



KANCARE 2.0

QUALITY MANAGEMENT STRATEGY

JULY 2, 2018



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Introduction and Overview

INTRODUCTION AND OVERVIEW

The State of Kansas (State) maintains, when developed and implemented deliberately, the Quality Management Strategy (QMS) can advance the state's focus on performance improvement (PI) activities by: building a culture that is focused on outcomes, efficiently deploying resources, setting realistic and attainable goals, and providing a pathway of progressive discipline to hold managed care contractors responsible. Because the KanCare program offers a comprehensive benefit package which includes physical (PH) and behavioral health (BH) services, as well as long-term services and supports (LTSS), we have found each component plays a critical part in the development of the State's QMS.

The Kansas Department of Health & Environment (KDHE), in partnership with the Kansas Department for Aging and Disability Services (KDADS), is revising its QMS in accordance with the Code of Federal Regulations (CFR) at 42 CFR 438.340. KDHE and KDADS maintain the authority and responsibility for the updating and annual evaluation of the QMS and that it is updated as needed based on performance, feedback from stakeholders, and/or changes in policy resulting from legislative, State, or Federal authorities.

In order to demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) quality strategy requirements set forth in 42 CFR 438.340, Kansas prepared an analysis that identifies each required element of the State's QMS and where it has been addressed in the State's QMS (Appendix A). The State will use this analysis as one of our many tools in our toolkit to evaluate the effectiveness of the QMS on improving the performance of our managed care partners and improving the quality of care our KanCare members receive.

INTENTION OF THE QMS

The QMS is designed to provide an overarching framework for the State to allocate resources in an efficient manner with the objective of driving meaningful quality improvement (QI). Underneath the QMS lies the State's monitoring and oversight activities, across KDHE and KDADS, that act as an early alert system to more rapidly address MCO compliance issues and reported variances from expected results. Those monitoring and oversight activities represent the State's ongoing actions to ensure compliance with Federal and State contract standards.

The framework of the QMS has been redesigned to look at the KanCare program and the population it serves in a holistic fashion to address all physical, behavioral, functional and social determinants of health and independence needs of the enrolled population. The QMS serves as the launch pad from which the State will continue to build and implement continuous QI principals in key areas of the KanCare program. The State will continue to scale the requirements of the QMS to address and support ongoing system transformation.

HISTORY OF THE KANCARE PROGRAM

KanCare is an integrated managed care Medicaid program that serves the State of Kansas through a coordinated approach. In 2011, Governor Sam Brownback identified the need to fundamentally reform the Kansas Medicaid program to control costs and improve outcomes. Managed care enables provision of efficient and effective health care services and facilitates coordination of care and integration between and among PH and BH services and home- and community-based services (HCBS).

On December 27, 2012, CMS approved the State of Kansas Medicaid Section 1115 demonstration proposal entitled “KanCare” and implemented it on January 1, 2013. An extension is being requested to renew KanCare through December 31, 2022. KanCare is operating concurrently with the State’s Section 1915(c) HCBS waivers and together provide the authority necessary for the State to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible). The KanCare managed care delivery system provides state plan and HCBS waiver services to Medicaid recipients statewide.

KanCare expands upon the previous Kansas managed care program, which consisted of a managed care program referred to as HealthWave and HealthConnect Kansas’ primary care case management (PCCM) program, and provided services to children, pregnant women, and parents in the State’s Medicaid and Children’s Health Insurance Program (CHIP) programs. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured. Additional incentives are offered to hospitals for programs resulting in delivery system reforms that enhance access to health care and improve the quality of care.

A requirement for approval of the 1115 waiver was development of a State QMS to define waiver goals and corresponding statewide strategies, as well as all standards and technical specifications for contract performance measurement, analysis, and reporting. CMS finalized new expectations for managed care service delivery in the 2017 Medicaid and CHIP Managed Care Final Rule. The intent of this QMS revision is to comply with the Final Rule, to establish regular review and revision of the State quality oversight process, and maintain key State values of quality care to Medicaid recipients through continuous program improvement. Review and revision will feature processes for stakeholder input, tribal input, public notification, and publication to the Kansas register.

The current QMS defines technical specifications for data collection, maintenance, and reporting to demonstrate recipients are receiving medically necessary services and providers are paid timely for service delivery. The original strategy includes most pre-existing program measures for specific services and financial incentives called pay for performance (P4P) measures to withhold a percentage of the capitation payment the managed care organizations (MCOs) can earn by satisfying certain quality benchmarks. Many of the program-specific, pre-existing measures were developed for the 1915(c) disability waivers designed and managed by the operating agency, KDADS, and administered by the single State Medicaid agency, KDHE.

Regular and consistent cross-agency review of the QMS will highlight progress toward State goals and measures and related contractor progress. The outcome findings will demonstrate areas of compliance and non-compliance with Federal standards and State contract requirements. This systematic review will advance trending year over year for the State to engage contractors in continuous monitoring and improvement activities that ultimately impact the quality of services and reinforce positive change.

PROGRAM ELIGIBILITY

The Kansas Medicaid population is divided into three distinct populations: (1) parents, pregnant women, and children; (2) various disability groups (e.g., children with technology assistance [TA]; individuals with traumatic brain injuries [TBI]; individuals with intellectual/developmental [IDD] or physical disabilities [PD], or both, and persons with severe and persistent mental illness [SPMI]); and (3) the aged (65 and older). All populations are currently covered by the State Medicaid Plan, KanCare, and will continue to be covered by the successful bidders related to this request for proposal (RFP). The total KanCare covered population is approximately 403,000. Roughly 323,000 are parents, pregnant women, and children. Another 44,000 individuals are individuals with disabilities and approximately 67,000 are aged.

Almost all Medicaid Beneficiaries and 100% of CHIP Beneficiaries will enroll in an MCO of their choosing. Native Americans may be voluntarily enrolled and may not be enrolled on a mandatory basis without a Waiver from CMS. Kansas' managed care program will operate under the Waiver authority specified in Sections 1115 and 1915(c) of the Social Security Act (SSA).

MANAGED CARE GOALS AND OBJECTIVES

The original goals of the KanCare demonstration focused on providing integrated and whole-person care, creating health homes, preserving or creating a path to independence, and establishing alternative access models with an emphasis on HCBS. Building on the success of the current KanCare demonstration, the goal for KanCare 2.0 is to help Kansans achieve healthier, more independent lives by coordinating services and supports for social determinants of health and independence in addition to traditional Medicaid benefits. The State seeks a five-year Section 1115 demonstration renewal from CMS to further improve health outcomes, coordinate care and social services, address social determinants of health, facilitate achievement of member independence, and advance fiscal responsibility. Specific to BH and LTSS services, the goal of KanCare 2.0 will be to ensure the right services are provided to participants at the right time and right place. The fundamental goal of both KanCare 2.0 and the State's QMS is to ensure that each individual receives the right services, in the right place, and at the right time. The goals for KanCare 2.0 serve as the foundation to the revised QMS and our commitment for ensuring Kansans receive the quality health care they rightly deserve.

The goals of the KanCare program include:

- **Provide integration and coordination of care** across the whole spectrum of health to include PH, BH (mental health and 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.

