KanCare Quality Management Strategy

Submitted to CMS on 12-09-2021

Table of Contents

Appendices

Figures

Tables

Overview

The State of Kansas (State) asserts that the Quality Management Strategy (QMS) will advance the state's focus on quality improvement 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. As the KanCare program offers a comprehensive benefit package that includes physical health (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 and 42 CFR 457.1240. KDHE and KDADS maintain the authority and responsibility for updating the QMS as needed based on performance, feedback from stakeholders, and/or changes in policy resulting from legislative, State, or Federal authorities.

The QMS is informed by the missions of KDHE, KDADS, and the Kansas Department of Children and Families (DCF) as State partners, to provide quality care to the KanCare population:

- "*To protect and improve the health and environment of all Kansans.*" – KDHE
- "*To foster an environment that promotes security, dignity and independence for all Kansans."* – KDADS
- "*To protect children, promote healthy families, and encourage personal responsibility*." – DCF

In order to demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) quality strategy requirements set forth in 42 CFR 438.340 and 42 CFR 457.1240, Kansas included an analysis that identifies each required element 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 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.

Description of the KanCare Program

On December 27, 2012, CMS approved the State of Kansas Medicaid Section 1115 demonstration proposal entitled "KanCare" that was then implemented on January 1, 2013. A continuation was approved on December 18, 2018, and will be in effect from January 01, 2019, through December 31, 2023. The state contracted with three Managed Care Organizations (MCOs) to provide services for this contract period, also known as KanCare 2.0. KanCare 2.0, is operating concurrently with the State's Section 1915(c) Home and Community Based Services (HCBS) waivers and together provide the authority necessary for the State to include enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible).

The following is a table of all populations served through managed care and fee for service:

Table 1.

Managed Care Organization Populations	
Program	Population

Managed Care	• HCBS Waiver members
	  ○ Technology Assisted (TA)
	  ○ Autism (AU)
	  ○ Intellectual/Developmental Disability (I/DD)
	  ○ Physical Disability (PD)
	  ○ Frail Elderly (FE)
	  ○ Serious Emotional Disturbance (SED)
	  ○ Brain Injury (BI)
	• Children up to age 19, including those who are in foster care or who get adoption support payments
	• Pregnant Women
	• Persons who are blind or disabled as defined by Social Security rules
	• Persons age 65 or older
	• Persons receiving inpatient treatment for tuberculosis
	• Low income families with children
	• Persons screened and diagnosed with breast or cervical cancer through the Early Detection Works program
	• Refugee Medical

Fee For Service (FFS)	• Sixth Omnibus Budget Reconciliation Act (SOBRA) • Qualified Medicare Beneficiary (QMB) • Low Income Medicare Beneficiary (LMB) • Expanded Low Income Medicare Beneficiary (ELMB) • Program of All-Inclusive Care for the Elderly (PACE) • AIDS Drug Assistance Program (ADAP) • Tuberculosis (TB) • MEDIKAN • Residents of mental health nursing facilities • People with retroactive coverage only • American Indians and Alaska Natives (AI/ANs) have the option to opt out of KanCare

Transitioning from Delivery System Reform Incentive Payment (DSRIP) Pool Hospitals to Alternative Payment Model (APM)

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. Additional information can be found at https://www.kancare.ks.gov/policies-and-reports/delivery-system-reform-incentive-payment

KanCare used the DSRIP model from 2014 through 2020. The DSRIP program aimed to advance the goals of access to services and healthy living by specifically focusing on incentivizing projects that increase access to integrated delivery systems and projects that expand successful models for prevention and

management of chronic and complex diseases. Participating hospitals were to work with community partners statewide to implement projects that have measurable milestones for improvements in infrastructure, processes, and healthcare quality.

The DSRIP program in Kansas included two major hospitals, The University of Kansas Health System and Children's Mercy Hospital and Clinics. The two hospital systems are major medical service providers to Kansas and Missouri residents. Each hospital system implemented two projects selected from a catalog of five projects approved by the Centers for Medicare & Medicaid Services (CMS) and KDHE, Division of Health Care Finance (KDHE-DHCF) that target specific needs of Kansas residents who are receiving Medicaid services or are uninsured low income.

