State of Kansas

KanCare Section 1115 Demonstration
Project No. 11-W-00283/7

Extension Application
July 31, 2017

Table of Contents

I. Introduction

The current KanCare demonstration expires on December 31, 2017. Pursuant to Section 1115(a) of the Social Security Act, the Kansas Department of Health and Environment (KDHE) is requesting a one-year extension of the current KanCare demonstration, including the Uncompensated Care (UC) Pool and the Delivery System Reform Incentive Payment (DSRIP) Pool. The requested extension period is January 1, 2018 through December 31, 2018. KDHE is not requesting any changes to the demonstration for the one-year extension period.

KDHE thanks the Centers for Medicare and Medicaid Services (CMS) for its guidance regarding the requirements of this demonstration extension application. The following sections fulfill the transparency and public notice requirements for Section 1115 demonstrations, in accordance with Section 10201(i) of the Affordable Care Act and the extension requirements set forth in the KanCare Special Terms and Conditions, as confirmed with CMS through multiple meetings and email communications.

In addition to this extension application, KDHE is currently developing a *Transition Plan for Funding Pools* report that will address the effect, adequacy, and accountability of UC Pool and DSRIP program payments on provider financing. KDHE will submit the *Transition Plan for Funding Pools* to CMS as soon as it is complete.

II. Historical Narrative Summary of KanCare and Requested Changes

KanCare is a managed care Medicaid program which serves the State of Kansas through a coordinated approach. The State determined that contracting with multiple managed care organizations (MCOs) will result in the provision of efficient and effective health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community-based services (HCBS). Three MCOs serve the KanCare program – Amerigroup, Sunflower, and UnitedHealthcare.

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by CMS on December 27, 2012, effective from January 1, 2013, through December 31, 2017. On August 19, 2013, the State submitted a letter to CMS requesting approval of an amendment to the KanCare demonstration detailing three changes to KanCare:

Proposed Change	CMS Approval Date
Provide LTSS for individuals with intellectual or developmental disabilities (I/DD) through KanCare managed care plans	CMS approved the LTSS integration of I/DD population in a letter dated January 29, 2014 and approved amendments to the HCBS I/DD waiver in a letter dated February 3, 2014
Establish a supplemental security income pilot program to support employment and alternatives to Medicaid	Approval pending

Proposed Change	CMS Approval Date
Change the timeline for the DSRIP Pool	CMS approved the DSRIP delay amendment on September 20, 2013

KanCare is operating concurrently with the State's section 1915(c) HCBS waivers, which together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the State into a managed care delivery system to receive state plan and waiver services. This represents an expansion of the State's previous managed care program, which provided services to children, pregnant women, and parents in the State's Medicaid program, as well as carved out managed care entities that separately covered mental health and substance use disorder (SUD) services.

KanCare also includes a DSRIP Pool, which aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two major hospitals, Children's Mercy Hospital and Clinics and The University of Kansas Hospital. The two hospital systems are major medical service providers to Kansas and Missouri residents. Each hospital system is implementing two projects selected from a catalog of five projects approved by CMS and KDHE that target specific needs of Kansas residents who are receiving Medicaid services or are uninsured. The Kansas DSRIP projects, originally planned to be implemented as four-year projects from 2014 through 2017, are now three-year projects that began in 2015.

KanCare also includes a UC Pool (also referred to as a Safety Net Care Pool). The UC Pool consists of two sub-pools, the Health Care Access Improvement Program Pool (HCAIP) and the Large Public Teaching Hospital/Border City Children's Hospital Pool LPTH/BCCH). The UC Pool provides payments to hospitals to defray hospital costs of uncompensated care provided to Medicaid-eligible or uninsured individuals.

Kansas requests to continue the DY5 funding levels for the UC Pool ($41 million for the HCAIP sub-pool and $9,856,550 for the LPTH/BCCH sub-pool) and the DSRIP Pool ($30 million) during the one-year extension.

Other features of the five-year KanCare demonstration include:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the State to require eligible individuals to enroll in MCOs to receive covered benefits, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but have the option of affirmatively opting-out of managed care; and
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care.

The original goals of the KanCare demonstration were to:

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

Please see Sections IV (Quality Reporting Summaries) and Section VI (KanCare Evaluation) for a summary of progress towards the demonstration goals and other program successes. Because Kansas is simply requesting a one-year extension of its 1115 demonstration, with no program changes, we intend to maintain these same goals as implemented over the original five-year demonstration approval period.

III. Requested Waiver and Expenditure Authorities

The State is requesting the same waiver and expenditure authorities as those approved in the current demonstration, which are restated below:

Waiver Authorities

1. **Amount, Duration, and Scope of Services – Section 1902(a)(10)(B)**

   To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. **Freedom of Choice – Section 1902(a)(23)(A)**

   To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

Expenditure Authorities

Service-Related Expenditures

1. **Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs**

   Expenditures for the following services furnished to individuals eligible under the approved state plan and concurrent 1915(c) waivers, pursuant to the limitations and qualifications provided in STC 22 to address behavioral health and SUD needs:

   - Physician Consultation (Case Conferences);

- Personal Care Services; and
- Rehabilitation Services.

Safety Net Care Pool (SNCP) Expenditures

Expenditures for the following categories of expenditures, subject to overall SNCP limits and category-specific limits set forth in the STCs.

2. **Uncompensated Care Pool**

   Pursuant to STC 68, expenditures for payments to hospitals to defray hospital costs of uncompensated care furnished to Medicaid-eligible or uninsured individuals that meets the definition of "medical assistance" under section 1905(a) of the Act, to the extent that such costs exceed the amounts received by the hospital pursuant to 1923 of the Act.

3. **Delivery System Reform Incentive Payment Program**

   Expenditures from pool funds for the DSRIP Program, pursuant to STC 69, for incentive payments to hospitals for the development and implementation of approved programs that support hospital efforts to enhance access to health care and improve the quality of care. DSRIP incentive payments are not direct reimbursement for service delivery, and may not duplicate other federal funding.

IV. Quality Reporting Summaries

The following provides summary information regarding Kansas' quality reporting activities. This section includes information contained in external quality review organization (EQRO) reports, MCO reports, and other quality assurance and monitoring activities.

External Quality Review Organization Reports

KDHE contracts with the Kansas Foundation for Medical Care to develop EQRO reports. The most recent *KanCare Program Annual External Quality Review Technical Report*, for the 2015-2016 reporting period covers the following areas:

- Performance Measure Validation
- Performance Improvement Project Validation
- Balanced Budget Act Compliance Review
- Survey Validation
  - Mental Health Survey
  - Consumer Assessment of Healthcare Providers and Systems

We describe summary information about these areas below:

Performance Measures

Kansas evaluates MCO performance on Healthcare Effectiveness Data and Information Set (HEDIS) measures on an annual basis, and compares MCO performance to national benchmarks. HEDIS is a tool used by most health plans to measure performance on important dimensions of care and

service. A February 2017 report produced by the Kansas Foundation for Medical Care indicates the following:

Performance of HEDIS Measures in CY2015	
> 75th Percentile National Benchmark	12
> 50th Percentile National Benchmark	10
< 50th Percentile National Benchmark, but Improvement Between 2013 and 2015	5

Note: The above table includes only selected HEDIS measures. See Appendix A for more detailed information on statewide HEDIS performance from CY 2013 – CY 2015.

Performance Improvement Projects

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

Amerigroup, Sunflower, and UnitedHealthcare are completing the following individual PIPs:

- Amerigroup chose to improve well-child visit rates in the third, fourth, fifth and sixth years of life.
- UnitedHealthcare chose to improve follow-up after hospitalization for mental illness.
- Sunflower chose to increase the rate of initiation and engagement of alcohol and other drug dependence treatment.

Each PIP methodology was reviewed and revised to ensure that clear interventions, outcomes, tracking, and measurement methods were identified. Representatives of each MCO report PIP progress at regularly occurring KanCare interagency meetings. Written updates have also been provided post-implementation of each PIP. The State also created monthly report templates for each MCO to send data showing the progress of each PIP.

Balanced Budget Act Compliance Review

Every three years, the Kansas Foundation for Medical Care completes a full review of MCO compliance with managed care-related federal regulations associated with the Balanced Budget Act (BBA), including:

- Enrollee Rights and Protections;
- Quality Assessment and Performance Improvement:
    - Access Standards
    - Structure and Operation Standards
    - Measurement and Improvement Standards; and
- Grievance System (9 regulatory areas).

Within the regulatory areas there are approximately 312 individual requirements for which the MCOs submit supporting evidence and documentation assessed by the Kansas Foundation for

Medical Care for compliance with the federal regulations and state contract requirements. The case review component for each MCO includes 60 cases for provider credentialing (including individual, institutional, initial credentialing, recredentialing, and denied credentialing) and 300 cases total for physical health records, behavioral health records, grievances, appeals, and denied claims.

The Kansas Foundation for Medical Care conducted full reviews in 2013 and 2016. In 2014 and 2015, the Kansas Foundation for Medical Care reviewed and reported on MCO follow-up efforts to address recommendations made in the full review. MCOs' overall compliance ratings from the 2013 full review, and follow-up improvements from 2014 and 2015 were:

- Amerigroup: 82% Fully Met, 15% Substantially Met, 3% Partially Met, 1% Minimally Met, and 0% Not Met. (Of 71 areas identified for improvement in the 2013 full review, Amerigroup brought 92% into full or substantial compliance.)
- UnitedHealthcare: 76% Fully Met, 16% Substantially Met, 5% Partially Met, 3% Minimally Met, and 0% Not Met. (Of 100 areas identified for improvement in the 2013 full review, UnitedHealthcare brought 98% into full or substantial compliance.)
- Sunflower: 69% Fully Met, 24% Substantially Met, 4% Partially Met, 2% Minimally Met, and 1% Not Met. (Of 151 areas identified for improvement in the 2013 full review, Sunflower brought 93% areas into full or substantial compliance.)

Mental Health Survey

Since 2010, the Kansas Foundation for Medical Care has administered and analyzed results of surveys of Kansas Medicaid members receiving mental health services. Survey results are reported by adults, youth (family members completing the survey, with separate questions completed by youth ages 12-17), and youth and young adults receiving Serious Emotional Disorder Waiver services. Survey results are analyzed annually for statistical significance and trends over time, including comparison of survey results in 2011 and 2012 (pre-KanCare) with survey results in 2013—2016 (KanCare). Members have consistently expressed high levels of satisfaction with services provided in both pre-KanCare and KanCare years.

Consumer Assessment of Health Care Providers and Systems Survey

The Consumer Assessment of Health Care Providers and Systems (CAHPS) is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ), and co-developed with National Committee for Quality Assurance (NCQA). The survey measures how well health plans are meeting their members' expectations and goals; to determine which areas of service have the greatest effect on members' overall satisfaction; and to identify areas of opportunity for improvement which could aid plans in increasing the quality of care provided to members. Detailed specifications are provided by NCQA to be used by health plans in conducting the survey. In order for a health plan's CAHPS survey to be a dependable source of information, it must be administered according to the published CAHPS technical specifications.

When administered properly, CAHPS surveys provide information regarding the access, timeliness and/or quality of health care services provided to health care consumers.

Since the launch of KanCare in January of 2013, CAHPS surveys have been conducted annually by the KanCare MCOs and validated by the Kansas Foundation for Medical Care.

The table below compares survey responses over the past three years from across all population members that rated their Health Plan with an 8, 9 or 10 on a 0-10 scale (0 being the worst plan and 10 being the best plan).

CAHPS Survey Rating of Health Plan - 2014 to 2016								
Population	**Program**	**MCO**	**2016**		**2015**		**2014**	
			%	**QC**	**%**	**QC**	**%**	**QC***
Adult		AGP	75.48%	<50th	71.08%	<25th	72.55%	<50th
		SHP	75.37%	<50th	73.49%	<50th	71.68%	<50th
		UHC	80.16%	>75th	76.91%	>50th	73.33%	<50th
	KanCare Adult		**76.54%**	**>50th**	**73.39%**	**<50th**	**72.54%**	**<50th**
General Child (GC)	Title XIX	AGP	85.20%	>50th	88.32%	>75th	**	**
		SHP	90.07%	>75th	86.47%	>66.67th	86.45%	>50th
		UHC	89.93%	>75th	87.77%	>75th	**	**
	Title XXI	AGP	87.83%	>66.67th	86.73%	>66.67th	**	**
		SHP	92.00%	>95th	89.06%	>75th	84.91%	>50th
		UHC	89.47%	>75th	87.54%	>75th	**	**
	KanCare GC		**88.74%**	**>75th**	**87.56%**	**>75th**	**86.79%**	**>50th**
Children with Chronic Conditions (CCC)	Title XIX	AGP	82.71%	<50th	83.61%	>75th	**	**
		SHP	84.55%	>66.67th	82.80%	>66.67th	82.17%	>50th
		UHC	86.10%	>75th	82.03%	<50th	**	**
	Title XXI	AGP	88.93%	>95th	85.46%	>90th	**	**
		SHP	89.92%	>95th	85.91%	>90th	81.38%	>50th
		UHC	85.95%	>75th	88.24%	>95th	**	**
	KanCare CCC		**85.22%**	**>75th**	**83.51%**	**>75th**	**81.08%**	**>50th**
Note: The percentages are for those who responded with either an 8, 9, or 10 on a scale of 0 to 10, where 0 is the worst possible and 10 is the best possible.								
*NCQA provided additional percentiles, 33.33rd and 66.67th, in 2015.								
**AGP and UHC did not conduct separate Title XIX and XXI surveys in 2014.								

MCO and State Quality Assurance Reporting

KDHE requires MCOs to submit a number of reports and facilitates monthly meetings with each MCO to discuss operational issues, data discrepancies, and areas for MCO improvement. Below, we summarize select aspects of MCO reporting. For more information, please see KDHE's quarterly and annual reports, which further highlight successes and areas for improvement in the KanCare program. These reports are available at the following webpage: http://www.kancare.ks.gov/policies-and-reports/annual-and-quarterly-reports.

Utilization

Utilization data for all three KanCare MCOs, separately addressing physical health, behavioral health, nursing facility, and HCBS services are analyzed and reported by demonstration quarter. These reports are one component of the State's utilization analysis.

The KanCare Utilization Report for DY3 is provided below. This information demonstrates the success of the KanCare program in moving toward its primary goal of controlling Medicaid costs by emphasizing health, wellness, prevention, and early detection.

A comparison of DY3 utilization data with pre-KanCare measurements demonstrates a trend towards reduced utilization of inpatient services and associated facility expenses during the third year of KanCare. As anticipated, the frequency of inpatient visits, nursing home stays and outpatient emergency room treatment has declined, thereby lowering the overall cost of health care. Of greatest significance is a 28% decrease in the annual utilization of inpatient days per 1,000 members.

Conversely, during the first three years of KanCare, there was an upward trend in utilization for 9 of the 12 service categories reviewed, averaging a 9% increase in overall utilization.

The value of this trend is emphasized in the upward movement of those community based, local, outpatient office visits and ancillary services that KanCare has provided to members at a greater frequency than before implementation, revealing the causal relationship between the increases in these services and the reduction in inpatient stays.

With the exception of behavioral health which experienced a modest (3%) reduction, overall services provided outside of a facility setting have seen an average increase of 16% in utilization since 2012. Member utilization of dental services, home and community based services and transportation services has increased by more than 25%.

Aggregate Utilization Report		CY 2015 (KanCare DY3) Encounter Claims	CY 2012 (Pre-KanCare) Encounter and FFS	Comparing CY 2015 to CY 2012	
Type of Service	**Units Reported**	**Utilization Per/1000**	**Utilization Per/1000**	**Utilization Per/1000**	**% Difference**
Behavioral Health	Claims	4,990	5,151	-161	-3%
Dental	Claims	1,161	880	281	32%
HCBS	Unit	5,183,500	3,058,464	2,125,036	69%
Inpatient	Days	851	1,189	-338	-28%
Nursing Facility	Days	328,593	336,732	-8,139	-2%
Outpatient ER	Claims	746	762	-16	-2%
Outpatient Non-ER	Claims	1,945	1,794	151	8%
Pharmacy	Prescriptions	10,328	9,859	469	5%
Transportation	Claims	793	617	176	29%
Vision	Claims	351	326	26	8%
Primary Care Physician	Claims	4,517	3,728	789	21%

Aggregate Utilization Report		CY 2015 (KanCare DY3) Encounter Claims	CY 2012 (Pre-KanCare) Encounter and FFS	Comparing CY 2015 to CY 2012	
Type of Service	**Units Reported**	**Utilization Per/1000**	**Utilization Per/1000**	**Utilization Per/1000**	**% Difference**
FQHC/RHC	Claims	876	855	21	2%

Network Adequacy

Since the beginning of the demonstration, the MCOs have effectively recruited providers to their networks. The average number of contracting providers under each plan since 2014 is displayed in the following table (for this table, providers were de-duplicated by National Provider Identifier):

KanCare MCO	Average # of Unique Providers during 2014	Average # of Unique Providers during 2015	Average # of Unique Providers during 2016
Amerigroup	14,200	14,918	16,430
Sunflower	17,007	19,912	20,790
UnitedHealthcare	19,752	19,245	22,881

The table above does not account for a provider who covers multiple specialties or areas. MCOs report gaps in coverage each month by the MCOs, using Geo Access Reports. Where gaps exist, the MCOs report their strategy for closing those gaps. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the MCOs have demonstrated their commitment to working with providers in adjacent cities and counties to provide services to members.

Dental Care

The KanCare program in collaboration with MCOs continues to increase dental health and wellness for the KanCare population. KanCare and partner agencies continue to emphasize the importance of regular dental care for our members and are committed to increasing utilization of these important services. Dental services data from 2015 show continued improvement over the 2014 data, as illustrated in the following table.

	SFY 2014	SFY 2015
Total Eligible receiving dental treatment	125,413	129,720
Total Eligible receiving preventative services	116,526	122,724

MCO Financial Performance

As of December 31, 2016, all three MCOs are in a sound and solvent financial standing. All three MCOs reported profits in 2016. Statutory filings for the KanCare MCOs can be found on the National

Association of Insurance Commissioner's (NAIC) "Company Search for Compliant and Financial Information" website: https://eapps.naic.org/cis/.

KanCare MCO Contract Annual Audit Process

The State and the Kansas Foundation for Medical Care conduct an MCO contract review process each year. One of the purposes of the audit process is to evaluate compliance with State contract requirements and MCO policies and procedures that the State has previously approved. The State and the Kansas Foundation for Medical Care conduct planning meetings to prepare for the reviews and establish the desk review and on-site review tools. The MCOs submit documentation prior to the desk and on-site reviews. For the on-site review, a three-day time block is scheduled with each MCO. Examples of focus areas for the on-site review have included appeals, grievances, finance, coordination of care, customer service, and provider credentialing. Following the conclusion of the desk and on-site reviews, the State works with the Kansas Foundation for Medical Care to develop an executive report and individual reports for each MCO.

V. Financial Data

Kansas does not anticipate a significant change in enrollment or aggregated expenditure trends for the extension period. The following table summarizes the annual enrollment and aggregated expenditures for KanCare, by DY. For DY5 and the one-year extension period (DY6), Kansas projects continued savings under the KanCare program as compared to the absence of the KanCare program.

The projected expenditures for DY6 in the table below include Kansas' request of $41 million for the HCAIP sub-pool, $9,856,550 for the LPTH/BCCH sub-pool, and $30 million for the DSRIP Pool.

	DY1 (Actual)	DY2 (Actual)	DY3 (Actual)	DY4 (Actual)	DY5 (Projected)	DY6 (Projected)
Total Member Months	3,923,495	4,274,950	4,613,313	4,440,125	4,356,280	4,378,062
Total Expenditures	$2,466,602,125	$2,676,549,112	$2,848,701,872	$3,014,689,869	$3,011,965,391	$3,281,495,553

Appendix B provides a historical budget neutrality summary for DY1 through DY4, including total expenditures, eligible member months, and PMPY costs. Appendices C through E summarize the projected member months and costs for DY5 and DY6:

- Appendix C illustrates the projected member months for DY5 and DY6;
- Appendix D illustrates the projected per member per month (PMPM) costs for DY5 and DY6; and
- Appendix E illustrates the projected expenditures for DY5 and DY6.

Finally, Appendix F summarizes the actual and projected expenditures for Kansas' HCAIP sub-pool, LPTH/BCCH sub-pool, and DSRIP Pool from DY1 through DY6.

VI. KanCare Evaluation

Kansas submitted to CMS for approval a draft Evaluation Design for overall evaluation of the demonstration on April 26, 2013. CMS provided comments on the draft KanCare Evaluation Design on June 25, 2013. After discussing the comments with CMS and gathering additional input from stakeholders, Kansas submitted the final KanCare Evaluation Design to CMS on August 24, 2013. CMS approved the KanCare Evaluation Design on September 11, 2013.

After submission of the final KanCare Evaluation Design, Kansas began implementation of the evaluation design as described in the approved document. Kansas contracted with the Kansas Foundation for Medical Care to serve as the independent evaluator for the KanCare demonstration. Kansas has submitted updates on the progress related to the implementation design of the KanCare Evaluation Design in each of the quarterly and annual reports. Kansas also submitted to CMS a revised KanCare Evaluation Design in March 2015, and CMS did not identify any concerns with this revised KanCare Evaluation Design.

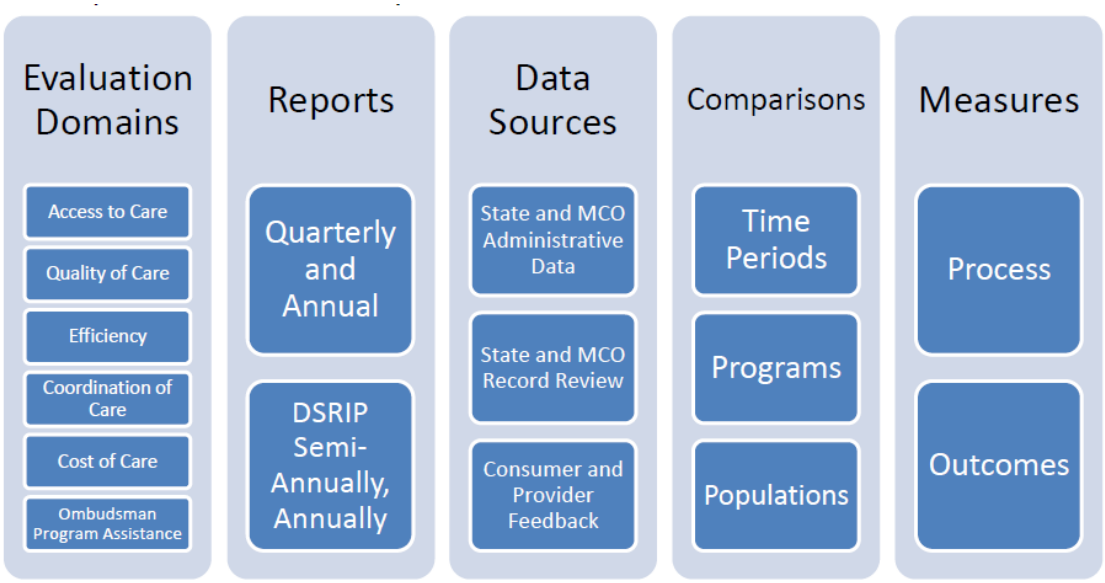
Research Questions/Hypotheses

The approved KanCare Evaluation Design includes the following hypotheses:

- By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

Evaluation Activities

The KanCare evaluation activities consider a number of evaluation designs, reports, data sources, comparisons, and measures, as illustrated in the figure below.



The reports and data sources also consist of elements that are quantitative and qualitative in nature, to provide KDHE and the Kansas Foundation for Medical Care a wide range of information to be considered as part of the overall evaluation. These quantitative and qualitative elements are outlined below.

Quantitative Reports

- HEDIS;
- Mental Health measures, including Serious Emotional Disturbance Waiver reports and National Outcome Measures;
- Nursing Facility measures;
- SUD measures;
- HCBS Waiver reports;
- Case Record reviews;
- Access reports; and
- Financial reports.

Qualitative Reports

- CAHPS;
- Mental Health Statistical Improvement Program consumer survey;
- SUD consumer survey;
- Provider survey;
- Kansas Client Placement Criteria database, which contains member self-reported data;
- Automated Information Management System database, which includes some self-reported data;
- Care manager feedback and surveys; and
- Grievance reports.

Evaluation Findings

In the KanCare annual evaluation reports, the Kansas Foundation for Medical Care reports on performance metrics related to the following categories, using the types of quantitative and qualitative reports listed above:

- Quality of care;
- Coordination of care and integration;
- Cost of care;
- Access to care; and
- Efficiency.

The evaluation reports also include findings regarding the UC and DSRIP Pools.

Below, we include selected findings from the *2016 KanCare Evaluation Annual Report*. See Appendix G for the full *2016 KanCare Evaluation Annual Report.*

1. **Quality of Care:** The baseline data submitted by the MCOs, including results by age group, revealed a mixed performance with areas of strength, where performance metric results were above the 50th or 75th percentile nationwide, and several measures below the 50th percentile. Many of these low-performing metrics have been persistently low for several years. Quality of care in mental health and SUD services improved over the duration of the demonstration.

2. **Coordination of Care (and Integration):** Members receiving waiver services had more primary care and annual dental visits over the course of the demonstration. These members also decreased their count of emergency department visits.

3. **Cost of Care:** From CY 2012 to CY 2015, there the following services has changes in utilization:

Service Utilized	Utilization Change
Primary Care Physician	24% Increase
Dental	32% Increase
Home and Community-Based Services	23% Increase
Transportation	33% Increase
Vision	16% Increase
Non-Emergency Room Outpatient Services	10% Increase
Inpatient Hospitalization	23% Decrease
Emergency Room Outpatient Visit	1% Decrease

4. **Access to Care:** In 2016, there were three provider types where Semi-Urban counties did not have access through at least one MCO. Behavioral Health services in CY 2014- CY 2016 were provided in all counties within the access standards required by the State. Of the 27 HCBS services, 17 were available in CY2015 from at least two providers in all 105 Kansas counties from all three MCOs.

5. **Efficiency:** Emergency department visit rates for HCBS were much lower in 2013-2015 compared to rates in 2012 pre-KanCare. However, inpatient hospitalization rates were higher in 2015 for some waiver participants, including members with I/DD, and lower for other waiver participants than inpatient admission rates in 2012, pre-KanCare.

Proposed Evaluation Activities for Extension Period

For the proposed one-year extension period (from January 1, 2018 – December 31, 2018), the Kansas Foundation for Medical Care will continue many of the same evaluation activities included in the current demonstration's evaluation design including, but not limited to:

- Evaluating the same four hypotheses;
- Monitoring HEDIS measures; and
- Conducting member surveys (e.g., CAHPS, mental health survey) and a provider survey.

For the proposed extension period, the Kansas Foundation for Medical Care will perform new focused studies. Kansas anticipates that the focused studies for the extension period will be on the topics of network adequacy and validation of waiver capitation payments to verify members are receiving appropriate access to and adequate services.

VII. Compliance with Special Terms and Conditions

Kansas has successfully completed, or discussed with CMS modified due dates, for the deliverables required by the KanCare demonstration Special Terms and Conditions. In a letter dated January 13, 2017, CMS identified needed improvements in KanCare program implementation. Kansas has developed correction action plans corresponding to CMS' findings and continues to work diligently to assure compliance with all Special Terms and Conditions.

During the demonstration period, Kansas has implemented changes to comply with modifications in such requirements, including the *Affordable Care Act* and the *Medicaid and CHIP Managed Care Final Rule* as published in the Federal Register on April 25, 2016.

KanCare Demonstration Benefits and Coordination

KanCare maintains benefits that were available before the demonstration's implementation in at least the same amount, duration, and scope that services are provided in the state plan. MCOs additionally offer value-added benefits at no cost to the State.

MCOs are contractually responsible for the management, coordination, and continuity of care for all members and are additionally required to maintain policies and procedures to address this responsibility. MCOs must also coordinate access to needed services excluded from KanCare and make every effort to permit members to continue, if they so desire, with previously established providers who meet the same qualifications and financial agreements as others in the network.

Compliance with DSRIP and UC Pool Terms

As discussed in Section II, CMS initially approved a DSRIP Pool of funds to be implemented as four-

year projects from 2014 through 2017. The 1115 demonstration was amended to change the projects begin in 2015, lasting three years. Kansas has implemented the following under the amended demonstration:

- The University of Kansas Hospital and Children's Mercy Hospital and Clinics are eligible to participate in the DSRIP program.
- Kansas convened the HK2020 Steering Committee to receive input on the proposed DSRIP focus areas and to provide the Steering Committee with an example of how their priority strategies were being put into practice in the State. CMS approved the DSRIP projects on February 5, 2015. Each hospital participating in the DSRIP program was required to select at least two projects.
- Each DSRIP project has milestones from each of the following four categories: Category 1 (infrastructure milestones), 2 (process milestones), 3 (quality and outcome milestones), and 4 (population focused improvements).
- Kansas completes annual reports regarding the progress and outcomes associated with the DSRIP Pool.

In addition to the DSRIP Pool, CMS also authorized a UC Pool that consists of two sub-pools: the Health Care Access Improvement Program Pool and the Large Public Teaching Hospital/Border City Children's Hospital Pool. Kansas has only made payments to the hospitals listed in the Special Terms and Conditions as eligible for the HCAIP sub-pool and the LPTH/BCCH sub-pool.

Compliance with Quality and Reporting Requirements

Kansas has submitted progress reports to CMS following the end of each quarter and each DY since the start of the KanCare demonstration period. Kansas has posted all reports on its publicly available webpage. Each report includes details of compliance with Special Terms and Conditions, including engaging the public through post award forums. Reports are additionally accompanied by demonstrations of network adequacy, documenting assurances that MCOs have sufficient capacity to serve the expected enrollment in their service area and offer an adequate range of preventive, primary, pharmacy, specialty, acute, and HCBS services for the anticipated number of enrollees in the service area. These reports are also publicly available on the KanCare website.

The KanCare annual reports also describe the implementation and effectiveness of the comprehensive Quality Strategy as it impacts the demonstration. The Medicaid State Quality Strategy was finalized in September 2014 and contains specific provisions for assessment of care quality and appropriateness as well as improvement following such an assessment. The State Quality Strategy is regularly reviewed and operational details continually evaluated, adjusted, and put into use. The Quality Strategy includes the KanCare Evaluation Design, approved by CMS on September 11, 2013 and updated in March 2015.

Kansas has also submitted quarterly expenditure reports using Form CMS-64 to separately report expenditures provided through the KanCare demonstration.

Continuing to Ensure Compliance with KanCare Program Requirements through a Corrective Action Plan

As discussed previously, in a letter dated January 13, 2017, CMS identified needed improvements in KanCare program implementation. In response to this letter, KDHE developed a corrective action plan, sent to CMS on February 17, 2017.[1] The corrective action plan outlines KDHE's responses to the CMS findings, and the actions KDHE and the Kansas Department for Aging and Disability Services (KDADS) are taking to address those findings.

CMS approved the corrective action plan on May 22, 2017. To implement the corrective action plan, KDHE is working with KDADS to address key areas such as:

- Monitoring and reporting;
- Standard operating procedures (SOPs);
- Training;
- Roles and responsibilities, including coordination between KDHE and KDADS; and
- Stakeholder engagement.

Below, we provide a sample of the KDHE responses contained in the corrective action plans:

- KDHE oversees and works with KDADS continually to improve its MCO oversight based on analysis of MCOs' submitted data, and the agencies use this information to inform decision-making at the programmatic level. Beyond its current efforts, KDHE will develop and implement SOPs regarding MCO data analysis and communication, focusing on MCO data verification and performance review.
- KDHE has been consistent in its monitoring operations since the implementation of KanCare and continues to facilitate monthly meetings with MCOs to discuss operational issues, data discrepancies, and areas for MCO improvement. In addition to its current efforts, KDHE will develop and distribute internal policies and procedures and train staff responsible for the state contract review annual report development.
- In 2015, KDHE worked with individual MCOs to perform a provider access and network adequacy data clean up as a result of onsite audits KDHE conducted in 2013 and 2014. KDHE will continue its efforts in monitoring provider network adequacy by conducting a comprehensive review of network adequacy reporting templates as compared to the managed care Final Rule. KDHE will also update internal policies and procedures to guide agency staff in the review and monitoring of KDHE provider network access and adequacy reports. In addition, KDHE will develop internal analysis tools to begin trending and comparing MCO data with each report submission based on the newly implemented MCO reporting templates.
- As it pertains to tracking critical incidents, Kansas has rigid and effective statutes surrounding the reporting and investigation of abuse, neglect, and exploitation (ANE). Continuing this process, KDHE, KDADS, the Department for Children and Families (DCF),

[1] In response to CMS feedback, KDHE submitted additional information on its corrective action plan to CMS on April 17, 2017.

and the MCOs have collectively charged a critical incidents workgroup with overseeing the development and implementation of enhanced reporting, tracking, and trending of critical incidents.

- KDHE is overseeing and working with KDADS to update policies regarding the person-centered planning processes for all three MCOs to comply with federal regulations at 42 C.F.R. *§* 441.301. In addition, KDHE has reviewed the audit findings and will continue to work collectively with KDADS to establish policies regarding the HCBS quality review process. KDHE will implement effective oversight to ensure the level of care and provision of services are provided to beneficiaries as indicated in their plan of care.
- KDHE and KDADS have an Interagency Agreement, which is an evergreen agreement that is automatically renewed every year. The latest agreement is from 2012, and KDHE will update this agreement with criteria for KDHE to evaluate KDADS. KDHE will also update position descriptions that describe specific roles and responsibilities of each agency and procedural documentation, such as SOPs.
- KDHE uses multiple methods for disseminating information and gathering stakeholder feedback including, but not limited to, website postings, memos to beneficiaries and providers, and public meetings and forums. To promote continued information sharing following standard procedures, KDHE will implement policies and procedures for programmatic communications to MCOs and stakeholders, as well as processes for collecting public and stakeholder feedback. KDHE will also train agency staff on proper procedures.

VIII. Public Notice Process

KDHE conducted a public comment period from June 8, 2017 through July 10, 2017. KDHE notified stakeholders of the public comment period to solicit input on the waiver extension using the following methods:

- Published abbreviated public notice in the *Kansas Register* on June 8, 2017, available at the following link: http://www.kssos.org/pubs/register/2017/Vol_36_No_23_June_8_2017_pages_557-580.pdf; please see Appendix H for the abbreviated public notice;
- Posted full public notice on the KanCare website, available at the following link: http://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/full-public-notice---kancare-extension.pdf?sfvrsn=2; please see Appendix I for the full public notice; and
- Posted a prominent link to the draft extension application on the KanCare website, available at the following link: http://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-1115-waiver-extension-053117-draft-for-public-comment.pdf?sfvrsn=2.

KDHE also e-mailed a notice regarding the demonstration extension to the tribes located in Kansas. Please see Appendix J for the e-mail documentation of this notice. No comments or questions were received from the tribes.

KDHE held public hearings about the KanCare extension in July 2017. Two public hearings were in-person hearings, while a third public hearing took place by conference call. Because it is often difficult for call-in participants to hear the presentation and comments, there was not telephonic or web conference capabilities at the in-person hearings. Instead, KDHE offered a dedicated public hearing for call-in participants on July 10, 2017 so that participants were better able to hear and provide comments. During the public hearings, KDHE presented information about the KanCare program and the draft extension application. KDHE also provided the opportunity for public comment at these hearings.

KDHE held the following public hearings:

Day/Date	Time	Location
Thur., July 6, 2017	1:30-3:00 pm	University of Kansas Edwards Campus, Best Conference Center, 12604 Quivira Rd., Overland Park, KS
Fri., July 7, 2017	1:30-3:00 pm	WSU Hughes Metroplex , Room 180, 5015 E. 29th St. North, Wichita, KS (Enter door N at the southeast corner of the building)
Mon., July 10, 2017	6:00-7:00 pm	Conference call: 877-400-9499 Access Code: 134 228 8045

Please see Appendix K for a summary of the public comments, along with KDHE's responses to the comments. KDHE has maintained compliance with the requirement for post-award forums and will continue to comply with all post-award public input requirements in compliance with 42 CFR 431.420(c).

Appendix A: Summary of Statewide HEDIS Performance

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
Comprehensive Diabetes Care							
HbA1c Testing (P4P)	Hybrid	84.90%	84.80%	83.10%	↓	↓	↓
Eye Exam (P4P)		62.50%	58.60%	50.10%	↑	↑	↓
Medical Attention for Nephropathy (P4P)		89.20%	76.80%	75.80%	↓	↓	↓
HbA1c Control (<8.0%) (P4P)		46.60%	39.30%	39.00%	↓	↓	↓
HbA1c Poor Control (>9.0%) (lower % is goal)		45.40%	52.90%	54.40%	↓	↓	↓
Blood Pressure Control (<140/90) (P4P)		58.80%	52.60%	53.10%	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life							
	Admin	62.70%	62.10%	60.80%	↓	↓	↓
Adolescent Well Care Visits							
	Admin	43.00%	42.60%	42.30%	↓	↓	↓
Adults' Access to Preventive/Ambulatory Health Services (P4P)							
Ages 20-44	Admin	83.70%	84.30%	85.40%	↑	↑	↑
Ages 45-64		92.30%	92.40%	92.20%	↑	↑	↑
Ages 65 and older		89.70%	88.60%	89.50%	↑	↑	↑
Total - Ages 20 and older		87.10%	87.50%	88.40%	↑	↑	↑
Annual Monitoring for Patients on Persistent Medications							
	Admin	90.20%	89.70%	84.90%	↑	↑	↓
Follow-up after Hospitalization for Mental Illness, within seven days of discharge							
	Admin	62.80%	56.20%	61.00%	↑	↑	↑
Prenatal Care							
	Hybrid	67.40%	70.40%	71.40%	↓	↓	↓
Postpartum Care							
	Hybrid	57.50%	55.80%	60.30%	↓	↓	↓
Chlamydia Screening in Women							
Ages 16-20	Admin	41.30%	41.00%	42.40%	↓	↓	↓
Ages 21-24		53.50%	54.50%	55.60%	↓	↓	↓
Total – Ages 16-24		45.80%	45.40%	46.10%	↓	↓	↓
Controlling High Blood Pressure							
	Hybrid	48.20%	51.50%	47.30%	↓	↓	↓
Initiation in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	Admin	46.40%	50.80%	49.00%	↑	↑	↑
Ages 18 and older		37.70%	41.30%	40.90%	↓	↑	↑
Total – Ages 13 and older		38.90%	42.60%	42.10%	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence							
Ages 13-17	Admin	26.80%	31.00%	32.50%	↑	↑	↑
Ages 18 and older		10.70%	12.10%	12.20%	↑	↑	↑
Total – Ages 13 and older		12.90%	14.80%	15.20%	↑	↑	↑
Weight Assessment/BMI for Children and Adolescents							
Ages 3-11	Hybrid	48.90%	44.30%	33.70%	↓	↓	↓
Ages 12-17		48.10%	47.30%	36.60%	↓	↓	↓

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
Total – Ages 3-17		48.60%	45.30%	34.70%	↓	↓	↓
Counseling for Nutrition for Children and Adolescents							
Ages 3-11	Hybrid	50.60%	50.80%	47.40%	↓	↓	↓
Ages 12-17		45.70%	47.00%	46.00%	↓	↓	↓
Total – Ages 3-17		49.10%	49.50%	46.90%	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents							
Ages 3-11	Hybrid	43.30%	43.50%	39.60%	↓	↓	↓
Ages 12-17		48.30%	50.60%	53.10%	↓	↓	↓
Total – Ages 3-17		44.90%	45.80%	44.00%	↓	↓	↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)							
	Admin	76.30%	73.50%	71.90%	↓	↓	↓
Appropriate Testing for Children with Pharyngitis							
	Admin	55.10%	52.20%	51.60%	↓	↓	↓
Diabetes Monitoring for People with Diabetes and Schizophrenia							
	Admin	65.30%	60.10%	62.90%	↓	↓	↓
Flu Shot or Spray, Ages 18-64 (P4P), CY2015 CAHPS Survey							
	Admin	43.70%	46.10%	47.50%	↑	↑	N/A
Annual Dental Visit							
Ages 2-3	Admin	42.80%	41.20%	40.80%	↑	↑	↑
Ages 4-6		66.20%	65.70%	66.30%	↑	↑	↑
Ages 7-10		70.40%	70.10%	70.70%	↑	↑	↑
Ages 11-14		63.20%	62.80%	62.80%	↑	↑	↑
Ages 15-18		54.10%	53.50%	53.90%	↑	↑	↑
Ages 19-21		34.70%	30.20%	31.50%	↑	↓	↓
Total - Ages 2-21		60.90%	60.00%	60.30%	↑	↑	↑
Smoking or Tobacco Use in last six months, CY2015 CAHPS Survey							
Do you smoke or use tobacco? If yes:	Admin	32.20%	33.50%	37.50%	↓	↓	↑
Often advised to quit smoking or using tobacco by a doctor or other health provider in your plan. (P4P)		79.50%	76.20%	75.70%	↑	↓	↓
Medication to assist with quitting recommended by health provider or discussed		46.10%	43.20%	48.30%	↓	↓	↑
Health provider discussed or provided methods or strategies other than medication to assist with quitting		44.40%	37.50%	38.60%	↑	↓	↓
Well-Child Visits in the First 15 Months of Life							
0 visits	Admin	3.40%	4.20%	N/A	↑^	↑^	N/A
1 visit		3.80%	4.80%	N/A	↑^	↑^	N/A
2 visits		5.20%	6.20%	N/A	↑^	↑^	N/A
3 visits		7.40%	8.30%	N/A	↑^	↑^	N/A
4 visits		10.00%	13.40%	N/A	↓	↑	N/A

HEDIS Measure Aggregated MCO Results for CY2013 - CY2015							
* ↑ indicates HEDIS aggregated results above the national Quality Compass (QC) 50th percentile; ↓ indicates HEDIS aggregated results below the QC 50th percentile. NA indicates no QC comparison available.							
^ HEDIS rates greater than 50th percentile that indicate poor performance							
Measure	Type (Hybrid/Admin)	HEDIS Aggregated Results			Quality Compass 50th Percentile*		
		CY15	CY14	CY13	CY15	CY14	CY13
5 visits		15.10%	18.40%	N/A	↓	↑	N/A
6 or more visits		55.10%	44.70%	N/A	↓	↓	N/A
Medication Management for People with Asthma							
5-11 years of age		29.10%	27.40%	N/A	↑	↑	N/A
12-18 years of age		26.60%	24.10%	N/A	↑	↑	N/A
19-50 years of age	Admin	38.80%	39.60%	N/A	↑	↑	N/A
51-64 years of age		55.10%	53.00%	N/A	↑	↑	N/A
Total - Ages 5-64		29.90%	28.10%	N/A	↓	↓	N/A
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication							
Initiation Phase	Admin	50.70%	48.00%	N/A	↑	↑	N/A
Continuation & Maintenance Phase		61.20%	54.80%	N/A	↑	↑	N/A
Adult BMI							
	Hybrid	77.60%	72.20%	N/A	↓	↓	N/A

Appendix B: Budget Neutrality Summary – DY1-DY4

DY Limit	102.00%	101.50%	101.00%	100.50%
DY Actual Limit	92.29%	85.51%	75.20%	87.24%
ALL MEGS	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$2,385,761,238	$2,596,087,408	$2,774,859,542	$2,939,589,998
Eligible Member Months	3,923,495	4,274,950	4,613,313	4,440,125
PMPY Cost	$56,232.03	$53,821.72	$48,903.51	$58,599.77
Limit	$60,932.12	$62,941.20	$65,030.36	$67,172.96
Variance	$4,700.09	$9,119.48	$16,126.85	$8,573.19
Variance %	7.71%	14.49%	24.80%	12.76%

MEG 1-ABD/SD DUAL	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$50,181,934	$44,791,332	$48,646,801	$20,828,437
Eligible Member Months	211,179	225,578	247,202	96,983
PMPY Cost	$950.45	$794.68	$798.77	$849.96
Limit	$771.32	$771.32	$771.32	$771.32
Variance	($179.13)	($23.36)	($27.45)	($78.64)
Variance %	(-23.22%)	(-3.03%)	(-3.56%)	(-10.20%)

MEG 2-ABD/SD NON DUA	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$357,988,970	$378,932,390	$376,070,764	$434,896,724
Eligible Member Months	347,731	366,838	443,060	433,643
PMPY Cost	$4,116.34	$4,131.94	$3,497.32	$4,018.55
Limit	$4,288.64	$4,371.00	$4,454.92	$4,540.44
Variance	$172.30	$239.06	$957.60	$521.89
Variance %	4.02%	5.47%	21.50%	11.49%

MEG 3-ADULTS	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$214,654,298	$279,284,904	$292,301,070	$330,339,542
Eligible Member Months	388,650	496,340	601,789	633,099
PMPY Cost	$2,191.88	$2,251.61	$1,956.26	$2,091.89
Limit	$2,524.20	$2,647.24	$2,776.28	$2,911.60
Variance	$332.32	$395.63	$820.02	$819.71
Variance %	13.17%	14.95%	29.54%	28.15%

MEG 4-CHILDREN	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$497,310,904	$556,789,823	$598,245,118	$655,702,690
Eligible Member Months	2,529,268	2,722,914	2,798,640	2,829,018
PMPY Cost	$786.41	$817.78	$856.39	$927.59
Limit	$873.88	$897.20	$921.16	$945.76
Variance	$87.47	$79.42	$64.77	$18.17
Variance %	10.01%	8.85%	7.03%	1.92%

MEG 5-DD WAIVER	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$396,128,466	$422,167,011	$469,367,237	$482,409,399
Eligible Member Months	104,597	108,672	130,346	107,803
PMPY Cost	$15,149.20	$15,541.71	$14,589.68	$17,904.09
Limit	$15,492.00	$15,663.96	$15,837.84	$16,013.64
Variance	$342.80	$122.25	$1,248.16	($1,890.45)
Variance %	2.21%	0.78%	7.88%	(-11.81%)

MEG 6-LTC	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$680,449,080	$745,275,470	$818,503,721	$834,845,120
Eligible Member Months	260,945	267,638	285,467	254,579
PMPY Cost	$10,431.51	$11,135.16	$11,575.02	$13,118.87
Limit	$13,954.44	$14,561.36	$15,194.64	$15,855.48
Variance	$3,522.93	$3,426.20	$3,619.62	$2,736.61
Variance %	25.25%	23.53%	23.82%	17.26%

MEG 7-MN DUAL	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$17,486,433	$15,009,979	$10,287,124	$8,860,767
Eligible Member Months	14,453	18,149	20,561	16,231
PMPY Cost	$4,843.94	$3,356.00	$2,032.11	$2,185.52
Limit	$5,520.40	$5,760.48	$6,011.00	$6,242.44
Variance	$676.46	$2,404.48	$3,978.89	$4,056.92
Variance %	12.25%	41.74%	66.19%	64.99%

MEG 8-MN NON DUAL	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$21,695,232	$24,648,491	$20,570,558	$25,066,878
Eligible Member Months	13,460	16,948	16,829	15,550
PMPY Cost	$6,483.52	$5,827.24	$4,866.95	$6,463.66
Limit	$7,143.44	$7,454.12	$7,778.32	$8,116.60
Variance	$659.92	$1,626.88	$2,911.37	$1,652.94
Variance %	9.24%	21.83%	37.43%	20.36%

MEG 9-WAIVER	**DY1T**	**DY2T**	**DY3T**	**DY4T**
Total Expenditures	$149,865,920	$129,188,008	$140,867,148	$146,640,443
Eligible Member Months	53,212	51,873	69,419	53,219
PMPY Cost	$11,278.77	$9,965.60	$8,731.00	$11,039.64
Limit	$10,363.80	$10,814.52	$11,284.88	$11,775.68
Variance	($914.97)	$848.92	$2,553.88	$736.04
Variance %	(-8.83%)	7.85%	22.63%	6.25%

Note: The total expenditures do not reflect expenditures for the HCAIP sub-pool, LPTH/BCCH sub-pool, or DSRIP Pool. See Appendix F for the expenditure summary for these funding pools.

