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

June 30, 2020

Christiane Swartz
Interim Medicaid Director
Kansas Department of Health and Environment
900 SW Jackson, Suite 900 N
Topeka, KS 66612

Dear Ms. Swartz:

The Centers for Medicare & Medicaid Services (CMS) has approved the evaluation design for the substance use disorder (SUD) component of Kansas's section 1115 demonstration entitled, "KanCare" (Project Number 11-W-00283/7), and effective through December 31, 2023. We sincerely appreciate the state's commitment to a rigorous evaluation of your demonstration.

CMS has added the approved SUD evaluation design to the demonstration's Special Terms and Conditions (STC) as Attachment S. A copy of the STCs, which includes the new attachment, is enclosed with this letter. The approved evaluation design may now be posted to the state's Medicaid website within thirty days, per 42 CFR 431.424(c). 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 renewal 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.

We look forward to our continued partnership with you and your staff on the Kansas KanCare demonstration. If you have any questions, please contact your CMS project officer, Michael Trieger. Mr.Trieger may be reached by email at Michael.Trieger1@cms.hhs.gov.

Sincerely,

Danielle Daly -S
Digitally signed by Danielle Daly -S
Date: 2020.06.24 08:47:45 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2020.06.30 08:01:37 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

cc: Michala Walker, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

Revised per CMS Feedback

May 22, 2020

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KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

A. General Background Information

The State of Kansas submitted the KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Implementation Plan ("Implementation Plan") to the Centers for Medicare & Medicaid Services (CMS) on June 14, 2019.[1] CMS approved the Implementation Plan on August 20, 2019, for the period of January 1, 2019 through December 31, 2023.[2]

The Implementation Plan is in alignment with the goals and objectives of the state's mandatory Medicaid managed care program: *KanCare*. The Implementation Plan outlines the State's strategy to provide a full continuum of services for SUD treatment to KanCare members. The KanCare program was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years and CMS approved a one-year extension on October 13, 2017. The State submitted the Section 1115 demonstration renewal application for the KanCare program, titled "KanCare 2.0," in December 2018.[1] CMS approved the renewal of the KanCare 2.0 demonstration for the period of January 1, 2019 through December 31, 2023.[3] KanCare 2.0, an integrated managed care program, serves populations covered by the Kansas Medicaid and Children's Health Insurance Programs (CHIP) through a coordinated approach. KanCare 2.0 is designed to provide efficient and effective health care services and to ensure coordination of care and integration of physical health (PH) and behavioral health (BH) services and Home and Community Based Services (HCBS). KanCare operates concurrently with the State's section 1915(c) HCBS waivers and together provides the authority necessary for the State to require enrollment of almost all Medicaid members (including the aged, people with disabilities, and those with dual Medicare-Medicaid eligibility) across Kansas into a managed care delivery system to receive state plan and waiver services.[3]

KanCare 2.0 provides access to all critical levels of care for SUD and opioid use disorder (OUD).[1,3] The State of Kansas contracts with three statewide managed care organizations (MCOs) to provide access to a range of services across much of the American Society of Addiction Medicine (ASAM) levels of care. The KanCare criteria for treatment are a fidelity-based adaptation of the ASAM Patient Placement Criteria. The Kansas Department for Aging and Disability Services (KDADS) provides required licenses to KanCare-enrolled SUD treatment providers. KanCare 2.0 delivers the outpatient benefits pursuant to the service requirements in the Kansas Medicaid State Plan.[1] The State Plan requires the provision of inpatient and detoxification (withdrawal management) services in State-certified facilities. The spectrum of care – which includes outpatient treatment, peer recovery support, intensive outpatient services, medication-assisted treatment (MAT), intensive inpatient services, withdrawal management, and residential treatment – is provided to eligible Medicaid and CHIP recipients who need SUD or OUD treatment.[1] MCO network providers include specialty providers such as designated women's treatment programs, which offer prenatal services for women and children. KanCare 2.0 requires the provision of person-centered case management, as a one-on-one goal-directed service for individuals with a SUD, to assist individuals in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO.[3] Additionally, KanCare will cover methadone for MAT as required by the SUPPORT Act during the 2020, though coverage was explored in 2019. Through the Implementation Plan, Kansas will amend state licensing standards to include the requirement that all inpatient residential treatment centers, including all those currently excluded as Institutions for Mental Disease (IMDs), provide access to MAT through direct provision or by coordinated referral and treatment initiation to a MAT provider.[1]

CMS's July 2016 regulation (Federal Rule 42 C.F.R. 438.6(e) as amended) prohibits the State from claiming federal financial participation for a monthly payment made by the State to a member's MCO responsible for all care of the member when the member's stay in an IMD is longer than 15 days during any given month. This exclusion causes a loss of Medicaid coverage for members requiring inpatient psychiatric care and limits provider innovation.[3] In its renewal application for KanCare 2.0, the State requested and received approval from CMS for a waiver of the authority to provide coverage under KanCare 2.0 for otherwise-covered services provided to Medicaid-eligible individuals aged 21 through 64 who are enrolled in a Medicaid MCO and who are receiving services in a publicly-owned or non-public IMD.[3,4] This approval will enable the State of Kansas to better address OUD and other SUDs and will assist the SUD program to improve access to high-quality addiction services that are critical to addressing SUD in the state. Under this program, all Medicaid members will continue to have access to all current mental health and SUD benefits. In addition, all members ages 19 through 64 will have access to additional covered services, authorized under section 1115(a)(2) of the Social Security Act, including SUD treatment services provided to individuals with SUD who are short-term residents in residential treatment facilities that meet the definition of an IMD. These services would otherwise be excluded from federal reimbursement due to the statutory restrictions on coverage of services provided in an IMD setting.[3,4]

KanCare 2.0 Section 1115 SUD Demonstration Goals

Kansas will use the 1115 demonstration authority to pursue the following goals to improve access to and quality of treatment for KanCare 2.0 program members with SUD:

1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.
2. Reduced utilization of emergency departments (EDs) 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.

B. Evaluation Questions and Hypotheses

KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

The following driver diagram for the overall SUD demonstration (Figure B-1) 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.

