–2017
      Amerigroup's TXXI rate in 2018 (91.9%) was >95th QC and significantly higher (*p*=.03) than in 2017 (81%, QC ranking *"NA"* due to fewer than 100 responses).

(15) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2018 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.

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

	Year (0% – 100%)	Rate	N/D	95% CI	*p*-value	Trend 6-Year	Trend 8-Year
	Adults (Age 18+)						
I was able to get all the services I thought I needed.	**2018**	**85.8%**	276 / 322	81.5% – 89.2%		.20	.14
	2017	83.9%	335 / 399	79.9% – 87.2%	.48		
	2016	80.7%	235 / 290	75.8% – 84.9%	.09		
	2015	84.9%	325 / 383	81.0% – 88.2%	.75		
	2014	86.5%	704 / 814	84.0% – 88.7%	.74		
	2013	86.0%	917/1,066	83.8% – 87.9%	.92		
	2012	78.8%	219 / 278	73.6% – 83.2%	**.02 +**		
	2011	91.3%	274 / 300	87.6% – 94.1%	**.03 -**		
	Youth (Ages 0–17), Family Responding						
My family got as much help as we needed for my child.	**2018**	**82.3%**	327 / 398	78.2% – 85.7%		.72	.88
	2017	83.5%	405 / 485	79.9% – 86.5%	.64		
	2016	82.2%	264 / 320	77.6% – 86.0%	.97		
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.28		
	2013	83.2%	799 / 966	80.7% – 85.4%	.68		
	2012	82.9%	213 / 257	77.8% – 87.0%	.85		
	2011	84.2%	278 / 330	79.9% – 87.8%	.49		
	Adults (Age 18+)						
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**2018**	**79.1%**	227 / 287	74.0% – 83.5%		**.04 ↓**	.24
	2017	80.7%	274 / 340	76.2% – 84.6%	.62		
	2016	78.7%	207 / 264	73.3% – 83.2%	.90		
	2015	80.4%	278 / 346	75.9% – 84.3%	.69		
	2014	82.3%	589 / 716	79.4% – 84.9%	.24		
	2013	83.4%	802 / 962	80.9% – 85.6%	.10		
	2012	76.7%	191 / 249	71.1% – 81.5%	.50		
	2011	82.3%	214 / 260	77.2% – 86.5%	.35		

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

- Adult members had a significantly higher percentage of positive responses in 2018 (85.8%) than in 2012 (78.8%; *p*=.02) and significantly lower than in 2011 (91.3%; *p*=.03).
- For Youth, the rate in 2018 was 82.3% and the percentage of positive responses from Urban youth families was significantly lower (75.9%) compared to Non-Urban (86.5%; *p*<.01). There was significant variation among the county types (Semi-Urban 82.9%; Densely-Settled Rural 88.7%; Rural and Frontier 88.4%; *p*=.04).

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

For Adult members, the rate in 2018 was 79.1%; there has been a statistically significant (*p*=.04) decreasing trend since 2013 (83.4%). The percentage of positive responses from Urban members was significantly lower (73.6%) compared to Non-Urban (83.5%; *p*=.04).

(16) Member Survey – SUD

Section 7 provides background on the SUD survey conducted by the three MCOs in CY2014 through CY2017; the SUD survey was not conducted in 2018. Questions related to perceptions of care coordination follow.

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% in 2016, 34.8% in 2015, and 35.7% in 2014.
- Of the 84 who received services from more than one 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, 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%).

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% in 2016, 3.1% in 2015, and 7.1% 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% 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 2018 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 32 provides the available survey results by individual MCO.

Amerigroup

In CY2018, **65.0**% of 243 providers surveyed reported they were very satisfied or satisfied with Amerigroup precertification and/or authorization, higher than the five previous years (40.7% [CY2013] – 62.5% [CY2017]). The percentage very dissatisfied or dissatisfied was lower in CY2018 (18.1%) than the five prior years (19.1% [CY2017]–42.6% [CY2013]).

Sunflower

In CY2018, **50.9**% of 173 providers surveyed reported they were very satisfied or satisfied, higher than in the four previous years (38.2% [CY2014]–46.1% [CY2016]); trend with caution due to CY2018 changes in survey methods. The percentage very dissatisfied or somewhat dissatisfied was lower in CY2018 (20.2%) than in three of four previous years (CY2017 – 23.5%; CY2015 – 23.8%; CY2014 – 29.0%) and higher than CY2016 (15.7%). No comparison can be made with the CY2013 general provider survey results since Sunflower's CY2013 survey questions were asked of providers only in comparison to other MCOs.

UnitedHealthcare

- **UnitedHealthcare general provider survey –** In CY2018, 57.7% of 26 providers surveyed were very or somewhat satisfied, higher than the three previous years (2017 – 44.0%; 2016 – 41.7%; 2015 – 50.0%). The percentage of providers reporting they were very or somewhat dissatisfied in CY2018 (26.9%) was lower than CY2017 (29.3%) but higher than in CY2016 (25.0%) and CY2015 (22.4%).
- **UnitedHealthcare (Optum) BH provider survey** – In CY2018, **41.9**% of 148 BH providers were very or somewhat satisfied, lower than the four previous years (2016 – 51.4%; 2014 – 52.3%; 2015 – 58.4%). In CY2018, 9.5% reported they were very or somewhat dissatisfied, higher than CY2015 to CY2017 (CY2015 – 5.0%; CY2016 – 8.9%; CY2017 – 6.4%) and lower than CY2014 (13.1%).

Table 32. Provider Satisfaction with Obtaining Precertification and/or Authorization for Their Members, CY2014 – CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	53.3%	61.2%	51.7%	62.5%	**65.0%**
Sunflower *(General Provider)*	38.2%	39.8%	46.1%	42.5%	**50.9%**
Cenpatico *(Behavioral Health)*	63.4%	42.5%	32.3%	57.6%	†
UnitedHealthcare *(General Provider)*	^	50.0%	41.7%	44.0%	**57.7%**
Optum *(Behavioral Health)*	52.3%	58.4%	51.4%	52.9%	**41.9%**
	Neither Satisfied nor Dissatisfied				
Amerigroup*	23.9%	18.1%	19.7%	18.4%	**16.9%**
Sunflower *(General Provider)*	32.8%	36.4%	38.2%	34.1%	**28.9%**
Cenpatico *(Behavioral Health)*	26.9%	44.1%	58.7%	36.4%	†
UnitedHealthcare *(General Provider)*	^	27.6%	33.3%	26.7%	**15.4%**
Optum *(Behavioral Health)*	34.5%	36.6%	39.7%	40.8%	**48.6%**
	Very or Somewhat Dissatisfied				
Amerigroup*	22.8%	20.7%	28.7%	19.1%	**18.1%**
Sunflower *(General Provider)*	29.0%	23.8%	15.7%	23.5%	**20.2%**
Cenpatico *(Behavioral Health)*	9.6%	13.4%	9.0%	6.1%	†
UnitedHealthcare *(General Provider)*	^	22.4%	25.0%	29.3%	**26.9%**
Optum *(Behavioral Health)*	13.1%	5.0%	8.9%	6.4%	**9.5%**
	Total Responses				
Amerigroup*	272	397	178	309	**243**
Sunflower *(General Provider)*	241	269	293	179	**173**
Cenpatico *(Behavioral Health)*	52	127	167	33	†
UnitedHealthcare *(General Provider)*	66	76	72	75	**26**
Optum *(Behavioral Health)*	84	101	146	157	**148**

*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."

†Cenpatico Behavioral Health transitioned to Sunflower September 1, 2018; therefore, no data is vailable.

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

Comparison of Pre-KanCare and KanCare Service Utilization

Table 33 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 CY2017. The State advised KFMC, *"In the 2017 KanCare Evaluation, HCBS service units reported as days in 2012 were mistakenly compared to service units reported in quarter-hour increments in 2016. Based on quarter-hour service increments in both years, the correct increase from 2012 to 2016 was 1.1%."* The correct CY2016 comparison to CY2012 service utilization is below:

- Non-Emergency Transportation: 55.1%
- Home & Community-Based Services: 1.1%
- Vision: 18.2%
- Dental: 7.4%
- Primary Care Physician: -0.1
- Inpatient: -22.1%
- Outpatient, Non-Emergency Room: -13.3%
- Outpatient Emergency Room: -9.4%
- Pharmacy: -1.4%

Table 33. Comparison of Pre-KanCare (2012) and KanCare (2017) Service Utilization

Type of Service	% Utilization Difference
Non-Emergency Transportation	61.4%
Home & Community-Based Services	1.1%
Vision	25.3%
Dental	3.6%
Primary Care Physician	3.0%
Inpatient	-18.6%
Outpatient, Non-Emergency Room	-8.0%
Outpatient Emergency Room	-5.8%
Pharmacy	3.0%

Services with increased utilization in CY2017 compared to CY2012 include Non-Emergency Transportation, Home and Community-Based Services, Vision, Dental, Primary Care Physician, and Pharmacy.

Services with decreased utilization include Inpatient Hospitalization, Non-Emergency Outpatient visits, and Emergency Room Outpatient visits. Decreases in utilization of these services are a positive outcome. KDHE reported that, due to increased member months in CY2016 from eligibility reconfiguration, utilization services fluctuated in comparison to the 2016 report, but a positive utilization trend continues to improve in comparison to CY2012.

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 34 shows the PMPM for CY2013 to CY2017 in total and by comparison groups.

Table 34. Per Member Per Month (PMPM) Service Expenditures by Medicaid Eligibility Group, CY2013 – CY2017

Comparison Groups	2013	2014	2015	2016	2017
Children & Families	172	187	180	175	192
Waiver Services	1,869	2,053	2,027	2,063	2,078
Long Term Care	2,666	3,106	3,154	3,261	3,466
Aged, Blind, Disabled – SSI & Medically Needy	582	663	666	672	641
Pregnant Women	593	625	580	423	468
Other	505	486	516	471	476
Total	467	488	472	464	498

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 34, 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.

In CY2018, the following changes were made, by the State, in comparison groups to better reflect level of care by category:

- Members receiving PD or FE waiver services were included in *"Waiver Services"* instead of *"Long Term Care"* and Autism was removed.
- To the group *"Long Term Care,"* residential facilities providing children care for mental health was added and PD, FE, and Child Institutions were removed.
- The *"Persons with Disabilities"* group did not change in criteria but was renamed *"Aged, Blind, Disabled – SSI and Medically Needy."*
- Due to changes in funding for Refugee services in 2017, and to more accurately present annual changes in PMPM, *"Refugee Services"* were excluded from the *"Other"* category for all five years.

The five comparison population groups in the CY2018 PMPM analysis consist of:

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

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 to CY2018.

At the approval of the State, Amerigroup submitted a condensed one-page document in lieu of a GeoAccess report due to their contract ending December 31, 2018; therefore, some GeoAccess results previously reported cannot be determined for CY2018. For Tables 36–39 that follow, Amerigroup data is not available.

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. In June 2018, KDHE provided another update to network adequacy reporting and the requirements became effective with the Q3 2018 reporting period, with initial reporting due October 2018. Also, ongoing review by KDHE occurred through the end of CY2018. Each quarter, KDHE has provided each MCO with feedback, via a report, as to their progress in presenting accurate representation of network adequacy. In July 2018, KDHE released the new network adequacy standards and the requirements are effective beginning with the Q1 2019 report period with initial reporting due February 2019.

The State began the process with reviewing the MCOs' Q4 2017 Provider Network Report. KFMC noted the following from the State's review of the Q4 CY2017–Q4 CY2018 Provider Network Report Feedback Report (AGP's contract ended December 31, 2018; therefore, the State report for Amerigroup is not available for Q3 and Q4 CY2018):

- Amerigroup
  - Total records reviewed: Q4 CY2017 – 71,551; Q1 CY2018 – 72,191; and Q2 CY2018 – 87,489.

  - For incorrectly included records, there was a decrease from 0.96% (685) in Q4 CY2017 to 0.34% (297) in Q2 CY2018.
  - For duplicate entries, there was a decrease from 0.33% [236] in Q4 CY2017 to 0% in Q1 and Q2 CY2018.
  - For apparent/presumed duplicate entries, from Q4 2017 to Q2 CY2018 the rate varied (Q4 CY2017 – 3.71% [2,651]; Q1 CY2018 – 7.16% [5,167]; Q2 CY2018 – 0.59% [514]).
- Sunflower
  - Total records reviewed: Q4 CY2017 – 54,252; Q1 CY2018 – 45,907; Q2 CY2018 – 45,189; Q3 CY2018 –53,291; and Q4 CY2018 – 71,687.
  - For incorrectly included records, the rate in Q3 CY2018 (.02%; 11) and Q4 CY2018 (.03%; 21) were lower than in the previous three quarters (Q4 CY2017 – 1,843 [3.40%]; Q1 CY2018 – 1,184 [2.58%]; Q2 CY2018 – 1,514 [3.35%]).
  - The rate of duplicate entries has decreased each quarter and in Q3 and Q4 CY2018 were at 0% (Q4 CY2017 – 3.50% [1,897]; Q1 CY2018 – 1.56% [717]; Q2 CY2018 – 0.98% [441]).
  - For apparent/presumed duplicate entries, the rate in Q3 CY2018 (.60% [319]) and Q4 CY2018 (.003% [2]) were lower than in the three previous quarters (Q4 CY2017 – 2.60% [1,413]; Q1 CY2018 – 3.27% [1,502]; Q2 CY2018 – 3.28% [1,482]).
- UnitedHealthcare:
  - Total records reviewed: Q4 CY2017 – 79,758; Q1 CY2018 – 79,537; Q2 CY2018 – 72,260; Q3 CY2018 – 122,267; and Q4 CY2018 – 124,006.
  - For incorrectly included records, rates decreased each quarter and in Q4 CY2018 were at 0% (Q4 CY2017 – 7.84% [6,256]; Q1 CY2018 – 7.70% [6,123]; Q2 CY2018 – 4.21% [3,043]; and Q3 CY2018 – .0008% [1].
  - The rate of duplicate entries has decreased each quarter (Q4 CY2017 – 2.50% [1,997]; Q1 CY2018 – 2.96% [2,353]; and Q2 CY2018 – .20% [141]; Q3 CY2018 – .06% [70]; Q4 CY2018 – .006% [8]).
  - For apparent/presumed duplicate entries, from Q4 2017 to Q4 CY2018 the rate varied (Q4 CY2017 – 6.46% [5,152]; Q1 CY2018 – 7.84% [6,239]; Q2 CY2018 – 3.89% [2,811]; Q3 CY2018 – .26% [321]; and Q4 CY2018 – .37% [458]).

The report category *"Data Issues"* details, for the fields in which a response was required, the number of records that have *"Missing Data," "Inconsistent Data/Incongruent Data,"* and *"Invalid Data."* Of the three categories, *"Missing Data"* had the highest percentage of records with data issues for the MCOs from Q4 CY2017 to Q4 CY2018. The following fields were among those with the highest percentages:

- Special Needs;
- Panel Count (where required);
- Panel Capacity (where required);
- KMAP ID & Service Location;
- Medicaid Member Count;
- Max Medicaid Member Count; and
- PCP.

- **Missing Data** – Number of records with missing data in a required field.
- **Inconsistent/Incongruent Data** – Number of records for which another record contained conflicting data for the same provider, specialty, and location in the field listed.
- **Invalid Data** – Number of records that were not consistent with an authoritative data source or which contained erroneous data.

The report also includes a category *"Outliers and Other Issues,"* where the State identifies additional outliers/issues (e.g., panel count exceeds the panel capacity; panel status is open, but the panel capacity shows zero; and records identify a home health provider whose home office is located more than 100 miles from the service location).

KDHE will also be reviewing the GeoAccess reports submitted quarterly. It appears these changes have had an impact on the GeoAccess reports, as there are less counties covered within the access standards than previously reported.

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 35, which summarizes counts reported in the GeoAccess reports for 2018 compared to 2017.

