DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 9, 2025

Christine Osterlund
Medicaid Director
Department of Health and Environment
900 SW Jackson Avenue, Suite 900
Topeka, KS 66612

Dear Director Osterlund:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STC) #9.3 of Kansas's section 1115 demonstration, "KanCare" (Project No: 11-W-00283/7). CMS has determined that the evaluation design, which was submitted on August 26, 2024, and revised on July 23, 2025, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's evaluation design.

CMS has added the approved evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment E. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved evaluation design may now be posted to the state's Medicaid website within thirty days. CMS will also post the approved evaluation design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an interim evaluation report, consistent with the approved evaluation design, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a summative evaluation report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the annual monitoring reports.

We look forward to our continued partnership on the Kansas KanCare section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

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Date: 2025.10.09 13:24:02 -04'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

cc: Ashli Clark, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

KanCare Section 1115(a) Demonstration Evaluation Design

Revised per CMS feedback

July 23, 2025

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A. General Background Information

The KanCare demonstration was originally approved on December 27, 2012, for a five-year demonstration period effective from January 1, 2013, through December 31, 2017. The Centers for Medicare & Medicaid Services (CMS) then approved a one-year temporary extension of this demonstration on October 13, 2017. A five-year extension approved on December 18, 2018, extended the KanCare program from January 1, 2019, through December 31, 2023, under two concurrent Section 1115 demonstrations—the KanCare 2.0 demonstration and the Substance Use Disorder (SUD) demonstration. On December 28, 2022, the State of Kansas submitted a Medicaid section 1115 demonstration five-year renewal application to extend certain features of the demonstrations. Other aspects of the KanCare program were transferred to other spending authorities.[1]

This KanCare Section 1115(a) demonstration will continue four programs that have been authorized under expenditure authority.[1]

- From the KanCare 2.0 demonstration, this five-year demonstration will
  - Maintain 12-month continuous eligibility for parents and other caretaker relatives,
  - Maintain continuous eligibility for the duration of the COVID-19 Public Health Emergency (PHE) unwinding period for Children's Health Insurance Program (CHIP) enrollees who turned 19 during the COVID-19 PHE unwinding period (and therefore lost eligibility for CHIP due to age) and who are otherwise ineligible for Medicaid, and
  - Continue federal financial participation for services provided in Institutions for Mental Diseases (IMDs) for Medicaid beneficiaries with Substance Use Disorder (SUD).
- From the SUD demonstration, this five-year demonstration will
  - Continue federal financial participation for physician consultation and personal care services for individuals with behavioral health needs.

With this extension of the KanCare demonstration, CMS required the State to submit an Evaluation Design with two components—one evaluating the program that maintains 12-month continuous eligibility for parents and other caretaker relatives and a second component evaluating the two programs related to SUD.[1] The evaluation designs with these two components are described in this document. A separate evaluation design was required for program maintaining continuous enrollment for CHIP enrollees. As per CMS guidance provided in the Special Terms and Conditions (STCs) for the KanCare demonstration, this evaluation design document was drafted in accordance with the STCs' Attachment A (Developing the Evaluation Design).[1]

The State has noted in its KanCare Section 1115(a) demonstration renewal application that the demonstration will maintain the critical goal of ensuring people still have access to the care and services through providing continuous eligibility for eligible adults and access to SUD services that cannot be authorized elsewhere.[2]

The State's justification for providing the twelve-month continuous eligibility for parents and other caretaker relatives included the following points.[3]

- As studies have shown, Kansas can minimize insurance gaps and guarantee better access to care for an extended period with the twelve-month continuous eligibility policy for parents and other caretakers.[4]
- Having consistent access to needed preventive health care services improves health outcomes and reduces long-term health care costs.

- Continuous eligibility has been crucial during the coronavirus pandemic to prevent gaps in coverage.
- This policy implementation will decrease Medicaid administrative costs by allowing Kansas to enroll beneficiaries for twelve months, regardless of changes in income that occur during that period.

Through its KanCare section 1115 waiver, the State covered the services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in an MCO and who are receiving services in a publicly-owned or non-public institution for mental diseases (IMD).[2]

The State noted the KanCare 2.0 and SUD demonstrations, implemented during 2019 through 2023, better addressed opioid use disorder (OUD) and other SUDs and to improved access to high-quality addiction services.[2] The KanCare SUD program provided access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.[2] In its renewal application, the State also summarized the key results of the SUD demonstration interim evaluation conducted to examine the demonstration's progress towards achieving its five goals. The State noted the primary drivers for Goals 1 through 4 showed improvements or mixed results, whereas the primary drivers for Goal 5 did not provide evidence of improvements specific to the SUD demonstration, but did experience improvements to some of the outcomes overall. Four of the five secondary drivers showed evidence they contributed to improvements to Goals 2 through 5.[2] To build upon the successes and the areas of improvement of the KanCare SUD demonstration, the State's SUD Demonstration Implementation Plan, initially approved for the period from August 7, 2019, through December 31, 2023, remains in effect for the current demonstration period.[5] The implementation plan is in alignment with the goals and objectives of the State's mandatory Medicaid managed care program. The implementation plan outlines the State's strategy to provide a full continuum of services for SUD treatment to KanCare members encompassing the five goals of the demonstration. The continuation of the strategies in the implementation plan allows the State to estimate the effects of the demonstration over a longer period, thus providing valuable insights into developing strategies and policies for further improving the members' access to and quality of the SUD services.

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B. Evaluation Design – Parents and Other Caretaker Relatives Component

Demonstration Goal

Goal: The KanCare demonstration, as it applies to 12-month continuous eligibility for parents and other caretaker relatives, will assist the state in its goal to "provide better access to services and reduce ineffective disenrollment for certain populations."[1]

Evaluation Hypotheses

Per CMS instructions, this evaluation is to focus on how the continuous eligibility policy affects coverage, enrollment, and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then reenroll within 12 months), as well as population-specific appropriate measures of service utilization and health outcomes. In addition, the eligible parents and other caretaker relatives, MCO, and State perceptions and experiences regarding the policy merits will be assessed.[6]

The following evaluation hypotheses will be examined through quantitative and qualitative components.

Hypothesis 1: The continuous eligibility policy will decrease temporary losses of coverage in which parents and other caretaker relatives are disenrolled but then reenrolled within 12 months.

Hypothesis 2: The continuous eligibility policy will provide continued access to preventive, acute, and chronic health care to parents and other caretaker relatives.

Parents and Other Caretaker Relatives Change Theory

The following driver diagram for the Parent and Other Caretaker Relatives amendment (Figure 1) shows the relationship between the amendment's purpose, the primary driver that contributes directly to achieve the purpose, and the secondary driver necessary to achieve the primary driver.

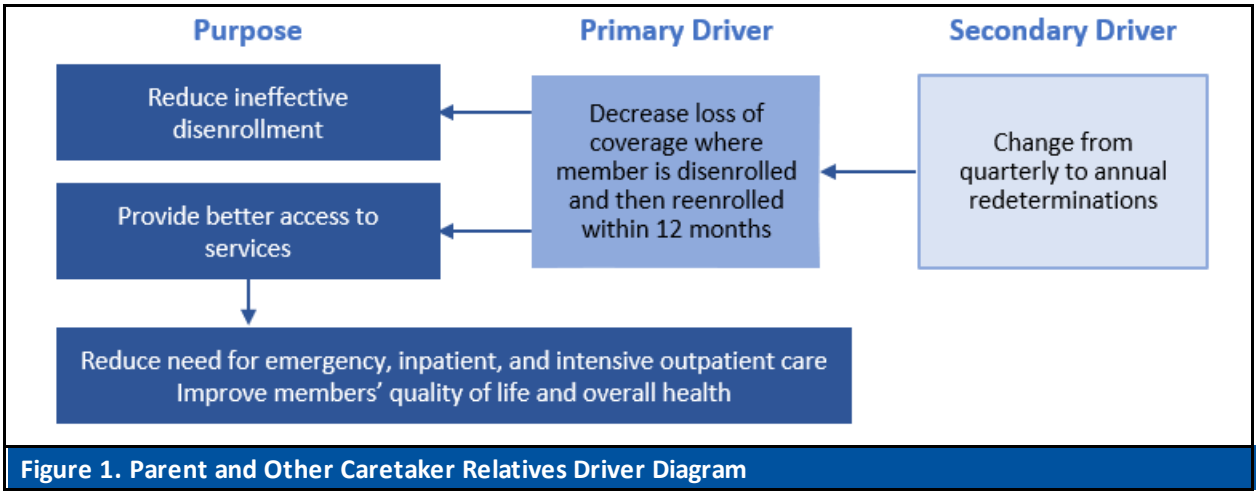

Figure 1. Parent and Other Caretaker Relatives Driver Diagram

As the diagram illustrates, changing the State's enrollment processes from quarterly to annual redeterminations for parents and other caretaker relatives is expected to lead to a decrease in loss of coverage where the member is disenrolled and then reenrolled within 12 months. That in turn is expected to enable the State to realize its stated goals of reducing ineffective disenrollment and providing better access to services.

Better access to services should lead to secondary benefits, although not explicitly stated as goals for the amendment, that are in line with the CMS quality mission, "To achieve optimal health and well-being for all individuals."[7] Secondary benefits include reducing the need for emergency, inpatient, and intensive outpatient care, and improving members' quality of life and overall health. These benefits are obtained through increased use of preventive care, continuity of care for chronic conditions, and treatment of acute conditions before they exacerbate into requiring emergency, inpatient, or extensive outpatient care.

The change theory does not hypothesize that implementation of the amendment will yield annual increases in service utilization rates or increases or decreases in disparities between racial, ethnic, regional, or other types of subpopulations. The theory assumes that services received by individuals during periods of enrollment gained through the amendment (i.e., periods that they would not have been eligible under quarterly redetermination) would be typical of services received during periods in which they would have been eligible under quarterly redetermination. Changes in utilization rates from year to year or within subpopulations are assumed to be due to outside factors (e.g., the severity of new strains of infectious diseases, regional changes in provider networks, or educational campaigns regarding racial or ethnic disparities).

Evaluation Questions

Quantitative Evaluation Questions

The first quantitative evaluation question relates to disenrollment from and reenrollment into KanCare by parents and other caretaker relatives. The question is, "Did the continuous eligibility policy decrease temporary losses of coverage?"

The second quantitative question asks, "What was the eligible members' service utilization during the measurement period?" Ideally, analyses of enrollment and claims data could identify services members received during periods when they would not have been enrolled had the amendment not been implemented. However, this cannot be done for two reasons. Claims data are not available for periods in which members are disenrolled (a limitation to baseline rates), and members who would have lost enrollment under quarterly redetermination cannot be identified with annual redeterminations. Given these data limitations, the evaluation assumes the services received directly as a result of the amendment would be typical of services received by parent and other caretaker relatives at large.

The third quantitative evaluation question, "What preventive, chronic, and acute care services were received during the measurement period?" explores the benefits of continuous enrollment on preventive, chronic, and acute care. As with the second question, the data available only allows for an indirect assessment. By looking at rates for the full parent and other caretaker relatives population, the probabilities that a member's preventive, chronic, and acute care may have benefited from the amendment is obtained. However, the amounts the amendment may have changed the outcome measures related to this question cannot be determined.

The evaluation questions and corresponding measures used to answer the evaluation questions are presented in Table 1.

Table 1. Quantitative Evaluation Questions and Measures – Parents and Other Caretaker Relatives

Evaluation Question		Measures
Question 1: Did the continuous eligibility policy decrease temporary losses of coverage?		
1.a.	Did fewer members experience temporary loss of coverage?	Percent of members experiencing temporary loss of coverage
1.b.	How many additional months of coverage did the policy provide?	Months of temporarily lost coverage per 100 members Additional months per 100 members = (baseline rate – current rate)
Question 2: What was the eligible members' service utilization during the measurement period?		
2.a.	What types of services did eligible members access during the measurement period?	Summary of encounters by type of service: • Professional Visits • Outpatient Visits ○ Emergency Department Visits • Pharmacy Fills • Inpatient Stays • Dental Visits • Vision Visits • NEMT Trips
2.b.	What diagnoses were associated with services received by eligible members during the measurement period?	Summary of diagnosis prevalence: • Primary diagnoses by ICD-10-CM chapter • Primary diagnoses by ICD-10-CM block or category
		Summary of inpatient stays by diagnosis: • CMS Major Diagnostic Category (MDC) • Medicare Severity Diagnosis Related Group (MS-DRG)
2.c.	Did eligible members receive new diagnoses during the measurement period? If so, what diagnoses?	Summary of diagnosis incidence: • Diagnoses by ICD-10-CM chapter • Diagnoses by ICD-10-CM block or category
Question 3: What preventive, chronic, and acute care services were received during the measurement period?		
3.a.	Did treatment for chronic conditions, including behavioral health issues, received in the prior measurement period continue during current measurement period?	Service utilization by chronic condition: • Asthma • Diabetes • Behavioral Health • Others to be determined based on prevalent diagnoses (question 2.b)
		Prescription (pre-existing prescriptions) prevalence rates by therapeutic class
		Percent of members with a prescription filled in 4 consecutive quarters
3.b.	What were the patterns of preventive and acute health care during the measurement period?	Prescription (new prescriptions) incidence rates by therapeutic class
		ED visits, observation stays, or inpatient admissions for selected conditions: • Acute respiratory infections • Acute severe asthma • Diabetic Ketoacidosis/ Hyperglycemia • SUD • Mental health issues • External Causes of Morbidity
		Outpatient or professional claims for selected acute conditions: • Respiratory infections • Others to be determined based on prevalent diagnoses (question 2.b)
		Percent of members receiving selected preventive care: • Annual physical exam • Annual dental visit • Annual eye exam
		HEDIS measures: • Adults' Access to Preventive/Ambulatory Health Services (AAP) • Ambulatory Care (AMB) • Inpatient Utilization (IPU) – General Hospitalization/Acute Care • Other HEDIS measures to be determined based on prevalent diagnoses

Qualitative Evaluation Questions

The qualitative evaluation question will focus on the experiences of the parents and other caretaker relatives during periods of temporary loss of coverage from KanCare. This question will be asked of members, State staff, and MCO staff.

