DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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State Demonstrations Group

June 26, 2025

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

Dear Director Osterlund:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of Kansas Final Report for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "KanCare" (Project No: 11-W-00283/7). This report covers the demonstration period from March 1, 2020 through the end of the PHE. CMS determined that the Final Report, submitted on February 25, 2025, is in alignment with the CMS-approved Evaluation Design, and therefore, approves the state's Final Report.

The approved Final Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Final Report on Medicaid.gov.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE demonstration under these extraordinary circumstances. We look forward to our continued partnership on Kansas section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S
Digitally signed by DANIELLE DALY -S
Date: 2025.06.26 11:17:48 -04'00'

Danielle Daly
Director
Division of Demonstration
Monitoring and Evaluation

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

KanCare Section 1115(a) COVID-19 Public Health Emergency (PHE) Amendment Evaluation

Submission Date: February 19, 2025

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KanCare Section 1115(a) COVID–19 Public Health Emergency (PHE) Amendment Evaluation Report
Executive Summary
February 19, 2025

Background Information

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) approved renewal of the KanCare demonstration (sometimes referred to as "KanCare 2.0") for the period of January 1, 2019, through December 31, 2023. KanCare operates concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers. Together they provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible) and Children's Health Insurance Program (CHIP) beneficiaries. CHIP provides low-cost health insurance coverage to children who are under the age of 19, do not qualify for Medicaid, have family incomes under 232% of the federal poverty level, and are not covered by private health insurance.

On August 15, 2022, CMS approved Kansas Department of Health and Environment's (KDHE) request for a KanCare demonstration amendment to address the COVID-19 Public Health Emergency (PHE). The amendment was authorized retroactively from March 1, 2020, through the end of the COVID-19 PHE unwinding period or until all redeterminations are conducted during the unwinding period. The amendment provided continuous coverage for CHIP enrollees who turned 19 during the PHE (and therefore lost eligibility for CHIP due to age) and who were otherwise ineligible for Medicaid.

KFMC Health Improvement Partners (KFMC), under contract with KDHE's Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the independent evaluator, KFMC conducted the required COVID-19 PHE amendment evaluation and has prepared this evaluation report as per CMS approved amendment's evaluation design.

COVID-19 PHE Amendment Goal, Evaluation Hypothesis and Questions

The amendment was implemented from March 1, 2020, through March 31, 2024. The 12-month PHE unwinding period was March 2023 to February 2024. Kansas had until April 2024 to complete the processing of all unwinding renewals.

COVID-19 PHE Amendment Goal

The COVID-19 PHE amendment extended eligibility for CHIP enrollees who turned 19 during the public health emergency, and were otherwise ineligible for Medicaid, with the goal of furnishing continued medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals affected by COVID-19.

Evaluation Hypothesis and Questions

The focus of the evaluation, through its quantitative and qualitative components, was to examine whether the KanCare demonstration COVID-19 PHE amendment achieved its goal and to identify successes, challenges, and lessons learned in implementing the demonstration amendment.

Evaluation Hypothesis

Extending eligibility for CHIP enrollees who turned 19 during the PHE, and were otherwise ineligible for Medicaid, provided continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE.

Evaluation Questions

Evaluation questions are presented in Table ES-1.

Table ES-1. Evaluation Questions
Quantitative Evaluation Questions
Question 1: What was the eligible members' service utilization during the period of extended coverage?
1.a. What types of services did eligible members access during the period of extended coverage compared to prior utilization? **1.b.** What diagnoses were associated with services received by eligible members during the period of extended coverage compared to prior diagnoses? **1.c.** Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage?
2.a. Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE? **2.b.** What were the patterns of preventive, routine, and acute health care during the period of extended coverage?
Question 3. What was the cost of the extended period of coverage?
3.a. What was the cost of services provided to members who received the extended coverage?
Qualitative Evaluation Questions
Question 4: What were the key stakeholder perceptions and experiences regarding the extended coverage?
4.a. What were the members' perceptions of their extended coverage? • Were eligible CHIP enrollees aware of their extended coverage? • How did the extended coverage help the eligible enrollee during the COVID-19 PHE?
4.b. What were the Managed Care Organizations' (MCOs') and State's experiences regarding implementation of the extended coverage? • What strategies did the MCOs use to engage members who turned 19 during the COVID-19 PHE? • What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency? • What strategies did the MCOs pursue to address those challenges?

Key Evaluation Conclusions

Quantitative Evaluation Conclusions

The study population for the quantitative evaluation was defined as KanCare 2.0 CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage. The quantitative evaluation focused on describing patterns in health and health care before and during the period of extended CHIP coverage. These patterns were identified by examining three areas:

- The service utilization by eligible members during their extended coverage period, including types of services accessed, diagnoses associated with services received, and new diagnoses received after turning age 19 (Q1).

- The preventive, routine, chronic and acute care service utilization among eligible members during their period of extended coverage and patterns of these services (Q2).
- The cost of services provided to members who received extended coverage (Q3).

For comparison across time, measurement periods were define based on length of time the member had extended coverage. These periods were independent of calendar years. Members were 19 years old in their first year of extended coverage; this period was denoted *Age 19*. The following year of coverage was denoted *Age 20*, and any additional coverage was the *Age 21+* period. The *extended coverage* period, or *Age 19+*, indicated the totality of the member's extended CHIP coverage. The period of CHIP coverage while the member was 18 years old, referred to as the *regular coverage* period or *Age 18*, was used as a base for comparisons.

Service Utilization by Eligible Members During the Extended Coverage

The key conclusions derived from the assessment of the three aspects of the service utilization patterns are summarized here.

Types of Services Accessed

- The average number of inpatient stays per 100 members increased during the first year of extended coverage (Age 19) and decreased each period thereafter.
- The rates for all other service types (outpatient visits including emergency department visits; professional visits/trips; dental visits; and pharmacy fills) decreased for each measurement period.
- The dental visit rates had the greatest relative decrease from regular coverage (Age 18) to Age 19.

Diagnoses Associated With Services Received

The ICD-10-CM diagnosis categories and chapters (ranges of categories) associated with services received by the members during the period of extended coverage were assessed:

- *Mental, behavioral and neurodevelopmental disorders* was the most frequently used diagnosis chapter, ranking first for all four measurement periods and represented more than one fifth of the total count, and *Other anxiety disorders* was the highest ranked category within the chapter.
- *Factors influencing health status and contact with health services* was the second most frequently used diagnosis chapter; and *Encounter for general examination without complaint, suspected or reported diagnosis* was the category with the highest average ranking for this chapter.
- *Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified* was the third most frequently used diagnosis chapter, and the category with the highest average ranking was *Abdominal and pelvic pain*.
- The assessment of the prevalence rates based on the primary diagnosis code (percent of members having a primary diagnosis in a given chapter or category) showed results mostly similar to those seen with frequency counts analyses. A few key differences seen were:
  - The first and second ranked diagnosis chapters were *Factors influencing health status and contact with health services* and *Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified*. *Mental, behavioral and neurodevelopmental disorders* dropped to fifth place.
  - The third ranked chapter, *Diseases of the eye and adnexa*, was from vision claims; its top category was *Disorders of refraction and accommodation* (it ranked second or third based on frequency analysis).

The inpatient stays were also examined based on their Major Diagnostic Category (MDC) and Medicare Severity Diagnosis Related Group (MS-DRG) codes. The key observations were:

- Two MDCs with the greatest increases from regular to extended coverage in their proportion of the inpatient stays within the coverage period were related to pregnancy, namely, inpatient stays for the mother (Pregnancy, Childbirth & The Puerperium) and stays for the newborn that were billed under the mother's Medicaid ID (Newborn & Neonates with Conditions Orig. Perinatal Period).
- The Mental Diseases & Disorders (D&D) MDC ranked second for both coverage periods.
- Within the Endocrine, Nutritional & Metabolic D&D MDC, the majority of the stays in the extended coverage period were for diabetes.

New Diagnoses Received After Turning Age 19

- The five diagnosis chapters with the greatest incidence rates (new diagnosis chapter or category during the extended coverage period) also had the greatest prevalence rates and contained the top 10 diagnosis categories.
- These top five diagnosis chapters were
  - Factors influencing health status and contact with health services (Z00–Z99);
  - Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified;
  - Diseases of the eye and adnexa;
  - Diseases of the respiratory system; and
  - Mental, behavioral and neurodevelopmental disorders.
- Three categories within chapter Z00–Z99 may be related to COVID-19: Contact with and (suspected) exposure to communicable diseases, Encounter for immunization, and Encounter for screening for infectious and parasitic diseases. The incidence rate for category U07 (Emergency use of U07), which includes diagnoses of COVID-19, was 10% (ranked 28th).

The Preventive, Routine, Chronic and Acute Care Service Utilization

The key observations of the assessment of preventive, routine, chronic and acute care service utilization among eligible members during the period of extended coverage and patterns of these services were:

- The continuation of services utilization for eight chronic conditions was assessed.
  - The four chronic conditions with the highest percentages of diagnosed members having treatment continued into the extended coverage period were diabetes mellitus (79%), diabetes ketoacidosis/hyperglycemia (76%), mental health issues (62%), and diabetes treatment (58%).
  - For members with treatment for a chronic condition that continued into the extended period, the majority had received treatment within the first year of extended coverage.
- The prescription (pre-existing condition) prevalence rates by generic therapeutic class (GTC) and specific therapeutic class (STC) were also assessed.
- The GTC average prescription prevalence rate was 38% for Age 19 and 44% for Age 19^{+}. This indicates, of the 14,370 prescriptions filled during regular coverage, 38% had a corresponding prescription in the same GTC filled by the member in their first year of extended coverage and 44% had a prescription of the same GTC filled by the member anytime during the extended coverage.
  - The prescriptions with prevalence rates higher than the GTC average rate fell into three categories – treatment for acute conditions (e.g., antibiotics), treatment for chronic conditions (e.g., psychotherapeutic drugs and antiasthmatics), and preventive medicine (e.g., contraceptives and anti-obesity drugs).
  - Several STC rates for treatment with psychotherapeutic drugs were higher than the Age 19^{+} GTC average rate, indicating members frequently maintain treatment within the same specific therapeutic class. In contrast, no STC rates for antibiotics were higher than the GTC average

rate, which may indicate treatments with antibiotics tend to change specific therapeutic classes to target specific bacterial infections.
    - Many of the prescriptions prevalence rates higher than the GTC average rate are used for chronic diseases. Prescriptions treating chronic conditions are required to be taken continually. However, the prevalence rates for these prescriptions indicated they were not continued into the extended coverage period by many members. For example, 34% of members filling a prescription for a psychotherapeutic medication discontinued taking it before turning 19 years old. Around half of members previously prescribed anti-convulsant, asthma, or heart medications did not continue them. The diabetes and thyroid prescriptions prevalence rates were a little better, but still around 30% of taking these medications at age 18 discontinued them. Although there might be some cases in which these medications were discontinued by the prescribing health professional, these rates seemed to indicate many were discontinued for non-medical reasons. This may be an area that could be improved by better communication and coordination among members, providers, pharmacies and MCOs.
- The prescription incidence rates (new prescriptions during the extended coverage period) were calculated for generic and therapeutic classes.
    - The highest rates were for treating common acute care conditions (e.g., infections, pain, nausea and vomiting, inflammation, or injuries).
    - The therapeutic classes with the greatest prescription incidence rates were Antibiotics (including penicillin antibiotics), Gastrointestinal, Analgesics (including opioid analgesic and non-salicylate analgesics), Biologicals, Hormones (glucocorticoids), and Antiarthritics (including NSAIDs, cyclooxygenase inhibitor type analgesics).
- The frequency counts and service utilization rates for selected conditions across the regular and extended coverage periods based on institutional claims for emergency department visits, observation stays, and inpatient stays were examined.
    - Utilization rates in the emergency department, observation room, and inpatient settings generally increased for the selected conditions, whereas utilization rates generally decreased in the professional and other outpatient settings.
- Four HEDIS measures, Annual Dental Visits, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits, and Inpatient Utilization, were also examined.
    - Two patterns were common to the three measures – Annual Dental Visits, Adults' Access to Preventive/Ambulatory Health Services, Well-Child Visits
        - For each age group (Eldest, Middle, and Youngest), rates decreased as members grew older.
        - Within each measurement period, the Eldest group had the highest rates, and the Youngest group had the lowest rates.
    - From Inpatient Utilization, three main observations were made:
        - Among females, maternity services utilization was greatest during the members' first year of extended coverage (nearly half of the maternity discharges).
        - In the surgery and medicine strata, the Discharge Rate and Days Rate declined each measurement period.
        - The longest stays were for surgeries in the first year of extended coverage.

Cost of Services Provided to Members

The cost of services provided to members who received extended coverage were calculated.

- The categories with the highest payments were professional (e.g., outpatient primary care, specialist, and behavioral health care visits; physician services at inpatient settings) and pharmacy claims.

- Overall, payment amounts decreased as members aged, both as total payment amounts and payments per 12 member-months (with two exceptions; non-emergency medical transportation and pharmacy payments increased from Age 18 to Age 19).
- The claim type with the greatest relative decrease in payments per 12 member months was dental.

Qualitative Evaluation Conclusions

The qualitative evaluation focused on describing member perceptions, as well as managed care organization (MCO) and State experiences regarding the extended CHIP coverage.

Member Perceptions

An online member survey was conducted to collect information to assess whether CHIP members over age 18 were aware of their extended coverage and how the extended coverage helped them during the PHE. Key themes derived from their responses include:

- Most of the members who responded to the survey were aware of their extended coverage during the COVID-19 pandemic.
- The extended coverage helped these members in getting services from health and pharmacy providers during the PHE.
- Furthermore, the extended coverage affected family, school, or work life by assisting them with getting treatment when they were sick, made paying bills and buying food easier, and helped them miss less school or work.
- These members also noted they were afraid of losing services from health and pharmacy providers, including emergency room and hospital services, if their KanCare coverage were to end.
- It should be noted, CHIP covers preventive and diagnostic services including cleaning (twice a year) and oral health screening or assessment (twice a year) for the members. However, some of the survey respondents noted they did not need any services from a dentist after turning 19, even though they knew about the extended coverage. In addition, a few respondents also noted they did not get needed dental services because they did not know they had coverage.
- Similarly, CHIP covers one annual complete routine eye exam for members. However, slightly less than half of the survey respondents noted they did not need any services from the eye doctor after turning 19. These results may indicate a need for providing education to the CHIP members and their guardians regarding the importance of preventive and diagnostic oral health services, as well as routine vision care services.

MCOs and State Experiences

The MCO and State questionnaires were emailed to the primary contacts of these organizations to collect information on experiences regarding the implementation of the extended coverage. Responses were compiled by the primary contacts with input from the subject matter experts within their organizations. Key themes derived from their responses include:

- The State informed the eligible CHIP members about the extended coverage during the PHE using several communication methods. The main methods were mailing information, IVR messaging, and web-based postings to the eligible CHIP enrollees. The members were notified when they were due for renewal. The State's efforts appeared to communicate the information well, as echoed by the responses provided by most of the respondents of the member perception survey.
- The State did not require eligible members to take any action to stay enrolled, thus making it easier for them to retain access to health services during the PHE.
- The MCOs also encouraged members to access services during the extended coverage. Case management and community outreach efforts (virtual and in field) were used to educate members

about preventive services including vaccinations for COVID-19 and other diseases, annual screenings, and well-visits. MCOs worked with providers and community partners to assist members in receiving appropriate services, including seeing appropriate providers (pediatric and adult care). The MCOs noted a few challenges in engaging members during the PHE. These challenges were mainly due to limited contact with the members due to overall reduced outreach, lack of up-to-date contact information, reduced provider availability for face-to-face visits, and limited time for providing preventive services.

- The MCOs also identified members' challenges with healthcare services during the extended coverage were related to healthcare access, including transportation issues, lack of awareness among members, and not considering health as a priority. The MCOs also noticed mental health issues, loneliness, and other social challenges among the members during this period.
- In addition, the health plans encountered challenges due to workforce shortages and increased workloads for their staff, provider shortages, and financial and administrative issues during the PHE.
- The MCOs noted applying several strategies to address the challenges encountered by the health plans, members, healthcare providers, and community organizations. Strategies included bringing in Pyx health to help with isolation, loneliness, and provision of community resources; rethinking community events to be drive-thru and outdoors; co-organizing and supporting vaccination clinics; and switching in- person activities to virtual. MCOs supported members, providers, and community organizations to ensure members had access to needed treatment and preventive services during the PHE.
- The MCOs stated the extended coverage had a beneficial impact on members' physical and behavioral health and wellness; allowed them to have continuous access to health services, including preventive care; helped members in receiving preventive care without out of pocket payment or not getting it due to inability to pay; and provided COVID-19 related education, resources, and services.
- The State also shared their experiences regarding the communication process used during the PHE unwinding period to inform members about disenrollment from this extended coverage.
    - The State, along with the MCOs and other stakeholders, applied several communication strategies, including sending texts and emails; phone calls; online postings (web and social media); providing print material in provider offices; and engagement with navigators and community organizations.

Overall Conclusions

- The evaluation showed by extending the eligibility for CHIP enrollees who turned 19 during the PHE, and were otherwise ineligible for Medicaid, the amendment provided continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE.
- The State informed the eligible CHIP members about the extended coverage during the PHE which made it easier for them to access health services.
- The MCOs applied member and community outreach strategies assisting members with using the services.
- The members obtained inpatient, outpatient, emergency department, professional, dental and pharmacy services. The services received were for existing and new conditions.
- Members also communicated their concern regarding losing services from health and pharmacy providers if their KanCare coverage were to end.

Lessons Learned and Recommendations

Valuable lessons were learned from the evaluation results of the KanCare demonstration COVID-19 PHE amendment. These lessons learned are also the recommendations to Kansas and other state Medicaid agencies and policy makers for future demonstrations.

- Public health emergencies, such as COVID-19 pandemic, lead to unprecedented circumstances associated with health and economic challenges. To assist states with addressing the COVID-19 PHE, CMS developed a new Section 1115 demonstration opportunity that provided states a variety of options for delivering the most effective care to their Medicaid/CHIP beneficiaries. These options provided flexibility around federal and state Medicaid/CHIP policies that is valuable to ensure health, safety, and welfare of the individuals enrolled in the program.
- By implementing the KanCare demonstration COVID-19 PHE amendment, the State of Kansas was able to extend the eligibility for CHIP enrollees who turned 19 during the PHE and were otherwise ineligible for Medicaid. The extended coverage provided continuity of medical assistance, thus enabling the CHIP members to receive health services, including preventive care during PHE. The availability of these types of Medicaid/CHIP amendments enabled members to receive needed care during the difficult circumstances caused by the PHE.
- The extended coverage of CHIP members assisted the eligible members in avoiding the effects on their physical and behavioral health status that could have resulted from their inability to pay out-of-pocket for needed health services.
- Through this extended coverage, the CHIP members were able to receive COVID-19 education, resources, vaccinations, and treatment services. The availability of such resources and services are essential for preventing and controlling the morbidity and mortality from the diseases causing public health emergencies.
- The State used a variety of communication methods to inform eligible CHIP members regarding their extended coverage and availability of health care services during the PHE. The MCOs and community organizations also encouraged members to access health care services and resources during the PHE. The education efforts conducted by the State and MCOs, in collaboration with the community organizations, showed continuous dissemination of the accurate information was needed throughout the PHE. However, some lack of awareness was still seen among members.
- The State of Kansas did not require the eligible CHIP members to take any action to stay enrolled, thus making it easier for the eligible members to have uninterrupted access to the health services during the PHE. It is important to keep the administrative processes as easy as possible to assist members in navigating health care system during difficult circumstances.
- MCOs applied case management and community outreach strategies to encourage members to get preventive services and offered service options to health providers for addressing physical and behavioral health issues encountered by the members during the PHE.
- There is a need to address members' concerns about losing access to healthcare services if they become ineligible for Medicaid or CHIP. Health plans could assist members transitioning out of Medicaid or CHIP by implementing strategies for connecting them with appropriate healthcare services and community resources and providing information for navigating through these services and resources.

KanCare Section 1115(a) COVID–19 Public Health Emergency (PHE) Amendment Evaluation Report
February 19, 2025

Background Information

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) approved renewal of the KanCare demonstration (sometimes referred to as "KanCare 2.0") for the period of January 1, 2019, through December 31, 2023.[1] KanCare operates concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers. Together they provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible) and Children's Health Insurance Program (CHIP) beneficiaries. CHIP provides low-cost health insurance coverage to children who are under the age of 19, do not qualify for Medicaid, have family incomes under 232% of the federal poverty level, and are not covered by private health insurance.[2]

On August 15, 2022, CMS approved Kansas Department of Health and Environment's (KDHE) request for a KanCare demonstration amendment to address the COVID-19 Public Health Emergency (PHE).[3] The amendment was authorized retroactively from March 1, 2020, through the end of the COVID-19 PHE unwinding period or until all redeterminations are conducted during the unwinding period as discussed in the State Medicaid Director Letter (SMDL #20-002) and the State Health Official Letter (SHO) #22-001.[3,4,5] The COVID-19 PHE amendment provided continuous coverage for CHIP enrollees who turned 19 during the public health emergency (and therefore, would have lost eligibility for CHIP due to age) and who were otherwise ineligible for Medicaid. These enrollees continued to receive the KanCare benefits through the end of the COVID-19 PHE unwinding period or until their redetermination was completed.

In the approval letter, CMS stated *"the COVID-19 PHE amendment to the KanCare demonstration is necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE and to ensure renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage at the end of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals who may be affected by COVID-19. This approval allows the state to align its policies for young adults in Medicaid and CHIP and prevent gaps in coverage during the public health emergency. Additionally, this amendment ensures that the state can mitigate churn for eligible beneficiaries and smoothly transition individuals between coverage programs during the COVID-19 PHE unwinding period."*[3]

In accordance with CMS guidelines, the State submitted a COVID-19 PHE amendment evaluation design for CMS approval. After receiving CMS feedback, an updated evaluation design as per CMS guidance and feedback was submitted, and it was approved by CMS on May 25, 2023.[6]

KFMC Health Improvement Partners (KFMC), under contract with the KDHE's Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the independent evaluator, KFMC conducted the required COVID-19 PHE amendment evaluation and prepared this evaluation report as per CMS guidelines for the preparation of evaluation reports.[7]

COVID-19 PHE Amendment Goal, Evaluation Hypothesis and Questions

The amendment was implemented from March 1, 2020, through March 31, 2024. The 12-month PHE unwinding period was March 2023 to February 2024. Kansas had until April 2024 to complete the processing of all unwinding renewals. The focus of the evaluation, through its quantitative and qualitative components, was to examine whether the KanCare demonstration COVID-19 PHE amendment achieved its goal, identifying successes, challenges, and lessons learned in implementing the demonstration amendment.

COVID-19 PHE Amendment Goal

The COVID-19 PHE amendment extended eligibility for CHIP enrollees who turned 19 during the public health emergency, and were otherwise ineligible for Medicaid, with the goal of furnishing continued medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals affected by COVID-19.

Evaluation Hypothesis

Extending eligibility for CHIP enrollees who turned 19 during the PHE, and were otherwise ineligible for Medicaid, provided continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE.

Evaluation Questions

The quantitative evaluation questions are presented in Table 1.

Table 1. Quantitative Evaluation Questions
Question 1: What was the eligible members' service utilization during the period of extended coverage?
1.a. What types of services did eligible members access during the period of extended coverage compared to prior utilization?
1.b. What diagnoses were associated with services received by eligible members during the period of extended coverage compared to prior diagnoses?
1.c. Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage?
2.a. Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?
2.b. What were the patterns of preventive, routine, and acute health care during the period of extended coverage?
Question 3. What was the cost of the extended period of coverage?
3.a. What was the cost of services provided to members who received the extended coverage?

The qualitative evaluation questions are presented in Table 2.

Table 2. Qualitative Evaluation Questions
Question 4: What were the key stakeholder perceptions and experiences regarding the extended coverage?
4.a. What were the members' perceptions of their extended coverage? • Were eligible CHIP enrollees aware of their extended coverage? • How did the extended coverage help the eligible enrollee during the COVID-19 PHE?
4.b. What were the Managed Care Organizations' (MCOs') and State's experiences regarding implementation of the extended coverage? • What strategies did the MCOs use to engage members who turned 19 during the COVID-19 PHE. • What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency? • What strategies did the MCOs pursue to address those challenges?

Methodology

Quantitative Evaluation

The quantitative evaluation focused on describing patterns in health and health care before and during the period of extended CHIP coverage. Detailed technical methods of data collection and analysis for assessing quantitative evaluation questions are provided in Appendix A, Methodology and Results of Quantitative Analysis. To ensure methodological soundness, the steps described in Protocol 2: Validation of Performance Measures of External Quality Review (EQR) Protocols, provided by the Centers for Medicare & Medicaid Services (CMS), revised February 2023, were used to conduct quantitative evaluation.[8]

Evaluation Design

As per CMS guidance, the quantitative evaluation design focused on examining the descriptive data and statistics to address the evaluation questions.[3]

Study Population

The study population was defined as KanCare 2.0 CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage.

The CHIP extended coverage population was identified from the Kansas Modular Medicaid System (KMMS) membership and enrollment tables received in August 2023 (records last updated July 21). To identify the study population, the last day of the month in which the member turned 19 years old was calculated and designated as the member's anchor date. Members enrolled on the anchor date and the day after formed the study population. The anchor date is the last day of *regular* CHIP coverage, and the next day is the first day of *extended* CHIP coverage. There were 7,087 members meeting this study population criteria. Dates of birth ranged from March 2001 through March 2023.

The study population was divided into three groups by age. The *eldest* members turned 19 years old in in the first year of the PHE (March 2020 to March 2021). The *middle* group turned 19 years old in the second year (April 2021 to March 2022). The *youngest* members turned 19 April 2022 to March 2023.

Evaluation Period

March 1, 2020 – March 31, 2024

Evaluation Measures

The evaluation measures are presented in Table 3.

Table 3. Quantitative Evaluation Measures		
Evaluation Question		**Measures**
Question 1: What was the eligible members' service utilization during the period of extended coverage?		
1.a.	What types of services did eligible members access during the period of extended coverage compared to prior utilization?	Summary of encounters by type of service: • Professional Visits • Pharmacy Fills • Outpatient Visits ○ Emergency Department Visits • Inpatient Stays • Dental Visits • Vision Visits • Non-Emergency Medical Transportation (NEMT) Trips
1.b.	What diagnoses were associated with services received by eligible members during the period of extended coverage compared to prior diagnoses?	Summary of diagnosis prevalence: • Primary diagnoses by ICD-10-CM chapter • Primary diagnoses by ICD-10-CM block or category Summary of inpatient stays by diagnosis: • CMS Major Diagnostic Category (MDC) • Medicare Severity Diagnosis Related Group (MS-DRG)
1.c.	Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?	Summary of diagnosis incidence: • Diagnoses by ICD-10-CM chapter • Diagnoses by ICD-10-CM block or category
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage?		

2.a.	Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?	• Service utilization by chronic condition:
		  ○ Asthma
		  ○ Diabetes
		  ○ Behavioral Health
		  ○ Others to be determined based on prevalent diagnoses (question 1.b)
		  ▪ Asthma with Exacerbation
		  ▪ Diabetes Treatment
		  ▪ Diabetes Ketoacidosis/Hyperglycemia
		  ▪ Substance Use Disorder (SUD)
		  ▪ Overweight and Obesity
		• Prescription (pre-existing prescriptions) prevalence rates by generic therapeutic class

2.b.	What were the patterns of preventive, routine, and acute health care during the period of extended coverage?	• Prescription (new prescriptions) incidence rates by generic therapeutic class
		• ED visits, observation stays, or inpatient admissions for selected conditions:
		  ○ COVID-19
		  ○ Acute respiratory infections
		  ○ Acute severe asthma
		  ○ Diabetic Ketoacidosis/Hyperglycemia
		  ○ SUD
		  ○ Mental health issues
		  ○ External Causes of Morbidity
		• Outpatient or professional claims for respiratory infections:
		  ○ Acute upper respiratory infections
		  ○ Influenza
		  ○ Pneumonia
		  ○ Other acute lower respiratory infections
		• HEDIS® measures (applicable age strata):
		  ○ Annual Dental Visit (ADV)
		  ○ Adults' Access to Preventive/Ambulatory Health Services (AAP)
		  ○ Child and Adolescent Well-Care Visits (WCV)
		  ○ Emergency Department Utilization (EDU) – Observed Events
		  ○ Inpatient Utilization (IPU) – General Hospitalization/Acute Care, excluding maternity admissions.
		(HEDIS® is a registered trademark of the National Committee for Quality Assurance.)

Question 3: What was the cost of the extended period of coverage?		
3.a.	What was the cost of services provided to members who received the extended coverage?	Spending per member per month: • Total • By service type (see 1.a)

Data Sources

Table 4 presents the data sources used for quantitative evaluation. See Appendix A for further details.

Table 4. Quantitative Evaluation Data Sources

Data Source	Type of Data	Description of Data Source
Demographic, Eligibility, and Assignment Database	Medicaid Eligibility and Enrollment data	Eligibility and enrollment detail for Medicaid members used to determine enrollee aid category and stratify data into subgroups
Encounter Records Database	Claims and Encounters	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and other performance, service utilization, and cost metrics for all enrollees
ICD10-CM Codes and Descriptions*	ICD10-CM codes and descriptions	ICD10-CM codes and descriptions for diagnosis codes, categories, and chapters were obtained from the Centers for Disease Control and Prevention

* Centers for Disease Control and Prevention, International Classification of Diseases, Tenth Revision, Clinical Modification ftp.cdc.gov -/pub/Health_Statistics/NCHS/Publications/ICD10CM/2024-Update/. Downloaded 3/20/2024.

Analytic Methods

Detailed analytic methods applied for assessing quantitative evaluation questions are described in Appendix A. An outline of the data collection and analysis steps are presented in Table 5.

Table 5. Quantitative Evaluation Data Collection and Analysis Steps

- Identified CHIP members with extended coverage (study population).
- Identified segments of regular (age 18) and extended coverage (age greater than or equal to 19).
- Stratified study population by independent variables – MCO, anchor date, measurement periods, and age range.
- Obtained stratified counts of members.
- Queried member encounter data for services provided from 18 years old onwards.
  - Data cleaning
  - Deduplication to one record per claim
  - Recoding the MCO claim status based on adjustment reason codes
  - Adding flags needed for stratification
- Calculated measurements for Evaluation Q1 – What was the eligible members' service utilization during the period of extended coverage?
  - Summary of encounters by type of service (Q1.a)
  - Summary of diagnosis prevalence (Q1.b)
    - Frequency counts
    - Prevalence rates
  - Summary of inpatient stays by diagnosis (Q1.b)
  - Summary diagnosis incidence (Q1.c)
    - Incidence rates
- Calculated measurements calculated for Evaluation Q2 – How was preventive, routine, chronic and acute care impacted during the period of extended coverage?
  - Service utilization by chronic condition (Q2.a)
  - Prescription (pre-existing condition) prevalence rates (Q2.a)
  - Prescription (new conditions) incidence rates (Q2.b)
  - Services for selected conditions (Q2.b)
  - HEDIS® measures (applicable age strata) (Q2.b)
- Calculated measurements for Evaluation Q3 – What was the cost of the extended period of coverage?
  - Spending per member per month (Q3.a)

Qualitative Evaluation

The qualitative evaluation focused on describing member, MCO, and State perceptions regarding the extended CHIP coverage. Detailed technical methods of data collection and analysis for assessing qualitative evaluation questions are provided in Appendix B, Methodology and Results of Qualitative Analysis. To ensure the methodological soundness, the steps described in Protocol 6: Administration and Validation of Quality of Care Surveys of External Quality Review (EQR) Protocols, provided by the Centers for Medicare & Medicaid Services (CMS), revised February 2023, were used to conduct the qualitative evaluation.[9]

Evaluation Design

The qualitative evaluation design focused on understanding both the perceptions of KanCare CHIP members regarding their extended coverage and the MCOs' and State's experiences regarding implementation of the extended coverage for the members through this amendment. Online survey design was used to collect qualitative data from members. The information regarding the MCOs and State experiences was collected by emailing a set of questions to MCO and State staff.

Study Population

- **Member Perception Survey:** The study population for the member survey was defined as KanCare CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage.
- **MCO Experience Questionnaire:** The study population was defined as each MCO's primary contact (Medicaid Compliance Officer) and subject matter experts within their organizations.
- **State Experience Questionnaire:** The study population was defined as KanCare program staff who were involved in the implementation of the amendment.

Evaluation Period

March 1, 2020 – March 31, 2024

Evaluation Measures

The member, State, and MCO questionnaires to collect qualitative data were designed by a KFMC committee of subject matter experts. Development of the member and MCO questionnaires included input and approval from the State.