CMS approved a bridge year to help Kansas transition from a DSRIP model to an APM model. This bridge year is taking place in 2021. Beginning in 2022 the APM model will be fully implemented in Kansas.

As part of the special terms and conditions (STC) of the Kansas section 1115(a) demonstration waiver, the state is required to develop and implement an alternative payment model (APM) to improve health outcomes and contribute to delivery systems reforms. These reforms were formerly developed under a DSRIP model. Under an APM, participating providers receive incentive payments for providing high-quality and cost-efficient care. The current incentives are for flu shots; screening for depression & follow-up; breast cancer screening; lung cancer screening; chlamydia screening for ages 16-20; and development of diabetes protocols for adults and children for use in hospitals statewide, particularly for those in rural areas.

Program Eligibility

The Kansas Managed Care population is divided into three distinct populations: (1) parents, pregnant women, and children; (2) various disability groups including seven waiver programs:

- AU Waiver
- FE Waiver
- BI Waiver
- PD Waiver
- I/DD Waiver
- SED Waiver
- TA Waiver

and (3) the aged (65 and older). All populations are currently covered by the State Medicaid Plan, KanCare. For fiscal year 2020, the total KanCare covered population was approximately 404,000. The three largest populations served are (1) children, (2) individuals with disabilities, and (3) parents.

Table 2.

Percentage of KanCare Population (Calendar Year 2020)		
	Population	**Expenditures**
Children	62.2%	24.0%
Disabled	13.3%	40.8%
Parents	11.7%	9.1%
Elderly	11.0%	22.0%
Other	1.3%	3.8%
MediKan	0.6%	0.2%

https://www.kdheks.gov/hcf/medicaid_reports/

Almost all Medicaid Beneficiaries and 100% of The Children's Health Insurance Program (CHIP) Beneficiaries will enroll in an MCO of their choosing. AI/ANs may be voluntarily enrolled and may not be enrolled on a mandatory basis without a Waiver from CMS. The Kansas managed care program operates under the Waiver authority specified in Sections1115 and 1915(c) of the Social Security Act (SSA).

The State of Kansas has increased the Protected Income Level (PIL) for HCBS and PACE members. The PIL increased from $1,157 per month to $2,383 per month (300% of Federal Supplemental Security Income) starting in fiscal year 2021. As a result of this change in PIL, currently only 0.72% of HCBS and PACE members now have a client obligation.

OneCare Kansas

OneCare Kansas (OCK) refers to a new Medicaid option to provide coordination of physical and behavioral healthcare with long term services and supports for people with chronic conditions. OCK expands upon medical home models to include links to community and social supports. OCK focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in an OCK member's health communicate with one another so that all a member's needs are addressed in a comprehensive manner.
OCK provides the following additional services:

- Comprehensive care management
- Care coordination
- Comprehensive transitional care, including appropriate follow-up, from inpatient to other settings
- Patient and family support (including authorized representative)
- Referral to community and social support services, if relevant
- Health Promotion

More information about the OneCare Kansas program can be found here:
https://www.kancare.ks.gov/home

Managed Care Goals and Objectives

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 deserve.

Kansas will test the below hypotheses in KanCare 2.0:

1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.
2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.
3. The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural areas. Specifically:
    A. Telemedicine will improve access to services such as speech therapy
    B. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions.
    C. Telementoring can pair rural healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.

4. Removing payment barriers for services provided in Institutions for Mental Disease (IMDs) for members who have a primary diagnosis of a substance use disorder or co-occurring substance use disorder will result in improved member access to behavioral health services.

The KanCare QMS will act as a roadmap outlining the program's performance measures and performance improvement 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.