Table 2 lists the primary question and a draft of auxiliary questions (used to answer the primary question). Final versions of auxiliary questions will be designed by a KFMC committee of subject matter experts. The questionnaire development will include an input and approval from the State.

Table 2. Qualitative Evaluation Questions – Parents and Other Caretaker Relatives	
Primary and Auxiliary Questions	
1. What are the experiences of the parents and other caretaker relatives during periods of temporary loss of coverage from KanCare?	
Draft Questions for Member Survey	
1.a	What were the reasons for a temporary loss of coverage from KanCare?
1.b	During the period of temporary loss of coverage from KanCare, did you have other insurance coverage?
1.c	During this period of temporary loss of coverage from KanCare, were you able to maintain treatment for existing conditions?
1.d	During this period of temporary loss of coverage from KanCare, did you delay or not get care for any new conditions?
1.e	During this period of temporary loss of coverage from KanCare, did you delay or not get any prescriptions filled?
1.f	During this period of temporary loss of coverage from KanCare, did you delay or not get preventive care, such as annual physicals, dental checkups or cleanings, vision care, flu shots, or cancer screening?
1.g	How this period of temporary loss of coverage from KanCare affected you and your family's life?
Draft Questions for State and MCO Staff	
1.h	What were the reasons for members to have a temporary loss of coverage from KanCare?
1.i	During the period of temporary loss of their coverage from KanCare, did these members have other insurance coverage?
1.j	During this period of temporary loss of their coverage from KanCare, were these members able to maintain treatment for existing conditions?
1.k	During this period of temporary loss of their coverage from KanCare, did these members delay or not get care for any new conditions?
1.l	During this period of temporary loss of their coverage from KanCare, did these members delay or not get prescriptions filled?
1.m	During this period of temporary loss of their coverage from KanCare, did these members delay or not get preventive care, such as annual physicals, dental checkups or cleanings, vision care, flu shots, or cancer screenings?
1.n	What were the effects of a period of temporary loss of coverage from KanCare on members and their families?

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C. *Evaluation Methodology – Parents and Other Caretaker Relatives*

The focus of the evaluation is to examine the achievement of the amendment's goal to provide continued Medicaid coverage to eligible parents and other caretaker relatives to help them achieve improved health outcomes and to reduce long-term health care costs. The evaluation will be completed through quantitative and qualitative analysis.

Quantitative Evaluation Methodology

The quantitative evaluation will focus on describing patterns in health and health care among eligible parents and other caretaker relatives during the amendment period.

Evaluation Period

September 1, 2022 – December 31, 2028

Study Population

The study population will be KanCare members identified as parents and other caretaker relatives by aid category description "Caretaker Medical – Parent or Caretaker."

As of January 1, 2024, there were 45,700 KanCare members identified as parents and other caretaker relatives. Table 3 shows the distribution of these members across several demographic variables. Note, the study population does not include members eligible for KanCare by the aid category "Caretaker Medical – Pregnant Women."

Table 3. Demographic Stratifications of Parents and Other Caretaker Relatives – January 1, 2024

Stratum	Count	Percent	Stratum	Count	Percent
Total (denominator)	**45,665**	**100%**			
Gender:			**Primary Language Spoken:**		
Male	7,673	16.8%	English	42,960	94.1%
Female	37,992	83.2%	Not English	2,705	5.9%
Age:			**Ethnicity:**		
0 to 17 years	47	0.1%	Hispanic or Latino	7,025	15.4%
18 to 24 years	6,765	14.8%	Not Hispanic or Latino	31,112	68.1%
25 to 34 years	18,890	41.4%	Ethnicity Unknown	7,528	16.5%
35 to 44 years	14,223	31.1%	**Race:**		
45 or older	5,740	12.6%	White, alone	31,154	68.2%
Region:			Black/African American (AA), alone	5,955	13.0%
Urban	24,569	53.8%	Race other than White or Black/AA	1,522	3.3%
Semi-Urban	6,361	13.9%	White or Black/AA, not alone	3,897	8.5%
Densely-settled Rural	9,313	20.4%	Unknown, alone or with a race	3,137	6.9%
Rural	4,281	9.4%	Members may select multiple races. The strata shown are disjoint.		
Frontier	1,141	2.5%			

Data Sources

All quantitative analysis will use the Kansas Modular Medicaid System (KMMS) databases for encounter, demographic, eligibility, and enrollment information. The managed care organizations' member-level HEDIS data files may also be accessed for HEDIS measures. See Section D for detailed discussion of data sources.

Analytic Methods

Performance measures for identifying patterns in health and health care are detailed in Table 4. Where possible, measures are developed according to technical specifications for recognized measures from sources such as: *Adult Core Set* measures, including *Healthcare Effectiveness Data and Information Set®* (HEDIS) measures, stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF). Descriptive statistics will be used for the evaluation, with comparisons across the consecutive years. The following analytical methods will be used to assess the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness for analyses required by the evaluation design.
- Descriptive statistics will examine demographic characteristics of the study population.
- The descriptive statistics (e.g., numbers and percentages or rates) of selected evaluation measures will be stratified by demographic characteristics including age range, race, ethnicity, and MCO. If needed, race and ethnicity categories with few members will be combined.
- Statistical tests such as Fisher's exact, Pearson chi-square, or Mantel-Haenszel chi-square tests, with *p* less than 0.05 indicating significance, will be used to compare percentages or rates between strata as appropriate to the data.
- The first two measures listed in Table 4 will be examined for the pre-demonstration and demonstration periods to assess any change over time. Other measures will be examined over the demonstration period.

Table 4. Performance Measure Details – Parents and Other Caretaker Relatives

Performance Measure	Denominator	Numerator	Unit of Measure
Measures of coverage calculated from enrollment data			
Percent of members experiencing temporary losses in coverage	Members in the study population at any point in the measurement year	Members in the denominator disenrolled from KanCare and reenrolled within 12 months	Percentage
Months of temporarily lost coverage per 1,000 members	Enrollment of study population in member-months	Number of months between disenrollment and subsequent reenrollment	Months per 1,000 members
NCQA HEDIS measures calculated from MCO data			
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Study Population	Members in denominator who had one or more ambulatory or preventive care visits during the measurement year	Percentage
Ambulatory Care (AMB) Summary of outpatient and ED visits	Enrollment of study population in member-months	Visits	Visits per 1,000 member-months
Inpatient Utilization (IPU) Stratified by maternity, surgical, and medical stays	Enrollment of study population in member-months	Number of acute inpatient discharges during the measurement period	Days per 1,000 member-months
Measures calculated from KMMS claim and encounter data			
Summary of Encounters by Type of Service: • Inpatient Stays • Outpatient Visits ○ Emergency Department • Professional Visits • Pharmacy Fills • Dental Visits • Vision Visits • NEMT Trips	Enrollment of study population in member-months	Services	Services per 1,200 member-months

Table 4. Performance Measure Details – Parents and Caretaker Relatives (Continued)

Performance Measure	Denominator	Numerator	Unit of Measure
Summary of diagnosis prevalence Diagnoses by ICD-10-CM chapter, block, or category	Encounter records – duplicated to count diagnosis category codes once per member per date of service	Deduplicated encounter records in stratum	Percentage
Summary of inpatient stays by diagnosis • CMS Major Diagnostic Category (MDC) Medicare Severity Diagnosis Related Group (MS-DRG)	Inpatient stays	Inpatient stays in stratum	Percentage
Summary of diagnosis incidence Diagnoses by ICD-10-CM chapter, block, or category	Study Population	Members having at least one diagnosis code in the specified chapter or category from claims with dates of service in the measurement period and not having any diagnosis codes in that code's category from claims with dates in the prior measurement period	Percentage
Service utilization by chronic condition • Asthma • Diabetes • Behavioral Health • Others to be determined	Study Population	Members with an inpatient, outpatient, or professional encounter having a primary or secondary diagnosis for the given condition during the measurement period	Percentage
Prescription (pre-existing prescriptions) prevalence rates by therapeutic class	Members who had a pharmacy claim with the given therapeutic class during the prior measurement period	Members in the denominator who had a pharmacy claim with the given therapeutic class during the measurement period	Percentage
Percent of members with a prescription filled in 4 consecutive quarters	Study Population	Members in denominator with a prescription filled in 4 consecutive quarters of the measurement year	Percentage
Prescription (new prescriptions) incidence rates by therapeutic class	Study Population	Members who had a prescription with the given therapeutic class filled during the measurement period but did not a prescription with the same therapeutic class filled within the prior measurement period	Percentage
ED visits, observation stays, or inpatient admissions for selected conditions: • Acute respiratory infections • Acute severe asthma • Diabetic Ketoacidosis/ Hyperglycemia • SUD • Mental health issues • External Causes of Morbidity	Enrollment of study population in member-months	Days of service	Days per 1,200 member-months

Table 4. Performance Measure Details – Parents and Caretaker Relatives (Continued)			
Performance Measure	**Denominator**	**Numerator**	**Unit of Measure**
Outpatient or professional claims for selected acute conditions: • Respiratory infections • Others to be determined based on prevalent diagnoses	Enrollment of study population in member-months	Days of service	Days per 1,200 member-months
Percent of members receiving selected preventive care: • Annual physical exam • Annual dental visit • Annual eye exam	Study Population	Members in denominator who received the selected service during the measurement year	Percentage

Qualitative Evaluation Methodology

The focus of the qualitative evaluation will be to describe the experiences of the parents and other caretaker relatives during periods of temporary loss of coverage from KanCare. The qualitative analysis is designed to complement the quantitative evaluation. Whereas the quantitative analysis looks at benefits the members may be obtaining through continuous enrolment, the qualitative analysis is designed to estimate the extent to which members were not able to obtain services during times of temporary disenrollment. Questions will be asked of members, State staff, and MCO staff.

Evaluation Period

September 1, 2022 – December 31, 2028

Study Population

The study population will be KanCare members identified as parents and other caretaker relatives by aid category description "Caretaker Medical – Parent or Caretaker" who had a temporary disenrollment between two twelve-month continuous KanCare coverage periods. Preliminary analysis estimates there will be 1,800 to 2,000 members in the study population per year.

Also, MCO and State staff involved in member enrollment or case management will be asked to provide anecdotal information related to the experiences of these members.

Data Sources

Online Member Surveys: An online member survey will be conducted using appropriate software (such as Microsoft Forms). Letters with a link and QR code for web-based completion of the survey will be mailed to these members. The survey data will be collected on a quarterly basis during 2026, 2027, and 2028. All members with temporary loss of coverage identified from the KMMS eligibility and enrollment tables (i.e., the study population) will be eligible to participate. Surveys will be sent in the quarter in which eligible members regained coverage.

Preliminary analysis indicates approximately 6,000 members are expected to formulate the study population in this three-year period. Based on a survey recently conducted using similar methods, between 150 and 180 responses are expected, which would yield margins of error between 7% and 8% on a 95% confidence interval for questions with 50% response distributions. These intervals will be sufficient to identify the types of services not obtained during periods of temporary loss of coverage and categorize them as not obtained by a few members, by some members, by many members, or by most

members. The survey will include open- and close-ended questions. The overarching patterns and themes related to the member experiences will be described from open-ended questions. Please note, probabilistic-statistical generalizability to the study population will not be the main focus of the survey.

MCO and State Questionnaires: The State and MCO questionnaires will be designed by a KFMC committee of subject matter experts. The questionnaire development will include an input and approval from the State. The questionnaires will be emailed to primary contacts at the State and three MCOs with directions to compile the questionnaire responses with input from the subject matter experts within their organizations. Questions will parallel those of the member survey and focus on determining types of services not obtained during periods of temporary loss of coverage and categorize them as not obtained by a few members, by some members, by many members, or by most members. The State and MCOs will also be asked for anecdotal information regarding members' experiences throughout the demonstration period. The primary contacts will be asked to return the completed questionnaires to KFMC through email. The State and MCO responses to the questionnaire will be collected in 2026, 2027, and 2028.