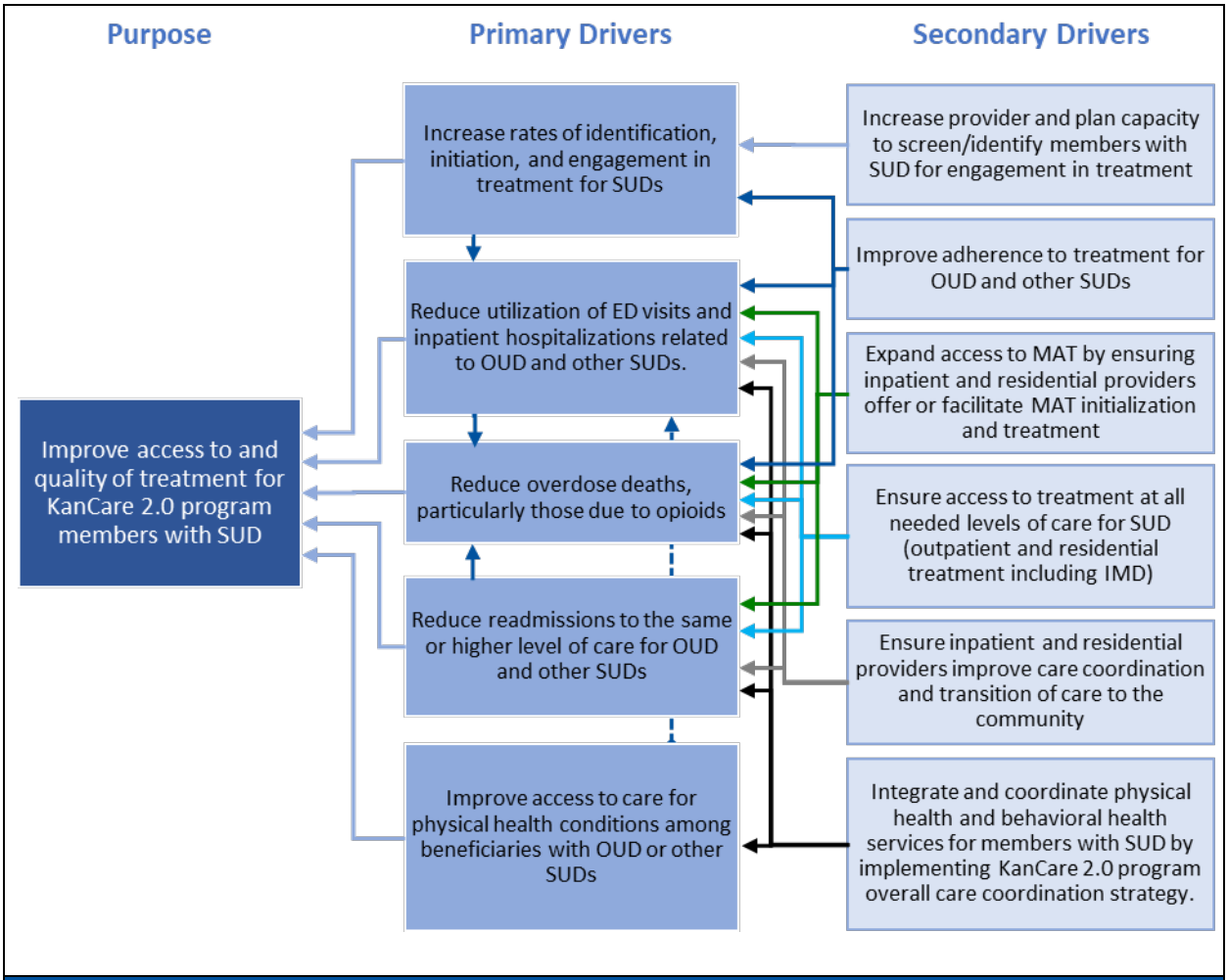

Figure B-1. KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

KanCare 2.0 Section 1115 SUD Demonstration Goals, Evaluation Questions and Hypotheses

As the focus of the KanCare 2.0 Section 1115 SUD Demonstration evaluation is to examine whether the demonstration achieved its goals, the following proposed evaluation questions are designed in alignment with the five goals and related hypotheses (Table B-1). This evaluation is in accordance with the CMS document, "SUD, Section 1115 Demonstration Evaluation Design, Technical Assistance," provided on March 6, 2019.[5]

Table B-1. KanCare 2.0 Section 1115 SUD Demonstration Goals, Evaluation Questions, and Hypotheses		
Goals	**Evaluation Questions**	**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. Are rates of opioid-related overdose deaths impacted by the demonstration?	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.

KanCare 2.0 Demonstration Hypothesis 4 (*associated with SUD Demonstration Evaluation Design Question 1*)

Within the CMS' November 18, 2019 review of the Kansas KanCare 2.0 Section 1115 Demonstration Evaluation Design, CMS noted that removing payment barriers for services provided in IMDs for KanCare members was a strategy in both the KanCare 2.0 Demonstration and SUD Demonstration.[6] To avoid duplicating evaluation for the activity, CMS recommended that the State remove evaluation of Hypothesis 4 and related questions from that evaluation design and address those components within the evaluation of the SUD Demonstration. Thus, the KanCare 2.0 Demonstration Hypothesis 4 has been reproduced within this document (see Table B-2 and Table B-15 and Subsection C.f).

Table B-2. KanCare 2.0 Section 1115 Demonstration Hypothesis 4 and Evaluation Question	
KanCare 2.0 Demonstration Hypothesis 4	**Evaluation Question for KanCare 2.0 Demonstration Hypothesis 4**
Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.	Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?

This evaluation question corresponds to the SUD Demonstration Evaluation Question 1, "Does the demonstration increase access to and utilization of SUD treatment services?"

KanCare 2.0 Section 1115 SUD Demonstration Process and Outcome Summary

As shown in the driver diagram for the overall SUD Demonstration (Figure B-1, above), the five *primary drivers* and six *secondary drivers* support the hypotheses for the five evaluation questions to the performance of the SUD Demonstration. An additional question related to KanCare 2.0 Demonstration Hypothesis 4, as a part of the first evaluation question, will also be examined within the SUD Demonstration evaluation. The hypotheses for the five SUD Demonstration evaluation questions, as well as the evaluation question for KanCare 2.0 Demonstration Hypothesis 4, will be assessed according to both processes and outcomes of the SUD Demonstration. Measures which may be investigated for inclusion of comparison groups are noted as 'candidate measures' within Analytic Approach. The SUD Demonstration evaluation questions and hypotheses are matched to their respective drivers and measure details within the following tables:

- Tables B-3 to B-7 provide information on the *outcome evaluation component* of the SUD Demonstration Evaluation Design according to the five primary drivers;
- Tables B-8 to B-14 provide information on the *process evaluation component* of the SUD Demonstration Evaluation Design according to the six secondary drivers; and
- Table B-15 provides information specific to *KanCare 2.0 Demonstration Hypothesis 4*.