Quality Management Goals, Strategies, and Objectives

The goals, strategies, and objectives of the QMS are included in the table below:

This area is intentionally left blank

Table 3. Quality Management Strategy Goals and Objectives

Goal #1: Improve the Delivery of Holistic, Integrated, Person Centered, and Culturally Appropriate Care to all members					
Strategy: Increase the Percentage of Providers who qualified for Value-Based Payment (VBP) rate by 2% year over year					
Objective	**Metric specifications**	**Baseline performance (2019)**	**Performance target (2023)**	**Annual Rate**	
Objective 1.1: Increase the number of VBPs offered by the MCOs which serve to integrate services	**Number of providers by Tax Identification Number (TIN) who qualified and received incentive/number of projects***	**2019**	**Increase by one project per year (2019-2023)**	**2020**	**2021**
Aetna Better Health of Kansas (ABH)		No data available		No data available	
Sunflower Health Plan (SHP)		50 TINs/5 projects		66 TINs/5 projects (+16 TINs/+ 0 projects)	
United HealthCare Community Plan of Kansas (UHCCP)		2,893 TINs/6 projects		3,361/7 projects (+468 TINs/+1 project)	
Total		2,943 TINs/ 11 projects		3,427 TINs/12 projects (+484 TINs/+1 project)	
***One TIN could represent multiple providers**					
Objective 1.2: MCOs will annually submit a cultural competency plan which includes robust elements of a health equity strategy along with all elements required in the contract (5.5.4.B.)	**Annual Contract Review**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		submitted	submitted
SHP		submitted		submitted	submitted
UHCCP		submitted		submitted	submitted

Objective 1.3 Increase the number of crisis response claims that occur in the community setting, including in the member's home	Kansas Modular Medicaid System (KMMS) data warehouse	2018	2023	2019	2020
ABH		N/A		4,104	3,508 (-14.5%)
SHP		6,712		6,842 (+1.9%)	6,345 (-7.2%)
UHCCP		5,301		5,775 (+8.9%)	4,890 (-15.3%)
Total		12,013		16,721 (+39.1%)	14,743 (-11.8%)
*Data is for those 18 years old and under					

Goal #2: Increasing Employment and independent living supports to increase independence and health outcomes

Strategy: Reduce Hospital admissions and the use of crisis services by 25% by the end of three years, through increased use of employment and Independent Living Support (ILS) services

Objective	Metric specifications	Baseline performance (2018)	Performance target (2023)	Annual Rate	
Objective 2.1: Improve the process to increase referrals and tracking to employment services for all members who express an interest and need	**KanCare Report Administration (KRA)***	**2018**	**2023**	**2019**	**2020**
ABH		N/A		N/A	N/A
SHP		N/A		N/A	N/A
UHCCP		N/A		N/A	N/A
Total		N/A		N/A	N/A
* Number of members referred by employment specialists to employment services will be reported quarterly effective 4th Quarter 2021					
Objective 2.2: Implement, support and expand the STEPS pilot program (program begins 07-01-21)	**EQRO**	**2021**	**2023**		
		2021 data will be available in 2022			
Objective 2.3: Increase the use of community integration codes, supportive housing, Operation Community Integration (OCI)	**KMMS**	**2019**	**2023**	**2020**	**2021**
Statewide		45		1046	

Objective 2.4: Increase the average utilization of Value Added Benefits (VABs) per member per year	KRA	2018	2023	2019	2020
ABH		N/A		1.61	1.02 ↓
SHP	The average number of VAB units utilized per member per year	1.04		1.07 ↑	0.55 ↓
UHCCP		1.35		1.54 ↑	1.15 ↓
Objective 2.5: Each MCO will implement a Performance Improvement Project (PIP) that addresses SDOH	**PIP methodology, PIP Activity Report data, PIP annual report**	**2019**	**2023**	**2020**	**2021**
ABH		N/A		Yes	Yes
SHP		N/A		Yes	Yes
UHCCP		N/A		Yes	Yes
Objective 2.6: Increase the rate of completed health screens	**KRA**	**2019**	**2023**	**2020**	**2021**
ABH		14.32%		3.46%	
SHP		13.17%		12.92%	
UHCCP		5.54%		3.72%	
Objective 2.7 Increase the rate of members enrolled into OCK by 10% year over year	**KRA**	**2019**	**2023**	**2020**	**2021**
ABH		N/A		202	
SHP		N/A		329	
UHCCP		N/A		390	
Total		N/A		921	
*Results are from 04-01-2020 to 12-21-2020 due to the program starting on 04-01-2020					
Objective 2.8 Increase percent of those enrolled in OCK that received a claim for care coordination by 10% year over year	**KRA**	**2019**	**2023**	**2020**	**2021**
ABH		N/A		100 (49%)	
SHP		N/A		171 (52%)	
UHCCP		N/A		206 (53%)	
Total		N/A		477 (52%)	

