State of Kansas

KanCare Program

Medicaid State Quality Strategy

September 2014 Version – Final

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I. Introduction

A. Background and Goals of Managed Care Program

The KanCare program is a managed care Medicaid program which will serve the State of Kansas through a coordinated approach. In 2010, Governor Sam Brownback identified the need to fundamentally reform the Kansas Medicaid program to control costs and improve the quality of services. The State of Kansas has determined that contracting with multiple managed care organizations (MCOs/CONTRACTOR(S)) will result in the provision of efficient and effective health care services to the populations currently covered by the Medicaid, Children's Health Insurance Program (CHIP), and substance use disorder (SUD) programs in Kansas, and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS).

On August 6, 2012, the State of Kansas submitted a Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare will operate concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers and together provides the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the state into a managed care delivery system to receive state plan and HCBS waiver services. This represents an expansion of the state's previous managed care program, which consisted of HealthWave (managed care organization) and HealthConnect Kansas (primary care case management), and provided services to children, pregnant women, and parents in the state's Medicaid program. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

This five year demonstration will:

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

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

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

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

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

This State Quality Strategy includes many of the performance measures, contract compliance plans,quality assessment features, operational descriptions and pay for performance details that will drive the KanCare program to meet its full potential to support strong health outcomes for Kansans who use KanCare services.

Purpose of Managed Care CONTRACT
Lieutenant Governor Jeff Colyer, M.D., outlined eight (8) primary goals for the Medicaid Reform Initiative. These goals were:

1. Improvement of quality of care and services;
2. Integration and coordination of care for a holistic, population-based approach;
3. Encouragement and elimination of disincentives for people with disabilities to work without losing health coverage;
4. Emphasis on Medicaid as a short-term option for coverage;
5. Expectation of personal responsibility for active participation in health care maintenance;
6. Elimination of silos between population groups and providers;
7. Expectation of accountability for outcomes; and
8. Achievement of significant savings.

In light of these goals, Kansas Medicaid CONTRACTOR(S) will be required to provide quality care that includes, but is not limited to:

- Providing adequate capacity and service to ensure Member's timely access to appropriate needs, services and care;
- Ensuring coordination and continuity of care;
- Ensuring Members receive the services they need to maintain their highest functional level;
- Ensuring that Members' rights are upheld and services are provided in a manner that is sensitive to the cultural needs of Members, pursuant to Section 2.2.5 of the RFP;
- Encouraging Members to participate in decisions regarding their care and educating them on the importance of doing so;
- Placing emphasis on health promotion and prevention as well as early diagnosis, treatment and health maintenance;
- Ensuring appropriate utilization of medically necessary services; and
- Ensuring a continuous approach to quality improvement.

B. Performance Objectives

The State Quality Strategy addresses many of the goals of the Medicaid Reform Initiative. The State has identified a number of explicit outcomes that will be worked toward through the comprehensive managed care CONTRACT(s). These outcomes include the following:

- Measurably improve health care outcomes for Members in the following areas:
  - Diabetes

    - Coronary Artery Disease
    - Chronic Obstructive Pulmonary Disease
    - Prenatal Care
    - Behavioral Health;
- Improve coordination and integration of physical health care with behavioral health care;
- Support Members successfully in their communities;
- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

The CONTRACTOR(S) shall provide for the delivery of quality care that is: (1) accessible and efficient; (2) provided in the appropriate setting; (3) provided according to professionally accepted standards; and (4) provided in a coordinated and continuous manner. The goal of the quality management process (also known as Quality Assessment and Performance Improvement (QAPI)) is to assess, monitor, and measure for improvement of the health care services provided to Members served by the CONTRACTOR(S). The CONTRACTOR(S) shall be held accountable for the quality of care delivered by providers and subcontractor(s). This includes ensuring that a process is in place to monitor services provided in home and community-based settings. The CONTRACTOR(S) shall ensure quality medical care is provided to Members, regardless of payer source or eligibility category.

Inherent in achieving these goals is the development of a process through which the State and the CONTRACTOR(S) can collaborate to establish objectives and timetables for improvements of health care service and delivery.

Performance Measures
Given the above-stated goals of the KanCare program, performance measures were selected to provide evidence of the overall quality of care and specific services provided to each KanCare population group. CONTRACTOR(S) and/or state data contributors shall report the performance measures listed in Appendices 1-11 to the State in the time and format specified. The CONTRACTOR will be expected to meet or exceed designated benchmarks for specific performance measures. The performance measures are only one form of performance requirements for the CONTRACTOR(S). All CONTRACTORS shall comply with all State and Federal Waiver requirements regardless of whether or not there is a specific performance measure related to the requirement.

II. Assessment

As part of Kansas' comprehensive KanCare Quality Improvement Strategy, each of the substantive areas below will be assessed in a variety of ways. Working closely with the MCOs to clarify expectations and operational details, the performance measures will be implemented and measured as described in each measure. In addition, the reporting requirements of the KanCare program, which likewise are developed with clarity of expectations and operational details – including both routine/standing reporting and ad hoc or specialized reporting – are analyzed for performance outcome and areas for improvement to be communicated back to the MCOs with resulting actions monitored for improvement. Finally, Kansas' External Quality Review Organization contractor conducts both specific reviews and a broad-based onsite review of performance on areas of federal regulatory requirement; and state staff conduct both a related annual onsite review of key contract requirements not otherwise reported/reviewed and targeted issue-specific reviews. The results of all assessment activities are regularly reviewed by state staff and MCO staff, and summarized to the Interagency Monitoring Team.

Summary information as to each KanCare MCOs' actions and analysis to achieve the issues addressed in this section are included below, and related operational details are addressed in each MCO's QAPI. That summary information is included as to Amerigroup Kansas (***Amerigroup***), Sunflower State Health Plan (***Sunflower***), and United HealthCare Community Plan – Kansas (***United***).

A. Quality and Appropriateness of Care

1. How information on the race, ethnicity, and primary language spoken for each enrollee is collected and transmitted to managed care plans

At the time of application into the Kansas Medicaid program, Members are given the opportunity to indicate their race, ethnicity and primary language. By Federal law these are voluntary fields included in the application, but the information is collected when provided. This information is received from the Kansas Medicaid eligibility system and passed to the Medicaid Management Information System (MMIS) system using Health Insurance Portability and Accountability Act (HIPAA) standards. This information is collected into an 834 transaction field and is indicated in the race field (DMG05) and the primary language field (LUI02) and is then passed to the CONTRACTOR(S) electronically via the enrollment roster at the time of enrollment in the CONTRACTOR.

In section 2.2.17.1.1, the CONTRACTOR(S) are required to provide written information in Spanish, which is the Kansas' designated prevalent non-English language. The CONTRACTOR(S) must also provide oral interpretation services free of charge to each Member. This applies to all non-English languages, not only prevalent non-English languages. The CONTRACTOR(S) shall notify Members that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. The CONTRACTOR(S) shall have means available to communicate with the Member in his/her spoken language, and/or access to a phone-based translation service so that someone is readily available to communicate orally with the Member in his/her spoken language.

Amerigroup: At least annually, Amerigroup performs a member demographic analysis to include assessment of available data on race, ethnicity and language to assist in determining language requirements for member materials in addition to English and Spanish. The member handbook provides information on how members can be assisted via telephone using Voiance, including different languages and dialects, request interpreters during medical appointments, and use AT&T Relay services or sign language for hearing impaired members.

Sunflower: Sunflower receives members' language preferences from information provided by the state through the 834 file referenced above. Sunflower provides instructions to members in multiple ways regarding how to obtain materials in languages other than English or in other formats such as in the new member welcome packet, the member handbook, the member newsletters, in our call centers, the provider manual, during case management visits and on our website.

Sunflower also has multiple policies to support the above requirement including but not limited to KS.MSPS.21, Telephone Call Response; CC.MBR.16-Hearing Impaired–Language Specific Interpreter Services; CC.MBR.15-Interpreter Services for Scheduled Medical Appointments; CC.MBRS.02-Member Materials Readability Policy, KS.MBRS.43- Alternate Media Requests; CC.MBRS.15. Interpreter Services for Scheduled Medical Appointments.

United: UHC receives and tracks member demographic information received via the 834 file from the State. Members of UnitedHealthcare Community Plan (UHC) have access to materials in a language or format that is best for them. They also have access to interpreters if their doctor does not speak their language. These are free services that are outlined in the Member Handbook. Hearing and speech impaired member also have access to a toll-free number, a TTY phone number and to Telecommunications Relay Service.

2. Use of External Quality Review Organization (EQRO) Technical Report to evaluate quality and appropriateness of care

An External Quality Review (EQR) of the CONTRACTOR(S) will be conducted annually related to quality outcomes, timeliness of and access to the services covered under each CONTRACT. The EQR is conducted consistent with the Centers for Medicare and Medicaid Services (CMS) protocols. The EQR is a technical report regarding three (3) mandatory activities and several optional activities required by the State. The report must include the following information:

- The manner in which the data was aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the CONTRACTOR(S);
- An assessment of the CONTRACTOR's strengths and weaknesses with respect to quality, timeliness, and access to health care services;
- Recommendations for improving the quality of health care services; and
- An assessment of the degree to which the CONTRACTOR implemented the previous year's EQR recommendations for quality improvement and the effectiveness of the recommendations.

The EQR consists of the following mandatory activities:

- Validation of at least two (2) performance improvement projects (PIPs) required by the State to comply with requirements set forth in 42 CFR §438.240(b)(1), that were underway during the preceding 12 months. Some performance measures may be required by the State to be continued, based on specific outcomes for a specified period of time. The State reserves the right to require additional performance improvement projects if they are deemed necessary.
- Validation of CONTRACTOR performance measures reported (as required by the State) or CONTRACTOR performance measure calculated by the State during the preceding 12 months to comply with requirements set forth in 42 CFR §438.240(b)(2).
- A review, conducted within the first year of this CONTRACT, and at least every three (3) years thereafter, to determine the CONTRACTOR's compliance with standards (except with respect to standards under 42 CFR §438.240(b)(1) and (2), for conducting performance improvement projects and calculations of performance measures, respectively) established by the State to comply with the requirements of 42 CFR §438.204(g).

For each activity, the report must specify the objectives, technical methods of data collections and analysis, a description of data obtained, and any conclusions drawn from the data. The EQR may also consist of optional activities as determined by the State.

Independent EQRs and activities are a primary means of assessing the quality, timeliness and accessibility of services provided by Medicaid CONTRACTORs. The EQRO annual technical report compiles the results of these reviews and activities, making it a streamlined source of unbiased, actionable data. The State can use this data to measure progress toward stated goals and objectives and to determine if new or restated goals are necessary.

Where applicable, the data in the annual technical report shall be trended over time to help the State identify areas where targeted quality improvement interventions might be needed. As mandated by 42 CFR § 438.364, technical report data make it possible to benchmark performance both statewide and nationally.

3. Clinical Standards and Guidelines

Provision of Services

Each CONTRACTOR must develop and/or adopt practice guidelines as described in 42 CFR 438.236. The CONTRACTOR must implement procedures that ensure the provision of medically necessary services as specified, subject to all terms, conditions and definitions of the CONTRACT. Any and all disputes relating to the definition and presence of medical necessity shall be resolved in favor of the State. Covered services shall be available statewide through the CONTRACTOR or its subcontractor(s). The CONTRACTOR shall maintain a benefit package and procedural coverage at least as comprehensive as the State Title XIX and Title XXI Plans. Experimental surgery and

procedures are not covered under the State Title XIX and Title XXI Plans as described in Attachment F-- Services.

The CONTRACTOR must ensure that during the delivery of services that the services may not be arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness, or condition. Appropriate limits should be placed on a service based on criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. Medical services shall be provided in a manner as described by the SP and as Medically Necessary (defined in KAR 30-5-58 and Attachment C- Definitions and Acronyms). Each CONTRACTOR must identify, define, and specify the amount, duration, and scope of each service that the CONTRACTOR is required to offer. The CONTRACTOR may offer value added services beyond the requirements of the SP, but must specify the amount, duration and scope of these services. The State will ensure that the required services offered under the CONTRACT are in an amount, duration, and scope that is no less than that required for the same services furnished to Members under FFS Medicaid.

Amerigroup: Amerigroup uses criteria and guidelines that are industry standards for medical necessity review by health plans, hospitals and governments agencies. Amerigroup uses State Regulatory Requirements and current editions of WellPoint Medical Policy, McKesson InterQual and WellPoint Clinical Utilization Management Guidelines. InterQual level of Care Criteria also serve as the primary criteria set for mental health services with State guidelines used to develop additional mental health guidelines not provided by InterQual. For services covered under the HCBS waivers, Amerigroup uses guidelines contained in the specific HCBS waiver application. The Kansas version of American Society of Addiction Medicine (ASAM) is used to evaluate requests for Substance Use Disorder Services.

The CONTRACTOR shall have a process in place to assess the quality and appropriateness of care furnished to Members. Certain Members must have individually documented care coordination plans as defined in section 2.2.25 of the RFP. The CONTRACTOR shall update and modify the care coordination plan when a high risk Member experiences a change in their health status. Documentation of care coordination must be available to the State upon annual audit and at any other time the State requests such information. Each CONTRACTOR must provide for a second opinion, when requested from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the Member.

Amerigroup: Amerigroup Clinical Case Managers and Service Coordinators work with members with special needs and who at high risk to assist in coordination of care to meet their individual needs. The care coordination plan documents the members needs and contains interventions to needs are met in a coordinated manner. The coordination of care between medical and behavioral health services is one important area of coordination to promote appropriate medical and behavioral health outcomes.

The Amerigroup Policy and Procedure, Provider Manual and Member Handbook document the process to obtain a second opinion for a member at no cost. A second opinion can be granted whenever a member or provider has questions about diagnosis or specific treatment or surgery. The provider makes the request to Amerigroup and notifies the member of the specific appointment date and time and the results of the second opinion. If there are no appropriate contracted providers available, arrangement for an out-out-network provider appointment for a second opinion is made.

The CONTRACTOR shall adopt practice guidelines that rely on credible scientific evidence published in peer reviewed literature generally recognized by the medical community. To the extent applicable, the guidelines shall take into account physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and other relevant factors. At minimum, clinical practice guidelines and best practice standards of care shall be adopted by the CONTRACTOR for the following conditions and services:

- Asthma;
- Congestive Heart Failure (CHF);
- Coronary Artery Disease (CAD);
- Chronic Obstructive Pulmonary Disease (COPD);
- Diabetes;
- Adult Preventive Care;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) for individuals age 0 to 20;
- Smoking Cessation for pregnant women;
- Behavioral Health (MH and SUD) screening, assessment, and treatment, including medication management and primary care provider (PCP) follow-up;
- Psychotropic medication management;
- Clinical Pharmacy Medication Review;
- Coordination of community support and services for Enrollees in HCBS Waivers;
- Dental services;
- Community reintegration and support; and
- LTC residential coordination of services.

The scope of the practice guidelines shall be comprehensive, addressing both quality of clinical care and the quality of non-clinical aspects of service, such as but not limited to: availability, accessibility, coordination and continuity of care.

Kansas will review the Clinical Practice Guidelines upon development of new practice guidelines or material change of existing Practice Guidelines. For pharmacy any guidelines used as part of the Medication Therapy Management, such as the psychotropic clinical guidelines for the medications/disease states, should be made available. Additionally if there are prescriber outreach/lettering templates generated on non-compliance with certain standards of clinical guidelines these will need to be made available to the state. The review of these guidelines will include feedback after review by the State's Medical Advisory Committee (MAC) as necessary.

Amerigroup: Amerigroup has developed, adopted and made available to providers Clinical Practice Guidelines to support the delivery of medically necessary care and services in the categories of Medical, Maternal-Child Health, Behavioral Health, and Preventative Health. Non-clinical guidelines have also been developed, adopted and released to the provider network.

Sunflower: Policies to cover provision of services are including but not limited to KS.UM.02 Clinical Decision Criteria and application and KS.UM. 01 Utilization Management Program description to ensure that all decisions are based on approved medical criteria. Policy KS.CM.01 Case Management Program Description ensures that there is consistent coordination for members from the medical management team.

B. CONTRACT Compliance of the CONTRACTORs

To ensure the goals of the RFP and Medicaid Reform Initiative are met, the State has established the following standards in the CONTRACTs for access to care, structure and operations, and quality measurement and improvement.

1. Access to Care

In addition to the access requirements set forth in Section 2.2.15 General Access Standards in the RFP, all services provided by the CONTRACTOR(S) must meet the criteria listed below for access and must comply with the provisions of 42 CFR 438.206.

24/7 Access to Services
Procedures must be in place to provide coverage, either directly or through its PCPs, to enrollees 24 hours per day, seven (7) days per week. The procedures shall include availability of 24 hours, 7 days per week access by telephone to a live voice (an employee of the CONTRACTOR or an answering service) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. **Recorded messages are not acceptable**. The management of incoming calls from Members must be clearly defined including equal access to all participants. Direct contact with qualified clinical staff must be available through a toll-free voice and telecommunication device for the deaf telephone number.

Amerigroup: 24 hour per day, seven (7) day per week access via telephone to live voice is provided by PCPs as defined by internal Amerigroup Policy and Procedures and clearly documented in the provider manual. Amerigroup conducts annual telephonic surveys to verify provider appointment availability and after-hours access. Providers are asked to participate in this survey each year to ensure access to primary care and high volume specialty care for appointment availability and primary care after-hours access. Additionally, Amerigroup monitors member satisfaction survey responses and member grievances to assess member access to services. As issues are identified, the Amerigroup Provider Relations team works directly with the provider as needed to address concerns.