Outcome Evaluation – Primary Drivers

Table B-3. 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; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
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; ITS design; Trend analysis

Table B-4. 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	MMIS Encounter data from MCOs; State Medicaid Eligibility and Enrollment data	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
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; ITS design; Trend analysis
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; ITS design; Trend analysis; *candidate for block grant comparison*
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; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-5. 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: *Are rates of opioid-related overdose deaths impacted by the demonstration?*

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); State Medicaid Eligibility and Enrollment data	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2022) and baseline year (2019).
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.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
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	MMIS Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2018).

Table B-6. 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)	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2); *candidate for block grant comparison*
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)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-7. 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	Descriptive statistics; ITS design; Trend analysis
Adults' Access to Preventive/ Ambulatory Health Services (AAP) (SUD stratum).	NCQA	Eligible beneficiaries 20 years and older with SUD diagnosis enrolled in Medicaid	Number of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Adolescent Well-Care Visits (AWC) (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; ITS design; Trend analysis
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; ITS design; Trend analysis
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 b/w 7 & 84 days after delivery.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Process Evaluation – Secondary Drivers

Table B-8. 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**
Percentage of physical health and behavioral health service providers that billed SBIRT services.	None	The number of distinct performing provider NPIs on claims. Measured on dental, outpatient and professional claims; see policy for provider types.	The number of distinct performing provider NPIs on claims for *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) services	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Receipt of care for SUD 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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-9. 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.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).	NCQA	ED visits for members ~~years of~~ age 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; ITS design; Trend analysis; *candidate for block grant comparison*
* 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)					

Table B-9. Summary of Measures and Analytic Approach for Secondary Driver 2 (*Process Evaluation*) (cont.)

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*	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
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*	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
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)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis

* 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)

Table B-10. 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 OUD discharges with MAT claim	None	Number of residential discharges for SUD treatment with 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; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; *candidate for block grant or rural/urban comparison*
Inpatient OUD discharges with MAT claim	None	Number of inpatient discharges for SUD treatment with 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; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; *candidate for block grant or rural/urban comparison*
Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period	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).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis via Mantel-Haenszel (MH) chi-square test; *candidate for block grant or rural/urban comparison*

Table B-11. 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).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
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).	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-12. 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.	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2) ; *candidate for block grant comparison*
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	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
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.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
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; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-13. 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
Follow-Up After High-Intensity Care for SUD (FUI)	NCQA	# of inpatient hospitalizations, residential treatment or detoxification visits for a SUD diagnosis among members age 13 or older	# 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; Trend analysis; Differences between final and baseline years (Fisher's Exact or X^2)
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; ITS design; Trend analysis

Table B-14. 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 2.0 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; Trend analysis (Mantel-Haenszel X^2); Differences between final and baseline years (Fisher's Exact or X^2)
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; Trend analysis

KanCare 2.0 Section 1115 Demonstration Hypothesis 4 Evaluation

Table B-15. Summary of Measures and Analytic Approach for KanCare 2.0 Section 1115 Demonstration Hypothesis 4

KanCare 2.0 Section 1115 Demonstration Hypothesis 4: ***Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved member access to substance use disorder (SUD) treatment services.***

KanCare 2.0 Hypothesis 4 Evaluation Question: *Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services?*

Performance Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Number of IMDs providing SUD services.	None	NA	Number of IMDs providing SUD services.	Provider Network reports; MMIS Encounter data; Provider licensing data; MCO utilization reports.	Descriptive statistic (count).
Number of geographic locations by region for SUD treatment in IMDs.	None	NA	Number of geographic locations by Kansas Department for Children and Families (DCF) region for SUD treatment in IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (count).
Number of admissions with SUD treatment services in IMDs.	None	NA	Number of admissions with SUD treatment services in IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (count).
Average length of stay for SUD treatment services within IMDs.	None	NA	Average length of stay for SUD treatment services within IMDs.	Network reports, encounter data, licensing data, utilization reports	Descriptive statistic (average).

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")[7];
- *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)[8]; and
- *Healthcare Effectiveness Data and Information Set®* (HEDIS) measures.[9]

C. Evaluation Design Methodologies

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 helping Medicaid members with SUD to have improved access to and quality of treatment.
The following sections present an overview of methods and rationale for the Demonstration evaluation, followed by sections detailing evaluation questions, evaluation hypotheses, and strategies for each goal of the Demonstration as well as the KanCare 2.0 Program Hypothesis 4 and the overall cost evaluation. See **Attachment 1- Detailed Design Methodology and Limitations** for additional methods discussions.

Evaluation Design Overview

Evaluation of the Demonstration is primarily focused on the subset of KanCare 2.0 members with a SUD diagnosis will be the primary participants ("study population"). 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. Due to state-wide implementation of the SUD Demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups as all KanCare 2.0 members will be eligible for the same benefits. Several potential comparison populations have been identified that may provide additional perspective for certain measures or drivers, such as the Beacon program block grant recipients (external comparison) and an internal comparison of access between rural and urban regions of the state (see Attachment 1). Target and comparison populations for each goal are described within that goal's evaluation methodology, discussed in the sections below.

The difference-in-differences evaluation design was considered for use with identified internal or external comparison populations but was ultimately determined to be infeasible due to lack of comparability of populations (see Attachment 1). To address those limitations, the **Interrupted Time Series** (ITS) and **One-Group Pretest-Posttest** (OGPP) evaluation designs will be used throughout the majority of the evaluation. The evaluation of KanCare 2.0 Hypothesis 4 focuses on increasing availability of IMD facilities providing SUD services following the removal of the Kansas Medicaid IMD Exclusion. Though, 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 KanCare 2.0 Hypothesis 4. 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. Further discussions on how to best evaluate SUD Demonstration costs will be held to determine alternative approaches such as a "shadow pricing" retrospective cost analysis.

Interrupted Time Series (ITS) Evaluation Design

The ITS 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. The quasi-experimental ITS evaluation design was selected for Evaluation Hypothesis 1 and the Demonstration Cost Hypothesis, in their entirety, and for subsets of Evaluation Hypotheses 2 through 5. As shown in Figure C-1, below, the two-year baseline measurements will be for years 2017–2018 and the five-year intervention period will span 2019–2023.

