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

State Demonstrations Group

May 29, 2024

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

Dear Director Osterlund:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the KanCare Interim Evaluation Report, which is required by the Special Terms and Conditions (STCs), specifically STC #102 "Interim Evaluation Report" of the Kansas "KanCare" (Project No: 11-W-00283/7). This Interim Evaluation Report covers the period from January 2019 through December 2021. CMS determined that the Evaluation Report, submitted on October 17, 2022 and revised on June 20, 2023, is in alignment with the CMS-approved Evaluation Design and the requirements set forth in the STCs, and therefore, approves the state's Interim Evaluation Report.

The Interim Evaluation Report is clearly written and structured, and provided a descriptive assessment of the progress towards the demonstration goals during the initial years of the demonstration approval period. The report incorporates a broad array of data sources and relevant outcome measures. The findings of the Interim Evaluation Report provide evidence that Kansas made progress toward its demonstration goals. For example, adult access to preventive/ambulatory health services and rates of ED, observation stays, and inpatient admissions for specified health conditions improved. The SUD-specific findings showed that measures of initiation and engagement in alcohol and other drug treatment modestly improved between 2017 and 2020. The state's Summative Evaluation Report is expected to provide a fuller understanding of the demonstration's effectiveness using advanced statistical analysis and leveraging additional years of data that may enable separating out the confounding effects of the COVID-19 PHE from those of the demonstration itself more effectively.

In accordance with STC #105, the approved Evaluation Report may now be posted to the state's Medicaid website within 30 days. CMS will also post the Interim Evaluation Report on Medicaid.gov.

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

Sincerely,

Danielle Daly -S

Digitally signed by Danielle Daly -S
Date: 2024.05.29 09:26:46 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Helenita Augustus, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Contract Number: 46100

Submission Date: October 14, 2022
Final Submission Date: October 20, 2022
Revision Date: June 6, 2023

Review Team: Ghazala, Perveen, MBBS, PhD, MPH, Epidemiologist Consultant
John McNamee, Ph.D., MA, Sr. Health Data Analyst
Lynne Valdivia, MSW, BSN, RN, CCEP, Vice President, Director of Quality Review, and Compliance Officer
Beth Nech, MA, EQRO Manager
Anne Dwyer, MA, Health Quality Data Analyst

Prepared for:

Table of Contents

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Table of Contents

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Figures and Tables

Figures

Executive Summary

Report

Table of Contents

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Tables

Report

Table of Contents

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

KanCare 2.0 Interim Evaluation Report
Evaluation of the Kansas Medicaid Section 1115(a) Demonstration
January 2019 – September 2022
Revision Date: June 6, 2023

Executive Summary

KanCare 2.0 Demonstration Overview

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. CMS approved the demonstration renewal titled, "KanCare 2.0" for the period of January 1, 2019, through December 31, 2023. KanCare is operating concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aging, people with disabilities, and some individuals who are dually eligible).

Building on the success of the previous 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 (SDOH) and independence in addition to traditional Medicaid and Children's Health Insurance Program (CHIP) benefits. KanCare 2.0 aims to improve integration and coordination of care across the healthcare spectrum. 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 (i.e., telemedicine, telemonitoring, and telementoring) services.

It must be highlighted, much of the interim evaluation measurement period overlapped with the COVID-19 public health emergency (PHE). The PHE was a very strong confounding variable that impacted almost all aspects of the evaluation. As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits. Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the characteristics of the population changed (impacting statewide outcome measures). Also, many types of health care utilization decreased during this time period due to stay-at-home and isolation processes, while telehealth for applicable services was implemented statewide.

KanCare 2.0 activities were also drastically affected during the onset of the PHE. Initially, the MCOs were instructed to pause many activities with members and providers to address the public health emergency. For instance, completion of Health Screening Tools (HSTs) was briefly waived. Some changes continued throughout the interim evaluation time period. For example,

- Monthly service utilization requirements were suspended for HCBS waiver participants
- One-year extensions for HCBS reassessments and reevaluations were allowed; and
- Telephonic or virtual services were allowed in lieu of face-to-face meetings.

Where feasible, adjustments were made to the analytic plans to account for the pandemic's impact on measurement outcomes. However, the overall impact of the COVID-19 pandemic on the KanCare 2.0 program overall is still unknown. The data and analytic results for 2022 and 2023 will provide a better assessment of the impact of KanCare 2.0 efforts. Thus, the results presented here should be interpreted with strong caution.

KanCare 2.0 Demonstration Goal and Hypotheses

The KanCare 2.0 demonstration goal and four hypotheses are described in Figures ES-1.

Goal	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.
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.
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.
Hypothesis 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.
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.

Figure ES-1. KanCare 2.0 Demonstration Goal and Hypotheses

Interim Evaluation of KanCare 2.0 Demonstration

In accordance with the CMS guidelines, the KanCare 2.0 evaluation design for January 1, 2019, through December 31, 2023, was submitted for CMS approval. An updated evaluation design as per CMS guidance and feedback was approved by CMS on February 19, 2020.

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required KanCare 2.0 evaluation, and has prepared this interim evaluation report to reflect evaluation progress and present findings to date. Measurement data are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

KanCare 2.0 Demonstration Evaluation Questions

The evaluation questions were developed in alignment with the demonstration's goal and four hypotheses (Figure ES-2).

Overall Care 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? 2. Did the OneCare Kansas program that implements comprehensive and intense method of care coordination improve the quality of care, health, and cost outcomes?
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?
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?
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 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	1. Did removing payment barriers for services provided in IMDs for KanCare members improve members' access to substance use disorder (SUD) treatment services. (Evaluation of Hypothesis 4 was conducted as a part of the SUD Demonstration Evaluation).

Figure ES-2. KanCare 2.0 Demonstration Evaluation Questions

KanCare 2.0 Demonstration Interim Evaluation Results

a. Evaluation of the KanCare 2.0 Service Coordination Strategy

To examine whether the Service Coordination Strategy of integrating physical and behavioral health services provided to KanCare members improves quality of care, and health and cost outcomes, the evaluation methodology included assessment of the performance measures (listed in Figure ES-3) in the following comparison populations.

- **Intervention Group:** Members who had a Health Risk Assessment (HRA) and Person-Centered Service Plan (PCSP) during 2019 to 2021
- **Comparison Group 1:** Intervention Group members from 2016 to 2018 (pre-intervention period).
- **Comparison Group 2:**
  - Members who had a Health Screen Assessment (HSA) that met an HRA threshold and received traditional care (i.e., did not receive a PCSP).
  - Members who had an HSA total score from 18 to 22 and did not meet an HRA threshold and received traditional care.

Measure 1	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure 2	Annual Dental Visit (ADV)
Measure 3	Adolescent Well-Care Visit (AWC)
Measure 4	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
Measure 5	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
Measure 6	Emergency Department Visits (Overall)

Figure ES-3. Performance Outcome Measures for KanCare 2.0 Service Coordination Strategy Evaluation

Since all HCBS waiver participants are eligible for service coordination, they represent a higher percentage of members participating in service coordination than non-HCBS participants. Examples of non-HCBS participants in service coordination may include members with behavioral health needs or complex/chronic conditions, members in nursing facilities, residential facilities, or hospitals, and members in foster care. The ratio of HCBS waiver participants to non-HCBS participants was different between the intervention and control groups: 82% of the 23,807 members in the Intervention Group were members receiving HCBS services compared to 26% of the 26,712 members in Control Group 2. Of the 4,366 non-HCBS recipients in the Intervention Group, 77% were from one MCO; the reason for this difference is unknown.

A lack of standardization of the HST, HRA, Needs Assessment and PCSP variable fields, in the datasets provided by the MCOs, created limitations in compiling the Intervention and Comparison Groups needed for the interim evaluation measurement period. Through an MCO contract amendment, the HST was standardized, with implementation of the standardized tool occurring in early 2022.

Key Results and Conclusions

- Assessment results support the assertion that KanCare 2.0 Service Coordination Strategy had a positive impact on rates of the following measure:
  - Outpatient or Professional Claims (for diabetic retinopathy, influenza, pneumonia, or shingles)
- While improvements were not seen in the other measures, no conclusions can be determined due to the changes in healthcare utilization during the pandemic.
- The MCOs' challenges in implementing the strategy as intended (e.g., contacting members, completing screenings and needs assessments) and the impacts of the COVID-19 pandemic must be considered before judging the success or failure of the strategy.

Recommendations

- As the State completes the PHE winding down period, review and improve the steps applied by the three MCOs to ensure all members eligible for participation in the Service Coordination Strategy receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate during the remaining years of the KanCare 2.0 demonstration. Application of the Service Coordination Strategy to all eligible members will assist in achieving its impact on the performance outcomes.

b. Evaluation of the OneCare Kansas Program

Quantitative Evaluation of OCK Program

KDHE-DHCF developed the OneCare Kansas (OCK) program that is offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the 'whole person' across the life span. The focus is on members with certain chronic conditions involving mental health and asthma. Initially, eligibility was limited to members diagnosed with severe bipolar disorder, paranoid schizophrenia, or asthma (plus one other qualifying health condition). Effective April 1, 2021, qualifying diagnoses were expanded to additional severe mental illnesses and/or expanded types of asthma which increased the eligible population. Eligible members are invited to opt-in to the program. Care coordination is provided by contracted providers, OCK Partners (OCKPs), which are primarily Community Mental Health Centers but also include Federally Qualified Health Centers, individual primary care practices, providers who serve individuals with developmental disabilities, and other community-based mental health providers. As of April 1, 2022, OCK had 3,272 enrolled members.

The OCK program evaluation included the assessment of the performance outcome measures (listed in Figure ES-4) the following comparison populations.

- **Intervention Group –** KanCare 2.0 members eligible for participation in OCK who were enrolled in the program for at least 3 months of the measurement year (2020 and 2021).
- **Comparison Group 1 –** Members of Intervention Group with their outcome data abstracted for the pre-intervention period (2016–2019).
- **Comparison Group 2 –** KanCare 2.0 members who met OCK eligibility criteria based on MMIS encounter data but did not enter OCK and received traditional care (2020–2021).

Measure 1	Adults' Access to Preventive/Ambulatory Health Services (AAP)
Measure 2	Annual Dental Visit (ADV)
Measure 3	Adolescent Well-Care Visit (AWC)
Measure 4	ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues
Measure 5	Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles
Measure 6	Emergency Department Visits (Overall)

Figure ES-4. Performance Outcome Measures for OneCare Kansas Program Evaluation

Key Results and Conclusions

- Results support the assertion that OCK had a positive impact on rates of the following measures:
  - Adults' Access to Preventive/Ambulatory Health Services
  - Adolescent Well-Care Visits
  - Annual Dental Visit – had a positive impact on Annual Dental Visits rates, but less definitively.
- There is potential for the other measures to improve during the remainder of the demonstration, as multiple measures showed relative improvements but were not statistically significant.
- While data are provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.
- MCOs' data files indicated the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from encounters using these criteria and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.

Recommendations

- Ensure standardization of the MCOs' processes to determine members' eligibility for the OCK program, per the State's criteria.

Qualitative Evaluation of OCK Program

Information from the OCK Learning Collaborative meetings summary reports from April 2020 through March 2022 was abstracted for qualitative evaluation. Information was also abstracted from the OCK Program's June 2021 online survey of OCK partners (OCKPs), six regional virtual meetings with OCKPs in July 2021, and a virtual polling session in March 2022. The six items examined are listed in Figure ES-5.

Item 1	Learning needs identified and discussed by the OCK Learning Collaborative participants
Item 2	Factors that facilitated the OCK implementation to achieve its goals, April 2020–March 2022
Item 3	Barriers/challenges seen in the implementation of the OCK program
Item 4	Observations related to the OneCare Kansas program success in achieving its goals
Item 5	Assistance needed by the OCK Partners from Partners' Network and State/MCO Implementation Team to assure quality services
Item 6	Recommendations and Potential Next Steps for the OCK program

Figure ES-5. Qualitative Items for OneCare Kansas Program Evaluation

Key Results and Conclusions

- OCKPs' key observations regarding OCK program successes included:
  - Improved care coordination
  - Improved support of members and increase in member trust and engagement
  - Increased partner collaboration
  - Sharing information about the program with community partners
- OCKPs' key recommendations and suggestions for potential next steps:
  - Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - OCKPs across the state could build their professional networks and provide mutual support outside the State forums.
  - Development and use of the provider directory to assist in communication and collaboration across OCKPs' network.
  - Improve program processes and systems.
  - Develop connections with local foster care contractors, child placing agencies, and local hospitals.
  - Identification of the opportunities to obtain hospital data and provision of organizational data.

Recommendations

- Determine OCK partners' continued learning needs specific to working with OCK members and their diagnoses; provide related Learning Collaborative training or other resources.

c. Evaluation of KanCare 2.0 Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs

Each of the three MCOs designed a value-based provider incentive program (VBPs) to address KanCare 2.0 Hypothesis 1:

- Aetna – CARE and CARE+ Programs with Community Mental Health Centers.
- Sunflower – Behavioral Health Project.
- UnitedHealthcare – Pediatric Care Network Project.

The three MCOs were in the process of initiating their VBPs. Therefore, data were not available from these projects. The evaluation of Hypothesis 1 will be conducted as a part of summative evaluation of KanCare 2.0.

d. Evaluation of KanCare 2.0 Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities

Outcome measures data for the evaluation of Hypothesis 2 were not collected by two MCOs as a part of their Health Risk Assessment (HRA) tool. In 2021, the State and MCOs revised the HST to include the questions required for data collection of the Hypothesis 2 evaluation measures. As the standardized HST was not fully implemented until May 2022, data for Hypothesis 2 outcome measures are not currently available. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

e. Evaluation of KanCare 2.0 Hypothesis 3 – Use of Telehealth Services

The evaluation of Hypothesis 3, comprised of quantitative and qualitative components, examined whether the use of telehealth services (telemedicine, telemonitoring, and telementoring) enhanced access to care for KanCare members living in rural and semi-urban areas.

- **Telemedicine:** connecting participating providers with members at distant sites for purposes of evaluation, diagnosis, and treatment through two-way, real time interactive communication.
- **Telemonitoring:** technologies that measure health indicators of patients in their homes and transmit the data to an overseeing Provider.
- **Telementoring:** technologies to connect community providers with specialists for consultations, grand rounds, education, and to fully extend the range of care available within a community practice.

Quantitative Evaluation of KanCare 2.0 Hypothesis 3

The use of telemedicine services and use of telemonitoring services were examined for the period of January 2018 through December 2021, with cross-year comparisons. The members who received telehealth strategies (telemedicine and telemonitoring strategies) constituted the Intervention Group. The evaluation measures regarding telemedicine and telemonitoring services are listed in Figures ES-6 and ES-7.

Measure 1	Percentage of telemedicine services received by the members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
Measure 2	Number of receiving sites for telemedicine services in the rural and semi-urban (Non-Urban) areas
Measure 3	Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services
Measures 4 & 5	Speech Therapy Analysis; Individual Psychotherapy Analysis; Family and Group Psychotherapy Analysis; and Community Psychiatric Supportive Treatment Analysis: • Measure 4: Number of paid claims with selected procedure codes • Measure 5: Number of members with selected diagnosis per 1,000 members • Percentage of KanCare members with selected diagnosis receiving selected treatment

Figure ES-6. Performance Outcome Measures for the Evaluation of Use of Telemedicine Services

Measure 1	Percentage of members living in the rural and semi-urban (Non-Urban) areas who received telemonitoring services
Measure 2	Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas
Measure 3	Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services

Figure ES-7. Performance Outcome Measures for the Evaluation of Use of Telemonitoring Services

Key Results and Conclusions

Telemedicine Services

- Results for all measures examined support the assertion that the use of telemedicine services increased among KanCare 2.0 members (Non-Urban and Urban).
- These increases corresponded to the onset of the PHE and may be due to changes related to the provision of services by providers and their usage by members made during these years.
- The increases in usage were higher among Urban members compared to Non-Urban members in these years.
- Though still above the pre-COVID-19 PHE years, usage of telemedicine services among members started showing decline in 2021 compared to 2020.

Telemonitoring Services

- Results for all telemonitoring evaluation measures support the assertion of increased use of telemonitoring services among Non-Urban KanCare 2.0 members:
  - Percentage of members living in rural and semi-urban (Non-Urban) areas who received telemonitoring services.
  - Number of telemonitoring services provided to members living in the rural and semi-urban (Non-Urban) areas.
  - Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services.

Qualitative Evaluation of Hypothesis 3

Use of Telementoring Services

The data sources are not currently available to describe the status of the use of telementoring; therefore, quantitative evaluation was not conducted. The evaluation focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri, using the Project ECHO (Extension for Community Healthcare Outcomes) Model.

Key Results and Conclusions

- From March 2019 through November 2021, there were twelve Project ECHO series comprised of fifty-one sessions, with an average of 42 participants (from multiple disciplines) per session. Project ECHO topics included behavioral health, SDOH, care coordination, preventive health, and care for individual populations and diagnoses.
- Evaluation results (obtained after each session by the Project ECHO host) indicated participants' knowledge of the topic improved, and they obtained helpful skills and techniques to improve professional practice.

Telehealth Provider Survey

Qualitative information was also collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. Seventy-three providers completed the survey, with the majority from behavioral health care providers.

Key Results and Conclusions

- Most respondents "strongly agree" or "agree" that telehealth has improved access to care for KanCare members. It expands their ability to see clients/patients over a greater geographic distance, and it is important to the success of their organization. About two-thirds of the respondents "strongly agree" or "agree" that telehealth increases their ability to see more clients/patients, it fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and it improves the quality of care for clients/patients.
- Most of the survey respondents "strongly agree" or "agree" clients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.
- Following are key barriers in providing telehealth services, identified by survey respondents, with the first two bullets being the most frequently noted:
  - Clients lacking the technology and resources for telehealth services (mobile phones, computers, internet access)
  - Lack of client familiarity or comfort with using telehealth services
  - Lack of reliable internet for providers
  - Telehealth services not considered as effective as in-person services
- Only 6% of respondents indicated their usage of telehealth visits would decrease in the future; 50% anticipating the number of telehealth visits for KanCare members will "increase somewhat."

Recommendations

- Ensure application of the strategies to improve the usage of telemedicine and telemonitoring services among Non-Urban members to increase their access to appropriate care.
- Continue to expand the use of telementoring, ensuring all MCOs develop and implement plans for this.
- Ensure increased provision and utilization of telementoring sessions to increase the capacity of rural and semi-urban healthcare providers for the treatment of chronic, complex conditions among Non-Urban members.
- Assist the University partners and Health Plans providing telementoring sessions in developing a standardized evaluation component to assess the impact of these sessions in improving the capacity of providers in rural and semi-urban areas.
- Develop a data warehouse to collect the information on the telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

f. The Evaluation of KanCare 2.0 Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with SUD

A separate report is prepared describing the results for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

g. Monitoring of the Overall KanCare 2.0 Performance Measures

The Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of the Healthcare Providers and Systems (CAHPS) Survey, National Core Indicators—Intellectual/Developmental Disability (NCI—I/DD) survey, and National Core Indicators—Aging and Disabilities (NCI-AD) Survey measures related to the areas for improvement from the prior evaluation of the KanCare Demonstration (2013–2018) were assessed. The measures examined are listed in Figure ES-8.

HEDIS Measures	• Prenatal and Postpartum Care (PPC)
	  ○ Timeliness of Prenatal Care
	  ○ Postpartum Care
	Comprehensive Diabetes Care
	• Hemoglobin A1c Control for Patients with Diabetes (HBD)
	  ○ HbA1c Control (<8.0%)
	  ○ Poor Control HbA1c (>9.0%)
	• Eye Exam Performed for Patients with Diabetes (EED)

CAHPS Survey Measures	Medical Assistance with Smoking and Tobacco Use Cessation • Advising Smokers and Tobacco Users to Quit • Discussing Cessation Medications • Discussing Cessation Strategies
NCI-I/DD Survey Measures	Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability (I/DD) Waiver Service • Can see and communicate with their family when they want (if not living with family) • Has friends (may be staff or family) and can see them when wants • Able to go out and do the things they like to do in the community as often as they want • Services and Supports help person live a good life • Decides or has input in deciding how to spend free time • Decides or has input in deciding daily schedule
NCI -AD Survey Measures	Social and Community Engagement Among Adults and Seniors Participating in the FE, PD, and BI Waiver Programs to Receive LTSS • Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person) • Percentage of people who are able to do things they enjoy outside of home as much as they want to • Percentage of people whose services help them live a better life • Percentage of people who like how they spend their time during the day • Proportion of people who get up and go to bed when they want to • Percentage of people who can eat their meals when they want to

Figure ES-8. Performance Measures for the Overall Monitoring of KanCare 2.0

Key Results and Conclusions

- Results for the following measures support the assertion that the overall performance of KanCare 2.0 improved:
  - HEDIS Measure
    - Postpartum Care
  - NCI-AD Survey Measure
    - Percentage of people whose services help them live a better life
- These measures had high percentages (≥80%) though no improvements were seen:
  - NCI-AD Survey Measures
    - Always able to see or talk to friends and family when they want to
    - Get up and go to bed when they want to
    - Can eat their meals when they want to
- While improvements were not seen in other measures, no conclusions can be determined due to the changes in healthcare utilization during the pandemic.
- 2019-20 NCI Survey data collection was halted due to COVID pandemic. Therefore, social and community engagement measures among adult KanCare members receiving at least one I/DD waiver service were not examined.

Recommendations

- Review and ensure strategies are applied by the MCOs and health care providers to improve provision of timely prenatal care, comprehensive diabetes care, and medical assistance for smoking and tobacco use cessation to KanCare 2.0 members.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve the social wellbeing of members receiving I/DD waiver services. Ensure the PCSPs of these members include the provision of assistance for them to engage socially, with friends and family, when they want.
- As the State completes the PHE winding down period, ensure MCOs and health care providers implement strategies to improve social and community engagement among adults and senior members obtain long term services and supports through the Frail Elderly, Physical Disability and Brain Injury waiver programs. Ensure the PCSPs of these members include provision of assistance for them to engage in activities of their interest outside their home when they want and to decide their daily activities.

Interpretations, and Policy Implication and Interactions with Other State Initiatives

KFMC will address the policy implications and interactions with other state initiatives in the summative KanCare 2.0 evaluation. It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the program, overall, outside of the context of the pandemic.

Lessons Learned and Recommendations for States

There were a few lessons learned as a result of this interim evaluation. These lessons learned are also recommendations to State Medicaid agencies for future demonstrations, as well as for the State of Kansas for the remainder of KanCare 2.0.

- There were additional delays in the implementation of KanCare 2.0 strategies that appeared unrelated to the delays due to the COVID-19 pandemic, such as the MCOs' Value Based Provider Incentive Program delays. These delays will impact the ability to evaluate the efficacy of the KanCare 2.0 program, as a whole. KFMC recommends State Medicaid agencies evaluate MCO delays to determine whether they are unavoidable or whether stronger enforcement of timelines is warranted.
- Some of the programs that began (or were intended to begin) during the evaluation timeframe proved to be more time-intensive to implement than anticipated. KFMC recommends State Medicaid agencies and MCOs explore ways to accelerate the time to implementation of the programs, as designed. This will help to ensure adequate time is allowed for fully conducting the strategy activities, collecting data, and fully testing the hypotheses.
- Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative KanCare 2.0 evaluation report.

Summary of Opportunities for Improvement and Recommendations

- **MCO care coordination assessment:** As the public health emergency completes its winding down period, all members eligible for participation in the Service Coordination Strategy should receive the appropriate assessments.
- **OneCare Kansas capacity and provider training:** The State should ensure the MCOs have a standardized process to determine member eligibility for OCK. The State and MCOs should continue to support the OCK Learning Collaborative, and address providers' training needs regarding working with OCK members (e.g., motivational interviewing, health literacy) and specific diagnoses.
- **Increase telemedicine and telemonitoring utilization:** The State and MCOs should review and implement, as feasible, the provider recommendations for how to improve telehealth services. The State and MCOs should also seek ways to increase the use of telemonitoring services.
- **Improve telementoring opportunities and capacity:** The State should ensure all MCOs develop and implement plans to increase telementoring opportunities targeted towards providers in rural and semi-urban areas of the state, as well as continue to support current telementoring efforts. Standardized methods should also be developed and implemented to collect information on telementoring opportunities across the state and to evaluate the impact for KanCare 2.0 providers, especially those in rural and semi-urban parts of Kansas.
- **Strategies to improve quality and timeliness of care:** The MCOs should evaluate their Quality Assurance and Performance Improvement Programs to ensure they and contracted providers are developing and applying strategies to improve identified KanCare 2.0 performance measures (prenatal, comprehensive diabetes care, medical assistance for smoking and tobacco use cessation).
- **Strategies to improve member social and community engagement:** As the public health emergency completes its winding down period, the State should ensure the MCOs are working through their own care management processes (specifically using the PCSP), as well as with contracted providers, to improve social and community engagement for members on waiver services (I/DD, FE, PD, and BI).

KanCare 2.0 Interim Evaluation Report
Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration
January 2019 – September 2022
Revision Date: June 6, 2023

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]

In accordance with CMS guidelines, the KanCare 2.0 evaluation design for the period of January 1, 2019, through December 31, 2023, was submitted for CMS approval. The CMS review of the evaluation design was received November 18, 2019. An updated evaluation design as per CMS guidance and feedback was submitted, and it was approved by CMS on February 19, 2020.[3]

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare. As the EQRO, KFMC is conducting the required KanCare 2.0 evaluation, and has prepared this interim evaluation report to reflect evaluation progress and present findings to date. Measurement data are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022. A KanCare 2.0 Interim Evaluation Report was submitted on October 20, 2022. CMS's feedback and recommendations for revisions were received April 21, 2023.[4] This updated interim report incorporates modifications recommended by CMS.

KanCare 2.0 is an integrated Medicaid managed care program that serves the State of Kansas through a coordinated approach. KanCare is operating concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers, and together they provide the authority necessary for the State to require enrollment of almost all Medicaid members (including the aging, 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.[5]

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. 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 (i.e., telemedicine, telemonitoring, and telementoring) services.

KanCare 2.0 expands 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 long term services and supports [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. 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 to optimize their health.[5]

KDHE-DHCF developed the OneCare Kansas (OCK) program that is "offered to KanCare 2.0 members with chronic conditions and is designed to apply a comprehensive and intense method of care coordination that integrates and coordinates all services and supports to treat the 'whole person' across the life span." The focus is on members with certain chronic conditions involving mental health and asthma. Initially, eligibility was limited to members diagnosed with Severe Bipolar Disorder, Paranoid Schizophrenia, or Asthma (plus one other qualifying health condition). Effective April 1, 2021, qualifying diagnoses were expanded to additional severe mental illnesses and/or expanded types of asthma which increased the eligible population. Eligible members are invited to opt-in to the program.[6] Care coordination is provided by contracted providers, OCK Partners (OCKPs), including primarily Community Mental Health Centers, as well as Federally Qualified Health Centers, individual primary care practices, providers who serve individuals with developmental disabilities, and other community-based mental health providers (CBMH).[7] 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 to optimize their health.[6] The OCKPs are required by KDHE policy to participate in the OCK Learning Collaborative, a peer-to-peer learning activity.[7] As of April 1, 2022, OCK had 3,272 enrolled members.

Value-based purchasing (VBP) strategies include provider payment and/or innovative delivery system design methods between managed care organizations (MCOs) and their contracted providers, as well as the pay-for-performance (P4P) program between the State and contracted MCOs.

The State has asked KanCare 2.0 MCOs 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): [8]

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."*

It must be highlighted, much of the interim evaluation measurement period overlapped with the COVID-19 public health emergency (PHE). KanCare 2.0 activities were drastically affected during the onset of the PHE (pandemic). Initially, the MCOs were instructed to pause many activities with members and providers in order to address the public health emergency. For instance, completion of Health Screening Tools (HSTs) were briefly waived. Some changes continued throughout the interim evaluation time period. For example:

- The State obtained an HCBS waiver amendment from CMS, effective January 27, 2020. This amendment remains effective through six months after the end of the public health emergency; the end date is yet to be determined. A couple elements of the amendment that could more directly impact this evaluation included
  - suspending the requirement for an HCBS waiver participant to use at least one service every 30 days;
  - allowing telephonic services for case management and monthly monitoring;
  - allowing an extension for reassessments and reevaluations for up to one year past the due date; and,
  - allowing the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
- In March 2020 a State moratorium on member face-to-face visits was implemented, and the MCOs and members needed to re-adjust to telephonic or tele-video visits. The moratorium was lifted in

April 2021, with judgement allowed related to the particular case or need, while there were some continued limitations on in-person group meetings (e.g., wrap-around team meetings) and nursing home visits. Through at least January 2022, there was variation in the MCOs' and members' resumption of face-to-face visits, due to continued fluctuations in COVID-19 rates.

Furthermore, the pandemic affected the overall utilization of health care services throughout the state. It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the KanCare 2.0 program outside of the context of the pandemic. Thus, the results presented here should be interpreted with strong caution.

Evaluation Question 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.[5]

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.

This area intentionally left blank

As described in the KanCare 2.0 Evaluation Design document (Attachment A), the logic model for the demonstration is as follows:

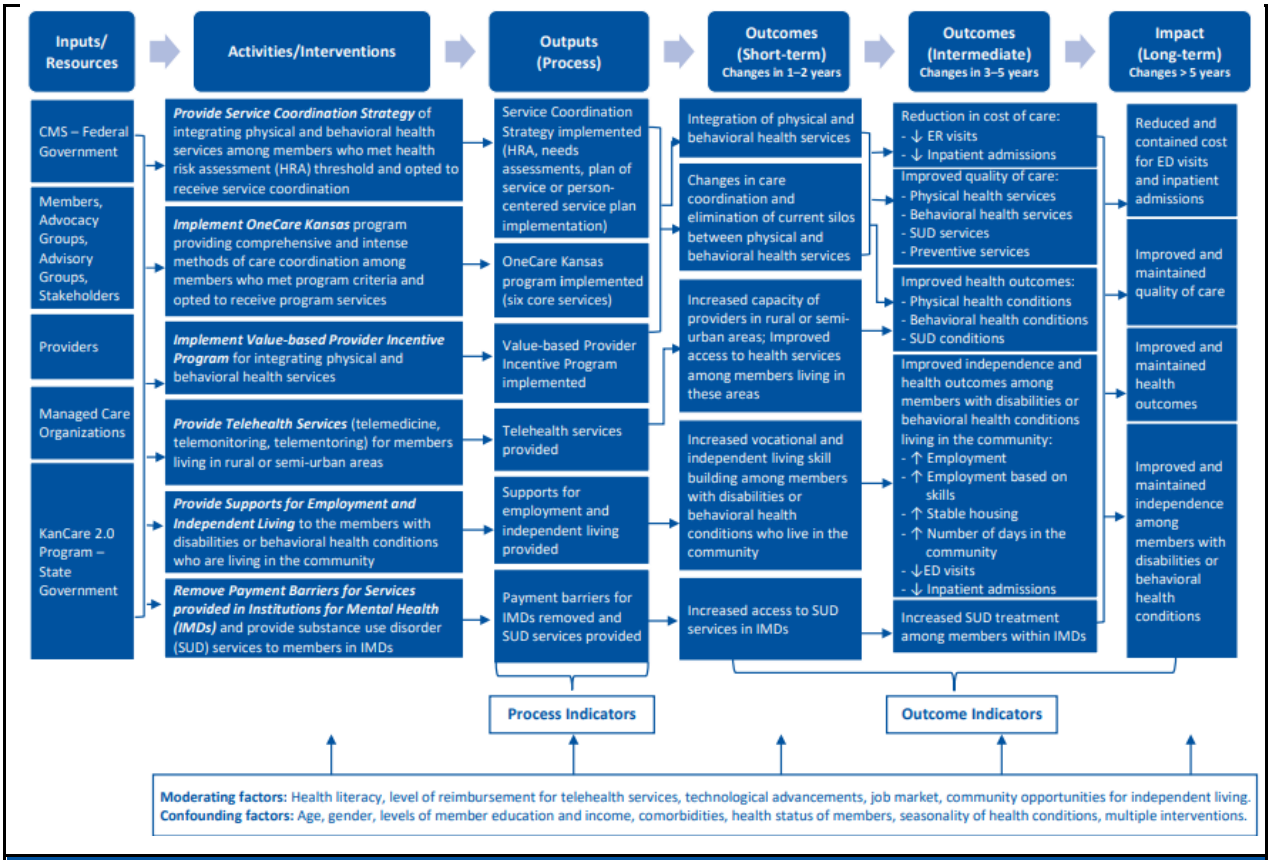


Figure 1. Logic Model for KanCare 2.0 Demonstration

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 following evaluation questions were developed in alignment with the demonstration's goal and four hypotheses (Tables 1 and 2). Table 1 describes two evaluation questions related to the KanCare 2.0 service coordination and OCK program strategies. The first examines the effectiveness of the Service Coordination Strategy that was designed to enhance the quality of care and health outcomes, as well as reduce costs of care. The second question evaluates the effectiveness of the OneCare Kansas program.

Table 1. Evaluation Questions for Examination of Overall Care 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 2 describes evaluation questions related to four hypotheses of the KanCare 2.0 demonstration.

Table 2. Evaluation Questions for Examination of the KanCare 2.0 Demonstration 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?
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 semiurban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. a. Telemedicine will improve access to services such as speech therapy.	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 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. (As per CMS guidance, evaluation of Hypothesis 4 was conducted as a part of the SUD Demonstration Evaluation).[11]

Methodology

The evaluation methodology presented in the KanCare 2.0 Evaluation Design (Attachment A) was designed to meet the standards of scientific rigor that will assist in obtaining statistically valid and reliable evaluation results. Where possible, measures were developed according to recognized measures from sources such as Adult Core Set[9] and Healthcare Effectiveness Data and Information Set® (HEDIS),[10] which is stewarded by the National Committee for Quality Assurance (NCQA) and endorsed by the National Quality Forum (NQF).

The detailed methodologies for the interim evaluation of the KanCare 2.0 Service Coordination Strategy, the OneCare Kansas program, and three KanCare 2.0 hypotheses are described in this section. As per a CMS recommendation, the evaluation of Hypothesis 4 was included as a part of the SUD Evaluation

Design.[11] The interim evaluation methodology for the KanCare 2.0 Hypothesis 4 is described in a separate interim evaluation report for the KanCare 2.0 Section 1115 SUD Demonstration. Appendix C, Table C1, provides a summary that lists each measure, the statistical tests and number of data points reported in the interim report, and the statistical tests and data points currently expected to be used for the summative report.

a. Methodology for the Evaluation of KanCare 2.0 Service Coordination Strategy

The KanCare 2.0 Service Coordination Strategy incorporates health risk assessments (HRA), needs assessments, and the development and implementation of person-centered service plans (PCSP) among KanCare 2.0 members who meet HRA thresholds based on health screening tool (HST) scores.

As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of KanCare 2.0 Service Coordination Strategy is comprised of a quantitative component.

Evaluation Design:

The KanCare 2.0 Evaluation Design was created before the onset of the COVID-19 pandemic and public health emergency. Consequently, an alternate approach was taken for the interim evaluation of the KanCare 2.0 Service Coordination Strategy. Relative improvements in measurement rates from a pre-KanCare 2.0 baseline period (2016–2018) to a KanCare 2.0 remeasurement period (2019–2021) were compared. Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the service coordination strategy was effective. However, the previously noted changes that were implemented to address the COVID-19 pandemic substantially impacted service coordination. The KanCare 2.0 Service Coordination Strategy could not be fully administered, as designed, during the pandemic. This impacted most of the of the evaluation remeasurement period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

The comparative interrupted time series (CITS) evaluation design proposed in the KanCare 2.0 Evaluation Design (Attachment A) was not performed for the interim evaluation because the number of data points available for the analysis was insufficient. The CITS analysis will be performed for the summative evaluation to compare the selected performance outcomes in intervention and comparison groups from 2016 through 2023 (Pre-Intervention Period: 2016–2018; and Post-Intervention Period: 2019–2023).

Instead of reporting utilization rates used for evaluation of the service coordination strategy using units "per 1,000 member-months," these rate are reported as "per 1,200 member-months" for easier interpretation. For example, "141.5 claims per 1,200 member-months" is equivalent to "on average, there were 141.5 claims per year for every 100 members."

Target and Comparison Populations:

Target Population: The target population for the interim evaluation of KanCare 2.0 Service Coordination Strategy was comprised of

- Members who had an HST total score of 23 or higher *or* had an HRA threshold score for any of the four sections of the HST,
- Members who had an HST total score from 18 to 22 *and* did not meet any other HRA threshold, and
- Members who received an HRA.

The HRA thresholds are as follows:

- A total HST Score ≥ 23
- Within the four sections of the HST (even if the total score was less than 23) –
  - Health Status Section Score ≥ 9
  - Health Conditions Section Score ≥ 5
  - Health Lifestyle Section Score ≥ 6
  - Home/Employment Section Score ≥ 4
- An activated automatic trigger of HST

The following members were excluded from the target population:

- Members who did not receive an HST and did not receive an HRA.
- Members with a total HST score less than 18 without meeting a section threshold and who did not receive an HRA.
- Members participating in OneCare Kansas program.

Comparison Populations: Comparison populations were comprised of an Intervention Group, Comparison Group 1, and Comparison Group 2.

- **Intervention Group:** Members who had an HRA and PCSP during 2019 to 2021
- **Comparison Group 1:** Intervention Group members from 2016 to 2018 (pre-intervention period).
- **Comparison Group 2:** This group included the following KanCare 2.0 members:
  - Members who had an HST that met an HRA threshold and received traditional care (i.e., did not receive a PCSP).
  - Members who had an HST total score from 18 to 22 and did not meet an HRA threshold and received traditional care.

Note: Intervention and comparison groups exclude members enrolled in OCK during 2020 or 2021. Members with an HST and HRA who did not meet sectional or total score thresholds are assumed to have met the trigger and will be in the intervention group if not receiving a PCSP. Members with an HRA but no HST and no PCSP are not in either the control or intervention group.

Evaluation Period:

Data were collected from January 1, 2019 – December 31, 2021.

Evaluation Measures:

The following outcome measures were assessed to examine the evaluation question:

- Adults' Access to Preventive/Ambulatory Health Services (HEDIS)
- Annual Dental Visit (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- ED visits, observation stays, or inpatient admissions for the following conditions (Administrative):
  - Diabetic ketoacidosis/hyperglycemia,
  - Acute severe asthma,
  - Hypertensive crisis,
  - Fall injuries,
  - SUD, or
  - Mental health issues

- Outpatient or professional claims for the following conditions (Administrative):
  - Diabetic retinopathy, or
  - Influenza,
  - Pneumonia, or
  - Shingles
- Emergency department visits overall (Administrative)

Data Sources:

Data for the interim evaluation of KanCare 2.0 Service Coordination Strategy were obtained from the following sources:

- Data files containing member-level HRA, Needs Assessment, and PCSP data abstracted from each MCO's data system
- The encounter, demographic, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse
- Files containing member-level HEDIS data for selected measures, 2019 and 2020

Analytic Methods:

The following analytical steps were applied to examine the outcome measures for the evaluation of the KanCare 2.0 Service Coordination Strategy:

1) Each MCO submitted data files containing member-level HRA, Needs Assessment, and PCSP data.
2) Member-level HRA, Needs Assessment, and PCSP data abstracted from the MCOs data files were reviewed for missing values, inconsistent patterns, and outliers.
3) KanCare 2.0 members constituting the target and comparison populations (intervention and comparison groups) were identified from member-level HRA, Needs Assessment, and PCSP data abstracted from the MCOs' data files.
4) Demographic characteristics of the members in the intervention and comparison groups were examined for homogeneity.
5) MMIS encounter records related to the outcome measures for the intervention and comparison groups were reviewed for missing values, inconsistent patterns, and outliers.
6) Outcome measures rates were calculated.
7) For HEDIS measures, measurement year (MY) 2019–2020 rates calculated by KFMC were compared to rates calculated from member-level data submitted by the MCOs.
8) Testing for statistically significant differences in rates between baseline (2016 to 2018) and remeasurement (2019 to 2021) periods was conducted for Intervention Group and Comparison Group 2.
9) Relative improvement from baseline to remeasurement was calculated for the Intervention Group and Comparison Group 2. A statistical test for equality of relative improvements was conducted with p less than 0.05 indicating statistical significance.

Because member-level HEDIS data were not available for measurement years 2016 through 2021, HEDIS rates were calculated from encounter data. If technical specifications changed between measurement years that required a break in trending, then the more current version of the specifications were applied to the earlier measurement years to allow trending. Rates calculated from encounter records are not to be considered HEDIS Health Plan rates; calculation of HEDIS rates by the MCOs incorporates supplemental data not available through encounters, such as data extracted from medical records and claims from other lines of business. HEDIS rates calculated from encounter data are Uncertified, Unaudited HEDIS rates. In addition to the three HEDIS rates listed above, 2016–2021 rates were

calculated for Prenatal and Postpartum Care (PPC), Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), and Follow-Up After Hospitalization for Mental Illness (FUH). PPC and FUH rates were not included in the evaluation of the Service Coordination Strategy due to low numerator or denominator counts for the Intervention Group; IET rates were excluded due to poor comparisons to rates calculated from MCO member-level detail records.

Emergency department (ED) visits, observation stays, inpatient admissions, and outpatient claims were identified for the utilization measures using HEDIS value sets: ED, Observation Stay, Inpatient Stay, and Outpatient. The alcohol or other drug (AOD) Abuse and Dependence value set, and the Mental Illness value set were used to identify diagnosis of SUD and mental health issues. Other diagnoses specified for the utilization measures were identified by the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis category codes: E08–E12 (diabetic ketoacidosis/hyperglycemia), J45 (acute severe asthma), I16 (hypertensive crisis), W00–W19 (fall injuries), E10 (diabetic retinopathy), J09–J11 (influenza), J12–J18 (pneumonia), and B02 (shingles). Encounters were deduplicated to one claim per member, per billing provider national provider identifier (NPI), per last date of service.

Testing for statistically significant differences between two HEDIS rates was conducted using Pearson's chi-square tests. Testing for differences in service utilization rates, which have Poisson distribution, used a large-sample *z*-test.[12]

Reduction in the failure rate (RFR) was used for relative improvement. RFR is the amount of improvement relative to the amount of potential improvement. The formula is:

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

For HEDIS rates with a rate increase as an improvement, the goal was set to 100%. The goal was set to 0 for the service utilization rate because the aim of service coordination was to reduce the number of emergency department visits and visits for the selected diagnosis at other care settings. When the goal is 0, the RFR is equal to the *relative decrease* in rates.

The tests for equality of relative improvement between the Intervention Group and Comparison Group 2 followed these steps:

1. Comparison Group 2's RFR was calculated.
2. The rate the Intervention Group would have had for 2019–2020 if the RFR from the group's 2016–2018 to the projected rate equaled Comparison Group 2's RFR (a.k.a., the *projected rate*) was calculated. The denominator of the projected rate was set equal to the denominator of 2016–2018 rate for the Intervention Group.
3. The statistical significance of the difference between the projected rate and the 2019–2021 rate for the Intervention Group was tested using either Pearson's chi-square test or the small sample *z*-test, depending on the type of measure.

b. Methodology for the Evaluation of OneCare Kansas Program

The OneCare Kansas (OCK) program started April 1, 2020. As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of the OCK program is comprised of quantitative and qualitative components.

Quantitative Evaluation

Evaluation Design:

The KanCare 2.0 Evaluation Design was created before the onset of the COVID-19 pandemic. Consequently, an alternate approach was taken for the interim evaluation of the OneCare Kansas Program. Relative improvements in measurement rates from a pre-KanCare 2.0 baseline period (2016–2019) to a KanCare 2.0 remeasurement period (2020–2021) were compared. Under the assumption that the pandemic and other external influences would equally impact rates for intervention and comparison groups, better relative improvements for the intervention group than for the comparison group would support the assertion that the program was effective. However, as previously noted, COVID-19 substantially impacted service coordination. While data is provided for the OCK evaluation measures, strong caution must be applied in making conclusions regarding the effectiveness of the strategy.

For the evaluation of OCK, a comparative interrupted time series (CITS) evaluation design was proposed in the KanCare 2.0 Evaluation Design (Attachment A) to compare the selected performance outcomes in intervention and comparison groups over the period of 2016 through 2023 (Pre-Intervention Period: 2016–2019; and Post-Intervention Period: 2020–2023). The CITS analysis was not performed for the interim evaluation because the number of data points available for the analysis was insufficient.

The KanCare 2.0 Evaluation Design indicated utilization rates used for evaluation of the OCK program would be reported "per 1,000 member-months." However, they are reported as "1,200 member-months" for easier interpretation. For example, "141.5 claims per 1,200 member-months" is equivalent to "on average, there were 141.5 claims per year for every 100 members."

Target and Comparison Populations:

Target Population: The target population for the interim evaluation of OCK was comprised of KanCare 2.0 members eligible for participation in OCK.

- Members having one of the following diagnoses for Severe Mental Illness (SMI):
  - Bipolar disorders
  - Schizophrenia
  - Major depressive disorders
- Members with chronic physical conditions identified as members with asthma and one "at risk" diagnosis listed below.
  - Substance use disorders
    - Alcohol related disorders
    - Opioid related disorders
    - Cannabis related disorders
    - Sedative, hypnotic or anxiolytic related disorders
    - Cocaine related disorders
    - Amphetamine or other stimulant related disorders
    - Hallucinogen related disorders
    - Inhalant related disorders
    - Other psychoactive substance related disorders
  - Mental illness disorders
    - Schizophrenia (excluding paranoid schizophrenia codes)
    - Schizotypal disorder
    - Delusional disorders
    - Shared psychotic disorder

- Schizoaffective disorders
- Psychosis
- Manic episode
- Bipolar disorder (excluding severe bipolar disorder codes)
- Major depression, recurrent
- Persistent mood (affective) disorders
- Unspecified mood (affective) disorder
- Other anxiety disorders
- OCD (obsessive compulsive disorder)
- Reaction to severe stress, and adjustment disorders
- Dissociative and conversion disorders
- Somatoform disorders
- Other nonpsychotic mental disorders
- Eating disorders
- Specific personality disorders
- Impulse disorders
- Attention-deficit hyperactivity disorders
- Conduct disorders
- Emotional disorders with onset specific to childhood
- Disorders of social functioning with onset specific to childhood and adolescence
- Tic disorder
- Other behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- Mental disorder, not otherwise specified

- Chronic Physical Conditions
  - Type 1 diabetes mellitus
  - Type 2 diabetes mellitus
  - Morbid (severe) obesity due to excess calories
  - Metabolic syndrome
  - Essential (primary) hypertension
  - Hypertensive heart disease
  - Hypertensive chronic kidney disease
  - Hypertensive heart and chronic kidney disease
  - Secondary hypertension
  - Chronic ischemic heart disease
  - Pulmonary heart disease, unspecified
  - Chronic lower respiratory diseases
  - Chronic kidney disease (Stage 1–3)
  - Kidney failure
  - Tobacco use or nicotine dependence
  - Contact with and (suspected) exposure to environmental tobacco smoke (acute or chronic)

KanCare 2.0 members who are in nursing facilities, Title XXI (CHIP), or hospice were excluded from the target population.

Comparison Populations: Comparison populations were comprised of an intervention group and two comparison groups.

- **Intervention Group –** KanCare 2.0 members eligible for participation in OCK who were enrolled in the program for at least 3 months of the measurement year (2020 and 2021).
- **Comparison Group 1 –** Members of Intervention Group with their outcome data abstracted for the pre-intervention period (2016–2019).
- **Comparison Group 2 –** KanCare 2.0 members who met eligibility criteria for participation in OCK based on MMIS encounter data but did not enter into OCK and received traditional care (2020–2021)

Evaluation Period:

Data were collected from April 1, 2020 – December 31, 2021.

Evaluation Measures:

The following outcome measures were assessed to examine the evaluation question:

- Annual Dental Visit (HEDIS)
- Adults' Access to Preventive/Ambulatory Health Services (HEDIS)
- Adolescent Well-Care Visits (HEDIS)
- ED visits, observation stays, or inpatient admissions for following conditions (Administrative):
  - Diabetic ketoacidosis/hyperglycemia,
  - Acute severe asthma,
  - Hypertensive crisis,
  - Fall injuries,
  - SUD, or
  - Mental health issues
- Outpatient or professional claims for following conditions (Administrative):
  - Diabetic retinopathy,
  - Influenza,
  - Pneumonia, or
  - Shingles
- Emergency department visits overall (Administrative)

Data Sources:

Data for interim evaluation of OCK were obtained from the following data sources:

- Data files containing member-level OCK eligibility data abstracted from each MCO's data system.
- Data files containing member-level OCK participation data abstracted from OCK's data system.
- Encounter, demographic, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse.

Analytic Methods:

The following analytical steps were applied to examine the outcome measures for the evaluation:

1) Each MCO submitted data files containing member-level OCK eligibility data.
2) Member-level OCK eligibility data abstracted from the MCOs data files and MMIS were reviewed for missing values, inconsistent patterns, and outliers.
3) KanCare 2.0 members constituting the target and comparison populations (intervention and comparison groups) were identified from member-level OCK eligibility and enrollment data abstracted from the MCOs' data files, OCK program data system files, and MMIS data files.

4) Demographic characteristics of the members in the intervention and comparison groups were examined for homogeneity.
5) MMIS encounter records related to the outcome measures for the intervention and comparison groups were reviewed for missing values, inconsistent patterns, and outliers.
6) Outcome measures rates were calculated.
7) Testing for statistically significant differences between 2020 and 2021 rates was conducted using a weighted Pearson chi-square test with *p* less than 0.05 indicating statistical significance. In addition, a chi-square test for equality of relative improvement of the intervention and comparison groups was conducted with *p* less than 0.05 indicating statistical significance.