Analytic Methods

Qualitative data analysis techniques will be used to analyze data collected from the stakeholders. The steps for qualitative data analysis will include

- Getting familiar with the data by looking for common observations and patterns;
- Developing a coding framework to identify broad ideas, concepts, behaviors, or phrases;
- Assigning codes for structuring and labeling data;
- Identifying themes, patterns, and connections to answer research questions; and
- Summarizing the qualitative information to add to the overall evaluation results.

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D. *Methodological Limitations – Parents and Other Caretaker Relatives*

Evaluation Design Limitations

Limitations to the methodology that are inherent to the source data are presented in Table 5, which also describes the data, efforts for cleaning and validation, and data quality. Three additional limitations are noteworthy:

- While administrative data might be able to identify key cases and statistical trends, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates.
- Due to the use of population-level data, the effect sizes of measured differences represent true differences; however, these may or may not correspond to meaningful changes.
- As the evaluation is based on multiple years, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period, thus leading to unavailability of appropriate data for the analysis.

Table 5. Detailed Discussion of Data Sources – Parents and Caretaker Relatives

Data Source	**Kansas Modular Medicaid System (KMMS) claim and encounter tables**
Type	Claims and encounters
Description	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and other performance, service utilization, and cost metrics for all enrollees
Efforts for Cleaning and Validation	• KMMS claims and encounter data obtained from KMMS will be reviewed for missing values, duplicate values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses of performance measures required by the evaluation design. • Encounter data related pay-for-performance metrics are validated annually by KFMC as a part of their validation of all pay-for-performance metrics. • For applying statistical procedures for analysis of performance measures, a final dataset with all required variables will be created by merging data variables obtained from the KMMS encounter database with other source data.
Quality and Limitations	• Encounters submitted to the State by MCOs are records of the billed claims MCOs receive from providers for service payment. Administrative claims and encounter data are routinely used in HEDIS and other performance measurement. These data sources will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. Most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. • Data are generally considered complete if one quarter is allowed for claims processing and encounter submission. • There is known inconsistency in the population of the MCO claim status field for zero-dollar paid claims. • Payment amounts by Medicare and commercial payors are incomplete.
Data Source	**Kansas Modular Medicaid System eligibility and enrollment tables**
Type	Medicaid eligibility, enrollment, and MCO assignments
Description	Eligibility and enrollment detail for Medicaid members used to determine enrollee aid category and stratify data into subgroups
Efforts for Cleaning and Validation	• Data variables obtained from the KMMS eligibility and enrollment database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.
Quality and Limitations	• Quality is high. • Enrollment records include beginning and end dates for eligibility periods. • MCOs receive updated KMMS eligibility and enrollment data daily.

Table 5. Detailed Discussion of Data Sources – Parents and Other Caretaker Relatives (Continued)	
Data Source	**Kansas Modular Medicaid System member tables**
Type	Medicaid member and demographic data
Description	The tables contain data on current and past members. Demographic data includes member's name, contact information, date of birth, date of death, gender, race, and ethnicity.
Efforts for Cleaning and Validation	• Data variables obtained from KMMS demographics database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures. • Contact information will be reviewed for missing and invalid entries prior to conducting member surveys.
Quality and Limitations	• Contact information is frequently not up to date. • Email addresses are not available. • Other demographics are considered high quality. • MCOs receive updated KMMS member data daily. • The coding of race and ethnicity changed in 2022, which limits comparisons to prior years' stratified rates.
Data Source	**HEDIS data from MCOs**
Type	Data for HEDIS performance measures
Description	Member-level detail tables for HEDIS measures submitted by the MCOs that provide numerator and denominator values for stratified HEDIS results.
Efforts for Cleaning and Validation	• Comparison of numerator and denominator counts to NCQA-certified compliance audit results. • The MCOs subcontract with HEDIS Certified Auditors to validate their HEDIS data for NCQA submission. • KFMC subcontracts with a different HEDIS Certified Auditor to conduct validation of MCO HEDIS data following CMS EQR protocols.
Quality and Limitations	• Data Quality is closely monitored by the MCOs and EQRO. • MCOs use NCQA Certified HEDIS software to calculate HEDIS measures and submit data to NCQA as part of their NCQA accreditation requirement. • Data become available seven months after the measurement year. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.
Data Source	**Online Member Survey**
Type	Qualitative survey data
Description	An online survey will collect qualitative information from parents and other caretaker relatives who had a temporary disenrollment between two twelve-month continuous KanCare coverage periods. The survey data will be collected on quarterly basis during 2026, 2027 and 2028.
Efforts for Cleaning and Validation	• Information from the online survey will be reviewed for completeness and clarity. • Themes will be identified to understand the members' experiences during the gap in their continued KanCare coverage. • Stratified response rates will be reviewed.
Quality and Limitations	• Few members may participate in the survey. • Results may not be generalizable to the study population due to low response rates. • Open-ended responses may not clearly communicate the respondent's intended message.
Data Source	**State and MCO Questionnaire**
Type	Qualitative data
Description	The questionnaire will be emailed to the State and MCO staff asking them to provide information related to the experiences of the parents and other caretaker relatives who had a gap in their KanCare enrollment between their two twelve-month continuous coverage periods. The questionnaire will be emailed to State an MCO staff in 2016, 2017 and 2018 to capture the information regarding members' experiences throughout the demonstration period.
Efforts for Cleaning and Validation	• State and MCO staff responses to the questionnaire will be reviewed for completeness and clarity. • Themes will be identified to understand the members' experiences during temporary gaps in KanCare coverage.
Quality and Limitations	• Open-ended responses may not clearly communicate the respondent's intended message.

E. Evaluation Design – Substance Use Disorder Component

The State's SUD Demonstration Implementation Plan, initially approved for the period from August 7, 2019, through December 31, 2023, remains in effect for the approval period from January 1, 2024, through December 31, 2028. The SUD Demonstration Implementation Plan is in alignment with the goals and objectives of the state's mandatory Medicaid managed care program.[1] The implementation plan outlines the State's strategy to provide a full continuum of services for SUD treatment to KanCare members.[5] This evaluation design builds upon and maintains most of the features included in the evaluation design for the 2019–2023 demonstration period.[8]

Demonstration Hypothesis and Goals

Hypothesis: The demonstration will improve access to appropriate SUD services for members with SUD.

Goals: Kansas will use the 1115(a) demonstration authority to pursue the following goals to improve access to appropriate SUD services for members with SUD:

1. Increased rates of identification, initiation, and engagement in treatment for opioid use disorder (OUD) and other SUDs
2. Reduced utilization of emergency department (ED) and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
3. Reduction in overdose deaths, particularly those due to opioids
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs
5. Improved access to care for physical health conditions among members with OUD or other SUDs

Substance Use Disorder Driver Diagram

The following driver diagram for the SUD component (Figure 2) shows the relationship between the demonstration's purpose, the primary drivers that contribute directly to achieve the purpose, and the secondary drivers necessary to achieve the primary drivers. The primary drivers are the demonstration's stated goals and are later referred to as outcomes in this evaluation design. The secondary drivers are later referred to as processes.

The demonstration will continue federal financial participation for services provided in Institutions for Mental Diseases (IMDs) for KanCare members with SUD by removing payment barriers for the services provided in IMDs. This strategy is related to the Secondary Driver 4, and in turn primarily contributes to Goal 1 and indirectly contributes to Goals 2, 3, and 4.

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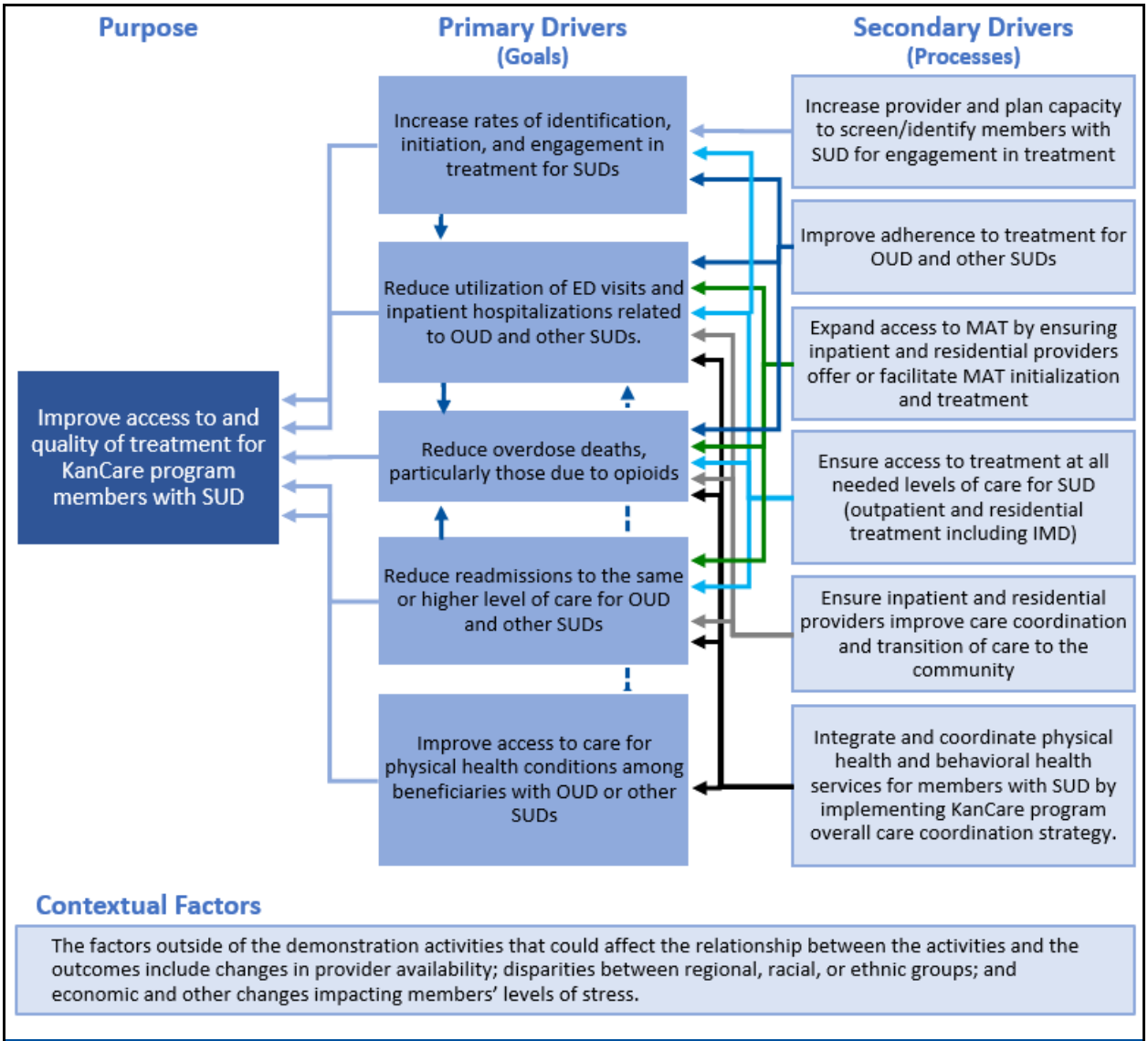

Figure 2. Substance Use Disorder Driver Diagram

Evaluation Questions and Hypotheses

Per CMS instructions, this evaluation will assess the demonstration's impact during the extension period, and includes quantitative**,** qualitative**,** and cross-cutting cost components.[6]

The evaluation questions and hypothesis used to assess the demonstration's goals for the SUD component are described in Table 6. The five primary drivers and six secondary drivers, as shown in the driver diagram for the overall SUD demonstration (Figure 2, above), support the hypotheses for the five evaluation questions to assess the performance of the SUD demonstration. The SUD component's goals in Table 6 are the primary drivers shown in Figure 2.

Table 6. Goals, Evaluation Questions, and Evaluation Hypotheses – Substance Use Disorder		
Goals	**Evaluation Questions**	**Evaluation Hypotheses**
1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	1. Does the demonstration increase access to and utilization of SUD treatment services?	1. The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	2. Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?	2. The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.
3. Reductions in overdose deaths, particularly those due to opioids.	3. Does the demonstration decrease opioid-related overdose deaths?	3. The demonstration will decrease the rate of overdose deaths due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.	4. Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?	4. Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.	5. Do enrollees receiving SUD services experience improved access to care for physical health conditions?	5. The demonstration will increase the percentage of members with SUD who access care for physical health conditions.
Related to Goals 1 through 4.	6. Does removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?	6. The demonstration will increase the KanCare members' access to SUD treatment services in IMDs by removing payment barriers for services provided in IMDs.

Quantitative Evaluation

The evaluation hypotheses for the six demonstration evaluation questions will be assessed. The demonstration evaluation questions and hypotheses are matched to their respective drivers and measure details within the following tables:

- Tables 7 to 11 provide information on the outcome evaluation according to the five primary drivers (primary analytic method is noted for each measure).
- Tables 12 to 17 provide information on the process evaluation according to the six secondary drivers (primary analytic method is noted for each measure).

Where applicable, measures were developed according to recognized measures from sources, such as,

- 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics ("CMS Metrics");
- Adult Core Set measures including those endorsed by the National Quality Forum (NQF) and stewarded by the National Committee for Quality Assurance (NCQA), and the Pharmacy Quality Alliance (PQA); and
- Healthcare Effectiveness Data and Information Set® (HEDIS) measures.