Sunflower: Sunflower policy, KS.MSPS.21, Telephone Call Response, and the member handbook address this requirement. Policies noted above include but are not limited to KS.MSP.21, Telephone Call Response and CC.MSPS.23 - Holiday Schedule.

United: UHC providers are required to be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for live telephone coverage by another UnitedHealthcare participating Primary Care Physician (or UnitedHealthcare participating Specialist) or answering service which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. Recorded messages are not acceptable.

Members of UnitedHealthcare Community Plan (UHC) have access to materials in a language or format that is best for them. They also have access to interpreters if their doctor does not speak their language. These are free services that are outlined in the Member Handbook. Hearing and speech impaired member also have access to a toll-free number, a TTY phone number and to Telecommunications Relay Service.

Network Provider Locations
Network providers including PCPs, pharmacies and hospitals shall be located in every county where Members reside. If no primary care physician, pharmacy or hospital is located in a given county, the CONTRACTOR shall ensure that services are provided to Members located within that county. The CONTRACTOR may include providers from other states in their provider network. Members may cross the state line for treatment, if they reside in a border city which is within 50 miles of the state line. However, CONTRACTOR(S) is required to establish a preference for in-state providers when available at competitive rates and levels of quality. The CONTRACTOR, in establishing and maintaining its network of providers must consider the geographic location of providers and Medicaid Members, considering distance, travel time, the means of transportation ordinarily used by Medicaid Members, and whether the location provides physical access for Medicaid Members with disabilities.

Amerigroup: Amerigroup policy defines urban and rural geographic access standards for PCPs. Long Term Care Services, Optometry, Hospitals, Lab/Radiology, Pharmacy and other Specialty Care Providers. To ensure network adequacy per standards, Amerigroup uses a GeoAccess application to measure access. In addition to on-going internal provider access initiatives, Amerigroup conducts quarterly reviews with pharmacy, dental and vision vendors to ensure network adequacy. GeoAccess

reports are provided to the State on monthly basis for State's review to support access assessments. Amerigroup continuously monitors the network for changes in the composition that could impact member access and to ensure Amerigroup is meeting the KanCare standards.

Sunflower: As outlined in KS CONT 01, Network Adequacy, and KS CONT 01, Network Adequacy, Sunflower's provider network includes an extensive network of Primary Care Physicians, pharmacies and hospitals. We monitor provider networks across Kansas and in neighboring states to identify any access to care issues and ensure continuity of care for our Members.

To effectively measure and monitor network adequacy, Sunflower tracks provider locations in relation to member locations and develops GeoAccess reports, LOI lists (Letters of Intent), and similar provider lists for network adequacy evaluation.

Sunflower is providing the State with GEO reports and Network Adequacy reports to provide evidence of its provider locations.

United: UnitedHealthcare has built the Kansas network based on the requirements of the contract. United provides the state with GeoAccess reports and other Network Adequacy reports to demonstrate the availability of their provider networks.

Provider Hours of Operation

Network providers shall offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid Members as specified in Section 2.2.7 of the RFP. The CONTRACTOR shall establish procedures to ensure that network providers comply with all timely access requirements and be able to provide documentation demonstrating the monitoring of this element. Corrective actions must be defined and utilized if a provider is found to be noncompliant within the scope of these procedures.

Amerigroup: Provider timely access requirements are established in the provider manual. Provider relations associates review access requirements during on-site servicing visits and address any identified issues with providers. To encourage after hours, evening and Saturday appointments, Amerigroup routinely monitors provider adherence to access-to-care standards and appointment wait times. Providers with identified access-to-care difficulties may be required to follow a corrective action plan and monitored until compliance is achieved.

Sunflower: Expectation for provider business hours are set forth in the Provider manual, captured at Credentialing (CC.CRED.01) and through routine verification/monitoring by the Quality Department (KS.QI.04 and 05) and the Provider Relations Department – (KS.PRVR.06 – Evaluation of Timely Access and KS.PRVR.14 – Provider Visit Schedule).

United: UHC Providers are required to comply with the following appointment availability standards:

Emergency Care

Immediately upon the member's presentation at a service delivery site

Primary Care

PCPs and providers of primary care should arrange appointments for:

• Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within forty-eight (48) hours. An urgent, symptomatic visit is associated with the presentation of medical signs that require immediate attention, but are not life-threatening.

• Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within 3 weeks from the date of a patient's request. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

• Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or another provider within 3 weeks from the date of a patient's request. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.
• Transitional health care by a PCP shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program. Transitional health care by a home care nurse or home care registered counselor shall be available within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program, if ordered by the enrollee's PCP or as part of the discharge plan.

Specialty Care
Specialists and specialty clinics should arrange appointments for:
• Urgent care within 48 hours of request
• Non-urgent "sick" visit within 48–72 hours of request, as clinically indicated
• Non-urgent care within 30 days of request

Provider accessibility, and availability monitoring is conducted on an ongoing basis to ensure that established standards for reasonable geographic location of providers, number of providers, appointment availability, provision for emergency care, and after hours service are measured. Monitoring activities include provider surveys (the annual Provider Availability Report and the annual Provider Accessibility Report), evaluation of member satisfaction, evaluation of complaints, geo-access surveys and, when applicable, monitoring of closed primary physician panels. Specific deficiencies are addressed with an improvement action plan, and follow-up activity is conducted to reassess compliance. Provider accessibility and availability activities are reported to the UHC Service Quality Improvement Subcommittee (SQIS).

Network Provider Standards
Each CONTRACTOR must ensure that its providers and subcontractor(s) are credentialed and re-credentialed per National Committee for Quality Assurance (NCQA) guidelines as required in regulation and Section 2.2.8 of the RFP. Each CONTRACTOR must submit documentation to the State to demonstrate in a format specified by the State, that it:

- Offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Members for the service area;
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area; and
- Requires its providers to meet State standards for timely access to care and services, taking into account the urgency of need for services.

The CONTRACTOR, in establishing and maintaining its network of providers, must consider the following:

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Title XIX – Medicaid and Title XXI populations represented in the CONTRACTOR enrollment population;
- The numbers and types (in terms of training, experience, and specialization) of providers required to provide the contracted services;
- The numbers of network providers who are not accepting new Title XIX – Medicaid and/or Title XXI.

The CONTRACTOR(S) shall maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the number of anticipated Members and shall document adequate capacity no less frequently than:

- at the time it enters into a CONTRACT with the State;
- at any time there is a significant change (as defined by the State) in the CONTRACTOR'S operation that would affect adequate capacity and services;
- if there are changes in services, benefits, geographic service areas; or
- if there are new populations enrolled with the CONTRACTOR.

The documentation of network adequacy shall be signed by the Chief Executive Officer (CEO) and submitted at least annually to the State.

Amerigroup: Amerigroup has established a network of providers sufficient to meet the membership mix and geographic distribution. GeoAccess is used periodically and when there are changes in services or benefits, to assess adequacy of access and distribution of appropriate provider specialties. All applicable providers are fully credentialed per NCQA guidelines prior to participation as a network provider, and Amerigroup performs re-credentialing as applicable per NCQA guidelines. Additionally, Utilization Management, Service Coordinators, Case Management or other associates communicate additional network provider expansion needs to the Provider Relations department. Amerigroup continuously monitors for changes in network composition which may impact member access.

Sunflower: Sunflower's policy CC.CRED.01- Credentialing Program Description ensures that all providers are credentialed and recredentialed according to 42 CFR 438.214(a), 42 CFR 438.214(b)(1), 42 CFR 438.214(b)(2), and Section 4.1.1.68.11.3 of the RFP. Sunflower's policies are consistent with National Committee for Quality Assurance (NCQA) requirements.

Sunflower also has a standing subcommittee of the Quality Improvement Committee (QIC), the Credentialing Committee, that is responsible for overseeing the daily oversight and operating authority of the provider Credentialing program. The QIC is the vehicle through which credentialing activities are communicated to Sunflower's Board of Directors.

As outlined in KS CONT 01, Network Adequacy, and KS CONT 01,Network Adequacy., Sunflower's provider network includes an extensive network of Primary Care Physicians, pharmacies and hospitals. We monitor provider networks across Kansas and in neighboring states to identify any access to care issues and ensure continuity of care for our Members.

To effectively measure and monitor network adequacy, Sunflower tracks provider locations in relation to member locations and develops GeoAccess reports, LOI lists (Letters of Intent), and similar provider lists for network adequacy evaluation.

Sunflower is providing the State with GEO reports and Network Adequacy reports to provide evidence of its provider locations.

United: All participating providers undergo a careful review of their qualifications, such as education and training, board certification status, license status, hospital privileges and malpractice and sanction history. The National Credentialing Center (NCC) and the Optum Behavioral Solutions Credentialing Committee facilitates credentialing and recredentialing primary source verification activities. All providers undergo initial credentialing and are re-credentialed every three years. These providers are reviewed and approved by the National Credentialing Committee and the Optum Behavioral Solutions Credentialing Committee. Re-credentialing decisions incorporate findings from quality of care and/or member satisfaction issues identified at the provider level. The National Credentialing Committees and the Optum Behavioral Solutions Credentialing Committee make final credentialing/recredentialing decisions. Detailed policies, procedures and process flow diagrams exist to describe the credentialing and recredentialing process. The QI Program monitors the timeliness of credentialing activities and interventions to meet standards.

UnitedHealthcare has built the Kansas network based the requirements of the contract. We continue to provide the Kansas Department of Health and Environment (KDHE) with weekly provider files and monthly GeoAccess reports, as requested by KDHE.

Out-Of Network Providers

Members shall have access to Out-of-Network Providers when appropriate services are not available within the CONTRACTOR network. Each CONTRACTOR must require that if the network is unable to provide necessary medical services covered under the CONTRACT to a particular Member, the CONTRACTOR must adequately and timely cover these services out of network for as long as the CONTRACTOR network is unable to provide them. Each CONTRACTOR shall require out-of-network providers to coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

Amerigroup: Amerigroup policy establishes the provision of Out-of-Network care for members to ensure there are no barriers to receiving medically necessary, out-of-network or out-of-area services in a timely manner when Amerigroup's provider network is unable to provide those services. The same provision applies to emergency based services.

The Out-of-Network policy applies to the following situations:

- There is not an available participating provider to treat a particular member within the applicable geographic access standards;
- A particular member requires specific services that are not available through a participating provider;
- To maintain continuity of care with an out-of-network provider for new members.

The health plan's utilization management team or other associates determine the need for out-of-network care. A system request is generated to Amerigroup's Contracting team who completes requests for Single Case Agreements within 72 hours. For providers with no claim history with Amerigroup, Provider Relations verifies the provider is licensed to provide services and performs the applicable data base checks through OIG and SAM completing a Single Case Agreement with the provider. Amerigroup will cover and pay for emergency services and care regardless of the participation status of the provider.

Sunflower: Information regarding out of network providers is included in the member handbook and provider handbook. Sunflower's Access to Out of Network Care policy, KS.CM.16.01, outlines the process for the evaluation of requests for Out of Network Services. Members may access any provider for emergency services regardless of provider's participation in the Plan's network. Sunflower's Single Case Agreement policy, CC.UM.17, is also applicable to this section.

United: UnitedHealthcare members have access to out-of-network providers when there is not adequate coverage within the UnitedHealthcare network. A primary care provider can request an authorization for out-of-network services.

Policies for Emergency Care and Prior Authorization (PA)

Written policies and procedures must be provided by the CONTRACTOR describing how Members and providers may contact the CONTRACTOR to receive individual instruction on accessing emergency and post stabilization care services or receive PA for treatment of an urgent medical problem and instruction when outside the State defined geographic area. Policies and procedures must be available in an accessible format upon request.

Amerigroup: Amerigroup policies address Emergency and Urgent care. Emergency care is described in the member handbook, including examples of conditions and symptoms that are most likely emergencies. The member handbook further instructs members to call their PCP or

Amerigroup On Call nurse advice line for more information on emergency care. It provides further instruction to call the PCP after visiting the emergency room for post stabilization care.

The Member Manual described Urgent care conditions and instructions to call the PCP for instructions. The manual provides specific instructions on how to access the Amerigroup On Call number, as well.

The Provider Manual describes emergency procedures, including Emergency Room Prudent Layperson Service. The management of after-hours urgent care is also documented in the provider manual. It directs PCPs to refer members to a participating urgent care center or other provider without the need for prior authorization. Notification to Amerigroup is requested if the member is referred to an out-of-network provider.

Sunflower: Policies include but are not limited to Sunflower's Access to Out of Network Care policy, KS.CM.16.01, which outlines the process for the evaluation of requests for Out of Network Services. Information regarding emergency care and Prior Authorization may be found in the member and provider handbooks.

United: UnitedHealthcare members do not need an authorization to obtain emergency services outside the State defined geographic area.

Service Authorization

The CONTRACTOR(S) and its subcontractor(s) must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services in accordance with 42 CFR 438.210.

Amerigroup: Amerigroup policies and the Provider Manual describe the required precertification and notification processes. These documents contain a full description of specialty services that require either precertification or prior notification. In addition, providers may access precertification and notification criteria and a look-up tool via the Amerigroup provider self-service (PSS) website.

United: UnitedHealthcare has policies and procedures for processing authorization requests in accordance with 42 CRF 438.210.

UnitedHealthcare's Care Coordinators work with members to develop and implement individualized plans of care for members requiring services. The Care Coordinators continue to review the member's progress and adjusts the plan of care, as necessary, to ensure that the member continues to receive the appropriate care in the least restrictive setting. The health plan began managing the HCBS services for the I/DD Waiver population on 2/1/14. Plans of care for fully served I/DD Waiver members were maintained during the continuity of care period, which ended on 7/31/14. During the continuity of care period, the health plan in conjunction with KDADS worked to address the issue of I/DD waiver members who had requested additional services, by granting those members the services that they were waiting for if found appropriate during the face-to-face assessment.

The Care Coordinator will involve the member, member's family and providers, including targeted case managers for the I/DD waiver, in the plan of care development process. Care Coordinators assist providers when necessary to direct the course of treatment in accordance with the evidence-based clinical guidelines that support our Care Management Program.

Cultural Competence and Translation

Each CONTRACTOR must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The CONTRACTOR shall notify Members, applicants or potential applicants of the right to receive any documents translated and/or oral interpretation

services at no cost. Translation services available must include; English, Spanish, French, German, Russian, Vietnamese, Arabic, Chinese, Korean, and Japanese languages. Additional languages may be required as updated state census data becomes available. The CONTRACTOR must comply with the provisions of 42 CFR 438.10 including related provisions 42 CFR 438.114, 42 CFR 422.113(c), 42 CFR 438.6(h), 42 CFR 438.106 and 42 CFR 438.108.

Amerigroup: Documents are available for members in a variety of languages and formats. Written materials, such as Member Handbooks and member notices are available in English and Spanish as well as Braille, large print and on audiotapes. We also provide translation of materials upon request. Languages available for translation are: Spanish, French, German, Russian, Vietnamese, Arabic, Chinese, Korean, and Japanese.

Sunflower: Sunflower receives members' language preferences from information provided by the state through the 834 file referenced above. Sunflower provides instructions to members in multiple ways regarding how to obtain materials in languages other than English or in other formats such as in the new member welcome packet, the member handbook, the member newsletters, in our call centers, the provider manual, during case management visits and on our website.

Sunflower also has multiple policies to support the above requirement including but not limited to KS.MSPS.21, Telephone Call Response; CC.MBR.16-Hearing Impaired–Language Specific Interpreter Services; CC.MBR.15-Interpreter Services for Scheduled Medical Appointments; CC.MBRS.02-Member Materials Readability Policy, KS.MBRS.43- Alternate Media Requests; CC.MBRS.15. Interpreter Services for Scheduled Medical Appointments.

United: Members of UnitedHealthcare Community Plan (UHC) have access to materials in a language or format that is best for them. They also have access to interpreters if their doctor does not speak their language. These are free services that are outlined in the Member Handbook. Hearing and speech impaired member also have access to a toll-free number, a TTY phone number and to Telecommunications Relay Service.

Primary Care Services

Each CONTRACTOR must implement procedures to ensure that each Member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Member. The services the CONTRACTOR furnishes to the Member must be coordinated with the services the Member receives from any other managed care entity and the results of the CONTRACTOR's identification and assessment of any Member with special health care needs (as defined by the State) must be shared to avoid duplication of services. The CONTRACTOR(S) must ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements in 45 CFR §160 and 164.

When appropriate, the CONTRACTOR shall provide a health home (HH) for each Member as specified in Section 2.2.26 and Attachment I.

Amerigroup: Documents are available for members in a variety of languages and formats. Written materials, such as Member Handbooks and member notices are available in English and Spanish as well as Braille, large print and on audiotapes. We also provide translation of materials upon request. Languages available for translation are: Spanish, French, German, Russian, Vietnamese, Arabic, Chinese, Korean, and Japanese.

Upon enrollment, members are assigned a Primary Care Physician based on geographic proximity. Members may retain their previous PCP if he/she is an Amerigroup contracted provider and the practice maintains open to new patients. Members may request a changed in PCP by calling Member Services.

Instructions for how to select or change a PCP, access care and the expected member support and care they will receive from their PCP is outlined in the Member Handbook. Additional instruction is provided for Native American or Alaskan Natives to use the Indian Health Service or Tribal 638 provider.

Amerigroup members receive an ID card which identifies their assigned PCP, however, for dual eligible members, no PCP is assigned and no PCP name will appear on the ID Card. Amerigroup Provider Relations monitors primary care access through the monthly GeoAccess network report.