Table 35. Providers and Provider Locations by MCO and by Provider Type, CY2018 Compared to CY2017*

Provider Type	Number of Providers/ Number of Locations			Difference from 2017 to 2018		
	AGP	SHP	UHC	AGP	SHP	UHC
Physicians						
Allergy	**69 / 84**	47 / 24	51 / 27	-66 / -70	+3 / -8	+13 / -8
Cardiology	232 / 130	457/ 165	**483 / 201**	-106 / -38	+99 / -43	+64 / -41
Dermatology	**95 / 113**	44 / 28	64 / 42	-53 / -63	-2 / -22	-12 / -32
Gastroenterology	**379 / 296**	135 / 63	134 / 115	-140 / -132	+12 / -16	+11 / -49
General Surgery	**412 / 265**	363 / 194	379 / 182	-67 / -47	+11 / -48	+29 / -91
Hematology/Oncology	186 / 113	141 / 47	**271 / 133**	-28 / -7	+21 / -23	+24 / -18
Neonatology	52 / **28**	**77** / 17	58 / 18	-45 / -19	+10 / -2	-5 / -14
Nephrology	**115 / 62**	100/ 49	101 / 42	+3 / +6	+38 / -4	-3 / -57
Neurology	237 / **153**	296 / 108	**304** / 115	-26 / +24	+7 / -24	+31 / -35
Neurosurgery	75 / **50**	**93** / 40	79 / 37	-16 / -4	-24 / -19	-8 / -20
OB/GYN	**580 / 403**	455 / 212	466 / 205	-58 / -35	+76 / -6	+10 / -81
Ophthalmology	**203 / 280**	138 / 163	166 / 101	-39 / -28	-1 / +4	+10 / -35
Orthopedics	**306 / 196**	286 / 123	297 / 141	-46 / -42	+24 / -40	-6 / -60
Otolaryngology	**160 / 137**	109 / 51	123 / 57	-43 / -49	+9 / -11	+14 / -32
Physical Medicine/Rehab	**84 / 100**	80 / 51	**84** / 46	-19 / -22	+9 / -6	0 / -29
Plastic & Reconstructive Surgery	**105 / 114**	53 / 38	52 / 29	-53 / -50	+8 / 0	+3 / -8
Podiatry	**311 / 298**	45 / 45	90 / 71	-138 / -127	+5 / -3	+15 / -40
Psychiatrist	**454 / 319**	318 / 155	379 / 313	-45 / -38	-28 / -69	+28 / +9
Pulmonary Disease	**190 / 139**	144 / 72	153 / 76	-50 / -46	+38 / -19	+22 / -30
Urology	**152 / 161**	99 / 60	135 / 62	-52 / -27	+13 / -20	+13 / -39
Hospital						
Hospitals	142 / **185**	**162** / 163	146 / 183	+56 / +60	-4 / -3	-1 / +32
Eye Care – Optometry						
Eye Care - Optometry	**505 / 505**	446 / 406	444 / 351	-47 / -58	-8 / +7	+40 / +26
Dental						
Dental Primary Care	431 / 297	413 / **348**	**438** / 307	+51 / +17	-11/ +12	+28 / +18
Ancillary Services						
Physical Therapy	**782 / 479**	689 / 399	452 / 229	+174 / +37	+102 / +86	+3 / 0
Occupational Therapy	**555 / 415**	300 / 296	258 / 169	+109 / +25	+65 / +96	+27 / +7
X-ray	**320 / 284**	165 / 172	26 / 93	+102 / +32	-16 / -32	-121 / -58
Lab	**318 / 282**	247 / 246	200 / 238	+131 / +63	+27 / +10	+51 / +72
Pharmacy						
Retail Pharmacy	642 / 639	**747 / 731**	657 / 651	0 / 0	-73 / -72	-1 / -2

The numbers in **bold** represent the highest number of providers and locations reported.
*Excluding Primary Care and Internal Medicine Providers due to reporting process revisions and updates that were implemented in 2018.

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. UnitedHealthcare, however, reports the same number of members for OB/GYN in each county as the number of members in their population.

Table 36 reports the number of counties (and whether the county is urban or non-urban) where Sunflower and UnitedHealthcare reported that, as of December 2018, 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 Sunflower and UnitedHealthcare. Each year, prior to CY2018, the numbers of counties where no access to a provider specialty were available from any MCO has decreased. The 2018 corrections to the Network Adequacy and GeoAccess reports are beginning to provide more accurate counts for provider specialty availability. Since the changes in reporting were made by the State, some specialties have had an increase in the number of counties where there is no access to a provider specialty. 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"*).

Urban and Semi-Urban Counties

For CY2018, Sunflower and UnitedHealthcare reported a total of 191,844 KanCare members were residents of Urban or Semi-Urban counties, and the three MCOs (includes Amerigroup) reported 273,640 in 2016 and 270,678 in 2017. 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.

There are some counties where both Sunflower and UnitedHealthcare had no access to a provider and due to Amerigroup's GeoAccess report not being available, KFMC was not able to determine provider types that were available in CY2018 in Urban and Semi-Urban counties by at least one MCO. Based on the GeoAccess reports, provider types were available in CY2017 in Urban and Semi-Urban counties by at least one MCO. In CY2017, provider types available from only one MCO included:

- 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

For CY2018, Sunflower and UnitedHealthcare reported 80,951 (40,472 [SHP] and 40,479 [UHC]) KanCare members were residents of Frontier, Rural, or Densely-Settled Rural 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).

Table 36. Counties with no Provider Access by MCO and County Type, CY2018									
Provider Type	Number of Counties with 0% Access (of 105 Counties)								
	Urban & Semi-Urban			Non-Urban			Counties with 0% Access from SHP and UHC Providers		
	AGP*	SHP	UHC	AGP*	SHP	UHC	Urban^	Non-Urban^	# SHP and UHC Members No Access
Physicians									
Primary Care Provider		-	-		-	-	-	-	-
Allergy		4	3		2	2	3	-	11,808
Cardiology		1	-		2	-	-	-	-
Dermatology		2	1		1	-	-	-	-
Gastroenterology		-	1		19	26	-	-	-
General Surgery		-	-		-	-	-	-	-
Hematology/Oncology		1	-		14	3	-	-	-
Internal Medicine		-	-		-	-	-	-	-
Neonatology		6	4		38	46	3	38	38,422
Nephrology		-	1		2	5	-	-	-
Neurology		-	-		4	3	-	-	-
Neurosurgery		2	3		33	35	2	33	29,027
OB/GYN		-	-		5	1	-	-	-
Ophthalmology		-	-		-	5	-	-	-
Orthopedics		-	-		-	-	-	-	-
Otolaryngology		-	-		-	1	-	-	-
Physical Medicine/Rehab		-	3		4	34	-	-	-
Plastic & Reconstructive Surgery		4	4		18	19	4	18	26,253
Podiatry		2	2		-	5	-	-	-
Psychiatrist		-	-		9	-	-	-	-
Pulmonary Disease		-	-		10	17	-	-	-
Urology		-	-		2	-	-	-	-
Hospital									
Hospitals		-	-		-	-	-	-	-
Eye Care - Optometry									
Eye Care - Optometry		-	-		1	-	-	-	-
Dental									
Dental Primary Care		-	-		-	3	-	-	-
Ancillary Services									
Physical Therapy		-	-		-	-	-	-	-
Occupational Therapy		-	-		-	-	-	-	-
X-ray		-	1		-	12	-	-	-
Lab		-	-		-	-	-	-	-
Pharmacy									
Retail Pharmacy		-	-		-	-	-	-	-

* Data not available, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data they were required to submit.
^ Counts only include SHP and UHC.

Due to Amerigroup data not being available, provider types available from only one MCO in CY2018 could not be determined. 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.

Due to Amerigroup data not being available, counties where over 95% of the members do not have access to particular provider types for CY2018 could not be determined. In CY2017, including counties where over 95% of the members do not have access to particular provider types added the following counties:

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

In Table 37, the number and percentage of members without access to provider types are listed by provider types. (Not included in the table is the Behavioral Health provider type that has 100% access, based on distance standards.)

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 CY2018 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 Settled Rural separately from Rural/Frontier Counties.

As of December 2018, the MCOs reported the following number of BH providers and number of locations of the providers (complete data is not available for Amerigroup):

- Amerigroup – 2,169 providers at 838 locations reported for CY2018 (205 fewer providers at 70 fewer locations, compared to CY2017)
- Sunflower – 4,089 providers at 987 locations reported for CY2018 (681 more providers at 52 more locations, compared to CY2017)
- UnitedHealthcare – 3,290 providers at 1,110 locations in CY2018 (225 additional providers at 178 additional locations, compared to CY2017)

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

- Amerigroup – Data not available.
- Sunflower – 95,462 members in Urban/Semi-Urban counties (3,473 more than reported in CY2017). The average distance to the closest provider was: *"5th closest"* – 2.3 miles; *"4th closest"*– 2.2 miles; *"3rd closest"* – 2.0 miles; *"2nd closest"* – 1.8 miles; and *"1st closest"* – 1.4 miles.
- UnitedHealthcare – 96,382 members in Urban/Semi-Urban counties (1,011 more members than in CY2017). The average distance to a choice of five providers was 2.1 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 1.3 miles.

Table 37. Number and Percentage of Members not Within Access Distance by Provider Type and MCO, CY2018

Provider Type	AGP*	SHP	UHC	Total ^	% of SHP and UHC Members
Neonatology		52,920	39,228	92,148	**33.8%**
Plastic/Reconstructive Surgery		25,696	23,440	49,136	**18.0%**
Physical Medicine/Rehab		5,973	24,354	30,327	**11.1%**
Allergy		14,288	11,016	25,304	**9.3%**
Neurosurgery		25,900	23,623	49,523	**18.2%**
Podiatry		6,845	7,875	14,720	**5.4%**
Gastroenterology		15,678	15,754	31,432	**11.5%**
Dermatology		10,205	7,816	18,021	**6.6%**
Pulmonary Disease		8,479	11,522	20,001	**7.3%**
Hematology/Oncology		10,001	1,084	11,085	**4.1%**
Nephrology		3,971	10,451	14,422	**5.3%**
Dental		903	3,365	4,268	**1.6%**
Cardiology		10,040	2,602	12,642	**4.6%**
OB/GYN		2,014	4,199	6,213	**2.9%**
Psychiatrist		4,514	1,157	5,671	**2.1%**
Occupational Therapy		717	-	717	**0.3%**
Retail Pharmacy		1,846	1,638	3,484	**1.3%**
Otolaryngology		915	3,880	4,795	**1.8%**
Lab		1,933	607	2,540	**0.9%**
X-ray		2,433	14,107	16,540	**6.1%**
Urology		1,598	867	2,465	**0.9%**
Optometry		844	-	844	**0.3%**
Neurology		2,128	1,469	3,597	**1.3%**
Hospitals		393	648	1,041	**0.4%**
Opthalmology		119	3,978	4,097	**1.5%**
Orthopedics		227	460	687	**0.3%**
Physical Therapy		31	-	31	**0.01%**

* Data not available, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.
^ Only includes SHP and UHC.

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

- Amerigroup – Data not available.
- Sunflower – 24,335 members in Densely-Settled Rural counties (768 more than reported in CY2017). The average distance to the closest provider was: *"5th closest"* – 6.7 miles; *"4th closest"* – 6.0 miles; *"3rd closest"* – 5.6 miles; *"2nd closest"* – 5.3 miles; and *"1st closest"* – 4.2 miles.
- UnitedHealthcare –25,398 members in Densely-Settled Rural counties (51 fewer than reported in CY2017). The average distance to a choice of five providers was 4.4 miles; to four providers was 4.4 miles; to three providers was 4.3 miles; to two providers was 4.1 miles; and to one provider was 3.3 miles.

- Rural/Frontier - Access standard is one provider within 60 miles
- Amerigroup – Data not available.
- Sunflower – 16,137 members in Rural/Frontier counties (959 more than reported in CY2017). The average distance to the closest provider was: *"5th closest"* – 22.4 miles; *"4th closest"* – 20.5 miles; *"3rd closest"* – 17.1 miles; *"2nd closest"* – 14.5 miles; and *"1st closest"* – 9.4 miles.
- UnitedHealthcare –15,081 members in Rural/Frontier counties (162 more than reported in CY2017). The average distance to a choice of five providers was 13.1 miles; to four providers was 12.0 miles; to three providers was 11.7 miles; to two providers was 10.9 miles; and to one provider was 8.9 miles.

Percent of counties covered within access standards for behavioral health
For CY2018, BH providers were available to members of Sunflower and UnitedHealthcare (Amerigroup data not available) within the State access standards for each county type.

The county access standards are within 30 miles – Urban/Semi-Urban (16 counties); within 45 miles – Densely-Settled Rural (21 counties); and distance of 60 miles – Rural/Frontier (32 Rural and 36 Frontier counties). For all county types, based on the MCO GeoAccess maps and data, this access standard was met each year CY2012 to CY2017 for 100% of the counties in Kansas and met for Sunflower and UnitedHealthcare for CY2018.

Home and Community Based Services (HCBS) – Counties with access to at least two providers by provider type and services
Table 38 provides information reported by Sunflower and UnitedHealthcare 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. Data is not available for Amerigroup. 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. Beginning in the fall of CY2018, MCOs were required by the State 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 38, for Sunflower and UnitedHealthcare, 17 of the 27 HCBS services were reported to be available in CY2018 from at least two service providers in all 105 counties for members. In Table 38, data is not available for Amerigroup.
Of the remaining 10 Home and Community Based Services:

- Speech Therapy (Autism Waiver)
  - Sunflower – In CY2018 (and CY2015–CY2017), Sunflower reported that in only **12** counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver. At least one service provider was reported to be available in **28** counties in CY2018 (29 – CY2016 and CY2017; 28 – CY2014 and CY2015).
  - UnitedHealthcare – Each year from CY2013 to CY2018, UnitedHealthcare has reported that these specialized services were only available from one or two providers in only **2** counties.
- Speech Therapy – TBI Waiver
  - Sunflower reported that at least two providers were available in CY2018 in **48** counties (50 – CY2015 through CY2017, and that at least one provider was available in all **105** counties.

  - UnitedHealthcare reported that at least two providers were available in CY2018 in **10** counties (11 – CY2017; 9 – CY2016; 4 – CY2015). At least one provider was reported to be available in **10** counties in CY2018 (28 – CY2016 and CY2017; 10 – CY2015).
- Behavior Therapy – TBI Waiver
  - 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 **37** counties (54 – CY2017; 72 – CY2016; 18 – CY2015). At least one provider was reported to be available in **60** counties (105 – CY2017 and CY2016; 43 – CY2015).
- Cognitive Therapy – TBI Waiver
  - From CY2013 to CY2018, 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 **57** counties (22 – CY2017; 26 – CY2016; 18 – CY2015). At least one provider was reported to be available in all **105** counties (54 – CY2017; 55 – CY2016; 43 – CY2015).
- Occupational Therapy – TBI Waiver
  - From CY2013 to CY2018, 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 CY2018, at least two providers were available in **10** counties, the lowest since 2013 (14 – CY2017; 12 – CY2016; 11 – CY2013 to CY2015). At least one provider was reported to be available in **10** counties (33 – CY2016 and CY2017; 19 – CY2015).
- Physical Therapy – TBI Waiver
  - Sunflower reported that at least two providers were available in all **105** counties in CY2013 to CY2018 for this specialized physical therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in **9** counties in CY2018, (30 – CY2016 and CY2017; 23 – CY2015). At least one provider was reported to be available in **10** counties in CY2018 (52 – CY2017; 55 – CY2016; 40 – CY2015).
- Adult Day Care
  - Sunflower – Services were available from at least two providers in **50** counties in CY2018 (49 – CY2017; 50 – CY2016; 52 – CY2015). At least one service provider was available in **78** counties (79 – CY2017; 81 – CY2016).
  - UnitedHealthcare – Services were available from at least two providers in **33** counties in CY2018 (44 – CY2017; 47 – CY2015 and CY2016). At least one provider was available in **58** counties in CY2018 (66 – CY2017; 58 – CY2016; 72 – CY2015).
- Intermittent Intensive Medical Care
  - Sunflower reported in CY2018 at least two service providers are available in **94** counties (95 – CY2017; 94 – CY2015 and CY2016). Sunflower reported in CY2013 to CY2018 that all **105** counties had at least one service provider.
  - UnitedHealthcare reported in CY2013 through CY2018 there were at least two service providers available in all **105** counties.
- Health Maintenance Monitoring
  - Sunflower – In CY2018, Sunflower reported two or more providers were available in **94** counties (96 – CY2017; 95 – CY2015 and CY2016). Sunflower reported at least one provider was available in **105** counties (CY2013 through CY2018).
  - UnitedHealthcare – In CY2013 to CY2018, UnitedHealthcare reported that at least two service providers were available in all **105** counties.