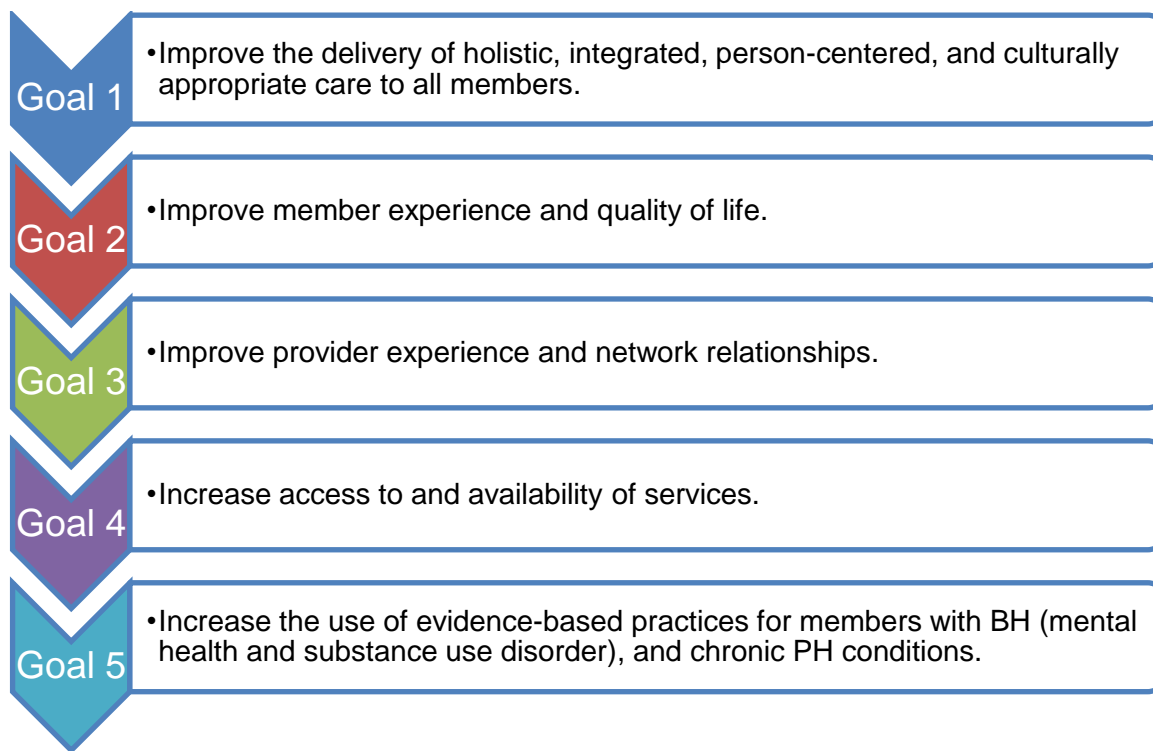
The QMS also supports the missions of KDHE, KDADS, and the Kansas Department of Children and Families (DCF) as one of our State partners, to provide quality care to the KanCare population:

- *“To protect and improve the health and environment of all Kansans.”* – KDHE
- *“To improve the quality of life and to empower Kansas older adults, persons with behavioral health challenges, and persons with disabilities to make informed choices and live as independently as possible.”* – KDADS
- *“To protect children, promote healthy families, and encourage personal responsibility.”* – DCF

The goals of the KanCare program, along with the missions of KDHE, KDADS, and DCF, serve as the foundation and unifying vision for the KanCare QMS. The KanCare QMS builds upon these goals and missions to further strengthen the program and serve as a beacon for change and improvements to the program.

The KanCare QMS acts as a roadmap outlining the PM and PI strategies to maximize health outcomes and the quality of life for all members to achieve the highest level of dignity, independence, and choice through the delivery of holistic person-centered and coordinated care and promote employment and independent living supports.

The goals of the KanCare QMS are to:



DEVELOPMENT & REVIEW OF QMS

The State has a multi-faceted approach in the development and review of the KanCare QMS by working collaboratively with various state agencies that have a stake in improving the quality of care for Kansans beyond KDHE and KDADS, including DCF, Department of Corrections Juvenile, the LTC Ombudsman, the KanCare Ombudsman, and the State’s Health Benefits Manager, DXC. In addition, the State reaches out to our partners in the delivery of health care, including the MCOs, provider community, members and their families/caretakers, and advocacy organizations for input on the QMS, as well as ongoing program improvements. The State engages in a collaborative stakeholder process for the 1115 demonstration waiver including a KanCare Advisory Committee and the future Quality Improvement Initiatives Task Force (QII-TF) that will be leveraged to obtain stakeholder input into the QMS.

Development of the KanCare QMS

The revised KanCare QMS grew out of the State’s desire to modernize its QMS to mirror the changes and evolution of the KanCare program since it first started in January 2013. In November 2017, an RFP for the KanCare 2.0 program was issued with the goal to improve integration and coordination of care, improve the quality of care, control Medicaid costs, and establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries. With these goals serving as the foundation to KanCare 2.0, KDHE and KDADS utilized these goals and built upon them to develop the revised KanCare QMS goals as indicated above. The State will seek input on the development of PM used to measure health plan

performance from our key partner, the MCOs, as well as, integrate national best practices for performance measurement in the implementation of the QMS.

Review, Dissemination, and Evaluation of the KanCare QMS

KDHE and KDADS continue to evaluate the effectiveness of the QMS as part of their ongoing monitoring efforts and oversight of the MCOs. CMS requires the QMS be reviewed and updated no less than once every three years per 42 CFR 438.340(c)(2). The State will achieve this ongoing review and evaluation through several mechanisms including its External Quality Review Organization (EQRO) and its Quality Management Integrated Model. The State will also submit a revised QMS at any point there is a significant change as a result of our ongoing review and evaluation¹. A significant change will encompass major program changes (i.e., new services, new populations) or a change in any of the program goals. The public input process described in further detail below will be utilized for any resubmission of the QMS to CMS.

The State, along with its EQRO, evaluates the effectiveness of the QMS as part of the annual external quality review (EQR) evaluation and state compliance audits. The strengths, opportunities, and progress towards goals are documented in the Annual EQRO Technical report as required by CMS. The technical report will provide details of each MCO's compliance with federal regulations governing the quality, access and timeliness of care, results of performance improvement projects (PIPs) and PMs, as well as compliance with State contract standards. The results of these activities, along with input from the MCOs, KanCare recipients, families, the provider community and other stakeholders, will be used to identify any necessary changes or updates to the QMS.

In addition to input from MCOs and the evaluation by the EQRO, the State will continue to seek participant and family/guardian, stakeholder, and public input into the review and evaluation of the QMS on an ongoing basis. This is achieved through the KanCare Medical Care Advisory Committee (MCAC), the KanCare LTSS Advisory Committee, as well as member and provider satisfaction surveys, member grievances and appeals, and public forums for the KanCare program. The QMS is also posted for a 30-day period to receive public input that will then be incorporated into the QMS and evaluated by the QII-TF, which is explained further below.

Quality Management Integrated Model

To support the revised QMS goals and support the dynamic process of continuous QI, including the review and evaluation of the KanCare QMS, the State has established the Quality Management Integrated Model. The Quality Management Integrated Model identifies the key participants in the ongoing review and evaluation of the KanCare QMS. The core of the integrated model consists of the KanCare quality committees whose objectives are to: (1) solicit external (member and provider) feedback about the KanCare program; (2) address QI activities; (3) demonstrate the structure of how KDHE and KDADS come together to address QI; and (4) drive QI activities.

¹ Required per 42 CFR 438.340(c)(3)

Obtaining and responding to stakeholder input is a key feature of the Quality Management Integrated Model. The State provides multiple forums through which stakeholder engagement and input is achieved. These forums include KDHE and KDADS stakeholder meetings as well as the KanCare Advisory Council. In addition to these forums, and as a component of the Quality Management Integrated Model, the State will utilize its KanCare MCAC and its LTSS Advisory Committee as a key source of stakeholder input into the KanCare QMS on an ongoing basis. The MCAC will meet quarterly to discuss a myriad of issues related to KanCare, with one being the implementation of the QMS. The MCAC, facilitated by KDHE and KDADS, will be an opportunity for KanCare stakeholders to provide feedback and input on the QMS and submit recommendations that will be reviewed and considered by the KanCare Steering Committee. The LTSS Advisory Committee, facilitated by KDADS with participation from KDHE, will also be an opportunity for the KanCare LTSS stakeholders to provide specific feedback and input with a special LTSS focus on the QMS. The LTSS Advisory Committee will also submit recommendations for consideration by the KanCare Steering Committee. The MCAC and LTSS Advisory Committee will be new forums under the KanCare 2.0 program with a kickoff in early 2019. In addition, the State will seek input from our Tribal Organizations as outlined in our Tribal Consultation Policy in the review and evaluation of the KanCare QMS.