Outcome Evaluation – Primary Drivers

Table 7. Summary of Measures and Analytic Approach for Primary Driver 1 (*Outcome Evaluation*)

Demonstration Goal 1: ***Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.***

Evaluation Question 1: *Does the demonstration increase access to and utilization of SUD treatment services?*

Evaluation Hypothesis 1: *The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Initiation:** Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	**Initiation:** Number of members who began initiation of treatment through an inpatient admission, residential, outpatient visits, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date	HEDIS data from MCOs	Descriptive statistics; Comparison of rates between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline rate (2017–2018) with rates for 2022–2023 and 2024–2028 (Fisher's exact or Pearson's chi-square tests)*
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Engagement:** Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	**Engagement:** Initiation of treatment and two or more engagement events (inpatient admissions, residential, outpatient visits, intensive outpatient encounters or partial hospitalizations) with any alcohol or drug diagnosis within 34 days after the initiation event	HEDIS data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; Comparison of baseline rates (2017–2018) with the rates for 2022–2023 and 2024–2028*

Evaluation Question 6: Does removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

Evaluation Hypothesis 6: The demonstration will increase the KanCare members' access to SUD treatment services in IMDs by removing payment barriers for services provided in IMDs.

Measure Description	Steward	Data Source	Analytic Approach
Number of IMDs providing SUD services	None	Provider Network reports, Provider licensing data, MCO utilization reports	Descriptive statistics (count)*
Number of geographic locations by region for SUD treatment in IMDs^	None	Network reports, licensing data, utilization reports	Descriptive statistics (count)*
Number of admissions with SUD treatment services in IMDs	None	KMMS encounter data	Descriptive statistics (count)*
Average length of stay for SUD treatment services within IMDs	None	KMMS encounter data	Descriptive statistics (average)*

*Primary analytic method.
^Kansas Department for Children and Families (DCF) regions for SUD treatment in IMDs

Table 8. Summary of Measures and Analytic Approach for Primary Driver 2 (*Outcome Evaluation*)

Demonstration Goal 2: ***Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.***

Evaluation Question 2: *Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?*

Evaluation Hypothesis 2: *The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	KMMS Encounter data from MCOs; State Medicaid Eligibility and Enrollment data	Descriptive statistics; Comparison of percentages between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis (Mantel-Haenszel χ^2); Stratified demographic analysis as per data availability; Comparison of baseline year (2017) with final year (2028) using Pearson's chi-square tests*
ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; Comparison of percentages between the years; Trend analysis; Stratified demographic analysis as per data availability; Comparison of baseline year (2017) with final year (2028)*
Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; Comparison of percentages between the years; Trend analysis; Stratified demographic analysis as per data availability; Comparison of baseline year (2017) with final year (2028)*
Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; Comparison of percentages between the years; Trend analysis; Stratified demographic analysis as per data availability; Comparison of baseline year (2017) with final year (2028)*

*Primary analytic method.

Table 9. Summary of Measures and Analytic Approach for Primary Driver 3 (*Outcome Evaluation*)

Demonstration Goal 3: ***Reduction in overdose deaths, particularly those due to opioids.***

Evaluation Question 3: *Does the demonstration decrease opioid-related overdose deaths?*

Evaluation Hypothesis 3: *The demonstration will decrease the rate of overdose deaths due to opioids.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum)	None	Number of adult beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number of overdose deaths due to Opioids among eligible beneficiaries	Mortality data (Vital Statistics); KMMS Medicaid Eligibility and Enrollment data	Descriptive statistics; Comparison of percentages between the years; (Fisher's exact or Pearson's chi-square tests); Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline year (2019) rate with demonstration's final year rate (2027) using Fisher's exact or Pearson's chi-square tests*
Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid beneficiaries. (CMS Metric #18)	NQF #2940 (Adult Core Set) PQA NCQA	Number of adult beneficiaries without cancer divided by 1,000. **Note**: Hospice patients will be excluded.	Number of beneficiaries with opioid prescription claims with daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.	KMMS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Comparison of percentages between the years; Comparison of baseline year (2019) measurement with demonstration's final year measurement (2028)*
Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries. (CMS Metric #21)	PQA (Adult Core Set)	Number of adult beneficiaries without cancer divided by 1,000. **Note**: Excludes patients in hospice care and those with cancer.	Number of beneficiaries with concurrent use of prescription opioids and benzodiazepines for at least 30 days	KMMS Encounter data from MCOs	Descriptive statistics; Trend analysis (Mantel-Haenszel χ^2); Stratified demographic analysis as per data availability; Comparison of baseline year (2020) measurement with demonstration's final year measurement (2028)*

*Primary analytic method.

Table 10. Summary of Measures and Analytic Approach for Primary Driver 4 (*Outcome Evaluation*)

Demonstration Goal 4: ***Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.***

Evaluation Question 4: *Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?*

Evaluation Hypothesis 4: *Among members receiving care for SUD, the demonstration will reduce readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis (Mantel-Haenszel X^2); Comparison of baseline year (2017) measurement with demonstration's final year measurement (2028) using Fisher's exact or Pearson's chi-square tests*
30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment)	None	Number of discharges from a residential or inpatient facility for OUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; Interrupted Time Series (ITS) design (pre- and post-intervention period comparison) will be done of data as per availability of data*

*Primary analytic method.

Table 11. Summary of Measures and Analytic Approach for Primary Driver 5 (*Outcome Evaluation*)

Demonstration Goal 5: ***Improved access to care for physical health conditions among members with OUD or other SUDs.***

Evaluation Hypothesis 5: *The demonstration will increase the percentage of members with SUD who access care for physical health conditions.*

Evaluation Question: *Do enrollees receiving SUD services experience improved access to care for physical health conditions?*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Annual Dental Visits (ADV) (SUD stratum).	NCQA	Eligible beneficiaries 2–20 years of age with SUD diagnosis enrolled in Medicaid	Number of members 2–20 years of age who had one or more dental visits with a dental practitioner during the measurement year.	HEDIS data from MCOs, KMMS encounter data	Descriptive statistics; Differences between rates tested using Pearson's chi-square; Trend analysis; Test for equality of relative improvement (a variant of Difference-in-Difference design) using reduction in the failure rate (RFR) between the Intervention Group (members with SUD diagnosis and Comparison Group (members without SUD diagnosis)*
Child and Adolescent Well-Care Visits (WCV) (SUD stratum).	NCQA	Eligible beneficiaries 12–21 years of age with SUD diagnosis enrolled in Medicaid	Number of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	HEDIS data from MCOs	Descriptive statistics; Differences between rates tested using Pearson's chi-square; Trend analysis; ITS design or Test for equality of relative improvement (whichever is appropriate)*
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that received a prenatal care visit in first trimester, on or before enrollment start date, or within 42 days of enrollment in the organization.	HEDIS data from MCOs	Descriptive statistics; Differences between rates tested using Pearson's chi-square; Trend analysis; ITS design or Test for equality of relative improvement (whichever is appropriate)*
Prenatal and Postpartum Care (PPC) – Postpartum Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that had a postpartum visit on or between 7 & 84 days after delivery.	HEDIS data from MCOs	Descriptive statistics; Differences between rates shown tested using Pearson's chi-square; Trend analysis; ITS design or Test for equality of relative improvement (whichever is appropriate)*

*Primary analytic method.

Process Evaluation – Secondary Drivers

Table 12. Summary of Measures and Analytic Approach for Secondary Driver 1 (*Process Evaluation*)

Secondary Driver 1 (*Related to Goal 1*): *Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Number of distinct performing providers) using KMAP ID) who billed for Screening, Brief Intervention, and Referral to Treatment (SBIRT) services.	None	NA	Number of distinct performing providers) using KMAP ID) who billed for SBIRT services	KMMS Encounter data from MCOs	Descriptive statistics; Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline year (2019) with final year (2028) using Fisher's exact or Pearson's chi-square tests*
Receipt of care for SUD after SBIRT service – Percentage of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service.	None	Number of beneficiaries who received SBIRT services. (CMS Metric #1)	Number of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis; ITS design as per availability of data*

*Primary analytic method.

Table 13. Summary of Measures and Analytic Approach for Secondary Driver 2 (*Process Evaluation*)

Secondary Driver 2 (*Related to Goal 1, Goal 2 and Goal 3*): *Improve adherence to treatment for OUD and other SUDs*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Continuity of Pharmacotherapy for OUD (POD) – (CMS Metric #22).	NCQA	Number of beneficiaries age 18 to 64 with an OUD diagnosis (excluding adults initiating pharmacotherapy after 6/30/20 and those deliberately phased out of MAT prior to the 180 days).	Number of beneficiaries with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.	KMMS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Comparison between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis Trend analysis (Mantel-Haenszel χ^2); Interrupted Time Series (ITS) design (pre- & post-intervention period comparison) as per availability of data*
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).	NCQA	ED visits for members ages 13 or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; Comparison between the years; Trend analysis; Comparison of 2017-2018 rates with rates for 2020-2022 and 2024-2028 (Fisher's exact or Pearson's chi-square tests)*

Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12)

*Primary analytic method.

Table 13. Summary of Measures and Analytic Approach for Secondary Driver 2 (*Process Evaluation*) (Continued)

Secondary Driver 2 (*Related to Goal 1, Goal 2 and Goal 3*): *Improve adherence to treatment for OUD and other SUDs*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive any SUD treatment service (CMS Metric #6). Stratified by service type	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*
Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with an OUD diagnosis (CMS Metric #3, OUD stratum).	Number of beneficiaries with an OUD diagnosis who receive any SUD treatment service (CMS Metric #6; OUD stratum). Stratified by service type	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*
Percentage of beneficiaries with SUD diagnosis who received peer support services during the monthly measurement period	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive peer support service (HCPCTS Codes: H0038, H0038 HQ)	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*

Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12)

*Primary analytic method.

Table 14. Summary of Measures and Analytic Approach for Secondary Driver 3 (*Process Evaluation*)

Secondary Driver 3 (*Related to Goal 2, Goal 3, and Goal 4*): *Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Residential and Inpatient OUD	None	Number of residential and inpatient discharges for SUD treatment for OUD diagnosis	Number of denominator discharges with MAT claim during the stay or within 15 days of discharge.	MCO Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline year (2019) with final year (2028) using Fisher's exact or Pearson's chi-square tests*
Percentage of members with OUD diagnosis who have a MAT claim for OUD.	None	Number of members with OUD diagnosis (CMS Metric #3, OUD stratum).	Number of members with a claim for MAT for OUD (CMS Metric #12, OUD stratum).	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*

*Primary analytic method.

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Table 15. Summary of Measures and Analytic Approach for Secondary Driver 4 (*Process Evaluation*)

Secondary Driver 4 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year.	None	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period (CMS Metric #4).	Number of beneficiaries with a claim for residential treatment in an IMD (CMS Metric #5).	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years (Fisher's exact or Pearson's chi-square tests); Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline year (2019) with final year (2028) using Fisher's exact or Pearson's chi-square tests*
Average length of stay for SUD treatment services within IMDs (CMS Metric #36).	None	Total number of discharges from an IMD for beneficiaries with a residential treatment stay for SUD.	Total number of days in an IMD for all beneficiaries with an identified SUD.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of baseline year (2017) with final year (2028)*
Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of beneficiaries in residential and inpatient treatment (refer to CMS Metric #10).	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*
Number of beneficiaries in outpatient, intensive outpatient, & partial hospitalization SUD treatment per 1,000 members with SUD diagnosis.	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of members in outpatient, intensive outpatient or partial hospitalization treatment (refer to CMS Metrics #8 & #9). **Note**: Partial hospitalization in KS has same service code as inpatient.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years; Trend analysis; ITS design as per availability of data*

*Primary analytic method.

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Table 16. Summary of Measures and Analytic Approach for Secondary Driver 5 (*Process Evaluation*)

Secondary Driver 5 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure inpatient & residential providers improve care coordination & transition of care to the community.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the years (Pearson's chi-square tests); Trend analysis Trend analysis (Mantel-Haenszel χ^2); Comparison of baseline year (2017) with final year (2028) using Pearson's chi-square tests*
ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the year; Trend analysis; Comparison of baseline year (2017) with final year (2028)*
ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the year; Trend analysis; Comparison of baseline year (2017) with final year (2028)*
Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the year; Trend analysis; Comparison of baseline year (2017) with final year (2028)*
Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	KMMS Encounter data from MCOs	Descriptive statistics; Comparison of percentages between the year; Trend analysis; Comparison of baseline year (2017) with final year (2028)*
Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA).	NCQA	ED visits for members 13 years or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; Comparison between the years; Trend analysis; Comparison of rate for 2017-2018 with rates for 2020-2022 and 2024-2028 (Fisher's exact or Pearson's chi-square tests)*

*Primary analytic method.