Sunflower: Sunflower's Provider Relations Department measures access to primary care services and behavioral health services at least annually. The Member Services Department measures telephone access to the Member Services Department at least annually. The Quality Improvement Committee (QIC), or designated subcommittee, analyzes the data and makes recommendations to address deficiencies in member access to practitioners or member services. Results are reported and reviewed by the QIC. Results are reported to State as required. Reference: KS.QI.05

KS.UM.01. Utilization Management Program, explains Sunflower's coordination of care effort.
The protection of members' privacy and confidentiality is covered in CC.COMP. PRVC.01-.55 and CC.MBR.20.

United: Every UnitedHealthcare member is assigned a Primary Care Provider (PCP), upon enrollment, who manages the member's health care and obtains prior authorization for services that require prior approval. The member's PCP is listed on their ID card. A member can call UnitedHealthcare to change their PCP if the PCP listed on their card is not the physician they would like to see.

All members with special health care needs are assigned a Care Coordinator. Care coordinators serve as a single point-of-contact for our members in assessing and coordinating their bio-psychosocial care needs.

Women's Health Services
The CONTRACTOR shall provide female enrollees with direct access to a women's health specialist within the network for routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist. Out-of-network providers shall be an option for the Member in the event a network provider is not available. Out-of-network providers must coordinate with the CONTRACTOR with respect to payment. The CONTRACTOR must ensure that cost to the Member is no greater than it would be if the services were furnished within the network.

Amerigroup: Amerigroup members have direct access to participating providers for women's health services without a referral. Members also do not need a referral for family planning services.
Members may choose a network or non-network provider for family planning services without a referral.

Sunflower: Sunflower's female members have direct access to women's health and family planning services as outlined in KS.UM.01.02. Information regarding Women's Health Services is included in the provider manual and member handbook.

United: UnitedHealthcare members may receive services from any women's health provider who has a contract with UnitedHealthcare Community Plan without a referral. Additionally, UnitedHealthcare members have access to out-of-network women's health providers without a referral.

2. Structure and Operations

Each CONTRACTOR shall provide documentation at the time of the annual audit or at any other time the State requests, information ensuring that participating providers have in place a process to meet the following requirements set forth 42 CFR 438.

a. Provider Selection

Service delivery by appropriately qualified individuals promotes patient safety and thus represents one essential structural component of a high quality delivery system. This standard ensures that managed care entities implement written policies and procedures for the selection and retention of providers.

The CONTRACTOR(S) must comply with the requirements specified in 42 CFR 438.214 and 42 CFR 438.12, including

- selection and retention of providers,
- credentialing and recredentialing requirements, and
- nondiscrimination.

The State requires the plans to have written policies and procedures and a description of its policies and procedures for selection and retention of providers following the State's policy for credentialing and recredentialing as specified in 42 CFR 438.214(a), 42 CFR 438.214(b)(1), 42 CFR 438.214(b)(2), and Section 4.1.1.68.11.3 of the RFP. The CONTRACTOR must demonstrate that its providers are credentialed as specified in 42 CFR 438.206(b)(6), which also references related requirements set forth in 42 CFR 438.214, during the initial CONTRACT application process and during the annual on-site surveys and desk reviews. The provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment as specified in 42 CFR 438.214(c). The CONTRACTOR shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act as specified in 42 CFR 438.214(d).

Amerigroup: Amerigroup has policies and procedures for selection and retention of providers who meet NCQA standards for Credentialing and Re-Credentialing every three years. Amerigroup observes the following provider selection requirements:

- Will not contract with providers for other long term services and supports or health services who provide either case management or functional eligibility assessments to prevent conflict free case management for LTC and HCBS services.
- Will contract with Medicare certified Nursing Facilities and will assist non-certified Nursing Facilities to obtain Medicare and Medicaid certification.
- Will use CAQH for professionals or the Kansas shared KanCare standard provider application.
- Will not discriminate against providers that service high-risk population or specialized conditions, requiring costly treatment.

Sunflower: Sunflower's policy CC.CRED.01- Credentialing Program Description ensures that all providers are credentialed and recredentialed according to 42 CFR 438.214(a), 42 CFR 438.214(b)(1), 42 CFR 438.214(b)(2), and Section 4.1.1.68.11.3 of the RFP.

United: All participating providers undergo a careful review of their qualifications, such as education and training, board certification status, license status, hospital privileges and malpractice and sanction history. The National Credentialing Center (NCC) and the Optum Behavioral Solutions Credentialing Committee facilitates credentialing and recredentialing primary source verification activities. All providers undergo initial credentialing and are re-credentialed every three years. These providers are reviewed and approved by the National Credentialing Committee and the Optum Behavioral Solutions Credentialing Committee. Re-credentialing decisions incorporate findings from quality of care and/or member satisfaction issues identified at the provider level. The National

Credentialing Committees and the Optum Behavioral Solutions Credentialing Committee make final credentialing/recredentialing decisions. Detailed policies, procedures and process flow diagrams exist to describe the credentialing and recredentialing process. The QI Program monitors the timeliness of credentialing activities and interventions to meet standards.

b. Enrollee Information

Good communication enhances access to care, appropriate use of services, and satisfaction. This standard delineates requirements for communicating with enrollees and potential enrollees. Each managed care entity shall provide all enrollee notices, information materials and instructional material in a manner and format that may be easily understood, in accordance with 42 CFR 438.10 and Section 2.3.3 of the RFP. This includes ensuring capacity to meet the needs of non-English linguistic groups in their service areas and making available materials in alternative formats upon request. The State or its enrollment broker provides all enrollment notices, information materials and instructional material to enrollees and potential enrollees in a manner and format that may be easily understood, in accordance with 42 CFR 438.100(b)(2)(i) which also references related requirements set forth in 42 CFR 438.10 including the previously stated related provisions. The CONTRACTOR must also comply with the provisions of 42 CFR 438.100 including related provisions 42 CFR 438.102, 42 CFR 438.6(i), and 42 CFR 417.436(d).

On an annual basis, managed care entities must provide enrollees with notice of their right to request and obtain information on the various items required in 42 CFR 438.10(f). In addition, managed care entities must provide enrollees with 30-day prior written notification of any significant changes, including changes to enrollee cost sharing and benefits. Managed care entities must make a good faith effort to provide written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by the terminated provider.

Amerigroup: Amerigroup issues a new Member Welcome Packet, containing a Welcome Letter, PCP selection material, a Member Handbook, a Provider Directory, a copy of Member Rights and Responsibilities and information about the ID card. Member materials and notices are written at the 6th grade reading level in a manner that is easy to understand. Materials are produced in English and Spanish with options to receive them in alternate languages and formats for the sight impaired.

Other written notices are provided annually or as necessary. These include an annual notice of Member Rights and Responsibilities, Notice of Rights to Request and Obtain information and Notification of Disenrollment Rights. Other notices are issued as necessary, including changes to cost sharing and benefits and termination of a contracted provider to members assigned to a PCP or other provider seen regularly.

United: Members of UnitedHealthcare Community Plan (UHC) have access to materials in a language or format that is best for them. They also have access to interpreters if their doctor does not speak their language. These are free services that are outlined in the Member Handbook. Hearing and speech impaired member also have access to a toll-free number, a TTY phone number and to Telecommunications Relay Service.

To help foster engagement among members, UnitedHealthcare distributes a quarterly newsletter to our members. On an annual basis the member newsletter will include information that reviews member rights and responsibilities.

UnitedHealthcare will make a good faith effort to communicate with our members within 15 days if their PCP terminates his/her relationship with us or if we issue a notice of termination to a provider. To help the member with the PCP transition, we review the list of members affected by any PCP termination and attempt to identify another PCP who meets the needs of the member. Our PCP assignment process takes gender, age, location and language into consideration. We work to ensure the PCP is located near the member's home and is the most appropriate type of provider to assign.

We also try to ensure that all family members see the same PCP, unless they request otherwise. This information will be shared with the State as required. If a member does not think that the PCP we selected meets his or her needs, we assist the member with selecting a new PCP at any time.

c. Confidentiality

This standard requires that managed care entities and the State take appropriate steps to safeguard personal health information (PHI). For medical records and any other health and enrollment information that identifies a particular enrollee, the CONTRACTOR(S) shall establish and implement procedures consistent with confidentiality requirements in 45 CFR parts 160 and 164 Subparts A and E, 42 CFR 438.224 and 42 CFR Part 2. During the initial CONTRACT application process, the State will ensure the plans establish and implement procedures consistent with Federal and State regulations including confidentiality requirements in 45 CFR parts 160 and 164, 42 CFR 438.224 and 42 CFR Part 2. The State conducts annual on-site surveys and desk reviews to ensure the plans maintain procedures consistent with State and Federal regulations.

Amerigroup: Amerigroup safeguards PHI and is in compliance with 45 CFR parts 160 and 164Subparts A and E, 42 CFR 438.224 and 42 CFR Part 2. Enforcement of the Privacy Program includes physical, technical and administrative safeguards of PHI, employee training on HIPAA requirements and technology to support transmission and communication safeguards. Network provider agreements require providers to comply with all applicable state and federal privacy standards, and the Provider Manual provides further guidance in this regard.

Sunflower: Sunflower adheres to 42 CFR 438.10. Sunflower's policy regarding protecting members' confidentiality is CC.MBR.20. The protection of members' privacy is covered in CC.COMP. PRVC.01-.55 and CC.MBR.20 and addressed in the member and provider handbooks.

United: UnitedHealthcare is in compliance with the requirements in 45 CFR Parts 160 and 164. In addition, we also require all providers, including those who provide treatment for individuals with special needs, to develop treatment plans that ensure each member's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. We meet all HIPAA privacy requirements and security standards, including sending out annual privacy notices to members and restricting internal view or use of PHI to an "as-needed" basis only.

d. Enrollment and Disenrollment

The Kansas fiscal agent will specify procedures for enrollment and reenrollment. In accordance with 42 CFR 438.226, which also references related requirements set forth in 42 CFR 438.56, the CONTRACTOR shall demonstrate the following standards for enrollment and disenrollment through CONTRACT monitoring and document review:

1. No restriction of choice for providers or disenrollment limitation.
2. Demonstrate collection of data that specifies the rationale for disenrollment requests by both Members and providers.
3. Disenrollments do not occur because of a change in the Member's health status, because of the Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CONTRACTOR seriously impairs the entity's ability to furnish services to either this particular Member or other Members),
4. The methods by which the CONTRACTOR assures the State that it does not request disenrollment for reasons other than those permitted in the CONTRACT.
5. Acceptance of individual in the order in which they apply without restriction, up to the limits set under the CONTRACT.
6. Non discrimination against individuals eligible to enroll on the basis of:
    - Health status or need for health care services, discriminate against individuals eligible to enroll.
    - Race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin.

All CONTRACTs applicable to disenrollment and resulting action must specify the following as causes:

1. The plan does not, because of moral or religious objections, cover the service the Member seeks.
2. The Member needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the Member's PCP or another provider determines that receiving the services separately would subject the Member to unnecessary risk.
3. Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the CONTRACT, or lack of access to providers experienced in dealing with the Member's health care needs.

Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the Member files the request. If the State fiscal agent fails to make the determination within the timeframes specified the disenrollment is considered approved. The CONTRACT must provide for automatic reenrollment of a Member who is disenrolled solely because he or she loses Medicaid eligibility for a period of two (2) months or less.

Amerigroup: There is no restriction placed on choice of providers and enrollment eligibility is not prohibited on the basis of health status, need for healthcare, race, color or national origin.

The Amerigroup Disenrollment Policy and Procedure describes the criteria and process for member initiated disenrollments with or without cause and State initiated disenrollments. Disenrollments are tracked and monitored to identify trends as applicable.

Sunflower: Sunflower's policy for disenrollment for a member is covered under KS.ELIG.02-Disenrollment.

United: UnitedHealthcare shall accept Medicaid enrollees as members without restriction. We will enroll any individual who selects or is assigned to our plan regardless of the individual's age, sex, ethnicity, language needs, health status, health history, need for health care services or adverse change in health status; or on the basis of religious belief, gender, or sexual orientation. We will accommodate the State's disenrollment time frame and the upfront enrollment choice period, as appropriate.

UnitedHealthcare's policy on Member Services Disenrollment Process and Procedure was provided as part of our Readiness Review and documents that UnitedHealthcare Community Plan agrees the State has sole authority and discretion for disenrolling program members from managed care plans subject to certain conditions outlined in the policy.

e. Grievance Systems

The CONTRACTOR(S) shall comply with all Grievances and Appeals provisions as specified in Attachment D—Grievances and Appeals. Such system must comply with the provisions of 42 CFR 438.228 and 42 CFR 438.400 – 438.424.

Amerigroup: Amerigroup complies with Grievance and Appeals provisions and documents the processes related to grievance and appeals intake, acknowledgement letters, investigation, resolution letters in an electronic documentation system. The timeframes for issuing acknowledgement letters and case resolution letters is tracked, trended and reported to the Quality Management Committee for evaluation and process improvement, as needed. Additionally, Amerigroup tracks, trends and analyzes complaint and grievance data for the purpose of improvement in the following areas, at a minimum:

- Quality of Care,
- Access,
- Attitude and Service,
- Billing and financial issues,
- Quality of Practitioner Office Site.

Sunflower: Sunflower established a grievance system outlined in its policies, KS.QI.11.01, Grievance System Description, and KS.QI.11, Grievance Process, that outline the grievance process, an appeal process and access to the State Fair Hearing process that complies with state and federal requirements. This program also provides regular reporting. The Grievance System and related policies and procedures are approved by, and are the direct responsibility of the Quality Improvement Committee (QIC), delegated by the Board of Directors.

United: UnitedHealthcare Community Plan's Grievances and Appeals system complies with the requirements of Attachment D, as amended by Amendment 2 to the contract.

f. Subcontractor(s)

Managed care entities typically contract with many different providers and vendors of services to deliver the full package of services to enrollees. These standards ensure that the CONTRACTOR(S) are accountable for the actions and performance of any subcontractor. This assurance shall be met through the annual auditing process and will require the CONTRACTOR to produce documentation that supports the following:

1. The CONTRACTOR must evaluate the prospective subcontractor's ability to perform any delegated activities.
2. The CONTRACTOR and the subcontractor must specify in writing the activities and reports being delegated.
3. Failure of the subcontractor to perform in accordance to their contract with the CONTRACTOR may result in sanctions and/or revoking the contract.
4. The CONTRACTOR must monitor the subcontractor(s)' performance on an ongoing basis and subject it to a formal review in accordance to a periodic schedule established by the State, consistent with industry standard or regulated by State or Federal laws/regulations.
5. The CONTRACTOR must identify deficiencies or areas for improvement, the entity and the subcontractor must take corrective action.

All subcontractual relationships and delegations must be in accordance with 42 CFR 438.230.

Amerigroup: Amerigroup may consider delegations among its subcontractors from time to time and all such agreements comply with 42 CFR 438.230.

Amerigroup Kansas, Inc., in conjunction with the Vendor Selection and Oversight Committee ensures that delegated vendors undergo pre-delegation audits and annual follow-up audits. Results of delegation audits are reported to the Corporate Vendor Oversight Committee and the Kansas Medical Advisory and Quality Management Committees for evaluation. Correction Action Plans for deficiencies and areas for improvement are reviewed and followed to completion.

Sunflower: Sunflower adheres to the requirements in 42 CFR 438.230. Information regarding Sunflower's subcontractor oversight program may be found in policies including but not limited to KS.COMP.100, CC.COMP.27,CC.COMP 21 and CC.COMP.21.03 It is the policy of Centene and Sunflower to provide oversight of national and local delegated vendors. Oversight evidence is retained in Compliance 360. The following evidence is maintained for each delegated vendor: types of delegated service, covered lines of business, form Ds, tracking of vendor reporting, evidence of monitoring vendor adherence to performance standards, meeting minutes, quality/service

improvement plans, corrective action plans, ratings of vendor responsiveness, method to automatically notify corporate of vendor issues, vendor – health plan contracts and amendments, policies and procedures, program descriptions, audit tools and vendor attestations

of contract compliance. In the event of material change, breach or termination of a delegated vendor agreement between the Plan and a delegated vendor, the Plan's notice to the

State Regulator(s) shall include a transition plan for their review and approval. Refer to CC.COMP.21.03.

Additionally, Sunflower has established a Joint Operations Committee (JOC) with each subcontractor. The JOC oversees and assesses the appropriateness and quality of services provided to members.

United: When UnitedHealthcare delegates functions to others, we maintain complete accountability for performance by our Kansas health plan leadership team — and we systematically oversee all delegated relationships. In particular, we have robust structures and processes to ensure that:

- Subcontractors meet their contractual expectations
- Compliance risks associated with subcontracted activity are minimized
- Subcontracted activities are geared toward benefiting the member
- Reporting responsibilities under the contract with KDHE are maintained by our Kansas health plan team
- In addition, tasks and workplans will clearly demonstrate lines of accountability with appropriately documented structures, processes, performance and compliance measures

3. Quality Measurement (QM) and Improvement

a. Practice Guidelines

The State requires that each CONTRACTOR adopt practice guidelines that meet the requirements of 42 CFR 438.236(b). The following requirements will be reviewed at annual audit and at any other time that the State requests. Practice guidelines shall

- be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- consider the needs of the enrollees;
- be adopted in consultation with contracting health care professionals; and
- be reviewed and updated periodically as appropriate.