The KanCare Leadership Team, as the entity ultimately responsible for the overall KanCare program including quality, includes the Secretaries of KDHE and KDADS, the State Medicaid Director, the KDADS Commissioners for Operations, Community Services and Programs, Aging, and Behavioral Health, and other key management staff who provide overall leadership to the KanCare program. The Leadership Team's role is to support the KanCare QMS and the Quality Management Integrated Model structure. Summarized stakeholder input, recommendations from the State's monitoring and oversight activities, as well as results and recommendations of the State's continuous QI efforts will be presented.

The KanCare Steering Committee is led by program managers from both KDHE and KDADS who have the operational responsibility for the KanCare day-to-day monitoring and oversight program including reporting out specific agency reviews and audit findings. The Steering Committee reports to the Leadership Committee with the intent of keeping them apprised of the progress towards achieving the goals of the KanCare QMS, as well as results of oversight activities from the other KanCare program areas. The Steering Committee works closely with the KanCare Quality Improvement Committee (QIC), a new entity within the State, to ensure the goals and objectives of the KanCare program and the State's QMS are being met. The QIC is an internal state workgroup, comprised of representation from both KDHE and KDADS, collaboratively working to assess the State's progress towards achievement of the QMS goals and objectives and, by extension, the broader goals of the KanCare program. When necessary and appropriate, the QIC may recommend or implement appropriate actions consistent with the objectives of continuous QI principles. The QIC also collaboratively reviews overall quality related to KanCare policies to ensure alignment with the QMS.

Kansas is proposing, with its revised QMS, to establish a QII-TF. The QII-TF will be an integral step toward supporting the integration, development, and implementation of the KanCare QMS. Leadership for the QII-TF will be provided by KDHE and KDADS with membership from key partners including DCF, Managed Care and Long-Term Care (LTC), Managed Care Ombudsman, DXC, and the KanCare contracted MCOs. Each organization or governmental entity represented on the QII-TF has their own quality framework that is accountable for conducting quality management and PI activities. QII-TF representatives link these QI activities to a unifying point. The QII-TF is the central forum for communication and collaboration and provides the opportunity to develop systematic and integrated approaches to achieve QI goals. Results of these activities will be documented in QII-TF meeting minutes and communicated to the larger stakeholder forums including the MCAC and the KanCare LTSS Advisory Committee. The MCAC and KanCare LTSS Advisory Committee review QMS activities and provide feedback and support for quality-related issues. These ongoing communications create a continuous feedback loop that impacts quality of care improvements for KanCare members. The task force will come together on a quarterly basis to identify issues and make recommendations to improve QI activities that impact the achievement of the KanCare 2.0 program goals in general and the KanCare QMS specifically.

The following table illustrates the KanCare Quality Management Integrated Model that supports the goals, objectives, and implementation activities of the KanCare QMS.

QUALITY MANAGEMENT INTEGRATED MODEL		
Entities	Membership	Roles and Responsibilities
KanCare MCAC	<ul style="list-style-type: none"> • KDHE • KDADS • Stakeholders 	<ul style="list-style-type: none"> • Forum for input from key stakeholders to review QMS, review quality outcomes, and receive input into the quality efforts
KanCare LTSS Advisory Committee	<ul style="list-style-type: none"> • KDHE • KDADS • LTSS Stakeholders 	<ul style="list-style-type: none"> • Multiple forums for input from key LTSS stakeholders to receive feedback on the design, implementation, and oversight of LTSS efforts (including quality)
KanCare Senior Leadership	<ul style="list-style-type: none"> • KDHE • KDADS 	<ul style="list-style-type: none"> • Overall leadership of the KanCare program including supporting the KanCare QMS and Quality Management Integrated Model
KanCare Steering Committee	<ul style="list-style-type: none"> • KDHE • KDADS 	<ul style="list-style-type: none"> • Day to day operational issues • Plan/arrange joint MCO meetings • Report out of specific agency reviews/audit findings • Corrective action planning

QUALITY MANAGEMENT INTEGRATED MODEL

Entities	Membership	Roles and Responsibilities
KanCare QIC	<ul style="list-style-type: none"> • KDHE • KDADS 	<ul style="list-style-type: none"> • Collaborative review of goals and objectives of QMS to determine if being met or not met and adjust as needed • Collaborative review of overall quality related policies to ensure alignment with QMS • Review reports and findings from ongoing monitoring and oversight activities
QII-TF	<ul style="list-style-type: none"> • KDHE • KDADS • DCF • LTC Ombudsman • Managed Care Ombudsman • DXC (HBM) • MCOs • EQRO 	<ul style="list-style-type: none"> • Supports the development, implementation, and integration of the KanCare QMS • Identification and implementation of QI strategies • Provides support and feedback to waiver programs • Provides feedback on quality measurements and best practices • Reports to QIC

The 2018 KanCare QMS was posted on May 22, 2018 on the KanCare website² and shared with the State's Tribal Organizations for a 30-day public comment period ending June 22, 2018. The State received comments on the draft QMS — from several interested stakeholders — that focused on the importance stakeholder engagement in the QMS development and implementation process; primarily ensuring “stakeholders” are clearly defined, developing a stronger communication strategy and clarifying the role of the QMS versus the role of monitoring and oversight of the KanCare program. Comments also requested more detail in the QMS, such as explicit performance metrics.

The State appreciates the feedback received and will work with the stakeholder community to support the development of the QMS. The State will develop a communication strategy and plan for the QMS. The State continues to work on the implementation of the QMS and additional details of that process will be shared later this year. In addition, the State added language to explain the QMS's role in continuous QI for the managed care program and complementary oversight and monitoring activities conducted by the State. Final performance metrics will be appended to the QMS.

KDHE and KDADS remain committed to holding additional forums with stakeholders to discuss the revised QMS. A similar process will be followed for any substantial revisions to the QMS moving forward.

In addition to the ongoing review and evaluation of the QMS, the State will evaluate the effectiveness of the previous QMS when an official resubmission of the QMS takes place³. This is required no less than once every three years. The evaluation of the effectiveness of the previous QMS will be posted on the KanCare website after the evaluation is complete and submitted to CMS, in early July 2018.

² KanCare Website: <http://www.kancare.ks.gov/>

³ Required per 42 CFR 438.340(c)(1)

Establishing Standards, Guidelines, and Definitions

SPECIAL HEALTH CARE NEEDS AND LTSS

KanCare utilizes its Service Coordination requirements to assist individuals who need LTSS or who have special health care needs. This includes populations who meet the following definition:

- Individuals enrolled on a 1915(c) Waiver or on a Waiver waiting list.
- Youth (birth up through age 21) with intensive BH needs.
- Youth who are in an out-of-home placement through the foster care system.
- Individuals who are institutionalized in a nursing facility, intermediate care facilities for individuals with developmental disabilities or hospital, psychiatric residential treatment facility, psychiatric hospital, or other institution.
- Adults with BH needs.
- Individuals with chronic and/or complex physical and/or mental health conditions.
- Individuals participating in the Work Opportunities Reward Kansans (WORK) program or Other Employment Programs.
- Other individuals who may benefit from Service Coordination including those who are identified as having a need relating to Social Determinants of Health and Independence, such as housing instability, food insecurity, and unemployment/under employment.