Appendix C: Budget Neutrality Member Months Projections – DY5-DY6

Without Waiver (WOW) Member Months Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	199,563	200,560
ABD/SD Non Dual	342,458	344,170
Adults	599,794	602,793
Children	2,782,231	2,796,142
DD Waiver	106,104	106,635
LTC	252,851	254,115
MN Dual	14,703	14,777
MN Non Dual	13,300	13,366
Waiver	45,277	45,503
Total	**4,356,280**	**4,378,062**

With Waiver (WW) Member Months Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	199,563	200,560
ABD/SD Non Dual	342,458	344,170
Adults	599,794	602,793
Children	2,782,231	2,796,142
DD Waiver	106,104	106,635
LTC	252,851	254,115
MN Dual	14,703	14,777
MN Non Dual	13,300	13,366
Waiver	45,277	45,503
Total	**4,356,280**	**4,378,062**

Note: The WOW and WW member months for DY5 and DY6 shown above were projected based on the projected CY2017 enrollment as part of CY2017 capitation rate development.

Appendix D: Budget Neutrality Per Member Per Month Projections – DY5-DY6

Without Waiver (WOW) Cost PMPM Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	$ 192.83	$ 192.83
ABD/SD Non Dual	$ 1,156.90	$ 1,179.11
Adults	$ 763.38	$ 800.59
Children	$ 242.75	$ 249.23
DD Waiver	$ 4,047.85	$ 4,092.78
LTC	$ 4,136.26	$ 4,316.15
MN Dual	$ 1,636.31	$ 1,707.48
MN Non Dual	$ 2,117.40	$ 2,209.49
Waiver	$ 3,071.96	$ 3,205.57
Total	**$ 742.51**	**$ 766.96**

With Waiver (WW) Cost PMPM Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	$ 244.00	$ 268.35
ABD/SD Non Dual	$ 1,207.84	$ 1,328.44
Adults	$ 516.45	$ 568.38
Children	$ 220.90	$ 243.11
DD Waiver	$ 4,695.44	$ 4,995.68
LTC	$ 3,487.80	$ 3,758.44
MN Dual	$ 593.27	$ 642.52
MN Non Dual	$ 1,824.22	$ 1,995.70
Waiver	$ 2,900.76	$ 3,148.46
Total	**$ 672.85**	**$ 731.06**

Notes:

1. The WOW cost PMPMs shown above for DY5 came from the approved 1115 waiver document and the WOW cost PMPMs for DY6 were projected based on DY1-DY5 WOW cost PMPMs by MEG included in the approved 1115 waiver document.
2. The WW cost PMPMs shown above for DY5 and DY6 were estimated based on the original CY2017 capitation rates before mid-year adjustment and the anticipated rate changes for CY2017 mid-year (Jul-Dec 2017) and CY2018 (DY6).

Appendix E: Budget Neutrality Expenditure Projections – DY5-DY6

Without Waiver (WOW) Expenditure Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	$ 38,481,653	$ 38,674,062
ABD/SD Non Dual	$ 396,189,819	$ 405,814,204
Adults	$ 457,870,930	$ 482,589,858
Children	$ 675,386,480	$ 696,877,933
DD Waiver	$ 429,493,752	$ 436,432,670
LTC	$ 1,045,855,497	$ 1,096,796,794
MN Dual	$ 24,059,415	$ 25,231,332
MN Non Dual	$ 28,161,093	$ 29,532,780
Waiver	$ 139,087,813	$ 145,862,850
Total	**$ 3,234,586,452**	**$ 3,357,812,483**

With Waiver (WW) Expenditure Projections

	2017(DY5)	2018(DY6)
ABD/SD Dual	$ 48,692,605	$ 53,819,666
ABD/SD Non Dual	$ 413,634,597	$ 457,208,345
Adults	$ 309,765,848	$ 342,615,849
Children	$ 614,596,411	$ 679,773,640
DD Waiver	$ 498,206,209	$ 532,712,905
LTC	$ 881,891,680	$ 955,074,463
MN Dual	$ 8,723,113	$ 9,494,576
MN Non Dual	$ 24,261,856	$ 26,675,188
Waiver	$ 131,336,521	$ 143,264,371
Total	**$ 2,931,108,841**	**$ 3,200,639,003**

Note: The expenditure projections do not reflect expenditures for the HCAIP sub-pool, LPTH/BCCH sub-pool, or DSRIP Pool. See Appendix F for the expenditure summary for these funding pools.

Appendix F: Funding Pool Expenditure Summary

	DY1 (Actual)	DY2 (Actual)	DY3 (Actual)	DY4 (Actual)	DY5 (Projected)	DY6 (Projected)
UC Pool - HCAIP	$ 40,984,339	$ 40,605,156	$ 40,929,060	$ 40,962,305	$ 41,000,000	$ 41,000,000
UC Pool - LPTH/BCCH	$ 39,856,548	$ 39,856,548	$ 29,892,411	$ 19,856,550	$ 9,856,550	$ 9,856,550
DSRIP	$ -	$ -	$ 3,020,859	$ 14,281,016	$ 30,000,000	$ 30,000,000

Appendix G: 2016 KanCare Evaluation Annual Report

[See following page.]

2016 KanCare Evaluation Annual Report

Year 4, January - December 2016

KFMC Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**March 31, 2017**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist** **Lynne Valdivia, BSN, RN, MSW, CCEP, Vice President Quality Improvement and Review**

Prepared for:

KanCare

Table of Contents

2016 KanCare Evaluation Annual Report

Year 4, January – December 2016

List of Tables

2016 KanCare Evaluation Annual Report
Year 4, January-December 2016
March 31, 2017

Background

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

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

Goals

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

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

Hypotheses

The evaluation will test the following KanCare hypotheses:

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

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

Performance Objectives

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

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

Evaluation Plan

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

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

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

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

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

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

Data for the performance measures are provided by the Kansas Department of Health and Environment, Division of Healthcare Finance (KDHE-DHCF) and the Kansas Department for Aging and Disability Services (KDADS). Data sources include state tracking systems and databases, as well as

reports from the MCOs providing KanCare/Medicaid services. In calendar year (CY) 2013 through CY2017, the three MCOs are Amerigroup Kansas, Inc. (Amerigroup or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC).

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

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

Annual Evaluation 2016

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

This fourth annual KanCare Evaluation includes analysis of performance for several measures that have pre-KanCare data, CY2013 through CY2015, and CY2016 available as of 3/10/2017. Data for CY2016 for many of the performance measures are not yet available. A major reason is that data for the entire year cannot be determined accurately until claims for the year, including fourth quarter CY2016 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for 2016 will not be available until July 2017. Some of the HEDIS measures are multi-year measures; for these measures, baseline data for 2013 and 2014 are first reported in the KanCare Annual Evaluation for 2015.

In addition to the measures reviewed annually, there are several measures reviewed quarterly that are briefly summarized in this report. These quarterly measures are analyzed and summarized in detail in the KanCare Evaluation Quarterly Reports, beginning in Quarter 4 (Q4) CY2013, that are available for public review on the KanCare website.

Quality of Care

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

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

(1) Physical Health

The Physical Health performance measures include 18 HEDIS measures:

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

Other Physical Health measures include Well-Child Visits (four or more) within the First Seven Months of Life (HEDIS-like measure) and Preterm Delivery.

The baseline data for most HEDIS and HEDIS-like measures are HEDIS 2014 (CY2013) administrative and hybrid data from claims and medical record review. (The baseline for multi-year measures is HEDIS 2015, including data from CY2013 and CY2014.) Administrative HEDIS data include all KanCare members from each MCO who met HEDIS eligibility criteria for each measure. Since these measures include all eligible members, the numerators and denominators for the three MCOs were combined to assess the aggregate baseline

percentages. Hybrid HEDIS data are based on samples of eligible members and include both administrative data and medical record review. As the hybrid HEDIS data are based on samples from each MCO, the aggregate data for hybrid measures were weighted to adjust for any differences in population and sample sizes.

The aggregated HEDIS percentages were compared to National Committee for Quality Assurance (NCQA) Quality Compass (QC) percentiles for HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. HEDIS results, including comparison to QC national percentiles, are summarized in Table 2. Beginning with HEDIS 2015, QC percentile categories were expanded to report the 33.33rd and 66.67th percentiles. As a result, comparisons with previous years' reported percentiles may not be directly comparable; a metric reported for CY2013 as below the 50th percentile (and above the 25th percentile) may in CY2014 be reported as below the 33.33rd percentile but not represent a percentile drop.

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015

Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile		
	CY2015	CY2014	CY2013	CY2015	CY2014	CY2013
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
Ages 20-44	**83.7%**	84.3%	85.4%	↑	↑	↑
Ages 45-64	**92.3%**	92.4%	92.2%	↑	↑	↑
Ages 65 and older	**89.7%**	88.6%	89.5%	↑	↑	↑
Total - Ages 20 and older	**87.1%**	87.5%	88.4%	↑	↑	↑
Annual Dental Visit (ADV)						
Ages 2-3	**42.8%**	41.2%	40.8%	↑	↑	↑
Ages 4-6	**66.2%**	65.7%	66.3%	↑	↑	↑
Ages 7-10	**70.4%**	70.1%	70.7%	↑	↑	↑
Ages 11-14	**63.2%**	62.8%	62.8%	↑	↑	↑
Ages 15-18	**54.1%**	53.5%	53.9%	↑	↑	↑
Ages 19-21	**34.7%**	30.2%	31.5%	↑	↓	↓
Total - Ages 2-21	**60.9%**	60.0%	60.3%	↑	↑	↑
Adolescent Well Care Visits (AWC)						
	43.0%	42.6%	42.3%	↓	↓	↓
Controlling High Blood Pressure (CBP)						
	48.2%	51.5%	47.3%	↓	↓	↓
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	**84.9%**	84.8%	83.1%	↓	↓	↓
Eye Exam (Retinal)	**62.5%**	58.6%	50.1%	↑	↑	↓
Medical Attention for Nephropathy	**89.2%**	76.8%	75.8%	↑	↓	↓
HbA1c Control (<8.0%)	**46.6%**	39.3%	39.0%	↓	↓	↓
HbA1c Poor Control (>9.0%) (lower % is goal)	**45.4%**	52.9%	54.4%	↓	↓	↓
Blood Pressure Control (<140/90)	**58.8%**	52.6%	53.1%	↓	↓	↓

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015 (Continued)						
Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile		
	CY2014		CY2013	CY2015	CY2014	CY2013
Chlamydia Screening in Women (CHL)						
Ages 16-20	**41.3%**	41.0%	42.4%	↓	↓	↓
Ages 21-24	**53.5%**	54.5%	55.6%	↓	↓	↓
Total – Ages 16-24	**45.8%**	45.4%	46.1%	↓	↓	↓
Appropriate Testing for Children with Pharyngitis (CWP)						
	55.1%	52.2%	51.6%	↓	↓	↓
Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH)						
	62.8%	56.2%	61.0%	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)						
Ages 13-17	**46.4%**	50.8%	49.0%	↑	↑	↑
Ages 18 and older	**37.7%**	41.3%	40.9%	↓	↑	↑
Total – Ages 13 and older	**38.9%**	42.6%	42.1%	↑	↑	↑
Engagement in Treatment for Alcohol or other Drug Dependence (IET)						
Ages 13-17	**26.8%**	31.0%	32.5%	↑	↑	↑
Ages 18 and older	**10.7%**	12.1%	12.2%	↑	↑	↑
Total – Ages 13 and older	**12.9%**	14.8%	15.2%	↑	↑	↑
Annual Monitoring for Patients on Persistent Medications (MPM)						
	90.2%	89.7%	84.9%	↑	↑	↓
Prenatal Care (PPC)						
	67.4%	70.4%	71.4%	↓	↓	↓
Postpartum Care (PPC)						
	57.5%	55.8%	60.3%	↓	↓	↓
Appropriate Treatment for Children with Upper Respiratory Infection (URI)						
	76.3%	73.5%	71.9%	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)						
	62.8%	62.1%	60.8%	↓	↓	↓
Weight Assessment/BMI for Children and Adolescents (WCC)						
Ages 3-11	48.9%	44.3%	33.7%	↓	↓	↓
Ages 12-17	48.1%	47.3%	36.6%	↓	↓	↓
Total – Ages 3-17	48.6%	45.3%	34.7%	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)						
Ages 3-11	50.6%	50.8%	47.4%	↓	↓	↓
Ages 12-17	45.7%	47.0%	46.0%	↓	↓	↓
Total – Ages 3-17	49.1%	49.5%	46.9%	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)						
Ages 3-11	43.3%	43.5%	39.6%	↓	↓	↓
Ages 12-17	48.3%	50.6%	53.1%	↓	↓	↓
Total – Ages 3-17	44.9%	45.8%	44.0%	↓	↓	↓

Table 2. Physical Health HEDIS Measures, CY2013 - CY2015 (Continued)					
Measure	HEDIS Aggregated Results			Quality Compass 50th Percentile	
Multi-Year HEDIS Measures Reported Beginning in CY2014 (HEDIS 2015)					
	CY2015	CY2014		CY2015	CY2014	CY2013
Adult BMI Assessment (ABA)					
	77.6%	72.2%		↓	↓	
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	50.7%	48.0%		↑	↑	
Continuation & Maintenance Phase	61.2%	54.8%		↑	↑	
Medication Management for People with Asthma (MMA)					
5-11 years of age	29.1%	27.4%		↑	↑	
12-18 years of age	26.6%	24.1%		↑	↑	
19-50 years of age	38.3%	39.6%		↑	↑	
51-64 years of age	55.1%	53.0%		↑	↑	
Total - Ages 5-64	29.9%	28.1%		↓	↓	
Well-Child Visits in the First 15 Months of Life (W15)					
0 visits	3.4%	4.2%		↑*	↑*	
1 visit	3.8%	4.8%		↑*	↑*	
2 visits	5.2%	6.2%		↑*	↑*	
3 visits	7.4%	8.3%		↑*	↑*	
4 visits	10.0%	13.4%		↑	↑	
5 visits	15.1%	18.4%		↓	↑	
6 or more visits	55.1%	44.7%		↓	↓	
* HEDIS rates greater than 50th percentile that indicate poor performance						

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

HEDIS measures

Adults' Access to Preventive/Ambulatory Health Services (AAP)

Population: Ages 20-44; 45-65; 65 and older; Medicaid

Analysis: Annual comparison to CY2013 baseline, trending over time

This measure tracks annual preventive/ambulatory visits. In each of the age ranges, the aggregate HEDIS results for CY2013 through CY2015 were above the QC 50th percentile; for ages 45-64 the results were again above the QC 90th percentile and for ages 20 and older continue to be above the QC 75th percentile. Pre-KanCare data were available for ages 20-44 and ages 45-64.

- **Ages 20-44 -** The KanCare aggregate rate based on administrative data for CY2015 was 83.7%, lower than in CY2014 (84.3%) and CY2013 (85.4%) but above the QC 75th percentile. SSHP was above the 75th percentile in all three years. In CY2012, the aggregate pre-KanCare percentage was slightly higher at 86.1%.

- **Ages 45-64 -** The KanCare aggregate rate based on administrative data for CY2015 (92.3%) was comparable to CY2014 (92.4%) and CY2013 (92.2%) and above the QC 90th percentile in all three years. In CY2012, the aggregate pre-KanCare percentage was lower at 87.8%.
- **Ages 65 and older -** The KanCare aggregate rate based on administrative data for CY2015 was 89.7%, higher than in CY2014 (88.6%) and comparable to CY2013 (89.5%). Rankings for all three MCOs were above the QC 66.67th percentile. (Pre-KanCare data were not reported by the MCOs for CY2012 for those ages 65 and older.)
- **Total – Ages 20 and older -** The KanCare aggregate rate based on administrative data for CY2015 was 87.1%, comparable to CY2014 (87.5%) and lower than in CY2013 (88.4%), and above the QC 75th percentile in all three years..

Annual Dental Visit (ADV) (P4P 2016)
Population: Medicaid and CHIP combined populations, Ages 2-3; Ages 4-6; Ages 7-10; Ages 11-14; Ages 15-18; Ages 19-21; Total (Ages 2-21)
Analysis: Annual comparison to CY2013 baseline and trending over time
In CY2015, aggregate administrative HEDIS rates for each age range were above the QC 50th percentile.

- **Ages 2-3** – 42.8% in CY2015 (>66.67th QC percentile), higher than 41.2% in CY2014 (>50th QC percentile) and 40.8% in CY2013 (>50th QC percentile).
- **Ages 4-6** – 66.2% in CY2015, higher than CY2014 (65.7%) and comparable to CY2013 (66.3%).
- **Ages 7-10** – 70.4% in CY2015, comparable to CY2014 (70.1%) and CY2013 (70.7%).
- **Ages 11-14** – 63.2% in CY2015, slightly above CY2014 (62.8%) and CY2013 (62.8%).
- **Ages 15-18** – 54.1% in CY2015, slightly above CY2014 (53.5%) and CY2013 (53.9%).
- **Ages 19-20** – 34.7% in CY2015 (>50th QC percentile), an increase from CY2014 (30.2%; <50th QC percentile) and 31.5% (<50th QC percentile).
- **Total - Ages 2-20** – 60.9% in CY2015 (>75th QC percentile for all three MCOs), comparable to 60.0% in CY2014 (>66.67th QC percentile for all three MCOs) and 60.3% in CY2013 (>50th QC percentile).

Adolescent Well Care Visits (AWC)
Population: Ages 12-21; Medicaid and CHIP combined populations
Analysis: Annual comparison to CY 2013 baseline and trending over time
(*AWC is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 43.0%, comparable to CY2014 (42.6%) and CY2013 (42.3%), and below the QC 50th percentile. Results for all three MCOs were below the QC 50th percentile; AGP again had the lowest result, 40.6%, which was below the QC 25th percentile.

Controlling High Blood Pressure (CBP)
Population: Medicaid
Analysis: Annual comparison to CY2013 baseline, trending over time
(*CBP is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)
The aggregate rate based on weighted hybrid data for CY2015 was 48.2% (below the QC 33.33rd percentile), a decrease compared to 51.5% in CY2014 (below the QC 33.33rd percentile), and an increase compared to CY2013 (47.3%; below the QC 25th percentile).

Comprehensive Diabetes Care (CDC)

This measure is a composite HEDIS measure composed of eight metrics. Five of these metrics are Kansas pay-for-performance (P4P) measures. In CY2013 through CY2015, the three MCOs reported hybrid data for seven of the eight measures. The eighth measure, glycated hemoglobin (HbA1c) <7.0% has a more limited eligibility; only two of the three MCOs reported HEDIS results for CY2014.

Population: Ages 18-75; Medicaid

Analysis: Pre-KanCare compared to KanCare and trending over time

(*HbA1c Testing and HbA1c Poor Control [>9.0%] are quality measures in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)

- **HbA1c Testing** (P4P 2014-2016) **-** The aggregate rate based on weighted hybrid data for CY2015 was 84.9%, comparable to CY2014 (84.8%) and higher than CY2013 (83.1%) and CY2012 pre-KanCare (76.5%). All three MCOs in CY2015 were below the QC 50th percentile.
- **Eye Exam (Retinal)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 62.5%, above the QC 75th percentile, and higher than CY2014 (58.6%; above the QC 50th percentile) and CY2013 (50.1%; below the QC 50th percentile). Rates in CY2013 to CY2015 were higher than in CY2012 (41.7%). In CY2015, SSHP and UHC rates were above the QC 75th percentile, and AGP's rate was above the QC 50th percentile.
- **Medical Attention for Nephropathy** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 89.2%, which was higher than in CY2014 (76.8%), CY2013 (75.8%), and CY2012 (66.3%), but below the QC 33.33rd percentile due to high national rates for this metric. The MCO rates in CY2015 ranged from 85.9% (<25th QC percentile) to 92.5% (>75th QC percentile).
- **HbA1c Control (<8.0%)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 46.6%. Though below the QC 50th percentile, the CY2015 rates were 7.3% higher than CY2014 (39.3%) and higher than CY2013 (39.0%) and CY2012 (16.0%). Rates and QC percentile ranks for all three MCOs increased in CY2015: AGP's rate increased 5.2% (49.3%; >50th QC percentile); SSHP's rate increased 5.5% (45.6%; <50th QC percentile); and UHC's percentage increased 16.7% (43.0%; <50th QC percentile).
- **Blood Pressure Control (<140/90)** (P4P 2014-2016) - The aggregate rate based on weighted hybrid data for CY2015 was 58.8%, which was above the rates in CY2014 (52.6%) and CY2013 (53.1%). QC ranking increased from below the QC 25th percentile to above the 33.33rd percentile. AGP's rate was above the QC 50th percentile; SSHP's and UHC's rates were below the QC 50th percentile.
- **HbA1c Poor Control (>9.0%)** – For this metric, the goal is to have a lower rate and lower QC percentile. The aggregate rate based on weighted hybrid data for CY2015 was 45.4%, an improvement compared to CY2014 (52.9%), CY2013 (54.4%), and CY2012 (83.4%) and was below the QC 50th percentile (i.e., nationally less than 50% had lower percentages of eligible members with HbA1c >9.0%). SSHP's and UHC's rates were below the 50th percentile; AGP's percentage (49.3%) was higher and was above the QC 50th percentile.

Appropriate Testing for Children with Pharyngitis (CWP)

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline and trending over time

The aggregate rate based on administrative data for CY2015 was 55.1% (<10th QC percentile), up from 52.2% in CY2014 and 51.6% in CY2013 (51.6%).

Chlamydia Screening in Women (CHL)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
(*CHL is a quality measure in the CMS Adult and Child 2017 Core Sets of Health Care Quality Measures for Medicaid*.)
The CY2015 and CY2014 aggregate rates and by age group were comparable and slightly lower than those of CY2013. Rates in CY2015 in total and for both age groups were below the QC 25th percentile for all three MCOs.

- **Ages 16-20** – 41.3% in CY2015; 41.0% in CY2014; 42.4% in CY2013.
- **Ages 21-24** – 53.5% in CY2015; 54.5% in CY2014; 55.6% in CY2013.
- **Total – Ages 16-24** – 45.8% in CY2015; 45.4% in CY2014; 46.1% in CY2013.

Follow-up after Hospitalization for Mental Illness, within seven days of discharge (FUH) (P4P 2014-2015)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time
(*FUH is a quality measure in the CMS Adult, Child, and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 62.8%, higher than in CY2014 (56.2%) and CY2013 (61.0%). SSHP's rate (67.2%) and UHC's rate (67.7%) were both above the QC 90th percentile in CY2015; AGP's rate (54.3%) was above the 66.67th percentile.

Initiation and Engagement in Treatment for Alcohol or other Drug Dependence (IET)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline, trending over time
(*IET is a quality measure in the CMS Adult and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)

- **Initiation in Treatment**
  The CY2015 aggregate HEDIS rates for the total eligible KanCare population and for both age strata were lower than rates in CY2014 and CY2013.
  - **Ages 13-17** - The aggregate rate based on administrative data for CY2015 was 46.4% (>50th QC percentile) and below CY2014 (50.8%) and CY2013 (49.0%). Rankings in CY2013 and CY2014 were above the 75th percentile. SSHP's rate in CY2015 (41.7%) was below the 50th percentile and was a drop of 13.6%. AGP's rate was >50th QC percentile and decreased 4.7%. UHC's rate increased 5.4% and was >75th QC percentile.
  - **Age 18 and older** - The aggregate rate based on administrative data for CY2015 was 37.7% (below the QC 50th percentile), dropping from 41.3% in CY2014 (>66.67th QC percentile) and 40.9% in CY2013 (>50th QC percentile). AGP's and UHC's rates were below the QC 50th percentile after being >75th (AGP) and >50th (UHC) QC percentiles in CY2014. SSHP's rate was >50th QC percentile, down from >75th QC percentile in CY2014.
  - **Total – Age 13 and older** - The aggregate rate based on administrative data for CY2015 was 38.9% (>50th QC percentile for all three MCOs), a decrease from 42.6% in CY2014 (>75th QC percentile) and 42.1% in CY2013.
- **Engagement in Treatment**
  The CY2015 aggregate HEDIS rate for the total population decreased from CY2014 and CY2013, but was above the QC 66.67th percentile. It should be noted, however, that the national HEDIS rates for engagement in treatment are not very high; although the total results for the KanCare population

in CY2015 were above the QC 66.67th percentile, only 12.9% of eligible members ages 13 and older were engaged in treatment.

- **Ages 13-17** - The aggregate rate based on administrative data for CY2015 was 26.8% (>90th QC percentile), a decrease from CY2014 (31.0%) and CY2013 (32.5%).
- **Age 18 and older** - The aggregate rate based on administrative data was only 10.7% in CY2015, a decrease from 12.1% in CY2014 and 12.2% in CY2013, but above the QC 50th percentile in all three years.
- **Total – Ages 13 and older** - The aggregate rate based on administrative data for CY2015 was 12.91%, a decrease from 14.8% in CY2014 (> QC 66.67th percentile in CY2014 and CY2015), and a decrease compared to 15.2% in CY2013 (>75th QC percentile).

Annual Monitoring for Patients on Persistent Medications (MPM) (P4P 2014-2016)
Population: Medicaid, Age 18 and older
Analysis: Annual comparison to CY2013 baseline, trending over time
(*MPM is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)
The aggregate rate based on administrative data for CY2015 was 90.2%, comparable to CY2014 (89.7%) and above the QC 75th percentile in both years. This is an improvement compared to CY2013 (84.9%) where all three MCOs' percentages were below the QC 50th percentile.

Prenatal and Postpartum Care (PPC) (P4P – Prenatal Care 2016)
Population: Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time
(*PPC- Prenatal Care is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*. *PPC – Postpartum Care is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid*.)

- **Prenatal Care** - The aggregate rate based on weighted hybrid data for CY2015 was 67.4%, a decrease compared to CY2014 (70.4%) and CY2013 (71.4%) and below the QC 25th percentile in all three years. SSHP had the highest rate in CY2015 (71.8%); rates for AGP (65.4%) and UHC (64.7%) were below the QC 10th percentile. This measure is a P4P measure beginning in CY2016. The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 57.9%.
- **Postpartum Care** - The aggregate rate based on weighted hybrid data for CY2015 was 57.5%, above the CY2014 rate (55.8%) and below CY2013 (58.5%). The rates were below the QC 50th percentile all three years. The CY2012 hybrid percentage available from one of the pre-KanCare MCOs was lower at 54.8%.

Appropriate Treatment for Children with Upper Respiratory Infection (URI)
Population: Medicaid and CHIP combined populations
Analysis: Annual comparison to CY2013 baseline and trending over time
The aggregate rate based on administrative data for CY2015 was 76.3% (<25th QC percentile), up from 73.5% in CY2014 and 71.9% in CY2013 (71.9%).

Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)
Population: Ages 3-6; Medicaid and CHIP combined populations
Analysis: Pre-KanCare compared to KanCare and trending over time
(*W34 is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

The aggregate rate based on administrative data for CY2015 was 62.8%, a slight increase over CY2014 (62.1%), higher than in CY2013 (60.8%), but lower than in CY2012 (65.4%). The aggregate rates in CY2013 through CY2015 were below the QC 25th percentile.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)

Population: Medicaid and CHIP combined populations, ages 3-17.
Analysis: Annual comparison to CY2013 baseline and trending over time
(*WCC – Weight Assessment/BMI is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

- **Weight Assessment/BMI**
  The aggregate weighted hybrid HEDIS rates for reporting BMI (Body Mass Index) have increased from CY2013 to CY2015 but have remained below the QC 25th percentile.
  - **Ages 3-11** – 48.9% in CY2015; 44.3% in CY2014; 33.7% in CY2013.
  - **Ages 12-17** – 48.1% in CY2015; 47.3% in CY2014; 36.6% in CY2013.
  - **Total – Ages 3-17** – 48.6% in CY2015; 45.3% in CY2014; 34.7% in CY2013.
- **Counseling for Nutrition**
  The CY2015 aggregate weighted hybrid HEDIS rates in total and by age group were below the QC 25th percentile.
  - **Ages 3-11** – 50.6% in CY2015, comparable to 50.8% in CY2014 and above CY2013 (47.4%).
  - **Ages 12-17** – 45.7% in CY2015, lower than CY2014 (47.0%) and comparable to CY2013 (46.0%).
  - **Total – Ages 3-17** – 49.1% in CY2015, comparable to CY2014 (49.5%) and higher than in CY2013 (46.9%).
- **Counseling for Physical Activity**
  The aggregate weighted hybrid HEDIS rate for each age strata (ages 3-11; ages 12-17; and ages 3-17) were below the QC 50th percentile in CY2013 through CY2015.
  - **Ages 3-11** – 43.3% (<25th QC percentile) in CY2015, comparable to 43.5% in CY2014 (<33.33rd QC percentile), higher than in CY2013 (39.6%; <50th QC percentile). AGP had the lowest percentage (37.4%) and UHC had the highest (48.2%).
  - **Ages 12-17** – 48.3% in CY2015, lower than in CY2014 (50.6%) and CY2013 (53.1; AGP had the lowest percentage (42.5%) and SSHP the highest (53.1%).
  - **Total – Ages 3-17** – 44.9% in CY2015, down from 45.8% in CY2014 and higher than in CY2013 (44.0%).

Multi-year HEDIS measures
The eligibility criteria for the following HEDIS measures extend beyond one year. Data reported in for CY2013 and CY2014 serve as baseline for assessing changes in subsequent years.

Adult BMI Assessment (ABA)

Data for this measure are based on aggregate weighted hybrid HEDIS data.
Population: Medicaid and CHIP combined populations age 18 and older
Analysis: Annual comparison to baseline reported in CY2014 and trending over time
(Adult BMI assessment is a quality measure in the CMS 2017 Core Set of Adult Health Care Quality Measures for Medicaid.)
The aggregate rate based on hybrid data for CY2015 was 77.6%, an increase compared to 72.2% in CY2014 was 72.2%, but below the QC 33.33rd percentile.

Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Data are based on aggregate weighted administrative HEDIS data.
Population: Ages 6-12; Medicaid and CHIP combined populations; Children diagnosed with Attention Deficit Hyperactivity Disorder (ADHD)
Analysis: Annual comparison to baselines reported in CY2014 and trending over time
(*ADD is a quality measure in the CMS Child and Behavioral Health 2017 Core Sets of Health Care Quality Measures for Medicaid*.)

- **Initiation Phase** – The aggregate weighted rate in CY2015 was 50.7% (>75th QC percentile), an increase 48.0% in CY2014 (>66.67th QC percentile). UHC had the highest rate (56.6%; >90th QC percentile); SSHP at 54.2% was above the QC 75th percentile; and AGP's 41.2% rate in CY2015 was below the QC 50th percentile.
- **Continuation & Maintenance Phase** – The aggregate weighted rate was 61.2% in CY2015 (>66.67th QC percentile), up from 54.8% in CY2014 (>50th QC percentile). Rates for continuation and maintenance increased for all three MCOs. UHC had the highest rate (67.3%; >90th QC percentile); SSHP at 66.3% was above the 75th percentile; AGP at 50.4% was below the QC 50th percentile, but was a 10% increase compared to CY2014.

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

- **Ages 5-11** – 29.1% in CY2015, up from 27.4% in CY2014, above the QC 50th percentile both years. UHC's rate (31.3%; >66.67th QC percentile) was the highest of the three MCOs, increasing more than 8%. AGP (30.1%) and SSHP (26.7%) were both above the QC 50th percentile.
- **Ages 12-18** – 26.6% in CY2015, an increase compared to 24.1% in CY2014, above the QC 50th percentile both years.
- **Ages 19-50** – 38.3% in CY2015 (>50th QC percentile), an increase compared to 39.6% in CY2014 (> 66.67th QC percentile). UHC had the highest rate (45.7%; >75th QC percentile), and AGP had the lowest (32.2%; <33.33rd QC percentile). SSHP's 38.1% rate was above the QC 50th percentile.
- **Ages 51-64** – 55.1% in CY2015, an increase compared to 53.0% in CY2014, above the QC 66.67th percentile both years.
- **Total (Ages 5-64)** – 29.9% in CY2015, an increase compared to 28.1% in CY2014, below the QC 50th percentile both years. UHC's 31.9% was the highest of the three MCOs (>50th QC percentile). AGP's rate (29.4%) and SSHP's rate (28.9%) were below the QC 50th percentile.

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

(*W15 is a quality measure in the CMS 2017 Core Set of Child Health Care Quality Measures for Medicaid*.)

- **0 visits** – 3.4% in CY2015, an improvement compared to 4.2% in CY2014 (>75th QC percentile both years).
- **1 visit** – 3.8% in CY2015 (>75th QC percentile), an improvement compared to 4.8% in CY2014 (>95th QC percentile).
- **2 visits** – 5.2% in CY2015 (>75th QC percentile), an improvement compared to 6.2% in CY2014 (>90th QC percentile).
- **3 visits** – 7.4% in CY2015 (>75th QC percentile), an improvement compared to 8.3% in CY2014 (>90th QC percentile).
- **4 visits** – 10.0% in CY2015 (>50th QC percentile), a decrease from 13.4% in CY2014 (>75th QC percentile).
- **5 visits** – 15.1% in CY2015 (<33.33rd QC percentile), a decrease from 18.4% in CY2014 (>50th QC percentile).
- **6 or more visits** – 55.1% in CY2015 (<33.33rd QC percentile), an increase from 44.7% in CY2014 (<25th QC percentile).

Additional P4P Physical Health Measures

Well-Child Visits, Four Visits within the First Seven Months of Life (P4P 2014-2015)

For this P4P measure, the MCOs reported the percentage of children who had four or more well-child visits within the first seven months (post-discharge after birth). This measure is HEDIS-like, in that the HEDIS criteria and software for Well-Child Visits within the first 15 months of Life (W15) was adapted to include well-child visits only within the first seven months to allow annual calendar year assessment of progress. Now that multiple years of MCO data are available, progress in completing well-child visits in these first months will be assessed through the Well-Child Visits in the First 15 Months of Life (W15) HEDIS measure.

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline, trending over time

In CY2015, 67.6% of 4,471 infant members born in January through May 2015 had four or more well-child visits by the time they were seven months of age. This was a 6.2% decrease compared to CY2014 (72.1% of 6,442) and comparable to CY2013 (66.9% of 5,824).

Preterm Delivery (P4P 2014-2015)

Population: Medicaid and CHIP combined populations

Analysis: Annual comparison to 2013 baseline, trending over time

Preterm delivery rates in 2013 to Medicaid and CHIP members were the baseline data. Each MCO uses unique systems for tracking preterm delivery. Because of differences in tracking methods and criteria, the preterm delivery rates should not be compared to preterm birth rates reported in vital statistics records of the State or other agencies. MCO preterm delivery rates ranged from 9.8% (SSHP) to 10.7% (AGP). SSHP had the highest improvement, with their preterm delivery rate dropping from 11.4% to 9.8%, a relative decrease of 14% from 2014 to 2015. UHC's preterm delivery rate, which had the largest improvement of the three MCOs from 2013 (10.3%) to 2014 (9.5%), increased to 10.5% in 2015. AGP's preterm delivery rate decreased 5% from 11.3% in 2014 to 10.7% in 2015.

(2) Substance Use Disorder (SUD) Services

The following performance measures are based on National Outcome Measurement System (NOMS) measures for members who are receiving SUD services, including improvement in living arrangements,

reduction in number of arrests, reduction in drug and alcohol use, attendance at self-help meetings, and employment status. Each of these measures is tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

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

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

Table 3. Number and Percent of Members Receiving SUD Services who were in Stable Living Situations at Discharge - Annual Quarterly Average, CY2012 - CY2016

	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members in stable living situations at discharge	199	218	189	183	190
Denominator: Number of KanCare members discharged from SUD services during the reporting period	201	220	190	185	196
Percent of KanCare members in stable living situations at discharge from SUD services	99.0%	99.1%	99.3%	98.7%	96.9%

Data for this measure are tracked and reported quarterly by KDADS. The percentages of members in stable living conditions at time of discharge from SUD services were consistently high throughout CY2012 through CY2016. The high rate, over 96% in each quarter of the four year period, is attributed by KDADS staff to the nature of treatment (active participation and attendance) in conjunction with the time of data collection (on day of discharge from treatment).

The number and percent of members receiving SUD services whose criminal justice involvement improved
The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (annual quarterly average) and whose criminal justice involvements were collected in the KCPC system at both admission and discharge from SUD services (see Table 4). The numerator is the number of members who reported no arrests in the 30 days prior to discharge.

Quarterly rates of those without arrests were over 98% for each quarter of CY2012 through CY2016. This equates to about 1 to 4 arrests per quarter.

Table 4. Number and Percent of Members Receiving SUD Services Whose Criminal Justice Involvement Decreased - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of members without arrests at time of discharge from SUD services	199	219	188	183	193
Denominator: Number of members discharged from SUD services during the reporting period	201	220	190	185	196
Percent of members without arrests during reporting period	99.0%	99.3%	98.9%	98.8%	98.5%

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

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

Table 5. Number and Percent of Members Receiving SUD Services with Decreased Drug and/or Alcohol Use - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of members discharged from SUD services who were abstinent from alcohol and other drugs	191	207	181	173	178
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	190	185	196
Percent of members abstinent from alcohol and other drugs at time of discharge from SUD services	95.3%	94.2%	95.5%	93.3%	90.8%

The quarterly percentages of decreased use of alcohol and other drugs were reported to be above 90% in each quarter of CY2012 through CY2016. The annual quarterly average for CY2016 (90.8%) was the lowest in the last five years.

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

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

The average annual quarterly percentage of attendance of self- help programs has been decreasing since CY2012. The annual quarterly average in CY2016 (39.0%) was the lowest in the five year period from CY2012 to CY2016.

Table 6. Number and Percent of Members Receiving SUD Services Attending Self-help Programs - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members attending self-help programs	121	93	85	73	71
Denominator: Number of KanCare members discharged from SUD services during quarter	201	220	190	185	182
Percent of KanCare members attending self-help programs	59.9%	42.3%	44.5%	39.5%	39.0%

The number and percent of members receiving SUD services whose employment status was improved or maintained (P4P 2014-2016)
The denominator for this measure is the number of members, ages 18 and older at admission to SUD services, (annual quarterly average) who were discharged from SUD services during the measurement period and whose employment status was collected in the KCPC database at discharge from SUD services (see Table 7). The numerator is the number of members who reported at discharge from SUD services that they were employed full-time or part-time.

Table 7. Number and Percent of Members Discharged from SUD Services who were Employed - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare members employed (full-time or part-time)	60	70	80	86	75
Denominator: Number of KanCare members discharged from SUD services during reporting period	201	220	229	206	196
Percent of members employed at discharge from SUD services	29.7%	31.8%	34.7%	41.8%	38.3%

The percentage of members reporting employment at discharge in 2015 (41.8%) was 20.5% higher (7.1 percentage points) than in 2014 (34.7%) In 2016, the percentage employed decreased by 9.1% (3.5 percentage points) compared to 2015.

There are two types of SUD treatment services: outpatient/reintegration and intermediate/residential. In outpatient/reintegration, working is allowed or encouraged, while in intermediate/residential treatment employment is not permitted, which is a major factor in the low percentage employed at discharge from SUD treatment.

(3) Mental Health Services
The following performance measures are based on NOMS for members who are receiving MH services, including adults with SPMI and youth experiencing SED. Measures focus on increased access to services for SPMI adults and SED youth, improvement in housing status for homeless adults, improvement or maintenance of residential status for youth, gain or maintenance of employment status for SPMI

adults, improvement in Child Behavior Checklist (CBCL) Competence scores, and reduction in inpatient psychiatric services. Each of these measures is to be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

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

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

Table 8. Number and Percent of KanCare Adults with SPMI - Annual Quarterly Average, CY2012 - CY2016

	Pre-KanCare	KanCare				
	CY2012	CY2013	CY2014	CY2014	CY2015	CY2016
Numerator: Number of KanCare adults with SPMI	8,051	5,745	5,440	7,515	7,389	6,933
Denominator: Number of KanCare adults	123,656	126,305	131,989	134,843	136,989	143,108
Percent of KanCare adults with SPMI	6.5%	4.5%	4.1%	5.6%	5.4%	4.8%
Adult access rate per 10,000	651.1	454.9	412.2	557.3	539.4	484.5

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data, which allows more accurate trend analysis. The percentage of members identified as SPMI was slightly lower in CY2015 (5.4%) than in CY2014 (5.6%). The CY2016 percentage (4.8%) was lower, but may be incomplete due to claims lag.

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

Table 9. Number and Percent of KanCare Youth Experiencing SED - Annual Quarterly Average, CY2012 - CY2016

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

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data that allows more accurate trend analysis. The percentage of youth identified as SED has been stable for the last three years at 5.2% of youth members.

The number and percent of adults with SPMI who were homeless at the beginning of the reporting period that were housed by the end of the reporting period

The denominator for this measure is the number of KanCare homeless adults with SPMI at the beginning of each quarter. The numerator is the number of KanCare adults with SPMI with improvement in their housing status by the end of the quarter for CY2012 to CY2015 (see Table 10).

Table 10. Number and Percent of Members with SPMI Homeless at the Beginning of the Quarter That were Housed at the End of the Quarter - Annual Quarterly Average, CY2012 - CY2015

	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare adults with SPMI homeless at the beginning of quarter housed at the end of the quarter	69	58	35	46
Denominator: Number of KanCare adults with SPMI homeless at the beginning of the quarter	150	100	70	104
Percentage of adults with SPMI who were homeless at the beginning of the quarter housed by the end of the quarter	45.7%	58.0%	49.1%	44.6%

The annual quarterly average number of adults with SPMI who were homeless at the start of each quarter decreased from an average of 150 in CY2012 to 100 in CY2013 to 70 in CY2014 and then increased again to an annual quarterly average of 104 in CY2015. Compared to CY2012 (45.7%), the average annual quarterly average of those who were housed at the end of each quarter was higher in CY2013 (58.0%) and CY2014 (49.1%), but dropped in CY2015 to 44.6%. No update was available for CY2016.

The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores)

The denominator is the number of youth with prior competence scores within clinical range (score of 40 or less). The numerator is the number of youth with improvement in their most recent competence score (see Table 11).

The numbers of SED/CBS (Community-Based Services) youth with prior competence scores of 40 or less have decreased each year from CY2012 to CY2014. The percentage with improvement in their most recent CBCL score has been relatively comparable in each of these testing periods. CY2015 continues this trend. No update was available for CY2016.