The member perception survey questionnaire was comprised of eleven questions. The questions were designed to collect data on four topics to understand members' perceptions regarding their extended coverage. These topics are summarized in Table 6. See Appendix B for more details.

Table 6. Member Perception Survey Questionnaire Topics

Evaluation Question	Questionnaire Topics
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?	
4.a. What were the members' perceptions of their extended coverage?	
• Were eligible CHIP enrollees aware of their extended coverage?	• Member awareness regarding extended KanCare coverage during the COVID-19 pandemic (Q1).
• How did the extended coverage help the eligible enrollee during the COVID-19 PHE?	• Services members get after they turned 19 (from doctor's office/clinic; dentist; eye doctor; for substance abuse disorder; for mental health; at an emergency room; at a hospital; and from pharmacy for prescription drugs, flu shot, or other vaccines) (Q2–Q9). • Effects of having KanCare coverage after turning 19 on members' family, school, or work life (Q10). • Type of services members are most afraid of losing if their KanCare coverage ends (Q11).

The MCO questionnaire was comprised of eight questions. The questions were designed to collect data on eight topics to understand MCOs' experience regarding implementation of the extended coverage for their CHIP enrollees. These topics are summarized in Table 7. See Appendix B for more details.

Table 7. MCO Questionnaire Topics

Evaluation Question	Questionnaire Topics
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?	
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?	
• What strategies did the MCOs use to engage members who turned 19 during the COVID-19 PHE?	• How Health Plans encourage these members to access services during their extended coverage (Q1)
• What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency?	• Challenges experienced by the health plan in engaging these members during this PHE (Q2) • Challenges these members experienced with healthcare services during the extended coverage (Q4) • Challenges experienced by the health plan during the PHE (Q7)
• What strategies did the MCOs pursue to address those challenges?	• Strategies pursued by the health plan for addressing the challenges experienced by the health plan in engaging these members during this PHE (Q3) • Strategies pursued by the health plan for helping members to overcome the challenges they have with healthcare services during the extended coverage (Q5) • Strategies pursued by the health plan to address the challenges it experienced during the public health emergency (Q8)
	• Overall impact of the extended coverage on members who turned 19 during the PHE (Q6)

The State questionnaire was comprised of eight questions. The questions were designed to collect data on three topics to understand State's experience regarding implementation of the extended coverage for their CHIP enrollees. These topics are summarized in Table 8. See Appendix B for more details.

Table 8. State Questionnaire Topics

Evaluation Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?
Questionnaire Topics • Communication process used to inform eligible CHIP members about extended coverage (Q1–Q5). • Process used by members to enroll for the extended coverage (Q6). • Communication process and strategies used during the public health emergency unwinding period to inform these enrollees about the disenrollment from this extended KanCare 2.0 coverage (Q7–Q8).

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Data Sources

Table 9 presents the data sources used for qualitative evaluation. See Appendix B for further details.

Table 9. Qualitative Evaluation Data Sources

Data Source	Type of Data	Description of Data Source
Member Perception Survey	Qualitative survey data	The online survey was conducted to collect data on members' perceptions regarding their extended coverage. Microsoft Office Forms was used as the data collection tool.
MCO Experience Questionnaire	Qualitative data	A questionnaire was emailed to MCO primary contacts (Medicaid Compliance Officers). The emails included directions for the primary contacts to compile questionnaire responses with input from subject matter experts within their organization. Responses to the questionnaire were returned by primary contacts via email.
State Experience Questionnaire	Qualitative data	A questionnaire was emailed to the primary contact for the State (Medicaid Communications Manager). The email included directions for the primary contact to compile questionnaire responses with input from subject matter experts within the organization. Responses to the questionnaire were returned by the primary contact via email.

Analytic Methods

Detailed analytic methods applied for assessing qualitative evaluation questions are described in Appendix B. An outline of the data collection and analysis steps are presented in Table 10:

Table 10. Qualitative Evaluation Data Collection and Analysis Steps

Data Collection Steps

- **Member Perception Survey**
  - Developed member perception survey cover letter, questionnaire and data collection tool in English and Spanish; all written at a grade 5 reading level.
  - Sent draft Member Survey questionnaire to State for review and approval.
  - Applied sampling plan steps to identify member survey participants.
    - Identified the sample frame from the members of the study population who met the following conditions:
      - ☐ Enrolled in CHIP on the day the survey was distributed (November 21, 2023)
      - ☐ Continuously enrolled in CHIP the 6 months preceding the survey distribution (May 1 through October 31, 2023)
    - Identified the sample from the sample frame – all members in the sample frame were selected in the sample.
  - Mailed survey cover letter with a quick-response (QR) code and link to the online collection tool to the members identified in the survey sample. Included survey completion due date in the cover letter.
  - Tracked the surveys submitted by the respondents through the data collection tool.
  - Retrieved and saved the file comprised of data collected through data collection tool.
- **MCO and State Experience Questionnaires**
  - Developed MCO and State experience questionnaires.
  - Sent draft MCO questionnaire to State for review and approval.
  - Decided whether to send the questionnaires to MCO and State primary contacts or to multiple staff (questionnaire was sent to primary contacts).
    - Identified MCO and State primary contacts.
    - Requested MCOs and State primary contacts to compile questionnaire responses with input from subject matter experts within their organizations.
  - Sent MCO and State questionnaires to the respective primary contacts via email. Include completion due dates.
  - Tracked the emails from the primary contacts to retrieve and save the completed questionnaire files.

Data Analysis Steps

- Applied qualitative analysis steps to data collected through member survey, MCO and State questionnaires.
  - Reviewed data collected through three data sources for completeness and clarity.
  - Applied data cleaning step to data collected through three data sources.
  - Calculated counts and percentages for member survey questionnaire items.
  - Identified themes from data collected through three data sources to understand key stakeholder perceptions and experiences regarding the extended coverage.

Methodological Limitations

Quantitative Evaluation

The quantitative analysis focused on the impact of the amendment and studied patterns of services used by members in the study population during the PHE. The impact of the pandemic on availability of services or on the health of members was outside the scope of the evaluation.

Analysis of diagnosis categories and prescription therapeutic classes showed types of conditions for which services were provided. The severity of an individual's medical conditions was not determined. Also, the analysis of prevalence rates did not include determining the reasons for members continuing or discontinuing a service or treatment. These determinations were outside the scope of the evaluation plan.

Results of utilization and performance measures for CHIP members receiving extended coverage (ages 19 and older) were compared to results for those members when they were 18 years old and receiving regular CHIP coverage. A comparative group of CHIP members aged 19 or older receiving regular coverage did not exist. Also, due to the specialized nature of the study population, suitable national or state benchmarks were unavailable.

Limitations related to source data are included in Appendix A, Activity 7.3.

Qualitative Evaluation

The low participation of members in the Member Perception Survey limits statistical-probabilistic generalizability to the study population. However, it should be noted, like most qualitative studies, the main focus of the survey was to study qualitative aspects of extended coverage from the perspective of CHIP members who turned 19 during the COVID-19 PHE, and the statistical-probabilistic generalizability of the findings to the study population was not an expected feature of the survey.[10,11] To achieve the main purpose of the survey and to limit recall bias, the sample frame for the survey included only those members of the study population who were enrolled in CHIP on the day the survey was distributed and in the six months preceding this date. The data obtained from the 57 respondents who completed the survey showed key recurring perceptions regarding members' awareness about their extended coverage, types of services used, how it affected their lives, and types of services they were most afraid of losing should their KanCare coverage end. The overarching patterns and themes that were derived from these key recurring perceptions provided the valuable information for the member-related qualitative evaluation questions.

Results

Quantitative Evaluation

The detailed results of the data analysis for the quantitative evaluation questions are presented in Appendix A. A synopsis of the results is presented here.

Final analysis is based on the population identified from KMMS membership, Medicaid enrollment, and MCO assignment and encounter tables received in April 2024 (records last updated March 29).

Table 11 shows the counts of the members stratified by their age group (eldest, middle, or youngest) and their ages during which they received regular and extended coverage (for at least one day). By design, the same number of members (7,087) who had coverage when they were 18 years old had extended coverage when they were 19 years old. As the PHE progressed, the number of members aging into extended coverage increased each year, which is seen in the increasing counts from the eldest (2,026), to the middle (2,395), and to the youngest (2,666) age groups. The study did not determine whether this was due to the economy (i.e., more Kansas families qualifying for CHIP) or the policy of extending Medicaid and CHIP coverage during the PHE.

Table 11. Count of Members with CHIP Coverage at Specified Ages

Age Group	Regular Coverage		Extended Coverage					
	Age 18		Age 19		Age 20		Age 21+	
	Count	%	Count	%	Count	%	Count	%
Total	**7,087**	**100%**	**7,087**	**100%**	**5,109**	**100%**	**2,477**	**100%**
Eldest	2,026	28.6%	2,026	28.6%	1,776	35.4%	1,632	65.9%
Middle	2,395	33.8%	2,395	33.8%	2,139	42.6%	845	34.1%
Youngest	2,666	37.6%	2,666	37.6%	1,104	22.0%	0	0.0%

Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

Table 12 provides a second view of the members in the study population. The table provides the average number of months members were enrolled in CHIP during regular and extended coverage periods. The 7,087 members of the study population were in CHIP an average of 11.3 months as 18-year-olds and averaged 20.1 months of extended CHIP coverage. The eldest and middle age groups averaged over 11 months in their first year of CHIP coverage (Age 19); reasons for not having a full year of coverage could include moving out of Kansas, entering prison, or death. The youngest members only averaged 9.5 months of CHIP coverage as 19-year-olds; many transitioned out of CHIP during the winddown period before turning 20 years old.

Table 12. Enrollment of CHIP Members with Extended Coverage, by Age Group and Measurement Period

Measurement Period	Total		Eldest		Middle		Youngest	
	Members	Average Months	Members	Average Months	Members	Average Months	Members	Average Months
Regular Coverage (Age 18)	**7,087**	**11.3**	**2,026**	**10.7**	**2,395**	**11.4**	**2,666**	**11.6**
Extended Coverage (Age 19+)	**7,087**	**20.1**	**2,026**	**30.2**	**2,395**	**21.2**	**2,666**	**11.3**
Age 19 years old	7,087	10.6	2,026	11.2	2,395	11.4	2,666	9.5
Age 20 years old	5,019	9.0	1,776	11.5	2,139	9.4	1,104	4.4
Age 21 and older	2,477	8.7	1,632	11.0	845	4.2	0	0.0

Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

Quantitative Evaluation Question 1

The first quantitative evaluation question (Q1) was focused on assessing the eligible members' service utilization during the period of extended coverage. Members' service utilization was assessed by examining types of services accessed during the period of extended coverage (Q1.a), the diagnoses associated with services received (Q1.b), and new diagnoses received after turning age 19 (Q1.c). The key results from these analyses are summarized below.

Summary of Encounters by Type of Service (Q1.a)

Appendix A, Table A3, summarizes service utilization, stratified by type of claim, age group, and age at time of service. The table shows counts of services and a utilization rate, services per 1,200 member months (which is equivalent to services per 100 members per year, where the number of members is the average of monthly membership counts). Note, the utilization rates may count a member multiple times (once per date of service). The key observations from these analyses are presented below, with associated results presented in Table 13.

Table 13. Services Utilization Rates by Claim Type

	Regular Coverage		Extended Coverage					
	Age 18		Age 19		Age 20		Age 21+	
	Members	MM	Members	MM	Members	MM	Members	MM
All Members	7,087	79,974	7,087	75,322	5,019	45,332	2,477	21,483
	Services	Rate	Services	Rate	Services	Rate	Services	Rate
Inpatient Stays	226	3.4	271	4.3	132	3.5	50	2.8
Outpatient Visits	9,681	145.3	7,925	126.3	4,302	113.9	1,846	103.1
– ED Visits	2,701	40.5	2,527	40.3	1,454	38.5	632	35.3
Professional								
– Non-Vendor Visits*	40,871	613.3	31,706	505.1	16,119	426.7	7,139	398.8
– Vision Visits	3,028	45.4	2,352	37.5	1,252	33.1	455	25.4
– NEMT Trips	225	3.4	136	2.2	28	0.7	17	0.9
Dental Visits	6,419	96.3	3,841	61.2	1,879	49.7	630	35.2
Pharmacy Fills	33,985	509.9	28,864	459.8	16,800	444.7	7,760	433.5

The rate is the expected number of services in a year for 100 members, calculated as 1,200 times services divided by member months (MM).
*Non-vendor visits include services billed on a professional claim form (e.g., CMS 1500) other than vision and NEMT claims (e.g., outpatient primary care, specialist, and mental health care services; and the professional component of inpatient stays).

Three observations from the service utilization analyses are noteworthy:

- The average number of inpatient stays increased from 3.4 stays per 100 members during regular coverage (Age 18) to 4.3 stays per 100 members during the first year of extended coverage (Age 19) and decreased each period thereafter.
- The rates for all other service types decreased for each measurement period.
- The dental visits rate had the greatest relative decrease (36%) from Age 18 to Age 19, decreasing from 96.3 visits per 100 members to 61.2 visits per 100 members.

Summary of Diagnosis Prevalence (Q1.b)

Prevalence was studied in two ways:

- Frequency Counts – counting once per person per date of service
- Prevalence Rates – counting once per person.

Frequency Counts

Appendix A, Table A4, shows counts and relative frequencies of claims based on the ICD-10-CM chapter or category of the primary diagnosis code. The key observations, presented below, include the highest rank categories and the categories with large changes in the ranks. The results pertaining to these observations are presented in Table 14.

Table 14. Frequency of Primary Diagnosis Chapters and Categories												
	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	**47,211**			**38,726**			**21,454**			**9,620**		
Chapter or Category	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**
F01-F99: Mental, behavioral and neurodevelopmental disorders	**10,681**	**22.6%**	**1**	**8,459**	**21.8%**	**1**	**5,046**	**23.5%**	**1**	**2,360**	**24.5%**	**1**
F41: Other anxiety disorders	2,742	5.8%	1	2,364	6.1%	1	1,217	5.7%	1	611	6.4%	1
F33: Major depressive disorder, recurrent	2,395	5.1%	3	1,872	4.8%	3	1,125	5.2%	2	597	6.2%	2
F12: Cannabis related disorders	397	0.8%	21	328	0.8%	20	74	0.3%	49	9	0.1%	64
Z00-Z99: Factors influencing health status and contact with health services	**8,781**	**18.6%**	**2**	**7,010**	**18.1%**	**2**	**3,365**	**15.7%**	**2**	**1,438**	**14.9%**	**2**
Z00: Encounter for general examination without complaint, suspected or reported diagnosis	1,461	3.1%	5	875	2.3%	8	431	2.0%	8	191	2.0%	7
Z34: Encounter for supervision of normal pregnancy	437	0.9%	19	673	1.7%	13	338	1.6%	13	119	1.2%	15
Z36: Encounter for antenatal screening of mother	152	0.3%	47	249	0.6%	29	157	0.7%	25	52	0.5%	34
Z12: Encounter for screening for malignant neoplasms	10	0.0%	146	14	0.0%	132	11	0.1%	104	74	0.8%	25
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**5,348**	**11.3%**	**3**	**4,804**	**12.4%**	**3**	**2,780**	**13.0%**	**3**	**1,181**	**12.3%**	**3**
R10: Abdominal and pelvic pain	1,057	2.2%	10	1,052	2.7%	6	595	2.8%	5	224	2.3%	6
R07: Pain in throat and chest	349	0.7%	25	357	0.9%	19	223	1.0%	18	99	1.0%	16
R30: Pain associated with micturition	276	0.6%	32	241	0.6%	31	133	0.6%	29	79	0.8%	21
R53: Malaise and fatigue	206	0.4%	42	148	0.4%	44	115	0.5%	34	72	0.7%	27

For the numerator and denominator of the rate, the category of a primary diagnosis is counted once per member per date of service. Rates were ranked from highest (1) to lowest.

- F01–F99 (Mental, behavioral and neurodevelopmental disorders) was the most frequently used diagnosis chapter, ranking first for all four measurement periods and represented more than one fifth of the total count (22% to 25%).
  - F41 (Other anxiety disorders) was the highest ranked diagnosis category.
  - F33 (Major depressive disorder, recurrent) was the third highest ranked category for the Age 18 and Age 19 periods and second highest ranked category for Age 20 and Age 21+.
  - F12 (Cannabis related disorders) had rates drop from 0.8% (ranked 21st) for Age 18 to 0.1% (ranked 64th) for Age 21+. The study could not determine from the data whether the prevalence of cannabis-related disorders decreased as members aged or if these members had fewer visits with providers.
- Z00–Z99 (Factors influencing health status and contact with health services) was the second most frequently used diagnosis chapter. These codes record reasons for a visit and not a specific disease or disorder. Most rates and ranking for most of the categories within this chapter displayed in Appendix A, Table A4, were relatively stable.
  - Z00 (Encounter for general examination without complaint, suspected or reported diagnosis) had the highest average ranking for this chapter.
  - Z34 (Encounter for supervision of normal pregnancy) and Z36 (Encounter for antenatal screening of mother) rates were higher for Age 19 and Age 20 than Age 18.
  - Z12 (Encounter for screening for malignant neoplasms) rankings increased from 146th for Age 18 to 25th for Age 21+.
- R00–R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) was the third most frequently used diagnosis chapter.
  - R10 (Abdominal and pelvic pain) had the highest average ranking for this chapter.

- R07 (Pain in throat and chest) rankings increased from 25th for Age 18 to 19th for Age 19, 18th for Age 20 and 16th for Age 21+.
- R30 (Pain associated with micturition) and R53 (Malaise and fatigue) rankings increased for Age 21+ (for R30 from 32nd rank for Age 18 to 21st for Age 21+; and for R53 from 42nd rank for Age 18 to 27th for Age 21+).

Prevalence Rates

Prevalence rates based on primary diagnosis codes, displayed in Appendix A, Table A5, show the expected number of people who would have a diagnosis from the category in a year from a group of 100 people. It should be noted, most chapters and category codes listed in Appendix A, Tables A4 (frequency) and A5 (prevalence), were the same, although rankings varied slightly between tables. The top five rankings of the chapters based on the prevalence rates are presented in Table 15.

Table 15. Prevalence Rates of Primary Diagnosis Chapters

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Member Months	79,974			75,322			45,332			21,483		
Chapter or Category	Count	Rate	Rank	Count	Rate	Rank	Count	Rate	Rank	Count	Rate	Rank
Z00-Z99: Factors influencing health status and contact with health services	3,531	53.0	1	2,764	44.0	1	1,437	38.0	1	595	33.2	1
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	2,144	32.2	3	1,960	31.2	2	1,133	30.0	2	457	25.5	2
H00-H59: Diseases of the eye and adnexa	2,399	36.0	2	1,906	30.4	3	1,042	27.6	3	376	21.0	3
J00-J99: Diseases of the respiratory system	1,527	22.9	4	1,261	20.1	4	754	20.0	4	326	18.2	4
F01-F99: Mental, behavioral and neurodevelopmental disorders	1,474	22.1	5	1,236	19.7	5	723	19.1	5	319	17.8	5

Rates are the expected number of people who would have a diagnosis from the category in a year from a group of 100 people; rates equal 1,200 times the count divided by member months. For the numerator of the rate, the category of a primary diagnosis is counted once per member per date of service. Rates were ranked from highest (1) to lowest.

The following key differences were seen in the rankings of the primary diagnosis chapters based on prevalence rates (Table 15) compared to those based on frequency analysis (Table 14).

- In Table 14, the highest ranked chapter was F01–F99 (Mental, behavioral and neurodevelopmental disorders) dropped to the fifth place in Table 15. This is typical of conditions that require multiple treatment days during a year.
- With F01–F99 moving downward in Table 15, Z00–Z99 (Factors influencing health status and contact with health services) and R00-R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) moved from second and third place to first and second place, respectively.

Regarding the rankings of primary diagnosis categories based on prevalence rates (Appendix A, Table A5), the following points were seen:

- The top ranked category code was H52 (Disorders of refraction and accommodation). The claims are mostly from annual eye exams. Based on frequency analysis (Table 14), H52 ranked second or third.
- Four category codes are related to COVID-19. The lowest ranks (indicating relatively lower prevalence rates) for each of these codes were in the Age 21+ measurement period. Keep in mind, claims for this period had dates of service near the end of the PHE or later, whereas the Age 19 period had claims with dates of service throughout the PHE. The four categories were
  - Z11 (Encounter for screening for infectious and parasitic diseases),
  - Z20 (Contact with and [suspected] exposure to communicable diseases),
  - Z23 (Encounter for immunization), and
  - U07 (Emergency use of U07), which includes U07.0 (Vaping-related disorder) and U07.0 (COVID-19).

Prevalence rates were also calculated using primary and secondary diagnosis codes. These results showed patterns similar to the prevalence rates calculated using primary diagnosis codes (Appendix A, Table A5). The main difference was the inclusion of category codes that are not generally used for primary diagnoses:

- Z68 (Body mass index [BMI])
- Z79 (Long term [current]drug therapy)
- Z3A (Weeks of gestation)
- Z87 (Personal history of other diseases and conditions)
- F17 (Nicotine dependence)
- E66 (Overweight and obesity)

Summary of Inpatient Stays by Diagnosis (Q1.b)

Inpatient stays were analyzed based on their Major Diagnostic Category (MDC) and Medicare Severity Diagnosis Related Group (MS-DRG) codes. The intent of the analysis was to identify the most frequently used codes. Based on review of preliminary stratified counts, the data are presented in Table 16 as a top-ten list of MDC codes from inpatient encounters in the extended coverage period. Corresponding frequency counts for the regular coverage period are provided for comparison.

Table 16. Top 10 Major Diagnostic Categories for Inpatient Stays

Major Diagnostic Category Code and Description	Regular Coverage		Extended Coverage	
	N	%	N	%
Inpatient Stays with MDC Code	**230**		**474**	
14. Pregnancy, Childbirth & The Puerperium	68	30%	189	40%
19. Mental Diseases & Disorders (D&D)	58	25%	78	16%
15. Newborn & Neonates with Conditions Orig. Perinatal Period	9	4%	45	9%
10. Endocrine, Nutritional & Metabolic D&D	10	4%	26	5%
18. Infectious & Parasitic Diseases	14	6%	18	4%
01. D&D of the Nervous System	10	4%	18	4%
06. D&D of the Digestive System	7	3%	16	3%
08. D&D Musculoskeletal System & Connect Tissue	13	6%	15	3%
21. Injuries, Poisonings, Toxic Effect of Drugs	7	3%	14	3%
04. D&D of the Respiratory System	5	2%	12	3%
All Other MDCs	29	13%	43	9%

Claims with MDC of 15 are from claims for newborns billed under the mother's Medicaid ID. For these, there is a claim for the mother's stay with MDC of 14.

A few key observations are as follows:

- The two MDCs with the greatest increases from regular to extended coverage in their percent of stays within the coverage period were related to pregnancy.
  - Inpatient stays for the mother (MDC 14 – Pregnancy, Childbirth & The Puerperium) increased from 30% of stays to 40% of stays.
  - Stays for the newborn that were billed under the mother's Medicaid ID (MDC – Newborn & Neonates with Conditions Orig. Perinatal Period) increased from 4% of stays to 9% of stays.
    - 57% (107) of 189 MDC 14 stays in the extended coverage period were for routine vaginal delivery (MS-DRG 807 – Vaginal delivery w/o sterilization/D&C w/o CC/MCC).
    - 5% (15) of 189 MDC 14 stays in the extended coverage period were for routine cesarean delivery (MS-DRG 788 – Cesarean section w/o sterilization w/o CC/MCC.
    - 49% (17) of 35 MDC 15 stays in the extended coverage period were normal newborn stays (MS-DRG 795).
- MDC 19 – Mental Diseases & Disorders (D&D) ranked second for both coverage periods.
  - 88% (69) of 78 MDC 19 stays in the extended coverage period were for psychoses (MS-DRG 885).

- Within MDC 10 – Endocrine, Nutritional & Metabolic D&D, 88% (26) of 29 stays in the extended coverage period were for diabetes (MS-DRGs 637, 638, and 639).

Summary Diagnosis Incidence (Q1.c)

Incidence rates were calculated at the chapter and category levels from outpatient, vision, and non-vendor professional claims. Incidence rates were defined as the percent of members that matched to a at least one "new" diagnosis from the specified chapter or category within the extended study period. A diagnosis was considered new if there was not a claim with a diagnosis code in the same category with an earlier date of service. Appendix A, Table A7, shows incidence rates for diagnosis chapters and categories. The key observations from these analyses are presented below. The results pertaining to these observations are presented in Table 17.

Table 17. Incidence Rates for Diagnosis Chapters and Categories

	Extended Coverage	
Count of Members (Denominator)	**7,087**	
Diagnosis Chapter or Category	**N**	**%**
Z00-Z99: Factors influencing health status and contact with health services	**5,361**	**75.6%**
Z20: Contact with and (suspected) exposure to communicable diseases	2,531	35.7%
Z23: Encounter for immunization	2,320	32.7%
Z00: Encounter for general examination without complaint, suspected or reported diagnosis	2,205	31.1%
Z11: Encounter for screening for infectious and parasitic diseases	1,733	24.5%
Z30: Encounter for contraceptive management	1,417	20.0%
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**4,323**	**61.0%**
R10: Abdominal and pelvic pain	1,567	22.1%
R05: Cough	1,240	17.5%
H00-H59: Diseases of the eye and adnexa	**3,476**	**49.0%**
H52: Disorders of refraction and accommodation	3,263	46.0%
J00-J99: Diseases of the respiratory system	**3,227**	**45.5%**
J02: Acute pharyngitis	1,759	24.8%
F01-F99: Mental, behavioral and neurodevelopmental disorders	**2,747**	**38.8%**
F41: Other anxiety disorders	1,611	22.7%

The *incidence rate* is the percent of the study population who had a primary or secondary diagnosis in the chapter or category during the extended coverage period but not in the regular coverage period.

The five chapters with the greatest incidence rates also had the greatest prevalence rates and contained the top 10 categories (Table 15):

- The highest incidence rate (75%) was for Z00–Z99 (Factors influencing health status and contact with health services).
  - This chapter also included five of the top 10 categories. The incidence rate was 36% for Z20 (Contact with and [suspected] exposure to communicable diseases); 33% for Z23 (Encounter for immunization); 31% for Z00 (Encounter for general examination without complaint, suspected or reported diagnosis); 24% for Z11 (Encounter for screening for infectious and parasitic diseases); and 20% for Z30 (Encounter for contraceptive management).
- The second highest incidence rate (61%) was for R00–R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified), followed by 49% for H00–H59 (Diseases of the eye and adnexa), 46% for J00–J99 (Diseases of the respiratory system), and 39% for F01–F99 (Mental, behavioral and neurodevelopmental disorders).
  - R00–R99 included two of the top 10 categories with the incidence rate of 22% for R10 (Abdominal and pelvic pain) and 17% for R05 (Cough).

- H00–H59, J00–J99, and F01–F99 each contained one of the top 10 categories. These categories were H52 (Disorders of refraction and accommodation) with the incidence rate of 46%, J02 (Acute pharyngitis) with the incidence rate of 25%, and F41 (Other anxiety disorders) with the incidence rate of 23%.

Codes in chapter Z00–Z99 are used to record the reason for a visit. Of the five top-10 categories in this chapter, three indicated preventive care (Z00, Z23, and Z30) and two indicated acute care (Z20 and Z11). Codes Z20, Z23, and Z11 (listed above) may be related to COVID-19. The incidence rate for U07 (Emergency use of U07), which includes diagnoses of COVID-19, was 10% (ranked 28th).

Appendix A, Table A7, also showed incidence rates for diagnosis chapters that include severe and life-threatening diagnoses, such as Diseases of the circulatory systems (6.9%), Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (7.2%), Neoplasms (4.5%), and Diseases of the genitourinary system (28.8%). This indicated the extended coverage assisted in identifying and providing needed treatment for the newly diagnosed severe diseases.

Quantitative Evaluation Question 2

The second quantitative evaluation question (Q2) was focused on the preventive, routine, chronic and acute care among eligible members during the period of extended coverage. This included assessing service utilization (Q2.a) of preventive, routine, and acute health care during the period of extended coverage; and the patterns of services (Q2.b). The key results from these analyses are summarized below.

Service utilization by chronic condition (Q2.a)

The results for analyses assessing the continuation of services utilization for eight chronic conditions are presented in Table 18. The rates shown are the percentages of members who received services for the given condition during regular coverage (Age 18) who also received services for the condition during the first year of extended coverage (Age 19) or any time during extended coverage (Age 19+). Services were counted from inpatient, outpatient, and professional encounters. Chronic conditions were identified using primary and secondary diagnosis codes.

Table 18. Service Utilization for Selected Chronic Conditions

Diseases	Age 18	Age 19		Age 19+	
	Denominator	Count	Rate	Count	Rate
Asthma	409	167	41%	202	49%
Asthma with Exacerbation	84	18	21%	22	26%
Diabetes Mellitus	76	54	71%	60	79%
Diabetes Treatment	38	18	47%	22	58%
Diabetes Ketoacidosis/Hyperglycemia	50	38	76%	38	76%
Mental Health Issue	1,680	953	57%	1,049	62%
Substance Use Disorder	279	101	36%	123	44%
Overweight and Obesity	536	195	36%	236	44%

Counts are the number of members with an inpatient, outpatient, or professional encounter having a primary or secondary diagnosis for the given condition.

- Asthma: Category J45
- Asthma with Exacerbation: Diagnoses J45.xx; with xx equal to 22, 31, 32, 41, 42, 50, 51, 52, 901, or 902
- Diabetes Mellitus: Categories E08 through E13
- Diabetes Treatment: Diagnoses Z79.4, Z79.84
- Diabetes Ketoacidosis/Hyperglycemia: Diagnoses Exx.10, Exx.11, Exx.65, Exx.69; xx from 08 to 13
- Mental Health Issue: Categories F01 through F09 and F20 through F99
- Substance Use Disorder: Categories F10 through F19
- Overweight and Obesity: Category E66 and Diagnoses Z68.xx; with xx from 25 to 45 or equal to 53 or 54

The chronic conditions with the highest percentages of diagnosed members having treatment continued into the extended coverage period were diabetes mellitus (79%), diabetes ketoacidosis/hyperglycemia (76%), mental health issues (62%), and diabetes treatment (58%).

For members with treatment for a chronic condition continued into the extended period, the majority had received treatment within the first year of extended coverage.

Prescription (pre-existing condition) prevalence rates by generic therapeutic class (Q2.a)
Table 19 displays results of analysis of pharmacy claims addressing Q2.a. The table includes generic therapeutic classes (GTCs) with the Age 19+ rates being above the Age 19+ GTC average rate. Specific therapeutic classes (STCs) with Age 19+ rates above the GTC average rate and denominators greater than or equal to 50 are also displayed. GTCs are shown in bold font, STCs are in regular font. See Appendix A, Table A9, for additional GTC and STC prescription prevalence rates.

Table 19. Prescription Prevalence Rates for Generic and Specific Therapeutic Classes

Generic or Specific Therapeutic Class (GTC or STC)	Age 18	Age 19		Ages 19+	
	D	N	%	N	%
GTC Average Rate	**14,370**	**5,447**	**37.9%**	**6,370**	**44.3%**
Age 19+ Rates Above the GTC Average Rate					
19: Antibiotics	**2,422**	**1,149**	**47.4%**	**1,417**	**58.5%**
80: Psychotherapeutic Drugs	**1,254**	**762**	**60.8%**	**826**	**65.9%**
8875: Selective Serotonin Reuptake Inhibitor (SSRIs)	828	450	54.3%	484	58.5%
8889: Serotonin-Norepinephrine Reuptake-Inhib (SNRIs)	135	75	55.6%	77	57.0%
0267: Tx for Attention Deficit-Hyperact (ADHD)/Narcolepsy	120	59	49.2%	61	50.8%
0292: Adrenergics, Aromatic, Non-Catecholamine	107	53	49.5%	57	53.3%
9158: Antipsychotic, Atypical, Dopamine, Serotonin Antagns	94	51	54.3%	51	54.3%
47: Contraceptives	**1,075**	**667**	**62.0%**	**700**	**65.1%**
0248: Contraceptives, Oral	926	561	60.6%	584	63.1%
65: Gastrointestinal	**953**	**358**	**37.6%**	**436**	**45.8%**
14: Antiasthmatics	**688**	**350**	**50.9%**	**396**	**57.6%**
G476: Beta-Adrenergic Agents, Inhaled, Short Acting	577	254	44.0%	295	51.1%
6205: Leukotriene Receptor Antagonists	194	101	52.1%	110	56.7%
E157: Glucocorticoids, Orally Inhaled	122	54	44.3%	57	46.7%
7779: Beta-Adrenergic and Glucocorticoid Combo, Inhaled	98	59	60.2%	64	65.3%
44: Central Nervous System Drugs	**204**	**95**	**46.6%**	**105**	**51.5%**
0275: Anticonvulsants	192	91	47.4%	99	51.6%
41: Cardiovascular	**178**	**93**	**52.2%**	**98**	**55.1%**
32: Autonomic Drugs	**162**	**89**	**54.9%**	**93**	**57.4%**
0292: Adrenergics, Aromatic, Non-Catecholamine	112	67	59.8%	69	61.6%
71: Antihyperglycemics	**119**	**80**	**67.2%**	**84**	**70.6%**
89: Thyroid Preps	**65**	**47**	**72.3%**	**49**	**75.4%**
56: Diuretics	**71**	**43**	**60.6%**	**45**	**63.4%**
72: Immunosuppressants	**36**	**21**	**58.3%**	**22**	**61.1%**
08: Anti-Obesity Drugs	**22**	**10**	**45.5%**	**11**	**50.0%**

The *prescription prevalence rate* is the percentage members who had a pharmacy claim having the given GTC or STC in the Age 18 period (D) who had a pharmacy claim with the same GTC (or STC) in the Age 19 or Age 19+ extended coverage periods (N). The *GTC average rate* was calculated by summing the numerators and denominators of the GTC rates. The table includes GTC with the Age 19+ rates being above the GTCs average Age 19+ rate. Rows are sorted by the Age 19+ numerator. Specific Therapeutic Classes (STCs) with Age 19+ rates above the GTC average rate and denominators greater than or equal to 50 are also displayed.