Qualitative Evaluation

Evaluation Design:

Information from OCK Learning Collaborative meetings conducted from April 2020 through March 2022 was abstracted from summary reports for the qualitative evaluation of the OCK program. As described in these reports, meetings were attended by KDHE, MCOs, state organizations, provider network, and contracted OCK partners (OCKPs). These meetings were focused on identifying and addressing evolving learning needs, which allowed for continual quality improvement of the OCK program. In June 2021, the Wichita State University Community Engagement Institute (WSU CEI) launched a brief online survey of OCKPs on behalf of KDHE. This survey was intended to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs. In July 2021, KDHE conducted six regional virtual meetings with OCK partners. In addition, the information regarding challenges encountered by providers in staffing their programs, and strategies used to address those challenges, was collected using a virtual polling platform during the March 22, 2022, OneCare Kansas Learning Collaborative session.

The qualitative information was abstracted as written in WSU CEI's Learning Collaborative meeting summaries, survey report, and six regional virtual meeting summaries. The information was reviewed for key themes as summarized in Appendix A, Tables A1–A8. These key themes are described in the Results section (Tables 5–11).

The qualitative evaluation focused on six items:

- Learning needs identified and discussed by OneCare Kansas Learning Collaborative participants
- Factors that facilitated the implementation of the OneCare Kansas program to achieve its goals
- Barriers/challenges seen in the implementation of the OneCare Kansas program
- Observations related to the OneCare Kansas program success in achieving its goals
- Assistance needed by OCK partners from the OCK Partners' Network and the State/MCO Implementation Team to assure quality services
- Recommendations and potential next steps for the OneCare Kansas program

c. Methodology for the Evaluation of Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs

As per the State's guidance and approval, each MCO designed a value-based provider incentive program (VBP) to address KanCare 2.0 Hypothesis 1. These VBPs will be evaluated to examine two questions included in the KanCare 2.0 Evaluation Design (Attachment A) by applying quantitative and qualitative evaluation methods (Table 2).

The three MCOs are in the process of initiating their VBPs. Aetna's project is in the early stages of development, whereas Sunflower and UnitedHealthcare have recently started implementing their projects. Therefore, data are not currently available, and an interim evaluation of Hypothesis 1 was not conducted. At the end of 2023, data for at least two years will be available and examined as a part of the summative evaluation of KanCare 2.0. The MCOs' VBPs are described below.

Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers

Proposed Launch Date of the Program:

This project was targeted to launch in the first quarter of 2022.

Program Details:

Aetna provided the following details of the CARE and CARE+ programs with Community Mental Health Centers (CMHCs) program.

"The CARE and CARE+ programs are a tiered pay-for-quality project designed to create integrated health care, bridging the gap between mental and physical health care for people diagnosed with mental illness (MI) or severe emotional disturbance (SED). A core assumption of the project is that people served within the public mental health system frequently experience silos within that system – a tendency to approach the person's health through a psychiatric lens, and difficulty accessing physical health resources. Our project leverages the ability of CMHC providers to influence the course of care for those they serve, incentivizing specific outcomes and activities that we believe will result in overall improvements to quality of life and better health outcomes. We are approaching all CMHCs as potential participants. In addition, six CMHCs well-positioned to provide supportive housing and employment services will be approached for participation in the CARE+ program, which provides a second suite of measures and incentives targeted toward housing and employment.

Number of providers participating in the CMHC project: We are approaching each of Kansas' community mental health centers as potential participants. As these discussions are ongoing, the final count is not yet determined.

There are two tiers of outcomes for this program. Outcomes are measured based on the total number of Aetna members served at each participating provider. The basic CARE program will measure:

- *Provider follow-up after emergency department usage*
- *Provider follow-up after inpatient admission/discharge*
- *Usage of the Aetna Better Health of Kansas crisis notification system*
- *Usage of SBIRT screens for potential substance/addiction needs*
- *Provision of tobacco cessation services*
- *Diabetes Screening for people with Schizophrenia, Schizoaffective Disorder or Bipolar Disorder who are using antipsychotic medications*
- *Increase in number of members receiving peer support services (H0038, H0038-HQ).*
- *Use of Z-codes from a provided list, targeted toward social determinants of health, including but not limited to:*
  - *Homelessness*
  - *Inadequate housing*
  - *Food/Water insecurity*
  - *Unemployment*
  - *Tobacco use*

In addition to the above, The CARE+ program will measure:

- *Utilization of Operation: Community Integration (OCI) supported housing services*
- *Housing status change*
- *Employment status change*

VBP Data Availability for Hypothesis 1 Evaluation: Aetna will be able to provide data needed for the evaluation to KFMC for at least two years. Provider data will be submitted at the onset of each CMHC agreement. Member data will be provided on an ongoing basis throughout the life of the program, with a 180-day delay to account for claims submission and processing."

Sunflower Health Plan VBP – Behavioral Health Project

Proposed Launch Date of the Project:

VBP Start Date: October 1, 2021

Project Details:

Sunflower provided the following details regarding the Behavioral Health Project.

"Sunflower Health Plan is just entering into a contract with Wheat State IPA to administer a Value Based Program with all 26 CMHCs (all currently contracted with Sunflower Health Plan). This is the first Behavioral Health VBP of its kind for Sunflower Health Plan but is rolling out to all Centene plans and live in CA as of April. This VBP is an all upside pay for performance contract for our CMHC providers who support our members on Medicaid. This program will encompass members who qualify for the VBP in the Children's Health Insurance Program; on Autism Waiver, foster care, intellectual or developmental disability waiver, severe emotional disturbance waiver, Supplemental Security Income (SSI Non-Dual), and Temporary Assistance for Needy Families. This model focuses on three main objectives aligned with provider incentives:

- *Engage moderate to high risk behavioral health members in appropriate levels of outpatient and community based treatment*
- *Measurement of member-reported improvement and outcomes*
- *Appropriate maintenance of members in the community*

Participating provider type: Clinic/Center: Mental Health (Including Community Mental Health Center)

Number of Providers: All TIN level providers (CMHCs) 26 have been invited to participate. One CMHC decided not to participate. They serve children.

Type of Medicaid Members Population:

- *We utilize machine-learned predictive modeling algorithms, to stratify members' risk for behavioral health issues, inpatient admissions, and emergency room admissions.*
- *For our VBC, we are focusing on members with moderate to high BH risk:*
  - *From this population, the goal of the model is to engage members who receiving OP BH treatment (which inherently means they are using a lot of higher levels of BH treatment)*

Number of Medicaid Members: Our starting membership level is 4,500 Medicaid members but this potentially change month over month with new members and existing members who might enter into the stratification guidelines based on needs. We continuously stratify all members BH risk, regardless of

provider. All age groups are included. We utilize Optum Impact Pro software to stratify members by BH risk, emergency room risk, and inpatient admission risk. The algorithms are proprietary to the software.

Outcomes and the Measures that will be assessed by Sunflower: The measures we will be monitoring and paying incentives on are by stratified risk levels for the following:

- *Treatment Initiation*
- *Speed to Care*
- *Member engagement in services*
- *Conducting baseline assessments*
- *Improvement in assessment scores*
- *Maintenance assessments*
- *Reduction of Emergency Room and Inpatient Utilization*
- *Outpatient follow-up from IP stay (timeliness to services)*

Our baseline measures for this program are utilization on ED/IP/OP/RX for current "non-engaged" members. Members in the catchment area of the CMHC who do not currently utilize their services or the services of other Behavioral Health professionals. We are also using predictive modeling algorithms for identification of moderate/high risk members, even if they don't yet have significant higher level of care utilization. "Non-engaged" is the member in risk group 1 to 5 who has not received more than three behavioral health care visits within the six-month period prior to being seen by the VBC provider. we continuously re-calculated every member status at time of their first visit with the VBC provider to determine if that member is eligible for the program.

The Wheat State IPA will monitor the data by CMHC, pay out the incentives based upon the agreed upon outcomes and coach/train during the initiation of the program as well as throughout the program implementation. For any participating CMHC who is struggling, the IPA will utilize behavioral health best practices and best practices of successful providers in the network to assist with their growth and ultimate success.

Number of providers are participating in the CMHC project: We are approaching each of Kansas' community mental health centers as potential participants. As these discussions are ongoing, the final count is not yet determined."

UnitedHealthcare VBP – Pediatric Care Network Project

Project Details:

UnitedHealthcare provided the following details regarding their Pediatric Care Network Project.

"UnitedHealthcare Community Plan of Kansas has contracted with the Pediatric Care Network (PCN) in a value-based arrangement which incentivizes the PCN network to care for all aspects of our members, their patients, needs. We annually review specific quality metrics and pay for performance measures that if PCN achieves the target, they can earn extra dollars above a normal fee-for-service arrangement.

We propose in 2021, this arrangement include an incentive to meet and exceed PCN's previous year's attainment of the Follow-up Care for Children Prescribed ADHD Medication (ADD) measure. This proposal was based on feedback from State staff and KFMC staff in response to a previous proposal.

Since we do not finalize our annual contract with PCN until after the mid-year rates are completed, it is still timely for us to add this incentive to our PCN contract for CY 2021.

UHC proposes to address Hypothesis 1 by augmenting our value-based agreement with PCN to include meeting and improving their 2020 performance in the ADD HEDIS measure. This will incentivize PCN to meet the requirements of the ADD HEDIS measure which include 1 follow up visit with a practitioner with prescribing authority within 30 days of their first prescription (Initiation phase), and at least two follow-up visits with a practitioner in the 9 months after the Initiation Phase (Continuation and Maintenance Phase).

This intervention is more about the members included and the way they are managed and identified than the providers that are providing the service. Members are identified based on their rate cell and geographic location. Providers are included because they are part of the UHC network and serve members in this population. Outcomes will be determined based on the results of specific HEDIS measures.

The individuals in the intervention group and the comparison group are the same individuals, the time period is what provides the comparison point. This pre-post research design which will measure the effect of the intervention, i.e., the ADD HEDIS measure being added to the value-based contract. Per the UHC proposal, HEDIS measure ADD was added to the PCN contract effective 01/01/2021 so the period before the intervention is the pre period and the period after the intervention will be the post period.

UHC can provide the requested data points. Any of provider data will be based on the date the provider joined the UHC network."

d. Methodology for the Evaluation of Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members with Disabilities

Outcome measures data for the evaluation of Hypothesis 2 were not collected by two MCOs as a part of their HRA tool. In 2021, the State and MCOs decided to revise the Health Screening Tool (HST) to include the questions required for data collection of the Hypothesis 2 evaluation measures. The HST was then incorporated by each MCO into their health assessment processes, and each of the MCOs started using this standardized HST for all members in 2022 (Sunflower Health Plan started in January 2022, UnitedHealthcare started in March 2022, and Aetna started in May 2022). As the standardized HST was not fully implemented until May 2022, data for Hypothesis 2 outcome measures are not currently available. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

e. Methodology for the Evaluation of Hypothesis 3 – Use of Telehealth Services

As described in the KanCare 2.0 Evaluation Design (Attachment A), the interim evaluation of Hypothesis 3 has quantitative and qualitative components.

Quantitative Evaluation

Evaluation Design:

The non-experimental One-Group Pretest–Posttest Design method was used to examine the evaluation questions of two components of Hypothesis 3, use of telemedicine services and use of telemonitoring services. The cross-year comparisons of the outcome measures among the Non-Urban members (living

in rural or semi-urban areas) who received telehealth were examined across 2019, 2020 and 2021. In addition, trend analysis over the three-year period (2019 through 2021) and comparisons to measures of Urban members were conducted.

Target and Comparison Populations:

- **Target Population:** KanCare 2.0 members living in the Non-Urban areas (rural or semi-urban areas) constituted the target population.
- **Intervention Group:** The members who received telehealth strategies (telemedicine and telemonitoring strategies) constituted the Intervention Group.
- **Comparison Population:** KanCare 2.0 members living in the Urban area was the comparison group for some measures.

Evaluation Period:

Data were collected from January 1, 2018 – December 31, 2021.

Evaluation Measures:

Since the evaluation measures are focused on the use of telehealth services among KanCare members living in the rural or semi-urban areas, data were examined in two geographic areas, Non-Urban and Urban. KDHE's grouping of counties into frontier, rural, densely rural, semi-urban and urban population density groups was used in defining the areas.[13] The Urban area contains the urban counties, as defined by KDHE: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The Non-Urban area contained the frontier, rural, densely rural, and semi-urban counties.

The following outcome measures were assessed to examine the evaluation questions:

Telemedicine

- Percentage of telemedicine services received by members living in the rural or semi-urban areas. Subgroup analyses by age, primary diagnosis type, and primary diagnosis classification strata of diagnosis types.
- Number and percentage of receiving sites for telemedicine services (in the rural and semi-urban areas. Subgroup analyses by age.
- Number and percentage of members living in the rural or semi-urban areas who received telemedicine services. Subgroup analyses by age.
- Number of paid claims with selected procedure codes, stratified by area, mode of delivery, provider specialty, and selected diagnosis categories.
- Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members, stratified by area.

The age strata used in analyzing the first three measures were 0–17 years, 18–45 years, and 46 years and older at the time of service received. These strata were selected to ensure adequate representation within each stratum. Also, the chronic diseases that can benefit from telemedicine services are more prevalent among 46 years and older adults.[14] In addition to age strata, counts by primary diagnosis were stratified by ICD-10-CM chapters and blocks, and strata with the highest counts are reported.

The stratified results for the two measures addressing fourth evaluation question (Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?) were combined to form eight additional measures:

- Percentage of KanCare Members Receiving Speech Therapy Who Had a Diagnosis in Category F80

- Percentage of KanCare Members with Diagnosis in Category F80 Who Received Speech Therapy
- Percentage of KanCare Members Receiving Individual Psychotherapy Who Had an Indicating Diagnosis (categories F34, F40, F43, F60, F91, and F93)
- Percentage of KanCare Members with an Indicating Diagnosis Who Received Individual Psychotherapy
- Percentage of KanCare Members Receiving Family or Group Psychotherapy Who Had an Indicating Diagnosis (categories F34, F91, F93, T74, and T76)
- Percentage of KanCare Members with Indicating Diagnosis Who Received Family or Group Psychotherapy
- Percentage of KanCare Members Receiving Community Psychiatric Supportive Treatment Who Had an Indicating Diagnosis (F20, F25, F34, F60, and F91)

Telemonitoring

- Number and percentage of members living in the rural and semi-urban areas (Non-Urban) who received telemonitoring services.
- Number of telemonitoring services provided to members living in the rural and semi-urban areas (Non-Urban).
- Number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services.

Data Sources:

Data for the interim evaluation of KanCare 2.0 Hypothesis 3 was obtained from the following source:

- The encounter, demographics, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse.

Analytic Methods:

The following analytical steps were applied to examine the outcome measures for the evaluation of use of telemedicine and telemonitoring services.

1) Variables including member Medicaid ID, telehealth codes, and county codes from encounter, demographic, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse were used to identify the target and intervention populations.
2) From encounter records, data for outcome measures were abstracted for the members identified for inclusion in the intervention and comparison populations.
3) Data abstracted in Steps 1 and 2 were reviewed for missing values, inconsistent patterns, and outliers to ensure quality and appropriateness of data for analyses required by the evaluation design.
4) The denominator and numerator counts and the rates or percentages of the outcome measures were calculated and stratified.
5) Appropriate statistical tests were applied. Statistical testing of differences in percentages between two consecutive years (2018 to 2019, 2019 to 2020, and 2020 to 2021) was conducted using a weighted Pearson chi-square test with p less than 0.05 indicating statistical significance. Weighted Mantel-Haenszel chi-square tests were applied to determine whether the slopes of 3-year trend lines were statistically significantly different from horizontal (trend analysis: 2019 to 2021) with p less than 0.05 indicating statistical significance.
6) Key outcome measure results and interpretations were described in narrative, tables, and figures (see Results section and Appendix B).

Qualitative Evaluation

Use of Telementoring Services:

As mentioned above, data sources are not currently available to describe the status of the use of telementoring; therefore, quantitative evaluation was not conducted. The evaluation of the use of telementoring services focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri.

The Project ECHO (Extension for Community Healthcare Outcomes) Model is used by Sunflower Health Plan, the University of Kansas, and the University of Missouri to provide telementoring services to providers. These efforts are summarized in Results section of this report.

Project ECHO Sunflower Health Plan

In response to the telementoring component of the KanCare 2.0 Hypothesis 3, Sunflower Health Plan served as a Project ECHO hub. A Project ECHO hub refers to "a regional center where a team of subject matter experts is located, replicates the ECHO Model™ and runs their own ECHO program."[15] Sunflower Health Plan collaborated initially with the University of Kansas and later with the University of Missouri's Office of Continuing Education, School of Medicine, and Sinclair School of Nursing to conduct this program. The information summarized in the Results section was abstracted from the report provided by Sunflower Health Plan titled "Project ECHO®. Sunflower Health Plan Kansas. 2019–Present."[16]

KUMC Project ECHO® Series

In April 2021, the University of Kansas Medical Center (KUMC) conducted the KUMC Project ECHO® Series titled "Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders" for physicians, advanced practice clinicians, nurses, behavioral health providers, and other providers.[17] The purpose of the series was to improve healthcare providers' capacity to implement evidence-based practices related to substance use disorder (SUD) prevention, screening, early intervention, referral to treatment, and risk reduction. The information summarized in the Results section is abstracted from the report, titled "Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders. KUMC Project ECHO® Series Summary Report", provided by the KUMC Project ECHO®.[17]

Telehealth Provider Survey:

In addition to the assessment of quantitative outcome measures to examine the use of telemedicine and telemonitoring services, a qualitative evaluation was also conducted.

The qualitative information was collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of their experiences providing telehealth services to KanCare members, including facilitators and barriers related to the use telemedicine and telemonitoring services, and whether the use of these services improved access to care among KanCare members. In addition, providers were asked to provide recommendations for removing barriers to increasing the use of these services and improving access to care among KanCare members.

Survey Population

The survey population was defined as KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. These providers were identified through encounter records from the MMIS reporting warehouse. A total of 9,710 providers constitute the survey population.

Survey Sample Frame

KanCare providers from the survey population with an email address were included in the survey frame. The contact information of the providers, obtained from the Kansas Medicaid Modular System (KMMS) database, was examined for the availability of an email address. A provider-specific or a group/organization email address was identified for 3,307 providers. A list of these 3,307 providers was compiled to serve as the sample frame.

Survey Sample

A sample of 843 providers who offered telehealth services to KanCare members in 2020 and 2021, with a unique or group/organization email address, was selected from the sample frame to send an invitation to participate in the Telehealth Provider Survey. The survey sample included all the providers for whom unique email addresses were available. The selection of providers with a group/organization email was done by examining the number of providers with that email. If the organization had a small number of providers, then all providers with that group/organization email address were included in the sample. For the large organizations with several providers with the same group/organization email address, 5 to 10 providers with 201 or more claims, 5 to 10 providers with 100 to 200 claims, and 5 to 10 providers with less than 100 claims were selected for the sample. Though these providers were selected randomly, a rigorous probability sampling methodology was not applied as the purpose of this survey is to collect qualitative information from providers regarding their experience with telehealth services for KanCare members.

Survey Questionnaire

The survey questionnaire had an introductory paragraph describing the purpose of the survey and twelve questions. The initial two questions were designed to collect information on primary locations of the respondents and the type of healthcare service they provide. The third question was directed toward confirming whether they provided telehealth services to KanCare members. For the respondents selecting "Yes" to the third question, nine subsequent questions were designed using a close-ended question format for eight of these questions, and an open-ended format for one question. For the respondents selecting "No" to the third question, before directing them to end the survey, an open-ended question was asked regarding the reasons for not providing telehealth services. To conduct the survey using the SurveyMonkey software platform, the survey questionnaire was formatted using the Software's online survey building features.

Survey Implementation

SurveyMonkey was used to conduct the survey. The email invitation with an online survey link was sent directly to the providers with provider-specific email addresses. For the providers using the same group/organization email address, the emailed invitation included a list of the selected providers' names and a request for the recipient to forward the survey link to all listed providers. If the recipient was a provider, the email also included a request to complete the survey as well as forward it to others. These emails were sent to 96 group/organization addresses to reach these providers.

Analytic Method

SurveyMonkey analysis and reporting features were used to collect the responses provided by the survey respondents. Respondents were kept anonymous. The responses to survey questions abstracted from SurveyMonkey were reviewed and categorized into key themes to summarize the providers' experiences related to use of telehealth services for providing healthcare to KanCare members.

f. Methodology for the Evaluation of Hypothesis 4

As per a recommendation from CMS, the KanCare 2.0 Hypothesis 4 evaluation methodology description is included in a separate report prepared for the interim evaluation of the KanCare 2.0 Section 1115 SUD Demonstration.

g. 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 KanCare 2.0 Evaluation design (Attachment A) proposed monitoring of thirteen performance measures related to a few of these areas during the period of 2019 through 2023. Changing circumstances made deviations from the proposal necessary. The changes will be explained below. The interim evaluation of overall performance measures was conducted using quantitative methods.

As proposed in the KanCare 2.0 Evaluation Design (Attachment A), two HEDIS measures and a Consumer Assessment of the Healthcare Providers and Systems (CAHPS) adult survey measure were examined for inclusion in the interim evaluation.

For the HEDIS measure Prenatal and Postpartum Care (PPC), only measurement years (MY) 2019 and 2020 rates were included in the evaluation. Because of specification changes, NCQA indicated a break in trending from prior rates. A break in trending was indicated for the HEDIS Comprehensive Diabetes Care (CDC) indicator Blood Pressure Control between MY 2019 and MY 2020; because only one data point remained, the indicator was excluded from the evaluation.

The comprehensive diabetes care HEDIS measures were reorganized by NCQA since the KanCare 2.0 Evaluation Design was written. Three indicators were discontinued: Medical Attention for Nephropathy, HbA1C Testing, and HbA1c Control (<7.0%). The remaining four indicators were separated into three independent measures that are percentages of members 18–75 years of age with diabetes (types 1 and 2).[17]

- Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
  - HbA1c Control (<8.0%)
  - Poor Control HbA1c (>9.0%)
- Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)

The KanCare 2.0 Evaluation Design proposed monitoring of four mental health measures using data from the Kansas Medicaid Mental Health Consumer Perception Survey reports. However, that survey was replaced in 2021 with the Experience of Care and Health Outcomes (ECHO) Survey. Because the questions related to the selected measures from the Kansas Medicaid Mental Health Consumer Perception Survey were not available in the ECHO Survey, data from Kansas ECHO survey for three years (2021, 2022, 2023) will be examined for the KanCare 2.0 Evaluation. Currently, ECHO Survey data for the mental health measures are available for only on year (2021); therefore, the measures were not included in the interim evaluation but are expected to be included in the KanCare 2.0 summative evaluation.

Also, the KanCare 2.0 Evaluation Design proposed monitoring of six measures related to social and community engagement among KanCare members receiving HCBS services by using data from the Kansas Consumer Assessment of Healthcare Providers and Systems Home and Community Based Services (HCBS CAHPS) Survey. The Kansas HCBS CAHPS survey was conducted only in 2019. The Kansas Department of Aging and Disability Services (KDADS) decided not to repeat this survey. Instead, Kansas data from the National Core Indicators (NCI) survey and National Core Indicators—Aging and Disabilities (NCI-AD) Survey will be used to monitor measures related to Social and Community Engagement among KanCare members receiving HCBS services. The measures from 2016-2017, 2017-2018 and 2018-2019 Kansas NCI surveys,[19,20,21] and from 2018-2019 and 2019-2020 Kansas NCI-AD surveys[22,23] were examined for the interim evaluation.

Target and Comparison Populations:

The HEDIS measures included in the evaluation assessed performance of adult and infant KanCare 2.0 members. The CAHPS adult surveys were distributed to adult KanCare 2.0 members aged 18 years or older.[24,25] The Kansas NCI surveys were conducted among members who are Medicaid eligible, 18 years and older, receiving at least one Intellectual/Developmental Disability (I/DD) waiver service (waiver services to not include services from Intermediate Care Facilities for Individuals with Intellectual Disabilities). The Kansas NCI-AD surveys were conducted among adults who are Medicaid eligible and receive long term services and supports (LTSS) through the Frail Elderly (FE), Physical Disability (PD) and Brain Injury (BI) waiver programs.

Evaluation Periods:

HEDIS measures – Measurement Years 2019–2020
CAHPS survey measure – Survey Years 2019–2021 (MY 2019–2020)
Kansas NCI Survey measures – Survey Years 2016-2017, 2017-2018, and 2018-2019
Kansas NCI-AD Survey measures – Survey Years 2018-2019 and 2019-2020

Evaluation Measures:

The following outcome measures were assessed.

- Prenatal and Postpartum Care (PPC) [HEDIS measure]
  - 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 and 84 days after delivery
- Comprehensive Diabetes Care [HEDIS measures; percentage of members 18–75 years of age with diabetes (types 1 and 2)]
  - Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
    - HbA1c Control (<8.0%)
    - Poor Control HbA1c (>9.0%)
  - Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam.
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)
- Medical Assistance with Smoking and Tobacco Use Cessation (MSC) [CAHPS survey HEDIS measure]
  - Advising Smokers and Tobacco Users to Quit – Percentage of members 18 years of age and older

who were current smokers or tobacco users and who received advice to quit during the prior six months
    - Discussing Cessation Medications – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medication in the prior six months
    - Discussing Cessation Strategies – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies in the prior six months.
- Social and Community Engagement [Kansas NCI Survey and Kansas NCI-AD Survey Measures]
    - Kansas NCI Survey Measures
        - Can see and communicate with their family when they want (if not living with family)
        - Has friends (may be staff or family) and can see them when wants
        - Able to go out and do the things they like to do in the community as often as they want
        - Services and Supports help person live a good life
        - Decides or has input in deciding how to spend free time
        - Decides or has input in deciding daily schedule
    - Kansas NCI-AD Survey Measures
        - Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)
        - Percentage of people who are able to do things they enjoy outside of home as much as they want to
        - Percentage of people whose services help them live a better life
        - Percentage of people who like how they spend their time during the day
        - Percentage of people who get up and go to bed when they want to
        - Percentage of people who can eat their meals when they want to

Data Sources:

- HEDIS measure data submitted by the MCOs for measurement years 2016 to 2020
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, 2018 to 2021[24,25]
- NCI In-Person Surveys, 2016-2017, 2017-2018, and 2018-2019 Kansas State Reports[19,20,21]
- NCI-AD Adult Consumer Surveys, 2018-2019 and 2019-2020 Kansas Results[22,23]

Analytic Methods:

The following analytical steps were applied to examine the monitoring of overall KanCare 2.0 performance measures.

- HEDIS and CAHPS Survey Measures:
    - The Prenatal and Postpartum Care (PPC) and Comprehensive Diabetes Care indicator rates were calculated from Certified, Audited HEDIS Health Plan rates that were calculated by the MCOs using administrative and medical record data for samples of members meeting administrative criteria. KanCare rates are weighted averages of the MCOs' rates, weighted by the measures' administrative denominators.
    - Four CAHPS questions on the adult survey questionnaire addressed smoking and tobacco use and cessation strategies among adult members. Respondents indicated whether or not they smoked or used tobacco. If respondents replied "*everyday*" or "*some days*" to the smoking and tobacco use question, they were asked three questions about cessation strategies that form indicators of the HEDIS measure Medical Assistance with Smoking and Tobacco Use Cessation (MSC). KanCare rates for the MSC indicators were calculated from CAHPS survey responses.

These rates represented the combined membership of each MCO's indicated populations. KanCare rates were averages weighted by the counts of members meeting survey eligibility criteria. MSC rates are reported as one-year rates, as opposed to two-year rolling averages, to accommodate statistical testing of differences between years.
    - KanCare rates were compared to national percentiles for all Medicaid and CHIP health plans made available through Quality Compass (QC). KanCare rates were ranked using the QC percentiles. The ranks are denoted, in order of worst to best performance: <5th, <10th, <25th, <33.33rd, <50th, ≥50th, >66.67th, >75th, >90th, and >95th. For example, a rate ranked <10th will be less than the 10th percentile but not less than the 5th percentile.
    - Statistical testing to assess statistically significant differences between two consecutive years (2019 to 2020, and 2020 to 2021) was conducted using a weighted Pearson chi-square test with *p* less than 0.05 indicating statistical significance.
- Kansas NCI Survey Measures:
    - The percentages for the NCI Survey measures were abstracted from the 2016-17, 2017-18, and 2018-19 National Core Indicators (NCI®) In-Person Surveys, Kansas State Reports.
    - Absolute improvement was examined by comparing percentages across the three survey years.
- Kansas NCI-AD Survey Measures:
    - The percentages for the NCI-AD Survey measures were abstracted from the 2018–2019 and 2019–2020 survey reports.
    - Absolute improvement was examined by comparing percentages across the three survey years.

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.

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.

Because MCO member-level HEDIS data were not available for measurement years 2016 through 2021, HEDIS rates were calculated from encounter data. Rates calculated from encounter records do not match the MCOs' rates and are not to be considered HEDIS Health Plan rates; calculation of HEDIS rates by the MCOs incorporates supplemental data not available through encounters, such as data extracted

from medical records and claims from other lines of business. HEDIS rates calculated from encounter data are Uncertified, Unaudited HEDIS rates. Not all HEDIS rates could be adequately produced from encounter data; Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) rates were excluded from the evaluation due to poor comparisons to rates calculated from MCO member-level detail records.

Data lag also causes a challenge in measuring and reporting change in a timely manner. Analysis from encounter data was limited to dates of service occurring in 2016 through 2021 and further limited to encounters received into the State's system within 3 months of the measurement year. The latest HEDIS data from the MCOs available for analysis was measurement year 2020.
As the evaluation covers multiple years, definitions and specifications of the evaluation measures, policies for data collection, and infrastructure of the data sources were subject to change during the evaluation period. Adjustments were made to analytic plans, where possible. These include adjusting HEDIS measure calculations to reflect more current technical specifications and modifying inclusion criteria for the Service Coordination Strategy intervention and comparison groups due to missing data.

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, multiple treatment threats due to other interventions, effect of confounding variables, inadequate statistical power, and multiple comparisons issues) that will require application of appropriate techniques.

A lack of standardization of the HST, HRA, Needs Assessment and PCSP variable fields, in the datasets provided by the MCOs, created limitations in compiling the Intervention and Comparison Groups needed for the interim evaluation measurement period. Through a contract amendment, the HST and HRA have been standardized, with implementation of the standardized tools occurring in early 2022.

Issues with comparability of intervention and control groups, time periods, or strata were encountered. Appropriate techniques were be applied to address these issues as much as possible.

- The COVID-19 public health emergency was a very strong confounding variable that impacted almost all aspects of the evaluation.
- As an emergency measure, disenrollment from KanCare was suspended for many members who would otherwise have become ineligible for benefits (e.g., CHIP members turning 19 years old and 60 days after delivery for women receiving benefits due to pregnancy). Consequently, the number of KanCare members increased in 2020 and 2021 (impacting utilization rates) and the homogeneity of the population changed (impacting statewide outcome measures).
- The intervention and control groups for evaluation of the Service Coordination Strategy and OneCare Kansas groups were subject to self-selection bias due to differences in the characteristics of members opting-in for the participation in the intervention and those not opting-in.
- Telehealth was implemented statewide, which creates spillover effects.
- Differences in the type of providers available to offer services differed between regions of the state, which made it a confounding variable for evaluation of telehealth.
- Some measures (e.g., Prenatal and Postpartum Care and Follow-Up After Hospitalization for Mental Illness for evaluation of the Service Coordination Strategy and OneCare Kansas groups) were not reported for due to inadequate statistical power (too few members met denominator criteria).

- Statistical testing results on measures with large denominators frequently produced *p*-values less than 0.001. If confounding variables were known, test results may not have been meaningful for evaluation of the hypotheses.

Results

a. KanCare 2.0 Service Coordination Strategy

Quantitative Evaluation

For the interim evaluation of the KanCare 2.0 Service Coordination Strategy, the six selected performance outcome measures were examined for the Intervention Group and Comparison Group 2 for the pre-intervention period (2016–2018) and intervention period (2019–2021). The Intervention Group rates calculated for the pre-intervention period (2016–2018) constituted the rates for Comparison Group 1. The results are summarized in Table 3.

Demographic Analysis:

Demographic analysis included stratifying the Intervention Group and Control Group 2 by MCO and by whether or not they received HCBS services. Since all HCBS waiver participants are eligible for service coordination, they represent a higher percentage of members participating in service coordination than non-HCBS participants. Examples of non-HCBS participants in service coordination may include members with behavioral health needs or complex/chronic conditions, members in nursing or residential facilities, hospitals or members in foster care. The ratio of HCBS waiver participants to non-HCBS participants was different between the intervention and control groups: 82% of the 23,807 members in the Intervention Group were HCBS recipients compared to 26% of the 26,712 members in Control Group 2. At the MCO-level, the percentages of HCBS recipients in the Intervention Group were 57%, 93%, and 95%; the percentages of HCBS recipients in Control Group 2 were 4%, 16%, and 44%. Because service coordination was available through HCBS services prior to KanCare 2.0, inclusion of HCBS recipients will dampen the planned analysis to measure the impact of extending service coordination to non-HCBS recipients. Of the 4,366 non–HCBS recipients in the Intervention Group, 77% were from one MCO; the reason for this difference is unknown.

As noted in the evaluation methodology for the service coordination strategy, the COVID-19 pandemic impeded the MCOs' abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the service coordination evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

Measure 1: Adults' Access to Preventive/Ambulatory Health Services (AAP):

The Intervention Group's RFR improvement was not statistically different from that of Comparison Group 2. The RFR, which measures improvement relative to the amount of possible improvement, should be higher for the intervention group to show effectiveness. The following results were seen for the AAP measure:

- The 2016–2018 AAP rates were high for both Intervention Group (95.8%) and Comparison Group 2 (94.3%). Since the Intervention Group has less potential for improvement, equal percentage point increases would result in larger RFRs for the Intervention Group than for Comparison Group 2.

- For both groups, the 2019–2021 AAP rates were about 1 percentage point lower than the 2016–2018 AAP rates, which is shown in Table 3 as a difference of –1 percentage points. The Intervention Group's rate decreased to 94.8%; the AAP rate for Comparison Group 2 decreased to 93.2%.
- The RFR improvements were also about the same. The RFR for the Intervention group was –22.9%; the formula is RFR = (94.8% – 95.8%)/(100% – 95.8%). The RFR for Comparison Group 2 was –19.1%.
- The difference in RFRs was not statistically significant (*p*=.27). Statistical significance of the differences between 2016–2018 and 2019–2021 rates was expected; it was assumed the COVID-19 pandemic would impact AAP rates. Also, the denominators are large, so small changes in rates would yield significant findings.
- The differences between Intervention Group and Comparison Group 2 rates are indications of comparability of the two groups. The significance of the differences was not surprising since members who elect to receive service coordination may be more likely have medical conditions requiring preventive or ambulatory health services. These differences are accounted for by comparing RFRs instead of percentage point differences between years.

Measure 2: Annual Dental Visit (ADV):

For Intervention Group and Comparison Group 2, negative RFRs for ADV measure were seen. For the Intervention Group, a statistically significant lower RFR was seen. The RFR should be higher for the intervention group to show effectiveness. The following results were seen for the ADV measure:

- The 2016–2018 ADV rates for the Intervention Group and the Comparison Group 2 were 54.4% and 63.9%, respectively. A statistically significant difference of 9.5 percentage points was seen between the rates for the two groups (p<.001).
- The 2019–2021 ADV rates for both groups were lower than the 2016–2018 rates. The Intervention Group's rate decreased to 47.9%, showing a difference of 6.5 percentage points. The rate for the Comparison Group 2 decreased to 62.3%, showing a difference of 1.6 percentage points.
- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –14.2%. The RFR for Comparison Group 2 was –4.5%. The difference in RFRs for the two groups was statistically significant (*p*<.001), showing the decrease was larger for the Intervention Group than for the Comparison Group 2.

Measure 3. Adolescent Well-Care Visit (AWC):

For Intervention Group and Comparison Group 2, negative RFRs for the AWC measure were seen. For the Intervention Group, a statistically significant lower RFR was seen. The RFR should be higher for the Intervention Group to show effectiveness. The following results were seen for AWC measure:

- The 2016–2018 AWC rates for the Intervention Group and the Comparison Group 2 were 47.2% and 52.3%, respectively. A statistically significant difference of 5.1 percentage points was seen between the rates for the two groups (p<.001).
- The 2019–2021 AWC rates for both groups were lower than the 2016–2018 rates. The Intervention Group's rate decreased to 42.4%, showing a difference of 4.8 percentage points. The rate for Comparison Group 2 decreased slightly to 52.0%, showing a difference of 0.2 percentage points.
- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –9.1%. The RFR for Comparison Group 2 was –0.5%. The difference in RFRs for the two groups was statistically significant (*p*<.001), showing the decrease was larger for the Intervention Group than for the Comparison Group 2.

Measure 4: ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions:

- *Diabetic ketoacidosis/hyperglycemia,*
- *Acute severe asthma,*
- *Hypertensive crisis,*
- *Fall injuries,*
- *SUD, or*
- *Mental health issues*

Rates for Intervention Group and Comparison Group 2 increased instead of improving. The relative increase was greater for the Intervention Group (i.e., the difference in RFRs was statistically significant), which indicates poorer performance. The following results were seen for the measure:

- The 2016–2018 ED Visits, Observation Stays, or Inpatient Admissions for Diabetic ketoacidosis/ hyperglycemia, Acute severe asthma, Hypertensive crisis, Fall injuries, SUD, or Mental health issues rates for the Intervention Group and the Comparison Group 2 were 52.6 occurrences (visits, stays, or admissions) per 1,200 member-months and 86.4 occurrences (visits, stays, or admissions) per 1,200 member-months, respectively.
- The Intervention Group's rate increased 9.4 occurrences per 1,200 member-months. The rate for the Comparison Group 2 increased only 3.7 occurrences per 1,200 member-months.
- The RFR for the Intervention Group was –17.9%, which indicates worse performance than the RFR of –4.3% for Comparison Group 2. The difference in RFRs for the two groups was statistically significant ($p<.001$).
- The difference between rates of 33.9 occurrences per 1,200 member-months indicates an underlying difference in health status between the two groups, which may have contributed to their differing performance under this measure.

Measure 5: Outpatient or Professional Claims for Following Conditions:

- *Diabetic retinopathy*
- *Influenza*
- *Pneumonia or*
- *Shingles*

Results support the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on the Outpatient or Professional Claims, for Diabetic Retinopathy, Influenza, Pneumonia or Shingles rates. Instead of decreasing, which would indicate improvement, rates for both the Intervention Group and Comparison Group 2 increased. However, the increase was greater for Comparison Group 2. The difference in RFRs was statistically significant, which indicates the Intervention Group performed better than Comparison Group 2 under the circumstances. The following results were seen for the measure:

- The 2016–2018 rates for Outpatient or Professional Claims for Diabetic Retinopathy, Influenza, Pneumonia or Shingles for the Intervention Group and Comparison Group 2 were 66.9 claims per 1,200 member-months and 56.6 claims per 1,200 member-months, respectively. The 10.3 claims per 1,200 member-months difference in these rates was statistically significant but was considered acceptable for the analysis.
- The 2019–2021 rates for both groups were higher than the 2016–2018 rates. The Intervention Group's rate increased 11.5 claims per 1,200 member-months. The rate for Comparison Group 2 increased 18.6 claims per 1,200 member-months.
- For both groups, negative values of RFRs were seen. The RFR for the Intervention group was –17.3%,

which was "less worse" than RFR of –32.8% for Comparison Group 2. The difference in RFRs for the two groups was statistically significant ($p<.001$).

Measure 6: Emergency Department Visits Overall (Administrative):

Neither intervention and comparison group's rate changed statistically significantly between time periods, and the difference in RFRs was not statistically significant. The following results were seen for the measure:

- The 2016–2018 Emergency Department Visits (Overall) rate was 141.5 claims per 1,200 member-months for the Intervention Group and 192.7 claims per 1,200 member-months for Comparison Group 2.
- For both groups, the 2019–2021 Emergency Department Visits (Overall) rates were lower than the 2016–2018 rates. The Intervention Group's rate decreased 2.3 claims per 1,200 member-months. The rate for the Comparison Group 2 slightly decreased 1.4 claims per 1,200 member-months. The decreases were not statistically significant ($p=.13$ and $p=.48$, respectively).
- The RFR for the Intervention Group (1.6%) and RFR for Comparison Group 2 (0.8%) were not statistically significantly different ($p=.41$).

Table 3. KanCare 2.0 Service Coordination Strategy Evaluation Measures

	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
Adults' Access to Preventive/Ambulatory Health Services (AAP)*						
2016–2018	95.8%	42,267	94.3%	26,770	1.5 pp	*p*<.001
2019–2021	94.8%	47,722	93.2%	37,684	1.6 pp	*p*<.001
Difference, *p*-value	-1.0 pp	*p*<.001	-1.1 pp	*p*<.001		
RFR Improvement	-22.9%		-19.1%			*p*=.27
Annual Dental Visit (ADV)*						
2016–2018	54.4%	10,280	63.9%	11,310	-9.5 pp	*p*<.001
2019–2021	47.9%	11,371	62.3%	13,766	-14.4 pp	*p*<.001
Difference, *p*-value	-6.5 pp	*p*<.001	-1.6 pp	*p*=.01		
RFR Improvement	-14.2%		-4.5%			*p*<.001
Adolescent Well-Care Visit (AWC)*						
2016–2018	47.2%	10,070	52.3%	10,780	-5.1 pp	*p*<.001
2019–2021	42.4%	11,176	52.0%	13,004	-9.6 pp	*p*<.001
Difference, *p*-value	-4.8 pp	*p*<.001	-0.2 pp	*p*=.70		
RFR Improvement	-9.1%		-0.5%			*p*<.001
ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions: Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues^						
2016–2018	52.6	44,132	86.4	30,447	-33.9	*p*<.001
2019–2021	62.0	51,549	90.2	45,367	-28.2	*p*<.001
Difference, *p*-value	-9.4	*p*<.001	-3.7	*p*=.01		
RFR Improvement	-17.9%		-4.3%			*p*<.001

Table 3. KanCare 2.0 Service Coordination Strategy Evaluation Measures (Continued)						
	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
Outpatient or Professional Claims for Following Conditions: Diabetic Retinopathy, Influenza, Pneumonia, or Shingles^						
2016–2018	66.9	44,132	56.6	30,447	10.3	*p*<.001
2019–2021	78.4	51,549	75.2	45,367	3.3	*p*<.01
Difference, *p*-value	-11.5	*p*<.001	-18.6	*p*<.001		
RFR Improvement	-17.3%		-32.8%			*p*<.001
Emergency Department Visits Overall^						
2016–2018	141.5	44,132	192.7	30,447	-51.2	*p*<.001
2019–2021	139.2	51,549	191.2	45,367	-52.1	*p*<.001
Difference, *p*-value	2.3	*p*=.13	1.4	*p*=.48		
RFR Improvement	1.6%		0.8%			*p*=.41

Reduction in failure rate (RFR) measures improvement relative to the amount of possible improvement. The formula is: RFR=(Final Rate minus Initial Rate)/(Goal minus Initial Rate), where Goal = 100% or 0%, depending on the measure.

*Measures were calculated from MMIS encounter data based on specifications for HEDIS Health Plan measures. Rates differ from Certified, Audited HEDIS health plan rates calculated by MCOs due to differences if available source data. To calculate RFR, the goal was 100%. Differences in rates are shown in percentage points (pp) and were tested for statistical significance using a Pearson chi-square test. A chi-square test was used to test for equality of RFR improvements.

^Measures were calculated from MMIS encounter data that was deduplicated to count one claim per member, per billing provider NPI, per last date of service. Rates are the number of claims in the measurement period per 1,200 member-month, which may be interpreted as the average number of claims in a year for 100 members. The denominator shown is the total member-months divided by 12 (i.e., the total of the average number of members in each year within the measurement period). Large sample *z*-tests were used to test for differences between rates and RFR improvements.

b. OneCare Kansas program

Quantitative Evaluation

For the interim evaluation of the OneCare Kansas (OCK) program, the six selected performance outcome measures were examined in the Intervention Group and Comparison Group 2 for the pre-intervention period (2016–2019) and intervention period (2020–2021). The rates calculated for the pre-intervention period (2016–2019) constituted the rates for the Comparison Group 1. The results are summarized in Table 4. As noted in the evaluation methodology, the COVID-19 pandemic impeded the MCOs' abilities to fully administer the service coordination strategy as designed, for much of the intervention period. While data is provided for the OCK evaluation measures, conclusions regarding the effectiveness of the strategy are not possible at this time.

Review of the MCOs' data files indicated the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from encounters (using the State's OCK program eligibility criteria), and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.

Measure 1: Adults' Access to Preventive/Ambulatory Health Services (AAP):

Results supports the assertion that the OCK program had a positive impact on Adult's Access to Preventive/Ambulatory Health Services rates. The Intervention Group's rate improved while Comparison Group 2's rate declined. The difference in the relative improvements was statistically significant. The following results were seen for the AAP measure:

- The 2016–2019 AAP rates were high for both the Intervention Group (97.5%) and Comparison Group 2 (94.6%). Since the Intervention Group has less potential for improvement, equal percentage point increases would result in larger RFRs for the Intervention Group than for Comparison Group 2.

- For the Intervention Group, the 2020–2021 AAP rate was 0.2 percentage points higher than the 2016–2019 AAP rate; the AAP rate for Comparison Group 2 decreased 2.4 percentage points.
- The increase in the Intervention Group's AAP rates was a 7.4% relative improvement. The RFR for Comparison Group 2 was –44.2%. The difference in RFRs was statistically significant ($p<.001$).
- Statistically significant differences between 2016–2019 and 2020–2021 rates were expected; it was assumed the COVID-19 pandemic would impact AAP rates. Also, the denominators are large, so small changes in rates can yield significant findings.
- The differences between the Intervention Group and Comparison Group 2 rates are indications of comparability of the two groups. The significance of the differences was not surprising since members who elect to receive OCK program services may be more likely have medical conditions requiring preventive or ambulatory health services. These differences are accounted for by comparing RFRs instead of percentage point differences between years.

Measure 2: Annual Dental Visit (ADV):

Results suggest the OCK program may have had a positive impact on Annual Dental Visit rates. Although ADV rates for both groups decreased, the Intervention Group's rate did not decrease as badly as the Comparison Group 2's rate did, based on the RFRs—the Intervention Group's RFR was closer to positive than Comparison Group 2's RFR, and the difference was statistically significant. The following results were seen for the ADV measure:

- The 2016–2019 ADV rates for the Intervention Group and the Comparison Group 2 were 72.2% and 66.3%, respectively.
- The 2020–2021 ADV rates for both groups were lower than the 2016–2019 rates; 3.0 percentage points for the Intervention Group and 9.5 percentage points for Comparison Group 2.
- The RFR for the Intervention Group was –10.7%. The RFR for Comparison Group 2 was –28.3%. The difference in RFRs for the two groups was statistically significant, showing the Intervention Group fared relatively better in the last two years than Comparison Group 2.
- The differences between groups within each period are large enough to warrant comparison of RFRs, but not so large as to indicate Comparison Group 2 is not suitable to be a comparison group for the analysis.

Measure 3. Adolescent Well-Care Visit (AWC):

Results support the assertion that the OCK program had a positive impact on Adolescent Well-Care Visit rates. As with the AAP rates, the AWC rate for the Intervention Group increased (non-significantly) while the AWC rate for Comparison Group 2 decreased. The difference in RFRs was statistically significant. The following results were seen for the AWC measure:

- The 2016–2019 AWC rates for the Intervention Group and the Comparison Group 2 were 59.1% and 51.4%, respectively. The difference of 7.7 percentage points was acceptable for the analysis.
- For Intervention Group, the 2020–2021 AWC rate was 0.8 percentage points higher than the 2016–2019 rate. The Comparison Group 2 AWC rate decreased 6.5 percentage points.
- The RFR for the Intervention Group was 2.0% and the RFR for Comparison Group 2 was -13.3%. The difference in RFRs was statistically significant.

Measure 4: ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions:

- *Diabetic ketoacidosis/hyperglycemia,*
- *Acute severe asthma,*
- *Hypertensive crisis,*
- *Fall injuries,*
- *SUD, or*
- *Mental health issues*

The Intervention Group's RFR improvement was not statistically different from that of Comparison Group 2. The following results were seen for the measure:

- The 2016–2019 rates for the ED Visits, Observation Stays, or Inpatient Admissions for Diabetic Ketoacidosis/hyperglycemia, Acute severe asthma, Hypertensive crisis, Fall injuries, SUD, or Mental health issues rates for the Intervention Group and the Comparison Group 2 were 61.1 and 32.7 occurrences (visits, stays, or admissions) per 1,200 member-months, respectively.
- For the Intervention Group, the 2020–2021 rate was 1.2 occurrences per 1,200 member-months higher than the 2016–2019 rate (shown in Table 4 as –1.2 since it is not an improvement). The rate for Comparison Group 2 increased 1.7 occurrences per 1,200 member-months from 2016 to 2019.
- The RFRs were –2.0% for the Intervention Group and –5.1% for Comparison Group 2; the difference was not statistically significant (p=.49).
- The difference between the Intervention Group and Comparison Group 2 rates was relatively large for both time periods. For 2016–2019, the difference was 28.4; the Intervention Group's rate was almost double Comparison Group 2's rate. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

Measure 5: Outpatient or Professional Claims for Following Conditions:

- *Diabetic retinopathy*
- *Influenza*
- *Pneumonia or*
- *Shingles*

For both the Intervention Group and Comparison Group 2, the RFR was –14%. The following results were seen for the measure:

- The 2016–2019 rates for the Outpatient or Professional Claims for the diabetic retinopathy, influenza, pneumonia or shingles for the Intervention Group and the Comparison Group 2 were 62.5 and 43.9 claims per 1,200 member-months, respectively.
- For the Intervention Group, the 2020–2021 rate was 8.8 claims per 1,200 member-months higher than the 2016–2019 rate. The Comparison Group 2 rate increased 6.1 claims per 1,200 member-months from 2016–2019.
- The RFRs (–14.1% for the Intervention Group, –14.0% for Comparison Group 2) were not statistically significantly different (p=.98)
- The difference between the groups' rates was relatively large for both time periods; Comparison Group 2's rates were about one and a half times the Intervention Group's rates. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

Measure 6: Emergency Department Visits Overall (Administrative):

The rates improved for both groups, but the RFR improvement was statistically significantly greater for Comparison Group 2 than the Intervention Group. The following results were seen for the measure:

- The 2016–2019 Emergency Department Visits (Overall) rate for the Intervention Group was 310.3 and 212.5 claims per 1,200 member-months for Comparison Group 2.
- For both groups, the 2020–2021 Emergency Department Visits (Overall) rates were about 37 claims per 1,200 member-month lower than the 2016–2019 rates.
- The RFR for the Intervention Group was 11.6%, but the RFR for Comparison Group 2 (17.6%) was statistically significantly greater ($p<.01$).
- The difference between the groups' rates was relatively large for both time periods; Comparison Group 2's rates were about one and a half times the Intervention Group's rates. This makes the comparability of the two groups questionable, and the results of the analysis should be interpreted with caution.