Since KanCare's inception, a continuous QI process has been in place and has been refined over time. Through this evolution KanCare has developed a more modernized framework for Service Coordination that encourages the use of innovative techniques for member outreach and engagement, requires a mix of telephonic and face-to-face assessments (depending on risk stratification and HCBS waiver requirements), and ensures an ongoing process to facilitate engagement of hard to reach members. The contracted MCOs are required to utilize state-specified screening and/or assessment tools and can supplement those tools with other evidence-based screening and assessment activities. Health Screenings, Health Risk Assessments (HRAs), and Needs Assessments must address the physical, behavioral, and functional needs of the member, as well as assist in identifying barriers to improved care outcomes including those related to Social Determinants of Health and Independence.

Assessment of compliance with these requirements occurs in a variety of ways including the following examples:

- All MCOs are required to achieve National Committee for Quality Assurance (NCQA) accredited with LTSS Distinction within 24 months of starting operations. MCOs are required, by contract, to provide KDHE with the entire accreditation survey and associated results. They are also required to submit to KDHE their annual NCQA Accreditation update.
- All contracted MCOs are required to submit a full set of Healthcare Effectiveness Data and Information Set (HEDIS) and Medicaid Child Core Measure sets, as well as experience of care results (i.e.; Consumer Assessment of Healthcare Providers and Systems [CAHPS] [adult, child, and HCBS], National Outcomes Measures [NOMS], and National Core Indicator [NCI]/NCI- Aging and Disabilities [AD] data to KDHE annually. This information is also provided to the State's EQRO, for review and trending. The EQRO then prepares an annual report of findings for KDHE.
- The MCOs are contractually required to submit a variety of reports to various divisions within KDHE and KDADS. The reports include PIPs, HRAs, Early and Periodic Screening & Diagnosis Treatment (EPSDT), Community Transitions, Children and Youth with Special Health Care Needs, Service Plan Revisions, QI/utilization management (UM) descriptions, evaluations and work plans, provider satisfaction surveys, etc. These reports are reviewed throughout the year and an annual analysis is completed.
- Managed care quality oversight and LTSS staff conduct MCO audits related to compliance with the Federal Special Terms and Conditions for the KanCare program, including its seven home- and community-based 1915(c) waivers.
- Collaborative workgroups including KDHE and KDADS staff, its EQRO and all contracted MCOs are held periodically. These workgroups address issues related to QI, EPSDT outreach, Emergency Department (ED) diversion, integration of physical, behavioral, and functional needs and Social Determinants of Health and Independence, and other topics related to QI efforts.

SOCIAL DETERMINANTS OF HEALTH AND HEALTH DISPARITIES

The KanCare QMS is designed to help Kansans achieve healthier, more independent lives by ensuring the provision of services and supports to help address Social Determinants of Health and Independence. Given that health disparities are rooted in the social, economic, and environmental circumstances in which people live, achieving health equity will require addressing these social and environmental determinants. This starts with being able to collect data about the population in order to focus on those populations experiencing the greatest disparities.

KDHE has taken steps to identify the age, race, ethnicity, sex, primary language, and disability statuses for each member at the time of enrollment. The Division of Health Care Finance (DHCF) within the KDHE formulates eligibility policy and manages the Eligibility Clearinghouse, where all KanCare eligibility determinations are made. The application includes questions about age, race, ethnicity, sex, primary language, and disability status and instructs the applicant that responses to

the race and ethnicity questions are voluntary. Member eligibility files capture this information and transmit it to contracted MCOs on a daily and monthly basis via the 834 Eligibility and Enrollment file. MCOs are required to process this information and share it, as appropriate, with any delegated and/or subcontracted vendors.

The MCOs are contractually required to evaluate and be responsive to members' health literacy needs, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, regardless of gender, sexual orientation, or gender identity. Within 90 days of starting operations, and annually thereafter, each MCO must submit a Cultural Competency Plan that, at a minimum, describes how the MCO will ensure care is delivered in a culturally competent manner, addresses how this will be achieved in rural areas of the State via telehealth strategies, the role of Social Determinants of Health and Independence in improving and sustaining positive health outcomes, strategies to assess and respond to the health literacy needs of members, goals of the program, and training and education of MCO staff, its provider network and members. The plan must also include a description of how the MCO will evaluate and conduct regular assessments of the provider network to ensure services are provided in a culturally competent manner to diverse populations, including taking action and improving the Cultural Competency Plan to address any variances.

Contracted MCOs and their network providers and subcontractors that provide services to KanCare members participate in Kansas' efforts to deliver care in a culturally competent manner to all members. Additional information requirements specific to the Provider Directory include the capture of each provider's linguistic capabilities, as well as whether the provider has completed cultural competence training, and whether the provider's offices, exam rooms, and equipment accommodate individuals with physical disabilities, in accordance with the Americans with Disabilities Act.

NATIONAL PERFORMANCE MEASURES

The State has identified clinical quality, access, and UM for the KanCare program using a mix of quantitative and qualitative measures. The State prefers to use nationally recognized measure sets whenever possible, including the NCQA's HEDIS and the Medicaid Adult and Child Core Measurement sets.

The State began using the CAHPS-HCBS Survey in 2018 to gather direct feedback from Medicaid beneficiaries receiving HCBS about their experiences and the quality of the LTSS they receive. In addition to the CAHPS-HCBS survey, the State also collects experience of care data through the NOMS, NCI, and NCI-AD and Mental Health survey. As performance measurement in home- and community-based programs continues to evolve, the State may revise HCBS-specific PMs in an effort to address improvements in the quality, access, and timeliness of services, support member engagement and achievement of goals, and drive continued re-balancing efforts.

The State recognizes that effective QI must be methodical, ongoing, and measureable. As the process for continuous QI has matured, both KDHE and KDADS have worked together to develop a

QI framework that addresses the specific needs of the population served and takes into consideration the availability and reliability of the data used to calculate the measures. When selecting the different objectives under each goal, the State engaged S.M.A.R.T. goal setting methodology that ensures each objective is Specific, Measurable, Attainable, Realistic and Timely.

The subset of measures listed under each of the goals below are prioritized for continuous QI and selected based on identified areas of opportunity and designed to achieve favorable outcomes in health status and experience of care. Annually, the State will publish a report evaluating progress towards the following goals and the comparative achievement of each objective by MCO. Additionally, the State will post, at a minimum, CAHPS (Adult, Child, and HCBS) data and all CMS required Medicaid Adult and Child Core Measurement set for each MCO to the KanCare website. We will also work to harmonize these measures with those identified in the 1115 demonstration waiver as they become finalized during the waiver renewal process. The State believes improvements in member health, well-being, and satisfaction will help to drive improved costs and long-term sustainability of the KanCare program.

Goal 1: Improve the delivery of holistic, integrated, person-centered, and culturally appropriate care to all members.

Objective 1.1: Ensure each MCO develops, submits for review, and annually revises its cultural competency plan.

Objective 1.2: Ensure each MCO submits an annual evaluation of their cultural competency plan to KDHE. The MCOs must receive a 100 Met compliance score for all seven elements of the cultural competency plan outlined in the contract.

Objective 1.3: Stratify data for PMs and utilization by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to holistic and integrated services.

Objective 1.4: Increase the rate of providers who have completed an approved course in delivery of cultural competency training.

Objective 1.5: Increase selected CAHPS-HCBS composite scores.*

Objective 1.6 Increase selected NCI composite measures.

Objective 1.7 Increase selected NCI-AD composite measures.

Objective 1.8 Increase selected NOMS composite measures.

Goal 2: Improve member experience and quality of life.

Objective 2.1: Increase the response rate for all member-focused surveys to demonstrate statistical significance, and promote generalizability to the broader population.

Objective 2.2: Increase composite measure scores for the CAHPS Adult and Child surveys.*

Objective 2.3: Increase quality of life survey results collected from the CAHPS-HCBS, NOMS, NCI, and NCI-AD surveys.