Table 38. Number of Counties with Access to Home and Community Based Services (HCBS) CY2018 Compared to CY2017*						
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			48↓	105	10↓	10↓
Behavior Therapy – TBI Waiver			105	105	37↓	60↓
Cognitive Therapy – TBI Waiver			105	105	57↑	105↑
Occupational Therapy – TBI Waiver			105	105	10↓	10↓
Physical Therapy – TBI Waiver			105	105	9↓	10↓
Adult Day Care			50↑	78↓	33↓	58↓
Intermittent Intensive Medical Care			94↓	105	105	105
Home Modification			105	105	105	105
Health Maintenance Monitoring			94↓	105	105	105
Specialized Medical Care/Medical Respite			105	105	105	105
Assistive Services			105	105	105	105
Assistive Technology			105	105	105	105
Attendant Care Services (Direct)			105	105	105	105
Comprehensive Support (Direct)			105	105	105	105
Financial Management Services (FMS)			105	105	105	105
Home Telehealth			105	105	105	105
Home-Delivered Meals (HDM)			105	105	105	105
Long-Term Community Care Attendant			105	105	105	105
Medication Reminder			105	105	105	105
Nursing Evaluation Visit			105	105	105	105
Personal Emergency Response (Installation)			105	105	105	105
Personal Emergency Response (Rental)			105	105	105	105
Personal Services			105	105	105	105
Sleep Cycle Support			105	105	105	105
Transitional Living Skills			105	105	105	105
Wellness Monitoring			102↓	105	105	105

* Arrows indicate whether the number of counties with access to the service increased or decreased compared to CY2017.

^ Data not available, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.

- Wellness Monitoring
  - Sunflower – In CY2018, Sunflower reported at least two providers were available in **102** counties (103 – CY2017; 105 – CY2013 through CY2016). In CY2018 and CY2017, Sunflower reported at least one provider was available in **105** counties.
  - In CY2013 to CY2018, 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 need the services that are not commonly needed or available.

I/DD Provider Services

I/DD provider services by county availability are listed in Table 39 (data is not available for Amerigroup). Seven of 14 services were reported, in CY2018, to be available from at least two I/DD providers by Sunflower and UnitedHealthcare.

Table 39. Number of Counties with Access to at Least Two I/DD Providers, by MCO, CY2018

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			105	105	105	105
Medical Alert Rental			105	105	105*	105
Residential Support – DD			105	105	105↑	105
Supportive Home Care – DD			105	105	105↑	105
Sleep Cycle Support – DD			105	105	105	105
Supported Employment Services – DD			97↓	105	23↓	69↓
Personal Assistant Services – DD			105	105	105	105
Assistive Services			105	105	105	105
Respite Care (Overnight)			105	105	105	105
Wellness Monitoring			101↓	105	63↑	88↑
Day Support – DD			105	105	61↑	97
Financial Management Services (FMS)*			105	105	105	105
Specialized Medical Care – RN			103↓	105	105	105
Specialized Medical Care – LPN			103↓	105	105	105

* Provider specialty not specific to I/DD

^ Data not available, as Amerigroup's contract ended December 31, 2018, and the State limited the amount of data Amerigroup was required to submit.

Services not available in CY2018 from at least two I/DD providers by Sunflower and UnitedHealthcare in all 105 Kansas counties include:

- Supported Employment Services – DD
  - Sunflower reported this service to be available from at least two I/DD providers in **97** counties (98 – CY2016 and CY2017) and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available in CY2018 from at least two I/DD providers in only **23** counties (24 – CY2017; 23 – CY2016), and from at least one provider in **69** counties (73 – CY2017; 48 – CY2016).
- Wellness Monitoring
  - Sunflower reported this service to be available in CY2018 from at least two I/DD providers in **101** counties (102 – CY2017; 95 – CY2016) and from at least one provider in all **105** counties (102 – CY2016).
  - UnitedHealthcare reported this service to be available in CY2018 from at least two I/DD providers in only **63** counties (62 – CY2017; 80 – CY2016), and from at least one provider in **88** counties (85 – CY2017; 105 – CY2016).
- Day Support
  - Sunflower reported this service to be available in CY2016 to CY2018 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 **61** counties in CY2018 (**59** – CY2017, 58 – CY2016), and from at least one provider in **97** counties (and CY2017).
- Specialized Medical Care - RN
  - Sunflower reported this service to be available in CY2018 from at least two I/DD providers in **103** counties (104 – CY2016 and CY2017), and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available in CY2016 to CY2018 from at least two I/DD providers in all **105** counties.
- Specialized Medical Care - LPN
  - Sunflower reported this service to be available in CY2018 from at least two I/DD providers in **103** counties (104 – CY2016 and CY2017), and from at least one provider in all **105** counties.
  - UnitedHealthcare reported this service to be available in CY2016 to CY2018 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. In June 2018, KDHE provided another

update to network adequacy reporting and the requirements became effective with the Q3 2018 reporting period, with initial reporting due October 2018. Also, ongoing review by KDHE occurred through the end of CY2018. After submission of their Network Adequacy report each quarter, KDHE has provided 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
From CY2016 to CY2018, Amerigroup's After-Hours Access survey was of PCPs and pediatricians. The vendor's (Morpace) interviewers used a prepared script that identified Amerigroup during the call. Calls were made between 5pm and 9pm on weekdays.

In CY2018, Morpace reported that 101 providers who were non-compliant in 2017 were contacted, with the 101 added after the 200 *"random sample quota"* was reached. In the CY2017 survey results, there were 104 non-compliant providers. It appears there were 3 providers in the *"random sample"* that were noncompliant providers from 2017.

Review of the descriptions of the survey sampling, methodology, survey conclusions, and comparisons to 2018 survey results raises the same questions, noted in 2017, 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 2017*." Morpace reported they dialed 267 phone numbers and had 200 "*completed*."
- 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 993 (rather than the 200 providers described as the *"random sample"* plus 101 non-compliant providers from CY2017 not randomly selected). Morpace reported that 89% of the 993 extrapolated providers were fully compliant, compared to 91% in CY2017.
    - 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 continues to be unclear whether there was a limit to the extrapolation by practice; if a large PCP practice, for example, had 15 PCPs, with only one in the *"random sample,"* were the results extrapolated to include all 15 PCPs in the practice? This could lead to the overall compliance results being skewed either positively or negatively depending upon the number of large practices in the sample. Larger practices may typically have more resources to support after hours support and technology, leading to the results being skewed to the positive. Morpace included counts and percentages of compliance results for the 101 non-compliant providers from CY2017 contacted again in CY2018, as well as counts and percentages for the 993 *"extrapolated"* providers; but, no counts or percentages of compliance were provided for the actual *"random sample"* of 200+101 providers. Also, the

"Total Surveyed" table details the *"Random Sample"* was 993 *and the number of "Actual Surveys Completed"* was 219, 19 more than the reported quota of n=200.

- Morpace reported 112 (11% of the 993 *"total providers"*) were noncompliant in CY2018; 91 were reported as having a recorded message that did not provide a way to reach a live party, and 21 providers were noncompliant due to "*no answer/no answer after following prompts*." Of the 101 providers who were non-compliant in CY2017, 30 (30%) were again reported to have been noncompliant.

Sunflower

For the 2017 KanCare Evaluation, Sunflower reported they conducted an after-hours access survey in 2017, but that, as of March 2018, results of that survey were still under review by Sunflower and were not yet available for release. For the 2018 KanCare Evaluation, Sunflower submitted information for their 2017 and 2018 After-hours survey. In 2017, Sunflower used SPH Analytics and in 2018 used Morpace to conduct an annual telephone survey of PCPs regarding after-hours access; it is not clear when the survey is conducted (i.e., during or after office hours). SSHP also continues to contract with NurseWise to provide after-hours services to members and providers. NurseWise reports daily numbers of calls received.

For CY2017, SHP/SPH Analytics reported 100% PCP compliance of an acceptable method of providing after-hours access for members of PCP offices who were successfully contacted. SHP/SPH Analytics reported, *"Of the 375 practitioners in the sample, 333 had a recording or auto attendant; 42 were answered by a live person; and zero were 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 the table provided above. Of the 103 answered by a live person, 80 were eligible for survey; 58 provided a passing response for urgent and emergent ..."* It is unclear what is meant by "*eligible for survey,"* or *"successfully contacted*" as it would be all providers sampled would be eligible and should be able to be contacted. Further detail is needed to ensure providers were not excluded from the results instead of considered non-compliant.

For CY2018, SHP/Morpace reported 45% PCP compliance of an acceptable method of providing after-hours access for members of PCP offices who were successfully contacted. SHP/SPH Analytics reported, *"Of the 300 practitioners in the sample, 196 had a recording or auto attendant; 48 provided a live person; 22 had no answer and 34 were unable to be reached. Of the 196 calls that were answered by a recorded/automated message, 73%* [143] *provided a passing response by either having met the performance standards set for those methods. Of the 61 providers with an automated message there was an option to speak to an unspecified live party, 90% (55 providers) provided a live party to speak to, while 2% (1 provider) connected to a physician and 8% (5 providers) received no answer at that point."* It is not clear how Morpace arrived at 45% PCP compliance, given 300 sampled, 135 were compliant and 165 were non-compliant. The report only identifies 114 as non-compliant: 22 as no answer; 34 unable to be reached; 53 recorded/automated messages without a passing response; and 5 live parties with no answer. The report did not specify a plan for SHP follow-up.

Morpace completed the survey for both AGP and SHP. However, for SHP, description of the survey sampling, methodology, and comparisons to 2017 survey results was not available. For both MCOs, there were several questions raised about the conclusions reached by Morpace.

UnitedHealthcare

UnitedHealthcare's After-Hours Survey was conducted in CY2016–CY2018 (May and June) by DialAmerica. Compliance rates have varied CY2016 through CY2018 (CY2018 – 84.1%, CY2017– 94.8%, and CY2016 – 83.8%).

In CY2018, 650 providers were selected by random sample. For the After-Hours Access survey, DialAmerica reported in Table 1 of their report, 393 of the 650 were sampled for after-hours calls, to PCPs, Specialists, and OB; however, Table 5 identifies 464 as the After-Hours sample size. Of the 464, results are only provided for 418 providers, with no information regarding the remaining 46. It is unclear what the After-Hours sample size was and how it was selected from the random sample of 650 providers. DialAmerica reports an 84% compliance rate (390/464). Further information is needed regarding the noted discrepancies.

CAHPS supplemental survey questions related to after-hours access for services common to Sunflower and UnitedHealthcare

Sunflower Q55/Q84 asked members if they phoned their doctor's office after hours to get help or advice for themselves or their child.

- Adults – 15.2% adults reported they had phoned their doctor after hours for help or advice.
- GC – 6.6% to 13.3% reported phoning their child's doctor after hours;
- CCC – 10.7% to 13.9% reported phoning their child's doctor after hours.

Sunflower Q56/Q85 and UnitedHealthcare Q55/Q86 asked members how often they received the help or advice they needed (Sunflower)/wanted (UnitedHealthcare).

- Adult Survey
  - SHP – 65 respondents who replied *"Yes"* to Q55 were asked this question, and 70.0% of the 64 adults responded that they received the help or advice they needed.
  - UHC – 65.3% of adult responses indicated that they received the help they wanted.
- Child Surveys
  - SHP – those who responded *"Yes"* to Q85, were asked Q56/Q85. The percentages of responses from parents and guardians who indicated that said they received the help or advice they needed ranged from 83.0% to 91.0%; each of the four subgroups had fewer than 100 responses to the question.
  - UHC – of the UHC parents/guardians who responded, the percentages indicating they received the help they wanted ranged from 76.0% to 81.2%; there were fewer than 100 responses for the in GC TXXI and CCC TXXI populations

Amerigroup supplemental survey question related to after-hours access to services

Amerigroup asked in the Adult survey a question related to access after-hours. Q56 asked Adults, *"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?"* – 57.7% of the respondents indicated their wait was less than 20 minutes.

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

Amerigroup's Appointment Availability Survey was administered August 28 – September 17, 2018. 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, and no calls were made from 12:00 to 2:00 p.m.

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. 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 Care (but non-life-threatening), Mental Health follow-up after hospital discharge, Initial Visit Routine Care, and Follow-up Routine Care.

Morpace reported 1,952 phone numbers were dialed. Of these, 679 (35%) completed surveys, 41% were contacted but did not complete the survey, and 481 (25%) had inaccurate phone numbers. Inaccurate phone numbers were categorized as:

- Wrong phone number/Doctor not at number listed (142; 30% of 481)
- Fax-Modem/Non-working (90; 19%)
- Generic Disposition Code (84; 17%)
- Wrong specialty/Script did not apply (78; 16%)
- Stuck in phone tree loop (38; 8%)
- Hospital-based provider (37; 8%)
- Doesn't take Amerigroup (11; 2%)
- Language Barrier (1; 0.2%)

As they did in the After-Hours Survey, Morpace referred to the 679 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 number of providers (1818 total: 702 PCPs, 436 High volume specialists, 342 High impact specialists, 142 Behavioral Health Prescribers, 292 Behavioral Health Non-Prescribers, and 147 Pediatrics). Results were not reported for the 679 providers in the actual random sample. A chart was provided showing the number of providers by provider type, but the number added up to 818 instead of 679.

Morpace reported 77% of the extrapolated providers were fully compliant in 2018 (74% in 2017). Morpace also resurveyed 274 providers in 2018 who had been non-compliant in 2017. Of the 274, 34% were again reported as non-compliant. Results by provider type for the 274 providers added up to 306, (which may possibly be due to the specialty categories not being mutually exclusive).

- Behavioral Health Non-Prescribers – 56% (52 of 93) were again non-compliant;
- Behavioral Health Prescribers – 61% (19 of 31) were again non-compliant, which is higher than the 2017 rate (33%);

- Specialists – 17% (10 or 58) of High Volume and no providers in the category High Impact were non-compliant and the 2018 rates for High Volume and High Impact were lower than 2017 (31% and 28%, respectively);
- PCPs – 11% (8 of 70) were again non-compliant; lower than the rate in 2017 (24%); and
- Pediatrics – 18% (4 of 22) were again non-compliant, higher than the rate in 2017 (9%).

Sunflower

For the 2017 KanCare Evaluation, Sunflower reported they conducted an appointment access survey in 2017, but that, as of March 2018, results of that survey were still under review by Sunflower with the vendor and were not yet available. For the 2018 KanCare Evaluation, Sunflower submitted information for their 2017 and 2018 appointment access surveys that were conducted.

From CY2016–CY2018, Sunflower reported practitioner availability monitoring was completed for PCPs and high-impact and high-volume specialty care practitioners. Calls were placed during normal business hours. Practitioner data was pulled from the Sunflower provider management system, Portico, for a statistically significant sample size of practitioners in the Sunflower Health Plan network.

Appointment types assessed for availability were:

- PCPs: Routine and Urgent Care. In CY2018, Sunflower expanded reporting to detail:
  - Urgent Care: First available (in prior years the category was primary care urgent appointments within 48 hours);
  - New Patients: Routine Care, 1st–3rd available; and
  - Established Patients: Routine Care, 1st–3rd available.
- Specialists: Routine and Urgent Care. In CY2016 and CY2017, results for specialists were reported by OB/GYN high-volume and by Oncology high-impact. Specialties included Oncology appointment availability and OB/GYN appointment availability by trimester, 1st–3rd. Appointment availability specifically for prenatal care was not included in the CY2017 survey but was added in CY2018. High-risk pregnancy has not been reported in the summary data available to KFMC. In CY2018, Sunflower expanded reporting to include behavioral health and to more thoroughly determine accessibility of appointments to detail the following:
  - Oncology – Urgent care reported for both new and established patients;
  - Oncology reported for both new and established patients for routine care for 1st–3rd available;
  - OB/GYN prenatal urgent care (48 hours) reported for both new and established patients;
  - OB/GYN prenatal urgent care reported by both new and established patients each for 1st–3rd trimester for 1st – 3rd available (reported for each trimester);
  - Behavioral health reported by both prescribers and non-prescribers for urgent care for both new and established patients; and
  - Behavioral Health reported for both prescribers and non-prescribers routine care for both new and established patients, 1st–3rd available.

Sunflower reported there were 346 PCPs included in the CY2017 sample, and 185 PCPs fully completed the survey. For high-impact and high-volume specialists, 98 oncology practitioners were included in the sample, and 79 fully completed the survey. There were 361 OB/GYN practitioners included in the sample, and those that fully completed the survey questions were: 171 – for first trimester appointments, 154 – for second trimester appointments, and 148 – for the third trimester appointments.

In CY2018, Sunflower reported there were 400 PCPs included in the sample, 128 PCPs fully completed the survey. For oncology practitioners, 150 were included in the sample, and 42 fully completed the survey. For OB/GYN practitioners, 250 were included in the sample and 42 fully completed the survey. For the Behavioral Health surveys, 294 were surveyed with 69 fully responding to the survey.