Table 4. OneCare Kansas Program Evaluation Measures

	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
Adults' Access to Preventive/Ambulatory Health Services (AAP)*						
2016–2019	97.5%	7,125	94.6%	143,237	2.9 pp	*p*<.001
2020–2021	97.7%	5,012	92.2%	103,627	5.5 pp	*p*<.001
Difference, *p*-value	0.2 pp	*p*=.52	-2.4 pp	*p*<.001		
RFR Improvement	7.4%		-44.2%			*p*<.001
Annual Dental Visit (ADV)*						
2016–2019	72.2%	2,727	66.3%	139,906	5.9 pp	*p*<.001
2020–2021	69.2%	1,606	56.8%	81,137	12.5 pp	*p*<.001
Difference, *p*-value	-3.0 pp	*p*=.04	-9.5 pp	*p*<.001		
RFR Improvement	-10.7		-28.3%			*p*<.01
Adolescent Well-Care Visit (AWC)*						
2016–2019	59.1%	2,687	51.4%	135,928	7.7 pp	*p*<.001
2020–2021	59.9%	1,603	44.9%	80,084	15.0 pp	*p*<.001
Difference, *p*-value	0.8 pp	*p*=.59	-6.5 pp	*p*<.001		
RFR Improvement	2.0%		-13.3%			*p*<.001
ED Visits, Observation Stays, or Inpatient Admissions for Following Conditions: Diabetic Ketoacidosis/Hyperglycemia, Acute Severe Asthma, Hypertensive Crisis, Fall Injuries, SUD, or Mental Health Issues^						
2016–2019	61.1	7,936	32.7	168,872	28.4	*p*<.001
2020–2021	62.3	5,517	34.3	124,563	28.0	*p*<.001
Difference, *p*-value	-1.2	*p*=.66	-1.7	*p*<.001		
RFR Improvement	-2.0%		-5.1%			*p*=.49
Outpatient or Professional Claims for Following Conditions: Diabetic Retinopathy, Influenza, Pneumonia, or Shingles^						
2016–2019	62.5	7,936	43.9	168,872	18.5	*p*<.001
2020–2021	71.3	5,517	50.1	124,563	21.2	*p*<.001
Difference, *p*-value	-8.8	*p*<.01	-6.1	*p*<.001		
RFR Improvement	-14.1%		-14.0%			*p*=.98

Table 4. OneCare Kansas Program Evaluation Measures (Continued)

	Intervention Group		Comparison Group 2		Statistics	
	Rate	Denominator	Rate	Denominator	Difference	Significance
Emergency Department Visits Overall^						
2016–2019	310.3	7,936	212.5	168,872	97.8	*p*<.001
2020–2021	273.5	5,517	175.2	124,563	98.4	*p*<.001
Difference, *p*-value	36.8	*p*<.001	37.3	*p*<.001		
RFR Improvement	11.9%		17.6%			*p*<.01

Reduction in failure rate (RFR) measures improvement relative to the amount of possible improvement. The formula is:
RFR=(Final Rate minus Initial Rate)/(Goal minus Initial Rate), where Goal = 100% or 0%, depending on the measure.

*Measures were calculated from MMIS encounter data based on specifications for HEDIS Health Plan measures. Rates differ from Certified, Audited HEDIS health plan rates calculated by MCOs due to differences if available source data. To calculate RFR, the goal was 100%. Differences in rates are shown in percentage points (pp) and were tested for statistical significance using a Pearson chi-square test. A chi-square test was used to test for equality of RFR improvements.

^Measures were calculated from MMIS encounter data that was deduplicated to count one claim per member, per billing provider NPI, per last date of service. Rates are the number of claims in the measurement period per 1,200 member-month, which may be interpreted as the average number of claims in a year for 100 members. The denominator shown is the total member-months divided by 12 (i.e., the total of the average number of members in each year within the measurement period). Large sample *z*-tests were used to test for differences between rates and RFR improvements.

Qualitative Evaluation

Learning Needs Identified:

The learning needs identified by OCK Learning Collaborative participants were collected from information available from April 2020 through March 2022, including the virtual regional meetings and survey. An overview of participants' responses and related key themes are described in Appendix A, Table A.1. These key themes are summarized below (Table 5).

Table 5. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020 – March 2022 Key Themes

- Health assessment tools and trainings for use of different types of health assessment tools including those for the comprehensive care
- Trainings for setting and writing goals and use of health assessment tools to identify goals
- Tracking outcomes and improvement of goals
- Ways to build program and engage members during COVID-19 pandemic
- MCO resources and benefits, tools, and portals
- Staff recruitment, retention, and engagement
- Provider engagement, networking, and peer learning
- Member engagement, recruitment, retention, and outreach tips
- Finance and billing
- Information and guidance on program processes and protocols:
  - Service codes
  - Use of same protocols by MCOs
  - Simplifying inclusion process
  - Patient transfers and referrals
  - Staff-to-member ratios
  - Required staff
  - HIPAA
  - Foster care system
  - Advanced directives
  - Program manual, including demonstrating compliance

Table 5. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020 – March 2022 Key Themes (Continued)

• Trainings on OCK focused conditions:
  ○ Asthma
  ○ Asthma and mental health issues
  ○ Addiction (SBIRT, etc.)
  ○ Motivational interviewing
  ○ Health literacy

• Health promotion resources for members

A variety of topics were identified by the participants to be discussed in Learning Collaborative meetings to gain information and guidance on various aspects of OCK program, including member and provider resources, program processes and protocols, provider and member engagement and strategies, staffing, and trainings on program focused conditions.

OCK Learning Collaborative Discussions and Sessions:

The main focus of the Learning Collaborative meetings was to identify and address evolving learning needs of OCK partners, which allows for continual quality improvement of the OCK program. To achieve this objective, fourteen virtual meetings were conducted from April 2020 through March 2022, providing information and guidance to participants on various aspects of the program. These meetings were attended by KDHE, MCOs, state organizations, provider network and contracted OCKPs. KDHE and other state agencies' staff, WSU CEI staff, and OCK partners presented information on various topics identified by participants as learning needs. These sessions also included interactive discussions among the participants using small and large group discussion formats. The approximate number of participants attending these meetings ranged from forty-five to seventy. Feedback was also collected after each session. Detailed information on these sessions is provided in Appendix A, Table A2. An overall summary of the topics presented in these meetings is provided below (Table 6). One identified learning need theme, that did not appear to be addressed, pertained to working with OCK members and their conditions, such as asthma, behavioral health, motivational interviewing, and health literacy.

Table 6. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020 – March 2022
April 2020 through November 2020: Eight Learning Collaborative meetings presented eleven topics.
• Information about adjustments to OCK policy during the COVID-19 emergency; Information regarding recommended and mandatory learning opportunities that impact OCK providers
• Recruitment and engagement of potential OCK members
• Quality measures for the OneCare Kansas program
• Information on the difference between a Health Risk Assessment conducted by the MCOs (KanCare care coordination strategy) and an OCK Health Assessment; Model for providing services to OCK members (including the Health Assessment process) shared by partners from the Community Health Centers; and strategies for engaging other providers in the process
• Programs available to support OCK partners for health promotion activities
• Challenges and opportunities that the partners have experienced in the first six months of the program's implementation
• Promoting staff resilience
• Recruitment of potential OCK members

Table 6. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020 – March 2022 (Continued)
January 2021 through November 2021: Five Learning Collaborative meetings presenting thirteen topics, one online survey, and six regional virtual meetings with OCK partners were conducted.
• Use and benefits of GIS map; use of map for collaboration; barriers in its use; and strategies to overcome these barriers
• A review of the first year; introduction of a data dashboard posted by KDHE to the OCK website; a review of aggregate results of the first OCK audit; OCK partner's experience in achieving financial sustainability for their program; expectations for the 2nd year of the program; and description on the expanded eligibility criteria
• Experiences of three OCK partners related to engagement of the members in their OCK program
• Online survey to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs (June 2021)
• Six regional virtual meetings with OCKPs – program success, concerns, needs and offers and potential next steps for the program (July 2021)
• OCK quality goals and partner expectations related to monitoring program quality; processes applied by the participant for gathering member feedback and challenges encountered
• Collaborations with local healthcare partners in the community
March 2022: One Learning Collaborative meeting presented three topics.
• Challenges and potential opportunities to hire support level staff to complete certain tasks; organizational changes need to allow for hiring additional support staff such as CNA/CMAs in their programs; and consideration of an option of adding community health workers as a potential support role for the OCK program

Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020–March 2022:

During discussions in the OCK Collaborative meetings, participants identified factors that facilitated their efforts to implement the OCK program and achieve its goals. An overview of participants' responses and related key themes are described in Appendix A, Table A3. Those key themes are summarized below (Table 7).

Table 7. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020 – March 2022 Key Themes
• Getting familiar with the program, its processes, and benefits
• Provision of trainings and re-trainings for the OCK providers for increasing their knowledge base to support their efforts, readily available information about the trainings and their time frames
• Availability of resources, variety of tools, OCK dashboard and GIS maps from State, MCOs and other agencies
• Diagnostic codes expansion and updates
• Tracking and reporting of quality measures and focus on outcomes

This area intentionally left blank

Table 7. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals, April 2020 – March 2022 Key Themes (Continued)
• Staffing options and expertise; Staff support
• Incorporation of the health promotion and risk factor prevention and control as the provision of care options; submission of separate claims for these options; and sharing of health promotion resources with clients
• Discussing challenges encountered in member recruitment and engagement; and application of strategies, methods and processes for member recruitment, enrollment, engagement, and outreach
• Referral processes and assistance from MCOs
• Collaboration with other entities such as psychosocial groups, hospitals, clinics, PCPs, and pharmacies to recruit clients • Use of prescription program to recruit clients
• Applying strategies for building and improving collaboration with other local health partners/providers who work with the members
• Collaboration, peer learning, and support among OCK partners to address similar challenges and implement OCK program
• Ensuring documentation fully reflects all activities and interactions for purposes of ongoing work with the client, billing, getting credit for work completed, and identification of successes
• Strategies applied to address OCK program staffing challenges: o Hiring and recruiting staff o Hiring of staff to work in two roles o Providing more support to staff by regular debriefing o Contracting with other agencies o Financial strategies such as increasing pay/wages, sign on bonus, staff bonuses, cross training of staff for OCK to bill the program o Reducing staff turnover rates

OCK Learning Collaborative participants noted several factors that facilitated their efforts for the implementation of the OCK program to achieve its goals. Fourteen overall themes described these factors. These themes could be further grouped into five broad categories: availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic codes expansion, health promotion options, and outcome focused program processes and systems.

Barriers/Challenges Seen in the Implementation of the OneCare Kansas Program:

During the discussions conducted in the OCK Collaborative meetings, participants identified the barriers and challenges they encountered in the implementation of the OCK program. An overview of participants' responses and related key themes are described in Appendix A, Table A4. Those key themes are summarized below (Table 8).

Table 8. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020 – March 2022 Key Themes
• Issues with program structure and processes: o Labor intensive and time-consuming Health Assessment Plans o Multiple levels of bureaucracy and their requirements o Unclear or inconsistent expectations o Inadequate time to incorporate audit feedback o Limited diagnostic criteria (identified in 2020)
• Unclear information on outcome and process measures gathering, and role OCK partners in collection of the measures
• Financial concerns o Payment structure
• Issues with access to member information
• Member enrollment, roster, and engagement issues
• Issues related to opt-in/opt-out process
• Training, education, and support needed for employees, providers, and members

Table 8. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020 – March 2022 Key Themes (Continued)
• Barriers in collaborating with other health partners/providers who work with the members: ○ Time consuming ○ COVID-19 pandemic ○ Providers are not readily available or do not have buy in for the collaboration. ○ Members not ready to join OCK ○ Members not wanting to share their information with all of their providers
• Challenges for staffing OCK program: ○ Unavailability of professionals and recruiting staff needed for the program ○ Adequate number of staff not available ○ Inadequate staffing and time constraints (staff with multiple roles, covering multiple counties, and increased enrollment) ○ Getting medical staff ○ Staff retention ○ Financial issues as competitive wages and justifying the costs
• Issues related to access to care in rural areas

Learning Collaborative participants noted barriers and challenges in the implementation of OCK. Ten overall themes summarized these barriers and challenges. Participants noted certain issues related to program structure and processes had created challenges in program implementation. Participants also noted some aspects of these processes are labor-intensive and time consuming, and often expectations were unclear and inconsistent. In earlier stages of program implementation, participants identified use of limited diagnostic criteria for members' eligibility to participate in the program as a barrier. The expansion of the criteria by the state addressed this issue, and participants have noted it as a facilitating factor. Other barriers and challenges, including those related to access to member information, financial concerns, member enrollment, roster, and engagement, opt-in/opt-out process, collaborations with partners and providers, staffing and access to care in rural areas, were noted by the participants throughout the interim evaluation period (April 2020 through March 2022).

Observations Related to the OneCare Kansas Program Success in Achieving its Goals:

The information on the impressions of OCK partners regarding major successes related to individual members, organization and systems, connecting with other community partners and marketing of the program to the community was collected through an online survey and the virtual meetings conducted in June 2021 and July 2021. Participants' responses and related key themes are described in Appendix A, Table A5. Those themes are summarized below (Table 9).

This area intentionally left blank

Table 9. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 – Key Themes
Individual Member Successes
• Coordination of care to assist members with their multiple health and social issues
• Provision of resources to the members for morbid conditions, and pre-surgical education and support
• Provision of health promotion resources and support to the members to assist them with their disease prevention efforts
Organization/System Successes
• Engaging with the members and their families to support them with their health improvement efforts
• Provision of information on program services available for the members
• Growth and sustainability of the program due to increased number of members, member engagement and trust, and hiring of staff dedicated to OCK
• Collaboration between providers such as PCPs, dental providers, other medical providers, hospitals, and MCOs that connect members to medical, dental, and community resources
Program Successes in Connecting with Other Community Providers
• Utilizing collaborative strategies with community providers, such as PCPs, hospitals, and FQHCs for member recruitment and referral to the OCK program
• Using EHR global alert technology to assist providers in sending member enrollment information to the OCK program and in making referrals to the program
Successes Related to the Marketing of the Program to the Community
• Use of a variety of marketing strategies for community and provider outreach ○ Program presentations and discussions at the Community Coalitions' and community agencies' meetings and at community events conducted at public venues ○ Communication of program information to PCPs and other internal and external partners using word of mouth, packages with tailored information, and presentations
• Direct communication with the new clients attending various clinics and use of organization's mass text alert system to provide information and to encourage them to join the OCK program and make appointments

Learning Collaborative participants made several observations regarding the successes achieved by the OCK program. These successes were noted at the individual member level, as well as at organization and system levels. Successes were also seen in the program's efforts to connect with other community providers and to market the program to the community.

At the individual member level, noted successes were related to care coordination and provision of resources to members for medical and surgical care and for health promotion. Participants noted several achievements at their organization or system that led to the program success. These achievements were related to providing support to members and their families with their health improvement efforts, provision of program information to members, growth and sustainability of the program with increases in member trust and engagement, appropriate staffing for the program, and collaboration with providers, provider entities and MCOs to connect members with appropriate medical and community resources.

Additionally, participants shared their observations related to OCK successes in connecting with other community providers, such as Primary Care Providers (PCPs), hospitals, and Federally Qualified Health Centers (FQHCs), for member recruitment and referral. They noted these successes were achieved using multiple collaborative strategies with these providers for member recruitment and referral to OCK and by using electronic health record (EHR) global alert technology to exchange member enrollment and referral information with these providers.

Participants noted several successes in the marketing of the program to the community. These successes included use of variety of marketing strategies for community and provider outreach, direct

communication with new clients attending various clinics, and use of a text alert system that encouraged clients to join the program.

Assistance Needed by the OCK Partners from OCK Partners' Network and State/MCO Implementation Team to Assure Quality Services:

During the July 2021 virtual meetings, participants were asked what their needs were that other partners within the OCK network or the State-MCO implementation team could address to assure quality services are provided to members participating in the OCK program. The participants' responses and related key themes are described in Appendix A, Table A6 and A7. Those themes are summarized below (Tables 10 and 11).

Table 10. Needs to be Addressed Among OCK Partners, July 2021

- Peer learning and support
  - Peer mentoring
  - Conducting joint trainings
  - Sharing ideas and successes
- Making provider and community connections to identify resources.
  - Connections between CMHCs and FQHCs
  - Community business donations
  - Hospital discharge planners
  - Dental resources
  - Listserv for clinics to contact all the other participating FQHCs
  - Communication between partners sharing clients

OCK partners emphasized a need for continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges encountered and to improve quality of program efforts to achieve its goals. The partners showed their willingness to share contact information for their teams, to pair up with new and small programs to offer them advice and support related to program operations and resource sharing, and to offer joint training to their communities.

Table 11. Assistance Needed from the State/MCO Implementation Team, July 2021

- Information needed:
  - Each program's demographics
  - Contacts within OCK partners
  - Clarification on new federal Certified Community Behavioral Health Clinics initiative
  - Diagnosis/qualifying information on clients
  - Organizational data on trends in clinical outcomes, cost benefits, etc.
- Improvement in program processes and systems for member recruitment, engagement, discharge, and transition:
  - Add OCK flag and service start date to KMAP
  - Notification of member's OCK enrollment with another provider
  - Electronic system in place for easier access and transfers of the records
  - Improved process to remove from the roster the members who opt-out
  - Improved education of members and providers regarding opt-in process, including need for active participation in client invitation letter
  - Access to ER and hospital data for better follow-up and transition planning for members
  - Attention to organizational capacity of OCKPs
- State assistance needed to provide education about the program to hospitals, foster care agencies, and foster parents; and in locating children in the foster care system.
- Timely provision of audit results to implement changes; agreement on audit results; bypassing the subsequent audit depending on audit results
- MCO communications and systems
  - Regular meetings with MCOs and review of information on their provider portals
  - Consistency in MCOs' systems and improvement in timely communication by MCO staff

OCK partners discussed the assistance they needed from State and MCOs' teams to implement the program. They asked the State to provide information related to program processes and program outcomes. They also requested the State's assistance in improving program processes and systems for member recruitment, engagement, discharge, and transition. They asked for the State's assistance in reaching children in the foster care system and timely provision of audit results. OCK partners also asked the MCOs for regular communication and consistency between their systems.

OCK Partner Recommendations and Potential Next Steps for the OneCare Kansas Program:

During the July 2021 virtual meetings, OCK partners made the following recommendations and suggested potential next steps for the program.

- Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - To overcome the challenge of patients in rural areas who were dismissed from the clinic for non-compliance and were unable to access medical care, determine if patients are able to make an initial "meet" appointment with a specialist and have virtual appointments after that.
- OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.
  - Overall, OCKPs across the state indicated a desire to build their professional networks and provide mutual support outside of the formal opportunities offered by the KDHE-DHCF and WSU CEI. All partners recognized that this would take intentional time and effort that they sometimes feel they do not have due to staffing shortages and high workload, but many regions reported that this investment would be beneficial to their programs.
- Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
  - Discussion between MCO representatives and WSU CEI staff to develop a provider directory to be distributed across the network (not publicly).
  - OCK partners will utilize the directory to reach out to one another to establish local and regional opportunities for connection and information sharing to enhance professional relationships across the network. This may be through email or regularly scheduled virtual or in-person meetings.
- Improve program processes and systems.
  - OCKPs promote services within other programs to help boost their referrals as well.
  - KDHE-DHCF will continue to work with Gainwell Technologies to assure timely entry of information into the Kansas Medical Assistance Program (KMAP).
  - KDHE-DHCF and the MCOs will review opportunities to improve processes related to member invitations, program audits, notice of enrollment when there are multiple potential providers and the Health Action Plan portal.
- Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
  - OCKPs will reach out to local foster care contractors and child placing agencies to offer education about their local programs and the benefits to youth in foster care.
  - OCKPs will continue to develop connections with local hospitals and emergency departments.
  - KDHE-DHCF will continue to research the relationship between Certified Community Behavioral Health Clinics and OCK.
- Identify opportunities to obtain hospital data and provision of organizational data.
  - The State team will work to identify opportunities to obtain data from the hospital systems in Kansas.

- KDHE-DHCF opportunities to provide organizational level data for quality improvement efforts.

c. Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs

As mentioned in the Methodology section, the three MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects and an interim evaluation of Hypothesis 1 was not conducted. The evaluation of Hypothesis 1 will be conducted as part of the summative evaluation of KanCare 2.0.

d. Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities

As mentioned in the Methodology section, data for the Hypothesis 2 outcome measures are not currently available. Therefore, the interim evaluation of Hypothesis 2 was not conducted. The evaluation of Hypothesis 2 will be conducted as part of the summative evaluation of KanCare 2.0.

e. Hypothesis 3 – Use of Telehealth Services

Quantitative Evaluation

The quantitative outcome measures for the evaluation of KanCare 2.0 Hypothesis 3 components—use of telemedicine services and use of telemonitoring services—were examined for January 2018 through December 2021 for the interim evaluation.

Results of the Evaluation of Use of Telemedicine Services

The results of the evaluation of the outcome measures to assess the use of telemedicine services are summarized here. Detailed information, including denominator and numerator counts and statistical analysis results, is provided in Appendix B.

Measure 1: Percentage of telemedicine services received by the members living in the rural or semi-urban (Non-Urban) areas:

Table 12. Telemedicine Services Received by KanCare Member Location

Measure 1: Percentage of KanCare telemedicine services that were received by members living in rural or semi-urban areas (Non-Urban) of Kansas.

Geographic Group	Pre-KanCare 2.0	KanCare 2.0			Statistical Analysis: Percent Non-Urban	
	2018	2019	2020	2021	Comparison Periods	*p*-value
Non-Urban	24,034	26,844	355,386	251,844	2018 & 2019	*p*<.01
Urban	4,550	5,429	341,522	269,302	2019 & 2020	*p*<.001
Total	28,584	32,273	696,908	521,146	2020 & 2021	*p*<.001
Percent Non-Urban	84.08%	83.18%	50.99%	48.33%	Trend: 2019 to 2021	*p*<.001

Counts of telemedicine services were stratified by member's county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences in Non-Urban percentages between two years used a weighted Pearson chi-square test, and testing whether the slopes of the 3-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test (*p*<.05 was considered statistically significant).

The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members. This pattern was also seen for each age stratum except for Urban members aged 46 years or older. The considerably large increases from 2019 to 2020 corresponded to the onset of the COVID-19 public health emergency. Counts for Non-Urban and Urban members decreased from 2020 to 2021 but remained well above pre-public health emergency levels. The increases were relatively greater in Urban areas than Non-Urban areas. Consequently, the percentage of telemedicine services received by Non-Urban members decreased each year.

Subgroup Analyses:

The data and statistical results for subgroup analyses are shown in Appendix B, Tables B1–B3.

Stratification by Age (0–17 years, 18–45 years, and 46 years and older)

The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members for each age stratum except for Urban members aged 46 years or older. With regard to counts for Non-Urban and Urban members, a pattern similar to the overall measure was seen for each age stratum. The percentage of the telemedicine services received by Non-Urban members decreased each year, except for the increase from 2018 to 2019 for members aged 46 years or older.

Stratification of Primary Diagnosis Codes by ICD-10-CM Chapter

The chapter Mental, Behavioral and Neurodevelopmental Disorders (Codes F01–F99) had the highest ranking for Non-Urban members in both time periods. For 2018–2019, the number of claims with codes F01–F99 was over 60 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). In 2021, the number of claims was 17 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). The next five highest ranked chapters were the same in 2018–2019 as in 2021, but the rankings were slightly different. Similar patterns were seen for Urban members. (Appendix B, Table B2).

Table 13. Telemedicine Services Ranked by ICD-10 CM Diagnosis Chapter

Area of Member Residence: Non-Urban ICD-10-CM Chapter of Primary Diagnosis Code	**Code Range**	**2018+2019 Rank**	**2021 Rank**
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	2	2
Diseases of the Respiratory System	J00–J99	4	3
Diseases of the Nervous System	G00–G99	3	4
Factors Influencing Health Status and Contact with Health Services	E00–E89	6	5
Endocrine, Nutritional and Metabolic Diseases	Z00–Z99	5	6

Counts of telemedicine services were stratified by the ICD-10-CM chapter of the primary diagnosis code and by member's county of residence; Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. The six top ranked chapters for 2018–2019 and 2021 are shown in order of 2021 rank.

This area intentionally left blank

Stratification of Primary Diagnosis Codes by ICD-10-CM Block

The top four blocks of primary codes for Non-Urban members were the same in 2018–2019 and in 2021, although the rankings had changed. Each of the five blocks were from the Mental, Behavioral and Neurodevelopmental Disorders chapter. Mood [affective] disorders (Codes F30–F39) ranked first in both years. Mental and behavioral disorders due to psychoactive substance use (Codes F10–F19), which ranked 8th for 2018–2019, rose to 5th for 2021—displacing Mental disorders due to known physiological conditions (F01–F09). Similar patterns were seen for Urban areas. (Appendix B, Table B3).

Table 14. Telemedicine Services Ranked by ICD-10 CM Diagnosis Block

Area of Member Residence: Non-Urban ICD-10-CM Block of Primary Diagnosis Code	Code Range	2018+2019 Rank	2021 Rank
Mood [affective] disorders	F30–F39	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	4	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	3	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	8	5
Mental disorders due to known physiological conditions	F01–F09	5	16

Counts of telemedicine services were stratified by the ICD-10-CM chapter block of the primary diagnosis code and by member's county of residence; Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Blocks shown were in the top 5 ranked blocks for either 2018–2019 or 2021 and are shown in order of 2021 rank.

Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban (Non-Urban) areas:

Figure 2 shows the number of receiving sites, i.e., billing provider locations providing telehealth services to KanCare members. Stratification into Non-Urban and Urban areas was based on the member's county of residence.

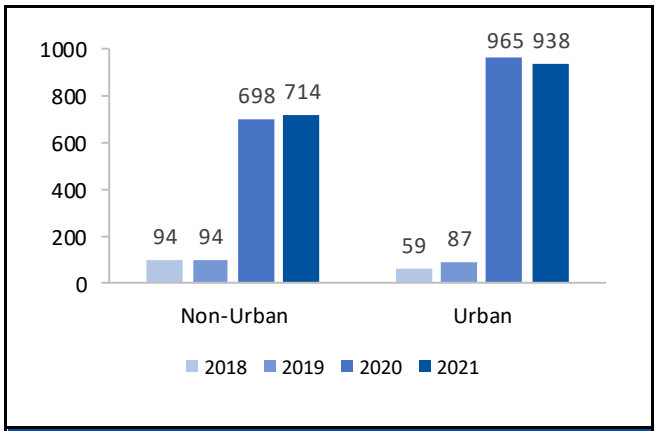


Figure 2. Receiving Sites for Telemedicine Services by KanCare Member Location

The number of receiving sites providing telemedicine services to Non-Urban KanCare members were relatively unchanged from 2018 to 2019, but increased considerably for 2020 and 2021, which were the initial years of the pandemic. The number of receiving sites providing telemedicine services to Urban KanCare members increased slightly between 2018 and 2019 and then increased considerably for 2020 and 2021.

Subgroup Analyses:

Stratification by Age (0–17 years, 18–45 years, and 46 years and older)

The data and statistical results for subgroup analyses by three age strata are shown in Appendix B, Table B4. The number of receiving sites providing telehealth services to Non-Urban and Urban members increased slightly from 2018 to 2019 for all age strata, except for Non-Urban members 46 years and older. The numbers increased considerably for all age strata for 2020 and 2021.

Measure *3: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services:*

The percentages of Non-Urban KanCare members who received telemedicine services increased from 2018 to 2019 and from 2019 to 2020. However, percentages decreased from 2020 to 2021 but remained well above pre-pandemic levels. Similar patterns were seen for Urban members. (Appendix B, Table B.5).

Table 15: KanCare Members Receiving Telemedicine Services

Measure 1: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services.

	Pre-KanCare 2.0	KanCare 2.0			Statistical Analysis	
	2018	2019	2020	2021	Comparison Periods	*p*-value
Non-Urban	3.94%	4.45%	24.73%	20.49%	2018 & 2019 2019 & 2020 2020 & 2021 Trend: 2019 to 2021	*p*<.001 *p*<.001 *p*<.001 *p*<.001

Non-Urban counties are all Kansas counties except Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte (Urban counties). Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing of the 2019–2021 trend line used a weighted Mantel-Haenszel chi-square test (*p*<.05 was considered statistically significant).

Subgroup Analyses:

Stratification by Age (0–17 years, 18–45 years, and 46 years and older)

Similar patterns were seen for the three age strata for Non-Urban members. Tests showed *p*<.001 except from 2018 to 2019 for members aged 45 or older (*p*=.02). (Appendix B, Table B.5).

Speech Therapy Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80*
- *Percentage of KanCare members with diagnosis in category F80 who received speech therapy*

The State approved a set of speech-language pathology or audiology codes for telemedicine delivery effective January 1, 2019.[25] Two new current procedural terminology (CPT) codes were added effective January 1, 2020. With the onset of the COVID-19 public health emergency, additional codes were authorized for telemedicine, including codes for diagnostic evaluations and HCBS procedures related to speech, language, and hearing. Services by speech-language pathologists (SLPs) and audiologists were tabulated from paid claims, and the percentages of those services provided via telemedicine were calculated. (Appendix B. Table B6.) Procedures related to speech and language billed by HCBS providers were also summarized. (Appendix B. Table B7.)

Measure 4

Very few services related to speech and language were provided by SLPs, audiologists, or HCBS providers in 2019. Services with the most paid claims in 2020 and 2021 were as follows (with counts of paid claims via telemedicine in 2020 and 2021, respectively, in parentheses):

- By speech-language pathologists and audiologists

  - 92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder (5,273 and 3,966)
  - 92526 – Treatment of swallowing dysfunction and/or oral function for feeding (658 and 446)
- By Home and Community Based Service providers
  - 97129 – Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (4,296 and 3,309)
  - 97130 – Therapeutic interventions that focus on cognitive function; each additional 15 minutes (4,022 and 3,141)
  - G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes (3,119 and 3,567)

The number of diagnostic evaluations performed via telemedicine was considered too small to address the hypothesis, "diagnostic evaluations via telemedicine would increase the number of members receiving diagnosis indicating services performed by SLPs and audiologists would be beneficial."

Based on Tables B6 and B7, procedure codes 92507 and G0153 were chosen for the next steps of the analysis. Although technically inaccurate, for this analysis *speech therapy* will refer to services billed with codes 92507 and G0153. The statewide utilization rate (i.e., the number of members who received speech therapy per 1,000 KanCare members) increased each year from 2018 to 2021. The statewide rate increases from 2018 to 2019 (from 5.34 to 6.56) suggest factors unrelated to telemedicine or the pandemic are impacting utilization; therefore the results of this analysis should be interpreted with caution. (Appendix B. Table B8.) Stratifying the count of paid services by billing provider type (e.g., therapist, hospital, HCBS provider) and by primary diagnosis showed differences between the Non-Urban and Urban areas. (Appendix B. Table B9.) Because these differences did not provide insight for answering the study question, discussion of these results are presented in Appendix B.

Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80

The most frequently used category of primary diagnoses on claims for speech therapy was F80, specific developmental disorders of speech and language. About two-thirds of the members receiving speech therapy had an F80 diagnosis. The statewide percentage of KanCare members receiving speech therapy who had a diagnosis in category F80 was relatively stable (61% in 2018, 2020, and 2021; 64% in 2019, corresponding to a bump in the Urban percentage). The Non-Urban percentages were about 4 percentage points below the Urban percentages, which may be related to differences in the billing provider strata observed in Table B9.

Measure 5

The Measure 5 rate for F80 diagnoses (the number of members diagnosed with an F80 category diagnosis per 1,000 KanCare members) is shown in Appendix B, Table B10. The rates for both areas alternately increased and decreased with a generally upward trend; the statewide rates for 2018 to 2021 were 17.6, 19.8, 18.0, and 20.3 members with F80 diagnosis per 1,000 KanCare members, respectively. Rates were greater for the Urban area. The dip in 2020 may be pandemic related.

Percentage of KanCare members with diagnosis in category F80 who received speech therapy

Table B10 also shows the percentages of Non-Urban members with a diagnosis in category F80 who received speech therapy were greater for 2020 (20.4%) and 2021 (19.7%) than for 2018 (17.1%) and 2019 (19.0%), which supports the hypothesis that telemedicine will enhance access to services such as speech therapy for KanCare members living in rural or semi-urban counties. Access to speech therapy services also appears to have been enhanced for Urban members (percentages from 2018 to 2021 were 17.7%, 20.3%, 23.7%, and 23.9%, respectively).

Telemedicine Services by Mental Health Providers – Background:

Telemedicine services were provided to KanCare members prior to KanCare 2.0. A KDHE provider bulletin lists 59 procedure codes approved for telemedicine as of January 1, 2018 (some codes had earlier approval dates).[26] The list included codes for services offered by mental health providers, such as, psychotherapies, psychiatric diagnostic evaluations, adaptive behavior treatments, office visits for evaluation and management (E&M), and medical consultations. With the onset of the pandemic, additional services were approved for telemedicine.

Measure 4: Number of Paid Claims with Selected Procedure Codes Billed by Mental Health Providers:

Telemedicine services commonly offered from 2019 to 2021 by mental health providers are summarized in Appendix B, Table B11. The table includes counts of paid claims by procedure code (Measure 4) and the number and percentage of those that were for telemedicine services. The following trends were observed in Table B11:

- Over 50% of services in 2020 were provided via telehealth for 30-minute psychotherapy sessions and evaluation and management (E&M) office visits for established patients (15-, 25-, and 40-minute sessions).
- The number of family and group psychotherapy sessions in 2020 and 2021 were below 2019 levels; the decreases are offset by increases in 30-minute psychotherapy sessions.
- The percentages decreased for most services from 2020 to 2021, which may indicate members' or providers' preference for face-to-face visits.
- Percentages increased from 2020 to 2021 for short E&M visits; psychiatric diagnostic evaluation with medical services; medical team conference with patient and/or family, and nonphysician health care professionals; and comprehensive management and care coordination for advanced illness. The increases could indicate members' and providers' experiences with telemedicine were positive.

Based on these and other analytic results, three areas were chosen for continued analysis: individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment.

Individual Psychotherapy Analysis:

- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy*

The number of members who received individual psychotherapy per 1,000 KanCare members for 2018 to 2021 is displayed in Appendix B, Table B12. The statewide rate increased from 2018 to 2019 (from 125.1 to 132.3), but statewide rates for 2020 (116.3) and (117.9) were lower than the 2018 level. The pattern was the same for Non-Urban and Urban rates.

Per 1,000 members, use of individual psychotherapy was greater in Non-Urban areas than Urban areas.

From 2018 to 2021, the average difference was 36.6 psychotherapy recipients per 1,000 KanCare members. The difference was lowest in 2020 (35.4 recipients per 1,000 KanCare members).

Individual psychotherapy is billed using CPT procedure codes (90832 through 90838). Coding depends on the length of the session and whether or not evaluation and management was included. To compare utilization between strata, hours of service was used as the unit of analysis instead of the number of claims. The number of hours was stratified by area and sub-stratified by mode of delivery, provider type, and primary diagnosis category. (Appendix B. Table B13.) Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas; Non-Urban's share was lower.
- The percentage of hours by telemedicine was slightly lower for Non-Urban members (37% for 2020 and 25% for 2021) than for Urban members (38% for 2020 and 32% for 2021).
- The percentages stratified by provider type and primary diagnosis varied slightly between years.
- Although fewer members received individual psychotherapy in 2020 than 2019 or 2021, the number of hours per person receiving psychotherapy was highest in 2021.

Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis

About two-thirds of claims for individual psychotherapy contained one or more diagnosis in the six diagnosis categories. (Appendix B. Table B14.) The six categories were chosen as the indicating diagnoses for the individual psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F40 – Phobic anxiety disorders
- F43 – Reaction to severe stress, and adjustment disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood

Measure 5

The numbers of members with an indicating diagnosis per 1,000 KanCare members were greater in Non-Urban areas than in Urban areas (e.g., 142.8 to 128.2 for 2020). These differences correspond to the Non-Urban areas having higher rates of members receiving individual psychotherapy (see Table B12).

The trend in the numbers of members with an indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the numbers of members who received individual psychotherapy per 1,000 KanCare—rates increased from 2018 to 2019, decreased in 2020, and increased again in 2021 but remained below the 2018 level. There are at least three likely factors.

- During the COVID-19 public health emergency, the State suspended disenrollment of members from KanCare under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 19, and women with coverage due to pregnancy were not disenrolled 60 days postpartum.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members' mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy

Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy slightly increased from 2018 to 2019 but declined for 2020 and 2021. The declines were greater in Non-Urban areas than Urban areas. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Family and Group Psychotherapy Analysis:

- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy*

Table B15 shows the number of members who received family or group psychotherapy per 1,000 KanCare members for 2018 to 2021. The statewide rate decreased each year from 2018 to 2021 (from 36.0 to 34.3, to 25.3, to 22.0). Per 1,000 members, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 4.2 recipients per 1,000 KanCare members. The difference was greatest in 2020 (4.5 recipients per 1,000 KanCare members).

For comparisons, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B16). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas. Non-Urban's share was slightly lower.
- The percentage of hours that were by telemedicine was lower for Non-Urban members (28% for 2020 and 18% for 2021) than for Urban areas (36% for 2020 and 32% for 2021).
- The Non-Urban area's use of telemedicine declined faster from 2020 to 2021 (10 percentage points) than the Urban area's did (4 percentage points).
- About 80% of family and group psychotherapy was provided by mental health providers and about 15% by "other providers" in Non-Urban areas from 2019 to 2021. In contrast, the Urban area's percentages were about 93% and 1%, respectively.

This area intentionally left blank

Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis

Analysis of primary and secondary diagnosis codes on paid claims identified five categories for which the percentage of members receiving family or group psychotherapy for whom there was a paid claim with at least one of diagnosis from the five categories was about 43%. (Appendix B. Table B17.) Those five diagnosis categories were chosen as the indicating diagnosis for the family and group psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood
- T74 – Adult and child abuse, neglect, and other maltreatment, confirmed
- T76 – Adult and child abuse, neglect, and other maltreatment, suspected

Measure 5

The prevalence rates, the number of members with an indicating diagnosis per 1,000 KanCare members, were considerably greater in Non-Urban areas than in Urban areas (e.g., 55.7 to 39.5 for 2020). These differences correspond to Non-Urban areas having higher rates of members receiving individual psychotherapy (see Table B15), but the difference is much wider.

The general trend in the rates of members with an indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received family or group psychotherapy per 1,000 KanCare members—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy

Percentages of KanCare members with an indicating diagnosis who received family or group psychotherapy slightly decreased each year, from 27% in 2018 to 19% in 2021 for Non-Urban areas and from 29% for 2018 to 21% for 2021 for Urban areas. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Community Psychiatric Supportive Treatment Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment*

Statewide, the number of members who received community psychiatric supportive treatment per 1,000 KanCare members was 47.8 in 2018, increased to 49.5 in 2019, decreased to 42.3 in 2020, and decreased again in 2021 to 40.9). Rates for Non-Urban and Urban areas did likewise. Per 1,000 member months, use of group and family psychotherapy was greater in Non-Urban areas than Urban areas. From

2018 to 2021, the difference increased each year (from 17.5 to 20.6 recipients per 1,000 KanCare members).

For comparisons, rates were calculated based on hours of service, stratified by Non-Urban and Urban area, and sub-stratified by mode of delivery, provider type, and primary diagnosis category. (Appendix B. Table B19.)

- There was roughly a 60 to 40 ratio of total hours of treatment between Non-Urban and Urban areas. The difference widened each year. The difference in hours of treatment per recipient also widened.
- The service was not approved for telehealth by KDHE until the public health emergency. In the Non-Urban area, the percent by telemedicine was 18.5% in 2020 but only 5.0% in 2021; the percentages for the Urban area were greater and had a smaller relative decrease (25.1% in 2020 and 12.1% in 2021).
- At least 99% of the hours of treatment were provided by mental health providers.

Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis

Five diagnosis categories were chosen as indicating diagnosis from among the categories with the highest ranked categories when ranked by the measure "percentage of claims for community psychiatric supportive treatment having a primary or secondary diagnosis in a given category." About three-fifths of claims for community psychiatric supportive treatment contained one or more diagnosis in the five categories. (Appendix B. Table B20.)

- F20 – Schizophrenia
- F25 – Schizoaffective disorders
- F34 – Persistent mood [affective] disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders

Measure 5

The numbers of members with an indicating diagnosis per 1,000 KanCare members were greater in Non-Urban areas than in Urban areas (e.g., 72.7 and to 58.9 in 2020). The rates were also greater in Non-Urban areas than Urban areas for individual psychotherapy and family and group psychotherapy (Appendix A. Tables B14 and B17.) The general trend in the rates from 2018 to 2021 follows a similar trend seen in the rates for two types of psychotherapy—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment

Percentages of KanCare members with an indicating diagnosis who received individual psychotherapy were about the same in 2018 and 2019 (36.6% and 36.7%, respectively), but in the last two years, decreased to 36.1% in 2020 and 35.1% in 2021. The pattern was the same for both areas. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does not mean telemedicine was not integral for members accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Results of the Evaluation of Use of Telemonitoring Services

The results of the evaluation of three outcome measures to assess the use of telemonitoring services are summarized here. Detailed information, including denominator and numerator counts and statistical results, is provided in the Appendix B.

Telemonitoring of KanCare members' health indicator data kicked off with the onset of the COVID-19 pandemic in 2020. (Table 16; Figure 3).

Table 16. KanCare Telemonitoring Service Utilization

Area of Member Residence	Measure 1: Percentage of members living in rural or semi-urban areas (Non-Urban) who received telemonitoring services.			Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas.		
	KanCare 2.0					
	2019	2020	2021	2019	2020	2021
Non-Urban	*	0.01%	0.02%	*	84	132
Urban	*	0.01%	0.04%	*	90	738

Non-Urban area was defined as all counties except Urban counties.
Urban area was defined as Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties.
*The number of members receiving telemonitoring services in 2019 was insufficient for analysis.

Measure 1: Percentage of members living in the rural and semi-urban areas who received telemonitoring services:

The percentage of Non-Urban and Urban members receiving telemonitoring services in 2019 was very low (less than 0.001%). However, the percentages of Non-Urban and Urban members who received telemonitoring services increased from 2019 to 2020 and 2021. Statistically significant increases from 2020 to 2021 for Non-Urban ($p<.01$) and Urban members ($p<.001$) occurred.

Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas:

In 2020 and 2021, the number of telemonitoring Services provided to Non-Urban and Urban members increased from 2019. Compared to 2020, the number of telemonitoring services provided in 2021 was 1.6 times higher for Non-Urban members and 8.2 times higher for Urban members.

Measure 3: Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services:

The number of billing and performing providers monitoring health indicator data transmitted to them by members receiving telemonitoring services in both Non-Urban and Urban areas of the state was small, however, the number roughly doubled from 2020 to 2021.

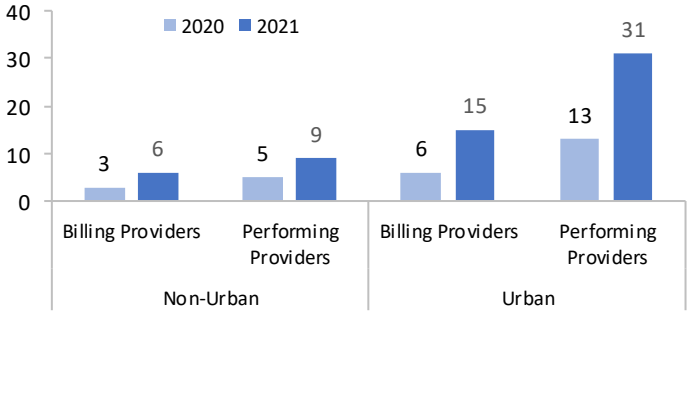


Figure 3. Providers Monitoring Health Indicator Data from Members Receiving Telemonitoring Services

Qualitative Evaluation

Results of the Evaluation of Use of Telementoring Services:

Project ECHO Sunflower Health Plan

The telementoring efforts implemented by Sunflower Health Plan's Project ECHO are summarized here. Detailed information on the goals and sessions of each series is provided in Appendix B, Tables B16, B17, and B18.

Table 17. Project ECHO Sunflower Health Plan

Year	ECHO Series Title	Number of Sessions	Average Number of Participants Per Session
2019	Fundamentals of Addiction Treatment	4	52
2020	Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities	4	41
	Social Determinants of Health	4	29
	Foster Care	4	43
	Cancer	4	21
	Behavioral Health	4	67
	Aging	4	36
	Preventative Health	4	38
2021	Behavioral Health and Addiction	4	52
	Preventative Care	4	18
	Care Coordination	6	28

From March 2019 through November 2021, eleven series comprised of forty-six sessions were conducted. Each series had four sessions, except the series for "Care Coordination" topic, which had six. The sessions were attended by staff from Centene (parent company of Sunflower Health Plan) and providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. The participants were from Non-Urban and Urban areas. On average, the four 2019 sessions had 52 participants. In 2020, the average number of participants per session ranged from 21 to 67. In 2021, the average number of participants per session ranged from 18 to 52.

An evaluation survey was conducted at the end of each session in the October-November 2021 Series titled "Care Coordination." The survey responses provide further insights on the effectiveness of the sessions' improving participant understanding of care coordination and knowledge on different care coordination supports related to unique needs of members, patients, and clients. The results are summarized in Table 18.

Table 18. Project ECHO Sunflower Health Plan October-November 2021 Series Survey

	Participants' Responses After Attending the Session		
Session Topic	Total Number of Survey Participants	Number of Participants Indicating Improvement in Understanding of Care Coordination	Number of Participants Indicating Improvement in Knowledge on Different Care Coordination Supports in Relation to Unique Needs of the Members/Patients/Clients
Week 1: Case Management Overview	17	10	11
Week 2: OneCare Kansas	12	8	10
Week 3: Behavioral Health	15	2	10
Week 4: Physical Health	5	5	5
Week 5: HCBS and Care Coordination	6	3	4
Week 6: Transitions to Employment	6	4	4

Insights were also gained with regard to the learning points from the sessions that survey participants indicated they will apply to their practice. Key themes based on their responses are as summarized in Figure 4.

Week 1: Case Management Overview	• Coordination of care and services for members • Case management and care coordination benefits managing member care and getting resources • Resources/ways to access more coordination • Networking and communication
Week 2: OneCare Kansas	• Information on benefits of OneCare Kansas program • Access to increased resources to assist members with services • Utilization of CMHCs for in-person help, and in coordination of medical services for members with dual diagnoses
Week 3: Behavioral Health	• Information on benefits of and resources available through Smart Start for Babies program for pregnant women • Referring pregnant women to Smart Start for Babies program for better outcomes • Several resources available for members
Week 4: Physical Health	• Information on benefits of coordinating behavioral health and medical care • Resources and services available for members
Week 5: HCBS and Care Coordination	• Importance of coordination with other agencies • Better understanding of final rule and KDADS expectations • Importance of communication
Week 6: Transition of Employment	• Continue member-centered work • Communications and giving choices • The dynamics that can occur with I/DD waiver and how to get other resources/departments involved

Figure 4. Project ECHO Sunflower Health Plan October-November 2021 Series Survey: Continuation Education Learning Points Applicable to Practice – Key Themes from Participants' Insights

KUMC Project ECHO® Series

The telementoring efforts implemented by the KUMC Project ECHO® Series titled "Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders" are summarized here. Detailed information on series sessions is provided in Appendix B, Tables B19-B22.

The series was conducted during April 2021 and was comprised of five sessions. A total of 383 attendees participated, with an average of 77 attendees per session. Through this ECHO series, 240 hours of Continuing Education (CE) Credit were awarded; on average, nearly 50 hours CE credit was claimed during each session. Out of 383 attendees, 240 attendees (63%) claimed CE credit. There were 212 unique registrants for the series. Out of these 212 registrants, 158 (75%) were target learners, including 33 physicians (21%), 49 advanced practice clinicians (31%), 42 nurses (27%), and 34 behavioral health providers (21%). Out of the 212 registrants, 172 (81%) were Kansas providers, whereas 40 registrants (19%) were from other states. The Kansas registrants were from both Non-Urban and Urban counties. Out of 172 Kansas registrants, 77 (45%) were from Non-Urban counties, and 95 (55%) were from Urban counties.

Attendees' knowledge was assessed through pre-test and post-test evaluations, and 46 attendees completed the evaluations. The post-test percentages for the correct response rates for three of the four evaluation items were improved.

