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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

State Demonstrations Group

April 13, 2022

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

Dear Ms. Fertig:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Kansas section 1115(a) Medicaid demonstration, titled "KanCare" (Project No. 11-W-00283/7), which was approved on December 18, 2018. The technical corrections ensure that the special terms and conditions (STC) reflect correct information in budget neutrality.

The changes include correcting errors that were made in the original rebasing calculations for budget neutrality due to erroneously excluding the entire managed care organization privilege fee and not accurately projecting the adults and children Medicaid eligibility group (MEG) costs. The changes to the budget neutrality agreement now reflect the entire managed care organization privilege fee and a corrected adults and children MEG. A copy of the updated budget neutrality worksheets is included as Attachment B to the STCs to clarify the correct budget neutrality limits.

If you have any questions, please do not hesitate to contact your project officer, Ms. Shelby Higgins. Ms. Higgins can be reached at (443) 926-6513, or at Shelby.Higgins@cms.hhs.gov.

We look forward to continuing work with your staff on the administration of the KanCare section 1115(a) demonstration.

Sincerely,

Angela D. Garner -S
Digitally signed by Angela D. Garner -S
Date: 2022.04.13 15:07:43 -04'00'

Angela D. Garner
Director
Division of System Reform Demonstrations

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning the date of the approval letter through December 31, 2023, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the state plan requirements contained in section 1902 of the Act are granted in order to enable Kansas to implement the KanCare Medicaid section 1115 demonstration for state plan populations and individuals eligible under the concurrent section 1915(c) waivers.

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures for services furnished or uncompensated safety net care costs incurred by providers during the period of this demonstration made by Kansas for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall be regarded as expenditures under the state's title XIX plan.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Kansas to implement KanCare Medicaid section 1115 demonstration.

I. 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 19 to address behavioral health and substance use disorder needs:

    a. Physician Consultation (Case Conferences);

    b. Personal Care Services; and

    c. Rehabilitation Services.

2. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease diseases (IMD).

3. **Disability and Behavioral Health Employment Support Pilot Program:** Pursuant to STC 22, expenditures for services furnished to (a) certain Medicaid eligible individuals (1) with specific behavioral health conditions who are also SSI or SSDI eligible or (2) on a 1915(c) waitlist for employment supports, independent living skills training, personal assistance, and transportation to encourage employment, and (b) medical assistance for SSDI eligible individuals not otherwise Medicaid eligible that also includes employment supports,

independent living skills training, personal assistance, and transportation to encourage employment.

SAFETY NET CARE POOL EXPENDITURES (SNCP): Expenditures for the following categories of expenditures, subject to overall SNCP limits and category- specific limits set forth in the STCs.

4. **Uncompensated Care Pool (UC Pool):** Pursuant to STC 53, 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.

5. **Delivery System Reform Incentive Payment (DSRIP) Program:** Expenditures from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program, pursuant to STC 54, 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. This funding is only for DY 7 – DY 8, and in DY 9 this expenditure authority will expire.

REQUIREMENTS NOT APPLICABLE TO EXPENDITURE AUTHORITY 3

All title XIX requirements that are waived for Medicaid eligible groups are also not applicable to the Voluntary Work Pilots. In addition, the following Medicaid requirement is not applicable:

1. **Comparability** **Section 1902(a)(10)(B)**

   To the extent necessary to enable Kansas to restrict comparability through the use of a voluntary work pilot for those on a 1915(c) waitlist, 1915(c) waiver participants who choose to leave the 1915(c) waiver to participate in the pilot, or those with specific behavioral health needs.

2. **Reasonable Promptness** **Section 1902(a)(8)**

   To the extent necessary to enable Kansas to restrict reasonable promptness to allow a cap of 500 individuals to participate in the voluntary work pilot.

CENTERS FOR MEDICARE & MEDICAID SERVICES SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00283/7**

TITLE: **KanCare**

AWARDEE: **Kansas Department of Health and Environment**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Kansas' KanCare section 1115(a) Medicaid demonstration (hereinafter "demonstration"). The parties to this agreement are the Kansas Department of Health and Environment (state) and the Centers for Medicare & Medicaid Services (CMS). CMS has granted the state waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs that are not otherwise matchable, which are separately enumerated. These STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. The demonstration will be statewide and is approved for a 5-year period from January 1, 2019 through December 31, 2023, with implementation no sooner than January 1, 2019.

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION AND OBJECTIVES

On December 26, 2017, the State of Kansas submitted a Medicaid section 1115 demonstration renewal application, entitled KanCare. KanCare will continue to operate concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers. It will build on the success of the current KanCare demonstration, which focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). The goal for the KanCare extension is to help Kansans achieve healthier, more independent lives by coordinating services and supports in addition to traditional Medicaid benefits. This represents an expansion of the state's previous demonstration to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility.

This five year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Continue to allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
  - American Indian/Alaska Natives will be presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care;
- Extend the Delivery System Reform Incentive Payment (DSRIP) program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.
- Provide work opportunites and support for individuals with specific behavorial health conditions and other disabilities.

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

- Help Kansas Medicaid beneficiaries achieve healthier, more independent lives by coordinating services to strengthen social determinants of health and independence, and person-centered planning;
- Promote higher levels of member independence through employment programs;
- Drive performance and improve quality of care for Kansas Medicaid beneficiaries by integrating value based models, purchasing strategies and quality improvement programs; and
- Improve effectiveness and efficiency of the state Medicaid program with increased alignment of MCO operations, data analytic capabilities and expanded beneficiary access to SUD services.

The state's demonstration evaluation will include an assessment of the following hypotheses:

1. That value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.

2. That increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.

3. That the use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:

    a. Telemedicine will improve access to services such as speech therapy

    b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions

    c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions

4. That removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Laws.** The state must comply with applicable federal civil rights laws relating to non-discrimination in services and benefits in its programs and activities. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Affordable Care Act (Section 1557). Such compliance includes providing reasonable modifications to individuals with disabilities under the ADA, Section 504, and Section 1557 with eligibility and documentation requirements, understanding program rules and notices, and meeting other program requirements necessary to obtain and maintain benefits.

2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in law, regulation, and written policy, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid and/or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes of an operational nature without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration, to comply with such change. Further, the state may seek an amendment to the demonstration (as per STC 7 of this section) as a result of the change in FFP.

   b. If mandated changes in the federal law require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

5. **State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPA) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state

plan may be required, except as otherwise noted in these STCs. In all such instances, the Medicaid and CHIP state plans governs.

6. **Changes Subject to the Amendment Process.** If not otherwise specified in these STCs, changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS either through an approved amendment to the Medicaid or CHIP state plan or amendment to the demonstration. Amendments to the demonstration are not retroactive and FFP, whether administrative or service-based expenditures, will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7, except as provided in STC 3.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to failure by the state to submit required elements of a viable amendment request as found in this STC, and failure by the state to submit reports required in the approved STCs and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

   a. A detailed description of the amendment including impact on beneficiaries, with sufficient supporting documentation;

   b. A data analysis worksheet which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detail projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c. An up-to-date CHIP allotment neutrality worksheet, if necessary;

   d. An explanation of the public process used by the state consistent with the requirements of STC 13; and,

   e. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.** States that intend to request a demonstration extension under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than twelve months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal

requirements at 42 Code of Federal Regulations (CFR) 431.412(c) or a transition and phase-out plan consistent with the requirements of STC 9.

9. Demonstration Phase Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements:

a. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment, and how the state incorporated the received comment into the revised transition and phase-out plan.

b. Transition and Phase-out Plan Requirements. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for those beneficiaries whether currently enrolled or determined to be eligible individuals, as well as any community outreach activities, including community resources that are available.

c. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 days after CMS approval of the transition and phase-out plan.

d. Transition and Phase-out Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 C.F.R. 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

e. Exemption from Public Notice Procedures, 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. Enrollment Limitation during Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended.

g. Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration authority expiration plan to CMS no later than six months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

1) Expiration Requirements. The state must include, at a minimum, in its demonstration authority expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility prior to the termination of the demonstration authority for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities.

2) Expiration Procedures. The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206, 431.210, 431.211, and 431.213. In addition, the state must assure all applicable appeal and hearing rights are afforded to demonstration beneficiaries as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and 431.221. If a demonstration beneficiary requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination as discussed in October 1, 2010, State Health Official Letter #10-008 and as required under 42 CFR 435.916(f)(1). For individuals determined ineligible for Medicaid, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e).

3) Federal Public Notice. CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR 431.416 in order to solicit public input on the state's demonstration authority expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration authority expiration plan. The state must obtain CMS approval of the demonstration authority expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than fourteen (14) days after CMS approval of the demonstration authority expiration plan.

4) Federal Financial Participation (FFP). FFP will be limited to normal closeout costs associated with the expiration of the demonstration authority including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

12. **Adequacy of Infrastructure.** The state must ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request.

    The state must also comply with tribal and Indian Health Program/Urban Indian Health Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, or as contained in the state's approved Medicaid State Plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

    The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

14. **Federal Financial Participation (FFP).** No federal matching for expenditures, both administrative and service, for this demonstration will take effect until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

15. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. The Secretary has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

IV. ELIGIBILITY

The KanCare demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Standards for eligibility for mandatory and optional Medicaid state plan populations remain as set forth under the state plan, and approved 1915(c) waivers. Medicaid state plan services and 1915(c) services are delivered through a statewide comprehensive managed care delivery system through managed care organizations (MCOs). Most beneficiaries eligible under the state plan and most beneficiaries eligible for home and community based services provided through the concurrent 1915(c) waivers are required to enroll in MCOs to obtain covered benefits with the exception of Native Americans and Alaskan Natives. The state plan and 1915(c) waiver populations, as identified below, are affected by the demonstration through the requirement to enroll in the Medicaid managed care program under the demonstration in order to receive state plan and, if eligible, 1915(c) waiver services. Full benefit dual eligibles are covered under this demonstration for Medicaid services.

16. **Eligibility Groups Affected By the Demonstration.** The following tables describe the mandatory and optional state plan populations and the 1915(c) waiver populations affected by this demonstration.

Table A. Medicaid State Plan Mandatory Populations

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
LOW INCOME FAMILIES	Parents and Other Caretaker Relatives 1902(a)(10)(A)(i)(I) 1931(b) and (d)	Adults
TRANSMED – WORK TRANSITION (Transitional Medical Assistance (TMA))	Coverage for up to 12 months is provided to families who receive coverage on the Low Income Families program and have lost financial eligibility due to an increase in earnings, increase in working hours, or loss of time-limited earned income disregard. Children are covered through the month of their 19th birthday. 1902(a)(10)(A)(i)(I) 408(a)(11)(A)1925	Children (age 18 and under) Adults (age 19 and over)

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
EXTENDED MEDICAL – SPOUSAL SUPPORT	Coverage for 4 months is provided to families who received coverage on the Low Income Families program and lost financial eligibility due to an increase in spousal support. 408(a)(11)(B) 1902(a)(10)(A)(i)(I) 1931(c)(1)	Children (age 18 and under) Adults (age 19 and over)
PREGNANT WOMEN	Consolidated group for pregnant women 1902(a)(10)(A)(i)(III) and (IV) 1902(a)(10)(A)(ii)(I), (IV) and (IX) 1931(b) and (d)	Adults
CHILDREN UNDER AGE 19	Consolidated group for children under age 19 1902(a)(10)(A)(i)(III), (IV), (VI) and (VII) 1902(a)(10)(A)(ii)(I), (IV) and (IX) 1931(b) and (d)	Children
Deemed Newborns	Children born to a Medicaid mother 1902(e)(4)	Children
FOSTER CARE/ADOPTION MEDICAL (IV-E)	This program is for children who are receiving IV-E foster care or guardianship maintenance payments or with IV-E adoption assistance agreements. 473(b)(3) 1902(a)(10)(A)(i)(I)	Children
SUPPLEMENTAL SECURITY INCOME (SSI) RECIPIENTS	1902(a)(10)(A)(i)(II) 1619(a) 1619(b)	ABD/SD Dual ABD/SD Non Dual
WORKING DISABLED	1905(q)	ABD/SD Dual ABD/SD Non Dual
PICKLE AMENDMENT	Section 503 of P.L. 94-566 1939(a)(5)(E)	MN Dual MN Non Dual
ADULT DISABLED CHILD	1634(c) 1939(a)(2)(D)	MN Dual MN Non Dual
EARLY OR DISABLED WIDOWS AND WIDOWERS	1634(b) (Disabled Widow/ers) 1939(a)(2)(C) 1634(d) (Early Widow/ers)	MN Dual MN Non Dual

State Plan Mandatory Medicaid Eligibility Groups	Description and Citation	Medicaid Eligibility Group (MEG)
CHILD IN AN INSTITUTION	This program is for children through the age of 21 years old who are residing in an institution for a long term stay. Children eligible under this program whose income exceeds the protected income level are responsible for a portion of the cost of their care in the facility.	Children

Table B. Medicaid State Plan Optional Populations

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG
FOSTER CARE MEDICAL (NON IV-E)	This program is for children under age 21 who are in foster care that does not meet the criteria for a IV-E foster care maintenance payment.	Children
INDEPENDENT FOSTER CARE ADOLESCENT MEDICAL (AGED OUT)	This program is for children transitioning to adult independent living who are being removed from the Foster Care Medical program because they are turning 18 years old. Medicaid coverage may continue through age 21. 1902(a)(10)(A)(ii)(XVII)	Children
ADOPTION SUPPORT MEDICAL (NON IV-E)	This program is for adopted children with special needs receiving non-IV-E state adoption assistance who do not meet the eligibility criteria for federal participation in the IV- E adoption support program and met the Medicaid eligibility requirements at the time of adoption and are under age 21. 1902(a)(10)(A)(ii)(VIII)	Children
BREAST AND CERVICAL CANCER	Uninsured individuals under age 65 who were screened and found to need treatment for breast or cervical cancer. 1902(a)(10)(A)(ii)(XVIII)	Adults

State Plan Optional Medicaid Eligibility Groups	Description and Citation	MEG
WORKING HEALTHY	1902(a)(10)(A)(ii)(XV)	ABD/SD Non Dual
WORKING HEALTHY MEDICALLY IMPROVED	1902(a)(10)(A)(ii)(XVI)	ABD/SD Non Dual
LONG TERM INSTITUTIONAL CARE	1902(a)(10)(A)(ii)(V) Except for individuals residing in a public ICF/ID	LTC
MEDICALLY NEEDY (Disabled, Blind, Aged, Pregnant Women, and Children)	1902(a)(10)(C)	MN Dual MN Non Dual ABD/SD Dual ABD/SD Non Dual

Table C. Section 1915(c) Waiver Populations. Individuals enrolled in the concurrent section 1915(c) waivers listed below are eligible for this demonstration.

Waiver Eligible Groups	Description and Citation	MEG
Autism Waiver	1902(a)(10)(A)(ii)(VI)	Waiver
Intellectual Disabilities/Developme	1902(a)(10)(A)(ii)(VI)	DD Waiver
Frail Elderly	1902(a)(10)(A)(ii)(VI)	LTC
Physically Disabled	1902(a)(10)(A)(ii)(VI)	LTC
Technology Assisted	1902(a)(10)(A)(ii)(VI)	Waiver
Traumatic Brain Injury / Brain Injury Waiver	1902(a)(10)(A)(ii)(VI)	Waiver
Serious Emotional Disturbance	1902(a)(10)(A)(ii)(VI)	Waiver

Table D. Voluntary Behavioral Health Employment Support Project Participants. Individuals enrolled in the Behavioral Health Employment Support Pilot who are not eligible for Medicaid without the pilot are eligible for this demonstration.

Waiver Eligible Groups	STC Reference	Expenditure Authority Reference
Individuals enrolled in the Behavioral Health Employment Support Pilot who are not eligible for Medicaid currently	#22(a)(i) and (b)(i)	#3

a. Individuals on the section 1915(c) waiver waiting lists who are not otherwise eligible for Medicaid through the approved state plan are excluded from the demonstration with the exception of the Behavorial Support Employment Support Pilot.

17. Exemptions and Exclusions. The following population is exempt from mandatory enrollment in mandatory managed care and is not affected by this demonstration except to the extent that individuals elect to enroll in managed care.

i. American Indians/Alaska Natives (AI/AN): The AI/AN population will be automatically enrolled in managed care under the demonstration. This population will have the ability to opt out of managed care at the beneficiary's discretion. The state will use the definition of Indian provided at 42 CFR §447.51.

Table E. Eligibility Exclusions. Notwithstanding STC 16, the following populations are excluded from this demonstration.

Exclusions from KanCare	Description
Aliens eligible for emergency services only	1903(v)(3)
QUALIFIED MEDICARE BENEFICIARY (QMB), not otherwise Medicaid eligible	1902(a)(10)(E)(i) 1905(p)(1)
SPECIAL LOW-INCOME MEDICARE BENEFICIARY (LMB) not otherwise Medicaid eligible	1902(a)(10)(E)(iii) 1902(a)(10)(E)(iii)

EXPANDED SPECIAL LOW-INCOME MEDICARE BENEFICIARY (E-LMB)	1902(a)(10)(E)(iv)(I)
PROGRAM OF ALL-INTENSIVE CARE FOR THE ELDERLY (PACE)	1934
LONG TERM INSTITUTIONAL CARE Individuals residing in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID)	1902(a)(10)(A)(ii)(V)
RESIDENTS OF MENTAL HEALTH NURSING	1902(a)(10)(A)(ii)(V)

V. BENEFITS

18. KanCare Benefits. Benefits provided through KanCare managed care entities are described below:

a. KanCare Benefits. All populations outlined in STC 16 are entitled to receive all mandatory and optional services under the approved Medicaid state plan, including Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for children up to age 21. These Medicaid state plan benefits are provided through KanCare MCOs in at least the same amount, duration and scope that services are provided through the state plan. Individuals enrolled in the following 1915(c) waiver programs will also receive 1915(c) waiver services authorized through the waiver program from the KanCare MCO in which they are enrolled:

b. Autism waiver KS-0476;

c. Physically Disabled waiver KS-0304;

d. Technology Assisted waiver KS-4165;

e. Traumatic Brain Injury Waiver KS-4164;

f. Serious Emotional Disturbance Waiver KS 0320;

g. Frail and Elderly Waiver KS-0303; and,

h. Intellectual Disabilities/Developmental Disabilities KS-0224.

19. Additional Services. In addition to the benefits described in STC 18, KanCare MCOs will provide the following services to certain populations below.

a. Additional services covered in the demonstration:

Service	Populations Eligible
Physician Consultation (Case Conferences) – Communication between licensed mental health practitioners (LMHP), advanced registered nurse practitioner (ARNP) or Psychiatrist for a patient consultation that is medically necessary for the medical management of the psychiatric conditions. These services are prior authorized, and limited to scheduled face to face meetings to discuss problems associated with the member's treatment	Severely and Persistently Mentally Ill (SPMI) adults and Seriously Emotionally Disturbed (SED)youth

Personal Care Services – These are services provided a consumer with severe and persistent mental illness or a serious emotional disturbance who would otherwise be placed in a more restrictive setting due to significant functional impairments resulting from an identified mental illness. This service enables the consumer to accomplish tasks or engage in activities that they would normally do themselves if they did not have a mental illness. Assistance is in the form of direct support, supervision and/or cuing so that the consumer performs the task by him/herself. Such assistance most often relates to performance of ADL and IADL and includes assistance with maintaining daily routines and/or engaging in activities critical to residing in their home community. These services are prior authorized.	SPMI and SED not receiving personal care under the SED waiver
Rehabilitation Services (Substance Use Disorder detoxification and treatment including, ASAM Levels of Care 3.1 and 3.3/3.5) (Step down services from inpatient hospital) – These are services designed to meet more intensive needs of individuals with a substance use disorder in their community, including to preventatively avoid the need for inpatient hospitalization. These services are prior authorized, and include the specific ASAM levels of care noted above, as well as medically monitored detoxification service or other community based ASAM Level 3 service.	All demonstration enrollees meeting medical necessity.

20. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).** The MCOs must fulfill the state's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

21. **Opioid Use Disorder/Substance Use Disorder Program.** Effective upon CMS' approval of the OUD/SUD Implementation Protocol, the demonstration benefit package for Kansas Medicaid recipients will include OUD/SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Kansas Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Kansas will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 62 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

    The coverage of OUD/SUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand 's current SUD benefit package available to all Kansas Medicaid recipients as outlined in Table 1. Room and board costs

are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Table 1: Kansas OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Services to be covered in this waiver under STC
Early Intervention (SBIRT)	*State plan*	
Outpatient Services (Individual, group and family therapy, peer recovery coaching/support for individuals and families, community psychiatric support, assessment)	*State plan*	
Intensive Outpatient Treatment (individual and group counseling and education)	*State plan*	
Residential Treatment (medically directed evaluation and treatment for SUD, reintegration, support for co-occurring medical and mental illnesses)	*State plan*	Services provided to individuals in IMDs
Medically Supervised Withdrawal Management	*State plan*	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT) (counseling and buprenorphine, combo products with naloxone and injectables, excluding methadone treatment)	*State plan*	Services provided to individuals in IMDs

The state attests that the services indicated in Table 1, above, as being covered under the Medicaid state plan authority are currently covered in the Kansas Medicaid state plan.

a. **SUD Implementation Protocol.** The state must submit an OUD/SUD Implementation Protocol within 90 calendar days after approval of the SUD program under this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment P, and once incorporated, may be altered only with CMS approval. After approval of the Implementation Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

   At a minimum, the SUD Implementation Protocol must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration:

i. **Access to Critical Levels of Care for OUD and other SUDs:** Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of OUD/SUD program demonstration approval;

ii. **Use of Evidence-based SUD-specific Patient Placement Criteria:** Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of OUD/SUD program demonstration approval;

iii. **Patient Placement:** Establishment of a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval;

iv. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities:** Currently, residential treatment service providers must be a licensed organization, pursuant to the residential service provider qualifications described in the Kansas Standards for Licensure/ Certification of Alcohol and/or Other Drug Abuse Programs, rev. 1/1/06. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval;

v. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

vi. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

vii. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for OUD:** An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval;

viii. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

ix. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 21(f) and Attachment R; and

x. **Improved Care Coordination and Transitions between levels of care:** Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

b. **SUD Monitoring Protocol.** The state must submit a SUD Monitoring Protocol within 150 calendar days after approval of the SUD demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment Q. At a minimum, the SUD Monitoring Protocol will include reporting relevant to each of the program implementation areas listed in STC 21(a). The SUD Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 64 of the demonstration. In addition, the SUD Monitoring Protocol must identify a baseline and a target to be achieved by the end of the demonstration. Where possible, baselines must be informed by state data, and targets must be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the Monitoring Protocol must be reported via the quarterly and annual monitoring reports.

c. **Mid-Point Assessment.** The state must conduct an independent mid-point assessment by June 30, 2021 of the demonstration. The state must require that the independent assessor collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The state must require that the assessment include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Protocol, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol. The state must also require that the assessment include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The state must also require that the mid-point assessment provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the assessor will provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state must require the assessor to provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS. The state must brief CMS on the report.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Protocol and SUD Monitoring Plan Protocols for ameliorating these risks subject to CMS approval.

d. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections XII General Reporting Requirements and XV Evaluation of the Demonstration of the STCs.

e. **SUD Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment M (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a revision to the Evaluation Design to include the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these amended STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

   i. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

   ii. **Evaluation Questions and Hypotheses Specific to OUD/SUD Program.** Consistent with Attachments M and N (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

f. **SUD Health Information Technology (Health IT).** The state must provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it must submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance, must be included as a section of the state's "Implementation Protocol" (see STC 21(a)) to be approved by CMS. The SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan must also be used to identify areas of SUD health IT ecosystem improvement.

   i. The SUD Health IT section of the SUD Implementation Protocol must include implementation milestones and dates for achieving them (see Attachment R).

ii. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

iii. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP)[1]

iv. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan will describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

v. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state must also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

vi. The SUD Health IT Plan must describe how the activities described in (i) through (v) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

vii. In developing the Health IT Plan, states should use the following resources.

1. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

2. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

3. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid*.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

h. The state must include in its Monitoring Plan (see STC 21(b)) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

i. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 64).

j. As applicable, the state must advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally-recognized standards, barring another compelling state interest.

ii. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

22. Disability and Behavioral Health Employment Support Pilot Program (BH Pilot). The state will operate a voluntary pilot program for eligible KanCare members through this section 1115 demonstration. This pilot program will help certain members obtain and maintain employment by providing supportive services. The pilot program will operate during the KanCare 2019-2023 demonstration extension, with a possibility of renewal and expansion through an applicable title XIX authority if shown to be effective. The program will begin no sooner than July 1, 2019.

a. Pilot Program Eligibility: The following KanCare members who are ages 16 through 65 will be eligible for the Disability and Behavioral Health Employment Support Pilot Program:

i. Members who have any of the following behavioral health primary diagnoses and who receive services through Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI):):

A. Schizophrenia;

B. Bipolar and major depression;

C. Delusional disorders;

D. Personality disorders;

E. Psychosis not otherwise specified;

F. Obsessive-compulsive disorder;

G. Post-traumatic stress disorder; or

H. Substance use disorder (SUD) or co-occurring SUD;

ii. SSI Members currently enrolled in Medicaid and waitlisted for Home and Community Based Service (HCBS) on the intellectual or developmental disability (I/DD), physical disability (PD), or any potential Brain Injury Waiver waiver waitlists[4]; or

iii. Members who have an intellectual or developmental disability (I/DD), physical disability (PD), or Brain Injury Waiver, who are willing to leave their HCBS waiver.

b. Disability and Financial Eligibility and Cost Sharing: Members may be eligible for the Disability and Behavioral Health Employment Support Pilot Program depending on criteria specified below, including financial eligibility. Persons must also meet general and non-financial eligibility criteria, and may be required to pay cost sharing. .

i. Individuals with a behavioral health diagnosis and who have been determined disabled according to Social Security criteria (e.g. SSDI or Railroad Retirement disability recipients). To be financially eligible:

A. Can have an income up to 300% of current Federal Poverty Level (FPL).

B. Can have resources up to $15,000 for an individual or for a couple.

C. Individuals with income up to 100% of FPL will not have a cost share. Participants with income that exceeds 100% of FPL who receive medical assistance under expenditure authority #3 will be subject to cost share that is the same as the Kansas "Working Healthy" program which can be accessed at the following site: http://www.kdheks.gov/hcf/workinghealthy/premium.htm

ii. Individuals with a behavioral health diagnosis and who are SSI eligible:

A. There shall be no cost share for the participant.

iii. Individuals waitlisted for the Intellectual/Developmental Disability (I/DD), Physical Disability (PD) or Traumatic Brain Injury (TBI) Waivers and who are SSI eligible:

A. There shall be no cost share for the participant.

iv. Individuals on the I/DD, PD, or TBI waivers who choose to leave the waiver and who are SSI eligible:

A. There shall be no cost share for the participant.

c. Benefit Specialists: The state will make available Benefit Specialists who will provide program guidance to potential participants.

[4] As of this draft STC submission, there are no individuals on the TBI waiver waitlist. However, Kansas may be expanding the TBI waiver to include individuals with Acquired Brain Injury, in which case, there may be individuals on the TBI witlist in the future.

d. Needs Assessment: The state will use a standardized needs assessment process to determine eligibility for the Disability and Behavioral Health Employment Support Pilot Program.

e. Program Enrollment: Member enrollment will operate with the following conditions:

i. *For an individual on the waiver waitlist who leaves the waitlist to participate in the Pilot:* The individual will not lose his or her place on the waitlist should employment support services prove to be ineffective in helping the individual obtain and maintain employment.

ii. *For an individual who leaves his or her waiver to participate in the Pilot:* The individual will be able to return to the waiver if employment support services prove to be ineffective in helping the individual obtain and maintain employment.

iii. If there is a waitlist for the Pilot program, the list shall be managed on a statewide basis using a standardized assessment tool and in accordance with criteria established by the state. Waiting list policies shall be based on objective criteria and applied consistently in all geographic areas served.

f. Enrollment Targets: For this pilot project, the state will not enroll more than 500 individuals. The purpose of the target is to permit the pilot program to grow in a controlled manner, while assuring appropriate service to members enrolled in the program. Limiting enrollment will also allow the state to evaluate the effectiveness of the pilot program, before deciding whether to implement the program for all eligible members.

g. Managed Care Organization (MCO) Support: Employment Support Pilot services will be provded exclusively as a managed care benefit. MCOs may play a role in:

i. Identifying eligible members who are interested in employment.

ii. Promoting the benefits of employment to members.

iii. Referring members to employment services.

iv. Reauthorizing continuation of services (e.g., 6-month increments for pre-vocational services, independent living skills training).

v. Providing (or paying for) Community Service Coordination and other pilot services.

h. Employment Guidelines: Employment shall be a minimum of 40 hours per month in a

competitive, integrated setting at the federal hourly minimum wage or more with Federal Insurance Contributions Act (FICA) withheld. Employment in a sheltered workshop shall not constitute employment for purposes of this pilot.

i. Pilot Program Services: The program will assist members through several potential services available to members depending on their need as outlined in Figure 1. Where applicable, the state will promote the use of evidence-based practices in the delivery of these services.

Figure 1: ***Disability and Behavioral Employment Support Pilot Services***

Service	Service Definition
1. Pre-Vocational Services *(available to participants who have not or are unable to access Vocational Rehabilitation Services)*	Individualized services/supports that assist persons to develop or reestablish the skills, attitudes, personal characteristics, interpersonal skills, work behaviors, functional capacities, etc., described in the individual's person-centered service plan and designed to lead to integrated competitive employment. Services will occur over a defined period of time and are not indefinite. The individual and his/her planning team will use an ongoing person-centered planning process to identify goals for specific outcomes. Services may include: career exploration and planning, development of work-related skills such as interviewing, punctuality, attendance, appropriate work behavior, etc. and job development and placement. However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.

Service	Service Definition
2. Supported Employment	Employment-related support services provided to participants who need sustained support to maintain a job in a competitive, customized or self-employment environment. Services may include: job coaching, individual and small group employment support, and other evidence-based practices. However, such services may only be furnished to a waiver participant to the extent that they are not available as vocational rehabilitation services funded under the Rehabilitation Act of 1973. When a state covers prevocational and/or supported employment services in a waiver, the waiver service definition of each service must specifically provide that the services do not include services that are available under the Rehabilitation Act (or, in the case of youth, under the provisions of the IDEA) as well as describe how the state will determine that such services are not available to the participant before authorizing their provision as a waiver service.
3. Personal Assistant Services	Services that assist members with Activities of Daily Living (ADLs) and instrumental ADLs (IADLs) such as meal preparation, shopping, light housekeeping and laundry.
4. Independent Living Skills Training	Training designed to enhance or improve the ability of the participant to live as independently as possible in the community and use existing community resources (e.g., assessment, training, and supervision of an individual with self-care, medication management, task completion, paying bills, housekeeping skills, etc.).
5. Assistive Technology	Equipment, devices, and modifications not already provided under the Medicaid State Plan, that enhance the functional abilities of individuals with disabilities, with emphasis on supporting employment and independent functioning.
6. Transportation	Services to transport members to and from locations essential to obtaining and maintaining employment.

j. Evaluation: The state shall also include an evaluation of the Disability and Behavioral Health Employment Support Pilot Program in the demonstration evaluation design required per STC 97.

k. Pilot Program Requirements.

i. HCBS Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2020 and home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

ii. HCBS Quality Systems and Strategy. The state is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and evaluate the effectiveness of implemented quality improvement activities.

iii. For for services that could have been authorized to individuals served under a 1915(c) waiver, the state must have an approved Quality Improvement Strategy and is required to develop and measure performance indicators for the following waiver assurances:

A. Administrative Authority: A performance measure should be developed and track any authority that the State Medicaid Agency (SMA) delegates to another agency, unless already captured in another performance measure.

B. Level of Care: Performance measures are required for the following two sub-assurances:
   1. Applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented.
   2. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.

C. Qualified Providers: The state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

D. Service Plan: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

E. Health and Welfare: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures that track that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves

incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved waiver.

iv. The state will submit a report to CMS following receipt of an Evidence Request letter and report template from the Regional Office no later than 18 months prior to the end of the approved waiver demonstration period on the status of the HCBS quality assurances and measures that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. The Regional Office will send a DRAFT report to the state which will have 90 days to respond to the DRAFT report. The Regional Office will issue a FINAL report to the state 60 days following receipt of the state's response

v. The CMS Regional Office will evaluate each evidentiary report to determine whether the assurances have been met and will issue a final report to the state 12 months prior to expiration to the demonstration.

vi. The state must report annually the deficiencies found during the monitoring and evaluation of the HCBS waiver assurances, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved. Submission is due no later than 6 months following the end of the demonstration year.

vii. HCBS Beneficiary Protections:

A. Person-centered planning: The state assures there is a person-centered service plan for each individual determined to be eligible for HCBS. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR 441.301(c)(1), and the written person-centered service plan meets federal requirements at 42 CFR 441.301(c)(2). The person-centered service plan is reviewed, and revised upon reassessment of functional need as required by 42 CFR 441.365(e), at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

B. Conflict of Interest: The state agrees that the entity that authorizes the services is external to the agency or agencies that provide the HCB services. The state also agrees that appropriate separation of

assessment, treatment planning and service provision functions are incorporated into the state's conflict of interest policies.

C. Each beneficiary eligible for long term services and supports will have informed choice on their option to self-direct LTSS, have a designated representative direct LTSS on their behalf, or select traditional agency-based service delivery. Both level of care and person-centered service planning personnel will receive training on these options. (MLTSS with self-direction)

D. The state, either directly or through its MCO contracts must ensure that participants' engagement and community participation is supported to the fullest extent desired by each participant. (MLTSS)

E. Beneficiaries may change managed care plans if their residential or employment support provider is no longer available through their current plan. (MLTSS)

VI. COST SHARING

23. Cost Sharing. Beneficiary cost sharing, including premiums and co-payments, will be limited to those authorized under the Medicaid state plan with the exception of certain participants in the Behavorial Health Employment Support Pilot.

VII. KANCARE ENROLLMENT

24. KanCare Enrollment Process.

- Enrollment Process after January 1, 2019. All individuals must have the opportunity to make an active selection of a KanCare MCO during the application process. If no MCO is selected, the state will pre-select an MCO for each KanCare member and enroll the individual in that MCO. That pre-selection shall be based on the principles set forth in 42 CFR § 438.52, while taking into account the MCO affiliation of the individual's historic providers, with a prior history with the MCO being taken into account first.
- Supports for Beneficiaries using LTSS. For individuals residing in a nursing facility or other residential facility, the nursing or residential facility will be used first to determine the selection of a KanCare MCO. For individuals using HCBS providers at the time of enrollment, the selection process must be customized to the specific waiver with specific attention paid to the types of providers critical to positive outcomes of the individuals within each of the waivers. All individuals enrolled in a 1915(c) waiver at the time of KanCare enrollment must have the opportunity to receive counseling from an independent options counselor to assist them in making an MCO selection and switching MCOs if desired.
- Number of enrollees receiving 1915(c) services**.** The state must allow all eligible individuals to enroll into each 1915(c) delivery system until the enrollment cap has been reached in a given year.

25. **KanCare Disenrollment.** Individuals who are temporarily or permanently placed in a public Intermediate Care Facility for Persons with Intellectual or Developmental Disabilities (ICF/ID) will be disenrolled from their MCO.

26. **For Cause Reasons for Disenrollment.** In addition to the for cause reasons for disenrollment in 42 CFR 438.56, and any other state specific reasons for disenrollment, enrollees will have the following reasons for disenrolling from an MCO and will be able to choose a different MCO:

i. MLTSS Service Planning Dissatisfaction. Members with an existing LTSS service plan transitioning from FFS or a different MCO, who, when the new service plan is created, wish to change MCOs because of their service planning process experience, will be permitted to disenroll for cause within 30 days of the date of the initial service assessment. Members will only be able to use this for cause reason once annually.

ii. Residential provider leaves the MCO. Where an individual's residential provider is leaving a participant's MCO, the state shall allow the impacted participants the opportunity to change MCOs at any time within 90 days from the date of notice of provider departure from the MCO. If a safe transfer cannot be arranged within 90 days, there will be an extension of coverage provided to permit the individual to remain in his/her residence until an appropriate transfer arrangement can be made.

VIII. DELIVERY SYSTEM

27. **Managed Care Requirements.** The state must comply with the managed care regulations

published at 42 CFR § 438. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR § 438.5. The certification shall identify historical utilization of state plan and HCBS services used in the rate development process.

28. **Managed Care Benefit Package.** Individuals enrolled in any managed care program within the state must receive from the managed care program the benefits as identified in section V of the STCs. Benefits should be delivered and coordinated in an integrated fashion, using an interdisciplinary care team, to coordinate all physical, behavioral, acute and long-term services and supports.

29. **Managed Care Services During Appeals.** The state shall adopt policies that ensure authorized LTSS continue to be provided in the same amount, duration and scope while a modification, reduction or termination is on appeal. Notices of Action must clearly state the process to ensure services remain in place during appeal and state who is responsible for the cost of services during the appeal process. The notices must provide the contact information for one or more resources that may assist the individual. The state shall monitor MCO service authorization processes and participant appeals of service authorization, reductions, or expirations, and intervene if the results of appeal indicate broader problems in the service authorization process.

30. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR § 438 requirements prior to CMS approval of such contracts and/or contract amendments. The state shall submit any supporting documentation deemed necessary by CMS. The state must provide CMS with a minimum of 60 days to review and approve changes. If changes to contracts are needed based on CMS approval of initial or amended STCs, the state must submit amended contracts within 60 days of approval of the demonstration documents. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

31. **Public Contracts**. Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals.

32. **Network Requirements**. The following requirements must be included in the state's MCO contracts:

33. **Access to Care, Network Adequacy and Coordination of Care Requirements for Long Term Services and Supports (LTSS)**. The state shall set specific requirements for MCOs to follow regarding providers of LTSS, consistent with 42 CFR § 438 Subpart Part D. These requirements shall be outlined within each MCO contract. These standards should take into consideration individuals with special health care needs, out of network requirements if a provider is not available within the specific access standard, ensuring choice of provider with capacity to serve individuals, time/distance standards for providers who do not travel to the individual's home, and physical accessibility of covered services. The MCO should contract with at least two providers serving each county for each covered LTSS service in the benefit package, unless the county has an insufficient number of providers licensed, certified, or available in that county. See https://www.kancare.ks.gov/policies-and-reports/network-adequacy for more information

about network adequacy in Kansas.

34. **State Advisory Committee**. The state must maintain for the duration of the demonstration, a public managed care advisory group comprised of individuals, family members, interested parties, and stakeholders impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of beneficiary members in the agency program. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving LTSS as well as other eligibility groups. The state shall maintain minutes from these meetings and use them in evaluating program operations and identifying necessary program changes. Copies of committee meeting minutes must be made available to CMS upon request and the outcomes of the meetings may be discussed on the bimonthly demonstration calls in STC 63.

35. **MCO Participant Advisory Committees**. The state shall require each MCO, through its contracts, to create and maintain participant advisory committees through which the MCO can share information and capture enrollee feedback. These committees must fairly represent KanCare stakeholders, be operated in ways that are reasonably transparent and convenient to their members, and allow members free expression of opinions. The MCOs will be required to support and facilitate participant involvement and submit meeting minutes to the state. Copies of meeting minutes must be made available to CMS upon request.

36. **Independent Consumer Supports (Ombudsman).** To support the beneficiary's experience receiving medical assistance and long term services and supports in a managed care environment, the state shall maintain a permanent system of independent consumer supports (hereafter referred to as the Ombudsman) to assist enrollees in understanding the coverage model and in resolving problems regarding services, coverage, access and rights. Please see Attachment H for additional information on the Ombudsman Plan.

a. Core Elements of the Ombudsman.

i. *Organizational Structure*. The Ombudsman shall be autonomous to any KanCare MCO and the State Medicaid agency. If the Ombudsman operates within a sister state agency, the State shall establish protections such that no undue influence will be imposed that restricts the ability of the Ombudsman to perform all of the core functions. The organizational structure of the Ombudsman shall demonstrate transparency and collaboration with beneficiaries, MCOs, community based organizations, and state government.

ii. *Accessibility*. The services of the Ombudsman are available to all Medicaid beneficiaries enrolled in KanCare, with priority given to those receiving long-term services and supports (institutional, residential and community based). The Ombudsman must be accessible through multiple entryways (e.g., phone, internet, office) and must use various means (mail, phone, in person), as appropriate, to reach out to beneficiaries and/or authorized representatives

through.

iii. *Functions*. The Ombudsman assists beneficiaries to navigate and access covered health care services and supports. The services of the Ombudsman help individuals understand the delivery system and resolve problems and concerns that may arise between the individual and a provider/payer. The following list encompasses the Ombudsman's minimum scope of activity. The Ombudsman:

A. Shall serve as an access point for complaints and concerns about access to services and other related matters when the beneficiary isn't able to resolve their concern directly with a provider or health plan
B. The Ombudsman shall help enrollees understand the state's Medicaid fair hearing process, grievance and appeal rights, and grievance and appeal processes provided by the health plan, and shall assist enrollees in navigating those processes and/or accessing community legal resources, if needed/requested.
C. The Ombudsman shall develop a protocol for referring unresolvable issues to the State Medicaid Agency and other state officials as necessary to ensure the safety and well-being of beneficiaries.
D. The Ombudsman shall develop and implement a program of training and outreach with KanCare MCOs, providers, and community based organizations to facilitate cross-organizational collaboration, understanding, and the development of system capacity to support beneficiaries in obtaining covered plan benefits. The state shall track and report all such activities to the State Medicaid Agency and CMS, as specified in subparagraph v. of this STC.
E. The Ombudsman shall assist enrollees to understand and resolve billing issues, or notices of action.

iv. *Staffing and training*. The Ombudsman must employ individuals who are knowledgeable about the state's Medicaid programs; beneficiary protections and rights under Medicaid managed care arrangements; the health and support needs of persons with complex needs, including those with a chronic condition, disability, and cognitive or behavioral needs, and the community based systems that support them. In addition, the Ombudsman shall ensure that its services are delivered in a culturally competent manner and are accessible to individuals with limited English proficiency and people with disabilities. The state shall develop an access standard to measure the availability and responsiveness of the system to beneficiaries and others seeking support from the Ombudsman, and shall report compliance with this standard to CMS in its quarterly and annual reports, as specified in STC 64. The system shall be staffed sufficiently to address all requests for support consistent with this access standard.

v. The State and CMS will review the performance of the Ombudsman against this access standard and against the functions described in these STCs 12 months following approval of this demonstration. The State shall take any

necessary corrective action to comply with this standard.

vi. *Data Collection and Reporting*. The Ombudsman shall include a robust system of data collection and reporting. The state shall include this data in all quarterly and annual reports to CMS as specified in STC 64. The state shall also develop a mechanism for public reporting. At a minimum, the state shall collect and report on the following elements:

1) The date of the incoming request as well as the date of any change in status.
2) The volume and type (email, phone, verbal, etc.) of incoming request for assistance.
3) Time required for beneficiaries to receive assistance from the Ombudsman, including time from initial request to resolution.
4) The issue(s) presented in incoming requests for assistance.
5) The health plan (s) involved in the request for assistance, if any.
6) The geographic area where the beneficiary involved resides, if applicable.
7) Which 1915(c) waiver authority if applicable (ID/DD, PD, Aging, etc) the beneficiary receives services from.
8) The current status of the request for assistance, including actions taken to resolve.
9) The number and type of education and outreach events conducted by the Ombudsman.
10) System Enhancement. The Ombudsman shall generate periodic public reports that describe the functioning of the Ombudsman and any enhancements to the program that the state makes. The first report of the new demonstration period will be submitted to CMS within 6 months of approval of the demonstration. Subsequent reports will be submitted to CMS within 6 months of the end of the calendar year.
11) Transparency and Stakeholder Involvement. The State shall assure transparency in the operation of the Ombudsman, including public reporting of all aggregate data and performance reports and changes made to improve the Ombudsman program. The State shall develop a mechanism to secure stakeholder input into the operation and performance of the Ombudsman and demonstrate inclusion of stakeholder input in its on-going operation, evaluation, and enhancement of the program.

b. The State will evaluate the impact of the Ombudsman program in the demonstration evaluation per STC 97.

37. KanCare Website. The state must maintain and keep current a KanCare website for the lifetime of the demonstration. The website should include the approved or proposed program design features, descriptions of eligibility and enrollment processes, options for choice counseling, and an area for beneficiaries and stakeholders to provide input on the program design and implementation. The state must also publish information about its program operations and outcomes at least annually. The state must ensure that all information on this website is presented in an easily accessible manner (language, reading level), including for individuals with disabilities, in order to support beneficiaries in making decisions about their plans, providers, and care. The state must make this information available in hard copy upon request. MCO-specific information should be

included in the information that is considered public and is regularly published.

IX. HCBS SERVICE DELIVERY

38. Service Planning Firewalls. The State Medicaid Agency ensures:

a. Has clear conflict-free guidelines for contracted entities participating in the service planning process so that these entities offer choices to the participant regarding the services and supports they receive and available alternatives;

b. Includes a method for the participant to request changes to the service plan;

c. Records the alternative HCBS and settings that were considered by the participant; and

d. Grants beneficiaries the fair hearing and appeal rights provided for under Medicaid statute, regulation, and policy.

39. Participant-Direction. The State Medicaid Agency, either directly or through its contracts with its MCOs and level of care enrollment entities, must educate LTSS participants about the opportunity to self-direct their services and ensure that MCOs provide adequate supports to help beneficiaries be successful in self-directing their services. Both Level of Care and Service Planning personnel must be required to receive training to ensure they can offer participants sufficient information to make an informed choice on their option to self-direct

40. Critical Incident Management System. The State Medicaid Agency or the MCO must operate a critical incident management system according to the State Medicaid Agency's established policies, procedures and regulations. On an ongoing basis the State Medicaid Agency must ensure that all entities, including the MCOs, prevent, detect, report, investigate, and remediate instances of abuse, neglect and exploitation, and ensures participant rights are maintained through policies concerning seclusion, restraint, and medication management. MCOs, providers and participants must be educated about this system initially at the start or at hire, and at least annually thereafter. MCO and provider obligations include specific action steps that MCOs and providers must take in the event of suspected or substantiated abuse, neglect or exploitation, including risk mitigation. If the State Medicaid Agency delegates the responsibility for the critical incident management systems to the participating MCOs, the State Medicaid Agency must collect and analyze the data collected by the MCOs on a regular, periodic basis, and ensure that individual situations are remediated in a timely manner and that system-wide issues are identified and addressed.

41. HCBS Settings and Community Integration. The State Medicaid Agency must ensure that services are provided in a setting that has a home-like character by providing full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, and visitors at times convenient for the participant. The settings/services support community integration, including facilitation of employment and easy access to resources and activities in the community. HCBS LTSS are not provided in institution-like settings

except when such settings are employed to furnish short term respite to participants. The state, either directly or through its MCO contracts, must ensure that: (1) all participants receive appropriate services in the least restrictive and most integrated home and community-based setting, in accordance with CMS community- based setting requirements outlined in the regulatory text at 42 CFR 441.530; and, (2) all participants' engagement and community integration is supported and facilitated to the fullest extent desired by each participant and reflected in the member's service plan. The state must ensure that all HCBS settings comply with any revisions to Medicaid regulations.

42. **HCBS Authority.** The 1915(c) waivers of KS-0224, KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303 will continue to be the authority under which HCBS operates the state must follow the section 1915(c) amendment process to make alterations to its HCBS waivers. The state must notify CMS demonstration staff in writing of any proposed amendments to the section 1915(c) waivers concurrently with the submission of the section 1915(c) amendment.

X. PROGRAM IMPLEMENTATION BENEFICIARY PROTECTIONS

The KanCare demonstration is a continuation of the comprehensive reform for the state's Medicaid program. The beneficiary protections below reflect the discussions between CMS and the state regarding continuity of care.

43. **Verification of Beneficiary's MCO Enrollment**. The state must implement the CMS approved process (see Attachment I) for an MCO, network and non-network providers, or the state to confirm enrollment of enrollees who do not have a card or go to the wrong provider.

44. **State Ride-Alongs**. The state must complete ride-alongs with each MCO that was not a provider on January 1, 2017 to observe the service planning process for each MCO. A ride along consists of an experienced state employee who accompanies an MCO employee to observe and assist in the performance of a needs assessment and service plan development for individuals enrolled in the concurrent section 1915(c) HCBS waivers. The amount of ride alongs should be a random sample that reasonably captures the experience of beneficiaries in the waivers.

45. **State Operated Call Center**. The state must operate a call center independent of the MCOs for the duration of the demonstration. This can be achieved either by providing the call center directly or through the enrollment broker or other state contracted entities. This entity should be able to help enrollees in making independent decisions about MCO choice, and members should be able to voice complaints about each of the MCOs independent of the MCOs.

46. **Call Center Response Statistics**. Data and information regarding call center statistics, including beneficiary questions and concerns, must be made available to CMS upon request.

47. **Auto-assignment Algorithm Review**. The state must review the outcomes of the auto-assignment algorithm, and if an MCO is found to get a larger number of beneficiaries associated with no match to an existing provider relationship due to a more limited network, that MCO will not be able to receive as many auto-assignees until such time as the network has improved.

48. **Implementation Calls with the MCOs**. During the first 30 days of the renewal period, the state must hold calls at least once per week with any new MCOs who were not providers on December 31, 2018 to discuss any issues that arise. The calls should cover all MCO operations and determine plans for correcting any issues as quickly as possible. After the first 30 days, if it is found that the frequency of calls is no longer needed then the state can scale back the calls, but must maintain biweekly calls for the first 90 days and monthly calls for the next 90 days. After the first 180 days of the program, the state may move to the regular timeframe intended for meeting with each of the MCOs.

49. **State Review of Beneficiary Complaints, Grievances, and Appeals.** During the first 180 days of the renewal period, the state must review complaint, grievance, appeal notices, and

appeal logs for each new MCO who was not a provider on January 1, 2017. and data from the state or MCO operated incident management system. The state will use this information to implement any immediate corrective action necessary including revising notices. The state must review the data at least weekly for the first 90 days and then at least bi-weekly for the next 90 days. The state shall monitor MCO service authorization processes and participant appeals of service authorizations, reductions, or expirations, and intervene if the results of the appeals indicate broader problems in the service authorizations process. The state will continue to monitor these statistics throughout the demonstration period and report on them in the quarterly reports as specified in STC 64. Data and information regarding the beneficiary complaints, grievances, and appeals process must be made available to CMS upon request.

50. **Protections from Improper Institutionalizations of ID/DD Beneficiaries**. When a beneficiary who resides in the community has been recommended for placement into an ICF/IID or nursing facility, the state must review and approve the placement before the beneficiary can be admitted into the ICF/IID or nursing facility.

51. **Care Coordination Reports.** The State shall design and include in its reports to CMS performance metrics on consumer satisfaction with care coordination.

XI. SAFETY NET CARE POOL

The terms and conditions in section XI apply to the operation of the state's safety net care pools (SNCPs), as authorized by Expenditure Authority II: Safety Net Care Pool Expenditures.

52. Terms and Conditions Applying to Pools Generally.

a. The non-federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. All payments must remain with the provider and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

b. The state must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly monitoring report required by STC 64, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

c. The state may not amend its Medicaid state plan to authorize supplemental payments for hospitals, except as related to Graduate Medical Education payments, so long as the expenditure authorities for pool payments under this demonstration remain in force.

d. The state will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the state plan or this demonstration. The preceding sentence is not intended to preclude the state from modifying the Medicaid benefit through the state plan amendment process.

e. Each quarter the state makes a pool payment (for either pool as described in STCs 53 and 54 below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

53. Uncompensated Care (UC) Pool. Through DY 8, the UC Pool is available to defray the actual uncompensated cost of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided to Medicaid eligible or uninsured individuals (defined as individuals who have no source of third party coverage) incurred by hospitals. Starting DY 9, the UC Pool is available to defray the actual uncompensated cost

of medical services that meet the definition of "medical assistance" contained in section 1905(a) of the Act, that are provided by hospitals to uninsured individuals as charity care, including uninsured full or partial discounts, that provide all or a portion of services free of charge to patients who meet the provider's charity care policy and that adhere to the charity care principles of the Healthcare Financial Management Association.[5] Annual UC Pool payments are limited to the annual amounts identified in STCs 53(b) and 55. Expenditures for UC payments must be claimed in accordance with CMS-approved claiming protocols for each provider type and application form in Attachment E. The methodology used by the state to determine UC payments will ensure that payments are distributed to hospitals without any relationship to source of nonfederal share. Expenditures must be claimed in accordance with the methodology described in STC 53(c) below.

a. UC Pool Eligibility. The UC Pool is made up of two sub-pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool.

   i. Hospitals eligible for the HCAIP Pool are listed in Attachment C.

   ii. Hospitals eligible for the LPTH/BCCH Pool are listed in Attachment D.

   iii. Changes to Attachments C and D must be submitted to CMS for review and approval prior to implementation, but are not subject to the amendment process outlined in STC 7.

b. Annual UC Payment Limits. The state may claim FFP for UC Payments in each DY up to the limits (total computable) described in the table in this STC.

Demonstration Year	HCAIP Pool (total computable)	LPTH/BCCH Pool (total computable)	UC Pool (total computable)
DY7	$41,000,000	$9,856,550	$50,856,550
DY8	$41,000,000	$9,856,550	$50,856,550
DY9	$41,000,000	$9,856,550	$50,856,550
DY10	$41,000,000	$9,856,550	$50,856,550
DY11	$41,000,000	$9,856,550	$50,856,550

c. UC Payment Methodology

   i. Payments are made each calendar quarter based on a UC Payment Application that contains information reported by each hospital from its Medicare hospital cost report associated with the state's most recent DSH audit collection tool net of any DSH payments received in that fiscal year. All UC payments must be based on uncompensated care costs calculated in accordance with the General DSH Audit and Reporting Protocol, CMS-2198-F. In DY 9 and subsequent years, UC payments must be based on the uncompensated cost of medical services provided to uninsured individuals as charity care, and no longer need to be net of DSH payments received

[5] Available at http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=14589.

during the fiscal year as DSH payments can be applied to Medicaid shortfall.

ii. HCAIP Pool. The payment structure for the HCAIP UC payments is as follows, subject to the annual limits in STC 53(b):

A. *Uniform Percentage*: The state shall calculate aggregate uncompensated care costs for HCAIP hospitals based on the information identified in STC 53(c)(i) above. Each hospital eligible under the HCAIP UC section shall then receive a uniform percentage of its eligible uncompensated care costs (UCC);

B. *Specialty Service Uniform Percentage*: Each hospital that furnishes at least 1 of the following specialty services shall receive an additional uniform percentage of its eligible UCC:

a. Psychiatric services;
b. Level II or Level III Neonatal Intensive Care Unit (NICU) services; or,
c. Level I or Level II Trauma Services.

C. *Tri-Level NICU Services Uniform Percentage*: Each hospital system that furnishes all 3 levels of NICU services (Levels I, II, and II) shall receive an additional uniform percentage of its eligible UCC.

D. *Tri-Specialty Uniform Percentage*: Each hospital that provides all 3 specialty services identified above and has inpatient net patient revenue less than the amount identified in Attachment J shall receive an additional uniform percentage of its eligible UCC. The goal of including an inpatient net patient revenue threshold as a criterion for this adjustment is to recognize the added difficulty in providing access to multi-specialty services in smaller facilities. As such, the threshold must be evaluated annually to ensure smaller facilities that offer such multi-specialty services would not be inadvertently ineligible for such payment merely based on standard industry growth in patient revenues.

E. In addition to the inpatient net patient revenue threshold applicable to the Tri-Specialty adjustment the uniform percentages for each of the four adjustments for each demonstration year may also be found in Attachment J. By February 28th of each year (DY 7 through 11), the state must submit a revised Attachment J to CMS for review and approval. This revision is not subject to the amendment process provided in STC 7.

iii. LPTH/BCCH Pool. The payment structure for the LPTH/BCCH UC payments will be calculated in accordance with STC 53(c)(i), up to the limits set forth in STCs 53(b) and 55. Within the LPTH/BCCH Pool, 75 percent of the funding is available to the designated LPTHs while the remaining 25 percent is available to the designated BCCHs (see Attachment D for additional information on LPTH/BCCH Pool eligible hospitals).

d. UC Payment Application. To qualify for a UC Payment, a hospital must submit to the state an annual UC Payment Application that will collect cost and payment data on

services eligible for reimbursement under the UC Pool. The UC Payment Application is Attachment E. Data collected from the application will form the basis for UC Payments made to individual hospitals. The state must require hospitals to report data in a manner that is consistent with the Medicare 2552-10 cost report. By July 1, 2019, the state must submit to CMS for review and approval a revised UC Payment Application template that is consistent with the revised focus of the UC Pool on unreimbursed cost of charity care for the uninsured.

i. The state may accept applications from hospitals for UC Payments for DY 7 and 8. After CMS has approved the revised UC Payment Application template, the state may begin accepting applications from hospitals for UC Payments in DY 9. Hospitals are required to submit their UC Payment Applications to the state by December 31st of each year, in order to qualify for a UC Payment for the DY that begins on January 1st.

ii. Cost and payment data included on the application must be based on the Medicare 2552.10 cost report, or similar Medicaid cost report for hospitals not enrolled with Medicare. The state may trend the data to model costs incurred in the year in which payments are to be made. Subsequent DY application will be used to verify that a hospital's UC Payments, when combined with Disproportionate Share Hospital (DSH) payments under the state plan, did not exceed its actual uncompensated care costs in that year. For example, uncompensated care costs data from a DY 9 application will be used to determine the actual uncompensated care for DY 7 UC Payments for a qualifying hospital and the state will verify that UC Payments plus DSH payments attributable to DY 7 did not exceed the hospital's actual uncompensated care costs. Any overpayments identified in the verification process that occurred in a prior year must be recouped from the provider, with the FFP returned to CMS.

e. **UC Payment Protocol.** The UC Payment Protocol, also known as the funding and reimbursement protocol, establishes rules and guidelines for the State to claim FFP for UC Payments. By July 31, 2019, in addition to the revised UC Payment Application template, the state must submit a draft UC Payment Protocol to CMS for approval that will establish rules and guidelines for the state to claim FFP for UC Payments beginning in DY 9. CMS and Kansas will work collaboratively with the expectation of CMS approval of the protocol within 90 calendar days after CMS receives the draft protocol. The state cannot claim FFP for any UC Payments for DY 9 or later until a UC Protocol has been approved by CMS. The UC Payment Protocol must include precise definitions of eligible uncompensated provider charity care costs (consistent with the Medicare cost reporting principles and revenues that must be included in the calculation of uncompensated charity care cost for purpose of reconciling UC payments to unreimbursed charity care cost). The Protocol will also identify the allowable source documents to support costs; it will include detailed instructions regarding the calculation and documentation of eligible costs, and a timetable and reconciliation of payments against actual charity care cost documentation. This process will align the application process (based on prior cost periods) to the reconciliation process (using the application costs from subsequent years to reconcile earlier payments). The Protocol will contain not only allowable costs and revenues, it will

also indicate the twelve (12) month period for which the costs will apply. Once approved by CMS, the UC Payment Protocol will become Attachment L of the STCs.

f. All applicable inpatient and outpatient hospital UC payments received by a hospital count as title XIX revenue, and must be included as offsetting revenue in the state's annual DSH audit reports. Providers receiving both DSH and UC Payments cannot receive total payments under the state plan, DSH, and the UC Pool (related to inpatient and outpatient hospital services) that exceed the hospital's total eligible uncompensated costs. UC Payments for physicians, non-physician professionals, pharmacy, and clinic costs are not considered inpatient or outpatient Medicaid payments for the purpose of annual hospital specific DSH limits and the DSH audit rule. All reimbursement must be made in accordance with CMS approved cost claiming protocols that are consistent with the Medicare 2552-10 cost report.

g. Annual Reporting Requirements for UC Payments. The state must submit to CMS two reports related to the amount of UC Payments made from the UC Pool per demonstration year. The reporting requirements are as follows:

    i. By March 31st of each demonstration year, the state shall provide the following information to CMS:
        1) The UC payment applications submitted by eligible providers for the current DY; and
        2) A chart of estimated UC Payments to each provider for the current DY.

    ii. Within 90 days after the end of each demonstration year, the state shall provide the following information to CMS:
        1) The UC Payment applications submitted by eligible providers; and,
        2) A chart of actual UC payments to each provider for the previous DY.

h. UC Pool Timeline

    i. DY 7 through 11:

        1) By December 31st of each year, hospitals must submit to the state the UC Payment Application for the DY beginning January 1.

    ii. DY 7 through 11:

        1) By February 28th of each year, the state must submit a revised Attachment J to CMS for review and approval.
        2) By March 31st of each year, the state must submit to CMS the UC Payment Applications and a chart of the estimated UC Payments to each provider for the DY.
        3) Within 90 days of the end of the previous DY, the state must submit to CMS:
            a. The UC Applications submitted by eligible providers; and,
            b. A chart of actual UC Payments for the previous DY.