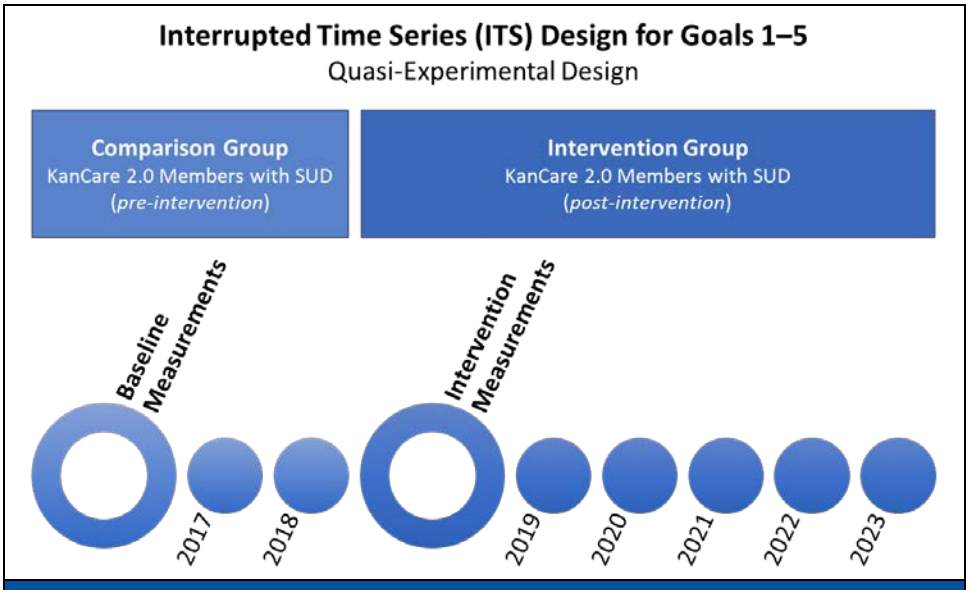

Figure C-1. Interrupted Time Series Evaluation Design for Evaluation of KanCare SUD Demonstration

We will estimate ITS models using the following 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.

One Group Pretest-Posttest (OGPP) Evaluation Design

As some demonstration strategies are currently in development (subject to State guidelines and approval) and appropriate comparison groups may not be available, the OGPP non-experimental evaluation design will 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. Where possible, the quasi-experimental OGPP with non-equivalent comparison groups will be applied with an appropriate comparison group and pre- and post-intervention data. The OGPP evaluation design was selected to examine the evaluation questions for subsets of Hypotheses 2 through 5. As shown in Figure C-2, below, the one-year baseline pretest measurement will be taken from 2019 and the four-year posttest period will span 2020–2023.

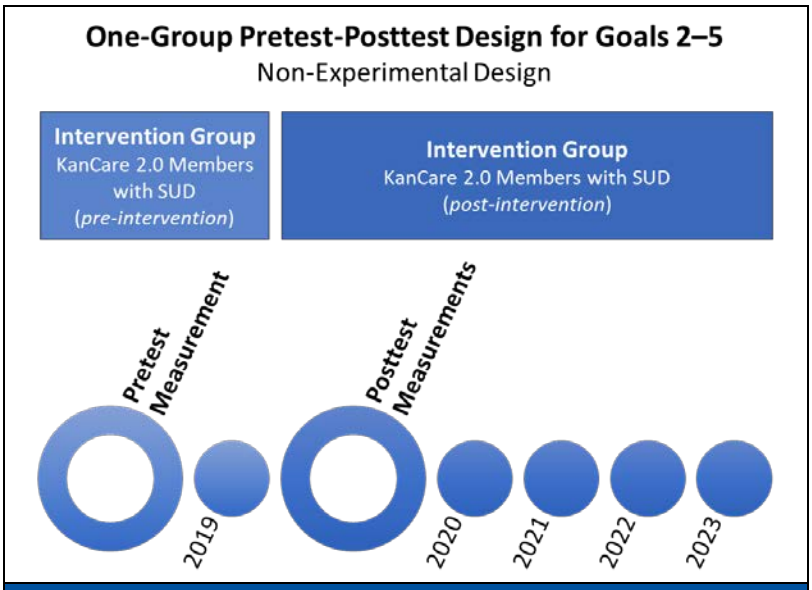

Figure C-2. One-Group Pretest-Posttest Evaluation Design for Evaluation of KanCare SUD Demonstration

a. Evaluation Methodology for SUD Demonstration Goal 1

Demonstration Goal 1

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

Evaluation Question for Goal 1

Does the demonstration increase access to and utilization of SUD treatment services?

Evaluation Hypothesis for Goal 1

The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.

Demonstration Strategies for Goal 1

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

- 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; and
  - Working with the MCOs to increase the utilization of SBIRT.
- Run 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 (SOR) grant).

The two strategies described here will contribute to the following two 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 1).

Drivers and Performance Measures for Goal 1

The primary and secondary drivers for Goal 1 and their associated performance measures are shown in Table C-1.

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Table C-1. Drivers and Associated Performance Measures for SUD Demonstration 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). (2017–2022)*
Secondary Drivers	**Performance Measures**
Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment.	• Percentage of physical health and behavioral health service providers that billed *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) services. (2017–2023)* • Receipt of care for SUD and/or OUD after SBIRT service. (2017–2023)*
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2017–2023)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*† • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*^ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*^ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period.*
* 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) † Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients).	

All eight performance measures will be examined using the interrupted time series design. The post-intervention observation period for six performance measures will be 2019 through 2023. The remaining two performance measures are based on HEDIS data (IET and FUA). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (IET and FUA) will be 2019 through 2022. The FUA measure may be investigated for feasibility of comparison group analysis (Beacon block grant recipients).

b. Evaluation Methodology for SUD Demonstration Goal 2:

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 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.

Demonstration Strategies for Goal 2

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

- 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.
- Expansion of medication-assisted treatment (MAT). This includes:
  - Changing licensing requirements for all residential providers
  - 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
  - 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); and
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 6).

Drivers and Performance Measures for Goal 2

The evaluation of this goal involves assessment of twenty-five performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate twenty-two outcome and process measures related to the primary and secondary drivers, whereas one-group pretest–posttest design will be used to examine three process measures related to its secondary drivers. The primary and secondary drivers for Goal 2 and their associated performance measures are shown in Table C-2.

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration 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; 2017–2023)* • ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2013)* • Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2023)*^ • Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*^ • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*[†] • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*[†] • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)*
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	• Residential OUD discharges with MAT claim. (2017–2023)^[‡] • Inpatient OUD discharges with MAT claim. (2017–2023) ^[‡] • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)*^
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).	• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)* • Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)* • Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)* • Number of outpatient, intensive outpatient, & partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis.(2017–2023)* **Note**: *Partial hospitalization in KS has same service code as inpatient*.
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). [†] 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). [‡] One-group Pretest–Posttest Design will be used for the assessment of the performance measure.	