Table 16. Summary of Measures and Analytic Approach for Secondary Driver 5 (*Process Evaluation*) (Continued)

Secondary Driver 5 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure inpatient & residential providers improve care coordination & transition of care to the community*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Follow-Up After High-Intensity Care for SUD (FUI)	NCQA	Number of inpatient hospitalizations, residential treatment or detoxification visits for a SUD diagnosis among members ages 13 or older	Number of visits or discharges that result in a follow-up visit or service for SUD within 7/30 days	HEDIS data from MCOs	Descriptive statistics; Comparison between the years; Trend analysis; Comparison of baseline rate for the 2019 with the rates for 2020-2022 and 2024-2028*
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Initiation:** See above Table B-3 – Primary Driver, Goal 1. **Engagement:** See Table B-3 – Primary Driver, Goal 1	**Initiation:** See Table B-3 – Primary Driver 1. **Engagement:** See Table B-3 – Primary Driver 1.	HEDIS data from MCOs	Descriptive statistics; Comparison between the years; Trend analysis; Comparison of baseline rate for the 2017-2018 with the rates for 2020-2022 and 2024-2028*

*Primary analytic method.

Table 17. Summary of Measures and Analytic Approach for Secondary Driver 6 (*Process Evaluation*)

Secondary Driver 6 (*Related to Goal 2, Goal 3, Goal 4, and Goal 5*): *Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy.*

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager	None	Number of Medicaid beneficiaries with SUD diagnosis	Number of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager	MCO case management data (available for 2019 onwards)	Descriptive statistics; Comparison between the years (Pearson's chi-square); Trend analysis Trend analysis (Mantel-Haenszel χ^2); One-group Pretest–Posttest Design*
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have service/treatment plan or person-centered service plan (PCSP)	None	Number of Medicaid beneficiaries with SUD diagnosis.	Number of Medicaid Beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and service/treatment plan or PCSP	MCO case management data (available for 2019 onwards)	Descriptive statistics; Comparison between the years; Trend Analysis; One-group Pretest–Posttest Design*

*Primary analytic method.

Qualitative Evaluation

The qualitative evaluation component will focus on qualitative elements related to the goals and hypothesis of the demonstration. These may include examining the experiences of members and providers related to different aspects of care provided through the demonstration, including access to and quality of care.

The qualitative evaluation is designed to complement the quantitative evaluation. While the quantitative data analysis looks at benefits the members may be obtaining from the demonstration strategies and policies directed towards improving their access to appropriate SUD services, the qualitative data analysis is designed to get insights into the impact of the demonstration from members' and providers' perspectives.

The qualitative assessment of the members' perspective will be based on the results obtained from the annual SUD member surveys conducted by MCOs during the demonstration period. The results for applicable survey questions will be reviewed to identify patterns/themes. The information obtained from these patterns/themes will be summarized to provide information regarding the demonstration's impact from the members' perspective. Table 18 lists a few examples of the SUD member survey questions that may be used to assess member feedback.

The qualitative analysis of Kancare provider perspectives regarding the SUD services will be based on the results of online surveys conducted twice during the demonstration period. The survey will include open-ended questions to gather provider feedback on how the demonstration is doing with regard to providing different SUD services. A few examples of draft provider survey questions are listed in Table 18. Final versions of survey questions will be designed by a KFMC committee of subject matter experts. The questionnaire development will include input and approval from the State. Similar to the member surveys, the provider surveys will provide the valuable insights to quantitative evaluation results.

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Table 18. Examples of the Survey Questions for the Qualitative Evaluation – Substance Use Disorder	
SUD Member Survey	
Evaluation Topic	**Survey Questions (Examples)**
Access to care for OUD and other SUDs	• Is the distance you travel to your counselor a problem or not a problem?
	• In the last year, did you need to see your counselor right away for an urgent problem?
	• If you were placed on a waiting list, how long was the wait?
	• How satisfied are you with the time it took you to see someone?
	• Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours?
Satisfaction with the SUD treatment services	• How satisfied are you with the number of treatment sessions with your counselor?
	• Were you told how many days you were going to stay in this particular treatment facility program?
	• How satisfied are you with your discharge plan?
Medication-Assisted Treatment (MAT)	• Was Medication-Assisted Treatment (MAT) discussed with you at the treatment facility? Medications discussed may have included buprenorphine, methadone, and naltrexone.
	• If yes, did you then receive Medication-Assisted Treatment (MAT) at the treatment facility or from a provider they referred you to?
Coordination between physical health care and behavioral health care	• Thinking about the coordination of all your health care, do you have a primary care provider or medical doctor?
	• Has your counselor asked you to sign a "release of information" form to allow him/her to discuss your treatment with your primary care provider or medical doctor?
SUD Provider Survey	
Evaluation Topic	**Survey Questions (Examples)**
Type of provider's service	• How are you involved in providing Substance Use Disorder (SUD) services to KanCare members?
Access to critical levels of care for Opioid Use Disorder (OUD) and other SUDs	• What challenges or barriers did you encounter within the last year in getting KanCare members who are identified as having an OUD or other SUD into the right level of care?
Transitions between levels of care	• Has the use of the SUD-specific Patient Placement Criteria (American Society of Addiction Medicine (ASAM) levels of care Criteria) improved the process of placing members with an SUD in the appropriate level of care?
Medication Assisted Treatment (MAT)	• What are the challenges in meeting licensure and contract requirements for providers of Medication-Assisted Treatments?
	• What challenges you encounter in offering Medication-Assisted Treatment?
	• What challenges you encounter in referring KanCare members with an OUD to a MAT provider?
Coordination between physical health care and behavioral health care	• What has been the impact of case management by MCO staff on coordination of care for physical health or mental health co-morbidities among your KanCare patients with an SUD?
	• In the last 12 months, what successes have you had with coordinating care between physical and behavioral health for your KanCare patients with an SUD?
	• In the last 12 months, what barriers have you had with coordinating care between physical and behavioral health for your KanCare patients with an SUD?
Access to SUD treatment services in IMDs	• What are the challenges in meeting new licensure and contract requirements for providers of SUD services in Institutes of Mental Disorders (IMDs)

F. Evaluation Methodology – Substance Use Disorder

The evaluation design methodologies are designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the evaluation is to examine the effectiveness of demonstration strategies and policies on achievement of the overall goal of improving access to appropriate SUD services for KanCare members with SUD.

This section presents the methods and rationale for the demonstration evaluation (quantitative, qualitative, and cross-cutting cost evaluation components). It also describes evaluation questions, evaluation hypotheses, and strategies for each goal of the demonstration. Please note, the measurement years specified here for analyses may change as per data availability at the time of performing interim and final evaluations.

Quantitative Evaluation Methodology

Evaluation Period

January 1, 2024 – December 31, 2028

Study Population

The primary participants ("study population") for the SUD evaluation is the subset of KanCare members with an SUD diagnosis. In certain cases, members without an SUD diagnosis may access services (e.g., SBIRT or assessment) and will be included within the target population for certain measures or hypotheses.

Data Sources

The following data sources will be utilized for the evaluation (see Table 19). The majority of data will be provided by the KanCare MCOs with additional administrative data from the State of Kansas. Specific datasets and elements for evaluation are discussed with each metric within Sections E and F.

Table 19. Data Sources for Quantitative Evaluation – Substance Use Disorder

Data Source	Owner/Steward	Brief Description
Healthcare Effectiveness Data and Information Set (HEDIS)	KanCare MCOs	Member-level detail tables for HEDIS measures submitted by the MCOs.
Managed care case management data	KanCare MCOs	Member-level data maintained by MCOs within their specific case management data systems.
Kansas Modular Medicaid System (KMMS) encounter data	KanCare MCOs	Encounter/claims data submitted to the State by MCOs used to support HEDIS and HEDIS-like performance, Medication-Assisted Treatment, service utilization, and cost metrics for all enrollees.
Medicaid eligibility and enrollment files ("834 files")	State of Kansas	Eligibility and enrollment detail for KanCare members used to determine enrollee aid category and stratify data into subgroups.
Mortality data	State of Kansas	Public health birth, death and other vital records used to track overdose deaths attributed to Kansas residents.
Tennessee HEDIS/CAHPS reports	State of Tennessee	Comparative analysis of audited results from TennCare MCOs.

Source data will be cleaned as appropriate with steps to include reviewing data for missing values, inconsistent patterns, and identification of outliers to ensure quality and appropriateness of data for analyses required by the evaluation design.

Analytic Methods

Due to state-wide implementation of the demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups, as all KanCare members will be eligible for the same benefits. The **Interrupted Time Series** (ITS) as per availability of data, and **One-Group Pretest-Posttest** (OGPP) evaluation designs will be used throughout the majority of the evaluation. A few performance measures will be assessed by applying **Test for Equality of Relative Improvement** using reduction in the failure rate (RFR) between the Intervention Group, comprised of members with an SUD diagnosis, and the Comparison Group, comprised of members without an SUD diagnosis. The evaluation of the demonstration's strategy of increasing availability of IMD facilities providing SUD services by removal of the Kansas Medicaid IMD Exclusion is limited by data availability; due to changes in data systems, pre-demonstration data will not be available. Therefore, non-experimental methods (descriptive statistics) will be used for conducting the evaluation of this strategy. Specific to cost analyses, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Thus, performance measures for the cost analyses will be assessed by examining descriptive statistics, conducting trend analyses, and comparing data for the baseline period with that for the demonstration period.

The primary analytic method for each performance measure is noted in Tables 7–17. These tables also included additional analytic methods that may serve as contingencies should the main analytic method not be feasible. Additional methods may also be considered if there are concerns about the primary approach (these methods cannot be determined until concerns are identified during data review and analysis).

Interrupted Time Series Evaluation Design

The quasi-experimental ITS evaluation design is performed as a continuous series of measurements on a population based on the variable of interest within a treatment or intervention to determine trends "interrupted" by application of the treatment or intervention at those times.[9,10,11] Depending on the availability of data, ITS evaluation design will be applied for assessing some of the performance measures. As per availability of the data for these measures, the pre-intervention period measurements will be comprised of either six-month data points from 2017 to 2019 and 2022 to 2023 or quarterly data points from 2022 and 2023. The intervention period measurements will be comprised of either quarterly or six-month data points for years 2024–2028.

We will estimate ITS models using the segmented linear regression equation

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 T X_t,$$

where Y_t is the outcome at time t, T represents the time elapsed since the start of the program, β_0 represents the baseline (where T=0), X_t is a dummy variable indicating the pre-intervention period, β_1 represents the increment change per time unit before intervention (i.e., baseline trend), β_2 is the level change following the intervention, and β_3 indicates the slope change following the program.[11]

One Group Pretest-Posttest Evaluation Design

If only one or a few observations are available, but a suitable comparison group is not available, the OGPP non-experimental evaluation design may be used. The OGPP is performed for a single population based on the variable of interest within a treatment or intervention with initial (pre-) and subsequent (post-) measurements.[9,10] Where possible, the quasi-experimental OGPP with non-equivalent comparison groups will be applied with an appropriate pre- and post-intervention data

for assessing some of the performance measures. The pretest measurement will be taken from 2017–2018 or 2019 and the five-year posttest period will span 2024–2028.

Fisher's exact and chi-square tests will be used with this design.

Test for Equality of Relative Improvement

When data for both pre- and post-intervention periods for Intervention and Comparison groups are available, then a "*Test for Equality of Relative Improvement"* using reduction in the failure rate (RFR) may be applied. RFR is the amount of improvement relative to the amount of potential improvement. The formula is

RFR = (Remeasurement Rate minus Initial Rate)/(Goal minus Initial Rate).

The Test for Equality of Relative Improvement is a chi-square test that is conceptually similar to the difference-in-differences method that tests for equality of absolute improvement between two groups. The two methods are equivalent when the initial rates are equal. Statistical significance will be indicated by *p* less than 0.05.

To ensure the intervention and comparison groups are comparable over time, the test for Equality of Relative Improvement will be accompanied by monitoring for changes in the composition of these two groups. The Test for Equality of Relative Improvement may also be used to compare improvements between demographic groups.

Descriptive statistics

Descriptive statistics will be used to describe demographic characteristics of the study population, intervention groups, comparison groups, and any subgroups. Stratified analysis will be performed to evaluate the impact of the demonstration on subpopulations if evidence suggests significant differences may exist. The analyses of various performance measures may include comparison of percentages/rates between the years using Fisher's exact or Pearson's chi-square tests; trend analysis using Mantel-Haenszel chi-square; and comparison of baseline measurements with the final year measurements using Fisher's exact or Pearson's chi-square tests. These statistical tests' results will be interpreted with *p* less than 0.05 indicating statistical significance. As per availability of the data for various performance measures, stratified analyses by demographic groups (e.g., age, sex, race/ethnicity, primary language) will be conducted.

Internal Comparison Population Groups

Potential internal comparison groups can be comprised of key subpopulations based on demographics groups (e.g., age, sex, race/ethnicity, primary language).The comparison of performance measures between different groups of these subpopulations will help in assessing any existing disparities in quality of care and access to SUD treatment services.[1] Estimated counts of the SUD study population, stratified by demographic characteristics, are provided in Table 20. The table shows some strata with counts that may be too low to provide meaningful results—comparisons by race may be limited to White versus Black/African American or White versus non-White, and comparisons by primary language will not be done.