Table 11. Number and Percent of KanCare SED/CBS Youth with Improvement in Their Child Behavior Checklist (CBCL) Scores, CY2012 - CY2015								
	Pre-KanCare		KanCare					
	CY2012		CY2013		CY2014		CY2015	
	S1	S2	S1	S2*	S1	S2	S1	S2
Numerator: Number of KanCare SED/CBS youth with increased total competence score	1313	1170	1466		912	785	958	886
Denominator: Number of KanCare SED/CBS youth with prior competence score less than 40	2,490	2,207	2,796		1,705	1,513	1,804	1,666
Percent of KanCare SED/CBS youth with improvement in their most recent CBCL competence score	52.7%	53.0%	52.4%		53.5%	51.9%	53.1%	53.2%
* No data available								

The number and percent of youth with an SED who experienced improvement in their residential status

The denominator for this measure is the number of KanCare SED youth with unstable living arrangements at the beginning of each quarterly measurement period. The numerator for this measure is the number of KanCare SED youth with improved housing status at the end of the quarterly measurement period (see Table 12).

Table 12. Number and Percent of SED Youth who Experienced Improvement in Their Residential Status - Annual Quarterly Average, CY2012 - CY2015				
	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare SED youth with improved housing status at end of quarter	208	177	142	168
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of quarter	254	219	174	198
Percent of SED youth with improved housing status	81.7%	80.6%	81.3%	84.9%

The annual quarterly average percentage of SED youth with improved housing status in CY2015 (84.9%) was higher than in the CY2012 (81.7%), CY 2013 (80.6%), and CY2014 (81.3%). The quarterly rates in CY2015, however, fluctuated from 82.7% in Q1 to 88.2% in Q2 and 88.9% in Q3, then dropping to 78.8% in Q4. No data were available for CY2016.

The number and percent of youth with an SED who maintained their residential status

The denominator for this measure is the number of KanCare SED youth with stable living arrangements at the beginning of the measurement period. The numerator is the number of KanCare SED youth who maintained a stable living arrangement at the end of the measurement period (see Table 13).

Table 13. Number and Percent of SED Youth who Maintained Their Residential Status - Annual Quarterly Average, CY2012 - CY2015				
	Pre-KanCare	KanCare		
	CY2012	CY2013	CY2014	CY2015
Numerator: Number of KanCare SED youth who maintained a stable living arrangement at end of quarter	5,284	4,554	3,293	4,279
Denominator: Number of KanCare SED youth with stable living arrangements at beginning of quarter	5,568	4,612	3,316	4,328
Percent of SED youth that maintained residential status	94.9%	98.7%	99.3%	98.9%

Rates of maintaining stable living arrangements for SED youth were consistently and strongly high in CY2012 through CY2015. At the end of Q4 CY2012, 99.4% of SED youth had maintained a stable living arrangement, and this rate remained steady throughout CY2015 dropping slightly by Q4 CY2015 to 98.5%. While the percentages have remained stable each year, the reported numbers of youth with stable living arrangements at the beginning of each quarter varied greatly each year; the quarterly average dropped from 5,568 in CY2012 to 4,612 in CY2013 to 3,316 in CY2014, and then increased to a quarterly average of 4,328 in CY2015. No data were available for CY2016.

The number and percent of KanCare members, diagnosed with SPMI, who were competitively employed (P4P 2014-2016)
The denominator for this measure is the number of KanCare adults with SPMI in each measurement period, and the numerator is the number of adults with SPMI who are competitively employed during the measurement period and whose employment status is reported by the CMHC providing services to the members (see Table 14).

Table 14. Number and Percent of KanCare Adults Diagnosed with an SPMI who were Competitively Employed - Annual Quarterly Average, CY2012 - CY2016					
	Pre-KanCare	KanCare			
	CY2012	CY2013	CY2014	CY2015	CY2016
Numerator: Number of KanCare SPMI adults competitively employed	481	382	610	628	567
Denominator: Number of KanCare SPMI adults	3,596	3,100	3,900	3,854	3,562
Percent of SPMI adults competitively employed	13.4%	12.3%	15.6%	16.3%	15.9%

Tracking for this measure is dependent on consistent and complete reporting of data to KDADS by the CMHCs. In CY2015, KDADS implemented policies that have resulted in increased and more complete reporting of this data that allows more accurate trend analysis.

From CY2014 to CY2015, the percentage of SPMI members employed increased by 4.5% (0.7 percentage points) from 15.6% to 16.3%. In 2016, the percentage of SPMI members employed decreased slightly to 15.9%, but may be based on incomplete data due to claims lag.

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

Table 15. Number and Percent of KanCare Members Utilizing Inpatient Services Annual Quarterly Average, CY2012 - CY2015

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

Each year the annual quarterly average rate (per 10,000) of inpatient admissions decreased from 39.9 in CY2012 to 31.9 in CY2013 to 31.2 in CY2014. The low 27.45 average rate in CY2015 is due in part to a significant drop in rates in Q4 to 10.64 per 10,000 due to a statewide change in screening policy that as of October 2015 no longer requires inpatient screens to be completed by CMHC personnel at non-CMHC at non-CMHC locations. This is no longer a P4P performance measure; no additional data are available for CY2016.

(4) Healthy Life Expectancy

Health Literacy
Survey questions for this performance measure are based on questions in CAHPS surveys.

In 2014, although all three MCOs conducted separate surveys of sample populations of adults, general child population (GC), and children with chronic conditions (CCC), two of the MCOs (Amerigroup and UnitedHealthcare) did not sample the Title XIX/Title XXI populations separately. In 2015, all three MCOs administered the CAHPS survey to separate sample populations of Title XIX and Title XXI children using the child survey with CCC module. In 2016, Sunflower did not sample the Title XIX/Title XXI populations separately. Comparisons to calendar years 2015, 2014, and pre-KanCare (2012) and aggregate weighted rates for the three MCOs' Adult, GC, and CC surveys are reported where data are available and where questions were worded the same.

The analysis below is based on the percentage of positive responses as reported in the CAHPS surveys. Table 16 shows percentages of positive responses for CAHPS questions related to physical health. (See Table 23 for questions related to quality of care, Table 30 for questions related to coordination of care, Table 41 for questions related to access to care, and Table 48 for an efficiency-related question.)

Table 16. Healthy Life Expectancy - CAHPS Survey

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last six months, did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?	Adult	**70.1%**	68.0%	71.6%	↓	↓	↓
	GC	**67.3%**	67.1%	70.7%	↓	↓	↓
	CCC	**71.4%**	71.6%	73.3%	↓	↓	↑
In the last six months, did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?	Adult	**50.2%**	52.9%	53.5%	NA	NA	NA
	GC	**33.2%**	33.3%	31.9%	NA	NA	NA
	CCC	**53.2%**	50.7%	51.3%	NA	NA	NA
Did you and a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?	Adult	**93.3%**	91.0%	93.3%	↑	↓	NA
	GC	**96.7%**	94.8%	98.3%	↑	↑	NA
	CCC	**97.8%**	96.7%	98.2%	↑	↑	NA
Did you and a doctor or other health provider talk about the reasons you might not want (your child) to take a medicine?	Adult	**68.9%**	72.3%	73.1%	↑	↑	NA
	GC	**69.4%**	68.0%	77.4%	↑	↑	NA
	CCC	**74.3%**	76.8%	81.5%	↓	↑	NA
When you talked about (your child) starting or stopping a prescription medicine, did a doctor or other health provider ask you what you thought was best for you (your child)?	Adult	**79.4%**	79.5%	75.9%	↑	↑	↓
	GC	**80.6%**	80.0%	77.7%	↑	↑	↑
	CCC	**82.3%**	86.0%	83.5%	↓	↑	↑
In the last six months, how often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?	Adult	**93.0%**	91.8%	91.9%	↑	↑	↑
	GC	**95.2%**	94.9%	95.5%	↑	↑	↑
	CCC	**95.0%**	95.6%	95.3%	↓	↑	↑
In the last six months, how often did your (child's) personal doctor listen carefully to you?	Adult	**91.5%**	91.2%	89.7%	↑	↑	↓
	GC	**94.5%**	95.2%	95.7%	↓	↑	↑
	CCC	**94.6%**	94.9%	94.4%	↓	↑	↑

Table 16. Healthy Life Expectancy - CAHPS Survey (Continued)							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Child Surveys only							
In the last six months, how often did you have your questions answered by your child's doctors or other health providers?	**GC**	**90.0%**	89.3%	89.6%	NA	NA	NA
	CCC	**91.1%**	91.9%	90.9%	NA	NA	NA
In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?	**GC**	**92.5%**	91.4%	91.1%	NA	NA	NA
	CCC	**92.8%**	92.1%	92.4%	NA	NA	NA
Questions on Adult Survey only							
Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?	**Adult**	**43.7%**	46.5%	47.5%	↑	↑	NA
Do you now smoke cigarettes or use tobacco every day, some days, or not at all?	**Adult**	**32.2%**	33.5%	37.6%	↑	↓	↑
In the last six months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?	**Adult**	**79.5%**	76.2%	75.7%	↑	↓	↓
In the last six months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.	**Adult**	**46.1%**	43.2%	48.3%	↓	↓	↑
In the last six months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco?	**Adult**	**44.4%**	37.5%	38.6%	↑	↓	↓

Questions on both adult and child surveys:

In the last 6 months:

- **Did you and a (your child's) doctor or other health provider talk about specific things you could do to prevent illness (in your child)?**
  Results for the aggregate rates for the adult and child surveys were comparable across years (Adult: CY2016 – 70.1%, CY2015 – 68.0%, CY2014 – 71.6%, CY2012 – 70.0%; GC: CY2016 – 67.3%, CY2015 - 67.1%, CY2014 – 70.7%, CY2012 – 68.90%; CCC: CY2016 – 71.4%, CY2015 – 71.6%, CY2014 – 73.3%). The CY2016 Adult rate was below the QC 33.33rd percentile; GC rate was below the QC 25th percentile; and CCC rate was below the QC 10th percentile.
- **Did you and a (your child's) doctor or other health provider talk about starting or stopping a prescription medicine (for your child)?**
  Over half of the adult survey respondents in CY2014 through CY2016 (50.2% - 53.5%) and CCC survey respondents (50.7% - 53.2%) indicated they had talked with a provider about starting or stopping a medication in the previous six months, while closer to one-third of the GC survey

respondents talked with a provider about starting or stopping a prescription medication (31.9% - 33.3%).

If yes:

When you talked about (your child) starting or stopping a prescription medicine,

- **How much did a doctor or other health provider talk about the reasons you might want (your child) to take a medicine?**
  In CY2015, the response options for this question changed from the previous years' responses of "a lot," "some," "a little," and "none" to "yes" and "no." The CY2016 and CY2015 "yes" responses were compared to CY2014's "a lot," "some," and "a little" responses. Results were generally comparable in CY2014 to CY2016 for all populations (Adult: CY2016 – 93.3%, CY2015 – 91.0%, CY2014 – 97.0%; GC: CY2016 – 96.7%, CY2015 – 94.8%, CY2014 – 98.2%; CCC: CY2016 – 97.7%, CY2015 – 96.7%, CY2014 -98.2%).
- **How much did a doctor or other health provider talk about the reasons you might <u>not</u> want (your child) to take a medicine?**
  In CY2015, the response options for this question changed from the previous years' responses of "a lot," "some," "a little," and "none" to "yes" and "no." The CY2016 and CY2015 "yes" responses were compared to CY2014's "a lot," "some," and "a little" responses. While positive response results for all populations were generally comparable between CY2016 and CY2015, they were notably lower than CY2014 results (Adult: CY2016 – 68.9%, CY2015 – 72.3%, CY2014 – 79.2%; GC: CY2016 – 69.4%, CY2015 – 68.0%, CY2014 – 78.2%; CCC: CY2016 – 74.3%, CY2015 – 76.8%, CY2014 – 81.5%). The decrease in CCC rate from 76.8% in CY2015 to 74.3% in CY2015 resulted in a decrease in the QC percentile from above the 75th to below 50th.
- **Did a doctor or other health provider ask you what you thought was best for you (your child)?**
  Results for all CY2016 weighted aggregate results decreased or were comparable to CY2015 in CY2016 (Adult: CY2016 – 79.4%, CY2015 - 79.5%, CY2014 - 75.9%; GC: CY2016 – 80.6%, CY2015 - 80.0%, CY2014 - 77.7%; CCC: CY2016 – 82.3%, CY2015 - 86.0%, CY2014 - 83.5%).

- **How often did your (child's) personal doctor explain things (about your child's health) in a way that was easy to understand?**
  The weighted aggregate rates were generally comparable for all populations in CY2014 through CY2016 (Adults: 91.8 % – 93.0%; GC: 94.9% - 95.5%; CCC: 95.0% - 95.6%).
- **How often did your (child's) personal doctor listen carefully to you?**
  The weighted aggregate rates were comparable for all populations in CY2014 through CY2016 (Adults: 89.7% - 91.5%; GC: 94.5% - 95.7%; CCC: 94.4% - 94.9%).

Questions on child surveys only:

- **In the last 6 months, how often did you have your questions answered by your child's doctors or other health providers?**
  Since CY2014, responses have remained comparable for both child survey populations (GC: 89.3% - 90.0%; CCC: 90.9% - 91.9%).
- **In the last 6 months, how often did your child's personal doctor explain things in a way that was easy for your child to understand?**
  Results were generally comparable in CY2014 through CY2016 for both populations (GC: 91.1% – 92.5%; CCC: 92.1% - 92.8%).

Questions on adult survey only:

Flu shots for adults (P4P 2014-2015)

- **Have you had either a flu shot or flu spray in the nose since July 1, [previous year]?**
  Of those in the adult survey sample, 43.7% in CY2016, 46.5% in CY2015, and 47.5% in CY2014 indicated they received a flu shot or flu spray in the second six months of previous calendar year. All MCO percentages decreased from CY2015. The CY2014 rate serves as the baseline year since the flu shot question was a new CAHPS question in 2014.

Smoking Cessation

- **Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?**
  Rates of adults who reported that they smoke or use tobacco at least some days continued to decrease in all MCO adult populations, with the aggregate weighted adult rate in CY2016 at 32.2% (CY2015 - 33.5%; CY2014 – 37.6%; CY2012 – 37.2%). Members who responded "every day" or "some days" were asked the following questions:
  In the last 6 months,
  - **How often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?** (P4P 2014-2015)
    The weighted aggregate rate continued to improve (CY2016 – 79.5%; CY2015 – 76.2%; CY2014 – 75.7%; CY2012 – 65.5%) and increased to above the QC 50th percentile. Amerigroup had the greatest increase from 73.8% in CY2015 to 83.4% in CY2016. AGP's CY2016 rate was above the QC 90th percentile; SSHP and UHC were above the QC 50th percentile.
  - **How often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.**
    The weighted aggregate rate has fluctuated each year, while remaining above the CY2012 rate (CY2016 -46.1%; CY2015 – 43.2%; CY2014 – 48.3%; CY2012 – 41.5%). The CY2016 rate is below the QC 50th percentile.
  - **How often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.**
    The CY2016 weighted aggregate adult rate of 44.4% (above the QC 50th percentile) increased from the CY2015 rate of 37.5% (less than QC 25th percentile). This was impacted by an increase in AGP's rate from 32.4% in CY2015 to 50.3% in CY2016. UHC's rate also increased from 38.7% in CY2015 to 41.3% in CY2016. SSHP's rate decreased from 42.9% in CY2015 to 40.9% in CY2016.

HEDIS – Healthy Life Expectancy

Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)

Population: Members diagnosed with diabetes and schizophrenia

Analysis: Annual comparison to CY2013 baseline and trending over time

The aggregate rate based on administrative data for CY2015 was 65.3%, up from 60.1% in CY2014 and 62.9% in CY2013. The aggregate rate was below the QC 33.33rd percentile in CY2015. UHC had the highest rate (70.4%), an 11.1% annual increase and moved from below the 25th QC percentile to above the QC 50th percentile. AGP had the lowest rate (61.8%) and was below the QC 25th percentile. SSHP's rate was 66.6% (<50th QC percentile), which was an 11% annual increase.

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

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

Table 17. HEDIS-Like Measures - PD, I/DD, SMI Populations, CY2013 - CY2015

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

* Multi-year measure - CY2014, for example, includes members who were screened in CY2013 or CY2014.

- **Preventive Ambulatory Health Services** (P4P 2014-2015)
  In CY2013 through CY2015, over 94.5% of adult PD, I/DD, SMI members (ages 20-65) were reported to have had an ambulatory preventive care visit during the year. Rates for this subpopulation were higher than rates for all eligible KanCare members in CY2013 (95.6% for PD-I/DD-SMI adults, compared to 88.4% for all KanCare adult members); in CY2014 (95.2% for PD-I/DD-SMI, compared to 87.5% for all KanCare adult members); and in CY2015 (94.9% for PD-I/DD-SMI, compared to 87.1% for all KanCare adult members).
- **Breast Cancer Screening** (P4P 2014-2015) *(CMS 2017 Core Adult Health Care Quality Measure)*
  The breast cancer screening HEDIS measure has eligibility criteria that are multi-year. The numerators for CY2014 and CY2015 include two years of data for members (PD, I/DD, and SMI women ages 52-74) who had mammograms. The numerator for CY2013 includes only one year of data due to 2013 being the first year the MCOs began providing services in Kansas. Due to the multi-year HEDIS criteria, data for 2015 were the first HEDIS data reported by the three MCOs. The breast cancer screening rate reported for the CY2015 PD, I/DD, SMI population (50.5%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (45.0%; <10th QC percentile).
- **Cervical Cancer Screening** (P4P 2014-2015) *(CMS 2017 Core Adult Health Care Quality Measure)*
  The cervical cancer screening measure, as with the breast cancer screening measure, is a multi-year measure. The cervical cancer screening rate reported for the CY2015 PD, I/DD, SMI population (52.1%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (46.9%).
- **Comprehensive Diabetes Care** (P4P 2014-2015)
  The five HEDIS diabetes measures that are P4P for the general KanCare adult population are also P4P measures for KanCare adult members who have an SMI or are receiving I/DD or PD waiver services.

- **HbA1c testing** - *(CMS 2017 Core Adult Health Care Quality Measure)* Rates for PD-I/DD-SMI members were higher than rates for all eligible KanCare members in CY2015 (87.6% for PD-I/DD-SMI, compared to 84.9% for all KanCare adult members), in CY2014 (86.5% for PD-I/DD-SMI, compared to 84.8% for all KanCare adult members), and CY2013 (84.4% for PD-I/DD-SMI adults, compared to 83.1% for all KanCare adult members).
- **HbA1c control <8.0%** - Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%, CY2014 (84.8%), and CY2013 (83.1%).
- **Eye exam (retinal)** - Rates for PD-I/DD-SMI members were higher in CY2015 (66.5%) than in CY2014 (63.7%) and CY2013 (58.7%). Rates for PD-I/DD-SMI members were also higher each year than rates for all eligible KanCare members in CY2015 (62.5%), in CY2014 (58.6%), and in CY2013 (50.1%).
- **Medical attention for nephropathy** – Rates for the PD-I/DD-SMI population and for all eligible KanCare members greatly increased in CY2015 compared to the two previous years. The CY2015 rate for the PD-I/DD-SMI population (90.8%) was 20.7% higher than in CY2014 (75.2%), and was higher than the rate for all eligible KanCare members (89.2%).
- **Blood pressure control <140/90** - The CY2015 rate for PD-I/DD-SMI members (60.2%) was 18% higher than in CY2014 (51.0%) and higher than the rate for all eligible KanCare members (58.8%). In CY2014 and CY2013, the blood pressure control rates for PD-I/DD-SMI members were lower than rates for all eligible KanCare members in CY2014 (51.0% for PD-I/DD-SMI; 52.9% for all KanCare adult members) and in CY2013 (54.0% for PD-I/DD-SMI adults; 54.4% for all KanCare adult members).

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

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

The number and percent of KanCare members receiving PD or TBI waiver services who are eligible for the WORK program who have increased competitive employment (P4P 2014-2015)

This measure compares the number of members receiving PD or TBI waiver services who are enrolled in the Work Opportunities Reward Kansans (WORK) program. The WORK program provides personal services and other services to assist employed persons with disabilities (including PD, TBI, and I/DD). For the P4P measure, progress is measured based on enrollment as of April each year (after MCO open enrollment is completed) compared to enrollment as of December. In assessing progress, exceptions are allowed for members who have moved out of state, who age out of the program, who are hospitalized or deceased during the year, or graduated to full-time employment.

In April 2014, there were 143 PD Waiver members and 16 TBI Waiver members participating in the WORK program. During the year, 10 additional members participated (nine additional PD and one additional TBI). In April 2015, there were 72 PD Waiver members and 15 TBI Waiver members participating in the WORK program. During the year, one additional TBI member participated in the program.

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

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

Table 18. Percent of HCBS Waiver Participants Whose Service Plans Address Their Assessed Needs and Capabilities, CY2013 - CY2015

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

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 18, only the SED waiver service plans had consistently improving documentation of members' assessed needs and capabilities over the three-year period. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

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

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

Table 19. Percent of HCBS Waiver Participants who Received Services in the Type, Scope, Amount, Duration, and Frequency Specified in Their Service Plan, CY2013 - CY2015

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

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 19, SED waiver service plans had the most complete documentation of services received, as identified in member service plans. As part of remediation efforts in 2017, KDADS has drafted clear guidance to all three MCOs to ensure that all required service plan information and signatures/dates are clearly documented on each participant's plan of care to

render it valid for quality review in terms of type, scope, amount, duration, and frequency specified in the service plan.

(6) Long-Term Care: Nursing Facilities

Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO (P4P 2014)
The denominator for this measure is the number of NF claims, and the numerator is the number of these claims that were denied in the calendar year (see Table 20). Due to claims lag, data for 2016 will be reported in the 2017 annual report.

Table 20. Nursing Facility Claims Denials, CY2012 - CY2015

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

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

Percentage of NF members who had a fall with a major injury (P4P 2014-2015)
The denominator for this measure is the number of NF members in KanCare, and the numerator is the number of these members that had falls that resulted in a major injury during the year (see Table 21). Data for CY2016 include only the first three quarters due to the time lag for submitting and processing claims.

Table 21. Nursing Facility Major Injury Falls, CY2012 - CY2016

	CY2012	CY2013	CY2014	CY2015	CY2016 Q1-Q3
Nursing facility KanCare members	46,794	46,114	43,589	42,301	32,218
Number of nursing facility major injury falls	288	246	232	236	183
Percent of nursing facility Kancare members with major injury falls	0.62%	0.53%	0.53%	0.56%	0.57%

The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013 and CY2014. There were 42 fewer falls in CY2013 than in CY2012, and 46 fewer falls in CY2014 than in CY2012. In CY2015, the fall percentage increased slightly to 0.56% and during the first three quarters of CY2016, the rate was 0.57%. As many of the nursing facilities have members from more than one MCO, MCOs have been encouraged by the State to work together and with State agencies to ensure nursing facilities throughout Kansas are continuing to implement fall prevention practices.

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

The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and increased again in CY2014 to 12.70%. In CY2015, the percentage decreased to 12.04%, and, during the first two quarters of CY2016, the percentage increased to 13.60%. Data for CY2016 are limited to the first six months of the year due to the time lag for submitting and processing claims; the annual percentage for CY2016 will be reported in next year's KanCare Evaluation Annual Report. (Based upon the EQRO validation process, the numerator and denominator for calendar years 2013 and 2014 have been updated.)

Table 22. Hospital Admissions After Nursing Facility Discharge, CY2012 - CY2016

	CY2012	CY2013	CY2014	CY2015	CY2016 Q1-Q2
Number of nursing facility discharges	2,130	2,052	2,268	2,210	985
Number of hospital admissions after nursing facility discharge	153	250	288	266	134
Percent of hospital admissions after nursing facility discharge	7.18%	11.98%	12.70%	12.04%	13.60%

Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network (P4P 2014)

PEAK program data are used to identify nursing facilities designated as Person-Centered Care Homes, along with MCO provider files to verify inclusion in the network. PEAK program data are reported on a fiscal year basis, based on the State fiscal year that begins July 1.

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

(7) Member Survey – Quality

CAHPS Survey

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

Table 23. Member Survey (CAHPS) - Quality of Care Questions, 2014 - 2016							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Using any number from 0 to 10, where 0 is the worst score possible and 10 is the best score possible:							
What number would you use to rate all your (your child's) health care in the last 6 months? (Rating 9 or 10)	Adult	**53.9%**	50.9%	52.8%	↑	↓	↑
	GC	**70.7%**	68.9%	68.6%	↑	↑	↑
	CCC	**66.2%**	64.8%	65.2%	↑	↑	↑
What number would you use to rate your (your child's) personal doctor? (Rating 9 or 10)	Adult	**67.5%**	67.4%	64.4%	↑	↑	↑
	GC	**75.9%**	72.5%	73.4%	↑	↓	↓
	CCC	**74.3%**	72.9%	71.8%	↓	↓	↓
We want to know your rating of the specialist you (your child) saw most often in the last 6 months. What number would you use to rate that specialist? (Rating 9 or 10)	Adult	**66.5%**	66.1%	64.8%	↑	↑	↓
	GC	**70.1%**	69.3%	69.6%	↑	↓	↓
	CCC	**73.0%**	67.8%	68.5%	↑	↓	↓
What number would you use to rate your (your child's) health plan? (Rating 9 or 10)	Adult	**60.9%**	57.6%	54.6%	↑	↓	↓
	GC	**73.8%**	72.1%	71.0%	↑	↑	↑
	CCC	**67.4%**	66.8%	63.3%	↑	↑	↓
In the last 6 months, how often did your (your child's) personal doctor show respect for what you had to say?	Adult	**93.4%**	92.5%	91.9%	↑	↑	↑
	GC	**96.0%**	96.0%	96.7%	↑	↑	↑
	CCC	**95.3%**	95.8%	94.4%	↓	↑	↓
In the last 6 months, how often did your (your child's) personal doctor spend enough time with you (your child)?	Adult	**89.7%**	89.4%	89.0%	↑	↑	↑
	GC	**91.0%**	89.7%	90.4%	↑	↑	↑
	CCC	**91.2%**	91.3%	90.6%	↓	↓	↓

- **Rating of health care**
  In CY2016, 53.9% of adult survey respondents rated their health care as 9 or 10, up from 50.9% in CY2015 and 52.8% in CY2014. The adult survey respondent ratings were below the QC 50th percentile for AGP and UHC and above the QC 50th percentile for SSHP. Child survey ratings in CY2016 (GC – 70.7%, >66.67th QC percentile; CCC – 66.2%, >50th QC percentile) were higher than CY2015 rates (GC – 68.9%; CCC – 64.8%), which were comparable to CY2014.
- **Rating of personal doctor**
  Adult ratings of members' personal doctors as a 9 or 10 were comparable in CY2016 (67.5%) and CY2015 (67.4%); the pre-KanCare CY2012 rate was 66.7%. The adult rating remained above the QC 66.67th percentile in CY2016. Child survey results had higher positive ratings than the adult population (GC: CY2016 - 75.9%, CY2015 – 72.5%, CY2014 – 73.4%; CCC: CY2016 – 74.3%, CY2015-72.9%, CY2014 – 71.8%); however, the CY2015 GC rating was above the QC 50th percentile and the CY2015 CCC rate was below the QC 50th percentile.
- **Rating of health plan**
  The weighted aggregate adult ratings of their health plan as a 9 or 10 increased from 54.6% in CY2014 to 57.6% in CY2015 to 60.9% in CY2016 (>66.67th QC percentile). The aggregate GC survey results continued to improve in CY2016 (73.8%; >66.67th QC percentile) compared to CY2015

(72.1%), CY2014 (71.0%), and CY2012 (65.9%). The CY2016 CCC positive rating of their health plan increased from 66.8% in CY2015 to 67.4% in CY2016 and was above the QC 66.67th percentile.

- **Rating of specialist seen most often**
  The weighted aggregate adult survey rating of specialists was comparable in CY2014 through CY2016 (64.8% - 66.5%). The GC positive rating was also comparable across years (68.4% - 70.1%). The CCC CY2016 positive rating (73.0%) increased from CY2015 (67.8%) and CY2014 (68.5%). All survey populations' positive ratings were above the QC 50th percentile in CY2016.
- **Doctor respected member's comments.**
  Over 93% of survey respondents in CY2016 indicated their personal doctor showed respect for what they had to say. Weighted aggregate adult results in CY2016 (93.4%) were slightly higher than in CY2015 (92.5%), CY2014 (91.9%), and CY2012 (83.7%); the CY2016 adult results remained above the QC 50th percentile. The GC results were comparable in CY2014 through CY2016 (CY2016 -96.0%; CY2015 -96.0%; CY2014 -96.7%) and remained higher than CY2012 (91.8%). The CCC results were comparable across years (CY2016 - 95.3%; CY2015 - 95.8%; CY2014 – 94.4%).
- **Doctor spent enough time with the member.**
  The weighted aggregate results for all populations were comparable across years (Adult: – 89.0% - 89.7%; GC: 89.7% -91.0%; CCC: 90.6% – 91.3%).

Mental Health Survey

Member perceptions of MH provider treatment are based on responses to MH surveys conducted in 2016 of a random sample of KanCare members who had received one or more MH services in the prior six-month period. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past six years, were used for this project.

Questions were the same in 2011 through 2016, with the exception of a question added in CY2013 on whether medication was available timely and three questions added in CY2015 on smoking cessation (adults only). In 2016, at the request of the State, KFMC added three questions to the youth survey related to whether the parent/guardian feels the child's mental health provider believes the child can grow, change, and recover; talks to them in an encouraging way; and encourages the child's growth and success. Also, "mental health provider" was added to the professionals listed for asking whether the parent/guardian was informed of what side effects to watch for when the member takes medication for emotional/behavioral problems.

In CY2016, the survey was mailed to 10,196 KanCare members (not stratified by MCO) and the following were completed: 301 General Adult, 338 General Youth, 309 SED Waiver Youth, and 23 SED Waiver young adult surveys. Results were also stratified by whether the member completed the survey or whether a family member/guardian completed the survey for a child (age <18).

For most of the questions, responses were generally positive and did not change significantly from pre-KanCare (CY2011 and CY2012) to KanCare (CY2013 to CY2016).

Table 24 shows rates of positive responses for questions related to quality of care. (See Table 31 for questions related to coordination of care, Table 41 for questions related to access to care, and Table 49 for an efficiency-related question.)

Table 24. Mental Health Survey - Quality-Related Questions

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
If I had other choices, I would still get services from my mental health providers.	**General Adult (Age 18+)**						
	2016	**85.0%**	**246 / 289**	**80.4% – 88.7%**		.25	.94
	2015	88.4%	336 / 380	84.8% – 91.3%	.20		
	2014	89.4%	720 / 805	87.1% – 91.4%	.05		
	2013	88.3%	911/1,034	86.2% – 90.1%	.13		
	2012	84.4%	232 / 275	79.6% – 88.2%	.83		
	2011	88.3%	263 / 298	84.1% – 91.5%	.25		
I felt comfortable asking questions about my treatment and medication.	**General Adult (Age 18+)**						
	2016	**85.9%**	**245 / 285**	**81.3% – 89.5%**		.24	.29
	2015	94.5%	358 / 379	91.7% – 96.4%	**<.001 -**		
	2014	90.7%	733 / 808	88.5% – 92.5%	**.02 -**		
	2013	91.1%	959/1,052	89.2% – 92.7%	**<.01 -**		
	2012	87.5%	244 / 279	83.0% – 90.9%	.59		
	2011	93.6%	278 / 297	90.2% – 95.9%	**<.01 -**		
I have people I am comfortable talking with about my child's problems.	**General Youth (Ages 0-17), Family Responding**						
	2016	**91.5%**	**289 / 316**	**87.9% – 94.2%**		.89	.47
	2015	92.5%	300 / 324	89.0% – 94.9%	.66		
	2014	90.4%	688 / 761	88.1% – 92.3%	.57		
	2013	91.6%	871 / 954	89.7% – 93.2%	.95		
	2012	93.1%	244 / 262	89.3% – 95.7%	.47		
	2011	92.6%	301 / 325	89.2% – 95.0%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**89.9%**	**289 / 322**	**86.1% – 92.8%**		.84	.89
	2015	87.7%	288 / 328	83.7% – 90.9%	.39		
	2014	88.0%	366 / 417	84.5% – 90.8%	.43		
	2013	89.1%	423 / 475	85.9% – 91.6%	.71		
	2012	87.5%	281 / 321	83.4% – 90.7%	.34		
	2011	89.4%	254 / 284	85.3% – 92.5%	.85		
As a result of services I received, I am better able to deal with crisis.	**General Adult (Age 18+)**						
	2016	**69.2%**	**192 / 277**	**63.6% – 74.4%**		**<.01↓**	.12
	2015	79.3%	279 / 352	74.8% – 83.3%	**<.01 -**		
	2014	78.7%	602 / 765	75.7% – 81.5%	**<.01 -**		
	2013	79.1%	780 / 987	76.4% – 81.5%	**<.001 -**		
	2012	71.4%	182 / 255	65.5% – 76.6%	.59		
	2011	80.4%	221 / 275	75.2% – 84.6%	**<.01 -**		
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**General Adult (Age 18+)**						
	2016	**82.7%**	**230 / 278**	**77.8% – 86.7%**		.06	.20
	2015	86.3%	315 / 365	82.4% – 89.5%	.20		
	2014	86.8%	675 / 778	84.2% – 89.0%	.09		
	2013	87.6%	891/1,020	85.4% – 89.4%	**.03 -**		
	2012	81.6%	213 / 261	76.4% – 85.9%	.75		
	2011	89.3%	258 / 289	85.1% – 92.4%	**.02 -**		

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

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
As a result of services I received, I am better able to control my life.	**General Adult (Age 18+)**						
	2016	**74.8%**	**213 / 284**	**69.4% – 79.5%**		**.02↓**	.11
	2015	83.8%	309 / 369	79.7% – 87.2%	**<.01 -**		
	2014	84.9%	669 / 788	82.2% – 87.2%	**<.001 -**		
	2013	83.0%	851/1,025	80.6% – 85.2%	**<.01 -**		
	2012	76.4%	204 / 267	70.9% – 81.1%	.66		
	2011	86.5%	250 / 289	82.1% – 90.0%	**<.001 -**		
As a result of services I received, I am better at handling daily life.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**85.3%**	**131 / 154**	**78.8% – 90.1%**		.29	.93
	2015	87.0%	127 / 146	80.5% – 91.6%	.67		
	2014	86.0%	260 / 302	81.6% – 89.5%	.84		
	2013	88.6%	450 / 510	85.3% – 91.2%	.28		
	2012	88.8%	87 / 98	80.8% – 93.8%	.43		
	2011	83.1%	108 / 130	75.6% – 88.6%	.61		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**85.9%**	**140 / 163**	**79.7% – 90.5%**		.13	.83
	2015	83.0%	124 / 149	76.1% – 88.2%	.48		
	2014	84.1%	158 / 187	78.1% – 88.7%	.63		
	2013	79.6%	176 / 221	73.8% – 84.3%	.11		
	2012	82.4%	112 / 136	75.0% – 87.9%	.40		
	2011	90.1%	109 / 121	83.3% – 94.4%	.29		
As a result of services my child and /or family received, my child is better at handling daily life.	**General Youth (Ages 0-17), Family Responding**						
	2016	**77.8%**	**252 / 324**	**72.9% – 82.0%**		.17	.54
	2015	82.0%	265 / 323	77.4% – 85.8%	.18		
	2014	79.6%	606 / 764	76.6% – 82.3%	.50		
	2013	82.1%	772 / 948	79.5% – 84.4%	.09		
	2012	81.0%	205 / 253	75.7% – 85.4%	.34		
	2011	79.4%	258 / 325	74.6% – 83.4%	.61		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**75.9%**	**243 / 323**	**70.9% – 80.2%**		.81	.14
	2015	71.5%	233 / 326	66.4% – 76.1%	.21		
	2014	72.0%	297 / 407	67.4% – 76.1%	.24		
	2013	74.4%	355 / 477	70.3% – 78.1%	.64		
	2012	75.6%	241 / 319	70.6% – 80.0%	.93		
	2011	79.2%	227 / 286	74.2% – 83.5%	.32		
As a result of services I received, I am better able to do things that I want to do.	**General Adult (Age 18+)**						
	2016	**69.3%**	**195 / 280**	**63.6% – 74.4%**		**.04↓**	**.03↓**
	2015	78.9%	290 / 368	74.4% – 82.8%	**<.01 -**		
	2014	74.3%	581 / 782	71.1% – 77.3%	.10		
	2013	77.7%	786/1,012	75.0% – 80.2%	**<.01 -**		
	2012	70.1%	185 / 264	64.3% – 75.3%	.84		
	2011	82.4%	238 / 289	77.5% – 86.3%	**<.001 -**		
As a result of the services my child and/or family (I) received, my child is (I am) better able to do things he or she wants (I want) to do.	**General Youth (Ages 0-17), Family Responding**						
	2016	**80.7%**	**255 / 317**	**76.0% – 84.7%**		.26	.14
	2015	84.5%	268 / 317	80.1% – 88.1%	.20		
	2014	80.7%	606 / 751	77.8% – 83.4%	.99		
	2013	84.3%	780 / 930	81.8% – 86.5%	.14		
	2012	85.0%	215 / 253	80.0% – 88.9%	.18		
	2011	84.1%	264 / 314	79.6% – 87.7%	.27		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**73.5%**	**231 / 316**	**68.3% – 78.1%**		.79	.26
	2015	69.9%	227 / 324	64.7% – 74.7%	.32		
	2014	71.1%	290 / 405	66.6% – 75.3%	.49		
	2013	73.5%	349 / 475	69.4% – 77.3%	.98		
	2012	72.3%	229 / 317	67.1% – 76.9%	.74		
	2011	76.5%	210 / 275	71.1% – 81.1%	.40		

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

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I, not my mental health providers, decided my treatment goals.	**General Adult (Age 18+)**						
	2016	**78.6%**	**219 / 278**	**73.4% – 83.0%**		.77	.76
	2015	85.1%	303 / 356	81.1% – 88.5%	**.03 -**		
	2014	84.0%	655 / 780	81.3% – 86.5%	**.04 -**		
	2013	81.8%	809 / 989	79.3% – 84.1%	.22		
	2012	77.0%	198 / 257	71.5% – 81.8%	.67		
	2011	83.7%	237 / 283	79.0% – 87.6%	.12		
I helped to choose my treatment goals.	**General Youth (Ages 12-17), Youth Responding**						
	2016	**84.6%**	**128 / 151**	**77.9% – 89.5%**		.38	.96
	2015	91.0%	127 / 140	84.9% – 94.8%	.10		
	2014	84.1%	255 / 302	79.5% – 87.8%	.89		
	2013	88.8%	448 / 509	85.6% – 91.4%	.17		
	2012	81.6%	80 / 98	72.7% – 88.1%	.54		
	2011	86.8%	112 / 129	79.8% – 91.7%	.60		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**86.8%**	**140 / 161**	**80.6% – 91.2%**		.07	**.02↑**
	2015	92.3%	135 / 146	86.7% – 95.7%	.12		
	2014	86.9%	169 / 194	81.4% – 91.0%	.97		
	2013	82.2%	183 / 222	76.7% – 86.7%	.23		
	2012	81.3%	109 / 134	73.9% – 87.1%	.20		
	2011	83.5%	101 / 121	75.8% – 89.1%	.44		
I helped to choose my child's treatment goals. (I, not my mental health providers, decided my treatment goals.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**92.5%**	**288 / 311**	**89.0% – 95.0%**		.17	.21
	2015	92.7%	289 / 312	89.2% – 95.1%	.92		
	2014	92.2%	689 / 750	90.0% – 93.9%	.87		
	2013	90.5%	847 / 937	88.4% – 92.2%	.29		
	2012	91.6%	229 / 250	87.4% – 94.5%	.70		
	2011	90.7%	294 / 324	87.1% – 93.5%	.43		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**94.3%**	**301 / 318**	**91.2% – 96.4%**		.45	.78
	2015	95.0%	310 / 327	92.1% – 97.0%	.69		
	2014	95.8%	395 / 412	93.3% – 97.4%	.37		
	2013	93.1%	451 / 483	90.5% – 95.1%	.49		
	2012	96.1%	303 / 315	93.3% – 97.8%	.28		
	2011	93.8%	264 / 281	90.2% – 96.1%	.77		

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

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
My (my child's) mental health providers spoke with me in a way that I understood.	**General Adult (Age 18+)**						
	2016	**90.0%**	**266 / 295**	**86.0% – 92.9%**		.07	.60
	2015	**95.3%**	368 / 386	92.7% – 97.1%	**<.01 -**		
	2014	**93.6%**	765 / 817	91.7% – 95.1%	**.04 -**		
	2013	**94.3%**	1,002/1,063	92.8% – 95.6%	**<.01 -**		
	2012	91.5%	257 / 281	87.6% – 94.2%	.54		
	2011	93.4%	282 / 302	89.9% – 95.7%	.13		
	General Youth (Ages 12-17), Youth Responding						
	2016	**94.4%**	**148 / 157**	**89.5% – 97.2%**		.18	.06
	2015	93.9%	137 / 146	88.6% – 96.9%	.86		
	2014	95.5%	290 / 303	92.5% – 97.4%	.60		
	2013	96.3%	495 / 515	94.2% – 97.7%	.29		
	2012	98.0%	97 / 99	92.5% – 99.9%	.16*		
	2011	97.0%	131 / 135	92.4% – 99.1%	.27		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**95.5%**	**158 / 165**	**91.0% – 97.9%**		.31	**.02↑**
	2015	97.4%	147 / 151	93.3% – 99.2%	.36		
	2014	96.9%	183 / 189	93.2% – 98.7%	.49		
	2013	93.8%	213 / 227	89.8% – 96.3%	.46		
	2012	92.0%	126 / 137	86.1% – 95.6%	.20		
	2011	92.1%	116 / 126	85.9% – 95.8%	.22		
	General Youth (Ages 0-17), Family Responding						
	2016	**97.5%**	**323 / 331**	**95.1% – 98.8%**		.46	.30
	2015	98.8%	324 / 328	96.9% – 99.7%	.19		
	2014	97.5%	766 / 786	96.1% – 98.4%	.96		
	2013	97.3%	950 / 981	96.1% – 98.2%	.89		
	2012	97.8%	262 / 268	95.1% – 99.1%	.81		
	2011	96.7%	327 / 338	94.2% – 98.2%	.58		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**98.0%**	**324 / 331**	**95.8% – 99.1%**		.60	.43
	2015	97.9%	329 / 336	95.7% – 99.1%	.94		
	2014	98.2%	414 / 422	96.4% – 99.2%	.85		
	2013	97.4%	476 / 488	95.5% – 98.5%	.58		
	2012	97.8%	314 / 321	95.5% – 99.0%	.87		
	2011	97.2%	278 / 286	94.4% – 98.6%	.49		

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

- **Better control of daily life due to services provided.**
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (74.8%) compared to 2015 (83.8%; $p<.01$), compared to 2014 (84.9%; $p<.001$), and compared to 2013 (83.0%; $p<.01$). The 2016 rate was the lowest rate in the six-year period. There was a statistically significant negative trend from 2013 to 2016 ($p=.02$).
  - For SED Waiver youth and young adults, there was an increase from 71.5% in 2015 to 75.9% in 2016.
  - Rates for SED Waiver youth (ages 12-17, youth responding) increased from 83.0% in 2015 to 85.9% in 2016.
  - Rates for General Youth (ages 12-17, youth responding) decreased from 87.0% in 2015 to 85.3% in 2016.

  - For General Youth (family responding), rates ranged from 77.8% in 2016 to 82.1% in 2013.
- **Member choice of treatment goals.**
  - In 2016, the percentage of members who indicated they had a choice of treatment goals ranged from 78.6% (General Adult) to 94.3% (SED Waiver youth and young adults).
  - For General Youth (family responding) and SED Waiver youth and young adults (family/member responding) rates have been above 90% each year from 2011 to 2016. General Youth rates ranged from 90.5% to 92.7%; SED Waiver youth and young adult rates ranged from 93.1% to 96.1%.
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (78.6%) compared to 2015 (85.1%; p=.03) and compared to 2014 (84.0%; p=.04).
  - For General Youth (ages 12-17, youth responding), there was a decrease from 91.0% in 2015 to 84.6% in 2016.
  - For SED Waiver youth (ages 12-17, youth responding), positive response percentages decreased in 2016 to 86.8% from 92.3% in 2015 and were comparable to the 2014 rate of 86.9%. From 2011 to 2016, there was a statistically significant positive trend (2011 – 83.5%; 2012 – 81.3%; 2013 – 82.2%; 2014 – 86.9%; 2015 – 92.3%; 2016 – 86.8%; [p=.02]).
- **If given other choices, the member would still get services from their most recent mental health provider.**
  This question was asked of adults (non-SED Waiver). From CY2014 to CY2016 there was a decrease in positive response from 89.4% to 85.0%. From 2011 to 2016, rates ranged from 84.4% in 2012 to 89.4% in 2014.
- **Assistance in obtaining information to assist members in managing their health.**
  The 2016 rate for the General Adult population (82.7%) was lower than four of the five previous years, decreasing each year from 2013 (87.6%; p=.03) to 86.8% in 2014 to 86.3% in 2015.
- **Comfort in asking questions about treatment, medication, and/or children's problems.**
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (85.9%) compared to 2015 (94.5%; p<.001), 2014 (90.7%; p=.02), 2013 (91.1%; p<.01), and 2011 (93.6%; p<.01).
  - Rates for General Youth (family responding) were above 90% each year from 2011 to 2016.
  - Rates for SED Waiver youth and young adults (family/member responding) were generally comparable over the six-year period, ranging from 87.5% in 2012 to 89.9% in 2016.
- **Better able to do things the member wants to do, as a direct result of services provided.**
  From 2011 to 2016, there was a significant downward trend in rates for the General Adult population, dropping from 82.4% in 2011 to 69.3% in 2016 (p=.03). Rates for SED Waiver youth/young adult were also relatively low, ranging from 69.9% in 2015 to 73.5% in 2013 and 2016. General Youth rates ranged from 80.7% in 2016 and 2014 to 85.0% in 2012.
- **Better ability to deal with crisis, as a direct result of services provided.**
  The rate in 2016 (69.2%) for the General Adult population was the lowest since 2011 (80.4%). Trend analysis showed a significant decrease in positive responses from 2013 to 2016 (p<.01). The 2016 rate was significantly lower than the rate in 2015 (79.3%; p<.01), 2014 (78.7%; p<.01), 2013 (79.1%; p<.001), and 2011 (80.4%; p<.01).
- **Understandable communication from provider with member**
  - Rates for all five survey populations in the six-year period were 90% or above.
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (90.0%) compared to 2015 (95.3%; p<.01), compared to 2014 (93.6%; p=.04), and compared to 2013 (94.3%; p<.01).