About 89% of the attendees agreed that "complex care circumstances were mastered through case-based learning." The evaluation of three clinical practices for screening and treating SUDs was conducted at registration and again post-series to determine changes regrading screening for SUD, use of medication assisted treatment (MAT) waivers, and partnerships with local pharmacist related to opioid use disorder (OUD) care. The post-series improvement in the clinical practice change measure was seen for two practices (use of MAT waivers, and partnerships with local pharmacist related to OUD care). The pre- and post-ECHO series assessment of self-efficacy measures were evaluated. Respondents were asked about their confidence in their ability to employ SUD screening tools in the clinical setting, locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examine various harm reduction strategies and their role in disease treatment. The post-ECHO series evaluation results showed all four self-efficacy measurements were improved. At the end of the series, attendees were asked if they had made, or planned on making, changes based on what they learned in the series; 79% of them responded "yes."

Key points from attendee feedback provided by 46 attendees are summarized below:

- 98% agreed or strongly agreed that they gained helpful knowledge from the ECHO series (n=45).
- 91% estimate their confidence level using this new information to better treat patients at 50% to 100% (n=42).
- 89% agreed or strongly agreed that they obtained helpful skills and techniques to improve professional practice (n=41).
- 80% estimated 50% to 100% of information was new (n=37).
- 74% agreed and strongly agreed that ECHO's interactive format was more effective than standard webinars (n=34).

The continuing education evaluation was also conducted at the end of each session. The results, summarized below, are based on the responses provided by the attendees who claimed CE credit:

- Across all five sessions, more than 76% of respondents reported their level of achievement to be good or outstanding regarding the employment of SUD screening tools in the clinical setting, locating and utilizing state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examining various harm reduction strategies and their role in disease treatment.
- Across all five sessions, 43.9% to 63.4% of respondents indicated they will use the information to improve their current patient safety practices; however, only 14.6% to 34.3% indicated they will use the information to validate their current patient safety practices. Only 6.7% to 17.1% indicated they will use the information to improve their current medical error prevention and analysis practices, and 0.0% to 11.4% indicated they will use the information to validate their current medical error prevention and analysis practices. With regard to current risk management practices, 19.5% to 34.9% indicated they will use the information to improve these practices, and 4.9% to 17.1% indicated they will use the information to validate these practices.
- Across all five sessions, more than 80% of respondents rated their level of agreement as "*somewhat agree*" or "*strongly agree*" when asked about the positive affect on their ability to be a part of team, and they learned information that they could share with their team to improve outcomes.

Telehealth Provider Survey Results

The Telehealth Provider Survey was conducted from August 18, 2022, to September 12, 2022, with seventy-three providers responses from Urban and Non-Urban counties. Summary results are below.

Types of Healthcare Services Provided by the Survey Respondents:

The majority of the survey respondents (46 providers) indicated they provide behavioral health care (31 mental health care providers and fifteen providers providing both mental health care and substance use disorder health care). Thirteen respondents noted providing primary health care, three noted specialty health care, and one noted HCBS. Nine respondents noted providing other types of healthcare services, including urgent care (3), speech language pathologist (1), physical therapy services to provide wheelchair evaluation (1), occupation therapy (1), outpatient pediatric occupation therapy (1), applied behavior analysis (1), and long term and skilled care (1). Figure 5.

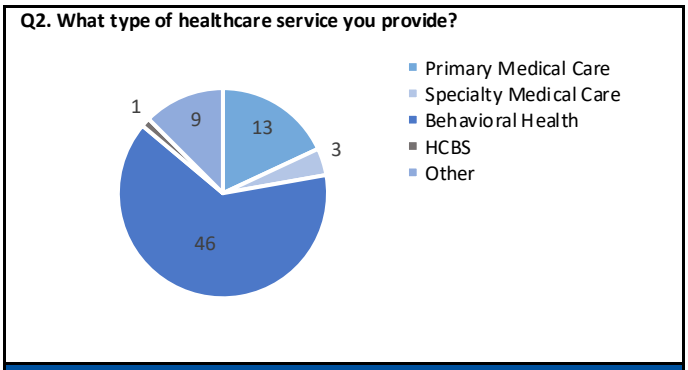


Figure 5. Type of Healthcare Services Provided – 2022

Out of seventy-three respondents, seventy-one noted they provide telehealth services to KanCare members; one respondent noted providing telehealth services but was not sure if providing to KanCare members; and one respondent was not providing these services due to difficulty to connect or having audio and video issues.

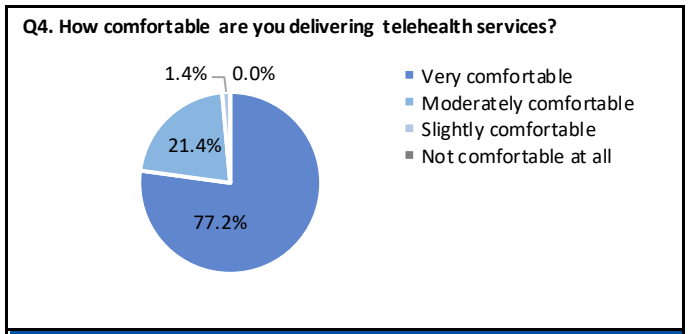


Figure 6. Providers' Comfortability with Delivering Telehealth Services – 2022

Providers' Comfortability with Delivering Telehealth Services:

Out of seventy survey respondents, the majority noted being *"very comfortable"* or *"moderately comfortable"* delivering telehealth services (77.2% and 21.4%, respectively). Figure 6.

Engagement of Clients/Patients and Progress on Their Treatment Goals Using Telehealth Visits as in Using Face-to-Face Visits:

Survey respondents were asked to mark their agreement level with the statement: *"My clients/patients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits."* (Q.5). Out of sixty-eight respondents, the majority *"strongly agree"* or *"agree"* with the statement (32.4% and 45.6%, respectively). Figure 7.

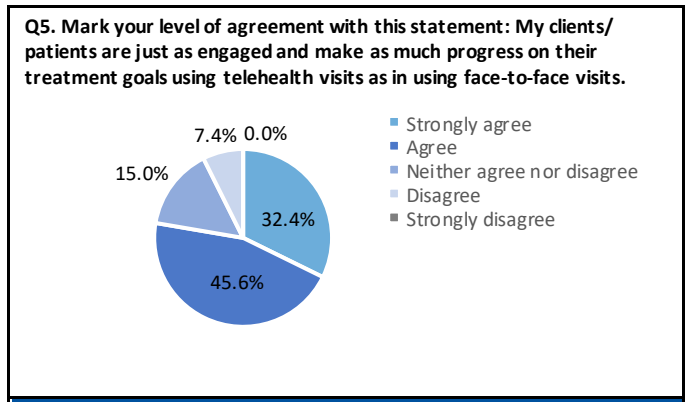


Figure 7. Engagement of Clients/Patients and Progress on Their Treatment Goals Using Telehealth Visits – 2022

Effectiveness of Services Delivered by Telehealth:

Survey respondents were asked whether the services delivered by telehealth were as effective as the same services they deliver in-person (Q6). Sixty-eight providers responded, with the majority of them noting effectiveness of the services delivered by telehealth was "*about the same*" as in-person (63.2%). Another 23.5% noted services delivered by telehealth were "*somewhat less effective*" than services delivered in-person. Figure 8.

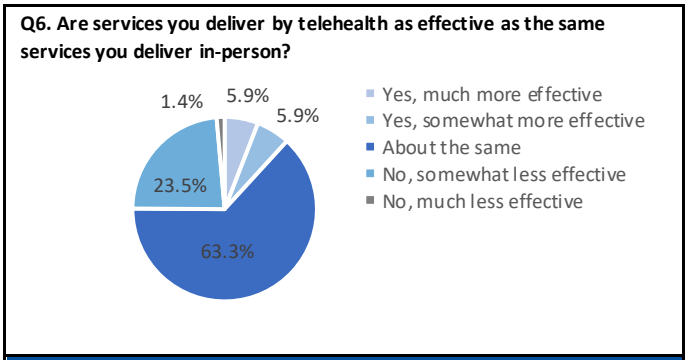


Figure 8. Effectiveness of Services Delivered by Telehealth – 2022

Telehealth Leading to an Improvement in the Overall Quality of Services Provided:

Survey respondents were asked whether telehealth had improved the overall quality of the services provided (Q7). Sixty-eight providers responded to the question. Results were mixed. About 59% of the respondents answered *"yes, much improved"* or *"yes, somewhat improved"* (35.3% and 23.5%, respectively). However, another 33.8% noted it as *"about the same"*, and 7.4% marked "*no, somewhat worse*."

Opinions Regarding Telehealth Services:

Survey respondents were asked to indicate their opinions regarding nine items related to telehealth services (Q8). For each item, respondents were asked to mark their opinion as "*strongly agree*," "*agree*," "*neither agree nor disagree*," "*disagree*," or "*strongly disagree*." The results are summarized in Table 19.

Table 19. Opinions Regarding Telehealth Services – Telehealth Provider Survey, 2022

Q8. Please indicate your opinions regarding telehealth services

Item Related to Telehealth Services		Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree
	N	% (n)	% (n)	% (n)	% (n)	% (n)
Telehealth has improved access to care for KanCare members.	64	71.9% (46)	26.6% (17)	1.5% (1)	0.0% (0)	0.0% (0)
Telehealth expands my ability to see clients/patients over a greater geographic distance.	64	75.0% (48)	17.2% (11)	7.8% (5)	0.0% (0)	0.0% (0)
Telehealth increases my ability to see more clients/ patients.	64	46.8% (30)	21.9% (14)	21.9% (14)	7.8% (5)	1.6% (1)
Telehealth fills an essential practitioner gap in my organization.	62	29.0% (18)	29.0% (18)	38.7% (24)	3.3% (2)	0.0% (0)
Telehealth improves workflow efficiencies in my practice.	63	33.3% (21)	33.3% (21)	23.9% (15)	7.9% (5)	1.6% (1)
Use of telehealth improves quality of care for clients/ patients.	64	32.8% (21)	29.6% (19)	21.9% (14)	14.1% (9)	1.6% (1)
Telehealth decreases profitability/revenue.	64	1.6% (1)	6.1% (4)	42.3% (27)	32.8% (21)	17.2% (11)
Telehealth provides competitive advantage over other organizations in my region.	64	14.1% (9)	32.8% (21)	48.4% (31)	1.6% (1)	3.1% (2)
Telehealth is important to the success of my organization.	64	34.4% (22)	53.1% (34)	10.9% (7)	1.6% (1)	0.0% (0)

More than 86% of the respondents "*strongly agree*" or "*agree*" that telehealth has improved access to care for KanCare members, expands their ability to see clients/patients over a greater geographic distance, and is important to the success of their organization. About two-thirds of the respondents "*strongly agree*" or "*agree*" that telehealth increases their ability to see more clients/ patients, fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and use of telehealth improves quality of care for clients/patients.

About half of the respondents indicated they "*strongly agree*" or "*agree*", whereas other half of them indicated they "*neither agree nor disagree*" that telehealth provides competitive advantage over other organizations in my region. The half of the respondents "*strongly disagree*" or "*disagree*", whereas slightly less than half of them indicated they "*neither agree nor disagree*" that telehealth decreases profitability/revenue.

Barriers to Providing Telehealth Services:

Survey respondents were asked about the barriers to providing telehealth services (Q9). Sixty-eight providers responded to the question. The results for this question are described in Table 20. Key points are summarized below.

- About 27% of the respondents noted no barriers to providing telehealth services.
- The following four barriers were selected by most of the providers:
  - *"Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)"* – selected by about 45% of the respondents.
  - *"Lack of client familiarity or comfort with using telehealth services"* – selected by about one-third (33.3%) of the respondents.
  - "*Lack of reliable internet for providers*" – selected by one in four (23.3%) respondents.
  - *"Do not consider telehealth services as effective as in-person services"* – selected by nearly one in five (21.7%) respondents.

Table 20. Barriers to Providing Telehealth Services – Telehealth Provider Survey, 2022

Q9. What are the barriers to providing telehealth services? (Mark all that apply)

Barriers	Responses	
	n	%
No barriers	16	26.7
Security/confidentiality of HIPAA compliance	6	10.0
Do not consider telehealth services as effective as in-person services	13	21.7
Lack of staff to implement telehealth services	4	6.7
Lack of training or education regarding telehealth services	7	11.7
Level of guidance available from payor of services	4	6.7
Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)	27	45.0
Lack of reliable internet for providers	14	23.3
Lack of staff familiarity or comfort with providing telehealth services	2	3.3
Lack of client familiarity or comfort with using telehealth services	20	33.3
Cost of starting telehealth services	0	0.0
Cost of maintaining telehealth services	3	5.0
Payor covers too few services	11	18.3
Other	6	10.0

Three Most Important Barriers:

When asked to select up to three from the list of barriers they selected in response to Q9 of the survey, providers listed following three barriers as most important to them (Q10):

- *"Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access)"* – listed by more than half of the respondents (55.8%). This barrier was also selected by most of the providers in response to Q9.
- *"Lack of client familiarity or comfort with using telehealth services"* – listed by about one-third (34.9%) of the respondents. This barrier was also selected by the second highest number of providers in response to Q9.
- *"Do not consider telehealth services as effective as in-person services"* – listed by about one-fifth (23.3%) of the respondents. This barrier was also selected by the fourth highest number of providers in response to Q9. It should be noted that this is consistent with the results seen for the question (Q6) asking whether the services delivered by telehealth as effective as the same services they deliver in-person (24.9% responded as "*somewhat less effective" or "much less effective")*.

Ideas to Improve Telehealth Services for KanCare Members

Providers were asked to provide recommendations for removing barriers to increase the use of these services and improve access to care among KanCare members (Q11). Thirty-four providers responded to this question. An overview of survey responses and key themes is described in Table C.14. The key similar and dissimilar themes are summarized below.

Several similar responses were provided by respondents that are summarized into eight key themes (Figure 9). However, three survey respondents provided specific comments related to use telehealth, that were dissimilar to those provided by rest of the respondents to this survey question. These comments are summarized into four key themes (Figure 10).

This area intentionally left blank

Provide consistency in application of rules and systems.
- Use of the same forms by all entities involved.
- Specify required in-person visits.
- Providers should not have to use specific platforms for each MCO.
- Providers should be able to utilize their selected HIPAA compliant platform for telehealth.

Increase reimbursement rate for telehealth services.
- Offer same reimbursement rate for telehealth services as in person services.
- Increase in reimbursement rates to make telehealth use cost-effective and for its increased use.
- Offer greater reimbursement to companies who participate in telehealth due to convenience of telehealth capabilities.

Increase and improve technology and resources for the members and providers.
- Ensure availability of reliable high speed internet technology for all members, especially in medically underserved and rural areas.
- Provide better technical resources and system capabilities for members and providers, such as devices, bigger screens, better audio, capability for providers to use audiovisual platforms of patients' choice.
- Members' access to mobile apps for monitoring of mood symptoms or electronic journals that they could electronically send to providers.
- Government phones with limited minutes or access to applications inhibits progress with care. Better devices should be provided to members.
- Giving information to members on how to apply for waivers/grants if they don't have access to internet or for free/reduced cost cell phone plans.

Ensure opportunities for telehealth services are available for all members.
- Access to telehealth as part of comprehensive health services for the member with the decision to use telehealth services being based on the provider's clinical judgment and the member.
- Provide more opportunities for telehealth services from school.

***Provide* trainings for providers.**
- Trainings with easy to understand terms and language for billing staff, leadership staff, and all providers.
- Provide trainings in user-friendly format that is easily accessible and easy to find on self-paced courses.
- Leadership buy-in to accommodate time for providers' trainings.
- Availability of trainings on a variety of specific situations providers deal with.
- Availability of credible subject matter experts to respond to the provider's exact situation to see if correct billing codes are applied.
- Provide easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational question
- Training on appropriate attitude and rules for telehealth appointments.

Continued coverage by insurance companies.

Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.

Telehealth is a valuable source for members and providers.
- Great resource for members.
- No recommendations for improving it.
- Telehealth services are needed for provision of behavioral health care services.

Figure 9. Ideas to Improve Telehealth Services for KanCare Members – Key Themes Summarized from the Similar Responses Provided by the Survey Respondents

Only one or few specific and dedicated therapists covering that service for organizations. However, there will be a gap in services if assigned provider leaves the organization.

Telehealth services should be used when in-person services cannot be provided.

Telehealth is not appropriate for clients with certain conditions such as speech and language disorders.

Parents do not want to bring their child for an in-person visit when telehealth services are available.

Figure 10. Ideas to Improve Telehealth Services for KanCare Members – Key Themes Summarized from the Dissimilar Responses Provided by the Survey Respondents

Telehealth Service Visits Usage Among KanCare Members in the Future:

Providers were asked whether they anticipate the number of telehealth visits they provide to KanCare members will increase or decrease in future (Q12). Sixty-two providers responded to this question. Half of them (50%) noted number will "Increase somewhat", and slightly more than one-third of the respondents noted it will "stay the same". Figure 11.

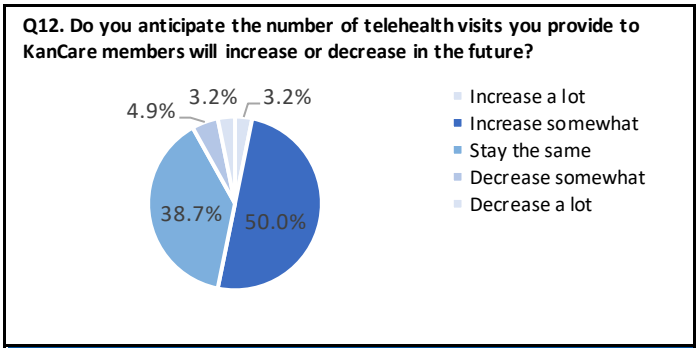


Figure 11. Telehealth Service Visits Usage Among KanCare Members in the Future – 2022

f. Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with Substance Use Disorders

As per a recommendation from, KanCare 2.0 Hypothesis 4 evaluation results are included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

g. Monitoring of the Overall KanCare 2.0 Performance Measures

Quantitative Evaluation

Overall KanCare 2.0 performance measures were examined, and the results are summarized here.

HEDIS Measures

Prenatal and Postpartum Care (PPC):

- 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 between 7 and 84 days after delivery.

This measure tracked PPC rates among the combined Medicaid and CHIP population. The KanCare PPC rates were weighted averages of MCO hybrid rates, weighted by administrative denominator. The goal for the PPC measure is to have higher rates and rankings. The rates from measurement years 2019 and 2020 were examined here. The results for this measure are described in Table 21.

Timeliness of Prenatal Care

The Timeliness of Prenatal Care rate declined 4.2 percentage points, from 84.3% for 2019 to 80.1% for 2020. The decline was statistically significant (p=.01). The rates in both years were below the 33.33rd percentile.

Postpartum Care

The Postpartum Care rates increased 8.9 percentage points, from 67.0% for 2019 to 76.0% for 2020, which was statistically significant (p<.001). The ranking increased from <25th to <50th.

Table 21. HEDIS Measure – Prenatal and Postpartum Care (PPC), MY 2019–2020						
Measure	**MY 2019**		**MY 2020**		**Change**	***p*-value**
Prenatal and Postpartum Care (PPC)	**Rate**	**Rank**	**Rate**	**Rank**	Percentage Points	2019 & 2020
Timeliness of Prenatal Care	84.28%	<33.33rd	80.06%	<33.33rd	- 4.2 pp	p=.01
Postpartum Care	67.04%	<25th	75.96%	<50th	+ 8.9 pp	*p*<.001
Note: The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test (*p*<.05 was considered statistically significant). Rank indicates Quality Compass ranking for the rate.						

Comprehensive Diabetes Care:

The comprehensive diabetes care measures were reorganized by NCQA since the KanCare 2.0 Evaluation Design was written. Three indicators were discontinued: Medical Attention for Nephropathy, HbA1C Testing, and HbA1c Control (<7.0%). The remaining four indictors were separated into three independent measures.

The following measures are percentages of members 18–75 years of age with diabetes (types 1 and 2).

- Hemoglobin A1c Control for Patients with Diabetes (HBD) – Percentage whose hemoglobin A1c (HbA1c) was at the following levels:
  - HbA1c Control (<8.0%)
  - Poor Control HbA1c (>9.0%)
- Eye Exam Performed for Patients with Diabetes (EED) – Percentage who had a retinal eye exam
- Blood Pressure Control for Patients with Diabetes (BPD) – Percentage whose blood pressure was adequately controlled (<140/90 mm Hg)

The goal for three comprehensive diabetes care indicators—HbA1c Control, Eye Exam Performed for Patients with Diabetes, and Blood Pressure Control for Patients with Diabetes—is to have higher rates and rankings. The goal for Poor Control HbA1c is to have a low rate and high ranking. The rates from measurement years 2018 to 2020 were examined for these four indicators of the CDC measure. There was a break in trending between 2019 and 2020 for the Blood Pressure Control for Patients with Diabetes indicator. Since only one data point was available, the indicator was not assessed for the interim evaluation. In addition to comparison of rates to the prior year's rate for 2018 to 2020, a Mantel-Haenszel chi-square test was used to determine if the slope of the five-year trend line (MY 2016–2020) was statistically significantly different from horizontal. These results are described in Table 22.

For 2018 to 2020, changes in rates from prior years were not statistically significant except for one case: the Eye Exam Performed for Patients with Diabetes (EED) rate decreased significantly from 2018 (64.8%) to 2019 (62.9%). From 2016 to 2020, the EED rate decreased an average 0.5 percentage points per year, which was statistically significant.

The Quality Compass rankings increased to >75th for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

This area intentionally left blank

Table 22. HEDIS Measures – Comprehensive Diabetes Care, MY 2018–2020

Measure	MY 2018		MY 2019		MY 2020		Statistic	
Comprehensive Diabetes Care	**Rate**	**Rank**	**Rate**	**Rank**	**Rate**	**Rank**	**Period**	***p*-value**
Hemoglobin A1c Control for Patients with Diabetes (HBD)							2018 & 2019	*p*=.33
							2019 & 2020	*p*=.62
HbA1c Control (<8.0%)	54.94%	>66.67th	53.23%	≥50th	53.91%	>75th	2016 to 2020	*p*=.21
							2018 & 2019	*p*=.19
Poor Control HbA1c (>9.0%)	36.79%	≥50th	39.01%	<50th	36.64%	>75th	2019 & 2020	*p*=.31
							2016 to 2020	*p*=.12
Eye Exam for Patients with Diabetes (EED)	64.80%	>75th	62.89%	>66.67th	61.53%	>75th	2018 & 2019	*p*<.001
							2019 & 2020	*p*=.46
							2016 to 2020	*p*<.01

Note: The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing whether the slopes of the 5-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test (*p*<.05 was considered statistically significant). Rank indicates Quality Compass ranking for the rate.

Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8.0%)

As mentioned above, the goal for this indicator was to see higher rates and ranks. No statistically significant change was seen in the rates for HbA1c Control (<8.0%) indicator from 2018 to 2019, and from 2019 to 20220 (MY 2018 rate: 54.94%, My 2019 rate: 53.23%, MY 2020 rate: 53.91%). A decline in rank was seen from 2018 to 2019 (>66.67th percentile vs. ≥50th percentile), however, an improvement was seen in MY 2020 to >75th percentile from >50th percentile in MY 2019. No statistically significant change was seen in the five-year trend from 2016 to 2020 for this indicator (*p*=.21).

Hemoglobin A1c Control for Patients with Diabetes: Poor Control HbA1c (>9.0%)

As mentioned above, the goal for this indicator was to see lower rates and higher ranks. No statistically significant change was seen in the rates for the Poor Control HbA1c (>9.0%) indicator from 2018 to 2019, and from 2019 to 2020 (MY 2018 rate: 36.79%, MY 2019 rate: 39.01%, MY 2020 rate: 36.64%). A decline in rank was seen from 2018 to 2019 (≥50th percentile to <50th percentile), however, it increased in CY 2020 to >75th percentile, showing improvement in the indicator ranking status. No statistically significant change was seen in the five-year trend from 2016 to 2020 for this indicator (*p*=.12).

Eye Exam Performed for Patients with Diabetes

As mentioned above, the goal for this indicator was to see higher rates and ranks. A statistically significant decline was seen in the rate for Eye Exam Performed for the Patients with Diabetes indicator of the CDC measure from 2018 to 2019 (MY 2018 rate: 64.80%, MY 2019 rate: 62.89%; *p*<.001), whereas no significant difference was seen in 2019 and 2020 rates (MY 2020 rate: 61.53%). A decline in rank was seen from 2018 to 2019 (>75th percentile vs. 66.67th percentile), however, it increased in MY 2020 to >75th percentile. A statistically significant decreasing (worsening) trend from 2016 to 2020 was seen for this indicator (*p*<.01), on average, the rate for the indicator worsened at 0.5 percentage points per year (Figure 12).

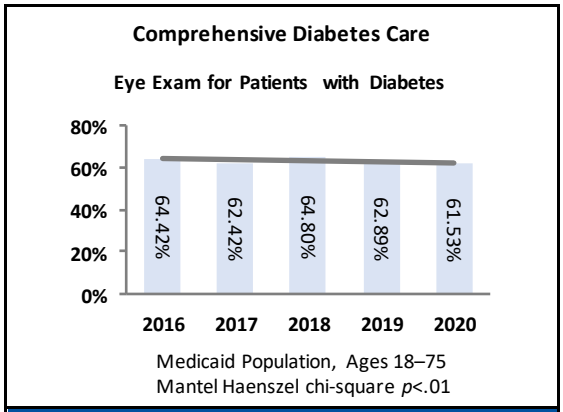


Figure 12. HEDIS Eye Exam for Patients with Diabetes, MY 2016–2020 Trend

CAHPS Survey Measures

Smoking and Tobacco Cessation:

HEDIS Measure – Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure included following indicators.

- Advising Smokers and Tobacco Users to Quit – Percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the prior six months
- Discussing Cessation Medications – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medication in the prior six months
- Discussing Cessation Strategies – Percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided cessation methods or strategies in the prior six months.

The goal for Smoking and Tobacco Usage is to have lower rates and rankings. For the MSC indicators, higher rates and rankings are preferred. Slightly less than a third of KanCare adults were smokers or tobacco users in the three-year period. No statistically significant decline in rates was seen from 2019 to 2020 and from 2020 to 2021. From 2019 to 2020, KanCare rates were near the 50th percentile (ranking <50th or ≥50th) for each MSC indicator, but rankings for Advising Smokers and Tobacco Users to Quit and Discussing Cessation Strategies both dropped to <33.33rd for 2021. The rank for Discussing Cessation Medications remained <50th.

Advising Smokers and Tobacco Users to Quit

After being stable for two years, the statistically significant decrease in percentage advised to quit suggests a need for improvement. While the rate had been as high as 78.8% (in 2020), it is now 72% and ranked <33.33rd.

Discussing Cessation Medications

The KanCare adult rates for discussing cessation medications did not show any significant improvement from 2019 to 2020 and from 2020 to 2021. About 50% of the members reported their doctor or health provider discussed or recommended medication to assist them with quitting or using tobacco, and the rank remained in the <50th percentile in each of the three years (2019, 2020 and 2021).

Discussing Cessation Strategies

In 2021, about 44% (<33.33rd) of KanCare adults who smoked cigarettes or used tobacco reported a doctor or other health provider discussed or provided methods and strategies other than medication to assist them with quitting smoking or tobacco use—a 4.5 percentage point decrease from 2020.

This area intentionally left blank

Table 23. Smoking and Tobacco Cessation Among Adult KanCare Members – 2019–2021

Adult HEDIS Measure: Medical Assistance with Smoking and Tobacco Use Cessation (MSC)	2019		2020		2021		Statistic	
	Percent	Rank	Percent	Rank	Percent	Rank	Period	*p*-value
Total % Current Smokers *(lower is better)*	31.8%	≥50th	30.0%	≥50th	30.3%	≥50th	2019 & 2020 2020 & 2021	*p*=.41 *p*=.90
Advising Smokers to Quit *("Always", "Usually", or "Sometimes")*	76.1%	<50th	78.8%	≥50th	72.0%	<33.33rd	2019 & 2020 2020 & 2021	*p*=.44 *p*=.04
Discussing Cessation Medications *("Always", "Usually", or "Sometimes")*	53.4%	<50th	54.1%	<50th	52.5%	<50th	2019 & 2020 2020 & 2021	*p*=.87 *p*=.68
Discussing Cessation Strategies *("Always", "Usually", or "Sometimes")*	46.1%	<50th	48.6%	≥50th	44.1%	<33.33rd	2019 & 2020 2020 & 2021	*p*=.54 *p*=.25

Note: The KanCare rate represents the combined percentage of MCO adult populations, weighted by MCO. Rates are annual rates and not 2-year rolling averages. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test (*p*<.05 considered statistically significant). Rank indicates Quality Compass ranking for the rate.

NCI Survey Measures

Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability (I/DD) Waiver Service:

Six measures were examined to assess the aspect of social and community engagement among the Medicaid eligible members, 18 years and older, who received at least one Intellectual/Developmental Disability (I/DD) waiver service and participated in the Kansas NCI surveys.

Table 24. Social and Community Engagement Among Adult KanCare Members Receiving At Least One Intellectual/Developmental Disability Waiver Service [Kansas NCI Survey Measures]

Measure	2016-2017		2017-2018		2018-2019		Statistic
	N	Percent	N	Percent	N	Percent	*p*-value
Can see and communicate with their family when they want (if not living with family)	196	82%	186	82%	195	82%	*p*>.99
Has friends (may be staff or family) and can see them when wants	262	83%	236	78%	244	78%	*p*=.28
Able to go out and do the things they like to do in the community as often as they want	253	81%	249	79%	245	85%	*p*=.24
Services and Supports help person live a good life	265	90%	264	91%	262	92%	*p*=.69
Decides or has input in deciding how to spend free time	384	91%	375	93%	393	89%	*p*=.15
Decides or has input in deciding daily schedule	385	83%	374	85%	387	84%	*p*=.77

Note: 2019-20 Survey: *"The 2019-2020 in-person surveys ended early due to COVID19; all data collection was halted on April 15, 2020. Very few states had completed data collection by that date. For this reason, NCI decided not to publicly report these data."* 2019-2020 National Core Indicators At-A-Glance Report (ncilegacy.com) (Accessed 03/24/2022)
Testing for independence of year used a chi-square test (*p*<.05 considered statistically significant).

- The percentages for four out of six measures were above 80% in all three years. The percentages of the measure assessing members' ability to go out and do things they like to in the community as often as they want were above 80% for two years. The percentages for the measure assessing members' ability to see friends when they want were less than 80% in recent two years. Can see and communicate with their family when they want (if not living with family)
  - In each of the three years, 82% of members reported they can see and communicate with their family when they want (if not living with family).
- Has friends (may be staff or family) and can see them when wants
  - In the 2017-18 and 2018-19 surveys, 78% of members reported they have friends (may be staff or family) and can see them when they want, which was a decline of 5 percentage points from 2016-17. However, this decline was not statistically significant.

- Able to go out and do the things they like to do in the community as often as they want
  - In 2017-18, 79% of members reported they were able to go out and do the things they like to do in the community as often as they want, showing a decline of 2 percentage points from 2016-17. However, compared to 2017-18, an increase by 6 percentage points was seen in 2018-19 with 85% of the members reporting they were able to go out and do the things they like to do in the community as often as they want. However, this increase was not statistically significant.
- Services and Supports help person live a good life
  - The percentages of members reporting services and supports help them in living a good life were 90% or higher in all three survey years and showed increases of one percentage point from 2016-17 to 2017-18 and from 2017-18 to 2018-19. The increase was not statistically significant.
- Decides or has input in deciding how to spend free time
  - The percentage of members reporting they decide or have input in deciding how to spend free time increased from 91% in 2016-17 to 93% in 2017-18 showing an increase of two percentage points. However, in 2018-19, a decline of four percentage points was seen compared to 2017-18 with 89% reporting they decide or have input in deciding how to spend free time. The decline was not statistically significant.
- Decides or has input in deciding daily schedule
  - The percentage of members reporting they decide or have input in deciding daily schedule increased from 83% in 2016-17 to 85% in 2017-18 showing an increase of two percentage points. However, in 2018-19, a slight decline of one percentage point was seen compared to 2017-18. The decline was not statistically significant.

NCI-AD Survey Measures

Social and Community Engagement Among Adults and Seniors Participating in the Frail Elderly (FE), Physical Disability (PD) and Brain Injury (BI) Waiver Programs to Receive LTSS

Six measures were examined to assess the aspect of social and community engagement among adults and seniors, Medicaid eligible, participating in the FE, PD and BI waiver programs to receive LTSS.

The percentages for three out of six measures were above 90% in both years. The percentage of the measure assessing members' ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in the recent year. The percentages for the measure assessing members' ability to do things they enjoy outside of home as much as they want remained 73% in both years. The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

Table 25. Social and Community Engagement Among Adults and Seniors Participating in the FE, PD, and BI Waiver Programs to Receive LTSS [Kansas NCI-AD Survey Measures]

Measure	2018-2019		2019-2020		Statistic
	N	Percent	N	Percent	*p*-value
Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)	342	91%	238	87%	*p*=.13
Percentage of people who are able to do things they enjoy outside of home as much as they want to	344	73%	247	73%	*p*>.99
Percentage of people whose services help them live a better life	357	90%	226	97%	*p*<.01
Percentage of people who like how they spend their time during the day	349	64%	249	53%	*p*<.01
Proportion of people who get up and go to bed when they want to	353	96%	254	96%	*p*>.99
Percentage of people who can eat their meals when they want to	356	94%	255	92%	*p*=.41

Note: Percentages reported are "State Average" for all three populations included in the survey.
Testing for significance of differences between years used a Fisher's exact test (*p*<.05 considered statistically significant).

- Percentage of people who are always able to see or talk to friends and family when they want to (if have friends and family who do not live with person)
  - In 2019-20, 87% of members reported they were always able to see or talk to friends and family when they want to (if have friends and family who do not live with person), a decline of 4 percentage points compared to 2018-19. However, the decline was not statistically significant.
- Percentage of people who are able to do things they enjoy outside of home as much as they want to
  - No change was seen in the two years with 73% of members reporting they were able to do things they enjoy outside of home as much as they want to.
- Percentage of people whose services help them live a better life
  - The percentages of members reporting their services help them live a better life were 90% or higher in both years and showed an increase of 7 percentage point from 2018-19 to 2019-20. This increase was statistically significant.
- Percentage of people who like how they spend their time during the day
  - The percentages of members reporting they like how they spend their time during the day were below 75% in both years. A considerable decline of 11 percentage points was seen in 2019-20 from 2018-19. This decline was statistically significant.
- Percentage of people who get up and go to bed when they want to
  - In both years, 96% of members reported they get up and go to bed when they want to.
- Percentage of people who can eat their meals when they want to
  - In both years, more than 90% of members reported they can eat their meals when they want to, however a decline of 2 percentage points was seen in 2019-20. This decline was not statistically significant.

Conclusions

KFMC has prepared this interim evaluation report to reflect evaluation progress and present findings to date to examine the KanCare 2.0 Service Coordination Strategy, OneCare Kansas (OCK) program, KanCare 2.0 hypotheses presented above (Hypothesis 1-4), as well as the monitoring of KanCare 2.0 overall performance measures identified during the final evaluation of the previous KanCare Demonstration. Measurement data are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022.

It should be noted, the COVID-19 pandemic affected the utilization of health care services throughout the state and may have impacted the outcomes from this period. Thus, the results presented here should be interpreted with caution. Where feasible, adjustments were made to the analytic plans to account for the pandemic's impact on measurement outcomes. Data and analytic results for 2022 and 2023 may provide a better assessment of the impact of KanCare 2.0 efforts.

a. KanCare 2.0 Service Coordination Strategy

The quantitative evaluation of the KanCare 2.0 Service Coordination Strategy examined whether the integration of physical and behavioral health services provided to KanCare members in the Intervention Group (received HRA and PCSP) improved quality of care, health outcomes, and cost outcomes.

- The results for the Outpatient or Professional Claims (for diabetic retinopathy, influenza, pneumonia or shingles) measure support the assertion that the KanCare 2.0 Service Coordination Strategy had a positive impact on its rates. It should be noted, instead of improving, this measure's rates increased

for both the Intervention Group and Comparison Group 2. Since the Intervention Group's rates changed less, relative to Comparison Group 2, the Intervention Group's performance was deemed better under the circumstances.

- The 2019–2021 rates for ED Visits, Observation Stays, or Inpatient Admissions (for diabetic ketoacidosis/hyperglycemia, acute severe asthma, hypertensive crisis, fall injuries, SUD, or mental health issues), Annual Dental Visits, and Adolescent Well-Care Visits, worsened for both groups from 2016–2018, with the Intervention Group having poorer performance than Comparison Group 2.
- The relative improvements in both groups were about the same for the Access to Preventive/ Ambulatory Health Services and Emergency Department Visits (overall) measures.

Opportunities for Improvement

- It was not clear from the MCOs' data whether all members eligible for participation in the Service Coordination Strategy received an HRA and Needs Assessment, along with a PCSP if applicable.

Recommendations

- Ensure standardization of the MCOs' processes to collect and abstract HST, HRA, Needs Assessment and PCSP data from their case management data systems. Each MCO's data system should include all variable fields needed for evaluation of the KanCare 2.0 Service Coordination Strategy.
- As the State complets its public health emergency winding down period, review and improve the steps applied by the three MCOs to ensure all members eligible for participation in the Service Coordination Strategy receive an HRA and Needs Assessment, along with a PCSP and coordinated care, as appropriate during the remaining years of the KanCare 2.0 demonstration. Application of the Service Coordination Strategy to all eligible members will assist in achieving its impact on the performance outcomes.

b. OneCare Kansas

The quantitative evaluation of the OCK program examined whether it improved the quality of care, health outcomes, and cost outcomes.

- The results support the assertion that the OCK program had a positive impact on the rates of three out of six measures (Adults' Access to Preventive/Ambulatory Health Services, Adolescent Well-Care Visits, and on Annual Dental Visits).).
- There is potential for the other measures to improve during the remainder of the demonstration, as multiple measures showed relative improvements but were not statistically significant.

Information from OCK Learning Collaborative participants through routine meeting, a survey, and regional virtual meetings conducted from April 2020 through March 2022 was abstracted from OCK program summary reports for the qualitative evaluation.

- Identified key factors that facilitated OCK implementation include the availability of program information, resources, and trainings; staffing strategies and support; collaboration among OCK partners; collaboration with community and provider entities; and diagnostic code expansion.
- Key themes of identified barriers and challenges in OCK implementation included
  - Issues with program structure, including labor and time-intensive processes and unclear expectations
  - Access to member information, financial concerns, member enrollment, roster and engagement, opt-in/opt-out process, collaborations with partners/providers, staffing, and access to care in rural areas

- Key observations regarding OCK program successes included the following:
  - Improved care coordination
  - Improved support of members and increase in member trust and engagement
  - Increased partner collaboration
  - Sharing information about the program with community partners
- One learning need theme, identified by Learning Collaborative participants, that did not appear to be addressed pertained to trainings on OCK focused conditions, such as asthma, behavioral health, motivational interviewing and health literacy.
- OCK partners emphasized a need of continued peer learning and support for program implementation, sharing guidance and strategies to address barriers/challenges.
- OCK partners made the following key recommendations and suggestions for potential next steps.
  - Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.
  - OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.
  - Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.
  - Improve program processes and systems.
  - Develop connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.
  - Identification of the opportunities to obtain hospital data and provision of organizational data.

Opportunities for Improvement

- Review of the MCOs' databases indicated that the MCOs' processes to determine members' OCK eligibility, per the State's criteria, had some variability. Differences were also seen between KFMC's identification of eligible members from the Claims database, using the State's OCK program eligibility criteria, and the dataset provided by one of the MCOs, with KFMC identifying more eligible members.
- Potential unmet OCK partners' learning needs include topics specific to working with OCK members, such as asthma, behavioral health, motivational interviewing, and health literacy.

Recommendations

- Ensure standardization of the MCOs' process to determine members' eligibility for the OCK program, per the State's criteria.
- Determine OCK partners' continued learning needs specific to working with OCK members and their diagnoses, and provide related Learning Collaborative training or other resources.

c. Hypothesis 1 – MCOs' Value-Based Provider Incentive Programs

Each of the MCOs designed a value-based provider incentive program (VBPs) to address KanCare 2.0 Hypothesis 1:

- Aetna VBP – CARE and CARE+ Programs with Community Mental Health Centers
- Sunflower Health Plan VBP – Behavioral Health Project
- UnitedHealthcare VBP – Pediatric Care Network Project

The MCOs are in the process of initiating their VBPs. Therefore, data are not currently available from these projects and an interim evaluation of Hypothesis 1 was not conducted. The evaluation of Hypothesis 1 will be conducted as a part of the summative evaluation of KanCare 2.0.

d. Hypothesis 2 – Employment and Independent Living Supports for KanCare 2.0 Members With Disabilities

Data for Hypothesis 2 outcome measures were not available. Therefore, an interim evaluation of Hypothesis 2 was not conducted. The evaluation of Hypothesis 2 will be conducted as a part of the summative evaluation of KanCare 2.0.

e. Hypothesis 3 – Use of Telehealth Services

The evaluation of Hypothesis 3, comprised of quantitative and qualitative components, examined whether the use of telehealth services (telemedicine, telemonitoring, and telementoring) enhanced access to care for KanCare members living in rural and semi-urban areas.

Quantitative Evaluation of Hypothesis 3:

Telemedicine

The results suggested that the usage of telemedicine services increased among KanCare Non-Urban members. However, the ability of these results to show improvement was overshadowed by the impact of the COVID-19 pandemic. It should be noted, the increases in usage were also seen in Urban members. In addition, these increases were higher among Urban members compared to Non-Urban members in these years. These increases corresponded to the onset of the pandemic and may be due to changes related to the provision of services by providers and their usage by members made during the pandemic years. It should also be noted, though still above the pre-pandemic years, usage of telemedicine services among members started showing decline in 2021 compared to 2020. Additional key findings are described below.

- Telemedicine services for Non-Urban members were used most frequently for Mental, Behavioral and Neurodevelopmental Disorders throughout the time period, specifically Mood [affective] disorders ranked first.
- Analysis related to speech therapy supports the assertion that telehealth enhanced access to care for KanCare members.

Telemonitoring

The results for three measures assessed to examine the usage of telemonitoring services among Non-Urban members showed low utilization of telemonitoring services. However, all three measures showed an improvement in counts/percentages from 2019 to 2020 and 2021. These improvements corresponded to the onset of the pandemic and may be due to its impact. The main findings related to the outcome measures are described below.

- Similar patterns were seen for all three telemonitoring measures—the number and percentage of Non-Urban members who received telemonitoring services, the number of telemonitoring services provided to Non-Urban members, and the number of providers monitoring health indicator data transmitted to them by the members receiving telemonitoring services increased from 2019 to 2020 and 2021.

Qualitative Evaluation of Hypothesis 3:

Telementoring

The data sources are not currently available to describe the status of the use of Telementoring;

therefore, quantitative evaluation was not conducted. The focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri, using the Project ECHO (Extension for Community Healthcare Outcomes) Model.

- From March 2019 through November 2021, there were twelve Project ECHO series comprised of fifty-one sessions, with an average of 42 participants per session. Following are the Project ECHO topics.
  - Behavioral health (3 of the 4 series focused on Substance Use Disorders)
  - Social Determinants of Health
  - Intellectual and Developmental Disabilities
  - Foster Care
  - Aging
  - Cancer
  - Care Coordination
  - Preventive Health
- The sessions were attended by providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. Participants were from non-urban and urban counties.
- Evaluation results (obtained after each session by the Project ECHO host) indicated participants' knowledge of the topic improved, and they obtained helpful skills and techniques to improve professional practice.

Recommendations

- Continue to expand the use of telementoring, ensuring all MCOs develop and implement plans for this.

Telehealth Provider Survey

Qualitative information was also collected, through a short online survey, from KanCare providers who offered telehealth services to KanCare members in 2020 or 2021. The survey was designed to gain an understanding of providers' telehealth experiences, perceptions regarding telehealth and access to care, and to identify providers' recommendations regarding telehealth. The survey was conducted in August and September 2022.

Seventy-three providers from urban and non-urban counties completed the survey, with the majority from behavioral health care providers. Other respondents were from primary care, specialty health care and home and community based services. The key points based on the survey results are summarized below:

- Most respondents "*strongly agree*" or "*agree*" that telehealth has improved access to care for KanCare members. It expands their ability to see clients/patients over a greater geographic distance, and it is important to the success of their organization. About two-thirds of the respondents "*strongly agree*" or "*agree*" that telehealth increases their ability to see more clients/patients, it fills an essential practitioner gap in their organization, improves workflow efficiencies in their practice, and it improves the quality of care for clients/patients.
- Most respondents noted being "*very comfortable*" or "*moderately comfortable*" delivering telehealth services.
- Most of the survey respondents "*strongly agree*" or "*agree*" clients are just as engaged and make as much progress on their treatment goals using telehealth visits as in using face-to-face visits.

- Three-fourths of respondents noted the effectiveness of services delivered by telehealth is "*about the same*" or "*better*" than services delivered in-person.
- Following are key barriers in providing telehealth services, identified by survey respondents, with the first two bullets being the most frequently noted.
  - Clients lack the technology and resources for telehealth services (mobile phones, computers, internet access).
  - Lack of client familiarity or comfort with using telehealth services.
  - Lack of reliable internet for providers; and
  - Do not consider telehealth services as effective as in-person services.
- Following are key recommendations (themes) by survey respondents.
  - Provide consistency in application of rules and systems.
  - Increase and improve technology and resources for the members and providers.
  - Continued coverage by insurance companies.
  - Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.
  - Increase reimbursement rate for telehealth services.
  - Ensure opportunities for telehealth services are available for all members.
  - Provide trainings for providers, including easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational questions.
  - Telehealth is a valuable source for members and providers.
- Only 6% of respondents indicated their usage of telehealth visits would decrease in the future, with 50% anticipating the number of telehealth visits for KanCare members will "*Increase somewhat.*"

Opportunities for Improvement

- KanCare 2.0 Hypothesis 3's focus is to enhance access to care for KanCare members living in rural and semi-urban areas. The results for the evaluation of telemonitoring service usage showed low utilization of the telemonitoring services. Although, some increases were seen in 2020 and 2021 among Non-Urban and Urban members, the increases seen were higher for Urban members than the Non-Urban members. Similarly, the increases seen in the telemedicine service usage were higher for the Urban members.
- Though still above pre-pandemic years, the results for the measures assessing the telemedicine and telemonitoring usage started showing a decline in 2021 compared to 2020, which may indicate the increases are due to COVID–19 pandemic.
- The focus of KanCare 2.0 Hypothesis 3, related to telementoring, is to pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions. A data warehouse is not in place to collect detailed information on telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

Recommendations

- Ensure application of the strategies to improve the usage of telemedicine and telemonitoring services among Non-Urban members to increase their access to appropriate care.
- Ensure increased provision and utilization of telementoring sessions to increase the capacity of rural

and semi-urban healthcare providers for the treatment of chronic, complex conditions among Non-Urban members.

- Assist the University partners and Health Plans providing telementoring sessions in developing a standardized evaluation component to assess the impact of these sessions in improving the capacity of providers in rural and semi-urban areas.
- Develop a data warehouse to collect the information on the telementoring sessions offered to providers and to assess their impact in increasing the capacity rural and semi-urban healthcare providers have for the treatment of chronic, complex conditions among Non-Urban members.

f. Hypothesis 4 – Removal of Payment Barriers for Services Provided in Institutions for Mental Diseases for KanCare Members with Substance Use Disorders

As per a CMS recommendation, the conclusion for the KanCare 2.0 Hypothesis 4 evaluation is included as a part of a separate report prepared for the evaluation of KanCare 2.0 Section 1115 SUD Demonstration.

g. Monitoring of the Overall KanCare 2.0 Performance Measures

The HEDIS, CAHPS Survey, NCI Survey and NCI-AD Survey measures related to the areas for improvement from the prior evaluation of the KanCare Demonstration (2013–2018) were assessed. The results for one HEDIS measure, two NCI Survey measures, and one NCI-AD Survey measure supported the assertion that an improvement was seen in the overall performance of KanCare 2.0.

HEDIS Measures

- The Prenatal and Postpartum Care (PPC) measure includes Timeliness of Prenatal Care and Postpartum Care. An improvement in the Postpartum Care rate and its QC ranking was seen from Measurement year (MY) 2019 to MY 2020. The QC ranking for Postpartum Care rate also increased from <25th to <50th percentile.
- The rest of the HEDIS measures did not show improvement from 2019 to 2020.
- A statistically significant decline in the Timeliness of Prenatal Care rate was seen in MY 2020 from MY 2019, with rates for both years below 33.33rd percentile.
- The Eye Exam Performed for Patients with Diabetes (EED) rate had a statistically significant declining trend from My 2016 to MY 2020.
- However, the QC rankings increased to >75th for 2020 for all three comprehensive diabetes care measures, which indicates KanCare members fared relatively well in the first year of the pandemic compared to members in other health plans.

CAHPS Survey Measures

- The three indicators of the Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measure — Advising Smokers and Tobacco Users to Quit; Discussing Cessation Medications; and Discussing Cessation Strategies — did not show improvement (with some declines), and had QC rankings less than the 50th percentile, suggesting a need for improvement.

Kansas NCI Survey Measures for Social and Community Engagement (2016–2017, 2017–2018, and 2018–2019)

- The percentage of members whose services and supports help them live a good life, was 90% or above in all three years.

- The percentages for three out of six measures—Can see and communicate with their family when they want (if not living with family); Decides or has input in deciding how to spend free time; and Decides or has input in deciding daily schedule—were above 80% in all three years.
- The percentage of members with the ability to go out and do things they like in the community was 85% in the most recent year.
- The percentage of members with the ability to see friends when they want was less than 80% (78%) in 2017-18 and 2018-19.

Kansas NCI-AD Survey Measures for Social and Community Engagement (2018–2019, and 2019–2020):

- The percentages for three out of six measures—Percentage of people whose services help them live a better life; Proportion of people who get up and go to bed when they want to; and Percentage of people who can eat their meals when they want to— were above 90% in both years.
- The percentage of members with the ability to go out and do things they like to in the community as often as they want was above 90% in 2018-19, however it decreased to 87% in recent year.
- The percentages for the measure assessing members' ability to do things they enjoy outside of home as much as they want remained same in both years.
- The percentage of people who like how they spend their time during the day was low in 2018-19, and it further declined in 2019-20.