54. **Delivery System Reform Incentive Payment (DSRIP) Pool.** The DSRIP Pool is available in DY 7 through 8 for the continuation of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. The metrics for the DSRIP will be updated to more accurately capture the success of the program and the programs for each hospital will continue to operate as they did in the previous demonstration period. The DSRIP Planning Protocol, DSRIP Funding and Mechanics Protocol, and Hospital Plans will remain in effect in the extension period.

    a. DSRIP Eligibility. Participation in the DSRIP is limited to hospitals designated as LPTH or BCCH in Attachment D.

    b. Project Focus Areas. The project focus areas for the DSRIP Pool must target specific care improvements, and may include those based on regional planning needs or state public health initiatives. Each focus area has an explicit connection to the achievement of the three-part aim. Each participating hospital will be required to select at least two projects from the menu of focus areas identified by the state through its public process. The approved DSRIP Project Focus Areas are listed in Attachment K.

    c. Project Categories. Each hospital project must include Category 1, 2 and 3 milestones. All hospitals must report the common Category 4 milestones and the Category 4 milestones specific to the selected projects:

        i. *Category 1: Infrastructure Milestones*. These are infrastructure-related milestones a hospital must achieve to move forward with its selected and approved project. These milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. These milestones must support the achievement of quality and outcomes milestones for each project.

        ii. *Category 2: Process Milestones*. These milestones focus on process changes and improvements. These milestones must support the achievement of quality and outcomes milestones for each project.

        iii. *Category 3: Quality and Outcomes Milestones*. These milestones address the impact of the project on quality metrics and beneficiary outcomes. This stage involves the broad dissemination of interventions from a list of activities identified by the state, in which major improvements in care can be achieved within 4 years. These are hospital-specific initiatives and will be jointly developed by hospitals, the state, and CMS and are unlikely to be uniform across all of the hospitals.

        iv. *Category 4: Population Focused Improvements*. This category evaluates the broader impact of the selected projects through the reporting of Performance

Indicators across several domains selected by the state in conjunction with CMS, and may include:

1) Patient experience;
2) Care outcomes; and,
3) Population health.

Category 4 will include both common (apply to all hospitals) and specific (apply to a given project) measures.

d. DSRIP Performance Indicators. The state has identified performance indicators that are connected to the achievement of providing better care, better access to care, enhanced prevention of chronic medical conditions, and population improvement. These DSRIP Performance Indicators comprise the list of measures that hospitals are required to report under Category 4: Population Focused Improvements.

e. Status of DSRIP Payments**.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospitals for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against DSH expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these STCs, and/or under the Medicaid state plan. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by the state. If the state determines that the hospital did not fully and successfully achieve a metric, payment to the hospital for that metric will not be issued.

f. Demonstration Years 7 through 8 Payments**.** Each hospital with a Hospital DSRIP Plan update approved by the state may receive DSRIP Payments in DY 7, and DY 8. The total amount of DSRIP Payments available shall be allocated 75 percent to LPTH and 25 percent to BCCH.

g. Annual DSRIP Payment Limits. Subject to the requirements of STC 54(j), the state may claim FFP for DSRIP Payments in each DY up to the limits (total computable) described in the table in STC 55.

h. DSRIP Pool Timeline. By Febuary 1, 2019, the state must submit to CMS its updates for the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol. The state and CMS agree to a target date of Febuary 28, 2019 for CMS to issue its final approval of these updated protocols. CMS may approve these protocols before the target date. The state may not claim FFP for DSRIP payments in DY 7 or 8 until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol updates.

i. Rapid Cycle Evaluation. The DSRIP will support a process of data-driven, rapid

cycle improvement that will gather data in real time and make recommendations to the state, CMS, and hospitals about how to ensure the timely progress in promoting the DSRIP goals. Under DSRIP, hospitals will implement continuous performance improvement in order to improve efficiencies, improve quality, improve experience, reduce inefficiencies, and eliminate waste and redundancies. Hospitals must disseminate their findings to allow other providers to learn from the DSRIP.

j. Federal Financial Participation (FFP) For DSRIP. The following terms govern the state's eligibility to claim FFP for DSRIP.

i. The state must not claim FFP for DSRIP until after CMS has approved the updated DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.

ii. The state may not claim FFP for DSRIP Payments in DY 7 through 8 until the state has concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the state to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the state or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.

iii. In addition to the documentation discussed in STC 52(e), the state must use the documentation discussed in the DSRIP Funding and Mechanics Protocol to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

55. Limits on Pool Payments. The state may claim FFP for the Safety Net Care Pool in each DY up to the limits on total computable listed in the table below. Annual SNCP total computable costs may not exceed $80,856,550 in any demonstration year.

	DY 7	DY 8	DY 9	DY 10	DY 11	Total
UC Pool HCAIP	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$205,000,000
UC Pool BCCH/LPH	$9,856,550	$9,856,550	$9,856,550	$9,856,550	$9,856,550	$49,282,750
DSRIP	$30,000,000	$30,000,000	$0	$0	$0	$60,000,000
Total	$80,856,550	$80,856,550	$50,856,550	$50,856,550	$50,856,550	$314,282,750

56. Assurance of Budget Neutrality.

a. By October 1 of each year, the state must submit an assessment of budget neutrality to CMS, including a summation of all expenditures and member months already reported to CMS, estimates of expenditures already incurred but not reported, and projections of future expenditures and member months to the end of the demonstration, broken out by DY and Medicaid Eligibility Group (MEG) or other spending category.

b. Should the report in (a) indicate that the budget neutrality Annual Target for any DY has been exceeded, or is projected to be exceeded, the state must propose adjustments to the limits on UC Pool and DSRIP Pool limits, such that the demonstration will again be budget neutral on an annual basis, and over the lifetime of the demonstration. The new limits will be incorporated through an amendment to the demonstration.

57. Amending the Safety Net Care Pool. Any changes to the SNCP (UC Pool or DSRIP Pool) are subject to the amendment process described in STC 7. SNCP amendments must be approved by CMS prior to implementation.

58. Alternative Payment Models (APM). The state will develop and implement an Alternative Payment Model (APM) to improve health outcomes and contribute to delivery system reform. The APM model will replace the DSRIP program no sooner than January 2021 contingent on CMS approval of a State Plan Amendment for state-directed payments under Section 42 CFR 438.6.

Under an APM, participating hospitals will receive performance-based payments for targeted conditions to address discharges back to rural communities. The state will develop a multi-year roadmap for how it will develop and implement an Alternative Payment Model. In developing this roadmap, the state will:

- Incorporate the APM framework, guidance, best practices, and lessons learned from the U.S. Department of Health and Human Services Health Care Payment Learning & Action Network to the extent appropriate
- Engage with its APM stakeholder group to propose recommendations regarding criteria for participation and guidance on how to structure, measure, assess, and fund the APM
- Collaborate with providers, manage care organizations (MCOs), and other stakeholders to evaluate the payment model options and set payment methodology standards

The state intends to implement APMs no sooner than January 1, 2021.

a. Stakeholder Engagement: The stakeholder group will meet monthly to design the APM proposal for the State and MCOs to consider. Stakeholders will include representatives from groups such as:
    A. The Kansas Hospital Association
    B. Critical access hospitals
    C. Large and small hospitals
    D. Hospitals representing urban, rural and frontier areas of the state
    E. Advocates
    F. Other provider types

b. APM Targeted Conditions: The state will work closely with the stakeholder group to select target conditions they will address. State and MCOs will consider proposals from providers and make decisions regarding stakeholder proposals and recommendations.

c. APM Eligibility: The state will work with the stakeholder group to finalize eligibility

requirements for participation. The stakeholder group will consider provider types such as:

i. Critical access hospitals
ii. Large and small hospitals
iii. Hospitals representing urban, rural and frontier areas of the state
iv. Federally qualified health centers
v. Other provider types

d. Potential APMs: The final APM design will depend on several factors, including stakeholder input, options analyses, and legislative support; however, the state expects to consider the following APMs:

i. Bonus payments and penalties for quality performance
ii. Bundled payments with upside or downside risk
iii. Episode-based payments

e. APM Milestones: The state intends to implement its APMs in 2021. The state has already begun communicating with stakeholders and the process of identifying APM goals, objectives, and accomplishments. In January 2019, the state will begin convening stakeholder group meetings.

Between January 1, 2019 and December 31, 2020, the state will conduct the following milestone activities:

i. Develop multi-year roadmap for implementing APMs by 2021
ii. Conduct ongoing APM stakeholder group meetings
iii. Solicit proposed APMs from eligible providers
iv. Select APM(s)
v. Complete the 438.6 preprint form based on APM approach and submit to CMS for approval
vi. Draft MCO contract language describing the APM requirements and approach for 2021 MCO contract period

f. Annual Updates: The state shall also include annual progress updates on the Alternative Payment Model development and DSRIP transition in its Annual Report as required per STC 64.

g. Evaluation: The state shall also include an evaluation of the APM models and DSRIP transition in the demonstration evaluation design required per STC 97.

XII. GENERAL REPORTING REQUIREMENTS

59. General Financial Requirements. The state must comply with all general financial requirements under title XIX of the Social Security Act as set forth in Section XIII of these STCs.

60. Compliance with Managed Care Reporting Requirements. The state must comply with all managed care reporting regulations at 42 CFR 438 et. seq.

61. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for monitoring budget neutrality as set forth in Section XIII of these STCs, including the submission of corrected budget neutrality data upon request.

62. Monitoring Protocol. The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after approval of the demonstration. Once approved, the Monitoring Protocol will be incorporated into the STCs, as an Attachment S.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct quarterly and annual monitoring in accordance with CMS' template. Any proposed deviations from CMS' template should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through quarterly and annual monitoring reports. For quantitative metrics (e.g., performance metrics as described in STC 64(b) below), CMS will provide the state with a set of required metrics, and technical specifications for data collection and analysis. The Monitoring Protocol will specify the methods of data collection and timeframes for reporting on the state's progress as part of the quarterly and annual monitoring reports. For the qualitative elements (e.g. operational updates as described in STC 64(a) below), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's quarterly and annual monitoring reports.

63. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to), any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

64. Monitoring Reports. The state must submit three (3) Quarterly Reports and one (1) Annual Report each DY. The information for the fourth quarterly report should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 days) following the end of each demonstration quarter. The Annual Report is

due no later than ninety (90 days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework to be provided by CMS, which will be organized by milestones. The framework is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

a. Operational Updates - The operational updates will focus on progress towards meeting the milestones identified in CMS' framework. Additionally, per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – The performance metrics will provide data to demonstrate how the state is progressing towards meeting the milestones identified in CMS' framework. The performance metrics will reflect all components of the state's demonstration, and may include, but are not limited to, measures associated with eligibility and coverage.

   Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals.

   The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook quarterly, using the Budget Neutrality Monitoring Tool described in STC 94, that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 22(f).

65. Corrective Action. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

66. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

67. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singularly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

i. CMS may decline the extension request.

ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

68. Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once

CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

69. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional 1115 waiver reporting and analytics functions, the state will work with CMS to:

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

    c. Submit deliverables to the appropriate system as directed by CMS.

70. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 67.

71. **Post Award Forum.** Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state shall afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least thirty (30) days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

72. **Close-out Report**. Within 120 days after the expiration of the demonstration, the state must submit a draft Close Out Report to CMS for comments.

    a. The draft report must comply with the most current guidance from CMS.

    b. The state will present to and participate in a discussion with CMS on the Close-Out report.

    c. The state must take into consideration CMS' comments for incorporation into the final Close Out Report.

    d. The final Close Out Report is due to CMS no later than thirty (30) days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the Close Out Report may subject the state to penalties described in STC 67.

XIII. GENERAL FINANCIAL REQUIREMENTS

73. Quarterly Expenditure Reports: The state must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

74. Reporting Expenditures Under the Demonstration. The following describes the reporting of expenditures subject to the budget neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 and Section 2115 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX and section 1115 of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS, including the project number extension which indicates the DY in which services were rendered or for which capitation payments were made).

b. Reporting by Demonstration Year (DY) by Date of Service. In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in STC 74(f) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service.

c. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual.

d. Premium and Cost Sharing Contributions. Premiums and other applicable cost sharing contributions that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both

total computable and federal share) should also be reported separately by DY on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration's actual expenditures on a quarterly basis.

e. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS-64.9 Base, and not allocated to any Form 64.9 or 64.9P Waiver.

f. Demonstration Years. The first Demonstration Year (DY1) will be January 1, 2013, through December 31, 2013, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	Jan. 1, 2013 to Dec. 31, 2013	12 months
Demonstration Year 2 (DY2)	Jan. 1, 2014 to Dec. 31, 2014	12 months
Demonstration Year 3 (DY3)	Jan. 1, 2015 to Dec. 31, 2015	12 months
Demonstration Year 4 (DY4)	Jan. 1, 2016 to Dec. 31, 2016	12 months
Demonstration Year 5 (DY5)	Jan. 1, 2017 to Dec. 31, 2017	12 months
Demonstration Year 6 (DY6)	Jan. 1, 2018 to Dec. 31, 2018	12 months
Demonstration Year 7 (DY7)	Jan. 1, 2019 to Dec. 31, 2019	12 months
Demonstration Year 8 (DY8)	Jan. 1, 2020 to Dec. 31, 2020	12 months
Demonstration Year 9 (DY9)	Jan. 1, 2021 to Dec. 31, 2021	12 months
Demonstration Year 10 (DY10)	Jan. 1, 2022 to Dec. 31, 2022	12 months
Demonstration Year 11 (DY11)	Jan. 1, 2023 to Dec. 31, 2023	12 months

g. Use of Waiver Forms. For each quarter of each Demonstration Year, 22 separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the *Category Names* shown in quotation marks below, to report expenditures for the demonstration. Items i though ix below represent *Medicaid Eligibility Groups* (MEGs); STC 16 specifies the populations within each MEG. Items x and xi refer to the SNCP. Expenditures should be allocated to these forms based on the guidance found below.

i. "ABD and LTC" includes the following listed below as subcategories:

A. Aged, Blind, and Disabled/Spend Down Dual ["ABD/SD Dual"]

B. Aged, Blind, and Disabled/Spend Down Non Dual ["ABD/SD Non Dual"]

C. "DD Waiver"

D. Long Term Care ["LTC"]

E. Medically Needy Dual ["MN Dual"]

F. Medically Needy Non Dual ["MN Non Dual"]

G. "Waiver"

ii. "Adults and Children" includes the following listed below as subcategories:

A. "Adults"

B. "Children"

iii. "BH Pilot SSDI Buy-In": Medical assistance expenditures for individuals qualifying for BH Pilot Program under STC 22(a)(1) and 22(b)(i). "

iv. "BH Pilot SSI": Expenditures for BH Pilot services for SSI-eligible individuals."

v. Safety Net Care Pool – Uncompensated Care Pool ["UC Pool"]

vi. Safety Net Care Pool – Delivery System Reform Incentive Payment Pool ["DSRIP Pool"]

vii. SUD IMD – All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD ["SUD IMD"].

75. Expenditures Subject to the Budget Neutrality Limit. For purposes of this section, the term "expenditures subject to the budget neutrality limit" must include:

h. All demonstration medical assistance expenditures (including those authorized through the Medicaid state plan, through the concurrent 1915(c) waivers, and through the section 1115 waiver and expenditures authorities), on behalf of all demonstration participants listed in the tables in STC 16, with dates of services within the demonstration's approval period; and,

i. All Safety Net Care Pool payments, including both UC Pool and DSRIP Pool payments.

All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

76. Title XIX Administrative Costs. Administrative costs will not be included in the budget neutrality limit, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

77. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue

to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

78. **Reporting Member Months.** For the purpose of calculating the budget neutrality limit and for other purposes, the state must provide to CMS on a quarterly basis the actual number of eligible member months for the demonstration enrollees. Member-month enrollment information must be provided to CMS in conjunction with the quarterly Monitoring Reports pursuant to STC 64.

    a. The state must report the actual number of member months for Eligibility Groups i though ix as defined in STC 74(g)(i), (ii), and (vii).

    b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of 4 eligible member/months.

    c. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions after the end of each quarter. Member month counts may be revised retrospectively as needed.

79. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality limit and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

80. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIV of the STCs:

    d. Administrative costs, including those associated with the administration of the demonstration;

    e. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

    f. Net medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the

demonstration period, including expenditures under the Safety Net Care Pool.

81. Sources of Non-Federal Share. The state must certify that matching the non-federal share of funds for the demonstration are state/local monies. The state further certifies that such funds must not be used to match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

g. CMS may review the sources of the non-federal share of funding for the demonstration at any time. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

h. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

i. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provisions, as well as the approved Medicaid state plan.

82. State Certification of Funding Conditions. The state must certify that the following conditions for non-federal share of demonstration expenditures are met:

j. Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

k. To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

l. To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for federal match.

m. The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments.

n. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider- related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

83. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration (including but not limited to primary data on enrollment, quality, encounters, and expenditures), upon request, in a reasonable time frame.

84. Program Integrity. The state must have processes in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XIV. MONITORING BUDGET NEUTRALITY

85. Limit on Title XIX Funding. The state shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method described in STC 88, and budget neutrality limits are set on a yearly basis with a cumulative budget neutrality limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

86. Risk. The state shall be at risk for the per capita cost (as determined by the method described below) for demonstration eligibles under this budget neutrality limit, but not for the number of demonstration eligibles. By providing FFP for all demonstration eligibles, the state shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have been realized had there been no demonstration.

87. Expenditures Excluded From Budget Neutrality Limit. Regular FFP will continue for costs not subject to budget neutrality limit. These exclusions include:

a. Allowable administrative expenditures;

b. Disproportionate Share Hospital (DSH) payments;

c. Medicaid Fee for Service (FFS) payments which are made outside the demonstration;

d. Pharmacy rebates (see STC 74(e)); and

e. Costs for excluded populations (see STC 16(a)).

88. Calculation of the Budget Neutrality Limit and How It Is Applied. The following are the PMPM costs for the calculation of the budget neutrality limit. ***The demonstration year is January 1 through December 31.***

Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
Adults and Children	3.8%	$347.66	$360.87	$374.58	$388.81	$403.58
ABD and LTC	4.1%	$2508.47	$2,611.32	$2,718.38	$2,839.83	$2,945.85

a. For each year of the budget neutrality agreement, an annual budget neutrality expenditure limit is calculated for each MEG. An annual MEG estimate must be calculated as a product of the number of eligible

member months reported by the state under STC 78 for each MEG, times the appropriate per member per month (PMPM) costs from the table in STC 88. Historical data used to calculate the budget neutrality limit are provided in Attachment B.

b. The annual budget neutrality limit for the demonstration as a whole is the sum of the projected annual expenditure caps for each EG calculated in subparagraph (b) above.

c. The lifetime (overall) budget neutrality limit for the demonstration is the sum of the annual budget neutrality limits calculated in STC 88(a). The federal share of the overall budget neutrality limit (calculated as the product of the overall budget neutrality limit times the Composite Federal Share 1) represents the maximum amount of FFP that the state may receive for demonstration expenditures during the demonstration period reported in accordance with STC 90.

d. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names: ABD/SD Dual, ABD/SD Non Dual, Adults, Children, DD Waiver, LTC, MN Dual, MN Non Dual, Waiver, BH Pilot SSDI Buy-In, UC Pool, and DSRIP Pool, plus any excess spending from the Supplemental Tests described in STC 89.

89. Supplemental Tests

a. **Supplemental Budget Neutrality Test 1: Substance Use Disorder Expenditures.** As part of the SUD component of this demonstration, the state may receive FFP for the continuum of services to treat OUD and other SUDs, provided to Medicaid enrollees in an IMD with a primary diagnosis of SUD. These "SUD Services" are, or could be state plan services that would be eligible for reimbursement if not for the IMD exclusion; therefore, they are being treated as hypothetical for the purposes of budget neutrality. Hypothetical services can be treated in budget neutrality in a way that is similar to how Medicaid state plan services are treated, by including them as a "pass through" in both the without-waiver and with-waiver calculations. The state may only claim FFP via demonstration authority for the SUD Services listed in Table XX that will be provided in an IMD for Medicaid beneficiaries with a primary diagnosis of SUD. However, the state will not be allowed to obtain budget neutrality "savings" from these services.SUD Services. Therefore, a separate expenditure cap is established for SUD IMD services, to be known as Supplemental Budget Neutrality Test 1.

i. The MEGs listed in the table below are included in calculation of Supplemental Cap 1, for the SUD IMD Supplemental BN Test.

Demonstration Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
SUD IMD	3.9%	$505.02	$524.72	$545.18	$566.44	$588.53

ii. The Supplemental Cap 1 is calculated by taking the PMPM cost projection for each group in the above table in each DY, times the number of eligible member months for that group and DY, and adding the products together across groups and DYs. The federal share of Supplemental Cap 1 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 2.

iii. Supplemental Test 1 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Name:. SUD IMD.

iv. If total FFP for hypothetical group should exceed the federal share of Supplemental Cap 1, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

b. **Supplemental Budget Neutrality Test 2: Disability and Behavioral Health Employment Support Pilots.** The state will operate a voluntary pilot program for eligible KanCare members with specific behavorial health diagnoses or disabilities through this section 1115 demonstration. This pilot program will help certain members obtain and maintain employment by providing supportive services. The pilot program will operate during the KanCare 2019-2023 demonstration extension, with a possibility of renewal and expansion through an applicable title XIX authority if shown to be effective. The program will begin no sooner than July 1, 2019. The state will receive FFP for this pilot.

i. The MEGs listed in the table below are included in calculation of Supplemental Cap 2.

Demonstration Eligibility Groups	Trend Rate	DY 7 (CY 2019)	DY 8 (CY 2020)	DY 9 (CY 2021)	DY 10 (CY 2022)	DY 11 (CY 2023)
BH Pilot SSI	N/A	$7,660,111	$7,853,302	$8,051,366	$8,254,425	$8,462,605

ii. The Supplemental Cap 2 ECM expenditures cap consists of the total computable dollar limits presented in the above table, summed across all DYs. The federal share of Supplemental Cap 2 is obtained by multiplying the total computable Supplemental Cap 1 by Composite Federal Share 3.

iii. Supplemental Test 2 is a comparison between the federal share of Supplemental Cap 1 and total FFP reported by the state for hypothetical groups under the following Waiver Name: BH Pilot SSI

iv. If total FFP for hypothetical groups should exceed the federal share of Supplemental Cap 2, the difference must be reported as a cost against the budget neutrality limit described in STC 88.

90. Composite Federal Share. The Composite Federal Share 1 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Names "Adults and Children" and "ABD and LTC". The Composite Federal Share 2 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Name "SUD IMD. The Composite Federal Share 3 is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period, by the sum of total computable demonstration expenditures for the same period, reported under Waiver Name BH Pilot. Should the demonstration be terminated prior to the end of the approval period (see STC 9), the Composite Federal Share will be determined based on actual expenditures for the period in which the demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable estimate of the Composite Federal Share may be used.

91. Impermissible DSH, Taxes, or Donations. CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

92. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration extension, which for this purpose will be from January 1, 2019 through December 31, 2023 (i.e., DY 7 through DY 11). The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period consisting of DY 2 through DY 6, but not from any earlier approval period. However, if the state's expenditures exceed the calculated cumulative budget neutrality limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval. The state will subsequently implement the approved corrective action plan.

Year	Cumulative target definition	Percentage
DY 7	Cumulative budget neutrality limit plus:	0 percent

DY 8	Cumulative budget neutrality limit plus:	0 percent
DY 9	Cumulative budget neutrality limit plus:	0 percent
DY 10	Cumulative budget neutrality limit plus:	0 percent
DY 11	Cumulative budget neutrality limit plus:	0 percent

93. Exceeding Budget Neutrality. If, at the end of this demonstration period, the cumulative budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

94. Budget Neutrality Monitoring Tool. The state will provide CMS with quarterly budget neutrality status updates using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section XIV. CMS will provide technical assistance, upon request.

XV. EVALUATION OF THE DEMONSTRATION

95. Independent Evaluator. Upon approval of the demonstration, the state must begin arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

96. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

97. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design, no later than 180 days after approval of the demonstration.

Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable.

The draft Evaluation Design must be developed in accordance with the following CMS guidance (including but not limited to):

a. All applicable evaluation design guidance provided by CMS.

b. Attachment M (Developing the Evaluation Design) of these STCs, technical assistance for developing SUD evaluation designs (as applicable, and as provided by CMS), and all applicable technical assistance on how to establish comparison groups to develop a draft evaluation design.

98. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

99. **Evaluation Questions and Hypotheses.** Consistent with Attachments M and N (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, CMS' measure sets for eligibility and coverage, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). The state must also include measures provided by CMS for monitoring and evaluation of the SUD demonstration. The state should also include measures that evaluate Medicaid expenditures and trends in the demonstration.

100. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

    a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

    d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

    e. The Interim Evaluation Report must comply with Attachment N (Preparing the Evaluation Report) of these STCs.

101. **Summative Evaluation Report.** The draft Summative Evaluation Report must be developed in accordance with Attachment N of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state shall submit the final Summative Evaluation Report within 60 days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 days of approval by CMS.

102. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

103. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, Approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

104. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration over which the state has control. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

105. Evaluation Goals and Objectives. The evaluation must include a discussion of the goals and objectives of the demonstration aligned with proposed research questions and hypotheses that the state intends to test. If the demonstration is extended beyond the current demonstration period, the evaluation design must include a summary of the previous evaluation findings and a discussion of how the evaluation design will build and expand on earlier findings.

106. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of a renewal process when associated with the state's interim evaluation report. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 11.

XVI. SCHEDULE OF STATE DELIVERABLES FOR THE DEMONSTRATION APPROVAL PERIOD

The state is held to all reporting requirements as outlined in the STCs; this schedule of deliverables should serve only as a tool for informational purposes only.

Date - Specific	Deliverable	STC Reference
July 1, 2019	Submit UC Payment Application template	STC 53
Within 120 days of expiration	Submit a Draft Close-Out Report	STC 72
Within 30 days of receipt of CMS comments	Submit Final Close-Out Report	STC 72
30 days after extension approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 days after SUD program approval date	SUD Implementation Protocol	STC 21(a)
150 days after SUD program approval date	SUD Monitoring Protocol	STC 21(b)
150 days after extension program approval date	Monitoring Protocol	STC 62
180 days after approval date	Draft Evaluation Design	STCs 97
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 98
30 days after CMS Approval	Approved Evaluation Design published to state's website	STCs 98
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 100
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 100
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 101
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 101

90 days after middle of DY10 (September 30, 2022)	Submit Draft SUD Mid-point Assessment	STC 21
60 calendar days after receipt of CMS comments	Submit Final SUD Mid-point assessment	STC 21
30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 101
Within 120 calendar days prior to the expiration of the demonstration	Draft Close-out Operational Report	STC 72
30 calendar days after receipt of CMS comments	Final Close-out Operational Report	STC 72

	Deliverable	STC Reference
Annual	By April 1st - Draft Annual Report	STC 64
	By March 31st – UC Payment Applications	STC 53
	Within 90 days of close of previous DY – UC Payment Applications and a chart of actual UC Payments for the previous DY	STC 53
	By February 28the, Attachment J, UC Pool Uniform Percentages	STC 53
Each Quarter (02/28, 05/31, 08/31, 11/30)		
	Monitoring Reports	STC 64
	Budget Neutrality Monitoring Tool	STC 94
	CMS-64 Reports	STC 64
	Eligible Member Months	STC 78

ATTACHMENT A

Quarterly Report Content and Format

Under Section XII, STC79, the state is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook is provided.

NARRATIVE REPORT FORMAT:

Title Line One – KanCare
Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 1 (1/1/2013 – 12/31/2013)
Federal Fiscal Quarter: 2/2013(1/13 - 3/13)

Introduction

Information describing the goals of the demonstration, what it does, and key dates of approval and operation. (This should be the same for each report.).

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate "N/A" where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by "0".

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 1: ABD/SD Dual			
Population 2: ABD/SD Non Dual			
Population 3: Adults			
Population 4: Children			
Population 5: DD Waiver			
Population 6: LTC			
Population 7: MN Dual			
Population 8: MN Non Dual			

ATTACHMENT A
Quarterly Report Content and Format

Demonstration Populations (as hard coded in the CMS 64)	**Enrollees at close of quarter** (date)	**Current Enrollees** (to date)	**Disenrolled in Current Quarter**
Population 9: Waiver			
Population 10:UC Pool			
Population 11:DSRIP Pool			

Outreach/Innovative Activities
Summarize marketing, outreach, or advocacy activities to current and potential enrollees and/or promising practices for the current quarter.

Operational Developments/Issues
Identify all significant program developments/issues/problems that have occurred in the current quarter or anticipated to occur in the near future that affect health care delivery, including but not limited to: systems and reporting issues, approval and contracting with new plans; benefits; enrollment; grievances; quality of care; changes in provider qualification standards; access; proposed changes to payment rates; health plan financial performance that is relevant to the demonstration; MLTSS implementation and operation; updates on the safety net care pool including DSRIP activities; information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals); pertinent legislative activity; and other operational issues.

Policy Developments/Issues
Identify all significant policy and legislative developments/issues/problems that have occurred in the current quarter. Include updates on any state health care reform activities to coordinate the transition of coverage through the Affordable Care Act.

Financial/Budget Neutrality Development/Issues
Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 reporting for the current quarter. Identify the state's actions to address any issues.

Member Month Reporting
Enter the member months for each of the EGs for the quarter, for use in budget neutrality calculations.

Eligibility Group	**Month 1**	**Month 2**	**Month 3**	**Total for Quarter Ending XX/XX**
Population 1: ABD/SD Dual				
Population 2: ABD/SD Non Dual				
Population 3: Adults				
Population 4: Children				
Population 5:DD Waiver				
Population 6:LTC				
Population 7:MN Dual				

ATTACHMENT A
Quarterly Report Content and Format

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Population 8:MN Non Dual				
Population 9: Waiver				
Population 10:UC Pool				
Population 11:DSRIP Pool				

Consumer Issues
A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter. The state must also report on the implementation and effectiveness of the updated comprehensive Quality Strategy as it impacts the demonstration.

Managed Care Reporting Requirements
A description of network adequacy reporting including GeoAccess mapping, customer service reporting including average speed of answer at the plans and call abandonment rates. A summary of: MCO appeals for the quarter (including overturn rate and any trends identified); enrollee complaints and grievance reports to determine any trends; summary of ombudsman activities including why people are accessing the ombudsman and outcomes of their assistance; and summary analysis of MCO critical incident report which includes, but is not limited to, incidents of abuse, neglect and exploitation.

Safety Net Care Pool
Provide updates on any activities or planning related to payment reform initiatives or delivery system reforms impacting demonstration population and/or undertaken in relation to the SNCP. As per STC 69, include projected or actual changes in SNCP payments and expenditures within the quarterly report. Please note that the annual report must also include SNCP reporting as required by STC 69.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

Enclosures/Attachments
Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

ATTACHMENT B

Historical Budget Neutrality Data

[See following 17 pages]

Budget Neutrality Summary

DEMONSTRATION YEARS (DY)

Without-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
Medicaid Populations						
Adults and Children	$ 1,201,424,314	$ 1,277,181,696	$ 1,357,825,860	$ 1,443,681,055	$ 1,535,090,467	$ 6,815,203,392
ABD and LTC	$ 2,472,578,644	$ 2,588,254,423	$ 2,709,396,994	$ 2,836,275,352	$ 2,969,164,190	$ 13,575,669,603
SUD WOW Total Expenditure	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
Voluntary Support Pilot Non-SSDI	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
UPL Diversion	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 394,719,702
TOTAL	$ 3,753,066,169	$ 3,944,506,461	$ 4,149,923,867	$ 4,366,471,294	$ 4,590,965,393	$ 20,804,933,185

With-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
Medicaid Populations						
Adults and Children	$ 1,133,765,642	$ 1,184,628,963	$ 1,237,975,424	$ 1,293,922,509	$ 1,352,623,283	$ 6,202,915,821
ABD and LTC	$ 2,371,878,995	$ 2,408,531,568	$ 2,446,201,377	$ 2,484,517,312	$ 2,523,491,361	$ 12,234,620,613
SUD WW Total Expenditure	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
HIPF	$ 65,876,282	$ 67,193,808	$ 68,537,684	$ 69,908,437	$ 71,306,606	$ 342,822,817
UC Pool : HCAIP	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 205,000,000
UC Pool : BCCH/LPH	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 49,282,750
DSRIP & APM	$ 30,000,000	$ 30,000,000				$ 60,000,000
Voluntary Support Pilot Non-SSDI	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
Voluntary Support Pilot SSDI	$ -	$ -	$ 362,311	$ 742,898	$ 761,634	$ 1,866,844
TOTAL	$ 3,652,496,741	$ 3,741,337,291	$ 3,807,690,418	$ 3,907,518,653	$ 4,006,806,231	$ 19,115,849,334

VARIANCE BY MEG						
Medicaid Populations	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
Adults and Children	$ 67,658,672	$ 92,552,732	$ 119,850,436	$ 149,758,546	$ 182,467,185	$ 612,287,571
ABD and LTC	$ 100,699,648	$ 179,722,855	$ 263,195,618	$ 351,758,040	$ 445,672,828	$ 1,341,048,990
VARIANCE TOTAL	$ 168,358,321	$ 272,275,587	$ 383,046,054	$ 501,516,586	$ 628,140,013	$ 1,953,336,561
UPL Diversion	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 78,943,940	$ 394,719,702
HIPF	$ (65,876,282)	$ (67,193,808)	$ (68,537,684)	$ (69,908,437)	$ (71,306,606)	$ (342,822,817)
EXPENDITURE AUTHORITIES	$ (80,856,550)	$ (80,856,550)	$ (51,218,861)	$ (51,599,448)	$ (51,618,184)	$ (316,149,594)

	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
SAVINGS	$ 100,569,429	$ 203,169,170	$ 342,233,449	$ 458,952,641	$ 584,159,163	$ 1,689,083,852

Hypothetical Budget Neutrality Test 1

Without-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
SUD WOW Total Expenditures	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
TOTAL	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046

With-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
SUD WW Total Expenditures	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
TOTAL	$ 119,271	$ 126,402	$ 133,957	$ 141,965	$ 150,451	$ 672,046
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

Hypothetical Budget Neutrality Test 2

Without-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
Voluntary Support Pilot	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
TOTAL	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442

With-Waiver Total Expenditures	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL
Voluntary Support Pilot	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
TOTAL	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$ 18,668,442
VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1		5 YEARS OF HISTORIC DATA												
2			7/2013-6/2014	7/2014-6/2015	7/2015-6/2016	7/2016-6/2017	7/2017-6/2018							
3		SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:										PB Trend (from North Carolina Approved 1115)		
4			SFY14	SFY15	SFY16	SFY17	SFY18		removed estimated PB trends				PB Trend	
5		Medicaid Pop 1	ABD/SD Dual					5-YEARS				ABD/SD Dual	4.60%	
6		TOTAL EXPENDITURES	$ 53,712,146	$ 43,560,644	$ 41,227,116	$ 44,094,609	$ 46,505,121	$ 229,099,636				ABD/SD Non Dual	4.60%	
7		ELIGIBLE MEMBER MONTHS	222,580	217,825	196,307	185,000	178,118					Adults	5.10%	
8		PMPM COST	$ 241.32	$ 199.98	$ 210.01	$ 238.35	$ 261.09					Children	4.50%	
9		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE				DD Waiver	4.60%	
10		TOTAL EXPENDITURE		-18.90%	-5.36%	6.96%	5.47%	-3.54%				LTC	4.60%	
11		ELIGIBLE MEMBER MONTHS		-2.14%	-9.88%	-5.76%	-3.72%	-5.42%	Lesser Of PB Trend and Historic Trend			MN Dual	4.60%	
12		PMPM COST		-17.13%	5.02%	13.49%	9.54%	1.99%	1.99%			MN Non Dual	4.60%	
13												Waiver	4.60%	
14														
15		Medicaid Pop 2	ABD/SD Non Dual					5-YEARS						
16		TOTAL EXPENDITURES	$ 388,194,341	$ 394,622,097	$ 404,028,115	$ 406,947,164	$ 434,482,605	$ 2,028,274,322						
17		ELIGIBLE MEMBER MONTHS	350,781	349,163	338,278	343,014	348,582							
18		PMPM COST	$ 1,106.66	$ 1,130.19	$ 1,194.37	$ 1,186.39	$ 1,246.43							
19		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
20		TOTAL EXPENDITURE		1.66%	2.38%	0.72%	6.77%	2.66%						
21		ELIGIBLE MEMBER MONTHS		-0.46%	-3.12%	1.40%	1.62%	-0.16%	Lesser Of PB Trend and Historic Trend					
22		PMPM COST		2.13%	5.66%	-0.67%	5.06%	3.02%	3.02%					
23														
24		Medicaid Pop 3	Adults					5-YEARS						
25		TOTAL EXPENDITURES	$ 282,184,279	$ 292,754,591	$ 304,036,443	$ 318,927,585	$ 359,433,785	$ 1,537,336,683						
26		ELIGIBLE MEMBER MONTHS	447,000	526,176	575,444	649,545	625,613							
27		PMPM COST	$ 586.54	$ 556.38	$ 528.35	$ 491.00	$ 574.53							
28		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
29		TOTAL EXPENDITURE		11.66%	3.85%	4.90%	12.70%	8.21%						
30		ELIGIBLE MEMBER MONTHS		17.71%	9.36%	12.86%	-3.68%	8.77%	Lesser Of PB Trend and Historic Trend					
31		PMPM COST		-5.14%	-6.04%	-7.07%	17.01%	-0.52%	0.00%	Adjusted due to impact of eligibility redetermination issues in historic data.				
32										Changed back to 0				
33		Medicaid Pop 4	Children					5-YEARS						
34		TOTAL EXPENDITURES	$ 548,753,673	$ 603,680,739	$ 626,137,383	$ 616,819,217	$ 662,513,461	$ 3,057,904,473						
35		ELIGIBLE MEMBER MONTHS	2,621,742	2,744,592	2,730,356	2,755,371	2,593,840							
36		PMPM COST	$ 209.31	$ 219.95	$ 229.32	$ 223.86	$ 255.42							
37		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
38		TOTAL EXPENDITURE		10.01%	3.72%	-1.49%	7.41%	4.82%						
39		ELIGIBLE MEMBER MONTHS		4.69%	-0.52%	0.92%	-5.86%	-0.27%	Lesser Of PB Trend and Historic Trend					
40		PMPM COST		5.09%	4.26%	-2.38%	14.10%	5.10%	5.10%					
41														
42		Medicaid Pop 5	DD Waiver					5-YEARS						
43		TOTAL EXPENDITURES	$ 412,864,264	$ 493,587,470	$ 485,338,020	$ 496,538,366	$ 533,360,932	$ 2,421,309,052						
44		ELIGIBLE MEMBER MONTHS	104,085	104,707	105,505	107,251	108,526							
45		PMPM COST	$ 3,968.61	$ 4,709.94	$ 4,600.36	$ 4,629.69	$ 4,916.62							
46		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
47		TOTAL EXPENDITURE		19.55%	-1.67%	2.31%	7.46%	6.62%						
48		ELIGIBLE MEMBER MONTHS		0.68%	0.67%	1.66%	1.19%	1.05%	Lesser Of PB Trend and Historic Trend					
49		PMPM COST		18.74%	-2.33%	0.64%	6.20%	5.51%	5.51%					
50														
51		Medicaid Pop 6	LTC					5-YEARS						
52		TOTAL EXPENDITURES	$ 863,712,158	$ 946,796,740	$ 956,395,028	$ 981,997,462	$1,018,581,096	$ 4,767,482,483						
53		ELIGIBLE MEMBER MONTHS	260,349	254,148	248,852	246,926	242,679							
54		PMPM COST	$ 3,317.52	$ 3,725.38	$ 3,843.23	$ 3,976.89	$ 4,197.24							
55		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
56		TOTAL EXPENDITURE		9.62%	1.01%	2.68%	3.73%	4.21%						
57		ELIGIBLE MEMBER MONTHS		-2.38%	-2.08%	-0.77%	-1.72%	-1.74%	Lesser Of PB Trend and Historic Trend					
58		PMPM COST		12.29%	3.16%	3.48%	5.54%	6.06%	6.06%					
59														
60		Medicaid Pop 7	MN Dual					5-YEARS						
61		TOTAL EXPENDITURES	$ 19,007,429	$ 11,548,409	$ 9,882,577	$ 10,204,671	$ 12,163,641	$ 62,806,727						
62		ELIGIBLE MEMBER MONTHS	16,663	16,712	15,558	16,053	15,026							
63		PMPM COST	$ 1,140.79	$ 691.02	$ 635.21	$ 635.69	$ 809.51							
64		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
65		TOTAL EXPENDITURE		-39.24%	-14.40%	3.26%	19.20%	-10.58%						
66		ELIGIBLE MEMBER MONTHS		0.29%	-6.91%	3.18%	-6.40%	-2.50%	Lesser Of PB Trend and Historic Trend					
67		PMPM COST		-39.42%	-8.08%	0.08%	27.34%	-8.22%	0.00%					
68														
69		Medicaid Pop 8	MN Non Dual					5-YEARS						
70		TOTAL EXPENDITURES	$ 24,737,878	$ 20,326,079	$ 22,105,398	$ 26,643,406	$ 26,825,625	$ 120,638,386						
71		ELIGIBLE MEMBER MONTHS	13,717	13,605	13,876	14,849	12,306							
72		PMPM COST	$ 1,803.45	$ 1,494.02	$ 1,593.07	$ 1,794.29	$ 2,179.88							
73		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
74		TOTAL EXPENDITURE		-17.83%	8.75%	20.53%	0.68%	2.66%						
75		ELIGIBLE MEMBER MONTHS		-0.82%	1.99%	7.01%	-17.13%	-2.68%	Lesser Of PB Trend and Historic Trend	HIPF				
76		PMPM COST		-17.18%	6.63%	12.63%	21.49%	4.85%	4.85%	MEG	SFY2018*			
77										ABD/SD Dual	$ 1,598,790			
78		Medicaid Pop 9	Waiver					5-YEARS		ABD/SD Non Dual	$14,444,043			
79		TOTAL EXPENDITURES	$ 145,012,568	$ 137,039,772	$ 145,597,949	$ 149,435,779	$ 163,899,337	$ 740,985,406		Adults	$12,711,704			
80		ELIGIBLE MEMBER MONTHS	50,267	46,525	48,743	54,179	53,621			Children	$23,704,301			
81		PMPM COST	$ 2,884.85	$ 2,945.51	$ 2,987.05	$ 2,758.19	$ 3,056.63			DD Waiver	$ 2,449,182			
82		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE		LTC	$ 5,560,839			
83		TOTAL EXPENDITURE		-5.50%	6.25%	2.64%	9.68%	3.11%		MN Dual	$ 163,642			
84		ELIGIBLE MEMBER MONTHS		-7.44%	4.77%	11.15%	-1.03%	1.63%	Lesser Of PB Trend and Historic Trend	MN Non Dual	$ 1,071,900			
85		PMPM COST		2.10%	1.41%	-7.66%	10.82%	1.46%	1.46%	Waiver	$ 3,250,535			
86											$64,954,036			
87														
88														
89														
90										Dollars to Add	Ratio			
91		Medicaid Pop A	Adults and Children					5-YEARS	HIPF 2018					
92		TOTAL EXPENDITURES	$ 810,937,952	$ 896,435,330	$ 930,173,826	$ 935,746,802	$1,058,363,251	$ 4,631,657,161	Adults and Children	$ 36,416,005	56.06%			
93		ELIGIBLE MEMBER MONTHS	3,068,742	3,270,788	3,305,800	3,404,916	3,219,453		ABD and LTC	$ 28,538,931	43.94%			
94		PMPM COST	$ 264.26	$ 274.07	$ 281.38	$ 274.82	$ 328.74							
95		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
96		TOTAL EXPENDITURE		10.54%	3.76%	0.60%	13.10%	6.88%						
97		ELIGIBLE MEMBER MONTHS		6.58%	1.07%	3.00%	-5.45%	1.21%	Lesser Of PB Trend and Historic Trend					
98		PMPM COST		3.72%	2.66%	-2.33%	19.62%	5.61%	5.61%					
99														
100		Medicaid Pop B	ABD and LTC					5-YEARS						
101		TOTAL EXPENDITURES	$ 1,907,240,784	$2,047,481,212	$ 2,064,574,204	$2,115,861,456	$2,264,577,287	$ 10,399,734,943						
102		ELIGIBLE MEMBER MONTHS	1,018,442	1,002,775	967,114	967,272	958,858							
103		PMPM COST	$ 1,872.70	$ 2,041.82	$ 2,134.78	$ 2,187.45	$ 2,361.74							
104		TREND RATES			ANNUAL CHANGE			5-YEAR AVERAGE						
105		TOTAL EXPENDITURE		7.35%	0.83%	2.48%	7.03%	4.99%						
106		ELIGIBLE MEMBER MONTHS		-1.54%	-3.56%	0.02%	-0.87%	-1.50%	Lesser Of PB Trend and Historic Trend					
107		PMPM COST		9.03%	4.55%	2.47%	7.07%	5.97%	5.97%					
108														
109														
110														
111			$ 2,718,178,736	$2,943,916,542	$ 2,994,748,030	$3,061,608,258	$3,322,940,538							
112			4,087,184	4,273,563	4,272,914	4,372,188	4,178,311							
113			5665.05	5688.87	5700.87	5697.96	5795.28							

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

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ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR SFY18	TREND RATE 2	PB TREND (added PB trends)	ACTUAL TREND	Demonstration Years DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL WOW
Medicaid Pop 1	ABD/SD Dual											
Pop Type:	**Medicaid**											
Eligible Member Months	5.91%	6	183,302	0.83%	Aged+Disabled		184,819	186,348	187,890	189,444	191,012	
PMPM Cost	1.99%	6	$ 263.68	1.99%	4.10%	1.99%	$ 268.93	$ 274.28	$ 279.74	$ 285.31	$ 290.99	
Total Expenditure							$ 49,703,320	$ 51,111,520	$ 52,560,287	$ 54,050,369	$ 55,582,521	$ 263,008,016
Medicaid Pop 2	ABD/SD Non Dual											
Pop Type:	**Medicaid**											
Eligible Member Months	1.04%	6	350,396	0.95%	Aged+Disabled		353,727	357,090	360,486	363,913	367,373	
PMPM Cost	3.02%	6	$ 1,265.11	3.02%	4.10%	3.02%	$ 1,303.32	$ 1,342.68	$ 1,383.23	$ 1,425.00	$ 1,468.04	
Total Expenditure							$ 461,019,667	$ 479,458,200	$ 498,634,666	$ 518,576,427	$ 539,318,892	$ 2,497,007,852
Medicaid Pop 3	Adults											
Pop Type:	**Medicaid**											
Eligible Member Months	-8.08%	6	599,801	0.39%	Adults		602,140	604,487	606,843	609,209	611,584	
PMPM Cost	0.00%	6	$ 574.53	0.00%	4.40%	0.00%	$ 574.53	$ 574.53	$ 574.53	$ 574.53	$ 574.53	
Total Expenditure							$ 345,947,228	$ 347,295,864	$ 348,649,758	$ 350,008,929	$ 351,373,399	$ 1,743,275,178
Medicaid Pop 4	Children											
Pop Type:	**Medicaid**											
Eligible Member Months	5.29%	6	2,661,539	2.86%	Children		2,737,645	2,815,927	2,896,447	2,979,269	3,064,460	
PMPM Cost	3.70%	6	$ 260.10	5.10%	3.70%	3.70%	$ 269.72	$ 279.70	$ 290.05	$ 300.78	$ 311.91	
Total Expenditure							$ 738,397,571	$ 787,614,680	$ 840,114,408	$ 896,104,680	$ 955,835,852	$ 4,218,067,191
Medicaid Pop 5	DD Waiver											
Pop Type:	**Medicaid**											
Eligible Member Months	-1.52%	6	107,700	0.03%	Disabled		107,729	107,758	107,787	107,815	107,844	
PMPM Cost	4.40%	6	$ 5,023.62	5.51%	4.40%	4.40%	$ 5,244.66	$ 5,475.43	$ 5,716.35	$ 5,967.87	$ 6,230.46	
Total Expenditure							$ 565,001,142	$ 590,019,684	$ 616,145,619	$ 643,428,347	$ 671,919,479	$ 3,086,514,270
Medicaid Pop 6	LTC											
Pop Type:	**Medicaid**											
Eligible Member Months	-0.02%	6	242,658	0.04%	Aged+Disabled		242,767	242,876	242,985	243,093	243,202	
PMPM Cost	4.10%	6	$ 4,282.42	6.06%	4.10%	4.10%	$ 4,458.00	$ 4,640.78	$ 4,831.05	$ 5,029.12	$ 5,235.31	
Total Expenditure							$ 1,082,255,935	$ 1,127,133,489	$ 1,173,870,979	$ 1,222,546,236	$ 1,273,239,660	$ 5,879,046,299
Medicaid Pop 7	MN Dual											
Pop Type:	**Medicaid**											
Eligible Member Months	6.69%	6	15,521	0.34%	Aged+Disabled		15,574	15,627	15,681	15,735	15,789	
PMPM Cost	0.00%	6	$ 809.51	0.00%	4.10%	0.00%	$ 809.51	$ 809.51	$ 809.51	$ 809.51	$ 809.51	
Total Expenditure							$ 12,607,350	$ 12,650,606	$ 12,694,010	$ 12,737,563	$ 12,781,265	$ 63,470,793
Medicaid Pop 8	MN Non Dual											
Pop Type:	**Medicaid**											
Eligible Member Months	50.30%	6	15,087	2.24%	Aged+Disabled		15,424	15,769	16,122	16,483	16,852	
PMPM Cost	4.10%	6	$ 2,224.12	4.85%	4.10%	4.10%	$ 2,315.31	$ 2,410.24	$ 2,509.06	$ 2,611.93	$ 2,719.02	
Total Expenditure							$ 35,712,141	$ 38,008,000	$ 40,451,419	$ 43,051,892	$ 45,819,580	$ 203,043,032
Medicaid Pop 9	Waiver											
Pop Type:	**Medicaid**											
Eligible Member Months	1.35%	6	53,982	-0.03%	Disabled		53,964	53,945	53,927	53,909	53,890	
PMPM Cost	1.46%	6	$ 3,078.86	1.46%	4.40%	1.46%	$ 3,123.81	$ 3,169.42	$ 3,215.69	$ 3,262.64	$ 3,310.27	
Total Expenditure							$ 168,571,894	$ 170,975,221	$ 173,412,493	$ 175,884,751	$ 178,391,959	$ 867,236,319
Medicaid Pop A	Adults and Children											
Pop Type:	**Medicaid**											
Eligible Member Months					Adults + Children		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM Cost	3.80%	6	$ 334.93	5.61%	3.80%	3.80%	$ 347.66	$ 360.87	$ 374.58	$ 388.81	$ 403.58	
Total Expenditure							$ 1,161,109,443	$ 1,234,324,636	$ 1,312,262,473	$ 1,395,236,380	$ 1,483,578,041	$ 6,586,510,973
Medicaid Pop B	ABD and LTC											

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year and is the minimum of the 5-Year Average Historical Trend and the President's Trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. There are 18 months between the midpoint of SFY11 (last historical year) and CY12 (Base Year).

"Trend Rate 2" is the trend rate that projects the first 5 DYs, starting from the Base Year, through the end of the first 5-year demonstration period.

"Trend Rate 3" is the trend rate that projects DY6, starting from DY5.

"Trend Rate 4" is the trend rate that projects DY7 through DY11, starting from DY6. These trends are based on the most recent five years of historic experience (CY14 to CY18), limited to the level of trends found in the most recently approved 1115 waiver (Massachusetts) without-waiver trends assuming these reflect the the President's Budget trends by MEG.

Membership for DY1 through DY4 represents actual membership. Membership for DY5 is projected based on emerging membership for that year, and membership after DY5 is projected.

Trends listed in "PB TREND" reflect trends from recently approved 1115 waiver (Massachusetts). This assumes that these trends are reflective of the PB Trend.