Sunflower reported survey results by provider type, asking providers about availability for urgent and routine care (goal 90%) (see Table 40):

- For accessibility of PCPs, Sunflower's goal of 90% compliance with appointment standards for urgent appointments was met in CY2016 (99%) but was not met in CY2017 (51%) and CY2018 (63%). First through third availability for routine appointments was not met in CY2017 (ranging from 78%–84%) and for new patients in CY2018 (ranging 80%–83%); however, rates were met in CY2018 for established patients for 1st–3rd appointment availability (ranging 91%–94%).
- For Oncology care, Sunflower's rates were not met for urgent appointments CY2016–CY2017 (39% and 45%, respectively) and for CY2018 (39% [new patients] and 56% [established patients]). In CY2016 (88%) and CY2017 (85%), 1st available routine appointment was not met; and in CY2017, second (93%) and third (91%) routine appointments were met. In CY2018, 1st available routine appointment was met for new and established patients (90% and 94%, respectively); however, 2nd and 3rd were not met (ranging 80%–89%).
- For OB care:
  - In CY2016, Sunflower's rate for OB (86%) was not met for routine care in the first trimester and met for the second and third trimester at 100%. In CY2017, the rate was not met for the 1st – 3rd trimester for first through third availability (ranging 82%–89%). In CY2018, Sunflower no longer reported routine care for 1st–3rd trimester.
  - The rate for urgent appointment availability (48 hours) was not met in CY2017 (42%) and CY2018 (52%, both new and established patients). The results for accessibility for urgent appointments was met for the 1st and 2nd available appointment for new and established patients, for the 1st–3rd trimester.
- In CY2018, for BH prescribers and non-prescribers, the goal was not met for urgent appointments (new patients: 33%–prescribers, 61%–non-prescribers; established patients: 38%–prescribers and 58%–non-prescribers). BH prescribers did not meet any category of routine appointment availability for new and established patients (1st–3rd available; ranging 58%–77%). BH non-prescribers, met the category of routine availability for first available for both new and established patients (95% and 98%, respectively) and 2nd available for established patients (91%); however, 2nd and 3rd availability for new patients and 3rd availability for established patients was not met (ranging 82%–88%).

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Table 40. Sunflower Appointment Availability Survey Results, CY2016 – CY2018, Provider Compliance to State Contractual Appointment Availability Standards															
Appointment Type	PCP			Oncology			Obstetricians			BH Prescribers			BH Non-Prescribers		
	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Urgent Care – 48 Hours – 1st Available	99%	51%	63%	82%	45%			42%							
New Patients – Urgent Care – 48 Hours						39%						33%			61%
Established Patients – Urgent Care – 48 Hours						56%						38%			58%
New Patients – OB Prenatal Care Urgent – 48 Hours									52%						
Established Patients – OB Prenatal Care Urgent – 48 Hours									52%						
Routine Care – 1st Available	86%	78%	83%	88%	85%	90%						77%			
Routine Care – 2nd Available		84%			93%							64%			
Routine Care – 3rd Available		80%			91%							59%			
New Patients – Routine Care – 1st Available			83%			90%									95%
New Patients – Routine Care – 2nd Available			81%			80%									82%
New Patients – Routine Care – 3rd Available			80%			80%									84%
Established Patients – Routine Care – 1st Available			94%			94%						77%			98%
Established Patients – Routine Care – 2nd Available			92%			89%						69%			91%
Established Patients – Routine Care – 3rd Available			91%			89%						58%			88%
OB Routine First Trimester							86%								
OB Routine Second Trimester							100%								
OB Routine Third Trimester							100%								
Shaded areas = Not Applicable															

UnitedHealthcare

UnitedHealthcare's Appointment Availability survey was conducted in CY2016–CY2018 (May and June) by DialAmerica. In CY2018, 650 providers (CY2016 – 562, CY2017 – 696) providers were selected by random sample. Of the 650, 454 (69.8%) were able to be contacted (down from80.0% in CY2017), and 355 (54.6% of the sample) completed an appointment availability survey, including 113 PCPs, 96 Obstetricians, 49 BH, and 97 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 216 providers in the sample who were not surveyed, 157 (24.2%) were *"unable to contact in 3 attempts"*; 30 (4.6%) *"moved, did not update information"*; 13 (2.0%) had *"technical problems"* (described as including wrong numbers and cell phones *"which cannot be called"*); and 16 (2.5%) *"refused to participate."*

The UnitedHealthcare report included the numbers and percentages of providers in the random sample contacted in CY2016 to CY2018 who were in compliance with State contractual standards (see Table 41).

Table 41. UnitedHealthcare Appointment Availability Survey Results, CY2016 – CY2018, Provider Compliance to State Contractual Appointment Availability Standards

Appointment Type	PCP			Specialists			Obstetricians			BH			Total*		
	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Emergency care	79.7%	74.9%	99.1%	39.3%	28.5%	100.0%							62.9%	56.0%	99.5%
Urgent care	91.5%	86.0%	99.1%	58.3%	38.2%	100.0%				56.3%	35.7%	83.7%	73.6%	59.8%	96.5%
Routine care	94.1%	96.1%	100.0%	95.2%	79.7%	100.0%				83.3%	84.5%	95.9%	92.4%	88.3%	99.2%
Adult physical	84.7%	83.2%	90.3%										84.7%	83.2%	90.3%
EPSDT/Well child	90.7%	79.9%	54.9%										90.7%	79.9%	54.9%
OB first trimester							93.3%	88.3%	99.0%				93.3%	88.3%	99.0%
OB second trimester							88.9%	75.0%	100.0%				88.9%	75.0%	100.0%
OB third trimester							82.2%	51.7%	99.0%				82.2%	51.7%	99.0%

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

CAHPS supplemental survey questions related to appointment availability

Sunflower in the 2018 Adult and Child surveys asked additional questions Q58/Q86, Q59/Q87, Q57/Q86 related to access to services:

- Q58/Q86 asked, *"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 provider for a non-urgent problem or health condition?"*
  - Adult survey – In 2018, 78.1% reported they were able to see a provider for a non-urgent problem within seven days or less.
  - Child surveys – GC and CCC survey respondents had similar percentages reporting they were able to see a provider within seven days for a non-urgent problem (87.0% to 89.7% and 87.1% to89.7%, respectively).
- Q59/Q87 asked, *"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 [for your child with a specialist] and actually seeing the specialist [for a non-urgent problem or health condition]?"* In 2018, 63.3% of the Adults and 67.7% to 72.4% of the GC and 50.7% to 54.6% of the CCC survey respondents reported they were able to see a provider for a non-urgent problem within seven days or less.
  - Child surveys – 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 compared to CCC survey respondents Among GC surveys, TXXI rates were higher than TXIX rates; whereas, among CCC surveys, TXIX rates were higher than TXXI rates.
- Q57 asked Adults, *"In the last 6 months, which of the following contributed to the problem you experienced seeing a specialist?"* Responses from the 89 members were:
  - 30% "*Appointment times were not available soon enough."*
  - 24% *"Specialist and/or procedures were not a covered benefit."*
  - 18% *"I did not know what type of specialist to see."*
  - 17% "*The specialist office is located too far away."*
  - 17% *"Unreasonable amount of time spent in exam room while waiting to see the doctor".*
  - 17% *"Unreasonable amount of time spent in waiting room after my scheduled appointment time".*
  - 15% *"I had difficulty reaching the specialist by telephone."*
  - 12% *"Not enough specialists to choose from"*
  - 10% *"The specialist I needed to see was out of network."*
  - 10% *"I thought I needed a referral but did not."*
  - 8% *"Office hours were inconvenient."*
  - 2% *"Problems with referrals/authorizations."*
  - 6% *"Other"*

- Q88 asked parents or guardians, *"If your child had a problem seeing a specialist, please indicate what the problem(s) were related to. Mark all that apply.* The top three problems that GC and CCC survey respondents indicated were:
  - *"Scheduling an appointment as soon as my child needed"* – 61.0% to 64.5%.
  - *"Getting the referral in a timely manner"* – 15.0% to 26.0%.
  - *"Quality of specialist"* – 8.0% to 13.0%

(20) Member Survey – CAHPS

Additional detail on the CAHPS survey, in 2018, can be found in Section 4 of this report in the Health Literacy section. CAHPS Access to Care questions are included in Table 42.

Table 42. Member Survey – CAHPS Access to Care Questions, CY2014 – CY2018

Question	Pop	Weighted % Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
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%	**45.2%**					
	GC	35.1%	37.9%	35.7%	37.9%	**39.4%**					
	CCC	43.6%	47.4%	43.1%	45.2%	**49.0%**					
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%	88.4%	**87.7%**	↑	↑	↑	↑	↑
	GC	94.1%	93.2%	93.7%	94.7%	**94.2%**	↑	↑	↑	↑	↑
	CCC	95.0%	93.9%	95.1%	97.0%	**95.2%**	↑	↑	↑	↑	↑
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%	**76.9%**					
	GC	70.8%	68.9%	69.5%	70.0%	**69.6%**					
	CCC	80.0%	78.7%	77.3%	78.4%	**79.5%**					
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%	**82.6%**	↑	↑	↑	↑	↑
	GC	90.6%	89.7%	90.0%	90.4%	**91.3%**	↑	↑	↑	↑	↑
	CCC	92.2%	92.4%	92.2%	93.3%	**93.1%**	↓	↑	↑	↑	↑
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	87.6%	88.1%	87.1%	88.0%	**87.1%**	↑	↑	↑	↑	↑
	GC	93.4%	92.0%	92.1%	93.0%	**93.7%**	↑	↑	↑	↑	↑
	CCC	93.0%	91.9%	92.4%	93.6%	**93.2%**	↑	↑	↑	↑	↑
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%	**45.3%**					
	GC	17.9%	19.4%	17.9%	19.5%	**21.4%**					
	CCC	38.4%	39.5%	39.8%	40.7%	**43.2%**					
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%	**83.1%**	↑	↑	↑	↑	↑
	GC	83.2%	84.6%	79.8%	87.6%	**85.2%**	↑	↑	↓	↑	↑
	CCC	85.3%	83.3%	86.0%	87.0%	**86.2%**	↑	↑	↑	↑	↑

↑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?

- **Adults: 45.2%** in 2018; 44.0%–46.3% in 2014–2017

- **GC: 39.4%** in 2018; 35.1%–37.9% in 2014–2017
- **CCC: 49.0**% in 2018; 43.1%–47.4% in 2014–2017
  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: 87.7%** in 2018 (**>75th QC**); 86.2%–88.4% in 2014–2017
    Sunflower's rate in 2018 was 91.1% (>90th QC).
  - **GC: 94.2%** in 2018 (**>75th QC**); 93.2%–94.7% in 2014–2017
    Rates for all MCO GC subgroups were above 91% in 2014 through 2018.
  - **CCC: 95.2**% in 2018 (**≥50th QC**); 93.9%–97.0% in 2014–2017
    Rates for all MCO GC subgroups were above 92% in 2014 through 2018. However, the overall CCC rate was significantly lower (*p*=.02) than in 2017 (97.0%; >90th QC).
    UnitedHealthcare's TXIX rate (93.6%; <33.33rd QC) was also significantly lower (*p*=.01) than in 2017 (99.3%; >95th QC).

In the last 6 months:
How often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?

- **Adults: 87.1%** in 2018 **(≥50th QC**); 87.1%–88.1% in 2014–2017
- **GC: 93.7%** in 2018 (**>75th QC**); 92.0%–93.4% in 2014–2017
  Rates for all MCO GC subgroups were above the 50th QC or higher and over 91% positive in 2018.
  UnitedHealthcare's TXIX rate (95.1%) was >95th QC.
- **CCC: 93.2%** in 2018 (**≥50th QC**); 91.9%–93.6% in 2014–2017
  Rates for all MCO CCC subgroups were above 92% in 2018.

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?

- **Adults: 76.9%** in 2018; 75.3%–77.1% in 2014–2017
- **GC: 69.6%** in 2018; 68.9%–70.8% in 2014–2017
- **CCC: 79.5**% in 2018; 77.3%–80.0% in 2014–2017
  Those who responded they made an appointment for a check-up or routine care were asked:
  How often (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic did you get as soon as you (your child) thought you needed?
  - **Adults: 82.6%** in 2018 (**>66.67th QC**); 82.5%–84.6% in 2014–2017
    Sunflower's 2018 rate (82.7%; >66.67th QC) was significantly lower (*p*=.04) than in 2017 (88.1%; >95th QC).
  - **GC: 91.3%** in 2018 (**>66.67th QC**); 89.7%–90.6% in 2014–2017
    UnitedHealthcare's 2018 TXIX rate (94.8%) was >90th QC.
  - **CCC: 93.1%** in 2018 (**≥50th QC**); 92.2%–93.3% in 2014–2017
    All of the MCO CCC subgroup rates in 2017 and 2018 were above 91% positive.
    UnitedHealthcare's TXIX rate (95.1%) and Sunflower's TXXI rate (95.2%) were >90th QC in 2018.

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

- **Adults: 45.3%** in 2018; 43.0%–46.8% in 2014–2017
  Sunflower's rate (40.9%) was significantly lower *(p*<.01) than the 2017 rate (49.9%).
- **GC: 21.4%** in 2018; 17.9%–19.5% in 2014–2017

- **CCC: 43.2%** in 2018; 38.4%–40.7% in 2014–2017
  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: 83.1%** in 2018 (**>66.67th QC**); 81.7%–86.2% in 2014–2017
    - **GC: 85.2%** in 2018 (**>66.67th QC**); 79.8%–87.6% in 2014–2017
      Amerigroup's TXXI rate in 2018 (87.3%) was >90th QC and significantly higher (*p*=.03) than in 2017 (78.7%; <50th QC).
    - **CCC: 86.2%** in 2018 (**≥50th QC**); 83.3%–87.0% in 2014–2017
      Amerigroup's TXXI rate in 2018 (91.9%) was >95th QC and significantly higher (*p*=.03) than in 2017 (81%, QC ranking *"NA"* due to fewer than 100 responses).

(21) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2018 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:

Ability to see a psychiatrist when the member wanted to
For Adult members, the rate in 2018 was 79.6%, which had a significant increase compared to 2012 (70.8%; *p*=.02).

Ability to get all the services the members thought they needed
- Adult members had a significantly higher percentage of positive responses in 2018 (85.8%) than in 2012 (78.8%; *p*=.02) and significantly lower than in 2011 (91.3%; *p*=.03).
- For Youth, the rate in 2018 was 82.3%, and the 2018 percentage of positive responses from Urban youth families was significantly lower (75.9%) compared to Non-Urban (86.5%; *p*<.01). There was significant variation among the county types (Semi-Urban 82.9%; Densely-Settled Rural 88.7%; Rural and Frontier 88.4%; *p*=.04).

Provider availability as often as member felt it was necessary
For Adult members, the rate in 2018 was 87.0%, and had a slightly lower percentage of positive responses than in five of seven previous years (84.0% [2016] to 88.8% [2011]).

Services were available at times that were good for the member
- For Adult members, the rate in 2018 was 90.8% and responses have been fairly high over the eight years (87.4% [2016] to 92.3% [2011].
- Youth had a higher percentage of positive responses in 2018 (89.9%) than in six of seven prior years, with a significant increase compared to 2016 (83.9%; *p*=.02); and the 2018 percentage of positive responses from Urban youth families was significantly lower (85.6%) compared to Non-Urban (92.8%; *p*=.02).

Ability to get services during a crisis
- For Adult members, the rate in 2018 was 85.9%, which had a higher percentage in 2018 than in six of seven prior years (79.2% [2012] to 86.0% [2014]), although there were no statistically significant differences.

- For Youth, family respondents, the rate in 2018 was 85.3%, and the 2018 percentage of positive responses for Urban youth families was significantly lower (79.7%) compared to Non-Urban (89.3%; *p*=.02).

Timely availability of medication

- From 2013 to 2018 the Adult population rates for medication availability have been above 90%.
- Youth responses had a significant positive trend from 2013 to 2018 (96%; *p*<.001). Youth positive responses were significantly higher in 2018 compared to 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).
- Youth positive responses are the highest they have been since 2013.

Provider return of calls within 24 hours

Adult members had a higher percentage of positive responses in 2018 (86.4%) than in six of seven prior years, with a significant increase from 2016 (79.6%; *p*=.03).