Objective 2.9 Increase the rate of claims that use of Z codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs	Z56.9, Z59.0, Z59.1, Z59.4, Z59.9, Z65.0, Z65.2, Z65.3, Z72.0, Z75.3, Z75.4, Z91.19	2019	2023	2020	2021
ABH		0.315%		0.318%	
SHP		0.252%		0.236%	
UHCCP		0.271%		0.253%	

Goal #3: Increase Telehealth usage through Speech Therapy, monitoring health indicators, pair rural healthcare providers with remote specialists

Strategy: Improve access to services by increasing the availability of telehealth services 2018-2023 (expecting a higher increase in 2020 than in subsequent years due to approval of additional procedure codes).

Objective	Metric specifications	Baseline performance (2018)	Performance target (2023)	Annual Rate	
Objective 3.1: Annually increase claims for speech therapy via telehealth	**KMMS**	**2018***	**2023**	**2019**	**2020**
ABH		No data		No data	1,275
SHP		No data		No data	3,092
UHCCP		No data		No data	3,817
Total		**No data**		**No data**	**8,184**
*NOTE: MCO data is not available for CY 2018 and 2019 because the option for speech therapy via telehealth was not exercised					
Objective 3.2: Annually increase claims for wellness monitoring via telehealth	**FE waiver & IDD waiver wellness monitoring S5190, TA waiver health maintenance monitoring T1001, and Evaluation and Management codes**	**2018**	**2023**	**2019**	**2020**
ABH		No data		4,489 (N/A)	28,331 (+531%)
SHP		5,022		6,258 (+24%)	43,372 (+593%)
UHCCP		4,809		6,233 (+29%)	37,397 (+500%)
Total		**9,831**		**16,980 (+72%)**	**109,100 (+542%)**

Objective 3.3: Annually increase number billed claims for specialists providing care via telehealth to frontier, densely-settled rural, and rural counties.	Q3104 code with 02 place of service for member residing in a rural county**	2018	2023	2019	2020*
ABH		NA		301	48,273 (+15,937%)
SHP		69		202 (+192%)	75,520 (+37,286%)
UHCCP		372		876 (+135%)	71,141 (+8,021)
Total		441		1,379 (+212%)	194,934 (+14,035%)

*NOTE: Effective Mar 12, 2020 members could receive telehealth services in the home so a pairing of Q3014 and 02 was not required after this date.
**Results based on count of paid claims with a telehealth procedure code, and place of service 02 (telehealth), with one line having Q3014 (date range 1/1/2018 – 3/11/2020), and place of service 02 with no Q3014 required (date range 3/12/2020-12/31/2020), for members in rural counties (https://www.kdheks.gov/phi/as/2019_Annual_Summary.pdf)

Goal #4: Removing payment barriers for services provided in Institutions for Mental Diseases (IMD's) for KanCare members will result in improved beneficiary access to Substance Use Disorder (SUD) treatment service specialists

Strategy: Decrease use of emergency room and hospital stays by increasing utilization of residential and outpatient BH services by 5% year over year

Objective		Baseline performance (2018)	Performance target (2023)	Annual Rate	
				2019	2020
ABH		N/A		3,992	5,293 (+33%)
SHP		3,325		3,406 (+2%)	4,345 (+28%)
UHCCP		4,835		3,745 (-23%)	5,179 (+38%)
Total		8,160		11,143 (+37%)	14,817 (+33%)

Trend of IMD utilization using H0014, H0018, H0019 codes

Objective 4.1: Implement, support, and expand IMD exclusion waiver for SUD	EQRO	2019	2023	2020	2021
	Medicaid members treated in an IMD for SUD	652		531 (-19%) COVID-19 limited space for residential care	