Other potential internal comparison populations for the demonstration may fall along the Kansas population density spectrum (frontier-to-urban) or location of services as availability, and access will likely differ by location in Kansas. For example, methadone treatment requires daily (or near daily)

clinic visits, but methadone clinics may not be accessible in regions of lower population density.[1] Kansas counties are designated to different population density peer groups according to their population relative to their size in persons per square mile (ppsm): Frontier (less than 6.0 ppsm), Rural (6.0–19.9 ppsm), Densely-settled Rural (20.0–39.9 ppsm), Semi-Urban (40.0–149.9 ppsm), and Urban (150.0 ppsm or more).[12] Another potential comparison could be comparing services or providers in different geographic locations, such as comparison between different urban areas offering methadone clinics and likelihood of accepting Medicaid. Non-urban regions will be investigated for their potential to serve as comparison groups to urban regions for select MAT measures.

Table 20. Demographic Stratifications of SUD Study Population – 2023 (estimated)

Stratum	Count	Percent	Stratum	Count	Percent
Total (denominator)	**26,782**	**100%**			
Gender:			**Primary Language Spoken:**		
Male	15,709	58.7%	English	26,469	98.8%
Female	11,073	41.3%	Not English	313	1.2%
Age:			**Ethnicity:**		
0 to 17 years	2,609	9.7%	Hispanic or Latino	2,773	10.4%
18 to 24 years	4,774	17.8%	Not Hispanic or Latino	20,140	75.2%
25 to 34 years	5,040	18.8%	Ethnicity Unknown	3,869	14.4%
35 to 44 years	4,784	17.9%	**Race:**		
45 or older	9,575	35.8%	White, alone	18,735	70.0%
Region:			Black/African American (AA), alone	3,953	14.8%
Urban	14,751	55.1%	Race other than White or Black/AA	490	1.8%
Semi-Urban	4,192	15.7%	White or Black/AA, not alone	2,642	9.9%
Densely settled Rural	5,030	18.8%	Unknown, alone or with a race	962	3.6%
Rural	2,262	8.4%	Members may select multiple races. The strata shown are disjoint.		
Frontier	547	2.0%			

The denominator is the number of KanCare members enrolled in 2023 who had a claim for a service in 2022 or 2023 with a diagnosis in the HEDIS MY 2023 values set Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence.

External Comparison Population Groups

Initial analysis to identify potential external (non-Kansas) comparison populations was conducted. To represent what would have happened to members in the intervention group if they had never been exposed to an SUD demonstration, the external comparison group must consist of non-Kansas individuals who are similar to the intervention group in their observable characteristics, not be exposed to the interventions, and be exposed to the same policy environment.[9] One state without an SUD demonstration, Tennessee, met the criteria used for identifying states with similar Medicaid program characteristics: no Medicaid expansion, similar MCO penetration rates, similar percents of Medicaid beneficiaries with SUD treatment.

Kansas and Tennessee HEDIS rates for selected measures related to behavioral health measures will be trended (from 2017 through 2028, as data allow). If trending graphs show differences that can be attributed to the demonstration with reasonable confidence, then the results will be reported. For this analytic approach to provide meaningful results, Kansas and Tennessee will need to maintain the same policy environments over the years trended. Also, the external comparison group should not be exposed to interventions or conditions impacting the HEDIS rates that are not also applied to the intervention group.

Detailed Description of Quantitative Evaluation Methods

Detailed quantitative methods for evaluating the demonstration's goals and hypothesis are described below.

a. Evaluation Methodology for Substance Use Disorder Goal 1

Goal 1

Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.

Evaluation Questions for Goal 1

- Does the demonstration increase access to and utilization of SUD treatment services?
- Does removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

Evaluation Hypotheses for Goal 1

- The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
- The demonstration will increase the KanCare members' access to SUD treatment services in IMDs by removing payment barriers for services provided in IMDs.

Strategies for Goal 1

The strategies contributing to the primary and secondary drivers for Goal 1 will be implemented over the demonstration period:

- Support the expansion of Screening, Brief Intervention, and Referral to Treatment (SBIRT) among physical health and behavioral health service providers to identify members at different risk levels for OUD or other SUDs and provide the appropriate level of referral to SUD providers. This support will be provided by
  - Increasing training opportunities for the physical health and behavioral health service providers to become credentialed to bill for SBIRT services,
  - Working with the MCOs to expand their network of SBIRT-credentialed providers,
  - Working with the MCOs to increase the utilization of SBIRT, and
  - Running a statewide media campaign to increase member and general population awareness of primary prevention and availability of treatment (utilizing funding from the federal State Opioid Response grant).
- Remove the Kansas Medicaid IMD Exclusion, thus allowing IMDs to bill for SUD treatment services, with the expectation that access to SUD services will increase for members with behavioral health conditions.

The strategies described here will contribute to the following three secondary drivers, which in turn will increase the rates of identification, initiation, and engagement in treatment for OUD and other SUDs (Primary Driver 1 for Goal 1):

- Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment (Secondary Driver 1).
- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2).
- Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD) (Secondary Driver 4).

Drivers and Performance Measures for Goal 1

The evaluation of this goal involves assessment of 12 performance measures for its primary and secondary drivers. The primary and secondary drivers for Goal 1 and their associated performance measures are shown in Table 21.

Table 21. Drivers and Associated Performance Measures for Substance Use Disorder Goal 1

Primary Driver	Performance Measure
Increase rates of identification, initiation, and engagement in treatment for SUDs	• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). (2017–2028)
Secondary Drivers	**Performance Measures**
Increase provider and plan capacity to screen/identify members with SUD for engagement in treatment [Secondary Driver 1].	• Number of distinct performing providers (using KMAP ID) who billed for SBIRT services (2019–2028)† • Receipt of care for SUD and/or OUD after SBIRT service. (2019–2028)*
Improve adherence to treatment for OUD and other SUDs [Secondary Driver 2].	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2017–2028)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2028) • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028)*^ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028).*^ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period (2017–2028).*
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD) [Secondary Driver 4].	• Number of IMDs providing SUD services (2024–2028).‡ • Number of geographic locations of IMDs providing SUD services (by region/county) (2024–2028).‡ • Number of admissions with SUD treatment services in IMDs (2024–2028).‡ • Average length of stay for SUD treatment services within IMDs (2024–2028).‡

*As per data availability, Interrupted Time Series Design will be used for the assessment of the performance measure.
^Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12)
†Comparison of baseline year measurement with demonstration's final year measurement will be used for the assessment of the performance measure.
‡Descriptive data will be used for the assessment of performance measure.

The comparison of percentages/rates between the years (using Fisher's exact or Pearson's chi-square tests) will be conducted for seven performance measures. The trend analysis (using Mantel-Haenszel chi-square) will be done for eight performance measures. As per data availability, stratified analyses by demographic groups will be conducted. Depending on the availability of data, five performance measures will be examined using the interrupted time series design. The post-intervention observation period for all five performance measures will be 2024 through 2028. One process measure will be examined by comparing baseline year measurement for 2017 with demonstration's final year (2028)

measurement using Fisher's exact or Pearson's chi-square tests. The two HEDIS measures (IET and FUA) will be analyzed in two steps. The first analysis step will include comparison of 2017–2018 rate (baseline) with the 2020–2022 rate; and second step will include comparison of 2023 rate (baseline) with the 2024–2028 rate (please note, there is a break in trending between 2022 and 2023). Non-experimental methods (descriptive statistics) will be used for assessing the four performance measures related to IMDs (listed for the Secondary Driver 4) as pre-demonstration data are not available due to changes in data systems.

b. Evaluation Methodology for Substance Use Disorder Goal 2:

Goal 2

Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Evaluation Question for Goal 2

Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?

Evaluation Hypothesis for Goal 2

The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.

Strategies for Goal 2

Four strategies contributing to the Primary and Secondary Drivers for Goal 2 will be implemented over the demonstration period:

- The five Community Crisis Centers (CCCs) across the state became operational in 2019 and provide support and stabilization services for Kansans in crisis and engage with them in community-based services. Early indicators show the Crisis Centers to be effective in diverting members from admission to hospitals and emergency rooms. Groundbreaking on a sixth CCC occurred in late 2019 and it is expected that more CCCs will become operational.
- Expand use of medication-assisted treatment (MAT). This includes
  - Changing licensing requirements for all residential providers, and
  - Coverage of methadone maintenance by Medicaid.
- Expand of the use of peer-supported rehabilitation and recovery services ("peer support services"). This includes
  - Increasing the number of peer mentors credentialed, and
  - Increasing utilization of peer support services.
- Improve transitions between levels of care related to SUD treatment.

The four strategies described here will contribute to the following five secondary drivers, which in turn will reduce the utilization of preventable or medically inappropriate emergency department visits and inpatient hospital admissions related OUD and other SUD (Primary Driver 2 for Goal 2):

- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2).
- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment (Secondary Driver 3).
- Ensure access to services at all needed levels of care for SUD, including outpatient treatment

(group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 4).

- Ensure inpatient and residential providers improve care coordination and transition of care to the community (Secondary Driver 5).
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy (Secondary Driver 6).

Drivers and Performance Measures for Goal 2

The evaluation of this goal involves assessment of twenty performance measures for its primary and secondary drivers. The primary and secondary drivers for Goal 2 and their associated performance measures are shown in Table 22. Please note, five measures for assessment of the Goal 2 listed in Table 19 are common between the multiple drivers—four are common across the primary driver and Secondary Driver 5, and one measure is common across Secondary Drivers 2 and 5.

Table 22. Drivers and Associated Performance Measures for Substance Use Disorder Goal 2

Primary Driver	Performance Measures
Reduce utilization of ED visits and inpatient hospitalizations related to OUD and other SUDs.	• ED utilization for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #23; 2017–2028)† • ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2028)† • Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2028)† • Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2028)†
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs [Secondary Driver 2].	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2028)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2028) • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028)*^ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028)*^ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2028)*
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and Treatment [Secondary Driver 3].	• Residential and Inpatient OUD discharges with MAT claim. (2017–2028)† • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2028)*

*Interrupted Time Series Design will be used for the assessment of the performance measure.

^Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12).

†Comparison of baseline year measurement with demonstration's final year measurement will be used for the assessment of the performance measure.

Table 22. Drivers and Associated Performance Measures for Substance Use Disorder Goal 2 (Continued)	
Secondary Driver	**Performance Measures**
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD) [Secondary Driver 4].	• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2019–2028)† • Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2028)† • Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2028)* • Number of outpatient, intensive outpatient, and partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2028)* **Note:** Partial hospitalization in KS has same service code as inpatient.
Ensure inpatient and residential providers improve care coordination and transition of care to the community [Secondary Driver 5].	• 30-Day Readmission for SUD treatment. (2017–2028)† • ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2028)† • ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2028)† • Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2028)† • Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2028)† • Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2028) • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2028) • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2028)
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy [Secondary Driver 6].	• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2028)‡ • Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2028)‡
*Interrupted Time Series Design will be used for the assessment of the performance measure. ^Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12). †Comparison of baseline year measurement with demonstration's final year measurement will be used for the assessment of the performance measure. ‡One-group Pretest-Posttest Design will be used for the assessment of the performance measure.	

The comparison of percentages/rates between the years (using Fisher's exact or Pearson's chi-square tests) and trend analysis (using Mantel-Haenszel chi-square) will be conducted for nineteen performance measures. The stratified analyses by demographic groups will be conducted for the performance measures as per data availability. The demonstration's baseline measurement will be compared with its final year measurement using Fisher's exact or Pearson's chi-square tests for eight outcome and process measures. Interrupted time series evaluation design will be used to evaluate seven process measures related to the secondary drivers as per availability of data. The post-intervention observation period for performance measures will be 2024 through 2028. Two process measures will be examined using the One group pretest-posttest design. The post-intervention

observation period for this performance measure will be 2024–2028 (using Fisher's exact or Pearson's chi-square tests). Three HEDIS measures (IET, FUA, and FUI) will be analyzed in two steps. For two HEDIS measures (IET and FUA), the first analysis step will include comparison of 2017–2018 rate (baseline) with the 2020–2022; the second step will include comparison of 2023 rate (baseline) with the 2024–2028 (please note, there is a break in trending between 2022 and 2023). For the third HEDIS measure (FUI), the first analysis step will include comparison of 2019 rate (baseline) with the 2020–2022; and second step will include comparison of 2019 rate (baseline) with 2024–2028.

c. Evaluation Methodology for Substance Use Disorder Goal 3:

Goal 3

Reduction in overdose deaths, particularly those due to opioids.

Evaluation Question for Goal 3

Does the demonstration decrease opioid-related overdose deaths?

Evaluation Hypothesis for Goal 3

The demonstration will decrease the rate of overdose deaths due to opioids.

Strategies for Goal 3

Two strategies contributing to the primary and secondary drivers for Goal 3 will be implemented over the demonstration:

- Expansion of medication-assisted treatment (MAT). This includes
  - Changing licensing requirements for all residential providers; and
  - Coverage of methadone maintenance by Medicaid.
- Care coordination requirements by the MCOs to improve transitions to the community and participation in community-based recovery services.

These two strategies will contribute to the following three secondary drivers, which in turn will lead to the reduction in overdose deaths, particularly those due to opioids (Primary Driver 3 for Goal 3):

- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2).
- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment (Secondary Driver 3).
- Ensure inpatient and residential providers improve care coordination and transition of care to the community (Secondary Driver 5).