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
80		**Pop Type:**	**Medicaid**																		
81		Eligible Member Months					Aged + Disabled		974,004	979,414	984,877	990,393	995,963								
82		PMPM Cost	4.10%	6	$ 2,409.67	5.97%	4.10%	4.10%	$ 2,508.47	$ 2,611.32	$ 2,718.38	$ 2,829.83	$ 2,945.85								
83		Total Expenditure							$ 2,443,259,529	$ 2,557,563,659	$ 2,677,269,757	$ 2,802,643,629	$ 2,933,956,709	$ 13,414,693,284							
84																					
85																					
86																					
87									**HCAIP Incremental Increase (PMPM)**												
88									**Medicaid Pop A**	Adults and Children											
89									**Pop Type:**												
90									Eligible Member Months	3,420,414											
91									PMPM Cost	$ 45.62											
92									Total Expenditure	$ 156,055,540											
93																					
94									**Medicaid Pop B**	ABD and LTC											
95									**Pop Type:**												
96									Eligible Member Months	979,414											
97									PMPM Cost	$ 93.38											
98									Total Expenditure	$ 91,454,987											
99																					
100																					
101																					
102		**Final WOW PMPM**																			
103		**Medicaid Pop A**	Adults and Children																		
104		**Pop Type:**	**Medicaid**																		
105		Eligible Member Months							3,339,784	3,420,414	3,503,290	3,588,479	3,676,045								
106		PMPM Cost						3.80%	$ 359.73	$ 373.40	$ 387.59	$ 402.31	$ 417.59								
107		Total Expenditure							$ 1,201,424,314	$ 1,277,181,696	$ 1,357,825,860	$ 1,443,681,055	$ 1,535,090,467	$ 6,815,203,392							
108																					
109		**Medicaid Pop B**	ABD and LTC																		
110		**Pop Type:**																			
111		Eligible Member Months							974,004	979,414	984,877	990,393	995,963								
112		PMPM Cost						4.10%	$ 2,538.57	$ 2,642.66	$ 2,751.00	$ 2,863.79	$ 2,981.20								
113		Total Expenditure							$ 2,472,578,644	$ 2,588,254,423	$ 2,709,396,994	$ 2,836,275,352	$ 2,969,164,190	$ 13,575,669,603							
114																					
115																					
116		**UPL Diversion Technical Correction 9-24-2020**																			
117									DY7	DY8	DY9	DY10	DY11								
118		**Expenditures**																			
119		Adult and Children							$42,763,186.62	$42,763,186.62	$42,763,186.62	$42,763,186.62	$42,763,186.62								
120		ABD and LTC							$36,180,753.69	$36,180,753.69	$36,180,753.69	$36,180,753.69	$36,180,753.69								
121		Total							$78,943,940.31	$78,943,940.31	$78,943,940.31	$78,943,940.31	$78,943,940.31								
122																					
123		**MCO Fee Technical Correction 3-24-2022**																			
124									DY7	DY8	DY9	DY10	DY11								
125		**Expenditures**																			
126		Adult and Children							$13,933,313.32	$14,811,895.63	$15,747,149.68	$16,742,836.57	$17,802,936.49								
127		ABD and LTC							$29,319,114.35	$30,690,763.91	$32,127,237.09	$33,631,723.54	$35,207,480.51								
128		Total							$43,252,427.67	$45,502,659.55	$47,874,386.76	$50,374,560.11	$53,010,417.00								
129																					
130		**Adult and Child Acuity MEG Technical Correction 3-24-2022**																			
131									DY7	DY8	DY9	DY10	DY11								
132		**Expenditures**																			
133		Adult and Children							$26,381,558.10	$28,045,163.84	$29,816,237.66	$31,701,837.57	$33,709,490.22								

HCAIP increase not used in WOW

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP		DY0 (CY18)	DEMO TREND RATE	Benefit Changes	Projected DEMONSTRATION YEARS (DY) DY1 (CY19)	Projected DY2 (CY20)	Projected DY3 (CY21)	Projected DY4 (CY22)	Projected DY5 (CY23)	TOTAL WW
Medicaid Pop 1	ABD/SD Dual									
Pop Type:	**Medicaid**									
Eligible Member Months		183,302			184,819	186,348	187,890	189,444	191,012	
PMPM Cost		$ 263.68	2.0%	2.3%	$ 275.18	$ 280.80	$ 286.53	$ 292.38	$ 298.35	
Total Expenditure		$ 48,333,120			$ 50,858,437	$ 52,326,508	$ 53,836,059	$ 55,389,740	$ 56,988,367	$ 269,399,112
Medicaid Pop 2	ABD/SD Non Dual									
Pop Type:	**Medicaid**									
Eligible Member Months		350,396			353,727	357,090	360,486	363,913	367,373	
PMPM Cost		$ 1,265.11	2.5%	2.3%	$ 1,326.50	$ 1,359.95	$ 1,394.25	$ 1,429.41	$ 1,465.46	
Total Expenditure		$ 443,288,886			$ 469,219,062	$ 485,625,152	$ 502,607,219	$ 520,181,285	$ 538,371,069	$ 2,516,003,786
Medicaid Pop 3	Adults									
Pop Type:	**Medicaid**									
Eligible Member Months		599,801			602,140	604,487	606,843	609,209	611,584	
PMPM Cost		$ 574.53	2.2%	2.3%	$ 600.40	$ 613.49	$ 626.86	$ 640.52	$ 654.48	
Total Expenditure		$ 344,603,829			$ 361,524,578	$ 370,846,674	$ 380,405,874	$ 390,210,640	$ 400,269,546	$ 1,903,257,313
Medicaid Pop 4	Children									
Pop Type:	**Medicaid**									
Eligible Member Months		2,661,539			2,737,645	2,815,927	2,896,447	2,979,269	3,064,460	
PMPM Cost		$ 260.10	2.5%	2.3%	$ 272.61	$ 279.37	$ 286.30	$ 293.40	$ 300.68	
Total Expenditure		$ 692,266,369			$ 746,309,365	$ 786,685,424	$ 829,252,732	$ 874,117,671	$ 921,421,961	$ 4,157,787,154
Medicaid Pop 5	DD Waiver									
Pop Type:	**Medicaid**									
Eligible Member Months		107,700			107,729	107,758	107,787	107,815	107,844	
PMPM Cost		$ 5,023.62	1.1%	2.3%	$ 5,192.60	$ 5,247.96	$ 5,303.91	$ 5,360.46	$ 5,417.61	
Total Expenditure		$ 541,043,874			$ 559,392,778	$ 565,508,043	$ 571,690,136	$ 577,940,189	$ 584,258,255	$ 2,858,789,401
Medicaid Pop 6	LTC									
Pop Type:	**Medicaid**									
Eligible Member Months		242,658			242,767	242,876	242,985	243,093	243,202	
PMPM Cost		$ 4,282.42	0.7%	2.3%	$ 4,410.53	$ 4,441.50	$ 4,472.69	$ 4,504.10	$ 4,535.73	
Total Expenditure		###########			$ 1,070,731,779	$ 1,078,733,185	$ 1,086,795,001	$ 1,094,917,302	$ 1,103,100,164	$ 5,434,277,431
Medicaid Pop 7	MN Dual									
Pop Type:	**Medicaid**									
Eligible Member Months		15,521			15,574	15,627	15,681	15,735	15,789	
PMPM Cost		$ 809.51	1.5%	2.3%	$ 840.59	$ 853.46	$ 866.53	$ 879.80	$ 893.27	
Total Expenditure		$ 12,564,243			$ 13,091,392	$ 13,337,434	$ 13,588,146	$ 13,843,569	$ 14,103,742	$ 67,964,283
Medicaid Pop 8	MN Non Dual									
Pop Type:	**Medicaid**									
Eligible Member Months		15,087			15,424	15,769	16,122	16,483	16,852	
PMPM Cost		$ 2,224.12	2.9%	2.3%	$ 2,340.26	$ 2,407.72	$ 2,477.13	$ 2,548.54	$ 2,622.01	
Total Expenditure		$ 33,554,978			$ 36,096,978	$ 37,968,261	$ 39,936,639	$ 42,007,048	$ 44,184,815	$ 200,193,742
Medicaid Pop 9	Waiver									
Pop Type:	**Medicaid**									
Eligible Member Months		Impact of WW Change			53,964	53,945	53,927	53,909	53,890	
PMPM Cost		$ 3,078.86	1.5%	2.3%	$ 3,196.39	$ 3,244.64	$ 3,293.61	$ 3,343.32	$ 3,393.78	
Total Expenditure		#VALUE!			$ 172,488,569	$ 175,032,985	$ 177,614,484	$ 180,234,107	$ 182,892,351	$ 888,262,496

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections.
DY1 through DY4 represent actual expenditures. Expenditures for DY5 is projected based on emerging expenditures for that year.
Capitation Rate Update is used in conjunction with the CY17 PMPM, and the result is the average negotiated rate for CY18.
"Demo Trend" is the trend rate that projects DY7 to DY11, starting from DY6.
"Benefit Changes" represents a one-time adjustment to reflect preliminary estimated increase in care coordination services and increase in privilege fee.

ELIGIBILITY GROUP		DY0 (CY18)	DEMO TREND RATE	Benefit Changes	DEMONSTRATION YEARS (DY) DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)	TOTAL WW
Medicaid Pop A	Adults and Children									
Pop Type:	**Medicaid**									
Eligible Member Months					3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM Cost			2.03%		$ 331.71	$ 338.42	$ 345.29	$ 352.33	$ 359.54	
Total Expenditure					$ 1,107,833,943	$ 1,157,532,098	$ 1,209,658,607	$ 1,264,328,311	$ 1,321,691,507	$ 6,061,044,466
Medicaid Pop B	ABD and LTC									
Pop Type:	**Medicaid**									
Eligible Member Months					974,004	979,414	984,877	990,393	995,963	
PMPM Cost			1.00%		$ 2,435.18	$ 2,459.16	$ 2,483.63	$ 2,508.61	$ 2,534.13	
Total Expenditure					$ 2,371,878,995	$ 2,408,531,568	$ 2,446,067,684	$ 2,484,513,239	$ 2,523,898,764	$ 12,234,890,251

HCAIP Incremental Increase (PMPM)

Medicaid Pop A	Adults and Childre	**HCAIP Increase is NOT used in WW**
Pop Type:		
Eligible Member Months	3,420,414	
PMPM Cost	$ 45.62	
Total Expenditure	$ 156,055,540	
Medicaid Pop B	ABD and LTC	
Pop Type:		
Eligible Member Months	979,414	
PMPM Cost	$ 93.38	
Total Expenditure	$ 91,454,987	

Final WW PMPM

Medicaid Pop A	Adults and Children									
Pop Type:	**Medicaid**									
Eligible Member Months					3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM Cost			2.03%		$ 339.47	$ 346.34	$ 353.39	$ 360.58	$ 367.92	
Total Expenditure					$ 1,133,765,642	$ 1,184,628,963	$ 1,237,975,424	$ 1,293,922,509	$ 1,352,623,283	$ 6,202,915,821
Medicaid Pop B	ABD and LTC									
Pop Type:										
Eligible Member Months					974,004	979,414	984,877	990,393	995,963	
PMPM Cost			1.00%		$ 2,435.18	$ 2,459.16	$ 2,483.76	$ 2,508.62	$ 2,533.72	
Total Expenditure					$ 2,371,878,995	$ 2,408,531,568	$ 2,446,201,377	$ 2,484,517,312	$ 2,523,491,361	$12,234,620,613

Adult and Child Acuity MEG Technical Correction 3-24-2022

	DY 7	DY 8	DY 9	DY 10	DY 11
Expenditures					
Adult and Children	$25,931,699	$27,096,865	$28,316,817	$29,594,198	$30,931,776

Kansas 1115 UPL Diversionary Spending: Technical Correction Amount

MEG	DY6 (CY18) PMPM	DY6 (CY18) MMs	DY6 (CY18) Expenditures
ABD/SD Dual	$ 3.93	180,759	$ 710,383
ABD/SD Non Dual	$ 71.38	354,815	$ 25,326,695
Adults	$ 33.23	601,623	$ 19,991,932
Children	$ 8.83	2,578,851	$ 22,771,254
DD Waiver	$ 6.26	109,268	$ 684,018
LTC	$ 24.64	241,385	$ 5,947,726
MN Dual	$ 7.16	15,554	$ 111,367
MN Non Dual	$ 146.94	11,420	$ 1,678,055
Waiver	$ 31.80	54,167	$ 1,722,511
Total	**$ 19.03**	**4,147,842**	**$ 78,943,940**

DY7-DY11 Annual Amount	**$ 78,943,940**
DY7-DY11 Total	**$ 394,719,702**

Privilege Fee Difference: Technical Correction Amount

	Privilege Fee
CY17	3.31%
CY18	5.77%
DY0 Effective (SFY18)	**4.58%**
CY18	5.77%
Difference	**1.2%**

WOW Expenditures*

Year	Adults and Children	ABD and LTC	Total
DY7	$1,161,109,443	$2,443,259,529	$3,604,368,972
DY8	$1,234,324,636	$2,557,563,659	$3,791,888,296
DY9	$1,312,262,473	$2,677,269,757	$3,989,532,230
DY10	$1,395,236,380	$2,802,643,629	$4,197,880,009
DY11	$1,483,578,041	$2,933,956,709	$4,417,534,750
Total	**$6,586,510,973**	**$13,414,693,284**	**$20,001,204,257**

Impact

Year	Adults and Children	ABD and LTC	Total
DY7	$13,933,313	$29,319,114	$43,252,428
DY8	$14,811,896	$30,690,764	$45,502,660
DY9	$15,747,150	$32,127,237	$47,874,387
DY10	$16,742,837	$33,631,724	$50,374,560
DY11	$17,802,936	$35,207,481	$53,010,417
Total	**$79,038,132**	**$160,976,319**	**$240,014,451**

New WOW Expenditures

Year	Adults and Children	ABD and LTC	Total
DY7	$1,175,042,756	$2,472,578,644	$3,647,621,400
DY8	$1,249,136,532	$2,588,254,423	$3,837,390,955
DY9	$1,328,009,623	$2,709,396,994	$4,037,406,617
DY10	$1,411,979,217	$2,836,275,352	$4,248,254,569
DY11	$2,895,557,258	$2,969,164,190	$5,864,721,448
Total	**$8,059,725,386**	**$13,575,669,603**	**$21,635,394,989**

MEG	Rate Cell	CY18 Proj. MMs	CY18 Redetermination PMPM Impact
Adult & Children	BCC	3,170	$0.00
Adult & Children	Children in Long Term Care (LTC)	2,112	$0.00
Adult & Children	Deliveries	11,218	$0.00
Adult & Children	FC/AS M/F <1	4,469	$0.00
Adult & Children	FC/AS M/F 1+	196,950	$0.00
Adult & Children	PLE PW < 30	64,083	$0.00
Adult & Children	PLE PW 30+	18,002	$0.00
Adult & Children	TAF + PLE < 1	205,008	$0.00
Adult & Children	TAF + PLE 1 - 21	2,253,000	$12.86
Adult & Children	TAF 22+	514,546	$44.68
Adult & Children	M-CHIP	153,066	$0.00
Adult & Children Total		**3,414,407**	**$15.22**

Impact of shift from SFY18 to CY18	
CY18 Rates	$15.22
Adjustment	50%
1115 Base Impact	$7.61

PMPM Adjustment

	Base PMPM	Trend Rate	DY 7	DY8	DY 9	DY 10	DY11
WOW PMPM Adustment	$7.61	3.80%	$7.90	$8.20	$8.51	$8.83	$9.17
WW PMPM Adjustment	$7.61	2.03%	$7.76	$7.92	$8.08	$8.25	$8.41

Original WOW

	Trend Rate	DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
Eligible Member Months		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM	3.80%	$347.66	$360.87	$374.58	$388.81	$403.58	
Total Expenditures		$1,161,109,443	$1,234,324,636	$1,312,262,473	$1,395,236,380	$1,483,578,041	$6,586,510,973

New WOW

	Trend Rate	DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
Eligible Member Months		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM	3.80%	$355.56	$369.07	$383.09	$397.64	$412.75	
Total Expenditures		$1,187,491,001	$1,262,369,800	$1,342,078,711	$1,426,938,218	$1,517,287,531	$6,736,165,261

Impact of WOW Change

DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
26,381,558	28,045,164	29,816,238	31,701,838	33,709,490	$149,654,287.38

Original WW

	Trend Rate	DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
Eligible Member Months		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM	2.03%	$331.71	$338.42	$345.29	$352.33	$359.54	
Total Expenditures		$1,107,833,943	$1,157,532,098	$1,209,658,607	$1,264,328,311	$1,321,691,507	$6,061,044,466

New WW

	Trend Rate	DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
Eligible Member Months		3,339,784	3,420,414	3,503,290	3,588,479	3,676,045	
PMPM	2.03%	$339.47	$346.34	$353.38	$360.58	$367.96	
Total Expenditures		$1,133,765,642.15	$1,184,628,963.37	$1,237,975,424.00	$1,293,922,508.65	$1,352,623,282.80	$6,202,915,821

Impact of WW Change

DY 7	DY8	DY 9	DY 10	DY11	Total Expenditures
25,931,699	27,096,865	28,316,817	29,594,198	30,931,776	$141,871,355

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS	2013	2014	2015	2016	2017
State DSH Allotment (Federal share)	$ 43,299,536.37	$ 43,991,906.91	$ 44,695,777.94	$ 44,829,864.90	$ 44,012,998.73
State DSH Claim Amount (Federal share)	$ 43,299,536.37	$ 43,991,906.91	$ 44,695,777.94	$ 44,829,864.90	$ 44,012,998.73
DSH Allotment Left Unspent (Federal share)	$ -	$ -	$ -	$ -	$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (2019)	FFY 01 (2020)	FFY 02 (2021)	FFY 03 (2022)	FFY 04 (2023)	FFY 05 (2024)
State DSH Allotment (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
State DSH Claim Amount (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
DSH Allotment Projected to be Unused (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
State DSH Claim Amount (Federal share)	$ 35,164,473.60	$ 33,097,908.00	$ 31,031,342.40	$ 28,964,776.80	$ 26,898,211.20	$ 24,831,645.60
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Alltoment Diverted (Federal share)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	$ -	$ -	$ -	$ -	$ -	$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS	DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)					
FMAP for Leading FFY	0.5616	0.5616	0.5616	0.5616	0.5616
DSH Diversion to Trailing FFY (total computable)					
FMAP for Trailing FFY	0.5616	0.5616	0.5616	0.5616	0.5616
Total Demo Spending From Diverted DSH (total computable)	$ -	$ -	$ -	$ -	$ -

Population Status Drop-Down
Medicaid
Hypothetical
Expansion

Voluntary Work Support Pilot (CY19)

COS	Membership	Hours per Month	Unit Cost	PMPM	Total Cost
Supported Employment	5,250	4	$ 45.50	$ 202.26	$ 1,061,874
Prevocational Supports	5,250	10	$ 40.44	$ 409.77	$ 2,151,297
Independent Living Skills Training	5,250	5	$ 30.00	$ 144.96	$ 761,045
Personal Assistance Services	5,250	46	$ 13.25	$ 614.80	$ 3,227,700
Assistive Technology	5,250			$ 4.09	$ 21,496
Peer Support	5,250	2	$ 41.59	$ 83.18	$ 436,699
Transportation (included in Personal Assistance Services)		-	$ -	$ -	$ -
	5,250			$ 1,459.07	**$ 7,660,111**

PMPM Trend 2.52%

	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
PMPM	$ 1,459.07	$ 1,495.87	$ 1,533.59	$ 1,572.27	$ 1,611.92
Membership	5,250	5,250	5,250	5,250	5,250
Total Cost	$ 7,660,111	$ 7,853,302	$ 8,051,366	$ 8,254,425	$ 8,462,605

Implementation Adjustment (7/1/21)	$ -	$ -	$ 4,025,683	$ 8,254,425	$ 8,462,605	
SSDI Population Estimate		10% *Based on discussion with State*				
SSDI (Expenditures Section)	$ -	$ -	$ 402,568	$ 825,442	$ 846,261	$ 2,074,271
Non-SSDI (Hypothetical Section)	$ -	$ -	$ 3,623,115	$ 7,428,982	$ 7,616,345	$18,668,442

Notes:
Hours per month for each service are based on discussions with State staff.
Unit cost for each service based on discussions with State staff and current fee schedule.
Membership is reflective of 500 members as the target population size for the pilot program.
Population includes SMI, and SSI members that are on either the PD or I/DD waiting list.
PMPM Trend based on ABD/SD Non Dual WW trend.

Implementation Date is now 7/1/21, and the projection has been adjusted accordingly.
Expenditures have been split based on SSDI vs. Non-SSDI per CMS request.

IP & OP HCAIP Dollars

Current in WOW

MEG	SFY18	CY19	CY20
ABD/SD Dual	$ 431,789	$ 475,868	$ 499,477
ABD/SD Non Dual	$ 13,847,710	$ 14,925,109	$ 15,684,767
Adults	$ 18,840,804	$ 19,177,272	$ 19,983,610
Children	$ 16,664,221	$ 18,600,087	$ 19,858,963
DD Waiver	$ 835,112	$ 880,479	$ 916,824
LTC	$ 4,147,086	$ 4,406,328	$ 4,589,042
MN Dual	$ 49,034	$ 53,979	$ 56,385
MN Non Dual	$ 586,922	$ 781,351	$ 831,582
Waiver	$ 693,405	$ 741,189	$ 771,316
Adults and Children	$ 35,505,025	$ 37,777,359	$ 39,842,572
ABD and LTC	$ 20,591,057	$ 22,264,302	$ 23,349,392
Total	**$ 56,096,082**	**$ 60,041,661**	**$ 63,191,964**

Notes:

SFY18: Based on HCAIP amount built into 2HCY17 and 1HCY18 capitation rates, and has been grossed up for the Privilege Fee effective during the SFY18 time period to account for total expenditures related to HCAIP.

CY19 and CY20: Based on projecting SFY18 forward at 1115 waiver trends and membership growth

New IP & OP HCAIP Amount

MEG	SFY18	CY19	CY20
ABD/SD Dual			$ 2,455,830
ABD/SD Non Dual			$ 77,118,921
Adults			$ 98,255,489
Children			$ 97,642,623
DD Waiver			$ 4,507,842
LTC			$ 22,563,418
MN Dual			$ 277,236
MN Non Dual			$ 4,088,723
Waiver			$ 3,792,409
Adults and Children			$ 195,898,112
ABD and LTC			$ 114,804,379
Total			**$ 310,702,491**

Notes:

CY20: Based on new HCAIP amount, distributed to each MEG using prior HCAIP utilization, and has been grossed up for the Privilege Fee that will be effective during the CY20 time period to account for total expenditures related to HCAIP.

Difference

MEG	SFY18	CY19	CY20
ABD/SD Dual			$ 1,956,353
ABD/SD Non Dual			$ 61,434,155
Adults			$ 78,271,879
Children			$ 77,783,660
DD Waiver			$ 3,591,018
LTC			$ 17,974,376
MN Dual			$ 220,850
MN Non Dual			$ 3,257,142
Waiver			$ 3,021,093
Adults and Children			$ 156,055,540
ABD and LTC			$ 91,454,987
Total			**$ 247,510,527**

MMs

MEG	SFY18	CY19	CY20
ABD/SD Dual			186,348
ABD/SD Non Dual			357,090
Adults			604,487
Children			2,815,927
DD Waiver			107,758
LTC			242,876
MN Dual			15,627
MN Non Dual			15,769
Waiver			53,945
Adults and Children			3,420,414
ABD and LTC			979,414
Total			**4,399,828**

PMPM

MEG	SFY18	CY19	CY20
ABD/SD Dual			$ 10.50
ABD/SD Non Dual			$ 172.04
Adults			$ 129.48
Children			$ 27.62
DD Waiver			$ 33.32
LTC			$ 74.01
MN Dual			$ 14.13
MN Non Dual			$ 206.55
Waiver			$ 56.00
Adults and Children			$ 45.62
ABD and LTC			$ 93.38
Total			**$ 56.25**

Historic Data by 6 month periods (CY13 to SFY18)

From CMS 64, including all adjustments that have previously been discussed with CMS

MMs

MEG	CY13 SFY2013 Jan-June	CY13 SFY2014 July-Dec	CY14 SFY2014 Jan-June	CY14 SFY2015 July-Dec	CY15 SFY2015 Jan-June	CY15 SFY2016 July-Dec	CY16 SFY2016 Jan-June	CY16 SFY2017 July-Dec	CY17 SFY2017 Jan-June	CY17 SFY2018 July-Dec	CY18 SFY2018 Jan-June
ABD/SD Dual	110,579	110,095	112,495	111,304	106,521	101,497	94,810	92,777	92,222	89,880	88,238
ABD/SD Non Dual	175,335	174,982	175,799	175,598	173,565	170,113	168,165	171,295	171,719	172,493	176,089
Adults	200,022	208,302	238,798	253,530	272,656	274,471	300,973	322,201	317,344	314,805	310,808
Children	1,278,407	1,275,224	1,346,518	1,367,449	1,377,143	1,330,914	1,390,442	1,435,887	1,319,494	1,290,481	1,302,359
DD Waiver	51,690	51,803	52,282	52,270	52,527	52,580	52,920	53,689	53,562	53,958	54,568
LTC	133,133	130,266	130,083	127,527	126,621	126,067	122,795	124,329	122,587	121,894	120,795
MN Dual	8,460	7,963	8,700	8,399	8,313	7,905	7,653	8,036	8,017	7,520	7,506
MN Non Dual	6,565	6,867	6,850	6,835	6,780	6,724	7,152	7,490	7,350	6,622	6,694
Waiver	27,296	25,581	24,696	23,530	23,005	23,514	25,239	26,050	27,229	26,314	27,407
	1,993,596	1,990,983	2,095,301	2,136,412	2,147,131	2,103,795	2,170,139	2,252,673	2,119,515	2,083,957	2,094,454

Total Expenditures

MEG	CY13 SFY2013 Jan-June	CY13 SFY2014 July-Dec	CY14 SFY2014 Jan-June	CY14 SFY2015 July-Dec	CY15 SFY2015 Jan-June	CY15 SFY2016 July-Dec	CY16 SFY2016 Jan-June	CY16 SFY2017 July-Dec	CY17 SFY2017 Jan-June	CY17 SFY2018 July-Dec	CY18 SFY2018 Jan-June
ABD/SD Dual	$ 30,668,102	$ 33,034,804	$ 21,111,583	$ 25,259,528	$ 19,605,210	$ 18,697,325	$ 23,363,457	$ 21,972,258	$ 22,122,351	$ 22,334,889	$ 24,170,231
ABD/SD Non Dual	$ 171,862,567	$ 188,545,101	$ 203,493,916	$ 201,776,914	$ 203,495,308	$ 199,077,806	$ 211,446,310	$ 207,259,984	$ 199,687,180	$ 209,663,840	$ 224,818,764
Adults	$ 108,495,840	$ 125,108,979	$ 140,089,454	$ 148,513,007	$ 152,859,011	$ 153,113,969	$ 156,274,567	$ 163,739,472	$ 155,188,113	$ 165,200,466	$ 194,233,320
Children	$ 244,770,911	$ 266,113,244	$ 287,536,484	$ 301,114,849	$ 316,699,484	$ 308,782,599	$ 326,184,318	$ 321,681,626	$ 295,137,591	$ 306,095,439	$ 356,418,022
DD Waiver	$ 190,958,975	$ 202,649,832	$ 210,595,567	$ 252,874,234	$ 242,160,592	$ 241,113,259	$ 245,359,955	$ 244,635,905	$ 251,902,461	$ 262,496,953	$ 271,093,979
LTC	$ 388,612,859	$ 424,256,955	$ 440,611,738	$ 462,778,950	$ 487,565,266	$ 484,986,565	$ 473,703,026	$ 488,724,467	$ 493,272,995	$ 512,484,310	$ 506,096,785
MN Dual	$ 9,271,632	$ 9,541,094	$ 9,553,399	$ 6,441,574	$ 5,370,915	$ 5,080,732	$ 4,972,689	$ 5,247,986	$ 4,956,695	$ 4,917,647	$ 7,345,994
MN Non Dual	$ 10,490,175	$ 11,436,137	$ 13,530,172	$ 11,427,752	$ 9,463,700	$ 9,808,811	$ 12,614,493	$ 12,847,029	$ 13,796,378	$ 12,782,456	$ 14,043,170
Waiver	$ 72,322,958	$ 78,349,954	$ 67,457,909	$ 66,950,457	$ 72,442,356	$ 73,696,726	$ 73,392,695	$ 74,416,287	$ 75,019,492	$ 77,497,941	$ 86,401,396
	$1,217,353,920	$1,339,036,100	$1,393,959,123	$1,477,237,265	$1,509,661,842	$1,494,357,891	$1,527,321,509	$1,540,525,012	$1,511,083,246	$1,573,473,942	$1,684,511,661

HIPF

MEG	CY13 SFY2013 Jan-June	CY13 SFY2014 July-Dec	CY14 SFY2014 Jan-June	CY14 SFY2015 July-Dec	CY15 SFY2015 Jan-June	CY15 SFY2016 July-Dec	CY16 SFY2016 Jan-June	CY16 SFY2017 July-Dec	CY17 SFY2017 Jan-June	CY17 SFY2018 July-Dec	CY18 SFY2018 Jan-June
ABD/SD Dual	$ -	$ -	$ 434,241	$ 470,428	$ 833,666	$ 833,666					
ABD/SD Non Dual	$ -	$ -	$ 3,834,577	$ 4,154,125	$ 6,496,000	$ 6,496,000					
Adults	$ -	$ -	$ 3,014,155	$ 3,265,334	$ 5,352,093	$ 5,352,093					
Children	$ -	$ -	$ 4,896,055	$ 5,304,060	$ 8,829,533	$ 8,829,533					
DD Waiver	$ -	$ -	$ 371,136	$ 402,063	$ 1,145,392	$ 1,145,392					
LTC	$ -	$ -	$ 1,156,535	$ 1,252,913	$ 2,294,563	$ 2,294,563					
MN Dual	$ -	$ -	$ 86,064	$ 93,236	$ 170,844	$ 170,844					
MN Non Dual	$ -	$ -	$ 228,430	$ 247,466	$ 317,907	$ 317,907					
Waiver	$ -	$ -	$ 795,295	$ 861,570	$ 1,491,471	$ 1,491,471					

Net HIPF

[illegible]

SFY Historic Base Data

[illegible]

Comparison and Checks

[illegible]

MEG	DY Projected Trend Rate 1	DY Projected Trend Rate 2
ABD/SD Dual	5.91%	0.83%
ABD/SD Non Dual	1.04%	0.95%
Adults	-8.08%	0.39%
Children	5.29%	2.86%
DD Waiver	-1.52%	0.03%
LTC	-0.02%	0.04%
MN Dual	6.69%	0.34%
MN Non Dual	50.30%	2.24%
Waiver	1.35%	-0.03%
	2.49%	1.98%

MEG	Actual SFY2014	Actual SFY2015	Actual SFY2016	Actual SFY2017	Actual SFY2018	Projected DY0 (CY18)	DY Projected DY1 (CY19)	DY Projected DY2 (CY20)	DY Projected DY3 (CY21)	DY Projected DY4 (CY22)	DY Projected DY5 (CY23)
ABD/SD Dual	222,580	217,825	196,307	185,000	178,118	183,302	184,819	186,348	187,890	189,444	191,012
ABD/SD Non Dua	350,781	349,163	338,278	343,014	348,582	350,396	353,727	357,090	360,486	363,913	367,373
Adults	447,000	526,176	575,444	649,545	625,613	599,801	602,140	604,487	606,843	609,209	611,584
Children	2,621,742	2,744,592	2,730,356	2,755,371	2,593,840	2,661,539	2,737,645	2,815,927	2,896,447	2,979,269	3,064,460
DD Waiver	104,085	104,797	105,500	107,251	108,526	107,700	107,729	107,758	107,787	107,815	107,844
LTC	260,349	254,148	248,852	246,926	242,679	242,658	242,767	242,876	242,985	243,093	243,202
MN Dual	16,663	16,712	15,558	16,053	15,026	15,521	15,574	15,627	15,681	15,735	15,789
MN Non Dual	13,717	13,605	13,876	14,849	12,306	15,087	15,424	15,769	16,122	16,483	16,852
Waiver	50,267	46,525	48,743	54,179	53,621	53,982	53,964	53,945	53,927	53,909	53,890
	4,087,184	4,273,543	4,272,914	4,372,188	4,178,311	4,229,986	4,313,788	4,399,828	4,488,167	4,578,872	4,672,007

Historic Pool Expenditures

Name	SFY08[1]	SFY09[2]	SFY10	SFY11	SFY12
UC Pool : HCAIP	$ 24,151,085	$ 24,151,114	$ 24,151,114	$ 24,151,114	$ 23,723,342
UC Pool : BCCH	$ -	$ 2,575,155	$ 4,440,694	$ 5,491,365	$ 8,880,873
UC Pool : LPH	$ 8,373,120	$ 24,079,321	$ 28,836,150	$ 27,557,989	$ 28,900,000
DSRIP	$ -	$ -	$ -	$ -	$ -

[1] *LPH Outpatient based on paid dates 2/28/2008 - 7/1/2008.*

[2] *LPH Outpatient based on paid dates 7/1/2008 - 12/31/2009.*

Pools - WW

Name	SFY12	CY13	CY14	CY15	CY16	CY17	DY0 (CY18)	DY1 (CY19)	DY2 (CY20)	DY3 (CY21)	DY4 (CY22)	DY5 (CY23)
UC Pool : HCAIP	$ 23,723,342	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000	$ 41,000,000
UC Pool : BCCH/LPH	$ 37,780,873	$ 39,840,887	$ 39,830,955	$ 29,543,300	$ 34,099,871	$ 12,357,066	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550	$ 9,856,550
DSRIP & APM	$ -	$ -	$ -	$ 3,020,859	$ -	$ 10,162,500	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000

Voluntary Work Support Pilot (CY19)

COS	Membership	Hours per Month	Unit Cost	PMPM	Total Cost
Supported Employment	5,250	4	$ 45.50	$ 202.26	$ 1,061,874
Prevocational Supports	5,250	10	$ 40.44	$ 409.77	$ 2,151,297
Independent Living Skills Training	5,250	5	$ 30.00	$ 144.96	$ 761,045
Personal Assistance Services	5,250	46	$ 13.25	$ 614.80	$ 3,227,700
Assistive Technology	5,250			$ 4.09	$ 21,496
Peer Support	5,250	2	$ 41.59	$ 83.18	$ 436,699
Transportation (included in Personal Assistance Services)		-	$ -	$ -	$ -
	5,250			$ 1,459.07	**$ 7,660,111**

PMPM Trend 2.52%

	DY7 (CY19)	DY8 (CY20)	DY9 (CY21)	DY10 (CY22)	DY11 (CY23)
PMPM	$ 1,459.07	$ 1,495.87	$ 1,533.59	$ 1,572.27	$ 1,611.92
Membership	5,250	5,250	5,250	5,250	5,250
Total Cost	$ 7,660,111	$ 7,853,302	$ 8,051,366	$ 8,254,425	$ 8,462,605

Notes:
Hours per month for each service are based on discussions with State staff.
Unit cost for each service based on discussions with State staff and current fee schedule.
Membership is reflective of 500 members as the target population size for the pilot program.
Population includes SMI, and SSI members that are on either the PD or I/DD waiting list.
PMPM Trend based on ABD/SD Non Dual WW trend.

ATTACHMENT C
HCAIP Hospitals

Hospital Name	City	County
Blue Valley Hospital Inc.	Overland Park	Johnson
Bob Wilson Memorial Hospital	Ulysses	Grant
Children's Mercy Hospital	Overland Park	Johnson
Coffeyville Regional Medical	Coffeyville	Montgomery
Doctors Hospital	Leawood	Johnson
Geary Community Hospital	Junction City	Geary
Hays Medical Center	Hays	Ellis
Hutchinson Regional Medical	Hutchinson	Reno
Kansas City Orthopedic	Leawood	Johnson
Kansas Heart Hospital	Wichita	Sedgwick
Kansas Medical Center	Andover	Butler
Kansas Rehabilitation Hospital	Topeka	Shawnee
Kansas Spine Hospital	Wichita	Sedgwick
Kansas Surgery & Recovery	Wichita	Sedgwick
Labette County Medical Center	Parsons	Labette
Lawrence Memorial Hospital	Lawrence	Douglas
Manhattan Surgical Hospital	Manhattan	Riley
McPherson Memorial Hospital	McPherson	McPherson
Meadowbrook Hospital	Gardner	Johnson
Menorah Medical Center	Overland Park	Johnson
Mercy Health Center - Fort	Fort Scott	Bourbon
Mercy Hospital - Moundridge	Moundridge	McPherson
Miami County Medical Center	Paola	Miami
Mid-America Rehabilitation	Overland Park	Johnson
Morton County Health System	Elkhart	Morton
Newton Medical Center	Newton	Harvey
Olathe Medical Center	Olathe	Johnson
Overland Park Regional	Overland Park	Johnson
Prairie View Hospital	Newton	Harvey
Pratt Regional Medical Center	Pratt	Pratt
Premier Surgical Institute	Galena	Cherokee
Newton Medical Center	Newton	Harvey
Olathe Medical Center	Olathe	Johnson
Overland Park Regional Medical Center	Overland Park	Johnson
Premier Surgical Institute	Galena	Cherokee
Pratt Regional Medical Center	Pratt	Pratt
Hutchinson Regional Medical Center	Hutchinson	Reno
Providence Medical Center	Kansas City	Wyandotte
Ransom Memorial Hospital	Ottawa	Franklin

Saint Catherine Hospital	Garden City	Finney
Saint Francis Health Center	Topeka	Shawnee
Saint John Hospital	Leavenworth	Leavenworth
Saint Luke's South Hospital	Overland Park	Johnson
Salina Regional Health Center	Salina	Saline
Salina Surgical Hospital	Salina	Saline
Select Specialty Hospital Kansas City	Overland Park	Johnson
Select Specialty Hospital Topeka	Topeka	Shawnee
Select Specialty Hospital Wichita	Wichita	Sedgwick
Shawnee Mission Medical Center	Overland Park	Johnson
South Central Kansas RMC	Arkansas City	Cowley
Southwest Medical Center	Liberal	Seward
Promise Hospital of Overland Park	Overland Park	Johnson
Stormont-Vail Regional Health Center	Topeka	Shawnee
Summit Surgical, LLC	Hutchinson	Reno
Sumner Regional Medical Center	Wellington	Sumner
Susan B. Allen Memorial Hospital	El Dorado	Butler
Via Christi Hospital St. Teresa	Wichita	Sedgwick
Via Christi Regional Medical Center	Wichita	Sedgwick
Via Christi Rehabilitation Center	Wichita	Sedgwick
Wesley Medical Center	Wichita	Sedgwick
Wesley Rehabilitation Hospital	Wichita	Sedgwick
Western Plains Medical	Dodge City	Ford
Hospital Name	**City**	**County**
Complex		

ATTACHMENT D
LPTH/BCCH Hospitals

Hospital Name	City	County
Large Public Teaching Hospital		
The University of Kansas Hospital	Kansas City, KS	Wyandotte
Border City Children's Hospital		
Children's Mercy Hospital	Kansas City, MO	Jackson

ATTACHMENT E
UC Payment Application Template

[PLACEHOLDER: Following CMS review and approval, the UC Payment Application Template (see STC 53) will be placed in this attachment]

ATTACHMENTS F and G
DSRIP Planning Protocol

Section 1. Preface

Section XI of the Kansas KanCare Section 1115 Demonstration authorizes a Delivery System Reform Incentive Payment (DSRIP) pool available in DY 3 (CY 2015) through DY 8 (CY 2020) for the continuation of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.

This protocol serves as both Attachments F and G to the STCs and supplements the general DSRIP requirements specified in the STCs. Specifically, this protocol describes the specific delivery system improvement activities that are eligible for DSRIP funding (Attachment F, DSRIP planning protocol as described in STC 69 (e)) and also describes the State and CMS review process for DSRIP project plans, incentive payment methodologies, and reporting requirements for DSRIP payments (Attachment G, program funding and mechanics protocol, as described in STC 69 (f)).

This protocol is supplemented by five appendices, which will assist hospitals in developing and implementing their projects and will be used in the state's review of the approvability and the valuation of DSRIP projects.

Appendix A is a ***Project Toolkit*** that describes the core components of each DSRIP strategy listed on the DSRIP strategy menu below. This supplement describes how DSRIP strategies are distinct from each other and the state's rationale for selecting each strategy (i.e. the evidence base for the strategy and its relation to community needs for the Medicaid and uninsured population). The core components and other elements of the strategy description will be used as part of the DSRIP plan checklist (described below).

Appendix B is a ***Metric Specification Guide*** that provides additional information on the metrics described in the metrics list below. Specifically, this appendix specifies the data source for each measure (specifically whether the measure is collected by the state or providers), the reference for the data steward for each metric (i.e. National Quality Forum reference number, etc), and the high performance level for each pay-for-performance metric. The high performance level for each metric will be used to establish outcome targets for all pay-for-performance measures, as described further below.

Appendix C is the ***DSRIP Application Template*** which participating hospitals will use to submit their DSRIP plans in accordance with the requirements described in section 5 below.

Appendix D is the ***DSRIP Semi-annual Reporting Template*** which participating hospitals will use to reporting on progress achieving their DSRIP metrics in order to receive DSRIP payments, pursuant to the requirements in sections 6 and 7 below.

Appendix E is a Summary of the ***Public Engagement Process*** which led to the development of the project focus areas for DSRIP.

a. Background

The DSRIP pool program will be implemented in Kansas as part of a major delivery system

overhaul that converted nearly all Kansas Medicaid and CHIP populations and services into a risk-based capitated managed care program. That program is known as KanCare and represents one of the largest reform efforts for the Kansas Medicaid and CHIP programs in recent years.

The goals of the KanCare program are to improve overall health outcomes while slowing the rate of cost growth over time. This will be accomplished by providing the right care, in the right amount, in the right setting, at the right time. The selected KanCare managed care plans focus on ensuring that consumers receive the preventive services and screenings they need and ongoing help with managing chronic conditions. The DSRIP program will work alongside the KanCare health plans and the State to further promote delivery system reform with the end goals of improved outcomes and decreasing costs.

The Kansas DSRIP pool will have only two participants—the members of the Large Public Teaching Hospital (LPTH) and Border City Children's Hospital (BCCH) pool (The University of Kansas (KU) Hospital and Children's Mercy Hospital). Both of these participants, termed "participating hospitals" in this document, are unique in their ability to impact the systemic delivery of care across Kansas.

b. DSRIP and Healthy Kansans 2020- Public Health and System Reform Collaboration

Due to the statewide emphasis of the DSRIP program, Kansas considered the three-part aim of the Section 1115 waiver, the goals of DSRIP and how to best align these initiatives with the efforts already in process throughout Kansas to improve health and the health care delivery system. The Healthy Kansans 2020 (HK2020) initiative emerged as an important effort already underway in Kansas.

The Healthy Kansans Steering Committee began meeting in August of 2012. The Steering Committee is comprised of the leaders of more than 35 organizations across the state, and was gathered together to discuss the health issues facing Kansans. The Steering Committee used the Healthy People 2020 objectives as a springboard for discussion, but the primary focus was ensuring that the unique issues facing Kansas in the coming years were addressed. The Steering Committee represents a broad array of stakeholders in Kansas, and includes membership from health care providers, consumer groups, state and local government entities, and other groups.

The result of the Steering Committee's efforts was a document identifying the cross-cutting themes and priority strategies, which has been further developed as part of the state's ongoing public engagement process. More detail regarding this document is provided in Appendix E.

c. DSRIP Goals and Focus Areas

The three cross-cutting themes developed by the HK 2020 Steering Committee also serve as the overall goals of the DSRIP program, and embody the results that Kansas will attempt to achieve through DSRIP:Access to services

- Healthy living, and
- Healthy communities

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. The specific objectives for each of these focus area were developed and revised based on the stakeholder input received and are summarized below.

I. Access to integrated delivery systems
   a. Increase access to services, including primary care and preventive services
   b. Increase the effective and efficient use of population health management through health information technology (HIT)
   c. Increase integration of the health care delivery system, including medical, behavioral health, and social services.

II. Prevention and management of chronic and complex diseases
   a. Improve health literacy, including nutrition education and tobacco use prevention and control
   b. Expand health and wellness programs and develop incentives for participation in these programs
   c. Expand chronic and complex care management models

Participating hospitals continuting DSRIP projects are expected to advance the goal of healthy communities by assuming responsibility for the overall health needs of the Medicaid beneficiaries and low income uninsured people in their communities, not simply responding to the patients that arrive at the doors of a hospital. Participating hospitals are required to engage community partners in the development and implementation of their DSRIP projects, and the state will work with providers to ensure that the pay for performance metrics that are used to measure improvement on DSRIP projects adequately reflects the project's target population, rather than the patients enrolled in a particular intervention.

Section 2. DSRIP Projects and Project Metrics

This section presents a menu of projects and metrics from which participating hospitals may select when designing their individual hospital DSRIP plans. Within each project, participating hospitals must select infrastructure, process, and quality and outcomes milestones and related metrics, as well as population-focused improvements to report. Reported metrics and population- focused improvements must support the goals of the projects selected and align with the standardized target setting approach outlined below.

a. Projects

Participating DSRIP hospitals have designed and implemented at least 2 DSRIP projects, selected from the list below.

Each project was developed according to the specifications in the project toolkit (Appendix A) based on the community needs assessment of the baseline data for the target population selected by the hospital.

1. Focus area 1: Access to integrated delivery systems

- Project 1.a: Expansion of Patient Centered Medical Homes and Neighborhood

2. Focus area 2: Prevention and management of chronic and complex diseases
   - Project 2.a: Self Management and Care (SMAC)/Resiliency
   - Project 2.b: HeartSafe Community
   - Project 2.c: Improving Coordinated Care for Medically Complex Patients
   - Project 2.d: Statewide Expansion of Sepsis Early-Warning and Escalation Process

b. Metrics

In order to measure progress towards achieving the goals of DSRIP, each project must include metrics in all four of the following milestone categories. (A metric is a measure of the extent to which a participating hospital achieves a milestone; a milestone is a particular target related to the implementation and outcomes of the DSRIP project).

Participating hospitals will select and report on metrics associated with their projects from the metric specification guide in Appendix B. All metrics must be reported in accordance with the specifications described in the metric specification guide.

The metrics below are designated as pay for reporting (P4R) or pay for performance (P4P).

1. ***Infrastructure milestones (Category 1):*** Metrics associated with these milestones lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Because of the differing starting points for each provider, hospitals will select and the state will approve unique category 1 milestones for each project and provider. In addition, as part of the ongoing monitoring of DSRIP projects (as described in section 6 below), the state or CMS may add category 1 metrics to a project prospectively in order to address implementation concerns with "at risk" projects.

   i. Project specific metrics selected by hospitals and approved by the state for each project, as specified in Appendix A (P4P)
   ii. Additional project-specific metrics, established prospectively by the state or CMS for "at risk" projects (P4P)

2. ***Process milestones (Category 2):*** Metrics associated with these milestones focus on process changes and improvements. All providers must include a measure of the quantifiable patient impact of each project on the Medicaid and low-income uninsured population. In addition, as part of the ongoing monitoring of DSRIP projects (as described in section 6 below), the state or CMS may add category 2 metrics to a project prospectively in order to address implementation concerns with "at risk" projects.

   i. Number of Medicaid/ CHIP beneficiaries served by the project (P4P)
   ii. Project specific metrics selected by hospitals and approved by the state for each project, as specified in Appendix A (P4P)

iii. Additional project-specific metrics, established by the state or CMS for a particular project, especially "at risk" projects (P4P)

3. ***Quality and outcomes milestones (Category 3):*** Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes. The Category 3 metrics for each project correspond to the project selected (as further described in Appendix A) and must be reported according to all metric specifications described in Appendix B). Since improving beneficiary outcomes is the primary goal of DSRIP, hospitals are not allowed to select Category 3 metrics (and their corresponding projects) if their baseline data indicates that the provider is within 15 percentile points from the high performance level on a particular metric (as described further in 2.c below).

   All DSRIP providers must select at least three Category 3 metrics per project from the list in Attachment B. The Category 3 metrics must meet the following standards:

   i. The metrics must be outcome measures, i.e. measures that assess the results of care experienced by patients, including patients' clinical events, patients' recovery and health status, patients' experiences in the health system, and efficiency/cost.
   ii. The metrics must align with existing state data quality infrastructure in order to ensure that all beneficiaries who are attributed to the hospital can be included in the calculation of the measure
   iii. The metrics must be reported to specifications by the relevant national measure steward, such as the National Quality Forum.

4. ***Population focused improvement milestones (Category 4):*** Metrics associated with these milestones evaluate the broader impact of the selected projects through Performance Indicators across several categories. As further described in appendix B, all hospitals must include the two state priority areas: (1) emergency department (ED) visits and (2) readmissions within 30 days of hospital discharge. In addition, hospitals will choose two additional Category 4 metrics from the CMS adult and/or child core set to ensure that the quality of care is maintained in areas that are not a direct focus of the provider's DSRIP projects.

c. Metric Targets

All participating hospitals must have a target for all pay-for-performance metrics, which will be used to determine whether or not the associated milestone was achieved (and whether the participating hospital is eligible for DSRIP payments, based on the mechanism described in section 6 below).

To assist participating hospitals in setting targets, the state will specify a high performance level for all category 3 pay-for-performance metrics in Appendix B. Performance targets should be based on the higher of top decile of performance for state or national data, or an alternative method approved by CMS.

Yearly improvement targets for project metrics will be established using the methodology of reducing the gap to the goal by 10%. For example if the baseline data for a measure is 52 percent and the goal is 90 percent, the gap to the goal is 38. The target for the project's first year of performance would be 3.8 percent increase in the result (target 55.8 percent). Each subsequent year would continue to be set with a target using the most recent year's data. This will account for smaller gains in subsequent years as performance improves toward the goal or measurement ceiling.

d. Metric attribution method

As further described in the metric specification guide (Appendix B), metrics associated with quality and outcome milestones (Category 3) and population focused improvement milestones (Category 4) will measure improvement for the Medicaid and CHIP populations served by the participating hospital and its community partners (as specified in the DSRIP project plan, described in section 3 below). Category 3 metrics will be reported based on the DSRIP project network (DSRIP hospital and identified project participants [e.g., community partners: other hospitals, outpatient providers, nursing facilities]) used for the associated DSRIP project. Category 4 metrics will be reported using all permutations of project networks for all associated DSRIP projects, but pay-for-performance payments for Category 4 will only be based on performance of beneficiaries attributed to the DSRIP hospital directly.

The state will prospectively determine the attribution of Medicaid/CHIP beneficiaries to Category 3 and 4 metrics as follows:

The DSRIP hospital must propose a target population including a specific geography and population for each of their selected DSRIP projects. The target population will be beneficiaries assigned to the hospital and identified project participants (IPPs). Assignment may occur through an enrollment or formal provider assignment process, or through patterns of service usage. Attributed populations may be identified based on exclusion/inclusion criteria for a particular measure (e.g., specific diagnoses). If there is overlap in DSRIP projects among the DSRIP hospitals, a beneficiary will only be attributed to one DSRIP project network, based on the methodology described below. Using the proposed geography and proposed population as appropriate, for each DSRIP project plan, KDHE will prospectively identify the Medicaid beneficiaries that will be attributed to that DSRIP project network at the beginning of the measurement year. This will provide an initial prospective attribution at the start of the measurement year to determine the populations to be included. For annual measurement purposes in determining the denominator, patient attribution will be defined as of the last day of the measurement year. Depending on the measurement, this will allow for adjustments at the end of the measurement year to remove beneficiaries that were not enrolled in Medicaid per the specific measure specification for continuous enrollment criteria. It will also allow for the addition of new Medicaid beneficiaries attributed to the DSRIP Project during the year, and any other adjustments necessary to assure a proper measurement denominator.

Attribution will be completed using the following hierarchy to determine assignment to one DSRIP hospital and associated identified provider participants:

1. Beneficiaries who do not receive qualifying services from the DSRIP hospital or project

associated community partners will be excluded from the attribution.

2. When there is only one DSRIP hospital that has selected an identified project, the entire matched Medicaid beneficiary population will be the assigned population. A match will occur in the following situations:

    - The beneficiary is assigned through an enrollment process to an IPP (e.g., assigned to a Primary Care Provider [PCP] or Health Home [HH]; resident of a nursing facility[NF])
    - The beneficiary has claims indicating receipt of qualifying services from the DSRIP hospital or IPP.

3. When there is more than one DSRIP hospital that has selected an identified project, the following method of assignment will occur:

    i. Matching Goal – the goal is to make the best assignment to the DSRIP hospital based on the beneficiary's current utilization patterns and assigned providers. If the project specifically targets IPPs that have a responsibility for beneficiaries due to assignment through an enrollment process (PCPs, HHs, and NFs), the provider with the current assignment will be matched regardless of past utilization of services. Otherwise, the DSRIP hospital and its IPPs that have provided a higher proportion of qualifying services for the beneficiary will be assigned the beneficiary.
    ii. Service Groupings – To meet this goal, the methodology will aggregate beneficiary service volume across four different groups of services (depending upon the identified project) and assign attribution using a defined hierarchy such as:
        - 1st priority – assigned providers (PCPs, HHs, NFs)
        - 2nd priority – other outpatient providers (specialists, behavioral health)
        - 3rd priority – emergency department (ED);
        - 4th priority – inpatient hospitalization.
    iii. Attribution Method – Once the identified project's network of providers (DSRIP hospital and associated IPPs) is finalized, the network will be loaded into the attribution system for beneficiaries to be assigned based on the above matching methods and service groupings. Depending on the specific project's hierarchical prioritization, the first step may be to try to assign a beneficiary to a DSRIP provider network based on enrollment/assignment to any of the project's IPPs. If no beneficiary assignments with the IPPs exist, the algorithm would move on to tally the number of services received by the beneficiary from IPPs that are other outpatient providers (specialists, behavioral health). The beneficiary would be assigned to the provider network with the most IPP services provided. If no outpatient provider visits, the algorithm would proceed to look for ED visits at

EDs within the project network. If no ED visits, the algorithm would look for hospitalizations at hospitals within the project network.

iv. Finalizing Match and Ties – For beneficiaries that have an equal amount of services based on the highest applicable service priority, the algorithm will tally total services for the beneficiary among all service priorities for each DSRIP project network. The network that has provided the most services to the beneficiary will be assigned the beneficiary.

Section 3. Hospital DSRIP Plan Requirements

Each participating hospital submitted an individual hospital DSRIP plan that identifies the projects, population-focused objectives, and specific metrics adopted from Section 3 and 4 of this planning protocol. DSRIP plans must meet all requirements pursuant to STC 69 (g).
Hospital DSRIP plans must be submitted in the structured format described in Attachment C and must include the following sections:

a. Executive Summary

The Executive Summary shall provide a summary of the hospital DSRIP plan, a summary of the hospital's vision of delivery system reform, and a table of the projects included in the plan, including project titles, brief descriptions of the projects, and goals.

b. Background Section

The background section shall include, at a minimum, a summary of the hospital's community context, a description of the hospital's patient population, a description of the health system, a description of challenges facing the hospital, and the goals and objectives of its DSRIP plan. The background section also shall include a brief description of any initiatives in which the hospital is participating that are funded by the U.S. Department of Health and Human Services and are directly related to any of the hospital's DSRIP projects.

Specifically, the background section will include the following components:

1) **Provider Demographics** including:
   a) Name, Address, Senior level person responsible for the DSRIP project and to whom all correspondence should be addressed
   b) The name of community partners participating in each project Definition of service area and the name of the community partners participating in the project that will be used for the purpose of attributing members for calculating metrics, according to the method described in 2.d above.

2) Identification of Need for Project:
The participating hospital will need to provide objective data-driven evidence that this is a relevant goal for the participating hospital and its service area. The participating hospital must demonstrate that all relevant Category 3 metrics for the projects selected align with community needs and that these areas have room for improvement by

submitting baseline data on its Category 3 metrics at the time of application. If the participating hospital's baseline performance on the majority of any chosen Category 3 metric set is within 10 percentage points or 1.5 standard deviations to the high performance goal (whichever is greater) , the project would not be approved.

Participating hospitals should also include brief rationale for project choice and summary (including citations) of existing evidence showing that project can lead to improvement on goals of project. Logic models such as driver diagrams may be helpful to demonstrate how the elements of the project all contribute to the central goals.

3) Public Input

The DSRIP plan should include documentation of collaboration with local departments of public health, public stakeholders and consumers. In addition, the participating hospital will need to document how there will be ongoing engagement with the community stakeholders, including active participation in any regional health planning activities currently underway in their community. Participating hospitals will need to include workers and their representatives in the planning and implementation of their overall project. Participating hospitals will (in collaboration with the state) maintain a website including contact information, overview of public comment opportunities, results of public processes, application materials, and required reporting.

c. Project Descriptions

Pursuant to STC 69 (g) (ii), each hospital shall include a narrative for each project that describes the following elements of the project:

1) Goals

This section should provide a description of the goal(s) of the project, which describes the specific challenges of the hospital system and the major delivery system solution identified to address those challenges by implementing the particular project. Analytics should be included to support these conclusions specific to the hospital.

2) Expected Results

The expected results section should provide a description of the target goal over the demonstration approval period, metrics associated with the project and the significance of that goal to the hospital system and its patients.

3) Rationale

The hospital DSRIP plan must include a narrative on the hospital's rationale for selecting the project, milestones, and metrics based on relevance to the hospital system's population and circumstances, community need, and hospital system priority and starting point with baseline data.

4) Relationship to Other Projects

The plan must also include a narrative describing how this project supports, reinforces, enables and is related to but does not duplicate other projects and interventions within the hospital system.

The participating hospital will submit a description of any initiatives that the provider is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiative currently in place. The participating hospital will, by signature, attest that the submitted DSRIP project is not a duplication of a project from these other funded projects and does not duplicate the deliverables required by the former project (s). It should be noted if this project is built on one of these other projects or represents an enhancement of such a project that may be permissible, but it must be clearly identified as such in the DSRIP project plan.

5) Rapid cycle evaluation

The plan must include an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to report to CMS on a rapid cycle basis.

6) **Budget**: Participating Hospitals must provide a detailed budget for all 3 years of their DSRIP project.

7) **Governance:** The plan must include a detailed description of how the participating hospital and its community partners will be governed and how they will evolve into a highly effective Integrated Delivery System. A clear corporate structure will be necessary and all providers that participate in the project will need to commit to the project for the life of the waiver.

8) **Data sharing and confidentiality**: Metrics will be collected in a uniform and valid fashion across the participating hospital and its community partners. As a result, the plan must include provisions for appropriate data sharing arrangements that permit this and appropriately address all HIPPA privacy provisions. **Expectation of Sustainability:** Participating hospitals are asked to explain how the outcomes of this project will be sustained at the end of DSRIP and how gains can be continued after the conclusion of the project period.

d. Project Milestones and Performance Indicators Table

For each project, participating hospitals submitted milestones from Categories 1-4 for each demonstration year. The milestones and required performance indicators must be adopted in accordance with STC 69 (c) and (d).

e. Funding Estimates

The DSRIP project valuation will be described in the DSRIP plan and will be calculated by the state according to the methodology described in section 4 below.

Section 4. Project Valuation

a. Valuation for each project

The state will calculate a valuation for each DSRIP project according to the following method:

Step 1: Base Valuation

Each hospital's projects will be assigned a base, three-year valuation proportionate to the total amount of DSRIP funds available to each hospital, per demonstration year. For each DSRIP hospital, the base valuation is 75 percent of the total demonstration year funding. The following table is the sum of all projects in each pool.

Project Base Valuation								
DSRIP Hospital	**Base Value Proportion**	**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**	**DY 8**	**Total**
LPTH Pool	75%	5,625,000	11,250,000	16,875,000	16,875,000	16,875,000	16,875,000	84,375,000
BCCH Pool		1,875,000	3,750,000	5,625,000	5,625,000	5,625,000	5,625,000	28,125,000
	Total	7,500,000	15,000,000	22,500,000	22,500,000	22,500,000	22,500,000	112,500,000

Step 2: Secondary Valuation

Hospitals will be eligible for secondary valuation payments based the number of Medicaid/CHIP beneficiaries served through the project, and the percent of patients primarily served by external community partners.

The secondary valuation will be applied as follows:

- Partner valuation payments: 15 percent secondary payment valuation if at least 20 percent of the patients served through the project are affiliated with external community partners.
- Trailblazer valuation payments: 10 percent secondary payment valuation for including outreach and capacity-building components that disseminate the project's outcomes and methods to rural and underserved areas of Kansas in order to expand access to best practices.

			Secondary Project Valuation						
DSRIP Hospital	**"Partner" Secondary Value Proportion**		**DY 3**	**DY 4**	**DY 5**	**DY 6**	**DY 7**	**DY 8**	**"Partner" Total**
LPTH Pool	15%		1,125,000	2,250,000	3,375,000	3,375,000	3,375,000	3,375,000	16,875,000
BCCH Pool			375,000	750,000	1,125,000	1,125,000	1,125,000	1,125,000	5,625,000
	Subtotal		1,500,000	3,000,000	4,500,000	4,500,000	4,500,000	4,500,000	22,500,000

DSRIP Hospital	"Trailblazer" Secondary Value Proportion	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	"Trailblazer" Total
LPTH Pool	10%	750,000	1,500,000	2,250,000	2,250,000	2,250,000	2,250,000	11,250,000
BCCH Pool		250,000	500,000	750,000	750,000	750,000	750,000	3,750,000
	Subtotal	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	15,000,000
	Total	2,500,000	5,000,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000

Step 3 Calculation of Total Value

The total value for a project will be the sum of the base valuation plus the secondary values.

b. DSRIP Allocation

A total of $60 million is allocated for the Kansas DSRIP as specified below:

DSRIP Program	Funding Allocation	DY 3	DY 4	DY 5	DY 6	DY 7	DY 8	Total
LPTH (KU Hospital)	75%	7,500,000	15,000,000	22,500,000	22,500,000	22,500,000	22,500,000	112,500,000
BCCH (Children's Mercy Hospital)	25%	2,500,000	5,000,000	7,500,000	7,500,000	7,500,000	7,500,000	37,500,000
		10,000,000	20,000,000	30,000,000	30,000,000	30,000,000	30,000,000	150,000,000

c. Milestone Valuation

Once the overall project valuation is set,	Payment Type	DY 3 2015	DY 4 2016	DY 5 2017	DY 6 2018	DY 7 2019	DY 8 2020
Project Category 1 (Infastrusture Milestones)	Performance / Reporting	45%	25%	10%	10%	10%	10%
Project Category 2 (Process Milestones)	Performance / Reporting	30%	25%	20%	20%	20%	20%
Project Category 3 (Quality and Outcome	Performance	5%	25%	45%	45%	45%	45%
	Reporting	10%	10%	5%	5%	5%	5%
Project Category 4 (Population Focused Improvement Milestones)	Performance	0%	5%	15%	15%	15%	15%
	Reporting	10%	10%	5%	5%	5%	5%

Section 5. Hospital Plan Review Process

a. Overview of Review Responsibilities

Each DSRIP hospital submitted a plan in accordance with the DSRIP Plan guidelines outlined in this protocol and the demonstration's Special Terms and Conditions. Participating hospitals are expected to provide accurate information in their DSRIP plans and respond to the state and CMS' requests for additional information and/or plan revisions in accordance with the timelines specified.