The results presented in Table 19 showed the following key observations.

- The GTC average prescription prevalence rate was 38% for Age 19 and 44% for Age 19+. This indicates, of the 14,370 prescriptions filled during regular coverage, 38% had a corresponding prescription in the same GTC filled by the member in their first year of extended coverage and 44% had a prescription of the same GTC filled by the member anytime during the extended coverage.

- The prescriptions with prevalence rates higher than the GTC average rate fall into three categories:
  - Treatment for acute conditions (e.g., antibiotics)
  - Treatment for chronic conditions (e.g., psychotherapeutic drugs and antiasthmatics)
  - Preventive medicine (e.g., contraceptives and anti-obesity drugs)
- Several STC rates for treatment with psychotherapeutic drugs were higher than the Age 19+ GTC average rate, indicating members frequently maintain treatment within the same specific therapeutic class. In contrast, no STC rates for antibiotics were higher than the GTC average rate, which may indicate treatments with antibiotics tend to change specific therapeutic classes to target specific bacterial infections.
- Table 19 showed many of the prescriptions prevalence rates higher than the GTC average rate are used for chronic diseases. Prescriptions treating chronic conditions are required to be taken continually. However, the prevalence rates for these prescriptions indicated they were not continued into the extended coverage period by many members. For example, 34% of members filling a prescription for a psychotherapeutic medication discontinued taking it before turning 19 years old. Around half of members previously prescribed anti-convulsant, asthma, or heart medications did not continue them. The diabetes and thyroid prescriptions prevalence rates were a little better, but still around 30% of taking these medications at age 18 discontinued them. Although there might be some cases in which these medications were discontinued by the prescribing health professional, these rates seemed to indicate many were discontinued for non-medical reasons. This may be an area that could be improved by better communication and coordination among members, providers, pharmacies and MCOs.

Prescription (new prescriptions) incidence rates by generic therapeutic class (Q2.b)
Table 20 displays *prescription incidence rates* calculated as the percent of members in the study population who had a prescription during the extended coverage period that they did not have during the regular coverage period. The technical terms are as defined for prescription prevalence rates. See Appendix A, Table A10, for additional detail.

Six GTCs and four STCs had prescription incidence rates greater than 10% for Age 19+:
- Antibiotics (14% for Age 19, 21% for Age 19+)
  - Penicillin Antibiotics (9%, 15%)
- Gastrointestinal (8%, 12%)
- Analgesics (8%, 12%)
  - Opioid Analgesic and Non-Salicylate Analgesics (6%, 10%)
- Biologicals (8%, 10%)
- Hormones (7%, 12%)
  - Glucocorticoids (7%, 11%)
- Antiarthritics (6%, 10%)
  - NSAIDs, Cyclooxygenase Inhibitor Type Analgesics (6%, 10%)

The medications shown in Table 20 with relatively high prescription incidence rates are consistent with conditions with high incidence rates shown in Table 17. For example, the GTC having the highest prescription incidence rate was Antibiotics. This is consistent with the relatively high incident rates shown in Table 7A that indicate conditions commonly treated with antibiotics—for example, Z20 (Contact with and [suspected] exposure to communicable diseases, Z11 (Encounter for screening for infectious and parasitic diseases), J02 (Acute pharyngitis), or J06 (Acute upper respiratory infections of multiple and unspecified sites).

Table 20. Prescription Incidence Rates for Generic and Specific Therapeutic Classes				
	Age 19		Age 19+	
Count of Members (Denominator)	7,087		7,087	
Generic or Specific Therapeutic Class (GTC or STC)	**N**	**%**	**N**	**%**
All GTCs (Members with any new GTC)	**3,219**	**45.4%**	**4,016**	**56.7%**
19: Antibiotics	**1,001**	**14.1%**	**1,508**	**21.3%**
0476: Penicillin Antibiotics	651	9.2%	1,046	14.8%
0478: Tetracycline Antibiotics	286	4.0%	509	7.2%
0479: Macrolide Antibiotics	288	4.1%	480	6.8%
9256: Cephalosporin Antibiotics - 1st Generation	251	3.5%	459	6.5%
0502: Anaerobic Antiprotozoal-Antibacterial Agents	179	2.5%	323	4.6%
0491: Absorbable Sulfonamide Antibacterial Agents	172	2.4%	299	4.2%
0494: Nitrofuran Derivatives Antibacterial Agents	153	2.2%	283	4.0%
0388: Topical Antibiotics	141	2.0%	249	3.5%
0402: Ophthalmic Antibiotics	111	1.6%	209	2.9%
65: Gastrointestinal	**541**	**7.6%**	**860**	**12.1%**
0282: Antiemetic/Antivertigo Agents	414	5.8%	663	9.4%
8026: Proton-Pump Inhibitors	158	2.2%	293	4.1%
02: Analgesics	**538**	**7.6%**	**879**	**12.4%**
B974: Opioid Analgesic and Non-Salicylate Analgesics	455	6.4%	727	10.3%
0268: Opioid Analgesics	108	1.5%	219	3.1%
92: Biologicals	**532**	**7.5%**	**714**	**10.1%**
I529: COVID-19 Vaccines	454	6.4%	604	8.5%
0512: Influenza Virus Vaccines	171	2.4%	255	3.6%
68: Hormones	**501**	**7.1%**	**833**	**11.8%**
0360: Glucocorticoids	473	6.7%	774	10.9%
11: Antiarthritics	**424**	**6.0%**	**732**	**10.3%**
0439: NSAIDs, Cyclooxygenase Inhibitor Type Analgesics	420	5.9%	724	10.2%
80: Psychotherapeutic Drugs	**391**	**5.5%**	**622**	**8.8%**
8875: Selective Serotonin Reuptake Inhibitor (SSRIs)	296	4.2%	478	6.7%
17: Antihistamines	**315**	**4.4%**	**497**	**7.0%**
3218: Antihistamines - 1st Generation	207	2.9%	335	4.7%
8541: Antihistamines - 2nd Generation	139	2.0%	212	3.0%
86: Skin Preps	**291**	**4.1%**	**464**	**6.5%**
22: Antifungals	**264**	**3.7%**	**451**	**6.4%**
0498: Antifungal Agents	179	2.5%	315	4.4%
47: Contraceptives	**261**	**3.7%**	**388**	**5.5%**
0248: Contraceptives, Oral	244	3.4%	361	5.1%
14: Antiasthmatics	**226**	**3.2%**	**364**	**5.1%**
G476: Beta-Adrenergic Agents, Inhaled, Short Acting	216	3.0%	350	4.9%
62: EENT Preps	**215**	**3.0%**	**364**	**5.1%**
0409: Nasal Anti-Inflammatory Steroids	180	2.5%	299	4.2%
77: Muscle Relaxants	**176**	**2.5%**	**309**	**4.4%**
0281: Skeletal Muscle Relaxants	176	2.5%	309	4.4%
50: Cough/Cold Preparations	**171**	**2.4%**	**329**	**4.6%**
0279: Antitussives, Non-Opioid	127	1.8%	252	3.6%
99: Unclassified Drug Products	**142**	**2.0%**	**240**	**3.4%**
21: Antivirals	**126**	**1.8%**	**257**	**3.6%**
0510: Antivirals, General	106	1.5%	215	3.0%
41: Cardiovascular	**110**	**1.6%**	**200**	**2.8%**

The *prescription incidence rate* is the percent of the members who had a pharmacy claim having the given GTC or STC during the extended coverage period but did not have a claim for that GTC or STC in the regular coverage period. GTCs and STCs with Age 19+ numerator (N) greater than or equal to 200 are shown.

Services for selected conditions (Q2.b)

Tables 21 and 22 display frequency counts and service utilization rates for selected conditions across the regular and extended coverage periods. Table 21 is based on institutional claims for emergency department visits, observation stays, and inpatient stays. Table 22 is based on professional and outpatient, excluding emergency room visits and observation stays.

Table 21. ED Visits, Observation Stays, and Inpatient Admissions for Selected Conditions

Condition	Regular		Extended	
	Count	Rate	Count	Rate
COVID-19	42	0.6	120	1.0
Acute Respiratory Infections	72	1.1	289	2.4
Acute Severe Asthma	47	0.7	301	2.5
Diabetes Ketoacidosis/Hyperglycemia	36	0.5	81	0.7
External Cause of Morbidity	12	0.2	24	0.2
Mental Health Issue	175	2.6	527	4.4
Substance Use Disorder	145	2.2	687	5.8

The rates are the expected number for 100 members per year, calculated as count of visits times 1,200 divided by member months.

Table 22. Outpatient and Professional Visits for Selected Conditions

Condition	Regular		Extended	
	Count	Rate	Count	Rate
Acute Upper Respiratory Infections	1,912	28.7	2,944	24.9
Pneumonia	45	0.7	87	0.7
Other Acute Lower Respiratory Infections	151	2.3	169	1.4
Diabetes Ketoacidosis/Hyperglycemia	529	7.9	796	6.7
Substance Use Disorder	1,030	15.5	1,616	13.6
Influenza	127	1.9	206	1.7

The count and rates are from professional and outpatient claims, excluding ED visits and observation stays. The rates are the expected number for 100 members per year, calculated as count of visits times 1,200 divided by member months.

These results show one key observation:

- Utilization rates in the emergency department, observation room, and inpatient settings generally increased for the selected conditions, whereas utilization rates generally decreased in the professional and other outpatient settings.

HEDIS® measures[14] (applicable age strata) (Q2.b)

Two HEDIS technical specifications were adjusted to calculate rates for the following four performance measures from encounter data:

- Annual Dental Visits (ADV)
- Adult's Access to Preventive/Ambulatory Health Services (AAP)
- Child and Adolescent Well-Care Visits (WCV)
- Inpatient Utilization (IPU)

Tables 23 displays percentages of members receiving annual dental visits, preventive and ambulatory health services, and well-care visits.

Table 23. HEDIS Measures ADV, AAP, and WCV

Indicator and Age group	Age 18			Age 19			Age 20		
	D	N	Rate	D	N	Rate	D	N	Rate
Annual Dental Visits (ADV)	**6,272**	**2,787**	**44.4%**	**5,276**	**1,607**	**30.5%**	**2,661**	**664**	**25.0%**
Eldest	1,591	749	47.1%	1,791	581	32.4%	1,640	428	26.1%
Middle	2,177	967	44.4%	2,158	646	29.9%	1,021	236	23.1%
Youngest	2,504	1,071	42.8%	1,327	380	28.6%			
Adult's Access to Preventive/Ambulatory Health Services (AAP)	**6,272**	**4,793**	**76.4%**	**5,276**	**3,576**	**67.8%**	**2,661**	**1,708**	**64.2%**
Eldest	1,591	1,260	79.2%	1,791	1,235	69.0%	1,640	1,061	64.7%
Middle	2,177	1,651	75.8%	2,158	1,475	68.4%	1,021	647	63.4%
Youngest	2,504	1,882	75.2%	1,327	866	65.3%			
Child and Adolescent Well-Care Visits (WCV)	**6,272**	**1,282**	**20.4%**	**5,276**	**689**	**13.1%**	**2,661**	**307**	**11.5%**
Eldest	1,591	359	22.6%	1,791	258	14.4%	1,640	187	11.4%
Middle	2,177	455	20.9%	2,158	273	12.7%	1,021	120	11.8%
Youngest	2,504	468	18.7%	1,327	158	11.9%			

Rates are adjusted, uncertified, unaudited HEDIS rates. Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

Two patterns were common to all three measures in Table 23:

- For each age group (Eldest, Middle, and Youngest), rates decreased as members grew older.
- Within each measurement period, the Eldest group had the highest rates, and the Youngest group had the lowest rates.

Table 24 shows inpatient utilization rates, stratified as maternity, surgery stays and medicine. Three rates are shown, days per discharge, discharges per 12,000 member months (the *Discharge Rate*), and days per 12,000 member months (the *Days Rate*).

Table 24. Inpatient Utilization (IPU) Measure Based on HEDIS

Indicator	Period	Discharges	Days	Days/Discharge	MM	Discharge Rate	Days Rate
IPU Total	**Age 18**	179	682	3.8	79,974	26.9	102.3
	Age 19	197	658	3.3	75,322	31.4	104.8
	Age 20	86	299	3.5	45,332	22.8	79.1
Maternity	**Age 18**	60	164	2.7	40,327	17.9	48.8
	Age 19	104	246	2.4	38,099	32.8	77.5
	Age 20	50	126	2.5	22,906	26.2	66.0
Surgery	**Age 18**	34	181	5.3	79,974	5.1	27.2
	Age 19	25	147	5.9	75,322	4.0	23.4
	Age 20	11	54	4.9	45,332	2.9	14.3
Medicine	**Age 18**	85	337	4.0	79,974	12.8	50.6
	Age 19	68	265	3.9	75,322	10.8	42.2
	Age 20	25	119	4.8	45,332	6.6	31.5

The count of discharges and days are from paid inpatient claims. Member months (MM) for Maternity are limited to female members. The Discharge and Days Rates are the expected number of discharges or days for 1,000 members per year, calculated as count of discharges or days times 12,000 divided by member months.

Three main observations were seen in Table 24:

- Among females, maternity services utilization was greatest during the members' first year of extended coverage—nearly half of the maternity discharges were during the Age 19 period.
- For surgery and medicine, the Discharge Rate and Days Rate declined each measurement period.
- The longest stays were for surgeries in the first year of extended coverage.

Quantitative Evaluation Question 3

The third quantitative evaluation question (Q3) focused on costs during the extended period of coverage. This included determining the cost of services provided to members who received extended coverage (Q3.a). The costs were identified from the encounter records used to determine service utilization rates (see Table 13 above and Appendix A, Table A3). The key results from these analyses are summarized below.

Table 25 presents MCO claim payments to providers (in total and per 12 member months), stratified by claim type. Appendix A, Table A13, also includes totals and amounts per 12 member months that include MCO payments, member copay and spenddown amounts, and claim payments by Medicare and commercial insurances.

Table 25. Estimated Claim Payments of Extended Coverage, by Claim Types

	Regular coverage	Extended Coverage		
	18 Years	19 Years	20 Years	21+ Years
Members Months	**79,974**	**75,322**	**45,332**	**21,483**
MCO Payments	**$14,182,476**	**$12,541,357**	**$6,390,340**	**$2,298,124**
Inpatient	$1,901,856	$1,622,818	$938,938	$301,512
Outpatient	$1,485,366	$1,305,338	$621,643	$303,259
Professional	$4,499,486	$3,785,335	$1,952,469	$826,966
Dental	$1,569,145	$827,180	$411,428	$110,489
Vision	$386,419	$309,548	$162,118	$56,818
NEMT	$22,606	$24,103	$4,859	$1,420
Pharmacy	$4,317,598	$4,667,036	$2,298,886	$697,660
Per 12 Member Months	**$2,128**	**$1,998**	**$1,692**	**$1,284**
Inpatient	$285	$259	$249	$168
Outpatient	$223	$208	$165	$169
Professional	$675	$603	$517	$462
Dental	$235	$132	$109	$62
Vision	$58	$49	$43	$32
NEMT	$3	$4	$1	$1
Pharmacy	$648	$744	$609	$390

Data source: KMMS encounter records as of April 4, 2024.

The following key observations were seen in Table 25:

- The categories with the highest payments were professional and pharmacy claims.
- Overall, payment amounts decreased as members aged, both as total payment amounts and payments per 12 member months. There were two exceptions; NEMT and Pharmacy payments increased from Age 18 to Age 19.
- The claim type with the greatest relative decrease in payments per 12 member months was dental. MCO dental payments decreased 44% (from $230 to $132) between Age 18 and Age 19 and 74% (from $230 to $60) between Age 18 and Age 20+.

Qualitative Evaluation

The detailed results of the qualitative analysis of member, MCO, and State responses are presented in Appendix B. A synopsis of the results is presented here.

Member Perceptions

The study population of the member survey was comprised of 7,087 KanCare CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage. A sample frame of 2,302 members was determined using two criteria—being enrolled in CHIP on the day the survey was distributed and also enrolled in the preceding six months to this date. All members in the sample frame were selected into the survey sample. The survey was mailed on November 21, 2023, to 2,302 members. The data collection tool was available to the respondents until December 29, 2023. The last response was received on December 28, 2023. The survey included eleven questions. Fifty-seven respondents completed the survey, with each providing responses to all the questions. The detailed results of the survey are described in Appendix B. The key themes derived from these results are presented in Table 26.

Table 26. Member Perception Survey Results

Evaluation Question	Survey Questionnaire Topic	Key Themes
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.a. What were the members' perceptions of their extended coverage?		
Were eligible CHIP enrollees aware of their extended coverage?	Member awareness regarding extended KanCare coverage during the COVID-19 pandemic (Q1)	• **Most of the eligible CHIP enrollees were aware of their extended coverage during the COVID-19 pandemic.** ○ They learned about it either before or after turning 19 years of age.
How did the extended coverage help the eligible enrollee during the COVID-19 PHE?	Services members get after they turned 19 (Q2–Q9)	• **Extended coverage helped CHIP enrollees get services from health and pharmacy providers after turning 19 during the COVID-19 PHE.** ○ The services were obtained from doctor's offices and clinics, dentists, and eye doctors; for mental health; at emergency rooms and hospitals; and from pharmacies for prescription drugs, flu shots, and other vaccinations. At the top of this list were services from doctors' offices and clinics, followed by services from dentists and pharmacies. ○ CHIP covers preventive and diagnostic services (twice a year) including cleaning and oral health screening or assessment.[12] However, 12 respondents noted they did not need any services from a dentist, and two, who learned about KanCare coverage after turning 19, noted they did not get the needed services as did not know they have coverage. ○ CHIP covers one annual complete routine eye exam.[13] However, about 42% of the respondents noted they did not need any services from the eye doctor after turning 19.
	Effects of having KanCare coverage after turning 19 on members' family, school, or work life (Q10)	• **Extended coverage affected CHIP enrollees' family, school, or work life after turning 19 during the COVID-19 PHE.** ○ Extended coverage helped them in getting treatment when they were sick; made it easier for them to pay bills; made it easier for them to buy food; helped them in missing less school or work; and helped them in some other ways.
	Type of services members are most afraid of losing if their KanCare coverage ends (Q11)	• **CHIP enrollees are afraid of losing services if their KanCare coverage were to end** ○ Types of services members were most afraid of losing were to end included doctor's office/clinic; dental; prescription drugs, flu shots, or other vaccinations; eye exam or glasses; emergency room; hospital, for mental health, for SUD; and certain other specific services.

MCO and State Experiences

The MCO questionnaires were emailed to the primary contacts on September 9, 2024, and responses were received within one month. The questionnaire was comprised of eight questions. The responses for these questions were compiled by the Medicaid Compliance Officers with input from the subject matter experts within their organizations. The MCOs' responses regarding their experiences are described in Appendix B. The key themes derived from these responses are presented in Table 27.

Table 27. MCO Experience Questionnaire Results

Evaluation Question	Questionnaire Topic	Key Themes
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?		
What strategies did the MCOs use to engage members who turned 19 during the COVID-19 PHE?	Encouragement of members by Health Plan to access services during the PHE (Q1)	• **Health Plans encouraged members, including CHIP members, to access services during their extended coverage.** ○ Member outreach efforts occurred through case management, letters, and websites to inform them about availability of the services throughout the PHE. ○ Case management encouraged members to get preventive services; discussed members' care gaps and quality measures; and provided further assistance with the needs identified through HRST, inpatient stay discharges, and by members, family, or providers. ○ Community outreach efforts (virtual and in field) were used to educate members about preventive services including vaccinations for COVID-19 and other diseases, annual screenings, and well-visits. ○ Providers and community partners were reached to assist members in receiving appropriate services, including seeing appropriate providers (pediatric and adult care).
What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency?	Challenges experienced by the health plan in engaging these members during the PHE (Q2)	• **Health plans experienced challenges in engaging the members during the PHE** ○ Reduced outreach availability caused challenges in engaging all members. ○ Members contact information was not current and an alternative contact number could not be located. ○ Reduced face-to-face visits made it difficult for the members to see providers for well visits and other preventive measures. ○ Other challenges included difficulty in reaching 19 years old members during daytime (often no call backs to the messages left); transport issues for COVD-19 positive patients; lack of necessary personal protective equipment (PPE) for providers; technology issues; social determinants of health (SDOH) concerns; and limited provider time to provide preventive services.
	Challenges members experienced with healthcare services during the PHE (Q4)	• **Members experienced challenges with the healthcare services during the PHE** ○ Healthcare access issues: Difficulty in accessing health services; provider unavailability; transportation issues; and difficulty in accessing community resources by the members transitioning to waivers. ○ Lack of awareness among members. ○ Health is not a priority among young members without chronic diseases. ○ Issues related to SDOH and mental health challenges.
	Challenges experienced by the health plan during the PHE (Q7)	• **Health plans experienced challenges during the PHE** ○ Providers not conducting in-person visits, unawareness of members of their extended coverage, and member disengagement were noted as challenges by all three health plans. ○ Shortage of providers, increased workload for providers, and transition of CHIP members who turned 19 from pediatric to adult primary care providers were experienced as challenges by at least two health plans. ○ Health plan workforce shortages, increased workload for staff, administrative or financial challenges for health plan, administrative or financial challenges for providers, and members not going for the needed well-person visits noted as challenges by at least one of the three health plans.

Table 27. MCO Experience Questionnaire Results (Continued)

Evaluation Question	Questionnaire Topic	Key Themes
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?		
What strategies did the MCOs pursue to address those challenges?	Strategies pursued by the health plan for addressing the challenges experienced by the health plan in engaging these members during this PHE (Q3)	• **Health plans applied several strategies for addressing the challenges experienced in engaging members during this PHE** ○ Virtual community outreach efforts were used for providing member education and assistance for receiving services from the community providers. ○ Telehealth and other outdoor community outreach activities were used to continue assisting members with services such as vaccinations. ○ Case management efforts were used for member education and to assist them in finding new providers if needed. ○ Members' alternate contact information was located from various sources (such as claims and case files). ○ Providers were assisted by providing needed supplies, offering telehealth options, and co-organizing vaccination services for members to get appropriate services.
	Strategies pursued by the health plan for helping members to overcome the challenges they have with healthcare services during the extended coverage (Q5)	• **Health plans pursued several strategies for helping members to overcome the challenges they have with healthcare services during the extended coverage** ○ Healthcare access issues: ▪ Health services and provider access: Provided member education for available resources through website and case management contacts; provided education for the proper use of provider and health services (PCPs, urgent care and emergency department); worked with providers to utilize EPSDT services; and provided resources to community stakeholders and advocacy groups for member education and to improve access to services, including vaccines. ▪ Transportation: Worked with transportation vendors to ensure access and availability of appropriate services; provided extra transportation value-added benefits; and added bus passes for some counties. ▪ Community resources access: Ensured availability of community resources to the members transitioning to waivers. ○ Lack of awareness among members: Used online resources and worked with providers and community partners to create awareness and communicate about the availability of health services and extended coverage during the PHE. ○ SDOH and mental health challenges among members: Provided innovative resources for isolation and loneliness issues; provided community resources; and extended Youth Mental Health First Aid trainings in English and Spanish.
	Strategies pursued by the health plan to address the challenges it experienced during the PHE (Q8)	• **Health plans pursued several strategies to address the challenges they experienced during the PHE** ○ Member education: Provided education on the importance of using benefits, completing HRST for identifying and addressing health needs, proper use of provider and health services, COVID-19 vaccine education and resources; dissemination of PHE unwinding information; and offered resources for redetermination. ○ Provider engagement and support: Engaged providers in using EPSDT services, provided increased provider options for offering virtual visits through telehealth or by phone; encouraged access to Nurse Advice lines; and worked with companies with innovative solutions to address mental issues among members. ○ Community outreach and resources access: Engaged community organizations in using telehealth for SUD services; ensured availability of community resources to the members transitioning to waivers; engaged transportation vendors for increased access to and availability of appropriate transport services; and used innovative ways to continue community outreach during public health emergency. ○ MCO processes and operations: Applied strategic programming; assisted members through case management, and implemented programs for locating alternative member contact information for better communication.

Table 27. MCO Experience Questionnaire Results (Continued)		
Evaluation Question	**Questionnaire Topic**	**Key Themes**
Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?		
Overall, how did the extended coverage impact members who turned 19 during the PHE?	Overall impact of the extended coverage on members who turned 19 during the PHE (Q6)	• **Extended coverage had an overall impact on the members who turned 19 during the PHE** ○ Beneficial for members' physical and behavioral health and wellness. ○ Members were able to continuously receive health services, including preventive care. ○ The continuous coverage helped members in receiving preventive care without out of pocket payment or not getting it due to inability to pay. ○ Members were able to receive COVID-19 education, resources and services.

The State experience questionnaire was emailed to the primary contact (Medicaid Communications Manager) on August 14, 2023, and responses were received on September 7, 2023. The responses for the eight questions regarding the experiences of the State staff in implementation of the amendment were compiled by Medicaid Communications Manager with input from the subject matter experts within the State. The State staff's responses are described in Appendix B. The key themes derived from these responses are presented in Table 28.

Table 28. State Experience Questionnaire Results	
Questionnaire Topic	**Key Themes**
Evaluation Question 4. What were the key stakeholder perceptions and experiences regarding the extended coverage?	
4.b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?	
Communication process used to inform eligible CHIP members about extended coverage (Q1–Q5)	• The state informed eligible CHIP enrollees about the extended coverage through mailed letters. Other steps included posting frequently asked questions on website, and Interactive Voice Response (IVR) messaging. • Eligible CHIP enrollees were notified at regular intervals when they were due for renewal.
Process used by members to enroll for the extended coverage (Q6)	• Enrollees were not required to take any action to stay eligible. However, all members were encouraged to report changes, such as income changes.
Communication process and strategies being used during the public health emergency unwinding period to inform these enrollees about the disenrollment from this extended KanCare 2.0 coverage (Q7–Q8)	• In early 2023, notifications about the PHE unwinding period began. The text, robocall and emails were used by State and MCOs to inform enrollees about the disenrollment from the extended coverage. • The State engaged the stakeholders; and posted quarterly social media posts and website updates before that time. • The main communication strategies included texts, calls, and emails from State and the MCOs; web updates; physical copy in provider offices and other health care facilities; engagement with navigators and community organizations; social media posts; and outreach by MCOs and stakeholders.

Conclusions

As described above, KanCare demonstration COVID-19 PHE amendment extended the eligibility for CHIP enrollees who turned 19 during the PHE and were otherwise ineligible for Medicaid. The main purpose of this amendment was to provide these members continued medical assistance to protect their health, safety, and welfare during the PHE. To assess whether the KanCare demonstration amendment achieved its goal, and to identify successes, challenges, and lessons learned in implementing the demonstration amendment, quantitative and qualitative evaluation was conducted. The methodology and results of these evaluation components are described in detail in the Appendices A and B of the report; as well as summarized above in this report.

The key conclusions derived from the quantitative and qualitative evaluation results are presented in this section.

Quantitative Evaluation Conclusions

The quantitative evaluation focuses on describing patterns in health and health care before and during the period of extended CHIP coverage. These patterns were identified by examining three areas:

- The service utilization by eligible members during the extended coverage period, including types of services accessed, diagnoses associated with services received, and new diagnoses received after turning age 19.
- The preventive, routine, chronic and acute care service utilization among eligible members during the period of extended coverage and patterns of these services.
- The cost of services provided to members who received extended coverage.

Service Utilization by Eligible Members During the Extended Coverage

The conclusions derived from the assessment of the three aspects of the service utilization patterns are summarized here.

The assessment of types of services accessed by the members showed three noteworthy observations. The average number of inpatient stays rate increased during the first year of extended coverage (Age 19) and decreased each period thereafter. The rates for all other service types (outpatient visits including emergency department visits; professional visits/trips; dental visits; and pharmacy fills) decreased for each measurement period. The dental visit rates had the greatest relative decrease from regular coverage (Age 18) to Age 19.

The ICD-10-CM diagnosis categories and chapters (ranges of categories) associated with services received by the members during the period of extended coverage were examined. The top three diagnosis chapters included Mental, behavioral and neurodevelopmental disorders; Factors influencing health status and contact with health services; and Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified. Mental, behavioral and neurodevelopmental disorders was the most frequently used diagnosis chapter, ranking first for all four measurement periods and represented more than one fifth of the total count, and Other anxiety disorders was the highest ranked diagnosis category within the chapter. Factors influencing health status and contact with health services was the second most frequently used diagnosis chapter; and Encounter for general examination without complaint, suspected or reported diagnosis was the category with the highest average ranking for this chapter. Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified was the third most frequently used diagnosis chapter, and the category with the highest average ranking was Abdominal and pelvic pain.

In addition to frequency counts, prevalence rates based on the primary diagnosis codes were examined. The results for this analysis were mostly similar to those seen with frequency counts analyses, with few key differences. The first and second ranked diagnosis chapters were Factors influencing health status and contact with health services and Symptoms, signs and abnormal clinical and laboratory findings not elsewhere classified. The third ranked chapter, Diseases of the eye and adnexa, was from vision claims; its top category was Disorders of refraction and accommodation (it ranked second or third based on frequency analysis). Mental, behavioral and neurodevelopmental disorders dropped to fifth place.

The inpatient stays were also examined based on their Major Diagnostic Category (MDC) and Medicare Severity Diagnosis Related Group (MS-DRG) codes. The results showed the two MDCs with the greatest

increases from regular to extended coverage in their proportion of the inpatient stays within the coverage period were related to pregnancy, namely, inpatient stays for the mother (Pregnancy, Childbirth & The Puerperium) and stays for the newborn that were billed under the mother's Medicaid ID (Newborn & Neonates with Conditions Orig. Perinatal Period). The Mental Diseases & Disorders (D&D) MDC ranked second for both coverage periods. Within the Endocrine, Nutritional & Metabolic D&D MDC, the majority of the stays in the extended coverage period were for diabetes.

The five diagnosis chapters with the greatest incidence rates also had the greatest prevalence rates and contained the top 10 diagnosis categories. These top five diagnosis chapters were Factors influencing health status and contact with health services (Z00–Z99); Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified; Diseases of the eye and adnexa; Diseases of the respiratory system; and Mental, behavioral and neurodevelopmental disorders. Three categories within chapter Z00–Z99 may be related to COVID-19: Contact with and (suspected) exposure to communicable diseases, Encounter for immunization, and Encounter for screening for infectious and parasitic diseases. The incidence rate for category U07 (Emergency use of U07), which includes diagnoses of COVID-19, was 10% (ranked 28th).

The Preventive, Routine, Chronic and Acute Care Service Utilization

The conclusions derived from the examination of the preventive, routine, chronic and acute care service utilization among eligible members during the period of extended coverage and patterns of these services are summarized here.

The continuation of services utilization for the eight chronic conditions was assessed. The four chronic conditions with the highest percentages of diagnosed members having treatment continued into the extended coverage period were diabetes mellitus (79%), diabetes ketoacidosis/hyperglycemia (76%), mental health issues (62%), and diabetes treatment (58%). For members with treatment for a chronic condition continued into the extended period, the majority had received treatment within the first year of extended coverage.

The prescription (pre-existing condition) prevalence rates by generic therapeutic class (GTC) were also examined. The GTC average prescription prevalence rates for Age 19 and Age 19^{+} indicated 38% of the 14,370 prescriptions filled during regular coverage had a corresponding prescription in the same GTC filled by the member in their first year of extended coverage, and 44% had a prescription of the same GTC filled by the member sometime during the extended coverage. The prescriptions with prevalence rates higher than GTC average rate fall into three categories: treatment for acute conditions (e.g., antibiotics), treatment for chronic conditions (e.g., psychotherapeutic drugs and antiasthmatics), and preventive medicine (e.g., contraceptives and anti-obesity drugs). Several STC rates for treatment with psychotherapeutic drugs were higher than the Age 19^{+} GTC average rate, indicating members frequently maintain treatment within the same specific therapeutic class. In contrast, no STC rates for antibiotics were higher than the GTC average rate, which may indicate treatments with antibiotics tend to change specific therapeutic classes to target specific bacterial infections.