The State requires that the CONTRACTOR(S) disseminate the guidelines to all affected providers and, upon request, to enrollees and potential enrollees. Decisions for utilization management (UM), Member education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines. These will be reviewed upon annual audit and at any other time that the State requests.

Amerigroup: Amerigroup has developed, adopted and made available to providers Clinical Practice Guidelines to support the delivery of medically necessary care and service in the categories of Medical, Maternal-Child Health, Behavioral health, and Preventive Health. Non-Clinical guidelines have also been developed, adopted and released to the provider network and will be re-reviewed and released annually. Effectiveness of guidelines is determined by scientific evidence; or professional standards, in the absence of scientific evidence; or by expert opinion, in the absence of professional standards. In addition, a review of government research sources, review of clinical or technical literature, and involvement of board-certified practitioners from appropriate specialties or professional standards is indicated. Recognized sources of evidenced-based guidelines include national organizations such as the Centers for Disease Control (CDC) and National Institutes of Health (NIH), professional medical specialty organizations such as the American Academy of Pediatrics (AAP),

U.S. Preventive Services Task Force (USPTF), American College of Obstetricians and Gynecologists (ACOG), American Academy of Family Practice (AAFP), and voluntary health organizations such as the American Diabetes Association (ADA) and American Cancer Society (ACS). The American Psychiatric Association (APA), American Academy of Child and Adolescent Psychiatry (AACAP), Texas Implementation of Medication Algorithm (TIMA) and Texas Medicaid Algorithm Project (TMAP) are currently more specific sources recognized for behavioral health guidelines. Other sources that may be referenced in developing or updating behavioral health guidelines include organizations such as the Substance and Mental Health Services Administration (SAMSHA) and National Institute of Mental Health (NIMH). Anytime additional information from the behavioral health discipline may be referenced for optimal guidelines for medical diagnosis, there is integration of both specialties in the review processes.

Sunflower: As outlined in Practice Guidelines – CC.QI.08, Sunflower has developed and distributed preventive health and clinical practice guidelines to help practitioners and members make decisions about appropriate health care for specific clinical circumstances as per our policy CC.QI.08. Guidelines will be updated at least every two years or upon significant new scientific evidence or changes in national standards. Board-certified practitioners who will utilize the guidelines are given the opportunity to review and give advice on the guidelines through the Plan's QIC.

Sunflower utilizes various methods of data for improvement. Data is collected through member and provider satisfaction surveys, internal Performance Improvement Committees and other committees as the Sunflowers structure outlines. This data is tracked, trended and benchmarked against local, regional, and national benchmarks. Upon analysis of the data, Sunflower then will develop standardized performance measures that are clearly defined, objective, measurable, and able to track over time to improve the outcome and services provided to the members.

Sunflower will continuously evaluate the effectiveness of our QAPI program, using the same methods that affiliated health plans have developed and enhanced over years of systematic assessments of clinical and nonclinical performance.

United: Evidenced-based guidelines are used to monitor and improve the quality of care provided by participating providers. UnitedHealthcare Community Plan adopts pediatric, adolescent, adult and maternal preventive health and clinical practice guidelines that are reviewed at least annually and approved by UnitedHealthcare's National Medical Care Management Committee (NMCMC).

The Health Plan Provider Advisory Committee also reviews and approves these guidelines which include the behavioral health clinical practice guidelines. The NMCMC evaluates guidelines from the most current and reasonable medical evidence available, including but not limited to, the U.S. Preventive Services Task Force, the Centers for Disease Control and Prevention and specialty organizations. UnitedHealthcare Community Plan measures population-based performance against preventive health and clinical guidelines annually, primarily through HEDIS measurement. UnitedHealthcare Community Plan adopts NMCMC approved guidelines through the National Quality Management Oversight Committee (NQMOC) and the Provider Advisory Committee (PAC).

Preventive health and clinical practice guidelines are available to both members and providers.

b. Quality Assessment and Performance Improvement (QAPI) Program

The CONTRACTOR shall have an ongoing QAPI program which assesses monitors, evaluates and improves the quality of care provided to Members. This program shall conform, as applicable, to all the requirements prescribed by CMS in 42 CFR 438, Subpart D, and include processes which provide for the evaluation of access to care, availability of services, continuity of care, health care outcomes, and services which are provided or arranged for Members by the CONTRACTOR(S). The QAPI program shall consist of internal monitoring by the CONTRACTOR(S), oversight by Federal and State governments, and evaluations by an EQRO. Areas found to be deficient during the above processes

shall be addressed by the CONTRACTOR(S) through a Corrective Action Plan (CAP) process initiated internally or by the State as specified in RFP Section 2.3.4.2.

The QAPI program shall objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its Medicaid population. The CONTRACTOR's written policies and procedures must address components of effective health care management including but not limited to anticipation, identification, monitoring, measurement, evaluation of enrollee's health care needs, and effective action to promote quality of care.

The QAPI program will be reviewed at least annually by the State as described in 42 CFR 438.240(e) and shall include:

- Conducting PIPs described in 42 CFR 438.240 (d) and as specified by the State;
- Submitting performance measurement data described in 42 CFR 438.240 (c) including related provisions 438.204(c) and in this Attachment;
- Establishing mechanisms for detecting both underutilization and over utilization of services described in 42 CFR 438.240(b)(3);
- Establishing mechanisms for assessing the quality and appropriateness of care furnished to Members, including those with special health care needs described in 42 CFR 438.240(b)(4);
- Reporting on measures related to homelessness and employment; and
- Reporting all behavioral health, disabilities and physical health data in separate reports.

Additionally, as part of the QAPI program, the CONTRACTOR(S) are required to have programs and procedures in place to measures the quality and outcomes for nursing facilities. Each CONTRACTOR must submit a plan for oversight of nursing facilities, which shall be approved by the State on an annual basis.

Through the QAPI program, the CONTRACTOR(S) shall define and implement improvements in processes that enhance clinical efficiency and focus on improved outcome management achieving the highest level of success. Each CONTRACTOR and the CONTRACTOR'S quality improvement program is required to demonstrate how specific interventions better manage the care and impact healthier patient outcomes to achieve the goal of providing comprehensive, coordinated, high quality, accessible, cost effective, and efficient health care to Medicaid beneficiaries. Pursuant to 42 CFR 438.208(c)(1), the State requires the plans to implement mechanisms to identify persons with special health care needs, as those persons are defined by the State. CMS, in consultation with the State and other stakeholders, may specify performance measures and topics for PIPs.

The CONTRACTOR shall provide a written description of the QAPI program that identifies full-time staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e. projects selection, interventions) and reevaluation. The CONTRACTOR(S) shall provide for quality improvement staff specifically trained to handle the Medicaid business which have the responsibility for identifying their Medicaid beneficiaries' needs and problems related to quality of care for covered health care and professional services, measuring how well these needs are met, and improving processes to meet these needs.

The QAPI program shall evaluate ways in which care is provided, identify outliers to specific indicators, determine what shall be accomplished, ascertain how to determine if a change is an improvement, and initiate interventions that will result in an improved quality of care for covered health care and professional services. Each CONTRACTOR is required to prioritize problem areas for resolution and design strategies for change as well as implement improvement activities and measure success.

The CONTRACTOR(S) shall cooperate with the State and the External Quality Review Organization (EQRO) vendor in developing its QAPI program. The State sets methodology and standards for QAPI performance improvement with advice from the EQRO. Prior to implementation, the State and/or the

EQRO review each CONTRACTOR's QAPI program. Each CONTRACTOR's QAPI program must be approved, in writing, by the State no later than three (3) months following the effective date of the CONTRACT. If a CONTRACTOR has submitted and received approval for the present calendar year, an extension may be granted for the submission of new projects.

Each CONTRACTOR shall have a QAPI governing body. This body shall monitor, evaluate, and oversee results of the QAPI program to improve care. The governing body shall have written guidelines and standards defining their responsibilities for:

1. Supervision and maintenance of an active QAPI committee;
2. Ensuring ongoing QAPI activity coordination with other management activity, demonstrated through written, retrievable documentation from meetings or activities;
3. Planning, decisions, interventions, and assessment of results to demonstrate coordination of QAPI processes;
4. Oversight of QAPI program activities; and
5. A written diagram that demonstrates the QAPI system process.

The QAPI committee shall:
1. Direct and review quality improvement activities;
2. Assure that quality improvement activities take place throughout the plan;
3. Include a meaningful representation of stakeholders;
4. Review and suggest new or improved quality improvement activities;
5. Direct task forces/committees in the review of focused concern;
6. Designate evaluation and study design procedures;
7. Publicize findings to appropriate staff and departments within the plan;
8. Report findings and recommendations to the appropriate executive authority; and
9. Direct and analyze periodic reviews of Members' service utilization patterns.

For each year of the CONTRACT, the CONTRACTOR(S) shall comply with the QAPI Program standards established by the State as well as the NCQA standards/guidelines. The CONTRACTOR(S) shall monitor NCQA standards/guidelines and remain updated on any changes. The State reserves the right to revise established standards and their respective elements to ensure compliance with changes to Federal or State statutes, rules, and regulations as well as for clarification and to address identified needs for improvement.

Each CONTRACTOR will be required to annually review and evaluate the overall effectiveness of the QAPI program to determine if the program has demonstrated improvement in the quality of care and provision of services to Members. As necessary, the CONTRACTOR(S) may modify its QAPI program with the approval of the State. The CONTRACTOR(S) shall prepare a written report to the State, detailing the annual review which shall include a summary and review of completed and continuing quality improvement activities that address the quality of clinical care and services; trending and analysis of measures to assess performance in quality of clinical care and services; any corrective actions which are recommended, implemented, or in progress, as well as modifications made to the program. The CONTRACTOR(S) shall demonstrate that its quality improvement activities have contributed to improvement of the quality of clinical care and services, including but not limited to preventive health care provided to Members. The CONTRACTOR shall submit this report annually in a format specified by the State.

Amerigroup: The Amerigroup QAPI Program Description addresses the following: Quality Improvement Program Goals and Objectives:

- To develop and maintain QM resources, structure and processes that support the organization's commitment to quality health care for our members;
- To collaborate with the State in the administration and coordination of care and services, in the development of policy and procedures and to cooperate with the process of oversight;

- To develop effective methods or adopt those advanced by the state through contract or other requirements for measuring the outcomes of care and services provided to members and to intervene to achieve continuous measureable improvements using a CQI approach;
- To ensure adequate accessibility to care and service;
- To monitor and ensure our members receive seamless, continuous and appropriate care throughout the continuum of care;
- To coordinate, monitor and report QM activities;
- To improve member health status;
- To improve coordination and integration of physical health (PH), behavioral health (BH), and long terms services and supports (LTSS) coordination and integration
- To ensure effective credentialing and re-credentialing processes for providers that comply with state, federal and accreditation requirements;
- To implement and monitor programs designed to improve the safety of our members and the quality of services they receive;
- To increase member and provider awareness of patient safety and quality activities
- To ensure providers are informed of member rights and responsibilities;
- To ensure member confidentiality is maintained at all times;
- To monitor medical record-keeping including compliance with medical record documentation guidelines, record storage, handling and retention ;
- To improve the quality and care of our members through member education regarding appropriate preventive services and healthy lifestyles;
- To measure member satisfaction and implement effective interventions to address areas of dissatisfaction;
- To ensure effective coordination/communication of QM activities with all appropriate functional areas, including but not limited to utilization management, customer service, appeals and grievances and provider relations;
- To provide effective oversight of all delegated activities to ensure compliance with all state, federal and accrediting organizations;
- To ensure the quality of care delivered by providers and subcontractor(s);
- To promote and facilitate improved continuity and coordination of care in clinical care and between medical, behavioral, and long term services and supports (LTSS);
- To develop and implement programs based on population analysis that incorporates cultural diversity, and healthcare disparities;
- To ensure vulnerable and special needs populations have access to appropriate care management and care coordination programs, including Case Management, Disease Management and Service Coordination;
- To ensure full compliance with all applicable state, federal and accreditation requirements;
- To ensure members' rights are upheld and services are provided in a manner that is sensitive to the cultural needs of members
- Annually develop, update, discuss and approve the QM Program (QAPI) and the QM Work Plan and Evaluation

The Amerigroup QAPI Program Description describes the governance of the program from the Board of Directors to the Quality Management committee and its subcommittees.

Sunflower: Sunflower's QAPI program is outlined in KS.Q1.01, QAPI Program Description. Our QAPI Program includes sophisticated data management, analysis, and reporting capabilities that facilitate performance monitoring and support effective service utilization. Our QIC oversees all QI and QAPI activities.

Sunflower's QI staff collects and facilitates analysis of encounter and other types of data to identify potential areas where improvements in clinical outcomes or service delivery are necessary or desired. Our assessments not only encompass indicators of *quality of care* provided by network and other providers, but also the quality of service that Sunflower provides.

Sunflower's QAPI program, KS.QI,01, outlines the written description of its program including the structure and process to monitor and improve the quality and safety of clinical care and the quality of services. The QAPI description includes the following: specific roles, structure and function of the QI committee and other committees, including meeting frequency; accountability to the governing body; a description of resources that are devoted to QIP; behavioral health; and patient safety.

Sunflower's Management Information Systems enable key personnel necessary access and ability to manage the data required to support the measurement aspects of the QI acitiviities including but not limited to Quality Spectrum Insight (QSI), a software system to monitor, profile and report on the treatment of specific episodes, care quality and care delivery patterns. QIS is an NCQA-certified software.. QSI enables Sunflower to integrate claims, member, provider and supplemental data into a single repository, by applying a series of clinical rules and algorithms that automatically convert raw data into statistically meaningful information.

Quality is integrated throughout Sunflower. To this end, we have established various committees, subcommittees and ad-hoc committees to monitor and support its QAPI Program. Ultimate authority is held by the Board of Directors. Sunflower will actively involve participating network providers, often times unfamiliar with managed care, at various levels throughout its QAPI Committee structure. We will include practitioners who represent the range of specialties in KanCare on committees such as the QIC, CC and PAC, as described above. Through these Committees, providers will be involved in analyzing data, will have an active voice in prioritizing quality studies and developing interventions for improvement, and will participate in the annual review of the QAPI program. Practitioners will have the opportunity to give input on the clinical practice guidelines to be adopted by Sunflower.

Sunflower will submit an annual report to the State after review by its Board of Directors (BOD.) Sunflower's BOD oversees development, implementation and evaluation of the QAPI Program and has the ultimate authority and accountability for oversight of the quality of care and services provided to Members at the plan.

United: The annual QI Work Plan focuses on QI Program goals, objectives and planned projects for the upcoming year. The QI Work Plan includes specific tasks, responsible owners of activities, and anticipated time frames for completion. It serves as the road map to reflect a coordinated strategy to implement the QI program including planning, decision-making, interventions, assessment of results, and achievement of the desired improvements. The Health Plan Board of Directors and the QMC approve the QI Evaluation as well as the annual QI Work Plan based on the QI Program Description. The QI Work Plan is a living document with periodic updates expected as a result of interim project findings and reports. Updates to the QI Work Plan are reviewed and approved by the Health Quality and Utilization Management Committee (HQUM), QMC, and submitted to state or federal agencies as required and/or when substantial changes are made.
The annual QI Work Plan specifically addresses the following:

- Quality of clinical care
- Quality of service
- Safety of clinical care
- Program scope
- Yearly objectives
- Yearly planned activities
- Time frame within which each activity is to be achieved
- The staff member responsible for each activity
- Monitoring previously identified issues
- Evaluation of the QI program

c. Performance Measures
The State requires the CONTRACTOR(S) to collect data on patient outcome performance measures, as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) or otherwise defined by

the State in Appendices 1-11 and to report the results of the measures to the State annually. The CONTRACTOR(S) shall submit data on the corresponding national and regional benchmarks when available as specified by the State. The State may add or remove reporting requirements with 30-days advance notice. The CONTRACTOR(S) shall comply with all QM requirements to improve performance on all established performance measures.

Amerigroup: Amerigroup's HEDIS data warehouse is an integrated repository fed directly from the core operations system to ensure data quality, control and consistency. The data warehouse maximized our capacity for data collection and analytics and affords us the flexibility to produce targeted reporting to support our state customers, business processes, providers and members.

In the HEDIS warehouse, encounter data sources are dived into three categories: claims, Rx and laboratory results, following our HEDIS Certified software vendors' data category and layout. We map data info standard formats within the three categories of claims, pharmacy, lab form internal and vendor transaction systems and data from state agencies such as member historical date and immunization registry data. Data in this warehouse is audited by a national auditor NCQA certified auditor (Attest Healthcare Advisors, LLC) before being submitted to NCQA for HEDIS reporting.

The Amerigroup HEDIS Data Management team oversees the HEDIS data processes to verify that our quality metrics accurately reflect our performance.

Sunflower: Sunflower State Health Plan (Sunflower) understands that KDHE's EQRO is responsible for conducting annual, external independent reviews of the quality outcomes, timeliness of, and access to the services we provide under the contract. Sunflower will cooperate fully with the EQRO's validation of our performance in providing the services covered in our contract

Sunflower will actively participate with KDHE to review the results of performance measures in comparison to established benchmarks, performance improvement projects, and any other EQRO activities.

Sunflower has multiple policies related to its QAPI and are outlined within its QAPI.