- For the SED Waiver youth (ages 12-17, youth responding), rates were above 90% for the six-year period. The six-year positive trend from 2011 (92.1%) to 2016 (95.5%) was statistically significant (p=0.2).
- General Youth (ages 0-17 family responding) rates ranged from 96.7% to 98.8%. SED Waiver youth and young adults (family/member responding) rates ranged from 97.2% to 98.2%. General Youth (ages 12-17, youth responding) rates ranged from 93.9% to 98.0%.

SUD Consumer Survey

In 2011 and 2012, Value Options-Kansas (VO) conducted satisfaction surveys of members who accessed SUD treatment services. The survey consisted of 30 questions administered in 2012 by mail and through face-to-face interviews at provider locations. The VO survey was administered to 629 individuals, including Medicaid members and others receiving SUD services. Amerigroup, Sunflower, and UnitedHealthcare administered the survey to 342 in 2016 KanCare members, up from 193 in 2015 and 238 in 2014. The survey was a convenience survey administered in May through August through face-to-face interviews, mail, and follow-up phone calls. The demographics differed somewhat in that 43.9% of the 2014 survey respondents, 44.8% of 2015 respondents, and 42.1% of 2016 respondents were male compared to 61.6% for the 2012 VO survey. The average age for the 2016 survey was 33.9, compared to 32 in 2015, 33.7 in 2014, and 31.8 in 2012.

The 2012 results are reported for the SUD survey questions in this report; however, due to the difference in numbers of survey respondents and the additional non-Medicaid members surveyed in 2012, comparisons cannot be directly made with survey results in 2014 to 2016. SUD survey questions related to quality of care include the following summarized in Table 25:

Table 25. SUD Survey - Quality-Related Questions, CY2014 - CY2016

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

- **Overall, how would you rate the quality of service you have received from your counselor?**
  In 2016, 93.3% of 327 members rated the quality of service as very good or good, comparable to 2015 (93.2%) and 2014 (94.3%), and to pre-KanCare (2012 - 95.3%).
- **How would you rate your counselor on involving you in decisions about your care?**
  In 2016, 92.6% of 324 members rated counselor involvement of members in decisions about their care as very good or good, which was higher than in 2015 (88.4%) and comparable to 2014 (92.0%). (2012 – 93.5%; 2011 – 96.7%).
- **Since beginning treatment, in general are you feeling much better, better, about the same, or worse?**
  In 2016, 88.9% of 323 members responded they were feeling much better or better since beginning

treatment, lower than in 2015 (92.6%) and slightly higher than in 2014 (87.1%). The percentage of members reporting they were feeling much better or better was much higher in 2012 (98.8%).

(8) Provider Survey

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

Two of the MCOs, Sunflower and UnitedHealthcare, administer separate surveys to their BH providers. The MCOs were asked to include these three questions on their BH surveys as well. The UnitedHealthcare survey (conducted by Optum) included the three questions with wording for questions and response options as directed. Sunflower's BH survey (conducted by Cenpatico) included the questions and response options in 2015.

The surveys also differed in the numbers of survey responses. For the three questions reviewed in this report, in 2016 Amerigroup had 160 to 215 provider responses; Sunflower had 261 to 311 physical health provider responses and 167 to 172 BH survey responses; and UnitedHealthcare had only 71 to 72 physical health provider responses and 145 to 146 BH survey responses.

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

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

Providers were asked, "**Please rate your satisfaction with (MCO name's) demonstration of their commitment to high quality of care for their members."** Table26 provides the available survey results by individual MCO.

Amerigroup - Amerigroup conducts one survey for both physical health providers and BH providers. In 2016, Amerigroup received 215 completed surveys, approximately half as many as in 2015 (427) and fewer than in 2014 (283). In 2016, 60.9% of providers surveyed responded they were very or somewhat satisfied related to whether Amerigroup is committed to high quality of care for their members, slightly lower than in 2015 (62.8%), but much higher than in 2014 (50.9%). The percentage of providers responding "very dissatisfied" or "somewhat dissatisfied" with that statement was higher in 2016 (16.3%) than in 2015 (13.8%) and lower than in 2014 (18.8%).

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

- **Sunflower general provider survey** – In 2016, 50.8% of 311 providers responded they were very or somewhat satisfied, up from 47.1% in 2015 and much higher than in 2014 (37.5%). The percentage

responding they were very or somewhat dissatisfied decreased from 17.6% in 2014 to 11.9% in 2015, decreasing again in 2016 to 10.3%.

- **Sunflower (Cenpatico) BH provider survey -** This question was not asked in the 2014 BH survey. As directed by the State, this question was added to the 2015 survey. In 2015, 51.6% of 126 BH providers responded they were very or somewhat satisfied, and 7.2% were very or somewhat dissatisfied. Rates were comparable in 2016 – 48.8% of 172 BH providers responded they were very or somewhat satisfied, and 7.0% said they were very or somewhat dissatisfied.

Table 26. Provider Satisfaction with MCO'sCommitment to High Quality of Care for Their Members, CY2014 - CY2016

MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Amerigroup	**60.9%**	62.8%	50.9%	**22.8%**	23.4%	30.4%	**16.3%**	13.8%	18.8%	**215**	427	283
Sunflower	**50.8%**	47.1%	37.5%	**38.9%**	41.0%	45.0%	**10.3%**	11.9%	17.6%	**311**	293	251
UnitedHealthcare	**40.3%**	44.7%	^	**44.4%**	40.8%	^	**15.3%**	14.5%	^	**72**	76	^
Behavioral Health Provider Surveys+												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Cenpatico (SSHP)	**48.8%**	51.6%	**	**44.2%**	41.3%	**	**7.0%**	7.2%	**	**172**	126	**
Optum (UHC)	**55.9%**	59.4%	54.7%	**35.2%**	34.7%	36.9%	**9.0%**	5.9%	8.4%	**145**	101	84

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

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

- **UnitedHealthcare general provider survey** – As in the two previous years, UHC's 2016 survey had fewer than one-third of the provider responses as the other MCOs. Compared to AGP and SSHP, UHC had the lowest percentage of providers responding they were very or somewhat satisfied – 40.3% in 2016 (compared to 50.8% for SSHP and 60.9% for AGP) and lower than in 2015 (44.7%). The percentage responding they were very or somewhat dissatisfied increased slightly to 15.3% in 2016, compared to 14.5% in 2015. In 2014, UHC surveyed 66 providers, but, due to a typographical error in the survey instrument, the results cannot be compared.
  - Recommendation: In the 2014 UHC provider survey validation report, KFMC recommended UHC increase the number of providers surveyed. In 2015, the number of responses increased by only ten and decreased in 2016. KFMC recommends UHC consider other methods for surveying providers, including online options such as "Survey Monkey," and/or greatly increase the sample size to increase the number of providers surveyed.
- **UHC (Optum) BH provider survey –** In 2016, 55.9% of 145 BH providers responded they were very or somewhat satisfied, fairly comparable to 2015 (59.4%) and 2014 (54.7%). The percentage responding they were very or somewhat dissatisfied increased in 2016 to 9.0%, up from 5.9% in 2015 and 8.4% in 2014.

(9) Grievances – Reported Quarterly

Compare/track number of grievances related to quality over time, by population type.

Grievances are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KDHE KanCare website for public review.

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

The focus and topics for "other studies" will be determined based on review of the various program outcomes, planned preventive health projects, and value-added benefits provided by the MCOs. One of the studies underway that will be reported in the 2017 KanCare Evaluation Annual report is an evaluation of the impact of P4P on HEDIS measures in years when P4P is in effect and in the time period that follows.

Coordination of Care (and Integration)

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

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

(11) Care Management for Members Receiving HCBS Services

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

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

The denominator for this measure is the number of waiver participants whose service plans were reviewed, and the numerator is the number of waiver participants with documented change in needs whose service plans were revised, as needed, to address the change (see Table 27).

Table 27. Percent of HCBS Waiver Participants with Documented Change in Needs Whose Service Plans were Revised, as Needed, to Address the Change, CY2013 - CY2015

Waiver	CY2013	CY2014	CY2015
Intellectual/Developmental Disability (I/DD) Waiver	7%	23%	28%
Physical Disability (PD) Waiver	75%	39%	53%
Frail Elderly (FE) Waiver	78%	38%	54%
Traumatic Brain Injury (TBI) Waiver	53%	38%	38%
Technical Assistance (TA) Waiver	92%	42%	75%
Serious Emotional Disturbance (SED) Waiver	85%	86%	88%
Autism Waiver	45%	11%	11%

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As shown in Table 27, documentation in service plans of changes in needs was highest in CY2013 to CY2015 for the SED waiver. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

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

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

These data are gathered through MCO record review by KDADS quality staff, and compliance percentages vary by waiver. As part of remediation efforts, KDADS is currently in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the plan of care development process.

Table 28. Percent of Waiver Participants who had Assessments Completed by the MCO that Included Physical, Behavioral, and Functional Components to Determine the Member's Needs, CY2014 - CY2015

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

For the following HCBS HEDIS-like performance measures, members with dual eligibility, i.e., enrolled in both Medicare and Medicaid, are excluded because Medicaid is a secondary payer to Medicare; claims paid partially or entirely by Medicare are not always available to the MCOs at the time of analysis, which complicates interpretation and reporting of rates. These measures were P4P in 2014 and 2015; though no longer P4P, the State has directed the MCOs to continue to report these rates separately for the HCBS population to allow continued tracking of progress in improving these rates.

Table 29. HEDIS-Like Measures - HCBS Populations, CY2013 - CY2015			
	CY2015	CY2014	CY2013
Adults' access to preventive/ambulatory health services	94.0%	93.1%	92.0%
Annual Dental Visits	51.6%	49.0%	49.4%
Decrease in number of Emergency Department Visits* *(Visits/1000 member months)*	79.64	78.06	77.58
* The goal for this measure is to decrease the rate.			

Increased preventive care – Increase in the number of primary care visits (P4P 2014-2015)
This measure is based on the HEDIS "AAP" measure, but includes only HCBS members who were not dual-eligible.
Population: HCBS
Analysis: Annual comparison to baseline, trending over time
The percentage of HCBS members who had an annual preventive health visit increased from 92.0% in CY2013 to 93.1% in CY2014 and to 94.0% in CY2015. The rates for the HCBS member subpopulation were 4% to 8% higher than the rates for all KanCare adult members in all three years (88.4% in CY2013, 87.5% in CY2014, and 87.1% in CY2015).

Increase in Annual Dental Visits (P4P 2014-2015)
This measure is based on the HEDIS "ADV" measure, but includes only HCBS members who were not dual-eligible.
Population: HCBS (ages 2-21)
Analysis: Annual comparison to 2013 baseline, trending over time
The percentage of HCBS members who had an annual dental visit was higher in CY2015 (51.6%) compared to CY2014 (49.0%) and CY2013 (49.4%). The annual dentist visit rates for HCBS members were 15% to 18% lower than the HEDIS rates for the overall KanCare population in each of the three years – CY2015 (60.9%), CY2014 (60.0%) and (CY2013 (60.3%).

Decrease in number of Emergency Department Visits (P4P 2014-2015)
This measure is based on the HEDIS "Ambulatory Care – Emergency Department Visits (AMB)" measure. As per HEDIS criteria, this metric is reported as a rate based on visits per 1,000 member-months.
Population: HCBS
Analysis: Annual comparison to 2013 baseline, trending over time
From CY2013 to CY2015, emergency department (ED) visit rates (per 1,000 member-months) for the HCBS population increased slightly from 77.58 in 2013 to 78.06 in 2014 to 79.64 in 2015. The rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (65.17 in CY2013, 64.19 in CY2014, and 66.31 in CY2015).

(12) Other (Tentative) Study (Specific study to be determined)
This measure will be reported when a specific study and study criteria are determined and defined, and will be based on areas of special focus on care coordination and integration of care.

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

(14) Member Survey – CAHPS

CAHPS questions related to coordination of care (see Table 30) include the following questions focused on perception of care and treatment in the Medicaid and CHIP populations. Additional detail on the CAHPS survey In CY2016 can be found in Section 4 of this report in the Health Literacy section.

Questions on both adult and child surveys:

- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  The weighted aggregate rates remain generally comparable for all populations in CY2014 through CY2016 (Adult: 87.2% - 88.1%; GC: 92.0% - 93.4%; CCC: 91.9% - 93.0%). All results remain above the QC 50th percentile.
- **In the last 6 months, did you (your child) get care from a doctor or other health provider besides your (child's) personal doctor?**
  The 2016 survey positive responses were comparable within each population in CY2014 through CY2016 (Adult: 60.9% - 62.0%; GC: 39.5% - 44.1%; CCC: 58.3% - 60.7%).
  - **In the last 6 months, how often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?**
    Those who responded positively to receiving care from a provider other than their personal doctor were asked this question.

    The CY2016 weighted aggregate result for adults (85.0%) increased from CY2015 (82.7%) and CY2014 (83.0%). The GC rates were comparable in CY2014 through CY2016 (81.9% - 82.3%) The CCC aggregate rates were generally comparable across years (CY2016 -80.7%; CY2015 -83.3%; CY2014 – 80.5%).

Table 30. Member Survey - CAHPS Coordination of Care Questions

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last 6 months…							
How often was it easy to get the care, tests, or treatment you (your child) needed?	Adult	**87.2%**	88.1%	87.6%	↑	↑	↑
	GC	**92.1%**	92.0%	93.4%	↑	↑	↑
	CCC	**92.4%**	91.9%	93.0%	↑	↑	↑
Did you (your child) get care from a doctor or other health provider besides your (his or her) personal doctor?	Adult	**60.9%**	61.4%	62.0%	NA	NA	NA
	GC	**39.6%**	44.1%	39.5%	NA	NA	NA
	CCC	**58.6%**	60.7%	58.3%	NA	NA	NA
How often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?	Adult	**85.0%**	82.7%	83.0%	↑	↑	↑
	GC	**81.9%**	82.3%	81.9%	↓	↑	↑
	CCC	**80.7%**	83.3%	80.5%	↓	↑	↓
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	Adult	**44.3%**	46.5%	43.0%	NA	NA	NA
	GC	**17.9%**	19.4%	17.9%	NA	NA	NA
	CCC	**39.8%**	39.5%	38.4%	NA	NA	NA
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	Adult	**86.2%**	81.7%	84.8%	↑	↑	↑
	GC	**80.8%**	84.6%	83.2%	↓	↑	↑
	CCC	**86.2%**	83.3%	85.3%	↑	↑	↑

Table 30. Member Survey - CAHPS Coordination of Care Questions (Continued)							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Child Surveys only							
Did your child get care from more than one kind of health care provider or use more than one kind of health care service?	**GC**	**21.9%**	24.5%	22.3%	NA	NA	NA
	CCC	**45.3%**	48.0%	46.2%	NA	NA	NA
Did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?	**GC**	**55.2%**	56.4%	56.7%	NA	NA	NA
	CCC	**57.7%**	58.2%	57.9%	↓	↓	↓
Did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?	**GC**	**10.2%**	11.2%	10.4%	NA	NA	NA
	CCC	**16.8%**	17.3%	16.6%	NA	NA	NA
Did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	**GC**	**94.5%**	92.5%	91.1%	NA	NA	NA
	CCC	**94.9%**	93.1%	96.5%	NA	NA	↑
Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?	**GC**	**26.7%**	28.6%	24.5%	NA	NA	NA
	CCC	**74.8%**	76.8%	77.2%	NA	NA	NA
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your child's day-to-day life?	**GC**	**91.4%**	92.4%	92.9%	NA	NA	NA
	CCC	**92.0%**	92.4%	92.3%	↓	↓	↓
Does your child's personal doctor understand how these medical, behavioral, or other health conditions affect your family's day-to-day life?	**GC**	**89.5%**	88.8%	92.5%	NA	NA	NA
	CCC	**88.9%**	89.1%	90.3%	↓	↓	↑
In the last 6 months, did you get or refill any prescription medicines for your child?	**GC**	**50.3%**	53.0%	50.8%	NA	NA	NA
	CCC	**84.0%**	86.0%	86.5%	NA	NA	NA
How often was it easy to get prescription medicines for your child through his or her health plan?	**GC**	**94.5%**	93.1%	95.2%	NA	NA	NA
	CCC	**94.4%**	93.2%	94.7%	NA	NA	NA
Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?	**GC**	**54.7%**	59.5%	56.7%	NA	NA	NA
	CCC	**57.0%**	59.6%	57.6%	↓	↑	↓

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2016, 44.3% of adults, 17.9% of the GC population, and 39.8% of the CCC population reported having one or more appointments with a specialist. The CY2016 rates were comparable to CY2015 and CY2014.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    Of those who had appointments with a specialist in the previous six months, 86.2% of adults in CY2016 obtained an appointment as soon as they needed, compared to 81.7% in CY2015, 84.8% in CY2014, and 75.9% in CY2012. The CY2016 adult results increased from above the QC 50th percentile to above the 95th QC percentile. All three MCOs had increases in the adult populations' rates and QC percentiles. The CY2015 GC results continued to be higher than CY2012, although there were variations across years (GC: CY2016 – 80.8%, CY2015 – 84.6%, CY2014 – 83.2%, CY2012 – 79.0%). The CCC results in CY2016 increased to 86.2% from CY2015 – 83.3% and CY2014 – 85.3%, and were above the QC 75th percentile in 2016.

Questions on child surveys only (pre-KanCare results for CY2012 were not available for these questions):

- **In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service?**
  The percentage of children obtaining care from more than one kind of health care provider and/or service decreased slightly (GC: CY2016 – 21.9%, CY2015- 24.5%, CY2014 – 22.3%; CCC: CY2016 – 45.3%, CY2015 -48.0%, CY2014 – 46.2%).
  - **In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**
    Of those receiving these additional services, 55.2% of the GC population in CY2016 responded they received help from the health plan, doctor's office, or clinic to coordinate their child's care among the different providers or services; the rate was slightly higher in CY2015 (56.4%) and CY2014 (56.7%). The CY2016 results for the CCC population (57.7%) were slightly lower than CY2015 (58.2%) and CY2014 (57.9%) and remained below the QC 25th percentile.
- **Does your child have any medical, behavioral, or other health conditions that have lasted more than 3 months?**
  This question is used to help identify children who have chronic conditions; 26.7% of the CY2016 GC survey respondents indicated their child had a condition lasting longer than 3 months (CY2015 - 28.6; CY2014 - 24.5%); 74.8% of the CY2016 CCC population (CY2015 - 76.8%; CY2014 - 77.2%) responded positively to this question.
  - **Does your child's personal doctor understand how these medical behavioral or other health conditions affect your child's day-to-day life?**
    Of those in CY2016 that indicated their child has a chronic medical, behavioral, or other health condition, 91.4% of the GC population (CY2015 - 92.4%; CY2014 - 92.9%) and 92.0% of the CCC population (CY2015 - 92.4%; CY2014 - 92.3%) responded that their personal doctor understands how these health conditions affect their child's life.
  - **Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?**
    Of those in CY2016 who indicated their child has a chronic medical, behavioral, or other health condition, 89.5% of the GC population (CY2015 - 88.8%; CY2014 - 92.5%) and 88.9% of the CCC population (CY2015 - 89.1%; CY2014 - 90.3%) responded that their doctor understands how their condition affects the family's day-to-day life.
- **In the last 6 months, did you get or refill any prescription medicines for your child?**
  In CY2016, 50.3% of the GC population surveyed indicated they obtained prescription medicines for

their child, compared to 53.0% in CY2015 and 50.8% in 2014. Of the CCC population surveyed, 84.0% in CY2016, 86.0% in CY2015 and 86.5% in CY2014 indicated they had prescriptions filled for their child.

- **In the last 6 months, was it easy to get prescription medicines for your child through his or her health plan?**
  Of those who indicated they had gotten or refilled a prescription for their child in the last 6 months, 94.5% of the CY2016 GC population (CY2015 - 93.1%; CY2014 - 95.2%) and 94.4% of the CCC population (CY2015 - 93.2%; CY2014 - 94.7%) indicated it was easy to get prescriptions for their child through their health plan.
- **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
  Of the CY2016 respondents who indicated they had gotten or refilled a prescription for their child in the last 6 months, 54.7% of the GC population (CY2015 - 59.5%; CY2014 -56.7%) and 57.0% of the CCC population (CY2015 - 59.6%; CY2014 - 57.6%) indicated they received help from their health plan, doctor's office, or clinic to get the child's prescription.

- **In the last 6 months, did you need your child's doctors or other health providers to contact a school or daycare center about your child's health or health care?**
  The percent of child survey respondents with a positive response was comparable in CY2014 through CY2016 within each population (GC: 10.2% - 11.2%; CCC 16.6% - 17.3%).
  - **In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?**
    Of those who needed help in contacting a school or daycare, 94.5% of the CY2016 GC respondents (CY2015 - 92.5%; CY2014 - 91.1%) and 94.9% of the CY2016 CCC respondents (CY2015 - 93.1%; CY2014 -96.5%) indicated they received the help they needed.

(15) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2016 are described above in Section 7 "Member Survey – Quality." The questions in Table 31 are related to the perception of care coordination for members receiving MH services.

- **Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.)**
  General Adult positive response percentages ranged from 76.7% in 2012 to 83.4% in 2013. The 78.7% rate in 2016 was the lowest since 2012.
- **Perception that the members were able to access all of the services that they thought they needed**
  - Rates in 2016 ranged from 77.6% for SED Waiver youth and young adults (family/member responding) to 83.1% (General Youth, ages 12-17, youth responding). The 2016 rates in each of the five survey populations were lower than in 2015.
  - The 2016 General Adult rate (80.7%) is the second lowest of the six year period, with only the 2012 rate (78.8%) lower.
  - For the SED Waiver youth (ages 12-17, youth responding), there was a significant increase in rates from 71.8% in 2013 to 79.3% in 2016 (p=0.03).
  - For the General Youth (family responding), the 2016 rate (82.2%) decreased from the 2015 rate (86.3%). Rates decreased each year from 2011 (84.2%) to 79.7% in 2014.
  - The rate for General Youth (ages 12-17, youth responding) decreased in 2016 (83.1%) from 2015 (87.5%); the only rate lower than the 2016 rate was 82.8% in 2013.

- The rate for the SED Waiver youth and young adults decreased in 2016 (77.6%) from 2015 (78.9%). The 2015 rate was the highest in the six-year period.

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

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**General Adult (Age 18+)**						
	2016	**78.7%**	**207 / 264**	**73.3% – 83.2%**		.05	.52
	2015	80.4%	278 / 346	75.9% – 84.3%	.60		
	2014	82.3%	589 / 716	79.4% – 84.9%	.20		
	2013	83.4%	802 / 962	80.9% – 85.6%	.08		
	2012	76.7%	191 / 249	71.1% – 81.5%	.59		
	2011	82.3%	214 / 260	77.2% – 86.5%	.30		
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**235 / 290**	**75.8% – 84.9%**		.05	.05
	2015	84.9%	325 / 383	81.0% – 88.2%	.15		
	2014	86.5%	704 / 814	84.0% – 88.7%	**.02 -**		
	2013	86.0%	917/1,066	83.8% – 87.9%	**.03 -**		
	2012	78.8%	219 / 278	73.6% – 83.2%	.56		
	2011	91.3%	274 / 300	87.6% – 94.1%	**<.001 -**		
	General Youth (Ages 12–17), Youth Responding						
	2016	**83.1%**	**126 / 152**	**76.3% – 88.3%**		.55	.94
	2015	87.5%	126 / 144	81.0% – 92.1%	.28		
	2014	83.8%	260 / 309	79.2% – 87.5%	.85		
	2013	82.8%	427 / 518	79.1% – 86.0%	.94		
	2012	85.0%	85 / 100	76.6% – 90.8%	.68		
	2011	85.1%	114 / 134	78.0% – 90.2%	.64		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**79.3%**	**127 / 161**	**72.3% – 84.9%**		**.03↑**	.27
	2015	81.5%	123 / 151	74.6% – 86.9%	.61		
	2014	74.8%	138 / 184	68.0% – 80.5%	.33		
	2013	71.8%	165 / 229	65.7% – 77.2%	.10		
	2012	76.3%	103 / 135	68.4% – 82.7%	.54		
	2011	77.6%	97 / 125	69.5% – 84.1%	.74		
My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**82.2%**	**264 / 320**	**77.6% – 86.0%**		.87	.62
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.34		
	2013	83.2%	799 / 966	80.7% – 85.4%	.67		
	2012	82.9%	213 / 257	77.8% – 87.0%	.83		
	2011	84.2%	278 / 330	79.9% – 87.8%	.48		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**77.6%**	**253 / 325**	**72.7% – 81.8%**		.29	.68
	2015	78.9%	260 / 330	74.2% – 83.0%	.67		
	2014	76.4%	318 / 413	72.0% – 80.2%	.70		
	2013	75.2%	363 / 482	71.1% – 78.8%	.43		
	2012	77.3%	248 / 321	72.4% – 81.6%	.93		
	2011	77.4%	220 / 284	72.2% – 81.9%	.97		

(16) Member Survey – SUD

Section 7 provides background on the SUD survey conducted by the three MCOs in CY2014, CY2015, and CY2016. Questions related to perceptions of care coordination include the following questions (see Table 32):

Table 32. SUD Survey - Questions Related to Coordination of Care, CY2014 - CY2016

	CY2016	CY2015	CY2014
In the last year, have you received services from any other substance use counselor in addition to your current counselor? (Percent of "Yes" responses)	**44.3%**	**34.8%**	**35.7%**
If yes to previous question: Has your current counselor asked you to sign a "release of information" form to share details about your visit(s) with the other substance use counselor who you saw? (Percent of "Yes" responses)	**82.4%**	**85.1%**	**60.3%**
Thinking about the coordination of all your health care, do you have a primary care provider or medical doctor?* (Percent of "Yes" responses)	**66.4%**	**64.4%**	**64.9%**
If yes to previous question: Has your counselor asked you to sign a "release of information" form to allow him/her to discuss your treatment with your primary care provider or medical doctor? (Percent "Yes" responses)	**70.4%**	**69.8%**	**52.5%**

*Denominator for question includes "Don't know" responses in addition to "Yes" and "No" responses.

- **Has your counselor requested a release of information for this other substance abuse counselor who you saw?**
  - In 2016, 44.3% (136) of 307 members who responded indicated they had received services in the past year from a substance abuse counselor in addition to their current counselor, from 34.8% (63 of 181 surveyed) in 2015 and 35.7% (70 of 196) surveyed in 2014.
  - Of the 136 who received services from more than on substance use counselor, 108 responded to the follow-up question asking if their counselor requested a release of information from the other counselor. Of the 108, 89 (82.4%) indicated their counselor requested a release of information, comparable to 2015 (85.1%) and higher than in 2014 (60.3%).
- **Has your counselor requested a release of information for and discussed your treatment with your medical doctor?**
  - In 2016, 4.0% (14) of 327 members responding indicated they did not know if they have a primary care provider (PCP), compared to 3.1% (6 of 191) in 2015 and 7.1% (15 of 211) in 2014. In 2016, 66.4% (217 of 327) indicated they have a PCP, comparable to 64.4% in 2015 and 64.9% in 2014.
  - Of those who indicated they have a PCP, 70.4% (107 of 152) in 2016 reported their counselor requested a release of information, comparable to 69.8% in 2015 and higher than in 2014 (52.5%).

(17) Provider Survey

Background information and comments on the 2014 Provider Survey are described in Section 8. In this section, results are reported for satisfaction with the preauthorization process. The provider survey results for the quality-related question are in Section 8, and results for the access-related question are in Section 23.

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

Table 33. Provider Satisfaction with Obtaining Precertification and/or Authorization for Their Members, CY2014 - CY2016

MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Amerigroup	**51.7%**	61.2%	53.3%	**19.7%**	18.1%	23.9%	**28.7%**	20.7%	22.8%	**178**	397	272
Sunflower	**46.1%**	39.8%	38.2%	**38.2%**	36.4%	32.8%	**15.7%**	23.8%	29.0%	**293**	269	241
UnitedHealthcare	**41.7%**	50.0%	^	**33.3%**	27.6%	^	**25.0%**	22.4%	^	**72**	76	66
Behavioral Health Provider Surveys+												
	2016	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**	**2016**	**2015**	**2014**
Cenpatico (SSHP)	**32.3%**	42.5%	63.4%	**58.7%**	44.1%	26.9%	**9.0%**	13.4%	9.6%	**167**	127	52
Optum (UHC)	**51.4%**	58.4%	52.3%	**39.7%**	36.6%	34.5%	**8.9%**	5.0%	13.1%	**146**	101	84

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

Amerigroup

- In 2016, 51.7% of 178 providers were very or somewhat satisfied with AGP preauthorization and precertification, down from 61.2% in 2015 and comparable to 53.3% in 2014, but higher than in 2013 (40.7%).
- In 2016, 28.7% of providers surveyed were very or somewhat dissatisfied, higher than in 2015 (20.7%) and 2014 (22.8%), but lower than in 2013 (42.6%).

Sunflower

- **Sunflower general provider survey** - No comparison can be made with the 2013 general provider survey results since Sunflower's 2013 survey questions were asked of providers only in comparison to other MCOs. In 2016, 46.1% of providers surveyed indicated they were very or somewhat satisfied, higher than In 2015 (39.8%) and 2014 (38.2%). In 2016, 15.7% of the providers were very or somewhat dissatisfied, lower than in 2015 (23.8%) and in 2014 (29.0%).
- **Sunflower (Cenpatico) BH provider survey** – In 2016 32.3% of 167 BH providers indicated they were very or somewhat satisfied with Cenpatico precertification/preauthorization, lower than in 2015 (42.5%) and 2014 (63.4%). The percentage dissatisfied or very dissatisfied was lower in 2016 (9.0%) than in 2015 (13.4%) and 2014 (9.6%). BH providers were asked, "How would you rate the authorization process (sending in a form) for your Cenpatico clients?" (i.e., worded differently from the 2015 survey question). Of 52 BH providers surveyed in 2014, 63.4% (33) replied "very good or good" and 9.6% (5) replied "very poor or poor."

UnitedHealthcare

- **UnitedHealthcare general provider survey –**In 2016, 41.7% of 72 providers surveyed were very or somewhat satisfied, lower than in 2015 (50.0%). The percentage indicating they were very or somewhat dissatisfied was higher in 2016 (25.0%) than in 2015 (22.4%).
- **UHC (Optum) BH provider survey** –In 2016, 51.4% of the 146 BH providers surveyed were very or somewhat satisfied with Optum's precertification and authorization process, down from 2015

(58.4%) and comparable to 2014 (52.3%). In 2016, 8.9% of BH providers were very or somewhat dissatisfied, up from 5.0% in 2015 and down from 13.1% in 2014.

Cost of Care

Goals, Related Objectives, and Hypotheses for Costs subcategory:

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

(18) Costs

The data for the following measures continue to be analyzed; additional analysis (e.g., per member per year costs of HCBS, utilization of services by a specific population group) will be included in future reporting.

Population: KanCare Members by Medicaid Eligibility Group (MEG)

Analysis: Pre-KanCare compared to KanCare and trending over time beginning in DY2

Comparison of Pre-KanCare and KanCare Service Utilization

Table 34 shows a comparison of the annual number of services used by those eligible for Medicaid services pre-KanCare in CY2012 with services used by KanCare members in CY2015.

Table 34. Comparison of Pre-KanCare (2012) and KanCare (2015) Service Utilization

Type of Service	% Utilization Difference
Dental	32%
Home & Community-Based Services	23%
Primary Care Physician	24%
Inpatient	-23%
Outpatient Emergency Room	-1%
Outpatient, Non-Emergency Room	10%
Pharmacy	7%
Transportation	33%
Vision	16%

Services with increased utilization in CY2015 compared to CY2012 were Primary Care Physician (24% increase), Dental (32% increase), Home and Community-Based Services (23% increase), Vision (16% increase), Transportation (33% increase), and Non-Emergency Room (ER) Outpatient Services (10% increase).

Inpatient Hospitalization decreased 23% in CY2015 compared to CY2012, and Emergency Room Outpatient Visits decreased by 1%. Decreases in utilization of these services are a positive outcome, reflecting increased access of treatment from .the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays.

Per Member Per Month (PMPM) Average Annual Service Expenditures

Per member per month (PMPM) is the annual average monthly cost to provide care. "Cost to provide care" is based on encounters, i.e., payments to providers who have submitted claims for services. Table 35 shows the PMPM for CY2013, CY2014, and CY2015 in total and by comparison groups.

Table 35. Per Member Per Month (PMPM) Service Expenditures by Medicaid Eligibility Group, CY2013 - CY2015

Comparison Groups	CY2013	CY2014	CY2015
Children & Families	150	213	209
Waiver Services	3,275	3,192	3,617
Long Term Care	1,644	3,108	2,963
Persons with Disabilities	554	827	829
Pregnant Women	504	674	655
Other	502	665	680
Total	503	699	694

Due to "claims lag," i.e., the time allowed for providers to submit claims and the time allowed for the MCOs to process the claims, a certain portion of service costs in one year will be reflected in the PMPM the following year. As shown in Table 35, CY2013 would appear to have lower PMPM, when in actuality, the differences are likely due to CY2013 being the first year of KanCare, and some of the service costs in CY2013 were paid in CY2014. On the same note, some of the costs for services received in CY2014 were paid in CY2015 and are reflected in those numbers. PMPMs for CY2014 and CY2015 (and CY2016 to be reported in next year's report) are better used for comparison of service costs over time.

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

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

Access to Care

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

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

(19) Provider Network – GeoAccess

Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [physical therapy, occupational therapy, x-ray, and lab], and pharmacy).

KFMC reviewed the GeoAccess reports, maps, and other data to identify the percent of counties where specific provider types are not available from at least one MCO. KFMC also reviewed GeoAccess maps showing provider access by provider type for CY2012-CY2016. The number of providers and number of locations by service type and MCO, as reported by the MCOs to KDHE in December 2016, are listed in Table 36. Service types include physicians by specialty, hospitals, retail pharmacies, dental primary care, and ancillary services (physical therapy, x-ray, lab, optometry, and occupational therapy). Table 36 also includes the change in the number of providers and locations for each provider type by MCO from 2015 to 2016. MCOs with the highest number of providers and locations by provider type are also highlighted in the table.

The GeoAccess reports include access to services by county and county type, number of members in each county by MCO, and percentage of each county within prescribed mileage ranges, depending on the type of service. Table 37 reports the number of counties (and whether the county is urban or non-urban) where each MCO reported that 100% of the county has no access to that particular provider type from the MCO at the time the report was submitted to the State. As shown in the table, there are some specialties, particularly in rural and frontier counties, where the number of counties without access is comparable for all three MCOs. Plastic & Reconstructive Surgery, for example, is not available in 19 to 23 counties. For other specialties, however, the number of counties without access to a specialty differs more widely, indicating opportunities for MCOs to expand their networks. Physical Medicine/Rehab providers, for example, are not available in 31 counties for UHC and only 6 counties for SSHP, and Gastroenterology providers are not available in 4 counties for UHC and 22 to 24 counties in the AGP and SSHP networks.

Of the 105 counties in Kansas, 16 are “Urban” or “Semi-Urban” and 89 are non-urban (21 “Densely-Settled Rural,” 32 “Rural,” and 36 “Frontier”).

Table 36. Number of Providers and Provider Locations by MCO and by Provider Type, CY2016						
Provider Type	Number of Providers/ Number of Locations			Difference from 2015 to 2016		
	AGP	SSHP	UHC	AGP	SSHP	UHC
Physicians						
Primary Care Provider	2,300 / 748	3,256 / 1,020	**6,639/ 2,128**	+44 / -32	+139 / +65	+1,342 / +509
Allergy	39/ 22	42 / 30	**46 / 45**	-2 / -2	+1 / +5	-1 / -1
Cardiology	345 / 152	335 / 178	**436 / 283**	+19 / -3	-9 / +6	+26 / +4
Dermatology	40 / 45	44 / 37	**79 / 80**	-3 / +8	-2 / +5	+11 / +16
Gastroenterology	111 / 57	116 / 75	**133 / 182**	-3 / -2	0 / +3	+4 / +68
General Surgery	331 / 181	346 / 224	**374 / 313**	-25 / -8	+14 / +14	-42 / -27
Hematology/Oncology	217 / 111	105 / 53	**265 / 205**	-16 / +16	-12 / -2	+1 / -6
Internal Medicine	**1,142** / 389	782 / 383	904 / **840**	-130 / -36	+12 / +17	+237 / +380
Neonatology	69 / 11	**74** / 20	72 / **33**	-4 / -1	+7 / +1	-25 / -7
Nephrology	92 / 35	71 / 50	**107 / 76**	-1 / +1	0 / +3	-8 / -11
Neurology	206 / 104	266 / 124	**306 / 225**	-11 / +4	+19 / +10	+40 / +48
Neurosurgery	73 / 37	87 / 52	**98 / 93**	+4 / -3	+6 / +5	+12 / +20
OB/GYN	382 / 185	391 / 219	**484 / 291**	-7 / 0	+9 / +17	+3 / +24
Ophthalmology	129 / **204**	136 / 168	**185** / 160	-9 / -21	-17 / +17	+32 / +1
Orthopedics	221 / 107	265 / 150	**330 / 256**	-2 / -9	+23 / +19	+33 / +39
Otolaryngology	93 / 62	**104** / 62	103 / **91**	-2 / -3	-1 / -7	+1 / -2
Physical Medicine/Rehab	55 / 41	72 / 61	**90 / 81**	-3 / 0	-3 / +2	+2 / -14
Plastic & Reconstructive Surgery	37 / 30	43 / 36	**60 / 61**	0 / 0	0 / 0	+2 / +7
Podiatry	37 / 47	38 / 41	**105 / 149**	+2 / -8	0 / -2	+26 / -2
Psychiatrist	475 / **365**	**513** / 237	335 / 296	+119 / +153	+29 / +13	-49 / -51
Pulmonary Disease	139 / 66	119 / 100	**141 / 127**	+15 / -7	+6 / +11	-9 / -10
Urology	100 / 57	100 / 72	**159 / 136**	-2 / -5	-10 / +4	+15 / +17
Hospital						
Hospitals	**247 / 233**	166 / 166	149 / 152	+126 / +111	0 / 0	-4 / -1
Eye Care - Optometry						
Eye Care - Optometry	401 / 417	450 / 445	**548 / 484**	-23 / -9	+15 / +34	+10 / +33
Dental						
Dental Primary Care	395 / **286**	**405** / 285	396 / 284	+30 / +9	-3 / -7	+26 / +4
Ancillary Services						
Physical Therapy	494 / **368**	**536** / 301	420 / 224	-46 / +31	-1 / +16	-1 / -5
Occupational Therapy	**503 / 344**	224 / 192	207 / 158	+227 / +92	+10 / +11	+7 / -4
X-ray	**277 / 263**	179 / 186	149 / 152	+70 / +26	+24 / +31	-3 / 0
Lab	**287 / 276**	226 / 243	152 / 156	+87 / +41	+57 / +84	-11 / -12
Pharmacy						
Retail Pharmacy	642 / 639	578 / **724**	**699** / 685	+2 / +2	-34 / -38	+43 / +31

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

Table 37. Counties with no Provider Access by MCO and County Type, CY2016									
Provider type	Number of Counties with 0% Access (of 105 Counties)								
	Urban & Semi-Urban			Non-Urban			Counties with 0% access from all 3 MCOs' providers		
	AGP	SSHP	UHC	AGP	SSHP	UHC	Urban	Non-Urban	# members no access
Physicians									
Primary Care Provider	-	-	-	-	-	-	-	-	-
Allergy	2	2	1	11	3	1	1	-	6,731
Cardiology	-	2	-	1	3	3	-	1	273
Dermatology	-	-	1	2	3	5	-	-	-
Gastroenterology	-	-	1	22	24	4	-	4	1,828
General Surgery	-	-	-	-	-	-	-	-	-
Hematology/Oncology	-	3	-	-	14	-	-	-	-
Internal Medicine	-	-	-	-	-	-	-	-	-
Neonatology	4	3	3	39	21	19	1	5	10,598
Nephrology	-	-	2	4	17	3	-	2	1,174
Neurology	-	-	-	3	-	-	-	-	-
Neurosurgery	3	3	1	12	2	-	-	-	-
OB/GYN	-	-	-	1	6	-	-	-	-
Ophthalmology	-	-	-	-	-	-	-	-	-
Orthopedics	-	-	-	-	-	2	-	-	-
Otolaryngology	-	-	-	5	8	-	-	-	-
Physical Medicine/Rehab	1	1	-	13	5	31	-	2	1,174
Plastic & Reconstructive Surgery	4	5	4	15	18	18	3	15	27,905
Podiatry	-	2	-	8	19	6	-	-	-
Psychiatrist	-	-	-	-	-	-	-	-	-
Pulmonary Disease	-	1	-	2	1	3	-	-	-
Urology	-	-	-	2	3	-	-	-	-
Hospital									
Hospitals	-	-	-	-	-	-	-	-	-
Eye Care - Optometry									
Eye Care - Optometry	-	-	-	-	1	1	-	-	-
Dental									
Dental Primary Care	-	-	-	1	6	5	-	1	221
Ancillary Services									
Physical Therapy	-	-	-	-	-	-	-	-	-
Occupational Therapy	-	-	-	-	5	4	-	-	-
X-ray	-	-	-	-	-	-	-	-	-
Lab	-	-	-	-	-	-	-	-	-
Pharmacy									
Retail Pharmacy	-	-	-	-	-	-	-	-	-

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

Frontier, Rural, and Densely-Settled Rural (Non-Urban) Counties
In CY2016, 30.7% (121,327) of KanCare members were residents of Frontier, Rural, or Densely-Settled Rural counties. KanCare members who lived in some of the Densely-Settled Rural, Rural, or Frontier counties did not have access to provider types from any of the MCOs. In CY2016, there were seven provider types where one or more county had no access through any of the three MCOs in 2016. The seven provider types and numbers of non-urban counties without access included:

- Cardiology - one county (Cheyenne) in 2016 and 2014; two counties in 2015;
- Gastroenterology - four counties in 2016 (Cheyenne, Decatur, Rawlins, and Sherman); four in 2015; 28 in 2014; 27 in 2013; and 12 in 2012;
- Neonatology - five counties in 2016 (Cheyenne, Greeley, Rawlins, Sherman, and Wallace); five in 2015; 13 in 2014; 36 in 2013; and 28 in CY2012;
- Nephrology - two counties in 2016 (Cheyenne and Sherman); two in 2015; and one in 2014;
- Physical Medicine/Rehab - two counties in 2016 (Cheyenne and Sherman); two in 2015; one in 2014;
- Plastic and Reconstructive Surgery - 15 counties in 2016 (Cheyenne, Clark, Grant, Greeley, Hamilton, Haskell, Kearny, Meade, Morton, Seward, Sherman, Stanton, Stevens, Wallace, and Wichita); 17 counties in 2015; and 15 in 2014; and
- Dental Primary Care -one county in 2015 (Lane); one in 2015; six in 2013; and two in 2012.

The counties with the least amount of access to providers in 2016 were Cheyenne and Sherman Counties, Frontier type counties in the northwest corner of Kansas. Both counties did not have access from any MCO to five provider types listed above, including Gastroenterology, Neonatology, Nephrology, Physical Medicine/Rehab, and Plastic/Reconstructive Surgery. Cheyenne County also did not have access to Cardiology. Of the other 16 counties with no access to one or more provider types: three counties had no access to two provider types, and 13 had no access to one provider type. Not factored into this analysis are the numbers of counties with no access to one or more providers that are adjacent on all sides to counties with no access to these same provider types.

Table 37 also only reports the number of counties where the MCOs reported 0% access. Including counties where over 90% of the members do not have access to particular provider types from any MCO would greatly expand the list. One example is Dental - only one county, Lane County, in western Kansas had no Dental provider access through all three MCO. In Logan and Wallace Counties, over 99% of members did not have access to dental services within their counties.

Access also varies by MCO; members in Seward County have over 99% reported access to dental services from one MCO, while only 3-5% of members in the other two MCOs have access to dental services through the MCO. In Table 38, the number and percentage of members without access to provider types are listed by provider types. (Not included in the table are provider types, such as PCP, Internal Medicine, and Behavioral Health that have 100% access, based on distance standards.) The provider types with least access in 2016 were Neonatology and Plastic/Reconstructive Surgery.