Table 43. Mental Health Survey – Access-Related Questions

	Year	Rate	N/D	95% CI	*p*-value	Trend 6-Year	Trend 8-Year
		Adults (Age 18+)					
I was able to see a psychiatrist when I wanted to.	**2018**	**79.6%**	228 / 287	74.5% – 83.8%		.15	.90
	2017	81.3%	295 / 363	77.0% – 85.0%	.58		
	2016	73.6%	195 / 265	67.9% – 78.5%	.10		
	2015	83.4%	291 / 349	79.2% – 87.0%	.21		
	2014	80.5%	598 / 744	77.5% – 83.2%	.75		
	2013	82.3%	807 / 981	79.8% – 84.6%	.29		
	2012	70.8%	187 / 264	65.1% – 76.0%	**.02 +**		
	2011	82.1%	225 / 274	77.1% – 86.2%	.44		
		Adults (Age 18+)					
I was able to get all the services I thought I needed.	**2018**	**85.8%**	276 / 322	81.5% – 89.2%		.20	.14
	2017	83.9%	335 / 399	79.9% – 87.2%	.48		
	2016	80.7%	235 / 290	75.8% – 84.9%	.09		
	2015	84.9%	325 / 383	81.0% – 88.2%	.75		
	2014	86.5%	704 / 814	84.0% – 88.7%	.74		
	2013	86.0%	917/1,066	83.8% – 87.9%	.92		
	2012	78.8%	219 / 278	73.6% – 83.2%	**.02 +**		
	2011	91.3%	274 / 300	87.6% – 94.1%	**.03 -**		
		Youth (Ages 0–17), Family Responding					
My family got as much help as we needed for my child.	**2018**	**82.3%**	327 / 398	78.2% – 85.7%		.72	.88
	2017	83.5%	405 / 485	79.9% – 86.5%	.64		
	2016	82.2%	264 / 320	77.6% – 86.0%	.97		
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.28		
	2013	83.2%	799 / 966	80.7% – 85.4%	.68		
	2012	82.9%	213 / 257	77.8% – 87.0%	.85		
	2011	84.2%	278 / 330	79.9% – 87.8%	.49		

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

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Year	Trend 8-Year
My mental health providers were willing to see me as often as I felt it was necessary.	**Adults (Age 18+)**							
	2018		**87.0%**	280 / 322	82.9% – 90.3%		.17	.24
	2017		86.3%	341 / 395	82.6% – 89.4%	.78		
	2016		84.0%	243 / 289	79.3% – 87.8%	.28		
	2015		87.2%	332 / 381	83.4% – 90.2%	.95		
	2014		87.9%	706 / 804	85.5% – 90.0%	.68		
	2013		88.2%	927/1,051	86.2% – 90.1%	.56		
	2012		85.3%	233 / 273	80.6% – 89.1%	.55		
	2011		88.8%	262 / 295	84.7% – 92.0%	.50		
Services were available at times that were good for me (convenient for us/me).	**Adults (Age 18+)**							
	2018		**90.8%**	292 / 322	87.1% – 93.5%		.43	.59
	2017		91.9%	367 / 399	88.8% – 94.3%	.57		
	2016		87.4%	258 / 294	83.1% – 90.8%	.18		
	2015		90.0%	343 / 381	86.6% – 92.7%	.75		
	2014		89.8%	733 / 817	87.5% – 91.7%	.63		
	2013		92.1%	985/1,071	90.4% – 93.6%	.43		
	2012		87.7%	242 / 276	83.2% – 91.1%	.23		
	2011		92.3%	277 / 300	88.7% – 94.9%	.48		
	Youth (Ages 0–17), Family Responding							
	2018		**89.9%**	364 / 405	86.5% – 92.5%		.99	.60
	2017		87.4%	428 / 489	84.2% – 90.1%	.25		
	2016		83.9%	276 / 328	79.6% – 87.5%	**.02 +**		
	2015		90.9%	297 / 327	87.2% – 93.6%	.65		
	2014		86.9%	682 / 783	84.4% – 89.1%	.14		
	2013		88.7%	871 / 983	86.5% – 90.5%	.51		
	2012		88.0%	235 / 267	83.5% – 91.4%	.45		
	2011		85.9%	287 / 334	81.8% – 89.3%	.10		
During a crisis, I was able to get the services I needed.	**Adults (Age 18+)**							
	2018		**85.9%**	228 / 266	81.2% – 89.6%		.39	.81
	2017		83.5%	277 / 332	79.1% – 87.1%	.42		
	2016		80.7%	196 / 242	75.3% – 85.2%	.11		
	2015		85.0%	265 / 312	80.6% – 88.5%	.75		
	2014		86.0%	586 / 682	83.2% – 88.4%	.97		
	2013		85.4%	742 / 870	82.9% – 87.6%	.82		
	2012		79.2%	183 / 231	73.5% – 84.0%	.05		
	2011		83.9%	209 / 249	78.8% – 88.0%	.53		
During a crisis, my family was able to get the services we needed.	**Youth (Ages 0–17), Family Responding**							
	2018		**85.3%**	256 / 302	80.9% – 88.9%		.99	.23
	2017		86.3%	285 / 330	82.1% – 89.6%	.74		
	2016		83.8%	209 / 248	78.7% – 87.9%	.62		
	2015		84.6%	197 / 233	79.3% – 88.7%	.81		
	2014		83.4%	457 / 548	80.1% – 86.3%	.47		
	2013		86.2%	604 / 706	83.5% – 88.6%	.70		
	2012		87.4%	173 / 198	82.0% – 91.4%	.52		
	2011		89.5%	204 / 228	84.8% – 92.9%	.16		

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

	Year 0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Year	Trend 8-Year
Medication available timely*	**Adults (Age 18+)**						
	2018	**92.1%**	243 / 264	88.2% – 94.9%		.82	
	2017	91.0%	310 / 341	87.5% – 93.6%	.62		
	2016	92.9%	237 / 255	89.0% – 95.5%	.74		
	2015	90.3%	296 / 328	86.5% – 93.1%	.43		
	2014	92.7%	661 / 713	90.5% – 94.4%	.78		
	2013	91.8%	827 / 903	89.8% – 93.4%	.86		
	Question introduced in 2013						
	Youth (Ages 0–17), Family Responding						
	2018	**96.0%**	218 / 227	92.5% – 98.0%		**<.001 ↑**	
	2017	95.6%	263 / 275	92.4% – 97.6%	.83		
	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						
My mental health providers returned my calls in 24 hours.	**Adults (Age 18+)**						
	2018	**86.4%**	254 / 294	82.0% – 89.9%		.54	.95
	2017	85.9%	303 / 353	81.8% – 89.2%	.84		
	2016	79.6%	213 / 267	74.4% – 84.1%	**.03 +**		
	2015	84.4%	292 / 346	80.2% – 87.9%	.47		
	2014	83.3%	618 / 742	80.5% – 85.8%	.22		
	2013	84.4%	840 / 995	82.0% – 86.5%	.39		
	2012	80.8%	202 / 250	75.4% – 85.2%	.08		
	2011	88.1%	251 / 285	83.8% – 91.4%	.56		

*Not asked in 2012 and 2011

(22) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2017; the SUD survey was not conducted in 2018. Questions related to perceptions of access to care for members receiving SUD services follow.

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 44 provides the available survey results by individual MCO.

Amerigroup

In CY2018, **59.8%** of 209 providers surveyed were very or somewhat satisfied, higher than the four previous years (45.9% [CY2014]–59.5% [CY2015]). The percentage of providers very or somewhat dissatisfied with availability of specialists was 16.3% in CY2018, lower than the four previous years (17.6% [CY2017]–21.9% [CY2016]).

Sunflower

In CY2018, **41.0%** of 161 providers surveyed were very or somewhat satisfied with the availability of specialists, comparable to CY2017 (41.9%) and CY2014 (40.7%) and higher than CY2016 (39.8%) and lower than in CY2015 (52.9%). The percentage of providers very or somewhat dissatisfied with availability of specialists was 15.5% in CY2018, comparable to 15.0% in CY2014 and lower and higher than CY2015–CY2017 (CY2015 – 16.2%; 2016 – 8.4%; 2017 – 9.6%).

Table 44. Provider Satisfaction with Availability of Specialists, CY2014 – CY2018

MCO Provider Survey Type	2014	2015	2016	2017	2018
	Very or Somewhat Satisfied				
Amerigroup*	45.9%	59.5%	59.4%	56.3%	**58.9%**
Sunflower *(General Provider)*	40.7%	52.9%	39.8%	41.9%	**41.0%**
Cenpatico *(Behavioral Health)*	†	27.4%	28.1%	48.5%	‡
UnitedHealthcare *(General Provider)*	^	45.2%	43.7%	40.5%	**68.2%**
Optum *(Behavioral Health)*	32.1%	38.6%	44.1%	41.0%	**35.6%**
	Neither Satisfied nor Dissatisfied				
Amerigroup*	37.0%	23.7%	18.8%	26.1%	**23.9%**
Sunflower *(General Provider)*	44.2%	30.9%	51.7%	48.5%	**43.5%**
Cenpatico *(Behavioral Health)*	†	65.3%	64.7%	51.5%	‡
UnitedHealthcare *(General Provider)*	^	32.9%	39.4%	37.8%	**22.7%**
Optum *(Behavioral Health)*	54.8%	55.4%	44.1%	49.4%	**56.4%**
	Very or Somewhat Dissatisfied				
Amerigroup*	17.1%	16.8%	21.9%	17.6%	**16.3%**
Sunflower *(General Provider)*	15.0%	16.2%	8.4%	9.6%	**15.5%**
Cenpatico *(Behavioral Health)*	†	7.3%	7.2%	0%	‡
UnitedHealthcare *(General Provider)*	^	21.9%	16.9%	21.6%	**9.1%**
Optum *(Behavioral Health)*	13.1%	5.9%	11.7%	9.6%	**8.1%**
	Total Responses				
Amerigroup*	257	333	160	272	**209**
Sunflower *(General Provider)*	226	259	261	167	**161**
Cenpatico *(Behavioral Health)*	†	124	167	33	‡
UnitedHealthcare *(General Provider)*	63	73	71	74	**22**
Optum *(Behavioral Health)*	84	101	145	156	**149**

*Amerigroup includes Behavioral Health Providers in their General 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."
†Question was not asked in Cenpatico survey in 2014.
‡Cenpatico Behavioral Health transitioned to Sunflower September 1, 2018; therefore, no data is vailable.

UnitedHealthcare

- **UnitedHealthcare general provider survey** – In CY2018, **68.2%** of the 22 providers surveyed were very or somewhat satisfied, higher than in the three previous years (CY2017 – 40.5%; CY2016 – 43.7%; CY2015 – 45.2%). In CY2018, 9.1% of the providers surveyed were very or somewhat dissatisfied, lower than the three previous years (CY2017 – 21.6%; CY2016 – 16.9%; CY2015 – 21.9%). CY2014 survey results are not available due to a typographical error on the survey instrument.
- **UnitedHealthcare (Optum) BH provider survey** – In CY2018, **35.6%** of 149 BH providers were very or somewhat satisfied, and it has fluctuated from CY2014 to CY2017 (ranging from 32.1% [CY2014] to 44.1% [CY2016]). The percentage of BH providers reporting they were very or somewhat dissatisfied was 8.1% in CY2018, and it has fluctuated from CY2014 to CY2017 (5.9% [CY2015] – 13.1% [CY2014]).

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 – CY2017 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 except I/DD (see Table 46). Dual-eligible members in CY2017 composed approximately 10% of the overall KanCare population and approximately 69% of the HCBS population of TBI, FE, I/DD, and PD members. The percentage of dual members varied, too, by waiver type: FE–93% dual, PD–66% dual, I/DD–56% dual, and TBI–52% dual.

There are differences in the numbers and rates of ED visits for the TBI, FE, I/DD, PD, and MH members in CY2012 through CY2017 when including dual eligible members (Table 45) and excluding dual-eligible members (Table 46).

Table 45. HCBS and MH Emergency Department (ED) Visits, Including Dual-Eligible Members (Medicare and Medicaid), CY2012 – CY2017						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
All KanCare Members						
ED Visits	326,831	307,575	356,652	369,262	365,363	333,153
Members	463,285	467,632	481,950	490,441	498,611	490,325
Member-Months	4,592,675	4,655,420	4,918,690	5,005,417	5,160,959	4,863,127
Visits per 1,000 member months	**71.16**	**66.07**	**72.51**	**73.77**	**70.79**	**68.51**
Waiver Members						
Traumatic Brain Injury (TBI)						
ED Visits	1,452	1,202	1,295	1,109	931	754
Members	744	748	694	590	577	573
Member-Months	6,596	7,406	6,667	5,991	5,608	5,371
Visits per 1,000 member months	**220.13**	**162.30**	**194.24**	**185.11**	**166.01**	**140.38**
Frail Elderly (FE)						
ED Visits	6,199	3,945	4,232	4,000	4,006	3,841
Members	7,341	6,899	6,879	6,683	6,272	6,115
Member-Months	68,631	64,328	62,984	61,240	58,785	57,085
Visits per 1,000 member months	**90.32**	**61.33**	**67.19**	**65.32**	**68.15**	**67.29**
Intellectual/Developmental Disability (I/DD)						
ED Visits	5,601	4,218	4,894	5,008	5,266	4,840
Members	9,037	9,084	9,123	9,141	9,257	9,477
Member-Months	103,258	103,575	104,737	105,222	106,514	107,400
Visits per 1,000 member months	**54.24**	**40.72**	**46.73**	**47.59**	**49.44**	**45.07**
Physical Disability (PD)						
ED Visits	12,424	8,089	8,483	8,367	9,528	9,232
Members	6,984	6,340	6,166	6,368	6,905	6,836
Member-Months	75,087	68,468	64,782	66,098	71,236	71,525
Visits per 1,000 member months	**165.46**	**118.14**	**130.95**	**126.58**	**133.75**	**129.07**
Total - TBI, FE, I/DD, PD						
ED Visits	25,676	17,454	18,904	18,484	19,731	18,667
Members	24,106	23,071	22,862	22,782	23,011	23,001
Member-Months	253,572	243,777	239,170	238,551	242,143	241,381
Visits per 1,000 member months	**101.26**	**71.60**	**79.04**	**77.48**	**81.48**	**77.33**
Mental Health (MH)						
ED Visits	113,755	108,503	136,237	150,513	151,554	135,675
Members	89,020	90,979	99,696	107,728	114,822	112,249
Member-Months	939,152	959,909	1,058,918	1,160,450	1,269,478	1,227,271
Visits per 1,000 member months	**121.13**	**113.03**	**128.66**	**129.70**	**119.38**	**110.55**

Table 46. HCBS and MH Emergency Department (ED) Visits, Excluding Dual-Eligible Members (Medicare and Medicaid), CY2012 – CY2017						
	2012	**2013**	**2014**	**2015**	**2016**	**2017**
All KanCare Members - Excluding Dual-Eligible						
ED Visits	271,689	254,076	295,969	308,455	306,465	283,794
Members	405,448	411,120	425,636	435,122	445,132	440,215
Member-Months	4,026,589	4,100,783	4,361,384	4,463,500	4,633,272	4,361,233
Visits per 1,000 member months	**67.47**	**61.96**	**67.86**	**69.11**	**66.14**	**65.07**
Waiver Members - Excluding Dual-Eligible						
Traumatic Brain Injury (TBI)						
ED Visits	797	579	680	588	530	423
Members	303	305	281	242	251	274
Member-Months	2,727	3,081	2,662	2,467	2,361	2,438
Visits per 1,000 member months	**292.26**	**187.93**	**255.45**	**238.35**	**224.48**	**173.50**
Frail Elderly (FE)						
ED Visits	296	194	225	277	292	419
Members	263	251	307	323	381	424
Member-Months	2,515	2,293	2,800	3,157	3,645	4,218
Visits per 1,000 member months	**117.69**	**84.61**	**80.36**	**87.74**	**80.11**	**99.34**
Intellectual/Developmental Disability (I/DD)						
ED Visits	2,372	1,613	1,819	1,980	2,294	2,180
Members	4,255	3,392	3,530	3,664	3,870	4,176
Member-Months	46,812	37,633	39,583	41,461	43,791	46,186
Visits per 1,000 member months	**50.67**	**42.86**	**45.95**	**47.76**	**52.39**	**47.20**
Physical Disability (PD)						
ED Visits	4,419	2,683	2,938	3,230	3,874	4,267
Members	2,215	1,623	1,624	1,776	2,156	2,299
Member-Months	22,999	17,161	16,767	18,223	21,622	23,739
Visits per 1,000 member months	**192.14**	**156.34**	**175.23**	**177.25**	**179.17**	**179.75**
Total - TBI, FE, I/DD, PD						
ED Visits	7,884	5,069	5,662	6,075	6,990	7,289
Members	7,036	5,571	5,742	6,005	6,658	7,173
Member-Months	75,053	60,168	61,812	65,308	71,419	76,581
Visits per 1,000 member months	**105.05**	**84.25**	**91.60**	**93.02**	**97.87**	**95.18**
Mental Health (MH)						
ED Visits	78,317	74,166	95,035	106,950	110,631	101,816
Members	64,107	66,170	73,903	81,135	90,132	89,181
Member-Months	672,690	692,989	780,539	871,817	995,816	968,684
Visits per 1,000 member months	**116.42**	**107.02**	**121.76**	**122.67**	**111.10**	**105.11**