United: Our QAPI Program provides an integrated, coordinated and Continuous Quality Improvement (CQI) system to ensure compliance with contract, state and federal requirements and improve care for our members. We employ a knowledgeable, multi-disciplinary Quality Management team and proven structures and processes that emulate national benchmarks, standards and best practices. We continue to work with the State to define performance measures and associated reporting. We will monitor performance measures and track them over time. We will compare these performance metrics to Kansas' minimum performance standards, goals and benchmarks as well as to national and regional data, with the objective of achieving sustained improvement year after year and meeting benchmarks as quickly as possible. Our philosophy supporting quality assessment and performance improvement is to leverage our assets, capabilities and engage employees to provide our members, providers and state partners with cost effective, high value and high quality services.

C. Impact of Health Information Technology

KDHE, the State designee for health information technology (HIT), is facilitating the creation of strategic and operational plans for a statewide infrastructure for health information exchange (HIE). These plans will act as a blueprint for not-for-profit organizations responsible for the deployment and operation of the Kansas health information exchange (KHIE). The primary goal of the KHIE is to enable health care stakeholders to share data for coordinating patient care and to support public entities in achieving their population health goals. More specifically, this process will assist in the development of health homes for Kansans. The implementation of managed care will support the

current HIT/HIE efforts in Kansas through a number of CONTRACTOR requirements. Specifically, the following requirements are provided in Section 2.2.14 of the RFP.

The CONTRACTOR shall submit a plan to the State that details how it will use HIT to improve coordination and integration of care, promote prevention and wellness, and improve quality through appropriate sharing of clinical and administrative data among providers and to the State. This plan, at a minimum, will:

a. Specify how the CONTRACTOR will work within the framework outlined by the KHIE Board to facilitate electronic exchange of health information between providers and the CONTRACTOR, and between the CONTRACTOR and the State;
b. Demonstrate how the CONTRACTOR will work with providers to assist in their acquisition and use of certified electronic health record (EHR) technology in accordance with the Kansas Medicaid HIT Plan (located at http://www.kdheks.gov/hcf/hite/download/Overview_Activities_HIT_HIE.pdf.) and how they will assist providers to meet "meaningful use" of EHR.
c. Demonstrate how the CONTRACTOR will accept and use data from certified EHR technology.
d. Resubmission annually with updates when significant policy or community driven initiative occurs that changes how EHR is utilized.

III. Improvement

State Strategies and Interventions for Quality Improvement

Based on the results of the assessment activities, quality of care delivered by the CONTRACTOR will be improved in a number ways. As results from assessment activities become available, the State may define additional improvement opportunities.

Performance Improvement Projects

Each CONTRACTOR will conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. The State will approve and provide input on the selected topics for all PIPs. The CONTRACTOR(S) must ensure that CMS protocols for PIPs are followed and that the following are documented for each activity:

- Rationale for selection as a quality improvement activity;
- Specific population targeted including sampling methodology if relevant;
- Metrics to determine meaningful improvement and baseline measurement;
- Specific interventions (Member and provider);
- Relevant clinical practice guidelines; and
- Date of re-measurement.

Each CONTRACTOR must submit new data on at least two (2) PIPs annually to the State. This does not mean two (2) new PIPs a year. PIPs must be submitted to and approved by the State prior to implementation. PIPs must include the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions;
- Planning and initiation of activities for increasing or sustaining improvement; and
- Reporting the status and results of each project to the State on an annual basis.

Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care every year. The CONTRACTOR(S) shall report the status and results of each project to the State and its designee as requested. The State reserves the right to require additional PIPs if it is deemed necessary to improve the performance of the CONTRACTOR(S).

The CONTRACTOR(S) shall identify HEDIS, National Outcome Measurement System (NOMS), CMS approved HCBS Waiver Performance Measures and other benchmarks identified by the State and set achievable performance goals for each of its PIPs. The CONTRACTOR(S) shall identify and implement intervention and improvement strategies for achieving the performance goal set for each PIP and promoting sustained improvements.

Amerigroup: Amerigroup will evaluate claims and other data to identify the most significant and appropriate areas of study for clinical and non-clinical Performance Improvement Projects to improve health outcomes and member satisfaction. The PIPs will be drafted for State approval, using CMS protocols and format to include identification of appropriate benchmarks.

Accreditation

Kansas Medicaid CONTRACTOR(S) and subcontractor(s) are required to become accredited by the National Committee for Quality Assurance (NCQA) as defined by the State. NCQA is an independent, 501(c) (3) non-profit organization that assesses and scores CONTRACTOR performance in the areas of quality management and improvement, utilization management (UM), provider credentialing and recredentialing, and Members' rights and responsibilities. This process leaves only those CONTRACTORS demonstrating the highest quality of care and service to provide for enrollees. In conjunction with accreditation, CONTRACTORS are required to annually submit a full set of audited measures from HEDIS and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to NCQA. NCQA uses the results to reevaluate the organization's performance on specified HEDIS/CAHPS measures, and may change the organization's accreditation status based on the results.

A CONTRACTOR which holds current NCQA accreditation status shall submit a copy of its current certificate of accreditation with a copy of the complete accreditation survey report. The submission shall include scoring of each category, standard, and elements levels and recommendations, as presented via the NCQA Interactive Survey System (ISS): Status, Summarized & Detailed Results, Performance, Performance Measures, Must Pass Results Recommendations, and History to the State in accordance within timelines established by the State.

If a CONTRACTOR has not earned accreditation of its Medicaid product through the NCQA, the CONTRACTOR shall be required to obtain such accreditation within 18 months of the effective date of this CONTRACT.

Amerigroup: Amerigroup successfully completed its bid for an Interim NCQA accreditation status in May 2014. Work towards a 2015 First Year Accreditation status has begun. The NCQA onsite visit is scheduled for October 2015.

Sunflower: Sunflower is committed to obtaining NCQA accreditation within the required timeframe. Sunflower will conduct a gap analysis in May 2013. The gap analysis will be the basis of the work plan to ensure compliance with the standards and prepare for the required areas of analysis. Sunflower will begin monthly file reviews (denials, appeals, case management) in July 2013 in order to ensure compliance during the look back period of 6 months. Sunflower will submit in March 2014 in order to have a final report by July 1, 2014**.**

United: UnitedHealthcare currently holds Health Plan Accreditation (HPA) at the Corporate Level for its Medicaid health plans. Each UHC Community plan (Medicaid Plan) is allowed to apply this

corporate credit for standard processes that are followed at the corporate level. The health plan earned NCQA Interim accreditation in March 2014. The next NCQA survey is planned for September 2015, which will be a First Survey. Those standards that are scored at the health plan level will be assessed throughout the year in the various quality committee structures defined in the 2014 Quality Improvement Program Description. The health plan will perform HEDIS and the three required CAHPS surveys (Adult, Child and Child with Chronic Conditions; the latter two will be stratified by Title 19 and 21) in 2015 for measurement year 2014. Internal planning documents for HEDIS have been submitted to the HEDIS development team. The health plan also maintains a comprehensive Quality Improvement Program Description and Work Plan to ensure the plan meets NCQA requirements. An evaluation of the Program Description and Work Plan is completed yearly to ensure the quality program met its stated objectives.

Health Information System Initiatives

Each CONTRACTOR must maintain a Health Information System (HIS) that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to utilization, grievances and appeals and disenrollments for other than loss of Medicaid eligibility. Such system must comply with the provisions of 42 CFR 438.242.

The HIS must

- Collect complete and accurate data on Members and providers regarding information and services furnished through encounter data,
- Ensure data is accurate and complete by
  - Verifying accuracy timeliness reported data.
  - Screening data for completeness, logic, and consistency; and
  - Collecting service information in standardized formats to the extent feasible and appropriate.
- Makes sure data is available to the State of Kansas and CMS.
- The quality of encounter data will be ensured by review of the Plan's HIS systems for data management and validation by the State of Kansas utilizing both on site monitoring and encounter data submitted.

  To ensure quality of data submitted by plan's HIS systems for data management the state will utilize submitted data and on site review, as well as findings of EQRO reviews.

Amerigroup: The Amerigroup Management Information System (MIS) is fully operational with a dedicated internal Technical Support Department of individuals who are highly skilled and expected in information technology and managed health care.

Amerigroup maintains an integrated data warehouse that consolidates data from internal and external sources to support the ongoing requirement for scheduled reports and specialized ad hoc reporting needs. Internal data include claims, membership, authorization/utilization management, provider, capitation, customer service, and grievance and appeals. Data from external sources include items such as claims history, laboratory results, delegated vendor claims (ie; pharmacy and dental) and immunization registry data. We load data from an external source into the data warehouse then integrate the data for immediate availability through surrounding applications. The data warehouse is fed directly from source systems to ensure data accuracy and employs a relational data model. The data warehouse supports operational reporting using data available from the cores operations system supplemented with data from external sources.

The Amerigroup MIS ensures data accuracy and completeness and allows us to provide the State with timely, accurate reporting. In 2013, Amerigroup underwent an EQRO Information Systems Capability Assessment, (ISCA) assessment of its MIS processes. Overall, the 2013 report was favorable, with no corrective action plans requested.

Pay for Performance (P4P) Incentives
As discussed in previous sections of this quality strategy, the CONTRACTOR(S) will be required to report on all HEDIS, CAHPS, and other performance measures for specific populations as required in Appendices 1-12 of this Strategy.

Additionally, the State will implement a pay-for-performance (P4P) program. During the first CONTRACT year, six (6) operational performance measures have been selected to measure the CONTRACTOR(S)'s performance during implementation and the transition of Members to the KanCare program. To incentivize high performance in year one (1), three (3) percent of the total capitation payments will be held back for the purpose of incentive payments to CONTRACTORs meeting the higher levels of performance dictated in the P4P program. These performance standards require CONTRACTOR(S) to exceed the minimum performance standard required for CONTRACT compliance and incentivize the CONTRACTOR(S) to perform at a higher level in six areas determined by the State to be critical for successful integration of Members into the new program. The year one operational measures are listed in the table below, with the contractual requirements in the middle column, and the P4P incentive requirements in the right column.

Performance Measure	**Required Contractual Standard**	**Standard Required to Receive Incentive Payment (Benchmark)**
Timely claims processing	Section 2.2.39.2.1- 100% of clean claims are processed within 30 days 2.2.39.2.2-99 % of all no clean claims are processed within 60 days 2.2.39.2.3-100% of all claims are processed within 90 days	100% of all clean claims are processed within 20 days 99% of all non clean claims are processed within 45 days 100% of all claims are processed within 60 days
Encounter data submission	See Attachment K	Contractor meets all of the performance standards within 60 days from implementation date.
Credentialing process	Section 2.2.4.1.7- credentialing of providers shall be completed as follows: 90% in 30 days 100% in 45 days	 90% are completed in 20 days 100% are completed in 30 days
Grievances	(See Attachment D) 98 % of grievances are resolved within 30 days 100% of grievances are resolved within 60 days	 98 % of grievances are resolved within 20 days 100% of grievances are resolved within 40 days
Appeals	(See Attachment D) The CONTRACTOR must send a letter to the member within five (5) business days acknowledging receipt of the appeal request.	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request
Customer Service	Section 2.2.42.7 95% of all inquiries shall be resolved within two (2) business days of receipt 98% of all inquiries shall be resolved within five (5) business days 100% of all inquiries shall be resolved within 15 business days	98% of all inquiries are resolved within 2 business days from receipt date 100% of all inquiries are resolved within 8 business days from receipt date

Each of the six (6) areas identified above (timely claims processing, encounter data submission, credentialing process, grievances, appeals, and customer service) will be weighted at .5% of the 3% capitation withhold. A CONTRACTOR failing to meet all the required standards for an incentive payment in a given area will not receive .5% of their capitation payments back for each area in which it fails to meet the benchmark standard in full or in part. For example, if a CONTRACTOR fails to meet all of the required benchmarks in grievances, appeals, and customer services will not receive back 1.5% of their capitation payments back.

For CONTRACT years two (2) and three (3), 15 measures have been selected by the State as pay for performance (P4P) indicators (Five (5) for physical health, five (5) for behavioral health, and five (5) for LTC). To incentivize high performance and quality health outcomes, up to 5% of each CONTRACTOR's total per-Member, per-month payments will be held at risk and based on performance each year for the purpose of incentive payments in years two (2) and year (3). If the CONTRACTOR meets quality benchmarks established by the State for each of the 15 selected P4P indicators, the CONTRACTOR will receive the at risk payments in full.

The P4P indicators are listed below, and additional operational details are included in Appendix 12 to this document. Final measurement details, and any necessary adjustments over time, will be specified by the state to each MCO in the required reporting template associated with each measure.

Physical Health:

- Comprehensive Diabetes Care
    - This measure is actually a composite HEDIS measure composed of 8 rates. To be considered compliant with this measure, the CONTRACTOR must meet or exceed the benchmark rate for HbA1c screening, and meet or exceed the benchmark for five (5) of the remaining seven (7) Comprehensive Diabetes Care rates following all required HEDIS methodology
- Well-Child Visits in the First 7 Months of Life
    - The CONTRACTOR(S) shall meet or exceed the benchmark using state-approved methodology and specifications.
- Preterm Births
    - CONTRACTOR(S) shall utilize State-approved methodology and meet or exceed the State-defined benchmark.
- Annual Monitoring for Patients on Persistent Medications
    - The CONTRACTOR(S) shall meet or exceed the benchmark using HEDIS methodology and specifications.
- Follow-up after Hospitalization for Mental Illness
    - The CONTRACTOR(S) shall meet or exceed the benchmark using HEDIS methodology and specifications.

Behavioral Health, LTC and HCBS Waivers (for complete description and methodology please see Appendix 12 of this Attachment):

- Increased Competitive Employment: An increased number of people with developmental or physical disabilities, or with significant mental health treatment needs, will gain and maintain competitive employment.
- National Outcome Measures (NOMs):
    - The NOMs for people receiving Substance Use Disorder services will meet or exceed the benchmark in these areas: Living Arrangements; Number of Arrests; Drug and Alcohol Use; Attendance at Self-Help Meetings; and Employment Status.
    - The NOMs for people with SPMI or SED receiving mental health services will meet or exceed the benchmark in these areas: Adult Access to Services; Youth Access to Services; Homeless SPMI; Youth School Attendance; and Youth Living in a Family Home.

- Decreased Utilization of Inpatient Services: A decreased number of people with mental health treatment needs will utilize inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.
- Improved Life Expectancy: The life expectancy for people with disabilities will improve.
- Increased Integration of Care: The rate of integration of physical, behavioral (both mental health and substance use disorder), long term care and HCBS waiver services will increase.

Long-Term Care (for complete description and methodology please see Appendix 12 of this Attachment):

- Nursing Facility Claim Denials: The MCO will meet or exceed the benchmark for denial of nursing facility claims.
- Fall Risk Management: The percentage of people who have a fall with major injury will be decreased.
- Decreased Hospital Admission After Nursing Facility Discharge: The percentage of members discharged from a nursing facility who had a hospital admission within 30 days will be decreased.
- Decreased Nursing Facility Days of Care: The number of nursing facility days used by eligible beneficiaries will be decreased.
- Increase in number of Person-Centered Care Home (as recognized by PEAK) providers in Network: The number of PEAK facilities is to be increased annually.

CONTRACTOR(S) shall follow the required HEDIS, NOMS, or State-defined/State-approved methodology when calculating the P4P indicators in years two (2) and three (3). Each of the above 15 P4P indicators shall be externally validated by the EQRO. Each CONTRACTOR is required to collect performance data for all 15 of the P4P measures in CONTRACT year one (1) to serve as baseline data upon CONTRACTOR(S) will be expected to increase.

CONTRACTORS will be assessed with regard to acceptable performance on the P4P indicators. For performance to be considered acceptable, the CONTRACTOR must meet the respective performance standards for each of the 15 P4P measures. The criteria for performance standards will be governed by the final measurement details, and any necessary adjustments over time, specified by the state to each MCO in the required reporting template associated with each measure, and guided by the following:

- Failure to Meet Performance Standard – For HEDIS performance measures, any CONTRACTOR which has performed below the national Medicaid 50th percentile as defined by the NCQA (or other national benchmarks, when applicable) for the measurement year or five (5) percent higher than the CONTRACTOR's Medicaid benchmark rate for Kansas from the previous measurement year, whichever is higher, shall be considered as failing to meet performance standards. Other performance measures require a 5% performance improvement, or maintenance of designated high performance.
- Minimum Acceptable Performance – For HEDIS performance measures, any CONTRACTOR which has performed at or above the national Medicaid 50th percentile as defined by the NCQA (or other national benchmarks, when applicable) for the measurement year or five (5) percent higher than the CONTRACTOR's Medicaid benchmark rate for Kansas from the previous measurement year, whichever is higher, or maintaining high performance, shall be considered to have accomplished acceptable performance. Other performance measures require a 5% performance improvement, or maintenance of designated high performance.

The State expects to achieve continuous improvement in its Medicaid and CHIP programs, and will establish escalating targets for each measure over the three (3) year period of this CONTRACT. CONTRACTOR(S) will be expected to accomplish a five (5) percentile improvement on each P4P indicator in CONTRACT years two and three, or maintain high performance, the details of which are specified in the operational guidelines and reporting template. This requirement is designed to ensure that CONTRACTOR(S) work to continually improve their performance on all P4P

indicators and other performance measures. If any CONTRACTOR fails to meet the five (5) percent improvement standard in year two or three, up to1/15th of the PMPM at risk will be kept by the State for each P4P indicator for which the CONTRACTOR failed to meet the performance benchmark. Further, in year three, if a CONTRACTOR fails to meet the year two (2) performance benchmark for any one of the 15 performance measures, up to 2/15^{ths} of the PMPM at risk will be kept by the State and not returned to the CONTRACTOR for each indicator where performance levels were not met. In the event of additional CONTRACT years, 3/15^{ths} would be kept for failure to meet the year two (2) benchmark in year four (4), or to meet the year three (3) benchmark in year five (5), and 4/15^{ths} would be kept for failure to meet the year two (2) benchmark in year (5).