Objective 2.4: Increase mental health survey results.

Objective 2.5: Trend critical Incident reporting per 1,000 members stratified by HCBS and Institutional.

Objective 2.6: Trend grievances per 1,000 members.

Goal 3: Improve provider experience and network relationships.

Objective 3.1: Increase results of provider satisfaction survey.

Objective 3.2: Ensure each MCO submits an annual evaluation of their Provider Satisfaction Survey result to KDHE. Each evaluation must provide a work plan that includes a timeline, barrier analysis, and intervention(s) to address results.

Objective 3.3: Decrease volume of unpaid claims greater than 90 days.

Objective 3.4: Ensure each MCO develops, submits for review, and annually revises its Provider Network Development Plan, including how capacity issues in HCBS, Autism, and TA services have been addressed.

Objective 3.5: Ensure each MCO submits its annual provider training.

Objective 3.6: Ensure the Annual Provider Training plan and annual provider forum agenda is submitted to KDHE for review and approval. The MCOs must receive a 100 Met compliance score for all seven elements of the provider services requirements.

Objective 3.7: Ensure KDADS state policy and other program training requirements are met.

Goal 4: Increase access to and availability of services.

Objective 4.1: Improve adult access to primary and preventive care services.*

Objective 4.2: Improve children and adolescents' access to primary care practitioners.*

Objective 4.3: Improve Identification of alcohol and other drug services.*

Objective 4.4: Improve mental health utilization.*

Objective 4.3: Ensure tracking of appeal (pre- and post-service) rate per 1,000 and tracking and trending of final disposition of appeal adjudication (i.e., overturned, upheld, overturned in-part, State Fair Hearing).

Objective 4.4: Ensure each MCO develops, submits for review, and annually revises its Provider Network Development Plan, including strategies to proliferate telehealth usage.

Goal 5: Increase the use of evidence-based practices for members with BH (mental health and substance use disorder), and chronic physical health conditions.

Objective 5.1: Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.*

Objective 5.2: Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase.*

Objective 5.3: Reduce use of multiple concurrent antipsychotics in children and adolescents.*

Objective 5.4: Increase follow-up after hospitalization for mental illness—7 days.*

Objective 5.5: Increase follow-up after hospitalization for mental illness—30 days.*

Objective 5.6: Increase rate of HbA1c testing for members with diabetes.*

Objective 5.7: Decrease rate of HbA1c poor control (>9.0%) for members with diabetes.*

Objective 5.8: Increase rate of HbA1c good control (<8.0%) for members with diabetes.*

Objective 5.9: Increase rate of eye exams performed for members with diabetes.*

Objective 5.10: Increase medical attention for nephropathy for members with diabetes.*

Objective 5.11: Increase blood pressure control (<140/90 mm Hg) for members with diabetes.*

Objective 5.12: Increase medication management for people with asthma—medication compliance 50%.*

Objective 5.13: Increase medication management for people with asthma—medication compliance 75%.*

The * next to an objective identifies a HEDIS measure. All MCOs are expected to achieve the National HEDIS 75th percentile (25th percentile for inverse measures) for all reported HEDIS data. To support the State’s continuous QI process, MCOs should take action to improve all HEDIS measures that have achieved the 75th percentile with the goal of obtaining the 90th percentile (10th percentile for inverse measures). HEDIS measures falling below the 75th percentile (25th percentile for inverse measures) and for all other non-HEDIS quantitative measures the State has devised the following PM improvement strategy aimed at reducing, by 10%, the gap between the PM baseline rate and 100%. For example, if the baseline rate was 55%, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5%. Each measure that shows improvement equal to or greater than the performance target is considered achieved.

STRATEGY FOR MEETING GOALS AND OBJECTIVES

The methods employed by the State to achieve these goals include:

- Developing and maintaining collaborative strategies between KDHE and KDADS and other state agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all KanCare members.
- Working collaboratively with community resources and other system stakeholders to improve access to and quality of care and health outcomes of the populations served by KanCare.
- Using additional PMs, PIPs, EQR activities, contract compliance monitoring, and emerging practice activities to drive improvement in member health care outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members’ health status and achievement of the highest level of dignity, independence, and self-efficacy.
- Enhancing overall satisfaction with the KanCare program through activities aimed at improving both the member and provider experience.
- Improving the use of innovative strategies such as leveraging health information technology (HIT), telehealth (tele-medicine, tele-mentoring, and tele-monitoring) and value-based payment (VBP) mechanisms to drive systemic improvements.

MONITORING AND COMPLIANCE

Both KDHE and KDADS have defined quality units within each of their respective organizations responsible for the day-to-day oversight and monitoring activities. KDAD's 1915(c) waiver quality monitoring is defined within the parameters of the individual waiver. Provider qualifications and waiver assurance metrics have been harmonized, to the extent possible, across each waiver to allow for consistency in review and evaluation of the data. MCOs are required to submit reports through the State's Report Administration Database. The database has been developed to capture the report owner at the State, track report submission dates/times, and allows for transmission of State approval and/or rejection of the report. The report database can also aggregate and report on trended information pertaining to timeliness and acceptance at the individual report level and in aggregate, across all reports, at the MCO level.

KDADS has implemented the Adverse Incident Reporting (AIR) database to capture critical incidents. This web-based application is used by providers and individuals to report adverse/critical incidents involving individuals receiving services from agencies licensed or funded by KDADS. The AIR and review process is designed to facilitate ongoing QI to ensure the health and safety of individuals receiving services by agencies licensed or funded by KDADS. It is intended to provide information to improve policies, procedures, and practices. The AIR reporting form is made available to providers and individuals via a link on the KDADS website at www.kdads.ks.gov. On a quarterly basis the State, including KDHE and KDADS, and its EQRO, conduct meetings with the contracted MCOs. The intent of these meetings is to discuss PIPs on a collaborative level, focus on HEDIS and Adult/Child Core measure and activities and interventions to improve results, discuss P4P or other value-based incentive programs, and plan for upcoming reviews and surveys.

In an effort to diffuse quality throughout the KanCare program and build capacity for continuous QI throughout the system, the State has designed the new QII-TF. The QII-TF's purpose is to help implement and revise the KanCare QMS. Through reporting of results and trends and dissemination of information the QII-TF and its members can comparatively benchmark results and collaboratively identify proven strategies for success.

An overview of the activities and processes used to support oversight and monitoring of the KanCare program include:

- Evaluation of results of EQR and State contract compliance audits, including the strengths, opportunities, and recommendations for improvement.
- Annual and interim review of HEDIS results.
- Review of the accuracy, timeliness, and completeness of contractually-required reporting which includes but is not limited to:
 - Grievance and Appeal logs.

- Claims payment timeliness and encounter submission reports.
- UM timeliness of decision making and rates of service utilization reports.
- Evaluation of each MCOs Quality Assessment and Performance Improvement Program.
- Geo-spatial reports of Network Adequacy and timeliness of appointment.
- Trending reports for HCBS waiver assurance measures.
- Progress of PIPs.
- Results of provider incentive and/or VBP programs.
- Review of each MCOs value-based purchasing model and its impact on:
 - Expanding service coordination to include assisting members with accessing affordable housing, food security, employment, and other Social Determinants of Health and Independence will increase independence and stability, and improve health outcomes.
 - Increasing employment and independent living supports for members with BH needs, or who have intellectual, developmental, PDs, or TBIs will increase independence and improve health outcomes.
 - Providing service coordination for all youth in foster care will decrease the number of placements, reduce psychotropic medication use, and improve health outcomes for these youth.
- Results of each MCO’s performance under the State’s P4P program.

EQR

Kansas has a contracted with its EQRO, to provide EQR activities. EQR activities are considered a core feature in the State’s Medicaid managed care QI initiatives. The core services provided under this contract include:

- Validation of select PMs.
- Validation of select PIPs.
- Review and analysis of CAHPS surveys.
- Conduct surveys.
- Conduct targeted audits.