Recommendations

- Review and ensure strategies are applied by the MCOs and health care providers to improve provision of timely prenatal care, comprehensive diabetes care, and medical assistance for smoking and tobacco use cessation to KanCare 2.0 members.
- Ensure MCOs and health care providers implement strategies to improve the social wellbeing of members receiving I/DD waiver services. Ensure the PCSPs of these members include the provision of assistance for them to engage socially, with friends and family, when they want.
- As the State completes the public health emergency winding down period, ensure MCOs and health care providers implement strategies to improve social and community engagement among adults and senior members obtain long term services and supports through the Frail Elderly, Physical Disability and Brain Injury waiver programs. Ensure the PCSPs of these members include provision of assistance for them to engage in activities of their interest outside their home when they want and to decide their daily activities.

Interpretations, and Policy Implication and Interactions with Other State Initiatives

KFMC will address the policy implications and interactions with other state initiatives in the summative KanCare 2.0 evaluation. For this interim evaluation, the following interpretations could be made.

- It is not yet known how much the COVID-19 pandemic will influence the impact of the KanCare 2.0 program overall. It will take more years to assess the impact of the program, overall, outside of the context of the pandemic.
- It is difficult to interpret the interactions with other Medicaid and State programs due to the pandemic, as well. KanCare 2.0 activities were drastically affected during the onset of the pandemic. The MCOs were instructed to pause many initiatives with members and providers in order to address the public health emergency. As a result, many of the projects that would have provided

data for this evaluation were on hold for a considerable amount of time. Also, the Service Coordination Strategy could not be fully administered as designed, during much of the evaluation time period, due to limitations in face-to-face visits.

Lessons Learned and Recommendations for States

There were a few lessons learned as a result of this interim evaluation. These lessons learned are also recommendations to State Medicaid agencies for future demonstrations, as well as for the State of Kansas for the remainder of KanCare 2.0.

- There were additional delays in the implementation of KanCare 2.0 strategies that appeared unrelated to the delays due to the COVID-19 pandemic, such as the MCOs' Value Based Provider Incentive Program delays. These delays will impact the ability to evaluate the efficacy of the KanCare 2.0 program, as a whole. KFMC recommends State Medicaid agencies evaluate MCO delays to determine whether any are unavoidable or whether stronger enforcement of timelines is warranted.
- Some of the programs that began (or were intended to begin) during the evaluation timeframe proved to be more time-intensive to implement than anticipated. KFMC recommends State Medicaid agencies and MCOs explore ways to accelerate the time to implementation of the programs. This will help to ensure adequate time is allowed for conducting the strategies as designed, collecting data and fully testing the hypotheses.
- Lessons learned and recommendations for other State Medicaid agencies will be further addressed in the summative KanCare 2.0 evaluation report.

Summary of Opportunities for Improvement and Recommendations

- **MCO care coordination assessment:** As the public health emergency completes its winding down period, all members eligible for participation in the Service Coordination Strategy should receive the appropriate assessments.
- **OneCare Kansas capacity and provider training:** The State should ensure the MCOs have a standardized process to determine member eligibility for OCK. The State and MCOs should continue to support the OCK Learning Collaborative, and address providers' training needs regarding working with OCK members (e.g., motivational interviewing, health literacy) and specific diagnoses.
- **Increase telemedicine and telemonitoring utilization:** The State and MCOs should review and implement, as feasible, the provider recommendations for how to improve telehealth services. The State and MCOs should also seek ways to increase the use of telemonitoring services.
- **Improve telementoring opportunities and capacity:** The State should ensure all MCOs develop and implement plans to increase telementoring opportunities targeted towards providers in rural and semi-urban areas of the state, as well as continue to support current telementoring efforts. Standardized methods should also be developed and implemented to collect information on telementoring opportunities across the state and to evaluate the impact for KanCare 2.0 providers, especially those in rural and semi-urban parts of Kansas.

- **Strategies to improve quality and timeliness of care:** The MCOs should evaluate their Quality Assurance and Performance Improvement Programs to ensure they and contracted providers are developing and applying strategies to improve identified KanCare 2.0 performance measures (prenatal, comprehensive diabetes care, medical assistance for smoking and tobacco use cessation).
- **Strategies to improve member social and community engagement:** As the public health emergency completes its winding down period, the State should ensure the MCOs are working through their own care management processes (specifically using the PCSP), as well as with contracted providers, to improve social and community engagement for members on waiver services (I/DD, FE, PD, and BI).

References:

1. Kansas Department of Health & Environment. KanCare 2.0 Section 1115 Demonstration Renewal Application: Final Submission to CMS. Topeka, KS: KDHE; 2018. Submitted December 20, 2017. https://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-renewal/kancare-2-0-demonstration-renewal-application-(002).pdf?sfvrsn=76194a1b_4. Accessed June 1, 2022.
2. Mayhew M. Approval letter for KanCare 2.0 Section 1115 Demonstration (Proj. No. 11-W-00283/7). Baltimore, MD: CMS; 2018. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/section-1115-waiver-comments/ks-kancare-2-0-ap. Accessed June 1, 2022.
3. Trieger M. CMS Review: Kansas "KanCare 2.0" Section 1115 Demonstration Evaluation Design (without SUD & DSRIP). Baltimore, MD: CMS; 2019.
4. Centers for Medicare & Medicaid Services Kansas KanCare 2.0 Medicaid Section 1115 Demonstration: CMS Comments on the Draft Interim Report. April 21, 2023.
5. Kansas Department of Health & Environment. KanCare 2.0 Quality Management Strategy. Topeka, KS: KDHA;2016. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-2-0---quality-mgmt-strategy_final-cms-submission.pdf?sfvrsn=25484d1b_4. Accessed June 1, 2022.
6. OneCare Kansas Program. OneCare Kansas General Information Fact Sheet. onecarekansas-fact-sheet.pdf (ks.gov). Accessed September 25, 2022.
7. OneCare Kansas. 2021 provider Listening Tour. Event Summary August 2021.
8. State of Kansas. Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0 (Bid Event No. EVT0005464). Topeka, KS: Kansas Department of Administration; 2017.
9. Centers for Medicare & Medicaid Services. Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting. Baltimore, MD: CMS; 2019.
10. National Committee for Quality Assurance. HEDIS® 2020 Volume 2: Technical Specifications for Health Plans. Washington, DC: NCQA; 2019.
11. Kansas Department for Aging and Disability Services. Section 1115 Substance Use Disorder (SUD) Demonstration: Evaluation Design. Topeka, KS: KDADS; 2020.
12. NCSS, LLC. PASS Sample Size Software, Tests for the Difference Between Two Poisson Rates. https://ncss-wpengine.netdna-ssl.com/wp-content/themes/ncss/pdf/Procedures/PASS/Tests_for_the_Difference_Between_Two_Poisson_Rates.pdf. Accessed October 1, 2022.
13. Kansas Department of Health and Environment. Population Density by County of Residence, Kansas, 2019. Issued September 2020. https://www.kdhe.ks.gov/DocumentCenter/View/12623/Population-Density-by-County-of-Residence-Kansas-2019-AS-FB6-PDF. Accessed October 6, 2022.
14. Zhehui Wang, Tubao Yang, and Hanlin Fu. Prevalence of diabetes and hypertension and their interaction effects on cardio-cerebrovascular diseases: a cross-sectional study. *BMC Public Health.* 2021; 21: 1224. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8229421/. Accessed on September 25, 2022
15. Project ECHO Sunflower Health Plan. Frequently Asked Questions. https://www.sunflowerhealthplan.com/providers/project-echo.html. Accessed on 06/27/2022.
16. Project ECHO®. Sunflower Health Plan Kansas. 2019-Present.
17. Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders. KUMC Project ECHO® Series Summary Report

18. HEDIS 2022: See What's New, What's Changed and what's Retired. August 3, 2021. NCQA Communication. https://www.ncqa.org/blog/hedis-my-2023-see-whats-new-whats-changed-and-whats-retired/. Accessed on 09/29/2022.
19. 2016-17 National Core Indicators (NCI®) Kansas Adult Consumer Survey Final Report. https://www.nationalcoreindicators.org/upload/state-reports/KS_State_Report_2016-FINAL.pdf. Accessed March 24, 2022.
20. 2017-2018 National Core Indicators (NCI®) In-Person Surveys, Kansas State Report. https://www.nationalcoreindicators.org/upload/core-indicators/2017_IPS_KS_MAR2020.pdf. Accessed March 24, 2022.
21. 2018-2019 National Core Indicators In-Person Surveys, Kansas State Report. https://www.nationalcoreindicators.org/upload/core-indicators/KS_IPS_state_508.pdf. Accessed March 24, 2022.
22. 2018-2019 National Core Indicators – Aging and Disabilities Adult Consumer Surveys (NCI-AD™), Kansas State Report. https://nci-ad.org/upload/state-reports/KS_2018-2019_NCI-AD_state_report_FINAL.pdf. Accessed March 29, 2022.
23. 2018-2019 National Core Indicators – Aging and Disabilities Adult Consumer Surveys (NCI-AD™), Kansas State Report. https://nci-ad.org/upload/state-reports/KS_19-20_NCI-AD_state_report_FINAL.pdf. Accessed March 29, 2022.
24. 2021 Consumer Assessment of Health Providers and Systems (CAHPS) Health Plan 5.0H Survey Validation Report (submitted to the State by KFMC).
25. KanCare Program Annual External Quality Review Technical Report. 2021-2022 Reporting Cycle (submitted to the State by KFMC).
26. Kansas Department of Health and Environment. KMAP General Bulletin 1865, Speech-Language and Audiology Services via Telemedicine. December 2018. https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/18265%20-%20General%20-%20Telemedicine_Services.pdf. Accessed October 7, 2022.
27. Kansas Department of Health and Environment. KMAP General Bulletin 18004, General - Telemedicine. December 2018. https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/18004%20-%20General%20-%20Telemedicine.pdf. Accessed October 7, 2022.
28. Kansas Department of Health and Environment. KMAP General Bulletin 20073, UPDATED - Expansion of Telemedicine Services for Therapy Services During COVID-19 Emergency. June 2020. https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/20073%20-%20General%20-%20Expansion_of_Telemedicine_Services_for_Therapy_Services.pdf. Accessed October 7, 2022.
29. Kansas Department of Health and Environment. KMAP General Bulletin 20120, Expansion with Select Telemedicine Allowed Codes/Home Setting. May 2020. https://portal.kmap-state-ks.us/Documents/Provider/Bulletins/20120%20-%20General%20-%20Expansion_Select_TM_Allowed_Codes_Home_Setting.pdf. Accessed October 7, 2022.

End of written report

Appendix A

KanCare 2.0 Interim Evaluation Report Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

OneCare Kansas Program Evaluation

Interim Evaluation of the KanCare 2.0 Demonstration OneCare Kansas Program Evaluation

Qualitative Evaluation of OCK Program

The qualitative information was reviewed for key themes as summarized below.

1. Learning Needs Identified and Discussed by the OneCare Kansas Learning Collaborative Participants

a) Learning Needs Identified (Table A.1.)

The following learning needs were collected from information available from April 2020 through March 2022, including the virtual regional meetings and the survey.

Table A.1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022

Learning Collaborative Participant Responses	Key Themes
• Health assessment tools (9)	• Health assessment tools and trainings for use of different types of health assessment tools including those for the comprehensive care
• Health assessment tools for children	
• Outcomes Health Assessment tools	
• Whole person assessment discussion would be helpful as well, more guidance on the whole person approach to care and how to do an assessment that captures a comprehensive picture of the person and how that would lead into goals more readily than asking a person what goals you are working on or want to work on.	
• How to provide a complete picture of care for a member when they are in several programs within our agency.	
• Health assessment portal use and training	
• Additional training on the different tools available for health assessment	
• SUD assessment tools	
• Goal mapping/setting with patients, goal setting ideas (3)	• Trainings for setting and writing goals and use of health assessment tools to identify goals
• Goal writing	
• Further training or discussion re: goal writing, it was done once, and that topic is one that needs intermittent review	
• SMART goal specifics	
• Using Health Assessment Tools to help id smart goals, use of MI tech	
• Maybe ways to think about how we as an agency and state can show benefit and outcomes of OCK	• Tracking outcomes and improvement of goals
• Review of tracking and utilizing health assessment tools to tracking members outcomes and improvements on goals.	
• I was a bit lost on the discussion of how outcome measures are gathered, suggest that the focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped.	
• Would be interested to know if any organizational or process measures may be planned to assess the system(s) providing OCK services and to evidence progress toward the OCK goals.	
• The focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped.	

Table A.1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022 (Continued)

OCK Partners' Responses	Key Themes
• How each partner responds to building the program during the pandemic	• Ways to build program and engage members during COVID-19 pandemic
• How others are developing creative ways during this Covid crisis to engage individuals	
• How others are dealing with limitations placed upon us all due to coronavirus. Are others maybe standing out in the yard while the client is on the porch or at the window. Maybe using phone X% of the time or mail X% of the time, etc.	
• COVID resources	
• How each partner responds to building the program during the pandemic	
• MCO resources and benefits (2)	• MCO resources and benefits, tools, and portals
• MCO portals, MCO portal usage (2)	
• What the MCOs want on the surveys.	
• Member portals and tools	
• Recruiting, staff retainment.	• Staff recruitment, retention, and engagement
• How to engage staff to do what is asked of them re: OCK.	
• Engaging providers in programs with members	• Provider engagement, networking, and peer learning
• How to coordinate with other providers to obtain records for continuity	
• Learning from each other	
• I will like a training on way that show us how to connect or what connecting with other provider look like / who does the connecting	
• Interesting to hear how others use their OCK information to further their agencies help clients in other ways (network with other agencies, etc.)	
• Member engagement and recruitment strategies and information; helping clients to buy into the program (6)	• Member engagement, recruitment, retention, and outreach tips
• Discussion of serving members who are not otherwise engaged in services at your agency. About half of our engaged members are not getting any other services from our agency (the OCK provider).	
• How to encourage patients to continue to actively participate in the program.	
• Outreach tips (2)	
• How to discuss benefits of OCK to members not interested in improving health outcomes.	
• How to provide a complete picture of care for a member when they are in several programs within our agency.	
• A "World Cafe" style of obtaining feedback to understand strengths/weaknesses/opportunities/threats that is participant driven.	
• Community events and supports of interest to OCK members	
• Financial counseling/budgeting may be a good topic to address with members, so it would be awesome if there was a tool/assessment we could train with coordinators	• Finance and billing
• Concrete examples of common activities done with members, per billable service category.	
• A final copy instead of a continuously changing draft. All billing information listed under the billing section instead of in the appendix.	
• Differences between CMHCs and FQHCs (billing).	
• Probably resources	
• Resources is always a plus how to afford to do OCK, right now this is a money loser.	

Table A.1. Learning Needs Identified by OneCare Kansas Learning Collaborative Participants, April 2020–March 2022 (Continued)	
OCK Partners' Responses	**Key Themes**
• Staff to member ratios • Required staff spelled out, verbiage on HIPAA, more detailed services under the codes. • Ways to simplify inclusion process. All MCOs use same processes/protocols. Having different things for different situations. • How the State and MCOs might simplify opt-in and opt-out • Processes on accepting, transferring, or patient refusal of OCK services. • How to work collaboratively with MCO and Emergency Rooms for referrals. • OCK services and where to make referrals or what to look for in providers of other services for referrals of members. • Working with the foster care system. • Advanced directives • Information about how to demonstrate compliance with the manual.+ • A blurb on we work on regulations [*sic*], the required staff laid out in the manual (MD, nurse, SW) - not referring to the application.	• Information and guidance on program processes and protocols: ○ Service codes ○ Use of same protocols by MCOs ○ Simplifying inclusion process ○ Patient transfers and referrals ○ Staff-to-member ratios ○ Required staff ○ HIPAA ○ Foster care system ○ Advanced directives • Program manual, including demonstrating compliance
• Considering all the One Care Kansas patient have asthma, schizophrenia, or bipolar, I would think that education would be focused on these. • More asthma education; more information about asthma (2) • Using Peak Flow Meters to create action asthma plans in adults vs. kids; diagnosing the different levels of severity of asthma; interpreting in-office spirometry. • Discussion over Asthma and how it affects mental health/possible drug interactions with asthma meds and psychotropics. • Anything from KDADS on addiction including trainings on SBIRT. Also, various other topics on misuse of prescription meds (opioids, etc.) that we might incorporate into our assessments. Various tools that are out there to detect concerning use of mood-altering substances. • More in depth motivational interviewing, health literacy	• Trainings on OCK focused conditions: ○ Asthma ○ Asthma and mental health issues ○ Addiction (SBIRT, etc.) ○ Motivational interviewing ○ Health literacy
• Health Promotion resources and examples (12) • Health Promotion Resources for rural areas • Health promotion resources that can be given to members • Creating exercise programs and carving out time to participate in the exercise-group?	• Health promotion resources for members

b) OCK Learning Collaborative Discussions and Sessions (Table A.2)

Table A.2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022		
2020 Meetings		
Date	**Session Topics**	**Approximate Number of Participants**
April 21	• Information about adjustments to OCK policy during the COVID-19 emergency (presented by KDHE Staff). • Information regarding recommended and mandatory learning opportunities that impact OCK providers (presented by Aetna and WSU CEI staff).	50
May 19	• Recruitment and engagement of potential OCK members: ○ KDHE shared the tools from the OCK website to assist in these efforts. ○ Staff from a Behavioral Healthcare organization then shared tips and tools that they use to recruit members for their Integration Partnership initiative.	45

Table A.2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)

Date	Session	Approximate Number of Participants
2020 Meetings		
June 16	• Quality measures for the OneCare Kansas Program: ○ KDHE staff reviewed the quality measures that will be collected as well as how and when the information will be gathered and reported. ○ Group discussion on: ▪ Additional tools they are using to collect health related data • Strategies for using the information to tell the OCK story to potential partners and funders	45
July 21	• Information provided by KDHE on the difference between a Health Risk Assessment conducted by the MCOs and an OCK Health Assessment. • Partners from the Community Health Center of Southeast Kansas shared their model for providing services to OCK members (including the Health Assessment process); and strategies for engaging other providers in the process.	50
August 18	• KDHE shared information on a variety of programs available to support OCK partners for health promotion activities.	50
September 15	• Small group discussions related to challenges and opportunities that the partners have experienced in the first six months of the program's implementation.	60
October 20	• Promoting staff resilience: ○ Small groups discussion on: ▪ Efforts to improve staff competence around OneCare Kansas as one protective factor against stress. ○ Small and large group discussions on: ▪ Additional strategies that they employ to support their staff.	60
November 17	• Recruitment of potential OCK members: ○ Updates provided by KDHE staff on upcoming adjustments in how potentially eligible individuals are identified. ○ WSU CEI staff shared resources available via the OneCare Kansas website that can be used for talking with potentially eligible members and other community partners about the program. ○ Staff from the HealthCore Clinic and High Plains Mental Health Center shared the strategies that they use for identifying and recruiting new members. ○ Small group discussion on: ▪ Challenges they face related to member recruitment, those that are outside their control; and ▪ Strategies to make progress on the challenges that can be controlled. ▪ Participants shared their major takeaways from their small group discussion with the larger group.	60
2021 Meetings		
January 19	• Use of GIS map: ○ KDHE staff presented how to use, and the benefits of a GIS map developed to make it easier to locate OCK partners across the state. ○ Small group discussion to discuss following three questions: ▪ How can you use the map to set yourselves up to collaborate more intentionally? ▪ What are the barriers you might face? ▪ What are some strategies to overcome these? • Participants shared their small group discussion points with the larger group. • Participants asked to identify what else they need from the State team to successfully utilize the mapping tool.	60

Table A.2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)

2021 Meetings

Date	Session	Approximate Number of Participants
March 16	• A review of the first year done. • Introduction of a data dashboard that is compiled and posted by KDHE to the OCK website was done. • A review of aggregate results of the first OCK audit was done. • The story of one OCK Partner who achieved financial sustainability for their program during the first year was presented. • Expectations for the 2nd year of the program were discussed. • Described and held a large group discussion on the expanded eligibility criteria.	70
May 18	• Highlighted three OCK Partners, COMCARE of Sedgwick County, HealthCore Clinic, and Mental Health Association of South-Central Kansas. ○ Each partner presented the information to answer following questions: ▪ What are you doing to get members engaged with your OCK program? ▪ What is working well and what made this possible? ▪ What's been the biggest challenge along the way and how did you overcome it? ▪ What are the elements of this activity that you are most proud of? ○ Small groups discussion to discuss three questions: ▪ What themes did you hear as you listened to today's presentations? ▪ What additional questions do you have? ○ What would you like to hear more about in the future?	60
September 21	• Program quality: ○ WSU staff reviewed the OCK quality goals and partner expectations related to monitoring program quality. ○ KDHE staff then shared the results of a member survey that had been conducted earlier in the year. ▪ Participants were then asked to discuss their own processes for gathering member feedback and what challenges they encounter in gathering this information.	50
November 16	• Collaborations with local healthcare partners in the community. ○ Groups were divided by regions of the state and asked to reflect on the following questions: ▪ What is program's plan or procedures for collaborating with other providers who work with the member? ▪ What gets in the way? ▪ What are the opportunities to improve these connections? ○ As a large group, participants were asked to share their learnings and discuss the following questions: ▪ How do you document your interactions with partners? ▪ How do you use your documentation to assure that staff get the credit they deserve for the good work that they do as they walk alongside the members they serve? ▪ How are you using that documentation to not only talk to other providers, but also help communicate the value of the program to organizational leadership and funders such as the state legislature?	60

Table A.2. Topics Discussed in OneCare Kansas Learning Collaborative Meetings, April 2020–March 2022 (Continued)

2022 Meetings		
Date	**Session**	**Approximate Number of Participants**
March 15	• In response to provider concerns related to staffing their OCK programs, the virtual session focused on the challenges they face as well as potential opportunities to hire support level staff to complete certain tasks: ○ Using a virtual polling platform, participants were asked to share their biggest challenges when staffing their programs as well as strategies they have used to address those challenges. ○ KDHE announced that OCKPs would now be able to hire CNA/CMA staff to complete tasks under the supervision of a nurse. Participants were then asked if they would consider this option and what, if any, additional information they would need to consider this option. ○ KDHE is also currently considering an option of adding community health workers as a potential support role for the OCK program. GraceMed currently utilizes CHWs in a program that is similar in structure to OCK and was asked to share their experiences with this program. OCK partners were then asked for additional ideas for incorporating CHWs into the OCK program. • Finally, OCK partners were asked to consider what organizational changes would need to happen to allow for hiring additional support staff such as CNA/CMAs in their programs.	50

2. Factors that Facilitated the Implementation of the OneCare Kansas Program to Achieve Its Goals.

During discussions in the OCK Collaborative meetings, the participants identified the factors that facilitated their efforts for the implementation of the OCK program to achieve its goals. This information is reviewed, and key themes are summarized in Table A 3.

Table A.3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022

OCK Partners' Responses	Key Themes
• Learning about the OneCare program	• Getting familiar with the program, its processes, and benefits.
• This is my first OCK meeting, so it was all informational today, bulletins and required learning.	
• Educating staff about One Care Kansas Program	
• Newsletter will be useful.	
• Newsletters and campaigns	
• I appreciate the helpful information that was shared.	
• How we need to look at documentation and the benefit of the program to show to board of directors.	
• Training is great tool for me to understand the program as a whole. I would like to get a clear understanding of the OCK role and how much we as case Manager should be doing.	

Table A.3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)

OCK Partners' Responses	Key Themes
• The time frame for the completion of trainings • The information on additional training, I'm a new coordinator and this helps provide structure to how I move forward with staff • About the training series for care coordinators/social workers • The trainings that are being offered • Required ACEs (Adverse Childhood Experiences) training for all staff involved • Required training reminders • Continue getting training to improve services to members • Learned of an organization that has many resources re: training and/or training topics to help support the OCK staff and increase their knowledge base.	• Provision of trainings and re-trainings for the OCK providers for increasing their knowledge base to support their efforts, readily available information about the trainings and their time frames.
• Engaging members questions and tools • OCK Dashboard will be useful • Utilizing the resources from the MCOs • Population health portals with MCOs • MCO partners are there to help us if we need to reach out with questions. • Contact info for MCOs • Hearing about other tools used by other agencies. • Different tools that can be used to gather data • Learning about the different programs available to help our patients. • GIS maps will be helpful • Using the GIS map will be helpful to locate OCK partners across the state • Creating newsletter for health promotion hospital liaison opportunities	• Availability of resources, variety of tools, OCK dashboard and GIS maps from State, MCOs and other agencies
• The expansion of the Diagnostic Codes • Diagnosis expansion will be helpful • Diagnostic codes updates (2)	• Diagnostic codes expansion and updates
• The core measure set review was helpful in knowing for sure what the state is looking at. • Quality Measures in use and considerations for data collection and reporting. • Focus more on success stories, and data collection that tells the story of the services we provide and the outcomes from those services. • Figuring out what internally we should be tracking outside of state reporting • I understand that there will be outcome measurements that we need to track	• Tracking and reporting of quality measures and focus on outcomes.
• Level of staff from FQHC • Continuing to look for medical background or knowledge in new hires for our OCK program • Up to date knowledge, having access to individuals who are knowledgeable in OCK domain. • KDHE announced that OCKPs would now be able to hire CNA/CMA staff to complete tasks under the supervision of a nurse. • KDHE is also currently considering an option of adding community health workers as a potential support role for the OCK program. • The option for CMA/CNA and Community Health Workers (5) • Staffing options • We can hire other staff to include CNA/CMAs to help with specific patient care. • Conversation about how we could utilize CNA's and CMA's in our work. • Investment of current staff's skills to promote services, which are provided by our agency. • How other agencies have their Integrated meetings set up - meaning what staff are involved. • Effective ways to show support to team • I liked the agency that got everyone to build moral within their own agency! • Staff connecting with each other regularly to boost each other's resilience.	• Staffing options and expertise; Staff support

Table A.3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)

OCK Partners' Responses	Key Themes
• Incorporating tobacco cessation options for full integration of care • Making an exercise program with patients and participating in that exercise. • Health Promotion topics resource I can share with participants • Just learning the latest about the KDHE Health Promotion Bureau is helpful to our agency and ultimately can be helpful to our clients. • Offering healthy living groups regularly	• Incorporation of the health promotion and risk factor prevention and control as the provision of care options; submission of separate claims for these options; and sharing of health promotion resources with clients.
• Doing home visits and recruiting peer support to help with enrollment. • Loved hearing from CHC/SEK. Loved the positive approach to members and potential members! • Increase engagement of clients to the program • Other ideas on how to help members opt-in despite COVID-19 issues • Sending our own invitation letters to attributed members • Sending letters might help get more people engaged • One thing I heard that will be helpful is how they connect with clients • Asking questions such as how we could help or how can this program benefit you. Instead of assuming a goal is right for the member. Let them be actively involved in goal setting. • Continuing to use a strengths-based approach • It was helpful to hear we are using same/similar strategies as others in engaging potential members for OCK. • Outreach methods • The way others are reaching out • Improving outreach • Do more specific outreach in the area to work with specific provider organizations. • Knowledge that we are not alone in the struggle to recruit new members to the program. • It was helpful to hear that we are not alone in experiencing difficulty in engaging clients, some of whom said they didn't know what we were talking when we talked to them about OCK.	• Discussing challenges encountered in member recruitment and engagement; and application of strategies, methods and processes for member recruitment, enrollment, engagement and outreach
• The referral process • That more referrals are coming in. • That Aetna is sending email confirmations for referrals. Will check with our Care Coordinator to see if she is getting them. • Hearing others have a little more advantage than CMHC in collaborating with getting physician referrals. Going to see how to make changes on this for us at CMHC.	• Referral processes and assistance from MCOs
• Ideas on Incorporating Psychosocial Groups • Working with hospitals and clinics in the area • Engaging the PCPs with this plan also and getting them on board • Utilizing the prescription program in a Community Mental Health setting to capture those current patients who may have Asthma through their comprehensive med lists. Also, having a question re: Asthma on our intake forms, this hasn't been the case until the idea came out of this collaborative. • Work with the pharmacies for recruiting… BRILLIANT!	• Collaboration with other entities such as psychosocial groups, hospitals, clinics, PCPs, and pharmacies to recruit clients ○ Use of prescription program to recruit clients

Table A.3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)

OCK Program Partners' Responses	Key Themes
• Calling providers offices has been helpful • Utilizing KHIN to identify providers that can help connect providers and members together when there is no good contact information. • Utilizing more internal providers in OCK program within agency. • Care coordinators see providers with clinicians. • Go to lots of team meetings to talk to case managers, homeless outreach, children and family services to discuss OCK and services they can provide. • Partners working to connect with two hospitals in Topeka. Referrals, presentations, and helping other providers within their health care network. • External and internal marketing • Word of mouth • Reached out to some therapists of Central Kansas Medical Health (CKMH) for referrals (CKMH is one of the partners). • Working with the hospital with the behavioral health discharges. • Working in 5 county area - making calls to assist in coordinating care. • Ask for feedback from other providers/practitioners • Reaching out to individual providers, putting a face to the program and general education regarding the program. • Integrated team meetings to address holistic issues for members. • Email, snail mail, numerous meetings with internal staff. • Meetings with 1) Community based services (CBS), a service line within the Community Mental Health Services network; 2) Comprehensive Support and Stabilization (CSS), a service line within the Community Mental Health Services network; 3) medical staff (nurses/physicians who work with the FQHC and CMHCs; and 4) therapists. • Having an integrated providers meeting every month to stay connected. Staff certain cases that a provider might need help on.	• Applying strategies for building and improving collaboration with other local health partners/ providers who work with the members
• Hearing from other organizations • More ways to creatively grow your program • Reassurance that we were on the same track • The different struggles of other partners and ways to work around those difficulties. • Others are having similar problems. • Just knowing that other providers are experiencing similar challenges • Understanding we can only control so much and focusing time on those we can. • To not give up and keep doing what we are doing. • To continue what we are currently doing • Keep focusing on what we can do. • Thinking more outside of the box for on how to provide these services in a COVID world	• Collaboration, peer learning, and support among OCK partners to address similar challenges and implement OCK program

Table A.3. Factors that Facilitated Implementation of OneCare Kansas to Achieve Its Goals, April 2020–March 2022 (Continued)

OCK Program Partners' Responses	Key Themes
• OCK hours are added to my monthly billables. • Our staff do their notes using a certain few codes, so they get full credit for their work – if not documented it did not happen. • Document everything in ECW (eClinicalWorks) whether its billable or not. • EHR made a OCK template that allows us to capture most of what we do. • Looking for ways to include even if it is a zero dollar claim. • Make this part of the training. Discuss updates in team meetings, when there is a gap between what is being described and what is in the record, we discuss why there are gaps between the two. • Document every interaction in our EHR with the patients. • Document how clients are integrated into other areas of the organization, including family members becoming involved • Group supervision forms that we document our meetings and have a spot just for successes. • Executive Director asks for successes from each department as part of the report to the Board. • Document in both OneCare and Smart care to ensure that all documentation is accessible in both systems.	• Ensuring documentation fully reflects all activities and interactions for purposes of ongoing work with the client, billing, getting credit for work completed, and identification of successes.
• Recruiting (5) • Hire more staff (4) • Heavily recruiting (3) • Add an additional staff (3) • Just hired new nurse coordinator • Hired FTE who serves in both roles (2) • Moving positions around (3) • We have some part-time care coordinators who also function as BHC's. However, the 2 roles cannot overlap • Setting clear boundaries for staff who have multiple roles i.e., doing one care follow ups on certain days of the week (4) • Debriefing on regular basis to provide more support to staff • Contracting with other agencies to provide medical staff. • Cross training within the agency to bill OCK for people they are already working in other roles (10) • Staff bonuses (3) • Increasing pay (3) • Increased our wages (3) • Sign on bonus (2) • For us it's just a matter of internalizing a lower turnover rate	• Strategies applied to address OCK program staffing challenges: ○ Hiring and recruiting staff ○ Hiring of staff to work in two roles ○ Providing more support to staff by regular debriefing ○ Contracting with other agencies ○ Financial strategies such as increasing pay/wages, sign on bonus, staff bonuses, cross training of staff for OCK to bill the program ○ Reducing staff turnover rate

3. Barriers/Challenges Seen in the Implementation of the OneCare Kansas Program

During the discussions conducted in the OCK Collaborative meetings, the participants identified the barriers and challenges they encountered in the implementation of the OCK program. This information is reviewed, and key themes are summarized in table A 4.

Table A.4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program, April 2020–March 2022

OCK Program Partners' Responses	Key Themes
• Health Assessment Plans [HAP] are very labor intensive and take time to happen. Hope that with the use of technology that will improve over time.	• Issues with program structure and processes: ○ Labor intensive and time-consuming HAP ○ Multiple levels of bureaucracy and their requirements ○ Unclear or inconsistent expectations ○ Inadequate time to incorporate audit feedback. ○ Limited diagnostic criteria
• Different levels of bureaucracy and each level wanting something different or having different requirements.	
• Requirement to continue to contact members for 6 months before issuing a refusal. I have had several people block our number due to trying to get them through the opt out process.	
• Individuals who qualify mental health Targeted Case Management (TCM) may not receive all the MH services they are eligible for if they choose another OCK provider outside the CMHC system.	
• The biggest issue we have had is with audits and we do not feel like the purpose of the audit and expectations of what is needed matches what we are originally told and what is in the program manual. Some parts of the audits are repetitive and more complex than they need to be. Not to seem simple minded but it would be easier if the Program manual would give a straightforward outline of what is needed, what needs to be in place, what policie s you should have, etc. Our agency has some policies in place that would cover the OCK program, and we still get dinged for not having something else "created."	
• Agencies not given adequate time to develop and implement necessary changes to the program and processes after audit results are provided. Results of the first audit provided at the same time of submitting documents for the spring audit. This left us unable to show growth in our and appropriate use of the data to make necessary changes. Second audit results for member charts looked largely like the results of our first audit.	
• We feel some inconsistencies at times and do not feel like the program should have launched when it did last year. We have somehow managed to pull it together with one of the smallest OCK teams ever and are working on finding our own way.+	
• Diagnostic Code F20.9 not included	
• Expanding diagnosis criteria to have a more positive impact (state/national) decision	
• I was a bit lost on the discussion of how outcome measures are gathered, suggest that the focus of these type of conversations be clear in what our role is and if it is that we simply gather the info, and it is collected by OCK state staff then that would have helped. Thanks for all you do to help us be successful! These forums are very helpful.	• Unclear information on outcome and process measures gathering, and role OCK partners in collection of the measures
• This was a difficult webinar to understand initially, I think the presenter on the quality measures was going through the information so fast, it was hard for me to understand.	
• Would be interested to know if any organizational or process measures may be planned to assess the system(s) providing OCK services and to evidence progress toward the OCK goals.	
• How to afford to do OneCare program, right now this is a money loser for us.	• Financial concerns ○ Payment structure
• Reimbursement from MCOs Staffing.	
• Better delineation on when/how to bill the different codes.	
• Funding (lack of funding/resources) is one of the biggest barrier to providing OCK services.	
• The program is not money making at this time at our organization, is anyone making profit or at least breaking even and how are they doing so.	
• Paid more than 1 x a month.	
• Correct telephone numbers and addresses	• Issues with access to member information
• Sharing information with hospitals regarding members being inpatient and discharging.	
• Create a central information source (something similar to KHIN), that will work on increasing the provider portals with the MCOs.	
• OCK partners report ongoing difficulties reaching members due to inaccurate contact information or engaging those who have opted in. Some OCKPs are able to access their own agency records, internet searches and pharmacy contacts to attempt to locate updated information.	

Table A.4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)

OCK Program Partners' Responses	Key Themes
• Members are not understanding the program. • Members not wanting to participate. • Challenges with the refusing non-participating members • Adding to roster • Rural areas and reaching patients (access) • Identify and anything to get them through the gate of the opt in process • Improve outreach; help with educating staff and clients with the availability • The provider organizations carry the burden of making OCK work. (Finding patients, finding contact info, getting patients to opt-in, etc.) • Foster parents are not told about OCK when the Foster Care Agency opts children into OCK, making it difficult to engage with them. • Being able to get ahold of clients, Zoom was a challenge but as of the beginning of this month we are seeing clients face to face which helps. • Explore more populations for OneCare eligibility. • People enrolled in the program engaged fully	• Member enrollment, roster and engagement issues
• Opt-in/ opt-out: discrepancy in numbers • The opting out and opting in of the clients in the program • Opt-in - better outcomes in long run, but the opt in process isn't working effectively • Timeline from opting in from appearing in the roster can be a long time - can be frustrating. • Clients opting themselves in and then not knowing what they've signed up for. • Requiring a referral to receive OneCare services is another level of administrative paperwork that has to be completed • Decrease the requirements for opting in; provide closer OCK partners for patients (>100 miles away) • Reaching patients. They have opted in, but we don't have current addresses or phone numbers. By the time we reach patients that have been attributed to us, sometimes they don't remember opting in. • Clients opting in has been the biggest barrier at our agency. It has felt like the onus to recruit clients has been shifted to the providers, but when we submit opt ins or referrals they get denied for technicalities (i.e., didn't submit the most recent version of the form). • Individuals may indicate they don't want to engage with the system even after opting in but have not gone through the process of opting out. This is occasionally attributed to "accidental" opt-ins where members may not have understood what they were agreeing to and how the program can help. Others may be receiving services through Medicaid waiver programs and did not understand how OCK would impact those services.	• Issues related to opt-in/opt-out process
• Learning the process by employees. • Some programs are not engaging in efforts due to new staff or adjusting to the increased number of members due to the expansion. • Training (lack of/limited training) was also identified as one of the biggest barriers to providing OCK services. • Educate foster care and IDD population • Educate primary care providers • I think it is great to hear success stories, miss having some time to help problem solve barriers that occur. • Still have not received our email to access the HAP portal/Portal access • I am very frustrated with the required meetings for both me and my case manager regarding OCK. Considering all the OCK patient have asthma, schizophrenia, or bipolar, I would think that education would be focused on these. However, the education, including this one, and the CDC mandatory training on trauma-informed care, had NOTHING to do with the majority of our OCK patients. This program should not require more than 1 hour/month of for meetings but should have "office hours" available for providers having problems or questions that can be answered.	• Training, education, and support needed for employees, providers, and members

Table A.4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)

OCK Program Partners' Responses	Key Themes
• At the point where we could use another care coordinator. • Time constraints due to other job duties. • Many different job titles • Not training enough staff currently. • Time is main factor. • Time consuming • COVID has slowed things down. • The not knowing due to COVID-19 mandates • Lack of providers. • Lack of correct information for outside contacts. • No buy in from outside providers • Getting phone calls back from providers. • Doctors attending to the things they prioritized vs. other things. • Reaching out PCPs to let them know about the OCK program, they do not always have time to speak, especially with COVID. • When hospitals are not letting you in, making sure care coordinators are referring the clients where they need to go. • Clients are not ready yet. • Spend lot of time just trying to connect with members. • Members not wanting their information shared with all of their providers. • Confidentiality.	• Barriers in collaborating with other health partners/providers who work with the members: ○ Time consuming ○ COVID-19 pandemic ○ Providers are not readily available or do not have buy in for the collaboration. ○ Members not ready to join OCK ○ Members not wanting to share their information with all of their providers
• OCK program being short staffed. • Staffing challenges • We have agency wide staffing challenges • Getting a Nurse Care Coordinator on board • Finding Care Coordinators • We no longer have a peer support • Lack of professionals in the area • Multiple roles for same staff for sure (4) • Getting the case managers to actually do OCK work • Covering multiple counties • OCK Providers noted that staffing shortages that were present prior to the public health emergency have been exacerbated by the pandemic, making it difficult to meet the needs of current members and hampering efforts to promote and expand their programs. • Building our number of OneCare members to a high enough level that we can hire staff • Some reported they don't promote the program because they don't have the staff to serve additional members. • Medical Staff (4) • Retaining staff • Keeping a fulltime Care Coordinator • Competitive wages with other social work type jobs • Care Coordinators are required to have a degree. People who have a degree (social work, public health, psychology, etc.) want more than our organization can pay • Justifying the costs • Finding other duties for an FTE until the case load is built up	• Challenges for staffing OCK program: ○ Unavailability of professionals and recruiting staff needed for the program ○ Adequate number of staff not available ○ Inadequate staffing and time constraints (staff with multiple roles, covering multiple counties, and increased enrollment) ○ Getting medical staff ○ Staff retention ○ Financial issues as competitive wages and justifying the costs

Table A.4. Barriers/Challenges Encountered by OneCare Kansas Partners in the Implementation of the Program (Continued)	
OCK Program Partners' Responses	**Key Themes**
• In rural areas, some members are "dismissed" from a clinic—often for "non-compliance"—which then prevents them from accessing medical care anywhere in the area and distance travel is usually unrealistic. This is especially true for specialists. One suggestion for overcoming this challenge was to determine if patients are able to make an initial "meet" appointment with a specialist and then have virtual appointments after that.	• Issues related to access to care in rural areas
• Rural areas compared to urban areas.	

4. Observations Related to the OneCare Kansas Program Success in Achieving its Goals

In June of 2021, the Wichita State University Community Engagement Institute (WSU CEI) launched a brief online survey of OCK partners (OCKPs) on behalf of KDHE DHCF. This survey was intended to obtain a point-in-time impression of program success in achieving its goal from the perspective of contracted OCKPs. In addition, KDHE DHCF scheduled six regional virtual meetings with OCK partners in July 2021. The information collected through online survey and the virtual meetings is reviewed and key themes are summarized in Table A 5.

Table A.5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021	
Individual Member Successes	
OCK Program Partners' Responses	**Key Themes**
• Helped a member who was homeless find housing. He is very happy about that and managing his chronic illness very well now that he is stable.	• Coordination of care to assist members with their multiple health and social issues
• A hearing-impaired patient has benefitted from the coordination of her care. It's been difficult for her to reach other providers who do not provide a portal for communication.	
• Received a call from a health provider regarding a client that has been inconsistently involved with the program. This patient often has medication discrepancies and has established creative ways to get her needs met that may not be to her benefit. By working with other internal staff, they were able to do a wellness check at the home to make sure the patient was safe. The team was also able to establish a single point of contact for the patient to assure the team has consistent information to reduce opportunities for treatment errors. This was an example of also showing the providers that the program was here to support their treatment efforts.	
• A patient with significant wounds on her legs who was previously in a wheelchair is now able to get up and walk around her house (one of her goals). The OCK partner (OCKP) spoke with her the day of this meeting and was able to provide her more resources with other medical concerns. This also helped her family member present in the room today. She was very grateful for the assistance.	• Provision of resources to the members for morbid conditions, and pre-surgical education and support
• Patient was able to complete pre-education required for bariatric surgery and had a successful surgery with support from the OCKP to manage her anxiety prior to surgery.	

Table A.5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)

Individual Member Successes	
OCK Program Partners' Responses	**Key Themes**
• Patient was referred to and successfully completed Tobacco Cessation program. Is still tobacco-free 13 months later.	• Provision of health promotion resources and support to the members to assist them with their disease prevention efforts
• A patient who had weight loss as a HAP goal has been making progress on that goal, but she didn't have a scale at home and wanted to monitor her weight between visits. The OCKP was able to secure a scale for her. She is now pursuing getting a free gym membership. She likes that the OCKP is supporting her.	
• Client that resisted engagement with any activities has multiple health issues but only wanted to focus on weight. Despite expressed interest, she was resistant. The OCKP was able to get her and her son (who also has significant weight issues) to accept enrollment in their Wellness Center's scholarship program. Both mother and son are now visiting the gym to walk together 1 - 3 times a week. They also have access to other types of fitness equipment as well as fitness measurements and goal setting to help monitor their progress. This has also led to them having conversations about eating differently. The OCKP is hoping this will lead to the two of them hold each other accountable and providing one another support on their weight loss journey.	
• Family (both parents in OCK program) with a newborn baby that had some feeding and growth concerns. PCP called the team to report these issues and concerns about parenting. During a home visit, the nurse care coordinator noticed they were putting rice in the baby's bottle which was counterproductive to the parent's goal to increase baby's weight. With some education, the baby is now gaining weight and doing very well. These efforts benefit the future health of the whole family.	
Organization/System Successes	
• Engagement with those members who participate is good and they appreciate having regular contact with someone who can act as a "wingman" or act as a sounding board.	• Engaging with the members and their families to support them with their health improvement efforts
• Our agency serves children only, so the ability to support the family with tasks to benefit the family as a whole has been a great benefit to a few of the families that we serve.	
• For individuals who are seeing increased health issues as they age, it is helpful to have a "cheerleader" on your side to help identify alternative ways to exercise, etc.	
• Offering a monthly "meet and greet" for enrolled members to meet the OCK team and get a tour of the facility. Also discuss services and offer food from their food pantry program. Have only held this once so far but future events will have a theme like self-care, "Chopped" food demo, etc.	• Provision of information on program services available for the members
• Success with just letting members know all the different benefits offered through their KanCare plans with the various MCO's. Several had not realized they could schedule transportation to health appointments!	
• Hiring additional or dedicated staff within the organization which allows the OCK team to focus more that program.	• Growth and sustainability of the program due to increased number of members, member engagement and trust, and hiring of staff dedicated to OCK
• OCK program is growing in members and in staff – now at a point that the program is sustaining itself.	
• Members who are engaged seem to participate more fully because they have chosen to be in the program by opting in.	
• Seeing success with members identifying their own needs as they review assessments together and what they need to meet those needs.	
• OCKP is beginning to have more patients start reaching out to them for assistance, demonstrating that they are beginning to trust the partner and know they will be there to help.	

Table A.5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)

Organization/System Successes	
OCK Program Partners' Responses	**Key Themes**
• Collaboration with MCO providers on patient rosters and getting members that have moved to other areas of the state connected to a OCK partner in their community quickly.	• Collaboration between providers such as PCPs, dental providers, other medical providers, hospitals and MCOs that connect members to medical, dental, and community resources
• Successes connecting members with resources in their community to meet needs beyond their physical health needs, like accessing food, managing insect infestations, improved living conditions.	
• Many members who had not seen a primary care provider in quite some time are going in to see their doctors and even having additional testing done as issues are being identified. Others getting into dental providers after not receiving ongoing care.	
• CMHC partnered with KU Cancer Center to hold an onsite cancer health screening for their patients/OCK members. Members received vouchers for more significant screenings (mammograms, etc.). MCOs provided incentives to give out at the event.	
• Engagement with medical providers has been good most of the time.	
• When visiting medical providers in the community, their staff are praising how the OCKP is helping their patients and asking how to enroll others.	
• Improved relationships with Primary Care Providers as their team attends appointments with members, etc.	
• Seen increased collaboration with internal staff as they are seeing how the OCK program can also benefit them as providers in addition to the patient.	
• Accessing internal providers to get information on community resources that can benefit OCK members.	
Program Successes in Connecting with Other Community Providers	
• Has worked well to introduce ourselves to primary care providers as a care coordinator first as this is a role they understand, address the business at hand, and then talk to them more about OCK and what it can offer.	• Utilizing collaborative strategies with community providers, such as PCPs, hospitals and FQHCs for member recruitment and referrals to OCK program.
• Sending flyers to different organizations and potential clients.	
• Branded flyers that briefly explain the program in a tangible way • helped to educate both providers and members.	
• Word of mouth when engaging with providers – offering what we do, who we serve, what is the focus of the program and what you plan to do. This sharing of information seems to also help with those who may be hesitant to engage.	
• Care coordinators are contacting local hospital social workers, etc. to inform about the program.	
• We educated foster care contractor staff about the program and its benefits as they often have never heard of it when children get opted in.	
• Staff did a "tour" of all of their own satellite locations across their service area to explain the program and establish an internal referral network.	
• Using medication reconciliation or Health Action Plan (HAP) process has led to an increase in communication with primary care physicians.	
• Have placed emphasis with physicians and medical providers on how the OCKP can enhance their work and act as an extension of their practice.	
• Participated in a case conference with staff from a local hospital emergency department to consult on a patient they have in common. This resulted in the hospital requesting that the OCKP do a presentation for new hospital social work staff to increase awareness of the program and reduce ER utilization. This resulted in the hospital contacting the OCKP more proactively about members.	
• OCKP (CMHC) has been in contact with another OCKP (FQHC) in town who is the primary provider for one of our patients. I was able to speak with his nurse to coordinate his care	
• For CMHCs, taking advantage of the hospital liaison staff to engage hospital providers for behavioral health needs. Others have "behaviorists" at local primary care clinics that have helped support connections.	
• CMHC sends patients to local FQHC (who is not an OCKP) for primary care. They have regular meetings with this organization, and this allows for opportunities to discuss the program.	