The State reserves the right to assess and modify the P4P indicators and benchmarks after the first CONTRACT year. If optional years are added to the CONTRACT with a CONTRACTOR, the State expects to escalate expected levels of performance on the original levels and/or to add additional performance measures to the process. For each new indicator the performance target would be set at an initial level in the first year of its inclusion and this target would escalate each year until reaching an exemplary level. New indicators may replace a corresponding number of previous indicators in the calculation of performance incentives, maintaining a list of 15 for which performance payments are calculated. Sustained performance at the highest levels would be expected for the growing list of performance targets, including those selected by the State for replacement by new measures.

The State reserves the right to tie PIP requirements to P4P indicators where the CONTRACTOR has failed to meet the benchmark or improvement standard. CAPs may also be instituted by the State for less than acceptable performance by a CONTRACTOR on the P4P indicators.

CONTRACTOR Proposals for Additional P4P Indicators

CONTRACTOR(S) who believe they can exceed the acceptable benchmark standard will be provided an opportunity to create and present additional performance targets and appropriate incentives. The State desires to add P4P measures which focus on patient outcomes, health and functional status. The State is particularly interested in P4P measures which address smoking cessation and obesity rates. Any plan for additional P4P incentives must be submitted by the CONTRACTOR at the same time as the QAPI plan. The State reserves the right to accept, reject, or modify any additional incentive plan proposed by a CONTRACTOR.

The State recognizes that improvements in quality will require enhanced coordination of care and consumer engagement, and will entail cooperation and improved systems of care among providers. The State acknowledges the central role that providers will play in achieving improved outcomes and encourages CONTRACTOR(S) to enable providers to share in the modest financial rewards available under this program for high-performing CONTRACTORS. The State also encourages the adoption of innovative, evidence-based provider payment mechanisms that incorporate performance and quality initiatives. Additional performance measures proposed by any CONTRACTOR should strive to decrease the level of reporting and administrative burden on providers.

United: UnitedHealthcare welcomes the opportunity to work with the State to develop and add P4P measures focusing on patient outcomes, health and functional status, particularly as they relate to chronic diseases such as smoking and obesity. Smoking cessation and obesity performance measures already exist within the CAHPS member satisfaction survey and HEDIS methodology.

UnitedHealthcare has the innovative UHC Complete ™ Accountable Care Shared Savings and Basic Quality Program, a comprehensive portfolio of incentive models that balance standardization with customization, where providers are incentivized with HEDIS-like measures that are collected administratively, rather than through chart review . The providers do not have to report, we collect the data through claims, which reduces the administrative burden for the providers, while providing incentives designed to increase access to care, reduce avoidable hospital admissions and inappropriate ER utilization and improve care of high risk members. We welcome the opportunity to consider innovate options such as these for Kansas providers.

Dually-Eligible Individuals

The State recognizes that data for individuals who are dually eligible for Medicare and Medicaid can be difficult to obtain and could impact the rates for certain P4P indicators. If a CONTRACTOR foresees that it will be unable to obtain an accurate measurement for any P4P measure because of data issues in the dual population, that CONTRACTOR shall work with the state to address the issue and the results will be specified in the operational details of the measure involved. Going forward, the State expects CONTRACTOR(S) to assist in preparing recommendations to CMS for shared savings relative to serving Medicare-Medicaid dually eligible Members.

Quality Assessment and Performance Improvement (QAPI) Program Review

The State will annually review the impact and effectiveness of each CONTRACTOR(S)'s QAPI programs. The review must include but is not limited to performance on the standard required measures and the results of each PIP. The review will serve to pinpoint areas where quality and access can be improved. Additionally, each CONTRACTOR must have in effect a process for its own evaluation of the impact and effectiveness of its QAPI program.

CONTRACTOR Sanctions

To ensure quality of care and services, the State may impose sanctions upon the CONTRACTOR(S) for certain actions if the actions are confirmed by on onsite surveys, Member or other complaints, changes in financial status or any other source.

The following results may result in sanctions upon the CONTRACTOR(S).

- Failing substantially to provide medically necessary services that the CONTRACTOR is required to provide, under law or under its CONTRACT with the State, to a Member covered under the CONTRACT;
- Imposing premiums or charges on Members in excess of permitted charges;
- Acting to discriminate among Members on the basis of their health status or need for health care services;
- Misrepresenting or falsifying information that it furnishes to CMS or to the State.
- Misrepresenting or falsifying information that it furnishes to a Member, potential Member, or health care provider;
- Failing to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR §422.208 and 422.210;
- Failing to obtain minimum acceptable performance levels on any performance measure specified in Appendix 1-11 of this Strategy;
- Distributing directly, or indirectly through any agent or independent CONTRACTOR, marketing materials that have not been approved by the State or that contain false or materially misleading information; and
- Violating any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.

Intermediate Sanctions that may be imposed include civil monetary sanctions, suspension of all new enrollment, including default enrollment, after the effective date of the sanction, and termination of the CONTRACT for failure to carry out the substantive terms of this CONTRACT or to meet applicable requirements in section 1932, 1903(m) and 1905(t) of the Act.

IV. Review of Quality Strategy

A. Timeline Planned for Frequency of Strategy Assessments

In the effort to achieve safe, effective, patient-centered, timely and equitable care the State will assess the quality strategy on at least an annual basis and revise the State Quality Strategy document accordingly.

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, it will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

The State values a collaborative, race to the top type approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-a-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas will work collaboratively with the MCOs, and provide ongoing policy guidance and program direction, in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalize; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process has been completed (and as it recurs over time), as determined by Kansas, the final details as to each measure will be communicated and will be binding upon each MCO. These operational adjustments and updates will not require contract amendments, but will be documented as part of the quality strategy or in related operational guidelines/reporting templates and will be binding upon and put into place by each MCO.

B. Timeline Planned for Reporting Strategy Updates to CMS

Kansas values a collaborative, interactive and communicative relationship with CMS, and will ensure that progress and assessment results regarding KanCare quality issues are communicated to CMS. In the event that substantive revisions need to be made to the State Quality Strategy, the State will document these changes and report these revisions to CMS for review when significant changes have been applied to the Strategy document. In addition, whenever ongoing operational revisions and updates are made to the State Quality Strategy, the State will provide the updated documents to CMS for review and information. Ongoing routine adjustments will be included in core reporting to CMS, such as the STC quarterly/annual reports and HCBS waiver-related reporting when applicable.

C. Strategy Effectiveness

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care waiver program. As the single state agency with primary responsibility for implementation, management, reporting, and monitoring of the programs under the KanCare waiver, the Kansas Department of Health and Environment (KDHE) has established the KanCare Interagency Monitoring Team (IMT) as an important component of comprehensive oversight and monitoring. The IMT is a review and feedback body that will meet in work sessions quarterly, focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS), consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. The IMT includes representatives from KDHE and the Kansas Department of Aging and Disabilities services (KDADS), and operates under the policy direction of the KanCare Steering Committee which includes leadership from both KDHE and KDADS. Within KDHE, the KanCare Interagency Coordination and

Contract Monitoring (KICCM) team, which facilitates the IMT, has the oversight responsibility for the monitoring efforts and development and implementation of the QIS – including the effectiveness of this State Quality Strategy.

These sources of information guide the ongoing review of and updates to the KanCare QIS: results of KanCare managed care organization (MCO) and state reporting, quality monitoring and other KanCare contract requirements; external quality review findings and reports; the state's onsite review results; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and the IMT's review of and feedback regarding the overall KanCare quality plan. This combined information assists the IMT and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

Appendix 1. Performance Measures: Physical Health

Indicator	Reporting Frequency	Methodology	Benchmark Objective
All applicable Medicaid HEDIS measures calculated and submitted	Annually	HEDIS	Rates for each measure shall be at or above the national 50th percentile for Medicaid plans, or at or above the historical Kansas FFS rates—whichever is higher.
Preterm Births	Annually	As defined in state-approved guidelines and reporting template	Based upon the 2013 baselines (specific to each individual MCO) the rate of preterm births among members will decrease by 5% annually.
CAHPS Adult Survey CAHPS Child Survey (stratified by Title 19 Medicaid and Title 21 CHIP) CAHPS Children with Chronic Conditions (stratified by Title 19 Medicaid and Title 21 CHIP)	Annually	HEDIS/AHRQ	Survey completed by date set by the State. Plans must meet or exceed 2013 National average for each item as reported in the National CAHPS Benchmarking Database. CAHPS 5.0H
Total Eligibles who received preventive dental services	Annually	EPSDT	Plans must meet or exceed participation levels as reported in the 2012 CMS Form 416 as published by the state.
Total Eligibles who received dental treatment services	Annually	EPSDT	Plans must meet or exceed participation levels as reported in the 2012 CMS Form 416 as published by the state.
Prevention Quality Indicators • Diabetes short-term complication admission rate • Diabetes long-term complication admission rate • COPD or asthma in older adults admission rate • Hypertension admission rate • CHF admission rate • Dehydration admission rate • Bacterial pneumonia admission rate • Urinary tract infection admission rate • Angina without procedure admission rate • Uncontrolled diabetes admission rate • Asthma in younger adults admission rate • Lower extremity amputation rate among patients with diabetes • Perforated appendix admission rate • Low birth weight rate	Annually	AHRQ (Please refer to http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx)	Measures are optional, but a selectionof these should be submitted by CONTRACTOR(S) to provide additional information to beneficiaries about the quality of services provided by the CONTRACTOR(S).

Appendix 2. Performance Measures: Mental Health and HCBS – SED programs

Indicator	Measurement	Numerator and denominator	Data source for measuring	Frequency of measuring
Mental Health Quality of Life Indicators	Percentage of Members reporting their physical health as good within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by KDADS.	Numerator: Number of Adults with SPMI reporting they are in good physical health Denominator: total number of persons interviewed. KDADS will provide each MCO with list of SPMI adults annually	Member Data to be gathered by the CONTRACTOR phone interviews with Members. The frequency of the survey hasn't been determined but will not be initiated until 7/1/13	The phone survey universe is derived from a random sample of active mental health consumers.
Mental Health Quality of Life Indicators	The Percentage of Members reporting they are connected to the people who support them the most within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by KDADS.	Numerator: Number of Adults with SPMI reporting connectivity to people who support them the most Denominator: total number of persons interviewed. KDADS will provide each MCO with list of SPMI adults annually	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers.
Mental Health Quality of Life Indicators	The Percentage of Members reporting they are doing what they want for their work within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by KDADS.	Numerator: Number of adults with an SPMI who report doing what they want for work. Denominator: total number of persons interviewed. KDADS will provide each MCO with list of SPMI adults annually	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers.
Mental Health Quality of Life Indicators	Percentage of adults with an SPMI who report having a place to live that is comfortable for them	Numerator: Number of adults with an SPMI who report having a place to live that is comfortable for them Denominator: total number of persons interviewed. KDADS will provide each MCO with list of SPMI adults annually	Member Data to be gathered by the CONTRACTOR phone interviews with Members	The phone survey universe is derived from a random sample of active mental health consumers

Indicator	Measurement	Numerator and denominator	Data source for measuring	Frequency of measuring
Access to initial appointments at a CMHC	The CONTRACTOR will ensure CMHC providers offer timely initial appointments. All new Members will be offered an initial appointment within 10 calendar days.	**Denominator:** Total number of new Members at a CMHC requesting an appointment within the reporting time period. **Numerator:** Members who are scheduled for services within 10 calendar days (240 hours from the date and time) of the initial contact date/time.	AIMS/KDADS Field 6:Initial Contact Date/Time Field 7:Scheduled Appointment Date/Time Field 8: Appointment Time Lapse Reason	KDADS will generate a monthly report that will be summarized quarterly for monitoring this measure.
Access standards for post-stabilization in an Emergency Room setting	The CONTRACTOR will maintain the following access standards for screening by a CMHC for institutional care: **Post-Stabilization** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Emergent** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Urgent** - 24 hours from initial contact to arrival of CMHC staff to the emergency room setting.	**Denominator:** Total number of requests for mental health inpatient screens of Members originating in a Hospital Emergency Room during the reporting time period. **Numerator:** Total number of Member screens indicating CMHC staff arrival within the designated time for each standard. Performance for all access standards is measured in total minutes from the time of the initial call to the screener's arrival time at the Member's location. This measure is designed to demonstrate adequate timeliness in reaching the Emergency Room setting and is not reliant on the initiation of the screen for that determination. All requests for CMHC staff to evaluate the need for an inpatient screen in a Hospital Emergency Room are included in this measure regardless of whether the response resulted in a screening service, e.g., in situations that are resolved thru crisis stabilization.	Inpatient Screening Database (IPS)/KDADS	KDADS will generate a monthly report for each standard that will be summarized quarterly for monitoring this measure.

Home and Community Based Services

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes

Frequency of Measuring	Methodology	Benchmark	Data Source
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously /Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Continuously /Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=The number of charts reviewed with evidence the POC was developed by a wraparound team D=Total number of charts reviewed	100% of participants' POC are developed by a wraparound team.	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=The number of SED Waiver participants whose POC was reviewed for needed changes within 90 days of the last review. D=The total number of active SED Waiver participants	100% of participants POC will be reviewed within 90 days of the last review.	KDADS Record Reviews
Quarterly	N=Number of charts reviewed with evidence the participant received a Notice of Action form containing information regarding their rights to a State Fair Hearing. D=Total number of charts reviewed	100% of participants will receive information regarding their rights to a State Fair Hearing via the Notice of Action (NOA) form.	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the number of specified days	KDADS Record Reviews
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	KDADS Record Reviews
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation

Indicator	Proposed measurement	Numerator and denominator	Data source for measuring	Frequency of measuring

Adult Inpatient Recidivism at 30 days post-discharge	The percentage of adult Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	Denominator: Total number of adults age 18 and over discharged from any SMHH, private psychiatric hospital or local acute psychiatric unit during the reporting period. Numerator: Total number of adults represented in denominator with a prior discharge from any facility occurring within 90 days.	Inpatient Screening Database	KDADS will generate a quarterly monitoring report for this measure.
Youth Inpatient Recidivism at 30 days post-discharge	The percentage of youth Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	Denominator: Total number of youth under age 18 discharged from any contracted state hospital alternative facility for youth, private psychiatric hospital, local acute psychiatric unit, or psychiatric residential treatment facility during the reporting period. Numerator: Total number of youth represented in denominator with a prior discharge from any facility occurring within 90 days.	Inpatient Screening Database	KDADS will generate a quarterly monitoring report for this measure..
Youth Inpatient Recidivism at 90 days post-discharge	The percentage of youth Members readmitted to an inpatient psychiatric facility within 90 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	Denominator: Total number of youth under age 18 discharged from any contracted state hospital alternative facility for youth, private psychiatric hospital, local acute psychiatric unit, or psychiatric residential treatment facility during the reporting period. Numerator: Total number of youth represented in denominator with a prior discharge from any facility occurring within 90 days.	Inpatient Screening Database	KDADS will generate a quarterly monitoring report for this measure.
Average length of stay for youth Members in Psychiatric Residential Treatment	The average number of inpatient days per youth for all youth Members discharged from a PRTF during the reporting period.	Denominator: Total number of days from admission to discharge for all youth Members discharged during the reporting period. Numerator: Total number of discharges for youth Members represented in	Admission/discharge information from MCO PRTF discharge reports.	MCOs will generate a quarterly monitoring report for this measure.

Facilities (PRTF)		denominator. Youth with more than one discharge during the reporting period are counted		

*For performance measures associated with chart reviews, the CMHC is responsible for completing the task being measured and KDADS staff are responsible for conducting the chart reviews and for data reporting and analysis.

**For performance measures associated with licensing and agreements with the State Medicaid Fiscal Agent, KDADS is currently responsible for data reporting and analysis.

***For performance measures associated with provider training, Wichita State University is currently responsible for data reporting and analysis.