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration Goal 2 (cont.)	
Secondary Driver	**Performance Measures**
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	• 30-Day Readmission for SUD treatment. (2017–2023)*^ • ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)* • ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)* • Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)*^ • Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)*^ • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2022)* • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)‡
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy	• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)‡ • 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). (2019–2023)‡
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). [†] 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). ‡ One-group Pretest–Posttest Design will be used for the assessment of the performance measure.	

Twenty-two performance measures will be examined using the interrupted time series design. The post-intervention observation period for nineteen performance measures will be 2019 through 2023. The remaining three performance measures are based on HEDIS data (FUA and IET). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (FUA and IET) will be 2019 through 2022.

Three process measures will be examined using the one group pretest–posttest design. The post-intervention observation period for two performance measures will be 2019 through 2023. The remaining one performance measure is based on HEDIS data (FUI). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for this performance measure (FUI) will be 2019 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients) and MAT claim measures (Beacon recipients and rural/urban comparisons).

c. Evaluation Methodology for SUD Demonstration Goal 3:

Demonstration Goal 3

Reduction in overdose deaths, particularly those due to opioids.

Evaluation Question for Goal 3

Are rates of opioid-related overdose deaths impacted by the demonstration?

Evaluation Hypothesis for Goal 3

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

Demonstration Strategies for Goal 3

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

- 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 in 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 2.0 program overall care coordination strategy (Secondary Driver 5).

Drivers and Performance Measures for Goal 3

The evaluation of this goal involves assessment of eighteen performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate fifteen outcome and process measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine three outcome and process measures related to Goal 3's primary and secondary drivers. The primary and secondary drivers for Goal 3 and their associated performance measures are shown in Table C-3.

Table C-3. Drivers and Associated Performance Measures for SUD Demonstration Goal 3	
Primary Driver	**Performance Measures**
Reduce overdose deaths, especially those due to opioids.	• Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2022)* • Use of Opioids at High Dosage in Persons without Cancer. (CMS Metric #18; 2017–2023)^ • Concurrent Use of Opioids and Benzodiazepines. (CMS Metric #21; 2018–2023)*
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^† • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)^
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	• Residential OUD discharges with MAT claim. (2017–2023)^† • Inpatient OUD discharges with MAT claim. (2017–2023)^† • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)^†
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	• 30-Day Readmission for SUD treatment. (2017–2023)^† • ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23). (2017–2023)^ • ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2023)^ • Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2023)^† • Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2023)^† • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^† • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2022)^ • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)*
* One-group pretest–posttest design will be used for the assessment of the performance measure. ^ Interrupted time series design will be used for the assessment of the performance measure. † Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). ‡ 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).	

Fifteen performance measures will be examined using the interrupted time series design. The post-intervention observation period for twelve performance measures will be 2019 through 2023. The post-intervention period for three performance measures are based on HEDIS data. Since HEDIS data for 2023 is not expected to be available for analysis, the post-intervention observation period for the

performance measures based on HEDIS data will be 2019 through 2022.
Three outcome measures will be examined using the one-group pretest–posttest design. The evaluation periods will vary by measure, as discussed below.

The baseline observation period for the Concurrent Use of Opioids and Benzodiazepines measure will be 2018; the post-intervention data points will be 2019 through 2023.

The Opioid Drug Overdose Deaths measure of overdose deaths due to any opioid is related to the primary driver of this goal. Currently, KDHE is in the process of developing a warehouse, "HealtheIntent Data Warehouse," to link birth and death data to Medicaid members. The development of this warehouse will assist in death-Medicaid data linking. This system will be used to provide data for calculating the rates of overdose deaths due to any opioid. It is anticipated that these data will be available for 2019 through 2022 for analysis; therefore, the one-group pretest–posttest evaluation design will be used. If this system can provide opioid overdose death data for the years 2017 and 2018, then the interrupted time series design will be applied to examine this measure.

Follow-Up After High-Intensity Care for SUD (FUI) became a HEDIS measure starting with measurement year 2019. Since HEDIS data for 2023 may not be available for analysis, the pre-intervention year for FUI will be 2019, and the post-intervention period will be 2020 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients) and MAT claim measures (Beacon recipients and rural/urban comparisons).

d. Evaluation Methodology for SUD Demonstration Goal 4

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 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.

Demonstration Strategy 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 in 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 2.0 program overall care coordination strategy.

Drivers and Performance Measures for Goal 4

The evaluation of this goal involves assessment of fourteen performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate thirteen performance measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine one performance measure related to one of its secondary drivers. The primary and secondary drivers for Goal 4 and their associated performance measures are shown in Table C-4.

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Table C-4. Drivers and Associated Performance Measures for SUD Demonstration 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. (2017–2013)*^ • 30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment). (2017–2023)*^
Secondary Drivers	**Performance Measures**
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).	• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)* • Average length of stay for SUD treatment services within IMDs (CMS Metric #36; 2017–2023)* • Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)* • Number of outpatient, intensive outpatient, & partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis. (2017–2023)* **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.	• 30-Day Readmission for SUD treatment. (2017–2023)*^ • ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)* • ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2023)* • Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2023)*^ • Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2023)*^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)*^ • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2022)* • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)†
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). † One-group Pretest–Posttest Design will be used for the assessment of the performance measure.	

Thirteen performance measures will be examined using the interrupted time series design. The post-intervention observation period for eleven performance measures will be 2019 through 2023. The remaining two performance measures are based on HEDIS data (FUA and IET). As 2022 HEDIS data will be available in the final year of the demonstration period (2023), therefore, the post-intervention observation period for the performance measures based on HEDIS data (FUA and IET) will be 2019 through 2022.

One performance measure will be examined using the one-group pretest–posttest design. The post-intervention observation period for this performance measure will be 2019 through 2022. The performance measure with data availability for 2019 through 2022 is based on HEDIS data (FUI). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for this performance measure (FUI) will be 2019 through 2022.

Several measures may be investigated for feasibility of comparison group analysis such as readmission and inpatient stays (Beacon block grant recipients).

e. Evaluation Methodology for SUD Demonstration Goal 5

Demonstration 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.

Demonstration Strategy for Goal 5

The **strategy** contributing to the primary and secondary drivers for Goal 5 will be implemented over the demonstration period. The strategy includes:

- KanCare 2.0 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 2.0 program overall care coordination strategy.

Drivers and Performance Measures for Goal 5

The evaluation of this goal involves assessment of six performance measures for its primary and secondary drivers. Interrupted time series evaluation design will be used to evaluate five performance measures related to the primary and secondary drivers, whereas the one-group pretest–posttest design will be used to examine two performance measure related to its secondary driver. The primary and secondary drivers for Goal 3 and their associated performance measures are shown in Table C-5.