The state is responsible for reviewing all DSRIP plans using a CMS approved checklist and other review process requirements described below. The state's review will be supplemented by a review of the state's External Quality Review Organization (EQRO), which should inform the state whether to approve a DSRIP plan.

CMS will monitor the state's review process sand approve projects in accordance with section (c) below.

b. State Review Process

KDHE members of the DSRIP Project Team will review the Plans, using the following checklist:

- The plan is in the format and contains all required elements outlined in the Kansas DSRIP Planning, Funding and Mechanics Protocols and is consistent with STC 69.
- All projects clearly identify Category 1, 2 and 3 milestones as described in STC 69 (c)(i-iii)
- All projects clearly identify the population focused health improvement measures (Category 4) to be reported.
- The description of the project is coherent and comprehensive and includes a logic model clearly representing the relationship between the goals, the interventions and the measures of progress and outcome
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim), and while at the same time charting a path towards future sustainability.
- The likelihood for success of this intervention is based on, where available, accurate and robust citations to the evidence base.
- The plan includes an approach to rapid cycle evaluation that informs the system of progress in a timely fashion, and how that information will be consumed by the system to drive transformation and who will be accountable for results, including the organizational structure and process to oversee and manage this process. The plan must also indicate how it will tie into the state's requirement to

report to CMS on a rapid cycle basis.

- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- The amount and distribution of funding is in accordance with STC 69 (g)(iii) , STC 70 and Section 8 of this combined protocols document
- The proposed projects are new or significantly enhance existing health care initiatives and do not duplicate other CMS and Department of Health and Human Services (HHS) funded initiatives in which the hospital participates
- The plan and all of the projects proposed are consistent with the overall goals of the DSRIP program

The ultimate decision on State approval will rest with the Secretary of KDHE and State Health Officer.

In in collaboration with its EQRO, KDHE will complete its initial review of each timely submitted Hospital DSRIP Plan and will respond to the hospital in writing with any questions or concerns identified. The hospital must respond in writing to any notification by KDHE of questions or concerns. The hospital's response must be received by KDHE within 3 business days of that notification. The hospital's initial response may consist of a request for additional time to address KDHE's comments; however, the hospital's revised plan must address all of KDHE's comments.

The state's EQRO will make an independent assessment of all DSRIP projects submitted and KDHE will take action on each hospital-specific DSRIP plan, approving each plan that it deems satisfactory according to the criteria outlined above. KDHE will then submit approved plans to CMS for final review and approval by September 30. Any deviations from the external quality review organization's recommendations should be clearly explained to CMS.

c. CMS Review

The State will submitted hospital DSRIP plans to CMS before September 30, 2014 for CMS review.

In addition to approving the review protocol, CMS reviewed the plans to determine whether the protocol was followed, identified any systematic gaps between the protocol and the actual reviews, and will provided such findings to the state to address these gaps in reviews by the independent assessor and by the state. CMS found the reviews were consistent with the review protocol and CMS accepted the state's recommendations for approval with the following possible exceptions which will be applied at CMS's discretion:

i. The state's decision about approval is not consistent with the EQRO finding
ii. There is evidence in the plan, or exogenous information made available to CMS that calls into question of funding duplication; and
iii. There is evidence in the plan, or exogenous information made available to CMS calls into question whether the project is new or significantly expanded or enhanced from a project already underway

CMS will completed its review before December 31, 2014. CMS reserves the right to

conditionally approve plans, and to allow modifications to plans to resolve issues it identifies in its review provided that the modifications are made to the plan and found acceptable by CMS according to the timeline provided by CMS.

Section 6. Reporting Requirements and Ongoing Monitoring

Performance management and assessment of DSRIP will occur throughout its duration and will take several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning. The final DSRIP plans will provide the basis for monitoring each project.

1. As described in (a) below, participating hospitals will submit semi-annual reports and annual reports to the state using a reporting template developed by the state to document progress on milestones (for DSRIP payments) and to provide timely and actionable feedback on the initiative's progress, in terms of infrastructure changes, implementation activities and outcomes.
2. As described in (b) below, a learning collaborative will be implemented to discuss hospital input on project level development of action plans, implementation approaches and project assessment.
3. As described in (c) below, in addition to monitoring, an interim and final summative statewide evaluation of DSRIP will be completed by the independent evaluator to examine the effect of DSRIP activities on achieving the State goals. Among other things, the interim evaluation will provide broad learning both within the state and across the nation. Part of this interim evaluation will examine issues overlapping with ongoing provider-level evaluations, and part of this effort will examine questions overlapping with the final evaluation.

a. Semi-annual reports

Two times per year, DSRIP hospitals shall submit reports to the state and CMS. Semi-annual and annual reports must be submitted demonstrating progress on DSRIP projects. These reports will serve as the basis for authorizing incentive payments to each hospital for achievement of DSRIP metrics. Category specific metrics achieved during each reporting period will be measured. The reports shall be submitted using the standardized reporting forms approved by KDHE-DHCF and CMS. The following shall be included in the reports:

- Data on progress made for all Demonstration year metrics
- Narrative description of the project completion progress, lessons learned, challenges faced and other pertinent findings
- Copy or list of all data sources and supporting documentation as identified per metric in the hospital's approved DSRIP plans to demonstrate achievement of each metric for which the hospital is seeking payment

The state must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital. A hospital may only receive DSRIP payments following the successful achievement of metrics as reflected in its reports and as approved by the state. If the state determines the hospital did not fully and successfully achieve a metric, payment

to the hospital for that metric will not be issued. DSRIP hospitals will have all supporting documentation available for review by the state, if requested.

The timeline for the hospital reporting process, the state and CMS review process, and the state payment process will be as follows:

	Report Period Begin Date	Report Period End Date	CMS Report Review Due Date	Payment Due Date
DY 3 Semi - Annual	1/1/2015	6/30/2015	9/30/2015	10/31/2015 *
DY 3 Annual	1/1/2015	12/31/2015	3/30/2016	4/30/2016
DY 4 Semi - Annual	1/1/2016	6/30/2016	9/30/2016	10/31/2016 *
DY 4 Annual	1/1/2016	12/31/2016	3/30/2017	4/30/2017
DY 5 Semi - Annual	1/1/2017	6/30/2017	9/30/2017	10/31/2017 *
DY 5 Annual	1/1/2017	12/31/2017	3/30/2018	4/30/2018
DY 6 Semi - Annual	1/1/2018	6/30/2018	9/30/2018	10/31/2018 *
DY 6 Annual	1/1/2018	12/31/2018	3/30/2019	4/30/2019
DY 7 Semi - Annual	1/1/2019	6/30/2019	9/30/2019	10/31/2019*
DY 7 Annual	1/1/2019	12/31/2019	3/30/2020	4/30/2020
DY 8 Semi - Annual	1/1/2020	6/30/2020	9/30/2020	10/31/2020*
DY 8 Annual	1/1/2020	12/31/2020	3/30/2021	4/30/2021
** Payment crossses state fiscal year, encumbrance may be required*				

Note: Because many category 2, 3, and 4 metrics are annual measures, these annual measures will only be available to be reported once a year for purposes of authorizing and determining incentive payments.

b. Rapid Cycle Evaluation

The DSRIP program will support a process of data-driven, rapid cycle improvement that will gather data in real time and make recommendations to the State, CMS and hospitals about how to ensure timely progress in promoting the overall goals of the DSRIP program. As previously noted, these goals are: healthy living; healthy communities; and access to services. Each Hospital DSRIP Plan will address their process for continuous performance improvement in order to improve efficiencies, quality and experience while reducing or eliminating inefficiencies, waste and redundancies. Upon completion and approval of the Hospital Plans, the State and the external evaluator developed the process for rapid cycle evaluation for the DSRIP program overall by submitting a learning collaborative plan to CMS before March 1, 2015.

The Learning Collaborative will be managed by the state and the EQRO designee through both virtual and in-person collaboration that both builds relationships as well as facilitates project analysis and measurement. The Learning Collaborative will be designed to promote and perform the following:

1. Sharing of DSRIP project development including data, challenges, and

proposed solutions
2. Collaborating based on shared ability and experience
3. Identifying key project personnel
4. Identification of best practices
5. Provide updates on DSRIP program and outcomes
6. Encourage the principles of continuous quality improvement cycles

An example of a process framework for continuous performance improvement, or rapid cycle improvement, is the "Model for Improvement," developed by the Associates in Process Improvement[1] and used by the Institute for Healthcare Improvement (IHI). This model has two parts:

- Three fundamental questions, which can be addressed in any order.
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What changes can we make that will result in improvement?
- The Plan-Do-Study-Act (PDSA) cycle[2] tests changes in real work settings, by planning it, trying it, observing the results, and acting on what is learned.
- After testing the change, learning from each test, and refining the change through PDSA cycles, the change would be implemented on a broader scale, or at a minimum the findings would be disseminated to allow other providers to learn from DSRIP.

The semi-annual and annual hospital report requirements will also include instruction for the hospitals to provide descriptions of rapid cycle evaluations that occurred during the previous six month timeframe and any planned evaluations or changes during the upcoming timeframe. While the hospitals must submit semi-annual and annual reports to the State, more frequent evaluation

[2]Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

[3] The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

[2] The Plan-Do-Study-Act (PDSA) cycle was originally developed by Walter A. Shewhart as the Plan-Do-Check-Act (PDCA) cycle. W. Edwards Deming modified Shewhart's cycle to PDSA, replacing "Check" with "Study." [See Deming WE. *The New Economics for Industry, Government, and Education*. Cambridge, MA: The MIT Press; 2000.]

will occur by the hospitals, State and the external evaluator. DSRIP meetings will occur, at least on a quarterly basis, with the hospitals, State, and external evaluator. During these meetings, rapid cycle evaluation and improvement will be discussed relevant to the various hospital processes and interim data points. These discussions will facilitate identification of potential issues that could interfere with the success of DSRIP improvement projects and plans, and assure changes are in place to help the hospitals successfully reach the outcome measures/milestones of each plan.

c. Independent Evaluation of DSRIP Program and Projects

The DSRIP evaluation will include review of process and outcome measures related to milestones identified in Categories 1 through 4. Quantitative and qualitative data sources will be used in calculation of the process and outcome measures. The DSRIP evaluation plan (see table below)

will be more fully designed once specific DSRIP project documents are further developed. The Kansas Foundation for Medical Care, Inc has been contracted with as the external evaluator, in accordance with STC 69 (e) vi.

At a minimum, the evaluation will address the following questions:

1. Were the participating hospitals able to show statistically significant improvements on measures within Categories 1 through 3 related to the goals of the three part aim: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement?
2. Were the participating hospitals able to show improvements on measures within Category 4 related to the goals of the three part aim?
3. What is the impact of health care delivery system and access reform measures on the quality of care delivered by participating providers?
4. What is the impact of DSRIP on managing short and long term per-capita costs of health care?
5. How did the amount paid in incentives compare with the amount of improvement achieved?
6. How did the performance of hospitals participating in DSRIP compare with the performance of other hospitals in the state and/or another appropriate comparison group?

Section 7. Disbursement of DSRIP funds

a. General principles

Aggregate incentive payments available over the 6 year demonstration period will be based on the project valuation approved by the state, subject to the limits set forth in section 4.c. above. DSRIP payments for each participating hospital are contingent on:

- The hospital fully meeting project milestones defined in the approved hospital-specific Hospital DSRIP Plan; and
- KDHE certifying the hospital's achievement of a given milestone, subject to CMS review.

In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the Section 6 of this document, and the result must be certified by the state, and is subject to CMS review.

Hospitals will not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.

b. Incentive Payment Formula

Hospitals will receive DSRIP payments based on achievement of reporting milestones for projects. This is Pay for Reporting. Hospitals will receive DSRIP payments based on achievement of performance targets for metrics. This is Pay for Performance.

Within each project, the value for achieving each performance metric or milestone is the same (evenly weighted) and will be calculated as "meeting" or "not meeting" the milestone or metric. The points given for reaching a specified milestone or metric will be called an "Achievement Value" and will be calculated as a 0 or 1 value.

If a milestone or metric is met, the hospital will receive an Achievement Value of 1 for in the reporting period. If the hospital does not meet a milestone or metric, it will receive an Achievement Value of 0 for that reporting period. This will be done across every project in every category.

Hospital improvement metric targets will be established annually using baseline data for DY 3 and then annually thereafter for DY 4-8, as described in section 2.c above. The Achievement Value for Pay for Performance metrics will be established by comparing the hospital results for the reporting period with the improvement target for the hospital. If the hospital meets the improvement target for the metric, the hospital will receive an AV of 1.

Achievement Values will then be grouped into either a Pay for Reporting or a Pay for Performance classification for each category. The Pay for Performance and Pay for Reporting Achievement Values in each category will be summed to determine the Total Achievement Value for the category. A Percentage Achievement Value will then be calculated by dividing the Total Achievement Value by the maximum Achievement Value (the total number of metrics) for Pay for Performance and Pay for Reporting in each category. The Percentage Achievement Value will demonstrate the percentage of achieved metrics within the Pay for Reporting and Pay for Performance metrics for each category for that reporting period.

Example: A Participating Hospital has a project in year one with a project level valuation of $100,000 for year one. If the Participating Hospital achieves two out of five of its metrics/milestones for that project it would receive 40 percent of the $100,000 or $40,000. The metrics/milestone value would be assigned Achievement Values and Percentage Achievement Values as follows:

Metric/Milestone	Achievement	Achievement Value
Milestone 1	Achieved	1
Milestone 2	Achieved	1
Milestone 3	Not Achieved	0
Milestone 4	Not Achieved	0
Milestone 5	Not Achieved	0
	Total Achievement Value	2
	Percentage Achievement Value 2/5	40%

The Percentage Achievement Value will be used to determine the level of the total payment the hospital has earned for that reporting period based upon the performance payment distribution provided under the metric valuation. The level of payment for a hospital within a category will be proportionate to the Percentage Achievement Value allocated to that category.

If either the state or CMS determines that a hospital has failed to meet its approved metric, no incentive payment will be made. A hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the entire associated incentive payment. There will be no payment for partial fulfillment of a performance metric (on a metric-by-metric basis).

c. Non-Duplication of Federal Funds

Each DSRIP hospital will be required to provide to the state all of the CMS and HHS funded initiatives in which they participate. Also, each hospital will provide a detailed explanation of how it proposes DSRIP activities are not duplicative of HHS funded activities.

Unique accounting codes will be created within the state accounting system and assigned to DSRIP Pool payments as an additional means to ensure the selected DSRIP project funding does not duplicate existing or future federal funding.

Kansas will claim federal financial participation (FFP) for all DSRIP payments. FFP will only be available for DSRIP payments made in accordance with all pertinent STCs, including Attachment F DSRIP Planning Protocol and Attachment G DSRIP Funding and Mechanics Protocol.

All DSRIP project plans are subject to audits. The state will report DSRIP payments to CMS on the CMS 64.9 waiver form on a quarterly basis, using a specific waiver group set-up exclusively for DSRIP payments.

Pursuant to STC 76, STC 79 and STC's 80 through 84, DSRIP will be a component of the state's quarterly and annual operational reports related to the demonstration. These reports will include:

All DSRIP payments made to hospitals that occurred in the quarter

- Expenditure projections reflecting the expected pace of future payments for each hospital
- A summarized assessment of each hospital's DSRIP project activities during the given reporting period
- Planning, evaluation activities and interim findings pursuant to the reporting requirements outlined in section XI of the Demonstration's STCs

The LPTH and BCCH shall have available for review, by the state and CMS upon request, all documentation evidencing performance as described under the hospital's plan for DSRIP incentive payments. Failure of the LPTH or BCCH to maintain adequate documentation or inaccurate reporting of data may result in recoupment of DSRIP payments.

Section 8. DSRIP Plan Modifications in Limited Circumstances

No more than once a year, participating hospitals may submit proposed modifications to an approved DSRIP project plan for state and CMS review. These modifications may not decrease the scope of the project unless they also propose to decrease the project's valuation. The state and CMS will follow the same review process described in section 5 above.

Reasons to approve a plan modification request that will be considered are:

- New federal or state policies are implemented that impact a DSRIP project and a hospital seeks to update the affected project to reflect the new environment
- New national data definitions for a measure have been implemented that impact a DSRIP project and a hospital seeks to update the affected project to reflect the new standards
- Other acceptable reasons, subject to review and approval by KDHE and CMS, that are reasonable and support the goals of the DSRIP program

CMS may require that a plan be modified if it becomes evident that the previous targeting or estimation is no longer appropriate or that targets were greatly exceeded or underachieved. This process does not allow modification for failure to comply with the STCs 69 and 70 or the requirements contained in this document.

ATTACHMENT H

Ombudsman Plan

The following report was submitted by the state of Kansas on November 26, 2012, as a part of CMS' KanCare review. This report describes the qualified independent, conflict-free entity which will assist KanCare enrollees in the resolution of problems and conflicts between the MCOs and participants regarding services, coverage, access and rights. The Ombudsman should help participants understand the fair hearing, grievance, and appeal rights and processes at each MCO and proactively assist them through the process if needed. Ombudsman activities are available to all demonstration eligible populations, but specific focus and outreach activities will be directed towards KanCare enrollees utilizing LTSS (institutional, residential and community based). (see STC 36).

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Robert Moser, MD, Secretary
Kari Bruffett, Director

Sam Brownback, Governor

KanCare Implementation Activity: KanCare Consumer Ombudsman
Date Updated: Dec. 5, 2012

Purpose:
The ombudsman will help Kansas consumers enrolled in a KanCare plan, with a primary focus on individuals participating in the HCBS waiver program or receiving other long term care services through KanCare.

The ombudsman will assist KanCare consumers with access, service and benefit problems. The ombudsman will provide information about the KanCare grievance and appeal process that is available through the KanCare plans and the State fair hearing process, and assist KanCare consumers seek resolution to complaints or concerns regarding their fair treatment and interaction with their KanCare plan.

The ombudsman will:

- Help consumers to resolve service-related problems when resolution is not available directly through a provider or health plan.
- Help consumers understand and resolve billing issues, or notices of non-coverage.
- Assist consumers learn and navigate the grievance and appeal process at the KanCare plan, and the State fair hearing process, and help them as needed.
- Assist consumers to seek remedies when they feel their rights have been violated.
- Assist consumers understand their KanCare plan and how to interact with the programs benefits.
- Serve as a point of contact and resource for legislative and other inquiries into the provision of LTSS in managed care.

Organization:
The KanCare Ombudsman will be located in the Kansas Department for Aging and Disability Services (KDADS). The Ombudsman will be organizationally

independent from other KDADS commissions which set and direct Medicaid program, and reimbursement policy. The Ombudsman will receive administrative and legal support from the Office of the Secretary division of KDADS.

The Ombudsman will make an annual report to the legislature detailing the activities of the office and other relevant information related to the provision of LTSS in KanCare.

Personnel:
Recruitment of candidates for the Ombudsman position began November 12. Interviews are scheduled for the week of November 26. The Ombudsman will be selected and hired by January 1, 2013.

Program and Training:
Initially, the Ombudsman will be trained on the grievance and appeals process available through the KanCare plans, and the State fair hearing process, as well as the utilization management policies and procedures adopted by the KanCare plans, State Medicaid policy and the State contract governing the KanCare plans.

Additionally, the Ombudsman will receive orientation covering Kansas eligibility processes, KanCare covered benefits, and care coordination.

The Ombudsman will work with consumers and providers in distributing information about the Ombudsman services. Contact information for the Ombudsman will be provided through state processes and contractors such as eligibility offices, KanCare hotline and mailings, Aging and Disability Resource Centers, KanCare member materials, and consumer and provider advocates. In addition to assisting consumers with the items listed in the overview, the Ombudsman will provide information, assistance, and referrals to consumers with issues not covered in the Ombudsman's scope of work.

Supporting Resources:
The Ombudsman will be presented as a source for assistance when a consumer cannot find an acceptable outcome by speaking directly with their KanCare plan, or through the normal processes. While the Ombudsman will be trained on eligibility criteria and covered benefits, the State does not expect the Ombudsman's office to be the first contact for all such questions. The state's enrollment broker, MCO call centers, State eligibility staff, and the ADRC are established resources for member inquiries. Similarly, while the Ombudsman will assist individuals exercise their rights to the grievance and appeals process, the Ombudsman is not expected to file or represent the consumer in the grievance or appeal. The Ombudsman will assist in mediating those cases that cannot be handled by state eligibility case workers, hotline staff, or the ADRC, when assistance is needed in starting a grievance or appeal, and when satisfaction cannot be obtained through the grievance and appeals processes.

There have not been calls for an Ombudsman program for the current managed care population, suggesting the new Ombudsman's efforts will likely be focused on the new populations entering managed care. The following additional resources can be added as needed:

In the event contacts with the Ombudsman office exceed capacity of the full time Ombudsman, up to five administrative positions can be reallocated to assist in providing information and referral services to consumers seeking assistance with issues that may be properly addressed by other entities. These administrative positions may be supported by 40 QM staff with training and knowledge of the waiver systems. Administrative staff and QM support will identify and transfer appropriate cases to the Ombudsman.

Additionally, the Ombudsman will receive legal support through the office of the Secretary. The office of the Secretary includes nine legal staff that can support the Ombudsman with legal research and information.

These resources will be made available to the Ombudsman as need develops and may be deployed within five business days.

Following the implementation and transition to KanCare, the Ombudsman will develop volunteer resources in the state to assist in one-to-one assistance and other cases.

Policy and Advocacy:
As noted, the Ombudsman will advocate for the rights and proper treatment of KanCare consumers through direct involvement and mediation with consumers, State policy divisions, and KanCare plans. Additionally, the Ombudsman will represent the Secretary of KDADS on consumer councils and focus groups convened by the KanCare plans, and provide the Secretary with counsel on suggested policy changes or additions to enhance consumer protections and engagement under KanCare. The Ombudsman will present the Legislature an annual report detailing the activities of the office, summarizing major issues of concern, and present suggested policy changes or additions to enhance consumer protections and engagement under KanCare.

Coordination with Quality Oversight:
KanCare program quality and outcome performance will be monitored through an Interagency Monitoring Team, which includes program managers, contract managers, fiscal staff and other relevant staff/resources from both KDHE and KDADS. Key activities of the KanCare Ombudsman will be included as a critical component of monitoring the performance of MCOs and providers within the KanCare program, as part of the statewide quality improvement strategy and the operating protocols of the Interagency Monitoring Team.

ATTACHMENT I
Verification of Beneficiary's MCO Enrollment

Members are encouraged to contact the Kansas Member Services team for help with any questions, including inquiries about their eligibility. Member Services answers member calls live between the hours of 8 AM and 8 PM CST, Monday through Friday. Additionally, providers have the opportunity to contact Provider Services toll-free number 24 hours/7 days a week to access the *Self Service* tool, which provides eligibility information over the phone through an automated system.

Each MCO maintains multiple avenues for members and providers to verify coverage for a member including secure portals available on the MCO's website with 24/7 access, phone lines staffed during regular business hours and automated phone systems. MCO provider and member service staff receive training to access enrollment and eligibility information through use of the Kansas Medcial Assistance Program (KMAP) website. The MCOs are responsible for supplying members and providers with guidance for accessing portals, phone numbers and contact information in member and provider manuals and as requested.

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ATTACHMENT I
Verification of Beneficiary's
MCO Enrollment

The State's enrollment broker provides multiple options for verification of eligibility and enrollment into a plan through the current Kansas Medical Assistance Program (KMAP) system. KMAP has been the system used by providers over the past decade to access information related to eligibility, managed care enrollment, claims status, and other information. KMAP will provide the following access points for entities to verify a beneficiary's eligibility and KanCare enrollment in absence of a Medicaid or KanCare MCO ID card. Different access points are available to different stakeholders such as MCOs, network/non-network providers or DHCF.

Access Point	Functionality	Availability	MCO	Providers		State	Fiscal Agent
				Network	Non-Network		
KMAP Secure Web Site	Entities enrolled with KMAP have access to the Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	X	X		N/A	N/A
State Secure Web Site	Approved users have access to the KMAP Secure Web Site realm used by enrolled MCOs and provider by accessing a dedicated State Secure Web site. Through the site, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth • Name and date of birth	22 hrs/day 7 days/week	N/A	N/A	N/A	X	X
Automated Voice Response	Entities enrolled with KMAP have access to the Automated Voice Response System by	22 hrs/day 7 days/week	X	X		N/A	N/A

System	dialing 1-800-933-6593. Through the phone line, a user can verify eligibility by keying a valid combination of the following: • Beneficiary ID and date of birth • Social Security No. and date of birth						
MMIS	Access to all Medicaid-related information by authorized users. Users would share information verbally with requesting entities.	22 hrs/day 7 days/week		N/A	N/A	X	X
KMAP Customer Service	All entities can reach a KMAP Customer Service agent by calling 1-800-933-6593 (provider) or 1-800-766-9012 (beneficiary).	8 am – 5 pm Monday - Friday	X	X	X	X	N/A
MCO Processes	The MMIS provides each MCO eligibility and enrollment information via the 834 to allow the MCO to share through their own access points.		N/A	X	X		

The following chart profiles the information returned by the various access points in response to eligibility or enrollment verification.

Access Point	KMAP Eligibility	MCO Enrollment		TPL Carrier			Medicare	
		Plan Name	Phone	Name	Address	Phone	Part A	Part B
KMAP Secure Web Site	X	X	X	X	X	X	X	X
State Secure Web Site	X	X	X	X	X	X	X	X
Automated Voice Response System	X	X	X	X	X	X	X	X
MMIS	X	X	X	X	X	X	X	X
KMAP Customer Service	X	X	X	X	X	X	X	X
MCO Processes	X	X	X	X	X	X	X	X

ATTACHMENT J
UC Pool: HCAIP Uniform Percentages

The table below provides the uniform percentages for the UC Pool (STC 53). Should the state elect to revise the uniform percentages for DY 1 and the inpatient net patient revenue threshold, the state must submit a revised Attachment J by April 30, 2013. The state must submit a revised version of this attachment to CMS by February 28th of DY 2 through 11 for review and approval.

	DY 1	DY 2	DY 3	DY 4	DY 5
Uniform Percentage	18.55%	14.65%	12.67%	11.13%	10.94
Specialty Service Uniform Percentage	3.72%	3.72%	3.72%	3.72%	3.72%
Tri-Level NICU Services Uniform Percentage	10.92%	10.92%	10.92%	10.92%	10.92%
Tri-Specialty Uniform Percentage	11.83%	11.83%	11.83%	11.83%	11.83%
Tri-Specialty Inpatient Net Patient Revenue Threshold		$300,000,000	$300,000,000	$300,000,000	$300,000,000
Date revised	3/27/2013	3/31/2014	3/31/2015	5/27/2016	5/3/2017

ATTACHMENT K
DSRIP Focus Areas

Proposed Focus Areas

Delivery System Reform Incentive Payment Pool

March 29, 2013

Overview of Delivery System Reform Incentive Program (DSRIP) Work in Kansas

Beginning in early 2013, State staff and partners from the two participating DSRIP hospitals (the University of Kansas Hospital and Children's Mercy Hospital) formed a DSRIP project team. The team includes the membership of the Kansas Department of Health and Environment (KDHE)'s Division of Health Care Finance Director Kari Bruffett, Medicaid Director Dr. Susan Mosier, and the Secretary of KDHE, Dr. Robert Moser. Additional project team members include staff from both DHCF and the Division of Health at KDHE. The project team will also utilize input from the State's External Quality Review Organization (EQRO) and actuarial contractors for specific program deliverables. The project team will work to ensure the DSRIP project is implemented on time and according to the requirements of the Special Terms and Conditions (STCs) of Kansas Medicaid's Section 1115 Demonstration Waiver.

The team completed the following initial projects:

- Preparing a timeline of required deliverables for the DSRIP program based on the STCs
- Developing an summary document of the DSRIP program to share with stakeholders and other interested parties
- Brainstorming focus areas and strategies for ensuring meaningful input from a variety of stakeholders.

Development of Draft Focus Areas

Bearing in mind the statewide emphasis of the DSRIP program, the project team considered the three-part aim of the Section 1115 waiver, the goals of DSRIP and how to best align these initiatives with the efforts already in process throughout Kansas. The Healthy Kansans 2020 (HK2020) initiative emerged as an important effort already underway to improve the health and health care delivery system in Kansas.

The Healthy Kansans Steering Committee began meeting in August of 2012. The Steering Committee is comprised of the leaders of more than 35 organizations across the state, and was gathered together to discuss the health issues facing Kansans. The Steering Committee used the Healthy People 2020 objectives as a springboard for discussion, but the primary focus was ensuring that the unique issues facing Kansas in the coming years were addressed. The Steering Committee represents a broad array of stakeholders in Kansas, and includes membership from health care providers, consumer groups, state and local government entities, and other groups. A list of Steering Committee members and their affiliated organizations is provided as Exhibit A to this report.

The result of the Steering Committee's efforts was a document identifying the cross- cutting themes and priority strategies that will be used to drive health improvement initiatives. A copy of this summary document is attached as Exhibit B to this report. Three cross-cutting themes (healthy living, healthy communities and access to services)

were identified by the HK2020 Steering Committee. Eleven priority strategies to drive health improvements in the three cross-cutting areas were selected.

Given the deliberate process, stakeholder engagement, and strategic focus of the HK2020 Steering

Committee's work, the DSRIP project team recognized a great opportunity to capitalize on the wealth of knowledge and experience that went into the development of the priority strategies. After consultation with additional DSRIP hospital stakeholders and partners at CMS, the DSRIP project team decided to use the priority strategies as a basis for the proposed DSRIP focus areas. The goal of this approach was to build upon the intentional, focused work that had already been completed in Kansas, and to provide a future path for meaningful integration of DSRIP projects across Kansas communities and the existing health system infrastructure across the state.

Using the priority strategies as a guide, the DSRIP project team then produced a draft list of focus areas to discuss with stakeholders. The draft focus areas attempted to capture the goals and strategies identified by the HK 2020 process, while translating them into a format that could easily be used for the development of actual DSRIP hospital projects in the future.

Stakeholder Input Process from the Healthy Kansans 2020 Steering Committee

After creating the draft focus areas for stakeholder input, the DSRIP project team worked with staff in KDHE's Division of Health to reconvene the HK2020 Steering Committee. The Steering Committee agreed to meet once more, this time with the DSRIP project team. The purpose of this meeting would be twofold: to provide input on the proposed focus areas, and to provide the Steering Committee with an example of how their priority strategies were already being put into practice in the State. To prepare for this discussion, the Steering Committee received information about the DSRIP program, background information on why their input was important and necessary for the program's success, and the draft version of focus areas produced by the project team.

On March 14, 2013, the DSRIP project team met to discuss and receive input from the Steering Committee on the draft focus areas. The meeting included several presentations designed to help participants understand what the DSRIP program is and how it relates to the HK2020 project. Participants heard information from Ms. Kari Bruffett of DHCF, who provided an overview of DSRIP, the program goals, funding involved, and requirements for participating hospitals and the state Medicaid program. Ms. Bruffett also went over the proposed focus areas for DSRIP and described how the HK2020 priority strategies were used in their development. Then each of the participating hospitals presented on past hospital projects that served as examples of how their organizations could produce meaningful impacts on the service delivery system statewide.

Later in the meeting, Steering Committee members broke out into smaller roundtable discussion groups to consider the following questions:

- Given what you have learned about DSRIP today, what is your reaction to the focus areas selected – are they the right ones?
- Does the way we have synthesized HK2020 priorities make sense for DSRIP?
- Are there issues from HK2020 that we should add to the DSRIP focus area list?
- Which of the focus areas is the best fit for DSRIP? Are there clear priorities? Some that do not fit as well?
- What would a quality improvement process, similar to what KU Hospital and Children's Mercy outlined today look like in your organization? Are you currently using HK2020 priorities in your organization's QI processes?
- How has your organization used HK2020 priorities to date in other ways (recognizing that the priorities are fairly "new")?
- What suggestions do you have for KDHE with regard to how to make HK2020 more inclusive and actionable with respect to achieving improved health outcomes (besides DSRIP)?

As evidenced by the discussion questions, the DSRIP project team and KDHE Division of Health staff members not only intended for the Steering Committee to assist in refining the focus areas, but also to consider how the priority strategies for HK2020 could find other practical applications throughout participants' organizations. DSRIP was an example of how the HK2020 process could provide the basis for actual system reform projects that will impact the health of Kansans.

Summary of Input

The roundtable discussions produced helpful insights and information for the DSRIP project team that was integrated into the proposed focus areas. Some input will also be helpful as the DSRIP project moves forward into the development of protocols and specific hospital DSRIP projects.

The list below summarizes the key areas of input provided by stakeholders. Overall, stakeholder participants expressed excitement over the DSRIP program, and the opportunity to work with the participating hospitals.

- Overall, participants expressed that the alignment and translation of KH2020 strategies into focus areas was appropriate.
- Participants generally expressed satisfaction with the focus areas, noting that they would allow for numerous projects and strategies for health improvement.
- The proposed focus areas were sufficiently broad to allow for innovation by the hospitals to create projects that will produce true reform.
- The focus areas should support the involvement of a variety of community partners, including community health providers, schools, local farmers' markets and other organizations.

- Disparate populations should not be lost in focus areas or DSRIP projects. Although they are not an explicit area of focus, the needs of these populations should be considered in any and all DSRIP projects.
- The focus areas should allow for projects that improve supports for the social and emotional development of children and families.
- Participants emphasized that the focus areas should allow the hospitals to work in their areas of expertise, and involve community partners for their expertise as well.
- Participants would like to see proposed DSRIP projects work toward eliminating silos in the care delivery system.
- Participants expressed their support for DSRIP projects that truly produce statewide impacts.
- The focus areas should allow for the inclusion of oral health and dental programs.
- Environmental factors (such as clean air and water programs) should be included in focus areas and projects as needed.
- The focus areas should produce projects that help make healthy choices for individuals easier and focus on prevention.

KDHE also sought and received volunteers from among the Steering Committee to advise the DSRIP project team through focused input on the DSRIP planning and funding and mechanics protocols, as well as specific hospital DSRIP plans.

Proposed Focus Areas

The list below comprises Kansas' proposed DSRIP focus areas. The focus areas have been revised according to the stakeholder input received.

- Increase access to services, including primary care and preventive services
- Increase the effective and efficient use of population health management through health information technology (HIT)
- Increase integration of the health care delivery system, including medical, behavioral health, and social services.
- Promote physical activity through encouraging and marketing the benefits of physical activity and expanding access and opportunities for physical activity
- Improve health literacy, including nutrition education and tobacco use prevention and control
- Expand health and wellness programs and develop incentives for participation in these programs
- Expand chronic and complex care management models
- Promote healthy communities, including access to clean air and water and healthy food and lifestyle choices

The DSRIP project team respectfully submits the above proposed focus areas and looks forward to future collaboration with the DSRIP hospitals, CMS partners, and other stakeholders for the DSRIP program.

EXHIBIT A: Healthy Kansans 2020 Steering Committee Members

Sector	Organization	Name
Aging	KS Dept on Aging & Disability Services	Shawn Sullivan
Academia	KU Preventive Medicine-KC	Dr. Ed Ellerbeck
Children & Families	KS Dept for Children & Family Services	Phyllis Gilmore
Clinical Health	KU Cancer Center	Dr. Gary Doolittle
	KS Hospital Association	Leonard Hernandez
	KS Hospital Association	Tom Bell
	KS Medical Society	Dr. Mark Synovec
	KS Medical Society	Jerry Slaughter
	KS Dental Association	Dr. Hal Hale
	KS Dental Association	Dr. Kevin Robertson
	KS Academy of Family Physicians	Dr. Chris Cupp
Commerce	Dept. of Commerce	Pat George
	Public Square Communities	Terry Woodbury
Crime & Justice	Dept. of Corrections	Ray Roberts
	Juvenile Justice Authority	Terri Williams
Disability	KS Commission on Disability Concerns	Martha Gabehart
Disparate Populations	KS Hispanic and Latino American Affairs Commission	Adrienne Foster
	KS Native American Affairs Office	Chris Howell
	KS African American Affairs Commission	Dr. Mildred Edwards
Education	KS Dept. of Education	Dr. Diane DeBacker
	KS Association of School Boards	Dr. John Heim
Food & Nutrition	KS Dept. of Agriculture	Dale Rodman
	KS Rural Center	Julie Mettenberg
	KU Dietetics & Nutrition	Dr. Debra Sullivan
	KU Preventive Medicine-Wichita	Judy Johnston
Health Care Delivery Systems	KS Insurance Dept.	Sandy Praeger
	BCBS (Private Insurance)	Matt All
HIE/HIT	KS Health Information Exchange	Dr. Joe Davison
Housing	KS Housing Resources Corp.	Dennis Mesa
Injury	Safe Kids Kansas	Dr. Jeffrey Colvin
Legislature	KS Senate	Sen. Laura Kelly
	KS Senate	Sen. Vicki Schmidt
	KS House	Rep. Barbara Ballard
	KS House	Rep. David Crum
	KS House	Rep. Don Hill
	KS House	Rep. Brian Weber
Philanthropic	Kansas Health Foundation	Steve Coen
	Sunflower Foundation	Billie Hall
	REACH Healthcare Foundation	Brenda Sharpe
	United Methodist Health Ministry Fund	Kim Moore

EXHIBIT A: Healthy Kansans 2020 Steering Committee Members

Physical Activity	KS Recreation & Parks Assoc.	Doug Vance
Public Health	KDHE	Dr. Robert Moser
	Kansas Health Institute	Dr. Robert St. Peter
	KS Assoc. Local Health Depts.	Michelle Ponce
	Urban Health Dept.	Claudia Blackburn
	Rural Health Dept.	Gina Frack
	Consultant	Shirley Orr
Transportation & Planning	KS Dept. of Transportation	Mike King
	Sedgwick County Board of Commissioners	Tim Norton

EXHIBIT B: Healthy Kansans 2020 Cross-Cutting Themes and Priority Strategies

HEALTHY KANSANS 2020

Working together, working smarter to routinely connect state and local partners across disciplines and sectors to enhance implementation of innovative systems and strategies, and improve individual and community well-being in Kansas by 2020.

Cross-cutting Themes and Priority Strategies

Healthy Living	Healthy Communities	Access to Services
• **Promote physical activity** (encourage and market the benefits of physical activity, expand access to public places for physical activity, expand opportunities for physical activity in schools and child care settings)	• **Promote access to healthy foods, and support policies that promote healthy food choices** (label healthy vending and menu options, encourage farmers' markets and expand access to target seniors and low income Kansans)	• **Improve access to services that address the root causes to poor health** (food insecurity, homelessness, low education, income and health literacy)
• **Promote healthy eating** (provide nutrition education to address low health literacy, encourage healthy eating through marketing materials, promote availability of healthy local foods)	• **Support policies that make the default choice the healthy choice** (policies that influence/support the adoption of healthy lifestyle behaviors, reduce prevalence of chronic disease, injury and rates of infectious disease, and support the quality and availability of child care)	• **Effectively and efficiently use population health management through health information technology (HIT)** (optimize use of electronic health records (EHR's) and health information exchange (HIE))
• **Develop incentives for Kansans to participate in health and wellness programs** (smoking cessation, weight loss, nutrition classes, chronic disease self-management)	• **Promote environments and community design that impact health and support healthy behaviors** (ensure access to clean air and water, promote adoption of complete streets designs, promote walking trails, bike trails and ensure safe housing free of lead, mold and radon)	• **Promote integrated health care delivery, including integrated behavioral health, social services and medical care** (patient-centered medical home, trainings for health professionals)
• **Promote tobacco use prevention and control** (cessation, policy and education)		
• **Improve supports for the social and emotional development of children and families** (healthy home visitors, mental health, bullying, parents as teachers, breastfeeding education and prenatal care)		
Kansans equipped to take an active role in improving their health and supporting their families and friends in making healthy choices.	**Kansans working together to impact the natural as well as human-formed conditions that influence health and/or risk for injury.**	**Kansans ready access to information and health and social services to achieve the best health outcomes.**

Attachment M
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

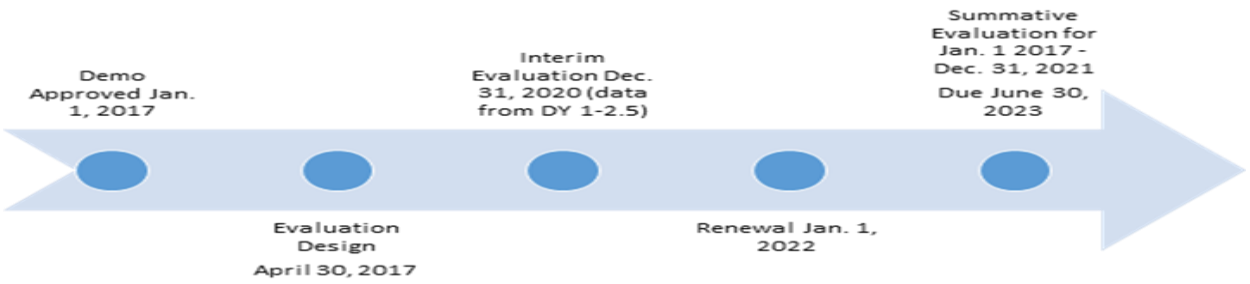
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references). This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
e. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations – CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment N:
Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

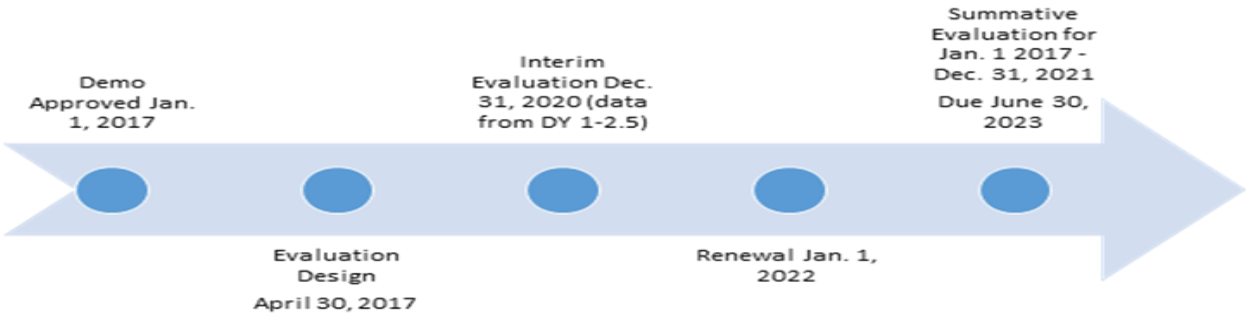
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;

D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2. Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.
An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section

should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design* – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations* – Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period* – Describe the time periods for which data will be collected
4) *Evaluation Measures* – What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic Methods* – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

KanCare 2.0 Evaluation Design

Revised per CMS feedback

January 17, 2020

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List of Tables and Figures

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A. General Background Information

KanCare, the Kansas statewide mandatory Medicaid managed care program, was implemented January 1, 2013, under authority of a waiver through Section 1115 of the Social Security Act. The initial demonstration was approved for five years, and the Centers for Medicare and Medicaid Services (CMS) approved a one-year extension on October 13, 2017. The State submitted the Section 1115 demonstration renewal application for the KanCare program, titled "KanCare 2.0," in December 2018.[1] CMS approved the renewal of the KanCare 2.0 demonstration for the period of January 1, 2019 through December 31, 2023.[2] The KanCare Evaluation Design was submitted within 180 days of the CMS approval, as required. The CMS review of the evaluation design was received November 18, 2019. This updated evaluation design submission incorporates modifications recommended by CMS. [3]

KanCare 2.0 is an integrated managed care Medicaid program that serves the State of Kansas through a coordinated approach. KanCare is operating concurrently with the State's Section 1915(c) HCBS waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aged, people with disabilities, and some individuals who are dually eligible). The KanCare managed care delivery system provides state plan and HCBS waiver services to Medicaid recipients statewide.[4]

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on home and community-based services (HCBS). Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid and Children's Health Insurance Program (CHIP) benefits.[1] KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. Services related to social determinants of *health* include addressing safe housing; food sources; educational, economic, and job opportunities; access to health care services; transportation options; community-based resources in support of community living; and opportunities for recreational and leisure-time activities. Services that address social determinants of *independence* are tailored to an individual's vision for their life, including areas such as career, community participation and contribution, and social/emotional connections. Strategies to achieve the enhanced goals of KanCare 2.0 include service coordination, the OneCare Kansas (OCK) program, value-based models and purchasing strategies, increasing employment and independent living supports, and telehealth (e.g., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 will expand upon care coordination to provide service coordination, which is a comprehensive, holistic, integrated approach to person centered care.[1] It allows for maximum access to supports by coordinating and monitoring all of an individual's care (acute, behavioral health, and LTSS) through direct interventions, provider referrals, and linkages to community resources. Case management, disease management, discharge planning, and transition planning are also elements of service coordination.

OCK is a care management service model, based on the health home model, where all professionals involved in a member's care communicate with one another so that the member's medical and behavioral health and social service needs are addressed in a comprehensive manner. The coordination of a member's care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to optimize member health.

Value-based models and purchasing strategies will include provider payment and/or innovative delivery system design methods between MCOs and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs. Also, in 2021, the Delivery System Reform Incentive Payment (DSRIP) program will transition to an Alternative Payment Model (APM) approach, shifting from DSRIP project-based metrics to APM

provider-based quality and outcome metrics. Similar to the DSRIP program, the APM approach will require that providers meet or exceed predetermined quality and outcome improvements to receive incentive payments.[1] Increasing employment-related services in KanCare 2.0 includes the Employment Support Pilot. The pilot will provide access to pre-employment services for individuals that are ineligible for, or less likely to seek, existing post-employment services and benefits. The two disability groups served by the pilot are individuals with a behavioral health condition who are eligible for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and individuals eligible for a Home and Community Based Services (HCBS) wait list or waiver and who are SSI eligible only. Services will include supported employment, personal assistant services, assistive technology, pre-vocational services (if not able to access Vocational Rehabilitation [VR] service), transportation, and independent living skill building.

B. Evaluation Questions and Hypotheses

KanCare 2.0 Demonstration Goal

The goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits.[4]

KanCare 2.0 Demonstration Hypotheses

1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
3. Use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically:
    a. Telemedicine will improve access to services such as speech therapy.
    b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.
    c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.
4. Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services. The evaluation question and methodology are described in the SUD-specific evaluation design, *KanCare 2.0 Section 1115 Substance Use Disorder (SUD) Demonstration Evaluation Design* (submitted separately), in accordance with the first research question noted in Table B.1 of Appendix B of CMS's *Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Abuse Disorders*.[5]

KanCare 2.0 Demonstration Evaluation Questions

As the focus of the evaluation is to examine whether the KanCare 2.0 Demonstration achieved its objectives, the proposed evaluation questions are developed in alignment with the demonstration's goal and hypotheses (Tables B1 and B2).

Table B1 describes two evaluation questions. The **first evaluation question** will examine the effectiveness of the overall ***Service Coordination Strategy*** of the KanCare 2.0 demonstration that is designed to enhance the quality of care and health outcomes and to reduce cost of care. A **quasi-experimental evaluation design** will be used to assess this question. The evaluation design for the overall ***Service Coordination Strategy*** of KanCare 2.0 demonstration will include an intervention group and appropriate comparison groups. The Intervention Group will include members who met a health risk assessment (HRA) threshold and receivedservice coordination (excluding those members who opted for the OneCare Kansas program). These members in the pre-intervention period will serve as the Comparison Group 1, whereas KanCare 2.0 members who scored 3 to 5 points below the HRA threshold and received traditional care instead of service coordination will serve as the Comparison Group 2. The Comparison Group 2 will also include KanCare 2.0 members who met the HRA threshold but opted not to receive service coordination and received traditional care. The further details of the evaluation design are described in the Methodology section.

The **second evaluation question** will evaluate the effectiveness of the ***OneCare Kansas*** program of KanCare 2.0 demonstration, a new Medicaid option based on the health home model. This program will be offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that will integrate and coordinate all services and supports to treat the "whole person" across the life span. A **quasi-experimental evaluation design** will be used to assess this question. The evaluation of the ***OneCare Kansas*** program of KanCare 2.0 demonstration will include an intervention group and appropriate comparison groups. The Intervention Group will include eligible members for the OneCare Kansas program who opted to participate in the program and received core services of the program. These members in the pre-intervention period will serve as the Comparison Group 1. The KanCare 2.0 members eligible for the OneCare Kansas program who did not opt to participate in the program and received traditional care will constitute the Comparison Group 2. Further details of the evaluation design are described in the Methodology section.

Table B1. Evaluation Questions for Examination of Overall Service Coordination Among KanCare 2.0 Demonstration Members
1) Did the ***Service Coordination Strategy*** of integrating physical and behavioral health services provided to KanCare members **improve quality of care, health and cost outcomes**?
2) Did the ***OneCare Kansas*** program that implements comprehensive and intense method of care coordination **improve the quality of care, health and cost outcomes**?

Table B2 describes evaluation questions related to **four hypotheses of the KanCare 2.0 demonstration**. Depending upon the availability of appropriate comparison groups for the evaluation of these hypotheses, the **quasi-evaluation designs (with comparison groups) and non-experimental designs (without comparison groups)** will be applied for the evaluation of these hypotheses. The further details of the evaluation designs are described in the Methodology section.

Table B2. Evaluation Questions for Examination of the KanCare 2.0 Hypotheses	
KanCare 2.0 Hypotheses	**Evaluation Questions**
Hypothesis 1: Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.	1) Did the ***Value-Based Provider Incentive Program*** increase integration and reduce silos between physical and behavioral health services provided to KanCare members?
	2) Did the ***Value-Based Provider Incentive Program*** for integration between physical and behavioral health services **improve quality of care, health, and cost outcomes**?

Table B2. Evaluation Questions for Examination of the KanCare 2.0 Hypotheses (Continued)	
KanCare 2.0 Hypotheses	**Evaluation Questions**
Hypothesis 2: Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.	1) Did ***provision of supports for employment and independent living*** to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community **improve their independence and health outcomes?**
Hypothesis 3: The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural and semi-urban areas. Specifically: a. Telemedicine will improve access to services such as speech therapy. b. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions. c. Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.	1) Did ***use of telemedicine services increase over the five-year period*** for KanCare members living in **rural or semi-urban areas**?
	2) Did ***use of the tele-monitoring services increase over the five-year period*** for KanCare members with chronic conditions living in **rural or semi-urban areas?**
	3) **Evaluation question related to *telementoring***: Data sources for describing the baseline and five-year status of the use of telementoring to pair rural and semi-urban healthcare providers with remote specialists are currently not known; therefore, **the related evaluation question and design will be developed later.**
	4) Did ***use of telemedicine increase access to services over the five-year period*** for KanCare members living in **rural or semi-urban areas**?
Hypothesis 4: Removing payment barriers for services provided in Institutions for Mental Diseases (IMDs) for KanCare members will result in improved beneficiary access to substance use disorder (SUD) treatment services.	1) Did ***removing payment barriers for services provided in IMDs*** for KanCare members **improve members' access to substance use disorder (SUD) treatment services.** (See SUD-specific Evaluation Design)[6]

Logic Model for KanCare 2.0 Demonstration

See Appendix 1.

C. Evaluation Design Methodology

The detailed proposed methodologies for the evaluation of the Service Coordination Strategy, the OneCare Kansas program, and three KanCare 2.0 hypotheses are described in this section and summarized in Table C1. The proposed evaluation methodology for the KanCare 2.0 Hypothesis 4 is also summarized in Table C1, though a more detailed proposed methodology for this hypothesis is described in a separate evaluation design for the *KanCare 2.0 Section 1115 SUD Demonstration*.[6]

The present evaluation methodology is designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the evaluation is to examine the effectiveness of demonstration strategies and policies on achievement of the goal of helping Medicaid members to live healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. Where possible, measures are developed according to recognized measures from sources such as: *Adult Core Set*[7] measures, including *Healthcare Effectiveness Data and Information Set®* (HEDIS) measures,[8] stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF).

The two final appendices to this evaluation design incorporate enhanced discussion on the performance measures and data sources that will be used for the evaluation of the KanCare 2.0 program. **Appendix 2** offers tables providing more detailed summaries of the performance measures in Table C1, including measure name, steward, numerator, denominator, unit of measure, and data source. **Appendix 3** offers tables providing further details on the data sources of the evaluation, including data source name, type of data provided by data source, description of data source, efforts for cleaning/validation of data, and quality/limitation of data source.

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Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration				
Evaluation Question	**Outcome Measures**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Overall Service Coordination				
1. Did the *Service Coordination Strategy* of integrating physical and behavioral health services provided to KanCare members improve quality of care, health, and cost outcomes?	• Annual Dental Visit (HEDIS) • Adults' Access to Preventive/ Ambulatory Health Services (HEDIS) • Adolescent Well-Care Visits (HEDIS) • Follow-Up After Hospitalization for Mental Illness (HEDIS) • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS) • Antidepressant Medication Management (HEDIS) • ED visits, observation stays, or inpatient admissions for following conditions (Administrative): o Diabetic Ketoacidosis/ Hyperglycemia, or o Acute severe asthma, or o Hypertensive crisis, or o Fall injuries, or o SUD, or o Mental health issues • Outpatient or professional claims for following conditions (Administrative): o Diabetic retinopathy, or o Influenza, or o Pneumonia, or o Shingles • Emergency department visits overall (Administrative) • Inpatient Utilization (IPU)—General Hospitalization/Acute Care, excluding maternity admissions.	**Intervention Group:** All members who met an HRA threshold based on health screening scores and received service coordination (excluding those who opted for the OneCare Kansas program). **Comparison Group 1:** Above mentioned members in pre-intervention period. **Comparison Group 2:** All members who received health screening score 3 to 5 points below the HRA threshold and received traditional care instead of service coordination, as well as the members who met an HRA threshold but opted not to receive service coordination. **Potential Subgroups:** Members with specific chronic conditions, members with specific behavioral conditions, & members receiving HCBS services.	• Medicaid Management Information System (MMIS) Encounter database; • MMIS Eligibility and Enrollment database. • MCOs' Member-level case management data systems.	Comparative Interrupted Time Series Evaluation Design

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Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	**Outcome Measures**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Overall Service Coordination (Continued)				
2. Did the *OneCare Kansas* program, by implementing comprehensive and intense method of care coordination, improve the quality of care, health, and cost outcomes?	Quantitative Measures: • Same as above. Qualitative Measures: • Learning needs identified by the OneCare Kansas Learning Collaborative. • Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative. • Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal. • Barriers encountered in implementation of the OneCare Kansas program. • Processes to further improve the quality of OneCare Kansas program. • Observations about why this program was able to succeed or why it did not meet its goals.	**Intervention Group:** All members eligible for OneCare Kansas program who opted to participate in the program and received its core services. **Comparison Group 1:** Above mentioned members in pre-intervention period. **Comparison Group 2:** All members eligible for OneCare Kansas program who opted not to participate in the program and received traditional care. **Potential Subgroups:** Members with severe bipolar disorder; members with paranoid schizophrenia; & members with asthma.	• MMIS Encounter database. • MMIS Eligibility and Enrollment database. • OneCare Kansas members' eligibility & participation database. • MCOs' Member-level case management data systems. • OneCare Kansas Learning Collaborative reports.	Comparative Interrupted Time Series Evaluation Design
Hypothesis 1				
1. Did the *Value-Based Provider Incentive Program* increase integration and reduce silos between physical and behavioral health services provided to KanCare members? 2. Did the *Value-Based Provider Incentive Program* for integration between physical and behavioral health services improve quality of care, health, and cost outcomes provided to the KanCare members?	**Potential list (to be finalized according to the specific programs):** **Quantitative Measures:** • Same as above. • Identification of Alcohol and Other Drug Services (HEDIS) • Follow-Up Care for Children Prescribed ADHD Medication (HEDIS) • Use of Opioids at High Dosage (HEDIS) • Use of Opioids from Multiple Providers (HEDIS) • Mental Health Utilization (HEDIS) • MCO-specified measures on effectiveness of their value-based provider incentive programs (to be determined)	**Intervention Group:** All members seen by the providers who participated in the *Value-Based Provider Incentive Program* will serve as the Intervention Group. **Comparison Group 1:** Above-mentioned members in the pre-intervention period. **Comparison Group 2:** All members seen by the providers who did not participate in the *Value-Based Provider Incentive Program.* **Potential Subgroups:** Rural-urban groups, other identified subgroups.	• MCOs' administrative databases on Value-Based Provider Incentive Programs. • Medicaid Management Information System (MMIS) Encounter database. • MMIS Eligibility and Enrollment database. • MCOs' Member-level case management data systems.	Comparative Interrupted Time Series Evaluation Design

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	**Outcome Measures**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypothesis 1 (Continued)				
	Qualitative Measures: • Factors that facilitated the implementation of the Value-Based Provider Incentive Program. • Barriers encountered in implementing the Value-Based Provider Incentive Program. • Recommendations to further improve Value-Based Provider Incentive Program. • Recommendations to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program. Observations about why this program was able to succeed or why it did not meet its goals.		• MCO databases/ tables for Value-based Provider Incentive Programs performance measures. • Online provider survey. • Key informant interviews of the providers.	
Hypothesis 2				
1. Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and behavioral health conditions who are living in the community improve their independence and health outcomes?	Final list of outcomes will be determined based on data availability: • Current employment status • # of members who felt they were employed based on their skills and knowledge (If employed) • Increased stable housing – # of addresses member lived in the past year (and assess type of housing). • Decreased current legal problem (e.g., probation, parole, arrests) • # of days living in the community • # of members worried about paying bills • Decreased ED visits • Decreased inpatient hospitalizations	**Study population:** Members living in the community and receiving behavioral health services or HCBS services in the Physical Disability, Intellectual or Developmental Disability, and Brain Injury waiver programs who opted to receive service coordination and were identified as potentially needing employment or independent living supports. **Target Intervention Group:** Study population members who received employment or independent living supports through KanCare 2.0 service coordination.	• MMIS Encounter database; • MMIS Eligibility and Enrollment database; • MCOs Member-level case management data systems (including HRA questionnaire).	Pretest-Posttest Design with Nonequivalent Groups

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	**Outcome Measures**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypothesis 2 (Continued)				
		Comparison Group: Study population members who did not receive supports through KanCare 2.0 service coordination. **Potential subgroups:** Members receiving behavioral health services; members receiving HCBS services in the PD, I/DD, & BI waiver programs.		
Hypothesis 3				
1. Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas? 2. Did use of the telemonitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas? 3. Evaluation question related to the telementoring: Evaluation question and design will be developed later	**Quantitative Measures:** **Telemedicine:** • % of telemedicine services received by the members living in rural or semi-urban areas. • # of receiving sites for telemedicine services in rural or semi-urban areas • % of members living in rural or semi-urban areas who received telemedicine services **Telemonitoring:** • % of members living in rural or semi-urban areas who received telemonitoring services • # of telemonitoring services provided to members living in rural or semi-urban areas (total number and by types of service or claims) • # of providers monitoring health indicator data transmitted to them by the members living in rural or semi-urban counties receiving telemonitoring services • Other measures (TBA)	**Intervention Group:** All members living in the rural or semi-urban areas and the providers who participated in the telehealth strategies. **No Comparison Group.** **Potential Subgroups:** Telemedicine and/or telemonitoring service type; provider specialty type; specific chronic conditions; & geographic regions of the state	• MMIS Encounter database. • MMIS Eligibility and Enrollment database. • Other data sources for measures (will be identified later).	Non-experimental method (One-Group Pretest–Posttest Design)

Table C1. Design for the Evaluation of the KanCare 2.0 Demonstration (Continued)				
Evaluation Question	**Outcome Measures**	**Sample or Population Subgroups to be Compared**	**Data Sources**	**Analytic Methods**
Hypothesis 3 (Continued)				
4. Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?	• # of paid claims with selected procedure codes, stratified by area, mode of delivery, and service type. • # of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members. **Qualitative Measures:** • Factors that facilitated the use of telemedicine and/or telemonitoring services for the Medicaid members. • Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members. • Recommendations about how to further improve the use of telemedicine and/or telemonitoring services. • Recommendations about how to remove barriers encountered in using telemedicine and/or telemonitoring services. • Observations about why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.	**Area Strata**: rural, semi-urban, urban counties. **Mode Strata**: telehealth, in-person. **Service Type Strata**: e.g., speech-language pathology, audiology, primary care, behavioral health.	• MMIS Encounter database. • Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.	Trending analysis; Independence of variables (Pearson's chi-square); Homogeneity of odd ratios (Breslow-Day)
Hypothesis 4				
1. Did removing payment barriers for services provided in IMDs for KanCare members improve member access to SUD treatment services.	• Number of IMDs providing SUD services. • Number of geographic locations (by region/ county) for SUD treatment in IMDs. • Number of admissions with SUD treatment services in IMDs. • Average length of stay for SUD treatment services within IMDs.	The evaluation will focus on examining increased availability of IMD facilities providing SUD treatment services over the five-year period. **No Intervention or Comparison groups will be examined.**	• Provider Network Report • MMIS encounter data • Provider licensing data • MCO utilization reports	Non-experimental method (descriptive data)

a. Methodology for the Evaluation of the Service Coordination Strategy

Evaluation Question

Did the ***Service Coordination Strategy*** of integrating physical and behavioral health services provided to KanCare members **improve quality of care, health, and cost outcomes**?