Table A.5. Impressions of the OCK Program Partners Regarding Major Successes of the Program, June and July 2021 (Continued)	
Program Successes in Connecting with Other Community Providers	
OCK Program Partners' Responses	**Key Themes**
• Have added a "global alert" in their internal electronic health record (EHR) to alert providers that a patient is enrolled in the program. This has led to their own internal providers making referrals for new patients as well. • FQHC reported having a Population Health Team that gets alerts for hospital and ER admissions and they have done a good job of checking the global alerts and getting that info to the OCK team.	• Using EHR global alert technology to assist providers in sending member enrollment information to the OCK program, and in making referrals to the program.
Successes Related to the Marketing of the Program to the Community	
• Several OCKPs reported being members of a variety of community coalitions such as local community needs assessment committees, monthly United Way meetings. LGBTQ Health Coalition, etc. They make an effort to discuss the OCK program during agency updates at these meetings • OCKPs report doing community presentations at agencies such as local homeless shelters and Area Agencies on Aging to promote awareness of the program for the clients they serve. • Having an OCK booth at a local Mental Health Awareness Day event in the courthouse square instead of holding it at the CMHC which meant they were exposed to a wider sector of the community than they have been in the past. • Small programs report that they are relying on "word of mouth." Word about the program seems to be spreading this way among primary care providers. • Marketing the program to other providers within our own organization. • Assembled packets of information to distribute to providers in the area that includes tailored information about their specific program and role expectations for both the OCKP and the Primary Care Provider. • Presentations to partners emphasize the program's ability to focus on physical and mental health needs at the same time and use written materials to supplement oral presentations.	• Use of a variety of marketing strategies for community and provider outreach ○ Program presentations and discussions at the Community Coalitions' and community agencies' meetings and at the community events conducted at the public venues. ○ Communication of program information to the PCPs and other internal and external partners using word of mouth, packages with tailored information, and presentations
• Have designated staff for the OCK team that can talk with new clients to the CMHC who may be eligible for OCK. • Looking at using the organization's mass text alert systems to reach out to members that they have been unable to engage and encourage them to come in for an appointment. • Others have attended COVID Vaccine clinics to identify potential members and provide education—even finding some individuals that are currently eligible and assisting them to opt-in.	• Direct communication with the new clients attending various clinics and use of organization's mass text alert system to provide information and encouraging them to join the OCK program and make appointments.

5. Assistance Needed by the OCK Partners from OCK Partners' Network and State/MCO Implementation Team to Assure Quality Services

During the July 2021 virtual meetings, participants were asked what their needs are that could be addressed by other partners within the OCK network, as well as by the State/MCO implementation team to assure quality services are provided to the members participating in the OCK program. This information is summarized in Tables A 6 and A 7.

Table A.6. Needs to be Addressed Among OCK Partners, June and July 2021

OCK Program Partners' Responses	Key Themes
• Contact information for staff working within OCK partners from across the state and establishing a line of communication at regional or state level. • Establishing a line of communication to identify individuals receiving TCM services and the best way to serve them. • Opportunities for OCK partners to meet without members of the state/MCO team present. This could happen through provider associations (ACMHCK, CCNK, etc.) or organized independently at the local or regional level. • A "database" to share ideas. • Information from other providers regarding their programs operate. Allowing providers to learn from one another's experiences. • New providers could benefit from a seasoned provider helping to navigate the system and be a contact for any questions. • Send out an email once a month asking to submit one success/thing that they helped a consumer with/new resource and then a list could be compiled and emailed out to everyone. One partner reported this would be helpful to have as something to save and review periodically that may spark ideas that could be used as agencies and with their consumers, that they may not have thought of. • Local meetings of OCKPs in the area to discuss what was learned in official OCK gatherings, mutual challenges, offer support, and share processes/ resources. • Ideas for how others are engaging members. • Willing to share contact information for their teams. • Willing to pair up with programs that may be new or small to offer them advice and support related to program operations and resource sharing. • Some partners have offered joint training to their communities and willing to continue to stay in contact that way.	• Peer learning and support ○ Peer mentoring ○ Conducting joint trainings ○ Sharing ideas and successes
• Strategies for marketing within Emergency Departments in some parts of the state. Especially when the doctors in those settings are somewhat transient. (Suggestion was to connect with hospital discharge planners and make them aware of the program. • One partner asked if anyone knew of or had an available nurse that the OCKP could purchase time or share – another partner offered someone they knew that would perhaps be interested in part-time work and exchanged contact information. • Additional dental resources (Johnson Co Community College has a dental hygiene school that offers cleanings and fillings as does Concorde Career College. Topeka Correctional Facility has a partnership with the Kansas Association for the Medically Underserved for dentures.) • Opportunities to identify and build bridges between CMHCs and FQHCs where there have been some historically strained relationships. • Knowledge of programs within CMHCs so that FQHCs can refer to additional specialty services for high need clients. • A way to identify when individuals who qualify for Mental Health TCM are assigned to a FQHC for OCK and ways to educate the patient about which organization would best meet the patients' needs. • Ideas for connecting with community businesses to donate undesignated funds that could be used for items such as scales, pedometers, etc. • Community Care Network of Kansas was able to create a listserv for clinics to contact all the other FQHCs participating. • FQHC willing to get CMHC OCKPs patient records as quickly as possible and willing to advise staff on how the organization works when attending appointments with patients • Communication between partners when there are clients who may be shared.	• Making provider and community connections to identify resources. ○ Connections between CMHCs and FQHCs. ○ Community business donations ○ Hospital discharge planners ○ Dental resources ○ Listserv for clinics to contact all the other participating FQHCs ○ Communication between partners sharing clients

Table A.7. Assistance Needed from the State/MCO Implementation Team, July 2021

OCK Program Partners' Responses	Key Themes
• Demographics about each program (Who they serve, how many, etc. • A list of contacts within OCK partners – create a directory that includes the demographics of the programs. • Clarification about the impact of the new federal Certified Community Behavioral Health Clinics initiative on the OCK network. • More transparent diagnoses/qualifying information on clients. Even with portal access OCKPs may find it very difficult to find that information. • Additional organization level data from the HAP portal – trends in clinical outcomes and cost benefits, etc.	• Information needed: ○ Each program's demographics ○ Contacts within OCK partners ○ Clarification on new federal Certified Community Behavioral Health Clinics initiative ○ Diagnosis/qualifying information on clients ○ Organizational data on trends in clinical outcomes, cost benefits, etc. needed
• Improvements to adding the OCK flag and service start date to KMAP so that providers can verify eligibility more quickly. • Notification when any member one provider may have active claims on enrolls in OCK with another provider. • It would be helpful if the invitation letter could include that the member needs to actively participate in the program. • A universal electronic health record to make record access and transfers easier. • Improved process for getting members removed from monthly rosters whether it is an opt-out or the member doesn't ever engage. • Improved systems for educating members with developmental disabilities as well as the IDD TCM providers to understand what it means to opt-in. • Gaining access to Emergency Department and Hospital data to allow the OCKP to follow up and provide better transition planning. Often learn about the hospitalization after discharge. • Honoring organization capacity reports to allow OCKPs to balance staffing shortages with the number of individuals who opt-in.	• Improvement in program processes and systems for member recruitment, engagement, discharge, and transition: ○ Add OCK flag and service start date to KMAP ○ Notification of member's OCK enrollment with another provider ○ Electronic system in place for easier access and transfers of the records ○ Improved process to remove from the roster the members who opt-out ○ Improved education of members and providers regarding opt-in process, including need for active participation in client invitation letter. ○ Access to ER and hospital data for better follow-up and transition planning for members ○ Attention to organizational capacity of OCKPs
• More overarching state level education to hospitals, foster care, etc. and then we can follow up with them, but they are already aware of the expectations to participate. • Additional assistance with locating children in the foster care system and educating foster parents about the program (suggestions for local efforts offered - OCKPs request to visit local foster parent support group meetings to provide education and also for the child placing agencies who support foster parents).	• State assistance needed to provide education about the program to hospitals, foster care agencies, and foster parents; and in locating children in the foster care system.
• More timely audit results so that the program can make changes and have time to implement the changes prior to the next audit. • Agreement on the audit results. Perhaps if we pass an audit, we earn the opportunity to bypass the next one.	• Timely provision of audit results to implement changes; agreement on audit results; bypassing the subsequent audit depending on audit results
• One OCKP reported that they appreciate the monthly meetings with the MCOs to just check in. Being able to review information on their provider portals is very helpful. • Consistent design between MCO portals and how they are populated and updated. Also access to SUD information. • MCO staff not responding to emails timely which adds to the administrative burden.	• MCO communications and systems ○ Regular meetings with MCOs and review of information on their provider portals ○ Consistency in MCOs' systems and improvement in timely communication by MCO staff

6. Recommendations and Potential Next Steps for the OneCare Kansas Program

During the July 2021 virtual meetings, OCK program partners made recommendations and suggested potential next steps for the program. This information is summarized in Table A8.

Table A.8. Recommendations and Potential Next Steps, July 2021

- **Increase access to medical care among non-compliant patients by allowing initial in-person appointment and virtual appointments for follow-up visits.**
  - For overcoming the challenge of patients in rural areas who were dismissed from clinic for non-compliance and were unable to access medical care, determine if patients are able to make an initial "meet" appointment with a specialist and then have virtual appointments after that.
- **OCKPs across the state could build their professional networks and provide mutual support outside of the formal opportunities offered by the State.**
  - Overall, OCKPs across the state indicated a desire to build their professional networks and provide mutual support outside of the formal opportunities offered by the KDHE DHCF and WSU CEI. All partners recognized that this would take intentional time and effort that they sometimes feel they do not have due to staffing shortages and high workload, but many regions reported that this investment would be beneficial to their programs.
- **Development and use of the provider directory to assist in communication and collaboration across the network of OCK partners.**
  - Discussion between MCO representatives and WSU CEI staff to develop a provider directory to be distributed across the network (not publicly).
  - OCK partners will utilize the directory to reach out to one another to establish local/regional opportunities for connection and information sharing to enhance professional relationships across the network. This may be through email or regularly scheduled virtual/in-person meetings.
- **Improve program processes and systems.**
  - OCKPs promote services within other programs to help boost their referrals as well.
  - KDHE DHCF will continue to work with Gainwell Technologies to assure timely entry of information into KMAP.
  - KDHE DHCF and the MCOs will review opportunities to improve processes related to member invitations, program audits, notice of enrollment when there are multiple potential providers and the Health Action Plan portal.
- **Developing connections with local foster care contractors, child placing agencies, local hospitals, and emergency departments.**
  - OCKPs will reach out to local foster care contractors and child placing agencies to offer education about their local programs and the benefits to youth in foster care.
  - OCKPs will continue to develop connections with local hospitals and emergency departments.
  - KDHE DHCF will continue to research the relationship between CCBHCs and OCK.
- **Identification of the opportunities to obtain hospital data and provision of organizational data.**
  - The State team will work to identify opportunities to obtain data from the hospital systems in Kansas.
  - KDHE DHCF opportunities to provide organizational level data for quality improvement efforts.

Appendix B

KanCare 2.0 Interim Evaluation Report Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Hypothesis 3: The Use of Telehealth Services

Interim Evaluation of the KanCare 2.0 Demonstration Hypothesis 3: The Use of Telehealth Services

Quantitative and qualitative analysis were used for the interim evaluation of KanCare 2.0 Hypothesis 3, stated in Figure B1. Measurement data for quantitative evaluation are provided, as available, for the time period of January 1, 2019, through December 31, 2021, while updates and qualitative data are provided for the time period through September 30, 2022. The results of the analyses assessing the quantitative and qualitative evaluation measures are described here.

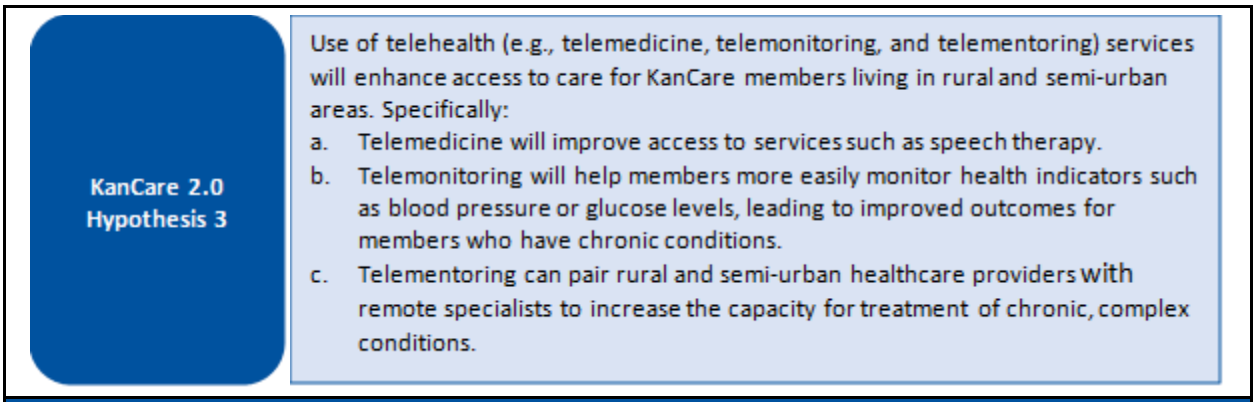


Figure B.1. KanCare 2.0 Demonstration Hypotheses 3

Quantitative Evaluation

Results of the Evaluation of Use of Telemedicine Services

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."*

Two evaluation questions related to the use of telemedicine services were examined in the interim evaluation:

- Did use of telemedicine services increase over the five-year period for KanCare members living in rural or semiurban areas?
- Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?

Since the evaluation measures are focused on the use of telehealth services among KanCare members living in the rural or semi-urban areas, data were examined in two geographic areas, *Non-Urban* and *Urban*. KDHE's grouping of counties into frontier, rural, densely rural, semi-urban and urban population density groups was used in defining the areas.[13] The Urban area is KDHE's urban counties: Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The Non-Urban area contained the frontier, rural, densely rural, and semi-urban counties.

Five outcome measures were analyzed to evaluate the above-mentioned question:

1. Percentage of telemedicine services received by members living in the rural or semi-urban areas (Non-Urban). Subgroup analyses by age and primary diagnosis.
2. Number of receiving sites for telemedicine services in the rural and semi-urban areas (Non-Urban). Subgroup analyses by age.
3. Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services. Subgroup analyses by age.
4. Number of paid claims with selected procedure codes, stratified by area, mode of delivery, provider specialty, and selected diagnosis categories.
5. Number of members with selected diagnosis (e.g., speech-language pathology) per 1,000 members, stratified by area.

Based on outcomes of the first three measures, four sets of procedure and diagnosis codes were chosen to address the evaluation question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" The sets were related to speech therapy, individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment. The strategy was to identify members (using diagnosis codes) for whom those services were likely to be beneficial (or *indicated*). Increases in the percent of members with indicating diagnosis who received the selected services would be evidence of an affirmative answer to the question. Toward this end, stratified results of Measures 4 and 5 were used to form eight additional metrics:

- Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80
- Percentage of KanCare members with diagnosis in category F80 who received speech therapy
- Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis (categories F34, F40, F43, F60, F91, and F93)
- Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy
- Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis (categories F34, F91, F93, T74, and T76)
- Percentage of KanCare members with indicating diagnosis who received family or group psychotherapy
- Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis (F20, F25, F34, F60, and F91)

The age strata used in analyzing the first three measures were 0–17 years, 18–45 years, and 46 years and older at the time of service received. These strata were selected to ensure adequate representation within each stratum. Also, the chronic diseases that can benefit from telemedicine services are more prevalent among 46 years and older adults.[14] In addition to age strata, counts by primary diagnosis were stratified by ICD-10-CM chapters and blocks, and strata with the highest counts are reported.

The encounter, demographics, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse were used for the analyses of KanCare 2.0 data from January 2019 through December 2021, and pre-KanCare 2.0 data for 2018.

Measure 1: Percentage of telemedicine services received by members living in rural or semi-urban areas

Analytic results and findings of Measure 1 are presented in Table B1. The table includes stratifications by geographic area and age. Tables B1 and B2 provides result of stratification of primary diagnosis codes by ICD-10-CM chapter and block (a *chapter* is a major division of the diagnosis codes based on body function or condition; a *block* is a subdivision of a chapter). Counts for 2018 and 2019 were combined and compared to counts for 2021 by ranking the strata by claim count. Chapters and blocks in the top five ranks of either period are included in the tables.

Table B.1. Telemedicine Services Received by KanCare Member Location and Age Group

Measure 1: Percentage of KanCare telemedicine services that were received by members living in rural or semi-urban areas (Non-Urban) of Kansas

Age on Day of Service	Pre-KanCare 2.0	KanCare 2.0			Statistical Analysis (For Percent Non-Urban)	
Area	2018	2019	2020	2021	Comparison Periods	*p*-value
All Ages						
Non-Urban	24,034	26,844	355,386	251,844	2018 & 2019	p<.01
Urban	4,550	5,429	341,522	269,302	2019 & 2020	*p*<.001
Total	28,584	32,273	696,908	521,146	2020 & 2021	*p*<.001
Percent Non-Urban	84.08%	83.18%	50.99%	48.33%	Trend: 2019 to 2021	*p*<.001
0–17 Years						
Non-Urban	9,148	10,235	173,446	102,449	2018 & 2019	*p*<.001
Urban	2,512	3,310	166,369	111,851	2019 & 2020	*p*<.001
Total	11,660	13,545	339,815	214,300	2020 & 2021	*p*<.001
Percent Non-Urban	78.46%	75.56%	51.04%	47.81%	Trend: 2019 to 2021	*p*<.001
18–45 Years						
Non-Urban	5,912	6,308	94,188	83,409	2018 & 2019	*p=.28*
Urban	1,013	1,137	98,842	97,621	2019 & 2020	*p*<.001
Total	6,925	7,445	193,030	181,030	2020 & 2021	*p*<.001
Percent Non-Urban	85.37%	84.73%	48.79%	46.07%	Trend: 2019 to 2021	*p*<.001
46 Years and Older						
Non-Urban	8,974	10,301	87,752	65,986	2018 & 2019	*p*<.001
Urban	1,025	982	76,311	59,830	2019 & 2020	*p*<.001
Total	9,999	11,283	164,063	125,816	2020 & 2021	*p*<.001
Percent Non-Urban	89.75%	91.30%	53.49%	52.45%	Trend: 2019 to 2021	*p*<.001

Interpretation/Comments:

- The number of telemedicine services increased from 2018 to 2019 for Non-Urban and Urban members. This pattern was also seen for each age stratum except for Urban members aged 46 years or older. The considerably large increases from 2019 to 2020 corresponded to the onset of the COVID-19 pandemic. Counts for Non-Urban and Urban members and each age stratum decreased from 2020 to 2021 but remained well above pre-pandemic levels.
- The increases were relatively greater in the Urban area than the Non-Urban area. Consequently, the percentage of the telemedicine services received by Non-Urban members decreased each year, except for the increase from 2018 to 2019 for members aged 46 years or older.
- The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.

Counts of telemedicine services were stratified by age group and member's county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences in Non-Urban percentages between two years used a weighted Pearson chi-square test, and testing whether the slopes of the 3-year trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test (p<.05 was considered statistically significant).

Table B.2. Telemedicine Services Ranked by ICD-10 CM Diagnosis Chapter

Area of Member Residence ICD-10-CM Chapter of Primary Diagnosis Code	Code Range	2018–2019 Count	2021 Count	2018–2019 Rank	2021 Rank
Statewide					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	55,781	421,511	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	893	29,382	3	2
Diseases of the Respiratory System	J00–J99	915	10,048	2	3
Diseases of the Nervous System	G00–G99	696	9,967	4	4
Endocrine, Nutritional and Metabolic Diseases	E00–E89	529	7,901	5	6
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	325	8,092	6	5
Non-Urban					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	47,403	202,712	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	645	12,127	2	2
Diseases of the Respiratory System	J00–J99	453	5,802	4	3
Diseases of the Nervous System	G00–G99	543	5,152	3	4
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	208	4,218	6	5
Endocrine, Nutritional and Metabolic Diseases	E00–E89	349	3,988	5	6
Urban					
Mental, Behavioral and Neurodevelopmental Disorders	F01–F99	8,378	218,799	1	1
Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	R00–R99	248	17,255	3	2
Diseases of the Nervous System	G00–G99	153	4,815	5	3
Diseases of the Respiratory System	J00–J99	462	4,246	2	4
Endocrine, Nutritional and Metabolic Diseases	E00–E89	180	3,913	4	5
Factors Influencing Health Status and Contact with Health Services	Z00–Z99	117	3,874	6	6

Interpretation/Comments:

- The chapter Mental, Behavioral and Neurodevelopmental Disorders (Codes F01–F99) had the highest ranking for Non-Urban and Urban members in both time periods. For 2018–2019, number of claims for Non-Urban members with codes F01–F99 was over 60 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified). In 2021, the number of claims for Non-Urban members was 17 times the number of claims in the second ranked chapter (Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified).
- The next five highest ranked chapters were the same in 2018–2019 as in 2021, but the rankings were slightly different.

Counts of telemedicine services were stratified by the ICD-10-CM chapter of the primary diagnosis code and by member's county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. The six top ranked chapters for 2018–2019 and 2021 are shown in order of 2021 rank.

This area intentionally left blank

Table B.3. Telemedicine Services Ranked by ICD-10 CM Diagnosis Block

Area of Member Residence ICD-10-CM Block of Primary Diagnosis Code	Code Range	2018–2019 Count	2021 Count	2018–2019 Rank	2021 Rank
Statewide					
Mood [affective] disorders	F30–F39	23,501	153,875	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	8,123	114,371	3	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	11,574	68,294	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	7,887	32,990	4	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	644	25,757	8	5
Mental disorders due to known physiological conditions	F01–F09	1,865	1,817	5	21
Non-Urban					
Mood [affective] disorders	F30–F39	19,934	77,127	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	6,520	49,777	4	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	9,926	36,770	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	6,789	15,498	3	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	570	11,360	8	5
Mental disorders due to known physiological conditions	F01–F09	1,818	1,336	5	16
Urban					
Mood [affective] disorders	F30–F39	3567	76,748	1	1
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	F40–F48	1603	64,594	3	2
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	F90–F98	1648	31,524	2	3
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	F20–F29	1098	17,492	4	4
Mental and behavioral disorders due to psychoactive substance use	F10–F19	74	14,397	13	5
Chronic lower respiratory diseases	J40–J47	299	1,945	5	10

Interpretation/Comments:

- In 2021, the top five ranked blocks of primary diagnosis codes on telemedicine claims had the same rank for Non-Urban and Urban areas. Each of the five blocks were from the Mental, Behavioral and Neurodevelopmental Disorders chapter. Mood [affective] disorders (codes F30–F39) ranked first in both years.
- The top four blocks of primary codes were the same in 2018–2019 and in 2021 (statewide, Non-Urban and Urban areas), although the rankings had changed.
- Mental and behavioral disorders due to psychoactive substance use (codes F10–F19), which ranked 8th in Non-Urban and 13th in Urban areas for 2018–2019, rose to 5th for 2021—displacing mental disorders due to known physiological conditions (F01–F09) in the Non-Urban area and chronic lower respiratory diseases (J40–J47) in the Urban area.

Counts of telemedicine services were stratified by the ICD-10-CM chapter block of the primary diagnosis code and by member's county of residence; Urban counties are Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Blocks shown were in the top 5 ranked blocks for either 2018–2019 or 2021 and are shown in order of 2021 rank.

Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban areas

Table B4 shows the number of *receiving sites*, that is, billing provider locations providing telehealth services to KanCare members. Stratification into Non-Urban and Urban areas is based on the member's county of residence.

Table B.4. Receiving Sites for Telemedicine Services by KanCare Member Location and Age Group

Measure 2: Number of receiving sites for telemedicine services in the rural and semi-urban areas (Non-Urban).

Area of Member Residence	Pre-KanCare 2.0	KanCare 2.0		
Age Group	2018	2019	2020	2021
Non-Urban				
0–17 Years	57	65	514	485
18–45 Years	70	71	547	521
46 Years and Older	73	65	458	440
All Ages	94	94	698	714
Urban				
0–17 Years	38	50	653	612
18–45 Years	32	56	727	727
46 Years and Older	23	36	505	475
All Ages	59	87	965	938

Interpretation/Comments:

- The number of receiving sites providing telemedicine services to Non-Urban KanCare members were relatively unchanged from 2018 to 2019, but increased considerably for 2020 and 2021, which were the initial years of the COVID-19 pandemic.
- The number of receiving sites providing telemedicine services to Urban KanCare members increased slightly between 2018 and 2019 and then increased considerably for 2020 and 2021.
- The data for 2022 and 2023 may indicate whether the increases observed during 2020 and 2021 are maintained as the pandemic resides.
- Note, the data do not indicate the number of sites capable of offering telehealth services (many of the receiving sites counted for 2020 or 2021 may have been providing telehealth to non-KanCare persons in 2018 and 2019).

Telemedicine services provided to KanCare members were deduplicated to count the receiving site's (i.e., provider location's) billing provider National Provider IDs once per age group per area of the member's residence. Counties defining the Urban area were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte.

This area intentionally left blank

Measure 3: Percentage of members living in the rural or semi-urban areas who received telemedicine services

Table B5 shows the number and percentage of KanCare members who received telemedicine services, stratified by age and area. Stratification into Non-Urban and Urban areas is based on the member's county of residence.

Table B.5. KanCare Members Receiving Telemedicine Services by Member Location and Age

Measure 3: Percentage of members living in the rural or semi-urban areas (Non-Urban) who received telemedicine services.

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
Age at Time of Service	Statistic	2018	2019	2020	2021
Non-Urban	Members (denominator)	179,043	176,020	188,599	206,837
All Ages	Members Receiving Telehealth	7,063	7,825	46,635	42,380
	Percent	**3.94%**	**4.45%**	**24.73%**	**20.49%**
Non-Urban	Members (denominator)	100,879	100,879	106,498	111,518
0–17 Years	Members Receiving Telehealth	3,021	3,539	21,167	18,489
	Percent	2.99%	3.51%	19.88%	16.58%
Non-Urban	Members (denominator)	40,576	38,040	42,695	53,775
18–45 Years	Members Receiving Telehealth	2,197	2,322	13,126	13,374
	Percent	5.41%	6.10%	30.74%	24.87%
Non-Urban	Members (denominator)	37,588	37,101	39,406	41,544
46 Years and Older	Members Receiving Telehealth	1,845	1,964	12,342	10,517
	Percent	4.91%	5.29%	31.32%	25.32%
Urban	Members (denominator)	190,873	188,146	204,013	226,764
All Ages	Members Receiving Telehealth	1,610	1,937	44,150	38,966
	Percent	**0.84%**	**1.03%**	**21.64%**	**17.18%**
Urban	Members (denominator)	111,069	110,907	118,526	125,173
0–17 Years	Members Receiving Telehealth	925	1,178	20,588	16,957
	Percent	0.83%	1.06%	17.37%	13.55%
Urban	Members (denominator)	43,837	41,686	47,434	60,831
18–45 Years	Members Receiving Telehealth	410	520	13,021	13,279
	Percent	0.94%	1.25%	27.45%	21.83%
Urban	Members (denominator)	35,968	35,553	38,054	40,760
46 Years and Older	Members Receiving Telehealth	275	239	10,541	8,730
	Percent	0.76%	0.67%	27.70%	21.42%

Interpretation/Comments:

- The percentages of Non-Urban and Urban KanCare members who received telemedicine services increased from 2018 to 2019, and from 2019 to 2020. However, percentages decreased from 2020 to 2021 but remained well above pre-pandemic levels. Similar patterns were seen for three age strata for Non-Urban members.
- These patterns were also seen for each age stratum for Non-Urban members. Similar patterns were seen for each age stratum for Urban members, except for 2018–2019 comparison period for the members 46 years and older (no statistical difference seen in percentage from 2018 to 2019).
- The overall increase in use of telemedicine services occurred in 2020 and 2021, the initial years of the COVID-19 pandemic. The data and analytic results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemedicine services in Non-Urban areas of Kansas.

Counts of KanCare members and KanCare members who received telemedicine services were stratified by age group and member's county of residence; Urban counties were Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte. Testing for statistically significant differences between two consecutive years used a weighted Pearson chi-square test and testing whether the slopes of the 2019–2021 trend lines were statistically significantly different from horizontal used a weighted Mantel-Haenszel chi-square test ($p<.05$ was considered statistically significant). Tests showed $p<.001$ except from 2018 to 2019 for members aged 45 or older in the Non-Urban ($p=.02$) and Urban ($p=.14$) areas.

Speech Therapy Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving speech therapy who had a diagnosis in category F80*
- *Percentage of KanCare members with diagnosis in category F80 who received speech therapy*

The State approved a set of speech-language pathology or audiology codes for telemedicine delivery effective January 1, 2019.[26] The list of procedure allowed to be offered via telemedicine was expanded to include CPT codes 97129 and 94130, which became effective in January 2020. With the onset of the COVID-19 pandemic, telemedicine was approved for diagnostic evaluations related to speech and language and to procedures performed in homes.[28,29] Service delivery trends for these codes, and other codes approved for telemedicine during the demonstration, were studied, and Non-Urban (rural and semi-urban) and Urban tends were compared. During development of the evaluation design, it was hypothesized that an increase in access to evaluation services could lead to an increase in diagnosis of related conditions. Thus, the number of members diagnosed with speech-language and audiology pathological conditions were analyzed.

The first step of the analysis was to identify the procedure codes to be selected for the measures. Table B6 provides codes and descriptions of procedures commonly offered by speech-language pathologists (SLPs) and audiologists that had been provided via telemedicine at least once in 2019, 2020, or 2021. The table includes counts of paid services (strata of Measure 4) and the percentages of those which were by telemedicine. Paid claims on which a multiple-specialty billing provider (e.g., clinics) was listed as the performing provider instead of an individual SLP or Audiologist were excluded from the analysis for Table B6 because some procedure codes are not exclusive to speech and language. Table B7 provides codes and descriptions of procedures related to speech and language billed by HCBS providers.

Tables B6 and B7 show very few services related to speech and language were provided by SLPs, audiologists, or HCBS providers in 2019. Services with the most paid claims in 2020 and 2021 were as follows (with counts of paid claims via telemedicine in 2020 and 2021, respectively in parentheses):

- By speech-language pathologists and audiologists
  - 92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder (5,273 and 3,966)
  - 92526 – Treatment of swallowing dysfunction and/or oral function for feeding (658 and 446)
- By Home and Community Based Service providers
  - 97129 – Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes (4,296 and 3,309)
  - 97130 – Therapeutic interventions that focus on cognitive function; each additional 15 minutes (4,022 and 3,141)
  - G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes (3,119 and 3,567)

Table B.6. Services by Speech-Language Pathologist and Audiologist Provided via Telemedicine

Procedure Code* / Procedure Description	Statistic	KanCare 2.0 2019	2020	2021
92507 Treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	45,766	51,523	67,346
	Via Telehealth	0	5,273	3,966
	% via Telehealth	0.0%	10.2%	5.9%
92508 Group treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	723	435	787
	Via Telehealth	0	1	0
	% via Telehealth	0.0%	0.2%	0.0%
92522 Evaluation of speech sound production	Paid Services	204	235	250
	Via Telehealth	0	10	3
	% via Telehealth	0.0%	4.3%	1.2%
92523 Evaluation of speech sound production with evaluation of language comprehension and expression	Paid Services	2,076	2,006	2,296
	Via Telehealth	0	86	76
	% via Telehealth	0.0%	4.3%	3.3%
92524 Behavioral and qualitative analysis of voice and resonance	Paid Services	178	119	185
	Via Telehealth	0	3	0
	% via Telehealth	0.0%	2.5%	0.0%
92526 Treatment of swallowing dysfunction and/or oral function for feeding	Paid Services	13,445	15,803	21,074
	Via Telehealth	0	658	446
	% via Telehealth	0.0%	4.2%	2.1%
92610 Evaluation of oral and pharyngeal swallowing function	Paid Services	1,327	1,308	1,503
	Via Telehealth	0	1	3
	% via Telehealth	0.0%	0.1%	0.2%
96112 Developmental test administration by qualified health care professional with interpretation and report; first 60 minutes	Paid Services	188	153	271
	Via Telehealth	0	22	53
	% via Telehealth	0.0%	14.4%	19.6%
96113 Developmental test administration by qualified health care professional with interpretation and report; additional 30 minutes	Paid Services	180	71	158
	Via Telehealth	0	11	30
	% via Telehealth	0.0%	15.5%	19.0%
97112 Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes	Paid Services	1	12	104
	Via Telehealth	0	10	20
	% via Telehealth	0%	83%	19.2%
97129 (effective 1/1/2020) Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Paid Services		1,135	1,338
	Via Telehealth		72	66
	% via Telehealth		6.3%	4.9%
97130 (effective 1/1/2020) Therapeutic interventions that focus on cognitive function; each additional 15 minutes	Paid Services		930	1,014
	Via Telehealth		73	63
	% via Telehealth		7.8%	6.2%
97535 Self-care or home management training, each 15 minutes	Paid Services	6	227	185
	Via Telehealth	0	9	14
	% via Telehealth	0%	4.0%	7.6%
G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	Paid Services	125	111	200
	Via Telehealth	0	28	0
	% via Telehealth	0.0%	25.2%	0.0%

*Includes procedure codes with at least 100 paid claims and at least one paid telemedicine service identified from long-term care and outpatient claims with revenue codes 440–449 (speech-language pathology) and 470–479 (audiology) and professional claims for performing providers with specialty codes 173 (speech-language pathology) and 200 (audiology). Because some of the procedures (e.g., 96112 or 97129) are also provided other types of providers, counts excluded professional claims for which the performing provider was a clinic, practice, or home health agency listing multiple specialties.

Table B.7. HCBS Services Related to Speech and Language Provided via Telemedicine

Procedure Code* / Procedure Description	Statistic	KanCare 2.0 2019	KanCare 2.0 2020	KanCare 2.0 2021
92507 Treatment of speech, language, voice, communication, and/or hearing processing disorder	Paid Services	615	658	231
	Via Telehealth	0	283	25
	% via Telehealth	0.0%	43.0%	10.8%
97129 (effective 1/1/2020) Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	Paid Services		10,355	12,472
	Via Telehealth		4,296	3,309
	% via Telehealth		41.5%	26.5%
97130 (effective 1/1/2020) Therapeutic interventions that focus on cognitive function; each additional 15 minutes	Paid Services		10,225	12,214
	Via Telehealth		4,022	3,141
	% via Telehealth		39.3%	25.7%
G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes	Paid Services	4,445	7,528	8,592
	Via Telehealth	0	3,119	3,567
	% via Telehealth	0.0%	41.4%	41.5%

*Includes procedure codes with at least 100 paid claims and at least one paid telemedicine service professional claims with billing provider type 55 (HCBS).

Based on tables B6 and B7, procedure codes 92507 and G0153 were chosen for the next steps of the analysis. Although codes 97129 and 97130 had sufficient volume for HCBS providers, the low counts from SLP and Audiologist indicated too many of the services may have been for therapeutic interventions focusing on cognitive functions not related to speech. The other procedures had too small of counts for inclusion in the analysis. Although technically inaccurate, for this analysis *speech therapy* will refer to services billed with codes 92507 and G0153.

Table B8 shows the ratio of members who received speech therapy to the number of KanCare members as a rate "per 1,000 members" for 2018 to 2021. Statewide, rates increased each year. The statewide rate increases from 2018 to 2019 (from 5.34 to 6.56) suggest causes unrelated to telehealth or the pandemic.

Table B.8. Speech Therapy Recipients Per 1,000 KanCare Members

Area of Member Residence	Statistic	Pre-KanCare 2.0 2018	KanCare 2.0 2019	KanCare 2.0 2020	KanCare 2.0 2021
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Speech Therapy	923	1,163	1,235	1,455
	Rate per 1,000 Members	4.85	6.28	6.00	6.52
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Speech Therapy	1,202	1,380	1,668	2,070
	Rate per 1,000 Members	5.80	6.82	7.32	8.37
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Speech Therapy	2,125	2,543	2,903	3,525
	Rate per 1,000 Members	5.34	6.56	6.69	7.49

Procedure codes used to identify speech therapy were 92507 (Treatment of speech, language, voice, communication, and/or hearing processing disorder) and G0153 (Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes).

The number of paid claims with procedure codes 92507 and G0153 (Measure 4) was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B9).

Table B.9. Stratifications of Paid Claims Related to Speech Therapy

Number of Paid Claims with Procedure Code 92507 or G0153

92507 – Treatment of speech, language, voice, communication, and/or hearing processing disorder

G0153 – Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes

Area of Member Residence	Stratum	Pre-KanCare 2.0 2018 N	%	KanCare 2.0 2019 N	%	2020 N	%	2021 N	%
Statewide	Statewide Total (Denominator)	41,837		51,496		59,503		77,200	
	Non-Urban	16,946	40.5%	21,184	41.1%	23,135	38.9%	27,896	36.1%
	Urban	24,891	59.5%	30,312	58.9%	36,368	61.1%	49,304	63.9%
Non-Urban	Non-Urban Total (Denominator)	16,946		21,184		23,135		27,896	
	Mode: Telemedicine	1	0.0%	0	0%	2,286	9.9%	2,322	8.3%
	Non-Telemedicine	16,945	100%	21,184	100%	20,849	90.1%	25,574	91.7%
	Provider Type: Hospital	8,117	47.9%	10,193	48.1%	9,346	40.4%	10,401	37.3%
	Therapist	3,120	18.4%	5,943	28.1%	7,253	31.4%	8,681	31.1%
	Custodial Care Facility	2,089	12.3%	2,951	13.9%	4,472	19.3%	5,702	20.4%
	HCBS	755	4.5%	922	4.4%	1,428	6.2%	2,350	8.4%
	Physician	2,499	14.7%	874	4.1%	501	2.2%	426	1.5%
	Other Provider Types	366	2.2%	301	1.4%	135	0.6%	336	1.2%
	Primary Diagnosis:* F80	8,169	48.2%	10,165	48.0%	10,196	44.1%	11,032	39.5%
	R47–R49	1,495	8.8%	2,140	10.1%	1,818	7.9%	2,011	7.2%
	R68	654	3.9%	696	3.3%	1,254	5.4%	2,297	8.2%
	F84	630	3.7%	672	3.2%	1,099	4.8%	1,499	5.4%
	Other Diagnoses	5,998	35.4%	7,511	35.5%	8,768	37.9%	11,057	39.6%
Urban	Urban Total (Denominator)	24,891		30,312		36,368		49,304	
	Telemedicine	0	0%	0	0%	6,253	17.2%	5,227	10.6%
	Non-Telemedicine	24,891	100%	30,312	100%	30,115	82.8%	44,077	89.4%
	Therapist	7,559	30.4%	13,131	43.3%	17,045	46.9%	26,435	53.6%
	HCBS	4,188	16.8%	4,137	13.6%	6,798	18.7%	6,783	13.8%
	Hospital	4,599	18.5%	4,650	15.3%	3,891	10.7%	5,272	10.7%
	Physician	4,611	18.5%	5,474	18.1%	3,282	9.0%	2,799	5.7%
	Custodial Care Facility	1,650	6.6%	1,951	6.4%	4,278	11.8%	5,751	11.7%
	Other Provider Types	2,284	9.2%	969	3.2%	1,074	3.0%	2,264	4.6%
	F80	11,577	46.5%	15,070	49.7%	16,428	45.2%	23,293	47.2%
	R68	3,824	15.4%	4,068	13.4%	6,273	17.2%	6,574	13.3%
	F84	2,151	8.6%	3,199	10.6%	3,933	10.8%	5,869	11.9%
	R47–R49	1,636	6.6%	1,336	4.4%	1,167	3.2%	1,510	3.1%
	Other Diagnoses	5,703	22.9%	6,639	21.9%	8,567	23.6%	12,058	24.5%

*F80 – Specific developmental disorders of speech and language

F84 – Pervasive developmental disorders (96% were F84.0, Autistic Disorder.)

R47–R49 – Symptoms and signs involving speech and voice

R68 – Other general symptoms and signs (R68.89 is often used claims for HCBS services.)

In 2018 and 2019, the total number of paid claims with the two codes was about 41% Non-Urban and 59% Urban. During the pandemic, the Non-Urban percentages declined, to 39% in 2020 and to 36% in 2021. In 2020, about 10% of the paid claims for the Non-Urban area were for services provided by telemedicine. The corresponding percentage for the Urban area was 17%. The Urban area's greater ability, or need (mandates and COVID-10 incidence rates varied by county), was a contributing factor to the Non-Urban areas percentage of all paid claims declining to 39% for 2020. The percentages of services offered by telehealth was more equitable in 2021 (8% for Non-Urban, 11% for Urban), but the Non-Urban rates percentage of all paid claims decline even more from 2020 to 2021 (3 percentage points) than it had from 2019 to 2020 (2 percentage points). For a possible explanation, look at the counts in the statewide stratification by Non-Urban and Urban. Counts increased each year for both strata, with the greatest increase in the last year; the Urban area had a 36% relative increase, which is

disproportional to the increases in the KanCare membership for that year. Strata with the highest count increases from 2020 to 2021 were as follows (counts and relative increases are in parentheses):

- Non-Urban providers
  - Therapists (1,428; 20%)
  - Custodial Care Facilities (1,230; 28%)
  - Hospitals (1,055; 11%)
- Non-Urban primary diagnosis
  - Other Diagnoses (2,289; 26%)
  - Other general symptoms and signs (1,043; 83%)
- Urban providers
  - Therapists (9,390; 55%)
  - Custodial Care Facilities (1,473; 34%)
  - Hospitals (1,381; 35%)
- Urban primary diagnosis
  - Specific developmental disorders of speech and language (6,865; 42%)
  - Other Diagnoses (3,491; 41%%)
  - Pervasive developmental disorders (1,936; 49%)

The ranking of the provider type strata shows fundamental differences between the two areas. For members in Non-Urban counties, the provider type with the greatest number of paid claims from 2018 through 2021 for speech therapy was hospitals. Therapists and custodial care facilities ranked second and third, respectively. In the Urban area, therapists ranked first, HCBS providers second, and hospitals third.

The most frequently used primary diagnosis on claims for speech therapy was F80, specific developmental disorders of speech and language. The percentage of paid claims for speech therapy that had an F80 category primary diagnosis was 40% for Non-Urban members and 47% for Urban members.

Based on review of Table B9, only F80 was selected for further analysis. The categories in the other strata were considered to have too little claims volume or would have a large proportion of claims not associated with speech therapy.

The prevalence rate for F80 diagnoses (the proportion of members diagnosed with an F80 category diagnosis per 1,000 KanCare members) is shown in Table B10. The statewide rate has a generally increasing trend—with a dip in 2020 that may be pandemic related.

The prevalence rates were greater for the Urban area than for the Non-Urban area, by about 4 diagnosed members per 1,000 KanCare members. The data do not indicate if the disparity is due to differences in members' heath status, access to care for evaluation or treatment, or providers' coding of claims.

The statewide percentage of KanCare members receiving speech therapy who had a diagnosis in category F80 was relatively stable (61% in 2018, 2020, and 2021; 64% in 2019, corresponding to a bump in the Urban percentage). The choice of F80 as an indicating diagnosis for speech therapy is supported by these percentages; a about two-thirds of the members receiving speech therapy had an F80 diagnosis. As with the prevalence rates, the percentages for Urban members was greater than for Non-

Urban members, and the data do not indicate if the differences are due to differences in members' heath status, access to care for evaluation or treatment, or providers' coding of claims.

Table B.10. Analytic Results Related to Developmental Disorders of Speech and Language

Members with F80 Diagnosis per 1,000 KanCare Members					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With F80 Diagnosis	2,949	3,257	3,326	3,944
	Rate per 1,000 Members	15.5	17.6	16.2	17.7
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With F80 Diagnosis	4,061	4,402	4,461	5,608
	Rate per 1,000 Members	19.6	21.7	19.6	22.7
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With F80 Diagnosis	7,010	7,659	7,787	9,552
	Rate per 1,000 Members	17.6	19.8	18.0	20.3
Percentage of KanCare Members Receiving Speech Therapy Who Had a Diagnosis in Category F80					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members in Speech Therapy	923	1,163	1,235	1,455
	With F80 Diagnosis	535	669	699	798
	Percent	57.96%	57.52%	56.60%	54.85%
Urban	Members in Speech Therapy	1,202	1,380	1,668	2,070
	With F80 Diagnosis	764	952	1,078	1,362
	Percent	63.56%	68.99%	64.63%	65.80%
Statewide	Members in Speech Therapy	2,125	2,543	2,903	3,525
	With F80 Diagnosis	1,299	1,621	1,777	2,160
	Percent	61.13%	63.74%	61.21%	61.28%
Percentage of KanCare Members with Diagnosis in Category F80 Who Received Speech Therapy					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members With F80 Diagnosis	3,132	3,514	3,432	4,054
	With Speech Therapy	535	669	699	798
	Percent	17.08%	19.04%	20.37%	19.68%
Urban	Members With F80 Diagnosis	4,310	4,682	4,541	5,692
	With Speech Therapy	764	952	1,078	1,362
	Percent	17.73%	20.33%	23.74%	23.93%
Statewide	Members With F80 Diagnosis	7,442	8,196	7,973	9,746
	With Speech Therapy	1,299	1,621	1,777	2,160
	Percent	17.45%	19.78%	22.29%	22.16%

Procedure codes used to identify speech therapy were 92507 (Treatment of speech, language, voice, communication, and/or hearing processing disorder) and G0153 (Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes). Diagnosis Category F80 codes specific developmental disorders of speech and language.

Table B10 also the percentages of Non-Urban members with a diagnosis in category F80 who received speech therapy were greater for 2020 (20.4%) and 2021 (19.7%) than for 2018 (17.1%) and 2019 (19.0%), which supports the hypothesis that telemedicine will enhance access to services such as speech therapy for KanCare members living in rural or semi-urban counites. Access to speech therapy services also appears to have been enhanced for Urban members (percentages from 2018 to 2021 were 17.7%, 20.3%, 23.7%, and 23.9%, respectively).

Telemedicine Services by Mental Health Providers – Background:

Telemedicine services were provided to KanCare members prior to KanCare 2.0. A KDHE provider bulletin lists 59 procedure codes approved for telemedicine as of January 1, 2018 (some codes had earlier approval dates).[26] The list included codes for services offered by mental health providers, such as, psychotherapies, psychiatric diagnostic evaluations, adaptive behavior treatments, office visits for evaluation and management (E&M), and medical consultations. With the onset of the pandemic, additional services were approved for telemedicine.

Table B11 lists services commonly offered by mental health providers from 2019 to 2021. The table includes counts of paid claims by procedure code (Measure 4) and the number and percentage of those that were for telemedicine services. The following trends were observed in Table B11:

- Over 50% of services in 2020 were provided via telemedicine for 30-minute psychotherapy sessions and evaluation and management (E&M) office visits for established patients (15-, 25-, and 40-minute sessions).
- The number of family and group psychotherapy sessions in 2020 and 2021 were below 2019 levels; the decreases are offset by increases in 30-minure psychotherapy sessions.
- The percentages decreased for most services from 2020 to 2021, which may indicate members or providers preferred for face-to-face visits.
- Percentages increased from 2020 to 2021 for short E&M visits; psychiatric diagnostic evaluation with medical services; medical team conference with patient and/or family, and nonphysician health care professionals; and comprehensive management and care coordination for advanced illness. The increases could indicate members' and providers' experiences with telemedicine were positive.

After review of Table B11, three areas were chosen for continued analysis: individual psychotherapy, family and group psychotherapy, and community psychiatric supportive treatment.