- A comprehensive review of the MCO's compliance with the Federal and State quality, access, and timeliness standards at least once every three years. This includes conducting the Information Systems Capabilities Assessment (ISCA), which evaluates the MCO's ability to pay claims, capture, and control data from various sources and encounter information to the State's Medicaid Management Information Systems system.
- Validation of network adequacy.

Kansas has relied on its EQRO to provide technical assistance to the State's contracted Medicaid MCOs, much of which has focused on PIPs and PM reporting. The EQRO is viewed as a critical partner in the State's monitoring and oversight activities and helps to drive collaboration and provide a national perspective on emerging and promising practices. The State includes at least two optional EQR services within its scope of work which may include, but is not limited to conducting focused studies of specific populations and/or services, PM calculation to support VBP or other PIPs, and validating encounter data accuracy and completeness.

The State currently requires each MCO attain a minimum NCQA "Accredited" status within 24 months of starting operations. During this time, the State relies on its EQRO and its annual contract compliance audit process to determine overall compliance with Federal and State requirements. While the State does not currently use the deeming option available under Federal rules, it does monitor MCO performance against certain standards to identify opportunities to potentially deem other survey results in an effort to minimize duplication of activities.

PIPS

The KanCare MCO contract requires each MCO to measure and report on performance to assess the quality and appropriateness of care and services. One mechanism used to evaluate aspects of care and service is the development and implementation of PIPs. MCOs are contractually required to perform at least three clinical and two non-clinical PIPs annually, with one of the non-clinical PIPs focused on LTSS. Additionally, when an MCO falls below the 85% mark on its EPSDT 416 report measures, the MCO is required to initiate an EPSDT Outreach and Engagement PIP. The focus of each PIP must be approved, in advance, by the State. Clinical PIPs should focus the quality and appropriateness of care (e.g., use of Screening, Brief Intervention, and Referral to Treatment (SBIRT) to improve BH referral for services) while non-clinical PIPs should address operational or service related issues (e.g., claims payment timeliness).

PIPs should be designed to achieve significant and sustained improvement in clinical and non-clinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and the member/provider experience. The State's PIP template is designed to require the use of objective quality indicators, support in-depth barrier analysis, and support ongoing evaluation of the effectiveness of interventions in driving systemic and sustainable improvements. The State's EQRO assesses the validity of selected PIPs annually.

It is an expectation of the State that MCOs develop and implement performance improvement activities (PIAs) around all PMs that fall below State-defined standards, including HEDIS and CAHPS measures that fall below the 75th percentile (25th percentile for inverse measures). PIAs are not required to use the State-mandated PIP template and do not require State approval, but results of each PIA must be made available to the State, or its designee, upon request. CMS, in consultation with states and other stakeholders, may specify additional PIPs topics.

The KanCare QMS is aligned with MCO contractual requirements pertaining to each MCO's Quality Assessment and Performance Improvement (QAPI) program. Specific goals, objectives, and guiding principles are outlined within the contract and require the following key concepts be infused throughout the MCO's organization:

- Collect complete and accurate data to support robust analysis and reporting of data.
- Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.
- Deploy rapid-cycle QI.
- Develop strong provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered.
- Drive collaboration and innovation internally, across business units and externally with members, caregivers, participating providers, stakeholders, and community-based entities.

TRANSITION OF CARE

The State has developed its comprehensive transition of care (TOC) policy to address the transitional care needs for all KanCare members. Transitional care management is defined as the specialized care coordination for members whose health care needs are changing, and is designed to facilitate transition of treatment plans from hospitals, ED, and inpatient-units, to home, LTSS providers, rehabilitation facilities, and other health service systems, thereby interrupting patterns of frequent ED use, and reducing avoidable hospital stays. Transitional care is also required when members are moving from one MCO to another, moving from the fee-for-service delivery system into the managed care service system, or moving from non-traditional settings (e.g., incarceration into managed care). MCOs must ensure that transitional care occurs with minimal service disruption and with continuance of current provider(s) when possible.

To ensure the most seamless TOC regardless of the member's setting or system of care, the State is developing TOC operational protocols. These protocols will incorporate timelines, data elements, and responsibilities of each stakeholder engaged in the TOC process. Upon finalization, the State will post the TOC policy, operational protocols, and required tools to the KanCare website. Each contracted MCO is contractually obligated to follow the TOC policy.

State Standards

ACCESS AND AVAILABILITY STANDARDS

KanCare has developed standards to ensure all covered Medicaid services delivered through the contracted MCOs are available and accessible to members by having an adequate provider network. Kansas has a large and diverse geography covering 105 different counties of which over half are considered rural or frontier (32 rural and 36 frontier). There are 16 urban/semi-urban counties and 21 counties considered densely-settled. In developing the network standards, the State has taken into account the need to expand service availability through the use of innovative strategies such as expansion of tele-health and engagement of value-based provider incentives to expand coverage while ensuring KanCare members have timely access to the full scope of services and that service delivery is provided in a culturally competent manner.

Provider-Specific Time and Distance Standards

In compliance with Federal law, KanCare has developed time-distance standards for provider types that include adult and pediatric primary care, OB/GYN, BH, HCBS, adult and pediatric specialist, hospital, pharmacy, and pediatric dental.

Time and distance standards have been established taking into account the characteristics and special needs of the KanCare population, the geographic composition of the state, and the various provider types necessary to deliver the full suite of benefits. Differentiation in the time and distance standards are based on the urban, rural, and frontier designations of the different counties and support member choice through availability of at least two providers of each type located within the established time/distance radius.

Provider-Specific Standards Other Than Time and Distance

For provider types that travel to see the member, as is the case with many of the HCBS service providers, the State is required to establish standards other than time and distance. To address those requirements, the State has developed the following approach.

Development of Network Adequacy Standards

The State identifies and quantifies the needs of the major KanCare subpopulations and projections for future Medicaid enrollment, historical utilization patterns, and the characteristics and health care needs of the KanCare population including the health and LTSS needs, child development and EPSDT requirements, and services and provider types necessary to address physical and behavioral integration and substance use disorder services. To identify and prioritize provider types of interest to the State, assessment of service authorization and referral patterns along with utilization data were analyzed and additional considerations regarding the expansion of telemedicine, triage lines, and other technology solutions were also factored into the development of the adequacy standards.

Exception Process

The State does allow for an exception process should an MCO not meet defined network access and availability standards. The approval for such an exception request is on a case by case basis and reflective of KanCare's desire to support member choice of provider and strategies supporting community integration of the member. If the State grants the exception, member access for that provider type will be monitored on an ongoing basis and the findings will be included in the managed care program assessment report as required under §438.66.

Provider-Specific Adequacy Standards

The State has published the KanCare program's provider-specific time and distance standards and standards other than time and distance for those providers who may drive to the member. Those standards are available at:

<https://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/geo-access-standards.pdf?sfvrsn=6>

Upon request, network adequacy standards are also made available at no cost to members in alternative formats or through the provision of auxiliary aids and services.

To ensure these standards are achieved and maintained, the KDHE and KDADS monitor and hold the MCOs accountable for meeting these standards.

Access Standards and Women's Health

In accordance with Federal rules, all KanCare female members have 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 female members in the event a network provider is not available.

Appointment Standards

Appointment standards require MCOs, through the contracts with its provider network, to adhere to specific standards based on the nature and acuity of the presenting condition. Appointment standards encompass the time between the request for an appointment and when the appointment can be granted, as well as the maximum wait time a member must wait before seeing a provider once arriving for the appointment. Given the need to address the immediate health and safety needs of certain populations, the State is in the process of developing specific standards addressing HCBS and BH services. These standards will focus on two specific requirements: (1) time to initiate HCBS services and (2) general standards for HCBS and BH services. Upon finalization of those standards, all contracted KanCare MCOs will be required to implement and monitor compliance of its provider network to the State defined standards. The following standards are currently in place:

- Respond to referrals 24 hours per day seven days per week and provide access to evening and weekend appointments.