Table 38. Number and Percentage of Members not Within Access Distance by Provider Type and MCO, CY2016					
Provider type	AGP	SSHP	UHC	Total	% of all members
Neonatology	32,737	23,598	21,439	77,774	19.7%
Plastic/Reconstructive Surgery	20,084	25,965	18,971	65,020	16.5%
Physical Medicine	11,763	9,922	16,221	37,906	9.6%
Allergy	15,131	11,128	7,945	34,204	8.7%
Gastroenterology	11,830	13,188	6,112	31,130	7.9%
Podiatry	9,123	17,146	2,559	28,828	7.3%
Dermatology	9,283	13,714	4,148	27,145	6.9%
Neurosurgery	10,943	11,518	4,487	26,948	6.8%
Nephrology	2,975	12,282	7,263	22,520	5.7%
Hematology/Oncology	168	15,610	181	15,959	4.0%
Cardiology	250	10,035	1,731	12,016	3.0%
Dental	3,615	2,578	3,494	9,687	2.5%
Otolaryngology	2,723	2,760	2,577	8,060	2.0%
Pulmonary Disease	583	3,484	3,358	7,425	1.9%
OB/GYN	1,381	2,541	2,701	6,623	1.7%
Occupational Therapy	-	2,106	2,547	4,653	1.2%
Retail Pharmacy	757	1,752	1,270	3,779	1.0%
Lab	-	2,115	899	3,014	0.8%
X-ray	-	2,115	899	3,014	0.8%
Psychiatrist	421	1,423	998	2,842	0.7%
Urology	500	1,551	635	2,686	0.7%
Neurology	667	1,095	566	2,328	0.6%
Optometry	665	427	674	1,766	0.4%
Orthopedics	291	676	465	1,432	0.4%
Hospitals	-	473	899	1,372	0.3%
Opthalmology	-	121	181	302	0.1%
Physical Therapy	-	41	37	78	0.02%

The provider types that had the biggest improvements over time in reductions in numbers of counties without access were:

- Neonatology – In 2016 members in six counties did not have access through any MCO, compared to 36 counties in CY2013 and 13 counties in CY2014. It should be noted, however, that, while at least one MCO provided access to a Neonatologist in all but 5 counties, AGP had no access for 43 counties, SSHP had no access in 24 counties, and UHC had no access to Neonatologists for members in 22 counties.
- Neurosurgery – In 2015 and 2016, access was available through at least one MCO in all 105 Kansas counties. In CY2013, members in 20 counties did not have access, and in CY2014, members in 11 counties did not have access. UHC reported access for members in all but one county, compared to no access in five counties for SSHP (down from 32 in 2015) and 15 counties for AGP.

Average distance to a behavioral health provider

Average distance to one, two, three, four, and five BH providers by county type and by MCO in CY2016 are described below. As of December 2016, the MCOs reported the following number of BH providers and number of locations of the providers:

- Amerigroup – 2,805 providers at 977 locations
- Sunflower – 3,104 providers at 875 locations
- UnitedHealthcare – 3058 providers at 934 locations

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

- Amerigroup – 84,115 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.0 miles; to four providers was 1.8 miles; to three providers was 1.7 miles; to two providers was 1.5 miles; and to one provider was 1.2 miles.
- Sunflower – 98,854 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.2 miles; to four providers was 2.1 miles; to three providers was 2.0 miles; to two providers was 1.8 miles; and to one provider was 1.5 miles.
- UnitedHealthcare– 90,690 members in Urban/Semi-Urban counties. The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.8 miles; to two providers was 1.7 miles; and to one provider was 1.4 miles.

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

- Amerigroup – 25,892 members in Densely-Settled Rural counties. The average distance to a choice of five providers was reported as 4.6 miles; to four providers was 4.3 miles; to three providers was 3.6 miles; to two providers was 3.2 miles; and to one provider was 2.4 miles.
- Sunflower – 25,834 members in Densely-Settled Rural counties. The average distance to a choice of five providers was 6.1 miles; to four providers was 5.8 miles; to three providers was 5.7 miles; to two providers was 4.9 miles; and to one provider was 4.0 miles.
- UnitedHealthcare – 24,066 members in Densely-Settled Rural counties. The average distance to a choice of five providers was 4.3 miles; to four providers was 4.3 miles; to three providers was 4.2 miles; to two providers was 4.0 miles; and to one provider was 3.3 miles.

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

- Amerigroup – 14,800 members in Rural/Frontier counties. The average distance to a choice of five providers was 19.3 miles; to four providers was 17.1 miles; to three providers was 14.5 miles; to two providers was 12.1 miles; and to one provider was 8.1 miles.
- Sunflower – 16,496 members in Rural/Frontier counties. The average distance to a choice of five providers was 17.6 miles; to four providers was 16.4 miles; to three providers was 15.1 miles; to two providers was 13.6 miles; and to one provider was 11.9 miles.
- UnitedHealthcare – 13,396 members in Rural/Frontier counties. The average distance to a choice of five providers was 12.8 miles; to four providers was 11.8 miles; to three providers was 11.1 miles; to two providers was 10.3 miles; and to one provider was 9.2 miles.

Percent of counties covered within access standards for behavioral health

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

Urban/Semi-Urban - The access standard for Urban and Semi-Urban counties is a distance of 30 miles. This access standard was met in CY2015 for 100% of the 16 Urban and Semi-Urban counties in Kansas,

as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in the four previous years, CY2012 to CY2015.

Densely-Settled Rural - The access standard for Densely-Settled Rural counties is a distance of 45 miles. This access standard was met in CY2015 for 100% of the 21 Densely-Settled Rural counties in Kansas, as reported by the three MCOs. Based on the GeoAccess map reports, the access standard was also met in CY2014, CY2013, and CY2012.

Rural/Frontier - The access standard for Rural and Frontier counties is a distance of 60 miles. This access standard was met in CY2015 for 100% of the 32 Rural counties and 36 Frontier counties in Kansas, as reported by Amerigroup, Sunflower, and United. Based on the GeoAccess map reports, the access standard was also met in CY2012 to CY2015.

Home and Community Based Services (HCBS) - Counties with access to at least two providers by provider type and services.
Table 39 provides information reported by the three MCOs indicating the number of counties that have at least two service providers, and the number of counties that have at least one service provider, for each HCBS provider type. The baseline for this measure is CY2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review. Information on the counties without access or limited access is not yet reported through GeoAccess mapping.

As indicated in Table 39, as in CY2015, 17 of the 27 HCBS services were available in CY2016 from at least two service providers in all 105 counties for members of all three MCOs. Of the remaining 10 Home and Community Based Services:

- Adult Day Care
  - Amerigroup - Services were available from at least two providers in 102 counties in CY2015, same as reported in CY2016. In CY2014, services from at least two providers were available in only 82 counties, and in CY2013 only 74 counties. At least one service provider is available in the three remaining counties.
  - Sunflower - Services were available from at least two providers in only 50 counties in 2016 and 2014, two fewer than in 2015 and five more than in CY2013. At least one service provider is available in 81 of the 105 counties, six more than in CY2015.
  - UnitedHealthcare - Services were available from at least two providers in only 47 counties in CY2016 and CY2015, 27 fewer than in CY2014. At least one provider was available in 68 counties, down from 72 counties in CY2015.
- Intermittent Intensive Medical Care
  - Amerigroup – In CY2016 and CY2015, 77 counties had access to at least two service providers; compared to 84 in CY2013 and CY2014. In CY2016 and CY2015, 102 counties had at least one service provider 2 fewer counties than in CY2014.
  - Sunflower reported in CY2016 and CY2015 at least two service providers are available in 94 counties, 3 more than in CY2014, and 16 more than in CY2013. SSHP reported in CY2013 to CY2016 that all 105 counties had at least one service provider.
  - UnitedHealthcare reported in CY2013 through CY2016 that there were at least two service providers available in all 105 counties.

Table 39. Number of Counties with Access to Home and Community Based Services (HCBS) CY2016 Compared to CY2015*

Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Speech therapy - Autism Waiver	**7↓**	**7**	**12**	**27↓**	**2**	**2**
Speech therapy - TBI waiver	105	105	**50**	105	**9↑**	**28↑**
Behavior therapy - TBI waiver	105	105	105	105	**72↑**	**105↑**
Cognitive therapy - TBI waiver	105	105	105	105	**26↑**	**55↑**
Occupational therapy - TBI waiver	105	105	105	105	**12↑**	**33↑**
Physical therapy - TBI waiver	105	105	105	105	**30↑**	**55↑**
Adult day care	**102**	105	**50↓**	**81↑**	**47**	**68↓**
Intermittent intensive medical care	**77**	**102**	**94**	105	105	105
Home modification	**27↑**	**101↓**	105	105	105	105
Health maintenance monitoring	**69**	**103**	**95**	105	105	105
Specialized medical care/medical respite	105	105	105	105	105	105
Assistive services	105	105	105	105	105	105
Assistive technology	105	105	105	105	105	105
Attendant care services (Direct)	105	105	105	105	105	105
Comprehensive support (Direct)	105	105	105	105	105	105
Financial management services (FMS)	105	105	105	105	105	105
Home telehealth	105	105	105	105	105	105
Home-delivered meals (HDM)	105	105	105	105	105	105
Long-term community care attendant	105	105	105	105	105	105
Medication reminder	105	105	105	105	105	105
Nursing evaluation visit	105	105	105	105	105	105
Personal emergency response (installation)	105	105	105	105	105	105
Personal emergency response (rental)	105	105	105	105	105	105
Personal services	105	105	105	105	105	105
Sleep cycle support	105	105	105	105	105	105
Transitional living skills	105	105	105	105	105	105
Wellness monitoring	105	105	105	105	105	105

* Arrows indicate whether the number of counties with access to the service increased or decreased compared to CY2015

- Speech Therapy (Autism Waiver)
  - Amerigroup – In CY2016, AGP reported this service to be available from two or more providers in only 7 counties. In CY2015 and CY2014, Amerigroup reported that in 79 counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver. In CY2013, Amerigroup reported services from at least two providers were only available in three counties.
  - Sunflower - In CY2016 and CY2015, SSHP reported that in only 12 counties there were two or more providers available for specialized speech therapy for those on the Autism Waiver, 3 fewer than in CY2014. At least one service provider was available in 27 counties in CY2016, down from 28 counties in CY2015 and CY2014.

  - UnitedHealthcare – In CY2015, CY2014, and CY2013, UHC reported that these specialized services were only available from one or two providers in only 2 counties.
- Speech Therapy – TBI Waiver
  - Amerigroup - In CY2013 to CY2016, Amerigroup reported that at least two providers were available in all 105 counties for this specialized speech therapy for those with TBI.
  - Sunflower – In CY2013 and CY2014, Sunflower reported that at least two providers were available in all 105 counties. In CY2015 and CY2016, this dropped to 50 counties. All 105 counties continue to have at least one provider reported to be available.
  - UnitedHealthcare reported that at least two providers were available in CY2016 in 9 counties, up from 4 counties in CY2015, 5 counties in CY2014 and 7 counties in CY2013. At least one provider was available in 28 counties, up from 10 counties in CY2015 and 21 counties in CY2014 and CY2013.
- Behavior Therapy – TBI Waiver
  - Amerigroup and Sunflower again reported that at least two providers were available in all 105 counties for this specialized behavior therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 72 counties, up from 18 counties in CY2015, 12 counties in CY2014 and 1 county in CY2013. At least one provider was available in all 105 counties in CY2016, up from 43 counties in CY2015, 41 in CY2014, and 4 in CY2013.
- Cognitive Therapy – TBI Waiver
  - In CY2013 to CY2016, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized cognitive therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 26 counties in CY2016, up from 18 counties in CY2015, 12 counties in CY2014 and 1 county in CY2013. At least one provider was available in 55 counties in CY2016, up from 43 counties in CY2015, 41 counties in CY2014, and 4 counties in CY2013.
- Occupational Therapy – TBI Waiver
  - In CY2013 to CY2016, Amerigroup and Sunflower reported that at least two providers were available in all 105 counties for this specialized occupational therapy for those with TBI.
  - UnitedHealthcare reported that in CY2016, at least two providers were available in 12 counties, up from 11 counties in CY2013 to CY2015. In CY2016, UHC reported that at least one provider was available in 33 counties, up from 19 counties in CY2014, 26 counties in CY2014, and 32 counties in CY2013.
- Physical Therapy – TBI Waiver
  - Amerigroup and Sunflower reported that at least two providers were available in all 105 counties in CY2013 to CY2016 for this specialized physical therapy for those with TBI.
  - UnitedHealthcare reported that at least two providers were available in 30 counties in CY2016, up from 23 counties in CY2015, 24 counties in CY2014, and 14 counties in CY2013. At least one provider was available in 55 counties, up from 40 counties in CY2015 and 53 counties in CY2014.
- Health Maintenance Monitoring
  - Amerigroup – In CY2015 and CY2016, Amerigroup reported that at least two service providers were available in 69 counties, compared to 70 counties in CY2014 and CY2013. In each of the four years, Amerigroup reported 103 counties had at least one service provider.
  - Sunflower – In CY2015 and CY2016, Sunflower reported that two or more providers were available in 95 counties, compared to 91 in CY2014 and 105 in CY2013, and that at least one provider was available in 105 counties (all four years).

  - UnitedHealthcare – In CY2015, CY2014, and CY2013, UHC reported that at least two service providers were available in all 105 counties.
- Home Modification
  - Amerigroup reported only 27 counties had at least two service providers in CY2016, up from 14 in CY2015 and 23 counties in CY2013 and CY2014. In CY2016, Amerigroup reported 101 counties had at least one service provider, down from 102 in CY2015 and 105 counties in CY2013 and CY2014.
  - In CY2013 to CY2016, Sunflower and UnitedHealthcare reported that at least two service providers were available in all 105 counties.

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

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

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

I/DD Provider Services

I/DD provider services by county availability are listed in Table 40. Services reported in 2016 to be available from at least two I/DD providers by all three MCOs include: Targeted Case Management, Residential Support, Sleep Cycle Support, Personal Assistant Services, Financial Management Services, and Respite Care (Overnight).

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

- Supported Employment Services – AGP reported this service to be available from at least two I/DD providers in 51 counties, and from at least one provider in 81 of the 105 counties. SSHP reported this service to be available from at least two I/DD providers in 98 counties, and from at least one provider in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 25 counties, and from at least one provider in 48 of the 105 counties.
- Wellness Monitoring - AGP reported this service to be available from at least two I/DD providers in 92 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 95 counties, and from at least one provider in 102 counties. UHC reported this service to be available from at least two I/DD providers in 80 counties, and from at least one provider in all 105 counties.

Table 40. Number of Counties with Access to at Least Two I/DD Providers, by MCO, CY2016						
Provider type	Amerigroup		Sunflower		UnitedHealthcare	
	2 or more	at least 1	2 or more	at least 1	2 or more	at least 1
Targeted Case Management	105	105	105	105	105	105
Medical Alert Rental	105*	105	**55**	105	105*	105
Residential Support	105	105	105	105	105	105
Supportive Home Care	105	105	105	105	**103**	105
Sleep Cycle Support	105	105	105	105	105	105
Supported Employment Services	**51**	**81**	**98**	105	**25**	**48**
Personal Assistant Services	105	105	105	105	105	105
Assistive Services	**104**	105	105	105	105	105
Respite Care (Overnight)	105	105	105	105	105	105
Wellness Monitoring	**92**	105	**95**	**102**	**80**	105
Day Support	105	105	105	105	**58**	**98**
Financial Management Services (FMS)*	105	105	105	105	105	105
Specialized Medical Care - RN	**101**	105	**104**	105	105	105
Specialized Medical Care - LPN	**101**	**104**	**104**	105	105	105

* Provider specialty not specific to I/DD

- Medical Alert Rental - AGP and UHC reported Medical Alert Rental to be available from at least two providers in all 105 counties, but not specifically from I/DD providers. SSHP reported this service to be available from at least two I/DD providers in 55 counties, and from at least one I/DD provider in all 105 counties.
- Supportive Home Care - AGP and SSHP reported Supportive Home Care to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 103 counties, and from at least one provider in all 105 counties.
- Assistive Services - SSHP and UHC reported Assistive Services to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Day Support - AGP and SSHP reported Day Support to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 58 counties, and from at least one provider in 98 counties.
- Specialized Medical Care – RN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Specialized Medical Care – LPN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in 104 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.

Recommendations:

- KFMC again recommends this year that reporting be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
- KFMC again recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.

Provider Open/Closed Panel Report

The MCOs submit monthly Network Adequacy reports that include a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. This is primarily populated for PCP types.

In previous years, KFMC recommended that, due to a high frequency of duplicate entries (including exact duplicates, address variations for the same address, P.O. Box address and street address in a small town, etc.), the MCOs should review this report and remove duplicate entries. While the MCOs have been making efforts to improve reporting, in reviewing 2016 Network Adequacy reports, KFMC identified duplicate entries continue to be an area for improvement (e.g., including exact duplicates, variations of the same address with all other information the same, variations of the same provider name, provider addresses that only differed by one number).”Real time” information available to members on-line or through customer service contacts varies by MCO in timeliness. KFMC also found some inconsistencies and errors in how providers are classified (e.g., a Urologist and a Pulmonologist were listed instead as Neurologists, an Orthopedic Surgeon was listed instead as a Urologist, and an Anesthesiologist was listed as a Plastic Surgeon). Many providers have multiple locations in multiple counties; the Network Adequacy report does not indicate how often providers provide services at each location and whether their availability, particularly in non-urban counties, meets access requirements for the particular service and region. Provider panel status also is not included for all applicable providers. In a 2016 provider survey conducted for the State, a number of providers were found to have moved to distant states, were no longer in the networks for other reasons, or had moved to another city/practice.

Provider After-Hour Access (24 hours per day/7 days per week)

The MCOs are required by the State to ensure that the 24/7 requirement is met. No tracking report templates, however, are required of the MCOs by the State for tracking this. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards.

- Amerigroup conducts an annual survey of providers. After hours compliance in CY2016 was reported as 89% for PCPs and Pediatrics. Amerigroup staff members meet with providers not in compliance. In previous years, they indicated they then followed up with “secret shopper” type activities to confirm that changes have been put in place.
- Sunflower uses a nurse advice line, an affiliated organization, to conduct an annual telephone survey of PCPs regarding after-hours access; it appears the survey is conducted during office hours. SSHP also continues to contract with NurseWise to provide after-hours services to members and providers. NurseWise reports daily numbers of calls received. For CY2016, SSHP reported 100% PCP

compliance of PCP offices who were successfully contacted; 59% of the 342 sampled providers were successfully contacted. The inability to contact a PCP indicates the members may not be able to reach the PCP. The 139 PCPs that either refused to answer the survey questions, had an out-of-service phone number or wrong number, or that did not answer the phone or have an answering service should not be excluded from the denominator in determining compliance. SSHP is researching the incorrect or out-of-service phone numbers to identify correct information. KFMC recommends Sunflower follow up after office hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

- UnitedHealthcare contracts with a vendor (Dial America) that calls a random sample of providers after hours to ensure on-call service is available. In 2016, compliance with the 24/7 access requirement was 76.5%. UHC indicated they conduct follow-up phone calls related to the after-hours access results.

Amerigroup and UnitedHealthcare also included a supplemental question in their CAHPS surveys in CY2014 and CY2015 addressing after-hours appointment access. In CY2015, Sunflower added a supplemental question related to after-hours advice.

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

- In CY2016, 24.4% of adult survey respondents indicated they called after hours for an urgent need.
- In CY2016, 71.2% adults who called their doctor's office after hours said their wait to speak to a doctor or the doctor's representative was less than 20 minutes.
- The CY2016 rate of respondents reporting a wait over 60 minutes decreased to 8.3%, from 17.4% in CY2015 and 13.8% in CY2014.

UnitedHealthcare asked in their adult survey, ***"In the last 6 months, did you call a doctor's office or clinic after hours to get help for yourself?"*** A similar question was included in the child survey. A follow-up question was also added for both adult and child surveys of those who responded positively: ***"In the last 6 months, when you called a doctor's office or clinic after hours, how often did you get the help you wanted?"***

- **Adults** - In CY2016, 11.0% of adults called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 69.2% said they always or usually got the help they wanted, and 15.4% said they never got the help they wanted.
- **GC survey population** - In CY2016, 8.9% of GC survey respondents called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 87.0% said they always or usually get the help they wanted, and 2.80% (compared to 14.4% in CY2015) said they never got the help they wanted.
- **CCC survey population** - In CY2016, 10.0%of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours in CY2016, 80.0% said they always or usually got the help they wanted, and 4.2% (compared to 8.8% in CY2015) said they never got the help they wanted.

Sunflower asked in their adult survey, ***"In the past 6 months, did you phone your personal doctor's office after regular office hours to get help or advice for yourself?"*** A similar question was included in the child survey. A follow-up question was also added for both adult and child surveys of those who

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

- **Adults** - In CY2016, 14.0%of adults called their doctor's office or clinic after hours. Of those who indicated they called their provider after hours, 75.0% said they always or usually got the help or advice they needed and 15.0% said they never got the help or advice they needed (compared to 12.9% in CY2015).
- **GC survey population** - In CY2016, 13.6%of GC survey respondent called their doctor's office or clinic after hours Of those who indicated they called their provider after hours, 83.1% said they always or usually got the help they wanted; 9.9%said they never got the help they wanted (compared to 6.8% in CY2015).
- **CCC survey population -** In CY2016, 16.7% of CCC survey respondents indicated they called after hours to get help. Of those who indicated they called their provider after hours, 87.2% said they always or usually got the help they needed and 4.7% said they never got the help they wanted (remained the same from CY2015).

Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first second, third trimester and high risk)

The MCOs are required by the State to ensure that in-office wait time requirements are met. No tracking report templates, however, (as per the 24/7 access above) are required of the MCOs by the State for tracking these measures. MCOs submitted summaries that primarily focused on access to urgent and routine advice after hours. No information specifically related to in-office wait times and access to prenatal care visits was submitted for review.

Amerigroup – For CY2016, Amerigroup continued to report survey results by provider types, asking providers about availability of urgent and routine care.

- PCPs reported 95-97% compliance for urgent care and emergent care and 93% compliance for routine care.
- Specialists had 88% compliance for urgent care and 98%compliance for routine care.
- Pediatrics had 97-99% compliance for urgent and emergent care and 96% compliance for routine care.
- Behavioral health was reported as 92%-95% compliant and 92% compliance for mental health follow-up.

Sunflower – For CY2016, Sunflower reported survey results by provider type, asking providers about availability for urgent and routine care.

- PCPs reported 99% compliance for urgent care and 86% compliance for first available routine appointment.
- Oncology care for urgent appointments was 82% compliant and 88% compliant for first available routine appointment.
- OB was 86% compliant for routine care in the first trimester and 100% compliant for second and third trimester.

UnitedHealthcare – UHC employs a vendor to make calls on their behalf using a script in which the caller identifies themselves as representing the health plan (as opposed to a "secret shopper" approach), describes symptoms that represent either an urgent need or a routine need and requests the next available appointment with the specific provider named on the list. Script scenarios include both child and adult symptoms.

UHC reported the following survey results for CY2016 by provider type for CY2016, asking providers about availability of urgent and routine care.

- PCPs reported 58-71% compliance for urgent and emergent care and 93% compliance for routine care.
- Specialists had 25% compliance for urgent care and 73% compliance for routine care.
- Behavioral health was reported as 56% compliant for urgent care and 83% compliant for routine care.

Recommendations for the 24/7 and Appointment Access Requirements:

- KFMC recommends the State request a more consistent method of MCO tracking and reporting these measures. KFMC recommends that all MCOs confirm provider after-hour access through after-hours phone calls to the providers.
- MCOs should report compliance rates and appointment availability for calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO.
- MCOS are encouraged to continue to include access to care supplemental questions in the CAHPS survey to help identify member experience in accessing appointments.
- When reporting outcomes related to member access to after-hours phone contact to providers, the MCOS should include in the denominator all out-of-service or wrong numbers, and offices that did not answer the phone or have an answering service alternative. MCOs should follow up after office hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

(20) Member Survey – CAHPS

Additional detail on the CAHPS survey In CY2015 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to access of care include the questions in Table 41.

Questions on both adult and child surveys:

- **In the last 6 months did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**
  The rate of respondents that indicated they needed care right away in the last 6 months was comparable within the populations and across years (Adults: CY2016 - 44.0%, CY2015 - 45.7%, CY2014 - 45.2%, CY2012 - 44.3%; GC: CY2016 - 35.7%, CY2015 - 37.9%, CY2014 - 35.2%, CY2012 - 32.1%; CCC: CY2016 - 43.1%, CY2015 - 47.4%, CY2014 - 43.6% in CY2014).
  - **In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?**
    The weighted aggregate rate for adults in CY2016 (86.2%) was comparable to CY2015 (87.2%) and CY2014 (88.1%), higher than in CY2012 (80.0%) and above the QC 75th percentile. The rate for the GC population in CY2016 (93.9%) was comparable to CY2015 (93.2%) and CY2014 (94.1%); the CY2016 results remained above the QC 66.67th percentile. The CY2016 CCC population rate (95.1%) was comparable to CY2015 (93.9%) and CY2014 (95.0%) and was above the QC 75th percentile.
- **In the last 6 months, how often was it easy (for your child) to get the care, tests, or treatment you (your child) needed?**
  The weighted aggregate rates remain generally comparable for all populations in CY2014 through CY2016 (Adult: 87.2% - 88.1%; GC: 92.0% - 93.4%; CCC: 91.9% - 93.0%). All results remain above the QC 50th percentile.

Table 41. Member Survey - CAHPS Access to Care Questions, 2014 - 2016							
Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last six months, did you (your child) have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?	**Adult**	**44.0%**	45.7%	45.2%	NA	NA	NA
	GC	**35.7%**	37.9%	35.1%	NA	NA	NA
	CCC	**43.1%**	47.4%	43.6%	NA	NA	NA
In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	**Adult**	**86.2%**	87.2%	88.1%	↑	↑	↑
	GC	**93.9%**	93.2%	94.1%	↑	↑	↑
	CCC	**95.1%**	93.9%	95.0%	↑	↑	↑
In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?	**Adult**	**76.3%**	77.1%	75.8%	NA	NA	NA
	GC	**69.5%**	68.9%	70.8%	NA	NA	NA
	CCC	**77.3%**	78.7%	80.0%	NA	NA	NA
In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	**Adult**	**82.5%**	82.7%	82.9%	↑	↑	↑
	GC	**90.0%**	89.7%	90.6%	↑	↑	↑
	CCC	**92.1%**	92.4%	92.2%	↑	↑	↓
How often was it easy to get the care, tests, or treatment you (your child) needed?	**Adult**	**87.2%**	88.1%	87.6%	↑	↑	↑
	GC	**92.1%**	92.0%	93.4%	↑	↑	↑
	CCC	**92.4%**	91.9%	93.0%	↑	↑	↑
Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 6 months, did you make any appointments (for your child) to see a specialist?	**Adult**	**44.3%**	46.5%	43.0%	NA	NA	NA
	GC	**17.9%**	19.4%	17.9%	NA	NA	NA
	CCC	**39.8%**	39.5%	38.4%	NA	NA	NA
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	**Adult**	**86.2%**	81.7%	84.8%	↑	↑	↑
	GC	**80.8%**	84.6%	83.2%	↑	↑	↑
	CCC	**86.2%**	83.3%	85.3%	↑	↑	↑

- **In the last 6 months, did you make any appointments for a check-up or routine care (for your child) at a doctor's office or clinic?**
  The rate of adult respondents making appointments for a check-up or routine care was comparable from CY2014 through CY2016, with a range from 75.8% - 77.1%, higher than the CY2012 rate of 73.5%. The percentage of the GC population that scheduled a check-up or routine care ranged from 68.9% - 70.8% in CY2014 through CY2016; the CY2012 rate was 77.8%. The CCC population ranged from 77.3% - 80.0% in CY2014 through CY2016.
  - **In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for (your child) for a check-up or routine care at a doctor's office or clinic as soon as you thought you needed?**
    Of the adults who scheduled an appointment, the percentage reporting they received an appointment as soon as they thought was needed remained above the QC 75th percentile in CY2014 through CY2016 (82.5% - 82.9%). The GC results were comparable across years (CY2016

-90%; CY2015 – 89.7%; CY2014 – 90.6%; CY2012 – 89.9%); the CY2016 rate was above the 66.67th percentile. The CC results were also comparable across years (CY2016 - 92.1%; CY2015 - 92.4%; CY2014 - 92.2%), and in CY2016.remained above the GC 50th percentile.

- **In the last 6 months, did you make any appointments (for your child) to see a specialist?**
  In CY2016, 44.3% of adults, 17.9% of the GC population, and 39.8% of the CCC population reported having one or more appointments with a specialist. The CY2016 rates were comparable to CY2015 and CY2014.
  - **In the last 6 months, how often did you get an appointment (for your child) to see a specialist as soon as you needed?**
    Of those who had appointments with a specialist in the previous six months, 86.2% of adults in CY2016 obtained an appointment as soon as they needed, compared to 81.7% in CY2015, 84.8% in CY2014, and 75.9% in CY2012. The CY2016 adult results increased from above the QC 50th percentile to above the 95th percentile. All three MCOs had increases in the adult populations' rates and QC percentiles. The CY2015 GC results continued to be higher than CY2012, although there were variations across years (GC: CY2016 – 80.8%, CY2015 – 84.6%, CY2014 – 83.2%, CY2012 – 79.0%). The CCC results in CY2016 increased to 86.2% from CY2015 – 83.3% and CY2014 – 85.3%, and were above the QC 75th percentile in 2016.

(21) Member Survey – Mental Health

The MH Surveys conducted in CY2011 through CY2015 are described above in Section 7 "Member Survey – Quality."

Questions and survey results related to member perceptions of access to MH services are listed in Table 42 and are described below:

- **Provider availability as often as member felt it was necessary**
  Results from the general adult population were lower in 2016 (84.0%) than in the previous five years. The 2015 rate (87.2%) was comparable to rates in 2014 (87.9%) and 2013 (88.2%).
- **Provider return of calls within 24 hours**
  Response results in 2016 (79.6%) were the lower than in the previous five years. Response results in 2015 (84.4%) were comparable to 2014 (83.3%) and 2013 (84.4%). Pre-KanCare rates were 88.1% in 2011 and 80.8% in 2012.
- **Services were available at times that were good for the member**
  - Positive response percentages in 2016 ranged from 83.9% (General Youth, family responding) to 90.4% (General Youth, youth responding).
  - Results from the General Adult population in CY2016 (87.4%) are the lowest they have been in the six year period. Trend analysis showed a significant decrease in positive response percentages from 2013 to 2016 (p=.01).
  - For General Youth (family responding), there was a significant decrease in positive responses in CY2016 (83.9%) compared to 2015 (90.9%; p<.01) and 2013 (88.7%; p=.03); the CY2016 rate is the lowest of the six-year period.
- **Ability to see a psychiatrist when the member wanted to**
  For the General Adult population, there was a significant decrease in positive responses in 2016 (73.6%) compared to 83.4% in 2015 (p<.01); 80.5% in 2014 (p=.02); 82.3% in 2013 (p<.01); and 82.1% in 2011 (p=.02). Also, there was a significant negative trend 2013 to 2016 (2013 – 82.3%; 2014 – 80.5%; 2015 – 83.4%; 2016 – 73.6%; [p=.02]). In the six-year period, the 70.8% rate in 2012 was the only rate lower than the 2016 rate.

Table 42. Mental Health Survey - Access-Related Questions

Item	Year	0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
My mental health providers were willing to see me as often as I felt it was necessary.	**General Adult (Age 18+)**							
	2016		**84.0%**	**243 / 289**	**79.3% – 87.8%**		.08	.22
	2015		87.2%	332 / 381	83.4% – 90.2%	.24		
	2014		87.9%	706 / 804	85.5% – 90.0%	.09		
	2013		88.2%	927/1,051	86.2% – 90.1%	.05		
	2012		85.3%	233 / 273	80.6% – 89.1%	.65		
	2011		88.8%	262 / 295	84.7% – 92.0%	.09		
My mental health providers returned my calls in 24 hours.	**General Adult (Age 18+)**							
	2016		**79.6%**	**213 / 267**	**74.4% – 84.1%**		.15	.07
	2015		84.4%	292 / 346	80.2% – 87.9%	.12		
	2014		83.3%	618 / 742	80.5% – 85.8%	.17		
	2013		84.4%	840 / 995	82.0% – 86.5%	.06		
	2012		80.8%	202 / 250	75.4% – 85.2%	.74		
	2011		88.1%	251 / 285	83.8% – 91.4%	**<.01 -**		
Services were available at times that were good for me.	**General Adult (Age 18+)**							
	2016		**87.4%**	**258 / 294**	**83.1% – 90.8%**		**.01↓**	.08
	2015		90.0%	343 / 381	86.6% – 92.7%	.28		
	2014		89.8%	733 / 817	87.5% – 91.7%	.26		
	2013		92.1%	985/1,071	90.4% – 93.6%	**.01 -**		
	2012		87.7%	242 / 276	83.2% – 91.1%	.92		
	2011		92.3%	277 / 300	88.7% – 94.9%	.05		
	General Youth (Ages 0-17), Family Responding							
	2016		**83.9%**	**276 / 328**	**79.6% – 87.5%**		.16	.70
	2015		90.9%	297 / 327	87.2% – 93.6%	**<.01 -**		
	2014		86.9%	682 / 783	84.4% – 89.1%	.19		
	2013		88.7%	871 / 983	86.5% – 90.5%	**.03 -**		
	2012		88.0%	235 / 267	83.5% – 91.4%	.16		
	2011		85.9%	287 / 334	81.8% – 89.3%	.47		
	General Youth (Ages 12-17), Youth Responding							
	2016		**90.4%**	**141 / 156**	**84.6% – 94.2%**		.66	.53
	2015		88.5%	130 / 147	82.2% – 92.8%	.59		
	2014		87.5%	271 / 308	83.3% – 90.7%	.35		
	2013		88.7%	455 / 513	85.5% – 91.3%	.56		
	2012		83.0%	83 / 100	74.4% – 89.2%	.08		
	2011		89.5%	119 / 133	83.0% – 93.7%	.80		
	SED Waiver Youth and Young Adult, Family/Member Responding							
	2016		**84.1%**	**275 / 328**	**79.7% – 87.7%**		.66	.25
	2015		84.5%	283 / 336	80.2% – 88.0%	.88		
	2014		85.2%	356 / 418	81.5% – 88.3%	.66		
	2013		85.1%	415 / 487	81.6% – 88.0%	.70		
	2012		88.6%	287 / 324	84.7% – 91.7%	.09		
	2011		85.4%	243 / 285	80.8% – 89.0%	.65		
	SED Waiver Youth (Ages 12-17), Youth Responding							
	2016		**84.4%**	**139 / 164**	**78.0% – 89.2%**		.60	.47
	2015		85.7%	131 / 153	79.3% – 90.4%	.74		
	2014		86.0%	167 / 194	80.3% – 90.2%	.67		
	2013		82.6%	187 / 226	77.2% – 87.0%	.64		
	2012		82.2%	111 / 135	74.8% – 87.8%	.62		
	2011		83.7%	103 / 123	76.1% – 89.3%	.88		

Table 42. Mental Health Survey - Access-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
I was able to see a psychiatrist when I wanted to.	**General Adult (Age 18+)**						
	2016	**73.6%**	**195 / 265**	**67.9% – 78.5%**		**.02↓**	.67
	2015	83.4%	291 / 349	79.2% – 87.0%	**<.01 -**		
	2014	80.5%	598 / 744	77.5% – 83.2%	**.02 -**		
	2013	82.3%	807 / 981	79.8% – 84.6%	**<.01 -**		
	2012	70.8%	187 / 264	65.1% – 76.0%	.48		
	2011	82.1%	225 / 274	77.1% – 86.2%	**.02 -**		
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**235 / 290**	**75.8% – 84.9%**		.05	.05
	2015	84.9%	325 / 383	81.0% – 88.2%	.15		
	2014	86.5%	704 / 814	84.0% – 88.7%	**.02 -**		
	2013	86.0%	917/1,066	83.8% – 87.9%	**.03 -**		
	2012	78.8%	219 / 278	73.6% – 83.2%	.56		
	2011	91.3%	274 / 300	87.6% – 94.1%	**<.001 -**		
	General Youth (Ages 12-17), Youth Responding						
	2016	**83.1%**	**126 / 152**	**76.3% – 88.3%**		.55	.94
	2015	87.5%	126 / 144	81.0% – 92.1%	.28		
	2014	83.8%	260 / 309	79.2% – 87.5%	.85		
	2013	82.8%	427 / 518	79.1% – 86.0%	.94		
	2012	85.0%	85 / 100	76.6% – 90.8%	.68		
	2011	85.1%	114 / 134	78.0% – 90.2%	.64		
	SED Waiver Youth (Ages 12-17), Youth Responding						
	2016	**79.3%**	**127 / 161**	**72.3% – 84.9%**		**.03↑**	.27
	2015	81.5%	123 / 151	74.6% – 86.9%	.61		
	2014	74.8%	138 / 184	68.0% – 80.5%	.33		
	2013	71.8%	165 / 229	65.7% – 77.2%	.10		
	2012	76.3%	103 / 135	68.4% – 82.7%	.54		
	2011	77.6%	97 / 125	69.5% – 84.1%	.74		
My family got as much help as we needed for my child. (I was able to get all the services I thought I needed.)	**General Youth (Ages 0-17), Family Responding**						
	2016	**82.2%**	**264 / 320**	**77.6% – 86.0%**		.87	.62
	2015	86.3%	278 / 322	82.1% – 89.6%	.15		
	2014	79.7%	609 / 766	76.7% – 82.4%	.34		
	2013	83.2%	799 / 966	80.7% – 85.4%	.67		
	2012	82.9%	213 / 257	77.8% – 87.0%	.83		
	2011	84.2%	278 / 330	79.9% – 87.8%	.48		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**77.6%**	**253 / 325**	**72.7% – 81.8%**		.29	.68
	2015	78.9%	260 / 330	74.2% – 83.0%	.67		
	2014	76.4%	318 / 413	72.0% – 80.2%	.70		
	2013	75.2%	363 / 482	71.1% – 78.8%	.43		
	2012	77.3%	248 / 321	72.4% – 81.6%	.93		
	2011	77.4%	220 / 284	72.2% – 81.9%	.97		

Table 42. Mental Health Survey - Access-Related Questions (Continued)

Item	Year	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
During a crisis, I was able to get the services I needed.	**General Adult (Age 18+)**						
	2016	**80.7%**	**196 / 242**	**75.3% – 85.2%**		.15	.92
	2015	85.0%	265 / 312	80.6% – 88.5%	.18		
	2014	86.0%	586 / 682	83.2% – 88.4%	.05		
	2013	85.4%	742 / 870	82.9% – 87.6%	.08		
	2012	79.2%	183 / 231	73.5% – 84.0%	.69		
	2011	83.9%	209 / 249	78.8% – 88.0%	.35		
During a crisis, my family was able to get the services we needed.	**General Youth (Ages 0-17), Family Responding**						
	2016	**83.8%**	**209 / 248**	**78.7% – 87.9%**		.32	**.03↓**
	2015	84.6%	197 / 233	79.3% – 88.7%	.81		
	2014	83.4%	457 / 548	80.1% – 86.3%	.90		
	2013	86.2%	604 / 706	83.5% – 88.6%	.34		
	2012	87.4%	173 / 198	82.0% – 91.4%	.29		
	2011	89.5%	204 / 228	84.8% – 92.9%	.07		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**78.0%**	**205 / 260**	**72.6% – 82.7%**		.75	.83
	2015	78.3%	213 / 272	73.0% – 82.8%	.93		
	2014	81.5%	276 / 338	76.9% – 85.3%	.30		
	2013	76.4%	299 / 390	71.9% – 80.3%	.63		
	2012	79.1%	197 / 249	73.6% – 83.7%	.76		
	2011	80.0%	173 / 216	74.2% – 84.8%	.59		
Medication available timely*	**General Adult (Age 18+)**						
	2016	**92.9%**	**237 / 255**	**89.0% – 95.5%**		.96	
	2015	90.3%	296 / 328	86.5% – 93.1%	.26		
	2014	92.7%	661 / 713	90.5% – 94.4%	.91		
	2013	91.8%	827 / 903	89.8% – 93.4%	.57		
	General Youth (Ages 0–17), Family Responding						
	2016	**83.7%**	**171 / 204**	**78.0% – 88.2%**		.71	
	2015	88.0%	198 / 225	83.0% – 91.6%	.21		
	2014	85.3%	408 / 478	81.8% – 88.2%	.60		
	2013	86.1%	537 / 622	83.1% – 88.6%	.41		
	SED Waiver Youth and Young Adult, Family/Member Responding						
	2016	**94.5%**	**262 / 278**	**91.1% – 96.7%**		.10	
	2015	93.3%	275 / 294	89.8% – 95.7%	.55		
	2014	94.8%	356 / 376	92.0% – 96.7%	.86		
	2013	90.9%	379 / 416	87.8% – 93.3%	.08		

*Not asked in 2012 and 2011

- **Ability to get all the services the members thought they needed**
  - Rates in 2016 ranged from 77.6% (SED Youth and Young Adult, family responding) to 83.1% (General Youth, ages 12-17, youth responding).
  - For the General Adult population, there was a significant decrease in positive responses in 2016 (80.7%) compared to 2014 (86.5%; p=.02), compared to 2013 (86.0%; p=.03), and compared to 2011 (91.3%; p<.001).
  - For the General Youth (family responding), the 2016 rate (82.2%) was lower than the 2015 rate (86.3%), but higher than in 2014 (79.7%).

  - The rate for General Youth (ages 12-17, youth responding) decreased in 2016 (83.1%) from 2015 (87.5%); the rate in 2013 (82.8%) was the only rate lower in the six-year period.
  - The rate for SED Waiver youth and young adults decreased in 2016 (77.6%) from 2015 (78.9%). Rates in the six-year period ranged from 75.2% in 2013 to 78.9% in 2015.
- **Ability to get services during a crisis**
  - Rates in 2016 ranged from 78.0% (SED Waiver youth and young adults) to 83.8% (General Youth).
  - For the General Youth, there was a statistically significant negative trend from 2011 to 2016 (2011 – 89.5%; 2012 – 87.4%; 2013 – 86.2%; 2014 – 83.4%; 2015 – 84.6%; 2016 – 83.8%; *p*=.03).
  - In CY2016, the General Adult percentage of positive responses decreased from 85% in 2015 to 80.7%.
  - For the SED Waiver youth and young adults (family/member responding), the 2016 rate (78.0%) was slightly lower than the 78.3% rate in 2015. In the six-year period, only 2013 had a lower rate (76.4%).
- **Timely availability of medication**
  - From 2013 to 2016 the General Adult rates for medication availability have been above 90%. The 92.9% rate in 2016 was the highest of the four-year period.
  - SED Waiver youth and young adults responses have also been over 90% positive over the four-year period, ranging from 90.9% in 2013 to 94.5% in 2016
  - General Youth rates continued to be lower, ranging from 83.7% in 2016 to 88.0% in 2015.

(22) Member Survey – SUD

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014. Questions related to perceptions of access to care for members receiving SUD services follow (see Table 43).

Table 43. SUD Survey - Access-Related Questions, CY2014 - CY2016

	CY2016	CY2015	CY2014
Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? *(Percent of "Yes" responses)*	84.4%	87.7%	92.1%
In the last year, did you need to see your counselor right away for an urgent problem? *(Percent of "Yes" responses)*	28.4%	25.7%	28.5%
If yes:			
How satisfied are you with the time it took you to see someone? *(Percent of "Very satisfied" and "Satisfied" responses)*	94.1%	79.1%	98.2%
Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? *(Percent of ">48 hours" responses)*	16.0%	19.0%	10.9%
Is the distance you travel to your counselor a problem or not a problem? *(Percent of "Not a Problem" responses)*	87.9%	88.0%	89.1%
Were you placed on a waiting list? *(Percent of "Yes" responses)*	21.2%	15.6%	12.2%
If you were placed on a waiting list, how long was the wait? *(Percent of "3 weeks or longer" responses)*	42.1%	46.2%	26.1%

- **Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted?**
  In 2016, 84.4% (270) of 320 members indicated they got an appointment as soon as they wanted, compared to 87.7% in 2015, 92.1% in 2014, and 89.6% in 2012.
- **For urgent problems, how satisfied are you with the time it took you to see someone?**
  - In 2016, 28.4% (92) of 324 members surveyed indicated that in the past year they had needed to see their counselor right away for an urgent problem, compared to 25.7% in 2015, 28.5% in 2014, and 26% in 2012.
  - Of the 92 members who reported needing to see a counselor right away for an urgent problem, 84 responded to the follow-up question related to satisfaction with the wait time to see someone. In 2016, 94.1% of the 84 members indicated they were very satisfied or satisfied, compared to 79.1% (34 of 43 members) in 2015, 98.2% (56 of 57 members) in 2014, and 98.0% in 2012.
- **For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?**
  - Of the 92 members who reported needing to see a counselor right away for an urgent problem, 75 provided a response related to the length of the wait time.
  - In 2016, 16.0% (12) of the 84 members reported they had to wait 48 hours or longer, compared to 19.0% in 2015 (8 of 42 members), and 10.9% in 2014 (6 of 55 members).
  - In 2016, 64% (48) of the 84 members were seen within 24 hours, compared to 54.8% in 2015 and 58.2% in 2014.
- **Is the distance you travel to your counselor a problem or not a problem?**
  In 2016, 87.9% (275) of 313 members surveyed indicated travel distance was not a problem, comparable to 88.0% in 2015, 89.1% in 2014, and 90.5% in 2012.
- **Were you placed on a waiting list?**
  The number and percentage of members placed on a waiting list increased from 11.7% in 2012 to 12.2% (25 of 205) in 2014 to 15.6% (28 of 180) in 2015 to 21.2% (69 of 326) in 2016.
- **If you were placed on a waiting list, how long was the wait?**
  - In 2016, 57 of 69 members who reported they were placed on a waiting list responded. Of these, 42.1% (24) indicated their wait was three weeks or longer, and 38.6% (22) reported waiting one week or less.
  - In 2015, 26 of the 28 members placed on a waiting list responded. Of these, 46.2% (12) indicated their wait was three weeks or longer, and 23.1% (6) reported they waited one week or less.
  - In 2014, 23 of the 25 members that indicated they were put on a waiting list responded. Of these, 26.1% (6) indicated their wait was three weeks or longer, and 34.7% (8) waited one week or less.