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute to achieving the Goal 3:

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 3).
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy (Secondary Driver 5).

Drivers and Performance Measures for Goal 3

The evaluation of this goal involves assessment of seventeen performance measures for its primary and secondary drivers. The primary and secondary drivers for Goal 3 and their associated performance measures are shown in Table 20. Please note, one measure for assessment of the Goal 3 listed in Table 23 is common between two secondary drivers (Secondary Drivers 2 and 5).

Table 23. Drivers and Associated Performance Measures for Substance Use Disorder Goal 3

Primary Driver	Performance Measures
Reduce overdose deaths, especially those due to opioids.	• Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2027)† • Use of Opioids at High Dosage in Persons without Cancer. (CMS Metric #18; 2019–2028)† • Concurrent Use of Opioids and Benzodiazepines. (CMS Metric #21; 2020–2028)†
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs [Secondary Driver 2].	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2028)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2028) • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028)*^ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2028) *^ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2028)*
Expand access to medication- assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and Treatment [Secondary Driver 3].	• Residential and Inpatient OUD discharges with MAT claim. (2017–2028)† • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2028)*
Ensure inpatient and residential providers improve care coordination and transition of care to the community [Secondary Driver 5].	• 30-Day Readmission for SUD treatment. (2017–2028)† • ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23). (2017– 2028)† • ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2028)† • Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017– 2028)† • Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2028)† • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2028) • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2028) • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2028)

*Interrupted time series design will be used for the assessment of the performance measure.

^Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12).

†Assessment will compare the baseline year measurement with demonstration's final year measurement.

The comparison of percentages/rates between the years (using Fisher's exact or Pearson's chi-square tests) will be conducted for seventeen performance measures. The trend analysis (using Mantel-Haenszel chi-square) will be done for sixteen performance measures. The stratified analyses by demographic groups will be conducted for the performance measures as per data availability. Interrupted time series evaluation design will be used to evaluate five process measures related to the secondary drivers as per availability of data. The post-intervention observation period for six performance measures will be 2024 through 2028. The baseline measurement will be compared with the demonstration's final year measurement using Fisher's exact or Pearson's chi-square tests for assessment of nine outcome and process measures. Three HEDIS measures (IET, FUA, and FUI) will be analyzed as described above (see Goal 2).

d. Evaluation Methodology for Substance Use Disorder Goal 4

Goal 4

Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

Evaluation Question for Goal 4

Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?

Evaluation Hypothesis for Goal 4

Among members receiving care for SUD, the demonstration will reduce readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

Strategies for Goal 4

Two strategies contributing to the primary and secondary drivers for Goal 4 will be implemented over the demonstration period. The strategies include:

- To ensure admission of members with SUD to the appropriate level of care, documentation of an assessment which follows ASAM criteria will be required.
  - Licensing standards for all providers across the network will be aligned with the ASAM criteria.
- Care coordination requirements will aim to decrease readmission to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.

The two strategies described here will contribute to the following two secondary drivers, which in turn will lead to the reduced readmissions to the same or higher level of care for OUD and other SUDs (primary driver for Goal 4):

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services;
- Ensure inpatient and residential providers improve care coordination and transition of care to the community;

In addition to the above-mentioned secondary drivers and strategies, the following secondary drivers and their related strategies (described for Goal 2) will also contribute to achieving Goal 4.

- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment.

- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy.

Drivers and Performance Measures for Goal 4

The evaluation of this goal involves assessment of 13 performance measures for its primary and secondary drivers. The primary and secondary drivers for Goal 4 and their associated performance measures are shown in Table 21. Please note, one measure for assessment of the Goal 4 listed in Table 24 is common between primary and one of the secondary drivers (Secondary Driver 5).

Table 24. Drivers and Associated Performance Measures for Substance Use Disorder Goal 4

Primary Driver	Performance Measure
Reduce readmissions to the same or higher level of care for OUD and other SUDs.	• 30-Day Readmission for SUD treatment. (2017–2028)^ • 30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment). (2017–2028)*
Secondary Drivers	**Performance Measures**
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD) [Secondary Driver 4].	• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year (2019–2028)^ • Average length of stay for SUD treatment services within IMDs (CMS Metric #36; 2017–2028)^ • Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2028)* • Number of outpatient, intensive outpatient, & partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2028)* **Note**: Partial hospitalization in KS has same service code as inpatient.
Ensure inpatient and residential providers improve care coordination and transition of care to the community [Secondary Driver 5].	• 30-Day Readmission for SUD treatment. (2017–2028)^ • ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2028)^ • ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2028)^ • Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2028)^ • Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2028)^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2028) • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2028) • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2028)

*Interrupted Time Series Design will be used for the assessment of the performance measure.
^Comparison of baseline year measurement with demonstration's final year measurement will be used for the assessment of the performance measure.

The comparison of percentages/rates between the years (using Fisher's exact or Pearson's chi-square tests) will be conducted for twelve performance measures. The trend analysis (using Mantel-Haenszel chi-square) will be done for twelve performance measures. The stratified analyses by demographic groups will be conducted for the performance measures as per data availability. Interrupted time series evaluation design will be used to evaluate three outcome and process measures related to the secondary drivers as per availability of data. The post-intervention observation period for three performance measures will be 2024 through 2028. The baseline measurement will be compared with the demonstration's final year measurement using Fisher's exact or Pearson's chi-square tests for the assessment of seven outcome and process measures. Three HEDIS measures (IET, FUA, and FUI) will be analyzed as described above (see Goal 2).

e. Evaluation Methodology for Substance Use Disorder Goal 5

Goal 5
Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Evaluation Question for Goal 5
Do enrollees receiving SUD services experience improved access to care for physical health conditions?

Evaluation Hypothesis for Goal 5
The demonstration will increase the percentage of beneficiaries with SUD who access care for physical health conditions.

Strategy for Goal 5
One strategy contributing to the primary and secondary drivers for Goal 5 will be implemented over the demonstration period:

- KanCare contracts with MCOs will focus on the integration of behavioral health and physical health among members with SUDs.
    - Care coordination includes health screening, health risk assessment, needs assessment, and development and implementation of service/treatment plan or person-centered service plan (PCSP).

The strategy described here will contribute to the following secondary driver, which in turn will lead to improved access to care for physical health conditions among members with OUD or other SUDs (primary driver for Goal 5):

- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy.

Drivers and Performance Measures for Goal 5

The evaluation of this goal involves assessment of five performance measures for its primary and secondary drivers. The primary and secondary drivers for Goal 5 and their associated performance measures are shown in Table 25.

Table 25. Drivers and Associated Performance Measures for Substance Use Disorder Goal 5	
Primary Driver	**Performance Measures**
Improve access to care for physical health conditions among members with OUD or other SUDs.	• Annual Dental Visits (ADV). (SUD stratum; 2016–2028)* • Child and Adolescent Well-Care Visits (WCV). (SUD stratum; 2019–2028)^ • Prenatal and Postpartum Care (PPC). (SUD stratum; 2019–2028)^
Secondary Driver	**Performance Measure**
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare program overall care coordination strategy [Secondary Driver 6].	• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2028)† • Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have Service/Treatment plan or PCSP. (2019–2028)†
*Test for Equality of Relative Improvement using reduction in the failure rate (RFR) will be used ^Interrupted Time Series Design or Test for Equality of Relative Improvement will be applied as appropriate for the data available for the performance measure. †One-group Pretest-Posttest Design will be used for the assessment of the performance measure. Note: Care Coordination Includes: *health screening, health risk assessment, needs assessment and development and implementation of service/treatment plan or person-centered service plan (PCSP)*	

The comparison of percentages/rates between the years (using Fisher's exact or Pearson's chi-square tests) and the trend analysis (using Mantel-Haenszel chi-square) will be done for all five performance measures. The stratified analyses by demographic groups will be conducted for the performance measures as per data availability. For four HEDIS measures (ADV, WCV, PPC – Timeliness of Prenatal Care (SUD stratum), and PPC – Postpartum Care (SUD stratum), the differences between rates, shown as percentage points (pp), will be tested for statistical significance using Pearson's chi-square. For ADV, a test for equality of relative improvement will be applied using reduction in the failure rate (RFR) between the Intervention Group comprised of members with SUD diagnosis and a Comparison Group comprised of member without SUD diagnosis. To ensure the intervention and comparison groups are comparable over time, the Test for Equality of Relative Improvement will be accompanied by monitoring for changes in the composition of these two groups. For other three HEDIS measures, either Test for Equality of Relative Improvement or Interrupted time series design will be applied as appropriate for the available data. Two measures related the secondary driver will be examined using the one-group pretest-posttest design. The post-intervention observation period for the analysis of both measures will be 2024–2028.

Qualitative Evaluation Methodology

Qualitative data will be obtained from SUD member and provider surveys. The main focus of both qualitative surveys is to gather the information on member and provider experiences related to different aspects of care provided through the demonstration, including access to and quality of care. It should be noted that like most qualitative studies, the statistical-probabilistic generalizability of the findings to the study populations is not an expected feature of SUD member and provider surveys.[13,14]

Evaluation Period

January 1, 2024 – December 31, 2028

Study Population

The study population for the member surveys will be KanCare members with SUD diagnosis receiving SUD services. The study population for the provider surveys will be the providers delivering treatment services to members with SUD diagnosis.

Data Sources

Table 26. Data Sources for Qualitative Evaluation – Substance Use Disorder		
Data Source	**Owner/Steward**	**Brief Description**
Member survey data	KanCare MCOs	Member responses to questions within MCO-fielded SUD surveys.
Provider Survey data	KFMC	KanCare provider responses resulting from Provider Surveys. Survey questions to be developed by KFMC with State feedback and approval.

SUD Member Survey

The SUD Member Survey has historically been fielded by the MCOs on an annual basis. MCOs will continue to conduct this survey from 2024 to 2028. The data for the survey questions contributing to the assessment of the demonstration's impact during its five-year implementation period will be analyzed using qualitative data analysis techniques.

The convenience survey methodology applied by the MCOs includes anonymously surveying KanCare members who accessed substance use disorder treatment about their overall satisfaction with their SUD treatment. The surveys are completed at time of service. The package with the instructions on how to administer and return the surveys, as well as printed surveys and prepaid postage envelopes are mailed by the MCOs to the provider groups. The number of mailed surveys in each packet are based on facility volume. The MCOs apply their own process for deciding the number of surveys to be sent to provider groups, but the same letter template is used across the MCOs. Completed surveys are mailed by the provider group to the respective MCO, and survey responses are shared between MCOs for the compilation of the survey results. As mentioned above, the survey results for questions presented that contribute to the assessment of the demonstration's impact will be reviewed and the patterns/themes will be derived. The information obtained from these patterns/themes will be summarized to provide insights regarding the demonstration's impact from the members' perspective.

SUD Provider Survey

KanCare provider feedback and experiences related to SUD services will be gathered through online surveys conducted twice during the demonstration period. The first survey will be conducted in 2026, and the second survey will be conducted in 2028. All KanCare SUD providers that served KanCare members in the respective survey years (identified from KMMS claims files) will be invited to participate in the surveys. These providers will be requested to complete the survey to give feedback on how well the demonstration is doing in providing different SUD treatment services, such as access to needed levels of care, medication assisted treatment, helping with transitions between levels of care, and coordination between physical health care and behavioral health care. The survey will include open-ended questions. Please note, probabilistic-statistical generalizability to the study population will not be the main focus of the survey. Based on the historical experiences from implementing such surveys, it is expected that by inviting all providers in the identified study population, the recurring experiences,

ideas, or opinions expressed by those completing the open-ended survey questions allows the identification of patterns and themes for deeper insights beyond numerical data.

The surveys will be conducted using appropriate software (such as Microsoft Forms). Letters and emails containing a link and QR code will be sent to the providers for online completion of the survey. A follow-up reminder postcard/email will also be sent. The number of completed surveys will be tracked during survey implementation using the software system's tracking tools. After survey closing dates, data will be retrieved from the software system, reviewed, and the patterns/themes will be derived. The information obtained from these patterns/themes will be summarized to provide insights regarding the demonstration's impact from the providers' perspective.

Analytic Methods

Qualitative data analysis techniques will be used to analyze data collected through the member and provider surveys. Data from member and provider surveys will be analyzed through theming and descriptive statistics, where appropriate. Research and professional ethics (informed consent, risk minimization, confidentiality, etc.) will be adhered to for all qualitative research.

The steps for qualitative data analysis will include

- Getting familiar with the data by looking for common observations and patterns;
- Developing a coding framework to identify broad ideas, concepts, behaviors, or phrases;
- Assigning codes for structuring and labeling data;
- Identifying themes, patterns, and connections to answer research questions; and
- Summarizing the qualitative information to add to the overall evaluation results.

Cost Evaluation Methodology

The investigation of costs is a separate but cross-cutting element of the SUD component of the demonstration evaluation. Cost studies investigate both granular (i.e., specific treatment costs) and macro aspects of the KanCare unique to the demonstration. The demonstration is designed to maintain budget neutrality while improving the effectiveness of services delivered to the Medicaid population. The intent of cost studies is not to identify statistically significant increases or decreases in program costs but to understand how spending within different categories may contribute to enhanced program effectiveness. This is, in large part, due to how Medicaid managed care capitation payments obscure true administrative spending versus a fee-for-service paradigm.