Demonstration Strategy

The ***Service Coordination Strategy*** implements health risk assessments (HRA), needs assessments, and development and implementation of plans of service (POS) or person-centered service plans (PCSP) among KanCare 2.0 members who meet HRA thresholds based on health screening scores.

Evaluation Design

Comparative Interrupted Time Series Evaluation Design will be used to examine the evaluation question.

To conduct *Comparative Interrupted Time Series* analysis, KanCare 2.0 members who met the HRA threshold based on health screening scores and received service coordination (excluding those who opted for the OneCare Kansas program) will serve as the **Intervention Group**. The program members in the pre-intervention period will serve as the **Comparison Group 1.** The design will also include **Comparison Group 2** that will be comprised of KanCare 2.0 members who received a health screening score 3 to 5 points below the threshold and received traditional care, as well as members who met the HRA threshold but opted not to receive service coordination and received traditional care. Outcome data for pre- and post-intervention periods will be compared to examine whether pre-post intervention change differed between these groups or not. This comparison will assist in examining whether the intervention changed the level of outcome or if it also impacted the long-term trend.

Target and Comparison Population

Study Population: KanCare 2.0 members who met the HRA threshold or had scores 3-5 points below the HRA threshold based on health screening scores.

Intervention Group: KanCare 2.0 members who met the HRA threshold based on health screening scores and received service coordination (e.g., HRA, needs assessments, and development and implementation of the POS or PCSP) will constitute the Intervention Group (excluding those who opted for the OneCare Kansas program). Their post-intervention outcome data for the period of five years will be examined (2019 through 2023).

Comparison Group 1: Above-mentioned members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2018).

Comparison Group 2: This group will include: 1) KanCare 2.0 members whose health screening scores were 3-5 points below the HRA threshold and who received traditional care instead of service coordination; and 2) KanCare 2.0 members who met the HRA threshold but opted not to receive service coordination and received traditional care. The outcome data for the pre- and post-intervention periods for this group will be compared (pre-intervention period: 2016–2018; post-intervention period: 2019–2023).

Potential Subgroups:

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will also be conducted within these groups to identify the benefit of the *Service Coordination Strategy* on any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among Intervention and Comparison groups with the following conditions):

- Members with specific chronic conditions;
- Members with specific behavioral health conditions; and
- Members receiving HCBS services.

Evaluation Period

The total evaluation period will be 2016 through 2023.
Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023.

Evaluation Measures

The following outcomes will be assessed among Intervention and Comparison Groups to examine the evaluation question:

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults' Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care/Adherence outcome)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative measure – Health outcome)
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles
- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient Utilization (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)

See **Table A2.1** within **Attachment 2** for enhanced discussion of these measures.

Data Sources

The following data sources will be used to collect data to determine outcomes of the Service Coordination Strategy:

- MMIS Encounter database;
- MMIS Eligibility and Enrollment database; and
- MCOs' Member-level case management data systems.

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

Analytic Methods

The entire eligible populations for the Intervention and Comparison Groups will be included in the study, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be completed to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation question:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in Intervention and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally-spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will also be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of a varying range of model assumptions, such as different lags and types of impact models.
- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members with specific chronic conditions, members with specific behavioral conditions, and members receiving HCBS services). These subgroup analyses will depend on availability of sufficient sample sizes.

Design for the evaluation of the Service Coordination Strategy is summarized in Figure 1.

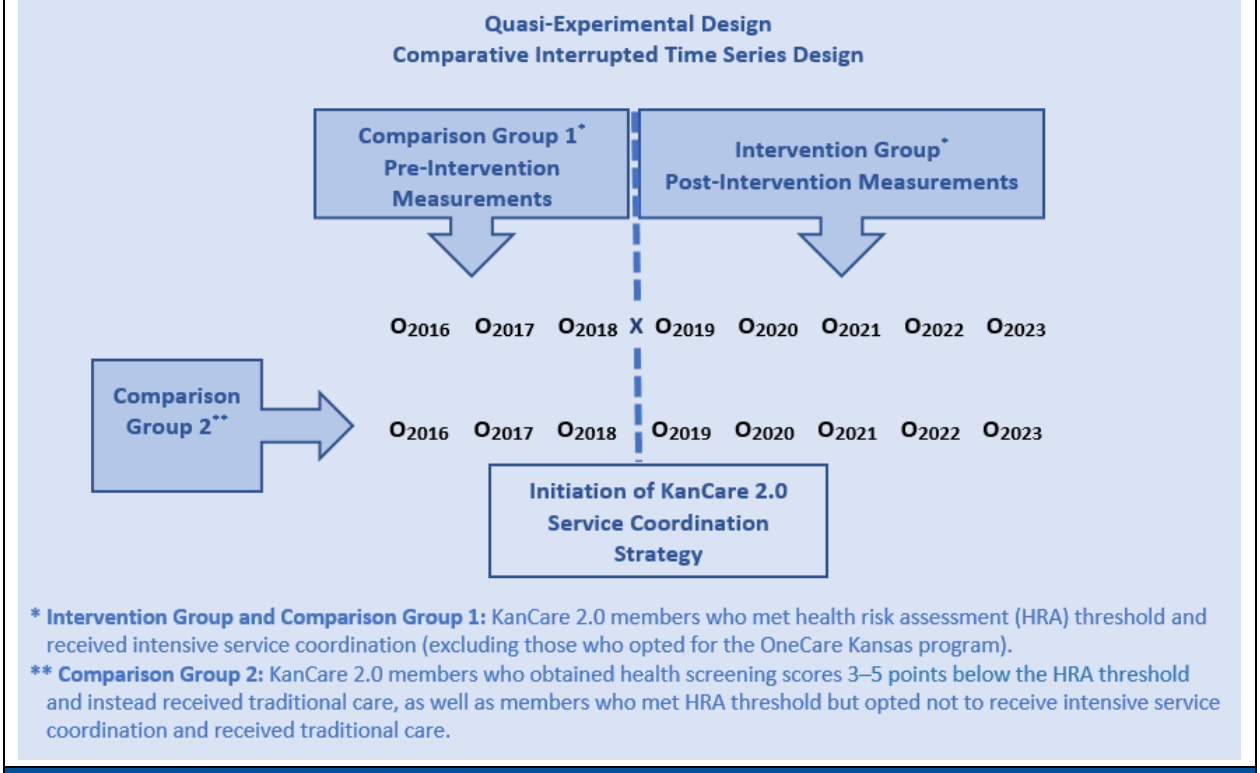

Figure 1. Evaluation Design for the KanCare 2.0 Service Coordination Strategy

b. Methodology for the Evaluation of OneCare Kansas

Evaluation Question

Did the ***OneCare Kansas*** program***,*** by implementing comprehensive and intense method of care coordination, **improve the quality of care, health, and cost outcomes**?

Demonstration Strategy

The ***OneCare Kansas*** program will provide coordination of physical and behavioral care with long term services and supports for KanCare members with chronic conditions, like diabetes, asthma, or mental illness. The program will be an opt-in program for adults and children. The program expands upon medical home models to include links to community and social supports. OneCare Kansas will use a "team of health professionals" approach of the health home model. In this model, the three KanCare managed care organizations (MCOs) will serve as the Lead Entities (LEs) for OCK and will contract with community providers to be OneCare Kansas Partners (OCKPs). The OCKPs will provide all OCK services, and the MCO will not provide any direct services in this model.[9] All the caregivers involved in a OneCare Kansas member's health will communicate with one another for addressing all needs of the patient in a comprehensive manner.[10] OneCare Kansas will provide six core services that include comprehensive care management, care coordination, health promotion, comprehensive transitional care (including appropriate follow-up) from inpatient to other settings, members and family support, and referral to community and social support services.[11]

Evaluation Design

Comparative Interrupted Time Series Evaluation Design will be used to examine the evaluation question.

To conduct *Comparative Interrupted Time Series* analysis, KanCare 2.0 members eligible for OneCare Kansas and opted to participate in the program and received core services of the program will serve as the **Intervention Group**. The program members in the pre-intervention period will serve as the **Comparison Group 1.** KanCare 2.0 members eligible for OneCare Kansas who did not opt to participate in the program and received traditional care instead of the OneCare Kansas services will constitute the **Comparison Group 2.** Outcome data for the pre- and post-intervention periods will be compared to examine whether pre-post intervention change differed between these groups or not. This comparison will assist in examining whether the intervention changed the level of outcome or if it also impacted the three-year trend.

Target and Comparison Population

Study Population: KanCare 2.0 members eligible for the OneCare Kansas program.

Intervention Group: KanCare 2.0 members eligible for the OneCare Kansas program who opted to participate in the program and received its core services will constitute the Intervention Group. The post-intervention outcome data for the period of four years will be examined (2020 through 2023). Please note, the length of post-intervention period will depend on the start date of the program. Currently, the program start date is planned as January 1, 2020.

Comparison Group 1: Program members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2019). The pre-intervention period will depend on the start date of the program.

Comparison Group 2: KanCare 2.0 members eligible for the OneCare Kansas program who did not opt to participate in the program and received traditional care will serve as the Comparison Group 2. The outcome data for the pre- and post-intervention periods for this group will be compared with the Intervention Group data (pre-intervention period: 2016–2019; post-intervention period: 2020–2023). The pre- and post-intervention period will depend on the start date of the OneCare Kansas program.

Potential Subgroups:

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will also be conducted within these groups to identify the benefit of the OneCare Kansas program on any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among the Intervention and Comparison groups with the following conditions):

- Members with severe bipolar disorder,
- Members with Paranoid Schizophrenia, and
- Members with asthma that are also at risk for developing:
  - Diabetes
  - Hypertension
  - Kidney Disease (not including Chronic Kidney Disease Stage 4 and ESRD)
  - Cardiovascular Disease
  - COPD
  - Metabolic Syndrome
  - Mental Illness (not including Paranoid Schizophrenia and Severe Bipolar Disorder)
  - Substance Use Disorder
  - Morbid Obesity (body weight 100lbs over normal body weight, BMI greater than 40, or BMI over 31 with obesity-related health problems)
  - Tobacco Use or exposure to second hand smoke

Evaluation Period

The tentative evaluation period will be 2016 through 2023.
Pre-Intervention Period: 2016–2019; and Post-Intervention Period: 2020–2023.
Please note, the pre- and post-intervention period will depend on the start date of the OneCare Kansas program.

Evaluation Measures

The following quantitative outcomes will be examined among Intervention and Comparison Groups to examine the evaluation question (tentative list, as it will depend on the final selection of chronic conditions to constitute eligibility criteria for the program):

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults' Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC)) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care outcome)
- ED visits, observation stays, or inpatient admissions for the following conditions (Administrative measure – Health outcome)
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles

- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient admissions (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)

In addition to the quantitative measures, qualitative information will be collected twice during the evaluation period (mid-year and the last year of the evaluation period) from the OneCare Kansas Learning Collaborative that will include KDHE, MCOs, OCK partners (OCKPs), and Association partners. The Learning Collaborative process will identify evolving learning needs, as well as ways to address those needs, allowing for continual quality improvement of the OCK system. This information will be categorized to examine similar and dissimilar themes to further understand the program.

Following is the potential list of qualitative measures:
- Learning needs identified by the OneCare Kansas Learning Collaborative.
- Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative.
- Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal.
- Barriers encountered in implementation of the OneCare Kansas program.
- Recommendations regarding how the quality of the OneCare Kansas program can be further improved.
- Observations why this program was able to succeed or why it did not meet its goals.

Additional qualitative measures will be examined based on the themes identified from the information obtained from the OneCare Kansas Learning Collaborative members.

See **Table A2.2** and **Table A2.3** within **Appendix 2** for enhanced discussion of these measures.

Data Sources

The following data sources will be used to collect data to determine outcomes of the Service Coordination Strategy:
- MMIS Encounter database
- MMIS Eligibility and Enrollment database
- OneCare Kansas members' eligibility and participation database
- MCOs' Member-level case management data systems.
- OneCare Kansas Learning Collaborative reports

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

Analytic Methods

The entire eligible populations for the intervention and comparison groups will be included in the study, and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation question:
- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in

time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to the analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of varying range of model assumptions, such as different lags, and types of impact models.

- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members with severe bipolar disorder, members with paranoid schizophrenia, and members with asthma and at risk for at least one other chronic condition). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through OneCare Kansas Learning Collaborative sessions/reports. The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the OneCare Kansas program is summarized in Figure 2.

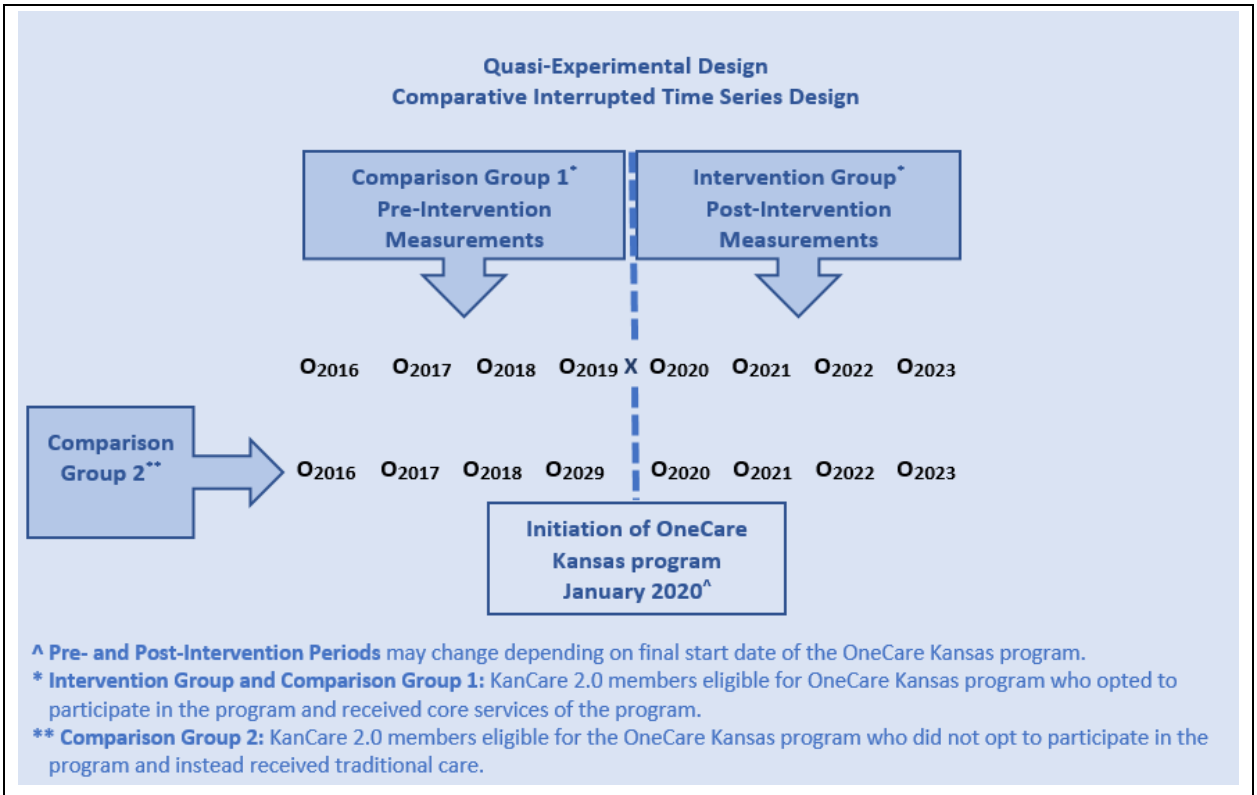

Figure 2. Evaluation Design for the OneCare Kansas Program

c. Methodology for the Evaluation of Hypothesis 1

Evaluation Questions

- Did the ***Value-Based Provider Incentive Program*** increase integration and reduce silos between physical and behavioral health services provided to KanCare members?
- Did the ***Value-Based Provider Incentive Program*** for integration between physical and behavioral health services **improve quality of care, health, and cost outcomes**?

Demonstration Strategy

A ***Value-Based Provider Incentive Program*** for integration between physical health and behavioral health services designed by the MCOs will be used to engage providers to implement physical and behavioral health service coordination (value-based purchasing strategy).

Evaluation Design

Comparative Interrupted Time Series Evaluation Design will be used to examine the evaluation questions for Hypothesis 1.

To evaluate the effect of the *Value-Based Provider Incentive Program* on the quality of care, health, and cost outcomes, *Comparative Interrupted Time Series* analysis will be conducted, in which KanCare 2.0 members seen by the providers who participated in the program will serve as the **Intervention Group**.

The program members in the pre-intervention period will serve as the **Comparison Group 1.** KanCare 2.0 members seen by the providers who did not participate in the *Value-Based Provider Incentive Program* will serve as the **Comparison Group 2.** The pre- and post-intervention outcome data will be examined to assess whether changes differed between Intervention and Comparison Groups. This comparison will assist in examining whether the intervention changed the level of outcome or if it also changed the long-term trend.

Target and Comparison Population

Intervention Group: KanCare 2.0 members seen by the providers who participated in the *Value-Based Provider Incentive Program* promoting physical and behavioral health service coordination will constitute the Intervention Group. Their post-intervention outcome data for the period of five years will be examined (2019 through 2023).

Comparison Group 1: Program members in the pre-intervention period will serve as the Comparison Group 1. The pre-intervention outcome data for the period of three years will be examined (2016 through 2018).

Comparison Group 2: KanCare 2.0 members seen by the providers who did not participate in the *Value-Based Provider Incentive Program* will serve as the Comparison Group 2. The outcome data for the pre- and post-intervention periods for this group will be compared with the Intervention Group data. The pre-intervention period will be comprised of 2016 through 2018 (as data allows). The post-intervention period will be comprised of 2019 through 2023.

Potential Subgroups:

The Intervention and Comparison Groups will be examined to identify potential subpopulation groups, such as rural-urban subgroups. In addition to assessing evaluation measures in overall Intervention and Comparison Groups, subgroup analyses will also be conducted to identify the benefit of the *Value-Based Provider Incentive Program* among identified subpopulation groups (depending on availability of sufficient sample size).

Evaluation Period

The total evaluation period will be 2016 through 2023.
Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023.

Evaluation Measures

Following is the potential list of quantitative outcomes to examine the evaluation questions (**final list will be based on specific value-based provider incentive programs implemented by the MCOs**):

- Annual Dental Visit (ADV) (HEDIS measure – Quality of Care outcome)
- Adults' Access to Preventive/Ambulatory Health Services (AAP) (HEDIS measure – Quality of Care outcome)
- Adolescent Well-Care Visits (AWC) (HEDIS measure – Quality of Care outcome)
- Follow-Up After Hospitalization for Mental Illness (FUH) (HEDIS measure – Quality of Care outcome)
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) (HEDIS measure – Quality of Care outcome)
- Antidepressant Medication Management (AMM) (HEDIS measure – Quality of Care/Adherence outcome)
- Identification of Alcohol and Other Drug Services (IAD) (HEDIS measure – Quality of Care outcome)
- Follow-Up Care for Children Prescribed ADHD Medication (ADD) (HEDIS measure – Quality of Care outcome)
- Use of Opioids at High Dosage (UOD) (HEDIS measure – Quality of Care outcome)
- Use of Opioids from multiple providers (UOP) (HEDIS measure – Quality of Care outcome)
- Mental Health Utilization (MPT) (HEDIS measure – Quality of Care and Health outcome)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative measure – Health outcome):
  - Diabetic Ketoacidosis/Hyperglycemia, or
  - Acute severe asthma, or
  - Hypertensive crisis, or
  - Fall injuries, or
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative measure – Health outcome):
  - Diabetic retinopathy, or
  - Influenza, or
  - Pneumonia, or
  - Shingles
- Emergency department visits (Administrative measure – Cost outcome)
- Inpatient admission (IPU), excluding maternity admissions (HEDIS measure – Cost outcome)
- MCO-specified measure on effectiveness of their value-based purchasing program on increasing physical and behavioral health service integration (to be determined)

In addition to the above-mentioned quantitative outcome measures, the qualitative information will also be collected twice during the evaluation period (mid-year and the last year of the evaluation period) to further assess whether the *Value-Based Provider Incentive Program* increased the integration between physical and behavioral services. The qualitative information will be collected by designing and conducting an online provider survey and/or key-informant interviews with the providers participating in the *Value-Based Provider Incentive Program.* The online survey will be designed using Survey Monkey software and will include open-ended questions. The survey questions will collect information from the providers on the facilitators and barriers related to the implementation of the *Value-Based Provider Incentive Program*. In addition, providers will be asked to provide recommendations for removing barriers and to further strengthen the program to make it successful in achieving its goals. The survey responses will be categorized to examine similar and dissimilar themes and finding areas that can be further explored through key informant interviews of the providers. Key informant interviews will be conducted from a random sample of the providers participating in the *Value-Based Provider Incentive Program* to collect in-depth information to assess the reasons why this program succeeded or why it did not meet its goals.

Following is the potential list of qualitative measures:

- Factors that facilitated the implementation of the Value-Based Provider Incentive Program.
- Barriers encountered in implementing the Value-Based Provider Incentive Program.

- Recommendation about how to further improve the Value-Based Provider Incentive Program.
- Recommendations about how to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program.
- Observations regarding why this program was able to succeed or why it did not meet its goals.

Additional qualitative measures will be examined based on the themes identified from the survey and Key informant interviews.

See **Table A2.4** and **Table A2.5** within **Appendix 2** for enhanced discussion of these measures.

Data Sources

The following data sources will be used for the evaluation of Hypothesis 1:

- MCOs' administrative databases on *Value-Based Provider Incentive Programs,*
- MMIS Encounter database,
- MMIS Eligibility and Enrollment database,
- MCOs' member-level case management data systems,
- MCO databases/tables for *Value-based Provider Incentive Program* performance measures,
- Online provider survey to collect qualitative information from the providers participating in the *Value-Based Provider Incentive Program,* and
- Key informant interviews from a sample of the providers participating in the *Value-Based Provider Incentive Program.*

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

Analytic Methods

The entire eligible population for the intervention and comparison groups will be included in the study and any pre- and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention Group and Comparison Group 2.
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.
- Comparative interrupted time series analysis will be conducted using aggregate data collected for equally spaced intervals before and after the intervention. A time series of selected outcomes of interest will be used to establish underlying trends and examined to see if these trends are "interrupted" by the intervention at known points in time (longitudinal effects of intervention), through regression modelling. The covariates such as age, gender, and multimorbidity will be included in the regression models to adjust for the confounding factors. If needed, adjustment will also be done for other appropriate confounding factors. The methodological issues related to this analytical method such as autocorrelation will be assessed by examining the plot of residuals and the partial autocorrelation function. Sensitivity analyses will be done to test the impact of varying range of model assumptions, such as different lags and types of impact models.

- Subgroup analyses using above-mentioned statistical procedures will be conducted for identified subpopulation groups (such as rural-urban groups). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through online survey and key informant interviews of the providers participating in the *Value-Based Provider Incentive Program.* The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the Hypothesis 1 is summarized in Figure 3.

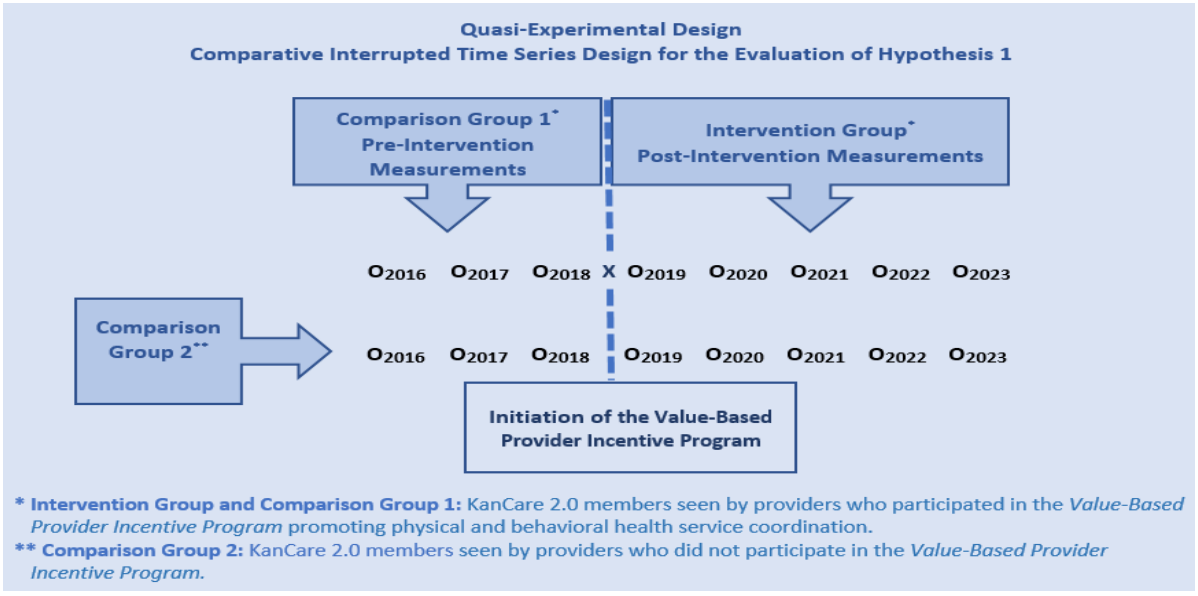

Figure 3. Evaluation Design for the KanCare 2.0 Value-Based Provider Incentive Program Strategy

d. Methodology for the Evaluation of Hypothesis 2

Evaluation Question

Did provision of supports for employment and independent living to the KanCare 2.0 members with disabilities and the behavioral health conditions who are living in the community improve their independence and health outcomes?

Demonstration Strategy

Employment or independent living supports will be provided through KanCare 2.0 service coordination to the members who are living in the community and receiving behavioral health services or HCBS services in the Physical Disability (PD), Intellectual or Developmental Disability (I/DD), and Brain Injury (BI) waiver programs.

Evaluation Design

Pretest–Posttest Design with Nonequivalent Groups will be used to examine the evaluation question.

The Intervention and Comparison Groups will be derived from the study population. The study population will include members living in the community and receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted to receive service coordination and were potentially needing employment or independent living supports, as indicated through a set of KanCare 2.0 health screening and HRA questions. The members from this

study population who received employment or independent living supports will constitute the **Intervention Group.** The members from the study population who did not receive employment or independent living supports will constitute the **Comparison Group**.

The outcome data for both groups obtained from the health screening and HRA conducted in 2019, as well as the 2019 encounter database will constitute the pre-test data. The 2020–2023 outcome data for both groups will constitute the post-test data. Pre- and post-test data for two groups will be compared.

Target and Comparison Population

Study Population: KanCare 2.0 members living in the community and receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination and were identified through a set of KanCare 2.0 health screening and HRA questions as potentially needing employment or independent living supports.

Intervention Group: Members in the study population receiving employment or independent living supports (as identified by billing procedure codes) through KanCare 2.0 service coordination will serve as the Intervention Group.

Comparison Group: Members in the study population not receiving employment or independent living supports through KanCare 2.0 service coordination will serve as the Comparison Group.

Potential Subgroups:

In addition to assessing evaluation measures in overall Intervention and Comparison Groups described above, subgroup analyses will be conducted within these groups to identify the benefit of the provision of employment or independent living supports among any specific subpopulation group.

Subgroup analyses will be conducted among the following subpopulation groups depending upon the availability of sufficient sample size (members among Intervention and Comparison groups in following subgroups):

- Members receiving behavioral health services,
- Members on HCBS wait lists, and
- Members receiving HCBS services in the PD, I/DD, and BI waiver programs.

Evaluation Period

The total evaluation period will be 2019 through 2023.
Pre-Intervention Period: 2019; and Post-Intervention Period: 2020–2023.

Evaluation Measures

The following outcomes will be assessed among Intervention and Comparison Groups to examine the evaluation question (Final list of outcomes will be determined based on data availability):

- Current employment status
- Number of members who felt they were employed based on their skills and knowledge (if employed)
- Number of members with stable housing – number of addresses member lived in the past year;
- Current legal problems (e.g., probation, parole, arrests)
- Number of days in the community
- Number of members who worried about paying bills
- ED visits
- Inpatient hospitalizations

See **Table A2.6** within **Appendix 2** for enhanced discussion of these measures.

Data Sources

The following data sources will be used for the evaluation of Hypothesis 2:

- MMIS Encounter database
- MMIS Eligibility and Enrollment database
- MCOs' member-level case management data systems.

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

Analytic Methods

The entire eligible population for the Intervention and Comparison Groups will be included in the study, and any baseline and post-intervention changes will be examined. If samples are needed, then power calculations will be done to ensure validity of the findings.

The following analytical methods will be used to examine the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine homogeneity of the demographic characteristics of the members in the Intervention Group and Comparison Group.
- Five-year trends for the outcomes will examined using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.
- Difference-in-differences (DID) statistical techniques will be used to analyze pre- and post-test data. By applying DID techniques, the impact of providing employment and independent living supports to the members will be measured as the pre-post difference in an outcome for the Intervention Group minus the pre-post difference for the Comparison Group. Assuming *parallel trends*, the amount by which outcomes changed in the Comparison Group over time is the amount by which outcomes in the Intervention Group would have changed over time in the absence of intervention. Given the differences in observed outcomes at the baseline, a similar pre-post difference in the post-intervention period would be considered normal. The additional difference between the Intervention and Comparison Groups (treatment effect) will be attributable to the intervention.
- Subgroup analyses using above-mentioned statistical procedures will be conducted for subpopulation groups (members receiving behavioral health services; members on HCBS wait lists; members receiving HCBS services in the PD, I/DD, and BI waiver programs). These subgroup analyses will depend on availability of sufficient sample sizes.

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The design for the evaluation of the Hypothesis 2 is summarized in Figure 4.

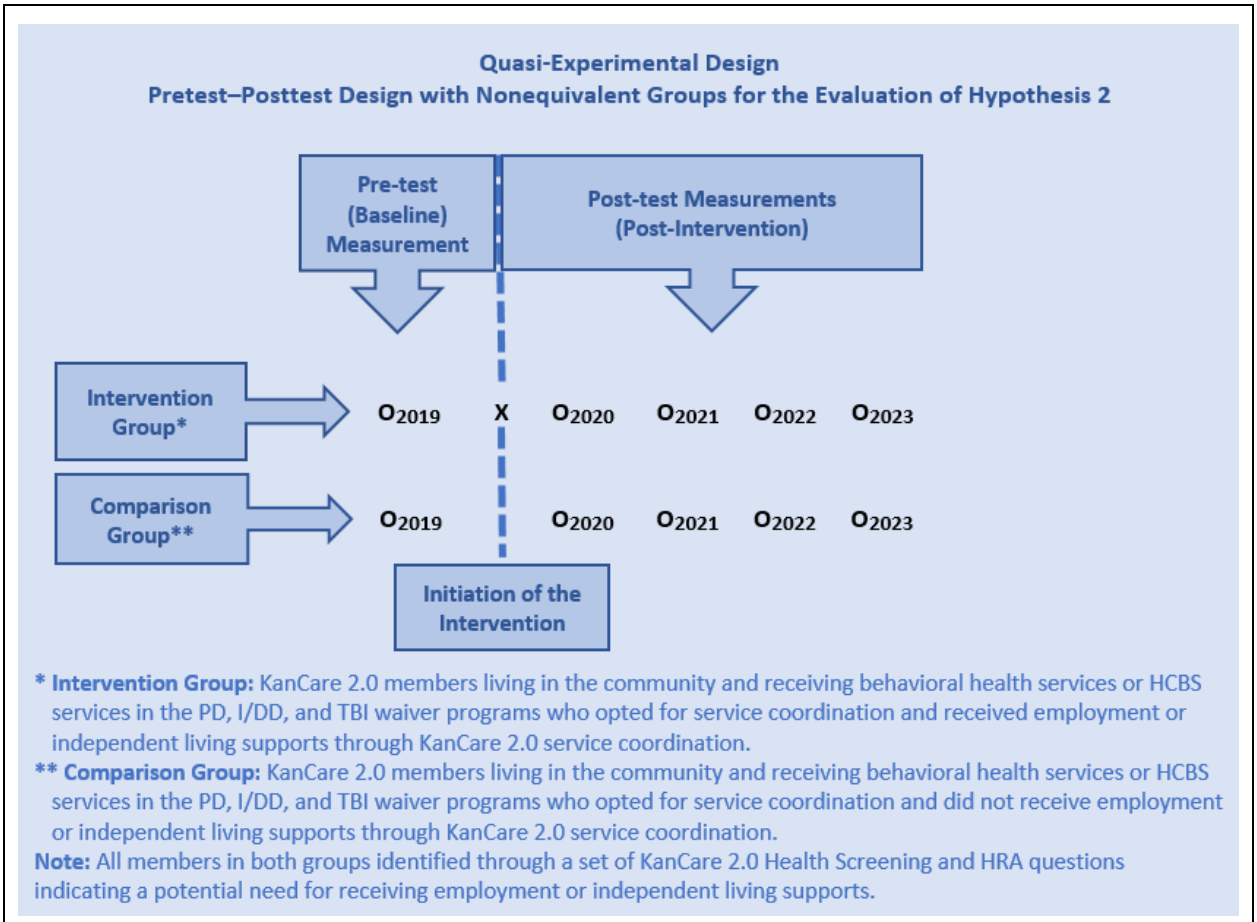

Figure 4. Evaluation Design for the Intervention Providing Employment or Independent Living Supports through Service Coordination to the KanCare 2.0 Members Living in the Community and Receiving Behavioral Health Services or HCBS Services in the PD, I/DD, and BI Waiver Programs

e. Methodology for the Evaluation of Hypothesis 3

Evaluation Questions

- Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semi-urban areas?
- Did *use of telemonitoring services increase over the five-year period* for KanCare members with chronic conditions living in rural or semi-urban areas?
- Evaluation question related to the *telementoring*: Data sources are currently not known to describe the baseline and 5-year status for the use of telementoring pairing rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions, therefore the related evaluation question and design will be developed later.
- Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?

Demonstration Strategies

The State has asked KanCare 2.0 managed care organizations to utilize telehealth solutions in designing, establishing, and maintaining provider networks and to develop models to expand use and effectiveness of telehealth strategies, including telemedicine, telemonitoring, and telementoring, with a focus on enhancing access to services in rural or

semi-urban areas, access to behavioral health services, and support chronic pain management interventions.[1] The State document for MCOs titled "Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0" has described telemedicine, telemonitoring, and telementoring as follows (pp. 106–107):[12]

a) *"**Telemedicine:** The State is interested in positively impacting member access by exploring telemedicine strategies that expand the full scope of practice by connecting network providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication. such projects can greatly enhance access, save time, money and improve outcomes in communities with limited access to health care."* The state has defined telemedicine as "connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication."
b) *"**Telemonitoring:** Technologies that target specific disease type (i.e. congestive heart failure) or high utilizers of health services, particularly ER services and medication regimen management. Technologies are available that measure health indicators of patients in their homes and transmit the data to an overseeing Provider. The provider, who might be a physician, nurse, social worker, or even a non-clinical staff member, can filter patient questions and report to a clinical team as necessary. The goal would be to reduce admission, ER utilization and improve overall health of the member."*
c) *"**Telementoring:** Technologies such as the Project ECHO model to connect community PCPs with specialists remotely located to provide consultations, grand rounds, education, and to fully extend the range of care available within a community practice. The State is also interested in ways that the use of telementoring can attract and retain providers in rural health shortage areas. This could include creating learning and joint consultation strategies that may make working in more isolated environments or practices more attractive."*

Evaluation Design

The demonstration strategies related to the three components of Hypothesis 3 will be developed during the five-year period by the MCOs as per State's guidelines and approval; currently no appropriate comparison group is available. Therefore, the ***Non-experimental method (One-Group Pretest–Posttest Design)*** will be used to examine the evaluation questions 1, 2, and 3 for Hypothesis 3. The evaluation design will include baseline and cross-year comparisons of the selected evaluation measures among the members living in rural or semi-urban areas who received telehealth strategies **(Intervention Group)**. Assessment of trends over time will also be conducted.

The fourth evaluation question is designed to determine if the number of services received is increased by telehealth or if in-person visits are converted to telehealth visits with no overall increase in frequency or level of care received. The State approved a set of speech-language pathology or audiology codes for telehealth delivery effective January 1, 2019. Service delivery trends for these codes, and other codes approved for telehealth during the demonstration, will be monitored and comparisons between rural, semi-urban and urban rates studied. Trends for other services available by telehealth prior to 2018 will also be analyzed, but the impact of telehealth on access to services may already be established. Increase in access to evaluation services may lead to an increase in diagnosis of related conditions. Thus, number of members diagnosed with speech-language and audiology pathological conditions will be analyzed.

Target and Comparison Population

Target Population: KanCare 2.0 members living in the rural or semi-urban areas will constitute the target population.

Intervention Group: The members who received telehealth strategies (telemedicine and telemonitoring strategies) will constitute the intervention group.

Comparison Group: As described above, the **evaluation design will not include comparison group**. If it is possible to apply the *Pretest–Posttest Design with Non-Equivalent Comparison Groups* for any of the telehealth strategies implemented by the MCOs, then an appropriate comparison group with pre- and post-intervention data will be selected.

Potential Subgroups:

Subgroup analyses will also be conducted to identify the benefit of the use of telemedicine and/or telemonitoring services in any specific subgroup. The subgroups, depending upon the availability of sufficient sample size, will be based on:

- Telemedicine and/or telemonitoring service type,
- Provider specialty type,
- Specific chronic conditions, and
- Geographic regions of the state (Western, Central, Eastern regions).

Evaluation Period

The baseline year will depend on the start dates of the implementation of telemedicine and telemonitoring strategies. The evaluation period will be comprised of the intervention start year through 2023.

Evaluation Measures

The following quantitative performance measures for the members living in the rural and semi-urban areas will be assessed to examine the evaluation questions:

Telemedicine:

- Percentage of telemedicine services received by the members living in the rural or semi-urban areas. Potential stratification by service, specialty type, or diagnosis.
- Number and percentage of receiving sites for telemedicine services in the rural and semi-urban areas. Potential stratification by service, specialty type, or diagnosis.
- Number and percentage of members living in the rural or semi-urban areas who received telemedicine services. Potential stratification by service, specialty type, or diagnosis.
- Number of paid claims with selected procedure codes, stratified by area, mode of delivery, and provider specialty.
- Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members.

Telemonitoring:

- Number and percentage of members living in the rural and semi-urban areas who received telemonitoring services. Potential stratification by service, specialty type, or diagnosis.
- Number of telemonitoring services provided to members living in the rural and semi-urban areas.
- Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.
- Other appropriate measures related to specific telemonitoring strategies implemented for the members living in the rural and semi-urban areas (to be determined).

In addition to the above-mentioned quantitative outcome measures, qualitative information will be collected twice during the evaluation period (mid-year and the last year of the evaluation period) through an online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services. The online survey will be designed using Survey Monkey software and will include open-ended questions. The survey questions will collect information from the providers on the facilitators and barriers related to the use telemedicine and telemonitoring services, and whether the use of these services improved access to care among Medicaid members living in rural and semi-urban areas. In addition, providers will be asked to provide recommendations for removing barriers to increasing the use of these services and improving the access to care among Medicaid members. The survey responses will be categorized to examine similar and dissimilar themes and to find areas that can be further explored through key informant interviews of the providers. Key informant interviews will be conducted from a random sample of these providers to collect in-depth information regarding why the use of these services succeeded or did not succeed in increasing the access to care among Medicaid members in rural and semi-rural areas.

Following is the potential list of qualitative measures that will be examined:

- Factors facilitating the use of telemedicine and/or telemonitoring services for the Medicaid members.
- Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members.

- Opinions about how to further improve the use of telemedicine and/or telemonitoring services.
- Opinion about how to remove barriers encountered in using telemedicine and/or telemonitoring services.
- Reasons why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.

Additional qualitative measures will be examined based on the themes identified from the survey and key informant interviews.

See **Table A2.7** and **Table A2.8** within **Appendix 2** for enhanced discussion of these measures.

Data Sources

The following data sources will be used for the evaluation of Hypothesis 3:

- MMIS Encounter database,
- MMIS Eligibility and Enrollment database,
- Other appropriate data sources for measures identified later in accordance with specific telehealth strategies,
- Online provider survey to collect qualitative information from the providers using telemedicine and telemonitoring services (identified through claims submitted for telemedicine and telemonitoring services), and
- Key informant interviews from a sample of the providers using telemedicine and telemonitoring services (identified through claims submitted for telemedicine and telemonitoring services).

See **Table A3.1** within **Appendix 3** for enhanced discussion of these data sources.

Analytic Methods

The following analytical methods will be used to assess the evaluation questions:

- Data obtained from various sources will be reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of the data for analyses required by the evaluation design.
- For statistical procedures, a final dataset with all required variables will be created by merging data from various sources.
- Descriptive statistics will examine demographic characteristics of the members.
- The descriptive statistics (e.g., numbers and percentages or rates) of the selected evaluation measures will be calculated for baseline and subsequent years of the evaluation period.
- Appropriate statistical tests such as Fisher's Exact and Pearson chi-square tests with $p<.05$ will be used to compare percentages or rates for the baseline and subsequent years.
- Absolute improvement will be examined by comparing percentages or rates for the baseline year and most recent year (as per availability of data).
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating significance.
- Difference of differences between subgroups will be tested using Breslow-Day tests for homogeneity of the odds ratio.
- Subgroup analyses using appropriate statistical procedures will also be conducted for subpopulation groups (telemedicine and/or telemonitoring service type; provider specialty type; specific chronic conditions; and geographic regions of the state). These subgroup analyses will depend on availability of sufficient sample sizes.
- Qualitative data analysis techniques will be used to analyze qualitative data collected through online survey and key informant interviews of the providers using telemedicine and/or telemonitoring services. The steps for qualitative data analysis will include: **getting familiar with the data** by looking for basic observations or patterns; **revisiting research objectives** to identify the questions that can be answered through the collected data; **developing a framework** (coding and indexing) to identify broad ideas, concepts, behaviors, or phrases, and assign codes for structuring and labeling data; **identifying themes, patterns, and connections** to answer research questions, and finding areas that can be explored further (Content and Narrative analyses); and **summarization of the qualitative information** to add to the overall evaluation results.

The design for the evaluation of the Hypothesis 3 is summarized in Figure 5.

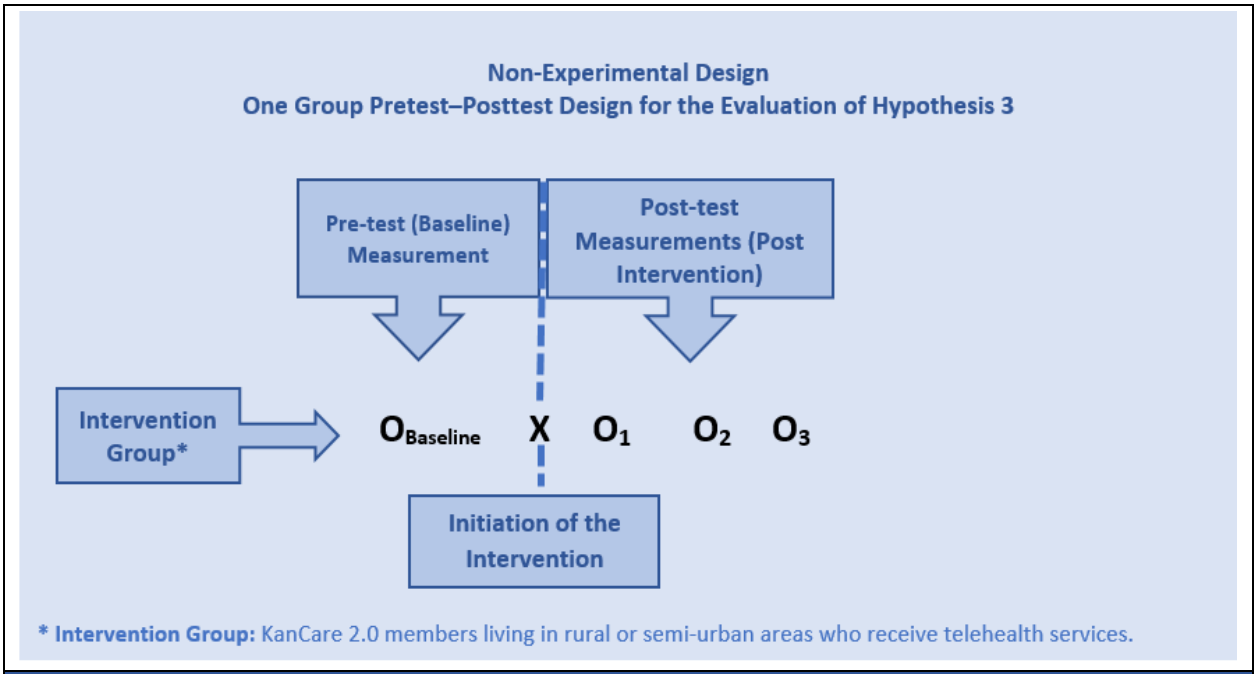

Figure 5. Evaluation Design for the Telehealth Services Strategy

f. Methodology for the Evaluation of Hypothesis 4

Evaluation Questions

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

Demonstration Strategy

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

Evaluation Design

As per CMS recommendation, evaluation of Hypothesis 4 will be conducted as part of the SUD Evaluation Design.[6]

g. SUD Evaluation

A separate evaluation design for the *KanCare 2.0 Section 1115 SUD Demonstration* is being developed to evaluate the approved Implementation Plan.[6,13] This evaluation is in accordance with the CMS document, "SUD, Section 1115 Demonstration Evaluation Design, Technical Assistance," provided March 6, 2019.[14]

h. Monitoring of the Overall KanCare 2.0 Performance Measures

The final Evaluation of the KanCare Demonstration conducted for the first six years of the program (2013–2018) identified areas for improvement. The following potential performance measures related to a few of these areas will be monitored during the period of 2019 through 2023:

- Prenatal and Postpartum Care (HEDIS measure)
- Comprehensive Diabetes Care (HEDIS Measure)
- Smoking and Tobacco Cessation (CAHPS Measure)

- Improved ability to handle daily life and deal with crisis (MH Survey)
- Social and Community Engagement (HCBS CAHPS)

See **Table A2.9** within **Appendix 2** for enhanced discussion of these measures.

Data Sources

- HEDIS data from MCOs
- Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey
- Mental Health Survey
- HCBS CAHPS Survey (potential data source)

See **Table A3.2** within **Appendix 3** for enhanced discussion of these data sources.

Analytical Methods

- The descriptive statistics (e.g., percentages or rates) of the selected evaluation measures will be calculated for baseline and subsequent years of the evaluation period.
- Comparison of the percentages or rates for the baseline year with the subsequent years will be done by applying appropriate statistical tests such as Fisher's Exact and Pearson chi-square tests with $p<.05$ indicating statistical significance.
- Absolute improvement will be examined by comparing percentages or rates for the baseline years with the most recent year (as per availability of data).
- Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating significance.

i. DSRIP Evaluation

The Delivery System Reform Incentive Payment (DSRIP) program was implemented in 2015 and extends through 2020. In January 2021, an Alternate Payment Model (APM) program will replace DSRIP. The DSRIP evaluation plan, submitted to CMS separately, reflects an additional two years of DSRIP assessment and a final overall evaluation summary. Also, the evaluation report for 2020 will summarize the activities KDHE has completed throughout the state meeting with a wide range of stakeholders to define the APM goals and metrics to be implemented in 2021 through 2023. The APM evaluation plan, including specific metrics, will be developed and submitted to CMS by the end of 2020.

D. Methodological Limitations

Due to state-wide implementation of the KanCare 2.0 Demonstration, the evaluation of overall strategies (Service Coordination Strategy and OneCare Kansas program) and four hypotheses is limited by the lack of true comparison groups. All Medicaid clients in the state are subject to participation in the Demonstration. As a result, the evaluation design included comparisons among members in the Intervention and Comparison Groups (without true external comparison groups); therefore, the pre- and post-test evaluation design or comparisons to baselines may suggest overall improvements in outcomes due to the demonstration and observed associations may not imply causality due to a specific intervention. To address this limitation, the ***Comparative Interrupted Time Series Evaluation Design*** will be used for the evaluation of Overall Strategies (Service Coordination Strategy and OneCare Kansas program) and Hypothesis 1. This will provide a possibility to assess causal inference between interventions and outcomes for these evaluations. The ***Pretest–Posttest Design with Nonequivalent Groups Design*** will be used for the evaluation of Hypothesis 2. This will also provide a possibility to assess causal inference.

As the demonstration strategies related to the three components of the Hypothesis 3 will be developed during the five-year period by the MCOs (subject to State guidelines and approval) and appropriate comparison group is currently not available, **Non-experimental method (One-Group Pretest–Posttest Design)** will be used to examine the evaluation questions. This will limit the ability to assess any causal relationship between the use of telehealth services and access or health outcomes among members living in rural or semi-urban areas.

Due to changes in the data system, pre-demonstration data on the participating members' characteristics and outcomes will not be used. Therefore, **Non-experimental methods (descriptive data)** will be used for conducting the evaluation of Hypothesis 4. Only descriptive data will be examined for assessing the evaluation question; therefore, association between the intervention and improved beneficiary access to SUD treatment services within IMDs cannot be assessed.

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

Data lag also causes a challenge in measuring and reporting change in a timely manner. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.

As evaluation is based on five-year period, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period, thus leading to unavailability of appropriate data for the analysis of multiple pre- and post- intervention evaluation points needed for comparative interrupted time series and one group pretest-posttest designs.

Comparison group options using members who are the members of the intervention's target population will be applied, therefore, there is a possibility of encountering methodological issues (such as selection bias due to differences in the characteristics of members opting-in for the participation in the intervention and those not opting-in, spillover effects, multiple treatment threats due to other interventions, effect of confounding variables, inadequate statistical power, and multiple comparisons issue) that will require application of appropriate techniques.[15,16] Appropriate techniques will be applied to address these issues as much as possible.

To have an adequate number of members in the Intervention and comparison groups for the evaluation of overall service coordination strategies (Service Coordination Strategy and OneCare Kansas program) and Hypothesis 1, the entire eligible population for the intervention and comparison groups will be included in the study, and pre- and post-intervention changes will be examined. However, if the eligible population is very large, then samples of eligible members with power calculations may be used to ensure validity of the findings.

Over the five-year period, eligibility for receiving Medicaid services may change for some members and they may not be the part of Intervention or Comparison Groups. Also, during subsequent years, some members may opt in or opt out of the interventions. This issue will be monitored and addressed accordingly by applying appropriate techniques (Intent-to-treat analysis; exclusion from analysis, etc.).

E. Special Methodological Considerations

MCOs are in the process of developing strategies for the implementation of the value-based provider incentive program. Therefore, final evaluation design and measures may need modifications based on specific aspects of the program.

MCOs have not yet developed specific strategies for the use of telehealth services and an appropriate comparison group cannot be currently be identified, therefore, a rigorous scientific design with additional comparison group (such as a comparative interrupted time series design) could not be used for the evaluation of Hypothesis 3. As mentioned above, a less rigorous non-experimental method (One-Group Pretest–Posttest Design) will be used. This will limit the ability to examine any causal relationship between use of telehealth services and access or health outcomes among members.

As mentioned above, due to data system changes, pre-demonstration data will not be used limiting the ability to compare pre- and post-intervention outcomes, a scientifically rigorous design could not be used for the evaluation of Hypothesis 4. For this evaluation, only descriptive data will be examined over the demonstration period.