- Respond to routine, urgent, and emergent needs within the established timeframes in conformance with State requirements.
- Appointment times shall be in accordance with usual and customary standards not to exceed three weeks for regular appointments and 48 hours for urgent care.
- Waiting times shall not exceed 45 minutes.

ADOPTION AND DISSEMINATION OF CLINICAL PRACTICE GUIDELINES

The State requires the following standards to ensure each MCO has the structure and clinical resources for adopting evidence-based clinical guidelines for meeting the bio-psycho-social needs of KanCare members. Practice guidelines must rely on credible scientific evidence published in peer reviewed literature and generally recognized by the provider community in which the guidelines would be used. To the extent applicable, the guidelines shall take into account specialty society recommendations and the views of clinicians practicing in their respective clinical areas and other relevant factors. At a minimum, evidence-based practice guidelines, as well as best practice and promising practice standards of care, shall be adopted by each contracted MCO and should cover the following areas:

- Chronic PH conditions (i.e., asthma, diabetes, human immunodeficiency virus [HIV], etc.).
- BH conditions (i.e., trauma informed care, first episode psychosis, serious emotional disturbances and SPMI, substance use disorders, and peer supports etc.).
- Community integration and person-centered service planning including freedom from seclusion and restraints and detection of abuse and exploitation.
- Dental services.
- Vision.
- EPSDT for individuals age 0 to 20.
- Social Determinants of Health and Independence (i.e., smoking cessation, supported housing, etc.).
- Pharmacy (i.e., psychotropic medication management, medication review/reconciliation, medication assisted treatment, medication therapy management, etc.).
- Coordination of community support and services for members in HCBS Waivers.
- TOC and community reintegration and support including coordination of services for individuals residing in LTC, and other institutional settings.

The scope of the practice guidelines shall be comprehensive, addressing aspects of quality of care and the quality of non-clinical aspects of service, such as but not limited to: availability, accessibility, coordination, and continuity of care. Each MCO must have an internal approval process, including mechanisms to solicit input from its contracted provider network prior to adoption of the guideline. All guidelines must be made available, without cost, by the MCO to members, prospective members and providers, and posted on each MCO's website in an easy to find, easy to read format.

Improvement and Interventions

IMPROVEMENT AND INTERVENTIONS

KanCare Leadership, in collaboration with Quality Management Integrated Model structure, will work throughout the year to support, oversee, and monitor the quality activities of the KanCare 2.0 program to achieve its goals and objectives. With additional technical support provided by the EQRO, the KanCare QIC works with the MCOs to ensure the PIPs and PMs continue to support the overall QMS and health of the program. All of these efforts work to strengthen the KanCare program to ensure the delivery of quality care and services are provided to KanCare members. In addition to the ongoing review and evaluation efforts, the State uses a variety of other tools to support the goals and objectives of the KanCare QMS, including intermediate sanctions and HIT.

CORRECTIVE ACTION PLANS AND INTERMEDIATE SANCTIONS

Kansas strongly believes in working closely with its MCOs in a collaborative and proactive manner to improve the quality of care and services received under the KanCare program and the nature of a continuous QI program. There will be, at times, a need for KanCare Leadership to impose corrective action plans (CAPs), sanctions, and even contract termination if the expected QI is not achieved or effective. These sanctions meet the KanCare contract requirements for CAPs, liquidated damages, and contract terminations. Under Federal rules, should any of the subcontractors fail to perform, the State has the ability to request the MCO terminate those contracts should they not be responsive to a CAP or improvements to performance.

The KanCare Steering Committee will request CAPs from the MCOs in cases for which non-compliance or the MCO did not demonstrate adequate performance. The CAPs will require clearly stated objectives, the individual/department responsible, and time frames to remedy the deficiency. The CAPs may include but not limited to:

- Education by oral or written contact or through required training.
- Prospective or retrospective analysis of patterns or trends.
- In-service education or training.
- Intensified review.
- Changes to administrative policies and procedures.

The KanCare MCOs play a key role in the success of the QMS. The MCOs shall meet the requirements under the KanCare contract including the performance standards in full or be subject to sanctions by the State, including but not limited to monetary or enrollment-related penalties. The

State believes strongly in our partnership with the MCOs and their commitment to providing high quality of care through the duration of their contract.

HIT/HEALTH INFORMATION EXCHANGE

HIT and Health Information Exchange (HIE) are two of the cornerstones of efforts in Kansas to improve the coordination and delivery of health care services which ultimately impacts quality. They are also central to Federal efforts under the Patient Protection and Affordable Care Act (PPACA) to improve the quality and effectiveness of health care services.

HIT refers to electronic systems that make it possible for health care providers to better manage patient care through secure use and sharing of health information. HIT includes the use of Electronic Health Records (EHRs) instead of paper medical records to maintain people's health information. HIE refers to the electronic movement of health-related data and information among organizations according to agreed standards, protocols, and other criteria.

KDHE's vision and strategy for implementing HIT initiatives is to pursue opportunities that encourage the adoption of certified EHR technology, promote health care quality, and advance HIE capacity in Kansas. The mission for HIT is to transform health care in Kansas through the deployment, coordination, and use of HIT and HIE.

Currently, there are two Regional Health Information Organizations (HIOs) providing technology services in Kansas:

1. The Kansas Health Information Network (KHIN) is a collaborative, Provider-led HIO solution originally formed by the Kansas Medical Society (KMS) and the Kansas Hospital Association (KHA). Currently, KHIN has a number of planned community-based HIOs which provide core HIT functionality. These include the Wichita HIE, eHealth Align in Kansas City, and the Rural Health Information Network.
2. The Lewis and Clark Health Information Exchange (LACIE) operates in Kansas and Missouri and participants range in size from small independent physician practices to large academic medical centers. Incorporated in 2009, LACIE has been exchanging data since 2010 between independent health care organizations and providers.
3. Additionally, two health systems, the University of Kansas Medical Center and KanCare Network, also incorporate tele-medicine, medical consultation, and other services beyond baseline EHR or HIE.

The MCOs work with the State and other relevant contractors to develop a joint plan to move HIT and EHRs forward in Kansas. An integral piece of this collaboration will be the tangible impact this work will have on the quality of care for members. The State will work with the MCOs through the QII-TF to ensure HIT/HIE remain an integral part of the QMS.

In addition, on April 17, 2013, Governor Sam Brownback signed into law the Kansas Health Information Technology Act (KHITA). This law amended the Kansas Health Information Technology Exchange Act (K-HITE) [K.S.A. 65-6821 et seq.] Both K-HITE and KHITA promote the electronic sharing of health information among providers in Kansas and regulate HIOs operating in the State. Responsibility for implementation of K-HITE is under the purview of KDHE's Office of Health Information Technology, known as KanHIT⁴. This presents another opportunity for the KanHIT to collaborate on quality related issues through the Quality Management Integrated Model committees.

⁴ KanHIT website: <http://www.kanhit.org/>

Opportunities

OPPORTUNITIES

Opportunity for improvement in delivering high quality, value-based care requires a continual and dynamic process.. After evaluation of its current QMS the State has sought to modernize the framework of the KanCare 2.0 QMS to distinctly outline the difference between compliance focused activities, achieved through the State's ongoing monitoring and oversight activities, and the deliberate and planned actions, as described in the QMS, that will be used to more efficiency and effectively focus resources in efforts aimed at delivering sustained improvements in the quality, access and timeliness of service delivery. The State remains committed to a dynamic evolving process for QI as a critical element to the success of the KanCare program. Kansas has begun a more methodological process for ensuring quality of care is being delivered to Kansans. The KanCare 2.0 program embodies change and change for the better health and independence for our Medicaid members. Steps have been taken to reduce the number of reports required by the MCOs while ensuring the reports that are still required will be reviewed for accuracy, completeness and timeliness of submission through the use of our reporting database. In turn, the State is building its capacity to unlock available data to drive greater understanding of the drivers and barriers of population health, health inequities and network gaps. Using MCO specific data as well as, aggregate program data can serve to identify populations, geographies, providers and systems that require more immediate attention allowing for more effective prioritization of issues and a more efficient allocation of resources.