Objective 4.2: Implement, support, and expand IMD exclusion waiver for MH	KDADS	2019*	2023	2020*	2021
		N/A		N/A	
*The Public Health Emergency for COVID-19 impacted our initial timeline and the agency still has interest in contracting with a consultant to develop an official exclusion plan/request.					
Objective 4.3: Increase peer support utilization for BH services by 10% year over year	**EQRO**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		8,459	9,208 (+9%)
SHP		12,774		13,797 (+8%)	14,676 (+6%)
UHCCP		14,011		14,295 (+2%)	19,672 (+38%)
Total		26,785*		36,551 (+5%) *	43,556 (+19%)
***does not include ABH**					
Objective 4.4: Reduction in use of antipsychotic medications in nursing homes < or = 12%	**MDS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		12.93%	In progress
SHP		12.50%		11.84%	In progress
UHCCP		12.76%		11.37%	In progress
Total		12.63%		12.04%	In progress
Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		38.20	46.68%
SHP		33.56		39.85	43.71%
UHCCP		32.54		33.71	43.27%
Total		34.75		37.30	44.51%

Objective 4.6: Develop and implement direct testing or secret shopping activities for provider network validation		Completed	Not completed		
2020 Project	Primary Care Physician after-hours study	Yes			
2021 Project	Primary Care Physician after-hours study will be repeated in 2021	In Progress			
2022 Project					
2023 Project					
Objective 4.7: Increase the rate of members who indicated a desire to be discharged from a NF or NFMH facility to a community setting who were discharged within 90 days	**MDS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		56.73%	In progress
SHP		57.02%		60.51%	In progress
UHCCP		58.15%		56.20%	In progress
Total		57.58%		57.81%	In progress

Goal #5: Improve overall health and safety for KanCare members

Strategy: All MCOs are expected to achieve the National HEDIS Quality Compass 75th percentile for all reported HEDIS data. *

Objective	Metric specifications	Baseline performance (2018)	Performance target (2023)	Annual Rate	
Objective 5.1: HbA1c good control (<8.0%) for members with diabetes	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		52.55	51.58%
SHP		48.18		45.99	51.34%
UHCCP		58.26		61.31	58.15%
Total		54.94		53.23	53.91%

***** All MCOs are expected to achieve the National HEDIS 75th Quality Compass (QC) percentile for all reported HEDIS data. HEDIS measures falling below the 75th percentile the State has devised the following strategy aimed at reducing annually, by 10%, the gap between the 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. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI.

Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)	HEDIS	2018	2023	2019	2020*
ABH		N/A		N/A	49.51%
SHP		54.42%		59.37%	56.97%
UHCCP		55.46%		66.91%	57.11%
Total		54.84%		63.02%	55.10%
Objective 5.2b: Well-Child Visits 15-30 months (15-30-month period & name change in 2020)	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		N/A	63.43%
SHP		N/A		N/A	67.41%
UHCCP		N/A		N/A	64.19%
Total		N/A		N/A	65.27%
Objective 5.3a Child and Adolescent Well-Care Visits (WCV) ages 3-11	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		N/A	46.40%
SHP		N/A		N/A	50.60%
UHCCP		N/A		N/A	47.64%
Total		N/A		N/A	48.41%
Objective 5.3b Child and Adolescent Well-Care Visits (WCV) ages 12-17	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		N/A	43.13%
SHP		N/A		N/A	48.88%
UHCCP		N/A		N/A	45.67%
Total		N/A		N/A	46.14%
Objective 5.3c Child and Adolescent Well-Care Visits (WCV) ages 18-21	**HEDIS**	**2018**	**2023**	**2019**	**2020**
ABH		N/A		N/A	21.53%
SHP		N/A		N/A	26.07%
UHCCP		N/A		N/A	23.49%
Total		N/A		N/A	23.90%
Objective 5.4: Increase the percentage of members who feel their long-term services meet their current needs and goals to 85% over the next three years	**NCI-AD 2019-2020**	**2018-2019**	**2022-2023**	**2019-2020**	**2020-2021**
Total		(378) 76%		(273) 71% (-5%)	
Objective 5.5: Number of waiver participants who receive their annual	**KDADS Quality review report**	**2018**	**2023**	**2019**	**2020**