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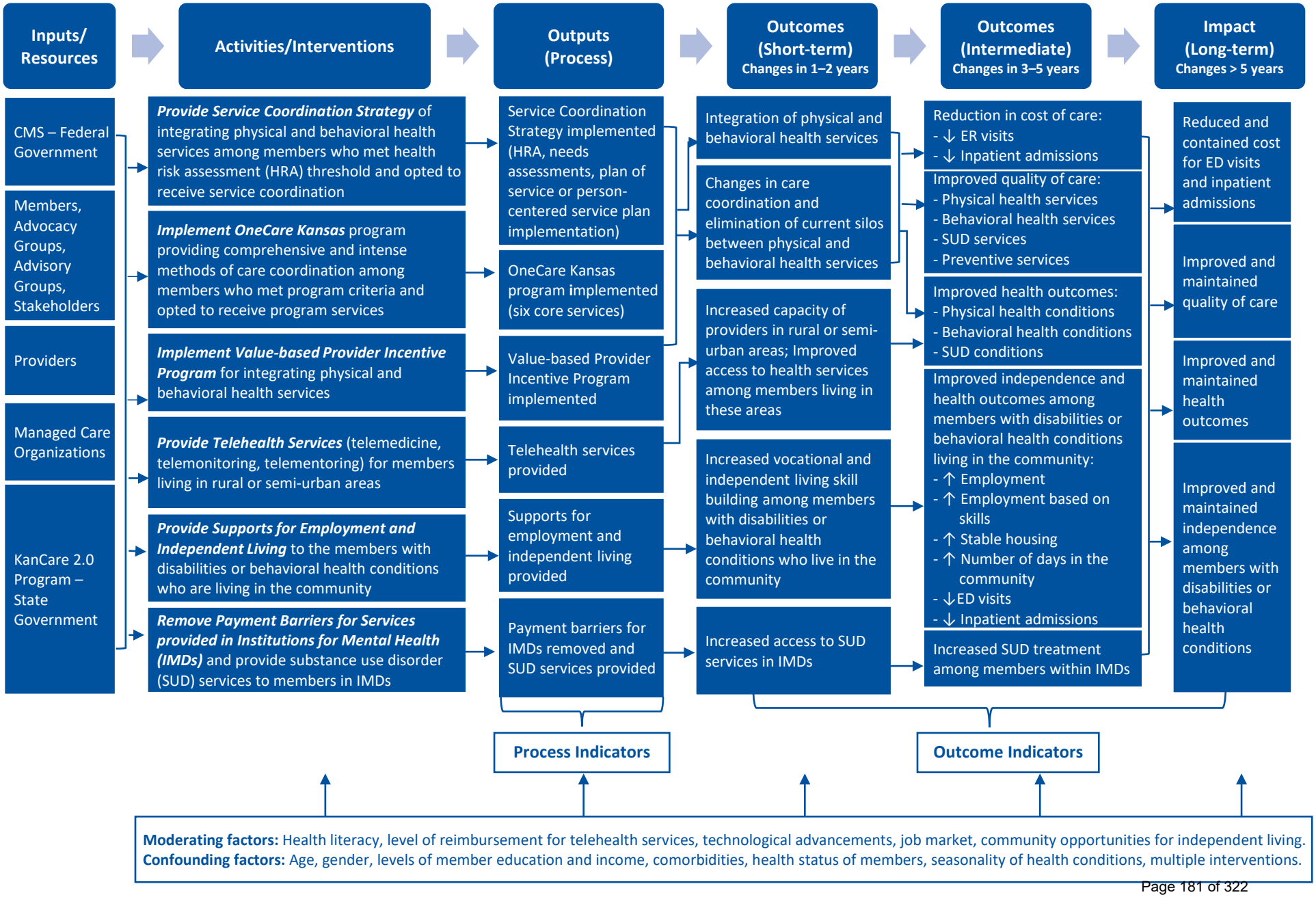
Appendices

Appendix 1: Logic Model for KanCare 2.0 Demonstration



Appendix 2: Detailed Summary of Performance Measures

Table A2.1. Detailed Summary of Performance Measures for Service Coordination Strategy

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Annual Dental Visit (ADV) Percentage of members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during the measurement year.	Percentage	Medicaid Management Information System (MMIS) Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems.
Adults' Access to Preventive/ Ambulatory Health Services (AAP) Percentage of Medicaid members 20 years & older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
Adolescent Well-Care Visits (AWC) Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
Follow-Up After Hospitalization for Mental Illness (FUH) Percentage of discharges for members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses & who had a follow-up visit with a mental health practitioner within 7 days after discharge.	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received: • **Initiation of AOD treatment:** % of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • **Engagement of AOD treatment:** % of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.	NCQA	**Initiation:** Members who were diagnosed with a new episode of AOD abuse or dependence during the first 10½ months of the measurement year. **Engagement:** Members who were diagnosed with a new episode of AOD during the first 10½ months of the measurement year.	**Initiation:** Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD). **Engagement:** Members who began initiation of AOD treatment within 14 days of IESD & had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits will be defined as per HEDIS administrative specifications].	**Initiation:** Percentage **Engagement:** Percentage	Same as above.
Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set®* (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for Intervention & Comparison Groups designed for the evaluation of *Service Coordination* strategy.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.1. Detailed Summary of Performance Measures for Service Coordination Strategy (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Antidepressant Medication Management (AMM) Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression & who remained on an antidepressant medication treatment: • **Effective Acute Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • **Effective Continuation Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications]. **Effective Continuation Phase Treatment:** Same as above.	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD. **Effective Continuation Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs Member-level case management data systems.
ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions • Diabetic Ketoacidosis/ Hyperglycemia, or • Acute severe asthma, or • Hypertensive crisis, or • Fall injuries, or • SUD, or • Mental health issues	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
Outpatient or professional claims for following conditions: • Diabetic retinopathy, or • Influenza, or • Pneumonia, or • Shingles	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
Emergency department visits per 1,000 member-months	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions	NCQA	Members, 18 years & older enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.
Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set®* (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of *Service Coordination S*trategy.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.2. Detailed Summary of Quantitative Performance Measures for OneCare Kansas Program

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Annual Dental Visit (ADV) Percentage of Medicaid members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during the measurement year.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; OneCare Kansas members' eligibility & participation database; MCOs Member-level case management data systems.
Adults' Access to Preventive/Ambulatory Health Services (AAP) Percentage of Medicaid members 20 years & older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
Adolescent Well-Care Visits (AWC) Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
Follow-Up After Hospitalization for Mental Illness (FUH) Percentage of discharges for members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses & who had a follow-up visit with a mental health practitioner within 7 days after discharge.	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received: • **Initiation of AOD treatment:** Percentage of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • **Engagement of AOD treatment:** Percentage of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.	NCQA	**Initiation:** Members who were diagnosed with a new episode of AOD abuse from January 1 – November 13 of the measurement year. **Engagement:** Members who were diagnosed with a new episode of AOD from January 1 – November 13 of the measurement year.	**Initiation:** Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD). **Engagement:** Members who began initiation of AOD treatment within 14 days of IESD & had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits will be defined as per HEDIS administrative specifications].	**Initiation:** Percentage **Engagement:** Percentage	Same as above.
Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set®* (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of *OneCare Kansas* program.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.2. Detailed Summary of Quantitative Performance Measures for OneCare Kansas Program (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Antidepressant Medication Management (AMM) Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression & who remained on an antidepressant medication treatment: • **Effective Acute Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • **Effective Continuation Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications.] **Effective Continuation Phase Treatment:** Same as above.	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD. **Effective Continuation Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.	Percentage	(MMIS Encounter database; MMIS Eligibility and Enrollment database; OneCare Kansas members' eligibility & participation database; MCOs' member-level case management data systems.
ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions (Administrative): • Diabetic Ketoacidosis/ Hyperglycemia, or • Acute severe asthma, or • Hypertensive crisis, or • Fall injuries, or • SUD, or • Mental health issues	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
Outpatient or professional claims for following conditions: • Diabetic retinopathy, or • Influenza, or • Pneumonia, or • o Shingles	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
Emergency department visits per 1,000 member-months	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions.	NCQA	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.

Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set®* (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019.
Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of OneCare Kansas program.

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.3. Detailed Summary of Qualitative Performance Measures for OneCare Kansas Program			
Performance Measure	**Steward**	**Unit of Measure**	**Data Source**
Learning needs identified by the OneCare Kansas Learning Collaborative.	N/A	Similar and dissimilar themes based on content and narrative analyses	OneCare Kansas Learning Collaborative reports.
Processes to address the learning needs identified by the OneCare Kansas Learning Collaborative.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Factors that facilitated the implementation of the OneCare Kansas program to achieve its goal.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Barriers encountered in implementation of the OneCare Kansas program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about how the quality of OneCare Kansas program can be further improved.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Observations why this program was able to succeed or why it did not meet its goals.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Additional qualitative measures will be examined based on the themes identified from the information obtained from the OneCare Kansas Learning Collaborative members.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Qualitative data will be collected through OneCare Kansas Learning Collaborative reports. Qualitative data analysis procedures will be applied.			

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Annual Dental Visit (ADV) Percentage of Medicaid members, 2–20 years, who had one or more dental visit with a dental practitioner during the measurement year.	NCQA	Medicaid members 2–20 years of age.	Members 2–20 years of age who had one or more dental visit with a dental practitioner during measurement year.	Percentage	MCOs' administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Programs performance measures.
Adults' Access to Preventive/Ambulatory Health Services (AAP) Percentage of Medicaid members 20 years & older who had an ambulatory or preventive care visit during the measurement year.	NCQA	Medicaid members 20 years & older.	Members 20 years & older who had one or more ambulatory or preventive care visits during the measurement year.	Percentage	Same as above.
Adolescent Well-Care Visits (AWC) Percentage of Medicaid members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	NCQA	Medicaid members 12–21 years of age.	Members, 12–21 years, who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	Percentage	Same as above.
Follow-Up After Hospitalization for Mental Illness (FUH) Percentage of discharges for members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses & who had a follow-up visit with a mental health practitioner within 7 days after discharge.	NCQA	Medicaid members, 6 years & older, who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses.	A follow-up visit with a mental health practitioner within 7 days of discharge.	Percentage	Same as above.
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) abuse or dependence who received: • **Initiation of AOD treatment:** Percentage of members who initiate a treatment through inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. • **Engagement of AOD treatment:** Percentage of members who initiated treatment and who are engaged in ongoing AOD treatment within 34 days of the initiation visit.	NCQA	**Initiation:** Members who were diagnosed with a new episode of AOD abuse or dependence during the first 10½ months of the measurement year. **Engagement:** Members who were diagnosed with a new episode of AOD during the first 10½ months of the measurement year.	**Initiation:** Members who began initiation of AOD treatment within 14 days of the index episode start date (IESD). **Engagement:** Members who began initiation of AOD treatment within 14 days of IESD & had two or more engagement visits within 34 days after the date of the initiation visit. [Engagement visits defined as per HEDIS administrative specifications].	**Initiation:** Percentage **Engagement:** Percentage	Same as above.
Denominators and numerators will be defined and calculated as per *Healthcare Effectiveness Data and Information Set*® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Antidepressant Medication Management (AMM) Percentage of members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression & who remained on an antidepressant medication treatment: • **Effective Acute Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 84 days (12 weeks). • **Effective Continuation Phase Treatment:** Percentage of members who remained on an antidepressant medication for at least 180 days (6 months).	NCQA	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication, had a diagnosis of major depression. [Eligible population for denominator will be defined as per HEDIS administrative specifications]. **Effective Continuation Phase Treatment:** Same as above.	**Effective Acute Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 84 days (12 weeks), beginning on the Index prescription Start Date (IPSD) through 114 days after IPSD. **Effective Continuation Phase Treatment:** Medicaid members, 18 years and older, who were treated with antidepressant medication for at least 180 days (6 months), beginning on IPSD through 231 days after IPSD.	Percentage	MCOs' administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs Member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Programs performance measures.
ED visits, observation stays, or inpatient admissions per 1,000 member-months for following conditions: o Diabetic Ketoacidosis/ Hyperglycemia, or o Acute severe asthma, or o Hypertensive crisis, or o Fall injuries, or o SUD, or o Mental health issues	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number (#) of ED visits, observation stays, or inpatient admissions for diabetic ketoacidosis /hyperglycemia, or acute severe asthma, or hypertensive crisis, or fall injuries, or substance use disorder, or mental health issues.	1,000 member-months	Same as above.
Outpatient or professional claims for following conditions: o Diabetic retinopathy, or o Influenza, or o Pneumonia, or o Shingles	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of Outpatient or professional claims for diabetic retinopathy, or influenza, or pneumonia, or shingles.	1,000 member-months	Same as above.
Emergency department visits per 1,000 member-months	N/A	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of ED visits during the measurement period.	1,000 member-months	Same as above.
Inpatient Utilization—General Hospitalization/Acute Care (IPU), excluding maternity admissions.	NCQA	Members, 18 years & older, enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	# of acute inpatient discharges (excluding discharges for maternity admissions) during the measurement period.	Days per 1,000 member-months	Same as above.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Identification of Alcohol and Other Drug Services (IAD) Percentage of members with an alcohol and other drug (AOD) claim who received chemical dependency services during the measurement year.	NCQA	Medicaid members with an AOD diagnosis during the measurement year.	Medicaid members with an AOD diagnosis who received a specific AOD-related service including inpatient, intensive outpatient or partial hospitalization, outpatient or medication treatment, ED visit, telehealth, or any service during the measurement year.	Percentage	MCOs' administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Programs performance measures.
Follow-Up Care for Children Prescribed ADHD Medication (ADD) Percentage of children newly prescribed ADHD medication who had at least 3 follow-up care visits within 10-month period: • **Initiation Phase**: Percentage of members 6–12 years as of IPSD with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during 30-day Initiation Phase. • **Continuation & Maintenance (*C&M*) Phase:** Percentage of members 6–12 years as of IPSD with an ambulatory prescription dispensed for ADHD medication, who remained on medication for at least 210 days and in addition to a visit in Initiation Phase, had at least two follow-up visits with practitioner within 270 days (9 months) after Initiation Phase ended.	NCQA	**Initiation Phase**: Children 6–12 years as of IPSD, with an ambulatory prescription dispensed for ADHD medication, and continually enrolled in Medicaid (120 days before IPSD through 30 days after IPSD). ***C&M* Phase:** Children 6–12 years as of IPSD, continually enrolled in Medicaid (120 days before IPSD through 300 days after IPSD) with an ambulatory prescription dispensed for ADHD medication, & who remained on medication for at least 210 days.	**Initiation Phase:** Eligible members with an outpatient, intensive outpatient or partial hospitalization follow-up visit with practitioner with prescribing authority within 30 days after the IPSD. ***C&M* Phase:** Eligible members with an outpatient, intensive outpatient or partial hospitalization follow-up visit with practitioner with prescribing authority within 30 days after the IPSD **and** at least two follow-up visits on different dates of service with any practitioner, from 31-300 days (9 months) after IPSD.	Percentage	Same as above.
Use of Opioids at High Dosage (HDO) Proportion of members, 18 years and older, who received prescription opioids at a high dosage (average morphine milligram equivalent dose [MME] ≥90) for ≥15 total days during measurement period.	NCQA	Medicaid members, 18 years and older, who met following criteria: • Two or more opioid dispensing events on different dates of service; and • ≥15 total days covered by opioids.	Number of members whose average MME was ≥90 during treatment period.	Percentage	Same as above.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.4. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program (Continued)					
Performance Measure	**Steward**	**Denominator**	**Numerator**	**Unit of Measure**	**Data Source**
Use of Opioids from multiple providers (UOP) Proportion of members, 18 years and older, receiving prescription opioids for ≥15 days during measurement period who received opioids from multiple providers. • **Multiple Prescribers:** Proportion of members receiving prescriptions for opioids from four or more different providers during the measurement year.	NCQA	Medicaid members, 18 years and older, who met following criteria: • Two or more opioid dispensing events on different dates of service; and • ≥15 total days covered by opioids.	Members who received prescriptions for opioids from four or more different providers during the measurement year	Percentage	MCOs' administrative databases on Value-Based Provider Incentive Programs; MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems; MCO databases/ tables for Value-based Provider Incentive Program performance measures.
Mental Health Utilization (MPT) Percentage of members receiving mental health services (inpatient, intensive outpatient or partial hospitalization, outpatient, ED, telehealth, or any service) during the measurement year.	NCQA	Medicaid members with a diagnosis of mental illness during the measurement year.	Members who received mental health services) during the measurement year.	Percentage	Same as above
MCO-specified measures on effectiveness of their value-based purchasing program on increasing physical and behavioral health service integration. To be Determined (TBD)	TBD	TBD	TBD	TBD	MCO measured data.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. Performance Measures: Measures will be calculated for the Intervention and Comparison Groups designed for the evaluation of Hypothesis 1.					

Table A2.5. Detailed Summary of Qualitative Performance Measures for KanCare 2.0 Hypothesis 1 – Value-Based Provider Incentive Program			
Performance Measure	**Steward**	**Unit of Measure**	**Data Source**
Factors that facilitated the implementation of the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Online provider survey and key informant interviews of the providers participating in the *Value-Based Provider Incentive Program.*
Barriers encountered in implementing the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about ways to further improve the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Recommendations about ways to remove barriers encountered in the implementation of the Value-Based Provider Incentive Program.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Observations why this program was able to succeed or why it did not meet its goals.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Additional qualitative measures based on the themes identified from the survey and Key informant interviews.	N/A	Similar and dissimilar themes based on content and narrative analyses	Same as above.
Qualitative data will be collected through online provider survey and/or key-informant interviews with the providers participating in the Value-Based Provider Incentive Program. Qualitative data analysis procedures will be applied.			

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.6. Detailed Summary of Performance Measures for KanCare 2.0 Hypothesis 2 – Provision of Supports for Employment & Independent Living to the Members with Disabilities and the Behavioral Health Conditions who are Living in the Community

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Current employment status.	N/A	Study Population (members living in the community & receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination & potentially needing employment or independent living supports).	Members in study population who are currently employed.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database; MCOs' member-level case management data systems.
Percentage of members who felt they were employed based on their skills and knowledge (if employed).	N/A	Members in study population who are currently employed.	Members who are currently employed & felt they were employed based on their skills and knowledge.	Percentage	Same as above.
Percentage of members with stable housing – number of addresses member lived in the past year.	N/A	Members in study population.	Members with one or two addresses in the past year.	Percentage.	Same as above.
Current legal problems (e.g., probation, parole, arrests).	N/A	Members in study population.	Members with no current legal problems.	Percentage	Same as above.
Number of days in the community.	N/A	N/A	Average # of days members live in the community.	Days in the community	Same as above.
Percentage of members who worried about paying bills.	N/A	Members in study population.	Members who worried about paying bills.	Percentage	Same as above.
ED visits per 1,000 member-months.	N/A	Members in study population (enrolled in Medicaid for at least 30 consecutive days during the measurement period).	# of ED visits during the measurement period.	1,000 member-months	Same as above.
Inpatient hospitalizations (excluding discharges for maternity admissions) per 1,000 member-months.	N/A	Members in study population (enrolled in Medicaid for at least 30 consecutive days during the measurement period).	# of acute inpatient discharges during the measurement period.	1,000 member-months	Same as above.
Study Population includes members living in the community & receiving behavioral health services or HCBS services in the PD, I/DD, and BI waiver programs who opted for service coordination & potentially needing employment or independent living supports.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.7. Detailed Summary of Quantitative Performance Measures for KanCare 2.0 Hypothesis 3 – Use of Telehealth Services (Telemedicine; Telemonitoring)					
Performance Measure	**Steward**	**Denominator**	**Numerator**	**Unit of Measure**	**Data Source**
Telemedicine					
Percentage of telemedicine services received by the members living in the rural or semi-urban areas (potential stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Number (#) of telemedicine services received by the members living in the rural or semi-urban areas.	Percentage	MMIS Encounter database; MMIS Eligibility and Enrollment database.
Number of receiving sites for telemedicine services in the rural and semi-urban areas. (potential stratification by service, specialty type, or diagnosis).	N/A	N/A	# of receiving sites for telemedicine services in the rural and semi-urban areas.	Sites	Same as above.
Percentage of members living in the rural or semi-urban areas who received telemedicine services (potential stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Medicaid members living in the rural or semi-urban areas who received telemedicine services.	Percentage	Same as above.
Number of paid claims with selected procedure codes (stratified by area, mode of delivery, and provider specialty).	N/A	N/A	Number of paid claims with selected procedure codes.	Paid claims	Same as above.
Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members.	N/A	Medicaid members living in the rural or semi-urban areas.	Number of members with selected diagnosis (e.g., speech-language pathology).	1,000 members	Same as above.
Telemonitoring					
Percentage of members living in the rural and semi-urban areas who received telemonitoring services (stratification by service, specialty type, or diagnosis).	N/A	Medicaid members living in the rural or semi-urban areas.	Medicaid members living in the rural or semi-urban areas who received telemonitoring services.	Percentage	Same as above.
Number of telemonitoring services provided to members living in the rural and semi-urban areas.	N/A	N/A	# of telemonitoring services received by the members living in the rural or semi-urban areas.	Telemonitoring services	Same as above.
Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.	N/A	N/A	# of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.	Providers	Same as above.
Other appropriate measures related to specific telemonitoring strategies implemented for the members living in the rural and semi-urban areas.	To be determined (TBD)	TBD	TBD	TBD	TBD
Other appropriate data sources for measures will be identified later in accordance with specific telehealth strategies.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.8. Detailed Summary of Qualitative Performance Measures for KanCare 2.0 Hypothesis 3 – Use of Telehealth Services (Telemedicine; Telemonitoring)			
Performance Measure	**Steward**	**Unit of Measure**	**Data Source**
Factors that facilitated the use of telemedicine and/or telemonitoring services for the Medicaid members.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Barriers encountered in using telemedicine and/or telemonitoring services for the Medicaid members.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Recommendations about how to further improve the use of telemedicine and/or telemonitoring services.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Recommendations about how to remove barriers encountered in using telemedicine and/or telemonitoring services.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Observations why the use of telemedicine and/or telemonitoring services succeeded or did not succeed in increasing the access to care for the Medicaid members in rural and semi-rural areas.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Additional qualitative measures based on the themes identified from the survey and key informant interviews.	N/A	Similar and dissimilar themes based on content and narrative analyses.	Online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services.
Qualitative data will be collected through online provider survey and/or key-informant interviews with the providers who submitted claims for telemedicine and/or telemonitoring services. Qualitative data analysis procedures will be applied.			

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.9. Detailed Summary of Performance Measures for Monitoring of Overall KanCare 2.0 Program

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Prenatal and Postpartum Care (PPC) Percentage of deliveries of live births on or between October 8 of the year prior to measurement year and October 7 of the measurement year: • Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. • Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 & 84 days after delivery.	NCQA	Number (#) of deliveries of live births on or between October 8 of the year prior to measurement year and October 7 of the measurement year among women continually enrolled in Medicaid.	• A prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment. • A postpartum care visit on or between 7 and 84 days after delivery.	Percentage	MCO HEDIS data.
Comprehensive Diabetes Care (CDC) Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: • Hemoglobin A1c (HbA1c) testing; • HbA1c poor control (>9.0%); • HbA1c control (<8.0%); • Eye exam (retinal) performed; • Medical attention for Nephropathy; • BP control (<140/90 mm Hg).	NCQA	Members 18-75 years of age with diabetes (type 1 and type 2) enrolled in Medicaid during the measurement year.	**HbA1c testing:** A HbA1c test performed during the measurement year. **HbA1c poor control (>9.0%):** Most recent HbA1c level is >9.0% or is missing a result, or if test was not done during the measurement year. **HbA1c control (<8.0%):** Most recent HbA1c level is <8.0%. **Eye exam (retinal) performed:** A retinal or dilated eye exam by eye care professional in the measurement year or a negative retinal or dilated eye exam in the year prior to measurement year or bilateral eye enucleation any time during the member's history through December 31 of the measurement year. **Medical attention for Nephropathy:** a nephropathy screening or monitoring test or evidence of nephropathy documented. **BP control (<140/90 mm Hg):** a member with most recent reading of BP <140/90 mm Hg taken during outpatient visit or a nonacute inpatient encounter during the measurement year.	Percentage	Same as above.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. HEDIS Measures: Measures will be calculated for the eligible KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.					

Appendix 2: Detailed Summary of Performance Measures (Continued)

Table A2.9. Detailed Summary of Performance Measures for Monitoring of Overall KanCare 2.0 Program (Continued)

Performance Measure	Steward	Denominator	Numerator	Unit of Measure	Data Source
Smoking and Tobacco Cessation Measure is based on the following Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey questions: • Do you now smoke cigarettes or use tobacco: every day, some days, or not at all? If response is "every day" or "some days": • 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? • In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? • In the last 6 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?	N/A	Number of survey respondents who currently smoke cigarettes or use tobacco every day or some days.	**Advice to quit smoking or using tobacco by a doctor or other health provider:** Current smokers who always/usually receive the advice. **Medication recommended or discussed by a doctor or health provider to assist with quitting smoking or using tobacco:** Current smokers to whom a doctor or health provider always/usually/sometimes recommended or discussed medication. **Doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco:** Current smokers with whom a doctor or health provider always/usually/sometimes discussed or provided methods and strategies other than medication.	Percentage	CAHPS Survey.
Improved ability to handle daily life and deal with crisis Measure is based on the following Mental Health (MH) Survey questions: **Youth:** As a direct result of the services my child and/or family received: • My child is better at handling daily life. • My child is better to cope when things go wrong. **Adults:** As a direct result of the services I received: • I deal effectively with daily problems. • I am better able to deal with crisis.	N/A	Number of survey respondents with responses "*Strongly Agree*," "*Agree*," "*Disagree*," or "*Strongly Disagree*."	**My child is better at handling daily life:** Number of responses marked "Strongly Agree" or "Agree." **My child is better to cope when things go wrong:** Number of responses marked "Strongly Agree" or "Agree." **I deal effectively with daily problems:** Number of responses marked "Strongly Agree" or "Agree." **I am better able to deal with crisis:** Number of responses marked "Strongly Agree" or "Agree."	Percentage	MH Survey.
Social and Community Engagement Measure is based on the following HCBS – CAHPS Survey questions: • Ability to get together with family who live nearby; • Ability to get together with friends who live nearby; • Ability to do things in the community; • Have enough help from staff to do things in the community; • Decided what to do with your time each day; • Decided when to do things each day.	N/A	Number of eligible survey respondents.	• **Ability to get together with family who live nearby:** Number of responses marked "Always" • **Ability to get together with friends who live nearby:** Number of responses marked "Always" • **Ability to do things in the community:** Number of responses marked "Always" • **Have enough help from staff to do things in the community:** Number of responses marked "Yes" • **Decided what to do with your time each day:** Number of responses marked "Yes" • **Decided when to do things each day:** Number of responses marked "Yes"	Percentage	HCBS – CAHPS Survey.
Denominators and numerators will be defined and calculated as per Healthcare Effectiveness Data and Information Set® (HEDIS) 2020 Technical Specifications for Health Plans, NCQA, 2019. HEDIS Measures will be calculated for the KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.					

Appendix 3: Detailed Discussion of Data Sources

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3)

Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
Medicaid Management Information System (MMIS) Encounter database.	Claims and Encounters.	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and HEDIS®-like performance, Medication Assisted Treatment, service utilization, and cost metrics for all enrollees.	• MMIS member demographics, enrollment, & encounter data obtained from the database will be reviewed for missing values, duplicate values, inconsistent patterns, & outliers to ensure quality & appropriateness of data for analyses of performance measures required by the evaluation design. • Encounter data related pay-for-performance metrics are validated annually by KFMC as a part of their validation of all pay-for-performance metrics. • For applying statistical procedures for analysis of performance measures, a final dataset with all required variables will be created by merging data variables obtained from the MMIS database with data from other data sources.	• Encounters submitted to the State by MCOs are records of the billed claims MCOs receive from providers for service payment. Administrative claims and encounter data are routinely used in HEDIS and other performance measurement. These data sources will be used in the evaluation to determine changes in access to services, quality of care, and health outcomes. Most of the measures selected for assessment of the evaluation questions are validated and widely used for this purpose. • Data are generally considered complete if one quarter is allowed for claims processing and encounter submission. • There are known gaps in MCO submission of pharmacy encounters. • There is known inconsistency in the population of the MCO claim status field for zero-dollar paid claims.
MMIS Eligibility and Enrollment database.	Medicaid Eligibility & Enrollment data.	Eligibility & enrollment detail for Medicaid members used to determine enrollee aid category and stratify data into subgroups.	• Data variables obtained from MMIS Eligibility and Enrollment database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• Enrollment records include beginning and end dates for eligibility periods. • MCOs receive updated MMIS Eligibility and Enrollment data daily.
MCOs' member-level case management data systems.	Administrative data on health screening scores & service coordination.	Member-level data maintained by MCOs within their specific case management data systems.	• Data on health screening scores & service coordination obtained from the MCOs will be reviewed for missing values, duplicate values, inconsistent patterns, and outliers to ensure quality and appropriateness of data. The data will be used for creation of intervention and comparison groups, as well as for analyses of performance measures required by the evaluation design. • Data variables obtained from MCOs' member-level case management data systems will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• In the first year, MCOs are establishing the health screening and service coordination strategies; the database may not capture information on all members. • MCOs have different case management systems, which may be a barrier to aggregating data.
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3) – Continued

Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
OneCare Kansas eligibility & participation database.	Administrative data on OneCare Kansas eligibility and participation.	Eligibility and participation details for KanCare 2.0 members for the OneCare Kansas program used for determining groups.	• Record counts will be trended to assess data completeness. • Data variables obtained from database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• In the first year, the OneCare Kansas program will be establishing the data collection system and the database may not capture all information for members.
OneCare Kansas Learning Collaborative reports	Qualitative data will be collected from the OneCare Kansas Learning Collaborative.	The Learning Collaborative reports will provide information on evolving learning needs for continual quality improvement of OneCare Kansas system. Learning Collaborative will include multiple program components to support provider implementation of OneCare Kansas program.	• Information from the OneCare Kansas Learning Collaborative reports will be reviewed for completeness and clarity. • Themes will be identified to understand learning needs of the partners and ways to improve the quality of program.	• Over the five-year period, changes may occur in the collection process for the report information.
MCOs' administrative databases on Intervention and comparison Provider Incentive Programs.	Data on providers participating and not participating in the Intervention and comparison Provider Incentive Program	MCOs' administrative databases providing detailed provider data for identification of providers participating and not participating in the Intervention and comparison Provider Incentive Program for creation of the intervention & comparison groups & for subgroup stratification.	• Record counts will be trended to assess data completeness. • Data variables obtained from database will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• In the first year, MCOs are establishing the Intervention and comparison Provider Incentive Program and the database may not capture information on all members. • MCOs have different case management systems, which may be a barrier to aggregating data.
MCO databases/ tables for the intervention and comparison Provider Incentive Program performance measures.	MCO measured effectiveness measures for intervention and comparison Provider Incentive Programs.	MCO databases/tables providing data for performance measures assessing effectiveness of the intervention and comparison Provider Incentive Programs.	• Data validation will be a responsibility of the MCOs. • Data variables obtained from MCO databases/tables for intervention and comparison Provider Incentive Program performance measures will be merged with data from other data sources to create a final database for applying statistical procedures for analysis of performance measures.	• Each MCO may have different provider incentives, metrics, and reporting periods. This may prevent aggregation of results across MCOs.
Online provider survey of the providers participating in intervention and comparison Provider Incentive Programs.	Qualitative data to understand the facilitating factors & barriers and recommendations from providers to make the program successful in achieving its goal.	Online provider survey will be conducted to collect qualitative information from the providers participating in the intervention and comparison Provider Incentive Programs.	• Information from the online provider survey will be reviewed for completeness & clarity. • Themes will be identified to understand facilitating factors & barriers and ways make the program successful in achieving its goal.	• Low response rate of the survey is a potential barrier to evaluation. • Three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in identifying similar and dissimilar themes from the survey data.
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.1. Detailed Discussion of Data Sources for KanCare 2.0 Evaluation Design (Service Coordination Strategy; OneCare Kansas program; Hypothesis 1, Hypothesis 2 and Hypothesis 3) – Continued

Data Source	Type of Data Provided by the Data Source	Description of Data Source	Efforts for Cleaning/Validation of Data	Quality/Limitations of Data Source
Key informant interviews from a sample of the providers participating in the intervention and comparison Provider Incentive Programs.	Qualitative data to explore reasons why this program succeeded or why it did not meet its goals.	Key informant interviews will explore further in-depth the themes identified through the provider survey to assess the reasons why this program succeeded or why it did not meet its goals.	• Information from the key informant interviews will be reviewed for completeness & clarity. • The in-depth information on the themes identified through provider interviews will be summarized.	• Few providers may participate in the interviews. • Three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in identifying similar and dissimilar themes from the survey data.
Appropriate data sources for measures identified later in accordance with specific telehealth strategies	TBD	TBD	TBD	TBD
Online Provider Survey to collect qualitative information from the providers using telemedicine &/or telemonitoring services	Qualitative data on facilitators & barriers in using telemedicine &/or telemonitoring services & how the use of these services increases access to care in rural or semi-urban areas.	Online Provider Survey will be conducted to collect qualitative information on facilitators & barriers encountered by the providers in using telemedicine &/or telemonitoring services among members living in rural or semi-urban areas; & how the use of these services increases the access to care in rural or semi-urban areas.	• Information from the Online Provider Survey will be reviewed for completeness & clarity. • Themes will be identified to understand facilitating factors & barriers and ways make the program successful in achieving its goal.	• Few providers may participate in the survey. • Time consuming process. • As providers may not start using telemedicine &/or telemonitoring services at the same time, therefore may not have same amount of time and experience in using these services. This may cause complexity in identifying similar and dissimilar themes from the survey data.
Key informant interviews from a sample of the providers using telemedicine &/or telemonitoring services	Qualitative data to explore reasons why use of telemedicine &/or telemonitoring was succeeded or not succeeded in increasing the access to care.	Key Informant interviews will explore further in-depth the themes identified through provider survey to assess the reasons why telemedicine &/or telemonitoring was succeeded or not succeeded in increasing the access to care.	• Information from the key informant interviews will be reviewed for completeness & clarity. • The in-depth information on the themes identified through provider interviews will be summarized.	• Inadequate number of providers participating in the survey. • Time-consuming process. • As all three MCOs may not start the program at the same time, therefore all providers may not have same amount of time and experience with the program. This may cause complexity in exploring in-depth information of the program.
Data Sources will provide data for creation of intervention and comparison groups, stratification into subgroups, and calculation of denominators & numerators of the performance measures for implementation of one or multiple components of KanCare Evaluation Design.				

Appendix 3: Detailed Discussion of Data Sources (Continued)

Table A3.2. Detailed Discussion of Data Sources for Monitoring of the Overall KanCare 2.0 Performance Measures				
Data Source	**Type of Data Provided by the Data Source**	**Description of Data Source**	**Efforts for Cleaning/Validation of Data**	**Quality/Limitations of Data Source**
HEDIS data from MCOs.	Data for HEDIS performance measures.	Member-level detail tables for HEDIS measures submitted by the MCOs.	• Comparison of numerator and denominator counts to NCQA-certified compliance audit results. • Files provide numerator and denominator values for stratified HEDIS results. • The MCOs subcontract with HEDIS Certified Auditors to validate their HEDIS data for NCQA submission. • KFMC subcontracts with a different HEDIS Certified Auditor to conduct validation of MCO HEDIS data; CMS validation protocols are followed.	• Data Quality is closely monitored by the MCOs and EQRO. • MCOs use NCQA Certified HEDIS software to calculate HEDIS measures and submit data to NCQA as part of their NCQA accreditation requirement. • Data become available seven months after the measurement year. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration.
Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey	Member survey data	Survey results on consumer reported experiences with healthcare. Member-level data are not available.	• Validated by KFMC following CMS protocols. • Trend analysis will be performed.	• MCOs use NCQA Certified CAHPS vendors to conduct the survey and submit data to NCQA as part of their NCQA accreditation requirement. • Member-level results are not available.
Mental Health Survey	Member survey data	Member-level data are available.	• Trend analysis will be performed.	• Member-level data are available. However, sample sizes restrict subgroup analysis.
HCBS– CAHPS Survey	Member survey data	Member-level data are available.	• Trend analysis will be performed.	• Member-level data are available. However, sample sizes restrict subgroup analysis.
HEDIS Measures will be calculated for the KanCare 2.0 population and associated strata. CAHPS, MH and HCBS-CAHPS Survey measures will be calculated for eligible KanCare 2.0 population.				

Attachments

Attachment 1: Independent Evaluator

Attachment 2: Evaluation Budget

Attachment 3: Timeline and Major Milestones

Attachment 1: Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the evaluation of KanCare 2.0 at the level of detail needed to research the approved hypotheses. They have agreed to conduct the demonstration
evaluation in an independent manner in accord with the CMS-approved draft Evaluation Design. KFMC has over 45 years of demonstrated success in carrying out both Federal and State healthcare quality related contracts. They have provided healthcare quality improvement, program evaluation, review, and other related services including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (over 24 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (38 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (19 years) and for five other states.

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

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

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

- Relationships with Insurance Organizations or Subcontractor of Insurance Organizations
- Relationships with Providers or Suppliers Furnishing Health Services Under Medicare
- Financial Interests in Health Care Related Entities
- Investments in Medical Companies, Healthcare or Medical Sector Funds
- Governing Body Positions

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Attachment 2: Evaluation Budget

Job Description	Description of Services	FTE	Cost
Researchers: • Epidemiologist Consultant (MBBS, PhD, MPH) • Senior Health Data Analyst (PhD, MA)	• Work with State and MCOs defining and developing measures (>65 measures with multiple indicators each). • Work with State and MCOs on data collection tools, databases, and reports. • Obtain data; review for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data. • Create final dataset for each measure merging data from various sources. • Examine homogeneity of the demographic characteristics of the members in Intervention and Comparison Group 2 for applicable study. • Conduct analysis according to the design, including trend, comparison, and regression analysis as appropriate. • Interpret analysis at least annually and create interim and summative reports.	.93	$120,000
Analyst and Programmers • Quality Review Analyst (RN) • Programmer	• Assists Researchers with steps noted above. • Assist with case record review as needed, ensuring inter-rater-reliability. • DSRIP evaluation.	.29	$35,680
Contract and Project Managers: • EQRO Director (RN, BSN, MSW, CCEP) • Project Manager (LMSW)	• Work with State and MCOs defining and developing measures. • Work with State and MCOs on data collection tools, databases, and reports. • Oversee evaluation operations and timelines to ensure deliverables are met. • Provider routine monthly or quarterly updates to KDHE regarding evaluation progress. • Assist with interpretation of data findings. • Assist with interim and summation report writing, • Facilitate communications with the Researchers, State, and MCOs as needed. • Assist with case record review as needed, ensuring inter-rater-reliability. • DSRIP evaluation.	.13	$22,681
Project Specialist • Administrative support • Data entry	• Provide administrative support for report development and submission. • Assist with data abstraction or data entry as needed/appropriate.	.13	$11,495
Total Annual Cost: *Evaluation time period; July 2019 through June 2025 (6 years); June 2025 is the due date of Draft Summative Evaluation Report, 18 months after the end of the demonstration date of December 2023.		1.5	$189,856

Attachment 3: Timeline and Major Milestones

Deliverable/Activity	Due Date(s)
Initiate meetings with EQRO/State/MCOs to finalize study measures, determining data sources.	July 31, 2019
Conduct meetings at least quarterly (more frequently in first year) with EQRO/State/MCOs to review and discuss data sources, reports, and findings.	To be determined
Quarterly update of KanCare 2.0 Evaluation progress.	August 31; November 30; February 28; May 31
Annual progress report of KanCare 2.0 Evaluation and key findings.	By April 1
Draft Interim Evaluation Report, in accordance with Attachment N (Preparing the Evaluation Report) of the STCs, will discuss evaluation progress and findings to date.	One year prior to the end of the demonstration **(December 2022)**, or with renewal application (to be determined)
Final Interim Evaluation Report.	60 days after receipt of CMS comments
Draft Summative Evaluation Report in accordance with Attachment N of the STCs.	18 months from the end of the demonstration **(June 2025)**
Final Summative Evaluation Report.	60 calendar days after receipt of CMS comments

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References

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Delivery System Reform Incentive Payment (DSRIP) Pool Evaluation Plan

Contract Number: 46100

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Kansas Delivery System Reform Incentive Payment pool (DSRIP) Evaluation Plan

The Delivery System Reform Incentive Payment (DSRIP) pool program is a component of the Kansas Section 1115 demonstration waiver, KanCare, which was approved for renewal from January 1, 2019 through December 31, 2023. The Kansas DSRIP projects were implemented in 2015 and now extend through 2020. An Alternate Payment Model (APM) program will replace DSRIP. This updated evaluation plan reflects an additional two years of DSRIP assessment and a final overall evaluation summary. The State will use the insights gained from DSRIP when determining metrics to test during the 2021 Bridge year. Experiences from DSRIP and the Bridge year will help inform the development of the APM program, effective 2022.

The DSRIP program supports hospital efforts to enhance access to health care, quality of care, and the health of patients and families they serve. The 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 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 hospitals, Children's Mercy Hospital (CMH) and the University of Kansas Health System (UKHS) that are major medical service providers to Kansas residents. The CMH projects are, "Expansion of Patient Centered Medical Homes and Neighborhood," and "Implementation of Beacon Program to Improve Care for Children with Medical Complexity (CMC)." The UKHS projects are "Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)," and "STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis." As the DSRIP funding is based on provision of services to Medicaid and uninsured Kansas residents, the approved metrics and the overall DSRIP evaluation focus on Kansas populations. The Kansas Foundation for Medical Care, Inc., (KFMC) is the External Quality Review Organization (EQRO) for the State's Medicaid program (KanCare) and the independent evaluator of the DSRIP program.

UKHS and CMH have specific semi annual reporting requirements and timelines that are monitored by the Kansas Department of Health and Environment, Division of Health Care Finance, (KDHE-DHCF) and evaluated by KFMC. Reports are submitted to CMS accordingly. The 2020 DSRIP year has been impacted by the COVID-19 pandemic, with UKHS, CMH, and their identified project participants focused on the pandemic response and ongoing non-COVID patient care. Patterns of availability and utilization of health care services have been altered, and quality measure data collection and reporting are affected.

Furthermore, methods for collecting additional DSRIP evaluation data are impacted by the need to help reduce administrative burden for the DSRIP hospitals and identified project participants, as they focus on the pandemic response.

The evaluation will identify lessons learned and achievements from 2015 through 2020 for each project and the DSRIP program overall. Data sources include quantitative and qualitative data from the following:

- UKHS and CMH DSRIP reports
- KFMC DSRIP evaluation reports
- KDHE key informant interviews/surveys

The evaluation will be structured by the phases of the DSRIP project, including:

- Pre-DSRIP implementation – program planning (including development of metric specifications, application templates, and reporting templates) and project proposal approval processes.
- Project implementation – learning collaborative and overlapping stages of defined activities and metrics (Appendix A):
  - **Infrastructure milestones (Category 1)** – laying the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
  - **Process milestones (Category 2)** – process changes and improvements.
  - **Quality and outcomes milestones (Category 3)** – Metrics associated with these milestones address the impact of the project on quality metrics and beneficiary outcomes.
  - **Population focused improvement milestones (Category 4)** – Metrics associated with the broader impact of the selected projects.
- Reporting and evaluation – DSRIP hospital reporting (semiannual and annual), State feedback, KFMC evaluation and recommendations, DSRIP hospital follow-up to recommendations, and overall DSRIP evaluation.

The following key evaluation themes will be addressed for the DSRIP phases noted above:

- Process and outcome successes
- Strengths
- Characteristics that facilitated success
- Process and outcome deficiencies
- Barriers to success
- Ability to spread/transfer successful processes
- Ability to sustain successes
- Other lessons learned
- Suggestions for future projects

Table 1 includes examples of specific topics to be considered when addressing the key evaluation themes.

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Table 1. Potential Topics for Evaluation
Changes to the health care system overall
Growth of Partnerships/collaboration – hospital to community providers/ and with clinical and community partners
Successes and challenges regarding DSRIP planning, implementation, and operation
Facilitation of DSRIP hospitals to address innovative population health efforts that Medicaid would not typically reimburse
Data sharing to improve quality of care and population health
Challenges associated with ongoing program maintenance and expansion and required policy changes
Strengthening perceived value and effectiveness of patient care models structured for population health management
Strategies used to address policy, legal, and business operation issues
Strategies for recruiting partners by type of partner (physician practices, other hospitals, NFs, EMS, non-clinical community organizations)
Connection with other programs and services received by participants
Hospital data collection and analytic capacity for meeting data reporting requirement and data exchanges with community partners
Organizational characteristics that had the most influence, positive or negative, on the ability to implement HIT strategies for data sharing
Use of rapid-cycle evaluation tools/PDSA
Progress by providers in building infrastructure to support redesigned processes of care delivery
Improvement in quality of care and health
Changes in data capabilities of reporting partners

Appendix A

Delivery System Reform Incentive Payment (DSRIP) Pool Evaluation Plan

CMS-Approved Project Metrics

For Categories 1 to 4

Kansas Foundation for Medical Care, Inc.

Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 1						
1.1	Identify community partners	Number of participating community partners (hospitals, nursing facilities, clinics, etc.	UKHS	Number of community partners interested/Total potential partners Number of community partners fully engaged/Total potential partners	10% of potential community partners	ongoing
1.2	Conduct assessment of readmission for HF patients with the participating	Identify patients eligible for SPARCC training	UKHS	Number of HF patients identified/Number of potential HF patients in the 43 identified counties	≥30%	ongoing
Category 2						
2.1	Develop train-the-trainer modules	Number of trainers prepared	UKHS	Number of trainers trained/Number of trainers required	75% of required trained for first 6 months	ongoing
2.2	Identify mechanisms by which to contact and disseminate information about the SPARCC	# patients who respond or indicate interest	UKHS	Number of patients identified/Total target number of patients	≥30%	ongoing
2.3	Patients participating	Number of patients participating in SPARCC/resilience training program and	UKHS	Number of patients that participate/Number of patients that are eligible	≥25%	ongoing
2.4	Develop virtual method to deliver and monitor program	Ability to deliver and monitor training remotely	UKHS	Beta test completed 6 months	Beta version validated	ongoing
Category 3						
3.1	Monitor HF/DM patients' blood glucose (BG)	Number of patients in HF training with comorbid DM/HF	UKHS	Number of patients with HF/DM reporting well-controlled or adequately controlled BG/Number of patients with poorly controlled BG	50% reporting well or adequately controlled BG	ongoing
3.2	Quality of life and functional health status	Measured by Patient Reported Outcomes Measurement Information System (PROMIS-29) Survey responses	UKHS	Baseline score/Post-intervention score	≥10% improvement	ongoing

Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 3 (Continued)						
3.3	Depression Assessment/Screening	Measured by the PROMIS Anxiety and Depression Form	CMS	Baseline score/post intervention score	≥10% improvement	ongoing
3.4	Daily Weight Monitoring	Measured by weekly weight and blood pressure readings as well as self-report (daily tracking) to the health professional. PROMIS-29 captures compliance via the functional health	UKHS	Enrolled patients weighing/# total patients enrolled	≥10% improvement	ongoing
3.5	Heart Failure Admission Rate	Measured by the average time between admissions for patients who have gone through SPARCC training	DAI	Rate of readmission for patients in the program/national readmission rate	≥10% improvement	ongoing
Category 4						
4.1a	Reduce overall ED utilization	# ED visits	Medicaid claims data statewide	Numerator: Number of ED visits Denominator: Population of the state (same reporting period)	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.1b		# of frequent users of ED	Medicaid claims data statewide	Numerator: Number of patients visiting the ED four times a year or more Denominator: Number of total ED visits	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"

Table A1: Supporting Personal Accountability and Resiliency for Chronic Conditions (SPARCC) (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 4 (Continued)						
4.2	Decrease 30-day, readmission rate following hospitalization	# of patients readmitted to the index hospital following a hospitalization	Medicaid claims data statewide	Numerator: Number of readmissions Denominator: Total hospital admissions	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.3	Controlling high blood pressure (HBP)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period	CMS	Numerator: Number of patients diagnosed with HBP whose BP was adequately controlled Denominator: Number of patients with a diagnosis of HBP	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.4	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	CMS	Numerator: Number of patients age 18+ screened and counseled if identified as a tobacco user Denominator: Total tobacco users identified	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"

Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 1						
1.1	Identify community partners	Nursing homes Long-Term Care Facilities Community Hospitals EMS	UKHS	Numerator: Number of facilities participating in sepsis initiative Denominator: Total number of potential facilities & EMS in designated areas	10% reduction in Gap or 10% increase in participation?)	2017
1.2	Database development	Number of community partners utilizing data to track sepsis and protocol activities	UKHS	Numerator: Number of registered facilities entering data Denominator: Number of facilities that register with database	10% increase in completion of data base	ongoing
1.3	Baseline Awareness Survey	Number of staff in participating facilities that are surveyed for their knowledge of the early signs and symptoms of sepsis and proper application escalation of care processes for the specific facility	UKHS	Numerator: Number of healthcare staff surveyed Denominator: Number of applicable healthcare staff in facility	10% reduction in Gap or 10% increase in participation?)	ongoing
Category 2						
2.1	LCA Engagement	Submission of monthly of data into the database	UKHS	Numerator: Number of registered facilities entering data Denominator: Number of facilities that register with database	10% increase in completion of data base	ongoing
2.2a	Educational curriculum development	Complete professional web-based modules	UKHS	Draft of Curriculum at start of project	BETA Curriculum 1.0 June 30, 2015	6/30/2015
2.2b		Complete Curriculum specific for nursing facilities	UKHS	Draft of Curriculum at start of project	BETA Curriculum 1.0 June 30, 2015	6/30/2015
Category 3						
3.1	Improved in-hospital implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign	Number of in-hospital documented, appropriate interventions using sepsis management bundles as defined by the Surviving Sepsis Campaign	Kansas Sepsis Project Database	Numerator: Number of hospitals following sepsis protocol Denominator: Number of hospitals with a protocol	10% reduction in Gap	ongoing
3.2	Increased ED identification of septic patients at any state of the continuum	Number of ED patients identified as septic pre- and post-implementation at each facility	Kansas Sepsis Database with DAI substantiation	Numerator: Number of patients identified with severe sepsis/septic shock at onset Denominator: Number of actual sepsis patients (identified at onset + identified retrospectively)	10% reduction in Gap	ongoing

Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 3 (Continued)						
3.3	Increased ED identification of septic patients in early stages of sepsis	Number of ED patients identified as septic at early stages at each facility	Kansas Sepsis Project Database	Numerator: Number of patients identified with early onset of sepsis Denominator: Number of actual early stage sepsis patients (identified at onset + identified retrospectively)	10% reduction in Gap	ongoing
3.4	Increased ED identification of septic patients with severe sepsis	Number of ED patients diagnosed initially with severe sepsis at each facility	Kansas Sepsis Database with DAI substantiation	Numerator: Number of patients identified with severe sepsis/septic shock at onset-early Denominator: Number of actual early stage sepsis patients (identified at onset + identified retrospectively)	10% reduction in Gap	ongoing
3.5	Increased ED identification of septic patients	Number of ED patients diagnosed initially with septic shock at each facility	Kansas Sepsis Project Database	Numerator: Number of patients identified with septic shock Denominator: Number of actual ED patients with septic shock (baseline)	10% reduction in Gap	ongoing
3.6	Improved ED implementation of sepsis management bundles as defined by the Surviving Sepsis Campaign	Number of ED documented, appropriate interventions using sepsis management bundles as defined by the Surviving Sepsis Campaign	Kansas Sepsis Project Database	Numerator: Number of EDs following sepsis protocol Denominator: Number of EDs with a protocol	10% reduction in Gap	ongoing
3.7	Decrease in transfer of septic patients to a higher level facility	Number of septic patients transferred to a higher level facility	Kansas Sepsis Database with DAI substantiation	Numerator: Number of septic patients transferred from a hospital Denominator: Total number of transferring hospital septic patients in timeframe	10% reduction	ongoing
3.8	Increased identification of septic patients transferred to the hospital from a long-term care facility	Number of septic patients transferred to the hospital from a long-term care facility who are identified as septic pre- and post-implementation at each participating facility	Kansas Sepsis Database with DAI substantiation	Numerator: Septic patients transferred in time to hospitals Denominator: Patients identified with severe sepsis or septic shock at the facility	Increase in appropriate transfers	ongoing
3.9	Decrease in proportion of septic patients progressing to septic shock after 12 months of facility participation	Ratio of septic shock patients to number of total of identified septic patients	Kansas Sepsis Database with DAI substantiation	Numerator: Total number of septic shock patients Denominator: Total # of severe sepsis + septic shock patients	10% reduction	ongoing

Table A2: STOP Sepsis: Standard Techniques, Operations, and Procedures for Sepsis (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 4						
4.1a	Reduce overall ED utilization	# ED visits	Medicaid claims data statewide	Numerator: Number of ED visits Denominator: Population of the state (same reporting period)	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.1b		# of frequent users of ED	Medicaid claims data statewide	Numerator: Number of patients visiting the ED four times a year or more Denominator: Number of total ED visits	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.2	Decrease 30-day, readmission rate following hospitalization	# of patients readmitted to the index hospital following a hospitalization	Medicaid claims data statewide	Numerator: Number of readmissions Denominator: Total hospital admissions	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.3	Controlling high blood pressure (HBP)	Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg) during the measurement period	CMS	Numerator: Number of patients diagnosed with HBP whose BP was adequately controlled Denominator: Number of patients with a diagnosis of HBP	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"
4.4	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user	CMS	Numerator: Number of patients age 18+ screened and counseled if identified as a tobacco user Denominator: Total tobacco users identified	10% improvement in the the metric each time reported for purposes of payment	"n/a (ongoing; likely beyond initial DSRIP period)"

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 1						
1.1	Build and define PCMH implementation team	Identification of a multidisciplinary team from each practice site to conduct an initial assessment of the practice readiness	Report	N/A	Documentation of PCMH implementation team	Q1 2015
1.2	NCQA PCMH Gap assessment of clinic(s)	Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria	Report	N/A	Report of gap assessment	Q3 2015
1.3	Build and define a Medical Neighborhood Support Team	Identification of Team Members representing network primary care practices and Children's Mercy Specialists	Report	N/A	Documentation of Medical Neighborhood Support Team	N/A
1.4	Gap assessment of processes necessary for specialty support of PCMH	Develop and implement a work plan to address gaps that will focus on the following elements: * Establish Collaborative Service Agreements (CSA) with primary care clinicians to exchange key information * Systematic approach to identify and track patients to coordinate care * Improve processes related to transitions to primary care from outpatient, ED, and inpatient services	Report	N/A	Report of gap assessment	Q4 2015
Category 2						
2.1	Develop and implement action plan for NCQA PCMH recognition and track processes associated with PCMH implementation	Documentation submission of the PCMH implementation work plan with periodic updates of progress in the areas described above	Report	N/A	Four practices with complete work plans	Q4 2017

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 2 (Continued)						
2.2	Percentage of Targeted Practices recognized as PCMH	Percent of selected clinics recognized PCMH	Report	N/A	Year 3 - Application period	Q4 2015
					Year 4 - 2 practices NCQA PCMH Level 1 or Higher	Q4 2016
					Year 5 - 3 Practices NCQA Level 1 or Higher	Q4 2017
2.3	Implement the action plan for Medical Neighborhood support of PCMH	Collaborative Service Agreements (CSA) use by selected practices with initial referral to CMH Specialists	Report	N/A	Year 3 - Plan for implementation in place	Q4 2015
					Year 4 - 10% of selected practice referrals to CMH contain CSA	Q4 2016
					Year 5 - 25% of selected practice referrals to CMH contain CSA	Q4 2017
Category 3						
3.1.a	Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity	Height/Weight/BMI screeningchildren 3-17 yoa	EHR/Claims	**BMI**	Year 3 - 39.2%	Q4 2015
				Baseline 34.7%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2017
				Denominator: Number of patients 3-17 yoa		

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 3 (Continued)						
3.1.b	Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity	Counseling for Nutrition for children 3-17 yoa	EHR/Claims	**Counseling for Nutrition**	Year 3 - 50%	Q4 2015
				Baseline 46.9%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2017
				Denominator: Number of patients 3-17 yoa		
3.1.c	Height/Weight/BMI screening with Counseling for Nutrition and Physical Activity	Counseling for Physical Activity for children 3-17 yoa	EHR/Claims	**Counseling for Physical Activity**	Year 3 - 47%	Q4 2015
				Baseline 44%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity	Q4 2017
				Denominator: Number of patients 3-17 yoa		

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 3 (Continued)						
3.2	Increase Immunization Rate in Children	Percent of patients who have completed recommended HEDIS combination 2 immunizations - children age 2 yoa	EHR/Claims	Baseline: 69% of patients aged 2 yoa have completed recommended HEDIS Combo 2 immunizations	Year 3 - 70.7% of patients age 2 yoa have completed recommended HEDIS Combo 2 immunizations	Q4 2015
				National benchmark - 90th		
				Numerator: The number of patients who received each of the following vaccines on or before their 2nd birthday: 4 DTaP; 3 IPV; 1 MMR; 3 HIB; 3 HepB; 1 VZV; 2 Influenza; and 2 Rotavirus (on or before 8 months of age)	Year 4 - 10% reduction in the gap to goal of HEDIS Combo 2 immunization rate in targeted population	Q4 2016
				Denominator: The number of patients who turn 2 years old during the measurement period	Year 5 - 10% reduction in the gap to goal of HEDIS Combo 2 immunization rate in targeted population	Q4 2017
3.3	Lead Screening	Percentage of children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	Hybrid Measure - Claims Data and Chart Review	Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test	Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests	Q4 2015
				National benchmark - 90th		
				Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday.	Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2016
				Denominator: Children who turn 2 years old during the measurement period	Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2017

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 3 (Continued)						
3.4	Anemia in Children	Percentage of children who turn two years of age who had hemoglobin and/or hematocrit testing for anemia screening by their second birthday	Hybrid Measure - Claims Data and Chart Review	Baseline:	Year 3 - 40% of children age two years of age will have one or more blood tests for anemia	Q4 2015
				Numerator: Children who turn two years of age during the measurement year with a hemoglobin and/or hematocrit test on or before the child's second birthday	Year 4 - 10% reduction in the gap to goal of screening rate in targeted population	Q4 2016
				Denominator: Children who turn 2 years old during the measurement period	Year 5 - 10% reduction in the gap to goal of screening rate in targeted population	Q4 2017
3.5	Adolescent Well-Care Visits	Percentage of patients 12-21 years of age who had at least one comprehenxive well-care visit.	Claims Data	Baseline: 42.3% of adolescents have at least one comprehensive well-care visit National benchmark - 90th: 65%	Year 3 - 44.6% of adolescents will have well-care visit	Q4 2015
				Numerator: Number of adolescent patients with two or more chronic conditions or one chronic condition that had a well-care visit.	Year 4 - 10% reduction in the gap to goal in well care visit rate in targeted population	Q4 2016
				Denominator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second in the measurement period.	Year 5 - 10% reduction in the gap to goal in well care visit rate in targeted population	Q4 2017

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 3 (Continued)						
3.6	Reduce ED Visits for patients with asthma	Percentage of patients 2-17 yoa with diagnosis of asthma that have had an ED visit for asthma in the last 6 months. (Exclude pregnancy, childbirth, transfer from other institution, additional diagnosis of cystic fibrosis or anomalies of the respiratory system).	DAI	Baseline: need to be determined	Year 3 - Baseline data collection	Q4 2015
				Numerator: Number of patients 2-17 yrs with a diagnosis of asthma who have one or more ED visits in the last 6 months	Year 4 - 5% reduction from baseline ED visit rate in targeted population	Q4 2016
				Denominator: Number of patients 2-17 yrs with a diagnosis of asthma	Year 5 - 10% reduction from baseline ED visit rate in targeted population	Q4 2017
Category 4						
4.1	ED utilization for asthma	X CMH ED visits with primary diagnosis of asthma/1,000 CMH patients with Kansas Medicaid and diagnosis of asthma	Report/EHR	Baseline rate 305/1,000	Year 3 - 300/1,000	Q4 2015
				Numerator: Number of CMH patients 2-17 yoa with a diagnosis of asthma who have 1 or more ED visits with primary diagnosis of asthma in the last 6 months	Year 4 - 2.5% decrease from baseline	Q4 2016
				Denominator	Year 5 - 5% decrease from baseline	Q4 2017
4.2	Decrease readmissions	30 day all-cause readmission rate following hospitalization for patients with Kansas Medicaid		Numerator: Number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30 days of admission to the hospital after an inpatient stay	Year 3 - Baseline data collection	Q4 2015
					Year 4 - 1% decrease from baseline	Q4 2016
				Denominator: The number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period	Year 5 - 2% decrease from baseline	Q4 2017

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 4 (Continued)						
4.3.a	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Height, weight, and body mass index (BMI) percentile documentation	EHR/Claims	**BMI**	Year 3 - 39.2%	Q4 2015
				Baseline 34.7%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2017
				Denominator: Number of patients 3-17 yoa		
4.3.b	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Counseling for nutrition	EHR/Claims	**Counseling for Nutrition**	Year 3 - 50%	Q4 2015
				Baseline 46.9%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2017
				Denominator: Number of patients 3-17 yoa		
4.3.c	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Counseling for physical activity	EHR/Claims	**Counseling for Physical Activity**	Year 3 - 47%	Q4 2015
				Baseline 44%	Year 4 & Year 5 - 10% reduction each year in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity	Q4 2016
				National benchmark - 90th		Q4 2017
				Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year.		
				Denominator: Number of patients 3-17 yoa		

Table A3: Expansion of Patient Centered Medical Homes and Neighborhood (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion date
Category 4 (Continued)						
4.4	Appropriate Testing for Children with Pharyngitis	The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	EHR/Claims	Baseline: 51.6%	Year 3 = 55.9%	Q4 2015
				National benchmark- 90th	Year 4 - 10% reduction in the gap to goal in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis	Q4 2016
				Numerator: A group A streptococcus test in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD	Year 5 - 10% reduction in the gap to goal in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis	Q4 2017
				Denominator: The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic		
4.5	Lead Testing	Percentage of children with Kansas Medicaid who had an outpatient well-child visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	EHR/Claims	Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test	Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests	Q4 2015
				National benchmark - 90th		
				Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday that have a well-child visit with a CMH Primary Care Physician.	Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2016
				Denominator: Children who turn 2 years old during the measurement period that have a well-child visit with a CMH Primary Care PHysician	Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2017

Table A4: Implementation of Beacon Program to Improve Care for CMC

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 1						
1.1	Build and define Beacon's PCMH implementation team	Identification of a multidisciplinary team from Beacon to conduct an initial assessment of the clinic's readiness assessement of the practice readiness	Report	N/A	Documentation of Beacon implementation team	Q1 2015
1.2	Conduct gap assessment of Beacon Program against NCQA PCMH criteria	Develop and implement a work plan to complete gap analysis against NCQA PCMH recognition criteria	Report	N/A	Report of gap assessment	Q3 2015
1.3	Expand Beacon Program staff in order to provide a comprehensive care coordination program for Kansas Medicaid CMC	Develop a multi-disciplinary team to implement and expand teh Beacon Program for Kansas Medicaid CMC	Report	N/A	Submission of annual FTE report	Q4 2015 Q4 2016 Q4 2017
1.4	Create reporting mechanisms/Electronic Care Plan Template	Submission of Care Plan delivered to internal and community based PCPs	Report	N/A	Care Plan Report Submission	Q4 2015
1.5	Develop electronic documentation templates and order sets to support the evidence-based care of and the reporing on the patients served by this clinic	Completion of electronic documentation templates and order sets	Report	N/A	Order sets report submission	Q4 2015 Q4 2016
Category 2						
2.1	Develop and implement action plan for NCQA PCMH recognition and track processes associated with PCMH implementation	Documentation submission of the PCMH implementation work plan with periodic updates of progress in the areas described above	Report	N/A	Work plan submission	Q4 2015
2.2	Beacon Program recognized as NCQA PCMH	Beacon Program is recognized as a Level III PCMH	Report	N/A	Year 3 - Application period	Q4 2015
					Year 4 - Beacon receives Level 3	Q4 2016

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 2 (Continued)						
2.3	Develop and implement the action plan for Medical Neighborhood support of Beacon	Collaborative Service Agreements (CSA) use by Beacon with initial referral to CMH Specialists	Report	N/A	Year 3 - Plan for implementation of Care Service Agreements	Q4 2015
					Year 4 - Implement the Plan for executing CSAs including significant changes to the EMR as well as staff training on use of CSAs to effectuate medical neighborhoods	Q4 2016
					Year 5 - 10% of Beacon referrals to Children's Mercy specialists and subspecialists contain CSAs	Q4 2017
Category 3						
3.1.a	Increase Immunization Rate in Children	Increase Immunization Rates for Children 2 years of age	DAI	Baseline: 38% for Beacon patients	Year 3 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile) (90th percentile for HHS Region 7 - 86%)	Q4 2015
				Numerator: The number of patients assigned to Beacon primary care provider who received each of the following vaccines on or before their 2nd birthday: 4 DTap; 3 IPV; 1 MMR; 3 HIB; 3 HepB; 1 VZV; 2 Influenza; and 2 Rotavirus (on or before 8 months of age)	Year 4 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile)	Q4 2016
				Denominator: The number of patients assigned to Beacon primary care provider who turn 2 years old during the measurement period	Year 5 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile)	Q4 2017

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 3 (Continued)						
3.1.b	Increase Immunization Rate in Children	Increase Immunization Rates for Children 6 years of age	DAI	Baseline: 75% for Beacon patients	Year 3 - Increase percentage by at least 10% annually or a total goal of at least 90%.	
				Numerator: The number of patients who are up-to-date on the following immunizations, including boosters: MMR, VZV, DTaP, IPV, Hep A, Hep B	Year 4 - Increase percentage by at least 10% annually or a total goal of at least 90%.	Q4 2016
				Denominator: The number of patients assigned to Beacon primary care provider who turn 6 years old during the measurement period	Year 5 - Increase percentage by at least 10% annually or a total goal of at least 90%.	Q4 2017
3.2.a	Increase Immunization Rate in Adolescents and Adults	Increase the percent of patients assigned to Beacon primary care provider who have completed recommended immunizations - adolescents	DAI	Baseline: 75% for Beacon patients	Year 3 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile)	Q4 2015
				Numerator: The number of patients that have each of the following on or before their 13th birthday: 1 MCV, 1 Tdap or 1 Td	Year 4 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile)	Q4 2016
				Denominator: The number of patients assigned to Beacon primary care provider who turn 13 years old during the measurement period	Year 5 - Increase percentage by at least 10% annually, or a 10% reduction to the gap to goal (90th percentile)	Q4 2017
				Baseline: 18% for Beacon patients	Year 3 - Increase percentage by at least 10% annually or a total goal of at least 50%.	