The prescription incidence rates (i.e., the percent of members in the study population who had a prescription during the extended coverage period that they did not have during the regular coverage period) calculated for generic and therapeutic classes. The highest rates were for treating common acute care conditions (e.g., infections, pain, nausea and vomiting, inflammation, or injuries).

The therapeutic classes with the greatest prescription incidence rates were Antibiotics (including penicillin antibiotics), Gastrointestinal, Analgesics (including opioid analgesic and non-salicylate

analgesics), Biologicals, Hormones (glucocorticoids), Antiarthritics (including NSAIDs, cyclooxygenase inhibitor type analgesics).

The frequency counts and service utilization rates for selected conditions across the regular and extended coverage periods based on institutional claims for emergency department visits, observation stays, and inpatient stay were examined. Utilization rates in the emergency department, observation room, and inpatient settings generally increased for the selected conditions, whereas utilization rates generally decreased in the professional and other outpatient settings.

Four HEDIS measures, Annual Dental Visits, Adult's Access to Preventive/Ambulatory Health Services, Well-Child Visits, and Inpatient Utilization, were also examined. Two patterns were common to the first three measures: for each age group (Eldest, Middle, and Youngest), rates decreased as members grew older; and within each measurement period, the Eldest group had the highest rates, and the Youngest group had the lowest rates. From Inpatient Utilization, three main observations were made: among females, maternity services utilization was greatest during the members' first year of extended coverage (nearly half of the maternity discharges); in the surgery and medicine strata, the Discharge Rate and Days Rate declined each measurement period; the longest stays were for surgeries in the first year of extended coverage.

Cost of Services Provided to Members

The cost of services provided to members who received extended coverage were calculated. Three key observations were noteworthy: the categories with the highest payments were professional (e.g., outpatient primary care, specialist, and behavioral health care visits; physician services at inpatient settings) and pharmacy claims; overall, payment amounts decreased as members aged, both as total payment amounts and payments per 12 member months (with two exceptions; NEMT and Pharmacy payments increased from Age 18 to Age 19); and the claim type with the greatest relative decrease in payments per 12 member months was dental.

Qualitative Evaluation Conclusions

The qualitative evaluation focused on describing member perceptions, as well as MCO and State experiences regarding the extended CHIP coverage.

Member Perceptions

The two areas assessed to understand the members' perceptions included their awareness regarding extended coverage, and whether this extended coverage helped them during the PHE. The results for these assessments showed most of the members who responded to the survey were aware of their extended coverage during the COVID-19 pandemic. The extended coverage helped these members in getting services from health and pharmacy providers during the PHE. Furthermore, the extended coverage affected family, school, or work life by assisting them with getting treatment when they were sick, made paying bills and buying food easier, and helped them miss less school or work. These members also noted that they were afraid of losing services from health and pharmacy providers, including emergency room and hospital services, if their KanCare coverage were to end. It should be noted, the CHIP covers preventive and diagnostic services including cleaning (twice a year) and oral health screening or assessment (twice a year) for the members.[12] However, some of the survey respondents noted they did not need any services from a dentist after turning 19, even though they knew about the extended coverage. In addition, a few respondents also noted they did not get needed dental services because they did not know they had coverage. Similarly, CHIP covers one annual complete routine eye exam for members.[13] However, slightly less than half of the survey respondents

noted they did not need any services from the eye doctor after turning 19. These results may indicate a need of providing education to the CHIP members and their guardians regarding the importance of the coverage for preventive and diagnostic oral health services, as well as routine vision exams.

MCOs and State Experiences

The assessment of the MCOs and State's experiences regarding implementation of the extended coverage also provided valuable information. The State informed the eligible CHIP members about the extended coverage during the PHE using several communication methods. The main methods were mailing information, IVR messaging, and web-based postings to the eligible CHIP enrollees. The members were notified when they were due for renewal. The State's efforts appeared to communicate the information well as echoed by the responses provided by most of the members who participated in the member perception survey. In addition, the State did not require the eligible members to take any action to stay enrolled, thus making it easier for the eligible members to retain access to health services during the PHE through the CHIP program.

The MCOs also encouraged members to access services during the extended coverage. Case management and community outreach efforts (virtual and in field) were used to educate members about preventive services including vaccinations for COVID-19 and other diseases, annual screenings, and well-visits. MCOs worked with providers and community partners to assist members in receiving appropriate services, including seeing appropriate providers (pediatric and adult care). The MCOs also encountered a few challenges in engaging members during the PHE. These challenges were mainly due to limited contact with the members due to reduced outreach and lack of an up-to-date contact information, reduced provider availability for face-to-face visits, and limited time for providing preventive services. The MCOs also described the challenges faced by the members with the healthcare services during the extended coverage. The challenges faced by the members were related to healthcare access, including transportation issues, lack of awareness among members, and not considering health as a priority. The MCOs also noticed mental health issues, loneliness, and other social challenges among the members during this period. In addition, the health plans encountered challenges due to workforce shortages and increased workloads for their staff, provider shortages, and financial and administrative issues during the PHE. The MCOs noted applying several strategies to address the challenges encountered by their health plans, members, healthcare providers and community organizations. Strategies included bringing in Pyx health to help with isolation, loneliness, and provision of community resources; rethinking community events to be drive-thru and outdoors; co-organizing and supporting vaccination clinics; and switching in- person activities to virtual. MCOs supported members, providers, and community organizations to ensure members had access to needed treatment and preventive services during the PHE. The MCOs stated that the extended coverage had a beneficial impact on members' physical and behavioral health and wellness; allowed them to have continuous access to health services, including preventive care; helped members in receiving preventive care without out of pocket payment or not getting it due to inability to pay; and provided COVID-19 related education, resources and services.

The State staff also shared their experiences regarding the communication process used by them during the PHE unwinding period to inform the members about the disenrollment from this extended KanCare coverage The State, along with the MCOs and other stakeholders, applied several communication strategies, including sending texts and emails; phone calls; online postings (web and social media); providing print material in provider offices; and engagement with navigators and community organizations.

Overall Conclusions

The PHE amendment evaluation through its quantitative and qualitative components indicated that by extending the eligibility for CHIP enrollees who turned 19 during the PHE, and were otherwise ineligible for Medicaid, the PHE amendment provided continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE. The State informed the eligible CHIP members about the extended coverage during the PHE which made it easier for them to access health services. The MCOs applied member and community outreach strategies to assist members with using the services. The members obtained inpatient, outpatient, emergency department, professional, dental and pharmacy services. The services received were for existing and new conditions. Members also communicated their concern regarding losing services from health and pharmacy providers, including emergency room and hospital services if their KanCare coverage were to end. This indicated a further need to address their concerns regarding losing the access to healthcare services if they do not have KanCare coverage. The State and health plans could assist the members who will be no longer eligible for the receiving healthcare through Medicaid or CHIP by providing contact information for appropriate healthcare and community resources, for example, providing information for navigating the use of these resources on the State and the health plans' websites.

Interpretations, Policy Implications and Interactions with Other State Initiatives

The COVID-19 PHE amendment was enacted in conjunction with policy changes that provided continuous coverage for some Title XIX Medicaid aid categories. During the PHE, many members remained in CHIP who may otherwise have been enrolled in another aid category upon turning 19 years old, such as, aid to pregnant women, new mothers, or parents and other caretakers (when redeterminations resumed after the PHE, transfers to the other aid categories may have taken place). The analysis of service utilization and its interpretation did not adjust for services utilized by CHIP members with extended coverage who may have been enrolled in another aid category if the COVID-19 PHE amendment had not been enacted.

This evaluation provides a glimpse into the healthcare needs of young adults. In 2023, about 14% of Kansas individuals aged 19–25 were uninsured.[15] When CHIP coverage ends at age 19, many individuals may become part of this statistic. Without preventive care or treatment for acute and chronic conditions, the ability of these young adults to pursue further education or maintain steady employment could be hampered, thus extending the cycle of poverty.[16]

Lessons Learned and Recommendations

Valuable lessons were learned from the evaluation results of the KanCare demonstration COVID-19 PHE amendment. These lessons learned are also the recommendations to Kansas and other state Medicaid agencies and policy makers for future demonstrations.

- Public health emergencies, such as COVID-19 pandemic, lead to unprecedented circumstances associated with health and economic challenges. To assist states with addressing the COVID-19 PHE, CMS developed a new Section 1115 demonstration opportunity that provided states a variety of options for delivering the most effective care to their Medicaid beneficiaries. These options provided flexibility around federal and state Medicaid/CHIP policies that is valuable to ensure health, safety, and welfare of the individuals enrolled in the program.

- By implementing the KanCare demonstration COVID-19 PHE amendment, the State of Kansas was able to extend the eligibility for CHIP enrollees who turned 19 during the PHE and were otherwise ineligible for Medicaid. The extended coverage provided continuity of medical assistance, thus enabling the CHIP members to receive health services, including preventive care during PHE. The availability of these types of Medicaid/CHIP amendments enabled members to receive needed care during the difficult circumstances caused by the PHE.
- The extended coverage of CHIP members assisted eligible members in avoiding the effects on their physical and behavioral health status that could have resulted from their inability to pay out-of-pocket for needed health services.
- Through this extended coverage, the CHIP members were able to receive COVID-19 education, resources, vaccinations, and treatment services. The availability of such resources and services are essential for preventing and controlling the morbidity and mortality from the diseases causing public health emergencies.
- The State used a variety of communication methods to inform eligible CHIP members regarding their extended coverage and availability of health care services during the PHE. The MCOs and community organizations also encouraged members to access health care services and resources during the PHE. The education efforts conducted by the State and MCOs, in collaboration with the community organizations, showed continuous dissemination of the accurate information was needed throughout the PHE. However, some lack of awareness was still seen among members.
- The State of Kansas did not require the eligible CHIP members to take any action to stay enrolled, thus making it easier for the eligible members to have uninterrupted access to the health services during the PHE. It is important to keep the administrative processes as easy as possible to assist members in navigating health care systems during difficult circumstances.
- MCOs applied various strategies and offered service options to health care providers for addressing physical and behavioral health issues encountered by the members during the PHE.
- There is a need to address members' concerns about losing access to healthcare services if they become ineligible for Medicaid or CHIP. Health plans could assist members transitioning out of Medicaid or CHIP by implementing strategies for connecting them with appropriate healthcare services and community resources and providing information for navigating through these services and resources.

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End of written report

Appendix A

KanCare Section 1115(a) COVID-19 Public Health Emergency (PHE) Amendment Evaluation

Methodology and Results of Quantitative Analysis

Activities and Components/Standards

Activity 1:Select the Study Topic

1.1 Topic selection process

See Summary Report for topic selection process.

1.2 Background Information

See Summary Report for background information.

Activity 2:Define the Study Question

2.1 State the Study Questions

The quantitative analysis focused on describing patterns in health and health care before and during the period of extended CHIP coverage (Study Questions 1, 2, and 3). The study questions and corresponding measures used to answer the evaluation questions are presented in Table A1.

Table A1. Quantitative Evaluation Questions and Measures

Evaluation Question		Measures
Question 1: What was the eligible members' service utilization during the period of extended coverage?		
1.a.	What types of services did eligible members access during the period of extended coverage compared to prior utilization?	Summary of encounters by type of service: • Professional Visits • Pharmacy Fills • Outpatient Visits ○ Emergency Department Visits • Inpatient Stays • Dental Visits • Vision Visits • NEMT Trips
1.b.	What diagnoses were associated with services received by eligible members during the period of extended coverage compared to prior diagnoses?	Summary of diagnosis prevalence: • Primary diagnoses by ICD-10-CM chapter • Primary diagnoses by ICD-10-CM block or category
		Summary of inpatient stays by diagnosis: • CMS Major Diagnostic Category (MDC) • Medicare Severity Diagnosis Related Group (MS-DRG)
1.c.	Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?	Summary of diagnosis incidence: • Diagnoses by ICD-10-CM chapter • Diagnoses by ICD-10-CM block or category

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Table A1. Quantitative Evaluation Questions and Measures (Continued)		
Evaluation Question		**Measures**
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage?		
2.a.	Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?	• Service utilization by chronic condition: ○ Asthma ○ Diabetes ○ Behavioral Health ○ Others to be determined based on prevalent diagnoses (question 1.b) ▪ Asthma with Exacerbation ▪ Diabetes Treatment ▪ Diabetes Ketoacidosis/Hyperglycemia ▪ Substance Use Disorder ▪ Overweight and Obesity • Prescription (pre-existing prescriptions) prevalence rates by generic therapeutic class
2.b.	What were the patterns of preventive, routine, and acute health care during the period of extended coverage?	• Prescription (new prescriptions) incidence rates by generic therapeutic class • ED visits, observation stays, or inpatient admissions for selected conditions: ○ COVID-19 ○ Acute respiratory infections ○ Acute severe asthma ○ Diabetic Ketoacidosis/ Hyperglycemia ○ SUD ○ Mental health issues ○ External Causes of Morbidity • Outpatient or professional claims for respiratory infections: ○ Acute upper respiratory infections ○ Influenza ○ Pneumonia ○ Other acute lower respiratory infections • HEDIS measures (applicable age strata): ○ Annual Dental Visit (ADV) ○ Adults' Access to Preventive/ Ambulatory Health Services (AAP) ○ Child and Adolescent Well-Care Visits (WCV) ○ Emergency Department Utilization (EDU) – Observed Events ○ Inpatient Utilization (IPU) – General Hospitalization/Acute Care, excluding maternity admissions.
Question 3: What was the cost of the extended period of coverage?		
3.a.	What was the cost of services provided to members who received the extended coverage?	Spending per member per month: • Total • by service type (see 1.a)

2.2 Define the Study Population

The study population was KanCare 2.0 CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage.

For this study, members having *extended CHIP coverage* were identified as members enrolled in KanCare CHIP any time during the month the member turned 19 and anytime in the following month (which was equivalent to coverage on last day of the month the member turned 19 and the first day of the following month).

Study Population Demographics

There were 7,087 members meeting this study population criteria. The oldest group of members having extended CHIP coverage were born March 2001 and turned 19 years old in March 2020. The youngest group of members were born in March 2004 and had their 19th birthday in March 2023.

2.3 List the Measures Used to Answer the Study Questions

See Table A1.

Activity 3:Select the Study Variables

3.1 Independent Variables (used to define or stratify denominators).

Managed Care Organization – analysis was stratified by MCO primarily for validation of programming code and uniformity of data completeness between MCOs. The analytic plan called for results to be reported by MCO only if reporting differences between MCOs clarified answers to the study questions.

Anchor Date – The last day of the month in which a member turned 19 years old was defined as the member's *anchor date*.

Measurement Periods – The anchor date was used to define measurement periods. Initial analysis used six-month measurement periods with the first period beginning with the month after the member turned 18 years old. Depending on the results of initial analysis, these measurement periods were aggregated into longer periods.

Age Range – Three age ranges were defined based on the calendar month of the member's anchor date. The age ranges divided the study population into three strata:

- Eldest March 2020 through March 2021 (born March 2001 through March 2002)
- Middle April 2021 through March 2022 (born April 2002 through March 2003)
- Youngest April 2022 through March 2023 (born April 2003 through March 2004)

Note: The count for March 2001 birthdays was low because many of the CHIP members who turned 19 in March 2020 had been eligible for, and enrolled in, other Medicaid programs before the amendment became effective. Only one CHIP member who turned 19 in March 2020 was not enrolled in KanCare in April 2020.

3.2 Dependent Variables (used to define or subset numerators).

Claim Form – The claim form used to bill services defined four strata, which were subdivided based on type of bill or MCO internal control numbers (ICNs).

- Institutional – billed by institutions on a UB-04 or equivalent form
  - Inpatient – type of bill code indicating hospital inpatient (011x, x=any digit), hospital Medicare Part B crossover (012x), or invalid type of bill with KMMS-assigned claim type "A" or "I."
  - Nursing Facility – type of bill code indicating skilled nursing facility (02xx), intermediate care (06xx), hospital swing bed (018x), or invalid type of bill with KMMS-assigned claim type "L" or "K."
  - Outpatient – all other institutional claims
    - Emergency Department (ED) – outpatient claims with revenue codes 450–459, 981.

- Professional – billed by professionals on a CMS-1500 or equivalent claim form
  - Vision – professional claims identified as being paid by the vision vendor based on the format of the MCO internal control number (ICN)
  - Non-Emergency Medical Transportation (NEMT) – professional claims paid by the transportation vendor identified by the format of the MCO ICN
  - Non-Vendor – professional claims other than vision and NEMT (e.g., outpatient primary care, specialty, and behavioral health professionals; inpatient physician services)
- Pharmacy – claims billed through the MCO's pharmacy benefits manager
- Dental – claims billed on an American Dental Association (ADA) dental claim form

Diagnosis Groups – Strata were defined based on preliminary analysis. Strata were identified using the following:

- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) chapter, block, or category
- Medicare Severity Diagnosis Related Group (MS-DRG) code
- CMS Major Diagnosis Category (MDC) code

Note, ICD10-CM diagnosis codes are organized into *categories* (identified by the first three characters of the code) and *subcategories*. The categories are grouped into 22 ranges of codes, or *chapters*, corresponding to body system or condition. Chapters may be subdivided into ranges of categories, called *blocks*.

Diagnosis prevalence – Strata were defined based on ICD-10-CM chapter and ICD-10-CM block or category with the following occurrences:

- Prevalence rate
- Incidence rate

Service utilization by chronic conditions – Strata were defined based on preliminary analysis. The analytic plan indicated strata could include the following chronic conditions:

- Asthma
- Diabetes
- Behavioral health
- Others depending on prevalence

Drug Therapeutic Class – Strata of pharmacy claims were based on the First Databank Enhanced Therapeutic Classification System:

- Generic therapeutic class (GTC)
- Specific therapeutic class (STC)

Other – other fields on the encounter records were used to calculate measures, such as place of service, payment amounts, adjustment reason codes.

Activity 4:Develop a Plan to Study the Population

4.1 Overall strategy

The study followed five general steps:

1. Collect the data (see Activity 5).
2. Identify the study population (see Activity 6.1).
   - **a.** Identify Members with Extended Coverage
   - **b.** Identify Segments of Regular and Extended Coverage
   - **c.** Stratify the study population by independent variables
   - **d.** Obtain stratified counts of members.
3. Query encounter data for services provided on or after the first day of the month of the member's 18th birthday (see Activity 6.2).
   - **a.** Clean data to remove records with invalid values in fields needed for analysis.
   - **b.** Deduplicate to one record per claim.
   - **c.** Recode the MCO claim status field (Paid or Denied) based on adjustment reason codes.
   - **d.** Add flags needed for stratification.
4. Calculate measurements described in Activity 2.3 (see Activity 6.3).
   - **a.** Stratify rates as time and data allow.
   - **b.** Perform statistical analysis where appropriate.
   - **c.** Create tables, figures, and graphs for visual display.
   - **d.** Draft interpretations of the results.
5. Report Results to the State (see Activity 7).
   - **a.** Complete analysis and submit draft report.
   - **b.** Allow two weeks for feedback from the State.
   - **c.** Submit final report.

Activity 5:Collect Data

For each type of source data, specify:

- *The data to be collected,*
- *How and when the data will be collected,*
- *Frequency of data collection,*
- *Who will collect the data,*
- *Instruments that will be used to collect the data, and*
- *Data cleaning steps.*

The Medicaid Management Information System (MMIS) was the State's information system for the Medicaid program through March 31, 2022. For external quality review and other State-contracted activities, KFMC routinely downloaded and archived member demographic records and member eligibility and assignment records from the reporting warehouse of MMIS. The process was automated using extract-transform-load (ETL) scripts.

The State transitioned to the Kansas Modular Medicaid System (KMMS) effective April 1, 2022. KFMC now receives copies of tables being loaded into the reporting warehouse module of KMMS from the State's fiscal agent.

Data Source 1: Demographic, Eligibility, and Assignment Data

Member demographic, eligibility, and assignment records were obtained within the first week of every month. Eligibility and assignment records included member's MCO, Medicaid ID, benefit information (i.e., eligibility through CHIP, Temporary Assistance for Needy Families (TANF), or waivers for Home and Community Based Services), and aid categories. Each record has effective beginning and ending dates. A status code identifies voided records, which were excluded from analysis.

Data Source 2: Encounter Records

The encounter records contained claims data submitted by providers to the MCO, claim processing and payment details added by the MCO, and MMIS/KMMS uploading and processing information. The initial billing of services (the "new-day claim") and subsequent re-billings ("adjusted claims") were housed on separate records. If an MCO needed to change information on an encounter previously processed by MMIS/KMMS, they voided the original record and submitted a replacement record. Both the voided and replacement encounters were archived by KFMC, and duplicates were removed at time of analysis.

Analysis was limited to encounters submitted to the fiscal agent by March 31, 2024.

Some encounters included interest payments made by the MCO to the provider in the amount paid by the MCO, and the logic for including interest differs among the MCOs. To better reflect medical expenses, the data cleaning steps in this study subtracted the amounts of interest from the amounts paid based on Claim Adjustment Reason Code (CARC) 225.

Prior analysis found zero-dollar paid claims (i.e., claims paid by primary payors so that $0.00 was left for the MCO to pay) that were given a claim status "denied" instead of "paid." This practice was not consistently applied by the MCOs. For uniform reporting, the MCO's claim status was recalculated using the following steps.

For each service line –

1. If amount paid by the MCO was greater than $0.00, then service was "paid."
2. Otherwise, if the amount billed was $0.00 or $0.01, then service was "denied."
3. Otherwise, if amount adjusted with CARC 45 ("Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement") equaled the amount billed, then the original MCO claim status was retained.
4. Otherwise, the adjustments related to third-party payment, member spenddown, or co-payment were tabulated. If this sum was greater than or equal to the amount billed minus the amount adjusted with CARC 45, then the service was "paid." The adjustment reasons used for this step were: "Coinsurance amount," "Co-payment amount," "The impact of prior payer(s) adjudication including payments and/or adjustments," "Monthly Medicaid patient liability amount," and "Patient has not met the required spend down requirements."
5. Otherwise, if the claim type was vision, dental, or NEMT, then the service was classified as "denied."
6. Otherwise, the original MCO claim status was retained.

For claim-level payment status –

1. If the amount paid by the MCO was greater than $0.00, then the claim was considered "paid."
2. Otherwise, if the amount paid by the MCO was greater than $0.00 on any of the service lines, then the claim was considered "paid."
3. Otherwise for dental, vision, and NEMT claims:
   a. If all service lines were denied, then the claim was considered "denied."
   b. Otherwise, there was at least one zero-dollar paid service, and the claim was considered "paid."
4. Otherwise for other claim types:
   a. If there was at least one zero-dollar paid service and the provider billed $0.00 or $0.01 for all non-zero-dollar paid services, then the claim was considered "paid."
   b. Otherwise, the original claim status is retained.

Data Source 3: ICD10-CM Codes and Descriptions

ICD10-CM codes and descriptions for diagnosis codes, categories, and chapters were obtained from the Centers for Disease Control and Prevention.[17]

Activity 6: Analyze and Interpret Study Results

6.1 Identify the Study Population

a. Identify members with extended coverage

The CHIP extended coverage population was initially identified from KMMS membership, Medicaid enrollment received in August 2023 (records last updated July 21). First, members with date of birth between March 1, 2001, and March 31, 2004, were identified from the membership table. The last day of the month in which the member turned 19 years old was calculated and designated as the member's *anchor date*. Next these were inner joined to CHIP enrollment segments. Consecutive segments were merged into one segment. Members with a segment spanning their anchor date formed the study population. The anchor date was the last day of *regular* CHIP coverage, and the next day was the first day of *extended* CHIP coverage.

b. Identify segments of regular and extended coverage

During the study, the eligibility segments were periodically refreshed with more recent KMMS data (the study population remained unchanged). Final analysis was based on the population identified from KMMS membership, Medicaid enrollment, and MCO assignment tables received in April 2024 (records last updated March 29). The segments spanning the anchor date were split into regular and extended coverage segments.

c. Stratify the study population by independent variables

The study population was stratified as described in Activity 3.1. Stratification by MCO was based on the MCO assignment on the member's anchor date using the August 2023 KMMS MCO assignment table.

d. Obtain stratified counts of members

Table A2 shows the counts of the members stratified by their age group (eldest, middle, or youngest) and their ages during which they received regular and extended coverage (for at least one day). By design, the same number of members (7,087) who had coverage when they were 18 years old had extended coverage when they were 19 years old. As the PHE progressed, the number of members aging into extended coverage increased each year, which is seen in the increasing counts from the eldest (2,026), to the middle (2,395), and to the youngest (2,666) age

groups. The study did not determine whether this was due to the economy (i.e., more Kansas families qualifying for CHIP) or the policy of extending Medicaid and CHIP coverage during the PHE.

Table A2. Enrollment of CHIP Members with Extended Coverage, by Age Group and Measurement Period

Measurement Period	Total		Age Group: Eldest		Middle		Youngest	
	Members		Members	% of Total	Members	% of Total	Members	% of Total
Regular Coverage (Age 18)	**7,087**		**2,026**	**28.6%**	**2,395**	**33.8%**	**2,666**	**37.6%**
Extended Coverage (Age 19+)	**7,087**		**2,026**	**28.6%**	**2,395**	**33.8%**	**2,666**	**37.6%**
Age 19 years old	7,087		2,026	28.6%	2,395	33.8%	2,666	37.6%
Age 20 years old	5,019		1,776	35.4%	2,139	42.6%	1,104	22.0%
Age 21 and older	2,477		1,632	65.9%	845	34.1%	0	0.0%
	Members	Average Months	Members	Average Months	Members	Average Months	Members	Average Months
Regular Coverage (Age 18)	**7,087**	**11.3**	**2,026**	**10.7**	**2,395**	**11.4**	**2,666**	**11.6**
Extended Coverage (Age 19+)	**7,087**	**20.1**	**2,026**	**30.2**	**2,395**	**21.2**	**2,666**	**11.3**
Age 19 years old	7,087	10.6	2,026	11.2	2,395	11.4	2,666	9.5
Age 20 years old	5,019	9.0	1,776	11.5	2,139	9.4	1,104	4.4
Age 21 and older	2,477	8.7	1,632	11.0	845	4.2	0	0.0

Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

Two factors caused the decrease in counts within columns of Table A2. The first was member disenrollment during the PHE (for reasons such as death, moving out of state, or voluntary disenrolling). The gradual decrease in counts for the eldest age group (from 2,026 to 1,776 to 1,632) was due to disenrollment during the PHE (all were 21 years old when the winddown disenrollments began). The second factor was member age during the study. Members in the middle age group had their twenty-first birthday during the first twelve months of the winddown that began April 1, 2023. Many were disenrolled from CHIP before their birthday, but 845 were disenrolled from CHIP after turning 21 years of age. Note, none of the youngest age group were 21 years or older by March 31, 2024 (the data cutoff period for the study), and many were only 19 years old when disenrolled during the winddown period.

Table A3 also provides the average number of months members were enrolled in CHIP during regular and extended coverage periods. The 7,087 members of the study population were in CHIP an average of 11.3 months as 18-year-olds and averaged 20.1 months of extended CHIP coverage. The eldest and middle age groups averaged over 11 months in their first year of CHIP coverage (Age 19); reasons for not having a full year of coverage could include moving out of Kansas, entering prison, or death. The youngest members only averaged 9.5 months of CHIP coverage as 19-year-olds; many transitioned out of CHIP during the winddown period before turning 20 years old.

6.2 Query encounter data for services provided from 18 years and onwards

a. Clean data to remove records with invalid values in fields needed for analysis.

Activity completed.

b. Deduplicate to one record per claim.

First, voided encounters were removed. Second, for all encounter records with the same MCO ICN and MCO paid date, the last record processed in MMIS/KMMS was retained.

c. Recode the MCO claim status field (Paid or Denied) based on adjustment reason codes.

Activity completed.

d. Add flags needed for stratification.

Activity completed.

6.3 Calculate measurements described in Activity 2.3 for Question 1

a. Summary of encounters by type of service (Q1.a)

After completing the data cleaning steps of Activity 6.2, encounters were further deduplicated to count service types (i.e., inpatient stay, office visit, prescription filled, etc.) once per member, per billing provider NPI, per service date. For inpatient stays, the service date was set equal to the first day of service on the claim header record. For all other claim types, the first date of service on the claim detail lines were used for the service date. Counts were stratified by measurement period and age group. To aid comparisons between strata, rates were calculated to show the average services per 1,200 members per month (i.e., the expected number of services for 100 members for one year).

Table A3 summarizes the service utilization, stratified by type of claim, age group, and age at time of service. The table shows counts of services and a utilization rate, services per 1,200 member months (which is equivalent to services per 100 members per year, where the number of members is the average of monthly membership counts). Note, the utilization rates may count a member multiple times (once per date of service).

Three observations from Table A3 are noteworthy:

- The average number of inpatient stays increased from 3.4 stays per 100 members during regular coverage (Age 18) to 4.3 stays per 100 members during the first year of extended coverage (Age 19) and decreased each period thereafter.
- The rates for all other service types decreased for each measurement period.
- The dental visits rate had the greatest relative decrease (36%) from Age 18 to Age 19, decreasing from 96.3 visits per 100 members to 61.2 visits per 100 members.

Table A3. Services Utilization Rates, by Claim Type and Age Group

	Regular Coverage		Extended Coverage					
	Age 18		Age 19		Age 20		Age 21+	
	Members	MM	Members	MM	Members	MM	Members	MM
All Members	**7,087**	**79,974**	**7,087**	**75,322**	**5,019**	**45,332**	**2,477**	**21,483**
Eldest	2,026	21,771	2,026	22,783	1,776	20,457	1,632	17,938
Middle	2,395	27,369	2,395	27,203	2,139	20,033	845	3,545
Youngest	2,666	30,834	2,666	25,336	1,104	4,842	0	0
	Services	**Rate**	**Services**	**Rate**	**Services**	**Rate**	**Services**	**Rate**
Inpatient Stays	**226**	**3.4**	**271**	**4.3**	**132**	**3.5**	**50**	**2.8**
Eldest	55	3.0	80	4.2	55	3.2	45	3.0
Middle	93	4.1	110	4.9	68	4.1	5	1.7
Youngest	78	3.0	81	3.8	9	2.2	0	0.0
Outpatient Visits	**9,681**	**145.3**	**7,925**	**126.3**	**4,302**	**113.9**	**1,846**	**103.1**
Eldest	2,840	156.5	2,557	134.7	1,968	115.4	1,629	109.0
Middle	3,450	151.3	3,045	134.3	1,940	116.2	217	73.5
Youngest	3,391	132.0	2,323	110.0	394	97.6	0	0.0
– ED Visits	**2,701**	**40.5**	**2,527**	**40.3**	**1,454**	**38.5**	**632**	**35.3**
Eldest	723	39.9	711	37.4	627	36.8	545	36.5
Middle	943	41.3	971	42.8	696	41.7	87	29.4
Youngest	1,035	40.3	845	40.0	131	32.5	0	0.0
Professional – Non-Vendor Visits	**40,871**	**613.3**	**31,706**	**505.1**	**16,119**	**426.7**	**7,139**	**398.8**
Eldest	11,371	626.8	10,481	552.0	7,516	440.9	6,163	412.3
Middle	14,944	655.2	11,787	520.0	6,932	415.2	976	330.4
Youngest	14,556	566.5	9,438	447.0	1,671	414.1	0	0.0
– Vision Visits	**3,028**	**45.4**	**2,352**	**37.5**	**1,252**	**33.1**	**455**	**25.4**
Eldest	893	49.2	756	39.8	604	35.4	393	26.3
Middle	1,037	45.5	823	36.3	542	32.5	62	21.0
Youngest	1,098	42.7	773	36.6	106	26.3	0	0.0
– NEMT Trips	**225**	**3.4**	**136**	**2.2**	**28**	**0.7**	**17**	**0.9**
Eldest	74	4.1	45	2.4	17	1.0	16	1.1
Middle	75	3.3	32	1.4	8	0.5	1	0.3
Youngest	76	3.0	59	2.8	3	0.7	0	0.0
Dental Visits	**6,419**	**96.3**	**3,841**	**61.2**	**1,879**	**49.7**	**630**	**35.2**
Eldest	1,924	106.0	1,281	67.5	894	52.4	530	35.5
Middle	2,242	98.3	1,333	58.8	804	48.2	100	33.9
Youngest	2,253	87.7	1,227	58.1	181	44.9	0	0.0
Pharmacy Fills	**33,985**	**509.9**	**28,864**	**459.8**	**16,800**	**444.7**	**7,760**	**433.5**
Eldest	9,266	510.7	8,642	455.2	7,593	445.4	6,655	445.2
Middle	11,991	525.7	10,563	466.0	7,510	449.9	1,105	374.0
Youngest	12,728	495.3	9,659	457.5	1,697	420.6	0	0.0

The rate is the expected number of services in a year for 100 members, calculated as 1,200 times services divided by member months (MM). Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

b. Summary of diagnosis prevalence (Q1.b)

Analysis of diagnosis codes was performed for the members during regular coverage (18 years) and extended coverage (19 and older). The diagnosis codes for the qualified members were sourced from inpatient, outpatient, vision, and non-vendor professional claims. Prevalence was studied in two ways:

- Frequency Counts – counting once per person per date of service
- Prevalence Rates – counting once per person

Frequency Counts

For frequency counts, encounter records were deduplicated to count diagnosis category codes once per member per date of service. Counts were stratified by chapter, category, and measurement period. Within the measurement periods, rates were calculated by dividing the stratified counts by the sum of the category-level counts. Counts were also ranked from greatest (rank equal to one) to least. Although this report focuses on the frequency of primary diagnosis categories, exploratory analysis included reviewing frequency tables created using primary and secondary diagnoses.