(23) Provider Survey

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

Providers were asked, "**Please rate your satisfaction with availability of specialists**." Table 44-provides the available survey results by individual MCO.

Table 44. Provider Satisfaction with Availability of Specialists, CY2014 - CY2016												
MCO	Very or Somewhat Satisfied			Neither Satisfied nor Dissatisfied			Very or Somewhat Dissatisfied			Total Responses*		
General Provider Surveys												
	2016	2015	2014	2016	2015	2014	2016	2015	2014	2016	2015	2014
Amerigroup	**59.4%**	59.5%	45.9%	**18.8%**	23.7%	37.0%	**21.9%**	16.8%	17.1%	**160**	333	257
Sunflower	**39.8%**	52.9%	40.7%	**51.7%**	30.9%	44.2%	**8.4%**	16.2%	15.0%	**261**	259	226
UnitedHealthcare	**43.7%**	45.2%	^	**39.4%**	32.9%	^	**16.9%**	21.9%	^	**71**	73	63
Behavioral Health Provider Surveys+												
	2016	2015	2014	2016	2015	2014	2016	2015	2014	2016	2015	2014
Cenpatico (SSHP)	**28.1%**	27.4%	**	**64.7%**	65.3%	**	**7.2%**	7.3%	**	**167**	124	**
Optum (UHC)	**44.1%**	38.6%	32.1%	**44.1%**	55.4%	54.8%	**11.7%**	5.9%	13.1%	**145**	101	84

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

Amerigroup

In 2016, 59.4% of providers were very or somewhat satisfied, comparable to 59.5% in 2015 and higher than 45.9% in 2014. The percentage of providers very or somewhat dissatisfied with availability of specialists was 21.9% in 2016, up from 16.8% in 2015 and 17.1% in 2014.

Sunflower

- **Sunflower general provider survey** – In 2016, 39.8% of providers were very or somewhat satisfied with the availability of specialists, down from 52.9% in 2015 and 40.7% in 2014. The percentage of providers very or somewhat dissatisfied with availability of specialists was 8.4% in 2016, down from 16.2% in 2015 and 15.0% in 2014.
- **Sunflower (Cenpatico) BH provider survey** - In 2016, only 28.1% of BH providers were very or somewhat satisfied, comparable to 2015 (27.4%). The percentage dissatisfied was only 7.2% in 2016 and 7.3% in 2015. Approximately two thirds of the BH providers in 2015 and 2016 were neither satisfied nor dissatisfied.

UnitedHealthcare

- **UnitedHealthcare general provider survey** –In 2016, 43.7% of the 71 providers surveyed were very or somewhat satisfied, comparable to 45.2% in 2015; 16.9% of the providers were very or somewhat dissatisfied in 2016, down from 21.9% in 2015. (2014 survey results are not available due to a typographical error on the survey instrument.)
- **UHC (Optum) BH provider survey** – In 2016, 44.1% of 145 BH providers surveyed were very or somewhat satisfied, higher than in 2015 (38.6%) and 2014 (32.1%). The percentage reporting they were very or somewhat dissatisfied was 11.7% in 2016, up from 2015 (5.9%) and lower than in 2014 (13.1%).

Efficiency

(24) Grievances – Reported Quarterly

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

(25) Calls and Assistance – Reported Quarterly

- **Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office.**
- **Track number and type of assistance provided by the Ombudsman's Office.**
  The types of assistance and numbers of contacts provided to KanCare members by the Ombudsman's Office are analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

(26) Systems

Data for the following measures are reported for the KanCare population and stratified by HCBS waiver I/DD, PD, TBI, and FE, and by MH – members who had a MH visit during the year. HEDIS data reported for CY2013 and CY2014 for ED visits and Inpatient Discharges are also reported for the KanCare population based on data submitted to KDHE by the three MCOs. The HCBS and MH stratified data differ somewhat from the HEDIS data, primarily due to inclusion or exclusion of members with dual coverage through Medicare or through private insurance (in addition to Medicaid eligibility).

Emergency Department (ED) Visits
Population: KanCare (all members) and stratified by TBI, FE, I/DD, PD, and MH
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2015 compared to rates in CY2012 pre-KanCare. ED rates for MH members and for the KanCare population decreased from CY2012 to CY2013, but have increased above CY2012 rates in CY2014 and CY2015.

ED visit rates for the KanCare population, in HEDIS data reported by the MCOs for all KanCare members, were also lower in CY2014 compared to CY2013. HEDIS rates for ED visits, however, exclude ED visits that result in inpatient admissions, while the data reported for HCBS and MH include all ED visits whether or not they resulted in an inpatient admission. As such, the data reported for HCBS and MH members below should not be compared to the HEDIS rates for ED visits.

As noted above, reported rates can differ a great deal depending on whether members with dual eligibility are excluded or included. MCOs often do not receive data (or data are delayed) for claims paid entirely by Medicare or other private insurance. Dual-eligible members compose approximately 12% of the KanCare population, and compose approximately 70% of the HCBS population.

While there are differences in the numbers and rates of ED visits for the TBI, FE, I/DD, PD, and MH members in CY2012 through CY2014 when including dual eligible members (Table 45) and excluding dual-eligible members (see Table 46) no differences were noted in ED usage patterns based on dual eligibility. The summaries that follow are based on data that include members with dual eligibility.

Table 45. HCBS and MH Emergency Department (ED) Visits, Including Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2015

	CY2015	CY2014	CY2013	CY2012
Traumatic Brain Injury (TBI)				
ED Visits	1,098	1,291	1,181	1,452
Members	590	694	748	744
Member-Months	5,991	6,667	7,406	6,596
Visits per 1,000 member months	**183.27**	**193.64**	**159.47**	**220.13**
Frail Elderly (FE)				
ED Visits	4,000	4,220	3,889	6,199
Members	6,683	6,879	6,899	7,341
Member-Months	61,240	62,984	64,328	68,631
Visits per 1,000 member months	**65.32**	**67.00**	**60.46**	**90.32**
Intellectual/Developmental Disability (I/DD)				
ED Visits	5,005	4,890	4,217	5,601
Members	9,141	9,123	9,084	9,037
Member-Months	105,222	104,737	103,575	103,258
Visits per 1,000 member months	**47.57**	**46.69**	**40.71**	**54.24**
Physical Disability (PD)				
ED Visits	8,352	8,465	8,045	12,424
Members	6,368	6,166	6,340	6,984
Member-Months	66,098	64,782	68,468	75,087
Visits per 1,000 member months	**126.36**	**130.67**	**117.50**	**165.46**
Total - TBI, FE, I/DD, PD				
ED Visits	18,455	18,866	17,332	25,676
Members	22,714	22,762	23,071	24,106
Member-Months	238,551	239,170	243,777	253,572
Visits per 1,000 member months	**77.36**	**78.88**	**71.10**	**101.26**
Mental Health (MH)				
ED Visits	156,336	141,799	113,226	118,754
Members	114,237	105,602	97,307	94,750
Member-Months	1,260,156	1,155,804	1,054,167	1,020,723
Visits per 1,000 member months	**124.06**	**122.68**	**107.41**	**116.34**

Table 46. HCBS and MH Emergency Department (ED) Visits, Excluding Dual-Eligible Members (Medicare and Medicaid), CY2012 - CY2015				
	CY2015	CY2014	CY2013	CY2012
Traumatic Brain Injury (TBI)				
ED Visits	626	681	575	797
Members	260	290	311	404
Member-Months	2,618	2,743	3,153	3503
Visits per 1,000 member months	**239.11**	**248.27**	**182.37**	**227.52**
Frail Elderly (FE)				
ED Visits	280	225	193	296
Members	328	311	255	263
Member-Months	3,211	2,833	2,340	2,515
Visits per 1,000 member months	**87.20**	**79.42**	**82.48**	**117.69**
Intellectual/Developmental Disability (I/DD)				
ED Visits	2,073	1,897	1,681	2,372
Members	3,828	3,688	3,543	4,255
Member-Months	43,365	41,377	39,317	46,812
Visits per 1,000 member months	**47.80**	**45.85**	**42.76**	**50.67**
Physical Disability (PD)				
ED Visits	3,291	2,969	2,700	4,419
Members	1,839	1,673	1,668	2,215
Member-Months	18,858	17,316	17,692	22,999
Visits per 1,000 member months	**174.51**	**171.46**	**152.61**	**192.14**
Total - TBI, FE, I/DD, PD				
ED Visits	6,270	5,772	5,149	7,884
Members	6,255	5,962	5,777	7,137
Member-Months	68,052	64,269	62,502	75,829
Visits per 1,000 member months	**92.14**	**89.81**	**82.38**	**103.97**
Mental Health (MH)				
ED Visits	112,926	100,689	78,933	83,238
Members	87,640	79,819	72,479	69,813
Member-Months	971,216	877,314	786,883	753,839
Visits per 1,000 member months	**116.27**	**114.77**	**100.31**	**110.42**

- **HCBS** (total visits per 1,000 member-months for TBI, FE, I/DD, and PD) – ED visit rates in CY2015 (77.36) were lower than CY2014 (78.88) and much lower than in CY2012 (101.26).
- **TBI** – TBI members had the highest rate of ED visits in CY2012 to CY2015, compared to the other waiver populations. The ED visit rates, however, significantly decreased from 220.13 in CY2012 to 159.47 in CY2013. The rate increased from CY2013 to CY2014 (193.64) and then decreased in CY2015 to 183.27.
- **PD** – PD members also had high rates of ED visits, but dropped from 165.46 in CY2012 pre-KanCare to 117.50 in CY2013. The rate increased to 130.31 in CY2014, but decreased again in CY2015 to 126.36 visits per 1,000 member-months.

- **FE** – FE member rates followed the same patter as TBI and PD, initially decreasing from 90.32 visits per 1,000 member-months in CY2012 to 60.46 in CY2013, and then increasing to 67.00 in CY2014 before decreasing to 65.32 visits per 1,000 member-months in CY2015.
- **I/DD** – I/DD member ED rates were lower than those of PD, FE, and TBI members each of the four years. From CY2012 to CY2013, rates dropped from 54.24 to 40.71. In CY2014, the rate increased to 46.69 and increased again in CY2015 to 47.57.
- **MH** –MH member ED visit rates initially dropped from 116.34 visits per 1,000 member-months in CY2012 to 107.41 in CY2013. The rate increased in CY2014 to 122.68 and then increased again in CY2015 to 124.06 visits per 1,000 member-months.
- **HEDIS (KanCare Population**: HEDIS rates exclude visits that result in inpatient admissions, while the data reported above include all ED visits. The aggregate number of ED visits per 1,000 member-months for CY2015, as reported for HEDIS 2016 by the three MCOs, was 66.31 visits per 1,000 member-months, which was higher than the CY2014 rate (64.19) and higher than the CY2013 rate (65.17 ED visits per 1,000 member-months). The ED visit rate in CY2015 that includes visits that result in inpatient admissions was 73.60, which was higher than in CY2014 (72.33), CY2013 (65.86), and CY2012 (71.16).

Inpatient Hospitalizations

Population: KanCare (all members) and stratified by TBI, FE, I/DD, PD, and MH
Analysis: Comparison of baseline CY2013 to annual measurement and trending over time.
Data reported below for HCBS (TBI, FE, I/DD, and PD) and for MH are based on inpatient admissions. HEDIS data reported for all KanCare members are based instead on inpatient discharges. Inpatient admission rates were higher in CY2015 for TBI, FE, and I/DD members and lower for PD members than inpatient admission rates pre-KanCare 2012. From CY2014 to CY2015, rates increased for TBI and I/DD and decreased for FE and PD members (see Table 45).

- **HCBS** (total admissions per 1,000 member-months for TBI, FE, I/DD, and PD) – Inpatient admission rates decreased from 35.27 in CY2012 to 34.03 in CY2013. The rate increased in CY2014 to 36.12 before decreasing again in CY2015 to 35.58 inpatient admissions per 1,000 member-months.
- **TBI** – Inpatient admission rates for TBI members decreased from CY2012 (46.91) to CY2013 (45.50) and to 45.34 in CY2014 before increasing in CY2015 to 49.82 admissions per 1,000 member-months, the highest rate of the four year period.
- **PD** – PD member admission rates decreased from 54.17 in CY2012 to 50.92 in CY2013. The rate increased in CY2014 to 55.96 (higher than in CY2012), but then decreased in CY2015 to 53.82, below the CY2012 rate.
- **FE** – FE member admission rates increased from 48.27 in CY2012 to 49.94 in CY2013 and increased again in CY2014 to 53.31 before decreasing somewhat in CY2015 to 51.19 admissions per 1,000 member-months.
- **I/DD** – I/DD member inpatient admission rates were much lower than those of PD, FE, and TBI members in each of the four years. Admission rates increased slightly from 12.37 admits per 1,000 member-months in CY2012 pre-KanCare to 12.44 in CY2013 and to 13.16 in CY2014 and 14.39 in CY2015.
- MH – MH admissions are based on MH-related admissions. MH admissions decreased each year from 8.08 admissions per 1,000 member-months in CY2012 to 6.95 in CY2015.

Table 47. HCBS and MH Inpatient Admissions and Readmissions within 30 days of Discharge, CY2012 - CY2016

		Inpatient Admissions		Readmissions after Discharge	
Year	Members	Admits	Admits per 1,000 Member months	Readmits	Readmits per 1,000 member months
Traumatic Brain Injury (TBI)					
2015	589	298	**49.82**	83	**13.88**
2014	693	301	**45.34**	46	**6.93**
2013	746	336	**45.50**	53	**7.18**
2012	743	308	**46.91**	55	**8.38**
Frail Elderly (FE)					
2015	6,613	3,091	**51.19**	479	**7.93**
2014	6,789	3,301	**53.31**	495	**7.99**
2013	9,797	3,144	**49.94**	444	**7.05**
2012	7,240	3,244	**48.27**	429	**6.38**
Intellectual/Developmental Disability (I/DD)					
2015	9,138	1,513	**14.39**	174	**1.66**
2014	9,115	1,376	**13.16**	179	**1.71**
2013	9,079	1,287	**12.44**	149	**1.44**
2012	9,033	1,276	**12.37**	136	**1.32**
Physical Disability (PD)					
2015	6,342	3,535	**53.82**	641	**9.76**
2014	6,136	3,601	**55.96**	696	**10.82**
2013	6,307	3,463	**50.92**	599	**8.81**
2012	6,953	4,043	**54.17**	674	**9.03**
Total - TBI, FE, I/DD, PD					
2015	22,682	8,437	**35.58**	1,377	**5.81**
2014	22,733	8,579	**36.12**	1,416	**5.96**
2013	25,929	8,230	**34.03**	1,245	**5.15**
2012	23,969	8,871	**35.27**	1,294	**5.14**
Mental Health (MH) - MH-Related Inpatient Admissions and Readmissions					
2015	87,640	6,750	**6.95**	911	**0.94**
2014	79,819	6,778	**7.73**	932	**1.06**
2013	72,479	6,167	**7.84**	875	**1.11**
2012	69,813	6,091	**8.08**	827	**1.10**

- **KanCare Population**: Inpatient for the KanCare population initially decreased from 70.91 admissions per 1,000 member-months in CY2012 to 65.67 in CY2013 before increasing to 72.12 in CY2014 and 73.39 in CY2015.

Inpatient Readmissions within 30 days of inpatient discharge
Population: KanCare (all members), and stratified by I/DD, PD, TBI, MH, FE, and MH.
Analysis: Comparison of baseline CY2012 to annual measurement and trending over time. Inpatient readmission rates decreased in CY2013 and CY2014 for TBI and MH members from CY2012 pre-KanCare but increased slightly for FE, I/DD, and PD members. (HEDIS data were not reported for readmissions for this time period.)

- **HCBS** (total readmissions per 1,000 member-months for TBI, FE, I/DD, and PD) – Readmission rates per 1,000 member-months increased each year from 5.14 in CY2012 to 5.15 in CY2013 to 5.96 in CY2014, but decreased in CY2015 to 5.81 readmissions per 1,000 member-months.
- **TBI** – TBI member readmission rates decreased from 8.38 in CY2012 to 7.18 in CY2013 to 6.93 in CY2014 before increasing to 13.88 in CY2015, higher than each of the three preceding years and higher than the other waiver population rates in the four-year period.
- **PD** – PD members had higher rates of readmissions than TBI, FE, I/DD, and MH members in CY2012 to CY2014. Readmission rates decreased slightly in CY2013 (8.81 readmissions per 1,000) compared to CY2012 pre-KanCare (9.03), but then increased to 10.82 in CY2014 before decreasing again to 9.76 in CY2015.
- **FE** – FE member rates increased from 6.38 readmissions (per 1,000 member-months) in pre-KanCare CY2012 to 7.05 in CY2013, increasing again in CY2014 to 7.99, and then decreasing slightly to 7.93 in CY2015.
- **I/DD** – I/DD member readmission rates were lower than those of PD, FE, and TBI members in each of the four years. Readmission rates increased slightly from 1.32 readmissions per 1,000 member-months in CY2012 pre-KanCare to 1.44 in CY2013 and to 1.71 in CY2014 before decreasing to 1.66 in CY2015.
- **MH** –MH members had much lower readmission rates than the HCBS members, but their readmission rates are based on MH-related readmissions only. Readmission rates were slightly higher in CY2013 (1.11 admits per 1,000 member-months) compared to CY2012 pre-KanCare (1.10) and decreased in CY2014 (1.06) and again in CY2015 to 0.94 readmissions per 1,000 member-months.

Quantify system design innovations implemented by KanCare such as: Person-Centered Medical Homes, Electronic Health Record use, Use of Telehealth, and Electronic Referral Systems
System design innovations for improved health care provision throughout Kansas, such as patient-centered medical homes, electronic health record use, use of telehealth, and electronic referral systems, were reported in the KanCare Evaluation Quarterly Reports in CY2013 and CY2014 and are now reported in the KanCare Evaluation Annual Reports. The following is a summary of 2016 activities.

To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC researches and summarizes the various related initiatives occurring in Kansas that have the potential to affect a broad KanCare population. KFMC collects the following information about the other initiatives, as available, to help determine overlap with KanCare initiatives:

- Consumer and provider populations impacted,
- Coverage by location/region,
- Available post-KanCare performance measure data, and
- Start dates and current stage of the initiative.

Health Homes

The Health Homes program for KanCare members with SMI continued to provide care coordination services through June 30, 2016, when the program was discontinued. Care Coordination and Targeted Case Management services are available through MCOs and CMHCs.

Patient Centered Medical Homes

- Blue Cross/Blue Shield of Kansas (BCBSKS)
  BCBSKS has a Quality-Based Reimbursement Program (QBRP) that allows their contracting providers to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSKS and their patients.
  - *Coverage by location/region:* Kansas, excluding metro Kansas City
  - *Start dates and current stage of the initiative*: Since 2011, BCBSKS has incentivized a number of provider-based quality improvement initiatives such as Electronic Health Record (EHR) adoption, electronic prescribing, participation in a Health Information Exchange (HIE), and Patient Centered Medical Home (PCMH). These incentives change each year and continued in 2016.
- Children's Mercy Hospital & Clinics (CMH) DSRIP - Expansion of Patient Centered Medical Homes and Neighborhoods
  - *Consumer and provider populations impacted:* Children and youth with medical complexity (CYMC) and their siblings.
  - *Coverage by location/region:* Four practices in Northeast Kansas
  - *Start dates and current stage of the initiative*: The project started January 1, 2015. The four practices are in active stages of modifying their processes, per the PCMH model, in preparation for NCQA certification. One practice became PCMH recognized by NCQA in 2016.

Other Practice Redesign Initiatives

- Kansas Healthcare Collaborative – Practice Transformation Network
  The Kansas Healthcare Collaborative (KHC), a quality organization founded by the Kansas Medical Society and the Kansas Hospital Association is the lead organization in Kansas for the Practice Transformation Network (PTN). The PTN involves group practices, health care systems and others joining forces to collectively share quality improvement expertise and best practices to reach new levels of coordination, continuity, and integration of care. KHC provides coaching and assistance to clinician practices preparing for clinical and operational practice transformation from a fee-for-service payment model to performance-based payment.
  - *Consumer and provider populations impacted:* Primary care practices, health care systems, and the consumers they serve.
  - *Coverage by location/region:* More than 1,000 Kansas clinicians are expected to participate in this effort.
  - *Start date and current stage of the initiative*: The grant was awarded September 29, 2015, and KHC was in the first phase of the program in 2016.
  - *Outcomes/Performance Measurement Results*: Not applicable due to initial phase of the program.
- The University of Kansas Hospital (KUH) – Kansas Heart and Stroke Collaborative
  The Kansas Heart and Stroke Collaborative is an innovative care delivery and payment model to improve rural Kansans' heart health and stroke outcomes and reduce total cost of care. The grant program is funded by the Centers for Medicare and Medicaid Services Innovation. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information

exchange, "big data" analysis, and population health management. The program includes the following objectives:

- Develop shared clinical guidelines for moving patients to the next level of care.
- Provide care coordination and management.
- Deliver more telemedicine resources.
- Leverage electronic health information exchanges.
- Establish standards and procedures to increase efficiency and economics of scale.
- Design and deploy payment models to support rural providers.
- Create a forum for sharing best practices and regional care strategies.

  - *Consumer and provider populations impacted:* All consumers of participating providers. *Coverage by location/region:* As noted in The University of Kansas Health System's 2016 annual report, "*The collaborative has expanded from its original 13 healthcare participants in 12 northwest Kansas communities to 38 hospitals in 37 Kansas counties*."
  - *Start date and current stage of the initiative*: The initiative started September 1, 2014, and extends through August 31, 2017.
  - *Outcomes/Performance Measurement Results*: The KHSC continues to collect data on outcomes. Data will be provided in the 2017 KanCare Evaluation report.

- Accountable Care Organizations (ACO)
  ACOs are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program. In CY2016, there were nine ACOs in Kansas.

  In November 2016, Blue Cross and Blue Shield of Kansas announced a partnership with the Aledade ACO to extend value-based reimbursement opportunities to smaller provider offices across Kansas. BCBS of KS has also entered into ACO agreements with larger hospital systems and provider groups.
- Kansas Association for the Medically Underserved – Health Center Controlled Network (HCCN)
  The HCCN is a group of safety net providers collaborating horizontally or vertically to improve access to care, enhance quality of care, and achieve cost efficiency through the redesign of practices to integrate services and optimize patient outcomes. Redesign includes a focus on health information technology systems, integration of electronic health record systems, Meaningful Use (MU) attestation, and quality improvement.
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.
  - *Coverage by location/region:* Locations of participating safety net clinics include: Atchison, Dodge City, Garden City, Great Bend, Halstead, Hays, Hoxie, Hutchinson, Junction City, Lawrence, Liberal, Manhattan, Newton, Salina, Topeka, Ulysses, Victoria, Wichita, and Winfield.
- Sunflower Foundation – Integrated Care Initiative
  Since its inception in 2012, the Integrated Care Initiative has awarded 37 grants totaling nearly $3.3 million in its support of primary care and behavioral health safety net systems that are working to deliver health care for the whole person. The Sunflower Foundation 2016 annual report notes, "*In 2016, Sunflower began funding research and analysis of the systemic barriers to the implementation of integrated care in Kansas. The project is intended to lay groundwork and chart the course for policy changes needed to make integrated care sustainable in Kansas*."

Health Information Technology (EHRs and MU)

As mentioned in previous KanCare evaluation reports, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created provisions to promote the Meaningful Use (MU) of health information technology. Through the Office of the National Coordinator for Health Information Technology Regional Extension Center program, KFMC provided support to more than 1,600 Eligible Professionals (EPs) and 95 Eligible Hospitals (EHs) across the state to achieve MU. The Regional Extension Center program was sunset on April 7, 2016.

CMS operationalized MU by setting up core and menu set measures that must be met by EPs and EHs to receive incentive dollars or to avoid Medicare reduced payment adjustments. The State of Kansas is in charge of the program for Kansas Medicaid providers within CMS guidelines. Medicaid incentives are for providers that adopt/implement/upgrade to certified EHR technology and for MU. From January 2011 to January 2017, Kansas EPs and EHs have obtained the following incentive payments:

- Medicare Eligible Professionals: $332,195,109
- Medicaid Eligible Professionals: $88,927,455
- Eligible Hospitals: $292,305,116

KFMC, through funding by KDHE/DHCF, is providing technical assistance to Medicaid providers, assisting them with selection, implementation, and meaningful use of an EHR between February 2014 and September 2017. KFMC has worked with 232 Medicaid providers to date.

Health Information Exchange

Increasing HIE capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of healthcare providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), have continued to expand their capabilities and to offer services to a wider audience. Below is a summary of the incorporation of HIE into the system for providing healthcare in Kansas.

- KHIN
    - Membership: Over 1,000 participating hospitals and clinics throughout Kansas. Personal Health Record (PHR): MyKSHealth eRecord is a PHR that is available to all consumers who receive care from Kansas health care providers. This allows consumers access to their records any time they need them.
    - KanCare MCOs: KHIN has worked with KanCare MCOs to ensure they have accurate, up-to-date information on their members. While a record of healthcare service is available to the MCOs upon receipt of a claim, KHIN provides the service information in real time at the point of care being received. KHIN can provide daily updates to the MCOs regarding member activity in the last 24 hours.
    - Quality Measure Reporting: Now that KHIN has a significant amount of clinical data, KHIN is beginning to focus more on quality measure reporting and has applied for NCQA certification; as well as to CMS to become a qualified clinical data registry. KHIN is able to perform data extracts for specified quality measures, e.g., hemoglobin A1c values, cholesterol levels, glucose monitoring, hypertension monitoring, etc., and report them back to the providers.
- LACIE
    - Patients queried: LACIE receives more than 100,000 queries per month.

- KS WebIZ: LACIE is working with providers to aid in their direct connection to KS WebIZ through LACIE.
- LACIE 2.0: LACIE is partnering with Health Metrics Services (HMS) in Palo Alto, California, to build a Private Health Information Exchange. This exchange can extract specific data that an organization wants to share with another provider or payer. The participating organizations have full control over their data. This allows participants to control what is shared, who it is shared with, duration of the sharing agreement, as well as the frequency of when data is shared. LACIE 2.0 is vendor agnostic and can extract data (with permission) from all nationally certified Electronic Medical Records (EMRs). LACIE 2.0 will be offered in connection with LACIE 1.0 or as a separate service for organizations that may not be connected to a Health Information Organization (HIO) or are connected to an HIO other than LACIE 1.0.

Telehealth and Telemedicine

Telehealth is a broad scope of remote healthcare services, including long-distance clinical healthcare, patient and professional health-related education, and health administration activities. Telehealth refers to a broader scope of remote healthcare services, while telemedicine refers specifically to remote clinical services using interactive televideo, including use of digital stethoscopes, otoscope cameras, general exam cameras, and intra-oral scopes.

- The University of Kansas Center for Telemedicine & Telehealth (KUCTT)
  KUCTT provides a wide range of telehealth services through its Heartland Telehealth Resource Center, as well as telemedicine services.
  - *Consumer and provider populations impacted:* Many hospitals and clinics across the state are equipped with video conferencing systems that allow providers to collaborate with KUCTT for specialty clinical consults. The KUCTT has provided consults to patients across Kansas in more than 30 medical specialties.
  - *Coverage by location/region:* More than 100 sites throughout Kansas
  - *Start date and current stage of the initiative*: This is an ongoing service provided since 1991

Timely resolution of grievances – Reported Quarterly

Timely resolution of grievances is analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

Compare/track number of access-related grievances over time, by population type – Reported Quarterly

Comparisons and tracking of access-related grievances over time and by population are reported in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review.

Timeliness of claims processing – Reported Quarterly

Timeliness of processing clean claims, non-clean claims, and all claims is reported and analyzed in the KanCare Evaluation Quarterly Reports. Each quarter since Q4 CY2013, these quarterly reports have been submitted by KDHE to CMS and are available on the KanCare website for public review. Included in this measure are the numbers of claims received each month, the number of claims processed within contractually required timeframes, and analysis of trends over time for turn-around times for processing clean claims.

(27) Member Surveys

CAHPS Survey

Additional detail on the CAHPS survey In CY2016 can be found in Section 4 of this report in the Health Literacy section. CAHPS questions related to efficiency include the following questions listed in Table 48.

Table 48. Member Survey - CAHPS

Question	Pop	Weighted % Positive Responses			QC 50th Percentile		
		2016	2015	2014	2016	2015	2014
Questions on Adult and Child Surveys							
In the last 6 months, did you get information or help from your (child's) health plan's customer service?	**Adult**	**32.6%**	33.2%	33.1%	NA	NA	NA
	GC	**28.9%**	27.3%	24.7%	NA	NA	NA
	CCC	**30.2%**	31.1%	28.3%	NA	NA	NA
In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?	**Adult**	**83.8%**	84.2%	80.0%	↑	↑	↓
	GC	**83.9%**	85.4%	86.7%	↑	↑	↑
	CCC	**82.2%**	84.4%	84.8%	↓	↑	↑

Questions on both adult and child surveys:

- **In the last 6 months, did you get information or help from your (child's) health plan's customer service?**
  Customer service contacts are similar across all survey populations and years, with some variation in the GC population (Adult: 33.1% - 32.6%; GC: 24.71% - 28.9%; CCC: 28.3% - 31.1%).
  - **In the last 6 months, how often did your (child's) health plan's customer service give you the information or help you needed?**
    Of adults who contacted their health plan's customer service in CY2016, 83.8% (CY2015 - 84.2%; CY2014 - 80.0%; CY2012 – 77.1%) received the information or help they needed; the adult rate remained above the QC 75th percentile. The GC results (CY2016 – 83.9%; CY2015 – 85.4%; CY2014-86.7%; CY2012 – 80.1%) decreased from above the QC 75th to above the 50th percentile. The CCC results (CY2016-82.2%; CY2015 -84.4%; CY2014-84.8%) decreased from above the QC 66.67th percentile to below the 33.33rd percentile.

Mental Health Survey

The MH Surveys conducted in CY2011 through CY2015 are described above in Section 7 "Member Survey – Quality." The question related to efficiency of MH services was: "**My mental health providers returned my calls in 24 hours**." As shown in Table 49, over 79.6% of the adults surveyed in 2016 indicated providers returned their calls within 24 hours, compared to 84.4% in 2015 and 2013, and compared to 83.3% in CY2014.

Table 49. Mental Health Survey - Efficiency-Related Questions

Item	Year	0% 100%	Rate	N/D	95% Confidence	*p*-Value	Trend 4-Year	Trend 6-Year
	General Adult (Age 18+)							
My mental health providers returned my calls in 24 hours.	**2016**		**79.6%**	**213 / 267**	**74.4% – 84.1%**		.15	.07
	2015		84.4%	292 / 346	80.2% – 87.9%	.12		
	2014		83.3%	618 / 742	80.5% – 85.8%	.17		
	2013		84.4%	840 / 995	82.0% – 86.5%	.06		
	2012		80.8%	202 / 250	75.4% – 85.2%	.74		
	2011		88.1%	251 / 285	83.8% – 91.4%	**<.01 -**		

SUD Survey

Section 7 above provides background on the SUD survey conducted by the three MCOs in 2014 and 2015. The question that follows is related to perception of efficiency for members receiving SUD services (see Table 50).

Table 50. SUD Survey - Efficiency-Related Question, CY2014 - CY2016

	CY2016	CY2015	CY2014
How well does your counselor communicate with you? *(Percent of "Very well" or "Well" responses)*	**92.1%**	**93.2%**	**93.9%**

- **How would you rate your counselor on communicating clearly with you?**
  Of the 330 surveyed in CY2016, 304 (92.1%) rated their counselor as communicating very well or well, comparable to CY2015 (93.2%) and CY2014 (93.9%).

Uncompensated Care Cost (UCC) Pool

Number of Medicaid Days for Uncompensated Care Cost Pool hospitals compared to UCC Pool Payments

The UCC Pool permits payments from the State to hospitals based on the uncompensated cost of furnishing services to Medicaid and uninsured individuals. The UCC Pool funding is based on historical costs. For instance, the UCC Pool funding for CY2015 is based on costs of care during FY2013, and funding for CY2014 is based on costs of care during FY2012.

There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, and to 178,721 in CY2016.

UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116.

Delivery System Reform Incentive Program (DSRIP)

The Kansas DSRIP projects, originally planned to be implemented as four-year projects from 2014 through 2017, are now three-year projects beginning in 2015. CMS provided feedback in 2014 and the DSRIP hospitals subsequently revised their project proposals based the feedback. CMS approval of the revised DSRIP projects was received on February 5, 2015.

The DSRIP program aims to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and management of chronic and complex diseases. Participating hospitals are to work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas includes two major hospitals, Children's Mercy Hospital and Clinics (CMH) and the University of Kansas Hospital (KUH). The two hospital systems are major medical service providers to Kansas and Missouri residents. CMH projects include *Improving Coordinated Care for Medically Complex Patients (Beacon Program)* and *Expansion of Patient-Centered Medical Homes and Neighborhoods (PCMH)*. KUH projects include STOP Sepsis (*Standard Techniques, Operations, and Procedures for Sepsis)* and SPARCC (*Supporting Personal Accountability and Resiliency for Chronic Conditions).*

KFMC, the External Quality Review Organization (EQRO) for the Medicaid program (KanCare) for the State of Kansas, reviewed annual reports for activities completed in CY2015 and CY2016 submitted to the KDHE by CMH and KUH. The major focus of the DSRIP Evaluation is to assess the progress in meeting overall goals of each project, along with providing an independent evaluation of progress in meeting each of the metrics delineated in levels one through four of the DSRIP project proposals approved by CMS in February 2015.

The University of Kansas Hospital

STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis
KUH is using the DSRIP initiative to spread their internal quality programs that address sepsis to rural Kansas populations in order to reduce the disparity of care for sepsis patients in rural nursing facilities and hospitals. KUH will share best practices on the early identification and treatment of sepsis with a goal of reducing the need for hospitalization or minimizing the length of stay and intensity of hospital care.

As reported by the Centers for Disease Control and Prevention in their August 2016 Vital Signs focused on sepsis, "*Sepsis begins outside of the hospital for nearly 80% of patients*." This highlights the importance of focusing this DSRIP project on implementing protocols not only by hospitals, but also by NFs, long-term care facilities, and Emergency Medical Service (EMS) providers.

In 2016 KUH conducted training in 19 counties statewide. KUH reported 554 workshop attendees in the from 103 partner facilities in 2016, including 20 NFs, 24 EMS providers, and 44 hospitals. Workshop attendance ranged from 15 to 50 per workshop.

KUH greatly increased data tracking and reporting in 2016. Of 147 partner facilities, 43 have a sepsis protocol in place, 27 newly implemented in 2016. In CY2016, 33 partner facilities, including three NFs,

began entering sepsis-related data in the Kansas Sepsis Program Database. KUH has developed an NF-specific curriculum that includes slides and posters providing information on basic sepsis symptoms. Of special interest are training materials for licensed practical nurses and nursing assistants in development for distribution in 2017.

In 2015, KUH conducted four workshops in Southeast, Northeast, and South Central Kansas. There were 94 workshop attendees from 45 facilities, including 22 NFs, eight EMS providers, and 10 hospitals (including two critical access hospitals). Workshop attendance ranged from 19 to 29 per workshop.

Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)
As described in the project proposal, *"Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) will focus on heart failure patients around the state, with an emphasis on those counties having highest incidence of heart failure admittance to hospitals. A key goal of the SPARCC model is building heart failure patients' ability to care for themselves and be resilient in the face of their chronic condition. This goal ties directly to the major goal for the DSRIP SPARCC initiative: reduce hospital readmission from heart failure though improved self-care."*

KUH has provided SPARCC facilitation training to over 160 individuals and has over 85 partners statewide. Focus is now on expanding the number of group sessions led by these trained facilitators. In 2016, 46 facilitators trained through the SPARCC program in 2015 and 2016 conducted 24 groups (four sessions per group), with 86 patients and 10 caregivers/supporters participating in one or more session. KUH has, thus, been successful in first training facilitators the first year of DSRIP (2015) who then followed through in successfully implementing the SPARCC program for patients in NE, North Central, and SW Kansas. KUH reported that 86 patients participated in 24 groups in 2016, 43 in groups meeting in the first half of the year and 43 in groups meeting in the second half of the year. The first six-month booster session was also completed in 2016, with 43 heart failure patients and caregivers participating.

KUH has also been successful in developing eight training videos for SPARCC facilitators soon to be uploaded to a DSRIP YouTube website.

Children's Mercy Hospital and Clinics

Improving Coordinated Care for Medically Complex Patients (Beacon Program)
The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013 and reported in December 2014 that 63 patients were from Kansas. In 2015 there were 56 Kansas Beacon patients– 38 CYMC and 18 siblings. In 2016, there were 92 Kansas Beacon patients – 65 CYMC and 27 siblings.

Another major focus of the Beacon program is to provide consultation to PCPs of children living in rural areas or distant from the Kansas City area. In the first six months of 2016, Beacon staff conducted extensive outreach to 82 providers statewide. They also developed a flyer with responses to frequently asked questions and provided PCPs with information on characteristics of children eligible for the Beacon program. As a result of the outreach, Beacon provided 20 consults, an increase compared to only one Kansas consult in 2015.

In 2015, the Beacon program obtained Level III Person Centered Medical Home status and added several additional staff, including two social workers, a dietician, a PCP physician, and a nurse practitioner care coordinator.

Expansion of Patient-Centered Medical Homes and Neighborhoods
CMH is promoting the Patient-Centered Medical Homes (PCMH) model to transform the way pediatric primary care is organized and delivered in Kansas. Components of the PCMH DSRIP project include increasing access to effective and efficient primary care services and increasing the use of population health management through health information technology. CMH is partnering with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. The participating practices are delivering improved care that meets the Triple Aim.

Each practice continues to implement the concepts and processes specific to the PCMH model. One practice has achieved NCQA PCMH recognition. A second practice plans to submit their application for recognition in early 2017, after implementing the new NCQA PCMH standards for 2017. CMH continues to work with each practice, providing technical assistanceTA and monthly learning collaborative sessions. CMH has also implemented two new information technology-related (IT) improvements and is working on a third. CMH developed an online message board to serve as a forum for the practices to communicate with each other on an ongoing basis. They will be evaluating the use of the message board in 2017. CMH has also developed an integrated database platform, providing patient data from multiple sources in one database. This was developed in an effort to assist the practices with using health information technology for population health management. CMH is in the process of developing an online searchable community resource database, to be available in 2017. This database provides more functionality than the current hard copy resource books, allowing providers to more easily search for specific resources. The online database will also allow CMH to keep the database up-to-date and to evaluate the extent it is used.

Conclusions

In this fourth KanCare Evaluation Annual Report, KFMC has found that performance outcomes continue to be generally positive.

Comparison data varied based on the type of measure and availability of data.

- Many measures reviewed in this report include comparisons with pre-KanCare outcomes, including: SUD Services (Section 2); SUD Survey (Sections 7, 16, 22, and 27); five MH NOMS (Section 3); MH Survey (Sections 7, 14, 21, and 27); NF (Section 6); CAHPS Survey (Sections 4, 7, 14, 20, and 27); Provider Network Access (Section 19); and UCC Pool.
- In the performance measure validation process, KFMC worked with KDADS, KDHE, and MCO staff to improve the accuracy and completeness of the reporting of P4P metrics. As a result, some of the data reported in last year's report were updated to provide more accurate data.
- Measures reported in KanCare Quarterly Evaluation reports, beginning in Q4 CY2013, are referenced in this report (Sections 9, 24, 25, and 26) and are available for public review on the KDHE KanCare website (www.kancare.ks.gov).

Quality of Care
Physical Health
The baseline data submitted by the MCOs for 18 HEDIS measures, including results by age group,

demonstrate areas of strength (where results were above the QC 50th percentile, and some higher than the 75th percentile) and areas where additional efforts should be focused (where results were below the QC 50th percentile or lower). The summary below includes identification of metrics that were P4P and those identified by CMS as 2017 Core Health Care Quality Measures.

HEDIS measures in CY2015 with weighted aggregated results above the QC 50th percentile included:

- **Adults' Access to Preventive/Ambulatory Health Services** (AAP) - All age ranges were above the QC 50th percentile in CY2013 - CY2015. Aggregate weighted rates for Ages 45-64 were above the QC 90th percentile in CY2013 – CY2015; for Ages 20-44 were above the QC 75th percentile in CY2015; for Ages 65 and older were above the QC 66.67th percentile; and for Total (ages 20 and older) were above the QC 75th percentile in all three years.
- **Annual Dental Visit** (ADV) – Results for all age groups were above the QC 50th percentile in CY2013 – CY2015. CY2015 was the first year the rate for ages 19-20 was above the QC 50th percentile. The total rate (ages 2 to 20) in CY2015 was above the QC 75th percentile.
- **Comprehensive Diabetes Care** (CDC)
  - **Eye Exam (Retinal)** (P4P 2014-2016) Aggregate rates for Eye Exam (Retinal) were above the QC 75th percentile in CY2015 and higher than CY2014 and CY2013.
  - **HbA1c Poor Control [>9.0%];***(CMS 2017 Core Adult Health Care Quality Measure)* For this metric, the goal is to have a lower rate and lower QC percentile. The aggregate rate based on weighted hybrid data for CY2015 was 45.4%, an improvement compared to CY2014 (52.9%), CY2013 (54.4%), and CY2012 (83.4%) and was below the QC 50th percentile (which, for this metric is the goal).
- **Follow-up (within 7 days) after Hospitalization for Mental Illness** (FUH) – *(CMS 2017 Core Adult, Child, and Behavioral Health Care Quality Measure)* The aggregate rate in CY2015 was higher than in CY2014 and CY2013. SSHP and UHC were both above the QC 90th percentile in CY2015, and AGP was above the 66.67th percentile.
- **Initiation and Engagement in Treatment for Alcohol or other Drug Dependence** (IET) *(CMS 2017 Core Adult and Behavioral Health Care Quality Measure)*
  - **Initiation** rates were above the QC 50th percentile in CY2013 to CY2015 for ages 13-17 and for the total population ages 13 and older. For those ages 18 and older, the rate dropped from 41.3% in CY2014 (>66.67th QC percentile) to 37.7% in CY2015 (<50th QC percentile).
  - **Engagement** rates were above the QC 66.67th percentile in CY2015 for the total population, above the QC 90th percentile for ages 13-17, and above the QC 50th percentile for ages 18 and older.
- **Annual Monitoring for Patients on Persistent Medications** (MPM) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 90.2%, comparable to CY2014 (89.7%) and above the QC 75th percentile in both years. This is an improvement compared to CY2013 (84.9%) where all three MCOs' percentages were below the QC 50th percentile.
- **Follow-up for Children Prescribed ADHD Medication** (ADD) *(CMS 2017 Core Child Health Care Quality Measure)*
  - **Initiation Phase** - The aggregate weighted rate in CY2015 was above the 75th QC percentile. UHC had the highest rate (56.6%; >90th QC percentile); SSHP at 54.2% was above the QC 75th percentile; and AGP's 41.2% rate in CY2015 was below the QC 50th percentile.
  - **Continuation & Maintenance Phase** - The aggregate weighted rate was >66.67th QC percentile in CY2015. Rates for continuation and maintenance increased for all three MCOs. UHC had the highest rate (67.3%; >90th QC percentile); SSHP at 66.3% was above the 75th percentile; AGP at 50.4% was below the QC 50th percentile, but was a 10% increase compared to CY2014.

- **Medication Management for People with Asthma** (MMA) – *(CMS 2017 Core Child Health Care Quality Measure)* Rates are reported by age ranges (ages 5-11, 12-18, 19-50, 51-64, and total – ages 5-64). Rates were above the QC 50th percentile for each age group in CY2014 and CY2015, with the exception of the total range.