The summaries that follow are based on data that include members with dual eligibility (Table 45). ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2017 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 CY2017 (**68.51)** was lower than in four of five previous years (ranging from 66.07 [CY2013] to 73.77 [CY2015]).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2017, compared to the other waiver populations. The ED visit rate in CY2017 (**140.38**) was lower than in the five previous years (ranging from 162.30 [CY2013] to 220.13 [CY2012]).
- **PD** – PD members also had high rates of ED visits, **129.07** in CY2017, and the CY2017 rate was higher than in CY2013 (118.14) and CY2015 (126.58) but lower than the rates in CY2012 (165.45); CY2014 (130.95); and CY2016 (133.75).
- **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 CY2017 (**110.55**) was lower than in the previous five years (ranging from 129.70 [CY2015] to 113.13 [CY2013]).
- **I/DD** – I/DD member ED rates were lower than those of PD, FE, TBI, and MH members each of the six years. The CY2017 rate (**45.07**) was lower than four of five previous years (ranging from 40.72 [CY2013] to 54.24 [CY2012]).
- **FE** – FE member ED rates were lower than those of PD, TBI, and MH members each of the six years. The CY2017 rate (**67.29**) was lower than in CY2012 (90.32) and CY2016 (68.15) 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, was higher in CY2017 (62.42 ED visits/1,000 member-months) compared to CY2016 (59.53) but lower than all previous years (CY2015 [66.31]; CY2014 [64.19]; CY2013 [65.17]). 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 47 for HCBS (TBI, FE, I/DD, and PD) and all members are based on inpatient admissions per 1,000 member-months. The overall KanCare population inpatient utilization HEDIS measure (per 1,000 member-months) had a 16.3% relative decrease/improvement in the rate from CY2013 (9.43) to CY2017 (7.89). HEDIS rates, however, are based on inpatient discharges, so are not directly comparable. The overall inpatient rates decreased from CY2016 to CY2017 and also for members receiving waiver services (TBI, FE, I/DD, and PD). In comparing the inpatient rates for CY2017 with CY2012, the rates also decreased/improved for all KanCare members and for two waiver types (TBI and PD).

- **KanCare Population**: The inpatient rate for KanCare members in CY2017 (**13.44**) was lower than the rates from the previous five years (14.51 [CY2016]–15.74 [CY2014]).
- **TBI** – The TBI member inpatient admission rate in CY2017 **(40.96)** was lower than the five previous years (45.30 [CY2014]–50.46 [CY2016]).
- **FE** – The FE inpatient admission rate in CY2017 (**47.35**) was lower than four of five previous years (47.27 [CY2012]–52.44 [CY2014].

- **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, and decreased in CY2017 to **12.90**.
- **PD** – The PD inpatient admission rate in CY2017 (**50.15**) was lower than the previous five years (50.58 [CY2013]–55.66 [CY2014]). 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 2017 for TBI and I/DD members, increased for FE and PD members, and decreased 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 to CY2017 have been slightly lower than the CY2012 rate (1.59). Rates increased each year from 1.45 in CY2013 to 1.54 in CY2016 and decreased in CY2017 to **1.47**.
- **TBI** – TBI member readmission rates in CY2017 (**6.73**) were lower than the previous five years (6.90 [CY2014]–13.02 [CY2015]).
- **PD** – The readmission rate for PD members in CY2017 (**11.56**) was higher than the five previous years (8.84 [CY2013]–11.16 [CY2016]) and higher than the readmission rates of TBI, FE, and I/DD members.
- **FE** – The FE member readmission rate in CY2017 (**9.50**) was higher than the five previous years (7.23 [CY2013]–8.25 [CY2015])
- **I/DD** – The I/DD member readmission rate was lower in CY2017 (**1.96**) 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 47. HCBS and MH Inpatient Admissions and Readmissions within 30 days of Discharge, CY2012 – CY2017

		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**
2017	490,325	65,349	**13.44**	7,135	**1.47**
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
2017	**573**	**220**	**40.96**	**36**	**6.73**
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	467	7.94
2017	**6,115**	**2,703**	**47.35**	**540**	**9.50**
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
2017	**9,477**	**1,385**	**12.90**	**211**	**1.96**
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	795	11.16
2017	**6,836**	**3,587**	**50.15**	**826**	**11.56**
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	1,535	6.34
2017	**23,001**	**7,895**	**32.71**	**1,613**	**6.69**

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 2018 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) and an Accountable Care Organization (ACO). These incentives change each year and continued in 2018. More than 600 providers served more than 191,500 Kansans who were attributed to either a PCMH or an ACO during 2017. Both ACOs and PCMHs are created through special provider contracts and are focused on improving the overall quality of health care, creating better experiences for members and better controlling the total cost of care for a sustainable future.
- 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 through 2017. In early 2018, the practice that received NCQA PCMH recognition was sold and is no longer a PCMH DSRIP participant. The three remaining practices continue to implement PCMH processes.
  - *Start dates and current stage of the initiative*: The project started January 1, 2015. One practice became PCMH-recognized by NCQA in 2016.The remaining three practices are in active stages of modifying their processes, per the PCMH model.

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 1,400 Kansas clinicians 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 Clinical Improvement Collaborative (KCIC- ACO), previously the Kansas Heart and Stroke Collaborative (KHSC). The KCIC-ACO is working in partnership with rural Kansas providers to implement new treatment models that result in better patient outcomes and reduced healthcare costs, including:
  - Shared clinical guidelines for moving patients to the next level of care.
  - Care coordination/management and health coaching.
  - Telemedicine resources.
  - Electronic health information exchanges.
  - Establishing 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:* The UKHS 2018 Annual Report indicates the collaborative has included greater than 50 hospitals, 1800 clinicians, and >49,000 patient interactions.
    - *Start date and current stage of the initiative*: The KHSC initiative started September 1, 2014 and extended through August 31, 2017.The KCIC-ACO was subsequently formed and continues into 2019.
- 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 February 2019, there were 11 ACOs in Kansas; this is a decrease from 13 in January 2018.
- 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, Garden City, Great Bend, Hays, Hoxie, Hutchinson, Junction City, Lawrence, Newton, Olathe, Salina, 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 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 from February 2014 to current.

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:

- Telemedicine services
  - *Consumer and provider populations impacted:* 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:* 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, with 97 of the 105 Kansas counties having at least one Project ECHO registered participant. It provides collaborative provider education, linking interdisciplinary specialty teams with multiple primary clinics and 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 four ECHO Hubs in Kansas and 97 of the 105 Kansas counties have at least one Project ECHO registered participant.
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 2015
- Telehealth Rocks Schools
  - *Consumer and provider populations impacted:* Includes ECHO "telementoring" to assist local medical, mental health, and school providers in developing expertise in developmental and

behavioral disorders to increase their capacity to identify and treat these disorders in local settings.

- *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 (see Table 48).

Table 48. Member Survey – CAHPS, CY2014 – CY2018

Question	Pop	% Positive Responses					Quality Compass ≥50th Percentile				
		2014	2015	2016	2017	2018	2014	2015	2016	2017	2018
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**	45.2%	33.2%	32.5%	31.4%	**31.5%**					
	GC	24.7%	27.3%	28.9%	26.6%	**28.0%**					
	CCC	28.3%	31.1%	30.2%	29.0%	**31.5%**					
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%	**83.3%**	↓	↑	↑	↑	↑
	GC	86.7%	85.4%	84.5%	83.1%	**83.6%**	↑	↑	↑	↑	↓
	CCC	84.8%	84.4%	82.8%	82.7%	**81.9%**	↑	↑	↓	↓	↓

↑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 2018 reported contacting customer service at their MCO for information or help.

- **Adults: 31.5%** in 2018; 31.4%–45.2% in 2014–2017
- **GC: 28.0%** in 2018; 24.7%–28.9% in 2014–2017
- **CCC: 31.5%** in 2018; 28.3%–31.1% in 2014–2017; statistically significant increase (*p*=.04) in 2018 rate compared to 2017 rate (29.0%).
  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, 82% or greater found the information provided helpful.
    - **Adults: 83.3%** in 2018 (**≥50th QC**); 80.0%–84.2% in 2014–2017
      Amerigroup's 2018 rate (84.7%) was >66.67th QC compared to <25th QC in 2017.
    - **GC: 83.6%** in 2018 (**<50th QC**); 83.1%–86.7% in 2014–2017
      Sunflower's TXXI rate (88.4%) in 2018 was >90th QC.
    - **CCC: 81.9%** in 2018 (**<33.33rd QC**); 82.7%–84.8% in 2014–2017

Mental Health Survey

The MH Surveys conducted in CY2011 through CY2018 are described above in Section 7 *"Member Survey – Quality."*

For the question ***"My mental health providers returned my calls in 24 hours,"*** Adult members had a higher percentage of positive responses in 2018 (86.4%) than in six of seven prior years, with a significant increase from 2016 (79.6%; *p*=.03) (see Table 49).

Table 49. Mental Health Survey – Efficiency-Related Questions

	Year	0% 100%	Rate	N/D	95% CI	*p*-value	Trend 6-Year	Trend 8-Year
	Adults (Age 18+)							
My mental health providers returned my calls in 24 hours.	**2018**		**86.4%**	254 / 294	82.0% – 89.9%		.54	.95
	2017		85.9%	303 / 353	81.8% – 89.2%	.84		
	2016		79.6%	213 / 267	74.4% – 84.1%	**.03 +**		
	2015		84.4%	292 / 346	80.2% – 87.9%	.47		
	2014		83.3%	618 / 742	80.5% – 85.8%	.22		
	2013		84.4%	840 / 995	82.0% – 86.5%	.39		
	2012		80.8%	202 / 250	75.4% – 85.2%	.08		
	2011		88.1%	251 / 285	83.8% – 91.4%	.56		

SUD Survey

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014–2017; the SUD survey was not conducted in 2018. The question that follows is related to perception of efficiency for members receiving SUD services.

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%).

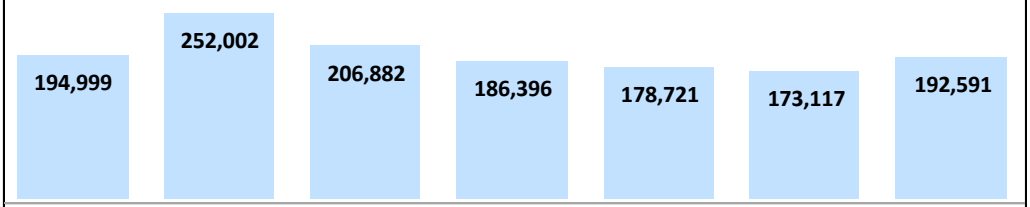
Uncompensated Care Cost (UCC) Pool

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 CY2018 is based on costs of care during FY2016.

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 each year from 2014 through 2017 and increased in CY2018 (see Table 50).

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 slightly fluctuated each year from CY2013 through CY2016, and there were larger increases/decreases between CY2016 through CY2018.

Table 50. UCC Payment History



UCC Annual Payment Totals						
2012	2013	2014	2015	2016	2017	2018
$20,568,567	$41,026,795	$40,974,407	$40,929,060	$40,960,116	$40,698,530	$40,983,780
FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016

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 EQRO for the Medicaid program (KanCare) for the State of Kansas, reviewed annual reports for activities completed in CY2015 through CY2018 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

- **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**
  In 2018, STOP Sepsis training was provided to 498 participants, bringing the total to 1,986 staff from hospitals, nursing facilities, emergency medical services (EMS), and other healthcare providers. In 2018, the STOP Sepsis project added 14 community partners, bringing the total to 227; 65 of the partners are nursing facilities (NFs). The database is now set up in REDCap, which project partners have found more user-friendly and has provided UKHS staff more efficient and expanded reporting of sepsis data from multiple types of partnering facilities. In 2018, there were 57 facilities sharing sepsis data and progress in identifying sepsis at any stage has been noted. Also, of the 61 patients treated for some form of sepsis at any facility that has been contributing data for at least 12 months, 13.1% of those patients progressed to septic shock. This is a 30.3% improvement since 2017. Specific classification of sepsis as severe sepsis or septic shock continues to need substantial improvement to ensure patients receive time-critical diagnoses and immediate initiation of treatment.

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 2018, 241 individuals throughout Kansas have been trained as SPARCC facilitators and 285 patients and caregivers have participated in SPARCC training. The number of Kansas community partners remains steady at 105 in 2018. UKHS has also been successful in developing 13 training videos for SPARCC facilitators they can now access through the YouTube website. UKHS has noted patient improvements from the first week to the fourth week of training, although denominators are small.
- Category 4: The goal of Category 4 metrics is to measure impact of the DSRIP projects on population health. Due to other related projects occurring in Kansas (e.g., KanCare MCOs, Kansas ACOs etc.), DSRIPs' specific impact on the improvement of Category 4 measures (KanCare HEDIS is not possible. The Category 4 measures are based on KanCare HEDIS and include:
  - Emergency Department(ED) visits per 1,000 member-months: 62.42 in 2017, a decrease (improvement) from 2013 (65.17), although both years were greater than or equal to the Quality Compass (QC) 50th percentile.
  - Controlling high blood pressure: the 2017 rate of 53.57% (<50th QC) was 13.4% higher (relatively) than the rate in 2013 (47.26; < 25th QC).

- The percentage of members indicating they smoked or used tobacco decreased 16.1% from 37.67% (≥50th QC) in 2013 to 31.62% (≥50th QC) in 2017.

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 CYMC and their siblings. The Beacon Clinic received recognition from NCQA as a Level III PCMH in 2015 and obtained PCMH re-recognition in early 2018. The number of Kansas Beacon patients continues to grow. CMH reported there were 63 Kansas Beacon patients in 2014, 56 in 2015, 92 in 2016, 108 in 2017 and 152 in 2018 (including 38 consults for children in rural Kansas communities). In 2018, the target (82) was met for the number of Kansas Beacon CYMC, as was the target (25) for the number consults. In 2018, Beacon staff focused on building relationships with PCPs (existing and potential partners/referral sources) through in-person site visits and streamlining referral processes. The number of consults more than doubled in 2018. The Beacon program currently has locations distributed throughout the state, except in northwest Kansas, where they anticipate exploring a location in 2019.

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 continues to actively work with the practices on their transformation goals. One practice, KU Project Eagle, achieved NCQA PCMH recognition in 2016. In early 2018, this practice was sold and is no longer a participant in the PCMH DSRIP project. The remaining three practices continue to be actively engaged with CMH and are making progress in their practice transformation journey. However, the two practices that were intending to submit their applications for recognition in 2017, will no longer be doing so, as they are preparing to retire or sell their businesses. Since the release of the new NCQA PCMH 2017 standards in late October 2017, CMH has worked diligently to assist the practices in reviewing and developing plans to implement the new components. CMH noted that much "*rework*" was required; they have developed a Competency Checklist to be used with practices to ensure they continue to develop and sustain all core PCMH competencies.

  Other changes have been the implementation of new electronic medical records (EMRs) by two of the practices. CMH has provided technical assistance to these practices, including communications with the EMR vendors and practices regarding implementation of 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. Collaborative Service Agreements have allowed for enhanced communication and collaboration between practices. The CMH Community Engagement Resource Application (CERA), contains detailed information about various community agencies and organizations that address various social determinants of health. This application contains over 850 community resources and was accessed 25,970 times in 2018 (an increase from 11,000 in 2017).
- Category 4: The CMH Category 4 measures are based on rates for Children's Mercy Hospital or Children's Mercy Primary Care Clinics and include:
  - Emergency department visits for patients with asthma decreased from 139.74/1000 in 2016 to 122.35/1000 in 2018.
  - Hospital readmissions decreased from 90.13/1000 in 2013 to 87.82/1000 in 2018.