Table A4 shows counts and relative frequencies of claims based on the category of the primary diagnosis code. Diagnosis categories are counted once per member per date of service. The following key observations were made:

- F01–F99 (Mental, behavioral and neurodevelopmental disorders) was the most frequently used diagnosis chapter, ranking first among all chapters for all four measurement periods and represented more than one fifth of the total count.
  - F41 (Other anxiety disorders) was the highest ranked diagnosis among all categories.
  - F33 (Major depressive disorder, recurrent) was the third highest ranked category for the Age 18 and Age 19 periods and second highest ranked category for Age 20 and Age 21+.
  - F12 (Cannabis related disorders) had rates drop from 0.8% (ranked 21st) for Age 18 to 0.1% (ranked 64th) for Age 21+. The study could not determine from the data whether the prevalence of cannabis-related disorders decreased as members aged or if these members had fewer visits with providers.
- Z00–Z99 (Factors influencing health status and contact with health services) was the second most frequently used diagnosis chapter. These codes record reasons for a visit and not a specific disease or disorder. Rates and ranking for most of the categories within this chapter displayed in Table A4 were relatively stable.
  - Z00 (Encounter for general examination without complaint, suspected or reported diagnosis) had the highest average ranking for this chapter.
  - Z34 (Encounter for supervision of normal pregnancy) and Z36 (Encounter for antenatal screening of mother) rates were higher for Age 19 and Age 20 than Age 18.
  - Z12 (Encounter for screening for malignant neoplasms) rankings increased from 146th for Age 18 to 25th for Age 21+.
- R00–R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) was the third most frequently used diagnosis chapter.
  - R10 (Abdominal and pelvic pain) had the highest average ranking for this chapter.
  - R07 (Pain in throat and chest) rankings increased from 25th for Age 18 to 19th for Age 19, 18th for Age 20 and 16th for Age 21+.
  - R30 (Pain associated with micturition) rankings increased from 32nd for Age 18 to 21st for Age 21+.
  - R53 (Malaise and fatigue) rankings increased from 42nd for Age 18 to 27th for Age 21+.
- H52 (Disorders of refraction and accommodation) had the second highest rank of all categories for Age 18 and Age 19. It is within H00–H59 (Diseases of the eye and adnexa), which was the 6th ranked chapter for those periods.

Table A4. Frequency of Primary Diagnosis Chapters and Categories

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	**47,211**			**38,726**			**21,454**			**9,620**		
Chapter or Category	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**
F01-F99: Mental, behavioral and neurodevelopmental disorders	**10,681**	**22.6%**	**1**	**8,459**	**21.8%**	**1**	**5,046**	**23.5%**	**1**	**2,360**	**24.5%**	**1**
F41: Other anxiety disorders	2,742	5.8%	1	2,364	6.1%	1	1,217	5.7%	1	611	6.4%	1
F33: Major depressive disorder, recurrent	2,395	5.1%	3	1,872	4.8%	3	1,125	5.2%	2	597	6.2%	2
F43: Reaction to severe stress, and adjustment disorders	1,453	3.1%	6	1,161	3.0%	4	814	3.8%	4	552	5.7%	3
F32: Depressive episode	1,192	2.5%	9	792	2.0%	9	457	2.1%	6	181	1.9%	9
F90: Attention-deficit hyperactivity disorders	733	1.6%	15	422	1.1%	17	313	1.5%	14	162	1.7%	12
F31: Bipolar disorder	384	0.8%	23	428	1.1%	16	267	1.2%	17	78	0.8%	22
F12: Cannabis related disorders	397	0.8%	21	328	0.8%	20	74	0.3%	49	9	0.1%	64
Z00-Z99: Factors influencing health status and contact with health services	**8,781**	**18.6%**	**2**	**7,010**	**18.1%**	**2**	**3,365**	**15.7%**	**2**	**1,438**	**14.9%**	**2**
Z00: Encounter for general examination without complaint, suspected or reported diagnosis	1,461	3.1%	5	875	2.3%	8	431	2.0%	8	191	2.0%	7
Z20: Contact with and (suspected) exposure to communicable diseases	1,302	2.8%	8	932	2.4%	7	388	1.8%	9	76	0.8%	23
Z23: Encounter for immunization	1,329	2.8%	7	779	2.0%	11	302	1.4%	15	89	0.9%	18
Z30: Encounter for contraceptive management	1,055	2.2%	11	781	2.0%	10	373	1.7%	10	130	1.4%	14
Z11: Encounter for screening for infectious and parasitic diseases	754	1.6%	14	731	1.9%	12	361	1.7%	12	175	1.8%	11
Z34: Encounter for supervision of normal pregnancy	437	0.9%	19	673	1.7%	13	338	1.6%	13	119	1.2%	15
Z01: Encounter for other special examination without complaint, suspected or reported diagnosis	393	0.8%	22	275	0.7%	27	186	0.9%	22	178	1.9%	10
Z36: Encounter for antenatal screening of mother	152	0.3%	47	249	0.6%	29	157	0.7%	25	52	0.5%	34
Z12: Encounter for screening for malignant neoplasms	10	0.0%	146	14	0.0%	132	11	0.1%	104	74	0.8%	25
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**5,348**	**11.3%**	**3**	**4,804**	**12.4%**	**3**	**2,780**	**13.0%**	**3**	**1,181**	**12.3%**	**3**
R10: Abdominal and pelvic pain	1,057	2.2%	10	1,052	2.7%	6	595	2.8%	5	224	2.3%	6
R07: Pain in throat and chest	349	0.7%	25	357	0.9%	19	223	1.0%	18	99	1.0%	16
R11: Nausea and vomiting	335	0.7%	28	297	0.8%	23	220	1.0%	19	75	0.8%	24
R05: Cough	365	0.8%	24	282	0.7%	25	124	0.6%	31	61	0.6%	29
R30: Pain associated with micturition	276	0.6%	32	241	0.6%	31	133	0.6%	29	79	0.8%	21
R00: Abnormalities of heart beat	245	0.5%	36	219	0.6%	32	129	0.6%	30	52	0.5%	34
R53: Malaise and fatigue	206	0.4%	42	148	0.4%	44	115	0.5%	34	72	0.7%	27
M00-M99: Diseases of the musculoskeletal system and connective tissue	**3,772**	**8.0%**	**4**	**2,683**	**6.9%**	**4**	**1,204**	**5.6%**	**6**	**696**	**7.2%**	**4**
M25: Other joint disorder, not elsewhere classified	1,617	3.4%	4	1,160	3.0%	5	453	2.1%	7	283	2.9%	5
M54: Dorsalgia	830	1.8%	12	547	1.4%	15	296	1.4%	16	183	1.9%	8
M79: Other and unspecified soft tissue disorders, not elsewhere classified	492	1.0%	17	295	0.8%	24	173	0.8%	23	84	0.9%	20

For the numerator and denominator of the rate, the category of a primary diagnosis was counted once per member per date of service. Rates were ranked from highest (1) to lowest. Ranks range from 1 to 22 for chapters. Categories were included in the table if they ranked less than or equal to 30 for at least one of the four rates

Table A4. Frequency of Primary Diagnosis Chapters and Categories (Continued)

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	**47,211**			**38,726**			**21,454**			**9,620**		
Chapter or Category	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**
S00-T88: Injury, poisoning and certain other consequences of external causes	**3,193**	**6.8%**	**5**	**2,391**	**6.2%**	**5**	**1,162**	**5.4%**	**7**	**512**	**5.3%**	**6**
S83: Dislocation and sprain of joints and ligaments of knee	340	0.7%	27	188	0.5%	37	108	0.5%	38	53	0.6%	33
H00-H59: Diseases of the eye and adnexa	**3,065**	**6.5%**	**6**	**2,388**	**6.2%**	**6**	**1,309**	**6.1%**	**4**	**462**	**4.8%**	**8**
H52: Disorders of refraction and accommodation	2,564	5.4%	2	1,997	5.2%	2	1,073	5.0%	3	367	3.8%	4
J00-J99: Diseases of the respiratory system	**2,861**	**6.1%**	**7**	**2,268**	**5.9%**	**7**	**1,283**	**6.0%**	**5**	**549**	**5.7%**	**5**
J02: Acute pharyngitis	821	1.7%	13	645	1.7%	14	372	1.7%	11	160	1.7%	13
J06: Acute upper respiratory infections of multiple and unspecified sites	347	0.7%	26	303	0.8%	21	209	1.0%	20	87	0.9%	19
J30: Vasomotor and allergic rhinitis	465	1.0%	18	258	0.7%	28	120	0.6%	33	63	0.7%	28
J45: Asthma	294	0.6%	30	258	0.7%	28	136	0.6%	28	54	0.6%	32
N00-N99: Diseases of the genitourinary system	**1,762**	**3.7%**	**8**	**1,670**	**4.3%**	**8**	**1,031**	**4.8%**	**8**	**464**	**4.8%**	**7**
N92: Excessive, frequent and irregular menstruation	251	0.5%	35	242	0.6%	30	154	0.7%	26	47	0.5%	37
N89: Other noninflammatory disorders of vagina	149	0.3%	48	200	0.5%	34	124	0.6%	31	73	0.8%	26
L00-L99: Diseases of the skin and subcutaneous tissue	**1,465**	**3.1%**	**9**	**1,116**	**2.9%**	**10**	**655**	**3.1%**	**10**	**292**	**3.0%**	**11**
L70: Acne	414	0.9%	20	299	0.8%	22	143	0.7%	27	51	0.5%	35
O00-O9A: Pregnancy, childbirth and the puerperium	**867**	**1.8%**	**12**	**1,307**	**3.4%**	**9**	**802**	**3.7%**	**9**	**369**	**3.8%**	**9**
E00-E89: Endocrine, nutritional and metabolic diseases	**1,228**	**2.6%**	**10**	**1,001**	**2.6%**	**11**	**603**	**2.8%**	**11**	**320**	**3.3%**	**10**
E10: Type 1 diabetes mellitus	558	1.2%	16	368	1.0%	18	199	0.9%	21	93	1.0%	17
E11: Type 2 diabetes mellitus	59	0.1%	100	52	0.1%	96	65	0.3%	57	60	0.6%	30
K00-K95: Diseases of the digestive system	**1,112**	**2.4%**	**11**	**972**	**2.5%**	**12**	**569**	**2.7%**	**12**	**275**	**2.9%**	**12**
G00-G99: Diseases of the nervous system	**732**	**1.6%**	**13**	**588**	**1.5%**	**13**	**419**	**2.0%**	**13**	**196**	**2.0%**	**13**
G43: Migraine	242	0.5%	37	189	0.5%	36	120	0.6%	33	63	0.7%	28
A00-B99: Certain infectious and parasitic diseases	**667**	**1.4%**	**14**	**565**	**1.5%**	**14**	**284**	**1.3%**	**14**	**121**	**1.3%**	**15**
H60-H95: Diseases of the ear and mastoid process	**551**	**1.2%**	**15**	**435**	**1.1%**	**15**	**278**	**1.3%**	**15**	**158**	**1.6%**	**14**
U00-U85: Codes for special purposes	**321**	**0.7%**	**16**	**279**	**0.7%**	**16**	**171**	**0.8%**	**17**	**35**	**0.4%**	**19**
U07: Emergency use of U07	319	0.7%	29	276	0.7%	26	169	0.8%	24	34	0.4%	42
I00-I99: Diseases of the circulatory system	**237**	**0.5%**	**17**	**246**	**0.6%**	**17**	**178**	**0.8%**	**16**	**74**	**0.8%**	**16**
D50-D89: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**193**	**0.4%**	**18**	**225**	**0.6%**	**18**	**130**	**0.6%**	**19**	**51**	**0.5%**	**17**
C00-D49: Neoplasms	**183**	**0.4%**	**20**	**202**	**0.5%**	**19**	**148**	**0.7%**	**18**	**40**	**0.4%**	**18**
Q00-Q99: Congenital malformations, deformations and chromosomal abnormalities	**190**	**0.4%**	**19**	**109**	**0.3%**	**20**	**33**	**0.2%**	**20**	**22**	**0.2%**	**20**
P00-P96: Certain conditions originating in the perinatal period	**2**	**0.0%**	**21**	**6**	**0.0%**	**21**	**4**	**0.0%**	**21**	**4**	**0.0%**	**21**
V00-Y99: External causes of morbidity	**0**	**0.0%**	**22**	**2**	**0.0%**	**22**	**0**	**0.0%**	**22**	**1**	**0.0%**	**22**

For the numerator and denominator of the rate, the category of a primary diagnosis was counted once per member per date of service. Rates were ranked from highest (1) to lowest. Ranks range from 1 to 22 for chapters. Categories were included in the table if they ranked less than or equal to 30 for at least one of the four rates.

Prevalence Rates

The prevalence rates were calculated by first counting members having at least one diagnosis code in the specified chapter or category from claims with dates of service in the measurement period. For comparing across measurement periods, the counts were then multiplied by 1,200 and divided by the number of member months in the period. The prevalence rate is therefore the expected number of people who would have a diagnosis from the category in a year from a group of 100 people.

Prevalence rates based on primary diagnosis codes are displayed in Table A5. The following are noteworthy observations of differences between Tables A4 and A5:

- In Table A4, the highest ranked chapter, F01–F99 (Mental, behavioral and neurodevelopmental disorders), dropped to the fifth place in Table A5. This is typical of conditions that require multiple treatment days during a year.
- With F01–F99 moving downward from Table A4 to Table A5, Z00–Z99 (Factors influencing health status and contact with health services) and R00-R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) moved from second and third place to first and second place, respectively.
- In Table A5, the top ranked category code was H52 (Disorders of refraction and accommodation). The claims are mostly from annual eye exams. In Table A4, H52 ranked second, third, or fourth.
- Most category codes listed in Table A4 were also listed in Table A5, and vice versa. Chapters raising in rank (e.g., Z00–Z99) may have gained a category in Table A5, while chapters falling in rank (e.g., F01–F99) had fewer category codes listed in Table A5. The order of categories within the chapters varied slightly between tables.

Four category codes are related to COVID-19. The lowest ranks (indicating relatively lower prevalence rates) for each of these codes were in the Age 21+ measurement period. Keep in mind, claims for this period had dates of service near the end of the PHE or later, whereas the Age 19 period had claims with dates of service throughout the PHE. The four categories were

- Z11 (Encounter for screening for infectious and parasitic diseases),
- Z20 (Contact with and [suspected] exposure to communicable diseases),
- Z23 (Encounter for Immunization), and
- U07 (Emergency use of U07), which includes U07.0 (Vaping-related disorder) and U07.1 (COVID-19).

Prevalence rates calculated using primary and secondary diagnosis codes showed patterns similar to Table A5. The main difference was the inclusion of category codes that are not generally used for primary diagnoses:

- Z68 (Body mass index [BMI])
- Z79 (Long term [current]drug therapy)
- Z3A (Weeks of gestation)
- Z87 (Personal history of other diseases and conditions)
- F17 (Nicotine dependence)
- E66 (Overweight and obesity)

Table A5. Prevalence Rates of Primary Diagnosis Chapters and Categories

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	**47,211**			**38,726**			**21,454**			**9,620**		
Chapter or Category	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**
Z00-Z99: Factors influencing health status and contact with health services	**3,531**	**53.0**	**1**	**2,764**	**44.0**	**1**	**1,437**	**38.0**	**1**	**595**	**33.2**	**1**
Z00: Encounter for general examination without complaint, suspected or reported diagnosis	1,373	20.6	2	816	13.0	2	400	10.6	2	178	9.9	2
Z11: Encounter for screening for infectious and parasitic diseases	580	8.7	7	527	8.4	6	295	7.8	7	129	7.2	5
Z20: Contact with and (suspected) exposure to communicable diseases	887	13.3	4	744	11.9	3	309	8.2	4	69	3.9	14
Z23: Encounter for immunization	970	14.6	3	580	9.2	4	248	6.6	9	84	4.7	9
Z30: Encounter for contraceptive management	603	9.0	6	487	7.8	8	253	6.7	8	93	5.2	7
Z01: Encounter for other special examination without complaint, suspected or reported diagnosis	341	5.1	12	256	4.1	12	165	4.4	13	162	9.0	3
Z34: Encounter for supervision of normal pregnancy	126	1.9	35	211	3.4	19	113	3.0	20	50	2.8	20
Z36: Encounter for antenatal screening of mother	91	1.4	45	141	2.2	30	78	2.1	29	35	2.0	27
Z13: Encounter for screening for other diseases and disorders	107	1.6	41	114	1.8	36	59	1.6	38	32	1.8	30
Z12: Encounter for screening for malignant neoplasms	10	0.2	108	14	0.2	102	11	0.3	79	70	3.9	13
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**2,144**	**32.2**	**3**	**1,960**	**31.2**	**2**	**1,133**	**30.0**	**2**	**457**	**25.5**	**2**
R10: Abdominal and pelvic pain	573	8.6	8	560	8.9	5	338	8.9	3	126	7.0	6
R07: Pain in throat and chest	257	3.9	19	254	4.0	13	151	4.0	15	69	3.9	14
R11: Nausea and vomiting	234	3.5	21	214	3.4	18	154	4.1	14	51	2.8	19
R05: Cough	297	4.5	14	241	3.8	14	112	3.0	21	53	3.0	18
R30: Pain associated with micturition	209	3.1	23	199	3.2	20	108	2.9	22	60	3.4	16
R51: Headache	198	3.0	26	170	2.7	23	78	2.1	29	34	1.9	28
R53: Malaise and fatigue	157	2.4	30	129	2.1	32	86	2.3	28	36	2.0	26
R00: Abnormalities of heart beat	140	2.1	32	117	1.9	35	72	1.9	32	33	1.8	29
R06: Abnormalities of breathing	108	1.6	40	118	1.9	34	64	1.7	35	33	1.8	29
H00-H59: Diseases of the eye and adnexa	**2,399**	**36.0**	**2**	**1,906**	**30.4**	**3**	**1,042**	**27.6**	**3**	**376**	**21.0**	**3**
H52: Disorders of refraction and accommodation	2,176	32.7	1	1,706	27.2	1	924	24.5	1	330	18.4	1
J00-J99: Diseases of the respiratory system	**1,527**	**22.9**	**4**	**1,261**	**20.1**	**4**	**754**	**20.0**	**4**	**326**	**18.2**	**4**
J02: Acute pharyngitis	681	10.2	5	527	8.4	6	306	8.1	5	126	7.0	6
J06: Acute upper respiratory infections of multiple and unspecified sites	304	4.6	13	272	4.3	11	183	4.8	10	74	4.1	12
J01: Acute sinusitis	204	3.1	24	157	2.5	25	97	2.6	25	49	2.7	21
J45: Asthma	185	2.8	28	156	2.5	26	77	2.0	30	36	2.0	26
J30: Vasomotor and allergic rhinitis	173	2.6	29	132	2.1	31	76	2.0	31	28	1.6	31

For the numerator and denominator of the rate, the category of a primary diagnosis was counted once per member per date of service. Rates were ranked from highest (1) to lowest. Ranks range from 1 to 22 for chapters. Categories were included in the table if they ranked less than or equal to 30 for at least one of the four rates.

Table A5. Prevalence Rates of Primary Diagnosis Chapters and Categories (Continued)

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	**47,211**			**38,726**			**21,454**			**9,620**		
Chapter or Category	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**	**Count**	**Rate**	**Rank**
F01-F99: Mental, behavioral and neurodevelopmental disorders	**1,474**	**22.1**	**5**	**1,236**	**19.7**	**5**	**723**	**19.1**	**5**	**319**	**17.8**	**5**
F41: Other anxiety disorders	557	8.4	9	502	8.0	7	299	7.9	6	136	7.6	4
F33: Major depressive disorder, recurrent	350	5.3	11	306	4.9	10	178	4.7	12	86	4.8	8
F43: Reaction to severe stress, and adjustment disorders	260	3.9	18	192	3.1	21	114	3.0	19	64	3.6	15
F32: Depressive episode	296	4.4	15	230	3.7	16	**103**	**2.7**	24	42	2.3	24
F90: Attention-deficit hyperactivity disorders	217	3.3	22	150	2.4	27	**92**	**2.4**	27	48	2.7	22
N00-N99: Diseases of the genitourinary system	**884**	**13.3**	**8**	**852**	**13.6**	**7**	**506**	**13.4**	**6**	**221**	**12.3**	**7**
N89: Other noninflammatory disorders of vagina	126	1.9	35	162	2.6	24	94	2.5	26	51	2.8	19
N92: Excessive, frequent and irregular menstruation	202	3.0	25	177	2.8	22	107	2.8	23	37	2.1	25
N39: Other disorders of urinary system	187	2.8	27	143	2.3	29	94	2.5	26	32	1.8	30
S00-T88: Injury, poisoning and certain other consequences of external causes	**1,122**	**16.8**	**6**	**907**	**14.4**	**6**	**493**	**13.1**	**7**	**214**	**12.0**	**8**
M00-M99: Diseases of the musculoskeletal system and connective tissue	**1,092**	**16.4**	**7**	**849**	**13.5**	**8**	**462**	**12.2**	**8**	**222**	**12.4**	**6**
M25: Other joint disorder, not elsewhere classified	529	7.9	10	406	6.5	9	182	4.8	11	82	4.6	10
M54: Dorsalgia	278	4.2	17	230	3.7	16	134	3.5	17	81	4.5	11
M79: Other and unspecified soft tissue disorders, not elsewhere classified	293	4.4	16	222	3.5	17	125	3.3	18	57	3.2	17
L00-L99: Diseases of the skin and subcutaneous tissue	**778**	**11.7**	**9**	**647**	**10.3**	**9**	**378**	**10.0**	**9**	**167**	**9.3**	**9**
L70: Acne	198	3.0	26	149	2.4	28	78	2.1	29	27	1.5	32
K00-K95: Diseases of the digestive system	**527**	**7.9**	**10**	**449**	**7.2**	**10**	**276**	**7.3**	**10**	**116**	**6.5**	**10**
E00-E89: Endocrine, nutritional and metabolic diseases	**370**	**5.6**	**12**	**374**	**6.0**	**12**	**227**	**6.0**	**11**	**98**	**5.5**	**11**
A00-B99: Certain infectious and parasitic diseases	**496**	**7.4**	**11**	**395**	**6.3**	**11**	**211**	**5.6**	**12**	**87**	**4.9**	**13**
H60-H95: Diseases of the ear and mastoid process	**357**	**5.4**	**13**	**306**	**4.9**	**13**	**177**	**4.7**	**13**	**98**	**5.5**	**11**
H66: Suppurative and unspecified otitis media	121	1.8	36	108	1.7	38	68	1.8	33	43	2.4	23
G00-G99: Diseases of the nervous system	**316**	**4.7**	**14**	**292**	**4.7**	**14**	**176**	**4.7**	**14**	**92**	**5.1**	**12**
G43: Migraine	128	1.9	34	109	1.7	37	76	2.0	31	37	2.1	25
O00-O9A: Pregnancy, childbirth and the puerperium	**157**	**2.4**	**16**	**240**	**3.8**	**16**	**137**	**3.6**	**16**	**62**	**3.5**	**14**
U00-U85: Codes for special purposes	**258**	**3.9**	**15**	**241**	**3.8**	**15**	**140**	**3.7**	**15**	**34**	**1.9**	**16**
U07: Emergency use of U07	256	3.8	20	238	3.8	15	139	3.7	16	33	1.8	29
I00-I99: Diseases of the circulatory system	**119**	**1.8**	**17**	**120**	**1.9**	**17**	**85**	**2.3**	**17**	**39**	**2.2**	**15**
D50-D89: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**101**	**1.5**	**18**	**100**	**1.6**	**18**	**54**	**1.4**	**19**	**25**	**1.4**	**17**

For the numerator and denominator of the rate, the category of a primary diagnosis was counted once per member per date of service. Rates were ranked from highest (1) to lowest. Ranks range from 1 to 22 for chapters. Categories were included in the table if they ranked less than or equal to 30 for at least one of the four rates.

Table A5. Prevalence Rates of Primary Diagnosis Chapters and Categories (Continued)

	Regular Coverage			Extended Coverage								
	Age 18			Age 19			Age 20			Age 21+		
Total Count of Diagnosis Categories	47,211			38,726			21,454			9,620		
Chapter or Category	Count	Rate	Rank	Count	Rate	Rank	Count	Rate	Rank	Count	Rate	Rank
C00-D49: Neoplasms	80	1.2	19	71	1.1	19	61	1.6	18	17	0.9	18
Q00-Q99: Congenital malformations, deformations and chromosomal abnormalities	77	1.2	20	60	1.0	20	24	0.6	20	12	0.7	19
P00-P96: Certain conditions originating in the perinatal period	2	0.0	21	6	0.1	21	2	0.1	21	2	0.1	20
V00-Y99: External causes of morbidity	0	0.0	22	2	0.0	22	0	0.0	22	1	0.1	21

For the numerator and denominator of the rate, the category of a primary diagnosis was counted once per member per date of service. Rates were ranked from highest (1) to lowest. Ranks range from 1 to 22 for chapters. Categories were included in the table if they ranked less than or equal to 30 for at least one of the four rates.

c. Summary of inpatient stays by diagnosis (Q1.b)

Inpatient stays were analyzed based on their Major Diagnostic Category (MDC) and Medicare Severity Diagnosis Related Group (MS-DRG) codes. The intent of the analysis was to identify the most frequently used codes. Based on review of preliminary stratified counts, the data are presented in Table A6 as a top-ten list of MDC codes from inpatient encounters in the extended coverage period. Corresponding frequency counts for the regular coverage period are provided for comparison.

Table A6. Top 10 Major Diagnostic Categories for Inpatient Stays

Major Diagnostic Category Code and Description	Regular Coverage		Extended Coverage	
	N	%	N	%
Inpatient Stays with MDC Code	**230**		**474**	
14. Pregnancy, Childbirth & The Puerperium	68	30%	189	40%
19. Mental Diseases & Disorders (D&D)	58	25%	78	16%
15. Newborn & Neonates with Conditions Orig. Perinatal Period	9	4%	45	9%
10. Endocrine, Nutritional & Metabolic D&D	10	4%	26	5%
18. Infectious & Parasitic Diseases	14	6%	18	4%
01. D&D of the Nervous System	10	4%	18	4%
06. D&D of the Digestive System	7	3%	16	3%
08. D&D Musculoskeletal System & Connect Tissue	13	6%	15	3%
21. Injuries, Poisonings, Toxic Effect of Drugs	7	3%	14	3%
04. D&D of the Respiratory System	5	2%	12	3%
All Other MDCs	29	13%	43	9%

Claims with MDC of 15 are from claims for newborns billed under the mother's Medicaid ID. The corresponding claim for the mother's stay will have MDC of 14.

A few key observations related to MDC and MS-DRG are as follows:

- The two MDCs with the greatest increases from regular to extended coverage in their percent of stays within the coverage period were related to pregnancy. Inpatient stays for the mother (MDC 14 – Pregnancy, Childbirth & The Puerperium) increased from 30% of stays to 40% of stays. Stays for the newborn that were billed under the mother's Medicaid ID (MDC – Newborn & Neonates with Conditions Orig. Perinatal Period) increased from 4% to 9%.
  - 57% (107) of 189 MSC 14 stays in the extended coverage period were for routine vaginal delivery (MS-DRG 807 – Vaginal delivery w/o sterilization/D&C w/o CC/MCC).
  - 5% (15) of 189 MSC 14 stays in the extended coverage period were for routine cesarean delivery (MS-DRG 788 – Cesarean section w/o sterilization w/o CC/MCC.

  - 49% (17) of 35 MSC 15 stays in the extended coverage period were normal newborn stays (MS-DRG 795).
- MDC 19 – Mental Diseases & Disorders (D&D) ranked second for both coverage periods.
  - 88% (69) of 78 MSC 19 stays in the extended coverage period were for psychoses (MS-DRG 885).
- Within MDC 10 – Endocrine, Nutritional & Metabolic D&D, 88% (26) of 29 stays in the extended coverage period were for diabetes (MS-DRGs 637, 638, and 639).

d. Summary diagnosis incidence (Q1.c)

Incidence rates were calculated at the chapter and category levels from outpatient, vision, and non-vendor professional claims. Incidence rates were defined as the percent of members that matched to a at least one "new" diagnosis from the specified chapter or category within the extended study period. A diagnosis was considered new if there was not a claim with a diagnosis code in the same category with an earlier date of service. More specifically,

- Denominator was the numbers of members in the study population, and
- Numerator was the number of those members having at least one diagnosis code in the specified chapter or category from claims with dates of service in the extended coverage and not having any diagnosis codes in that code's category from claims with dates in the regular coverage period.

Incidence rates shown in Table A7 are based on primary and secondary diagnosis. This table is not directly comparable to Tables A4 and A5 (rates were calculated across the entire extended coverage period instead of by Age 19, Age 20, and Age 20^{+}; rates are percentages of the study population; and categories with rates of 4% or greater are listed instead of being limited by rank).

The five chapters with the greatest incidence rates also had the greatest prevalence rates in Table A5 and contained the top 10 categories:

- Z00–Z99 (Factors influencing health status and contact with health services) – 75%
  - Z20 (Contact with and [suspected] exposure to communicable diseases) – 36%
  - Z23 (Encounter for immunization) – 33%
  - Z00 (Encounter for general examination without complaint, suspected or reported diagnosis) – 31%
  - Z11 (Encounter for screening for infectious and parasitic diseases) – 24%
  - Z30 (Encounter for contraceptive management) – 20%
- R00–R99 (Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified) – 61%
  - R10 (Abdominal and pelvic pain) – 22%
  - R05 (Cough) – 17%
- H00–H59 (Diseases of the eye and adnexa) – 49%
  - H52 (Disorders of refraction and accommodation) – 46%
- J00–J99 (Diseases of the respiratory system) – 46%
  - J02 (Acute pharyngitis) – 25%
- F01–F99 (Mental, behavioral and neurodevelopmental disorders) – 39%
  - F41 (Other anxiety disorders) – 23%

Codes Z20, Z23, and Z11 (listed above) may be related to COVID-19. The incidence rate for U07 (Emergency use of U07), which includes diagnoses of COVID-19, was 10% (ranked 28th).