Ongoing commitment to the Quality Management Integrated Model will help drive towards improvement by ensuring there is input, feedback, and review of the KanCare QMS on an ongoing basis, as well as identifying opportunities to facilitate change. In addition, the KanCare Leadership team remains committed to ensuring KanCare 2.0 helps Kansans achieve healthier, more independent lives by providing services and supports for Social Determinants of Health and Independence, in addition to traditional Medicaid and CHIP benefits.

Appendix A – KanCare QMS Crosswalk

#	FEDERAL CITATION	DESCRIPTION	QMS PAGE REFERENCE
SECTION I: Introduction – Managed Care Goals, Objectives and Overview			
1	N/A	Include a brief history of the State’s Medicaid (and CHIP, if applicable) managed care programs.	Section 1 – Introduction and Overview; Pages 1-2
2	N/A	Include an overview of the quality management structure that is in place at the State level.	Section 1 – Introduction and Overview; Pages 6-9
3	N/A	Include a description of the goals and objectives of the State’s managed care program. This description should include priorities, strategic partnerships, and quantifiable performance-driven objectives. These objectives should reflect the State’s priorities and areas of concern for the populations covered by the MCO contracts.	Section 1 – Introduction and Overview; Pages 3-4
SECTION II – Establishing Standards, Guidelines, and Definitions			
4	438.340(b)(1)	State-defined network adequacy standards developed in accordance with 438.68 (e.g., time and distance and LTSS provider standards).	Section 3 – State Standards; Page 21
5	438.340(b)(1)	State-defined availability of services standards developed in accordance with 438.206(b)(1)-(7) (e.g., direct access to women’s health specialist; timely access standards for routine urgent and emergent services; 24/7 service availability; access and cultural competency; accessibility considerations).	Section 3 – State Standards; Page 21
6	438.340(b)(1)	State’s approach to adoption and dissemination of evidence-based clinical practice guidelines in accordance with 438.236.	Section 3 – State Standards; Page 23
7	438.340(b)(5)	Description of the State’s TOC policy required under 438.62(b)(3).	Section 2 – Establishing Standards, Guidelines and Definitions; Page 20
8	438.340(b)(9)	Mechanisms implemented by the State to comply with 438.208(c)(1) (relating to the identification of persons who need LTSS or persons with special health care needs).	Section 2 – Establishing Standards, Guidelines and Definitions; Page 10
9	438.340(b)(10)	The information required under 438.360(c) (relating to non-duplication of EQR activities),	Section 2 – Establishing Standards, Guidelines and Definitions; Page 19

#	FEDERAL CITATION	DESCRIPTION	QMS PAGE REFERENCE
SECTION III: Driving Improvement and Monitoring Progress			
10	438.340(b)(2)	Developing goals and objectives for continuous QI, which must be measurable and take into consideration the health status of all populations served by MCOs.	Section 2 – Establishing Standards, Guidelines and Definitions; Pages 12-16
11	438.340(b)(3)(i)	A description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO with which the State contracts, including but not limited to, the PMS reported in accordance with 438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the KanCare website.	Section 2 – Establishing Standards, Guidelines and Definitions; Page 13
12	438.340(b)(3)(ii)	A description of the PIPs implemented in accordance with 438.330(d), including a description of any interventions the State proposes to improve access or timeliness of care for members.	Section 3 – State Standards; Page 19
13	438.340(b)(4)	Arrangements for annual, external independent reviews, in accordance with 438.350, of the quality outcomes and timeliness or, and access to, the services covered under each MCO.	Section 2 – Establishing Standards, Guidelines and Definitions; Page 18
14	438.340(b)(6)	The State’s plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status (as basis for Medicaid eligibility). States must identify this demographic information for each member and provide it to the MCO at time of enrollment.	Section 2 – Establishing Standards, Guidelines and Definitions; Page 11
15	438.340(b)(7)	Appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR part 438, subpart I.	Section 4 – Improvements and Interventions; Page 25
SECTION IV: Evaluating, Updating, and Disseminating the Quality Strategy			
16	438.340(c)(1)	Public Comment – Obtaining input from the Medical Care Advisory Committee and consulting with tribes.	Section 1 – Introduction and Overview; Pages 5-8
17	438.340(c)(1)(i)	Public Comment – process for broader stakeholder engagement and comment.	Section 1 – Introduction and Overview; Pages 6-8
18	438.340(c)(3)	Submitting the Quality Strategy to CMS.	Section 1 – Introduction and Overview; Page 5
19	438.340(c)(2)	Review and update Quality Strategy no less than once every three years.	Section 1 – Introduction and Overview; Page 9

#	FEDERAL CITATION	DESCRIPTION	QMS PAGE REFERENCE
20	438.340(d)	Posting the Final CMS-Approved Quality Strategy to the KanCare website.	Section 1 – Introduction and Overview; Page 9
21	438.340(c)(i)	Evaluation of Effectiveness of Previous Quality Strategy.	Section 1 – Introduction and Overview; Pages 5-6
22	438.340(b)(11)	The State’s definition of a “significant” change for purposes of revising the Quality Strategy and submitting to CMS.	Section 1 – Introduction and Overview; Page 5

Appendix B – Acronyms

ADHD	Attention-Deficit/Hyperactivity Disorder
AIR	Adverse Incident Reporting
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DCF	Kansas Department of Children and Families
DHCF	Division of Health Care Finance
ED	Emergency Department
EHR	Electronic Health Record
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
HCBS	Home- and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Information Exchange
HIO	Health Information Organization
HIT	Health Information Technology

HIV	Human Immunodeficiency Virus
HRA	Health Risk Assessment
IDD	Individuals with Intellectual Disabilities
ISCA	Information Systems Capabilities Assessment
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KHA	Kansas Hospital Association
KHIN	Kansas Health Information Network
KHIT	Kansas Office of Information Technology
KHITA	Kansas Health Information Technology Act
K-HITE	Kansas Health Information Technology Exchange Act
KMS	Kansas Medical Society
LACIE	Lewis and Clark Health Information Exchange
LEP	Limited English Proficiency
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
MCAC	Medical Care Advisory Committee
MCO	Managed Care Organization
NCI	National Core Indicators
NCI-AD	National Core Indicators-Aging and Disabilities
NCQA	National Committee for Quality Assurance
NOMS	National Outcome Measurement System
P4P	Pay for Performance

PCCM	Primary Care Case Management
PD	Physical Disabilities
PH	Physical Health
PI	Performance Improvement
PIA	Performance Improvement Activities
PIP	Performance Improvement Project
PM	Performance Measures
PPACA	Patient Protection and Affordable Care Act
QAPI	Quality Assessment and Performance Improvement
QI	Quality Improvement
QIC	Quality Improvement Committee
QII-TF	Quality Improvement Initiative Task Force
QMS	Quality Management Strategy
RFP	Request for Proposal
SBIRT	Screening, Brief Intervention and Referral to Treatment
SPMI	Serious and Persistent Mental Illness
SSA	Social Security Act
TA	Technology Assistance
TBI	Traumatic Brain Injury
TOC	Transition of Care
UM	Utilization Management
VBP	Value-Based Payment
WORK	Work Opportunities Reward Kansans