A number of HEDIS measures in CY2015 had weighted aggregate rates below the QC 50th percentile. For many of these, Kansas rates have been low for several years. Since the QC percentiles are based on comparison nationally, some metrics may have very high positive percentages but may still have a lower QC percentile due to high percentages nationally. In the summary below, metrics that are CMS Core Adult or Child Health Care Quality Measures for 2017 are first listed:

- **Adolescent Well Care Visits** (AWC) – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 43.0%, comparable to CY2014 (42.6%) and CY2013 (42.3%), and below the QC 50th percentile. Results for all three MCOs were below the QC 50th percentile; AGP again had the lowest rate, 40.6%, which was below the QC 25th percentile.
- **Controlling High Blood pressure** (CBP) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 48.2% (below the QC 33.33rd percentile), a decrease compared to 51.5% in CY2014 (<33.33rd QC percentile), and an increase compared to CY2013 (47.3%; <25th QC percentile).
- **Comprehensive Diabetes Care** (CDC) (P4P 2014-2016) – (HbA1c Testing is one of the two CDC rates included as a core measure.) Rates increased in CY2015 for HbA1c Testing (84.9%), Medical Attention for Nephropathy (89.2%), HbA1c Control (46.6%), and Blood Pressure Control (58.8%), but were below the QC 50th percentile.
- **Chlamydia Screening in Women** (CHL) – *(CMS 2017 Core Adult and Child Health Care Quality Measures)* The CY2015 and CY2014 aggregate rates and by age group were comparable and slightly lower than those of CY2013. Rates in CY2015 in total and for both age groups were below the QC 25th percentile for all three MCOs.
- **Prenatal and Postpartum Care** (PPC)
  - **Prenatal Care** (P4P 2016) *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 67.4%, a decrease compared to CY2014 (70.4%) and CY2013 (71.4%) and below the QC 25th percentile in all three years.
  - **Postpartum Care** - *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on weighted hybrid data for CY2015 was 57.5%, above the CY2014 rate (55.8%) and below CY2013 (58.5%). The rates were below the QC 50th percentile all three years.
- **Weight Assessment and Counseling for Nutrition and Physical Health for Children and Adolescents** (WCC) **: Weight Assessment/BMI** – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate weighted hybrid HEDIS rates for reporting BMI have increased from CY2013 (34.7%) to CY2015 (48.6%) but have remained below the QC 25th percentile.
- **Adult BMI Assessment** (ABA) – *(CMS 2017 Core Adult Health Care Quality Measure)* The aggregate rate based on hybrid data for CY2015 was 77.6%, an increase compared to 72.2% in CY2014 was 72.2%, but below the QC 33.33rd percentile
- **Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life** (W34) – *(CMS 2017 Core Child Health Care Quality Measure)* The aggregate rate based on administrative data for CY2015 was 62.8%, a slight increase over CY2014 (62.1%), higher than in CY2013 (60.8%), but lower than in CY2012 (65.4%). The aggregate rates in CY2013 through CY2015 were below the QC 25th percentile.
- **Well-Child Visits in the First 15 Months of Life** (W15) – *(CMS 2017 Core Child Health Care Quality Measure)* Rates are reported by the number of visits (0 visits, 1 visit, 2 visits, 3 visits, 4 visits, 5 visits, and 6 or more visits). The aggregate rate for 6 or more visits was 55.1% in CY2015 (<33.33rd QC percentile), up from 44.7% (<25th QC percentile).

The following HEDIS measures had rates below the 50th percentile in CY2015 but were not CMS core measures:

- **Appropriate Testing for Children with Pharyngitis** (CWP) - The aggregate rate based on administrative data for CY2015 was 55.1% (<10th QC percentile), up from 52.2% in CY2014 and 51.6% in CY2013 (51.6%).
- **Appropriate Treatment for Children with Upper Respiratory Infection** (URI) – The aggregate rate based on administrative data for CY2015 was 76.3% (<25th QC percentile), up from 73.5% in CY2014 and 71.9% in CY2013 (71.9%).
- **Weight Assessment and Counseling for Nutrition and Physical Health for Children and Adolescents** (WCC)
    - **Counseling for Nutrition for Children and Adolescents** – The CY2015 aggregate weighted hybrid HEDIS rates in total (ranging from 46.9% in CY2013 to 49.5% in CY2014) and by age group were below the QC 25th percentile.
    - **Counseling for Physical Activity for Children and Adolescents** – The aggregate weighted hybrid HEDIS rate for each age strata (ages 3-11; ages 12-17; and ages 3-17) were below the QC 50th percentile in CY2013 through CY2015. Total rates ranged from 44.0% in CY2013 to 45.8% in CY2014.

SUD Services

- The percentage of members reporting employment at discharge in 2015 (41.8%) was 20.5% higher (7.1 percentage points) than in 2014 (34.7%)
- Attendance of self-help programs decreased from 44.5% in CY2014 to 39.5% in CY2015 to 39.0% in CY2016, lower all three years than in CY2012 pre-KanCare (59.9%).
- Three of the five measures (stable living at time of discharge from SUD services, decreased arrests, and decreased use of alcohol and/or other drugs) have had consistently high success rates (over 90%) pre-KanCare (CY2012) and in KanCare (CY2013-CY2016).

Mental Health Services

- The percentage of SPMI adults who were competitively employed increased by 4.5% from 15.6% in CY2014 in to 16.3% in CY2015.
- The percentages of SPMI adults and SED youth with access to services (P4P 2014-2015) is based on the number of members assessed as having SED (youth) and SPMI (adults). Rates increased in CY2014, which is due in part to more complete reporting by CMHCs in CY2015.
- Compared to CY2012 (45.7%), the average annual quarterly average of those who were homeless who were housed at the end of each quarter decreased from 58.0% in CY2013 (58.0%) to 49.1% in CY2014 49.1% to 44.6% in CY2015 to 44.6%. No data were available for review, however, for CY2016.
- The annual quarterly average number of SED youth who experienced improvement in their residential status was higher in CY2015 (84.9%) than in the three previous years (ranging from 80.6% to 81.7%). No data were available for review for CY2016.

Healthy Life Expectancy

<u>CAHPS Survey</u>

Overall, the CAHPS questions related to Healthy Life Expectancy had high positive responses, particularly in the following areas that were greater than 90%:

- Personal doctor explaining things in a way that was easy to understand

- Personal doctor listening carefully to you (your child)
- Provider talking about the reasons you (your child) might want to take a medicine
- Your child's provider answering your questions
- Your child's provider explaining things in a way your child could understand

Improvements continue to be noted in the smoking cessation related questions, with the rate of smoking slowly decreasing (CY2016 – 32.2%; CY2014 - 37.6%; CY2012 – 37.2%) and the rate of smokers being advised to quit smoking by a doctor increasing (CY2016 – 79.5%; CY2014 – 75.7%; CY2012 – 65.5%). Less than 50% of respondents who smoke or use tobacco, however, reported their doctor recommended or discussed medications or other methods/strategies to assist with smoking cessation.

Although the CY2016 rate (43.7%) of adults receiving the flu shot or flu spray remains above the QC 50th percentile, the rate has decreased each year from 47.5% in CY2014, and the Healthy People 2020 target is 70% (www.healthypeople.gov).

Another area for improvement is regarding providers talking about specific things to do to prevent illness, with CY2016 rates of 67.3% to 71.4%. The Adult rate was below the QC 33.33rd percentile; the GC rate was below the QC 25th percentile; and the CCC rate was below the QC 10th percentile.

HEDIS – Healthy Life Expectancy
Diabetes Monitoring for people with Diabetes and Schizophrenia (SMD) - The aggregate rate for CY2015 was 65.3%, an increase compared to 60.1% in CY2014 and 62.9% in CY2013, but below the QC 33.33rd percentile.

Healthy Life Expectancy for persons with SMI, I/DD, and PD
The following measures are HEDIS-like in that HEDIS criteria were limited to SMI, I/DD, and PD members (and were P4P in 2014-2015).

- **Preventive Ambulatory Health Services** - In CY2013 to CY2015, over 94% of adult members with PD, I/DD, and SMI were reported to have had an ambulatory preventive care visit during the year. Rates for this subpopulation were higher than rates for all eligible KanCare members in CY2013 – CY2015.
- **Breast Cancer Screening** *(CMS 2017 Core Adult Health Care Quality Measure)* - . Due to the multi-year HEDIS criteria, data for 2015 were the first HEDIS data reported by the three MCOs. The breast cancer screening rate reported for the CY2015 PD, I/DD, SMI population (50.5%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (45.0%; <10th QC percentile).
- **Cervical Cancer Screening** *(CMS 2017 Core Adult Health Care Quality Measure)* - The cervical cancer screening rate reported for the CY2015 PD, I/DD, SMI population (52.1%) was higher than the aggregated CY2015 HEDIS rate for the eligible KanCare population (46.9%; <33.33rd QC percentile).
- **Comprehensive Diabetes Care**
  - **HbA1c testing** - *(CMS 2017 Core Adult Health Care Quality Measure)* Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%), CY2014 (84.8%), and CY2013 (83.1%).
  - **HbA1c control <8.0%** - Rates for HbA1c testing for PD, I/DD, and SMI with diabetes were higher in in CY2015 (87.6%), CY2014 (86.5%), and CY2013 (84.4%) than for all eligible KanCare members in CY2015 (84.9%), CY2014 (84.8%), and CY2013 (83.1%).
  - **Eye Exam** - Rates for PD-I/DD-SMI members were higher in CY2015 (66.5%) than in CY2014 (63.7%) and CY2013 (58.7%). Rates for PD-I/DD-SMI members were also higher each year than

rates for all eligible KanCare members in CY2015 (62.5%), in CY2014 (58.6%), and in CY2013 (50.1%).

- **Medical attention for nephropathy** - Rates for the PD-I/DD-SMI population and for all eligible KanCare members greatly increased in CY2015 compared to the two previous years. The CY2015 rate for the PD-I/DD-SMI population (90.8%) was 20.7% higher than in CY2014 (75.2%), and was higher than the rate for all eligible KanCare members (89.2%).
- **Blood pressure control <140/90** - The CY2015 rate for PD-I/DD-SMI members (60.2%) was 18% higher than in CY2014 (51.0%) and higher than the rate for all eligible KanCare members (58.8%).

HCBS Waiver Services

- **PD and TBI waiver members participating in the WORK employment program** – In April 2015, there were 72 PD Waiver members and 15 TBI Waiver members participating in the WORK program. During the year, one additional TBI member participated in the program. In April 2014 there were 143 PD and 16 TBI members participating in the WORK program. From April to December 2014, 10 additional members participated (nine PD and one additional TBI).
- KDADS is working with the MCOs to improve documentation that waiver members are receiving the type, scope, amount, duration, and frequency of services identified in their service plans.

Long-Term Care: Nursing Facilities (NF)

- The percentage of NF claims that were denied increased from 11.5% in CY2012 (pre-KanCare) to 13.5% in CY2013, and then decreased to 10.4% in CY2014. The denial rate in CY2015 (13.2%) was comparable to CY2013.
- The percentage of NF Medicaid members who had falls with major injuries decreased from 0.62% in CY2012 (pre-KanCare) to 0.53% in CY2013 and CY2014. In CY2015, the fall percentage increased slightly to 0.56%, and during the first three quarters of CY2016, the rate was 0.57%.
- The percentage of NF Medicaid members who were readmitted to a hospital after being discharged from an NF increased from 7.18% in CY2012 (pre-KanCare) to 11.98% in CY2013 and increased again in CY2014 to 12.70%. In CY2015, the percentage decreased to 12.04%, and, during the first two quarters of CY2016, the percentage increased to 13.60%.
- PEAK – The number of Person-Centered Care Homes increased from eight in FY2013 to 15 by the June of FY2016.

Member Survey – CAHPS

Overall, responses to the Quality of Care related CAHPS questions are consistently above the QC 50th percentile. The ratings of health care, personal doctor, specialist, and health plan are consistently improving. Ratings are based on a scale of 0 to 10, with 10 being best possible and 0 being worst possible. The CY2016 results (ratings of 9-10) range from 54.9% - 75.9%, with the lowest ratings from Adults regarding their health care and the highest ratings from the GC population regarding their personal doctor. The percentage of respondents rating their health plan a 9 or 10 ranged from 60.9% - 73.8%. A high percentage of survey respondents indicate their personal doctor shows respect for what they have to say (93.4% - 96.0%) and spends enough time with them (89.7% - 91.2%).

Member Survey – Mental Health

Responses related to quality of care were generally very positive (over 80%) in CY2016.

The most notable CY2016 positive rates and improvement across years were for the population of SED Waiver youth and young adults (family/member and youth only responses), in the following areas:

- Feeling comfortable asking questions about treatment, medication, and/or children's problems (SED Waiver youth and young adults: CY2016 -89.9%)
- Choice of treatment goals (SED Waiver youth ages 12-17: 86.8%)
- Members being better able to do the things they want to do (SED Waiver youth/young adult: 73.5%)
- Members being able to understand their provider (SED Waiver youth ages 12-17: 95.5%)

While remaining positive, the general adult population's rates have consistently decreased across years, in all of the quality of care related questions:

- Feeling comfortable in asking questions about treatment, medication, and/or children's problems (CY2016 - 85.9%; CY2011 – 93.6%)
- Member choice of treatment goals (CY2016 -78.6%; CY2014 – 84.0%)
- Members being able to have assistance in obtaining information to assist them in managing their health (CY2016 - 82.7%; CY2011 – 89.3%)
- Being better able to do the things they want to do (CY2016 - 69.3%; CY2011 – 82.4%)
- Being able to understand their provider (CY2016 - 90.0%; CY2013 – 94.3%)
- Having better control of their daily life (CY2016 - 74.8%; CY2011 – 86.5%)
- Being able to deal with crisis as a direct result of services provided (CY2016 – 69.2%; CY2011 – 80.4%)

Member Survey – SUD

The SUD surveys in 2014 to 2016 and 2012 were convenience samples of members contacted in person, by mail, and by phone. The surveys included 342 members in 2016, 193 members in 2015, 238 in 2014, and 629 in 2012. Results were generally very positive. In 2012 to 2015, over 90% of those surveyed rated the quality of services as very good or good. The percentage of members who rated counselor involvement of members in decision making as very good or good was 92.6% in 2016, up from 88.4% in 2015, 92.0% in CY2014. The percentage who responded they were feeling much better or better since beginning treatment was 88.9% in 2016, 92.6% in CY2015, 87.1% in CY2014, and 98.8% in 2012.

Provider Survey

For the question on "provider satisfaction with MCO's commitment to high quality of care for its members," responses in 2016 for very or somewhat satisfied ranged from 40.3% (UnitedHealthcare general provider survey) to 60.9% (Amerigroup). For very or somewhat dissatisfied, responses in 2016 ranged from 7.0% (Sunflower/Cenpatico BH provider survey) to 16.3% (Amerigroup general provider survey).

Coordination of Care (and Integration)

Care Management for Members receiving HCBS Services

- KDADS is working with the MCOs to improve documentation of assessments of member needs and updates of service plans as needs change.

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

- **Increase in the number of primary care visits** - The percentage of HCBS members who had an annual preventive health visit increased from 92.0% in CY2013 to 93.1% in CY2014 and to 94.0% in CY2015. The rates for the HCBS member subpopulation were 4% to 8% higher than the rates for all

KanCare adult members in all three years (88.4% in CY2013, 87.5% in CY2014, and 87.1% in CY2015).

- **Increase in Annual Dental Visits** - The percentage of HCBS members who had an annual dental visit was higher in CY2015 (51.6%) compared to CY2014 (49.0%) and CY2013 (49.4%). The annual dentist visit rates for HCBS members were 15% to 18% lower than the HEDIS rates for the overall KanCare population in each of the three years – CY2015 (60.9%), CY2014 (60.0%) and (CY2013 (60.3%).
- **Decrease in number of Emergency Department visits** - From CY2013 to CY2015, emergency department (ED) visit rates (per 1,000 member-months) for the HCBS population increased slightly from 77.58 in 2013 to 78.06 in 2014 to 79.64 in 2015. The rates for the HCBS population were higher than the HEDIS rates for the overall KanCare population (65.17 in CY2013, 64.19 in CY2014, and 66.31 in CY2015).

Member Survey – CAHPS

A high percentage of respondents indicated it was easy to obtain the following services:

- Care, tests and treatment needed (87.2% - 92.4%)
- Appointment with a specialist as soon as needed (80.8% - 86.2%)
- Prescription medicines for child through their health plan (94.4% - 94.5%)

For respondents receiving care from more than one provider, 80.7% - 85.0% indicated their personal doctor seemed informed and up-to-date regarding the care from other providers. Only 55.2% - 57.7% of the related GC and CCC populations noted they received help from their doctor's office or health plan in coordinating their child's care; the question does not ask whether coordination assistance was needed or requested. When child survey respondents indicated they needed their provider to contact a school or daycare regarding their child's health or health care, 94.5% - 94.9% responded that they received the needed assistance. A high percentage (89.5% - 92.0%) of child survey respondents reported their providers understand how their child's longer term health conditions impact their child's and their family's daily life.

Member Survey – MH

While the responses to care coordination related questions were generally positive, rates for the general adult population have decreased over time and the rates for the SED Waiver youth (ages 12-17) have increased over time.

- General Adults' use of consumer-run programs and ability to access services the members thought were needed: CY2016 – 78.7%; CY2014 – 80.4%.
- Members perceiving they were able to access all of the services that they thought they needed:
  - General adult: CY2016 - 80.7%; CY2011 – 91.3%.
  - SED Waiver youth (ages 12-17, youth responding): CY2016 – 79.3%; CY2013 – 71.8%.

Member Survey - SUD

Of the 66.4% who indicated they have a PCP, 70.4% in CY2016 indicated their counselor requested a release of information to allow discussion of the member's treatment with their PCP. In 2016, 44.3% of those surveyed reported they received services from another counselor within the last year; 82.4% of these members reported they were asked to sign a release to share details with the other counselor.

Provider Survey

For the survey question on "provider satisfaction with obtaining precertification and/or authorization for (MCO's) members," responses for very or somewhat satisfied ranged from 32.3%

(Sunflower/Cenpatico BH survey) to 51.7% (Amerigroup), and for very or somewhat dissatisfied ranged from 8.9% (UHC/Optum) to 28.7% (Amerigroup).

Cost of Care

From CY2012 to CY2015, there were increases in utilization of the following services: Primary Care Physician (24% increase), Dental (32% increase), Home and Community-Based Services (23% increase), Transportation (33% increase), Vision (16% increase) and Non-Emergency Room Outpatient Services (10% increase).

Inpatient Hospitalization decreased 23% in CY2015 compared to CY2012, and Emergency Room Outpatient Visits decreased by 1%. Decreases in utilization of these services are a positive outcome, reflecting increased access of treatment from .the member's primary care provider instead of an ER and increased preventive care and home services to avoid lengthy hospital stays.

Access to Care

Provider Network – GeoAccess

Access Standards

- In CY2016 there were three provider types where Semi-Urban counties did not have access through at least one MCO: Allergy – Montgomery County; Neonatology – Saline County; and Plastic & Reconstructive Surgery – Geary, Montgomery, and Riley Counties.
- In CY2016, there were seven provider types where one or more non-urban county had no access through any of the three MCOs
  - Cardiology - Cheyenne County
  - Gastroenterology - Cheyenne, Decatur, Rawlins, and Sherman Counties
  - Neonatology – Cheyenne, Greeley, Rawlins, Sherman, and Wallace Counties
  - Nephrology - Cheyenne and Sherman Counties
  - Physical Medicine/Rehab Cheyenne and Sherman Counties
  - Plastic & Reconstructive Surgery -Cheyenne, Clark, Grant, Greeley, Hamilton, Haskell, Kearny, Meade, Morton, Seward, Sherman, Stanton, Stevens, Wallace, and Wichita Counties
  - Dental - Lane County
- The counties with the least amount of access to providers were Cheyenne and Sherman Counties. Of the other 16 counties with no access to one or more provider types: three counties had no access to two provider types, and 13 had no access to one provider type. Not factored into this analysis are the numbers of counties with no access to one or more providers that are adjacent on all sides to counties with no access to these same provider types

Behavioral Health - BH services in CY2014- CY2016 were provided in all counties within the access standards required by the State.

HCBS – Counties with access to at least two providers by provider type and services

Of the 27 HCBS services, 17 were available in CY2015 from at least two providers in all 105 Kansas counties from all three MCOs. Of the remaining 10 HCBS services

- **Adult day care** - Services were available from at least two providers in only 47 counties through UHC, 50 through SSHP, and 102 through AGP. UHC reported availability through at least one service provider in only 68 counties; SSHP reported availability in 81 counties, and AGP reported availability in 105 counties.

- **Intermittent intensive medical care** – At least two service providers were available in all counties through UHC, 77 through AGP, and 94 through SSHP. At least one provider was available in the AGP network in 102 counties, in the SSHP network in 105 counties.
- **Speech therapy – Autism waiver** – Services were available from at least one or two providers in 7 counties through Amerigroup. Through Sunflower network, there were at least two providers in 12 counties and at least one service provider in 27 counties. Services through UnitedHealthcare were only available from at least one or two providers in 2 counties.
- **TBI waiver therapies: Speech, Behavior, Cognitive, Occupational, and Physical** – Again in CY2016 there was a wide gap in the availability of these specialized services as reported by MCOs. Amerigroup and Sunflower, as in 2013-2015, reported that at least two service providers for each of these services were available in all counties in 2016. Sunflower's one exception was Speech Therapy/TBI Waiver, where they reported at least two providers available in 50 counties (and at least one provider in all counties). UnitedHealthcare reported, as in 2013-2015, far fewer available providers for these TBI waivers: Speech Therapy -at least two providers in 9 counties, and only 28 in at least one county; Behavior Therapy -at least two providers in 72 counties and 105 in at least one county; Cognitive Therapy -at least two providers in 26 counties and 55 in at least one county; Occupational Therapy -at least two providers in 12 counties, and only 33 in at least one county; and Physical Therapy -at least two providers in 30 counties, and only 55 in at least one county.
- **Home modification** – At least two service providers were available through Sunflower and UnitedHealthcare in all counties. In Amerigroup, only 27 counties had at least two service providers, and 101 counties had at least one service provider.
- **Health maintenance monitoring** – At least two service providers were available through UnitedHealthcare in all counties. In Amerigroup, only 69 counties had at least two service providers, and 103 counties had at least one service provider. Through Sunflower, two service providers were available in 95 counties, and all counties had at least one service provider.

I/DD Provider Services – Counties with access to at least two providers by provider type and services
Services reported in 2016 to be available from at least two I/DD providers by all three MCOs include: Targeted Case Management, Residential Support, Sleep Cycle Support, Personal Assistant Services, Financial Management Services, and Respite Care (Overnight).

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

- Supported Employment Services – AGP reported this service to be available from at least two I/DD providers in 51 counties, and from at least one provider in 81 of the 105 counties. SSHP reported this service to be available from at least two I/DD providers in 98 counties, and from at least one provider in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 25 counties, and from at least one provider in 48 of the 105 counties.
- Wellness Monitoring - AGP reported this service to be available from at least two I/DD providers in 92 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 95 counties, and from at least one provider in 102 counties. UHC reported this service to be available from at least two I/DD providers in 80 counties, and from at least one provider in all 105 counties.
- Medical Alert Rental - AGP and UHC reported Medical Alert Rental to be available from at least two providers in all 105 counties, but not specifically from I/DD providers. SSHP reported this service to be available from at least two I/DD providers in 55 counties, and from at least one I/DD provider in all 105 counties.

- Supportive Home Care - AGP and SSHP reported Supportive Home Care to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 103 counties, and from at least one provider in all 105 counties.
- Assistive Services - SSHP and UHC reported Assistive Services to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Day Support - AGP and SSHP reported Day Support to be available from at least two I/DD providers in all 105 counties. UHC reported this service to be available from at least two I/DD providers in 58 counties, and from at least one provider in 98 counties.
- Specialized Medical Care – RN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in all 105 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.
- Specialized Medical Care – LPN - UHC reported this service to be available from at least two I/DD providers in all 105 counties. AGP reported this service to be available from at least two I/DD providers in 101 counties, and from at least one provider in 104 counties. SSHP reported this service to be available from at least two I/DD providers in 104 counties, and from at least one provider in all 105 counties.

As in 2013-2015, there is no indication in the HCBS report as to which counties do not have at least two services available. The report also again does not indicate whether members needing services are residents of the counties where there are no providers or where there are less than two providers. In a "Frontier" county, in particular, it is possible that there are no members in the county that are in need of one of the more specialized HCBS services.

Open/Closed Panels

Network Adequacy Reports and submitted to the State, as well as "real time" information available to members on-line and through customer service contacts, continue to be in need of timely updating to provide information on provider availability.

Provider After-Hours Access and Provider Appointment Standards Access

In 2016, each of the MCOs included one or more supplemental question in their CAHPS survey related to appointment access. Various methods were used by the MCOs, including surveys and calls during and after office hours. Amerigroup provided an update on appointment availability for urgent and routine visits with PCPs, Specialists, Pediatrics, and Behavioral Health. UnitedHealthcare employs a vendor who contacts providers, with callers identifying themselves as calling on behalf of UHC, relate adult and child symptom scenarios, and ask about appointment availability.

Member Survey – CAHPS

CY2016 survey respondents had highly positive responses to the following access related questions:

- When care was needed right away for an illness, injury or other condition, how often was it received as soon as the respondent needed (86.2% - 95.1%). The Adult and CCC responses were above the QC 75th percentile and GC responses were above the QC 66.67th percentile.
- Check-up or routine care received as soon as respondent needed (82.5% - 92.1%). The Adult rate was above the QC 75th percentile; the GC rate was above the 66.67th percentile; the CCC rate was above the 50th percentile.

- Appointment with specialist as soon as respondent needed (80.8% - 86.2%). The Adult rate was above the QC 95th percentile; the GC rate was above the 50th percentile; and the CCC rate was above the QC 75th percentile.
- Ease of getting the care, tests, and treatment the respondent needed (87.2% – 92.4%). The Adult and GC rates were above the QC75th percentile and the CCC rate was above the QC 66.67th percentile.

Member Survey – MH

Responses for each of the seven access-related questions were for the most part positive in CY2016; however, there were significant decreases or negative trends noted in the following five questions.

- Provider returned their call within 24 hours - General Adult: CY2016 – 79.6%; CY2011 - 88.1%.
- Services being available at times that were good for the member
  - General Adult: CY2016 -87.4%; CY2013 -92.1%
  - General Youth: CY2016 -83.9%; CY2013 - 88.7%
- Being able to see a psychiatrist when they wanted to - General Adult: CY2016 -73.6%; CY2011 - 82.1%
- Perceive their medication is available - General Youth: CY2016 - 83.7%; CY2013 -86.1%
- Ability to get the services they thought they needed - General Adult: CY2016 -80.7%; CY2011 - 91.3%
- Ability to get services during a crisis - General Youth: CY2016 – 83.8%; CY11 – 89.5%

Improvements or high percentages of positive responses were noted with the following questions and populations.

- Perceive their medication is available- General Adults: CY2016 -92.9%; SED Waiver youth and young adults: 94.5%
- Ability to get the services they thought they needed - SED Waiver youth (ages 12-17, youth responding): CY2016 – 79.3%; CY2013 – 71.8%

Member Survey – SUD

- Of 326 surveyed in 2016, 69 (21.2%) reported they were placed on a waiting list for an appointment, compared to 15.6% (28 of 180) in 2015 and 12.2% of 205 surveyed in 2014. While 38.6% in 2016 reported their wait was one week or less, 42.1% reported their wait to be three weeks or more, compared to 46.2% in 2015 and 26.1% in 2014.
- Members surveyed in 2014-2016 had consistently positive responses to questions related to distance to travel to see a counselor.
- In 2016, 84.4% of members surveyed said they were able to get an appointment for their first visit as soon as they wanted, compared to 87.7% in 2015 and 92.1% in 2014.
- In 2016, 28.4% of members surveyed indicated they had an urgent problem (compared to 25.7% in 2015 and 28.5% in 2014). Of those who reported needing an urgent visit, 16.0% reported in 2016 they waited more than 48 hours for an urgent visit compared to 19.0% in 2015 and 10.9% in 2014.

Provider Survey

For the survey question on “provider satisfaction with availability of specialists,” responses in 2016 for “very satisfied” or “somewhat satisfied” ranged from 28.1% (SSHP/Cenpatico BH survey) to 59.4% (Amerigroup). Responses for “very dissatisfied” or “dissatisfied” ranged from 7.2% (SSHP/Cenpatico BY Survey) to 21.9% (Amerigroup).

Efficiency

Emergency Department Visits

ED visit rates for HCBS (TBI, PD, FE, and IDD) were much lower in CY2013 – CY2015 compared to rates in CY2012 pre-KanCare. Rates described below are based on ED visits per 1,000 member-months.

- ED rates for MH members and for the KanCare population decreased from CY2012 to CY2013, but have increased above CY2012 rates in CY2014 and CY2015.
- ED visit rates for HCBS members in CY2015 (77.36) were lower than CY2014 (78.88) and much lower than in CY2012 (101.26).
- TBI members had the highest rate of ED visits in CY2012 to CY2015. The CY2015 rate decreased from 220.13 in CY2012 to 183.27 in CY2015.
- The ED visit rate for PD members decreased from 165.46 in CY2012 to 130.31 to 126.36 in CY2015.
- The FE waiver member ED rate decreased from 90.32 in CY2012 to 65.32 in CY2015.
- The I/DD member ED rates were lower than those of the PD, FE, TBI and MH members. From CY2012 to CY2015, the ED rate decreased from 54.24 to 47.57.
- MH ED visit rates increased from 116.34 visits per 1,000 member months in CY2012 to 124.06 in CY2015.

Inpatient Hospitalizations

Inpatient admission rates were higher in CY2015 for TBI, FE, and I/DD members and lower for PD members than inpatient admission rates pre-KanCare 2012. From CY2014 to CY2015, rates increased for TBI and I/DD and decreased for FE and PD members. Rates described below are based on inpatient admission visits per 1,000 member-months.

- The inpatient admission rates for HCBS members in CY2015 (35.58) and CY2012 (35.27) were comparable.
- TBI member inpatient admission rates initially decreased from 46.91 in CY2012 to 45.50 in CY2013 to 45.34 in CY2014, but increased to 49.82 in CY2015.
- The inpatient admission visit rate for PD members decreased from 54.17 in CY2012 to 53.82 in CY2015.
- The FE waiver member Inpatient admission rate increased from 48.27 in CY2012 to 51.19 in CY2015.
- I/DD member inpatient admission rates were much lower than those of PD, FE, and TBI members in each of the four years. Admission rates increased slightly from 12.37 admits per 1,000 member-months in CY2012 pre-KanCare to 14.39 in CY2015.
- MH admissions are based on MH-related admissions. MH admissions decreased each year from 8.08 admissions per 1,000 member months in CY2012 to 6.95 in CY2015.

Inpatient Readmissions within 30 days of inpatient discharge

Inpatient readmission rates decreased in CY2013 and CY2014 for TBI and MH members from CY2012 pre-KanCare but increased slightly for FE, I/DD, and PD members. Rates described below are based on inpatient readmissions per 1,000 member-months.

- Readmission rates per 1,000 member months increased each year from 5.14 in CY2012 to 5.15 in CY2013 to 5.96 in CY2014, but decreased in CY2015 to 5.81 readmissions per 1,000 member months.
- TBI member readmission rates decreased from 8.38 in CY2012 to 7.18 in CY2013 to 6.93 in CY2014 before increasing to 13.88 in CY2015, higher than each of the three preceding years and higher than the other waiver population rates in the four-year period.

- PD members had higher rates of readmissions than TBI, FE, I/DD, and MH members in CY2012 to CY2014. Readmission rates decreased slightly in CY2013 (8.81) compared to CY2012 pre-KanCare (9.03), but then increased to 10.82 in CY2014 before decreasing again to 9.76 in CY2015.
- The FE waiver member Inpatient admission rate increased from 6.38 in CY2012 to 7.93 in CY2015.
- I/DD member readmission rates were lower than those of PD, FE, and TBI members in each of the four years. Readmission rates increased slightly from 1.32 in CY2012 to 1.66 in CY2015.
- MH members had much lower readmission rates than the HCBS members, but their readmission rates are based on MH-related readmissions only. Readmission rates decreased from 1.06 in CY2012 to 0.94 readmissions per 1,000 member-months in CY2015.

Member Survey – CAHPS
Over 80% of survey respondents who contacted their health plan's customer service reported they received the information or help they needed. The CY2016 Adult rate (83.8%) was above the QC 75th percentile. The GC rate (83.9%) decreased from 85.4% in CY2015 and decreased from being above the QC 75th percentile to being above the 50th percentile. While the CCC rate (82.2%) was similar to the other populations, it decreased from 84.9% in CY2015 and decreased to below the QC 33.33rd percentile.

Member Survey – MH
For adult members, 79.6% in CY2016 indicated their MH provider returned their calls within 24 hours. This is lower than rates in CY2013 – CY2015 that ranged from 83.3% to 84.4%. The CY2016 rate is statistically significantly lower than CY2011 (88.1%).

Member Survey SUD
In 2016, 92.1% of members surveyed rated their counselor as communicating very well or well in communicating clearly with them, comparable to 2015 (93.2%) and 2014 (93.9%).

Uncompensated Care Cost Pool (UCC)
There were 194,999 Medicaid days for UCC Pool hospitals in CY2012. This number increased substantially to 252,002 Medicaid days in CY2013, in part because of the influx of beneficiaries at the start of KanCare. The number of Medicaid days subsequently decreased to 206,882 in CY2014, to 186,396 in CY2015, and to 178,721 in CY2016. UCC Pool payments increased from $20,568,567 in CY2012 to $41,026,795 in CY2013. This increase was partially due to a change in the Kansas Statute implemented at the start of the FY2013. The UCC Pool payments decreased slightly to $40,974,407 in CY2014 and to $40,929,060 in CY2015. The UCC Pool payments then increased slightly in CY2016 to $40,960,116.

Delivery System Reform Incentive Program (DSRIP)
The University of Kansas Hospital

- **STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis**
  In 2016 KUH conducted training in 19 counties statewide. KUH reported 554 workshop attendees in the from 103 partner facilities in 2016, including 20 nursing facilities (NF), 24 EMS providers, and 44 hospitals. Workshop attendance ranged from 15 to 50 per workshop. KUH greatly increased data tracking and reporting in 2016. Of 147 partner facilities, 43 have a sepsis protocol in place, 27 newly implemented in 2016. In CY2016, 33 partner facilities, including three NFs, began entering sepsis-related data in the Kansas Sepsis Program Database. KUH has developed an NF-specific curriculum that includes slides and posters providing information on basic sepsis symptoms. Of

special interest are training materials for licensed practical nurses and nursing assistants in development for distribution in 2017.

- **Supporting Personal Accountability and resiliency for Chronic Conditions (SPARCC)**
  KUH has provided SPARCC facilitation training to over 160 individuals and has over 85 partners statewide. Focus is now on expanding the number of group sessions led by these trained facilitators. In 2016, 46 facilitators trained through the SPARCC program in 2015 and 2016 conducted 24 groups (four sessions per group), with 86 patients and 10 caregivers/supporters participating in one or more session. KUH has, thus, been successful in first training facilitators the first year of DSRIP (2015) who then followed through in successfully implementing the SPARCC program for patients in NE, North Central, and SW Kansas. KUH reported that 86 patients participated in 24 groups in 2016, 43 in groups meeting in the first half of the year and 43 in groups meeting in the second half of the year. The first six-month booster session was also completed in 2016, with 43 heart failure patients and caregivers participating. KUH has also been successful in developing eight training videos for SPARCC facilitators soon to be uploaded to a DSRIP YouTube website.

Children's Mercy Hospital and Clinics

- **Improving Coordinated Care for Medically Complex Patients (Beacon Program)**
  The Beacon program functions as an independent medical home for children and youth with medical complexity (CYMC) and their siblings. Beacon staff began seeing Missouri patients in October 2013 and reported in December 2014 that 63 patients were from Kansas. In 2015 there were 56 Kansas Beacon patients– 38 CYMC and 18 siblings. In 2016, there were 92 Kansas Beacon patients – 65 CYMC and 27 siblings. Another major focus of the Beacon program is to provide consultation to PCPs of children living in rural areas or distant from the Kansas City area. In the first six months of 2016, Beacon staff conducted extensive outreach to 82 providers statewide. They also developed a flyer with responses to frequently asked questions and provided PCPs with information on characteristics of children eligible for the Beacon program. As a result of the outreach, Beacon provided 20 consults, an increase compared to only one Kansas consult in 2015.
- **Expansion of Patient Centered Medical Homes and Neighborhoods**
  CMH is partnering with four selected clinics that serve a high percentage or volume of Kansas Medicaid clients. The participating practices are delivering improved care that meets the Triple Aim. Each practice is embracing the model and has successfully begun implementing the components required for PCMH transformation. One practice has achieved NCQA PCMH recognition and a second practice plans to submit their application in 2017. CMH continues to work with each practice, providing TA and monthly learning collaborative sessions. CMH has implemented an online message board to serve as a forum for the practices to communicate on an ongoing basis. They have also developed an integrated database platform, providing patient data from multiple sources in one database. This was developed in an effort to assist the practices with using health information technology for population health management. CMH is in the process of developing an online searchable community resource database, to be available in 2017.

Recommendations

HEDIS and CAHPS Surveys

- MCOs should pay particular attention to improving results, not only for P4P measures, but also for HEDIS measures that have been identified by CMS as adult, child, and/or behavioral health core measures, particularly where results are below the QC 50th percentile, including:

  - Comprehensive Diabetes Control (CDC)
    - HbA1c Testing
    - Medical Attention for Nephropathy
    - HbA1c Control (<8.0%)
    - HbA1c Poor Control (>9.0%)
    - Blood Pressure Control (<140/90)
  - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
  - Well-Child Visits in the First 15 Months of Life (W15)
  - Prenatal and Postpartum Care (PPC)
  - Chlamydia Screening in Women (CHL)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) – Weight Assessment/BMI
  - Adult BMI Assessment (ABA)
  - Controlling High Blood Pressure (CBP)
  - Adolescent Well Care Visits
  - Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
  - Breast Cancer Screening (BCS)
- MCOs should also focus efforts on improving percentages of members engaged in treatment for alcohol or other drug use, as only 10.7% of those age 18 and older and 26.8% of those ages 13-17 identified as being in need of alcohol or drug use treatment were engaged in treatment in CY2015.
- MCOs should encourage providers to talk with patients about specific things to do to prevent illness, including:
  - For those who smoke or use tobacco products, offer medication or other smoking cessation treatment alternatives.
  - Encouraging and/or offering the annual influenza vaccination.
- MCOs should encourage their internal departments (customer service and case management) and network providers to offer members assistance with coordination of care, particularly for members obtaining services/care through more than one provider.

Mental Health Survey

- Related to questions with statistically significant negative trends (2011 to 2016 and 2013 to 2016), monitoring is recommended to ensure they do not continue to decline over time.
- MCOs should explore barriers and work with providers on improving the following:
  - Adult member choice of treatment goals
  - Adult members being better able to do the things they want to do and having better control of their daily life
  - Adult members being able to deal with crisis
  - Adult and General Youth perception of access to services
  - Adults' rate of providers returning member calls within 24 hours.

SUD Survey

- MCOs should encourage SUD providers to help members who don't know if they have a PCP to identify that provider or to assist them in obtaining a PCP.
- The State should work with the MCOs to assess and address reasons for reported increases in members placed on wait lists and reported increases in wait times while on the wait lists.

Mental Health Services

- The annual quarterly average of homeless members with SPMI who were housed at the end of each quarter had decreased from 58.0% in CY2013 to 49.1% in CY2014 to 44.6% in CY2015. No data were available for CY2016. If the State is no longer tracking this measure as a NOMS quarterly measure, an alternative tracking and reporting should be considered to monitor annual, if not quarterly, progress.

Provider Survey

- UnitedHealthcare should make efforts to greatly increase the number of general provider survey respondents.

Care Coordination

- Efforts should continue to improve care coordination, particularly for children with chronic conditions, including communication of PCPs with other healthcare providers; assistance from the MCO in coordinating care; and assistance in acquiring prescriptions.
- MCOs should continue to work to improve the percentage of HCBS waiver members receiving annual dental visits.

Access to Care

Provider Access

- KFMC recommends reporting requirements be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
- KFMC recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.
- Due to differences in availability of provider types by MCO, members enrolling or re-enrolling should be provided information on the number of providers and locations available by provider type in each MCO network (without need for additional approval processes), particularly if they reside in a Frontier or Rural County.
- The State should consider requiring MCOs to report for each provider/service type the specific counties that do not have access to at least one or two HCBS and IDD providers.
- KFMC recommends the State request a more consistent method of MCO tracking and reporting after hours and appointment access (by appointment type). KFMC recommends that all MCOs confirm provider after-hour access through after-hours phone calls to the providers.
- MCOs should report compliance rates and appointment availability for calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO.
- MCOS are encouraged to continue to include access to care supplemental questions in the CAHPS survey to help identify member experience in accessing appointments.
- When reporting outcomes related to member access to after-hours phone contact to providers, the MCOS should include in the denominator all out-of-service or wrong numbers, and offices that did not answer the phone or have an answering service alternative. MCOs should follow up after office

hours to verify appropriate after-hours access, at a minimum for the providers that refused to complete the survey or did not answer the phone.

- In addition to the need to de-duplicate, MCOs should make efforts to update the Network Adequacy reports, review how providers are classified, expand reporting to include a more detailed level of reporting, and ensure provider panel status is reported for all applicable providers.

Systems

- Emergency Department (ED) Visits – Additional efforts are needed to reduce ED visit rates for members with MH diagnoses, such as ensuring members have a PCP and care coordination.

End of written report.

Appendix A

2016 KanCare Evaluation Annual Report

Year 4, January – December 2016

List of Related Acronyms

Kansas Foundation for Medical Care, Inc.

List of Related Acronyms	
Acronym	**Description**
AAP	Adults' Access to Preventive/Ambulatory Health Services (HEDIS)
ABA	Adult BMI Assessment (HEDIS)
ACO	Accountable Care Organization
ADD	Follow-Up Care for Children Prescribed ADHD Medication (HEDIS)
ADHD	Attention Deficit Hyperactivity Disorder
ADV	Annual Dental Visit (HEDIS)
AGP	Amerigroup Kansas, Inc.
Amerigroup	Amerigroup Kansas, Inc.
AWC	Adolescent Well-Care Visits (HEDIS)
BCBSKS	Blue Cross/Blue Shield of Kansas
BH	Behavioral Health
BMI	Body Mass Index
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBCL	Child Behavior Checklist Competence T-Scores
CBP	Controlling High Blood Pressure (HEDIS)
CBS	Community-Based Services
CCC	Children with Chronic Conditions (CAHPS survey population)
CDC	Comprehensive Diabetes Care (HEDIS)
CHIP	Children's Health Insurance Program (Title XXI)
CHL	Chlamydia Screening in Women (HEDIS)
CMH	Children's Mercy Hospital and Clinics
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CWP	Appropriate Testing for Children with Pharyngitis (HEDIS)
CY	Calendar Year
CYMC	Children and Youth with Medical Complexity
DSRIP	Delivery System Reform Incentive Program
ED	Emergency Department
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EP	Eligible Professional
EQRO	External Quality Review Organization

List of Related Acronyms	
Acronym	**Description**
FE	Frail Elderly Waiver
FUH	Follow-Up after Hospitalization for Mental Illness (HEDIS)
GC	General Child - CAHPS Survey Population
HbA1c	Glycated Hemoglobin
HCBS	Home and Community-Based Services
HCCN	Health Center Controlled Network
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIO	Health Information Organization
HITECH	Health Information Technology for Economic and Clinical Health Act
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
I/DD	Intellectually/Developmentally Disabled
IET	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (HEDIS)
KCPC	Kansas Client Placement Criteria
KDADS	Kansas Department for Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Healthcare Finance
KFMC	Kansas Foundation for Medical Care, Inc. (the EQRO)
KHC	Kansas Healthcare Collaborative
KHIN	Kansas Health Information Network
KUCTT	University of Kansas Center for Telemedicine & Telehealth
KUH	The University of Kansas Hospital
LACIE	Lewis and Clark Information Exchange
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MFP	Money Follows the Person
MH	Mental Health
MHSIP	Mental Health Statistics Improvement Program
MMA	Medication Management for People with Asthma (HEDIS)
MPM	Annual Monitoring for Patients on Persistent Medications (HEDIS)
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NF	Nursing Facility
NOMS	National Outcome Measurement System

List of Related Acronyms	
Acronym	**Description**
P4P	Pay for Performance
PCMH	Patient Centered Medical Homes
PCP	Primary Care Provider
PD	Physically Disabled
PEAK	Promoting Excellent Alternatives in Kansas (Person-Centered Care Homes)
PHR	Personal Health Record
PLE	Poverty Level Eligible
PMPM	Per member per month
PPC	Prenatal and Postpartum Care (HEDIS)
PTN	Patient Transformation Network
Q	Quarter
QBRP	Quality-Based Reimbursement Program
QC	Quality Compass
RCIN	Rural Clinically Integrated Network
SED	Serious Emotional Disturbance
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia (HEDIS)
SMI	Serious Mental Illness
SPARCC	Supporting Personal Accountability and Resiliency for Chronic Conditions
SPMI	Serious and Persistent Mental Illness
SSHP	Sunflower State Health Plan of Kansas
SSI	Supplemental Security Income
STOP Sepsis	Standard Techniques, Operations, and Procedures Sepsis Awareness Program
SUD	Substance Use Disorder
Sunflower	Sunflower State Health Plan of Kansas
TA	Technical Assistance
TAF	Temporary Assistance for Families
TBI	Traumatic Brain Injury
Title XIX	Medicaid
Title XXI	CHIP, Children's Health Insurance Program
UCC	Uncompensated Care Cost Pool
UHC	UnitedHealthcare Community Plan of Kansas
UnitedHealthcare	UnitedHealthcare Community Plan of Kansas
URI	Appropriate Treatment for Children with Upper Respiratory Infection (HEDIS)
VO	Value Options-Kansas

List of Related Acronyms	
Acronym	**Description**
W15	Well-Child Visits in First 15 Months of Life (HEDIS)
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (HEDIS)
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents (HEDIS)
WebIZ	Kansas Statewide Immunization Information System
WORK	Work Opportunities Reward Kansas program

Appendix H: *Kansas Register* Abbreviated Public Notice

[See following page.]

to identify the sources and types of regulated air pollutants emitted from the facility; the emission limitations, standards, and requirements applicable to each source; and the monitoring, record keeping, and reporting requirements applicable to each source as of the effective date of permit issuance.