Table A7. Incidence Rates for Diagnosis Chapters and Categories

	Extended Coverage	
Count of Members (Denominator)	7,087	
Diagnosis Chapter or Category	**N**	**%**
Z00-Z99: Factors influencing health status and contact with health services	**5,361**	**75.6%**
Z20: Contact with and (suspected) exposure to communicable diseases	2,531	35.7%
Z23: Encounter for immunization	2,320	32.7%
Z00: Encounter for general examination without complaint, suspected or reported diagnosis	2,205	31.1%
Z11: Encounter for screening for infectious and parasitic diseases	1,733	24.5%
Z30: Encounter for contraceptive management	1,417	20.0%
Z68: Body mass index [BMI]	1,187	16.7%
Z01: Encounter for other special examination without complaint, suspected or reported diagnosis	956	13.5%
Z79: Long term (current) drug therapy	894	12.6%
Z13: Encounter for screening for other diseases and disorders	873	12.3%
Z32: Encounter for pregnancy test and childbirth and childcare instruction	636	9.0%
Z71: Persons encountering health services for other counseling and medical advice, not elsewhere classified	580	8.2%
Z87: Personal history of other diseases and conditions	514	7.3%
Z3A: Weeks of gestation	418	5.9%
Z86: Personal history of certain other diseases	404	5.7%
Z72: Problems related to lifestyle	391	5.5%
Z34: Encounter for supervision of normal pregnancy	387	5.5%
Z03: Encounter for medical observation for suspected diseases and conditions ruled out	368	5.2%
Z02: Encounter for administrative examination	325	4.6%
Z36: Encounter for antenatal screening of mother	296	4.2%
R00-R99: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified	**4,323**	**61.0%**
R10: Abdominal and pelvic pain	1,567	22.1%
R05: Cough	1,240	17.5%
R11: Nausea and vomiting	1,229	17.3%
R51: Headache	999	14.1%
R53: Malaise and fatigue	911	12.9%
R07: Pain in throat and chest	899	12.7%
R50: Fever of other and unknown origin	725	10.2%
R09: Other symptoms and signs involving the circulatory and respiratory system	681	9.6%
R30: Pain associated with micturition	655	9.2%
R06: Abnormalities of breathing	632	8.9%
R19: Other symptoms and signs involving the digestive system and abdomen	580	8.2%
R00: Abnormalities of heart beat	545	7.7%
R42: Dizziness and giddiness	464	6.5%
R63: Symptoms and signs concerning food and fluid intake	370	5.2%
R68: Other general symptoms and signs	306	4.3%
R21: Rash and other nonspecific skin eruption	299	4.2%
H00-H59: Diseases of the eye and adnexa	**3,476**	**49.0%**
H52: Disorders of refraction and accommodation	3,263	46.0%
H10: Conjunctivitis	528	7.5%
H53: Visual disturbances	293	4.1%
J00-J99: Diseases of the respiratory system	**3,227**	**45.5%**
J02: Acute pharyngitis	1,759	24.8%
J06: Acute upper respiratory infections of multiple and unspecified sites	1,003	14.2%
J30: Vasomotor and allergic rhinitis	785	11.1%
J45: Asthma	726	10.2%
J01: Acute sinusitis	568	8.0%

The *incidence rate* is the percent of the study population who had a primary or secondary diagnosis in the chapter or category during the extended coverage period but not in the regular coverage period. For categories, only rates greater than 4% are shown.

Table A7. Incidence Rates for Diagnosis Chapters and Categories (Continued)

	Extended Coverage	
Count of Members (Denominator)	7,087	
Diagnosis Chapter or Category	**N**	**%**
F01-F99: Mental, behavioral and neurodevelopmental disorders	**2,747**	**38.8%**
F41: Other anxiety disorders	1,611	22.7%
F32: Depressive episode	944	13.3%
F33: Major depressive disorder, recurrent	791	11.2%
F43: Reaction to severe stress, and adjustment disorders	642	9.1%
F90: Attention-deficit hyperactivity disorders	589	8.3%
F17: Nicotine dependence	528	7.5%
F12: Cannabis related disorders	332	4.7%
M00-M99: Diseases of the musculoskeletal system and connective tissue	**2,404**	**33.9%**
M25: Other joint disorder, not elsewhere classified	1,226	17.3%
M79: Other and unspecified soft tissue disorders, not elsewhere classified	1,036	14.6%
M54: Dorsalgia	892	12.6%
S00-T88: Injury, poisoning and certain other consequences of external causes	**2,307**	**32.6%**
N00-N99: Diseases of the genitourinary system	**2,044**	**28.8%**
N92: Excessive, frequent and irregular menstruation	712	10.0%
N39: Other disorders of urinary system	513	7.2%
N89: Other noninflammatory disorders of vagina	489	6.9%
N94: Pain and other conditions associated with female genital organs and menstrual cycle	424	6.0%
N30: Cystitis	307	4.3%
N93: Other abnormal uterine and vaginal bleeding	305	4.3%
N76: Other inflammation of vagina and vulva	301	4.2%
L00-L99: Diseases of the skin and subcutaneous tissue	**1,920**	**27.1%**
L70: Acne	471	6.6%
L03: Cellulitis and acute lymphangitis	322	4.5%
A00-B99: Certain infectious and parasitic diseases	**1,583**	**22.3%**
B34: Viral infection of unspecified site	414	5.8%
K00-K95: Diseases of the digestive system	**1,473**	**20.8%**
K21: Gastro-esophageal reflux disease	427	6.0%
K59: Other functional intestinal disorders	397	5.6%
E00-E89: Endocrine, nutritional and metabolic diseases	**1,459**	**20.6%**
E66: Overweight and obesity	676	9.5%
G00-G99: Diseases of the nervous system	**1,205**	**17.0%**
G43: Migraine	385	5.4%
G89: Pain, not elsewhere classified	369	5.2%
G47: Sleep disorders	345	4.9%
V00-Y99: External causes of morbidity	**1,062**	**15.0%**
Y92: Place of occurrence of the external cause	353	5.0%
Y93: Activity codes	280	4.0%
H60-H95: Diseases of the ear and mastoid process	**1,041**	**14.7%**
H66: Suppurative and unspecified otitis media	409	5.8%
U00-U85: Codes for special purposes	**730**	**10.3%**
U07: Emergency use of U07	719	10.1%
D50-D89: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	**508**	**7.2%**
I00-I99: Diseases of the circulatory system	**486**	**6.9%**
O00-O9A: Pregnancy, childbirth and the puerperium	**435**	**6.1%**
C00-D49: Neoplasms	**316**	**4.5%**
Q00-Q99: Congenital malformations, deformations and chromosomal abnormalities	**225**	**3.2%**
P00-P96: Certain conditions originating in the perinatal period	**49**	**0.7%**

The *incidence rate* is the percent of the study population who had a primary or secondary diagnosis in the chapter or category during the extended coverage period but not in the regular coverage period. For categories, only rates greater than 4% are shown.

6.4 Calculate measurements described in Activity 2.3 for Question 2

a. Service utilization by chronic condition (Q2.a)

Table A8 displays the results of analysis of medical claims aimed at answering the question, "Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?" The rates shown are the percentages of members who received services for the given condition during regular coverage (Age 18) who also received services for the condition during the first year of extended coverage (Age 19) or any time during extended coverage (Age 19+). Services were counted from inpatient, outpatient, and professional encounters. Chronic conditions were identified using primary and secondary diagnosis codes.

Table A8. Service Utilization for Selected Chronic Conditions

Diseases	Age 18	Age 19		Age 19+	
	Denominator	Count	Rate	Count	Rate
Asthma	409	167	41%	202	49%
Asthma with Exacerbation	84	18	21%	22	26%
Diabetes Mellitus	76	54	71%	60	79%
Diabetes Treatment	38	18	47%	22	58%
Diabetes Ketoacidosis/Hyperglycemia	50	38	76%	38	76%
Mental Health Issue	1,680	953	57%	1,049	62%
Substance Use Disorder	279	101	36%	123	44%
Overweight and Obesity	536	195	36%	236	44%

Counts are the number of members with an inpatient, outpatient, or professional encounter having a primary or secondary diagnosis for the given condition.

- Asthma: Category J45
- Asthma with Exacerbation: Diagnoses J45.xx; with xx equal to 22, 31, 32, 41, 42, 50, 51, 52, 901, or 902
- Diabetes Mellitus: Categories E08 through E13
- Diabetes Treatment: Diagnoses Z79.4, Z79.84
- Diabetes Ketoacidosis/Hyperglycemia: Diagnoses Exx.10, Exx.11, Exx.65, Exx.69; xx from 08 to 13
- Mental Health Issue: Categories F01 through F09 and F20 through F99
- Substance Use Disorder: Categories F10 through F19
- Overweight and Obesity: Category E66 and Diagnoses Z68.xx; with xx from 25 to 45 or equal to 53 or 54

The chronic conditions with the highest percentages of diagnosed members having treatment continued into the extended coverage period were diabetes mellitus (79%), diabetes ketoacidosis/hyperglycemia (76%), mental health issues (62%), and diabetes treatment (58%).

For members with services for a chronic condition continued into the extended period, the majority had received treatment within the first year of extended coverage.

b. Prescription (pre-existing condition) prevalence rates by generic therapeutic class (Q2.a)

Table A9 displays the results of analysis of pharmacy claims addressing the question, "Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?" In this analysis, the terms *treatment* and *prescription* are equated with a claim for a filled prescription within a given *therapeutic class*, and claims were deduplicated to count a therapeutic class once per Medicaid ID per measurement period. For each Generic Therapeutic Class (GTC) and Specific Therapeutic Class (STC), *prescription prevalence rates* were calculated as the percentage of members with prescriptions filled during regular coverage (Age 18) who had a prescription that continued into the extended coverage period (the denominator was the number of members who had a pharmacy claim with the given

GTC or STC during the regular coverage period, and the numerator was the number of those members who also had a claim during the extended coverage period with the same GTC or STC). Rates were calculated for the Age 19 and Age 19+ coverage periods.

Table A9. Prescription Prevalence Rates for Generic and Specific Therapeutic Classes

Generic or Specific Therapeutic Class (GTC or STC)	Age 18	Age 19		Ages 19+	
	D	N	%	N	%
GTC Average Rate	**14,370**	**5,447**	**37.9%**	**6,370**	**44.3%**
Age 19+ Rates Above the GTC Average Rate					
19: Antibiotics	**2,422**	**1,149**	**47.4%**	**1,417**	**58.5%**
80: Psychotherapeutic Drugs	**1,254**	**762**	**60.8%**	**826**	**65.9%**
8875: Selective Serotonin Reuptake Inhibitor (SSRIs)	828	450	54.3%	484	58.5%
8889: Serotonin-Norepinephrine Reuptake-Inhib (SNRIs)	135	75	55.6%	77	57.0%
0267: Tx for Attention Deficit-Hyperact (ADHD)/Narcolepsy	120	59	49.2%	61	50.8%
0292: Adrenergics, Aromatic, Non-Catecholamine	107	53	49.5%	57	53.3%
8891: Norepinephrine & Dopamine Reuptake Inhib (NDRIs)	103	47	45.6%	48	46.6%
8893: Serotonin-2 Antagonist/Reuptake Inhibitors (SARIs)	97	39	40.2%	44	45.4%
9158: Antipsychotic, Atypical, Dopamine, Serotonin Antagns	94	51	54.3%	51	54.3%
8877: Tricyclic Antidepressants, Rel. Non-Sel. Reupt-Inhib	94	43	45.7%	44	46.8%
9851: Antipsychotics, Atyp, D2 Partial Agonist/5HT Mixed	85	42	49.4%	43	50.6%
D237: Tx for ADHD - Selective Alpha-2 Receptor Agonist	48	23	47.9%	24	50.0%
47: Contraceptives	**1,075**	**667**	**62.0%**	**700**	**65.1%**
0248: Contraceptives, Oral	926	561	60.6%	584	63.1%
4139: Contraceptives, Injectable	88	42	47.7%	43	48.9%
65: Gastrointestinal	**953**	**358**	**37.6%**	**436**	**45.8%**
14: Antiasthmatics	**688**	**350**	**50.9%**	**396**	**57.6%**
G476: Beta-Adrenergic Agents, Inhaled, Short Acting	577	254	44.0%	295	51.1%
6205: Leukotriene Receptor Antagonists	194	101	52.1%	110	56.7%
E157: Glucocorticoids, Orally Inhaled	122	54	44.3%	57	46.7%
7779: Beta-Adrenergic and Glucocorticoid Combo, Inhaled	98	59	60.2%	64	65.3%
44: Central Nervous System Drugs	**204**	**95**	**46.6%**	**105**	**51.5%**
0275: Anticonvulsants	192	91	47.4%	99	51.6%
41: Cardiovascular	**178**	**93**	**52.2%**	**98**	**55.1%**
0147: Antihypertensives, ACE Inhibitors	39	25	64.1%	27	69.2%
32: Autonomic Drugs	**162**	**89**	**54.9%**	**93**	**57.4%**
0292: Adrenergics, Aromatic, Non-Catecholamine	112	67	59.8%	69	61.6%
71: Antihyperglycemics	**119**	**80**	**67.2%**	**84**	**70.6%**
0179: Antihyperglycemic, Biguanide Type	75	37	49.3%	42	56.0%
0177: Insulins	49	41	83.7%	41	83.7%
89: Thyroid Preps	**65**	**47**	**72.3%**	**49**	**75.4%**
0356: Thyroid Hormones	57	40	70.2%	42	73.7%
56: Diuretics	**71**	**43**	**60.6%**	**45**	**63.4%**
0425: Potassium Sparing Diuretics	62	39	62.9%	40	64.5%
72: Immunosuppressants	**36**	**21**	**58.3%**	**22**	**61.1%**
08: Anti-Obesity Drugs	**22**	**10**	**45.5%**	**11**	**50.0%**
Age 19+ GTC Rates Below the GTC Average Rate					
17: Antihistamines	**745**	**297**	**39.9%**	**329**	**44.2%**
8541: Antihistamines - 2nd Generation	476	211	44.3%	224	47.1%
02: Analgesics	**1,059**	**195**	**18.4%**	**272**	**25.7%**
0272: Antimigraine Preparations	107	48	44.9%	55	51.4%
68: Hormones	**740**	**197**	**26.6%**	**263**	**35.5%**

The *prescription prevalence rate* is the percentage of members who had a pharmacy claim having the given GTC or STC in the Age 18 period (D) who had a pharmacy claim with the same GTC (or STC) in the Age 19 or Age 19+ extended coverage periods (N). The *GTC average rate* was calculated by summing the numerators and denominators of the GTC rates. Row are separated into two parts based on the Age 19+ rate being above or below the All GTCs Age 19+ rate. In both parts, rows are sorted by the Age 19+ numerator. Specific Therapeutic Classes (STCs) with Age 19+ rates above the GTC average rate and denominators greater than or equal to 30 are displayed.

Table A9. Prescription Prevalence Rates for Generic and Specific Therapeutic Classes (Continued)					
Generic or Specific Therapeutic Class (GTC or STC)	Age 18	Age 19		Ages 19+	
	D	N	%	N	%
Age 19+ GTC Rates Below the GTC Average Rate (Continued)					
86: Skin Preps	**558**	**187**	**33.5%**	**223**	**40.0%**
6979: Acne Agents, Topical	105	41	39.0%	47	44.8%
11: Antiarthritics	**801**	**152**	**19.0%**	**203**	**25.3%**
92: Biologicals	**759**	**132**	**17.4%**	**156**	**20.6%**
62: EENT Preps	**421**	**127**	**30.2%**	**156**	**37.1%**
22: Antifungals	**388**	**82**	**21.1%**	**114**	**29.4%**
59: Elect/Caloric/H2O	**205**	**52**	**25.4%**	**60**	**29.3%**
50: Cough/Cold Preparations	**197**	**36**	**18.3%**	**44**	**22.3%**
21: Antivirals	**177**	**32**	**18.1%**	**43**	**24.3%**
74: Miscellaneous Medical Supplies, Devices, Non-Drug	**93**	**38**	**40.9%**	**40**	**43.0%**
0540: Needles/Needleless Devices	38	26	68.4%	26	68.4%
95: Vitamins	**137**	**33**	**24.1%**	**37**	**27.0%**
99: Unclassified Drug Products	**246**	**28**	**11.4%**	**32**	**13.0%**
77: Muscle Relaxants	**212**	**21**	**9.9%**	**30**	**14.2%**
53: Diagnostic	**70**	**19**	**27.1%**	**22**	**31.4%**
05: Anesthetics	**150**	**10**	**6.7%**	**15**	**10.0%**
94: Pre-Natal Vitamins	**34**	**9**	**26.5%**	**11**	**32.4%**
Other (14 GTCs with D≤20)	**129**	**36**	**27.9%**	**38**	**29.5%**

The *prescription prevalence rate* is the percentage members who had a pharmacy claim having the given GTC or STC in the Age 18 period (D) who had a pharmacy claim with the same GTC (or STC) in the Age 19 or Age 19+ extended coverage periods (N). The *GTC average rate* was calculated by summing the numerators and denominators of the GTC rates. Row are separated into two parts based on the Age 19+ rate being above or below the All GTCs Age 19+ rate. In both parts, rows are sorted by the Age 19+ numerator. Specific Therapeutic Classes (STCs) with Age 19+ rates above the GTC average rate and denominators greater than or equal to 30 are displayed.

The first data row of Table A9 shows the GTC average prescription prevalence rate was 38% for Age 19 and 44% for Age 19+. This means that of the 14,370 prescriptions filled during regular coverage (counting prescriptions once per member per GTC), 38% had a corresponding prescription in the same GTC filled by the member in their first year of extended coverage and 44% had a prescription of the same GTC filled by the member anytime during the extended coverage period. The remaining data rows are divided into two sections. GTC rates above the Age 19+ GTC average rate are in one section and those below the Age 19+ GTC average rate are in an another. Both sections are ordered by the Age 19+ numerator so that the more commonly filled prescriptions are shown first. The rows in Table A9 for GTC rates are in bold-face font.

The prescriptions with prevalence rates higher than average fall into three categories:

- Treatment for acute conditions (e.g., antibiotics)
- Treatment for chronic conditions (e.g., psychotherapeutic drugs and antiasthmatics)
- Preventive medicine (e.g., contraceptives and anti-obesity drugs)

STC prescription prevalence rates greater than the Age 19+ GTC average rate are also displayed in Table A9 (regular font) Several STC rates for treatment with psychotherapeutic drugs were higher than the Age 19+ GTC average rate, indicating members frequently maintain treatment within the same specific therapeutic class. In contrast, no STC rates for antibiotics were higher than the GTC average rate, which may indicate treatments with antibiotics tend to change specific therapeutic classes to target specific bacterial infections.

Note, lower rates do not indicate poorer performance. Treatments for acute conditions (e.g., cough/cold preparations, antifungals, antivirals) and diagnostics may not warrant refill.

c. Prescription (new prescriptions) incidence rates by generic therapeutic class (Q2.b)

Table A10 displays *prescription incidence rates* calculated as the percent of members in the study population who had a prescription during the extended coverage period that they did not have during the regular coverage period. The technical terms are as defined for prescription prevalence rates.

Table A10. Prescription Incidence Rates for Generic and Specific Therapeutic Classes

	Age 19		Age 19+	
Count of Members (Denominator)	7,087		7,087	
Generic or Specific Therapeutic Class (GTC or STC)	**N**	**%**	**N**	**%**
All GTCs (Members with any new GTC)	**3,219**	**45.4%**	**4,016**	**56.7%**
19: Antibiotics	**1,001**	**14.1%**	**1,508**	**21.3%**
0476: Penicillin Antibiotics	651	9.2%	1,046	14.8%
0478: Tetracycline Antibiotics	286	4.0%	509	7.2%
0479: Macrolide Antibiotics	288	4.1%	480	6.8%
9256: Cephalosporin Antibiotics - 1st Generation	251	3.5%	459	6.5%
0502: Anaerobic Antiprotozoal-Antibacterial Agents	179	2.5%	323	4.6%
0491: Absorbable Sulfonamide Antibacterial Agents	172	2.4%	299	4.2%
0494: Nitrofuran Derivatives Antibacterial Agents	153	2.2%	283	4.0%
0388: Topical Antibiotics	141	2.0%	249	3.5%
0402: Ophthalmic Antibiotics	111	1.6%	209	2.9%
9258: Cephalosporin Antibiotics - 3rd Generation	102	1.4%	178	2.5%
3668: Quinolone Antibiotics	79	1.1%	147	2.1%
0485: Lincosamide Antibiotics	82	1.2%	144	2.0%
0377: Vaginal Antibiotics	23	0.3%	58	0.8%
0417: Ear Preparations, Antibiotics	30	0.4%	56	0.8%
6520: Eye Antibiotic and Glucocorticoid Combinations	27	0.4%	55	0.8%
7554: Otic Preparations, Anti-Inflammatory-Antibiotics	27	0.4%	52	0.7%
65: Gastrointestinal	**541**	**7.6%**	**860**	**12.1%**
0282: Antiemetic/Antivertigo Agents	414	5.8%	663	9.4%
8026: Proton-Pump Inhibitors	158	2.2%	293	4.1%
0232: Laxatives and Cathartics	88	1.2%	150	2.1%
0582: Histamine H2-Receptor Inhibitors	80	1.1%	134	1.9%
0224: Anti-Ulcer Preparations	49	0.7%	95	1.3%
0288: Anticholinergics/Antispasmodics	36	0.5%	73	1.0%
0300: Intestinal Motility Stimulants	37	0.5%	69	1.0%
02: Analgesics	**538**	**7.6%**	**879**	**12.4%**
B974: Opioid Analgesic and Non-Salicylate Analgesics	455	6.4%	727	10.3%
0268: Opioid Analgesics	108	1.5%	219	3.1%
0272: Antimigraine Preparations	45	0.6%	87	1.2%
0271: Analgesic/Antipyretics, Non-Salicylate	25	0.4%	54	0.8%
92: Biologicals	**532**	**7.5%**	**714**	**10.1%**
I529: COVID-19 Vaccines	454	6.4%	604	8.5%
0512: Influenza Virus Vaccines	171	2.4%	255	3.6%
68: Hormones	**501**	**7.1%**	**833**	**11.8%**
0360: Glucocorticoids	473	6.7%	774	10.9%
0246: Progestational Agents	25	0.4%	59	0.8%
11: Antiarthritics	**424**	**6.0%**	**732**	**10.3%**
0439: NSAIDs, Cyclooxygenase Inhibitor Type Analgesics	420	5.9%	724	10.2%

The *prescription incidence rate* is the percent of the members who had a pharmacy claim having the given GTC or STC during the extended coverage period but did not have a claim for that GTC or STC in the regular coverage period. GTCs with Age 19+ numerator (N) greater than 20 and STCs with Age 19+ numerator greater than 50 are shown.

Table A10. Prescription Incidence Rates for Generic and Specific Therapeutic Classes (Continued)

	Age 19		Age 19+	
Count of Members (Denominator)	7,087		7,087	
Generic or Specific Therapeutic Class (GTC or STC)	**N**	**%**	**N**	**%**
80: Psychotherapeutic Drugs	**391**	**5.5%**	**622**	**8.8%**
8875: Selective Serotonin Reuptake Inhibitor (SSRIs)	296	4.2%	478	6.7%
8891: Norepinephrine and Dopamine Reuptake Inhib (NDRIs)	83	1.2%	153	2.2%
8889: Serotonin-Norepinephrine Reuptake-Inhib (SNRIs)	86	1.2%	136	1.9%
8893: Serotonin-2 Antagonist/Reuptake Inhibitors (SARIs)	60	0.8%	104	1.5%
H228: Anti-Anxiety - Benzodiazepines	53	0.7%	97	1.4%
0258: Anti-Anxiety Drugs	52	0.7%	95	1.3%
9158: Antipsychotic, Atypical, Dopamine, Serotonin Antagns	57	0.8%	86	1.2%
9851: Antipsychotics, Atyp, D2 Partial Agonist/5HT Mixed	41	0.6%	67	0.9%
8877: Tricyclic Antidepressants, Rel. Non-Sel. Reupt-Inhib	40	0.6%	66	0.9%
0292: Adrenergics, Aromatic, Non-Catecholamine	33	0.5%	64	0.9%
0267: Tx for Attention Deficit-Hyperact (ADHD)/Narcolepsy	32	0.5%	58	0.8%
17: Antihistamines	**315**	**4.4%**	**497**	**7.0%**
3218: Antihistamines - 1st Generation	207	2.9%	335	4.7%
8541: Antihistamines - 2nd Generation	139	2.0%	212	3.0%
86: Skin Preps	**291**	**4.1%**	**464**	**6.5%**
4445: Vitamin A Derivatives	63	0.9%	105	1.5%
6979: Acne Agents, Topical	38	0.5%	59	0.8%
22: Antifungals	**264**	**3.7%**	**451**	**6.4%**
0498: Antifungal Agents	179	2.5%	315	4.4%
0381: Topical Antifungals	98	1.4%	173	2.4%
47: Contraceptives	**261**	**3.7%**	**388**	**5.5%**
0248: Contraceptives, Oral	244	3.4%	361	5.1%
14: Antiasthmatics	**226**	**3.2%**	**364**	**5.1%**
G476: Beta-Adrenergic Agents, Inhaled, Short Acting	216	3.0%	350	4.9%
6205: Leukotriene Receptor Antagonists	45	0.6%	73	1.0%
E157: Glucocorticoids, Orally Inhaled	41	0.6%	63	0.9%
7779: Beta-Adrenergic and Glucocorticoid Combo, Inhaled	27	0.4%	62	0.9%
62: EENT Preps	**215**	**3.0%**	**364**	**5.1%**
0409: Nasal Anti-Inflammatory Steroids	180	2.5%	299	4.2%
77: Muscle Relaxants	**176**	**2.5%**	**309**	**4.4%**
0281: Skeletal Muscle Relaxants	176	2.5%	309	4.4%
50: Cough/Cold Preparations	**171**	**2.4%**	**329**	**4.6%**
0279: Antitussives, Non-Opioid	127	1.8%	252	3.6%
99: Unclassified Drug Products	**142**	**2.0%**	**240**	**3.4%**
0218: Dental Aids and Preparations	99	1.4%	168	2.4%
21: Antivirals	**126**	**1.8%**	**257**	**3.6%**
0510: Antivirals, General	106	1.5%	215	3.0%
41: Cardiovascular	**110**	**1.6%**	**200**	**2.8%**
0298: Beta-Adrenergic Blocking Agents	55	0.8%	110	1.6%
59: Elect/Caloric/H2O	**107**	**1.5%**	**196**	**2.8%**
0219: Fluoride Preparations	46	0.6%	84	1.2%
0173: Iron Replacement	48	0.7%	82	1.2%
44: Central Nervous System Drugs	**96**	**1.4%**	**157**	**2.2%**
0275: Anticonvulsants	85	1.2%	144	2.0%
05: Anesthetics	**84**	**1.2%**	**150**	**2.1%**
0250: Local Anesthetics	37	0.5%	73	1.0%
6046: Urinary Tract Anesthetic/Analgesic Agnt (azo-dye)	34	0.5%	52	0.7%

The *prescription incidence rate* is the percent of the members who had a pharmacy claim having the given GTC or STC during the extended coverage period but did not have a claim for that GTC or STC in the regular coverage period. GTCs with Age 19+ numerator (N) greater than 20 and STCs with Age 19+ numerator greater than 50 are shown.

Table A10. Prescription Incidence Rates for Generic and Specific Therapeutic Classes (Continued)

	Age 19		Age 19+	
Count of Members (Denominator)	**7,087**		**7,087**	
Generic or Specific Therapeutic Class (GTC or STC)	**N**	**%**	**N**	**%**
95: Vitamins	**82**	**1.2%**	**156**	**2.2%**
0195: Vitamin D Preparations	59	0.8%	117	1.7%
32: Autonomic Drugs	**80**	**1.1%**	**141**	**2.0%**
0292: Adrenergics, Aromatic, Non-Catecholamine	53	0.7%	97	1.4%
53: Diagnostic	**77**	**1.1%**	**140**	**2.0%**
I325: Diagnostic Test Devices, Supplies, and Services	60	0.8%	116	1.6%
74: Miscellaneous Medical Supplies, Devices, Non-Drug	**47**	**0.7%**	**91**	**1.3%**
94: Pre-Natal Vitamins	**35**	**0.5%**	**62**	**0.9%**
0197: Prenatal Vitamin Preparations	35	0.5%	62	0.9%
71: Antihyperglycemics	**31**	**0.4%**	**69**	**1.0%**
0179: Antihyperglycemic, Biguanide Type	24	0.3%	54	0.8%
89: Thyroid Preps	**24**	**0.3%**	**33**	**0.5%**
56: Diuretics	**23**	**0.3%**	**69**	**1.0%**
0425: Potassium Sparing Diuretics	18	0.3%	56	0.8%
24: Antiparasitics	**18**	**0.3%**	**21**	**0.3%**
83: Sedative/Hypnotics	**16**	**0.2%**	**30**	**0.4%**
08: Anti-Obesity Drugs	**15**	**0.2%**	**45**	**0.6%**
72: Immunosuppressants	**15**	**0.2%**	**31**	**0.4%**
38: Cardiac Drugs	**14**	**0.2%**	**34**	**0.5%**
23: Antiinfectives/Miscellaneous	**10**	**0.1%**	**22**	**0.3%**

The *prescription incidence rate* is the percent of the members who had a pharmacy claim having the given GTC or STC during the extended coverage period but did not have a claim for that GTC or STC in the regular coverage period. GTCs with Age 19+ numerator (N) greater than 20 and STCs with Age 19+ numerator greater than 50 are shown.

Six GTCs and four STCs had prescription incidence rates greater than 10% for Age 19+:

- Antibiotics (14% for Age 19, 21% for Age 19+)
  - Penicillin Antibiotics (9%, 15%)
- Gastrointestinal (8%, 12%)
- Analgesics (8%, 12%)
  - Opioid Analgesic and Non-Salicylate Analgesics (6%, 10%)
- Biologicals (8%, 10%)
- Hormones (7%, 12%)
  - Glucocorticoids (7%, 11%)
- Antiarthritics (6%, 10%)
  - NSAIDs, Cyclooxygenase Inhibitor Type Analgesics (6%, 10%)

The medications shown in Table A10 with relatively high prescription incidence rates are consistent with conditions with high prevalence rates shown in Table A7. For example, the GTC having the highest prescription incidence rate was Antibiotics. This is consistent with the relatively high incident rates shown in Table 7A that indicate conditions commonly treated with antibiotics—for example, Z20 (Contact with and [suspected] exposure to communicable diseases, Z11 (Encounter for screening for infectious and parasitic diseases), J02 (Acute pharyngitis), or J06 (Acute upper respiratory infections of multiple and unspecified sites).

d. Services for selected conditions (Q2.b)

Tables A11 and A12 display frequency counts and service utilization rates for selected conditions across the regular and extended coverage periods. Table A11 is based on institutional claims for emergency department visits, observation stays, and inpatient stays. Table A12 is based on professional and outpatient claims, excluding outpatient claims for emergency room visits and observation stays. The conditions were identified using primary and secondary diagnosis codes. Within both tables, claims data were deduplicated to count a condition once per member per date of service. Data were not deduplicated across tables (e.g., an emergency room visit may be counted in Table A11 from the institutional claim and in Table A12 from the professional claim). The utilization rates provide the expected count for 100 members in one year.

Table A11. ED Visits, Observation Stays, and Inpatient Admissions for Selected Conditions

Diseases	Regular		Extended	
	Count	Rate	Count	Rate
COVID19	42	0.6	120	1.0
Acute Respiratory Infections	72	1.1	289	2.4
Acute Severe Asthma	47	0.7	301	2.5
Diabetes Ketoacidosis/Hyperglycemia	36	0.5	81	0.7
External Cause of Morbidity	12	0.2	24	0.2
Mental Health Issue	175	2.6	527	4.4
SUD	145	2.2	687	5.8

The rates are the expected number for 100 members per year, calculated as count of visits times 1,200 divided by member months.

Table A12. Outpatient and Professional Visits for Selected Conditions

Diseases	Regular		Extended	
	Count	Rate	Count	Rate
Acute Upper Respiratory Infections	1,912	28.7	2,944	24.9
Pneumonia	45	0.7	87	0.7
Other Acute Lower Respiratory Infections	151	2.3	169	1.4
Diabetes Ketoacidosis/Hyperglycemia	529	7.9	796	6.7
SUD	1,030	15.5	1,616	13.6
Influenza	127	1.9	206	1.7

The count and rates are from professional and outpatient claims, excluding outpatient claims for ED visits and observation stays. The rates are the expected number for 100 members per year, calculated as count of visits times 1,200 divided by member months.

One main observation was made:

- Utilization rates in the emergency department, observation room, and inpatient settings generally increased for the selected conditions, whereas utilization rates generally decreased in the professional and other outpatient settings.

e. HEDIS measures (applicable age strata) (Q2.b)

Two HEDIS technical specifications were adjusted to calculate rates for four performance measures from encounter data:

- Annual Dental Visits (ADV)
- Adult's Access to Preventive/Ambulatory Health Services (AAP)
- Child and Adolescent Well-Care Visits (WCV)
- Inpatient Utilization (IPU)

The adjustments were restricting ages and changing the measurement periods from calendar years to the Age 18, Age 19, and Age 20 measurement periods. Other criteria were retained, including continuous enrollment, use of HEDIS measure sets, and numerator counts.

Table A13 displays percentages of members receiving annual dental visits, preventive and ambulatory health services, and well-care visits. Two patterns were noted:

- For each age group (Eldest, Middle, and Youngest), rates decreased as members grew older.
- Within each measurement period, the Eldest group had the highest rates, and the Youngest group had the lowest rates.