Table C-5. Primary Driver and Associated Performance Measures for SUD Demonstration 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; 2017–2022)* • Adults' Access to Preventive/Ambulatory Health Services (AAP). (SUD stratum; 2017–2022)* • Adolescent Well-Care Visits (AWC). (SUD stratum; 2017–2022)* • Prenatal and Postpartum Care (PPC). (SUD stratum; 2017–2022)*
Secondary Driver	**Performance Measure**
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.	• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)^ • Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have Service/Treatment plan or PCSP. (2019–2023)^
* Interrupted Time Series Design 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. † Care Coordination Includes: *health screening, health risk assessment, needs assessment and development and implementation of service/treatment plan or person-centered service plan (PCSP)*	

Four performance measures will be examined using the interrupted time series design. Each of the four performance measures are based on HEDIS data (ADV, AAP, AWC, and PPC). HEDIS data for 2022 will be available in the final year of the demonstration period (2023); therefore, the post-intervention observation period for the performance measures based on HEDIS data (ADV, AAP, AWC, and PPC) will be 2019 through 2022.

Two performance measure will be examined using the one-group pretest–posttest design. The post-intervention observation period for this performance measure will be 2019 through 2023.

f. Methodology for the Evaluation of KanCare 2.0 Hypothesis 4

KanCare 2.0 Hypothesis 4 Evaluation Question

Did removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members improve member access to substance use disorder (SUD) treatment services.?

This question corresponds to the SUD Demonstration Evaluation Question 1, "Does the demonstration increase access to and utilization of SUD treatment services?"

KanCare 2.0 Hypothesis 4

Removing payment barriers for services provided in IMDs for KanCare members will result in improved member access to SUD treatment services.

Demonstration Strategy for KanCare 2.0 Hypothesis 4

The Kansas Medicaid IMD Exclusion has been removed allowing IMDs to bill for SUD treatment services with the expectation that access to SUD services will increase for members with behavioral health conditions.

Evaluation Design for KanCare 2.0 Hypothesis 4

Non-experimental methods (descriptive data) will be used for assessing the evaluation question. Due to changes in data systems, pre-demonstration data will not be used.

Target and Comparison Population

The evaluation for this hypothesis will focus on increasing the availability of IMD facilities providing SUD treatment services over the five-year period. **No intervention and comparison groups will be examined**.

Evaluation Period

2019–2023 will be the evaluation period.

Evaluation Measures for KanCare 2.0 Hypothesis 4

- Number of IMDs providing SUD services
- Number of geographic locations of IMDs providing SUD services (by region/county)
- Number of admissions with SUD treatment services in IMDs
- Average length of stay for SUD treatment services within IMDs

g. Methodology for the Evaluation of Cross-Cutting Cost Measures

The investigation of costs for the KanCare 2.0 SUD Demonstration is a separate but cross-cutting element of the demonstration evaluation. Cost studies investigate both granular (i.e., specific treatment costs) and macro aspects of the KanCare program unique to the SUD demonstration. The SUD 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.

Goal for Costs of SUD Demonstration

Improved impact of the KanCare 2.0 program via provision of a full continuum of services for SUD treatment to members.

Evaluation Question for Demonstration Cost

Does the SUD demonstration maintain or decrease total KanCare 2.0 SUD expenditures?

Evaluation Hypothesis for Demonstration Cost

The SUD demonstration will maintain or decrease total KanCare 2.0 SUD expenditures.

Demonstration Strategy for Demonstration Cost

Each of the strategies within the Evaluation Design Methodology, 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. See subsections C.a through C.e for detailed discussion on evaluation strategies.

Evaluation Measures for Demonstration Cost

The SUD demonstration cost measures are stratified into three interrelated cost categories, each expressed in terms of dollars per member per month ($PMPM):

- **Type of Care Cost Drivers (*Table C-6*)**: treatment costs for members with SUD diagnosis, stratified by types of care using claims data;

- **SUD Cost Drivers (*Table C-7*)**: treatment costs for members, stratified by services rendered within IMDs and other SUD-related costs for members with and without SUD diagnosis; and
- **Total KanCare 2.0 SUD Demonstration Costs (*Table C-8*)**: treatment costs from the cost drivers listed above as well as administrative costs associated with the demonstration.

Table C-6. 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 ($PMPM).	**Numerator**: Spending on SUD treatment services in emergency department (ED) outpatient settings during the measurement period (CMS Metric #28, outpatient ED stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient non-ED stratum)
Non-ED Outpatient SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services and peer support in non-ED outpatient settings during the measurement period. (CMS Metric #28, outpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support service during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient stratum)
Inpatient and residential SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services in inpatient and residential settings during the measurement period. (CMS Metric #28, inpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, inpatient stratum)
Pharmacy SUD spending during the measurement period. ($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. (paid claims, only; CMS Metric #4, pharmaceutical stratum)
Total KanCare 2.0 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 or peer support service during the measurement period and/or in the 12 months before the measurement period. (*paid claims, only*; CMS Metric #4)

Note: Long-term care services are included within institutional claims and may be stratified from the Total.

Table C-7. SUD 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 ($PMPM). [CMS Metric #31]	**Numerator**: Spending on treatment or peer support for SUD within IMDs during the measurement period. (exclude room & board; CMS Metric #29)
	Denominator: Number of beneficiaries with a claim for treatment or peer support for SUD in an IMD during the reporting year. (paid service or pharmacy claims, only; CMS Metric #5)
SUD spending on services other than within IMDs during the measurement period. ($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. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on SBIRT services for beneficiaries without SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: Spending on SUD *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) for beneficiaries *without a SUD diagnosis and not within IMDs* during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	Denominator: Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on assessment services for beneficiaries without SUD diagnosis during the measurement period. ($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. (paid claims, only; CMS Metric #4, non-IMD stratum)
Total KanCare 2.0 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. (*paid claims, only;* CMS Metric #4, includes non-SUD diagnosis stratum)

Table C-8. Total KanCare 2.0 SUD Demonstration Costs	
Measure Description	**Numerator and Denominator Specification**
Total administrative costs related to the KanCare 2.0 SUD demonstration. Expressed in dollars per member per month ($PMPM).	**Numerator**: Sum of all administrative costs related to the SUD demonstration.
	Denominator: Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. (*paid claims, only;* CMS Metric #4, includes non-SUD diagnosis stratum)
Total administrative and SUD service costs related to the KanCare 2.0 SUD demonstration. ($PMPM)	**Numerator**: The sum of 1) all administrative costs related to the SUD demonstration and 2) all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (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. (*paid claims, only;* CMS Metric #4, includes non-SUD diagnosis stratum)
Total Federal costs related to the KanCare 2.0 SUD demonstration. ($PMPM)	**Numerator**: The Federal Medical Assistance Percentage (FMAP) multiplied by the sum of 1) all administrative costs related to the SUD demonstration and 2) all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (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. (*paid claims, only;* CMS Metric #4, includes non-SUD diagnosis stratum)

Evaluation Design for Demonstration Cost

Interrupted time series evaluation design will be used to examine the evaluation question for all measures. This approach will not include a comparison group but will demonstrate trends unique to the SUD demonstration as costs per member per month ($PMPM).