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 3 (Continued)						
3.2.b Cont'd.	Increase Immunization Rate in Adolescents and Adults	Increase the percent of patients assigned to Beacon primary care provider who have completed recommended immunizations - adolescents	DAI	Numerator: The number of patients assigned to Beacon primary care provider who receive the meningococcal vaccine (MCV) booster between their 16th and 18th birthdays	Year 4 - Increase percentage by at least 10% annually or a total goal of at least 50%.	Q4 2016
				Denominator: The number of patients assigned to Beacon primary care provider who turn 17 or 18 years old during the measurement period	Year 5 - Increase percentage by at least 10% annually or a total goal of at least 50%.	Q4 2017
3.3	Asthma Influenza Vaccine	Increase the percent of patients assigned to Beacon primary care provider with a diagnosis of asthma who receive an annual influenza vaccination	Claims, Vaccine Registry	Baseline: 68% for Beacon patients	Year 3 - Increase percentage by at least 10% annually or a total goal of at least 90%	Q4 2015
				Numerator: Number of patients assigned to Beacon primary care provider with diagnosis of asthma who have a record of influenza immunization in the previous 12 months.	Year 4 - Increase percentage by at least 10% annually or a total goal of at least 90%	Q4 2016
				Denominator: Number of patients assigned to Beacon primary care provider with a diagnosis of asthma	Year 5 - Increase percentage by at least 10% annually or a total goal of at least 90%	Q4 2017
3.4	Anemia in Children	Increase the percentage of children two years of age who had hemoglobin/hematocrit testing by their second birthday	Hybrid Measure - Claims Data and Chart Review	Baseline: 88% for Beacon patients	Year 3 - Increase percentage by at least 10% annually or a total goal of at least 98%	Q4 2015
				Numerator: Children assigned to Beacon primary care provider who turn two years of age during the measurement year with a hemoglobin and/or hematocrit test on or before the child's second birthday	Year 4 - Increase percentage by at least 10% annually or a total goal of at least 98%	Q4 2016
				Denominator: Children assigned to Beacon primary care provider who turn 2 years old during the measurement period	Year 5 - Increase percentage by at least 10% annually or a total goal of at least 98%	Q4 2017

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 3 (Continued)						
3.5	Patient/Family Experience Coordination of Care	Improve the patient/family experience Coordination of Care; "If your provider ordered labs/x-rays, or other studies, did someone call to follow up the results in a timely manner?" (Yes 90% of time)	Survey	Baseline: 68.2% for Beacon patients	Year 3 - Increase percentage by at least 10% annually, or a total goal of at least 80%	Q4 2015
				Numerator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second that receive depression screening with a standardized tool.	Year 4 - Increase percentage by at least 10% annually, or a total goal of at least 80%	Q4 2016
				Denominator: Number of adolescent patients with two or more chronic conditions or one chronic condition at risk for a second in the measurement period.	Year 5 - Increase percentage by at least 10% annually, or a total goal of at least 80%	Q4 2017
3.6	Establish Emergency Information Form (EIF)	Increase the percent of Beacon patients who have an Emergency Information Form for use by EMS and receiving health organizations	Medical Record Review	Baseline: 3% for Beacon patients	Year 3 - Increase percentage by at least 25% annually or a total goal of at least 90%	Q4 2015
				Numerator: Number of Beacon patients who have a Pediatric Information Form for EMS completed in a 12 month period	Year 4 - Increase percentage by at least 25% annually or a total goal of at least 90%	Q4 2016
				Denominator: Number of Beacon patients	Year 5 - Increase percentage by at least 25% annually or a total goal of at least 90%	Q4 2017
3.7	Care Plan Development	Improve the number of Beacon patients who receive effective care coordination of healthcare services when needed	Medical Record Review	Baseline: 0% since "Health and Services computerized template is not completed"	Year 3 - Increase percentage by at least 30% annually or a total goal of at least 90%	Q4 2015
				Numerator: Number of eligible Beacon patients with a documented Health and Services care plan in the previous 13 months	Year 4 - Increase percentage by at least 30% annually or a total goal of at least 90%	Q4 2016
				Denominator: Number of eligible Beacon patients	Year 5 - Increase percentage by at least 30% annually or a total goal of at least 90%	Q4 2017

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 4						
4.1	ED utilization for asthma	X CMH ED visits with primary diagnosis of asthma/1,000 CMH patients with Kansas Medicaid and diagnosis of asthma	Report/EHR	Baseline rate 305/1,000	Year 3 - 300/1,000	Q4 2015
				Numerator: Number of CMH patients 2-17 yoa with a diagnosis of asthma who have 1 or more ED visits with primary diagnosis of asthma in the last 6 months	Year 4 - 2.5% decrease from baseline	Q4 2016
				Denominator - Number of CMH patients ages 2-17 who have had a diagnosis of asthma in the previous six months	Year 5 - 5% decrease from baseline	Q4 2017
4.2	Decrease readmissions	30 day all-cause readmission rate following hospitalization for patients with Kansas Medicaid		Numerator: Number of CMH inpatient hospitalizations among Kansas Medicaid patients that occur within 30 days of admission to the hospital after an inpatient stay	Year 3 - Baseline data collection	Q4 2015
					Year 4 - 1% decrease from baseline	Q4 2016
				Denominator: The number of Kansas Medicaid patients admitted to CMH that had an inpatient hospital stay during the evaluation period	Year 5 - 2% decrease from baseline	Q4 2017
4.3.a	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Height, weight, and body mass index (BMI) percentile documentation	EHR/Claims	**BMI**	Year 3 - 39.2%	Q4 2015
				Baseline 34.7%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had height, weight, BMI documented during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Weight Assessment	Q4 2017
				Denominator: Number of patients 3-17 yoa		

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 4 (Continued)						
4.3.b	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Counseling for nutrition	EHR/Claims	**Counseling for Nutrition**	Year 3 - 50%	Q4 2015
				Baseline 46.9%	Year 4 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2016
				National benchmark - 90th		
				Numerator: Number of patients 3-17 yoa who had nutritional counseling during the measurement year.	Year 5 - 10% reduction in gap to goal in number of patients in targeted population will have documented Counseling for Nutrition	Q4 2017
				Denominator: Number of patients 3-17 yoa		
4.3.c	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Percentage of patients 3-17 years of age with Kansas Medicaid who had an outpatient visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic with: *Counseling for physical activity	EHR/Claims	**Counseling for Physical Activity**	Year 3 - 47%	Q4 2015
				Baseline 44%	Year 4 & Year 5 - 10% reduction each year in gap to goal in number of patients in targeted population will have documented Counseling for Physical Activity	Q4 2016
				National benchmark - 90th		Q4 2017
				Numerator: Number of patients 3-17 yoa who had counseling for physical activity during the measurement year.		
				Denominator: Number of patients 3-17 yoa		
4.4	Appropriate Testing for Children with Pharyngitis	The percentage of children 2-18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode	EHR/Claims	Baseline: 51.6%	Year 3 - 55.9%	Q4 2015
				National benchmark- 90th	Year 4 - 10% reduction in the gap to goal in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis	Q4 2016
				Numerator: A group A streptococcus test in the seven-day period from three days prior to the Index Episode Start Date (IESD) through three days after the IESD	Year 5 - 10% reduction in the gap to goal in the number of patients in targeted population will have Appropriate Testing for Children with Pharyngitis	Q4 2017
				Denominator: The number of children 2-18 years of age who were diagnosed with pharyngitis and dispensed an antibiotic		

Table A4: Implementation of Beacon Program to Improve Care for CMC (Continued)

Category	Measure	Metric	Data source	Baseline Performance Level (include numerator/denominator)	Target	Completion Date
Category 4 (Continued)						
4.5	Lead Testing	Percentage of children with Kansas Medicaid who had an outpatient well-child visit with a CMH Primary Care Physician (PCP) in a Children's Mercy Primary Care clinic who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday	EHR/Claims	Baseline: 42.7% of children age 2 yrs have at least one capillary of venous blood test National benchmark - 90th	Year 3 - 45.7% of patients age 2 yoa have one or more blood lead tests	Q4 2015
				Numerator: Children who turn two years of age during the measurement year with at least one capillary or venous blood lead test on or before the child's second birthday that have a well-child visit with a CMH Primary Care Physician.	Year 4 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2016
				Denominator: Children who turn 2 years old during the measurement period that have a well-child visit with a CMH Primary Care Physician	Year 5 - 10% reduction in the gap to goal of lead screening rate in targeted population	Q4 2017

ATTACHMENT P:

Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan

Introduction:

Although Kansas is still below the national average rate for drug overdose mortality, Opioid overdose deaths in Kansas have risen significantly in recent years, and the State is acting strategically to address the crisis as reported in the Kansas State Opioid Response Grant to Substance Abuse and Mental Health Services Administration (SAMSHA) (TI-18-015. P. 1) based on Kansas vital statistics data for age adjusted drug poisoning mortality rates, 2012-2016. Based this vital statistics data, some key facts include:

- The age adjusted drug poisoning mortality rate was 10.9 deaths per 100,000 Kansans.
- From 2012 to 2016, there were a total of 1,583 drug poisoning deaths in Kansas. From 1999 to 2014, drug poisoning death rates have tripled-placing deaths from poisoning the leading cause of injury related deaths in Kansas.
- Drugs, including prescription, over the counter and illicit drugs, account for more than 80% of all poisoning deaths.
- Seventy-five percent of the drug poisoning deaths in 2014 were unintentional, 17% were due to suicide and 7% were of an undetermined intent.
- Kansans aged 45 years old had the highest rate of drug poisoning deaths involved a prescription pain reliever such as hydrocodone or oxycodone.
- Almost 85% (84.3%) of those deaths involved either a pharmaceutical opioid (e.g., Oxycodone, Hydrocodone), a Methamphetamine/Amphetamine drug (e.g., illicit meth or Adderall), or a Benzodiazepine (e.g. Xanax, Valium). It is of note that, individuals born between 1955 and 1970 experienced a disproportionately higher drug poisoning mortality rate as compared to younger generations.

In addition to prescription opioid death, Kansas has also seen an increase in heroin related and synthetic opioid deaths since 2010. Specifically:

- In 2014, there were 56 drug deaths involving either heroin or a synthetic opioid, such as fentanyl, (age adjusted rate 2.0 deaths per 1000,000 population) representing about 34% of all drug deaths involving an opioid-a 200% increase since 2010 (age adjusted rate: 1.1 deaths per 100,000 population). These rates are likely under estimates of the drug deaths caused by narcotic agents since there are a number of drug deaths where the deaths do not mention a drug specifically.
- Along with an increase in heroin and synthetic opioid deaths is an estimated increase in the number of Kansans 26 years and older who have misused a prescription opioid pain reliever in the past year from 2010 (3.26% to 2014(3.49%).

This Substance Use Disorders (SUD) Demonstration Implementation Plan outlines the State's strategy to provide a full continuum of services for SUD treatment to KanCare members. This waiver request is consistent with Kansas' current strategy to combat the epidemic and builds off

its system of care in Medicaid to provide more complete services, particularly in areas of limited coverage and service gaps such as higher levels of care. The KanCare Section 1115 Waiver Demonstration Renewal Application, submitted to Center for Medicare and Medicaid Services (CMS) on December 20, 2017 *(Attachment #1, KanCare 2.0 Section 1115 Waiver Demonstration Renewal Application, Final Submission, Dec 2017, page 25)* includes this waiver request.

Kansas' SUD Crisis

National studies suggest that patients with a higher dose of opioids, multiple prescribers and several pharmacies are more likely to die from an opioid overdose.[1] Experts have attributed the rise in opioid use disorders (OUD) and the overdose crisis to the increased rate of prescription opioids dispensed since the 1990s.[2] According to the Centers for Disease Control (CDC), the number of prescription opioids dispensed in the U.S. has nearly quadrupled in the past decade. Concurrently, the rate of opioid-related deaths has more than doubled in the United States since 2005. Opioid overdoses accounted for a considerable number of Kansas's drug poisoning deaths from 2012 to 2016. Though the rate of overdose deaths in Kansas remains below the national average, 2016 Kansas vital statistics data indicates that the age-adjusted drug poisoning mortality rate was 10.9 deaths per 100,000 Kansans. From 2012 to 2016, there were a total of 1,583 drug poisoning deaths in Kansas. Almost eighty-five percent (84.3%) of those deaths involved either a pharmaceutical opioid (e.g., Oxycodone, Hydrocodone), a Methamphetamine/Amphetamine drug (e.g., illicit meth or Adderall), or a Benzodiazepine (e.g. Xanax, Valium).

An important factor associated with the increase in drug poisoning deaths in Kansas is the supply of prescription opioids. Kansas's Prescription Drug Monitoring Program, K-TRACS, tracks and monitors Schedule II through IV controlled substances, such as prescription opioids, and other drugs of concern dispensed in Kansas. K-TRACS provides public health and public safety professionals with dispensation data of these drugs statewide. In 2017, there were at least 2,579,058 opioid prescriptions and 189,525,054 opioid units (i.e., pills, patches, films, or vials) dispensed to Kansas patients. This corresponds to a rate of 88.5 prescriptions per 100 Kansans and 65.1 opioid units per Kansan. This is equivalent to dispensing an approximate 14-day supply of an opioid prescription to 8 out of 10 Kansas residents in 2017. Experts estimate that about 100,000 Kansans, or 3 out of every 10, have misused prescription pain medication in a way other than as directed by a doctor or more than the prescribed amount. There was an approximate 9 percent decrease in opioid dispensing statewide from 2016 to 2017 in Kansas, or approximately 249,942 fewer opioid prescriptions. This reduction is consistent with national trends. However, the use of opioids among young adults is a major concern. The Kansas Communities that Care Student Survey (KCTC) assesses prescription drug misuse among Kansas youth in addition to other health risk and protective factors. According to 2017 KCTC data, 3.7 percent of Kansas youth in grades 6, 8, 10 and 12 report using prescription medications not prescribed to them. Of those, more than 75 percent reported that they received, bought or stole them from a friend or relative. The Kansas

[1] CDC Wonder Online Database, released December 2016. Sourced from: https://www.kmap-state-ks.us/Documents/Content/Bulletins/18027%20-%20General%20-%20Opioid_2.pdf.
[2] National Institute on Drug Abuse, revised January 2019. Available at: https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis.

Young Adult Survey also measures prescription and illicit drug use among Kansas young adults ages 18 to 25. In 2017, 6.8 percent of young adults reported using prescription pain medication at least once in the past 30 days, 40 percent did not have a prescription for it. Of the people that report the misuse of prescription pain medications, more than 91 percent reported that they received, purchased or stole them from a friend or relative.

Kansas' Strategic Response to the Opioid Overdose Crisis

Kansas Department for Aging and Disability Services (KDADS) serves as both the State Mental Health Authority (SMHA) and Single State Agency (SSA) for Substance Abuse in Kansas. The Strategic Opioid Response set forth by the SSA with SAMSHA in the State Opioid Response Grant (SOR TI-18-015) will utilize a statewide strategic plan developed through a multidisciplinary statewide process. The strategic plan builds upon existing opioid efforts and tools to combat the opioid epidemic, including the SAMHSA funded State Targeted Response to the Opioid Crisis (STR) Grant, focused on OUD treatment, prevention, and recovery. Kansas was also a recipient of a Partnership For Success 2015 Grant to strategically address prescription drug misuse and abuse in four sites across the State. The Kansas Department of Health and Environment (KDHE) was the recipient of Prescription Drug Overdose (PDO): Data-Driven Prevention Initiative (DDPI) Grant from the Centers for Disease Control (CDC). The Kansas Foundation for Medical Care (KFMC) is the recipient of funds from CMS to coordinate a pain management project at multiple locations across the State. The Statewide Prescription Drug Workgroup serves as a means of coordination and collaboration for these multiple initiatives and will continue to function in this capacity for the SOR grant as well. As part of these federally funded efforts, Kansas will expand access to medication-assisted treatment (MAT) by using a regional approach. The State will require regional grantees to promote primary care provider enrollment in buprenorphine or buprenorphine/ naloxone combination medication prescribing accompanied by education on evidence-based best practices for prescribing opioids and the importance of behavioral health treatment with MAT. The Opioid SOR Grant Access to Care Project Coordinator in each region will be responsible for the development and expansion of MAT services in partnership with clinics, providers, and hospitals. Regional grantees will identify gaps in care specific to their regions and populations with strategies to address these gaps.

In September 2018, the Governor's Task Force on Substance Abuse set strategic priorities to combat the opioid epidemic. These strategies include expanding access to treatment and recovery support, as well as increasing the use of data and health information technology, particularly in reducing opioid prescribing and opioid dependence. These strategies are consistent with this SUD Demonstration request.

The Current Delivery System

KanCare currently integrates medical, behavioral, and long-term care health delivery systems and covers mandatory and optional services under the approved Medicaid State Plan. KanCare provides access to all critical levels of care for opioid use disorder (OUD) and SUD. KanCare contracts with three MCOs statewide to provide access to the American Society of Addiction Medicine (ASAM) levels. The KanCare criteria for treatment is a fidelity-based adaptation of the ASAM Patient Placement Criteria. The Kansas Department for Aging and Disability

Services (KDADS) provide required licenses to KanCare-enrolled SUD treatment providers. Currently State law also requires licenses for any provider who delivers SUD treatment services in a facility setting.

KanCare delivers the outpatient benefits described below pursuant to the service requirements in the Kansas Medicaid State Plan - Attachment 3.1-A, 13.d. The State Plan requires the provision of inpatient and detoxification (withdrawal management) services in State certified facilities. The Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual (KMAP-SUD-PM) details eligibility and service requirements for all KanCare OUD and SUD services by ASAM level. The Manual (*Attachment #2, KMAP-SUD-PM*) provides eligible Medicaid recipients who need SUD or OUD treatment with the full spectrum of care, including outpatient treatment, peer recovery support, intensive outpatient services, medication assisted treatment (MAT), intensive inpatient services, withdrawal management, and residential treatment. MCO network providers include specialty providers such as Women's Treatment Centers for woman and children, which offers prenatal services and services to meet the developmental needs of children. KanCare requires the provision of Person-Centered Case Management as a one-on-one goal-directed service for individuals with a SUD, to assist individuals in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO.

Access to treatment varies by region; western Kansas, a rural, frontier area has very little access to opioid use disorder treatment, including MAT (methadone clinics and buprenorphine prescribers). There are currently nine Methadone Maintenance Treatment clinics in Kansas located primarily in the largest urban areas of the State. These clinics provide non-residential services of long-term methadone maintenance and other medication assistance to support and sustain recovery. Most patients who access these services pay out of pocket for methadone maintenance treatment. Since KanCare does not pay for methadone as a MAT (it covers methadone only for use in pain management), there is currently only one methadone dispensing provider who is in the KanCare network. KanCare will revisit the issue of covering methadone for MAT and make a recommendation of policy within the first half of 2019. This policy will consider the requirement that all inpatient residential treatment centers (including all those currently excluded as IMDs) provide access to MAT through direct provision of the KanCare approved MAT formularies or by coordinated referral and treatment initiation to a KanCare MAT provider.

SUD Demonstration Goals

Kansas will use this 1115 demonstration authority to pursue the following goals:

1. *Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs*: Kansas receives federal funds through SAMSHA, including State Opioid Response and Strategic Targeted Response grants, to run awareness campaigns on the availability of treatment. Kansas continues to support expanding screening, brief intervention, and referral to treatment (SBIRT) as a SUD mitigation practice. Increasing outreach and community education efforts will, in turn, increase need for provider capacity for SUD services, particularly for residential treatment services. Kansas will need to engage facilities of 16 beds

or more (IMDs) to have the appropriate capacity for services at the residential and inpatient level.

2. *Reductions in overdose deaths, particularly those due to opioids*: Kansas continues its efforts toward reduction of opioid overdose deaths, and the addition of services under this IMD waiver exclusion is a crucial step in assuring access to treatment at all needed levels of care for Medicaid beneficiaries. KDADS currently provides ongoing certification training to SUD providers for Persons Centered Case Management based on the principals and practices of Strength Based Case Management as developed at the University of Kansas. KanCare delivers this service at all levels of care in SUD programs, and training outcomes reflect increased engagement and retention in services. Beginning in 2019, KanCare plans to require inpatient residential treatment facilities to:

    - Offer and initiate MAT to all patients who would be clinical candidates for MAT; and
    - Improve care coordination and transition of care to the community.

    MCOs will report readmission rates and the State will work with KanCare MCOs to develop incentives and/or financial measures to hold residential treatment providers accountable for demonstrating effective engagement of all patients in long term recovery services and reducing readmissions.

3. *Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services:* KDADS contracts with three existing Community Crisis Centers (CCCs) that support and stabilize individuals and engage them in community-based treatment. Services include assessment, sobering, withdrawal management and referral to treatment. Medicaid pays CCCs for crisis intervention and counseling services (but not sobering or withdrawal management) for its beneficiaries. Early data show CCCs have been successful in diverting clients served from incarceration as well as admission to emergency rooms and hospitals. Continued expansion of MAT services, peer supported recovery services, and increased care coordination between community and hospital providers are outlined in the tables below as future actions to be taken in this waiver implementation.

4. *Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs:* The KanCare program has taken measures to promote appropriate admissions for OUD and SUD treatment based on ASAM guidelines (see milestone tables below for more information). Beginning in 2019, KanCare MCOs will have to meet additional care coordination requirements for SUD, OUD and behavioral health conditions that specifically require MCOs to coordinate care with an aim toward reducing readmissions (see table 6 below).

5. *Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs*: KanCare has made the integration of physical healthcare and behavioral healthcare a focus for the new contracts in effect in 2019. These provisions will improve care coordination and the physical health of beneficiaries with OUD. The State will require MCOs

to work with inpatient and residential facilities to facilitate care transitions and care coordination. The State is also encouraging new payment models to encourage better health outcomes through integration. *(Attachment, #1, KanCare 2.0 Section 1115 Waiver Demonstration Renewal Application, Final Submission, Dec 2017).*

Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs- The spectrum of care required in Milestone 1 is summarized in the Table below.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a demonstration, include the program name and Special Term and Condition number.	Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115.	Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
Coverage of outpatient services	The State covers outpatient non-residential treatment consisting of group, individual, and/or family counseling, community psychiatric support, crisis intervention, and peer support. The State requires an individualized treatment plan, based on ASAM criteria, to be completed within 30 days of admission, updated every 90 days (*Kansas Medicaid State Plan 3.1-A, 13.d. Page I).*	No changes.	None

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of intensive outpatient services	Covered based on individualized plan and assessment tool that is based on ASAM criteria. Services delivered in regularly scheduled sessions of structured therapeutic activities that may include SUD educational didactic groups, group counseling, and individual counseling. *(Kansas Medicaid State Plan 3.1-A, 13.d. Page I)*	No changes.	None
Coverage of medication assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)	Coverage includes Buprenorphine products and combo products with naloxone. The State restricts Methadone coverage to pain management. MAT counseling is provided. *(Kansas Medicaid State Plan 3.1-A, 13.d. Page I)*	KanCare will require inpatient and residential providers to offer or facilitate MAT initialization and treatment for all who meet the need criteria and choose treatment. KDADS will provide training and work with MCOs to build network capacity for MAT over the course of 2019. KanCare will study the issue of covering methadone for MAT use by September 30, 2019. The State is currently organizing those discussions currently with new agency leadership and will advise CMS as they progress. If the State decides to cover methadone for MAT use, it will issue a draft policy and begin related	Revision of KanCare MCO contracts and/or payment policies to require MAT care/coordination in residential/ inpatient settings and education of the provider network. MCO credentialing of plans into the network and Payment live by 12-month mark.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		State Plan amendment process by the end of calendar year 2019.	
Coverage of intensive levels of care in residential and inpatient settings	Coverage of 24-hour medically directed evaluation and treatment services for SUD, with the availability of support services for co-occurring medical and mental disorders. (*Attachment #2, KMAP-SUD-PM)* The State currently covers ASAM levels 1, 2, 3.1, 3.3, 3.5, and 3.7 per the State Plan.	Coverage of SUD treatment includes IMDs with 16 or more beds that: (1) meet KDADS' licensing and certification requirements and (2) participate in MCO provider networks and meet appropriate credentialing requirements. Authorization for services will remain the same as MCOs' current procedure for residential SUD treatment (see Table 2 below).	Revision of Medicaid payment policies, and managed care contracts. Licensing and credentialing of IMDs as SUD residential providers by 12-month mark. Payment live by 12-month mark due to the time needed to license and credential IMDs as SUD providers.
Coverage of medically supervised withdrawal management	Per the Medicaid State Plan, covered for individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Includes 24-hour observation, monitoring, and counseling. *(Attachment #2 KMAP-SUD-PM)*	No changes.	None

2. Use of Evidence-based, SUD-specific Patient Placement Criteria

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current state use of evidence-based, SUD-specific patient placement criteria and utilization management approach to ensure placement in appropriate level of care and receipt of services recommended for that level of care.	Provide an overview of planned state implementation of requirement that providers use an evidence-based, SUD-specific patient placement criteria and use of utilization management to ensure placement in appropriate level of care and receipt of services recommended for that level of care.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines	The KanCare criteria for treatment is a fidelity-based adaptation of the ASAM Patient Placement Criteria. Contracted KanCare MCOs require their network providers to use ASAM criteria to assess patient treatment needs. Providers submit a common form to the KanCare MCOs to request authorization for residential treatment services. Each MCO uses its own criteria based on ASAM to make a determination to authorize treatment.	KDADS will work with MCOs and providers to develop one standardized placement criteria that has fidelity to the ASAM placement criteria and uses a multi-dimensional assessment by 2021.	Revise the current Kansas State Approved Placement Criteria (currently not in use at the MCOs) with a new KDADS approved criteria, available online to both MCOs and all providers by 2021. All MCOs and providers will be required to use the revised assessment tool.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care	KanCare MCO contracts require the implementation of a utilization management approach than ensures timely access to necessary services at the appropriate level of care. KanCare requires assessment, individual treatment plans and documentation of services. State monitoring of compliance is regular and ongoing. (*Attachment #3-Current KanCare Contract EVT 0001028, Sections 2.2.40- 2.2.40.14)*	No changes.	None
Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care	MCOs must have in place and follow, written policies, procedures, and practice guidelines for processing requests for prior authorization and authorization for requests for continuing services. The policies, procedures, and practice guidelines shall include requirements for use of the Kansas medical necessity definition and the ASAM criteria. (*Attachment #3-Current KanCare Contract EVT 0001028, Sections 2.2.40- 2.2.40.16)*	No changes.	None
Implementation of a utilization management approach such that (c) there is an	MCOs are responsible for the development of utilization management for residential treatment. The State reviews and	No changes.	None

Milestone Criteria	Current State	Future State	Summary of Actions Needed
independent process for reviewing placement in residential treatment settings	approves MCO utilization management policies. The State also monitors grievances and appeals. The decision or request shall be made by a health care professional who has appropriate clinical expertise in treating the Member's condition or disease. (*Attachment #3-Current KanCare Contract EVT 0001028, Sections 2.2.40- 2.2.40.16)*		

3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria	Provide an overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item
Implementation of residential treatment provider qualifications in licensure requirements, policy manuals,	KDADS licenses all provider organizations delivering SUD services, including all residential treatment facilities (IMD and others). Licensing regulations include standards for program	KanCare contracts effective in on 1/1/19 and in subsequent years will specify ASAM program compliant (or other national standards i.e. CARF) as the credentialing	Implementation of KanCare contracts effective on January 1, 2019. Development and use of ASAM program criteria compliant

Milestone Criteria	Current State	Future State	Summary of Actions Needed
managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings	management, clinical hours, clinical and supportive services, staffing ratios, staff qualifications, facility regulations, medication control, treatment planning, record keeping, client rights, confidentiality, and quality improvement. *(Attachment #4 Standards for Licensure/ Certification of Alcohol and/or Other Drug Abuse Programs, rev. 1/1/06).* The standards need to be reviewed and revised to meet ASAM program criteria and other national standards (i.e. CARF). See Future State for goals regarding revision. The Kansas Behavioral Sciences Regulatory Board (KSBSRB) licenses individual (non-agency) Addiction Counselors as Licensed Addiction Counselors or Licensed Masters Addiction Counselors. Standards and procedures are set forth in KAS 65-6607-6620 and KSBSRB regulations 102-7-1:12. *(see https://ksbsrb.ks.gov)* Under KanCare contracts, MCOs are responsible for assuring	standards for MCO provider agreements *(Attachment #5, Kansas Medicaid Managed Care (KanCare 2019) RFP EVT0005464 p.66-67).* The State will revise licensing standards within 12-24 months. To complete this step, the State will review MCO contract requirements for credentialing and is in the process of comparing current state licensing regulations to ASAM criteria to identify the extent of changes that will be required. Subsequently, the State will need to draft regulations for public comment and follow relevant state requirements before they are effective.	credentialing standards for residential care by all MCOs within 12 months. Revision (as needed) of licensing standards for residential care to comply with ASAM program criteria and other national standards within 12-24 months.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	the licensure and qualifications of providers according to the above established State licensure standards and Medicaid credentialing policies. *(Attachment #6 KanCare 2.0 RFP EVT 0005464-Attachment C- 3.0-SUD Services p. 11-13 and section 4.3.1.1.2-SUD Treatment and MAT p.14)*		
Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	KDADS completes initial and periodic licensing surveys every 1-3 years, depending on compliance. *(Attachment #4 Standards for Licensure/ Certification of Alcohol and/or Other Drug Abuse Programs, rev. 1/1/06 and Attachment #7 KDADS Licensing Surveyor Tool)*	KDADS reviews and licenses IMDs in accordance with the Current State column of this row. By the 12-month mark, MCOs will credential them in their networks according to credentialing policies that conform to ASAM program criteria or other national standards for staffing, hours, access, training, and other relevant standards.	Development and use of ASAM program criteria compliant credentialing standards for residential care by all MCOs within 12 months. Update of licensing survey tool to examine provider compliance with any new program standards (e.g., types of services offered, hours of clinical care, staff credentials) within 12-18 months.
Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site	There is currently no requirement that residential treatment facilities offer MAT on-site. The State requires them to assess and refer as appropriate.	KanCare will require residential treatment providers to assess clients and initiate MAT onsite for willing clients. To complete this step, the State will review MCO contract requirements for	The State will update the licensing requirements within 12-24 months to require residential treatment providers to assess clients and initiate MAT onsite for willing clients.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
		credentialing and is in the process of comparing current state licensing regulations to ASAM criteria to identify the extent of changes that will be required. Subsequently, the State will need to draft regulations for public comment and follow relevant state requirements before they are effective.	MCOs will implement provision by 18-month mark.

4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current provider capacities throughout the State to provide SUD treatment at each of the critical levels of care listed in Milestone 1.	Provide an overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the State at each of the critical levels of care listed in Milestone 1.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			each action item.
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT: Outpatient Services; Intensive Outpatient Services; Medication Assisted Treatment (medications as well as counseling and other services); Intensive Care in Residential and Inpatient Settings; Medically Supervised Withdrawal Management.	The MCOs submit Geo Mapping reports to the State each quarter. The reports include sub-reports by specialty (including SUD providers), provider access and availability reports, including distance to nearest provider, urgent access standards, county breakdowns, and trended access data. KDHE has established processes to monitor and manage the Reports. Provider network access standards require the MCOs to meet requirements for licensed outpatient, inpatient, intensive outpatient, residential treatment, and withdrawal management. (*Attachment #8 KanCare Network Adequacy Standards revised 8/6/18, p.9)* If the State identifies a provider network deficiency, the State will work with the MCO to develop a plan of action to meet the standards and/or if an exception is necessary. The State may also issue a corrective action plan or liquidated damages, as appropriate. KDADS has assessed the needs and gaps in access to treatment, particularly MAT.	The State will require MCOs to expand the existing infrastructure of MAT providers to improve member access to MAT, particularly in rural areas. The State will use Geo Mapping reports to monitor compliance. MCO will provide semi-annual reports outlining the network adequacy of each MCO for all levels of SUD service, by geographic region. These semi-annual reports will also include the number of providers accepting new patients for each level of care. Where Geo mapping does not provide this level of granularity, MCOs will be required to gather data for credentialing and provider network databases and report it to the State.	The State will revise the provider network standards to include MAT by the 12-month mark. KDADS will implement MAT access assessment, training, and network development according to the SOR State plan submitted to SAMSHA for the 2019 project period.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	Gaps vary by region and are most severe in rural and frontier regions of the State.	*(Attachment #5 Kansas Medicaid Managed Care (KanCare 2019) RFP EVT0005464 section 5.5.7 and section 5.8.3.2)* The KDADS SOR coordinator will work closely with KDHE and its contracted MCOs to address MAT service gaps in rural and western regions of the State using its assessment summary for each region. KDADS will provide training to providers for increasing MAT capacity.	

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current treatment and prevention strategies to reduce opioid abuse and OUD in the State.	Provide an overview of planned strategies to prevent and treat opioid abuse and OUD.	Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for

Milestone Criteria	Current State	Future State	Summary of Actions Needed
			completion of each action item. Include timeframe for completion of each action item.
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	KDHE issued KMAP General Bulletin 18101- effective June 1, 2018, to amend its prescribing guidelines for Opioid Products Indicated for Pain Management to require prior authorization for all patients covered under Kansas Medicaid for any prescription of long acting opioids and any prescription of short acting opioids exceeding a 7-day supply, with exceptions. *(Attachment #9 KMAP General Map Bulletin 18101)*	Though the Governor's SUD task force recommends requiring use of the prescription drug monitoring program (PDMP) K-TRACS by all clinicians authorized to prescribe medications subject to abuse and recommends all pharmacists register with K-TRACS, use is currently voluntary. Mandatory Registration with K-TRACS is currently under review by the KS AG as an administrative regulation. Once approved, the Board will implement the regulation. K-TRACS is integrating with the EHRs of large group providers, hospitals and pharmacies (Walmart and Sam's pharmacies are currently linked). K-TRACS is working to have 100% of all pharmacies in the system.	Final review of mandatory K-TRACS registration (currently before the AG) by 06/19. Implementation of regulation by 12/19.
Expanded coverage of, and access to, naloxone for overdose reversal	Medicaid covers Naloxone in certain forms without prior authorization and it is available at pharmacies without a prescription *(K.A.R. 68-7-23)*	No changes.	None

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Kansas remains a national leader for PDMPs. The Board created and hosted the first PDMP Administrators Roundtable in August 2017. K-TRACS includes all retail and outpatient dispensing records for any controlled substance or drug of concern dispensed in Kansas or to a Kansas resident, regardless of whether the pharmacy is in Kansas. The only exception is for quantities dispensed in the emergency room for 48 hours or less. The software accommodates large chains, independent and small pharmacies, and works seamlessly with the NABP PMP Interconnect® at no charge by NABP. PMPi facilitates the transfer and availability of PDMP data to all 41 participating states. Kansas is currently sharing data with 30 states. Prescriber E-Recap (PERx) is a convenient way for the PDMP to provide prescribers with a snapshot of their prescribing practices regarding controlled substances.	K-TRACS is expanding capabilities to provide interoperability services for all prescribers and pharmacists in Kansas to access K-TRACS through the PDMP Gateway®. This Statewide integration increases availability, ease of access, and use of a patient's controlled substance prescription history for making critical and informed prescribing and dispensing decisions. This integration creates one-stop-shop making K-TRACS data directly available in the patient's electronic record. Increase utilization of K-TRACS for surveillance and intervention.	None

6. Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Criteria for completion of milestone	Provide an overview of current care coordination services and transition services across levels of care.	Provide an overview of planned improvements to care coordination services and transition services across levels of care.	Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.
Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.	The State Opioid Response Grant includes activities of a State Opioid Coordinator to work with providers on care coordination and transition services across levels of care. MCOs are responsible to link beneficiaries with community-based services and providers that will coordinate transitions of care.	The current 1115 waiver expands the responsibilities of MCOs to ensure individualized care coordination and links with community-based recovery support for beneficiaries. *(Attachment #1 KanCare 2.0 Section 1115 Waiver Demonstration Renewal Application, Final Submission, Dec 2017)*	KDHE and KDADS will implement at coordinated approach to increasing service coordination across the spectrum of care, according to activities outlined in the State Opioid Response Grant and the KanCare 1115 wavier. These activities will be completed in a 12-month timeframe.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	KanCare requires the provision of Person-Centered Case Management as a one-on-one goal-directed service for individuals with a SUD, to assist individual in obtaining access to needed family, legal, medical, employment, educational, psychiatric, and other services. For individuals served by an MCO, this service must be a part of the treatment plan developed and determined medically necessary by the MCO or by the contracted ASO for all others.	The current 1115 waiver under review at CMS *(Attachment #1 KanCare 2.0 Section 1115 Waiver Demonstration Renewal Application, Final Submission, Dec 2017)* increases support for individuals with behavioral health needs (including SUD) and expands MCO service coordination to assist individuals with accessing housing, food, employment, and other social needs. MCOs will also manage transitions of care between hospital and emergency room admissions to reduce readmission and adverse outcomes. *(Attachment #5 Kansas Medicaid Managed Care (KanCare 2019) RFP EVT0005464 p.11,31-35,56, 59-63)*	KDHE will implement Future State activities in accordance with the 1115 waiver implementation timetable within 12 months of waiver approval.

Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the Implementation Plan.

Name and Title Andy Brown, Commissioner of Behavioral Health Services
Telephone Number: 785-291-3359
Email Address: Andrew.Brown@ks.gov

Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

Included under a separate cover are the following attached documents, referenced throughout this text:

1. KanCare Section 2.0 1115 Waiver Demonstration Renewal Application, Final Submission, Dec 2017
2. The Kansas Medical Assistance Program Substance Use Disorder Services Provider Manual (KMAP-SUD-PM)
3. Current KanCare MCO Contract EVT 0001028
4. Standards for Licensure/Certification of Alcohol and/or Other Drug Abuse Programs, rev. 1/1/06
5. Kansas Medicaid Managed Care (KanCare 2019) RFP EVT0005464
6. KanCare 2.0 RFP EVT 0005464 - Attachment C- 3.0-SUD Services
7. KDADS Licensing Surveyor Tool
8. KanCare Network Adequacy Standards revised 8/6/18
9. KMAP General Map Bulletin 18101

Attachment A –SUD Health Information Technology (IT) Plan

The Kansas State Board of Pharmacy is responsible for administration of the Kansas Prescription Drug Monitoring Program (PDMP), known as K-TRACS, which tracks and monitors Schedule II through IV controlled substances and other drugs of concern in Kansas. The goal of the PDMP is to prevent the misuse, abuse, and diversion of controlled substances and drugs of concern, while ensuring continued availability of these medications for legitimate medical use. The Board requires each dispenser (pharmacy) to electronically submit information to the central data collection system for each controlled substance prescription or drug of concern dispensed in an outpatient setting. Prescribers and pharmacists may register for K-TRACS through the Board prior to utilizing the system. K-TRACS is a real-time, web-based system, and users can obtain patient information instantly from any location at any time with the proper login credentials.[3]

The Board employs a Director and a program manager to oversee and administer the PDMP and an epidemiologist in a grant-funded position through August 2019 to analyze K-TRACS data and provide necessary reporting under the federal grants. Additional administrative support is provided by Board of Pharmacy licensing staff.

The Board contracts directly with Appriss for the K-TRACS software. Appriss is the PDMP vendor for 44 other states and provides a strong PDMP solution. The software accommodates large chains, independent and small pharmacies, and works seamlessly with the National Association of Boards of Pharmacy (NABP) - PMP Interconnect® (PMPi) which facilitates the transfer of PDMP data to the 47 participating states. Kansas is currently sharing data with 31 states, including Colorado, Oklahoma, and Texas and recently began sharing with the St. Louis, Missouri PDMP which covers 71 participating jurisdictions. Together these include 84% of the population of Missouri and 85% of the pharmacies.

The Board received a grant in 2012 from the Substance Abuse and Mental Health Services Administration (SAMSHA) through the U.S. Department of Health and Human Services which funded integration of K-TRACS data into the Lewis and Clark Information Exchange (LACIE) and Via Christi Health Systems, enabling a single sign-on for access to a patient's medical record and K-TRACS history. The Board, in conjunction with KDHE, is now expanding that project to provide interoperability services for all prescribers and pharmacists in Kansas to access K-TRACS through the PDMP Gateway®. The project is funded by a grant from the Centers for Disease Control awarded to KDHE. INTEGRx.8 makes K-TRACS data directly available in the patient's electronic record. As of January 2019, 33 hospital corporations (with multiple sites statewide) 130 pharmacy chains and independent pharmacies (with multiple locations statewide) and 11 physicians' offices are integrated with K-TRACS in Kansas.

NarxCare is the newest upgrade to the K-TRACS system beginning January 2019. NarxCare provides patient and clinical decision support beyond the state produced patient's prescription

[3]January 2018 Report to Legislature: https://pharmacy.ks.gov/docs/default-source/ktracs/reports/2018-pdmp-legislative-report---final.pdf?sfvrsn=d9caa501_2

history by: 1) Compiling multiple state reports into one cohesive profile; 2) Analyzing data to provide reports, use scores, predictive scores, red flags, visualizations, and K TRACS data including narcotics, sedatives, and stimulants; 3) Including Medication Assisted Treatment (MAT) locators and CDC printable educational handouts; and finally 4) The Care Team Communications, a powerful tool within NarxCare for the prevention and treatment of substance use disorder provides coordination of care.

K-TRACS was implemented and operated using federal grant funds through June 30, 2016. The Board has now exhausted available grant funding to sustain the program, and the only remaining grant funding is for program enhancements. While the Board continues to pursue grant opportunities, funding presents the largest obstacle to maintaining a PDMP in Kansas. A permanent funding solution will be required prior to July 1, 2019 to ensure program continuation.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to support its PDMP; and* *--Enhance and/or support clinicians in their usage of the state's PDMP.*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item.*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing to better track patient specific prescription data.	K-TRACS accommodates large chains, independent and small pharmacies, and works seamlessly with the NABP PMP Interconnect® (PMPi), provided by the National Association of Boards of Pharmacy at no charge. PMPi is a system which facilitates the transfer and availability of	Since Missouri has not been able to pass statewide legislation establishing a PDMP, Kansas is actively working connect St. Louis county and the other counties that have established a PDMP. St. Louis	Staff at the State Board of Pharmacy is responsible for K-TRACS coordinating with neighboring states. It is in the process of establishing PMPi links with PDMP active counties in

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	PDMP data to all participating states (48 available). Kansas is currently sharing data with 32 states.	County launched its PDMP in April 2017. Fourteen other jurisdictions participate, and more are joining. Currently 84% of Missouri's population live in county participating the PDMP program. Kansas will be sharing data with those PDMPs by October 2019.	Missouri and will go live with data exchange by October 2019. Kansas will continue to support efforts with the Nebraska legislature to share PDMP data, but no timeframe for completion can be established yet.
Enhanced "ease of use" for prescribers and other state and federal stakeholders.	K-TRACS disseminates materials, created under CDC guidelines, to healthcare providers and students as well as NGOs and academic instructors. MAT and pain management trainings also includes K-TRACS materials. An enhancement generates a "pop-up" in K-TRACS when a prescriber or pharmacist queries a threshold patient. Threshold patients are individuals who received at least five controlled substance prescriptions from prescribers and visited at least five pharmacies to fill those prescriptions in a 90-day period. The Board also maintains a website for K-TRACS at www.ktracs.ks.gov, with updated forms, frequently asked questions/answers, and other helpful resources for healthcare workers and the public. In addition, the Board publishes articles on best practices and	K-TRACS is in the process of implementing ease of use functionality for specialists. Specialists will be able to see prescribing patterns for other specialists in the same field, which will provide them with decision support on prescribing. and this enhanced feature is going live soon, funded by KDHE. NarxCare went live in January 2019, and provides patient and clinical decision support through reports, use scores, predictive scores, red flags and visualizations and	The Board of Pharmacy staff is responsible for adding functionality to the K-TRACS system, working with the State's vendor(s). The enhanced features for specialists will be live by August 31, 2019.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	reminders in a quarterly newsletter available on the Board website.	care coordination tools. It also includes MAT locators and CDC handouts.	
Enhanced connectivity between the state's PDMP and any statewide, regional, or local health information exchange.	In 2012, K-TRACS integrated with the Lewis and Clark Information Exchange (LACIE) and Via Christi Health Systems, enabling a single sign-on for access to a patient's medical record and K-TRACS history. The project, known as INTEGRx8, has expanded to provide interoperability services for all prescribers and pharmacists in Kansas to access K-TRACS through the PDMP Gateway®. The Kansas Health Information Network is actively pursuing a K-TRACS connection through the PDMP Gateway®.	K-TRACS is currently integrated with 33 hospital corporations (which have multiple additional locations statewide) 130 pharmacies and pharmacy chains (with multiple additional locations statewide), and 11 physician offices. K-TRACS will continue to work on integrating with more pharmacies (including CVS, which is not currently integrated) and more outpatient practices (including dentists and specialists).	The Board of Pharmacy staff is responsible for adding any new functionality to the K-TRACS system, working with the State's vendor(s).
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[4] (see also "Use of PDMP" #2 below).	In December 2017, the Board announce the first Prescriber E-Recap (PERx). PERx is a quick, convenient way for K-TRACS to provide prescribers with a snapshot of their prescribing practices regarding controlled substances. The PERx covers the previous six-month period and includes: (1) How many patients the prescriber has	The Board recently received additional CDC grant funding through KDHE to add advanced clinical alerts to the K-TRACS system. The system provides clinical alerts directly to K-TRACS users and use indicators	The Board of Pharmacy staff will continue to pursue future funding opportunities with the Federal agencies (in conjunction with KDADS and KDHE as appropriate), but Kansas' efforts have been limited by

[4] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	prescribed opioids to, as well as a comparison to other prescribers within the prescriber's specialty; (2) Morphine Milligram Equivalent (MME) information is broken out so the prescriber can readily see where their opioid prescribing falls within multiple MME ranges; (3) Opioid treatment duration shows the percentage of their patients who have been prescribed opioids for fewer than 7 days, 7 to 28 days, 29 to 90 days, or more than 90 days; (4) K-TRACS usage shows how much the prescriber and their delegate(s) are using K-TRACS; (5) Multiple Provider Episodes (MPE) provide a look at the number of the prescriber's patients who have met or exceeded the K-TRACS threshold – five prescribers and five pharmacies within 90 days; and (6) Dangerous Combination Therapy provides the prescriber with details of their patients' combination therapies that may increase a patient's risk for overdose.[5]	that a patient may have multiple provider episodes, previous overdose history, prescriptions for dangerous drug combinations, or high prescription milligram morphine equivalents. INTEGRx8 delivers a more efficient and patient-oriented program, saves users 4.22 minutes per patient on average, and increases the utilization of K-TRACS by a factor of seven. A supplemental FY2019 CDC grant award will allow the Board to deploy the NARxCARE® enhancement, which provides additional metrics, tools, and risk scores for patients prescribed controlled substances and drugs of concern.	recent requirements of several federal agencies to use RX Check (the Federal PDMP data hub being used by BJA, CDC and other Federal Agencies). The terms and conditions for RX Check are in conflict with Kansas' data use policy. Until such issues are resolved, (i.e. RX Check conforms its data disclosure policy with law enforcement to conform with the more restrictive policies in most states), Kansas will not seek federal funds for new grant initiatives that require use of RX Check.
Current and Future PDMP Query Capabilities			

[5] January 2018 Report to Legislature: https://pharmacy.ks.gov/docs/default-source/ktracs/reports/2018-pdmp-legislative-report---final.pdf?sfvrsn=d9caa501_2

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy regarding the PDMP query).	The use of K-TRACS is not mandatory in Kansas. As the Board launches statewide integration of K-TRACS data into hospital and pharmacy electronic health records systems, use of the Gateway is expected to increase queries substantially. These systems can check a patient's controlled substance prescription history more than one time per second and counts may represent multiple checks per patient.	The K-TRACS staff will continue to work closely with State partners from other agencies and providers to increase utilization of the system. The Board envisions that expansion of the Gateway is the best way to increase use and allow providers to properly match opioid prescriptions for their patients in the PDMP. The State will explore feasibility and options of developing a shared Master Patient Index.	The Board of Pharmacy staff is responsible for adding any new functionality to the K-TRACS system, working with the State's vendor(s).
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow/ business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.	The integration of K-TRACS, LACIE, and Via Christi Health Systems enabling a single sign-on for patient medical record access in conjunction with the PDMP Gateway® gives Kansas an opportunity to deliver a more efficient and patient-oriented program. This integration allows prescribers and pharmacists to log into one program instead of separate system to query patient data which takes valuable time away from patient care and interaction. This integration simplifies the process by	INTEGRx.8 makes K-TRACS data directly available in the patient's electronic record. As of January 2019, 33 hospital corporations (with multiple sites statewide) 130 pharmacy chains and independent pharmacies (with multiple locations statewide) and 11 physicians' offices are integrated with K-TRACS in Kansas.	The Board of Pharmacy staff is responsible for adding any new functionality to the K-TRACS system, working with the State's vendor(s).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	creating a one-stop-shop making K-TRACS data directly available in the patient's electronic record and saving 4.22 minutes per patient, on average and up to 10 minutes per patient in rural areas.		
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	In December 2017, the Board announce the first Prescriber E-Recap (PERx). PERx is a quick, convenient way for the PDMP to provide prescribers with a snapshot of their prescribing practices regarding controlled substances. The PERx covers the previous six-month period and includes: (1) How many patients the prescriber has prescribed opioids to, as well as a comparison to other prescribers within the prescriber's specialty. (2) The system provides Morphine Milligram Equivalent (MME) information broken out so the prescriber can readily see where their opioid prescribing falls within multiple MME ranges. (3) Opioid treatment duration shows prescribers the percentage of their patients prescribed opioids for fewer than 7 days, 7 to 28 days, 29 to 90 days, or more than 90 days. (4) K-TRACS usage, which shows how much the prescriber and their delegate(s) are using K-TRACS. (5) Multiple Provider Episodes (MPE) provide a look at the number of the prescriber's patients who	The Board will continue to expand the use of PERx with clinicians using the PDMP and will establish daily MME guidelines and compliance with those guidelines to providers using the PDMP. INTEGRx.8 makes K-TRACS data directly available in the patient's electronic record. As of January 2019, 33 hospital corporations (with multiple sites statewide) 130 pharmacy chains and independent pharmacies (with multiple locations statewide) and 11 physicians' offices are integrated with K-TRACS in Kansas.	The Board of Pharmacy staff will be responsible for adding functionality to the K-TRACS system, working with the State's vendor(s).

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	have met or exceeded the K-TRACS threshold of 5/5/90 – five prescribers and five pharmacies within 90 days. (6) Dangerous Combination Therapy provides the prescriber with details of their patients' combination therapies that may increase a patient's risk for overdose.[6]		
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The Kansas Eligibility Enforcement System (KEES) system includes a master person index (MPI) for each person that applies for Medicaid. The MPI serves as the system of record for all person-based information throughout KEES. The MPI issues a "client ID number" that identifies a person throughout KEES. The State recognizes limitations in currently supported patient matching in the PDMP and intends to find ways to link this issue to improve data linkage and identity mapping.	The State will explore feasibility and options of developing a shared Master Patient Index.	The Board of Pharmacy staff will be responsible for adding this functionality to the K-TRACS system, working with the State's vendor(s). The Board will identify: (1) facilitators and barriers, and (2) options to link Patient Identifiers and across different systems.
Overall Objective for Enhancing PDMP Functionality & Interoperability			

[6] January 2018 Report to Legislature: https://pharmacy.ks.gov/docs/default-source/ktracs/reports/2018-pdmp-legislative-report---final.pdf?sfvrsn=d9caa501_2

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA, or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.	Through the integration described in milestone objectives above, K-TRACS providers, including those treating Medicaid beneficiaries are using the tools and methods supported in the PDMP to minimize inappropriate opioid prescribing.	Continuation of all initiatives stated in the milestones above.	. The Board of Pharmacy staff will continue to pursue future funding opportunities with the Federal agencies (in conjunction with KDADS and KDHE as appropriate), but Kansas' efforts have been limited by recent requirements of several federal agencies to use RX Check (the Federal PDMP data hub being used by BJA, CDC and other Federal Agencies).

Attachment A, Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Lori K. Haskett, Assistant Director, K-TRACS
Telephone Number: 785-296-4040
Email Address: lori.k.haskett@ks.gov

Attachment A, Section III – Relevant Documents

Please provide any additional documentation or information that the state deems relevant to successful execution of the implementation plan.

1. January 2018 Report to Legislature: https://pharmacy.ks.gov/docs/default-source/ktracs/reports/2018-pdmp-legislative-report---final.pdf?sfvrsn=d9caa501_2
2. Presentation by Board of Pharmacy in December 2017 (contains great background on the PDMP): https://qioprogram.org/sites/default/files/editors/141/KS_PDMP_Recording_508.pdf
3. Presentation by Board of Pharmacy in March 2017: https://www.deadiversion.usdoj.gov/mtgs/pharm_awareness/conf_2017/march_2017/wichita/kenton.pdf

4. 2nd Quarter 2018 K-TRACS Quarterly Review: https://pharmacy.ks.gov/docs/default-source/ktracs/reports/july-20-2018.pdf?sfvrsn=ecba501_2

Medicaid and CHIP State Plan, Waiver, and Program Submissions

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in program monitoring of Medicaid Section 1115 Substance Use Disorder Demonstrations. This mandatory information collection (42 CFR § 431.428) will be used to support more efficient, timely and accurate review of states' SUD 1115 demonstrations monitoring reports submissions to support consistency of monitoring and evaluation of SUD 1115 Demonstrations, increase in reporting accuracy, and reduce timeframes required for monitoring and evaluation. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is **0938-1148 (CMS-10398 #57)**." If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. Transmittal Title Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Transmittal Title Page as part of its SUD Monitoring Protocol. This form should be submitted as the title page of all Monitoring Reports. The content of this transmittal table should stay consistent over time.