Table B.11. Percentages of Services by Mental Health Providers Conducted via Telemedicine

Telemedicine Services by Mental Health Providers*				
Procedure Code		**KanCare 2.0**		
Procedure Description	Statistic	**2019**	**2020**	**2021**
90832 Psychotherapy, 30 minutes	Paid Services	39,966	66,449	62,351
	Via Telehealth	736	38,038	24,647
	% via Telehealth	1.8%	57.2%	39.5%
90834 Psychotherapy, 45 minutes	Paid Services	115,661	115,168	115,302
	Via Telehealth	434	52,209	38,468
	% via Telehealth	0.4%	45.3%	33.4%
90837 Psychotherapy, 60 minutes	Paid Services	266,072	276,213	310,715
	Via Telehealth	565	91,189	79,898
	% via Telehealth	0.2%	33.0%	25.7%
90847 Family psychotherapy including patient, 50 minutes	Paid Services	46,306	38,306	34,344
	Via Telehealth	80	14,183	8,438
	% via Telehealth	0.2%	37.0%	24.6%
90853 Group psychotherapy (other than of a multiple-family group)	Paid Services	14,528	8,217	10,822
	Via Telehealth	0	1,909	3,387
	% via Telehealth	0.0%	23.2%	31.3%
90785 Interactive complexity (list separately in addition to the code for primary procedure)	Paid Services	16,729	15,621	20,596
	Via Telehealth	1	3,525	2,790
	% via Telehealth	0.0%	22.6%	13.5%

*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

Table B.11. Percentages of Services by Mental Health Providers Conducted via Telemedicine (Continued)

Telemedicine Services by Mental Health Providers*

Procedure Code Procedure Description	Statistic	KanCare 2.0 2019	 2020	 2021
90791 Psychiatric diagnostic evaluation	Paid Services	34,402	29,347	34,753
	Via Telehealth	317	8,142	7,789
	% via Telehealth	0.9%	27.7%	22.4%
90792 Psychiatric diagnostic evaluation with medical services	Paid Services	7,238	6,872	7,165
	Via Telehealth	1,091	3,288	3,589
	% via Telehealth	15.1%	47.8%	50.1%
97153 Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient, each 15 minutes	Paid Services	7,739	17,299	38,367
	Via Telehealth	1	540	459
	% via Telehealth	0.0%	3.1%	1.2%
97155 Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes	Paid Services	2,286	6,879	15,265
	Via Telehealth	1	1,261	1,227
	% via Telehealth	0.0%	18.3%	8.0%
97156 Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present), each 15 minutes	Paid Services	1,346	2,729	5,635
	Via Telehealth	0	1,103	990
	% via Telehealth	0.0%	40.4%	17.6%
99211 Established patient office or other outpatient visit, typically 5 minutes	Paid Services	2,094	1,384	2,133
	Via Telehealth	15	252	546
	% via Telehealth	0.7%	18.2%	25.6%
99213 Established patient office or other outpatient visit, typically 15 minutes	Paid Services	41,231	38,625	31,909
	Via Telehealth	5,569	25,564	22,429
	% via Telehealth	13.5%	66.2%	70.3%
99214 Established patient office or other outpatient, visit typically 25 minutes	Paid Services	51,182	51,960	63,762
	Via Telehealth	7,662	29,323	36,764
	% via Telehealth	15.0%	56.4%	57.7%
99215 Established patient office or other outpatient, visit typically 40 minutes	Paid Services	2,362	1,407	1,872
	Via Telehealth	367	710	698
	% via Telehealth	15.5%	50.5%	37.3%
99366 Medical team conference with patient and/or family, and nonphysician health care professionals, 30 minutes or more	Paid Services	6,396	5,914	6,066
	Via Telehealth	47	2,641	2,860
	% via Telehealth	0.7%	44.7%	47.1%
99368 Medical team conference with nonphysician health care professionals, 30 minutes or more or more	Paid Services	2,107	3,266	2,518
	Via Telehealth	5	1,410	800
	% via Telehealth	0.2%	43.2%	31.8%
H0001 Alcohol and/or drug assessment	Paid Services	4,993	3,858	4,537
	Via Telehealth	59	1,614	1,961
	% via Telehealth	1.2%	41.8%	43.2%
H0004 Behavioral health counseling and therapy, per 15 minutes	Paid Services	15,526	20,934	16,128
	Via Telehealth	21	9,030	6,003
	% via Telehealth	0.1%	43.1%	37.2%
H0005 Alcohol and/or drug services; group counseling by a clinician	Paid Services	32,369	21,920	24,898
	Via Telehealth	0	7,365	8,849
	% via Telehealth	0.0%	33.6%	35.5%

*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

Table B.11. Percentages of Services by Mental Health Providers Conducted via Telemedicine (Continued)

Telemedicine Services by Mental Health Providers*				
Procedure Code		**KanCare 2.0**		
Procedure Description	Statistic	**2019**	**2020**	**2021**
H0015 Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education	Paid Services	9,652	6,580	8,793
	Via Telehealth	0	1,627	2,547
	% via Telehealth	0.0%	24.7%	29.0%
H0036 Community psychiatric supportive treatment, face-to-face, per 15 minutes	Paid Services	390,369	421,587	410,869
	Via Telehealth	2	130,788	48,431
	% via Telehealth	0.0%	31.0%	11.8%
H0038 Self-help/peer services, per 15 minutes	Paid Services	41,795	47,510	45,589
	Via Telehealth	12	13,108	6,492
	% via Telehealth	0.0%	27.6%	14.2%
H2011 Crisis intervention service, per 15 minutes	Paid Services	37,478	36,028	37,942
	Via Telehealth	1,217	3,535	3,546
	% via Telehealth	3.2%	9.8%	9.3%
H2017 Psychosocial rehabilitation services, per 15 minutes	Paid Services	291,259	195,242	207,063
	Via Telehealth	1	17,254	5,207
	% via Telehealth	0.0%	8.8%	2.5%
H2021 Community-based wrap-around services, per 15 minutes	Paid Services	37,790	38,085	37,119
	Via Telehealth	21	8,826	8,709
	% via Telehealth	0.1%	23.2%	23.5%
S0311 Comprehensive management and care coordination for advanced illness, per calendar month	Paid Services		1,135	3,907
	Via Telehealth		112	509
	% via Telehealth		9.9%	13.0%
S5110 Parent support and training, per 15 minutes, HCBS-SED waiver.	Paid Services	22,501	28,367	25,803
	Via Telehealth	0	11,381	10,150
	% via Telehealth	0.0%	40.1%	39.3%
T1017 Targeted case management, each 15 minutes	Paid Services	172,414	199,322	167,440
	Via Telehealth	7	2,991	1,235
	% via Telehealth	0.0%	1.5%	0.7%
T1019 Personal care services, per 15 minutes, not for an inpatient or resident of a hospital, nursing facility, ICF/MR or IMD, part of the individualized plan of treatment (code may not be used to identify services provided by home health aide or certified nurse assistant)	Paid Services	96,848	94,838	104,752
	Via Telehealth	0	6,160	2,428
	% via Telehealth	0.0%	6.5%	2.3%
T2038 Community transition, waiver; per service	Paid Services	2,229	2,337	2,405
	Via Telehealth	0	488	127
	% via Telehealth	0.0%	20.9%	5.3%

*Includes procedure codes with at least 5,000 paid claims and at least 200 paid telemedicine service from 2019 to 2021 identified from long-term care and outpatient claims with revenue codes 914–915 (behavioral health treatment therapies) and professional claims with billing provider type 11 (mental health).

This area intentionally left blank

Individual Psychotherapy Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving individual psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received individual psychotherapy*

Table B12 shows the ratio of members who received individual psychotherapy to the number of KanCare members as a rate "per 1,000 members" for 2018 to 2021. The statewide rate increased from 2018 to 2019 (from 125.1 to 132.3), but statewide rates for 2020 (116.3) and (117.9) were lower than the 2018 level. The pattern was the same for Non-Urban and Urban rates. The pattern relates a decline in prevalence rates for indicating diagnosis and will be discussed further below.

Per 1,000 members, use of individual psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 36.6 psychotherapy recipients per 1,000 KanCare members. The difference was lowest in 2020 (35.4 recipients per 1,000 KanCare members).

Table B.12. Individual Psychotherapy Recipients Per 1,000 KanCare Members

Area of Member Residence	Statistic	Pre-KanCare 2.0	KanCare 2.0		
		2018	2019	2020	2021
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Individual Therapy	27,493	28,146	27,776	30,589
	Rate per 1,000 Members	144.4	151.9	134.9	137.1
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Individual Therapy	22,241	23,167	22,671	24,886
	Rate per 1,000 Members	107.4	114.4	99.5	100.6
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Individual Therapy	49,734	51,313	50,447	55,475
	Rate per 1,000 Members	125.1	132.3	116.3	117.9

Counts of KanCare members was as of December 31 of the measurement year.
Individual psychotherapy was identified from paid claims with the following procedure codes:
90832 – Psychotherapy, 30 minutes
90833 – Psychotherapy with an evaluation and management service, 30 minutes
90834 – Psychotherapy, 45 minutes
90836 – Psychotherapy with an evaluation and management service, 45 minutes
90837 – Psychotherapy, 60 minutes
90838 – Psychotherapy with an evaluation and management service, 60 minutes

Individual psychotherapy is billed using CPT procedure codes (90832 through 90838). Coding depends on the length of the session and whether or not evaluation and management was included. To compare utilization between strata, hours of service was use as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban areas and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B13). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas; Non-Urban's share was slightly lower.
- In percentage of hours that were by telemedicine was slightly lower for Non-Urban members (37% for 2020 and 25% for 2021) than for the Urban area (38% for 2020 and 32% for 2021).
- The percentages stratified by provider type and primary diagnosis varied slightly between years but were stable enough for the analysis.
- Although fewer member received individual psychotherapy in 2020 than 2019 or 2021, the number of hours per person receiving psychotherapy was highest in 2021.

Table B.13. Hours of Service from Paid Claims for Individual Psychotherapy

Hours of Individual Psychotherapy from Paid Claims with Procedure Codes 90832–90838

90832 – Psychotherapy, 30 minutes
90833 – Psychotherapy with an evaluation and management service, 30 minutes
90834 – Psychotherapy, 45 minutes
90836 – Psychotherapy with an evaluation and management service, 45 minutes
90837 – Psychotherapy, 60 minutes
90838 – Psychotherapy with an evaluation and management service, 60 minutes

Area of Member Residence	Stratum	Pre-KanCare 2.0		KanCare 2.0					
		2018 N	%	2019 N	%	2020 N	%	2021 N	%
Statewide	Statewide Total (Denominator)	378,550		403,576		426,338		462,297	
	Non-Urban	188,284	49.7%	198,703	49.2%	210,522	49.4%	227,758	49.3%
	Urban	190,266	50.3%	204,873	50.8%	215,816	50.6%	234,539	50.7%
Non-Urban	Non-Urban Total (Denominator)	188,284		198,703		210,522		227,758	
	Mode: Telemedicine	1,360	0.7%	1,479	0.7%	77,352	36.7%	57,559	25.3%
	Non-Telemedicine	186,925	99.3%	197,224	99.3%	133,170	63.3%	170,199	74.7%
	Provider Type: Mental Health	166,691	88.5%	183,419	92.3%	195,296	92.8%	210,102	92.2%
	Physician	13,311	7.1%	5,928	3.0%	4,851	2.3%	4,951	2.2%
	Clinic	4,956	2.6%	4,400	2.2%	7,570	3.6%	10,132	4.4%
	Other Provider Types	3,327	1.8%	4,956	2.5%	2,805	1.3%	2,573	1.1%
	Diagnosis categories:* F40–F48	73,740	39.2%	79,468	40.0%	87,427	41.5%	96,364	42.3%
	F30–F39	59,390	31.5%	62,155	31.3%	67,242	31.9%	74,344	32.6%
	F90–F98	39,757	21.1%	40,386	20.3%	38,004	18.1%	39,139	17.2%
	F20–F29	6,665	3.5%	7,679	3.9%	8,065	3.8%	7,983	3.5%
	Other F01–F99	7,677	4.1%	7,807	3.9%	8,506	4.0%	8,834	3.9%
	Other categories	1,055	0.6%	1,209	0.6%	1,277	0.6%	1,095	0.5%
Urban	Urban Total (Denominator)	190,266		204,873		215,816		234,539	
	Telemedicine	150	0.1%	351	0.2%	82,400	38.2%	74,068	31.6%
	Non-Telemedicine	190,116	99.9%	204,522	99.8%	133,416	61.8%	160,471	68.4%
	Mental Health	157,797	82.9%	190,483	93.0%	202,598	93.9%	218,768	93.3%
	Physician	27,367	14.4%	8,177	4.0%	9,972	4.6%	11,799	5.0%
	Clinic	2,601	1.4%	2,282	1.1%	2,119	1.0%	2,599	1.1%
	Other Provider Types	2,501	1.3%	3,930	1.9%	1,127	0.5%	1,373	0.6%
	F40–F48	89,041	46.8%	100,028	48.8%	110,893	51.4%	122,768	52.3%
	F30–F39	54,900	28.9%	56,497	27.6%	57,164	26.5%	64,009	27.3%
	F90–F98	31,444	16.5%	32,537	15.9%	30,038	13.9%	29,249	12.5%
	F20–F29	5,270	2.8%	5,481	2.7%	5,837	2.7%	6,557	2.8%
	Other F01–F99	8,550	4.5%	9,374	4.6%	10,840	5.0%	10,960	4.7%
	Other categories	1,063	0.6%	955	0.5%	1,045	0.5%	997	0.4%

Hours of Individual Psychotherapy per Member Receiving Individual Psychotherapy

Area of Member Residence	Stratum	Pre-KanCare 2.0	KanCare 2.0		
		2018	2019	2020	2021
Non-Urban	Hours	188,284	198,703	210,521	227,758
	Members	27,493	28,146	27,776	30,589
	Hours per Member	**6.8**	**7.1**	**7.6**	**7.4**
Urban	Hours	190,266	204,873	215,816	234,539
	Members	22,241	23,167	22,671	24,886
	Hours per Member	**8.6**	**8.8**	**9.5**	**9.4**

*Stratified by category of primary diagnosis:
F01–F99 – Mental, behavioral, and neurodevelopmental disorders
F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30–F39 – Mood [affective] disorders
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders
F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

In the next stage of analysis, six diagnosis categories were chosen as the indicating diagnosis for the individual psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F40 – Phobic anxiety disorders
- F43 – Reaction to severe stress, and adjustment disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood

These six were among the highest ranked categories when ranked by the measure "percentage of claims having a primary or secondary diagnosis in the given category that billed for an individual psychotherapy session." About two-thirds of claims for individual psychotherapy contain one or more diagnosis in the six categories (see Table B14).

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were greater in the Non-Urban area than in the Urban area (e.g., 142.8 to 128.2 for 2020). These differences correspond to the Non-Urban area having higher rates of members receiving individual psychotherapy (see Table B12).

The trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received individual psychotherapy per 1,000 KanCare members—rates increased from 2018 to 2019, decreased in 2020, and increased again in 2021 but remained below the 2018 level. There are at least three likely factors.

- During the COVID-19 public health emergency, the State suspended disenrollment of members from KanCare under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

The percentage of KanCare members with an indicating diagnosis who received individual psychotherapy slightly increased from 2018 to 2019 but declined for 2020 and 2021. The declines were greater in the Non-Urban area than the Urban area. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Table B.14. Prevalence Rates from Paid Claims – Individual Psychotherapy

Members with Indicating Diagnosis per 1,000 KanCare Members*

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
	Statistic	2018	2019	2020	2021
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Indicating Diagnosis	25,673	26,467	25,933	28,803
	Rate per 1,000 Members	134.8	142.8	126.0	129.1
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Indicating Diagnosis	24,762	25,951	24,999	28,358
	Rate per 1,000 Members	119.5	128.2	109.7	114.6
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Indicating Diagnosis	50,435	52,418	50,932	57,161
	Rate per 1,000 Members	126.9	135.2	117.4	121.5

Percentage of KanCare Members Receiving Individual Psychotherapy Who Had an Indicating Diagnosis^

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
	Statistic	2018	2019	2020	2021
Non-Urban	Members in Psychotherapy	27,493	28,146	27,776	30,589
	With Indicating Diagnosis	17,196	17,880	17,338	18,872
	Percent	62.5%	63.5%	62.4%	61.7%
Urban	Members in Psychotherapy	22,241	23,167	22,671	24,886
	With Indicating Diagnosis	14,853	15,651	15,069	16,682
	Percent	66.8%	67.6%	66.5%	67.0%
Statewide	Members in Psychotherapy	49,734	51,313	50,447	55,475
	With Indicating Diagnosis	32,049	33,531	32,407	35,554
	Percent	64.4%	65.3%	64.2%	64.1%

Percentage of KanCare Members with an Indicating Diagnosis Who Received Individual Psychotherapy

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
	Statistic	2018	2019	2020	2021
Non-Urban	Members Indicated	25,673	26,467	25,933	28,803
	With Psychotherapy	17,196	17,880	17,338	18,872
	Percent	67.0%	67.6%	66.9%	65.5%
Urban	Members Indicated	24,762	25,951	24,999	28,358
	With Psychotherapy	14,853	15,651	15,069	16,682
	Percent	60.0%	60.3%	60.3%	58.8%
Statewide	Members Indicated	50,435	52,418	50,932	57,161
	With Psychotherapy	32,049	33,531	32,407	35,554
	Percent	63.5%	64.0%	63.6%	62.2%

*Counts of KanCare members was as of December 31 of the measurement year.
Primary and secondary diagnosis in the following categories were designated as indicating individual psychotherapy:
F34 – Persistent mood [affective] disorders F40 – Phobic anxiety disorders F43 – Reaction to severe stress, and adjustment disorders
F60 – Specific personality disorders F91 – Conduct disorders F93 – Emotional disorders with onset specific to childhood
^Individual psychotherapy was identified from paid claims with the following procedure codes:
90832 – Psychotherapy, 30 minutes 90833 – Psychotherapy with an evaluation and management service, 30 minutes
90834 – Psychotherapy, 45 minutes 90836 – Psychotherapy with an evaluation and management service, 45 minutes
90837 – Psychotherapy, 60 minutes 90838 – Psychotherapy with an evaluation and management service, 60 minutes

This area intentionally left blank

Family and Group Psychotherapy Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving family or group psychotherapy who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received family or group psychotherapy*

Table B15 shows the ratio of members who received family or group psychotherapy to the number of KanCare members as a rate "per 1,000 members" for 2018 to 2021. The statewide rate decreased each year from 2018 to 2021 (from 36.0 to 34.3, to 25.3, to 22.0).

Per 1,000 members, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021, the average difference was 4.2 recipients per 1,000 KanCare members. The difference was greatest in 2020 (4.5 recipients per 1,000 KanCare members).

Table B.15. Family and Group Psychotherapy Recipients Per 1,000 KanCare Members

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
	Statistic	2018	2019	2020	2021
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Individual Therapy	7,213	6,776	5,689	5,381
	Rate per 1,000 Members	37.9	36.6	27.6	24.1
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Individual Therapy	7,081	6,528	5,266	4,966
	Rate per 1,000 Members	34.2	32.2	23.1	20.1
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Individual Therapy	14,294	13,304	10,955	10,347
	Rate per 1,000 Members	36.0	34.3	25.3	22.0

Counts of KanCare members was as of December 31 of the measurement year.
Individual psychotherapy was identified from paid claims with the following procedure codes:
90847 – Family psychotherapy including patient, 50 minutes
90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)

For comparisons to individual psychotherapy, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B16). Key observations were made:

- There was a near 50-50 split between Non-Urban and Urban areas Non-Urban's share slightly lower.
- In percentage of hours that were by telemedicine was lower for Non-Urban members (28% for 2020 and 18% for 2021) than for the Urban area (36% for 2020 and 32% for 2021).
- The Non-Urban area's use of telemedicine declined faster from 2020 to 2021 (10 percentage points) than the Urban area's did (4 percentage points).
- About 80% of family and group psychotherapy was provided by mental health providers and about 15% by "other providers" in the Non-Urban area from 2019 to 2021. In contrast, the Urban area's percentages were about 93% and 1%, respectively.
- Primary diagnoses varied between the two areas, but the difference was not a concern for the analysis.

Table B.16. Hours of Service from Paid Claims for Family and Group Psychotherapy

Hours of Individual Psychotherapy from Paid Claims with Procedure Code 90847 or 90853

90847 – Family psychotherapy including patient, 50 minutes
90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)

Area of Member Residence	Stratum	Pre-KanCare 2.0 2018 N	%	KanCare 2.0 2019 N	%	2020 N	%	2021 N	%
Statewide	Statewide Total (Denominator)	62,259		55,916		43,011		41,819	
	Non-Urban	29,256	47.0%	27,809	49.7%	21,145	49.2%	20,571	49.2%
	Urban	33,003	53.0%	28,107	50.3%	21,866	50.8%	21,248	50.8%
Non-Urban	Non-Urban Total (Denominator)	29,256		27,809		21,145		20,571	
	Mode: Telemedicine	67	0.2%	38	0.1%	5,935	28.1%	3,662	17.8%
	Non-Telemedicine	29,189	99.8%	27,771	99.9%	15,210	71.9%	16,909	82.2%
	Provider Type: Mental Health	24,124	82.5%	22,981	82.6%	17,359	82.1%	16,341	79.4%
	Physician	3,079	10.5%	521	1.9%	354	1.7%	433	2.1%
	Clinic	242	0.8%	232	0.8%	413	2.0%	337	1.6%
	Other Provider Types	1,811	6.2%	4,075	14.7%	3,019	14.3%	3,460	16.8%
	Diagnosis categories:* F40–F48	9,694	33.1%	8,794	31.6%	7,058	33.4%	6,886	33.5%
	F30–F39	7,582	25.9%	8,654	31.1%	6,393	30.2%	6,838	33.2%
	F90–F98	9,631	32.9%	8,167	29.4%	6,268	29.6%	5,395	26.2%
	F20–F29	764	2.6%	953	3.4%	421	2.0%	221	1.1%
	Other F01–F99	1,404	4.8%	1,091	3.9%	854	4.0%	1,109	5.4%
	Other categories	183	0.6%	151	0.5%	151	0.7%	123	0.6%
Urban	Urban Total (Denominator)	33,003		28,107		21,866		21,248	
	Telemedicine	12	0.0%	29	0.1%	7,883	36.1%	6,877	32.4%
	Non-Telemedicine	32,991	100%	28,078	99.9%	13,983	63.9%	14,371	67.6%
	Mental Health	26,217	79.4%	26,289	93.5%	20,386	93.2%	19,365	91.1%
	Physician	5,350	16.2%	1,282	4.6%	1,272	5.8%	1,613	7.6%
	Clinic	154	0.5%	145	0.5%	42	0.2%	9	0.0%
	Other Provider Types	1,282	3.9%	391	1.4%	166	0.8%	261	1.2%
	F40–F48	12,832	38.9%	11,749	41.8%	8,866	40.5%	8,852	41.7%
	F90–F98	8,837	26.8%	6,952	24.7%	5,801	26.5%	4,968	23.4%
	F30–F39	7,943	24.1%	6,821	24.3%	4,985	22.8%	4,923	23.2%
	F20–F29	607	1.8%	350	1.2%	392	1.8%	587	2.8%
	Other F01–F99	2,520	7.6%	1,983	7.1%	1,614	7.4%	1,776	8.4%
	Other categories	265	0.8%	252	0.9%	208	1.0%	141	0.7%

Hours of Group and Family Psychotherapy per Member Receiving Group or Family Psychotherapy

Area of Member Residence	Stratum	Pre-KanCare 2.0 2018	KanCare 2.0 2019	2020	2021
Non-Urban	Hours	29,257	27,809	21,145	20,571
	Members	7,213	6,776	5,689	5,381
	Hours per Member	**4.1**	**4.1**	**3.7**	**3.8**
Urban	Hours	33,003	28,107	21,866	21,247
	Members	7,081	6,528	5,266	4,966
	Hours per Member	**4.7**	**4.3**	**4.2**	**4.3**

*Stratified by category of primary diagnosis:
F01–F99 – Mental, behavioral, and neurodevelopmental disorders
F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30–F39 – Mood [affective] disorders
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders
F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Five diagnosis categories were chosen as the indicating diagnosis for the family and group psychotherapy measures:

- F34 – Persistent mood [affective] disorders
- F91 – Conduct disorders
- F93 – Emotional disorders with onset specific to childhood
- T74 – Adult and child abuse, neglect, and other maltreatment, confirmed
- T76 – Adult and child abuse, neglect, and other maltreatment, suspected

The categories chosen were among the highest ranked categories when ranked by the measure "percentage of claims having a primary or secondary diagnosis in the given category that billed for a family or group session." About two-fifths of claims for family and group psychotherapy contained one or more diagnosis in the five categories (see Table B17).

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were considerably greater in the Non-Urban area than in the Urban area (e.g., 55.7 to 39.5 for 2020). These differences correspond to the Non-Urban area having higher rates of members receiving individual psychotherapy (see Table B15), but the difference is much wider.

The general trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates of members who received family or group psychotherapy per 1,000 KanCare—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

- During the COVID-19 public health emergency, the State suspended disenrollment under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for psychotherapy; however, this seems unlikely during the pandemic.

Percentages of KanCare members with an indicating diagnosis who received individual psychotherapy slightly decreased each year, from 27% in 2018 to 19% in 2021 for the Non-Urban area and from 29% for 2018 to 21% for 2021 for the Urban area. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Table B.17. Prevalence Rates from Paid Claims for Family and Group Psychotherapy

Members with Indicating Diagnosis per 1,000 KanCare Members*					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Indicating Diagnosis	12,504	12,449	11,477	11,977
	Rate per 1,000 Members	**65.7**	**67.2**	**55.7**	**53.7**
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Indicating Diagnosis	10,458	10,054	9,003	9,185
	Rate per 1,000 Members	**50.5**	**49.7**	**39.5**	**37.1**
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Indicating Diagnosis	22,962	22,503	20,480	21,162
	Rate per 1,000 Members	**57.8**	**58.0**	**47.2**	**45.0**
Percentage of KanCare Members Receiving Family or Group Psychotherapy Who Had an Indicating Diagnosis^					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members in Psychotherapy	7,213	6,776	5,689	5,381
	With Indicating Diagnosis	3,373	3,164	2,457	2,272
	Percent	**46.8%**	**46.7%**	**43.2%**	**42.2%**
Urban	Members in Psychotherapy	7,081	6,528	5,266	4,966
	With Indicating Diagnosis	3,039	2,710	2,169	1,914
	Percent	**42.9%**	**41.5%**	**41.2%**	**38.5%**
Statewide	Members in Psychotherapy	14,294	13,304	10,955	10,347
	With Indicating Diagnosis	6,412	5,874	4,626	4,186
	Percent	**44.9%**	**44.2%**	**42.2%**	**40.5%**
Percentage of KanCare Members with Indicating Diagnosis Who Received Family or Group Psychotherapy					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members Indicated	12,504	12,449	11,477	11,977
	With Psychotherapy	3,373	3,164	2,457	2,272
	Percent	**27.0%**	**25.4%**	**21.4%**	**19.0%**
Urban	Members Indicated	10,458	10,054	9,003	9,185
	With Psychotherapy	3,039	2,710	2,169	1,914
	Percent	**29.1%**	**27.0%**	**24.1%**	**20.8%**
Statewide	Members Indicated	22,962	22,503	20,480	21,162
	With Psychotherapy	6,412	5,874	4,626	4,186
	Percent	**27.9%**	**26.1%**	**22.6%**	**19.8%**

*Counts of KanCare members was as of December 31 of the measurement year.
Primary and secondary diagnosis in the following categories were designated as indicating family or group psychotherapy:
F34 – Persistent mood [affective] disorders
F91 – Conduct disorders
F93 – Emotional disorders with onset specific to childhood
T74, T76 – Adult and child abuse, neglect, and other maltreatment; confirmed (T74) or suspected (T76)
^Family and group psychotherapies were identified from paid claims with the following procedure codes:
90847 – Family psychotherapy including patient, 50 minutes
90853 – Group psychotherapy (other than of a multiple-family group), per day (50 minutes assumed for analysis)

Community Psychiatric Supportive Treatment Analysis:

- *Measure 4: Number of paid claims with selected procedure codes*
- *Measure 5: Number of members with selected diagnosis per 1,000 members*
- *Percentage of KanCare members receiving community psychiatric supportive treatment who had an indicating diagnosis*
- *Percentage of KanCare members with an indicating diagnosis who received community psychiatric supportive treatment*

Table B18 shows the ratio of members who received community psychiatric supportive treatment to the number of KanCare members as a rate "per 1,000 members" for 2018 to 2021. The statewide rate (47.8 in 2018) increased in 2019 (49.5) but decreased in both 2020 (42.3) and 2021 (40.9). Rates for the Non-Urban and Urban areas did likewise.

Per 1,000 member months, use of group and family psychotherapy was greater in the Non-Urban area than the Urban area. From 2018 to 2021 the difference increased each year (from 17.5 to 20.6 recipients per 1,000 KanCare members).

Table B.18. Community Psychiatric Supportive Treatment Recipients Per 1,000 KanCare Members

Area of Member Residence		Pre-KanCare 2.0	KanCare 2.0		
	Statistic	2018	2019	2020	2021
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Individual Therapy	10,844	11,010	10,835	11,542
	Rate per 1,000 Members	56.9	59.4	52.6	51.7
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Individual Therapy	8,164	8,169	7,522	7,694
	Rate per 1,000 Members	39.4	40.4	33.0	31.1
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Individual Therapy	19,008	19,179	18,357	19,236
	Rate per 1,000 Members	47.8	49.5	42.3	40.9

Counts of KanCare members was as of December 31 of the measurement year.
Family and group psychotherapies were identified from paid claims with the following procedure codes:
H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes

For comparisons to individual psychotherapy, rates were also calculated using hours of service as the unit of analysis instead of the number of claims. The number of hours was stratified by Non-Urban and Urban area and sub-stratified by mode of delivery, provider type, and primary diagnosis category (see Table B19). Key observations were made:

- There was roughly a 60 to 40 ratio of total hours of treatment between Non-Urban and Urban areas. The difference widened each year. The difference in hours of treatment per recipient also widened.
- The service was not approved for telehealth by KDHE until the public health emergency. In the Non-Urban area, the percent by telemedicine was 18.5% in 2020 but only 5.0% in 2021; the percentages for the Urban area were greater and had a smaller relative decrease (25.1% in 2020 and 12.1% in 2021).
- At least 99% of the hours of treatment were provided by mental health providers.
- Primary diagnoses varied between the two areas, but the difference was not a concern for the analysis.

Table B.19. Hours of Service from Paid Claims for Community Psychiatric Supportive Treatment

Hours of Community Psychiatric Supportive Treatment from Paid Claims with Procedure Code H0036

H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes

Area of Member Residence	Stratum	Pre-KanCare 2.0 2018 N	%	KanCare 2.0 2019 N	%	2020 N	%	2021 N	%
Statewide	Statewide Total (Denominator)	478,809		479,154		432,214		469,358	
	Non-Urban	280,224	58.5%	285,832	59.7%	270,562	62.6%	299,001	63.7%
	Urban	198,585	41.5%	193,322	40.3%	161,652	37.4%	170,357	36.3%
Non-Urban	Non-Urban Total (Denominator)	280,224		285,832		270,562		299,001	
	Mode: Telemedicine	0	0.0%	3	0.0%	50,178	18.5%	15,061	5.0%
	Non-Telemedicine	280,224	100%	285,829	100%	220,384	81.5%	283,940	95.0%
	Provider Type: Mental Health	279,034	99.6%	285,171	99.8%	270,556	100%	298,997	100%
	Other Provider Types	1,190	0.4%	661	0.2%	6	0.0%	4	0.0%
	Diagnosis categories:* F90–F98	104,652	37.3%	106,127	37.1%	94,759	35.0%	104,493	34.9%
	F30–F39	88,873	31.7%	90,775	31.8%	85,554	31.6%	93,617	31.3%
	F40–F48	46,633	16.6%	49,354	17.3%	52,380	19.4%	61,738	20.6%
	F20–F29	31,607	11.3%	31,565	11.0%	29,711	11.0%	31,115	10.4%
	Other F01–F99	7,996	2.9%	7,616	2.7%	7,372	2.7%	7,599	2.5%
	Other categories	466	0.2%	396	0.1%	787	0.3%	440	0.1%
Urban	Urban Total (Denominator)	198,585		193,322		161,652		170,357	
	Telemedicine	0	0.0%	0	0.0%	40,506	25.1%	20,586	12.1%
	Non-Telemedicine	198,585	100%	193,322	100%	121,146	74.9%	149,771	87.9%
	Mental Health	195,692	98.5%	193,287	100%	161,634	100%	170,357	100%
	Other Provider Types	2,893	1.0%	35	0.0%	17	0.0%	0	0%
	F30–F39	71,299	35.9%	66,813	34.6%	59,093	36.6%	63,919	37.5%
	F90–F98	48,158	24.3%	48,473	25.1%	38,501	23.8%	38,381	22.5%
	F20–F29	44,693	22.5%	40,513	21.0%	33,242	20.6%	34,354	20.2%
	F40–F48	30,107	15.2%	33,675	17.4%	27,517	17.0%	29,472	17.3%
	Other F01–F99	3,995	2.0%	3,620	1.9%	3,166	2.0%	4,143	2.4%
	Other categories	333	0.2%	228	0.1%	132	0.1%	88	0.1%

Hours of Treatment per Member Receiving Community Psychiatric Supportive Treatment

Area of Member Residence	Stratum	Pre-KanCare 2.0 2018	KanCare 2.0 2019	2020	2021
Non-Urban	Hours	280,224	285,832	270,562	299,001
	Members	10,844	11,010	10,835	11,542
	Hours per Member	**25.8**	**26.0**	**25.0**	**25.9**
Urban	Hours	198,585	193,322	161,651	170,357
	Members	8,164	8,169	7,522	7,694
	Hours per Member	**24.3**	**23.7**	**21.5**	**22.1**

*Stratified by category of primary diagnosis:
F01–F99 – Mental, behavioral, and neurodevelopmental disorders
F20–F29 – Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders
F30–F39 – Mood [affective] disorders
F40–F48 – Anxiety, dissociative, stress-related, somatoform, and other nonpsychotic mental disorders
F90–F98 – Behavioral and emotional disorders with onset usually occurring in childhood and adolescence

Five diagnosis categories were chosen as the indicating diagnosis for the community psychiatric supportive treatment measures:

- F20 – Schizophrenia
- F25 – Schizoaffective disorders
- F34 – Persistent mood [affective] disorders
- F60 – Specific personality disorders
- F91 – Conduct disorders

The categories chosen were among the highest ranked categories when ranked by the measure "percentage of claims for community psychiatric supportive treatment having a primary or secondary diagnosis in a given category." About three-fifths of claims for community psychiatric supportive treatment contained one or more diagnosis in the five categories (see Table B20).

Table B.20. Prevalence Rates from Paid Claims for Community Psychiatric Supportive Treatment

Members with Indicating Diagnosis per 1,000 KanCare Members*					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	KanCare Members	190,429	185,323	205,871	223,064
	With Indicating Diagnosis	15,847	15,853	14,961	15,570
	Rate per 1,000 Members	**83.2**	**85.5**	**72.7**	**69.8**
Urban	KanCare Members	207,165	202,451	227,803	247,427
	With Indicating Diagnosis	14,503	14,382	13,422	13,920
	Rate per 1,000 Members	**70.0**	**71.0**	**58.9**	**56.3**
Statewide	KanCare Members	397,594	387,774	433,674	470,491
	With Indicating Diagnosis	30,350	30,235	28,383	29,490
	Rate per 1,000 Members	**76.3**	**78.0**	**65.4**	**62.7**
Percentage of KanCare Members Receiving H0036 Treatment Who Had an Indicating Diagnosis^					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members in Psychotherapy	10,844	11,010	10,835	11,542
	With Indicating Diagnosis	6,205	6,249	5,767	5,848
	Percent	**57.2%**	**56.8%**	**53.2%**	**50.7%**
Urban	Members in Psychotherapy	8,164	8,169	7,522	7,694
	With Indicating Diagnosis	4,906	4,842	4,482	4,495
	Percent	**60.1%**	**59.3%**	**59.6%**	**58.4%**
Statewide	Members in Psychotherapy	19,008	19,179	18,357	19,236
	With Indicating Diagnosis	11,111	11,091	10,249	10,343
	Percent	**58.5%**	**57.8%**	**55.8%**	**53.8%**
Percentage of KanCare Members with Indicating Diagnosis Who Received H0036 Treatment					
Area of Member Residence		**Pre-KanCare 2.0**	**KanCare 2.0**		
	Statistic	**2018**	**2019**	**2020**	**2021**
Non-Urban	Members Indicated	15,847	15,853	14,961	15,570
	With Psychotherapy	6,205	6,249	5,767	5,848
	Percent	**39.2%**	**39.4%**	**38.5%**	**37.6%**
Urban	Members Indicated	14,503	14,382	13,422	13,920
	With Psychotherapy	4,906	4,842	4,482	4,495
	Percent	**33.8%**	**33.7%**	**33.4%**	**32.3%**
Statewide	Members Indicated	30,350	30,235	28,383	29,490
	With Psychotherapy	11,111	11,091	10,249	10,343
	Percent	**36.6%**	**36.7%**	**36.1%**	**35.1%**

*Counts of KanCare members was as of December 31 of the measurement year.
Primary and secondary diagnosis in the following categories were designated as indicating community psychiatric supportive treatment:
F20 – Schizophrenia F25 – Schizoaffective disorders F34 – Persistent mood [affective] disorders
F60 – Specific personality disorders F91 – Conduct disorders
^Family and group psychotherapies were identified from paid claims with the following procedure codes:
H0036 – Community psychiatric supportive treatment, face-to-face, per 15 minutes

The prevalence rates, members with an indicating diagnosis per 1,000 KanCare members, were greater in the Non-Urban area than in the Urban area (e.g., 72.7 and to 58.9 in 2020). The prevalence rates were also greater in the Non-Urban area than the Urban are for individual psychotherapy and family and group psychotherapy (see Tables B14 and B17).

The general trend in the rates of members with indicating diagnosis per 1,000 KanCare members from 2018 to 2021 follows a similar trend seen in the rates for two types of psychotherapy—rates were stable from 2018 to 2019, decreased in 2020, and decreased again in 2021. The same factors listed for individual psychotherapy may have contributed to the rate declines.

- During the COVID-19 public health emergency, the State suspended disenrollment under most circumstances. For example, KanCare members covered under the CHIP program were not disenrolled when they turned 18, and women with coverage due to pregnancy were not disenrolled 60 days after delivery.
- Reduced access to diagnostic evaluations and treatments while stay at home orders were in effect may have led to fewer members receiving the indicating diagnoses.
- Members mental health may have improved, thus decreasing the need for treatment; however, this seems unlikely during the pandemic.

The percentages of KanCare members with an indicating diagnosis who received individual psychotherapy were about the same in 2018 and 2019 (36.6% and 36.7%, respectively), but in the last two years, to 36.1% in 202020 and 35.1% in 2021. The pattern was the same for both areas. These results do not support an affirmative response to the study question, "Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?" This conclusion does mean telemedicine was not integral for member accessing care; telemedicine was just not able to override the barriers presented by the pandemic.

Results for the Evaluation of Use of Telemonitoring Services

The State has defined telemonitoring as "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."

The following evaluation question related to the use of telemonitoring services was examined in the interim evaluation:

- Did use of telemonitoring services increase over the five-year period for KanCare members with chronic conditions living in rural or semi-urban areas?

Three outcome measures were assessed to evaluate the above-mentioned question:

1. Percentage of members living in the rural and semi-urban areas who received telemonitoring services.
2. Number of telemonitoring services provided to members living in the rural and semi-urban areas.
3. Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services.

The evaluation measures focused on the use of telehealth services among KanCare members living in rural or semi-urban areas, therefore, data were examined in two geographic areas, Urban and Non-Urban, based on county population density. Non-Urban area included all counties except Urban counties. Urban area is defined Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties.

The encounter, demographics, eligibility, and enrollment records from the State's Medicaid Management Information System (MMIS) reporting warehouse were used for the analyses of KanCare 2.0 data from January 2019 through December 2021, and pre-KanCare 2.0 data for 2018. Table B21 displays results for the three telemonitoring measures.

Table B.21. Use of Telemonitoring Services

Measure 1: Percentage of members living in rural or semi-urban areas (Non-Urban) who received telemonitoring services.

Area of Member Residence	Statistic	KanCare 2.0		
		2019	2020	2021
Non-Urban	Members (denominator)	176,020	188,599	206,837
	Members Receiving Telemonitoring	*	15	42
	Percent		0.01%	0.02%
Urban	Members (denominator)	188,146	204,013	226,764
	Members Receiving Telemonitoring	*	29	98
	Percent		0.01%	0.04%

Measure 2: Number of telemonitoring services provided to members living in rural and semi-urban (Non-Urban) areas.

Area of Member Residence	Statistic	KanCare 2.0		
		2019	2020	2021
Non-Urban	Telemonitoring Services	*	84	132
Urban	Telemonitoring Services	*	90	738
Statewide	Telemonitoring Services	*	174	870

Measure 3: Number of providers monitoring health indicator data transmitted to them by members receiving telemonitoring services.

Area of Provider Location	Statistic	KanCare 2.0		
		2019	2020	2021
Non-Urban	Billing Providers		3	6
	Performing Providers		5	9
Urban	Billing Providers		6	15
	Performing Providers		13	31
Statewide	Billing Providers		9	21
	Performing Providers		18	40

Interpretation/Comments:

- Telemonitoring of KanCare members' health indicator data kicked off with the onset of the COVID-19 pandemic in 2020.
- The percentages of Non-Urban and Urban members who received telemonitoring services increased from 2019 to 2020 and 2021. A statistically significant increase for Non-Urban and Urban members was seen in 2021 from 2020.
- In 2020 and 2021, the number of telemonitoring services provided to Non-Urban and Urban members increased from 2019.
- Compared to 2020, the number of telemonitoring services provided in 2021 was 1.6 times higher for to Non-Urban members and 8.2 times higher for Urban members. The increase was seen in 2021 for both Non-Urban and Urban members, however, higher increase was seen for Urban members.
- The statewide number of performing providers increased from 18 in 2020 and to 40 in 2021. In both Non-Urban and Urban areas of the state, the number of performing and billing providers roughly doubled from 2020 to 2021.
- It should be noted that these increases were seen in the initial years of the COVID-19 pandemic (2020 and 2021). The data and analytical results for 2022 and 2023 may provide a better assessment of the impact of State interventions on telemonitoring services in Non-Urban areas of Kansas.

Note: Counts of KanCare members and telemonitoring services received by members were stratified into Non-Urban and Urban areas by member's county of residence; counts of telemonitoring providers were stratified into Non-Urban and Urban areas by provider address; the Non-Urban area was defined as all counties except Urban counties; Urban area was defined as Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte counties. The increase in the percent of members receiving telemonitoring services from 2020 to 2021 was statistically significant for Non-Urban ($p<.01$) and Urban ($p<.001$) areas (weighted Pearson chi-square).

*The number of members receiving telemonitoring services in 2019 was insufficient for analysis (percent of members was less than 0.001%).

Qualitative Evaluation

Results for the Evaluation of Use of Telementoring Services

Hypothesis 3 stated, *"Telementoring can pair rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions."*[6]

The data sources describing the use of telementoring that pairs rural and semi-urban healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions are currently not known. Therefore, the related evaluation is focused on summarizing the telementoring efforts implemented by Sunflower Health Plan, the University of Kansas, and the University of Missouri.

The Project ECHO® (Extension for Community Healthcare Outcomes) Model was used by Sunflower Health Plan and the University of Kansas to provide telementoring services to providers. These efforts are summarized below.

Project ECHO® Sunflower Health Plan:

In response to the telementoring component of the KanCare 2.0 Hypothesis 3, Sunflower Health Plan served as a Project ECHO® hub. A Project ECHO hub refers to *"a regional center where a team of subject matter experts is located, replicates the ECHO Model™ and runs their own ECHO program."*[15] To conduct this program, Sunflower Health Plan collaborated initially with the University of Kansas and later with the University of Missouri's Office of Continuing Education, School of Medicine, and Sinclair School of Nursing.

The information summarized below is abstracted from the report provided by Sunflower Health Plan titled "Project ECHO®. Sunflower Health Plan Kansas. 2019-Present."[16]

From March 2019 through November 2021, eleven series comprised of forty-six sessions were conducted by the project. The sessions were attended by Centene staff (parent managed care company for Sunflower Health Plan) and providers from multiple disciplines, including medical and behavioral clinicians, nurses, pharmacists, and social workers. The participants were from non-urban and urban counties. Further information regarding the sessions is summarized in Tables B22-B24.

Table B.22. Sunflower Health Plan Project ECHO® Series Goals

ECHO Series	ECHO Series Goals
2019 Sunflower Project ECHO®	
Fundamentals of Addiction Treatment	• Broadening understanding of addiction therapies • Increasing the number of rural and frontier providers and addiction treatments • Maximizing access to medication assisted treatment
Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities	• Broadening understanding of needs of individuals with I/DD • Increasing collaboration with community, rural, and frontier providers • Maximizing access to coordinated supports for individuals with I/DD
Social Determinants of Health	• Broadening understanding of social determinants of health • Broadening understanding of how where we live, work, and play impacts our health • Understanding how to access supports within the state
Foster Care	• Broadening understanding of trauma informed interventions • Understanding how unique needs of members in foster care affect their health • Understanding how to access supports within Kansas

Table B.22. Sunflower Health Plan Project ECHO® Series Goals (Continued)	
ECHO Series	**ECHO Series Goals**
2020 Sunflower Project ECHO®	
Cancer	• Broadening understanding of the long-lasting effects of a cancer diagnosis and treatment • Broadening understanding of the unique needs of members who have cancer • Understanding how to access supports for members across Kansas
Behavioral Health	• Understanding evidence-based practices for people with behavioral health needs • Understanding the unique needs of members who have behavioral health needs • Understanding how to access supports for members across Kansas
Aging	• Supports available to members in the aging population • Unique medication needs and approaches for the aging population • Accessing supports for the aging population across Kansas
Preventative Health	• Broadening the understanding of expectations of Early Periodic Screening Diagnosis and Treatment (EPSDT) • Understanding the schedule for preventative care and immunizations for youth • Understanding how to access supports related to immunizations and preventative care in Kansas
2021 Sunflower Project ECHO®	
Behavioral Health and Addiction	• Broadening understanding of trauma informed interventions • Understanding how unique needs of members in foster care affect their health • Understanding how to access supports within Kansas
Preventative Care	• Broadening the understanding of preventive care across the lifespan • Understanding the impact of preventive health across the lifespan • Understanding how to navigate supports related to preventive care in Kansas
Care Coordination	• Understanding the expectations of care coordination • The unique needs of members who may benefit from care coordination • Understanding how to access supports related to care coordination

Table B.23. Project ECHO® Sunflower Health Plan Sessions			
ECHO Series	**Session**	**Date**	**Participants**
2019 Sunflower Project ECHO®			
Fundamentals of Addiction Treatment	Week 1: Overview of the Fundamentals of Addiction Treatment	3/07/2019	61
	Week 2: Pain Management and Addiction Interaction	3/14/2019	47
	Week 3: Opioid Dependence Addiction and Naloxone Education	3/21/2019	55
	Week 4: Medication Assisted Treatment, Kansas State Policy	3/28/2019	44
Supporting and Integrated Life for Members with Intellectual and Developmental Disabilities	Week 1: The Quality of Life Assessment: An Integrated Approach to Identifying Solutions	6/06/2019	47
	Week 2: Dementia and I/DD	6/13/2019	39
	Week 3: Crisis Planning for Dual Diagnosis	6/20/2019	41
	Week 4: Creating a Path to Employment	6/27/2019	35
Social Determinants of Health	Week 1: Social Determinants of Health	9/05/2019	31
	Week 2: Housing Supports	9/12/2019	26
	Week 3: Employment	9/19/2019	29
	Week 4: Food Insecurity	9/16/2019	28
Foster Care	Week 1: Trauma Informed Interventions	11/07/2019	52
	Week 2: Physical Health and Impact on Behavioral Health	11/14/2019	38
	Week 3: Culturally Competent Care for the LGBT Community	11/21/2019	44
	Week 4: Psychotropic Medication Use in the Foster Care Population in Kansas	12/05/2019	38

Table B.23. Project ECHO® Sunflower Health Plan Sessions (Continued)

ECHO Series	Session	Date	Participants
2020 Sunflower Project ECHO®			
Cancer	Week 1: How to Help Childhood Cancer Survivors Thrive	3/19/2020	22
	Week 2: Cancer Prevention and Immunization	3/26/2020	27
	Week 3: Supports, Prevention and Barriers to Care for Members with Intellectual and Developmental Disabilities	4/02/2020	22
	Week 4: Nutrition and Cancer	4/09/2020	16
Behavioral Health	Week 1: Parent Management Training Oregon Model	5/07/2020	81
	Week 2: Anxiety	5/14/2020	72
	Week 3: Peer Support	5/21/2020	59
	Week 4: Hope and Healing	5/28/2020	55
Aging	Week 1: Social Isolation and Aging	8/06/2020	38
	Week 2: Aging in COVID	8/13/2020	39
	Week 3: Nursing Home Planning in COVID	8/20/2020	31
	Week 4: Atypical Antipsychotics in the Elderly & Nursing Home Population	8/27/2020	35
Preventative Health	Week 1: EPSDT Overview	10/15/2020	39
	Week 2: KAN Be Healthy	10/22/2020	39
	Week 3: Childhood Immunizations	10/29/2020	38
	Week 4: Treatment and Therapies	11/05/2020	34
2021 Sunflower Project ECHO®			
Behavioral Health and Addiction	Week 1: Medication Assisted Treatment	3/10/2021	65
	Week 2: Peer Mentoring and Addition	3/17/2021	58
	Week 3: Methadone Clinic	3/24/2021	40
	Week 4: Therapeutic Supports	3/31/2021	45
Preventative Care	Week 1: Navigating Barriers to Preventative Care, Sunflower Approach	6/03/2021	20
	Week 2: COVID-19 Vaccine Equity	6/10/2021	19
	Week 3: Nutrition	6/17/2021	20
	Week 4: Dental Care	6/24/2021	13
Care Coordination	Week 1: Case Management Overview	10/07/2021	38
	Week 2: OneCare Kansas	10/14/2021	29
	Week 3: Behavioral Health	10/21/2021	21
	Week 4: Physical Health	10/28/2021	23
	Week 5: HCBS and Care Coordination	11/04/2021	23
	Week 6: Transitions to Employment	11/11/2021	18

This area intentionally left blank

Some of the participants attending the sessions in the October-November 2021 Series titled "Care Coordination" provided further insights by responding to survey questions asked regarding these sessions. This information is summarized below in Table B24.

Table B.24. Project ECHO® Sunflower Health Plan October-November 2021 Series Survey

Project ECHO® Sunflower October-November 2021 Series: Care Coordination	
Survey Item	**Survey Results/Key Themes**
Week 1: Case Management Overview (17 survey participants)	
• Understanding of care coordination	• Out of 17 participants, 10 (59%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	• Out of 17 participants, 11 (65%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Coordination of care and services for members • Benefits of case management and care coordination in managing member care and getting resources • Resources/ways to access more coordination • Networking and communication
Week 2: OneCare Kansas (12 survey participants)	
• Understanding of care coordination	• Out of 12 participants, 8 (67%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	• Out of 12 participant, 10 (83%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Information on benefits of OneCare Kansas program • Access to increased resources to assist members with services • Utilization of CMHCs for in-person help, and in coordination of medical services for members with dual diagnoses
Week 3: Behavioral Health (15 survey participants)	
• Understanding of care coordination	Out of 15 participants, 2 (13%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	Out of 15 participants, 12 (80%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Information on benefits of and resources available through Smart Start for Babies program for pregnant women • Referring pregnant women to Smart Start for Babies program for better outcomes • Several resources available for members
Week 4: Physical Health (5 survey participants)	
• Understanding of care coordination	All 5 participants (100%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	All 5 participants (100%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Information on benefits of coordinating behavioral health and medical care • Resources and services available for members

Table B.24. Project ECHO® Sunflower Health Plan October-November 2021 Series Survey (Continued)	
Project ECHO® Sunflower October-November 2021 Series: Care Coordination	
Survey Item	**Survey Results/Key Themes**
Week 5: HCBS and Care Coordination (6 survey participants)	
• Understanding of care coordination	• Out of 6 participants, 3 (50%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	• Out of 6 participants, 4 (66.7) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Importance of coordination with other agencies • Better understanding of final rule and KDADS expectations • Importance of communication
Week 6: Transitions to Employment (6 survey participants)	
• Understanding of care coordination	• Out of 6 participants, 4 (67%) indicated attending the session improved their understanding of care coordination.
• Knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients	• Out of 6 participants, 4 (67%) indicated attending the session improved their knowledge on different care coordination supports as it relates to unique needs of the members/patients/clients.
• What did you learn in this continuing education activity that you will apply to your practice?	Key themes based on participants responses: • Continue member-centered work • Communications and giving choices • The dynamics that can occur with I/DD waiver and how to get other resources/departments involved

KUMC Project ECHO® Series:

In 2021, Kansas University Medical Center (KUMC) conducted the KUMC Project ECHO® Series titled "Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders" for providers including physicians, advanced practice clinicians, nurses, behavioral health providers, and other providers.[17] The purpose of the series was to improve healthcare provider capacity to implement evidence-based practices related to substance use disorder (SUD) prevention, screening, early intervention, referral to treatment, and risk reduction.