To conduct interrupted time series analysis, the design will compare nine cost measures during pre- and post-intervention periods; these cost measures are also aggregated into four total measures across the three cost categories. The pre- and post-intervention comparisons will examine whether the pre-post intervention change shows a statistically significant shift in level or trend of demonstration costs. Though interrupted time series models without a comparison group cannot adequately determine whether any observed changes are associated with the demonstration, the cost measures will be used to track overall expenditures. If deemed appropriate, "shadow pricing" methods may be used to determine fee-for-service costs as a retrospective comparison.

Target and Comparison Population

Study Population: The study population for the cost measures will include those that support understanding both total health care spending and costs of individual member services:

- KanCare 2.0 members (*primarily those with SUD diagnosis*);
- State of Kansas administrative agencies overseeing KanCare 2.0 program (*KDHE, KDADS*);
- KanCare 2.0 MCOs (*Aetna Better Health, Amerigroup Kansas*, Sunflower State Health Plan, UnitedHealthcare*); and
- KanCare 2.0 in-network providers.

*Amerigroup Kansas, Inc. data may be used for calculations related to pre-intervention costs.

Comparison Population: Financial information for the Beacon program block grant recipients may be

available at sufficient detail to perform Demonstration cost comparisons for measures eligible for comparison group analysis.

Evaluation Period

The total evaluation period will be 2017 through 2023. The pre- and post-intervention periods for the Interrupted Time Series analysis will be as follows:
Pre-Intervention Period: 2017–2018;
Post-Intervention Period: 2019–2023.

Analytic Plan for Demonstration Cost

A general regression model will be developed for this analysis. Demonstration costs will be transformed to log costs to account for wide variation in spending across months. The final regression model will include covariates to control for confounding factors such as member demographics (including Medicare-Medicaid dual eligibility), geographic location of treatment, comorbid diagnoses, etc.

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D. Attachments

1. Detailed Design Methodology and Limitations

Study, Target and Comparison Populations

Due to state-wide implementation of the SUD Demonstration, the evaluation of overall strategies and hypotheses is hindered by the lack of true comparison groups as all KanCare 2.0 members will be eligible for the same benefits. The subset of KanCare 2.0 members with a SUD diagnosis will be the primary participants ("study population") in the Demonstration. It is also expected that for certain measures members without such diagnosis may receive SBIRT or assessment and will be included in the denominator of performance measures and costs within cost measures. Target populations for each intervention, hypothesis, and measure are specified when they differ from the study population (e.g., metric technical specifications). Target and any comparison populations for each goal are described within that goal's evaluation methodology, discussed in Section C.

Because of the lack of comparability, evaluation designs generally included comparisons among members in both intervention and comparison groups and a lack of true external comparison groups limits options for evaluation design. Based on CMS feedback, the design team considered multiple internal and external comparison groups, including utilizing an out-of-state comparison group.[10] The next subsections discuss selected internal and external comparison populations that may provide additional perspective for certain measures or drivers.

External Comparison Population – Administrative Services Organization (ASO) Individuals

A potential external comparison population for the Demonstration are block grant recipients within the Beacon program. The ASO program covers SUD treatment for recipients and providers used by recipients would provide the same services or treatments as they would Medicaid beneficiaries. Aggregate data made available in "Provider Report Cards" from the State Quality Committee of the Behavioral Health Services Planning Council may be compared to the KanCare 2.0 study population for certain measures such as seven-day and thirty-day readmissions, length of stay in treatment, follow-up to services, and MAT access (assumed to have reduced access for ASO individuals). A critical limitation in comparison to target and study populations is that the block grant recipient demographics differ greatly: recipients are uninsured, mostly male, and would not have similar access to services or care coordination. In the event Kansas moves forward with Medicaid expansion, these individuals would likely be included in the expansion gap and may no longer be a valid comparison group but may become an intervention subgroup. The block grant population will be investigated for their potential to serve as comparison groups for select readmission, length of stay, follow-up to services, and MAT measures.

Internal Comparison Population – Geographic Locations of Members and Services

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. 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).[11] 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.

Data Sources

The following data sources will be utilized for the Demonstration (see Table D-1, below). The majority of data will be provided by the KanCare 2.0 MCOs with additional member and administrative data from the State of Kansas. Specific datasets and elements for evaluating are discussed with each metric within Section B, above, and in the demonstration goal sections to follow.

Primary data collection is expected for the qualitative elements of the demonstration evaluation, with particular interest in understanding referrals for MAT from residential treatment facilities. Member survey questions related to SUD have historically been fielded by MCOs. Those surveys will be reviewed for validity and reliability and questions will be reviewed for precision to the qualitative objective with potential for modification (objectives to be determined). Key informant interviews and focus group sessions may also be a source of primary data collection, though the topics, objectives, and participants/settings have not yet been determined.

Table D-1. Data Sources for Evaluation of the SUD Demonstration

Data Source	Owner/Steward	Brief Description
Healthcare Effectiveness Data and Information Set (HEDIS)	KanCare 2.0 MCOs	Member-level detail tables for HEDIS measures submitted by the MCOs.
Managed care administrative data	KanCare 2.0 MCOs	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Managed care case management data	KanCare 2.0 MCOs	Member-level data maintained by MCOs within their specific case management data systems.
Medicaid Management Information System (MMIS) encounter data	KanCare 2.0 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.
Member survey data	KanCare 2.0 MCOs	Member responses to questions within MCO-fielded SUD surveys. Survey objectives and questions to be determined.
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.
State administrative data	State of Kansas	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Key informant / focus group responses	TBD	Feedback resulting from key informant interviews and/or focus group sessions. Qualitative topics, objectives, and participants/settings to be determined.

Analytic Methods

Standard data analysis methods will be used to examine each evaluation question and will be applied to the measures discussed in Section B, above. Where possible, the entire eligible population for the intervention and comparison groups will be included in the evaluation of Demonstration goals, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be completed to ensure validity of the findings.