Level of Care evaluation within 12 months of the previous level of care determination for all waivers will increase by 20% annually until an 87% compliance rate is reached. (not applicable for SED)					
PD		79%		72% (-7%)	66% (-6%)
FE		84%		80% (-4%)	70% (-10%)
IDD		97%		98% (+1%)	97% (-1%)
BI		70%		70% (+0%)	57% (-13%)
TA		99%		100% (+1%)	99% (-1%)
Autism		65%		69% (+4%)	100% (+31%)
Objective 5.6: Number of waiver participants whose service plans were developed according to the processes in the approved waiver for all waivers will increase by 20% annually until an 87% compliance rate is reached	**KDADS Quality review report**	**2018**	**2023**	**2019**	**2020**
PD					
ABH		N/A		58%	41% (-17%)
Amerigroup		91%		N/A	N/A
SHP		77%		86% (+9%)	47% (-39%)
UHCCP		94%		82% (-12%)	40% (-42%)
Statewide		87%		78% (-9%)	43% (-35%)
FE					
ABH		N/A		69%	37% (-32%)
Amerigroup		91%		N/A	N/A
SHP		76%		86% (+10%)	52% (-34%)
UHCCP		90%		81% (-9%)	35% (-46%)
Statewide		85%		81% (-4%)	41% (-40%)
IDD					
ABH		N/A		47%	40% (-7%)
Amerigroup		94%		N/A	N/A
SHP		79%		77% (-2%)	38% (-39%)
UHCCP		90%		72% (-18%)	30% (-42%)
Statewide		83%		71% (-12%)	36% (-35%)

BI					
ABH		N/A		43%	21% (-22%)
Amerigroup		79%		N/A	N/A
SHP		73%		77% (+4%)	30% (-47%)
UHCCP		84%		79% (-5%)	29% (-50%)
Statewide		78%		71% (-7%)	28% (-43%)
TA					
ABH		N/A		70%	33% (-37%)
Amerigroup		96%		N/A	N/A
SHP		89%		88% (-1%)	33% (-55%)
UHCCP		84%		90% (+6%)	24% (-66%)
Statewide		92%		86% (-6%)	29% (-57%)
Autism					
ABH		N/A		0%	0%
Amerigroup		91%		N/A	N/A
SHP		39%		31% (-8%)	60% (+29%)
UHCCP		35%		65% (+30%)	0% (-65%)
Statewide		50%		47% (-3%)	14% (-33%)
SED					
ABH		N/A		96%	30% (-66%)
Amerigroup		96%		N/A	N/A
SHP		97%		95% (-2%)	32% (-63%)
UHCCP		95%		98% (+3%)	38% (-60%)
Statewide		96%		97% (+1%)	34% (-63%)
Objective 5.7: Increase rates of selected Adult and Child Core measures by 5% annually	**KRA**	**2018**	**2023**	**2019**	**2020**
Breast Cancer Screening (BCS-AD)		48%		51% (+6%)	48% (-5%)
Chlamydia Screening in Women ages 16 to 24 (CHL)		43%		45% (+4%)	42% (-6%)

KanCare Quality Management Model

To support the revised QMS goals and support the dynamic process of continuous quality improvement, including the review and evaluation of the KanCare QMS, the State has incorporated several groups and stakeholders to provide feedback on quality initiatives. The groups listed below play an essential role in improving and integrating quality into the overall KanCare program.

Stakeholders: The 2021 KanCare QMS was posted online at Kancare.ks.gov from September 24, 2021 to December 02, 2021 for public feedback. The 2021 KanCare QMS was also shared with Tribal Organizations and the KanCare Medical Care Advisory Committee (MCAC), for a 30-day time period ending on October 26, 2021. Additionally, the 2021 KanCare QMS was shared with the Kansas Hospital Association, and the United Healthcare Member Advisory Committee for feedback for a 30-day time period ending December 02, 2021. Please see attachment D for all feedback and the State response.

Tribal Input: The Kansas KanCare tribal policy can be found here. The State will seek input from our Indian Health Programs, Tribal Governments, and Urban Indian Organizations (I/T/U). This is accomplished by notifying the I/T/Us via email of the proposed QMS revisions. In the email notice the I/T/Us will receive a copy of the QMS draft and will be notified of the 30-day timeframe for comments.

MCAC: The MCAC will meet quarterly to discuss a myriad of issues related to KanCare. 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.

LTSS Advisory 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 submit recommendations for consideration by the KanCare Steering Committee.

Leadership Team: 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. Summarized stakeholder input, recommendations from the State's monitoring and oversight activities, as well as results and recommendations of the State's continuous quality improvement efforts will be presented.