Table A13: HEDIS Measures ADV, AAP, and WCV

Indicator and Age group	Age 18			Age 19			Age 20		
	D	N	Rate	D	N	Rate	D	N	Rate
Annual Dental Visits (ADV)	**6,272**	**2,787**	**44.4%**	**5,276**	**1,607**	**30.5%**	**2,661**	**664**	**25.0%**
Eldest	1,591	749	47.1%	1,791	581	32.4%	1,640	428	26.1%
Middle	2,177	967	44.4%	2,158	646	29.9%	1,021	236	23.1%
Youngest	2,504	1,071	42.8%	1,327	380	28.6%			
Adult's Access to Preventive/Ambulatory Health Services (AAP)	**6,272**	**4,793**	**76.4%**	**5,276**	**3,576**	**67.8%**	**2,661**	**1,708**	**64.2%**
Eldest	1,591	1,260	79.2%	1,791	1,235	69.0%	1,640	1,061	64.7%
Middle	2,177	1,651	75.8%	2,158	1,475	68.4%	1,021	647	63.4%
Youngest	2,504	1,882	75.2%	1,327	866	65.3%			
Child and Adolescent Well-Care Visits (WCV)	**6,272**	**1,282**	**20.4%**	**5,276**	**689**	**13.1%**	**2,661**	**307**	**11.5%**
Eldest	1,591	359	22.6%	1,791	258	14.4%	1,640	187	11.4%
Middle	2,177	455	20.9%	2,158	273	12.7%	1,021	120	11.8%
Youngest	2,504	468	18.7%	1,327	158	11.9%			

Rates are adjusted, uncertified, unaudited HEDIS rates. Age groups are *Eldest* (born 3/1/2001 to 3/31/2002), *Middle* (born 4/1/2002 to 3/31/2003) and *Youngest* (born 4/1/2003 to 3/31/2004).

Table A14 shows inpatient utilization rates, stratified as maternity, surgery stays and medicine. Three rates are shown, days per discharge, discharges per 12,000 member months (the *Discharge Rate*), and days per 12,000 member months (the *Days Rate*). Among females, maternity services utilization was greatest during the members' first year of extended coverage—nearly half of the maternity discharges were during the Age 19 period. For surgery and medicine, utilization was the lowest for the Age 20 period.

Table A14: Inpatient Utilization (IPU) Measure Based on HEDIS

Indicator	Period	Discharges	Days	Days/Discharge	MM	Discharge Rate	Days Rate
IPU Total	**Age 18**	179	682	3.8	79,974	26.9	102.3
	Age 19	197	658	3.3	75,322	31.4	104.8
	Age 20	86	299	3.5	45,332	22.8	79.1
Maternity	**Age 18**	60	164	2.7	40,327	17.9	48.8
	Age 19	104	246	2.4	38,099	32.8	77.5
	Age 20	50	126	2.5	22,906	26.2	66.0
Surgery	**Age 18**	34	181	5.3	79,974	5.1	27.2
	Age 19	25	147	5.9	75,322	4.0	23.4
	Age 20	11	54	4.9	45,332	2.9	14.3
Medicine	**Age 18**	85	337	4.0	79,974	12.8	50.6
	Age 19	68	265	3.9	75,322	10.8	42.2
	Age 20	25	119	4.8	45,332	6.6	31.5

The count of discharges and days are from paid inpatient claims. Member months (MM) for Maternity are limited to female members. The Discharge and Days Rates are the expected number of discharges or days for 1,000 members per year, calculated as count of discharges or days times 12,000 divided by member months.

6.5 Calculate measurements described in Activity 2.3 for Question 3

a. Spending per member per month (Q3.a)

Table A3 above summarizes the service utilization, stratified by type of claim, age group, and age at time of service. Table A15 summarizes spending for those services. The table has two parts. The first shows MCO claim payments to providers; the second includes those payments plus member copay and spenddown amounts and claim payments by Medicare and commercial insurances. Payments are stratified by claim type. For comparison between measurement periods, payments per 12 member months are shown (which represents the expected payments for a member enrolled for the full year).

Table A15. Estimated Payment Amounts for Extended Coverage, by Claim Type

	Regular coverage	Extended Coverage		
	18 Years	19 Years	20 Years	21+ Years
Members-Months	**79,974**	**75,322**	**45,332**	**21,483**
MCO Payments	**$14,182,476**	**$12,541,357**	**$6,390,340**	**$2,298,124**
Inpatient	$1,901,856	$1,622,818	$938,938	$301,512
Outpatient	$1,485,366	$1,305,338	$621,643	$303,259
Professional	$4,499,486	$3,785,335	$1,952,469	$826,966
Dental	$1,569,145	$827,180	$411,428	$110,489
Vision	$386,419	$309,548	$162,118	$56,818
NEMT	$22,606	$24,103	$4,859	$1,420
Pharmacy	$4,317,598	$4,667,036	$2,298,886	$697,660
Per 12 Member Months (MCO)	**$2,128**	**$1,998**	**$1,692**	**$1,284**
Inpatient	$285	$259	$249	$168
Outpatient	$223	$208	$165	$169
Professional	$675	$603	$517	$462
Dental	$235	$132	$109	$62
Vision	$58	$49	$43	$32
NEMT	$3	$4	$1	$1
Pharmacy	$648	$744	$609	$390
All-Payor Payments	**$15,356,953**	**$13,318,189**	**$6,831,351**	**$2,324,751**
Inpatient	$2,479,724	$2,012,657	$1,335,605	$328,138
Outpatient	$1,816,075	$1,499,259	$652,188	$303,259
Professional	$4,731,268	$3,969,652	$1,961,971	$826,966
Dental	$1,601,199	$835,079	$414,966	$110,489
Vision	$388,483	$310,402	$162,875	$56,818
NEMT	$22,606	$24,103	$4,859	$1,420
Pharmacy	$4,317,598	$4,667,036	$2,298,886	$697,660
Per 12 Member Months (All)	**$2,304**	**$2,122**	**$1,808**	**$1,299**
Inpatient	$372	$321	$354	$183
Outpatient	$272	$239	$173	$169
Professional	$710	$632	$519	$462
Dental	$240	$133	$110	$62
Vision	$58	$49	$43	$32
NEMT	$3	$4	$1	$1
Pharmacy	$648	$744	$609	$390

Data source: KMMS encounter records as of April 4, 2024. All-payor payments include amounts paid by MCOs, member co-payments and spenddown, and third-party liabilities.

The following key observations were seen:

- The categories with the highest payments were professional and pharmacy claims.
- Overall, payment amounts decreased as members aged, both as total payment amounts and payments per 12 member months. There were two exceptions; NEMT and Pharmacy payments increased from Age 18 to Age 19.
- The claim type with the greatest relative decrease in payments per 12 member months was dental. MCO dental payments decreased 44% (from $230 to $132) between Age 18 and Age 19 and 74% (from $230 to $60) between Age 18 and Age 20+.

Activity 7: Report Results to the State

At minimum, the report should include the following information about the focus study:

- *Overall summary of findings*
- *Study question and objectives*
- *Methods of data collection and analysis*
- *Detailed findings, including tables and graphics*
- *Conclusions drawn from the data*

7.1 Overall summary of findings

The overall summary of findings is presented in the Results section, Quantitative Evaluation subsection, in the body of the report.

7.2 Conclusions drawn from the data

Conclusions drawn from the data are summarized in the Conclusions section, Quantitative Evaluation Conclusions subsection and Overall Conclusions subsection, in the body of the report.

7.3 Clearly state the study limitations and caveats

The quantitative analysis focused on patterns of services used by members in the study population during the PHE. The impact of the pandemic on availability of services or on the health of members was outside the scope of the evaluation.

Analysis of diagnosis categories and prescription therapeutic classes showed types of conditions for which services were provided. The severity of an individual's medical conditions was not determined. Analysis of pharmacy claims did not determine the medical conditions for which medications were prescribed, or whether the conditions were acute or chronic.

For comparing service utilization, services used by the study population when they were age 18 was compared to services used when they were ages 19 to 21. A comparable pre-pandemic group of CHIP members aged 19 to 21 years was not available. Also, the number of CHIP members who turned 19 years old during the PHE and did not receive extended coverage (e.g., a member who moved out of Kansas) was too small to form a comparison group.

HEDIS rates shown in Tables A13 are *adjusted, uncertified, unaudited HEDIS rates*. The adjustment on age that restricted the denominators to the study population prevents meaningful comparison to populations with different age restrictions. In particular, comparisons to Quality Compass® percentile ranges were not appropriate.[18]

Capitation rates and administrative expenses were not available for this study to estimate the cost to the State for extending coverage. Alternately, amounts of MCO and all-payor claim payments were calculated. Encounters may underreport non-MCO payment amounts; consequently, the estimated all-payor payments for extended coverage in Table A15 need to be used with caution.

The use of administrative claims and encounters data sources can be a limitation. These data sources are designed and collected for billing purposes but are used in the evaluation to describe patterns in health and health care before and during the period of extended CHIP coverage. However, these administrative data are used for national, standardized measures.

While administrative data might be able to identify key cases and statistical trends, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates. Also, due to the use of population-level data, the effect size of measured differences represents true differences; however, this may or may not correspond to meaningful changes at the program levels.

Appendix B

KanCare Section 1115(a) COVID-19 Public Health Emergency (PHE) Amendment Evaluation

Methodology and Results of Qualitative Analysis

Activities and Components/Standards

Activity 1:Identify Survey Purpose, Objectives, and Audience

1.1 Purpose and Objectives

The COVID-19 PHE amendment goal was stated in the Evaluation Design:

> *"The COVID-19 PHE amendment extends eligibility for CHIP enrollees who turn 19 during the PHE, and are otherwise ineligible for Medicaid, with the goal of furnishing continued medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals who may be affected by COVID-19."*

The *purpose* of the evaluation, including its qualitative and quantitative components, was to examine whether the KanCare 2.0 demonstration COVID-19 PHE amendment achieved its goal, and to identify successes, challenges, and lessons learned in implementing the demonstration amendment.

The *objective* of the qualitative analyses was to describe member, MCO, and State perceptions and experiences regarding the extended CHIP coverage. The objective corresponded to the fourth evaluation question stated in the Evaluation Design:

> *"4. What were the key stakeholder perceptions and experiences regarding the extended coverage?*
>
> *a. What were the members' perceptions of their extended coverage?*
>
> *b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?"*

1.2 Audience

The primary audience is the Centers for Medicare & Medicaid Services. Secondary audiences include the State of Kansas, members who received extended CHIP under the KanCare 2.0 demonstration COVID-19 PHE amendment, and other KanCare stakeholders.

Activity 2:Develop a Work Plan

2.1 Initial Work Plan

The work plan was initially presented in the Evaluation Design:

> *"An online member survey, using SurveyMonkey software, will be conducted at the conclusion of the PHE unwinding period. Letters will be mailed to members who received the extended CHIP coverage, with a link and QR code for web-based completion of the survey. MCO and State contacts will receive an email after the PHE unwinding period, with the link to an online stakeholder survey, using SurveyMonkey.*
>
> *"Qualitative data analysis techniques will be used to analyze data collected through the stakeholder surveys. The steps for qualitative data analysis will include: getting familiar with the data by looking for basic observations or patterns; revisiting evaluation questions that can be answered through the collected data; developing a framework (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; identifying themes, patterns, and connections to answer research questions; and summarization of the qualitative information to add to the overall evaluation results."*

2.2 Work Plan Revisions

The following revisions were made to the work plan while conducting the evaluation:

- The online member survey was conducted using Microsoft Office Forms instead of SurveyMonkey as the data collection tool.
- Instead of emailing surveys to multiple staff within the State and each MCO, questionnaires were emailed to State and MCO primary contacts. The emails included directions for the primary contacts to compile questionnaire responses with input from subject matter experts within their organization.
- Responses from State and MCO primary contacts were returned via email instead of by following a link to an online SurveyMonkey data collection tool.
- The timeline proposed in the Evaluation Design was revised to reflect more specific dates obtained for the PHE unwinding period.

Activity 3: Select the Survey Instrument

3.1 Questionnaire Development

The member, State, and MCO questionnaires were designed by a KFMC committee of subject matter experts that included the Vice President/Director of Quality Improvement, Epidemiologist Consultant, EQRO Senior Manager, Senior Health Data Analyst, Data Engineer, and Project Coordinator. The member and MCO questionnaires included input and approval from the State.

3.2 Survey Questions

Table B1 shows the evaluation questions for the qualitative analysis and the corresponding survey question.

Table B1. Qualitative Evaluation Questions and Corresponding Survey Questions

Evaluation Question		Survey Question
Question 4: What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.a.	What were the members' perceptions of their extended coverage?	Member Perception Survey Questionnaire: Q1. When did you learn your KanCare coverage did not end during the COVID-19 pandemic? Q2. After you turned 19, did you get any services from a doctor's office or clinic? Q3. After you turned 19, did you get any services from a dentist? Q4. After you turned 19, did you get any services from an eye doctor (exam or glasses)? Q5. After you turned 19, did you get any services for substance use disorder? Q6. After you turned 19, did you get any services for mental health? Q7. After you turned 19, did you get any services at an emergency room? Q8. After you turned 19, did you go to a hospital? Q9. After you turned 19, did you go to a pharmacy to get your prescription drugs, flu shot, or other vaccinations? Q2–Q9 Follow-up: What were the reasons for not getting the service you needed? Q10. How did having KanCare coverage after you turned 19 affect your family, school, or work life? (Mark all that apply) • Did not have any effect • Got treated when sick • Missed school or work less • Was easier to pay bills • Was easier to buy food • Other, specify

Table B1. Qualitative Evaluation Questions and Data Sources (Continued)

Evaluation Question		Survey Question
Question 4: What were the key stakeholder perceptions and experiences regarding the extended coverage?		
4.a	(continued)	Q11. If your KanCare coverage ends, what type of services would you be most afraid of losing? (Mark all that apply). • Doctor's office or clinic • Dental • Eye exam or glasses • Substance use disorder • Mental health • Emergency room • Hospital • Prescription drugs, flu shots, or other vaccinations • Other, specify
4.b.	What were the MCOs' and State's experiences regarding implementation of the extended coverage?	MCO Experience Questionnaire: Q1. How did your health plan encourage these members to access services during their extended coverage? Q2. What were the challenges your health plan experienced in engaging these members during this public health emergency? Q3. What strategies did your health plan pursue to address those challenges? Q4. What challenges did these members have with healthcare services during the extended coverage? Q5. How did your health plan help members overcome those challenges? Q6. Overall, how did the extended coverage impact members who turned 19 during the PHE? Q7. What challenges did your health plan experience during the public health emergency? (Mark all that apply) • Health plan workforce shortages • Increased workload for the health plan staff • Shortage of providers • Increased workload for providers • Providers not conducting in-person visits • Transition of CHIP members who turned 19 during the COVID-19 PHE from pediatric to adult primary care providers • Administrative or financial challenges for health plan • Administrative or financial challenges for providers • Members unaware of their extended coverage • Member disengagement • Other, specify Q8. What strategies did your health plan pursue to address those challenges?
		State Experience Questionnaire: Q1. Were eligible CHIP enrollees informed about the extended coverage? Q2. When were eligible CHIP enrollees contacted to inform them about their extended coverage? Q3. What process was used to communicate with eligible CHIP enrollees about their extended coverage during PHE? Q4. Who communicated with the enrollees – State, MCOs, or both? Q5. Who else assisted in this process – providers, CMHCs, other entities? Q6. Were the eligible CHIP enrollees asked to submit their application or their information to remain enrolled in KanCare for extended coverage during PHE? Q7. When did notifications regarding disenrollment during the PHE unwinding period begin? Q8. What communication process and strategies are being currently used during the PHE unwinding period to inform these enrollees about the disenrollment from this extended KanCare 2.0 coverage?

Activity 4:Develop the Sampling Plan

4.1 Overall strategy

The study population for the member survey was defined as KanCare CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage. The sampling plan followed these general steps for qualitative analysis of members' perceptions:

1. Identify the sample frame – A sample frame of 2,302 members was drawn from the 7,087 members of the study population who met the following conditions:
   - Enrolled in CHIP on the day the survey was distributed (November 21, 2023).
   - Continuously enrolled in CHIP the 6 months preceding the survey distribution (May 1 through October 31, 2023).
2. Identify the sample from the sample frame – Based on historical response rates from similar surveys conducted by KFMC, all members in the sample frame were selected.

For qualitative analysis of MCO and State experiences, the following steps were applied:

1. Identify MCO and State primary contacts.
2. Request primary contacts to compile questionnaire responses with input from subject matter experts within their organization and send the completed questionnaire to KFMC via email.

Activity 5:Develop a Strategy to Maximize Response

5.1 Strategy to Maximize Response (applicable to the Member Perception Survey only)

To maximize response rates, the Member Perception Survey included the following features:

- The cover letter mailed to the members included a quick-response (QR) code and link to the online collection tool.
- The data collection tool was created in English and Spanish.
- The cover letter was written in English on one side and Spanish on the other. The Spanish QR code and link connected to a Spanish collection tool.
- The survey was short. It was limited to 11 closed-ended questions.
- The questionnaire, cover letter, and collection tool were written at a grade 5 reading level.
- The cover letter included a toll-free number to provide help with the survey.

Activity 6: Develop a Quality Assurance Plan

6.1 Quality Assurance Plan

Surveys were completed online to avoid errors that may have been caused by manual data entry by KFMC staff of mailed survey responses.

Analysis was completed by KFMC's Epidemiologist Consultant. The epidemiologist's findings were validated by the Senior Health Data Analyst from the source data.

Activity 7: Implement the Survey According to the Work Plan

7.1 Survey Implementation

The member survey was mailed November 21, 2023. The data collection tool was available to the respondents until December 29, 2023. The last response was received on December 28, 2023.

The State questionnaire was emailed to the primary contact on August 14, 2023. The State's responses were received September 7, 2023. The MCO questionnaires were emailed to the primary contacts on September 9, 2024. Two MCOs sent their responses on September 30, 2024, and the third MCO on October 05, 2024.

Activity 8: Prepare and Analyze the Survey Data and Present Results in a Final Report

8.1 Presentation of Results

The detailed results of the qualitative analysis of member, MCO, and State responses are presented in Tables B2, B3, and B4, respectively. A synopsis of the results is presented in the main body of this report.

The following key themes were derived from the Member Perception Survey results presented in Table B2:

- Most of the eligible CHIP enrollees were aware of their extended coverage during the COVID-19 pandemic.
- Extended coverage helped CHIP enrollees in getting services from health care and pharmacy providers after turning 19 during the COVID-19 PHE.
  - The services were obtained from doctor's offices and clinics, dentists, and eye doctors; for mental health; at emergency rooms and hospitals; and from pharmacies for prescription drugs, flu shots, and other vaccinations. At the top of this list were services from doctors' offices and clinics, followed by services from dentists and pharmacies.
- Extended coverage affected CHIP enrollees' family, school, or work life after turning 19 during the COVID-19 PHE.
  - Extended coverage helped them get treatment when they were sick, made it easier for them to pay bills, made it easier for them to buy food, helped them miss less school or work, or helped in other ways.
- CHIP enrollees were afraid of losing services if their KanCare coverage were to end.
  - Types of services members were most afraid of losing included services at doctor's offices and clinic services, dentists, emergency rooms, and hospitals; prescription drugs, influenza or other vaccinations; eye exams or glasses; and services for mental health, substance use disorder, and other specific services.

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Table B2. KanCare Members Perception Survey Results

Question and Summary of Member Responses
Q1. When did you learn your KanCare coverage did not end during the COVID-19 pandemic?
Total: 57 respondents (respondents selected only one option) • Before turning 19 years of age: 25% (14) • After turning 19 years of age: 35% (20) • Not Sure: 30% (17) • I did not know I had coverage: 11% (6) **Conclusion:** • 89% (51) of the survey respondents knew their KanCare coverage did not end during the COVID-19 pandemic.   ○ Out of these 51 respondents, 20 (39%) learned about their extended coverage after turning 19 years of age, 14 (27%) learned before turning 19 years of age, and 33% (17) were unsure when they learn about their extended coverage. • 11% (6) did not know they had extended coverage after turning 19 years of age.
Q2. After you turned 19, did you get any services from a doctor's office or clinic?
Total: 57 respondents (respondents selected only one option) • Yes: 84% (48) • No, service was not needed: 14% (8) • No, I did not get any services but needed some: 2% (1) **Conclusion:** • The majority of survey respondents, 84% (48), noted they did get services from a doctor's office or clinic after they turned 19 years of age; 14% (8) indicated they did not need any services. • Only one respondent reported not getting needed services from a doctor's office.   ○ In response to the follow-up question regarding the reasons for not getting the needed service, the respondent noted, "Did not know I had coverage."
Q3. After you turned 19, did you get any services from a dentist?

Total: 57 respondents (respondents selected only one option)
• Yes: 67% (38)
• No, service was not needed: 21% (12)
• No, I did not get any services but needed some: 12% (7)
 	
Conclusion:
• Two-thirds of the survey respondents, 67% (38), noted they received services from a dentist after they turned 19 years of age; 21% (12) indicated they did not need any services.
• Seven respondents (12%) reported not getting needed services from a dentist.
  ○ In response to the follow-up question regarding the reasons for not getting the needed service, six out of seven respondents reported the reasons.
  ○ Four of these respondents noted they did not know they had coverage as a reason for not getting the services they needed. Two of these respondents indicated they learned they had KanCare coverage after turning 19 on Q1.
  ○ Two respondents noted they could not get the appointment when needed.
  ▪ Besides noting "could not get the appointment needed," one respondent also noted "did not want to," "did not have time," and "dentist was too far away."
• It should be noted, CHIP covers preventive and diagnostic services including cleaning (twice a year) and oral health screening or assessment (twice a year) for members.* However, 12 survey respondents noted they did not need any services from a dentist after turning 19, and two respondents, who indicated they learned they had KanCare coverage after turning 19, noted they did not get the needed dental services as they did not know they have coverage. This may indicate a need of providing education to CHIP members and their guardians regarding the importance of coverage for preventive and diagnostic oral health services.
 	
* Centers for Medicare & Medicaid Services. Summary of Benefits Report for Kansas, Medicaid. https://www.insurekidsnow.gov/coverage/ks/index.html (Accessed April 2, 2024).

Table B2. KanCare Members Perception Survey Results (Continued)

Question and Summary of Member Responses

Q4. After you turned 19, did you get any services from an eye doctor (exam or glasses)?

Total: 57 respondents (respondents selected only one option)

- Yes: 56% (32)
- No, service was not needed: 42% (24)
- No, I did not get any services but needed some: 2% (1)

Conclusion:

- About half of the survey respondents, 56% (32), noted they obtained services from an eye doctor after they turned 19 years of age; 42% (24) indicated they did not need any services from an eye doctor.
- Only one respondent reported not getting needed services from an eye doctor.
  - In response to the follow-up question regarding the reasons for not getting the needed service, the respondent noted, "Did not want to get the needed services."
- It should be noted, CHIP covers one annual complete routine eye exam for the members.* However, slightly less than half of the survey respondents (about 42%) noted they did not need any services from the eye doctor after turning 19. This may also indicate a need of providing education to CHIP members and their guardians regarding the importance of routine vision care services.

* Covered Benefits – UnitedHealthcare Community Plan – CHIP. https://www.marchvisioncare.com/docs/MarchDocuments/StateSpecificPRG/Kansas.pdf (Accessed April 2, 2024).

Q5. After you turned 19, did you get any services for substance use disorder?

Total: 57 respondents (respondents selected only one option)

- Yes: 0% (0)
- No, service was not needed: 100% (57)
- No, I did not get any services but needed some: 0% (0)

Conclusion:

No survey respondents noted they needed substance use disorder services after they turned 19 years of age.

Q6. After you turned 19, did you get any services for mental health?

Total: 57 respondents (respondents selected only one option)

- Yes: 23% (13)
- No, service was not needed: 74% (42)
- No, I did not get any services but needed some: 4% (2)

Conclusion:

- The majority of respondents, 74% (42), indicated they did not need any mental health services after they turned 19 years of age, whereas 23% (13) of the respondents noted they received mental health services.
- Two respondents noted they did not get services they needed for mental health after they turned 19.
  - In response to the follow-up question regarding the reasons for not getting the needed service, both respondents noted the reason as "did not know I had coverage." One of these indicated they learned they had KanCare coverage after turning 19.
  - One of these two respondents also noted "having problem with the transportation" as an additional reason.

Table B2. KanCare Members Perception Survey Results (Continued)

Question and Summary of Member Responses
Q7. After you turned 19, did you get any services at an emergency room?
Total: 57 respondents (respondents selected only one option) • Yes: 25% (14) • No, service was not needed: 75% (43) • No, I did not get any services but needed some: 0% (0) **Conclusion:** • Three-fourths of the survey respondents, 75% (43), indicated they did not need any services at an emergency room after they turned 19 years of age, whereas 25% (14) of the respondents noted they did get services at an emergency room. • None of the respondents reported not getting needed services.
Q8. After you turned 19, did you go to a hospital?
Total: 57 respondents (respondents selected only one option) • Yes, for an overnight stay or other services: 16% (9) • No, service was not needed: 82% (47) • No, I did not get any services but needed some: 2% (1) **Conclusion:** • The majority of the respondents, 82% (47), indicated they did not need services from a hospital after they turned 19 years of age, whereas 16% (9) noted they did go to the hospital for an overnight stay or other services. • One respondent reported not getting the needed services but did not provide a response to the follow-up question regarding the reasons for not getting the needed service.
Q9. After you turned 19, did you go to a pharmacy to get your prescription drugs, flu shot, or other vaccinations?
Total: 57 respondents (respondents selected only one option) • Yes: 67% (38) • No, service was not needed: 32% (18) • No, I did not get any services but needed some: 2% (1) **Conclusion:** • Two-thirds of the respondents, 67% (38) noted they went to a pharmacy to get their prescription drugs, flu shot, or other vaccinations after they turned 19 years of age; 32% (18) indicated they did not need any services from a pharmacy. • Only one respondent reported not getting needed services from a pharmacy.   ○ The reason noted was "did not have time to get the needed services."
Q10. How did having KanCare coverage after you turned 19 affect your family, school, or work life? (Mark all that apply)

Total: 57 respondents (respondents selected one or more options)
 	
The following percentages are calculated for all 57 respondents who selected one or more response options:
• Did not have any effect: 21% (12)
• Got treated when sick: 65% (37)
• Missed school or work less: 26% (15)
• Was easier to pay bills: 56% (32)
• Was easier to buy food: 37% (21)
• Other, specify: 14 % (8)
  ○ Two respondents indicated they did not use services.
  ○ Six respondents provided a response indicating the extended coverage affected their family, school, or work life.

Table B2. KanCare Members Perception Survey Results (Continued)

Question and Summary of Member Responses
Q10. How did having KanCare coverage after you turned 19 affect your family, school, or work life? (Continued)

Summary of the responses provided by 57 respondents (based on above-mentioned results):

- Did affect family, school, or work life: 77% (44)
- Did not have any effect: 19% (11)
- Did not use services: 4% (2)

Note: One respondent indicated both "Did not have any effect" and "Got treated when sick." In the summary analysis, this respondent was counted as having indicated an effect of extended KanCare coverage.

Following percentages are calculated for 45 respondents who noted one or more effects of extended coverage on their life:

- Got treated when sick: 82% (37)
- Missed school or work less: 33% (15)
- Was easier to pay bills: 71% (32)
- Was easier to buy food: 47% (21)
- Other, specify: 13% (6)

Conclusion:

- The majority of respondents, 77% (44) noted the extended KanCare coverage had one or more effects on their family, school, or work life; 11 respondents did not note it had an effect on their lives, and 2 noted not using the services.
- Out of 45 respondents noting KanCare coverage after they turned 19 had affected their family, school, or work life:
  - 82% (37) noted they got treatment when they were sick;
  - 71% (32) noted it made it easier to pay bills;
  - 47% (21) noted it made it easier to buy food;
  - 33% (15) noted they missed less school or work; and
  - 13% (6) noted other effects. They specified one or more effects. Following are their statements:
    - "Didn't have to worry about affording medication."
    - "Was able to get adequate health screenings and I was able to use my extended coverage for specialized services I would not have been able to have if it were not for the extended coverage."
    - "Was able to continue receiving important medications."
    - "Receive treatment for my genetic chronic condition."
    - "Was able to continue eye and dental care including surgical extraction."
    - "Was able to seek mental health care."
    - "Was able to get emergency room medical care when a critical incident occurred."
    - "Made life easier."
    - "Peace of mind to have health expenses covered."
    - "Did not have to worry about insurance/paying expensive health bills during the pandemic."
    - "Also received services I probably would not have had otherwise."
- As mentioned above, 11 respondents did not note the extended coverage affected their lives. Further assessment of their responses to the survey questions for receiving services from healthcare providers showed following results:
  - Eight of these respondents noted receiving services from one or more healthcare providers, including doctor's office or clinic, dentist, or eye doctor, services for mental health, and from ER, hospital, and pharmacy.
  - Two of these respondents noted "No, did not need services" to all these questions.
  - One respondent reported not getting the needed services from a doctor's office, a dentist and for mental health. For all three questions, respondent noted the reason for not getting the needed service as "did not know had coverage." One respondent indicated not receiving needed service from a dentist because did not know had coverage for dental care. The respondent reported receiving services from other types of healthcare providers.

Table B2. KanCare Members Perception Survey Results (Continued)

Question and Summary of Member Responses
Q11. If your KanCare coverage ends, what type of services would you be most afraid of losing? (Mark all that apply).

Total: 57 respondents (respondents selected one or more options)

All but one respondent indicated they were afraid of losing one or more types of services. One used the "Other" response option to specify "none."

The following percentages were calculated for 56 respondents who noted they are afraid of losing one or more types of services when their KanCare coverage ends:

- Doctor's office or clinic: 91% (51)
- Dental: 73% (41)
- Eye exam or glasses: 66% (37)
- Substance use disorder: 4% (2)
- Mental health: 30% (17)
- Emergency room: 61% (34)
- Hospital: 57% (32)
- Prescription drugs, flu shots, or other vaccinations: 73% (41)
- Other, specify: 9% (5)

Note: The respondent noting "None" also selected the response option "No, service not needed" to all survey questions regarding receiving services from different healthcare providers after turning 19 and noted having extended KanCare coverage did not have any effect on family, school, or work life.

Conclusion:

- All but one survey respondent noted being afraid of losing one or more types of services if their KanCare coverage were to end.
- Out of 56 respondents who noted being afraid of losing one or more types of services if their KanCare coverage were to end:
  - 91% (51) noted they are afraid of losing services from doctor's office or clinic;
  - 73% (41) noted they are afraid of losing dental services;
  - 73% (41) noted they are afraid of losing prescription drugs, flu shots, or other vaccinations;
  - 66% (37) noted they are afraid of losing services for eye exam or glasses;
  - 61% (34) noted they are afraid of losing ER services;
  - 57% (32) noted they are afraid of losing hospital services;
  - 30% (17) noted they are afraid of losing services for mental health;
  - 4% (2) noted they are afraid of losing services for substance use disorder; and
  - 9% (5) noted other services. Following are their comments:
    - "I'm currently getting looked at by a neurologist. I'm scared of possibly having to have an MRI or a CT scan, and it is not covered."
    - "Birth Control"
    - "Ongoing monitoring of and treatment for genetic condition"
    - "Seeing a specialist"
    - "My coverage ended 11-30-23 and the struggle is beginning already to afford prescriptions and mental health services."

The responses provided by the MCOs to the MCO Experience Questionnaire, and the key themes derived from these responses are presented in Table B3. The MCOs' responses are provided verbatim in the first column of the table. The responses provided by the three MCOs that are related to a similar theme are listed together. It should be noted, each MCO's responses correspond to its own PHE implementation strategies and experiences and are applicable only to the members enrolled in its health plan.

Table B3. Results of MCO Experience Questionnaire

MCO Responses	Key Themes
Q1. How did your health plan encourage these members to access services during their extended coverage?	
• These members were not differentiated from any of our other members from a communication perspective. They received member education outreach which provided education on available benefits, including Value-Added Benefits. Additionally, this population was eligible for a $25 gift card for completing vaccinations, a benefit offered to adult members. • Health Plan sent letters in May 2020 to every member a Covid Policy Change letter, notifying them of the waiver for changes to Medicaid federal requirements, to make sure that members were informed that their health services would be available throughout the public health emergency (PHE). We also put notices of this on our website. • We reached out to members to encourage them to apply and take steps to retain eligibility. We also encouraged these members to schedule their annual screenings during the time period of extended coverage. • Care Managers increased discussion with these members regarding preventative measures, test kits, testing, and benefits. • The Collaborative COVID-19 performance improvement plan aimed at increasing vaccinations for members. • Care management outreach attempts were made to eligible members for their care gaps or quality measures (well-child visits, lead screening, immunizations). • Additional care management was provided when a need was identified either through an HRST (Health Risk Screening Tool), as part of discharge planning from an inpatient stay, or requested by the member, family, or provider. • There was also increased communication and collaboration with providers in the community, i.e., with CMHCs and PRTFs. • Another intervention involved participating in community events to providing education along with other services such as health screenings, lead poisoning information & screenings, and Medicaid navigation. • In our community outreach activities, both in the field and virtually, we informed our providers and members about how several populations, especially youth, that would normally be aging out of eligibility, could still access services during the PHE. • Some members were still seeing pediatricians as 18-year-olds (technically adults), but this typically only occurred for members with special health care needs. Assistance was provided with the transition of members ages 18 and 19 into an adult system of care, if desired, or Care Managers worked with the pediatric providers to advocate for members who needed to stay in the pediatric system. • We notified providers and community-based organizations that work with our members regarding the PHE of continued coverage and services.	• Member outreach efforts occurred through case management, letters, and websites to inform them about availability of the services throughout the public health emergency. • Case management encouraged members to get preventive services; discussed members' care gaps and quality measures; and provided further assistance with the needs identified through HRST, inpatient stay discharges, and by members, family, or providers. • Community outreach efforts (virtual and in field) were used to educate members about preventive services including vaccinations for COVID-19 and other diseases, annual screenings, and well-visits. • Providers and other community partners were reached to assist members in receiving appropriate services, including seeing appropriate providers (pediatric and adult care).