- The 2018 rates of weight assessment (99.9%), Counseling for Nutrition (99.33%) and Physical Activity (95.8%) for Children and Adolescents who had an outpatient CMH PCP visit remained consistently high.
- The 2018 rate (85.10%) of appropriate testing for pharyngitis was higher than 2016 (77.45%).

Conclusions

Metrics in this annual evaluation are from the KanCare Evaluation Design approved by CMS. Data sources include:

- **MCO Annual HEDIS data** (for 19 HEDIS measures [60 metrics, including subparts]) – HEDIS data are aggregated and weighted by KFMC to evaluate overall KanCare performance. Individual MCO HEDIS data may be reported where results differed greatly by MCO or where data was not available for all MCOs. NCQA Quality Compass rankings are included in the analysis to allow comparison to national averages and percentiles. HEDIS-like data were also reported by the MCOs for several HEDIS metrics to evaluate rates for populations within KanCare, such as by HCBS Waiver.
- **National Outcome Measurement System (NOMS)** – KDADS provided 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 CY2018 by adults and youth who received mental health services in the prior six-month time-period.
- **CAHPS** – MCO data for Adult, GC, and CCC populations; aggregated and weighted by KFMC.
- **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 from MCO annual convenience surveys of members receiving SUD treatment services, from CY2012 (pre-KanCare) and CY2014–CY2017. The SUD survey was not conducted in 2018.
- **Provider Access Reports** – MCO Provider Network Reports, GeoAccess reports, After-Hours Access Survey reports, and Appointment Availability Survey reports.
- **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 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** – Annual update and evaluation 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.

Summary of Findings

HEDIS measures

CMS Core Health Care Quality Measures – KanCare results ≥50th QC in CY2017

- ***Annual Monitoring for Patients on Persistent Medications*** (MPM): >66.67th QC (90.0%)
- ***Flu Vaccinations for Adults*** (FVA): >90th QC (50.5%)
- ***Follow-Up (within 7 days) after Hospitalization for Mental Illness*** (FUH): >90th QC (59.0%)
- ***Follow-Up for Children Prescribed ADHD Medication*** (ADD):
  - Initiation Phase: >66.67th QC (49.5%)
  - Continuation Phase: ≥50th QC (57.5%)
- ***Initiation and Engagement in Treatment for Alcohol or other Drug Dependence*** (IET):
  - Initiation in Treatment: Ages 13–17 (43.6%): ≥50th QC
  - Engagement in Treatment: Ages 13–17 (23.6%): >75th QC
- ***Medical Assistance with Smoking and Tobacco Use Cessation*** (MSC):
  - Advised to Quit: ≥50th QC (78.8%)
  - Medication recommended or discussed: ≥50th QC (52.2%)
  - Methods other than medication discussed: ≥50th QC (46.0%)

Additional HEDIS measures – KanCare results ≥50th QC in CY2017

- ***Adults' Access to Preventive/Ambulatory Health Services*** (AAP):
  - Total – Ages 20–44 (83.6%), Ages 20 and older (86.7%), and Ages 45–64 (90.7%): >75th QC
  - Ages 65 and older (90.9%): >66.67th QC
- ***Annual Dental Visit*** (ADV):
  - Total – Ages 2–20 (64.8%) and Ages 7–10 (73.7%): >75th QC
  - Ages 2–3 (46.6%), Ages 4–6 (70.7%), Ages 11–14 (67.7%), Ages 15–18 (58.7%): >66.67th QC
- ***Comprehensive Diabetes Care*** (CDC):
  - HbA1c Control (<8.0%): (55.0%) >66.67th QC
  - Eye Exam (Retinal): (62.4%) >66.67th QC
  - HbA1c Poor Control (>9.0%): (35.3%) ≥50th QC
- ***Medication Management for People with Asthma*** (MMA):
  - Ages 5–11 (38.0%); Ages 12–18 (36.4%); Ages 19–50 (46.6%); and Ages 51–64 (60.2%): >75th QC
  - Total – Ages 5–64 (39.2%): ≥50th QC

CMS Core Health Care Quality Measures – KanCare results <50th QC in CY2017

- ***Prenatal and Postpartum Care*** (PPC):
  - Prenatal Care (69.3%): <10th QC
  - Postpartum Care (61.1%): <33.33rd QC
- ***Controlling High Blood Pressure*** (CBP): <50th QC (53.6%)
- ***Comprehensive Diabetes Care*** (CDC) – HbA1c Testing: <50th QC (86.2%)
- ***Adolescent Well-Care Visits*** (AWC): (53.3%) <50th QC
- ***Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*** (W34): <50th QC (71.0%)
- ***Well Child Visits in the First 15 Months of Life*** (W15): 6 visits (60.7%): <33.33rd QC
- ***Adult BMI Assessment*** (ABA): <50th QC (86.5%)
- ***Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*** (WCC):
  - Weight Assessment/BMI:
    - <25th QC (Total – Ages 3–17: 64.7% and Ages 3–11: 64.3%)
    - <33.33rd QC (Ages 12–17: 65.6%)

  - Counseling for Nutrition for Children/Adolescents:
    - <25th QC (Total – Ages 3–17: 59.2% and Ages 3–11: 60.6%)
    - <33.33rd QC (Ages 12–17: 6.7%)
  - Counseling for Physical Activity for Children/Adolescents: <33.33rd QC (Total – Ages 3–17: 53.9%; Ages 12–17: 57.8%; and Ages 3–11: 51.9%)
- ***Chlamydia Screening in Women*** (CHL):
  - <25th QC (Ages 21–24: 54.5%)
  - <10th QC (Ages 16–20: 39.6% and Total – Ages 16–24: 45.1%)
- ***Breast Cancer Screening***: (47.0%) <10th QC (all eligible KanCare population)
- ***Cervical Cancer Screening***: (58.3%) <50th QC (all eligible KanCare population)
- ***Initiation and Engagement in Treatment for Alcohol or other Drug Dependence*** (IET):
  - Initiation in Treatment:
    - Ages 13–17 (43.6%): ≥50th QC
    - Total – Ages 13 and older (35.8%): <25th QC
    - Ages 18 and Older (34.7%): <25th QC
  - Engagement in Treatment: Ages 18 and older (10.4%): <33.33rd QC

Additional HEDIS measures – KanCare results ≥50th QC in CY2017

- ***Comprehensive Diabetes Care*** (CDC):
  - Medical Attention for Nephropathy: (88.8%) < 33.33rd QC
  - Blood Pressure Control (<140/90): (61.1%) <50th QC
- ***Diabetes Monitoring for People with Diabetes and Schizophrenia*** (SMD): (63.7%) <25th QC
- ***Annual Dental Visit*** (ADV): Ages 19–20: (33.9%) <33.33rd QC
- ***Appropriate Testing for Children with Pharyngitis*** (CWP): (68.6%) <25th QC
- ***Appropriate Treatment for Children with Upper Respiratory Infection*** (URI): (81.9%) <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 CY2017 for ***Preventive Ambulatory Health Services*** (AAP), ***Cervical Cancer Screening*** (CCS), and ***HbA1c Testing*** (CDC), ***Eye Exam (retinal)*** (CDC) for the PD–I/DD–SMI populations were comparable to rates in CY2013 to CY2015.
  - Rates that were **higher** in the PD–I/DD–SMI population compared to the rate for the total KanCare population in CY2017 were:
    - ***Breast Cancer Screening***: 52.1% compared to 47.0%;
    - ***Preventive Ambulatory Health Services***: 94.5% compared to 86.7%; and
    - ***Eye Exam (retinal):*** 66.8% compared to 62.4%.
  - The ***Cervical Cancer Screening*** CY2017 rate was **lower** in the PD–I/DD–SMI population 50.9% compared to the rate for the total KanCare population 58.3%.
  - Rates that were **comparable** in the PD–I/DD–SMI population compared to the rate for the total KanCare population in CY2017 were the following Comprehensive Diabetes Management metrics:
    - ***HbA1c Testing***: 85.0% compared to 86.2%;
    - ***HbA1c Control (<8.0%)*****:** 56.7% compared to 55.0%;
    - ***Blood Pressure Control (<140/90)*** (CDC): 62.5% compared to 61.1%; and
    - ***Medical attention for Nephropathy***: 89.3% compared to 88.8%.

The following HEDIS-like measures apply to members receiving **HCBS waiver services (I/DD, PD, TA, TBI, Autism, SED, and FE)**:

- ***Increase in the number of primary care visits*** – The CY2017 rate (95.1%) was higher than the prior four years (ranging 92.0%–94.1%) and higher than the rate for all KanCare adult members (86.7%).
- ***Increase in annual dental visits*****:** The CY2017 rate (53.2%) was again lower than the rate for all KanCare members (64.8%).
- The CY2017 rate for ***Decrease in number of emergency department visits*** (75.90/1,000 visitor months) was higher than in CY2016 (71.55) but lower than CY2013 to CY2015 (77.58; 78.06; and 79.64, respectively) and was again higher than the HEDIS rate for the overall KanCare population (62.42).
- While HCBS preventive care, dental and ED visit rates have improved, the rates for the overall KanCare population are consistently better than the HCBS rates.

SUD Services

- Attendance of self-help programs increased in CY2018 to 45.2%, higher than in CY2013 through CY2017; but, lower than in CY2012 pre-KanCare (59.9%).
- From CY2013 to CY2018, there has been a 17.3 percentage point increase (54.4% relative increase) in the annual quarterly employment average for KanCare members completing SUD treatment.
- From CY2017 to CY2018, the annual quarterly average of employment increased by 3.4 percentage points to 49.1%, a one-year relative increase of 7.4%.
- 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 90.8%) pre-KanCare (CY2012) and in KanCare (CY2013–CY2018).

Mental Health Services

- The percentage of adults diagnosed with an SPMI who were competitively employed has been consistently stable between CY2014 and CY2018 between 15.4% 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 CY2018 has stayed relatively stable.
- The annual quarterly average number of adults with SPMI who were homeless at the start of each quarter was less in CY2013 through CY2018 (70 [2014] to 112 [2017]) than in CY2012 (150). Compared to CY2012 (45.7%), the 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 through CY2018.
- The annual quarterly average percentage of SED youth with improved housing status had been increasing each year from 80.6% in CY2013 to 90.1% in CY2017; however, in CY2018, the average percentage decreased to 85.5%. The annual quarterly average from CY2013 to CY2017 maintained a high percentage above 98%.

HCBS Waiver Services

- WORK employment program – In 2018, there were 150 PD, 16 TBI, and 135 I/DD Waiver members participating in the WORK program, which was fairly consistent with 2017.

Nursing Facilities (NF)

- The percentages of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013; the rate has remained consistent since CY2013. In CY2018, there were 75 fewer falls than in CY2012.
- The percentage of NF Medicaid members readmitted to a hospital after being discharged from an NF increased in CY2013 to 11.98% from 7.18% in CY2012 (pre-KanCare) and has fluctuated each year thereafter. CY2017 had 143 fewer discharges and 101 more hospital admissions after NF discharge compared to CY2012.
- The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013; CY2015 and CY2016 had similar rates. However, in CY2017, the percentage of denied NF claims (10.1%) was lower than the prior five years and comparable to CY2014 (10.4%).
- PEAK – The number of Person-Centered Care Homes increased from 8 in FY2013 to 17 by June of FY2017, and by June of FY2018, decreased to 13.

Member Survey – Mental Health

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2018 of a random sample of KanCare members who received one or more MH services in the prior six-month period. The MHSIP Youth Services Survey for Families and Adult Consumer Survey tools, as modified by KFMC over the past eight years, were used for this project.

Questions were the same in 2011 through 2018, with the exception of the following questions that were added at the request of the State and some later removed, in 2018, at the State's request:

- In 2018, in the adult survey tool, questions related to smoking cessation were removed. In the youth survey tool, the section for youth ages 12 and older to complete (to capture youth perceptions of care received) and questions related to providers' interaction with youth were removed.
- A question was added in 2017 related to whether the (adult) member is doing what he/she wants to for paid work.
- Three questions were 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.
- A question on whether medication was available timely added in 2013.

In 2018, the survey was mailed to 8,339 KanCare members and 754 (339 Adult and 415 Youth) were completed. Results are reported for the subgroups Adults (members ages 18 or older) and Youth (members ages 17 or younger) who received mental health services. The reported results for *"Youth"* reflect family member responses for members age 17 or younger.

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (2011 and 2012) to KanCare (2013 to 2018).

Responses related to quality of care were generally very positive (over 80%) in 2018 with the exception of the Adult population related to being better able to deal with crisis (78.6%) and Youth related to being better at handling daily life (79.6%). The percentage of Adult members (80.6%) who indicated they had a choice of treatment goals, as in previous years, was lower than the Youth subgroup (92.8%).

Survey questions with >90% satisfaction in 2018 included:

- Mental health provider spoke in a way the member understood (Adult and Youth);
- Youth, family respondent determining or helping determine treatment goals (Youth);
- I have people I am comfortable talking with about my child's problems (Youth);
- Services available at a convenient times (Adults); and
- Medication available timely (Adults and Youth).

There were a number of significant increases in 2018 compared to previous years, and trends over the 6-year KanCare years (2013–2018). Examples of some of the significant increases this year by survey population include:

- Better ability to deal with crisis (Adults – 2018: 78.6%, 2016: 69.2%; $p<.01$).
- Better able to control life (Adults – 2018: 82.0%, 2016: 74.8%; $p=.03$).
- As a result of services received, member is better able to do things he or she wants to do (Adults – 2018: 80.6%; 2016: 69.3%, $p<.01$; 2014: 74.3%, $p=.03$; 2012: 70.1%, $p<.01$).
- Comfort in asking questions about treatment, medication, and/or children's problems (Adults – 2018: 89.8%, 2015: 94.5%, $p=.02$).
- Able to get all the services member thought needed: (Adults – 2018: 85.8%, 2012: 78.8%, $p=.02$; 2011: 91.3%, $p=.03$).
- Able to see a psychiatrist when wanted to (Adults – 2018: 79.6%, 2012: 70.8%; $p=.02$).
- Services were available at times that were good for the member (Youth – 2018: 89.9%, 2016: 83.9%; $p=.02$).
- Medication available timely (Youth – 2017: 95.6%, significantly higher than each year 2013–2016, $p<.001$; and 5-year trend, $p<.01$) (Youth – 2018: 96.0%, significantly higher than 2016: 83.7%, $p<.001$; 2015: 88.0%, $p<.01$; 2014: 85.3%, $p<.001$; and 2013: 86.1%, $p<.001$; and 6-year trend, $p<.001$).
- Mental health providers returned calls in 24 hours (Adults – 2018: 86.4%, 2016: 79.6%; $p=.03$).

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:

- Able to get all the services member thought needed: Youth population – The 2018 percentage of positive responses from Urban youth families was significantly lower (75.9%) compared to Non-Urban (86.5%; $p<.01$). There was significant variation among the county types (Semi-Urban 82.9%; Densely-Settled Rural 88.7%; Rural and Frontier 88.4%; $p=.04$).
- Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.): Adults – The percentage of positive responses from Urban members was significantly lower (73.6%) compared to Non-Urban (83.5%; $p=.04$).
- Services were available at times that were good for the member (Youth – The 2018 percentage of positive responses from Urban youth families was significantly lower (85.6%) compared to Non-Urban (92.8%; $p=.02$).
- Ability to get services during a crisis: Youth population – The 2018 percentage of positive responses for Urban youth families was significantly lower (79.7%) compared to Non-Urban (89.3%; $p=.02$).