State	**Kansas**
Demonstration Name	**KanCare**
Approval Date	**August 7, 2019**
Approval Period	**January 1, 2019 – December 31, 2023**
SUD (or if broader demonstration, then SUD Related) Demonstration Goals and Objectives	**Under this SUD Demonstration, KanCare beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.**

2. Proposed Modifications to SUD Narrative Information on Implementation, by Reporting Topic

Summary of proposed modification	Related metric (if any)	Justification for modification
1. Assessment of Need and Qualification for SUD Services		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)		

☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		

☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
8. SUD Health Information Technology (Health IT)		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
9. Other SUD-Related Metrics		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
10. Budget Neutrality		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
11. SUD-Related Demonstration Operations and Policy		

☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
12. SUD Demonstration Evaluation Update		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
13. Other Demonstration Reporting		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		
14. Notable State Achievements and/or Innovations		
☐ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information with the modifications described above.		
☒ The state has reviewed the corresponding prompts for narrative information in the SUD Monitoring Report Template and confirms that it will report the narrative information as requested (no modifications).		

3. Acknowledgement of Budget Neutrality Reporting-

☒ The state has reviewed the Budget Neutrality workbook provided by the project officer and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (no modifications).

4. SUD Demonstration Monitoring Reporting Schedule

Dates of reporting quarter	Broader 1115 DY	SUD DY	Reports due (per STCs schedule)	Measurement period associated with SUD information in report, by reporting category
08/07/2019-09/30/2019	DY7 Q3	DY1 Q3	11/30/2019	*Protocol in development*
10/01/2019-12/31/2019	DY7 Q4	DY1 Q4	2/29/2020	*Protocol in development*
01/01/2020-03/31/2020	DY8 Q1	DY 2 Q1	5/31/2020	• Narrative information for SUD DY2 Q1 • Grievances and appeals for SUD DY2 Q1 • Other monthly and quarterly metrics for SUD DY1 Q4 • Other annual metrics for SUD DY1
04/01/2020-6/30/2020	DY8 Q2	DY 2 Q2	8/31/2020	• Narrative information for SUD DY2 Q2 • Grievances and appeals for SUD DY2 Q2 • Other monthly and quarterly metrics for SUD DY2 Q1 • Annual metrics that are established quality measures for CY 2019 • Retrospective metrics: (1) grievances for SUD DY1 Q3 and Q4 and (2) other monthly and quarterly metrics for SUD DY1 Q3
7/01/2020-09/30/2020	DY8 Q3	DY 2 Q3	11/30/2020	• Narrative information for SUD DY2 Q3 • Grievances and appeals for SUD DY2 Q3 • Other monthly and quarterly metrics for SUD DY2 Q2
10/1/2020-12/31/2020	DY8 Q4	DY 2 Q4	2/28/2021	• Narrative information for SUD DY2 Q4 • Grievances and appeals for SUD DY2 Q4 • Other monthly and quarterly metrics for SUD DY2 Q3

01/01/2021-03/31/2021	DY 9 Q1	DY 3 Q1	05/31/2021	• Narrative information for SUD DY3 Q1 • Grievances and appeals for SUD DY3 Q1 • Other monthly and quarterly metrics for SUD DY2 Q4 • Other annual metrics for SUD DY2
04/01/2021-06/30/2021	DY9 Q2	DY3 Q2	08/31/2021	• Narrative information for SUD DY3 Q2 • Grievances and appeals for SUD DY3 Q2 • Other monthly and quarterly metrics for SUD DY3 Q1 • Annual metrics that are established quality measures for CY 2020
07/01/2021-09/30/2021	DY9 Q3	DY3 Q3	11/30/2021	• Narrative information for SUD DY3 Q3 • Grievances and appeals for SUD DY3 Q3 • Other monthly and quarterly metrics for SUD DY3 Q2
10/01/2021-12/31/2021	DY9 Q4	DY3 Q4	02/28/2022	• Narrative information for SUD DY3 Q4 • Grievances and appeals for SUD DY3 Q4 • Other monthly and quarterly metrics for SUD DY3 Q3
01/01/2022-03/01/2022	DY10 Q1	DY4 Q1	05/31/2022	• Narrative information for SUD DY4 Q1 • Grievances and appeals for SUD DY4 Q1 • Other monthly and quarterly metrics for SUD DY3 Q4 • Other annual metrics for SUD DY 3
04/01/2022-6/30/2022	DY10 Q2	DY4 Q2	08/31/2022	• Narrative information for SUD DY4 Q2 • Grievances and appeals for SUD DY4 Q2 • Other monthly and quarterly metrics for SUD DY4 Q1 • Annual metrics that are established quality measures for CY 2021

07/01/2022-09/30/2022	DY10 Q3	DY4 Q3	11/30/2022	• Narrative information for SUD DY4 Q3 • Grievances and appeals for SUD DY4 Q3 • Other monthly and quarterly metrics for SUD DY4 Q2
10/01/2022-12/31/2022	DY10 Q4	DY4 Q4	2/28/2023	• Narrative information for SUD DY4 Q4 • Grievances and appeals for SUD DY4 Q4 • Other monthly and quarterly metrics for SUD DY4 Q3
01/01/2023-03/31/2023	DY11 Q1	DY5 Q1	05/31/2023	• Narrative information for SUD DY5 Q1 • Grievances and appeals for SUD DY5 Q1 • Other monthly and quarterly metrics for SUD DY4 Q4 • Other annual metrics for SUD DY 4
04/01/2023-06/30/2023	DY11 Q2	DY5 Q2	08/31/2023	• Narrative information for SUD DY5 Q2 • Grievances and appeals for SUD DY5 Q2 • Other monthly and quarterly metrics for SUD DY5 Q1 • Annual metrics that are established quality measures for CY 2022
07/01/2023-09/30/2023	DY11 Q3	DY5 Q3	11/30/2023	• Narrative information for SUD DY5 Q3 • Grievances and appeals for SUD DY5 Q3 • Other monthly and quarterly metrics for SUD DY5 Q2
10/01/2023-12/31/2023	DY11 Q4	DY5 Q4	2/29/2024	• Narrative information for SUD DY5 Q4 • Grievances and appeals for SUD DY5 Q4 • Other monthly and quarterly metrics for SUD DY5 Q3

Medicaid Section 1115 SUD Demonstration Monitoring Protocol
State: Kansas
Demonstration Name: KanCare
Submitted on: 03/05/2020

State will report (Y/N)	Reporting priority	#	Metric name	Metric description	Data source	Measurement period	Reporting frequency
Assessment of need and qualification for SUD treatment services							
N	Recommended	1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Medical record review or claims	Month	Quarterly
N	Recommended	2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period but not in the three months before the measurement period	Claims	Month	Quarterly
Y	Required	3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 11 months before the measurement period	Claims	Month	Quarterly
Y	Required	4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period	Claims	Year	Annually
Y	Required	5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential treatment for SUD in an IMD during the reporting year	Claims	Year	Annually
Milestone 1: Access to critical levels of care for OUD and other SUDs							
Y	Required	6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Claims	Month	Quarterly
Y	Required	7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Claims	Month	Quarterly
Y	Required	8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Claims	Month	Quarterly
Y	Required	9	Intensive Outpatient and Partial Hospitalization Services	Number of unique beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Claims	Month	Quarterly
Y	Required	10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Claims	Month	Quarterly
Y	Required	11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Claims	Month	Quarterly
Y	Required	12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Claims	Month	Quarterly
Y	Required	36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD residential treatment for SUD	Claims; State-specific IMD database	Year	Annually
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria							
There are no CMS-provided metrics related to milestone 2.							
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities							
There are no CMS-provided metrics related to milestone 3.							
Milestone 4: Sufficient provider capacity at critical levels of care including for medication assisted treatment for OUD							
Y	Required	13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Provider enrollment database; Claims	Year	Annually
Y	Required	14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD							
Y	Required	15	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]	1. Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis 2.Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Claims	Year	Annually
Y	Required	18	Use of Opioids at High Dosage in Persons Without Cancer [PQA, NQF #2940; Medicaid Adult Core Set]	Rate per 1,000 beneficiaries age 18 and older included in the denominator without cancer who received prescriptions for opioids with a daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer. Patients in hospice are also excluded	Claims	Year	Annually
N	Recommended	19	Use of Opioids from Multiple Providers in Persons Without Cancer [PQA; NQF #2950]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids from four or more prescribers and four or more pharmacies.	Claims	Year	Annually
N	Recommended	20	Use of Opioids at High Dosage from Multiple Providers in Persons Without Cancer [PQA, NQF #2951]	Rate per 1,000 beneficiaries included in the denominator without cancer who received prescriptions for opioids greater than 120mg morphine equivalent dose (MED) for 90 consecutive days or longer, and from four or more prescribers and four or more pharmacies	Claims	Year	Annually
Y	Required	21	Concurrent Use of Opioids and Benzodiazepines [PQA]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Patients with a cancer diagnosis or in hospice are excluded	Claims	Year	Annually
Y	Required	22	Continuity of Pharmacotherapy for Opioid Use Disorder [RAND; NQF #3175]	Percentage of adults in the denominator with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Claims	Year	Annually
Milestone 6: Improved care coordination and transitions between levels of care							
N	Recommended	16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission; NQF #1664]	SUB-3 rate: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a rate: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Medical record review or claims	Year	Annually
Y	Required	17	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence§ [NCQA; NQF #2605; Medicaid Adult Core Set]	Percentage of ED visits for beneficiaries who have a principal diagnosis of mental illness or AOD abuse or dependence and who had a follow-up visit for mental illness or AOD. Four rates are reported: **Percentage 1.** Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days). **Percentage 2.** Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) **Percentage 3.** Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness or AOD within 30 days of the ED visit (31 total days) **Percentage 4.** Percentage of ED visits for which the beneficiary received a follow-up visit for mental illness or AOD within 7 days of the ED visit (8 total days)	Claims	Year	Annually
SUD health information technology (SUD health IT) (Insert at least one selected metric per key health IT question 1-3. See instructions document for further guidance.)							
Y	Required	Q1	*How is information technology being used to slow down the rate of growth of individuals identified with SUD?*	Total number of PDMP users, total number of checks.	PDMP	Year	Annually
Y	Required	Q2	*How is information technology being used to treat effectively individuals identified with SUD?*	Total number of telehealth visits with an SUD diagnosis.	Claims	Year	Annually
Y	Required	Q3	*How is information technology being used to effectively monitor "recovery" supports and serivces for individuals identified with SUD?*	Total number of treatment episodes with patient receiving Opioid Medication Assisted T	State data on TEE	Year	Annually
Other SUD-related metrics							
Y	Required	23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Claims	Month	Quarterly
Y	Required	24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Claims	Month	Quarterly
Y	Required	25	Readmissions Among Beneficiaries with SUD	The number of acute inpatient stays among beneficiaries with SUD during the measurement period followed by an acute readmission within 30 days	Claims	Year	Annually
Y	Required	26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid)	State data on cause of death	Year	Annually
Y	Required	27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. States are encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid)	State data on cause of death	Year	Annually
N	Recommended	28	SUD Spending	Total Medicaid SUD spending during the measurement period	Claims	Year	Annually
N	Recommended	29	SUD Spending Within IMDs	Total Medicaid SUD spending on residential treatment within IMDs during the measurement period	Claims	Year	Annually
N	Recommended	30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Claims	Year	Annually
N	Recommended	31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Claims	Year	Annually
Y	Required	32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Claims	Year	Annually
Y	Recommended	33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Administrative records	Quarter	Quarterly
Y	Recommended	34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Administrative records	Quarter	Quarterly
N	Recommended	35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Administrative records	Quarter	Quarterly

#	Baseline Reporting Period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided specification (Y/N)	Explanation of any deviations from the CMS-provided specifications (different data source, definition, codes, target population, etc.)	Demonstration Year (DY) and Quarter(Q) in which reporting will begin (Format: DY1Q3)	Explanation of any plans to phase in reporting over time
1							
2							
3	01/01/2019-12/31/2019	1% decrease	Decrease	Y		DY2Q1	
4	01/01/2019-12/31/2019	1% decrease	Decrease	Y		DY2Q2	
5	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q2	
6	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q1	
7	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q1	
8	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q1	
9	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q1	
10	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q1	
11	01/01/2019-12/31/2019	TBD	Increase	Y		DY2Q1	
12	01/01/2019-12/31/2019	10% increase	Increase	Y		DY2Q1	
36	01/01/2019-12/31/2019	Maintain	No more than 30 days	Y		DY2Q2	
13	01/01/2019-12/31/2019	TBD	Increase	Y		DY2Q2	
14	01/01/2019-12/31/2019	TBD	Increase	Y		DY2Q2	
15	01/01/2019-12/31/2019	5% increase	Increase	Y		DY2Q2	
18	01/01/2019-12/31/2019	5% decrease	Decrease	Y		DY2Q2	
19							
20							
21	01/01/2019-12/31/2019	5% decrease	Decrease	Y		DY2Q2	
22	01/01/2018-12/31/2019	5% decrease	Increase	Y		DY2Q2	
16						DY2Q2	
17	01/01/2019-12/31/2019	1% increase	Increase	Y		DY2Q2	
Q1	01/01/2019-12/31/201	5% increase	Increase			DY2Q2	
Q2	01/01/2019-12/31/201	5% increase	Increase			DY2Q2	
Q3	01/01/2019-12/31/201	5% increase	Increase			DY2Q2	
23	01/01/2019-12/31/2019	5% decrease	Decrease	Y		DY2Q1	
24	01/01/2019-12/31/2019	5% decrease	Decrease	Y		DY2Q1	
25	01/01/2019-12/31/2019	1% decrease	Decrease	Y		DY2Q2	
26	01/01/2019-12/31/2019	TBD	Decrease	Y		DY2Q2	
27	01/01/2019-12/31/2019	TBD	Decrease	Y		DY2Q2	
28							
29							
30							
31							
32	01/01/2019-12/31/2019	10% increase	Increase	Y		DY2Q2	
33	01/01/2019-12/31/2019	5% decrease	Decrease	Y		DY2Q1	
34	01/01/2019-12/31/2019	5% decrease	Decrease	Y			
35							

The SUD Monitoring Protocol Workbook (Part A) is also available in spreadsheet format on Medicaid.gov

Attachment R:
Reserved for SUD Health IT Plan

KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design

Revised per CMS Feedback

May 22, 2020

List of Figures and Tables

Figures:

Tables:

A. General Background Information

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

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

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

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

KanCare 2.0 Section 1115 SUD Demonstration Goals

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

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

B. Evaluation Questions and Hypotheses

KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

The following driver diagram for the overall SUD demonstration (Figure B-1) shows the relationship between the demonstration's purpose, the primary drivers that contribute directly to achieve the purpose, and the secondary drivers necessary to achieve the primary drivers.

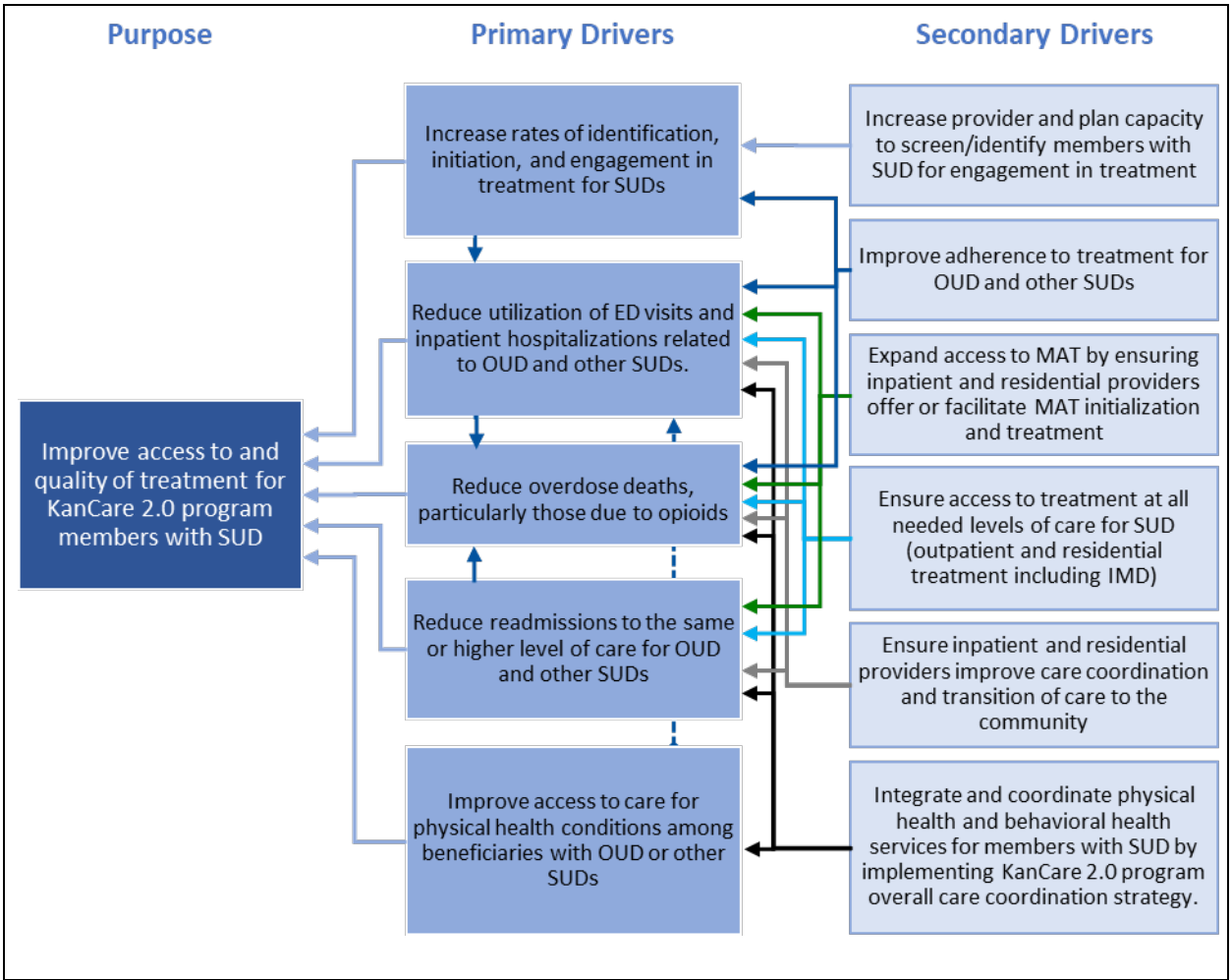

Figure B-1. KanCare 2.0 Section 1115 SUD Demonstration Driver Diagram

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

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

Table B-1. KanCare 2.0 Section 1115 SUD Demonstration Goals, Evaluation Questions, and Hypotheses		
Goals	**Evaluation Questions**	**Hypotheses**
1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.	1. Does the demonstration increase access to and utilization of SUD treatment services?	1. The demonstration will increase the percentage of members who are referred and engaged in treatment for SUDs.
2. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.	2. Does the demonstration decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population?	2. The demonstration will decrease the rate of emergency department visits and inpatient hospitalizations related to SUD within the member population.
3. Reductions in overdose deaths, particularly those due to opioids.	3. Are rates of opioid-related overdose deaths impacted by the demonstration?	3. The demonstration will decrease the rate of overdose deaths due to opioids.
4. Fewer readmissions to the same or higher level of care where readmissions are preventable or medically inappropriate for OUD and other SUDs.	4. Do enrollees receiving SUD services experience reduction in readmissions to the same or higher level of care for OUD and other SUDs?	4. Among members receiving care for SUD, the demonstration will reduce readmissions to SUD treatment.
5. Improved access to care for physical health conditions among members with OUD or other SUDs.	5. Do enrollees receiving SUD services experience improved access to care for physical health conditions?	5. The demonstration will increase the percentage of members with SUD who access care for physical health conditions.

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

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

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

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

KanCare 2.0 Section 1115 SUD Demonstration Process and Outcome Summary

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

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

Outcome Evaluation – Primary Drivers

Table B-3. Summary of Measures and Analytic Approach for Primary Driver 1 (*Outcome Evaluation*)

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

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

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

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Initiation:** Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	**Initiation:** Number of members who began initiation of treatment through an inpatient admission, residential, outpatient visits, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date	HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Engagement:** Members who were diagnosed with a new episode of alcohol or drug dependency during the first 10½ months of the measurement year	**Engagement:** Initiation of treatment and two or more engagement events (inpatient admissions, residential, outpatient visits, intensive outpatient encounters or partial hospitalizations) with any alcohol or drug diagnosis within 34 days after the initiation event	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-4. Summary of Measures and Analytic Approach for Primary Driver 2 (*Outcome Evaluation*)

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

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

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

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
ED utilization for SUD per 1,000 Medicaid beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	MMIS Encounter data from MCOs; State Medicaid Eligibility and Enrollment data	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
ED utilization for OUD per 1,000 Medicaid beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis
Inpatient stays for SUD per 1,000 Medicaid beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
Inpatient stays for OUD per 1,000 Medicaid beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	Encounter, eligibility, and enrollment data	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-5. Summary of Measures and Analytic Approach for Primary Driver 3 (*Outcome Evaluation*)					
Demonstration Goal 3: ***Reduction in overdose deaths, particularly those due to opioids.*** **Evaluation Question 3:** *Are rates of opioid-related overdose deaths impacted by the demonstration?* **Evaluation Hypothesis 3:** *The demonstration will decrease the rate of overdose deaths due to opioids.*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum)	None	Number of adult beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period.	Number of overdose deaths due to Opioids among eligible beneficiaries	Mortality data (Vital Statistics); State Medicaid Eligibility and Enrollment data	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2022) and baseline year (2019).
Use of Opioids at High Dosage in Persons without Cancer per 1,000 Medicaid beneficiaries. (CMS Metric #18)	NQF #2940 (Adult Core Set) PQA NCQA	Number of adult beneficiaries without cancer divided by 1,000. **Note**: Hospice patients will be excluded.	Number of beneficiaries with opioid prescription claims with daily dosage greater than 120 morphine milligram equivalents for 90 consecutive days or longer.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Concurrent use of opioids and benzodiazepines per 1,000 Medicaid beneficiaries. (CMS Metric #21)	PQA (Adult Core Set)	Number of adult beneficiaries without cancer divided by 1,000. **Note**: Excludes patients in hospice care and those with cancer.	Number of beneficiaries with concurrent use of prescription opioids and benzodiazepines for at least 30 days	MMIS Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2018).

Table B-6. Summary of Measures and Analytic Approach for Primary Driver 4 (*Outcome Evaluation*)

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

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

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

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2); *candidate for block grant comparison*
30-Day Readmission for SUD treatment (among discharges from a residential or inpatient facility for OUD treatment)	None	Number of discharges from a residential or inpatient facility for OUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days (i.e., inpatient-to-inpatient, inpatient-to-residential, and residential-to-residential)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-7. Summary of Measures and Analytic Approach for Primary Driver 5 (*Outcome Evaluation*)

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

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

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

Measure Description	Steward	Denominator	Numerator	Data Source	Analytic Approach
Annual Dental Visits (ADV) (SUD stratum).	NCQA	Eligible beneficiaries 2–20 years of age with SUD diagnosis enrolled in Medicaid	Number of members 2–20 years of age who had one or more dental visits with a dental practitioner during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Adults' Access to Preventive/ Ambulatory Health Services (AAP) (SUD stratum).	NCQA	Eligible beneficiaries 20 years and older with SUD diagnosis enrolled in Medicaid	Number of members 20 years and older who had an ambulatory or preventive care visit during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Adolescent Well-Care Visits (AWC) (SUD stratum).	NCQA	Eligible beneficiaries 12–21 years of age with SUD diagnosis enrolled in Medicaid	Number of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that received a prenatal care visit in first trimester, on or before enrollment start date, or within 42 days of enrollment in the organization.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis
Prenatal and Postpartum Care (PPC) – Postpartum Care (SUD stratum).	NCQA	Number of deliveries with live births for eligible members with SUD diagnosis	Number of deliveries that had a postpartum visit on or b/w 7 & 84 days after delivery.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Process Evaluation – Secondary Drivers

Table B-8. Summary of Measures and Analytic Approach for Secondary Driver 1 (*Process Evaluation*)					
Secondary Driver 1 (*Related to Goal 1*): *Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Percentage of physical health and behavioral health service providers that billed SBIRT services.	None	The number of distinct performing provider NPIs on claims. Measured on dental, outpatient and professional claims; see policy for provider types.	The number of distinct performing provider NPIs on claims for *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) services	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Receipt of care for SUD after SBIRT service.	None	Number of beneficiaries who received SBIRT services. (CMS Metric #1)	Number of beneficiaries who received SBIRT services with evidence of SUD service within 60 days after SBIRT service.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-9. Summary of Measures and Analytic Approach for Secondary Driver 2 (*Process Evaluation*)					
Secondary Driver 2 (*Related to Goal 1, Goal 2 and Goal 3*): *Improve adherence to treatment for OUD and other SUDs*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Continuity of Pharmacotherapy for OUD (POD) – (CMS Metric #22).	NCQA	Number of beneficiaries age 18 to 64 with an OUD diagnosis (excluding adults initiating pharmacotherapy after 6/30/20 and those deliberately phased out of MAT prior to the 180 days).	Number of beneficiaries with at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days.	MMIS Encounter data from MCOs; HEDIS data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA).	NCQA	ED visits for members ~~years of~~ age 13 or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
* Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12)					

Table B-9. Summary of Measures and Analytic Approach for Secondary Driver 2 (*Process Evaluation*) (cont.)					
Secondary Driver 2 (*Related to Goal 1, Goal 2 and Goal 3*): *Improve adherence to treatment for OUD and other SUDs*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive any SUD treatment service (CMS Metric #6). Stratified by service type*	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type.	None	Number of enrollees with an OUD diagnosis (CMS Metric #3, OUD stratum).	Number of beneficiaries with an OUD diagnosis who receive any SUD treatment service (CMS Metric #6; OUD stratum). Stratified by service type*	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Percentage of beneficiaries with SUD diagnosis who received peer support services during the monthly measurement period	None	Number of enrollees with a SUD diagnosis (CMS Metric #3).	Number of beneficiaries with a SUD diagnosis who receive peer support service (HCPCTS Codes: H0038, H0038 HQ)	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
* Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12)					

Table B-10. Summary of Measures and Analytic Approach for Secondary Driver 3 (*Process Evaluation*)					
Secondary Driver 3 (*Related to Goal 2, Goal 3, and Goal 4*): *Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Residential OUD discharges with MAT claim	None	Number of residential discharges for SUD treatment with OUD diagnosis.	Number of denominator discharges with MAT claim during the stay or within 15 days of discharge.	MCO Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; *candidate for block grant or rural/urban comparison*
Inpatient OUD discharges with MAT claim	None	Number of inpatient discharges for SUD treatment with OUD diagnosis.	Number of denominator discharges with MAT claim during the stay or within 15 days of discharge.	MCO Encounter data from MCOs	Descriptive statistics; Trend analysis via Mantel-Haenszel (MH) chi-square test or Fisher's Exact test for comparison of percentages for final year (2023) and baseline year (2019) ; *candidate for block grant or rural/urban comparison*
Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period	None	Number of members with OUD diagnosis (CMS Metric #3, OUD stratum).	Number of members with a claim for MAT for OUD (CMS Metric #12, OUD stratum).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis via Mantel-Haenszel (MH) chi-square test; *candidate for block grant or rural/urban comparison*

Table B-11. Summary of Measures and Analytic Approach for Secondary Driver 4 (*Process Evaluation*)					
Secondary Driver 4 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year.	None	Number of beneficiaries with a SUD diagnosis and a SUD-related service during the measurement period and/or in the 12 months before the measurement period (CMS Metric #4).	Number of beneficiaries with a claim for residential treatment in an IMD (CMS Metric #5).	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2)
Average length of stay for SUD treatment services within IMDs (CMS Metric #36).	None	Total number of discharges from an IMD for beneficiaries with a residential treatment stay for SUD.	Total number of days in an IMD for all beneficiaries with an identified SUD.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of beneficiaries in residential and inpatient treatment (refer to CMS Metric #10).	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
Number of beneficiaries in outpatient, intensive outpatient, & partial hospitalization SUD treatment per 1,000 members with SUD diagnosis.	None	Number of beneficiaries with SUD diagnosis divided by 1,000. (CMS Metric #3)	Total number of members in outpatient, intensive outpatient or partial hospitalization treatment (refer to CMS Metrics #8 & #9). **Note**: Partial hospitalization in KS has same service code as inpatient.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-12. Summary of Measures and Analytic Approach for Secondary Driver 5 (*Process Evaluation*)					
Secondary Driver 5 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure inpatient & residential providers improve care coordination & transition of care to the community.*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
30-Day Readmission for SUD treatment	None	Number of discharges from a residential or inpatient facility for SUD treatment.	Number of discharges with a subsequent admission to a residential or inpatient facility for SUD treatment at the same or higher level of care within 30 days.	MMIS Encounter data from MCOs	Descriptive statistics; Interrupted Time Series (ITS) design (pre- & post-intervention period comparison); Trend analysis (Mantel-Haenszel X^2) ; *candidate for block grant comparison*
ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23)	None	Beneficiaries enrolled for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for SUD during the measurement period	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of ED visits for OUD during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis
Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to a SUD stay during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum)	None	Beneficiaries enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period divided by 1,000.	Number of inpatient discharges related to an OUD stay during the measurement period.	MMIS Encounter data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*
Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA).	NCQA	ED visits for members 13 years or older with a principal diagnosis of alcohol or other drug abuse (AOD) or dependence in the measurement year.	A follow-up visit with any practitioner after a principal diagnosis of AOD within 7/30 days of the ED visit.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis; *candidate for block grant comparison*

Table B-13. Summary of Measures and Analytic Approach for Secondary Driver 5 (*Process Evaluation*)					
Secondary Driver 5 (*Related to Goal 2, Goal 3, and Goal 4*): *Ensure inpatient & residential providers improve care coordination & transition of care to the community*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Follow-Up After High-Intensity Care for SUD (FUI)	NCQA	# of inpatient hospitalizations, residential treatment or detoxification visits for a SUD diagnosis among members age 13 or older	# of visits or discharges that result in a follow-up visit or service for SUD within 7/30 days.	HEDIS data from MCOs	Descriptive statistics; Trend analysis; Differences between final and baseline years (Fisher's Exact or X^2)
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET)	NQF #0004 NCQA	**Initiation:** See above Table B-3 – Primary Driver, Goal 1. **Engagement:** See Table B-3 – Primary Driver, Goal 1	**Initiation:** See Table B-3– Primary Driver 1. **Engagement:** See Table B-3 – Primary Driver 1.	HEDIS data from MCOs	Descriptive statistics; ITS design; Trend analysis

Table B-14. Summary of Measures and Analytic Approach for Secondary Driver 6 (*Process Evaluation*)					
Secondary Driver 6 (*Related to Goal 2, Goal 3, Goal 4, and Goal 5*): *Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.*					
Measure Description	**Steward**	**Denominator**	**Numerator**	**Data Source**	**Analytic Approach**
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager.	None	Number of Medicaid beneficiaries with SUD diagnosis	Number of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager.	MCO case management data (available for 2019 onwards)	Descriptive statistics; Trend analysis (Mantel-Haenszel X^2); Differences between final and baseline years (Fisher's Exact or X^2)
Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have service/treatment plan or person-centered service plan (PCSP).	None	Number of Medicaid beneficiaries with SUD diagnosis.	Number of Medicaid Beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and service/treatment plan or PCSP.	MCO case management data (available for 2019 onwards)	Descriptive statistics; Trend analysis

KanCare 2.0 Section 1115 Demonstration Hypothesis 4 Evaluation

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

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

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

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

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

- *1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics* ("CMS Metrics")[7];
- *Adult Core Set* measures including those endorsed by the National Quality Forum (NQF) and stewarded by the National Committee for Quality Assurance (NCQA), and the Pharmacy Quality Alliance (PQA)[8]; and
- *Healthcare Effectiveness Data and Information Set®* (HEDIS) measures.[9]

C. Evaluation Design Methodologies

The evaluation design methodologies are designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. The focus of the evaluation is to examine the effectiveness of demonstration strategies and policies on achievement of the overall goal of helping Medicaid members with SUD to have improved access to and quality of treatment.
The following sections present an overview of methods and rationale for the Demonstration evaluation, followed by sections detailing evaluation questions, evaluation hypotheses, and strategies for each goal of the Demonstration as well as the KanCare 2.0 Program Hypothesis 4 and the overall cost evaluation. See **Attachment 1- Detailed Design Methodology and Limitations** for additional methods discussions.

Evaluation Design Overview

Evaluation of the Demonstration is primarily focused on the subset of KanCare 2.0 members with a SUD diagnosis will be the primary participants ("study population"). In certain cases, members without an

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

The difference-in-differences evaluation design was considered for use with identified internal or external comparison populations but was ultimately determined to be infeasible due to lack of comparability of populations (see Attachment 1). To address those limitations, the **Interrupted Time Series** (ITS) and **One-Group Pretest-Posttest** (OGPP) evaluation designs will be used throughout the majority of the evaluation. The evaluation of KanCare 2.0 Hypothesis 4 focuses on increasing availability of IMD facilities providing SUD services following the removal of the Kansas Medicaid IMD Exclusion. Though, due to changes in data systems, pre-demonstration data will not be available. Therefore, non-experimental methods (descriptive statistics) will be used for conducting the evaluation of KanCare 2.0 Hypothesis 4. Specific to cost analyses, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Further discussions on how to best evaluate SUD Demonstration costs will be held to determine alternative approaches such as a "shadow pricing" retrospective cost analysis.

Interrupted Time Series (ITS) Evaluation Design

The ITS is performed as a continuous series of measurements on a population based on the variable of interest within a treatment or intervention to determine trends 'interrupted' by application of the treatment or intervention at those times. The quasi-experimental ITS evaluation design was selected for Evaluation Hypothesis 1 and the Demonstration Cost Hypothesis, in their entirety, and for subsets of Evaluation Hypotheses 2 through 5. As shown in Figure C-1, below, the two-year baseline measurements will be for years 2017–2018 and the five-year intervention period will span 2019–2023.

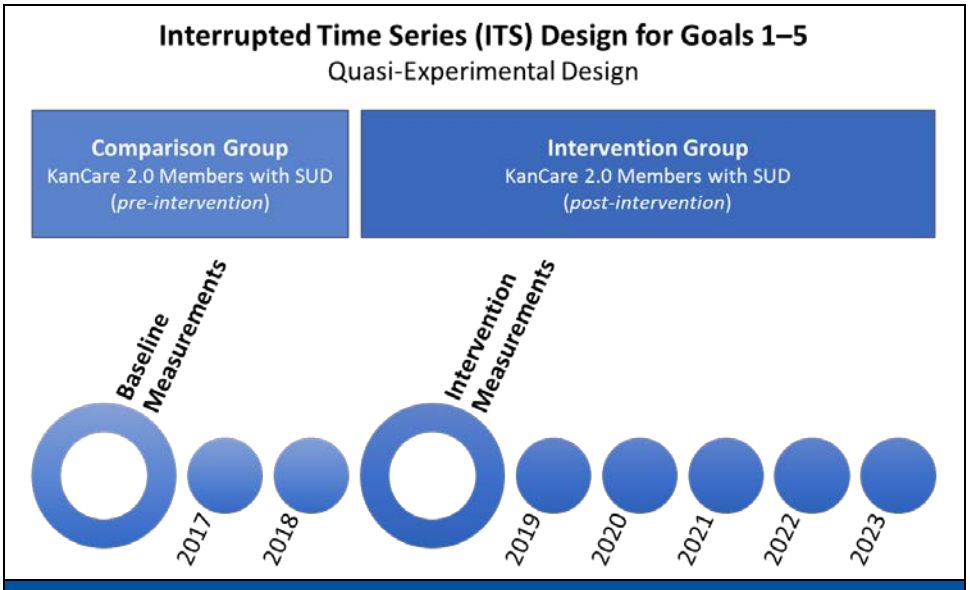

Figure C-1. Interrupted Time Series Evaluation Design for Evaluation of KanCare SUD Demonstration

We will estimate ITS models using the following segmented linear regression equation:

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

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

One Group Pretest-Posttest (OGPP) Evaluation Design

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

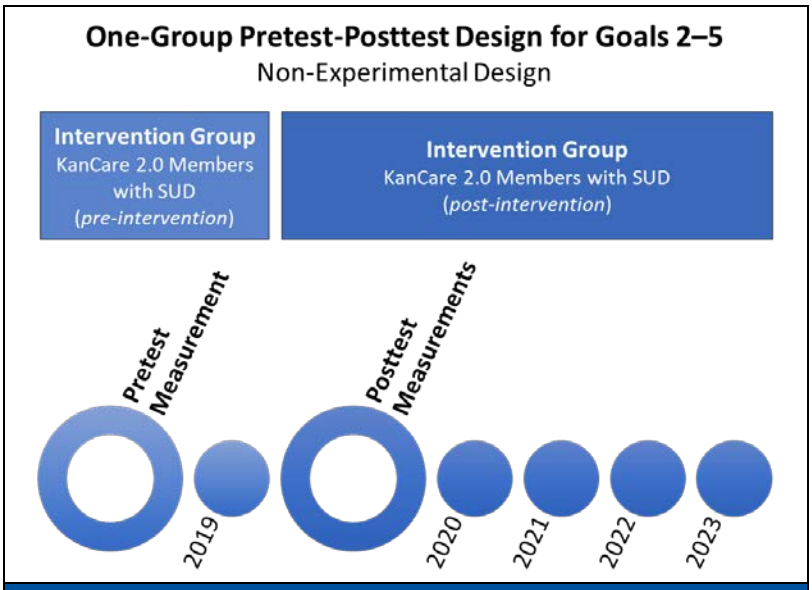

Figure C-2. One-Group Pretest-Posttest Evaluation Design for Evaluation of KanCare SUD Demonstration

a. Evaluation Methodology for SUD Demonstration Goal 1

Demonstration Goal 1

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

Evaluation Question for Goal 1

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

Evaluation Hypothesis for Goal 1

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

Demonstration Strategies for Goal 1

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

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

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

- Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment (Secondary Driver 1);
- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 1).

Drivers and Performance Measures for Goal 1

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

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Table C-1. Drivers and Associated Performance Measures for SUD Demonstration Goal 1	
Primary Driver	**Performance Measure**
Increase rates of identification, initiation, and engagement in treatment for SUDs	• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). (2017–2022)*
Secondary Drivers	**Performance Measures**
Increase provider and plan capacity to screen/ identify members with SUD for engagement in treatment.	• Percentage of physical health and behavioral health service providers that billed *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) services. (2017–2023)* • Receipt of care for SUD and/or OUD after SBIRT service. (2017–2023)*
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22). (2017–2023)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*† • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*^ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*^ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period.*
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12) † Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients).	

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

b. Evaluation Methodology for SUD Demonstration Goal 2:

Demonstration Goal 2

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

Evaluation Question for Goal 2

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

Evaluation Hypothesis for Goal 2

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

Demonstration Strategies for Goal 2

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

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

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

- Improve adherence to treatment for OUD and other SUDs (Secondary Driver 2);
- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment (Secondary Driver 3);
- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 4);
- Ensure inpatient and residential providers improve care coordination and transition of care to the community (Secondary Driver 5); and
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 6).

Drivers and Performance Measures for Goal 2

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

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration Goal 2	
Primary Driver	**Performance Measures**
Reduce utilization of ED visits and inpatient hospitalizations related to OUD and other SUDs.	• ED utilization for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #23; 2017–2023)* • ED utilization for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #23, OUD stratum; 2017–2013)* • Inpatient stays for SUD per 1,000 Medicaid beneficiaries. (CMS Metric #24; 2017–2023)*^ • Inpatient stays for OUD per 1,000 Medicaid beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)* • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)*^ • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023).*[†] • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)*[†] • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)*
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	• Residential OUD discharges with MAT claim. (2017–2023)^[‡] • Inpatient OUD discharges with MAT claim. (2017–2023) ^[‡] • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)*^
Ensure access to treatment at all needed levels of care for SUD (outpatient and residential treatment including IMD).	• Percentage of Medicaid beneficiaries with SUD diagnosis who were treated in an IMD for SUD during the measurement year. (2017–2023)* • Average length of stay for SUD treatment services within IMDs. (CMS Metric #36; 2017–2023)* • Number of beneficiaries in residential and inpatient treatment for SUD per 1,000 members with SUD diagnosis. (2017–2023)* • Number of outpatient, intensive outpatient, & partial hospitalization days of SUD treatment per 1,000 members with SUD diagnosis.(2017–2023)* **Note**: *Partial hospitalization in KS has same service code as inpatient*.
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). [†] Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12). [‡] One-group Pretest–Posttest Design will be used for the assessment of the performance measure.	

Table C-2. Drivers and Associated Performance Measures for SUD Demonstration Goal 2 (cont.)	
Secondary Driver	**Performance Measures**
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	• 30-Day Readmission for SUD treatment. (2017–2023)*^ • ED utilization for SUD per 1,000 beneficiaries. (CMS Metric #23; 2017–2023)* • ED utilization for OUD per 1,000 beneficiaries. (CMS Metric #23, OUD stratum; 2017–2023)* • Inpatient stays for SUD per 1,000 beneficiaries. (CMS Metric #24; 2017–2023)*^ • Inpatient stays for OUD per 1,000 beneficiaries. (CMS Metric #24, OUD stratum; 2017–2023)*^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse/ Dependence (FUA). (2017–2022)*^ • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2022)* • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)‡
Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy	• Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager (2019–2023)‡ • Percentage of Medicaid beneficiaries with SUD diagnosis who have an assigned MCO Care Manager and have a service/treatment plan or person-centered service plan (PCSP). (2019–2023)‡
* Interrupted Time Series Design will be used for the assessment of the performance measure. ^ Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). [†] Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12). ‡ One-group Pretest–Posttest Design will be used for the assessment of the performance measure.	

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

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

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

c. Evaluation Methodology for SUD Demonstration Goal 3:

Demonstration Goal 3

Reduction in overdose deaths, particularly those due to opioids.

Evaluation Question for Goal 3

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

Evaluation Hypothesis for Goal 3

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

Demonstration Strategies for Goal 3

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

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

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

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

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

- Ensure access to services at all needed levels of care for SUD, including outpatient treatment (group, individual, and/or family counseling, community psychiatric support, crisis intervention), residential treatment (including coverage of SUD treatment in IMDs), and peer support services (Secondary Driver 3);
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy (Secondary Driver 5).

Drivers and Performance Measures for Goal 3

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

Table C-3. Drivers and Associated Performance Measures for SUD Demonstration Goal 3	
Primary Driver	**Performance Measures**
Reduce overdose deaths, especially those due to opioids.	• Opioid Drug Overdose Deaths. (CMS Metric #27, OUD Stratum; 2019–2022)* • Use of Opioids at High Dosage in Persons without Cancer. (CMS Metric #18; 2017–2023)^ • Concurrent Use of Opioids and Benzodiazepines. (CMS Metric #21; 2018–2023)*
Secondary Drivers	**Performance Measures**
Improve adherence to treatment for OUD and other SUDs.	• Continuity of Pharmacotherapy for OUD (POD). (CMS Metric #22; 2017–2023)^ • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^† • Percentage of beneficiaries with OUD diagnosis who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡ • Percentage of beneficiaries with SUD who used SUD treatment services during the monthly measurement period, stratified by service type. (2017–2023)^‡ • Percentage of beneficiaries with SUD diagnosis who used SUD peer support services during the monthly measurement period. (2017–2023)^
Expand access to medication-assisted treatment (MAT) by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment.	• Residential OUD discharges with MAT claim. (2017–2023)^† • Inpatient OUD discharges with MAT claim. (2017–2023)^† • Percentage of members with OUD diagnosis who have a MAT claim for OUD during the measurement period. (2017–2023)^†
Ensure inpatient and residential providers improve care coordination and transition of care to the community.	• 30-Day Readmission for SUD treatment. (2017–2023)^† • ED utilization for SUD per 1,000 beneficiaries (CMS Metric #23). (2017–2023)^ • ED utilization for OUD per 1,000 beneficiaries (CMS Metric #23, OUD stratum; 2017–2023)^ • Inpatient stays for SUD per 1,000 beneficiaries (CMS Metric #24; 2017–2023)^† • Inpatient stays for OUD per 1,000 beneficiaries (CMS Metric #24, OUD stratum; 2017–2023)^† • Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence (FUA). (2017–2022)^† • Initiation & Engagement of Alcohol & Other Drug Dependence Treatment (IET). (2017–2022)^ • Follow-Up After High-Intensity Care for SUD (FUI). (2019–2022)*
* One-group pretest–posttest design will be used for the assessment of the performance measure. ^ Interrupted time series design will be used for the assessment of the performance measure. † Candidate measure to investigate feasibility of comparison group (Beacon block grant recipients, rural/urban comparison). ‡ Service Type Strata: *early intervention*, e.g., SBIRT (CMS Metric #7); *outpatient services* (CMS Metric #8); *intensive outpatient and partial hospitalization* (CMS Metric #9); *residential and inpatient services* (CMS Metric #10); *withdrawal management* (CMS Metric #11); *medication-assisted treatment (MAT)* (CMS Metric #12).	

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

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

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

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

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

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

d. Evaluation Methodology for SUD Demonstration Goal 4

Demonstration Goal 4

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

Evaluation Question for Goal 4

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

Evaluation Hypothesis for Goal 4

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

Demonstration Strategy for Goal 4

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

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

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

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

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

- Expand access to MAT by ensuring inpatient and residential providers offer or facilitate MAT initialization and treatment for those who meet the need criteria and choose treatment.
- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

Drivers and Performance Measures for Goal 4

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

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

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

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

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

e. Evaluation Methodology for SUD Demonstration Goal 5

Demonstration Goal 5

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

Evaluation Question for Goal 5

Do enrollees receiving SUD services experience improved access to care for physical health conditions?

Evaluation Hypothesis for Goal 5

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

Demonstration Strategy for Goal 5

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

- KanCare 2.0 contracts with MCOs will focus on the integration of behavioral health and physical health among members with SUDs.
    - Care coordination includes health screening, health risk assessment, needs assessment, and development and implementation of service/treatment plan or person-centered service plan (PCSP).

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

- Integrate and coordinate physical health and behavioral health services for members with SUD by implementing KanCare 2.0 program overall care coordination strategy.

Drivers and Performance Measures for Goal 5

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

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

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

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

f. Methodology for the Evaluation of KanCare 2.0 Hypothesis 4

KanCare 2.0 Hypothesis 4 Evaluation Question

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

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

KanCare 2.0 Hypothesis 4

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

Demonstration Strategy for KanCare 2.0 Hypothesis 4

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

Evaluation Design for KanCare 2.0 Hypothesis 4

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

Target and Comparison Population

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

Evaluation Period

2019–2023 will be the evaluation period.

Evaluation Measures for KanCare 2.0 Hypothesis 4

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

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

The investigation of costs for the KanCare 2.0 SUD Demonstration is a separate but cross-cutting element of the demonstration evaluation. Cost studies investigate both granular (i.e., specific treatment costs) and macro aspects of the KanCare program unique to the SUD demonstration. The SUD demonstration is designed to maintain budget neutrality while improving the effectiveness of services delivered to the Medicaid population. The intent of cost studies is not to identify statistically significant increases or decreases in program costs but to understand how spending within different categories may contribute to enhanced program effectiveness. This is, in large part, due to how Medicaid managed care capitation payments obscure true administrative spending versus a fee-for-service paradigm.

Goal for Costs of SUD Demonstration

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

Evaluation Question for Demonstration Cost

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

Evaluation Hypothesis for Demonstration Cost

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

Demonstration Strategy for Demonstration Cost

Each of the strategies within the Evaluation Design Methodology, that support the primary and secondary drivers, are also utilized in the investigation of program costs. The outcomes of these strategies are anticipated to contribute to enhanced program efficiency and effectiveness. Enhancements to efficiency may include reductions to admissions (or readmissions) and other burdens related to treatment of preventable or medically inappropriate encounters as well as any other outcomes which reduce unnecessary utilization or duplication of efforts. This may also shift costs associated with the transition from formal treatment to community recovery services. See subsections C.a through C.e for detailed discussion on evaluation strategies.

Evaluation Measures for Demonstration Cost

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

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

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

Table C-6. Type of Care Cost Drivers	
Measure Description	**Numerator and Denominator Specification**
ED Outpatient SUD spending during the measurement period. Expressed in dollars per member per month ($PMPM).	**Numerator**: Spending on SUD treatment services in emergency department (ED) outpatient settings during the measurement period (CMS Metric #28, outpatient ED stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient non-ED stratum)
Non-ED Outpatient SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services and peer support in non-ED outpatient settings during the measurement period. (CMS Metric #28, outpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support service during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, outpatient stratum)
Inpatient and residential SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD treatment services in inpatient and residential settings during the measurement period. (CMS Metric #28, inpatient stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, inpatient stratum)
Pharmacy SUD spending during the measurement period. ($PMPM)	**Numerator**: Spending on SUD pharmaceuticals during the measurement period. (CMS Metric #28, pharmaceutical stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, pharmaceutical stratum)
Total KanCare 2.0 SUD treatment spending on beneficiaries with SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: The sum of all Medicaid spending on SUD treatment and peer support services during the measurement period. (CMS Metric #28)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support service during the measurement period and/or in the 12 months before the measurement period. (*paid claims, only*; CMS Metric #4)

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

Table C-7. SUD Cost Drivers	
Measure Description	**Numerator and Denominator Specification**
SUD spending on inpatient/residential services and pharmaceuticals within IMDs during the measurement period. Expressed in dollars per member per month ($PMPM). [CMS Metric #31]	**Numerator**: Spending on treatment or peer support for SUD within IMDs during the measurement period. (exclude room & board; CMS Metric #29)
	Denominator: Number of beneficiaries with a claim for treatment or peer support for SUD in an IMD during the reporting year. (paid service or pharmacy claims, only; CMS Metric #5)
SUD spending on services other than within IMDs during the measurement period. ($PMPM) [CMS Metric #30]	**Numerator**: Spending on SUD treatment or peer support services *not within IMDs* during the measurement period. (CMS Metric #28, non-IMD stratum)
	Denominator: Number of beneficiaries with a SUD diagnosis and a SUD treatment or peer support during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on SBIRT services for beneficiaries without SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: Spending on SUD *Screening, Brief Intervention, and Referral to Treatment* (SBIRT) for beneficiaries *without a SUD diagnosis and not within IMDs* during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	Denominator: Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
SUD spending on assessment services for beneficiaries without SUD diagnosis during the measurement period. ($PMPM)	**Numerator**: Spending on SUD assessment for beneficiaries *without a SUD diagnosis and not within IMDs* during the measurement period. (CMS Metric #28, non-IMD and non-SUD diagnosis strata)
	Denominator: Number of beneficiaries without SUD diagnosis but with a SUD treatment during the measurement period and/or in the 12 months before the measurement period. (paid claims, only; CMS Metric #4, non-IMD stratum)
Total KanCare 2.0 SUD treatment spending during the measurement period. ($PMPM)	**Numerator**: The sum of all Medicaid spending on SUD treatment, SBIRT, assessment, and peer support services during the measurement period. (CMS Metric #28, includes non-SUD diagnosis stratum)
	Denominator: Number of beneficiaries who received SUD treatment, SBIRT, assessment, or peer support services during the measurement period and/or in the 12 months before the measurement period. (*paid claims, only;* CMS Metric #4, includes non-SUD diagnosis stratum)

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

Evaluation Design for Demonstration Cost

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

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

Target and Comparison Population

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

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

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

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

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

Evaluation Period

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

Analytic Plan for Demonstration Cost

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

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D. Attachments

1. Detailed Design Methodology and Limitations

Study, Target and Comparison Populations

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

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

External Comparison Population – Administrative Services Organization (ASO) Individuals

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

Internal Comparison Population – Geographic Locations of Members and Services

Potential internal comparison populations for the Demonstration may fall along the Kansas population density spectrum (frontier-to-urban) or location of services as availability and access will likely differ by location in Kansas. For example, methadone treatment requires daily (or near daily) clinic visits but methadone clinics may not be accessible in regions of lower population density. Kansas counties are designated to different population density peer groups according to their population relative to their size in persons per square mile (ppsm): Frontier (less than 6.0 ppsm), Rural (6.0 - 19.9 ppsm), Densely-settled Rural (20.0 - 39.9 ppsm), Semi-Urban (40.0 - 149.9 ppsm), and Urban (150.0 ppsm or more).[11] Another potential comparison could be comparing services or providers in different geographic locations, such as comparison between different urban areas offering methadone clinics and likelihood of accepting Medicaid. Non-urban regions will be investigated for their potential to serve as comparison groups to urban regions for select MAT measures.

Data Sources

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

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

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

Data Source	Owner/Steward	Brief Description
Healthcare Effectiveness Data and Information Set (HEDIS)	KanCare 2.0 MCOs	Member-level detail tables for HEDIS measures submitted by the MCOs.
Managed care administrative data	KanCare 2.0 MCOs	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Managed care case management data	KanCare 2.0 MCOs	Member-level data maintained by MCOs within their specific case management data systems.
Medicaid Management Information System (MMIS) encounter data	KanCare 2.0 MCOs	Encounter/claims data submitted to the State by MCOs used to support HEDIS® and HEDIS®-like performance, Medication-Assisted Treatment, service utilization, and cost metrics for all enrollees.
Member survey data	KanCare 2.0 MCOs	Member responses to questions within MCO-fielded SUD surveys. Survey objectives and questions to be determined.
Medicaid eligibility and enrollment files (“834 files”)	State of Kansas	Eligibility and enrollment detail for KanCare members used to determine enrollee aid category and stratify data into subgroups.
Mortality data	State of Kansas	Public health birth, death and other vital records used to track overdose deaths attributed to Kansas residents.
State administrative data	State of Kansas	Administrative overhead, contractual, and other costs unique to the SUD Demonstration.
Key informant / focus group responses	TBD	Feedback resulting from key informant interviews and/or focus group sessions. Qualitative topics, objectives, and participants/settings to be determined.

Analytic Methods

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

Source data will be cleaned as appropriate with steps to include reviewing data for missing values, inconsistent patterns, and identification of outliers to ensure quality and appropriateness of data for

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

Descriptive statistics will be used to describe demographic characteristics of the study population, intervention groups, comparison groups, and any subgroups. Stratified analysis will be performed to evaluate the impact of the Demonstration on subpopulations if evidence suggests significant differences may exist. Analysis may include chi square testing for independence, logistic regression, and Breslow-Day testing for homogeneity of odds ratios. Trend analysis will be conducted using statistical tests such as a Mantel-Haenszel chi-square test with $p<.05$ indicating statistical significance.

Interrupted Time Series (ITS) Analysis

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

One Group Pretest-Posttest (OGPP) Analysis

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

Qualitative Analyses

Qualitative analyses will be performed against the objectives of each qualitative study. For surveys and other qualitative approaches needing a representative sample of the population, a sampling strategy will be devised to include sampling method (random sampling, stratified sampling, convenience sampling, etc.), sample frame, sample size, desired response rate, and quality control and bias reduction elements. For key informant interviews or focus groups a participation strategy will be devised to include participant selection (purposive sample, quota sample, etc.), recruitment, discussion protocols, and communications procedures. Data will be analyzed through theming and descriptive statistics, where appropriate. Research and professional ethics (informed consent, risk minimization, confidentiality, etc.) will be adhered to for all qualitative research.

Evaluation Design Limitations

The Demonstration evaluation has a strong reliance upon quasi-experimental ITS and non-experimental OGPP designs. Therefore, the resultant pre- and post-test evaluation design or comparisons to baselines may not imply causality due to a specific intervention. Further, the reliance upon non-experimental methods for KanCare 2.0 Hypothesis 4 will inhibit interpretations and conclusions from investigation in changes to Kansas' IMDs. Lastly, the Kansas Medicaid managed care model hinders the ability to investigate costs with the same precision that would be possible in fee-for-service models due to capitation arrangements. Every attempt to ensure quality data and analysis will be made for observed

limitations to evaluation design.

Study Population Limitations

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

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

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

Data Source Limitations

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

Data lag also causes a challenge in measuring and reporting change in a timely manner. This can affect the availability of data for conducting the evaluation for the entire five-year period of the demonstration. As the evaluation is based on a five-year period, the definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources may change during the evaluation period following administrative rule or other policy changes, thus leading to unavailability of appropriate data for the analysis of multiple pre- and post- intervention evaluation points needed for comparative interrupted time series and one-group pretest-posttest designs. Additional challenges specific to cost data are lags related to both the resolution and reconciliation of claims but also in availability of administrative data due to fiscal timeframes and policies.

From a qualitative perspective, limitations may exist in the collection and coding of open-ended questions and comments. This includes limitations to the accuracy and precision of data obtained through primary data collection as well as the extent to which interpretations and conclusions may be made. As the SUD surveys are administered independently by each MCO, analysis across the KanCare 2.0 program may not be feasible if survey designs or fielding differs significantly between one or more of the MCOs.

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2. Independent Evaluator

KDHE has arranged to contract with the Kansas External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the evaluation of SUD Demonstration at the level of detail needed to research the approved hypotheses. They have agreed to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. KFMC has over 45 years of demonstrated success in carrying out both Federal and State healthcare quality related contracts. They have provided healthcare quality improvement, program evaluation, review and other related services including the following:

- Kansas Medicaid Managed Care EQRO since 1995 (24 years).
- CMS quality improvement organization (QIO) or QIO-Like entity since 1982 (37 years).
- Utilization Review/Independent Review Organization for the Kansas Insurance Department since 2000 (19 years) and for five other states.

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

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

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

- Relationships with Insurance Organizations or Subcontractor of Insurance Organizations
- Relationships with Providers or Suppliers Furnishing Health Services Under Medicare
- Financial Interests in Health Care Related Entities
- Investments in Medical Companies, Healthcare or Medical Sector Funds
- Governing Body Positions

3. EQRO Evaluation Budget

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

4. Timeline and Major Milestones

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

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