The information summarized below regarding the five sessions included in this ECHO series, conducted during April 2021, is abstracted from the report titled "Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders. KUMC Project ECHO® Series Summary Report" provided by the KUMC Project ECHO®.[17]

A total of 383 attendees participated in five series sessions, with an average of 77 attendees per session. Through this ECHO series, 240 hours of the Continuing Education (CE) Credit were awarded, with nearly 50 hours of CE credit claimed during each session, on average. Out of 383 attendees, 240 attendees (63%) claimed CE credit. There were 212 unique registrants for the series. Out of these 212 unique registrants, 158 (75%) were target learners, including 33 physicians (21%), 49 advanced practice clinicians (31%), 42 nurses (27%), and 34 behavioral health providers (21%). Out of the 212 unique registrants, 172 (81%) were Kansas providers, whereas 40 registrants (19%) were from other states. The Kansas registrants were from both non-urban and urban areas. Out of 172 unique Kansas registrants, 77 (45%) were from non-urban areas, whereas 95 registrants (55%) were from urban areas.

Table B.25. KUMC Project ECHO® Series Sessions			
ECHO Series	**Session**	**Date**	**Participants**
2021 KUMC Project ECHO®			
Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders	Session 1: Opioid Use Disorder: The Natural History of a Wicked Problem	4/01/2021	93
	Session 2: SBIRT: Starting the Conversation about Substance Use	4/08/2021	87
	Session 3: Implementing SUD Treatment in Primary Care: A Rural Health Example	4/15/2021	70
	Session 4: The Kansas Perceptive on the Opioid Crisis	4/22/2021	65
	Session 5: Strategies for Harm Reduction and Maximizing Pharmacy Partners	4/29/2021	68

Attendee knowledge was assessed through pre-test and post-test evaluations, and forty-six attendees completed the evaluations. The post-test percentages for the correct response rates for three of the four evaluation items were improved. The evaluation information is summarized in Table B26.

Table B.26. KUMC Project ECHO® Series Evaluation		
Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders		
Evaluation Item	**Percent Correct**	
	Pre-test	**Post-test**
Which of the following is NOT a tool available to all primary care providers attempting to reduce the risk of overdose and other harms related to substance use?	43%	60.%
SBIRT is a comprehensive, integrated, public health approach to the delivery of early intervention for individuals with risky alcohol and drug use, as well as the timely referral to more intensive substance abuse treatment for those who have substance use disorders.	91%	96%
What are the benefits to providing MAT to patients in a primary care setting?	89%	93%
Drug overdose events and controlled substance prescriptions were substantially impacted by the COVID-19 pandemic in Kansas.	98%	93%

About 89% of the attendees agreed that "Complex care circumstances were mastered through case-based learning". The evaluation of three clinical practices for screening and treating SUDs was conducted at registration and again post-series to determine practice change regrading screening for SUD, use of medication assisted treatment (MAT) waivers, and partnerships with local pharmacist related to opioid use disorder (OUD) care. This evaluation was conducted by using a 5-point measure, with 1 = no practice planned to 5 = established practice. The post-series improvement in the clinical practice change was seen for two practices (use of MAT waivers, and partnerships with local pharmacist related to OUD care). The pre- and post-ECHO series assessment of self-efficacy measures aligned with series' overarching learning objectives and were evaluated with a 5-point ranking scale (1= strongly disagree, and 5 = strongly agree). Respondents were asked about their confidence in their ability to employ SUD screening tools in the clinical setting, locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care, devise strategies to counteract stigma in SUD treatment, and examine various harm reduction strategies and their role in disease treatment. The post-ECHO series evaluation results showed an improvement in all four self-efficacy measures indicating improved self-efficacy of the attendees. At the end of the series, when attendees were asked if they had made, or planned on making changes based on what they learned in the series, 79% of them responded "yes."

Key points from attendee feedback are summarized in Table B27.

Table B.27. KUMC Project ECHO® Series Attendees' Feedback
Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders
Feedback provided by 46 attendees (N=46)
• 98% agreed or strongly agreed that they gained helpful knowledge from this ECHO series (n=45)
• 91% estimated their confidence level using this new information to better treat patients at 50% to 100% (n=42)
• 89% agreed or strongly agreed that they obtained helpful skills and techniques to improve professional practice (n=41)
• 80% estimated 50% to 100% of information was new (n=37)
• 74% agreed and strongly agreed that ECHO's interactive format is more effective than standard webinars (n=34)

The continuing education evaluation was also conducted at the end of each session. Three evaluation items were included in this assessment. These results, summarized in Table B28, are based on the responses provided by the attendees who claimed CE credit.

Table B.28. KUMC Project ECHO® Series Continuing Education Evaluation

Series: Substance Use Disorders 2021: A Primary Care Approach to Managing Substance Use Disorders

Continuing Education Evaluation Item	Session				
	#1	#2	#3	#4	#5
Number of Attendees Responding	63	56	45	35	41
Please rate your level of achievement (% reporting good or outstanding)					
• Employ SUD screening tools in the clinical setting	87%	89%	89%	83%	95%
• Locate and utilize state and local resources for SUD treatment and recovery-oriented systems of care	89%	80%	89%	89%	95%
• Devise strategies to counteract stigma in SUD treatment	92%	86%	89%	86%	98%
• Examine various harm reduction strategies and their role in disease treatment	89%	78%	93%	77%	100%
I will use this information to (% responding "yes")					
• Improve my current patient safety practices	59%	48%	53%	43%	63%
• Validate my current patient safety practices	21%	25%	18%	34%	15%
• Improve my current medical error prevention and analysis practices	14%	2%	7%	17%	12%
• Validate my current medical error prevention and analysis practices	5%	5%	4%	11%	0%
• Improve my current risk management practices	35%	20%	31%	20%	20%
• Validate my current risk management practices	11%	14%	13%	17%	5%
Please rate your level of agreement (% responding "somewhat agree" or "strongly agree"					
• This activity has positively affected my ability to function as part of a team	87%	82%	89%	86%	90%
• I learned something today that I can take back to my team to improve outcomes	92%	86%	93%	89%	93%

These results for the three continuing education evaluation items described in Table B28 are further summarized below.

- Across all five sessions, more than 76% of respondents reported their level of achievement to be good or outstanding regarding the employment of SUD screening tools in the clinical setting, locating and utilizing state and local resources for SUD treatment and recovery-oriented systems of care, device strategies to counteract stigma in SUD treatment, and examining various harm reduction strategies and their role in disease treatment.
- Across all five sessions, 43% to 63% of respondents indicated they will use the information to improve their current patient safety practices, however, only 15% to 34% indicated they will use the information to validate their current patient safety practices. Only 2% to 17% indicated they will use the information to improve their current medical error prevention and analysis practices, whereas 0% to 11% indicated they will use the information to validate their current medical error prevention and analysis practices. With regard to current risk management practices, 20% to 35% indicated

they will use the information to improve these practices, and 5% to 17% indicated they will use the information to validate these practices.

- Across all five sessions, more than 80% of respondents rated their level of agreement as "somewhat agree" or "strongly agree" when asked about the positive affect on their ability to be a part of team, and they learned the information that they can share with their team to improve outcomes.

Results for the Telehealth Provider Survey

The Telehealth Provider Survey was conducted in September 2022. The survey was designed to gain an understanding of providers' experiences regarding telehealth services they offer to KanCare members, including facilitators and barriers to the use of telehealth services, and whether use of the services improved access to care among KanCare members.

In addition, providers were asked to provide recommendations for removing barriers to increase the use of these services and improve access to care among KanCare members. An overview of survey responses and key themes are summarized in Table B29.

Table B.29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members

Survey Participants' Responses	Key Themes
• I think it would be helpful to have some consistency in terms of rules/forms, etc. It seems like everyone requires something different (Commercial/VA, etc.). • Specify required in-person visits, i.e. q6 month or yearly. • To keep telehealth open for all providers (no silos) and not having specific platforms we have to use per each MCO. As long as it is HIPAA certified, providers should be able to utilize their selected HIPAA compliant platform for telehealth.	• Provide consistency in application of rules and systems. ○ Use of the same forms by all entities involved. ○ Specify required in-person visits. ○ Providers should not have to use specific platforms for each MCO. ○ Providers should be able to utilize their selected HIPAA compliant platform for telehealth.
• Ensure reliable Wi-Fi connection for members with capable technology. • Increase internet access. • Ensure that all members can access telehealth services. • Improved access to higher speed internet access for patients in medically underserved regions. • Clients don't always have reliable internet/cell service as we are in rural area. • For therapy evaluations such as mine, I can perform up to 12 evaluations a day with outstanding effectivity and results. I have a better setup with a dual screen monitor to assess patient charts while documenting and using the audiovisual platform of their choice. • Bigger screens, better audio, connectivity issues. • Helping clients obtain reliable and adequate Internet services and devices to improve telehealth sessions, e.g., more than just phone. • I would like clients to have access to apps for monitoring of mood symptoms or electronic journals that they could electronically send to providers. It could provide insights into what may be triggering panic attacks, dreams about unresolved issues, and/or medication adherence monitoring. Government phones with limited minutes or access to applications inhibits progress with care. • Communicating to KanCare members that telehealth is available, free, and useful. Helping clients know what to do if they don't have access to internet (how to apply for waivers/grants if they don't have access to internet or for free/reduced cost cell phone plans).	• Increase and improve technology and resources for the members and providers. ○ Ensure availability of reliable high speed internet technology for all members, especially in medically underserved and rural areas. ○ Provide better technical resources and system capabilities for members and providers, such as devices, bigger screens, better audio, capability for providers to use audiovisual platforms of patients' choice. ○ Members' access to mobile apps for monitoring of mood symptoms or electronic journals that they could electronically send to providers. ○ Government phones with limited minutes or access to applications inhibits progress with care. Better devices should be provided to members. ○ Giving information to members on how to apply for waivers/grants if they don't have access to internet or for free/reduced cost cell phone plans.

Table B.29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)

Survey Participants' Responses	Key Themes
• Continued coverage. • Maintain coverage by insurance companies.	• Continued coverage by insurance companies.
• Provide education to member on the ease and benefit of telehealth. • Educate patients on the benefits of being seen from a telehealth platform. • Offer webinars to and members on telehealth, how it works, tips for effectiveness via Telehealth services • Most clients stumble upon me through Psychologytoday.com because they don't know how to find a qualified therapist who specializes in their needs when the therapist lives in a different area of the state. Any kind of database that's easily searchable for potential clients seeking services to be able to sort through all qualified providers in order for them to make an informed decision would go over well, I think. If that already exists, then getting the word out to KanCare members is the key that seems to be missing. • Assisting clients with lack of resources into getting those resources to receive services.	• Provide education, resources (such as searchable databases for identifying providers for needed services), and trainings to members to assist in the understanding benefits of telehealth and using it with ease.
• Provide telehealth services to your customers at the same rate as in person services. • Increase reimbursement. • Reimbursement rates prevent providers from taking new KanCare members. It is not cost effective to provide services with such poor rates and no pay for no-shows. • Increased rate for telehealth services as this opens doors for increased services. • Offer greater reimbursement to companies who participate in telehealth due to convenience of telehealth capabilities.	• Increase reimbursement rate for telehealth services. ○ Offer same reimbursement rate for telehealth services as in person services. ○ Increase in reimbursement rates to make telehealth use cost-effective and for its increased use. ○ Offer greater reimbursement to companies who participate in telehealth due to convenience of telehealth capabilities.
• I believe all KanCare members should have access to telehealth as a part of their comprehensive health services. It should be up to the clinical judgment of the provider and client to determine who would benefit from telehealth services delivery. • More opportunities for KanCare members to participate in telehealth services from school.	• Ensure opportunities for telehealth services are available for all members. ○ Access to telehealth as part of comprehensive health services for the member with the decision to use telehealth services being based on the provider's clinical judgment and the member. ○ Provide more opportunities for telehealth services from school.

This area intentionally left blank

Table B.29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)

Survey Participants' Responses	Key Themes
• Offer webinars to providers on telehealth, how it works, tips for effectiveness via Telehealth services • More training • We need training for billing staff, leadership staff, and all providers that is on easy-to-understand terms and language. Everything I have seen so far leaves more questions than it provides answers for. It is vague. It does not address my specific situation. I also want to see leadership buy in. I am always being pushed to see patients so always register for webinars I hope I get to see and then end up having to miss them because I have appointments. I would like to see the training easily accessible and easy to find on self-paced courses that I can watch, start, and stop on my own time. I want to be able to ask credible subject matter experts my question about my exact situation to see if I am applying the correct billing codes. My organization says telehealth is not profitable. Other organizations say it is. I think we are not billing it correctly. We also need easy to understand training for everyone on how to bill for it that we can access at any time. We also need an expert who can answer specific situational questions. • Right manners, attitude and rules when attend telehealth appointment.	• Provide trainings for providers. ○ Trainings with easy to understand terms and language for billing staff, leadership staff, and all providers. ○ Provide trainings in user-friendly format that is easily accessible and easy to find on self-paced courses. ○ Leadership buy-in to accommodate time for providers' trainings. ○ Availability of trainings on a variety of specific situations providers deal with. ○ Availability of credible subject matter experts to respond to the provider's exact situation to see if correct billing codes are applied. ○ Provide easy to understand training for everyone on how to bill that providers can access at any time and can reach an expert who can answer specific situational question ○ Training on appropriate attitude and rules for telehealth appointments.
• Telehealth is an amazing resource to KanCare members. I believe it has lessened the stress of members in attending appointments. It has improved show rates. • None. It is working well, and I have found a growing confidence in telehealth services. • None (3) • None at this time. • Telehealth is not the issue. • Our patients need this service because without it many will simply go untreated. At the beginning of the pandemic, I had one man on telehealth tell me "Thank God you offer Zoom sessions now. I tried to come see you for months about my anxiety but always turned around and went home because I was too anxious. I even got into the waiting room once and left. Now on Zoom I can finally feel comfortable enough to get the medication I need." I had several patients tell me they were homeless or jobless and had no food. They lived in another city or county or too many miles to walk in the heat of summer. They needed to maintain their mental health medications but did not have a car or could not afford the gas and did not have access to other transportation sources. Some of them do have jobs and can only take limited time off so cannot afford to take time off for every doctor appointment to keep up with seeing me to get their medications. Seeing me on a lunch break while in their car on Zoom is the only way they can stay on top of their mental health. Some patients were caring for kids with COVID, had COVID, had Strep throat, or recovering from a broken leg, or had cellulitis so bad they could not get in the car and drive. For them telehealth is the only way they can see a behavioral health provider to get their medication refilled and check in. Otherwise, they would miss an appointment and go without their meds. This would be detrimental to their health. WE NEED THIS SERVICE FOR BEHAVIORAL HEALTH.	• Telehealth is a valuable source for members and providers. ○ Great resource for members. ○ No recommendations for improving it. ○ Telehealth services are needed for provision of behavioral health care services.

Table B.29. Telehealth Provider Survey: Ideas to Improve Telehealth Services for KanCare Members (Continued)

Survey Participants' Responses	Key Themes
• Having a one or a few specific and dedicated therapist covering that service for organizations instead of spreading it among all providers. The benefit would be a person more familiar and specifically competent in this area. The barrier is that should the organization lose the faculty member covering this service, it may be difficult to cover those services until they have a replacement.	Note: Three survey respondents provided specific comments related to use telehealth that were dissimilar to those provided by rest of the respondents to this survey question. These comments are summarized into following dissimilar themes: • Only one or few specific and dedicated therapists covering that service for organizations. However, there will be a gap in services if assigned provider leaves the organization. • Telehealth services should be used when in-person services cannot be provided. • Telehealth is not appropriate for clients with certain conditions such as speech and language disorders. • Parents do not want to bring their child for an in-person visit when telehealth services are available.
• Use them as a fall back when usual in person visits are impeded.	
• I don't. I do not like telehealth for my profession. I cannot accurately see the child or hear the child. I work with speech and language disorders, often requiring intense evaluation of the articulators and if I can't easily see the child's mouth or be able to look into their mouth or be able to complete certain techniques to help teach the articulators how to make sounds it is not a functional session. I also do not like that our telehealth services have become a crutch for parents. All but one of my telehealth kids all attend school in person as well as attend other functions in person, yet do not come to in person therapy. It demonstrates lack of investment for many of the parents.	

Appendix C

KanCare 2.0 Interim Evaluation Report Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

Comparison of Interim and

Summative Evaluation Analytic Methods

Table C.1. Comparison of Interim and Summative Evaluation Analytic Methods

Overall Service Coordination		
Evaluation Question		
Outcome Measures	**Interim Report Analytic Methods**	**Summative Analytic Methods**
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, by implementing comprehensive and intense method of care coordination, improve the quality of care, health, and cost outcomes?		

Included in Interim (Quantitative):
• Annual Dental Visit (HEDIS)
• Adults' Access to Preventive/ Ambulatory Health Services (HEDIS)
• Adolescent Well-Care Visits (HEDIS)
• ED visits, observation stays, or inpatient admissions for following conditions (Administrative):
  ○ 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):
  ○ Diabetic retinopathy, or
  ○ Influenza, pneumonia or shingles
• Emergency department visits overall (Administrative)
	• 3 pre-KanCare, 3 KanCare data points were available.
	• Equality of Relative Improvements (a modification of Difference-in-Differences that assumes equal reductions in failure rates instead of equal slopes of trend lines) between intervention and control group
	• Utilization rates were reported per 1,200 member-months.
		• 3 pre-KanCare, 5 KanCare data points are expected.
		• Comparative Interrupted Time Series Evaluation Design as planned
		• Equality of Relative Improvements if points are removed due to COVID-19
		• Utilization rates will be reported per 1,200 member-months instead of per 1,000 member-months as planned.

Included in Interim (Qualitative):
• Learning needs identified by the OneCare Kansas (OCK) Learning Collaborative.
• Processes to address the learning needs identified by the OCK Learning Collaborative.
• Factors that facilitated the implementation of the OCK program to achieve its goal.
• Barriers encountered in implementation.
• Processes to further improve the quality of OCK program.
• Observations about why OCK program succeeded or did not meet its goals.
	• Key themes were identified from the following sources:
	  ○ April 2020 through March 2022 OCK Learning Collaborative participants' responses
	  ○ June 2021 WSU CEI survey
	  ○ July 2021 regional meetings led by KDHE
		• Key themes will be identified from the following sources:
		  ○ Interim validation report and sources
		  ○ Additional sources as data become available

Excluded in Interim: • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (HEDIS) • Antidepressant Medication Management (HEDIS) • Inpatient Utilization — General Hospitalization/ Acute Care, excluding maternity admissions.	• 0 pre-KanCare, 3 KanCare data points were available. • Initiation and engagement rates from encounter data were too different from HEDIS rates. • For the other two, suitability of pre-KanCare rates from encounters was being studied.	• 0 to 3 pre-KanCare, 5 KanCare data points are expected. • Comparative Interrupted Time Series Evaluation Design as planned (if 8 points available) • Equality of Relative Improvements (if fewer than 8 points are available)
Removed from Analytic Plan: Follow-Up After Hospitalization for Mental Illness (HEDIS)	Omitted due to low denominators	Will be omitted

Table C.1. Comparison of Interim and Summative Evaluation Analytic Methods (Continued)

Outcome Measures	Interim Report Analytic Methods	Summative Analytic Methods
Hypothesis 1		
Evaluation Question		
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?		
Excluded from Interim: • All quantitative measures	• Data were not available for determining comparison groups	• Comparative Interrupted Time Series Evaluation Design as planned (if 8 points available) • Equality of Relative Improvements (if fewer than 8 points are available)
Excluded from Interim: • All qualitative measures	• Data were not available	• Key themes will be identified
Removed from Analytic Plan: None		
Hypothesis 2		
Evaluation Question		
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?		
Excluded from Interim: • All quantitative measures	• Standardized data were not available for analysis	• Standardized data starting May 2022 is expected • Descriptive statistics and comparison of 2022 and 2023 data points
Hypothesis 3		
Evaluation Question		
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. 4. Did use of telemedicine increase access to services over the five-year period for KanCare members living in rural or semi-urban areas?		
Included in Interim: **– Quantitative Telehealth** • % 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	• 1 pre-KanCare, 3 KanCare data points were available. • Non-experimental method (One-Group Pretest–Posttest Design) • Subgroup analysis ○ Urban, non-urban ○ Age range	• 1 pre-KanCare, 5 KanCare data points are expected. • Non-experimental method (One-Group Pretest–Posttest Design) as planned • Subgroup analysis as planned

Table C.1. Comparison of Interim and Summative Evaluation Analytic Methods (Continued)

Hypothesis 3 (Continued)

Outcome Measures	Interim Report Analytic Methods	Summative Analytic Methods
• # of paid claims with selected procedure codes, stratified by area, mode of delivery, and service type. • # of members with selected diagnosis per 1,000 members (e.g., speech-language pathology).		
New in Interim (Quantitative Telehealth): • Percentage of KanCare members with selected procedure codes how had specific diagnoses codes • Percentage of KanCare members with specific diagnoses codes who had selected procedure codes	• 1 pre-KanCare, 3 KanCare data points were available. • Selected procedures/diagnoses ○ Speech therapy ○ Individual psychotherapy ○ Family or group psychotherapy • Descriptive statistics • Equality of Relative Improvement	• 1 pre-KanCare, 5 KanCare data points are expected. • Extend analysis with additional datapoints • Additional procedure/diagnoses codes will be considered
Included in Interim (Quantitative 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	• 1 pre-KanCare, 3 KanCare data points were available. • Non-experimental method (One-Group Pretest–Posttest Design) • Subgroup analysis Urban, non-urban	• 1 pre-KanCare, 5 KanCare data points are expected. • Non-experimental method (One-Group Pretest–Posttest Design) as planned
Included in Interim (Qualitative Telemedicine and Telemonitoring): • 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.	• Key themes were identified from the following sources: ○ August-September 2022 provider survey	• Key themes are expected to be identified from the following sources: ○ August-September 2022 provider survey ○ Follow-up provider survey ○ Key informant interviews

Table C.1. Comparison of Interim and Summative Evaluation Analytic Methods (Continued)		
Hypothesis 3 (Continued)		
Outcome Measures	**Interim Report Analytic Methods**	**Summative Analytic Methods**
Included in Interim (Qualitative Telemonitoring): • Summary of telementoring efforts	• Project ECHO® sessions were reviewed: ○ 46 Sunflower Health Plan sessions, 2019–2021 ○ 5 KUMC sessions, 2021	• Project ECHO sessions through 2024 will be reviewed. • Additional sources will be summarized, if available.
Excluded from Interim: • Quantitative telementoring	• Data source unknown	• Dependent on source data
Removed from Analytic Plan: None		

Appendix D

KanCare 2.0 Interim Evaluation Report Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
AAP	Adults' Access to Preventive/Ambulatory Health Services
ADV	Annual Dental Visit
Aetna or ABH	Aetna Better Health of Kansas
AOD	Alcohol or Other Drug
AWC	Adolescent Well-Care Visit
BI	Brain Injury
BPD	Blood Pressure Control for Patients with Diabetes
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBMH	Community-Based Mental Health
CDC	Comprehensive Diabetes Care
CE	Continuing Education
CHIP	Children's Health Insurance Program
CITS	Comparative Interrupted Time Series
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
E&M	Evaluation and Management
ECHO (Project ECHO)	Extension for Community Healthcare Outcomes
ECHO (Survey)	Experience of Health Outcomes
ED	Emergency Department
EED	Eye Exam Performed for Patients with Diabetes
EHR	Electronic Health Record
EQRO	External Quality Review Organization
FE	Frail Elderly
FQHC	Federally Qualified Health Center
FUH	Follow-Up After Hospitalization for Mental Illness
HbA1c	Hemoglobin A1c
HBD	Hemoglobin A1c Control for Patients with Diabetes
HCBS	Home and Community Based Services
HCBS CAHPS	Consumer Assessment of Healthcare Providers and Systems Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HRA	Health Risk Assessment
HST	Health Screening Tool
I/DD	Intellectual/Developmental Disability

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IET	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
IMDs	Institutions for Mental Diseases
KDADS	Kansas Department of Aging and Disability Services
KDHE-DHCF	Kansas Department of Health and Environment, Division of Health Care Finance
KFMC	KFMC Health Improvement Partners (the EQRO)
KMAP	Kansas Medical Assistance Program
KUMC	University of Kansas Medical Center
LTSS	Long Term Services and Supports
MAT	Medication Assisted Treatment
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
MSC	Medical Assistance with Smoking and Tobacco Use Cessation
MY	Measurement Year
NCI	National Core Indicators
NCI-AD	National Core Indicators Adults with Disabilities
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
NPI	National Provider Identifier
OCK	OneCare Kansas
OCKPs	OCK Partners
OCD	Obsessive Compulsive Disorder
OUD	Opioid Use Disorder
P4P	Pay-for-Performance
PCP	Primary Care Provider
PCSP	Person-Centered Service Plan
PD	Physical Disability
PPC	Prenatal and Postpartum Care
QC	Quality Compass
RFR	Reduction in the Failure Rate
SLP	Speech-Language Pathologist
SMI	Severe Mental Illness
SUD	Substance Use Disorder
Sunflower or SHP	Sunflower Health Plan
UnitedHealthcare or UHC	UnitedHealthcare Community Plan of Kansas

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
VBP	Value-Based Purchasing
WSU CEI	Wichita State University Community Engagement Institute

Attachment

KanCare 2.0 Interim Evaluation Report

Evaluation of the State of Kansas Medicaid Section 1115(a) Demonstration

Reporting Period – January 2019 – September 2022

KanCare 2.0 Evaluation Design

KanCare 2.0 Evaluation Design

Revised per CMS feedback

January 17, 2020

Table of Contents
KanCare 2.0 Evaluation Design

Table of Contents
KanCare 2.0 Evaluation Design

List of Tables and Figures

Tables:

Figures

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.

This area intentionally left blank

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):
	  ○ 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):
	  ○ Diabetic retinopathy, or
	  ○ Influenza, or
	  ○ Pneumonia, or
	  ○ 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

This area intentionally left blank

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.

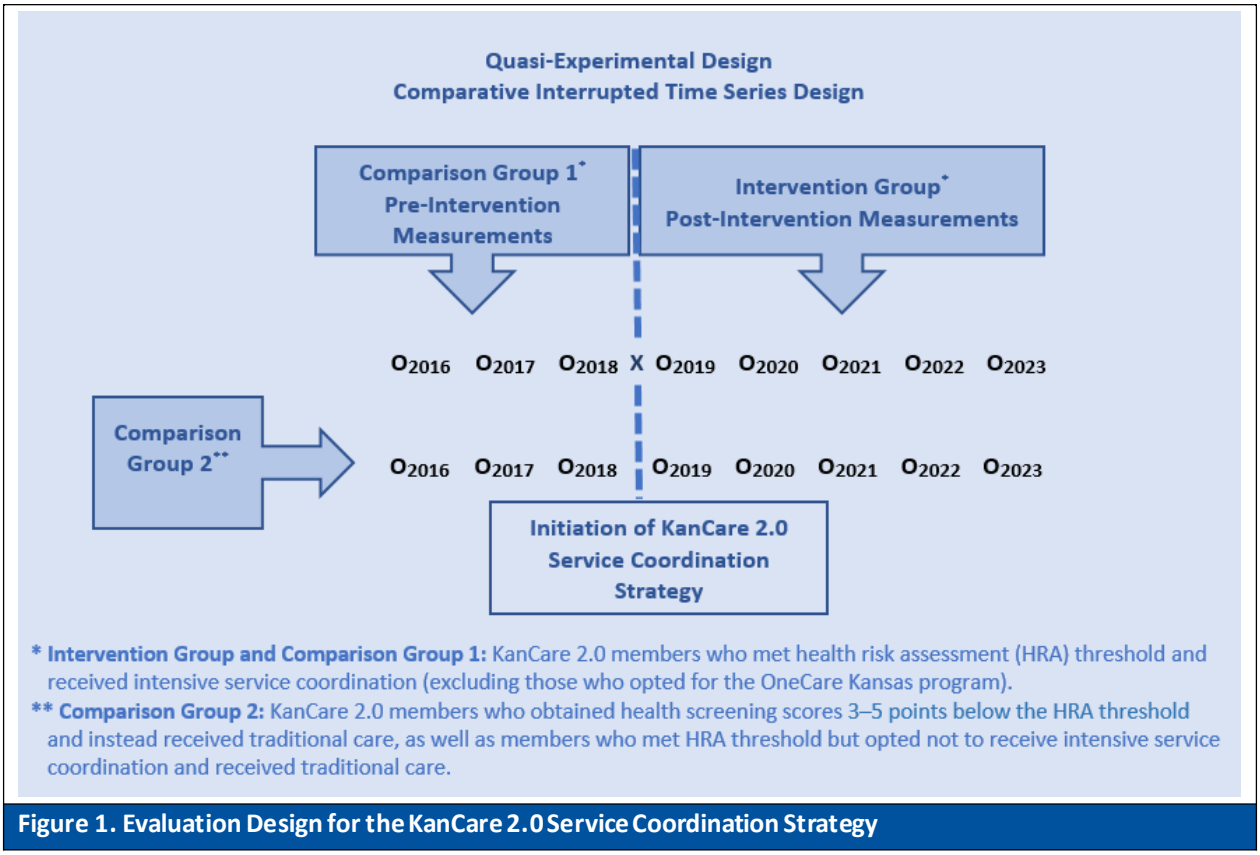


Figure 1. Evaluation Design for the KanCare 2.0 Service Coordination Strategy

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.

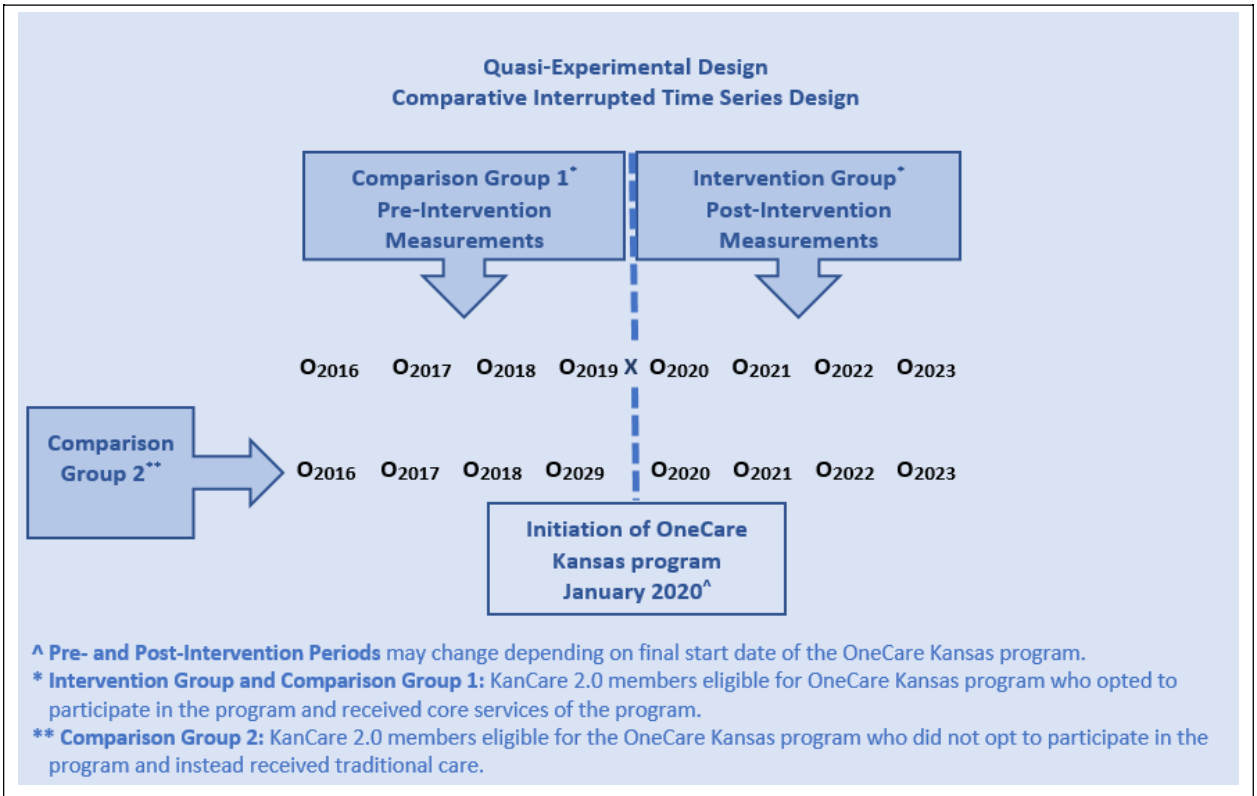


Figure 2. Evaluation Design for the OneCare Kansas Program

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.

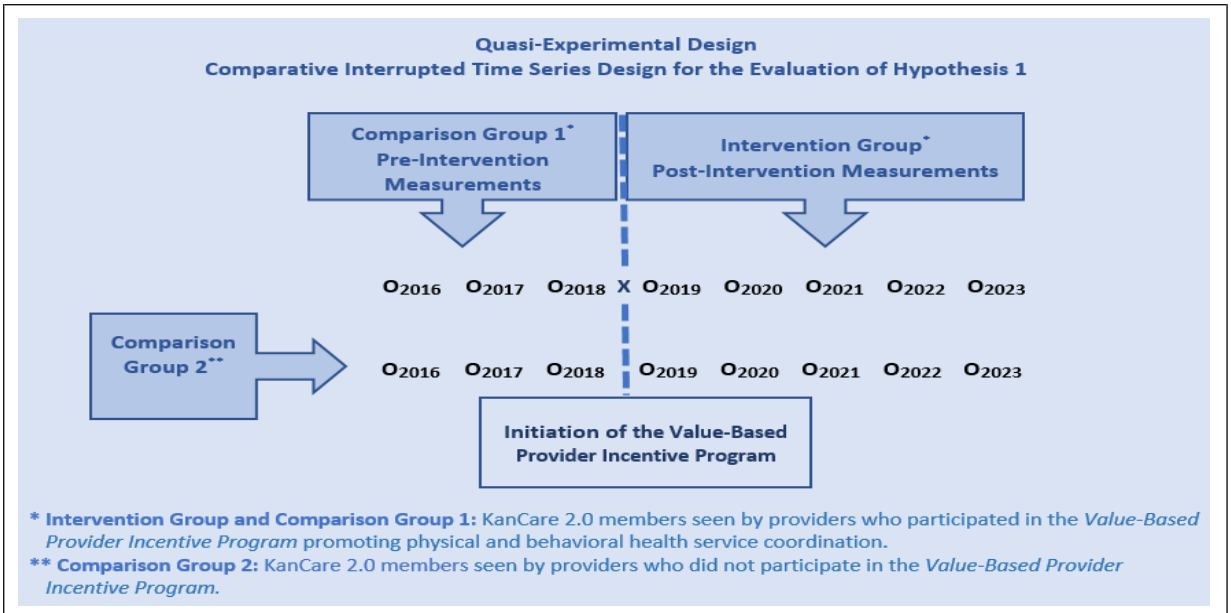


Figure 3. Evaluation Design for the KanCare 2.0 Value-Based Provider Incentive Program Strategy

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.

This area intentionally left blank

The design for the evaluation of the Hypothesis 2 is summarized in Figure 4.

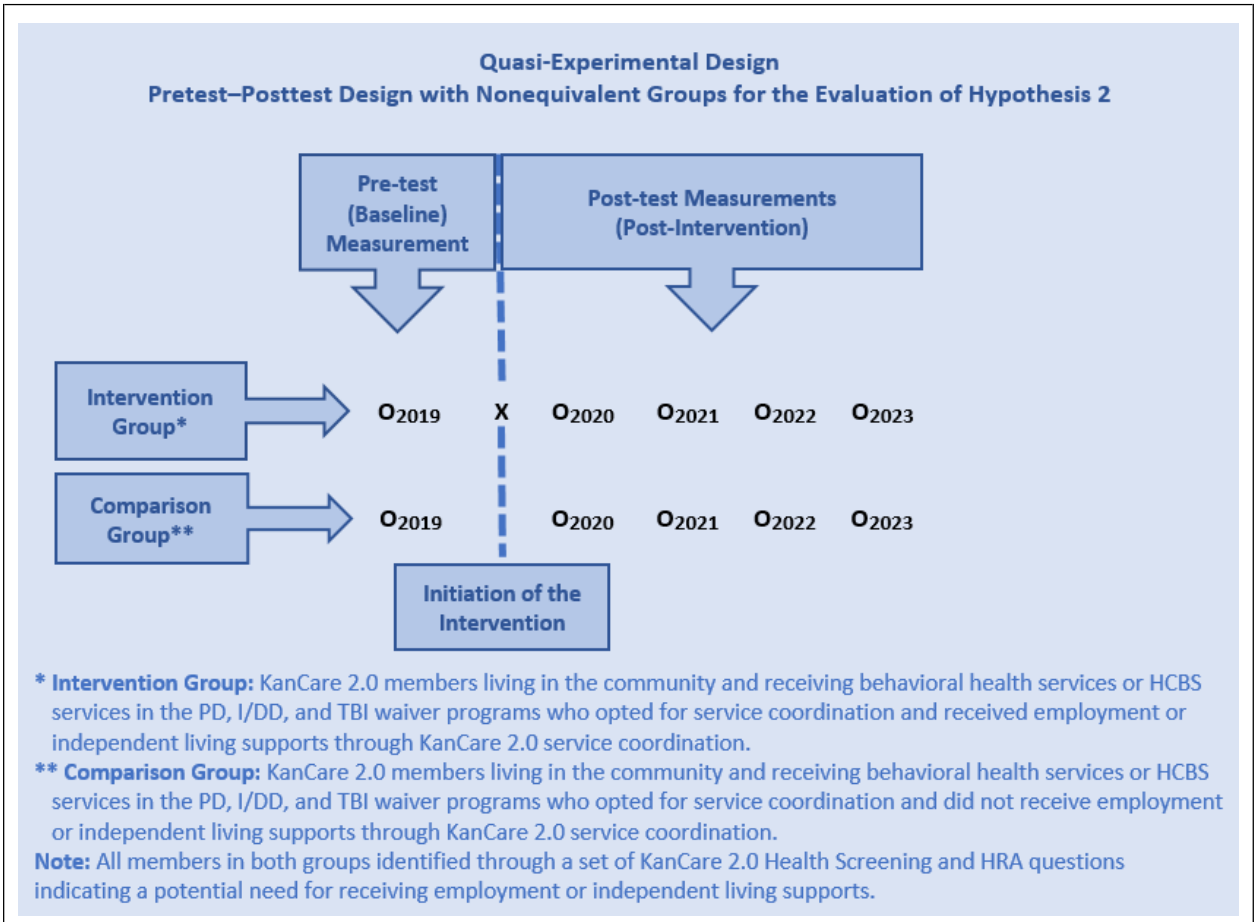


Figure 4. Evaluation Design for the Intervention Providing Employment or Independent Living Supports through Service Coordination to the KanCare 2.0 Members Living in the Community and Receiving Behavioral Health Services or HCBS Services in the PD, I/DD, and BI Waiver Programs

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.

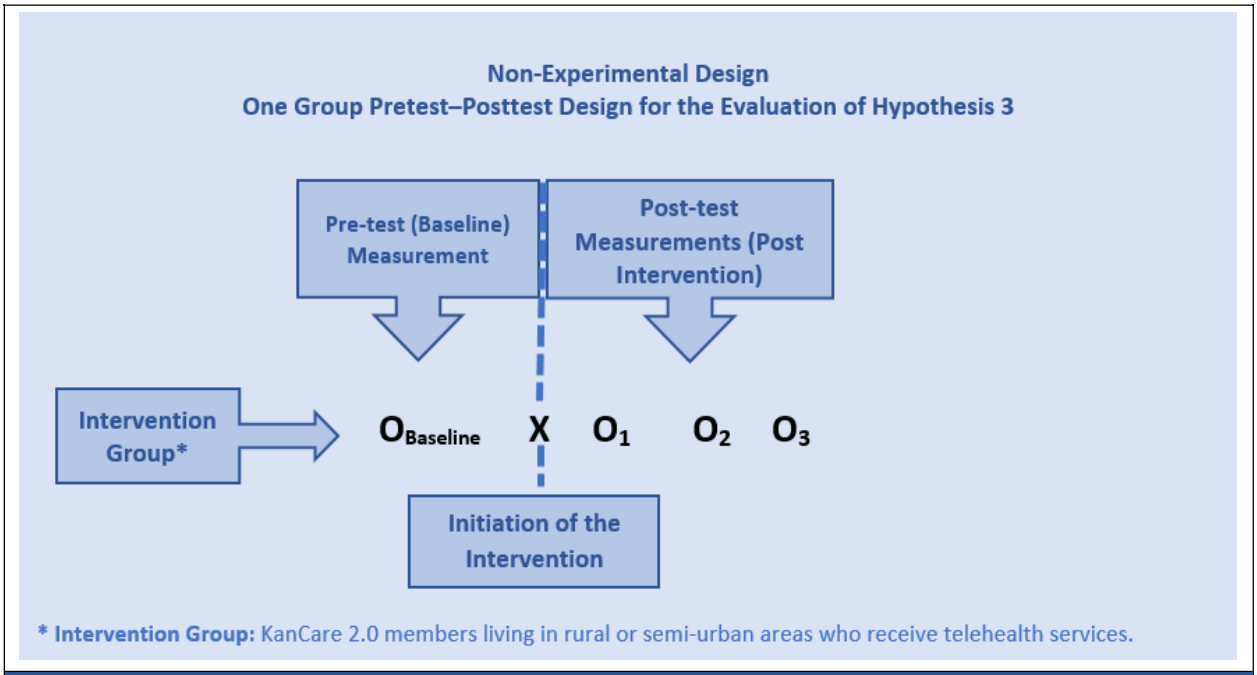


Figure 5. Evaluation Design for the Telehealth Services Strategy

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.

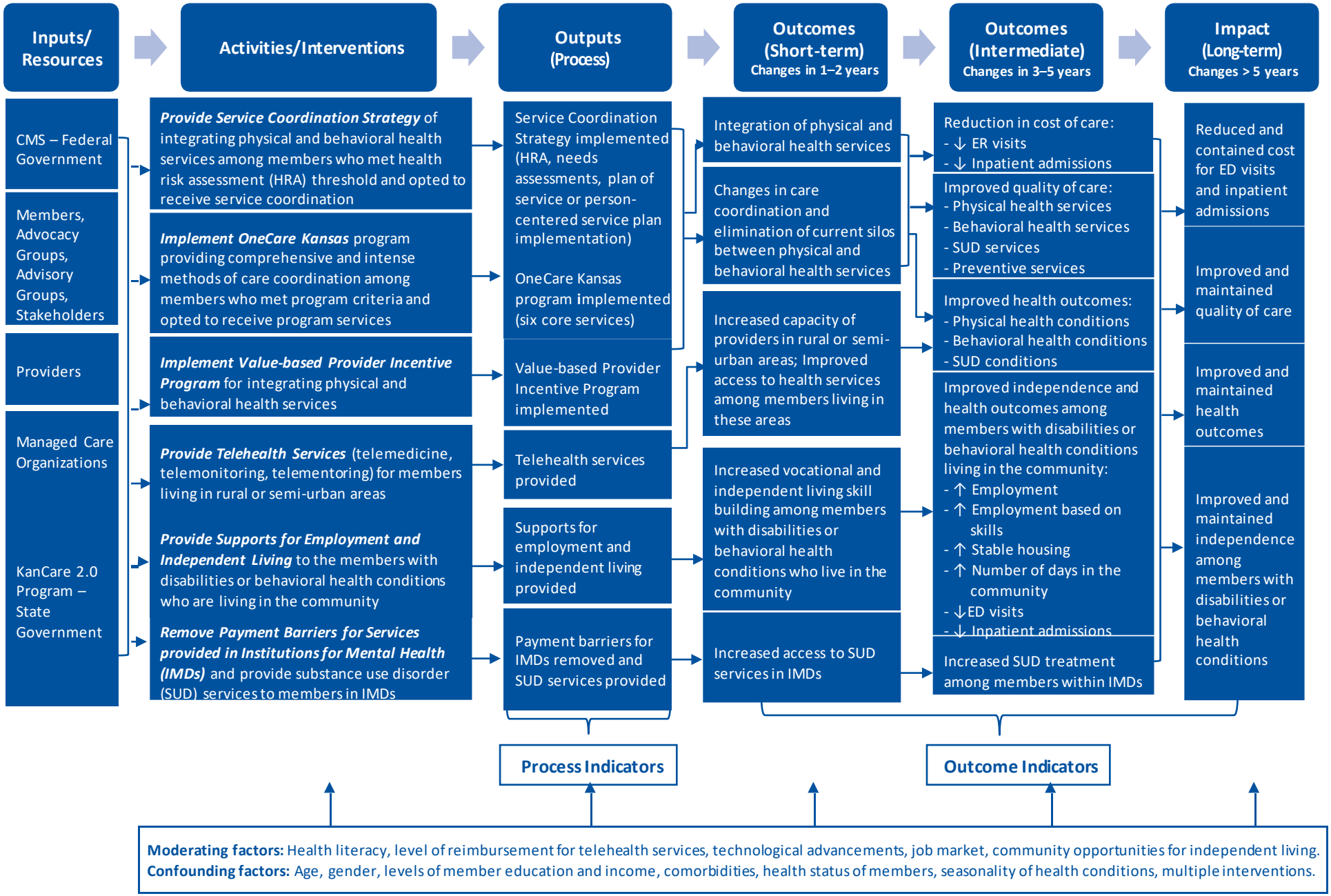
MCOs have not yet developed specific strategies for the use of telehealth services and an appropriate comparison group cannot be currently be identified, therefore, a rigorous scientific design with additional comparison group (such as a comparative interrupted time series design) could not be used for 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.

This area intentionally left blank

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* Strategy.

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

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

This area intentionally left blank

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

This area intentionally left blank

References

1. Kansas Department of Health & Environment. *KanCare 2.0 Section 1115 Demonstration Renewal Application: Final Submission to CMS*. Topeka, KS: KDHE; 2018. Submitted December 20, 2017. https://www.kancare.ks.gov/docs/default-source/about-kancare/kancare-renewal-forums/kancare-renewal/kancare-2-0-demonstration-renewal-application-(002).pdf?sfvrsn=76194a1b_4.
2. Mayhew M. *Approval letter for KanCare 2.0 Section 1115 Demonstration* (Proj. No. 11-W-00283/7). Baltimore, MD: CMS; 2018. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/section-1115-waiver-comments/ks-kancare-2-0-approval-letter-final-to-ks.pdf?sfvrsn=9ed84c1b_
3. Trieger M. *CMS Review: Kansas "KanCare 2.0" Section 1115 Demonstration Evaluation Design (without SUD & DSRIP)*. Baltimore, MD: CMS; 2019.
4. Kansas Department of Health & Environment. *KanCare 2.0 Quality Management Strategy*. https://www.kancare.ks.gov/docs/default-source/policies-and-reports/quality-measurement/kancare-2-0---quality-mgmt-strategy_final-cms-submission.pdf?sfvrsn=25484d1b_4. Topeka, KS: KDHE; 2018.
5 Centers for Medicare & Medicaid Services. *Evaluation Design Guidance for Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance and Substance Abuse Disorders*. Baltimore, MD: CMS; 2019.
6. Kansas Department for Aging and Disability Services. *Section 1115 Substance Use Disorder (SUD) Demonstration: Evaluation Design*. Topeka, KS: KDADS. Under development as of January 16, 2020.
7. Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set): Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting*. Baltimore, MD: CMS; 2019.
8. National Committee for Quality Assurance. *HEDIS® 2020 Volume 2: Technical Specifications for Health Plans*. Washington, DC: NCQA; 2019.
9. Kansas Department of Health & Environment. *OneCare Kansas (OCK) Program Manual*. Ver 2019-1. Topeka, KS: KDHE; draft under development as of November 15, 2019. https://www.kancare.ks.gov/docs/default-source/providers/ock/draft-onecare-kansas-program-manual.pdf?sfvrsn=242e4c1b_12
10. Kansas Department of Health & Environment. OneCare Kansas: Contracted OneCare Kansas Partners. KanCare Website. https://www.kancare.ks.gov/providers/onecare-ks-providers/contracted-onecare-kansas. Topeka, KS: KDHE; 2019.
11. Kansas Department of Health & Environment. *What does OneCare Kansas mean for hospitals and other providers?* https://www.kancare.ks.gov/docs/default-source/providers/ock/hospitals-and-other-providers-1-15-19dg.pdf?sfvrsn=a4fe4c1b_10. Topeka, KS: KDHE; 2019.
12. State of Kansas. *Kansas Medicaid Managed Care Request for Proposal for KanCare 2.0* (Bid Event No. EVT0005464). Topeka, KS: Kansas Department of Administration; 2017.
13. Kansas Department for Aging and Disability Services. *Section 1115 Substance Use Disorder (SUD) Demonstration: Implementation Plan*. Topeka, KS: KDADS. Submitted June 14, 2019; approved August 07, 2019.
14. Centers for Medicare & Medicaid Services. *Substance Use Disorder (SUD) Section 1115 Demonstration Evaluation Design – Technical Assistance*. Baltimore, MD: CMS; 2019.
15. Contreary K, Bradley K, Chao S. *Best practices in causal inference for evaluations of Section 1115 eligibility and coverage demonstrations*. Washington, DC: Mathematica Policy Research; 2018.
16. Reschovsky JD, Heeringa J, Colby M. *Selecting the best comparison group and evaluation design: a guidance document for state Section 1115 demonstration evaluations*. Washington, DC: Mathematica Policy Research; 2018.