Acme Brick – Kanopolis Plant, 1715 Ave. L, Kanapolis, KS 67454, owns and operates Brick Manufacturing Facility located at 1715 Ave. L, Kanopolis, KS 67454.

A copy of the proposed permit, permit application, all supporting documentation, and all information relied upon during the permit application review process are available for public review during normal business hours, 8:00 a.m. to 5:00 p.m., at the KDHE, Bureau of Air (BOA), 1000 SW Jackson, Suite 310, Topeka, KS 66612-1366 and at the North Central District Office (NCDO), 2501 Market Place, Suite D, Salina, KS 67401. To obtain or review the proposed permit and supporting documentation, contact Susana Pjesky, 785-296-1691, at the KDHE central office or Joshua Webb, 785-827-9639, at the NCDO. The standard departmental cost will be assessed for any copies requested.

Written comments or questions regarding the proposed permit may be directed to Susana Pjesky, KDHE, BOA, 1000 SW Jackson, Suite 310, Topeka, KS 66612-1366. In order to be considered in formulating a final permit decision, written comments must be received no later than noon Monday, July 10, 2017.

A person may request a public hearing be held on the proposed permit. The request for a public hearing shall be in writing and set forth the basis for the request. The written request must be submitted to Susana Pjesky, KDHE, BOA, no later than noon Monday, July 10, 2017 in order for the secretary of Health and Environment to consider the request.

The U.S. Environmental Protection Agency has a 45-day review period, which will start concurrently with the public comment period, within which to object to the proposed permit. If the EPA has not objected in writing to the issuance of the permit within the 45-day review period, any person may petition the administrator of the EPA to review the permit. The 60-day public petition period will directly follow the EPA's 45-day review period. Interested parties may contact KDHE to determine if the EPA's 45-day review period has been waived.

Any such petition shall be based only on objections to the permit that were raised with reasonable specificity during the public comment period provided for in this notice, unless the petitioner demonstrates that it was impracticable to raise such objections within such period, or unless the grounds for such objection arose after such period. Contact Ward Burns, U.S. EPA, Region 7, Air Permitting and Compliance Branch, 11201 Renner Blvd., Lenexa, KS 66219, 913-551-7960, to determine when the 45-day EPA review period ends and the 60-day petition period commences.

Susan Mosier, MD, MBA, FACS
Secretary and State Health Officer

Doc. No. 045468

State of Kansas

Department of Health and Environment

Notice of Hearing on Proposed Total Maximum Daily Loads

The Kansas Department of Health and Environment (KDHE) has prepared Total Maximum Daily Loads (TMDLs) for Stranger Creek and Shunganunga Creek in the Kansas-Lower Republican River Basin that are impaired by not meeting state surface water quality standards. The TMDLs presented for public review are:

Kansas-Lower Republican River Basin

Middle Kansas (HUC 10270102)
- Stranger Creek – Total Phosphorus
- Crooked Creek – Total Phosphorus

Lower Kansas (HUC 10270104)
- Shunganunga Creek – Total Phosphorus

These TMDLs are available for review on the Kansas Department of Health and Environment TMDL website at http://www.kdheks.gov/tmdl/planning_mgmt.htm. Additionally, copies of these TMDLs can be obtained by contacting the Bureau of Water, Watershed Planning Monitoring, and Assessment Section, 785-296-8791.

A public hearing to take testimony from interested parties will be held from 1:00 p.m. to 3:00 p.m. **Wednesday, June 28, 2017**, in the Azure conference Room—4th Floor, Curtis State Office Building, 1000 SW Jackson St., Topeka, Kansas.

The first portion of the hearing will be a briefing by the Watershed Planning, Monitoring, and Assessment Section outlining each of the TMDLs. The public comment period for these TMDLs will be held open from June 8 through July 15 of 2017. After reviewing the testimony and public comments, KDHE will make appropriate revisions to the TMDLs and will submit them to Region VII of the U.S. Environmental Protection Agency.

Any individual with a disability may request accommodation in order to participate in the public hearing process and may request the proposed TMDLs in an accessible format. Requests for accommodation to participate in the hearing process should be made at least five working days in advance of the hearing by contacting KDHE.

Requests, questions, or written comments should be directed to Trevor Flynn of the Watershed Planning, Monitoring and Assessment Section of KDHE at 1000 SW Jackson St., Suite 420, Topeka, KS 66612-1367; by email at Trevor.Flynn@ks.gov; by telephone at 785-296-8791; or by fax at 785-291-3266.

Susan Mosier, MD, MBA, FACS
Secretary and State Health Officer

Doc. No. 045479

State of Kansas

Department of Health and Environment Division of Health Care Finance

Notice of Additional Hearings and Extended Comment Period Concerning KanCare Extension

The Kansas Department of Health and Environment (KDHE) is offering additional opportunities to attend

public hearings regarding the state's proposed one-year extension of the KanCare program, and to provide comments about the extension request application.

Public Comment – Timing and Process

This public comment period has been extended to run from **June 8, 2017 until July 10, 2017**. Comments will be accepted until July 10, and the state intends to submit the extension request no later than August 31, 2017.

Information about the KanCare extension request is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. A summary is also available at that link, along with documented comments from public comment meetings held in March 2017. For individuals without access to the internet, copies of the summary application and public comment document may be obtained by calling 785-296-4753 or writing KanCare Renewal, c/o Becky Ross, KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, KS 66612. Such requests must be made before July 10, 2017. A copy of the extension application will also be located at the reception desks for KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, Kansas and the Kansas Department for Aging and Disabilities Services, New England Building , 503 S. Kansas Ave., Topeka, Kansas.

Written comments about the KanCare extension request may be sent to kdhe.kancarerenewal@ks.gov, or may be mailed to KanCare Renewal, c/o Becky Ross, KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, KS 66612.

Public Hearings – When and Where

Additional public hearings about the KanCare extension will be held as follows:

Day/Date	Time	Location
Thur., July 6, 2017	1:30-3:00 p.m.	University of Kansas Edwards Campus, Best Conference Center, 12604 Quivira Road, Overland Park, KS
Fri., July 7, 2017	1:30-3:00 p.m.	WSU Hughes Metroplex , Room 180, 5015 E. 29th St. North, Wichita, KS (Enter door N at the southeast corner of the building)
Mon., July 10, 2017	6:00-7:00 p.m.	Conference call: 877-400-9499 Access Code: 134 228 8045

All meeting rooms are ADA accessible.

Language Accommodations

If you need language accommodations, such as a sign language interpreter or large print or Braille, please contact Dawn Goertzen at 785-291-3461 or dawn.goertzen@ks.gov. Please make your request by June 5, 2017.

Si desea esta informacion en Español, por favor llame al 1-800-766-9012.

KanCare – Summary of Program and Extension Information

KanCare is the program through which the state of Kansas administers Medicaid. After a long period of study, the state determined that contracting with multiple managed care organizations would result in the provision of more efficient and effective health care services to the populations covered by Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and would ensure coordination of care and integration of physical and behavioral health services with each other and with home- and community-based services (HCBS).

On August 6, 2012, the state of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare, to the Centers for Medicare & Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. CMS approved that proposal on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The state is now preparing to submit an application to extend the KanCare program for one year, effective from January 1, 2018, through December 31, 2018.

KanCare is operating concurrently with the state's section 1915(c) Home- and Community-Based Services (HCBS) waivers. Together with the 1115 demonstration, these seven waivers provide the authority necessary for the state to require enrollment of almost all Kansas Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) into a managed care delivery system to receive state plan and waiver services. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and provides incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

The KanCare demonstration program:

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

The KanCare demonstration assists the state in its goals to:

- Provide integration and coordination of care across the whole spectrum of health including physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries as well as provide a model for other states that are reforming their programs for Medicaid payment and delivery systems.

(continued)

The one-year extension of KanCare is designed to continue the program as it is currently structured, including:

- Eligible members covered: No change is anticipated in any eligibility group.
- Benefits covered and cost sharing requirements: No change is planned as part of the extension.
- Annual enrollment and re-enrollment of members: No change is planned as part of the extension.
- Annual aggregate expenditures: No change to funding and payment methodology is planned as part of the extension.
- Waiver and expenditure authorities: No change is planned as part of the extension.
- Hypothesis and evaluation parameters for the program: No change is planned as part of the extension; will expect to see ongoing improvement within the more mature program, and related expectations will be reflected in contractual and program policy content.

Information about the KanCare extension process and related documents will be maintained and kept current throughout the public comment and review process, during which the Centers for Medicaid Services (CMS) is reviewing and acting upon the state's extension request. This information will continue to be available at the KanCare Renewal page of the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. In addition, once the request to extend the KanCare program is submitted to CMS, it will be posted by CMS on its website for viewing and commenting: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Michael Randol, Director
Division of Health Care Finance

Doc. No. 045470

State of Kansas

Department for Children and Families

Notice of Hearing on Proposed Administrative Regulations

A public hearing will be conducted at 10:00 a.m., Tuesday, August 15, 2017, in the Kansas Department for Children and Families Administration Building, 555 S. Kansas Ave., 1st Floor, Conference Room, Topeka, to consider the adoption of a new regulation and the revocation of an existing rule and regulation on a permanent basis effective 15 days after publication in the Kansas Register. Telephone conference is not available. This 60-day notice of the public hearing shall constitute a public comment period for the proposed regulation. All interested parties may submit written comments prior to the hearing to Beth Lange, Legal Division, DCF, 555 S. Kansas Ave. 6th Floor, Topeka, KS 66603, or by email to Beth.Lange@ks.gov. All interested parties will be given a reasonable opportunity to present their views at the hearing. It may be necessary to request each participant limit any oral presentation to five minutes. Copies of the regulation and the economic impact statement may be obtained by contacting Beth Lange at Beth.Lange@ks.gov.

Any individual with a disability may request accommodations in order to participate in the public hearing and may request the proposed regulation and economic impact statements in an accessible format. Requests for accommodations to participate in the hearing should be made at least five working days in advance of the hearing by contacting Patti Cazier at 785-296-3274 or by email at patti.cazier@ks.gov.

These regulations are proposed for adoption on a permanent basis. A summary of proposed regulations and their economic impact follows:

K.A.R. 28-4-802. Pursuant to Executive Order Number 43, responsibility for foster care licensing was transferred from the Kansas Department of Health and Environment (KDHE) to the Kansas Department for Children and Families (DCF). This regulation is being revoked as it is no longer applicable to KDHE. There is no economic impact to DCF, to the general public, or to foster care licensees.

K.A.R. 30-47-3. This is a new regulation that incorporates much of the language previously found in K.A.R. 28-4-802 and adds the requirement to provide basic household income and expense information when applying for or renewing a foster care license, as recommended by the Kansas Legislative Division of Post Audit. This regulation simply codifies current agency practice. There is no economic impact to DCF, the general public or to foster care licensees.

Phyllis Gilmore
Secretary

Doc. No. 045467

State of Kansas

Kansas Lottery

Temporary Administrative Regulations

Article 2.—LOTTERY RETAILERS

111-2-62. Outstanding sales achievement awards. (a) Beginning with the calendar year starting January 1, and ending December 31, each year the Kansas lottery shall recognize its outstanding retailer locations as members of the "Director's Club."

Membership in the Director's Club shall be determined by the executive director of the Kansas lottery or his designee in the following categories: (1) top-selling convenience stores; (2) top-selling grocery stores; (3) top-selling social environment retailer locations; (4) top-selling miscellaneous retailer locations; (5) most improved retailer locations; and (6) any retailer with lottery (or lottery ticket) sales of $500,000 or more who was not recognized in any other category. The following criteria shall apply to the membership categories of the Director's Club:

(1) The number of retailer locations selected for membership into each category of the Director's Club shall be determined at the discretion of the executive director of the Kansas lottery.

(2) The most improved retailer locations shall be determined among those retailers selling a minimum of one hundred fifty thousand dollars ($150,000) in lottery ticket sales per calendar year based upon the greatest percent-

Appendix I: Full Public Notice

[See following page.]

Public Notice and Comment Period – KanCare Extension

The Kansas Department of Health and Environment (KDHE) will be submitting to the Centers for Medicare and Medicaid Services (CMS) a request to extend the KanCare program under Section 1115(a) of the Social Security Act. The current KanCare demonstration expires on December 31, 2017. KDHE is requesting a one-year extension of the current KanCare demonstration, including the Uncompensated Care Pool and the Delivery System Reform Incentive Payment Pool. The requested extension period is January 1, 2018 through December 31, 2018. KDHE is not requesting any changes to the demonstration for the one-year extension period.

KanCare – Summary of Program and Extension Information

KanCare is the program through which the State of Kansas administers Medicaid. After a long period of study, the State determined that contracting with multiple managed care organizations (MCOs) would result in the provision of more efficient and effective health care services to the populations covered by Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and would ensure coordination of care and integration of physical and behavioral health services with each other and with home- and community-based services (HCBS).

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare, to CMS. CMS approved that proposal on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State is now preparing to submit an application to extend the KanCare program for one year, effective from January 1, 2018 through December 31, 2018.

KanCare is operating concurrently with the State's Section 1915(c) HCBS waivers. Together with the 1115 demonstration, these waivers provide the authority necessary for the State to require enrollment of almost all Kansas Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) into a managed care delivery system to receive state plan and waiver services. KanCare also includes a Safety Net Care Pool (also referred to as an Uncompensated Care Pool) to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and provides incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

The KanCare demonstration program:

- Maintains Medicaid state plan eligibility;
- Maintains Medicaid state plan benefits;
- Allows the State to require eligible individuals to enroll in MCOs to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives, who are presumptively enrolled in KanCare but who have the option of affirmatively opting out of managed care; and
- Provides benefits, including long-term services and supports (LTSS) and HCBS, via managed care.

The original goals of the KanCare demonstration were to:

- Provide integration and coordination of care across the whole spectrum of health including physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries as well as provide a model for other states that are reforming their programs for Medicaid payment and delivery systems.

Because Kansas is simply requesting a one-year extension of its 1115 demonstration, with no program changes, the KanCare goals remain the same for the extension period.

The one-year extension of KanCare is designed to continue the program as it is currently structured, including the following:

Eligibility

KanCare currently includes almost all Kansas Medicaid beneficiaries (including the aged, disabled, and some dual eligibles). See the current 1115 demonstration Special Terms and Conditions for the full list of groups included in KanCare at the following link: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf (pages 11-17). Because Kansas is not requesting changes to Medicaid eligibility or managed care covered populations in the extension, no change is anticipated in any eligibility group.

Covered Benefits

The KanCare program integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services under the approved Medicaid state plan. Kansas is not requesting any changes in covered benefits for this extension.

Cost Sharing Requirements

There are no co-payments under the KanCare MCOs. Kansas is not requesting any changes in cost sharing for this extension.

Annual Enrollment and Aggregated Expenditures

Kansas does not anticipate a significant change in enrollment or aggregated expenditure trends for the extension period. The following table summarizes the annual enrollment and aggregated expenditures for KanCare, by demonstration year (DY). For DY5 and the one-year extension period (DY6), Kanas projects continued savings under the KanCare program as compared to the absence of the KanCare program.

	DY1 (Actual)	DY2 (Actual)	DY3 (Actual)	DY4 (Actual)	DY5 (Projected)	DY6 (Projected)
Total Member Months	3,923,495	4,274,950	4,613,313	4,440,125	4,356,280	4,378,062
Total Expenditures	$2,385,761,238	$2,596,087,408	$2,774,859,542	$2,939,589,998	$2,931,108,841	$3,200,639,003

Waiver and Expenditure Authorities

Kansas is requesting the same waiver and expenditure authorities as approved in the current demonstration, described below:

Waiver Authorities

1. Amount, Duration, and Scope of Services

   To the extent necessary to enable Kansas to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to individuals who are enrollees in certain managed care arrangements.

2. Freedom of Choice

   To the extent necessary to enable Kansas to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

Expenditure Authorities

1. Expenditures for Additional Services for Individuals with Behavioral Health or Substance Use Disorder Needs
2. Uncompensated Care Pool
3. Delivery System Reform Incentive Payment Program

Hypothesis and Evaluation Parameters

The original KanCare evaluation design included the following hypotheses:

- By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
- The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

For the proposed extension period, Kansas will continue to evaluate these hypotheses. In addition, Kansas will monitor quality measures and conduct member and provider surveys to evaluate the

program. Kansas will also perform new focused studies on the topics of network adequacy and validation of waiver payments to verify members are receiving appropriate access to adequate services. Kansas expects to see ongoing improvement within the more mature program, and related expectations will be reflected in contractual and program policy content.

Public Comment – Timing and Process

The public comment period has been extended to run from June 8, 2017 until July 10, 2017. Comments will be accepted until July 10, 2017; and the State intends to submit the extension request no later than August 31, 2017.

Information about the KanCare extension request, including the extension application and documented comments from public comment meetings held in March 2017, is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. For individuals without access to the internet, copies of the application and public comment document may be obtained by calling 785-296-4753 or writing:

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas, 66612

Such requests must be made before July 10, 2017. A copy of the extension application will also be located at the reception desks for:

KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas 66612

Kansas Department for Aging and Disability Services
New England Building, 503 S. Kansas Ave.
Topeka, Kansas 66603

Written comments about the KanCare extension request may be sent to this email address: kdhe.kancarerenewal@ks.gov; or may be mailed to:

KanCare Renewal
c/o Becky Ross
KDHE-Division of Health Care Finance
900 SW Jackson, LSOB – 9th Floor
Topeka, Kansas, 66612

Information about the KanCare extension process and related documents will be maintained and kept current throughout the public comment and review process, during which CMS is reviewing and acting upon the State's extension request. This information will continue to be available at the KanCare Renewal page of the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. In addition, once the request to extend the KanCare program is submitted to CMS, it will be posted by CMS on its website for viewing and commenting: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/waivers_faceted.html.

Public Hearings – When and Where

Additional public hearings about the KanCare extension will be held as follows:

Day/Date	Time	Location
Thur., July 6, 2017	1:30-3:00 pm	University of Kansas Edwards Campus, Best Conference Center, 12604 Quivira Rd., Overland Park, KS
Fri., July 7, 2017	1:30-3:00 pm	WSU Hughes Metroplex , Room 180, 5015 E. 29th St. North, Wichita, KS (Enter door N at the southeast corner of the building)
Mon., July 10, 2017	6:00-7:00 pm	Conference call: 1-877-400-9499 Access Code: 134 228 8045

All meeting rooms are Americans with Disabilities Act (ADA) accessible.

Language Accommodations

If you need language accommodations, such as a sign language interpreter or large print or Braille, please contact Dawn Goertzen at 785-291-3461 or dawn.goertzen@ks.gov. Please make your request by June 5, 2017.

Si desea esta informacion en Español, por favor llame al 1-800-766-9012.

Appendix J: Tribal Notice

[See following page.]

From: Carol Arace
Sent: Thursday, June 08, 2017 3:05 PM
Subject: Tribal Notice-Notice of Additional Hearings and Extended Comment Period Concerning KanCare Extension

Notice of Additional Hearings and Extended Comment Period Concerning KanCare Extension

The Kansas Department of Health and Environment(KDHE) is offering additional opportunities to attend public hearings regarding the state's proposed one-year extension of the KanCare program, and to provide comments about the extension request application.

Public Comment – Timing and Process

This public comment period has been extended to run from **June 8, 2017 until July 10, 2017**. Comments will be accepted until July 10, and the state intends to submit the extension request no later than August 31, 2017. Information about the KanCare extension request is available for public review at the KanCare website: http://www.kancare.ks.gov/about-kancare/kancare-renewal. A summary is also available at that link, along with documented comments from public comment meetings held in March 2017. For individuals without access to the internet, copies of the summary application and public comment document may be obtained by calling 785-296-4753 or writing KanCare Renewal, c/o Becky Ross, KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, KS 66612. Such requests must be made before July 10, 2017. A copy of the extension application will also be located at the reception desks for KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, Kansas and the Kansas Department for Aging and Disabilities Services, New England Building , 503 S. Kansas Ave., Topeka, Kansas.

Written comments about the KanCare extension request may be sent to kdhe.kancarerenewal@ks.gov, or may be mailed to KanCare Renewal, c/o Becky Ross, KDHE-Division of Health Care Finance, 900 SW Jackson, LSOB – 9th Floor, Topeka, KS 66612.

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KanCare – Summary of Program and Extension Information

KanCare is the program through which the state of Kansas administers Medicaid. After a long period of study, the state determined that contracting with multiple managed care organizations would result in the provision of more efficient and effective health care services to the populations covered by Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and would ensure coordination of care and integration of physical and behavioral health services with each other and with home- and community-based services (HCBS).

On August 6, 2012, the state of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare, to the Centers for Medicare & Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. CMS approved that proposal on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The state is now preparing to submit an application to extend the KanCare program

for one year, effective from January 1, 2018, through December 31, 2018.

KanCare is operating concurrently with the state's section 1915(c) Home- and Community-Based Services (HCBS) waivers. Together with the 1115 demonstration, these seven waivers provide the authority necessary for the state to require enrollment of almost all Kansas Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) into a managed care delivery system to receive state plan and waiver services. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and provides incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

The KanCare demonstration program:

- Maintains Medicaid state plan eligibility;
- Maintains Medicaid state plan benefits;
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    - American Indian/Alaska Natives, who are presumptively enrolled in KanCare but who have the option of affirmatively opting out of managed care.
- Provides benefits, including long-term services and supports (LTSS) and HCBS, via managed care; and
- Creates a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

The KanCare demonstration assists the state in its goals to:

- Provide integration and coordination of care across the whole spectrum of health including physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries as well as provide a model for other states that are reforming their programs for Medicaid payment and delivery systems.

The one-year extension of KanCare is designed to continue the program as it is currently structured, including:

- Eligible members covered: No change is anticipated in any eligibility group.
- Benefits covered and cost sharing requirements: No change is planned as part of the extension.
- Annual enrollment and re-enrollment of members: No change is planned as part of the extension.
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Tribal nations are reminded an in-person consultation may be requested.

Michael Randol, Director
Division of Health Care Finance

Appendix K: Summary of Public Comments and State Responses

[See following page.]

Kansas Department of Health and Environment

KanCare Extension Public Comments

July 2017

Report prepared by:

The Center for Organizational Development and Collaboration

Wichita State University
Community Engagement Institute

Introduction

The state of Kansas is requesting a one-year extension of its existing 1115 demonstration Waiver, known as KanCare. The existing Waiver permission expires on December 31, 2017. Kansas is requesting an extension to allow time to fully evaluate changes that are being considered at the federal level and may offer new opportunities that may benefit Kansas' Medicaid recipients.

Kansas accepted public comment on the extension request from June 8th until July 10th, 2017. Comments could be provided via mail, email, during one of two (2) in person public hearings that were held in the state, or on a public hearing held via conference call. Kansas notified stakeholders of the public meeting locations and ways to provide input by mail, press release, website publication, listserv email, and provider bulletins. Public hearings facilitated by the WSU Community Engagement Institute Center for Organizational Development and Collaboration were held between July 6th and July 10th in Overland Park, Wichita, and by phone.

Date/Date	Time	Location
Thursday, July 6, 2017	1:30 – 3:00 pm	University of Kansas Edwards Campus Best Conference Center 12604 Quivira Rd. Overland Park, KS
Friday, July 7, 2017	1:30 – 3:00 pm	WSU Hughes Metroplex, Room 180 5015 E. 29th St. North Wichita, KS
Monday, July 10, 2017	6:00 – 7:00 pm	Conference Call:1-877-400-9499 Access Code: 134 228 8045

In total, 91 people attended the July hearings and had the opportunity to share comments and questions live and/or by writing on comment cards. Total written comments included 6 written on comment cards during public hearings and 2 by email, no written comments by postal mail or email attachment were received.

Technical Note

Where the commenter provided comments on multiple topics in one statement and when possible based on clear language breaks, the statement is segmented and categorized into different thematic categories. When the statement is unable to be segmented, it is themed in the category that it overwhelmingly represents. Some comments overlap multiple thematic areas and are not repeated in both to keep the report concise. All verbal comments, comment cards, and e-mailed comments are included only once in the themed document. Emailed comments are included in their entirety as an appendix at the end of the report.

Index

Return to Index

KanCare Extension

There were nine (9) questions/comments regarding the KanCare Extension. Two (2) general extension questions/comments, one (1) about the duration of the extension, four (4) asking what happens if the extension is denied, and two (2) voicing support of the extension.

General Questions/Comments Summary	State Response
There were two (2) general questions/comments about the extension, one (1) requesting no changes in the extension and one (1) asking why the meeting was ending early.	Thank you for your comment. The meeting ended early (2:20pm) because there were no more questions or comments.

Comments

1. I wanted to call to request no changes, same goals, same covered populations, same evaluation design and please continue the same funding. Could you verify the email address?
2. Why did it end so early, in the letter it said it when to 3:00pm. You guys were going to complain about the extensions in the program?

Purpose of 1-year Extension Summary	State Response
There was one (1) comment about the reason the extension is for one year.	We are in our fifth year of the original five-year demonstration. We want to have an additional year to plan our longer-term renewal request, so we are asking for a one-year extension, with no changes.

Comments

1. Why is it only a 1-year extension given the fact that it was a 5-year plan?

Denial of an Extension Summary	State Response
There were four (4) comments regarding the impact of CMS denying the KanCare extension.	We are working with CMS on the extension application, including having weekly calls with staff at CMS. We have every confidence that the request will be approved.

Comments

1. Earlier this year and the end of last year there was a renewal proposal for 5 years correct? Didn't the federal government deny the first extension request? So if you're not changing anything since the last time it was denied why do we anticipate it will be approved if nothing was changed?
2. In the event that that expectation is not (extension is approved) met and we are denied a second time, what is the follow up? What is the consequence? We did not anticipate denial the first time.
3. What if CMS says no for the extension?
4. She asked part of my question. About the extension and it was not approved what would happen?

Support of Extension Summary	State Response
There were two (2) comments in supporting the extension of KanCare.	Thank you for your comments.

Comments

1. My name is XX and my mother is one of your beneficiaries, I'm deeply grateful for the Medicaid program and services it provides and I'm whole heartedly favor the extension.

2.	In favor of extension 2018. No changes. Same goals. Same covered populations. Same evaluation design. Continue the same funding for program.

Return to Index

Managed Care Organizations (MCOs), Service Delivery & Network Adequacy

There were seven (7) comments regarding Managed Care Organizations (MCOs), service delivery and network adequacy. Two (2) about service delivery and nonemergency medical transportation, three (3) related to network adequacy, and two (2) related to care coordination. Of the seven (7) total comments, three (3) referenced rural areas specifically.

Service Delivery Summary	State Response
There were two (2) service delivery comments, both related to nonemergency medical transportation service.	We continue to work with the MCOs to ensure that such the number of incidents decrease. We encourage members who have care coordinators to alert them about these issues so they can help prevent them in the future.

Comments

1. Is there any look at the lack of transportation for individuals seeking service for medical help, mental, dental, out in our rural areas? Cities don't have that problem but you get in the rural areas the doctors, that will accept you as a KanCare participant, might be 60 miles away, and you're not a driver weather you have a MRD or IDD waiver working healthy, or elderly what are we supposed to do?
   When my daughter calls to get access to care and gets a confirmation number, and is told to be ready at 7:15 in the morning to either go to a mental health appointment to get here required 28 day bloodwork done or to go in for any other checks and nobody shows up, and nobody calls her and tells her, "well we couldn't find anybody". From St Louis they could not find anybody, from Newton Kansas to be available. Now, for example she needs blood work on July 4. She had no idea that she had no ride on July 4th it was a holiday. Did they notify her? No. Then I was told that I could have taken her, and made $.56 a mile, I wasn't available to do that, and I'm her guardian conservator and so I can't be compensated for things according to what I've been reading. So where does that put her? Again this is a required blood draw. You can tell me, "Yes it's on paper". But what are you going to do about it? How can we be sure that these individuals, because I know she is only one case, what are we going to do? How can we fix this?
2. Getting transportation reimbursement is very difficult, I send in the reimbursement paperwork and never see a check after calling to ask where it is. I have called several times after turning one in and have received 1 reimbursement check.

Network Capacity/Adequacy Summary	State Response
There were three (3) network adequacy comments. Two (2) related to access to mental health services in specific geographic areas and one (1) related to accessibility in dental providers.	We work with the MCOs continuously to ensure that they each have adequate networks. We review their network adequacy reports regularly.

Comments

1. I would like to know, I would like to share a personal story about KanCare. [Interrupted] I do have a question about the extension, since you say nothing is going to change does that mean you are going to find a way to get providers to actually accept KanCare? Because I have found that services are limited and it is difficult to find Doctors who will actually accept KanCare because the model is so flawed to these providers, because they don't actually get reimbursed. So they are getting themselves out of KanCare. I'm curious how you're going to say nothing changes which to me means that no psychiatrist will take clients, in the Johnson County area, will take KanCare to get someone with a mental health issue any kind of medication, because they do not accept KanCare. I would like to know, how will you address those issues if you say nothing changes?

2. I'm cornered about rural care for beneficiaries, for example my mother lives in Coldwell and doesn't have any access to mental health services. I also have some questions and comments about the administration of the program that I won't say here because this is about the extension perhaps I can speak to some of the staff about that offline? Thank you very much for the opportunity to be here.
3. We can't find a dental provider in the Wichita Area who has disability access (wheelchair)

Care Coordination Summary	**State Response**
There were two (2) care coordination questions/comments, one (1) asking what a care coordinator does and one (1) stating that people on a waiting list for a Waiver don't know they have a care coordinator.	Not everyone in KanCare is assigned a care coordinator at the MCO, but if a member has a care coordinator that position is responsible for helping to make sure the member gets needed physical and behavioral health service and that preventive care is provided. If the member is receiving long term services and supports, those will also be coordinated to ensure the member's needs are met.

Comments

1. Back to the slides that you pushed through here quickly it is a lot of information, you said something about coordinating care, I'd like for you to explain how that was implemented in the extension, or what has been addressed. It seems as though you were referring to someone that was coordinating dental mental health care combined or something? I have not seen that? So I would like to know where that is in the extension. So my daughter who is IDD and is on the waiver should be having one of those? And that person, the independent living counsel, is supposed to be aware of the medical needs?
2. Her question about care coordination brought up an issue that has been troubling to me. We work with IDD population and the IDD folks on the IDD waiver they typically know care coordinator and will meet with them. I will tell you that the people on waiting list do not know that they have a care coordinator. They don't have contact with them. If there is coordination of care going on they are not familiar with it. They know they have a TCM and that's who they rely on. The Coordination is a little different depending on weather you are on the waiting list.

Return to Index

Home and Community Based Services (HCBS)

There were five (5) comments regarding Home and Community Based Services (HCBS) in KanCare. Two (2) general comments and questions relating to HCBS services in KanCare and three (3) relating to HCBS policy.

General Questions/Comments Summary	State Response
There were two (2) general HCBS Waiver questions, asking how to find out what Waiver the person receives and one (1) asking what percent of the Medicaid population is on a Wavier.	Roughly 10% of the KanCare population is receiving services from one of the seven HCBS waivers. Members who must pay premiums are members who may qualify for one of the HCBS waivers, but have chosen to be on the Work Opportunities Rewarding Kansans (WORK) program. Some HCBS members may also have a client obligation, which is a cost share, due to their income.

Comments

1. If you have a job and you're on Medicaid, it's a full-time job, and you're trying to get off SSI, do you have to pay a premium to keep Medicaid? I have SSI and I have a job that pays me weekly, and I have Sunflower. I was told I have to pay a premium because I was working full-time even though – I was on the great expectation program, but you don't have that anymore. I don't know what program I'm under now. How do I find that out?
2. You mentioned how many KanCare folks are on Medicare. Can you tell us how many are HCBS recipients? I was thinking that the population maybe 2% of recipients or 15% of the recipients?

HCBS Policy Summary	State Response
There were three (3) HCBS policy comments/questions, two (2) related to a recent Person Centered Service Plan Policy and one (1) regarding capable person policy.	The policy mentioned in these comments has been withdrawn by KDADS.

Comments

1. I have a question, on why they are trying to cut home health care for quote "capable persons"?*
2. So you said that with the KanCare extension that nothing will change correct? So the MCOs determining the level of care, and the individual's level of need, and not the case managers, is that not considered a change? Ok you are just changing the people who determine those needs, who just so happen to be to people and companies who are paying for those needs, Ok.
3. When you talk about no changes, we just got a new policy draft from KDADS that said case management is going to, in my estimation, is going to change. It says in the policy that the MCOs are going to do the person centered support plans along with the ISPs, they already do the needs assessments. So right now if that goes through, which think is egregious, I think it's a conflict of interest, because you've got the MCOs determining services, determining funding, determining the needs, and it used to be separated out and now that is going to be one entity. That is a definite change, it goes against choice and it goes against what the case manager has always been mandated to do. So I would like you to explain who decided on this new policy and how you came up with this? It's up for comment until the 14 of July, and I encourage everybody to comment in this room, to make sure you make your comments are known. I would also like to say and make sure people in this room know that PAC is going to be having a meeting addressing this very same issue. We've invited CMS to come, we will be inviting the state as well, to explain this policy to everyone, and also we will have the press there. We've invited all of our families and providers so that we will have a very large meeting and people will understand what is going on.

Return to Index

Individual Situations

Summary	State Response
There were five (5) comments related to individual situations or experiences. One (1) was a provider comment related to MCO payment for services provided, one (1) related to renewal of a Working Healthy application, two (2) related to spenddown, and one (1) related to guardianship.	KDHE encourages individual providers and members with specific coverage or payment issues to contact us directly with details so that we may help them.

Comments

1. XX, Psychiatric Practitioner – I'm not saying that it's not appropriate, the extension. I am concerned about the babble with the current MCOs and being the most solvent, and literally seeing thousands of people including the Medicaid population particularly: the disabled, the SPMI, the CHIP, the children's program, foster care, DCF. However, the MCOs seem to have a serious problem with actually making payments for service. Literally, I have hundreds of payments that are not made. Whether or not if the extension is appropriate, in my case, and with having only 1 psychiatrist for 13 counties. This can't go on and the reason for my comment is I hope to have an understanding how the extension may change the current status with the 3 MCOs. Formal grievances have been made to all MCOs, and we're talking about 100s of services which are not taken care of. How will the extension help that issue as a provider of the most vulnerable population? [Becky asked if he was a practitioner.] Yes, I'm a private psychiatric practitioner in southwest Kansas. I see 20,000 people with all their follow-up. I travel 500,000 miles seeing folks in these counties. [Becky asked, "As a private provider the MCOs are not paying you?]. That's correct or they will drawback and then by the time is up, oh well, "time's up". I have a huge concern about everyone saying they will take the situation and keep on doing it because it is in the best interest of people we serve, but I just can't imagine how we can continue to sustain and support an extension if we cannot actually accomplish what I've been trying to clear up since 2013 with documented calls to the Kansas Department of Health and Environment, KanCare, and all the MCOs. I'm happy to provide testimony as well as call logs.

   With Medicaid being a state ran and MCOs being a for profit entity and being able to say oh we should go retroactive or do all of these "things" but uh not able to be able to make headway on this is where the meta error comes in.

2. Is the working healthy, is that still related to Medicaid? I'm working on that, and my daughter is just wanting to start working. I'm renewing an application and it says a new person on here. There is no new person and is same one that has been staying here. She's not on the renewal. I'm not sure if she had to be on that too. She's 16 and we live in Olathe. [Becky provided referral information to KDHE benefits specialist.]
3. What is a NSO? [Becky clarified, an MCO?] Affirmed. My brother was on Medicaid and he didn't spend enough in the spenddown and they cut him off. In 6-months they wanted him to spend at least $6,200 in medical and they didn't help him when he needed it. Now he owes the hospital over $25,000.
4. Supposedly, you said that this is supposed to be free correct? So what a copayment? I have the exact same income and even more expensive because I'm on food stamps, my food stamps were cut from $100 from the last state I lived in. Which was just as conservative as this state. I have a spend-down of $1600 which means I can't go to a doctor because I can't afford to pay anything. I don't have that kind of an income. So I have no medical coverage which means that, what it says about emergency rooms? Well if I have a problem that's where I'm going because don't have to pay. You need to revise this.

I had to pay my Medicare because you were to slow covering me and I did and after being billed for a total of three months of Medicare, I called KanCare and they said you're gonna be reimbursed, but I have not been and I have been reimbursed for two months and I lost a whole month that I had to pay.

5. I have a sibling that I am the payee for and care giver to an extent. On several occasions I have been asked to become his guardian. Do I do that through you? I mean I used to communicate with the case worker but in the past couple of years it have been harder to communicate with case workers. It seems to be what I was at ease with before now it seems to have changed drastically. I do have the papers where they signed for that, but to actually be guardian and put things in my control, I don't want to go that far but it will make it better for the individual.

Utilization and Cost Savings

Summary	State Response
There were two (2) questions/comments related to utilization of service, both related to utilization of inpatient services.	Thank you for your comments.

Comments

1. I'm XX with the SCDDO I wanted to mention I've seen the measure a few times about the reduction in outpatient visits and inpatient hospitalizations. I want to make sure that it's clear that a reduction in inpatient admissions doesn't mean people are getting the mental health care that they need, and there is in particular a real gap for folks with intellectual disabilities in getting the mental health care that they need, and that your measure may not be discrete enough in getting that. I think there is still some room for improvement in that.
2. Tip- when talking about the success, utilization of in-patient services is good for the health of recipients not just a $ savings

Return to Index

General Questions & Comments

There were five (5) general questions and seven (7) general comments. This category is formatted to allow the state to respond to each individual question due to their unique nature and acknowledge the comments the same as other comments.

Questions	State Response
1. What's the waiver that you refer too?	The 1115 demonstration waiver.
2. Like what requirements are we waiving with the 1115 Waiver, what requirements are we getting around by having KanCare?	This waiver allows us to require that almost all of the populations Kansas serves in Medicaid and all of the Children's Health Insurance Program (CHIP) population be served in managed care for all of their services including long term services and supports.
3. I'm not sure if this this regarding the extension or not but you mentioned KanCare 2.0 would come in after the extension. Can you speak to that at all?	KanCare 2.0 is the name we use to talk about the renewal of the 1115 demonstration waiver and the request for proposals (RFP) that we will be doing later this year to create a new contract with MCOs and do some new and different things we aren't doing in the current 1115.
4. With the repeal of Obama Care is this basically, you're saying if they decide to repeal it or do something else, this will stay the same for a year, is that the point you're trying to get across? No matter what they do? You're not going to guarantee an extension. You're saying that this is a one-year extension but whatever they (federal government) decide, then it all changes? So you're saying this isn't grandfather in then? So when they change federal law, basically with whatever they determine, you will be having these meetings again to explain whatever the law is? So you're basically getting feedback from the public for the new policy (from the federal administration)?	Until Congress passes a health care bill, we can only do some calculations and projections about how each might affect the KanCare program. We are proceeding with our extension request and will make adjustments, if a bill is passed that requires us to do so.
5. Isn't it true that KanCare doesn't comply with the law at this point though? Isn't that why we are making changes to KanCare now? (It) Is that KanCare doesn't comply with the federal Medicaid laws as they stand now? Isn't that why there are changes that have to be made I mean we're voted or got censured I'm not sure what the terms are because I'm not the head of Medicaid and I don't pay that close of attention, but I pay close enough attention to know that KanCare is literally not compliant with at the requirements of Medicaid at the federal level.	No, this is not true. The Centers for Medicare and Medicaid (CMS) required Kansas to prepare a corrective action plan for some issues they noted in their review of the program. We have submitted that CAP and have weekly calls with CMS about our progress. We also have weekly calls about our 1115 extension and we have every confidence that the extension request will be approved.

Comments	**State Response**
1. ::Gentleman interrupted the speaker:: This isn't right… [unintelligible] you aren't. Just like the rest of them. [Unintelligible]. I don't understand. Okay. There is a lot of confusion. 19th the 17th. October 2017. And then a year. Okay, a year and 2 months. But any benefit, I don't understand. [Unintelligible] what all the way to the 19th, because I don't understand. A lot of people are going to die… and a lot of people are going to die and how is this turning a negative into a positive? You upgrade in October? I don't understand. November and December in 18 and 19. And do I qualify? How do I know what category am I in in the 1115? I don't know? [Unintelligible background conversation]. What's your name? How do you spell your name? [Asked if he's calling about his Medicaid application by Becky Ross]. Yes. [Unintelligible background conversation]. People die over these issues every day. People are laughing over this. You all have a good day. God bless you.	Thank you for your comments.
2. KanCare SUCKS. It has done NOTHING to help IDD services. It's sickening to hear the state try to convince people otherwise!!	Thank you for your comment.
3. Thank you for offer us to use KanCare and help me out my child (kids). We use for long time we are happy for the service. God bless all of you.	Thank you for your comment.
4. A few years ago, in 2012, you guys had implemented this into KanCare. How long is it going to take for it to go through this process? There are lots who have the Medicaid. When we try to reach out or anything, when we try to get through the wormholes, we want to know what our future is and we're put on hold. Our MCOs say we can't do anything because we don't know. It's frustrating for people with disabilities. For people with disabilities and from all walks of life, can it be cut down to an easier format so we know exactly what you're trying to tell us? I'm on a council that's supposed to be working with you guys and when you set up these meetings, many of us can't get around. Some are in Wichita and Topeka and bigger cities and we can't make it. This concerns me. You want our feedback, but we are far away, some are in wheelchairs or are blind and can't give that feedback.	KDHE makes every effort to comply with federal public comment requirements by holding meetings in various cities, with populations that make it likely a number of our members and providers, as well as other stakeholders will be able to attend. We also always try to have a conference call option and accept comments via e-mail and through the U.S. Postal Service. We serve over 400,000 members and it is impractical to hold enough meetings to accommodate everyone.

5.	Current KanCare benefits very nice.	Thank you for your comment.
6.	Give medicaid back to the state, instead of privatizing it through “MCOs”.	Thank you for your comment.
7.	My Name is XX, I am 42 years old now and was diagnosed with MS with multiple connected problems at the age of 21. I have been fighting this horrible disease for more than twenty years now. From this I have learned a great deal about the Medical establishment, good and bad. I have fought with many Health Insurance companies over payment of services for many years now, so I guess you could call me an “expert” of sort. Please, if you will, let me start with the wonderful assistance KanCare has provided me. I know these day, you probably hear of all the complaints and problems related to the health care industry. It surely seems to me it can be a terrific amount of “Red Tape.” I know it’s not sustainable as is, change is needed. You should know of the wonderful job KanCare has been doing for me in the time I have had coverage with you. Your constant attention to my needs has been better than superb. All of your staff has been willing to step in and step up to help with any problems that may occur. I am especially thankful for XX my case manager. I do not give compliments very often, but you guys deserve all the credit you can get. Without your care and coverage, I feel my life would have been quite different than it is today. I would hate to imagine, what my life would be like without your services... So I am Grateful!!! Thank You for all you do for me. Your care and assistance even effects my Husband’s life. His health is poor and getting worse. You make it easier for him, You give him peace of mind. God only knows how many lives you touch because you care as you do. Like a pebble tossed into a calm lake, you make ripples that reach further than you realise. Thank you, for My Life being possible because of the wonderful care by all my providers. Especially Dr. XX, whose Awesome services, would Not be possible, without KanCare! Thank you!!!	Thank you for your comments.

Written Letters

From: [redacted]
To: KanCare Renewal
Subject: Kancare Renewal comment
Date: Monday, July 10, 2017 8:27:44 PM

July 10, 2017 (6:00- 7:00 pm)
Conference call: 1-877-400-9499 Access Code: 134 228 8045.

In favor of extension 2018. No changes. Same goals. Same covered populations. Same evaluation design. Continue the same funding for program.

Thank you

[redacted]

From: [redacted]
To: KanCare Renewal
Subject: KDHE KanCare Renewal Extension Question
Date: Monday, July 10, 2017 10:51:03 PM

[redacted]
Monday 10 July, 2017 10:30 P.M.

KanCare Extension Request Renewal
My Personal Account of KanCare

Re: KDHE KanCare Renewal Conference Call

My Name is [redacted] I am 42 years old now and was was diagnosed with MS with multiple connected problems at the age of 21. I have been fighting this horrible disease for more than twenty years now. From this I have learned a great deal about the Medical establishment, good and bad.

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Thank you, for My Life being possible because of the wonderful care by all my providers. Especially Dr. [redacted] D.O., whose Awesome services, would Not be possible, without KanCare! Thank you!!!

With all my Gratitude,
[redacted]
The "Silly Ole Lady" with a Lifetime of Listening To Others
Especially Medical Professionals and Patients

Sent from my iPad