Appendix 3. Performance Measures: Substance Use Disorders

Indicator	Reporting Frequency	Methodology	Benchmark Objective	Data Source	Notes
Appointment Access Referral timelines Urgent – means a service need that is not emergent and can be met by providing an assessment within 24 hours of the request for service, and treatment within 24 hours of the assessment, without resultant deterioration in the individual's functioning or worsening of his/her condition. If the client is pregnant, they are to be placed in the urgent category. Routine - a service need that is not urgent and can be met by receiving an assessment within 14 (calendar) days, and treatment within 14 calendar days of the assessment, without resultant deterioration in the individual's functioning or worsening of his/her condition.	Quarterly and Annually	Measures time between call, assessment and treatment. Utilization report to manage access to care performance guarantees based upon client level of urgency.	**Standards:** Note: These are the minimum standards. All calls for all Members are clinically triaged to ascertain if a more urgent level of care is appropriate. Emergent: Means a service need that must be met immediately because the individual is unsafe or his or her condition is deteriorating. If caller is determined to be at risk of self-harm or harm to others, or is a medical detox risk, the Member requires immediate assistance and intervention, and is referred to a hospital detox setting. The need is rated as Emergent. Urgent: Members are assessed within 24 hours; services delivered within 48 hours from the initial contact Routine: Members assessed within 14 days of request for services and treatment services are delivered within 14 days of assessment IV Drug Users: Members receive treatment within 14 days of first contact.	**MCO data systems**	

IV Drug Users – If a client has used IV drugs within the last 6 months, and they don't fall into the Emergent or Urgent categories because of clinical need, they will need to be placed in this category. Clients who have used IV drugs within the last 6 months need to be seen for treatment within 14 (calendar) days of initial contact.					
Utilization Data **Over and Under Utilization Report** **Higher Levels of Care Utilization** Detox Intermediate Reintegration Hospital-based services	Quarterly	Admissions/1000;visits/1000 (Medicaid only) then for all funding sources # of admissions, ALOS, etc. Utilization report including Hospital and community based acute Detox, Reintegration, and Intermediate split by adult/adolescent and Detox services. The report details include average covered lives/Per 1000 calculations for Medicaid only, and admissions and days. The report will be based on the service date begin and service date end & will provide the count of actual units. The report will be claim based as a rolling quarter to show a full year by 4th quarter. This report will be provided as an aggregate, as well as by KDADS region.	Monitor for trends	MCO Claims data	Can be rolled up into overall report but stratified by MH, SUD (Modality), SED

Over and Under Utilization Report **Lower Levels of Care Utilization** Intensive outpatient Outpatient Case Management Peer Support Telemedicine Crisis Intervention Assessment	Quarterly	Utilization report including Intensive Outpatient, Outpatient and Other services. The report details include average covered lives/Per 1000 calculations and admissions and days. The report will be claim based as a rolling quarter to show a full year by 4th quarter. The report will be based on the service date begin and service date end & will provide the count of actual units. This report will be provided as an aggregate, as well as by KDADS region.	Monitor for trends	MCO Claims data	Can be rolled up into overall report but stratified by MH, SUD (Modality), SED
Over and Under Utilization Report Inpatient and RTC Recidivism Rates	Annually	Readmission report showing recidivism for Higher Levels of Care within 30, 60, and 365 days. The report details include age band and gender, admissions in previous year, and total admits and percent readmission by day buckets. Data will be reported on an aggregate level only.	Review report for trends Will need two full years of data to calculate readmission rates. First year report will only show admits. Also, this report does not contain quarterly trending so in order to get a complete dataset, a 90 day lag is recommended.	MCO Claims data	Can be rolled up into overall report but stratified by MH, SUD (Modality), SED
Over and Under Utilization Report Average LOS, admissions	Annually	Utilization report to determine over and underutilization. Report is	Analysis: Documentation and investigation of providers with LOS < or > 1SD from modality Mean.	MCO Claims data	Can be rolled up into

and readmissions of all providers		broken out by all providers and reported separately by modality. The report will be delivered annually and will contain a rolling 12 months of data of all programs split by adult/adolescent including higher levels of care (hospital detox, social detox, reintegration, intermediate) and lower levels of care (intensive outpatient, outpatient and other). Graphs show Mean of length of stay (LOS) and one (1) Standard Deviation (SD) above and below the Mean for each provider over the entire rolling reporting period.			overall report but stratified by MH, SUD (Modality), SED
Grievance Report Grievance Summary by Region, Grievance Client Detail, Grievance Provider Detail	Annually	By category, by region, by type, timeliness of resolution Grievance Summary by Region, Grievance Client Detail, Grievance Provider Detail	Monitor for Trends	MCO tracking system	Can be rolled up into overall report but stratified by MH, SUD (Modality), SED
Appeals Report Appeals Summary by Region, Appeals Detail, and Fair Hearing detail	Semi-annual and Annual	Standard and expedited appeals. Appeals Summary by Region, Appeals Detail; Appeals reporting will be provided by region and detail. Appeals are categorized as Clinical and Administrative.	Monitor for Trends	MCO tracking system	Can be rolled up into overall report but stratified by MH, SUD, SED

Adverse Incident Report	Semi-annual and Annual	By category, , by Provider as appropriate. Summary information that represents occurrences of actual or potential serious harm to the wellbeing of a KDADS Member or to others by the actions of a KDADS Member, who is receiving services managed by the CONTRACTOR or has recently been discharged from services managed by the CONTRACTOR.		KDADS AIR Portal	Can be rolled up into overall report but stratified by MH, SUD, SED
Network Inventory Comparison of # and types of providers before and after this contract	Annually	The Network Inventory report provides a snapshot of the network for a given year to compare annually. Report includes a summary page of modalities and provider counts.	No decrease in # of providers	MCO tracking system	Can be rolled up into overall report but stratified by MH, SUD (by Modality), SED
Provider Satisfaction Survey	Annually	Provider survey information presented in a scaling format regarding their experience with the CONTRACTOR.	Monitor for trends	MCO tracking system	Can be rolled up into overall report but stratified by MH, SUD, SED
Member Satisfaction Survey	Annually	Member survey information presented in a scaling format regarding their experience with the CONTRACTOR and servicesMember random sample.	Monitor for trends	MCO tracking system	Can be rolled up into overall report but stratified

					by MH, SUD, SED
Penetration Rates Report	Monthly and Annually	Report of the Medicaid penetration rates, and new Members served each month.	.	Medicaid Eligibility file and MCO Claims	Can be rolled up into overall report but stratified by MH, SUD, SED
Authorization Decisions Timeliness report	Monthly	Documents authorization decisions are occurring within the required timeframes		KCPC Vouchers/MCO systems	Can be rolled up into overall report but stratified by MH, SUD, SED

Appendix 4. Performance Measures: HCBS - I/DD program

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed

Frequency of Measuring	Methodology	Benchmark	Data Source
			Care Organizations (MCOs) encounter data
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessorD=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously/ Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/ Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/ Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/ Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Continuously/ Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the Number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews
Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actions D=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notices of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	KDADS Record Reviews / Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident manage-ment system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodologyD=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation

Frequency of Measuring	Methodology	Benchmark	Data Source
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Appendix 5. Performance Measures: HCBS/PD program

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessorD=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously/Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the Number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews
Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actionsD=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notices of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Appendix 6. Performance Measures: HCBS/TBI program

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor six (six (6))D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within 6 working days of intake	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously /Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the Number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews
Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actions D=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notices of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Quarterly	N=Number of customers who are making progress during the review period D=Total number of customers who are receiving services during the review period	Number and percent of customers who are making progress	KDADS Record Reviews
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Appendix 7. Performance Measures: HCBS/TA program

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously /Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously /Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews
Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actions D=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notices of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Quarterly / Annually	N=Sample number of hospitalizations within six (6) months for the same children admitted to program D=Total number of children assessed for program eligibility	10% Percentage of children with re-hospitalization within the first six (6) months of program admission	DSS/DAI encounter data
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Appendix 8. Performance Measures: **HCBS/Autism program and ICF/MRs**

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	Quality Review Reports
Quarterly	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake	KDADS Record Reviews

Qualified Providers			
Continuously/Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Quarterly	N=Facility will be licensed and certified as either a small (4-8 bed) or medium (9-16) bed) size facility D=Total number of facilities licensed and certified as either a small (4-8 bed) or medium (9-16) bed) size facility	100% of ICF/MR facilities will be either classified as small or medium size facility	KDADS

Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews

Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews

Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=Number of participant Vineland II adaptive behavioral scores and composite scores from reassessments show an increase D=Number of participant Vineland II adaptive behavioral scores and composite scores from reassessments for all participants	The Vineland scores show a 40% overall improvement for participants on the waiver	KDADS Record Reviews
Quarterly	N=Number of participants in an ICF/MR setting has had gatekeeping completed prior to admission D=Total number of participants in an ICF/MR setting	100% of all admissions to the ICF/MR have gone through the LOC assessment process completed by the Local CDDO	KDADS Record Reviews
Quarterly	N=Number of participants in an ICF/MR meet active treatment guidelines D=Total number of participants in ICF/MR	100 % of all admissions to an ICF/MR meet the Condition of participation: Active treatment services	KDADS Record Reviews
Quarterly	N=Number of all participants will have a continuous active treatment program in place with 30 days of admission D=Total number of participants in ICF/MR	100% of all participants must receive a continuous active treatment program	KDADS Record Reviews
Quarterly	N=Number of participants in an ICF/MR younger than 18 D=Total number of participants in an ICF/MR	100% of participants in an ICF/MR will not be younger than 1six (6) years of age	KDADS Record Reviews
Quarterly	N=Number of "participants who have a guardian" who have obtained court approval prior to admission D=Total number of “participants” in an ICF/MR setting	100% of those participants who are "ward of the court" seeking admission to an ICF/MR have obtained courts' approval	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the Number of specified days D=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews

Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actions D=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notice of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews

Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews

Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation
Annually	N=Number of facilities operating will have cost reports completed and submitted timely D=Total number of operating facilities will have cost reports completed	100% of all ICF/MR facilities will submit accurate and timely cost reports	KDADS Program Evaluation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Appendix 9. Performance Measures: Money Follows the Person Grant (MR/DD, PD, TBI and FE)

Frequency of Measuring	Methodology	Benchmark	Data Source
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of MFP participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled MFP participants	Number and percent of MFP participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data
Quarterly / Annually	N=Number of MFP participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of MFP participants who received Level of Care redeterminations	Number and percent of MFP participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose Level of Care determinations used the approved screening tool D=Number of MFP participants who had a Level of Care determination	Number and percent of MFP participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews

Qualified Providers			
Continuously/Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports
Continuously/Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports
Continuously/Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports
Continuously/Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports
Continuously/Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports
Service Plan			
Quarterly	N=Number of MFP participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews

Quarterly	N=Number of MFP participants whose service plans address health and safety risk factors D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose service plans address participants' goals D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants whose service plans address participants' goals	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose service plans were developed according to the processes in the approved waiver D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of MFP participants (or their representatives) who were present and involved in the development of their service plan D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the MFP participant's annual redetermination date D=Number of MFP participants whose service plans were reviewed	Number and percent of service plans reviewed before the MFP participant's annual redetermination date	KDADS Record Reviews
Quarterly	N=Number of MFP participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of MFP participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of MFP participants whose service plans were reviewed	Number and percent of MFP participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews

Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of MFP participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS
Quarterly	N=Number of MFP participants whose record contains documentation indicating a choice of community-based services D=Number of MFP participants whose files are reviewed for the documentation	Number and percent of MFP participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of MFP participants whose files are reviewed for the documentation	Number and percent of MFP participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose record contains documentation indicating a choice of waiver service providers D=Number of MFP participants whose files are reviewed for the documentation	Number and percent of MFP participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of MFP participants whose record contains documentation indicating a choice of waiver servicesD=Number of MFP participants whose files are reviewed for the documentation	Number and percent of MFP participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Semi-Annually	N=Total number of annual transition benchmarks D=Total number of annual transition benchmarks achieved	100% of annual transition benchmarks are achieved.	MCO monthly MFP reports
Semi-Annually	N=Total number of MFP participants who are re-institutionalized D=Total number of MFP participants	Post transition success - 80% of people who transition will receive adequate services/supports to remain successfully in the community	MCO monthly MFP reports

Semi-Annually	N=Total number of MFP participants maintaining the same level of service after moving to HCBS D=Total number of MFP participants	Continuity of Care - 100% of people who complete their MFP year will maintain the level of service/supports when moving over to the HCBS waiver	KDADS Program Evaluation
Quarterly	N=Number of MFP transitionees who received a QA review D=Total number of transitionees.	100% of MFP participants who transition to the community receive a quality review during their MFP year.	KDADS Record Reviews
Quarterly	N=Total number of annual transition benchmarks achieved D=Total number of annual transition benchmarks.	100% of annual transition benchmarks are achieved.	MCO monthly MFP reports
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS
Quarterly	N=Number and percent of MFP participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of MFP participants who had assessments	Number and percent of MFP participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causesD=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews

Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews
Quarterly / Annually	N=Number of MFP participants who have a disaster red flag designation with a related disaster backup plan D=Number of MFP participants with a red flag designation	Number and percent of MFP participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of MFP participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of MFP participants interviewed by QMS staff or whose records are reviewed	Number and percent of MFP participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews

Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of MFP participants who received physical exams in accordance with State policies	KDADS Record Reviews
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of MFP participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology D=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation

Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation
Semi-Annually	N=Total number of dollars spent on institutional costs D=Total dollars spent on HCBS budget	Report on overall LTC spending to assure an annual percentage shift in spending as a result of an increase in spending on HCBS services and a decrease on institutional spending.	KDADS

Appendix 10. Performance Measures: HCBS/Frail Elderly program

Frequency of Measuring	Methodology	Benchmark	Data Source
Administrative Authority			
Quarterly / Annually	N=Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency D=Number of Quality Review reports	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	QuJuality Review Reports
Quarterly / Annually	N=Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS D=Total number of waiver amendments and renewals	Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency	Number of waiver amendments and renewals
Quarterly	N=Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency D=Number of waiver policy changes implemented by the Operating Agency	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	Presentation of waiver policy changes
Annually	N=Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports D=Number of Long-Term Care meetings	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	Meeting minutes
Evaluation / Reevaluation Level of Care			
Quarterly / Annually	N=Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services D=Total number of enrolled waiver participants	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	Other-Operating Agency's data systems and Managed Care Organizations (MCOs) encounter data

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination D=Number of waiver participants who received Level of Care redeterminations	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose Level of Care determinations used the approved screening tool D=Number of waiver participants who had a Level of Care determination	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	KDADS Record Reviews
Annually	N=Number of initial Level of Care (LOC) determinations made by a qualified assessor D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	Assessor and assessment records
Quarterly	N=Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied D=Number of initial Level of Care determinations	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	KDADS Record Reviews
Quarterly	N=Number of case file reviews reflect eligibility determination was made within six (6) working days of intake D=Total number of files reviewed	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake	KDADS Record Reviews
Quarterly	N=Number of participants whose cases were closed appropriately and timely D=Number of waiver participants who lost Medicaid financial eligibility	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility	KDADS Program Evaluation

Frequency of Measuring	Methodology	Benchmark	Data Source
Qualified Providers			
Continuously/Ongoing	N=Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services D=Number of all new licensed/certified waiver providers	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards D=Number of enrolled licensed/certified waiver providers	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services D=Number of all new non-licensed/non-certified providers	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	Managed Care Organization (MCO) reports and KDADS Record Reviews
Continuously/Ongoing	N=Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements D=Number of enrolled non-licensed/non-certified providers	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	Managed Care Organization (MCO) reports and KDADS Record

Frequency of Measuring	Methodology	Benchmark	Data Source
			Reviews
Continuously/Ongoing	N=Number of providers that meet training requirements D=Number of active providers	Number and percent of active providers that meet training requirements	Managed Care Organization (MCO) reports and KDADS Record Reviews
Service Plan			
Quarterly	N=Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address health and safety risk factors D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address health and safety risk factors	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose service plans address participants' goals D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans address participants' goals	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants whose service plans were developed according to the processes in the approved waiver D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	KDADS Record Reviews
Quarterly	N=Number of waiver participants (or their representatives) who were present and involved in the development of their service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	KDADS Record Reviews
Quarterly	N=Number of service plans reviewed before the waiver participant's annual redetermination date D=Number of waiver participants whose service plans were reviewed	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	KDADS Record Reviews
Quarterly	N=Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	KDADS Record Reviews
Quarterly	N=Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan D=Number of waiver participants whose service plans were reviewed	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	1. Electronic Visit Verification (EVV) reports 2. KDADS Record Reviews
Quarterly	N=Number of survey respondents who reported receiving all services as specified in their service plan D=Number of waiver participants interviewed by QMS staff	Number and percent of survey respondents who reported receiving all services as specified in their service plan	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of community-based services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver service providers D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	KDADS Record Reviews
Quarterly	N=Number of waiver participants whose record contains documentation indicating a choice of waiver services D=Number of waiver participants whose files are reviewed for the documentation	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	KDADS Record Reviews
Quarterly	N=Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the Number of specified daysD=Total number of files reviewed during the review period	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	KDADS Record Reviews
Quarterly	N=Number of participants who reported attendants/workers reported on time D=Total number of participants interviewed during that review period	Number and percent of participants who reported attendants/workers reported on time	Customer interviews by KDADS

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly	N=Number of customers who are surveyed and report satisfaction during the review period D=Total number of customers who are surveyed during the review period	Number and percent of customers who are satisfied	Customer interviews by KDADS
Quarterly	N=Number of participants who received timely (10 clear calendar days) Notices of Action for adverse actions D=Number of participants who had adverse actions	Number and percent of participants who received timely Notices of Action for adverse actions	KDADS Record Reviews
Quarterly	N=Number of participants who received Notices of Action for Plan of Care updates D=Number of participants who had Plan of Care updates	Number and percent of participants who received Notices of Action for Plan of Care updates	KDADS Record Reviews
Quarterly	N=Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs D=Number and percent of waiver participants who had assessments	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	KDADS Record Reviews
Health and Welfare			
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver D=Number of unexpected deaths	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiverD=Number of unexpected deaths	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of waiver participants who have a disaster red flag designation with a related disaster backup plan D=Number of waiver participants with a red flag designation	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	KDADS Record Reviews
Quarterly / Annually	N=Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation D=Number of waiver participants interviewed by QMS staff or whose records are reviewed	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	1. KDADS Record Reviews 2. Customer interviews by KDADS
Quarterly / Annually	N=Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver D=Number of participants' reported critical incidents	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	Critical incident management system
Quarterly / Annually	N=Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver D=Number of reported critical incidents	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	AIR APS or CPS KDADS Record Reviews
Quarterly / Annually	N=Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver D=Number of restraint applications, seclusion or other restrictive interventions	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	KDADS Record Reviews
Quarterly / Annually	N=Number of unauthorized uses of restrictive interventions that were appropriately reported D=Number of unauthorized uses of restrictive interventions	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	KDADS Record Reviews
Quarterly / Annually	N=Number of HCBS participants who received physical exams in accordance with State policies. D=Number of HCBS participants whose service plans were reviewed	Number and percent of waiver participants who received physical exams in accordance with State policies	KDADS Record Reviews