Member Survey – CAHPS

Overall, the CAHPS questions had high positive responses again in 2018. A number of questions have had >90% positive response in 2018 and previous years, as well as high QC rankings compared to national rates. Examples include:

- Doctor spent enough time with the member (**Adults** 90.3%, ≥50th QC; **GC** 91.4%, >66.67th QC; **CCC** 93.3%, >66.67th QC)
- Doctor talked about reasons to take a medicine (**Adult** 93.6%, >66.67th QC; **GC** 94.4%, >75th QC)
- Child's doctors and other health providers answered parents' questions (CCC 92.4%, ≥50th QC)
- Child's personal doctor explained things in a way that was easy for the child to understand (**GC** 94.6%; **CCC** 94.7%)
- Personal doctor listened carefully (**Adult** 93.3%, >66.67th QC; **GC** 96.3%, >66.67th QC; **CCC** 96.2%, ≥50th QC)
- Personal doctor explained things in a way that was easy to understand (**Adult** 92.4%, ≥50th QC; **GC** 96.6%, >75th QC; **CCC** 96.7%, >66.67th QC)
- Doctor respected member's comments (**Adult** 94.0%, >66.67th QC; **GC** 96.8%, ≥50th QC; **CCC** 96.5%, ≥50th QC)

Members' ratings of their health care, health plan, personal doctor, and specialist seen most often also continued to be highly positive in 2018. The following are based on members' rating responses of 8, 9, or 10 (where 0 is the worst and 10 is the best) in 2018. 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** 74.7%, <50th QC; **GC** 88.3%, ≥50th QC; **CCC** 86.9%, ≥50th QC
- **Health Plan: Adults** 77.8%, ≥50th QC; **GC** 88.5%, >66.67th QC; **CCC** 85.4%, ≥50th QC
- **Personal Doctor**: **Adults** 83.4%, >66.67th QC; **GC** 90.3%, ≥50th QC; **CCC** 89.9%, <33.33rd QC
- **Specialist seen most often**: **Adults** 82.4%, <50th QC; **GC** 90.7%, >75th QC; **CCC** 85.9%, <50th QC

Members also indicated high satisfaction with timely access to healthcare services. Examples in 2018 include:

- When care was needed right away, it was received as soon as needed (**Adults** 87.7%, >75th QC; **GC** 94.2%, >75th QC; **CCC** 95.2%, ≥50th QC) Rates for all MCO GC subgroups were above 92% in 2014 through 2018.
- For a check-up or routine care, how often got an appointment as soon as needed (**Adults** 82.6%, >66.67th QC; **GC** 91.3%, >66.67th QC; **CCC** 93.1%, ≥50th QC).
- Easy to get care, tests, or treatment needed (**Adults** 87.1%, ≥50th QC; **GC** 93.7%, >75th QC; **CCC** 93.2%, ≥50th QC).
- Appointment to see a specialist as soon as needed (**Adults** 83.1%, >66.67th QC; **GC** 85.2%, >66.67th QC; **CCC** 86.2%, ≥50th QC). For Amerigroup, the GC TXXI rate in 2018 (87.3%) was >90th QC and significantly higher (*p*=.03) than in 2017 (78.7%; <50th QC), and the CCC TXXI rate in 2018 (91.9%) was >95th QC and significantly higher (*p*=.03) than in 2017 (81%).
- Easy to get prescription for child (**GC** 93.5%; **CCC** 93.6%, >66.67th QC).

In 2018, 60.6% of adults, 63.3% of parents/guardians of children with CCC, and 45.8% parents/ guardians of children in the 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?"* The positive response percentage

for Adults was 83.8%; ≥50th QC and for GC was 81.4%; <33.33rd QC. For children with chronic conditions, who would seem likely to have a greater need for coordination of care, 82.9% (<50th QC) responded positively, which was up from 80.6% in 2017 (<25th QC), but still demonstrates an opportunity for improvement.

An additional opportunity for improvement, particularly for the CCC population, is: *"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 CY2018, the rate for CCC (77.1%) was ranked <25th QC. The Adult rate was 71.8% (<33.33rd QC) and the GC rate was 72.1% (<50th QC).

Provider Survey

Provider survey sample sizes ranged greatly from as few as 22 (UnitedHealthcare/Optum BH survey) to 303 (Amerigroup). UnitedHealthcare has separate surveys for general provider and for BH providers.

- The percentage of surveyed providers in CY2018 who were very or somewhat satisfied with *"obtaining precertification and/or authorization for (MCO's) members,"* ranged from 41.9%–65.0% and for very or somewhat dissatisfied ranged from 9.5%–26.9%.
- The percentages of providers very or somewhat satisfied with availability of specialists in CY2018 ranged from 35.6%–68.2%. The percentage very or somewhat dissatisfied ranged from 8.1%–16.3%.
- For the question on *"provider satisfaction with MCO's commitment to high quality of care for its members,"* responses in CY2018 for very or somewhat satisfied ranged from 49.3%–70.6%, and for very or somewhat dissatisfied, ranged from 7.7%–13.8%.

Network Adequacy

GeoAccess

Extensive efforts were made in 2018 to improve the network adequacy reporting and continued efforts are planned for CY2019. KDHE provided training to MCO staff and analyzed quarterly reports for each MCO, as well as provided a report showing each MCO the number of potential duplicates and reporting errors. KFMC has analyzed MCOs' quarterly network adequacy reports and provided 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 also reviewed the MCOs' GeoAccess quarterly reports and work was completed in CY2018 and continued efforts are planned for CY2019 to improve the MCO reports to ensure mapping and availability of services by county are accurately modeled and reported.

Each quarter in CY2018, KDHE provided each MCO with feedback, via a report, as to their progress in presenting accurate representation of network adequacy. Each quarter, the MCOs have improved in the accuracy of their data; however, there is still opportunity for improvement.

Based on the Sunflower and UnitedHealthcare GeoAccess reports (Amerigroup data not available) for the fourth quarter of CY2018, it appears these changes have had an impact on the GeoAccess reports, as there are less counties covered within the access standards than previously reported.

The number of counties with access to HCBS services with two or more providers per county and with at least one provider per county decreased in CY2018 compared to CY2017, which is likely due to the changes made in network adequacy reporting. The HCBS provider access reports continued in CY2018 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 for Sunflower and UnitedHealthcare. HCBS services with the lowest availability by county from Sunflower and UnitedHealthcare were:

- **Speech Therapy** – **Autism Waiver** (Amerigroup: data not available; Sunflower: 12 counties with 2 or more providers, 28 counties with at least one provider; UnitedHealthcare: 2 counties with 2 or more providers.
- **Speech Therapy** – **TBI Waiver** (Amerigroup: data not available; Sunflower: 48 counties with 2 or more providers, 105 counties with at least one provider; UnitedHealthcare: 10 counties with 2 or more providers; 10 counties with at least one provider).
- **Adult Day Care** – (Amerigroup: data not available; Sunflower: 50 counties with 2 or more providers, 78 counties with at least one provider; UnitedHealthcare: 33 counties with 2 or more providers; 58 counties with at least one provider).

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. In June 2018, KDHE provided another update to network adequacy reporting and the requirements became effective with the Q3 2018 reporting period, with initial reporting due October 2018. Also, ongoing review by KDHE occurred through the end of CY2018.

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). For the three MCOs, the appointment availability survey did not include availability of obstetric appointments by 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 2017 were contacted again in 2018. 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.
- Sunflower conducted an after-hours access survey of PCPs, high-impact (i.e., Oncology) and high-volume (i.e., OB/GYN), and BH providers (i.e., prescribers and non-prescribers) to assess availability of routine and urgent by provider type, obstetric appointments by trimester (1st–3rd available). In 2018, the Sunflower after-hours access survey was completed by the same vendor as AGP; and, for AGP, there were several questions raised about the conclusions reached (see bullet above). For the Sunflower survey, due to not receiving a description of the survey sampling, methodology, and comparisons to 2017 survey results, it is not clear if the conclusions were drawn in the same manner.
- 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 2017 were contacted. 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 – CY2017 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 CY2017 (**68.51)** was lower than in four of five previous years (ranging from 66.07 [CY2013]–73.77 [CY2015]).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2017, compared to the other waiver populations. The ED visit rate in CY2017 (**140.38**) was lower than in the five previous years (ranging from 162.30 [CY2013]–220.13 [CY2012]).
- **PD** – PD members also had high rates of ED visits, **129.07** in CY2017, and the CY2017 rate was higher than in CY2013 (118.14) and CY2015 (126.58) but lower than the rates in CY2012 (165.45), CY2014 (130.95), and CY2016 (133.75).
- **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 CY2017 (**110.55**) was lower than in the previous five years (ranging from 129.70 [CY2015]–113.03 [CY2013]).
- **I/DD** – I/DD member ED rates were lower than those of PD, FE, TBI, and MH members each of the six years. The CY2017 rate (**45.07**) was lower than four of five previous years (ranging from 40.72 [CY2013]–54.24 [CY2012]).
- **FE** – FE member ED rates were lower than those of PD, TBI, and MH members each of the six years. The CY2017 rate (**67.29**) was lower than in CY2012 (90.32) and CY2016 (68.15) but higher than the rates in CY2013–CY2015.

Inpatient Hospitalizations

Inpatient admission rates were lower in CY2017 than the five prior years for TBI and PD. Rates for FE, however, were higher in CY2017 than in CY2012 and I/DD was higher in CY2017 than in CY2012 (pre-KanCare) and CY2013. Rates described below are based on inpatient admission visits per 1,000 member-months.

- **KanCare Population** – The inpatient rate for KanCare members in CY2017 (**13.44**) was lower than the rates from the previous five years (14.51 [CY2016]–15.74 [CY2014]).
- **TBI** – The TBI member inpatient admission rate in CY2017 (40.96) was lower than the five previous years (45.30 [CY2014]–50.46 [CY2016]).
- **FE** – The FE inpatient admission rate in CY2017 (**47.35**) was lower than four of five previous years (47.27 [CY2012]–52.44 [CY2014].
- **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, and decreased in CY2017 to **12.90**.
- **PD** – The PD inpatient admission rate in CY2017 (**50.15**) was lower than the previous five years (50.58 [CY2013]–55.66 [CY2014]). 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

Inpatient admission rates were higher in CY2017 than the five prior years for FE and PD. The Inpatient admission rate was lower in CY2017 for TBI than in the five previous years. Rates described below are based on inpatient readmissions per 1,000 member-months.

- **KanCare** – The readmission rates for all KanCare members in CY2013 to CY2017 have been slightly lower than the CY2012 rate (1.59). Rates increased each year from 1.45 in CY2013 to 1.54 in CY2016 and decreased in CY2017 to 1.47.

- **TBI** – TBI member readmission rates in CY2017 (6.73) were lower than the previous five years (6.90 [CY2014]–13.02 [CY2015]).
- **PD** – The readmission rate for PD members in CY2017 (**11.56**) was higher than the five previous years (8.84 [CY2013]–11.16 [CY2016]) and higher than the readmission rates of TBI, FE, and I/DD members.
- **FE** – The FE member readmission rate in CY2017 (**9.50**) was higher than the five previous years (7.23 [CY2013]–8.25 [CY2015]).
- **I/DD** – The I/DD member readmission rate was lower in CY2017 (**1.96**) 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 each year from 2014 through 2017 and increased in CY2018. 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 slightly fluctuated each year from CY2013 through CY2016, and there were larger increases/decreases between CY2016 through CY2018.

Delivery System Reform Incentive Program (DSRIP)

The University of Kansas Health System (UKHS)

- **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**
  As of December 31, 2018, STOP Sepsis training has been provided to a total of 1,986 staff from hospitals, nursing facilities, EMS, and other healthcare providers. The project has 227 community partners (including 65 NFs). There are 57 facilities sharing sepsis data and progress in identifying sepsis at any stage has been noted. However, specific classification of sepsis as severe sepsis or septic shock continues to need substantial improvement to ensure patients receive time-critical diagnoses and immediate initiation of treatment.
- **Supporting Personal Accountability and resiliency for Chronic Conditions (SPARCC)**
  As of December 2018, 241 individuals throughout Kansas have been trained as SPARCC facilitators and 13 facilitator training videos have been developed. The number of Kansas community partners remains steady at 105. SPARCC facilitators have trained 285 patients and caregivers; UKHS has noted patient improvements from the first week to the fourth week of training.
- **Category 4 Population Health Measures**
  Due to other related projects occurring in Kansas (e.g., KanCare MCOs, Kansas ACOs etc.), DSRIPs' specific impact on the improvement of Category 4 measures is not possible. The Category 4 measures are based on KanCare HEDIS and include:
  - Emergency Department (ED) visits per 1,000 member-months: 62.42 in 2017, a decrease (improvement) from 2013 (65.17), although both years were greater than or equal to the QC 50th percentile.
  - Controlling high blood pressure: The 2017 rate of 53.57% (<50th QC) was 13.4% higher (relatively) than the rate in 2013 (47.26%, <25th QC).
  - The percentage of members indicating they smoked or used tobacco decreased to 16.1% from 37.67% (≥50th QC) in 2013 to 31.62% (≥50th QC) in 2017.

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; the clinic obtained PCMH re-recognition in early 2018. CMH reported 152 Kansas Beacon patients in 2018 (including 38 consults for children in rural Kansas communities). In 2018, Beacon staff focused on building relationships with PCPs (existing and potential partners/referral sources) through in-person site visits and streamlining referral processes. The number of consults more than doubled in 2018. The Beacon program currently has locations distributed throughout the state, except in northwest Kansas, where they anticipate exploring a location in 2019.
- **Expansion of Patient Centered Medical Homes and Neighborhoods**
  CMH continues to actively work with three practices on their transformation goals. The fourth practice achieved NCQA PCMH recognition in 2016 and is no longer participating in the DSRIP project due to the practice being sold in early 2018. CMH has developed a Competency Checklist to be used with practices to ensure they continue to develop and sustain all core PCMH competencies. The CMH CERA application contains over 850 community resources and was accessed 25,970 times in 2018 (an increase from 11,000 in 2017).
- Category 4: The CMH Category 4 measures are based on rates for Children's Mercy Hospital or Children's Mercy Primary Care Clinics and include:
  - Emergency department visits for patients with asthma decreased from 139.74/1000 in 2016 to 122.35/1000 in 2018.
  - Hospital readmissions decreased from 90.13/1000 in 2013 to 87.82/1000 in 2018.
  - The 2018 rates of weight assessment (99.9%), Counseling for Nutrition (99.33%) and Physical Activity (95.8%) for Children and Adolescents who had an outpatient CMH PCP visit remained consistently high.
  - The 2018 rate (85.10%) of appropriate testing for pharyngitis was higher than 2016 (77.45%).

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:
   a. Initiation and Engagement in Treatment for Alcohol or Other Drug Dependence (IET): Initiation in Treatment Ages 18 and older and Ages 13 and older <25th QC.
   b. Prenatal and Postpartum Care: Prenatal Care <10th QC.
   c. Chlamydia Screening in Women (CHL): Ages 16–20 and Ages 16–24 <10th QC; Ages 21–24 <25th QC.
   d. Breast Cancer Screening (BCS): <10th QC.
   e. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC): Weight Assessment/BMI Ages 3–11 and Total – Ages 3–17 <25th QC; Counseling for Nutrition Ages 3–11 and Total – Ages 3–17 <25th QC.
   f. Appropriate Treatment for Children with Upper Respiratory Infection (URI): <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 review and address in future reports KFMC's questions raised regarding vendors' processes and reports for Access related surveys.

4. 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.
5. 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.
6. 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.
7. 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 CY2018, by counts and not by county names).
8. UnitedHealthcare should revise their OB/GYN GeoAccess mapping and specific counts of access to members by county to exclude males.
9. MCOs should continue to work to improve the percentage of HCBS waiver members receiving annual dental visits.
10. MCOs should inform providers on areas identified through CAHPS surveys that show Kansas member satisfaction trailing compared to those in other states, including:
    a. PCPs staying informed and up-to-date on care provided by other doctors and healthcare providers;
    b. Increased awareness by PCPs on the impact on day-to-day lives of families caring for children with chronic health conditions; and
    c. Informing members on specific things they can do to prevent illness in themselves and their children.
11. For Adult members, related to mental health services, explore methods to improve:
    a. Increase positive results for the member being better able to deal with crisis.
    b. The Participation in Treatment Planning domain, particularly related to feeling like they decided their treatment goals.
    c. The ability to see a psychiatrist when they want to and review the results from the implemented methods, in conjunction with other MCO Access Monitoring, to identify specific opportunities for improvement going forward.

End of written report

Appendix A

2018 KanCare Evaluation Annual Report

Year 6, January – December 2018

List of Related Acronyms

Kansas Foundation for Medical Care, Inc
URAC ACCREDITED Independent Review Organization: External Expires 06/01/2021

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
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist Competence T-Scores
CCC	Children with Chronic Conditions (CAHPS survey population)
CDC	Comprehensive Diabetes Care
CERA	Community Engagement Resource Application
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
EMR	Electronic Medical 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

List of Related Acronyms	
Acronym	**Description**
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KHC	Kansas Healthcare Collaborative
KHSC	Kansas Heart and Stroke Collaborative
KUCTT	University of Kansas Center for Telemedicine & Telehealth
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
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)
PH	Physical Health
PMPM	Per member per month
PTN	Patient Transformation Network
Q	Quarter
QC	Quality Compass
SED	Serious Emotional Disturbance (Waiver)
SMI	Serious Mental Illness
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions
SPMI	Severe and Persistent Mental Illness
SHP	Sunflower 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
WORK	Work Opportunities Reward Kansas program