Table B3. Results of MCO Experience Questionnaire (Continued)

MCO Responses	Key Themes
Q2. What were the challenges your health plan experienced in engaging these members during this public health emergency?	
• As with all members, engagement was a challenge due to reduced outreach availability, but there were not specific engagement issues for this member population. Some general issues were encountered by the Care Management team. • From an outreach perspective, we had the same challenges we had initially to reach out to all members, given the lock-down and restrictions. • Incorrect or no contact information available through enrollment file. • Members' contact information was not current and an alternative contact number could not be located. • Members frequently change phone numbers, making it a challenge to reach them. When members move, we aren't notified, making it difficult to locate the member. • Acknowledging concerns due to decrease in face-to-face visits. • Many 19-year-olds are working during the day, making it difficult to reach them during business hours. Often, we don't receive a call back when a message is left. • Member transportation concerns when COVID-19 positive. • Providers didn't always have the necessary personal protective equipment (PPE) items or items to help assist members in their time of need. • Technology and wi-fi concerns (members). • Social Determinants of Health (SDOH) concerns. • Providers were a challenge to get into as they were seeing sick or COVID patients. Well visits were less of a priority and hard to get into providers.	• Reduced outreach availability caused challenges in engaging all members, including CHIP members eligible for extended coverage. • Members' contact information was not current and alternative contact numbers could not be located. • Reduced face-to-face visits made it difficult for members to see providers for well-visits and other preventive measures. • Other challenges included difficulty in reaching 19-year-old members during daytime (often no call backs to the messages left); transport issues for COVID-19 positive patients; lack of PPE for providers; technology issues; SDOH concerns; and limited provider time available for preventive services.
Q3. What strategies did your health plan pursue to address those challenges?	
• From a Community Development perspective, we began doing a lot of virtual outreach and attending virtual events but also attended events in-person when offered. • Engaged the SUD telehealth provider (Central Kansas Foundation). • From an outreach perspective, we quickly pivoted and developed innovative approaches to continue our interaction with the public: rethinking community events to be drive-thru and outdoors, co-organizing and supporting vaccination clinics, and switching in-person activities to virtual with a high degree of success. • From a care management perspective, we performed a lot of member advocacy and education. We also worked with members to locate new providers (if needed) who were accepting new members. • If care management was identified as a need, a case file review was completed to see if an updated contact number could be located. • Additionally, we implemented a program that located contact information from pharmacy/provider claims to assist with locating alternate contact information; engaged in strategic programming. • We helped provide PPE to provider offices in need. We also provided necessary items such as thermometers, distilled water, masks, and any items that the offices were having problems obtaining to help members. • Utilized telehealth provider options.	• Virtual community outreach efforts were used for providing member education and assistance in receiving services from the community providers. • Telehealth and other outdoor community outreach activities were used to continue assisting members with services such as vaccinations. • Case management efforts were used for member education and to assist them in finding new providers if needed. • Members' alternate contact information was located from various sources (such as claims and case files). • Providers were assisted by furnishing needed supplies, offering telehealth options, and co-organizing vaccination services to ensure members could receive appropriate services.

Table B3. Results of MCO Experience Questionnaire (Continued)

MCO Responses	Key Themes
Q4. What challenges did these members have with healthcare services during the extended coverage?	
• Difficulty getting into providers/provider availability • Provider availability • Emergency Department availability • Transportation with COVID 19 • Members in general experienced more transportation challenges. • Resource availability • The immigrant community struggled with vaccine access. • Members in general experienced more food insecurity and not knowing how to access resources. • Community resource availability for members transitioning to waivers via crisis exception/transition • Members and families may not have known coverage was extended. • Members in general struggled with misinformation. • Often, 19 years old don't have chronic health conditions and are not concerned with making their health a priority. We encourage annual health screenings and assist with transportation if needed. • Youth and young adults had an increase in mental health challenges. • Isolation	• Healthcare access issues: difficulty in accessing health services and resources, provider unavailability, transportation issues, and difficulty in accessing community resources by members transitioning to waivers • Lack of awareness among members • Health is not a priority among young members without chronic diseases. • Issues related to SDOH and mental health challenges
Q5. How did your health plan help members overcome those challenges?	
• If the member was engaged in care management, contact was made to provide education and resources. • Provided member education on appropriate use of Emergency Department (ED) vs PCP vs Urgent Care providers; worked with providers to utilize Early Periodic Screening Diagnosis and Treatment (EPSDT) services; and ensured members who were on waiver waitlists were wrapped in community supports/services and had adequate resources. • Engaged with our transportation vendor to ensure access and availability to appropriate transportation services. • We strengthened our extra transportation Value Added Benefits and added bus passes for some counties. • Resources regarding extended coverage was posted on the Health Plan website. • Providers were engaged in educating members and families about extended coverage. • Targeted communications sent regarding extended coverage, eligibility, and renewals. • We supported providers and organizations working on spreading correct COVID awareness information. • We worked on making both the information and resources more available, with a health equity emphasis. We supported local organizations with funding, volunteer hours, and translation and interpreting. • Worked closely with advocacy groups and the Kansas Hispanic and Latino American Affairs commission COVID Stakeholders group, to improve and increase access to vaccines for the Latino community. • We brought in Pyx health to help with isolation, loneliness, and provision of community resources. • We extended our offerings of Youth Mental Health First Aid Trainings in both English and Spanish.	• Healthcare access issues: ○ Health services and provider access – Provided member education for available resources through website and case management contacts; provided education for the proper use of provider and health services (PCPs, urgent care, and ED); worked with providers on use of EPSDT services; and provided resources to community stakeholders and advocacy groups for member education and improving access to services, including vaccines. ○ Transportation – Worked with transportation vendors to ensure access and availability of appropriate services, provided extra transportation value-added benefits, and added bus passes for some counties. ○ Community resources access – Ensured availability of community resources to the members transitioning to waivers. • Lack of awareness among members: Used online resources and worked with providers and community partners to create awareness and to communicate the availability of health services and extended coverage during the public health emergency. • SDOH and mental health challenges among members: Made available innovative resources to help members with isolation and loneliness, provided community resources, and extended Youth Mental Health First Aid trainings in English and Spanish.

Table B3. Results of MCO Experience Questionnaire (Continued)

MCO Responses	Key Themes
Q6. Overall, how did the extended coverage impact members who turned 19 during the PHE?	
• It was helpful in that these members were able to continue working toward their physical and behavioral health goals, continue with services, and were less likely to be impacted by gaps in care. • The extended coverage allowed CHIP members continued access to critical health care, including vaccines, behavioral health benefits, and well-child visits. • Extended coverage also enabled these members to continue to receive beneficial COVID-19 communications and resources. • Members received information about prevention and testing, had access to our Nurse Advice line, and were able to request additional support through our care management team. • It helped with access to preventative services. It was beneficial to their health and wellbeing, since extended coverage meant they could receive services for which they would normally have to pay out of pocket or go without. • For recent mothers, prior to the extension of post-pregnancy coverage from 2 to 12 months, it meant continue accessing care, behavioral health services	• Beneficial for members' physical and behavioral health and wellness. • Members were able to continuously receive health services, including preventive care. • The continuous coverage helped members in receiving preventive care without out of pocket payment or not getting it due to inability to pay. • Members were able to receive COVID-19 education, resources, and services.
Q7. What challenges did your health plan experience during the public health emergency?	
MCOs were asked to mark all response options that are applicable to them: • Health plan workforce shortages (marked by 1 MCO) • Increased workload for the health plan staff (by 1) • Shortage of providers (by 2) • Increased workload for providers (by 2) • Providers not conducting in-person visits (by 3) • Transition of CHIP members who turned 19 during the COVID-19 PHE from pediatric to adult primary care providers (by 2) • Administrative or financial challenges for health plan (by 1) • Administrative or financial challenges for providers (by 1) • Members unaware of their extended coverage (by 3) • Member disengagement (by 3) • Other (following specific challenges were specified by the respondents who selected "Other" as the response option) (by 1) ○ Members not going to the needed well-person visits	• Providers not conducting in-person visits, members unaware of their extended coverage, and member disengagement were noted as the challenges experienced by all three health plans. • Shortage of providers, increased workload for providers, and transition of CHIP members who turned 19 during the COVID-19 PHE from pediatric to adult primary care providers were experienced as challenges by at least two health plans. • Health plan workforce shortages, increased workload for the health plan staff, administrative or financial challenges for health plan, administrative or financial challenges for providers, and members not going for needed well-person visits were the challenges noted by at least one of the three health plans.

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Table B3. Results of MCO Experience Questionnaire (Continued)

MCO Responses	Key Themes
Q8. What strategies did your health plan pursue to address those challenges?	
• Continued educational outreach to all members on the importance of utilizing their benefits • Texting campaign for completing Health Risk Screening Tool (HRST) to capture crucial information about health care needs and ensure barriers were addressed when reported • As part of our ongoing member outreach, provided education on appropriate use of Emergency Department vs PCP vs Urgent Care providers • Inclusion in campaigns for HEDIS and health needs • Sent and texted COVID-19 education and resources • Helped with State efforts on COVID and COVID vaccine awareness • As the PHE was unwinding, education provided at all community outreach events, including rural health events • Provided education and offered resources for redetermination • Engagement with providers to utilize EPSDT services • Increased telehealth provider options, including engagement with the Central Kansas Foundation for SUD telehealth • Encouraged access to our Nurse Advice line • Members engaged in care management could receive visits via telehealth or by phone. Many providers were also utilizing telehealth so that visits could be conducted virtually. • Offered incentives for preventative services (old HEDIS $50 cards) • Engagement with Pyx health to help with isolation, loneliness, and providing community resources • Engagement with the Central Kansas Foundation for SUD telehealth • Ensured members who were on waiver waitlists were wrapped in community supports/services and had adequate resources • Found innovative ways to continue community outreach activities • Continual engagement with our transportation vendor to ensure access and availability to appropriate transportation services • Strategic programming • Care management offered to all members, including CHIP members. • Implemented a program that located contact information from pharmacy/provider claims to assist with locating alternate contact information	• Member education and outreach: Provided education on the importance of using benefits, completing health risk screening for identifying and addressing health needs and barriers, proper use of provider and health services; COVID-19 vaccine education and resources; dissemination of PHE unwinding information; and offered resources for redetermination. • Provider engagement and support: Engaged providers to use EPSDT services, provided increased options to the providers for offering virtual visits through telehealth or by phone, encouraged access to Nurse Advice lines, and worked with companies with innovative solutions to address mental issues among members. • Community outreach and resources access: Engaged community organizations in using telehealth for providing SUD services to the members, ensured availability of community resources to the members transitioning to waivers, engaged transportation vendors for increased access to and availability of appropriate transport services to the members; and used innovative ways to continue community outreach activities during public health emergency. • MCO processes and operations: Applied strategic programming; assisted members through case management, and implemented programs for locating alternative member contact information for better communication.

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The responses provided by the State staff to the State Experience Questionnaire are presented in Table B4. The following key themes were derived from these responses:

- The State used multiple methods, including mailed letters, IVR messaging, and online posting, to inform the eligible CHIP members about extended coverage during the public health emergency.
- Members were notified at regular intervals when they were due for renewal.
- Eligible members were not required to take any action to stay enrolled.
- During the PHE unwinding period, the State informed the enrollees about disenrollment from the extended coverage using several strategies.
    - Main strategies included sending texts and emails, making phone calls and online postings (web and social media), providing print material in provider offices, and engaging with navigators and community organizations.
    - The State also supported outreach activities conducted by MCOs and other stakeholders.

Table B4. Results of State Experience Questionnaire

Question and State Response
Q1. Were eligible CHIP enrollees informed about the extended coverage?
Yes
Q2. When were eligible CHIP enrollees contacted to inform them about their extended coverage?
Eligible CHIP enrollees were notified each month they were due for renewal. With the four-month extensions we implemented, some were notified every 4 months if they continued to meet the passive criteria.
Q3. What process was used to communicate with eligible CHIP enrollees about their extended coverage during PHE?
Eligible CHIP enrollees received mailed letters. An FAQ document was available on the KanCare website and IVR messaging was also implemented.
Q4. Who communicated with the enrollees – State, MCOs, or both?
The State communicated with enrollees.
Q5. Who else assisted in this process – providers, CMHCs, other entities?
N/A
Q6. Were the eligible CHIP enrollees asked to submit their application or their information to remain enrolled in KanCare for extended coverage during PHE?
No action was required by the enrollee to stay eligible. But we did encourage all members to continue to report changes, such as income changes, etc.
Q7. When did notifications regarding disenrollment during the PHE unwinding period begin?
Notifications about the PHE unwinding period began in full in early 2023. When we started sending notifications as the PHE unwinding began, both the State and MCOs were doing text, robocall and emails to reach members. KDHE was also engaging stakeholders and posting quarterly social media posts and website updates before that time.
Q8. What communication process and strategies are being currently used during the PHE unwinding period to inform these enrollees about the disenrollment from this extended KanCare 2.0 coverage?
There are many, so this is by no means a comprehensive list. The main strategies include texts, calls, and emails from both KDHE and the MCOs, as well as web updates; physical copy in provider offices and other health care facilities; engagement with Navigators and community organizations; social media posts from KDHE, MCOs and other stakeholders. Outreach conducted by stakeholders and supported by KDHE includes advertising campaigns on public transportation, on pizza boxes in rural communities, and through radio and video ads. Stakeholders have also conducted outreach at community events such as community baby showers and health fairs, conferences, and direct outreach. These stakeholders include staff in the Division of Public Health. MCOs are given a list of their members at risk for procedural termination and reach out to those members.

Attachment

KanCare Section 1115(a) COVID-19 Public Health Emergency (PHE) Amendment Evaluation

PHE Amendment Evaluation Design

KanCare 2.0 COVID-19 PHE Amendment Evaluation Design

October 11, 2022

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A. General Background Information

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) approved renewal of the KanCare demonstration (sometimes referred to as "KanCare 2.0") for the period of January 1, 2019, through December 31, 2023.[1] KanCare 2.0 operates concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers. Together they provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible) and Children's Health Insurance Program (CHIP) beneficiaries.

CHIP provides health care coverage for low-income children living in families with incomes that exceed Medicaid limits. Unlike Medicaid, CHIP is not open-ended; states are awarded yearly allotments. Kansas provides low-cost health insurance coverage to children who are under the age of 19, do not qualify for Medicaid, have family incomes under 232% of the federal poverty level, and are not covered by private health insurance.[2]

On August 15, 2022, CMS approved KDHE's request for a KanCare demonstration amendment to address the COVID-19 Public Health Emergency (PHE). The amendment was authorized retroactively from March 1, 2020, through the end of the COVID-19 PHE unwinding period or until all redeterminations are conducted during the unwinding period as discussed in the State Health Official Letter (SHO) #22- 001.[3] The COVID-19 PHE amendment provides for continuous coverage for CHIP enrollees who turn 19 during the public health emergency (and therefore lost eligibility for CHIP due to age) and who are otherwise ineligible for Medicaid. These enrollees will continue to receive the same benefits as they currently receive in KanCare.

In the approval letter, CMS stated the COVID-19 PHE amendment to the KanCare demonstration is "necessary to assist the state in delivering the most effective care to its beneficiaries in light of the COVID-19 PHE and to ensure renewals of eligibility and transitions between coverage programs occur in an orderly process that minimizes beneficiary burden and promotes continuity of coverage at the end of the COVID-19 PHE. The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals who may be affected by COVID-19. This approval allows the state to align its policies for young adults in Medicaid and CHIP, and prevent gaps in coverage during the PHE. Additionally, this amendment ensures that the state can mitigate churn for eligible beneficiaries and smoothly transition individuals between coverage programs during the COVID-19 PHE unwinding period."

COVID-19 PHE Amendment Goal

The COVID-19 PHE amendment extends eligibility for CHIP enrollees who turn 19 during the PHE, and are otherwise ineligible for Medicaid, with the goal of furnishing continued medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals who may be affected by COVID-19.

Hypothesis and Evaluation Questions

The focus of the evaluation is to examine whether the KanCare 2.0 demonstration COVID-19 PHE amendment achieved its goal, identifying successes, challenges, and lessons learned in implementing the demonstration amendment. Following is a general overview of the proposed evaluation questions.

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[1] CMS approval letter. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/section-1115-waiver-comments/ks-kancare-2-0-approval-letter-final-to-ks.pdf?sfvrsn=9ed84c1b_2

[2] About Medicaid & CHIP, Kansas Department of Health and Environment. http://kdhe.ks.gov/250/About-Medicaid-CHIP

[3] See SHO #22-001, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," available at https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf

Hypothesis

Extending eligibility for CHIP enrollees who turn 19 during the PHE, and are otherwise ineligible for Medicaid, will provide continued medical assistance to help protect their health, safety, and welfare during the COVID-19 PHE.

Evaluation Questions

1. What was the eligible members' service utilization during the period of extended coverage?
   a. What types of services did eligible members access during the period of extended coverage compared to prior utilization?
   b. What diagnoses were associated with services received by eligible members during the period of extended coverage compared to their prior diagnoses?
   c. Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?
2. How was preventive, routine, chronic, and acute care impacted during the period of extended coverage?
   a. Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?
   b. What were the patterns of preventive, routine, and acute health care during the period of extended coverage?
3. What was the cost of the extended period of coverage?
   a. What was the cost of services provided to members who received the extended coverage, in total and by service type?
4. What were the key stakeholder perceptions and experiences regarding the extended coverage?
   a. What were the members' perceptions of their extended coverage?
   b. What were the MCOs' and State's experiences regarding implementation of the extended coverage?

B. Evaluation Design Methodology

The focus of the evaluation is to examine the achievement of the goal to furnish continued health care to help protect the health, safety, and welfare of individuals who may be affected by COVID-19. The evaluation will be completed through quantitative and qualitative analysis.

Quantitative Analysis

The quantitative analysis will focus on describing patterns in health and health care before and during the period of extended CHIP coverage. See Appendix A for a detailed discussion of data sources, and Appendix B for performance measure details.

Evaluation Period

Extended CHIP coverage was provided to CHIP members who turned age 19 between March 1, 2020, and the end of the PHE (date to be determined). Data will be analyzed by age, including age 18 for comparison purposes.

Study Population

The study population will be KanCare 2.0 CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage.

Data Sources

All quantitative analysis will use the Kansas Modular Medicaid System (KMMS) databases for encounter, demographic, eligibility, and enrollment information. The Managed Care Organizations' member-level HEDIS data files may also be accessed for HEDIS measures. See Appendix 1 for detailed discussion of data sources.

Analytic Methods

Where possible, measures are developed according to technical specifications for recognized measures from sources

such as: *Adult Core Set* measures, including *Healthcare Effectiveness Data and Information Set®* (HEDIS) measures, stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF). Descriptive statistics will be used for the evaluation, with comparisons across the consecutive years, by age. The following analytical methods will be used to assess the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- Descriptive statistics will examine member demographic characteristics.
- The descriptive statistics (e.g., numbers and percentages or rates) of the selected evaluation measures will be calculated and stratified by age. Note, the "Age 19" stratum of the measure Total Spending Per Member-Month, for example, would include claim payments for services for one year for each member, beginning with the member's nineteenth birthday. Since members with extended coverage did not turn 19 years old in the same year, the claim payments included in the measure would be for services from multiple calendar years.
- Appropriate statistical tests such as Fisher's exact and Pearson chi-square tests, with $p<.05$ indicating significance, will be used to compare percentages or rates between strata or to benchmarks, if available.

Table 1 outlines the evaluation questions and associated quantitative measures. See Appendix 2 for performance measure details.

Table 1. Quantitative Evaluation Questions and Measures

Evaluation Question		Measures
Question 1: What was the eligible members' service utilization during the period of extended coverage?		
1.a.	What types of services did eligible members access during the period of extended coverage compared to prior utilization?	Summary of encounters by type of service: • Professional Visits • Pharmacy Fills • Outpatient Visits ○ Emergency Department Visits • Inpatient Stays • Dental Visits • Vision Visits • NEMT Trips
1.b.	What diagnoses were associated with services received by eligible members during the period of extended coverage compared to prior diagnoses?	Summary of diagnosis prevalence: • Primary diagnoses by ICD-10-CM chapter • Primary diagnoses by ICD-10-CM block or category
		Summary of inpatient stays by diagnosis: • CMS Major Diagnostic Category (MDC) • Medicare Severity Diagnosis Related Group (MS-DRG)
1.c.	Did eligible members receive new diagnoses after turning age 19? If so, what diagnoses?	Summary of diagnosis incidence: • Diagnoses by ICD-10-CM chapter • Diagnoses by ICD-10-CM block or category
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage?		

2.a.	Did treatment prior to age 19 for chronic conditions, including behavioral health issues, continue after members turned 19 years old during the COVID-19 PHE?	• Service utilization by chronic condition:
		  ○ Asthma
		  ○ Diabetes
		  ○ Behavioral Health
		  ○ Others to be determined based on prevalent diagnoses (question 1.b)
		• Prescription (pre-existing prescriptions) prevalence rates by generic therapeutic class

Table 1. Quantitative Evaluation Questions and Measures (Continued)		
Evaluation Question		**Measures**
Question 2: How was preventive, routine, chronic and acute care impacted during the period of extended coverage? (Continued)		
2.b.	What were the patterns of preventive, routine, and acute health care during the period of extended coverage?	• Prescription (new prescriptions) incidence rates by generic therapeutic class • ED visits, observation stays, or inpatient admissions for selected conditions: ○ COVID-19 ○ Acute respiratory infections ○ Acute severe asthma ○ Diabetic Ketoacidosis/ Hyperglycemia ○ SUD ○ Mental health issues ○ External Causes of Morbidity • Outpatient or professional claims for respiratory infections: ○ Acute upper respiratory infections ○ Influenza ○ Pneumonia ○ Other acute lower respiratory infections • HEDIS measures (applicable age strata): ○ Annual Dental Visit (ADV) ○ Adults' Access to Preventive/ Ambulatory Health Services (AAP) ○ Child and Adolescent Well-Care Visits (WCV) ○ Emergency Department Utilization (EDU) – Observed Events, not risk adjusted ○ Inpatient Utilization (IPU)— General Hospitalization/Acute Care, excluding maternity admissions.
Question 3: What was the cost of the extended period of coverage?		
3.a.	What was the cost of services provided to members who received the extended coverage?	Spending per member per month: • Total • by service type (see 1.a)

Qualitative Analysis

The focus of the qualitative analysis will be to describe member, MCO, and State perceptions regarding the extended CHIP coverage.

Evaluation Period

March 1, 2020, through the end of the PHE (date to be determined).

Study Population

The study population is KanCare 2.0 CHIP members who turned age 19 during the COVID-19 PHE and had extended CHIP coverage. Also, MCO and State staff involved in the implementation of the PHE amendment extended CHIP coverage will be identified.

Data Sources

An online member survey, using SurveyMonkey software, will be conducted at the conclusion of the PHE unwinding period. Letters will be mailed to members who received the extended CHIP coverage, with a link and QR code for web-based completion of the survey. MCO and State contacts will receive an email after the PHE unwinding period, with the link to an online stakeholder survey, using SurveyMonkey.

Analytic Methods

Qualitative data analysis techniques will be used to analyze data collected through the stakeholder surveys. The steps for qualitative data analysis will include: getting familiar with the data by looking for basic observations or patterns; revisiting evaluation questions that can be answered through the collected data; developing a framework (coding and

indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; identifying themes, patterns, and connections to answer research questions; and summarization of the qualitative information to add to the overall evaluation results.

Table 2 outlines the evaluation question and potential associated survey questions.

Table 2. Qualitative Evaluation Questions	
Question 4: What were the key stakeholder perceptions, and experiences regarding the extended coverage?	
Member perceptions	• Were eligible CHIP enrollees aware of their extended coverage? • How did the extended coverage help the eligible enrollee during the COVID-19 PHE?
MCO and State perceptions	• What strategies did the MCOs use to engage members who turned 19 during the COVID-19 PHE. • What were the principal challenges experienced with MCO engagement of CHIP beneficiaries turning age 19 during this public health emergency? • What strategies did the MCOs pursue to address those challenges?

c. Methodological Limitations

The use of administrative claims and encounters data sources has limitations. These data sources are designed and collected for billing purposes but will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. However, most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. While administrative data might be able to identify key cases and statistical trends, these are usually limited in providing detailed health and health behavior information, thus making it difficult to obtain information on possible covariates. Also, due to the use of population-level data, the effect size of measured differences represents true differences; however, this may or may not correspond to meaningful changes.

Data lag (the number of days from the date of service to the date the claims become available for analysis) may limit the amount of data available for the evaluation.

External administrative claims and encounters are not available, and it is not possible to answer the following key questions with KanCare encounter data.

- How did service utilization of the study group compare to utilization for non-CHIP persons aged 19–21-years during the PHE?
- In prior years, what services were utilized in the first two years after CHIP members lost eligibility on turning 19?

As evaluation is based on multiple years, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period, thus leading to unavailability of appropriate data for the analysis.

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Appendices

Appendix A: Detailed Discussion of Data Sources
Appendix B: Performance Measure Details

Appendix A: Detailed Discussion of Data Sources

Table A1. Detailed Discussion of Data Sources

Data Source	Type of Data	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
Kansas Modular Medicaid System (KMMS) Encounter database	Claims and Encounters	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and other performance, service utilization, and cost metrics for all enrollees	• KMMS member demographics, enrollment, and encounter data obtained from the database will be reviewed for missing values, duplicate values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses of performance measures required by the evaluation design. • Encounter data related pay-for-performance metrics are validated annually by KFMC as a part of their validation of all pay-for-performance metrics. • For applying statistical procedures for analysis of performance measures, a final dataset with all required variables will be created by merging data variables obtained from the KMMS encounter database with other source data.	• Encounters submitted to the State by MCOs are records of the billed claims MCOs receive from providers for service payment. Administrative claims and encounter data are routinely used in HEDIS and other performance measurement. These data sources will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. Most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. • Data are generally considered complete if one quarter is allowed for claims processing and encounter submission. • There is known inconsistency in the population of the MCO claim status field for zero-dollar paid claims. • Payment amounts by Medicare and commercial payors incomplete.
KMMS Eligibility and Enrollment database	Medicaid Eligibility and Enrollment data	Eligibility and enrollment detail for Medicaid members used to determine enrollee aid category and stratify data into subgroups	• Data variables obtained from KMMS eligibility and enrollment database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• Quality is high. • Enrollment records include beginning and end dates for eligibility periods. • MCOs receive updated KMMS eligibility and enrollment data daily.
KMMS Demographics database	Medicaid member demographic data	Demographic data includes member's name, contact information, date of birth, date of death, gender, race, and ethnicity.	• Data variables obtained from KMMS demographics database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures. • Contact information will be reviewed for missing and invalid entries prior to conducting member surveys.	• Contact information is frequently not up to date. • Email addresses are not available. • Other demographics are considered high quality. • Enrollment records include beginning and end dates for eligibility periods. • MCOs receive updated KMMS demographic data daily.

Table A1. Detailed Discussion of Data Sources (Continued)

Data Source	Type of Data	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
HEDIS data from MCOs	Data for HEDIS performance measures	Member-level detail tables for HEDIS measures submitted by the MCOs that provide numerator and denominator values for stratified HEDIS results	• Comparison of numerator and denominator counts to NCQA-certified compliance audit results. • The MCOs subcontract with HEDIS Certified Auditors to validate their HEDIS data for NCQA submission. • KFMC subcontracts with a different HEDIS Certified Auditor to conduct validation of MCO HEDIS data; CMS validation protocols are followed.	• Data Quality is closely monitored by the MCOs and EQRO. • MCOs use NCQA Certified HEDIS software to calculate HEDIS measures and submit data to NCQA as part of their NCQA accreditation requirement. • Data become available seven months after the measurement year. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.
Online Surveys	Qualitative survey data	One online survey will collect qualitative information from members who received extended CHIP coverage during the COVID-19 PHE. One online survey will collect qualitative information from MCO and State staff involved in the implementation of the CHIP coverage extension (e.g., member benefits or customer service staff).	• Information from the online survey will be reviewed for completeness and clarity. • Themes will be identified to understand successes and barriers in achieving its goal. • Stratified response rates will be reviewed.	• Few members may participate in the survey. • Open-ended responses may not clearly communicate the respondent's intended message.

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Appendix B: Performance Measure Details

Table A2. Performance Measure Details

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Annual Dental Visit (ADV) Percentage of members who had one or more dental visit with a dental practitioner during the measurement year	NCQA	CHIP members 18–20 years of age	Members 18–20 years of age who had one or more dental visit with a dental practitioner during the measurement year	Percentage	Kansas Modular Medicaid System (KMMS) databases; HEDIS data from MCOs
Adults' Access to Preventive/Ambulatory Health Services (AAP) Percentage of members who had an ambulatory or preventive care visit during the measurement year	NCQA	CHIP members 20–21 years of age	Members 20–21 years of age who had one or more ambulatory or preventive care visits during the measurement year	Percentage	Same as above.
Child and Adolescent Well-Care Visits (WCV) Percentage of members who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	NCQA	CHIP members 18–21 years of age	Members 18–21 years of age who had at least one comprehensive well- care visit with a PCP or an OB/GYN practitioner during the measurement year	Percentage	Same as above.
Inpatient Utilization—General Hospitalization/Acute Care Excluding maternity admissions	NCQA	Members, 18–21 years of age, enrolled in CHIP for at least one month (30 consecutive days) during the measurement period	Number of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period	Days per 1,000 member-months	Same as above.
Emergency Department Visits (EDU) Observed events, not risk adjusted	NCQA	Members, 18–21 years of age, enrolled in CHIP for at least one month (30 consecutive days) during the measurement period	Number of ED visits during the measurement period	Visits per 1,000 member-months	Same as above.

Table A2. Performance Measure Details (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
ED Visits, Observation Stays, and Inpatient Admissions For the following conditions: • COVID-19 • Acute respiratory infections • Acute severe asthma • Diabetic ketoacidosis/hyperglycemia • Substance use disorder • Mental health issues • External Causes of Morbidity	N/A	Members, 18 years and older, enrolled in CHIP for at least one month (30 consecutive days) during the measurement period.	Number of claims for emergency department visits, observation stays, and inpatient admissions for COVID-19, acute respiratory infections, acute severe asthma, diabetic ketoacidosis/ hyperglycemia, substance use disorder, mental health issues, or external causes of morbidity—deduplicated to one service per member, per billing provider NPI, per last date of service	Services per 1,000 member-months	Same as above.
Outpatient and Professional Services For following conditions: • Acute upper respiratory infections • Influenza • Pneumonia • Other acute lower respiratory infections	N/A	Members, 18 years and older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number of claims for outpatient or professional claims for diabetic retinopathy, influenza, pneumonia, or shingles—deduplicated to one service per member, per billing provider NPI, per last date of service	Services per 1,000 member-months	Same as above.

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Attachments

Attachment 1: Independent Evaluator
Attachment 2: Timeline and Major Milestones

Attachment 1: Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), KFMC Health Improvement Partners (KFMC), to conduct the evaluation of the KanCare 2.0 Demonstration COVID-19 PHE Amendment. They have agreed to conduct the demonstration evaluation in an independent manner. KFMC has over 50 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 (over 27 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (40 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (22 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. KFMC considers ethics and compliance an integral part of all their business decisions and the services they provide. The KFMC Corporate Compliance Program supports the commitment of KFMC to conduct its business with integrity and to comply with all applicable Federal and State regulations, including those related to organizational and personal conflicts of interest. The KFMC compliance program ensures potential, apparent, and actual organizational and personal conflicts of interest (PCI) will be identified, resolved, avoided, neutralized, and/or mitigated.

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

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

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

Attachment 2: Timeline and Major Milestones

Deliverable/Activity	Due Date
Initiate meeting with EQRO and State to finalize study measures.	January 15, 2023
Provide updates during routine quarterly EQRO/State/MCO meetings to review and discuss data sources, reports, and findings as applicable.	To be determined
Conduct online stakeholder surveys and analyze data.	1 to 6 months post PHE unwinding period.
Conduct final evaluation analysis, after the PHE unwinding period, allowing for data lag.	6–8 months post PHE unwinding period.
Draft evaluation report.	No later than one year after the end of the COVID-19 section 1115 demonstration authority.
Final evaluation report.	60 calendar days after receipt of CMS comments