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. For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.

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. Analysis may include chi square testing for independence, logistic regression, and Breslow-Day testing for homogeneity of odds ratios. Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.

Interrupted Time Series (ITS) Analysis

The ITS analysis will be conducted using aggregate data collected for equally-spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in time (longitudinal effects of intervention), through segmented regression modeling. Segmented regression modeling refers to a model with different intercept and slope coefficients for the pre- and post-intervention time periods.[12] This analysis will measure immediate (level) changes in the rate of the performance measures, as well as changes in the trend (slope) from pre-intervention to post-intervention associated with time. The general form of the ITS model will be used for segmented regression.[5,12] CMS suggestion to consider controls adjustments for confounding variables such as age, gender, race, dual Medicare-Medicaid enrollment, and an error term will be considered for the final model. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function.

One Group Pretest-Posttest (OGPP) Analysis

The OGPP analysis will include statistical tests such as Fisher's Exact and Pearson chi-square tests with $p<.05$ to compare percentages or rates for the baseline and subsequent years. Net improvement will be examined by comparing percentages or rates for the baseline year and final year of the demonstration (as per availability of data). The general form of the intent to treat model will be used for regression.[5] Similar to discussed for ITS, the final model will follow CMS' suggestion where appropriate.

Qualitative Analyses

Qualitative analyses will be performed against the objectives of each qualitative study. For surveys and other qualitative approaches needing a representative sample of the population, a sampling strategy will be devised to include sampling method (random sampling, stratified sampling, convenience sampling, etc.), sample frame, sample size, desired response rate, and quality control and bias reduction elements. For key informant interviews or focus groups a participation strategy will be devised to include participant selection (purposive sample, quota sample, etc.), recruitment, discussion protocols, and communications procedures. Data 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.

Evaluation Design Limitations

The Demonstration evaluation has a strong reliance upon quasi-experimental ITS and 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 KanCare 2.0 Hypothesis 4 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 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 SUD Demonstration. Potential internal and external comparison groups are also limited in their ability to generalize to the study population. The design team ultimately decided against utilizing comparison states due to factors such as T-MSIS Analytic File data lag and challenges in selecting comparison states that would have outcomes identical to Kansas pre-Demonstration state not influenced by state or national trends (e.g., SUPPORT Act and other opioid disaster response, Medicaid waivers or expansions, etc.). Similarly, difference-in-differences analysis was considered for the SUD evaluation but core assumptions were unable to be made due to either lack of true comparison populations ('group invariance'), limited phasing of the statewide demonstration to establish cohorts ('time invariance'), or dynamic changes in comparison population service needs and access ('strict exogeneity').[13]

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. The use of administrative accounting data for evaluation of costs may also present a challenge in reconciling costs unique to the demonstration across different accounting platforms and practices.

Data lag 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 five-year period of the demonstration. As the evaluation is based on a five-year period, 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. Additional challenges specific to cost data are lags related to both the resolution and reconciliation of claims but also in availability of administrative data due to fiscal timeframes and policies.

From a qualitative perspective, limitations may exist in the collection and coding of open-ended questions and comments. This includes 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 surveys are administered independently by each MCO, analysis across the KanCare 2.0 program may not be feasible if survey designs or fielding differs significantly between one or more of the MCOs.

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2. Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the evaluation of SUD Demonstration at the level of detail needed to research the approved hypotheses. They have agreed to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. KFMC has over 45 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 (24 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (37 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (19 years) and for five 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. Furthermore, through their sub-contract with the Great Plains Quality Innovation Network (a prime CMS contractor), KFMC submits an annual Organizational Conflict of Interest (OCI) certificate to CMS. 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 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

3. EQRO Evaluation Budget

Table D-2. Evaluation Budget for the KanCare 2.0 Section 1115 SUD Demonstration			
Job Description	**Description of Services**	**FTE**	**Total Cost**
Researchers: • Epidemiologist Consultant (MBBS, PhD, MPH) • Senior Health Data Analyst (PhD, MA)	• Work with State and MCOs defining and developing measures. • Work with State and MCOs on data collection tools, databases, and reports. • Obtain data; review for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data. • Create final dataset for each measure merging data from various sources. • Examine homogeneity of the demographic characteristics of the members in intervention and comparison groups for applicable study. • Conduct analysis according to the design, including trend, comparison, and regression analysis as appropriate. • Interpret analysis at least annually and create interim and summative reports.	.49	$316,100
Analyst and Programmers: • Quality Review Analyst (RN) • Health Quality Data Analyst (MPH) • Programmer	• Assists Researchers with steps noted above. • Assist with case record review as needed, ensuring inter-rater-reliability.	.15	$94,000
Contract and Project Managers: • EQRO Director (RN, BSN, MSW, CCEP) • Project Manager (MA)	• Work with State and MCOs defining and developing measures. • Work with State and MCOs on data collection tools, databases, and reports. • Oversee evaluation operations and timelines to ensure deliverables are met. • Provider routine monthly or quarterly updates to KDHE regarding evaluation progress. • Assist with interpretation of data findings. • Assist with interim and summation report writing, • Facilitate communications with the Researchers, State, and MCOs as needed. • Assist with case record review as needed, ensuring inter-rater-reliability.	.07	$59,700
Project Specialist: • Administrative support • Data entry	• Provide administrative support for report development and submission. • Assist with data abstraction or data entry as needed/appropriate.	.07	$30,200
Total Cost: **Evaluation time-period**; July 2019 through June 2025 (6 years); June 2025 is the due date of Draft Summative Evaluation Report, 18 months after the end of the demonstration date of December 2023.		.78	$500,000

4. Timeline and Major Milestones

Table D-3. Evaluation Budget for the KanCare 2.0 Section 1115 SUD Demonstration	
Deliverable/Activity	**Due Date(s)**
Finalize technical specifications for non-required (state-developed) metrics.	To be determined (following CMS evaluation feedback)
Discuss SUD Demonstration implementation and evaluation progress during existing quarterly EQRO/State/MCO meetings.	Quarterly (already in progress)
Quarterly EQRO/State meetings for preparation of SUD Demonstration progress reports.	Two weeks prior to State deliverable requirements
Draft Interim Evaluation Report in accordance with Attachment N (Preparing the Evaluation Report) of the STCs; will discuss evaluation progress and findings to date.	December 2022 (one year prior to the end of the demonstration)
Final Interim Evaluation Report.	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment N of the STCs.	June 2025 (18 months from the end of the demonstration)
Final Summative Evaluation Report.	60 calendar days after receipt of CMS comments

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