Frequency of Measuring	Methodology	Benchmark	Data Source
Quarterly / Annually	N=Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns D=Total participants observed by Quality Review staff during the review period	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns	Customer interviews by KDADS
Financial Accountability			
Quarterly / Annually	N=Number of provider claims that are coded and paid in accordance with the state's approved reimbursement methodologyD=Total number of provider claims paid	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	DSS/DAI encounter data
Quarterly / Annually	N=Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract D=Total number of provider claims	Number and percent of **clean** claims that are paid by the managed care organization within the timeframes specified in the **contract**	DSS/DAI encounter data
Annually	N=Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS D=Total number of capitation (payment) rates	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	Rate-setting documentation
Annually	N=Number of providers utilizing EVV D=Total number of providers enrolled	Number and percent of Providers utilize Electronic Visit Verification	KDADS Program Evaluation

Frequency of Measuring	Methodology	Benchmark	Data Source
Annually	N=Number of claims by type received and denied or suspended in accordance with the reimbursement methodology specified in the approved waiver D=Number of claims by type submitted in accordance with the reimbursement methodology specified in the approved waiver	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.	KDADS Program Evaluation

Appendix 11. Performance Measures: Nursing Facility

Indicator LD= Liquidated Damage if not met	Frequency of measuring	Methodology	Benchmark	Data source
Administrative Accountability	Quarterly	Total number of enrolled providers vs. total number of enrolled providers that obtained/maintained appropriate licensure/certification in accordance with State law and other provider qualifications prior to service provision.	100% of sample providers have obtained appropriate licensure/certification	Encounter Data and State Licensure/ Certification/ Enrolled Data
Financial Accountability	Quarterly	Claims received and coded in accordance with the reimbursement methodology specified in the approved State plan vs. claims paid for in accordance with the reimbursement methodology specified in the approved State plan.	100% of claims paid are in accordance with the reimbursement methodology specified in the State plan.	Encounter Data
Financial Accountability	Quarterly	Number of nursing facility claims received that are not denied or suspended vs. number of nursing facility claims not denied or suspended but paid within 14 days.	90% of clean nursing facility claims (claims that do not trigger an edit for denial or suspension) are processed within 14 days.	Encounter Data
Financial Accountability (LD)	Quarterly	Number of nursing facility claims received that are not denied or suspended vs. number of nursing facility claims not denied or suspended but paid within 21 days.	99.5% of clean nursing facility claims (claims that do not trigger an edit for denial or suspension) are processed with 21 days.	Encounter Data
Financial Accountability	Quarterly	Number of nursing facility claims received that are for Medicaid approved resident days vs. number of nursing facility claims for Medicaid approved resident days that are paid within 60days.	100% of valid claims (Medicaid approved resident days) are processed within 60 days.	Encounter Data
Health and Welfare	Annually	Total sample number of nursing facility residents receiving services between October and April vs. number of sample residents with documented flu vaccinations or declination of vaccination.	100% of nursing facility residents are given access to annual flu shots.	Annual Resurveys
Health and Welfare (LD)	Quarterly	Total number of nursing facility discharges vs. total number of nursing facility discharges that also are readmitted to a hospital within 30 days.	Percent of hospital re-admissions within 30 days of nursing facility discharge.	KDADS

Choice	Quarterly	Total number of beneficiaries that transition from a nursing facility placement to a community placement.	Number of beneficiaries that transition from a nursing facility placement.	CONTRACTORs self report
Health and Welfare	Quarterly	Total number of HCBS beneficiaries vs. the total number of HCBS beneficiaries that transfer to a nursing facility.	Percentage of HCBS beneficiaries that transfer to a nursing facility.	CONTRACTORs self report
Health and Welfare (LD)	Annually	Total number of nursing facility days of care vs. total number of nursing facility eligible beneficiaries(excluding temporary stays.)	Average nursing facility utilization for eligible beneficiaries	KDADS Program Evaluation
Health and Welfare	Quarterly	Percent of long-term stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome	10% annual reduction in utilization rate from MCO experience baseline	KDADS Program Evaluation and MDS data

For measures that are joint KDADS and MCO data sources: MCOs are to generate a data file and transmit to KDADS who will match this data with their data.

Appendix 12. Pay for Performance Measure Specifications

The following figures delineate the basic methodology and specifications for the behavioral health, HCBS, and long term care P4P measures for years two (2) and three (3). Final technical details and performance/reporting requirements associated with these measures will be governed by the state-approved template and related instructions, including any adjustments over time.

#	Measure	Population	Data Source	Baseline	Performance Target
Physical Health (5)					
PH1	**Comprehensive Diabetes Care (CDC)**	All members (age 18-75) with diabetes who meet HEDIS criteria;	MCO using HEDIS specs	HEDIS 2014 for 2013	50th percentile HEDIS (or greater); or 5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	HbA1C testing				
	Eye Exam				
	Monitoring for Nephropathy				
	HbA1C Poor Control (>9)				
	HbA1C Control (<7)				5% over previous year for LDL-C screening metric if selected.
	Blood Pressure control (<140/90)				For the HbA1C poor control (>9) - 5% less than previous year; or, the HEDIS 50% percentile (or less)
	LDL-C Screening				
	HbA1C Adequate Control (<8)				
PH2	**Well Child Visits - 4 or more in First 7 Months of Life post-hospital discharge after birth**	Births in January-May, enrolled in MCO continuously from DOB +7 months	MCO using HEDIS (W15) modified to include only births in Jan-May for first 7 months	2013 births Jan-May	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
PH3	**Preterm Births**	Births annually	MCO	2013 births	5% less than previous year

		Births to mothers enrolled in MCO one or more days during pregnancy			
PH4	**Annual Monitoring for Patients on Persistent Medications (MPM)**	HEDIS specs (all members who meet criteria)	MCO HEDIS	2014 HEDIS for 2013 data	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%; or 50th percentile HEDIS (or greater)
PH5	**Follow-up After Hospitalization for Mental Illness (FUH)**	HEDIS specs (all members who meet criteria)	MCO HEDIS	2014 HEDIS for 2013 data	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%; or 50th percentile HEDIS (or greater)
Waiver & Behavioral Health (5)					
WBH1. Increased Competitive Employment					
WBH1-1	**AIMS - Gained Employment**	SPMI age 18 & up	CMHCs	2013	5% over previous year
WBH1-2	**Participation in WORK program**	PD, DD, TBI, wait list, or other members eligible for WORK program	LTSS report	2013	5% over previous year
WBH1-3	**Increase in number of I/DD members employed, as reflected in BASIS**	DD	CDDO	2013	
WBH2. National Outcomes Measures (NOMS)					
WBH2-1	**# and % SUD whose living arrangements improved**	SUD	KCPC	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH2-2	**# and % SUD whose criminal justice involvement improved**	SUD	KCPC	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-3	**# and % SUD whose drug and/or alcohol use decreased**	SUD	KCPC	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-4	**# and % SUD whose attendance of self-help meetings increased**	SUD	KCPC	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-5	**# and % SUD whose employment status increased**	SUD	KCPC	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-6	**# and % SPMI adults with increased access to services**	SPMI	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-7	**# and % SED youth who had increased access to services**	SED	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-8	**# and % SPMI who were homeless at initiation of CSS services and experienced improvement in their housing status**	SPMI	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH2-9	**# and % of KanCare youth receiving MH services with improvement in their CBCL Competence T-scores**	SED	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-10	**# and % SED youth who experienced improvement in their residential status**	SED	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH2-11	**# and % SED youth who maintained their residential status**	SED	CMHCs	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH3. Decreased Utilization of Inpatient Mental Health Services					
WBH3	**Number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services**	KanCare	IPS/CMHCs	2013	5% less than previous year
WBH4. Improved Life Expectancy (5)					
WBH4-1 Health Literacy					
WBH4-1	**In the last 6 months...**				
	a - How often did your providers give you all the information you wanted about your health?	PD, SMI; I/DD 2014	MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for 2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	b. How often did your providers encourage you to talk about all your health questions or concerns?				5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

	c - How often did your providers ask you to describe how you were going to follow instructions?				5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	d - How often were instructions about how to take your medicines easy to understand?				5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2 Prevention					
WBH4-2(1)	**Mammograms (BCS)**	PD, I/DD, SMI, women age 50-74	MCO	2014 HEDIS for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(2)	**Cervical Cancer Screening (CCS)**	PD, I/DD, SMI, women age 21-64	MCO	2014 HEDIS for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(3)	**Chlamydia Screening (CHL)**	PD, I/DD, SMI, women age 18-24	MCO	2014 HEDIS for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(4)	**Adults' Access to Preventative/Ambulatory Health Services (AAP)**	Age 20 & older; PD, I/DD, SMI	MCO	2014 HEDIS for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH4-2(5)	**Flu Shot**	Age 18-74; PD, SMI; I/DD to be added in 2014	MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for 2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(6)	**Pneumonia Shot**	Age 65 & older - PD, SMI; I/DD beginning in 2014	MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for 2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(7)	**Hepatitis A Vaccination**	Age 3 or older (as included in survey); PD, SMI; I/DD beginning in 2014	MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for 2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-2(8)	**Hepatitis B Vaccination**	Age 2 or older (as included in survey); PD, SMI; I/DD to be added in 2014	MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for 2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
MCOs required to report on 3 of the following metrics in WBH4-3 to WBH4-9					
WBH4-3 Smoking Cessation					
WBH4-3	**Smoking Cessation**		MCO	2013 survey for 2014; new baseline for I/DD and combined using 2014 data for	
	1. Do you now smoke cigarettes or use tobacco: every day, some days, not at all?	PD, SMI; I/DD to be added in 2014			Report results annually; rates for initial question not a P4P factor
	If yes, In the last 6 months:				

	2. How often were you advised to quit smoking or using tobacco by a doctor or other health provider?	PD, SMI; I/DD to be added in 2014		2015	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	3. How often was medication recommended or discussed by a provider to assist you in quitting smoking or using tobacco?	PD, SMI; I/DD to be added in 2014			5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	4. How often did your doctor discuss methods other than medicaiton to assist you with quitting smoking or using tobacco?	PD, SMI; I/DD to be added in 2014			5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-4 Obesity					
WBH4-4	**BMI (ABA or as reported in survey from medical record data)**	PD, I/DD, SMI	MCO - HEDIS (ABA), or as reported by survey from medical record data		5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	BMI 30 or above	PD, SMI; I/DD in 2014	MCO		5% less than previous year
WBH4-5 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment					
WBH4-5	**Initiation & Engagement in Treatment Alcohol or other Drug (IET)** **% PD, DD, SMI with a new episode of alcohol or other drug dependence based on a screening assessment by an AOD treatment provider who received initiation of AOD treatment and Engagement of AOD treatment**	PD, I/DD, SMI	MCO	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
		PD, I/DD, SMI	MCO	2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-6 Diabetes					

WBH4-6	**Comprehensive Diabetes Care (CDC)**	All members with diabetes who meet HEDIS criteria & are PD, I/DD, or SMI	MCO using HEDIS specs	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
	HbA1C testing				
	Eye Exam				
	Monitoring for Nephropathy				
	HbA1C Poor Control (>9)				
	HbA1C Control (<7)				5% over previous year for LDL-C screening metric if selected.
	Blood Pressure control (<140/90)				
	LDL-C Screening				
	HbA1C Adequate Control (<8)				For the HbA1C poor control (>9) - 5% less than previous year
WBH4-7 Cholesterol Management for Patients with Cardiovascular Conditions					
WBH4-7	**Cholesterol Management for Patients with Cardiovascular Conditions** % of PD, DD< SMI, age 18-75, discharged for Acute Myocardial Infarction (AMI), coronary artery bypass graft (CABG), or percutaneous coronary interventions (PCI) from Jan 1 - Nov 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and and year prior to the measurement year who had each of the following during the measurement year	PD, I/DD, SMI	MCO using HEDIS 2014 specifications for PD, I/DD, SMI	HEDIS 2014 for 2013; no HEDIS after 2014 (will need to use 5% improvement)	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
		PD, I/DD, SMI			5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-8 Beta-Blocker Treatment after Heart Attack					
WBH4-8	**Beta-Blocker Treatment after Heart Attack (PBH)**	PD, I/DD, SMI	MCO using HEDIS specifications	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-9 Controlling High Blood Pressure					

WB9H4-9	**Controlling High Blood Pressure (CBP)**	PD, SMI; add I/DD 2014	MCO	HEDIS (hybrid) or medical record data from survey 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH4-10 Mortality Rate					
WBH4-10	**Mortality Rate**	PD, I/DD, SMI	MCO/State	tbd	
WBH5. Increased Integration of Care					
Integration of Care - Preventive Care					
WBH5-1	**Increase in # of primary care visits - Adults' Access to Preventive/Ambulatory Health Services (AAP)**	HCBS	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-2	**Increase in # of primary care visits - Adolescent Well-Care Visits (AWC) - The percentage of enrolled adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.**	HCBS	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-3	**Adult BMI Assessment (ABA) - The percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.**	HCBS	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH5-4	**Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) The percentage of members 3-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:** **BMI percentile documentation** **Counseling for nutrition** **Counseling for physical activity**	HCBS	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
Integration of Care - Behavioral Health Care					
WBH5-5	**Increase in the number of HCBS members with a primary or secondary SMI diagnosis receiving at least 1 behavioral service**	HCBS/SMI - Members with at least one of the following diagnoses: Schizophrenia; Bipolar and major depression; Delusional disorders; Personality Disorders; Psychosis not otherwise specified; Obsessive-Compulsive Disorder; Post-traumatic stress disorder	MCO	Calendar 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-6	**3 or more anti-psychotic prescriptions for longer than 90 days in HCBS with primary or secondary SMI diagnosis**	HCBS/SMI	MCO	Calendar 2013	Monitor only
WBH5-7	**Follow-up after Hospitalization for Mental Illness (within 7 days of discharge) (FUH)**	HCBS	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH5-8	**Decrease in % of members utilizing inpatient psychiatric Services**	HCBS	IPS/CMHCs	HEDIS 2014 for 2013	5% less than previous year
Integration of Care - Care Management Engagement					
WBH5-9	**Face to Face Visit - HCBS TBI - 1 per year**	HCBS - TBI	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-10	**Face to Face Visit - HCBS FE - 1 per year**	HCBS - FE	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-11	**Face to Face Visit - HCBS PD- 1 per year**	HCBS - PD	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-12	**Face to Face Visit MFP - PD/TBI/FE - 1 per year; I/DD - 2 per year**	HCBS - MFP (PD, TBI, FE, I/DD)	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-14	**Face to Face Visit - HCBS TA -2 per year**	HCBS - TA	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-15	**Face to Face Visit - HCBS I/DD - 2 per year**	HCBS - I/DD	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

WBH5-13	**Face to Face Visit - NF -1 per year**	HCBS - NF	LTSS report	Year-end 2013 LTSS report	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
Integration of Care - Health Outcomes					
WBH5-16	**Decrease in # of emergency room visits (AMB)**	HCBS	MCO	HEDIS 2014 for 2013	5% less than previous year
WBH5-17	**Increase in the use of annual dental visits (ADV)**	HCBS, age 2 and older	MCO	HEDIS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
Integration of Care - Integration Experienced by Members					
WBH5-18	**CAHPS Q#21. In the last 6 months, did you get care from a doctor or other health provider besides your doctor? Yes/No** **If yes** **CAHPS Q#22. In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers? Never, sometimes, usually, always**	KanCare	MCO	CAHPS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-19	**CAHPS Q#28. In the last 6 months, did your child get care from more than one kind of health care provider or use more than one kind of health care service? Yes/No** **If yes**	KanCare	MCO	CAHPS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%

	CAHPS Q#29. (If yes to #28) In the last 6 months, did anyone form your child's health plan, doctor's office, or clinic help you coordinate your child's care among these different providers or services? Yes/No				
WBH5-20	**CAHPS Q#17. In the last 6 months, how often did your personal doctor explain things in a way that was easy to understand? Response: Never, sometimes, usually, always**	KanCare	MCO	CAHPS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
WBH5-21	**CAHPS Q#32. In the last 6 months, how often did your child's personal doctor explain things about your child's health in a way that was easy to understand? Response: Never, sometimes, usually, always**	KanCare	MCO	CAHPS 2014 for 2013	5% over previous year if less than or equal to 95%; if >95%, maintain; if 91-94%, then achieve >=95%
Long Term Care (5)					
LTC1	**% of Medicaid NF claims denied by MCOs**	NF	MCO	2012	For 2014, 5% less than 2012. Future rates to be determined by the State
LTC2	**% of Medicaid NF residents who had a fall with major injury**	NF	State – KDADS	2012	5% improvement or maintain high performance as designated in reporting template details.
LTC3	**% of members discharged from a NF who had a hospital admission within 30 days**	NF	MCO/State – KDADS	2013	5% improvement or maintain high performance as designated in reporting template details.
LTC4	**Rate of NF days per eligible member**	NF	MC0/State – KDADS	2012	5% improvement or maintain high performance as designated in reporting template details.

LTC5	**Increase in number of Person-Centered Care Home (as recognized by PEAK) in Network (combined MCOs)**	NF	State – KDADS	2013 count	increase in # of PEAK homes annually