Cost Evaluation Goal, Question, and Hypothesis

Goal for Cost Evaluation

Improved impact of the KanCare program via provision of a full continuum of services for SUD treatment to members.

Cost Evaluation Question

Does the demonstration maintain or decrease total KanCare SUD expenditures?

Cost Evaluation Hypothesis

The demonstration will maintain or decrease total KanCare SUD expenditures.

Demonstration Strategies' Relationship to the Cost Evaluation

Each of the strategies within the Evaluation Methodology – Substance Use Disorder section that support

the primary and secondary drivers are also utilized in the investigation of program costs. The outcomes of these strategies are anticipated to contribute to enhanced program efficiency and effectiveness. Enhancements to efficiency may include reductions to admissions (or readmissions) and other burdens related to treatment of preventable or medically inappropriate encounters as well as any other outcomes which reduce unnecessary utilization or duplication of efforts. This may also shift costs associated with the transition from formal treatment to community recovery services.

Study Population

The study population for the cost measures will include KanCare members with a SUD diagnosis and a SUD treatment during the measurement period or in the 12 months before the measurement period (based on paid claims).

Evaluation Period

2017–2028 will be the evaluation period.

Analytic Plan

Cost measures will be trended across three time periods: 2017–2019 baseline, 2022–2023 post COVID–19, and 2024–2028 demonstration years. The slopes of trendlines will be calculated. Costs may be adjusted for inflation using national inflation rates or by recalculating costs based on the Kansas Medicaid fee schedule for a fixed year.

Cost Evaluation Measures

The cost evaluation measures are stratified in two interrelated categories of cost drivers, both expressed in terms of dollars per member per month ($PMPM):

- Type-of-Care Cost Drivers (Table 27) – treatment costs for members with SUD diagnosis, stratified by types of care using claims data
- Diagnosis and Treatment Cost Drivers (Table 28) – treatment costs for members, stratified by services rendered within or not within IMDs, and other SUD-related costs for members with and without SUD diagnoses

Note, the State tracks administrative costs for the entire Kansas Medicaid program but does not allocate costs specific to the 1115 demonstration. Similarly, managed care administrative expenses are not tracked specifically to the 1115 demonstration within KanCare. Thus, due to unavailability of data, the category Total KanCare SUD Costs (treatment costs from the cost drivers listed above as well as administrative costs associated with the demonstration) will not be studied.

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Table 27. Type-of-Care Cost Drivers	
Measure Description	**Numerator and Denominator Specification**
ED Outpatient SUD spending during the measurement period. Expressed in dollars per member per month ($PMPM).	**Numerator**: Spending on SUD treatment services in emergency department (ED) outpatient settings during the measurement period. (CMS Metric #28, outpatient ED stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only)
Non-ED Outpatient SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services and peer support in non-ED outpatient settings during the measurement period. (CMS Metric #28, non-ED outpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only)
Inpatient and residential SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services in inpatient and residential settings during the measurement period. (CMS Metric #28, inpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only)
Pharmacy SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD pharmaceuticals during the measurement period. (CMS Metric #28, pharmaceutical stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only)
Total KanCare SUD treatment spending on beneficiaries with SUD diagnosis during the measurement period. ($PMPM)	**Numerator:** The sum of all Medicaid spending on SUD treatment and peer support services during the measurement period. (CMS Metric #28)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only)

Table 28. Diagnosis and Treatment Cost Drivers	
Measure Description	**Numerator and Denominator Specification**
SUD spending on inpatient/ residential services and pharmaceuticals within IMDs during the measurement period. Expressed in dollars per member per month ($PMPM). [CMS Metric #31]	**Numerator**: Spending on treatment or peer support for SUD within IMDs during the measurement period. (CMS Metric #29, exclude room and board)
	Denominator: Number of beneficiaries with a claim for treatment or peer support for SUD in an IMD during the reporting year. (CMS Metric #5, paid service or pharmacy claims only)
SUD spending on services other than within IMDs during the measurement period. ($PMPM) [CMS Metric #30]	**Numerator**: Spending on SUD treatment or peer support services *not within IMDs* during the measurement period. (CMS Metric #28, non-IMD stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only, non-IMD stratum)
SUD spending on SBIRT services for beneficiaries without SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: Spending on SUD *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) for beneficiaries *without a SUD diagnosis and not within IMDs* during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	Denominator: Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only, non-IMD stratum)
SUD spending on assessment services for beneficiaries without SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: Spending on SUD assessment for beneficiaries *without a SUD diagnosis and not within IMDs* during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	Denominator: Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only, non-IMD stratum)
Total KanCare SUD treatment spending during the measurement period. ($PMPM)	**Numerator**: The sum of all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (CMS Metric #28, includes non-SUD diagnosis stratum)
	Denominator: Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. (CMS Metric #4, paid claims only, includes non-SUD diagnosis stratum)

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G. Methodological Limitations – Substance Use Disorder

Evaluation Design Limitations

The demonstration evaluation has a strong reliance upon quasi-experimental ITS, and the Test for Equality of Relative Improvement, as well as non-experimental OGPP designs. Therefore, the resultant pre- and post-test evaluation design or comparisons to baselines may not imply causality due to a specific intervention. Further, the reliance upon non-experimental methods for the SUD component's demonstration hypothesis will inhibit interpretations and conclusions from investigation in changes to Kansas' IMDs. Lastly, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Every attempt to ensure quality data and analysis will be made for observed limitations to the evaluation design.

Study Population Limitations

As noted previously, the lack of true comparison groups due to state-wide implementation is a major limitation in evaluating the demonstration in the SUD component. Potential internal comparison groups are also limited in their ability to generalize to the study population. Choices of external comparison groups are limited to states without SUD 1115 Demonstrations that have similar beneficiary characteristics and Medicaid programs as Kansas (e.g., non-Medicaid expansion, similar MCO penetration rates, SUPPORT Act and other opioid disaster response interventions, SUD provider availability). Changes to the beneficiary characteristics or Medicaid programs of the comparison state during the demonstration period will further affect comparability.

When available, subgrouping of members within a strategy's target population will be performed. Therefore, there is a possibility of encountering methodological issues that will require application of appropriate techniques. Methodological issues may include selection bias (e.g., differences between those who may opt-in versus those who may not); spillover effects; multiple treatment threats due to other interventions; effect of confounding variables; inadequate statistical power; and other issues inherent within experimental comparisons and inferences. Appropriate techniques will be applied to address these issues as much as possible.

Over the five-year period, eligibility for receiving Medicaid services may change for some members and they may not be part of intervention or comparison groups. Additionally, the SUD diagnosis status of members may change over time, and certain members may receive SBIRT or assessments even without diagnosis. These issues will be monitored and addressed accordingly by applying appropriate techniques (intent-to-treat analysis; exclusion from analysis, etc.).

Data Source Limitations

The use of administrative claims and encounters data sources for performance measures can be a limitation when used to determine changes in access to services, quality of care, and health outcomes. However, many of the performance measures are validated and stewarded by nationally recognized bodies such as NCQA and widely used for these purposes. While administrative data may identify key cases and statistical trends in performance, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates influencing performance.

Data lag for some data sources (e.g., mortality rates) also causes a challenge in measuring and reporting change in a timely manner. This can affect the availability of data for conducting the evaluation for the entire evaluation period of the demonstration.

As the evaluation is based on a 12-year period (2017–2028), the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period following administrative rule or other policy changes, thus leading to unavailability of appropriate data for the analysis of multiple pre- and post- intervention evaluation points needed for comparative interrupted time series and one-group pretest-posttest designs.

An additional challenge specific to cost data is inflation. General rising healthcare costs will impact trending of claim payments. Adjusting costs rates using national inflation rates may be possible. Calculating expenditures based on the Medicaid fee schedule for a specific year may also mitigate this challenge.

From a qualitative perspective, limitations may exist in the collection and coding of open-ended questions and comments. These include limitations to the accuracy and precision of data obtained through primary data collection as well as the extent to which interpretations and conclusions may be made. As the SUD member satisfaction surveys are administered independently by each MCO using a convenience survey methodology, the results are not generalizable to the study population. Also, the analysis across the KanCare program may not be feasible if survey designs, or fielding, differ significantly between one or more of the MCOs. The results of the SUD provider surveys may not be generalizable to the study population due to low response rates. Also, the open-ended responses may not clearly communicate the respondent's intended message.

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H. Attachment – Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), KFMC Health Improvement Partners (KFMC), to conduct the evaluation of the KanCare Section 1115(a) Demonstration's components—the maintenance of 12-month continuous eligibility for parents and caretakers and the Substance Use Disorder demonstration. They have agreed to conduct the demonstration components' evaluation in an independent manner. KFMC has over 52 years of demonstrated success in carrying out both Federal and State healthcare quality related contracts. They have provided healthcare quality improvement, program evaluation, review, and other related services including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (29 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (42 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (24 years) and for seven other states.

KFMC is accredited as an Independent Review Organization (IRO) through URAC (formerly known as the Utilization Review Accreditation Commission). The URAC Accreditation process is a rigorous, independent evaluation, ensuring that organizations performing IRO services are free from conflicts of interest and have established qualifications for reviewers. KFMC considers ethics and compliance an integral part of all their business decisions and the services they provide. The KFMC Corporate Compliance Program supports the commitment of KFMC to conduct its business with integrity and to comply with all applicable Federal and State regulations, including those related to organizational and personal conflicts of interest. The KFMC compliance program ensures potential, apparent, and actual organizational and personal conflicts of interest (PCI) will be identified, resolved, avoided, neutralized, and/or mitigated.

Prior to entering into any contract, KFMC evaluates whether the identified entity or the work presents an actual, potential, or apparent organizational conflict of interest (OCI) with existing KFMC contracts. KFMC will not enter into contracts that are an OCI. If it is undetermined whether the new work could be a conflict of interest with their EQRO and independent evaluation responsibilities, KFMC will discuss the opportunity with KDHE, to determine whether a conflict would exist. In some cases, an approved mitigation strategy may be appropriate.

All Board members, managers, employees, consultants, and subcontractors receive education regarding conflicts of interest and complete a CMS developed PCI Disclosure Form. Disclosures include the following:

- Relationships with insurance organizations or subcontractor of insurance organizations
- Relationships with providers or suppliers furnishing health services under Medicare
- Financial interests in health care related entities
- Investments in medical companies, healthcare, or medical sector funds
- Governing body positions

H. Attachment (Continued) – Timeline and Major Milestones

Timeline for Evaluation and Major Milestones for the KanCare Section 1115(a) Demonstration

The timelines and major milestones for the two evaluation components of the KanCare Section 1115(a) Demonstration are described in Table 29 and Table 30.

Table 29. Timeline and Major Milestones – Parents and Other Caretaker Relatives

Evaluation Activity and Major Milestone	Due Date
Finalize technical specifications for study population and performance measures.	December 2025
Provide updates during routine quarterly EQRO/State/MCO meetings to review and discuss data sources, reports, and findings as applicable.	Quarterly (already in progress)
Qualitative Member Survey, and MCOs and State Staff Questionnaire: • Member Surveys: Conduct online survey and analyze data. • MCOs and State Staff Questionnaire: Collect and analyze data.	• Data collection on quarterly basis during 2026, 2027 and 2028; Data analysis in 2029. • Data collection during 2026, 2027 and 2028; Data analysis in 2029.
Draft Interim Evaluation Report in accordance with Attachment B (Preparing the Evaluation Report) of the Demonstration's STCs; Report will present and discuss evaluation findings to date.	December 2027 (one year prior to the end of the demonstration, or with renewal application)
Revised Interim Evaluation Report	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment B of the Demonstration's STCs.	June 2030 (18 months from the end of the demonstration)
Revised Summative Evaluation Report.	60 calendar days after receipt of CMS comments

Table 30. Timeline and Major Milestones – Substance Use Disorder

Evaluation Activity and Major Milestone	Due Date
Finalize technical specifications for study population and performance measures.	December 2025
Provide updates during routine quarterly EQRO/State/MCO meetings to review and discuss data sources, reports, and findings as applicable.	Quarterly (already in progress)
Qualitative surveys: • Provider Surveys: Conduct online surveys and analyze data • SUD Member Satisfaction Surveys (conducted by MCOs): Analyze data from annual surveys	• Provider Surveys: June 2026 (for Interim evaluation); and September 2028 (for Summative evaluation) • Member Surveys: After receipt of the survey reports from MCOs.
Draft SUD Mid-point Assessment Report to the State	December 31, 2026
SUD Mid-point Assessment Report to CMS	March 1, 2027 (No later than 60 calendar days after December 31, 2026.)
Revised SUD Mid-point Assessment	60 days after receipt of CMS comments
Draft Interim Evaluation Report in accordance with Attachment B (Preparing the Evaluation Report) of the Demonstration's STCs; will present and discuss evaluation findings to date.	December 2027 (one year prior to the end of the demonstration, or with renewal application)
Revised Interim Evaluation Report	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment B of the Demonstration's STCs.	June 2030 (18 months from the end of the demonstration)
Revised Summative Evaluation Report.	60 calendar days after receipt of CMS comments

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