Steering Committee: 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 of the program, including reporting out specific agency reviews and audit findings. The Steering Committee also creates and reviews the agenda for the monthly Joint MCO Meetings. 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.

Joint MCO Meeting: All KanCare MCOs participate in a monthly meeting with KDHE and KDADS to discuss and review any current concerns or topics that need to be addressed quickly. These topics can include billing issues, quality issues, contractual issues, etc. This is a series of four meetings on the same day. The first meeting includes all three MCOs meeting with the State agencies. This is followed by each MCO meeting individually with the State agencies to allow the MCO to discuss any proprietary information confidentially.

Long-Term Care Committee: The Long-Term Care Committee meets once a month to review LTSS quality measures. KDADs reports to KDHE and DCF any quality concerns that they are experiencing in the LTSS programs. The KanCare Ombudsman, the KanCare fiscal agent, and the eligibility team also participate in these meetings. Quarterly the HCBS Long-Term Care Quality Review Report is presented and the team reviews the results for trends, areas for improvement, and remediation efforts. Information from this meeting is then reported to the KanCare steering committee. This committee was implemented as a resolution to corrective actions requested by CMS.

KanCare Quality Steering Committee: The KanCare Quality Steering Committee combines the previous Quality Improvement Committee and the Quality Improvement Initiative Task Force into a single committee. The KanCare Quality Steering Committee is an internal state workgroup, comprising 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. The KanCare Quality Steering Committee reports progress on quality initiatives and QMS objectives to the KanCare Steering Committee.

The following table illustrates the primary KanCare entities that support the goals, strategies, and implementation activities of the KanCare QMS.

Table 4.

KanCare Quality Management Model		
Entities	**Membership**	**Roles and Responsibilities**
KanCare MCAC	• KDHE • KDADS • Stakeholders	• Forum for input from key stakeholders to review QMS, review quality outcomes, and receive input into the quality efforts
KanCare LTSS Advisory Committee	• KDHE • KDADS • LTSS Stakeholders	• 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	• KDHE • KDADS	• Overall leadership of the KanCare program including supporting the KanCare QMS and Quality Management Integrated Model
KanCare Steering Committee	• KDHE • KDADS	• Day to day operational issues • Plan/arrange joint MCO meetings • Report out of specific agency reviews/audit findings • Corrective action planning
Joint MCO Meeting	• MCOs • KDHE • KDADS	• Discussion concerning MCO contract requirements • MCOs share initiatives and special projects • Discuss proposed projects that are under consideration by the State and/or MCO • Collaborative problem solving
Long-Term Care Committee	• KDADS • KDHE • DCF	• Quality review of LTSSS programs • Eligibility changes for LTSS programs • Program initiatives and topics • Policy revisions or development • Reports to KanCare Steering Committee

KanCare Quality Steering Committee	• KDHE • KDADS	• Collaborative review of goals and objectives of QMS to determine progress 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 • Identification and implementation of quality initiatives • Provides support and feedback to quality programs • Reports to KanCare Steering Committee

Network Adequacy and Availability of Services 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 (33 rural and 37 frontier). There are 16 urban/semi-urban counties and 19 counties categorized densely-settled rural. In developing the network standards, the State took into account the need to expand service availability through the use of innovative strategies such as expansion of telehealth 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 Standards

In compliance with Federal law, KanCare has developed time and distance standards for provider types that include:

- adult and pediatric
    - primary care
    - behavioral health
    - specialists
    - dental
- Home and Community Based Services where the member travels to the provider
- hospital
- pharmacy
- OB/GYN
- optometry
- ancillary services
    - physical therapy
    - occupational therapy
    - speech therapy
    - x-ray
    - lab
    - transportation

Mail order prescription and DME standards are a minimum of one provider per county. Home and Community Based Services, where the provider travels to the member, have time standards measured from the date the service is authorized in the electronic visit verification system. The current KanCare Network Adequacy Standards are posted here: https://www.kancare.ks.gov/policies-and-reports/network-adequacy. This document also describes the state's process for developing the standards, the exception process as well as the MCO's reporting requirements around provider network.

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 appointment 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. The following appointment standards apply:

Table 5.

KanCare Appointment Wait Time Standards	
KanCare Compliance Standards	
Emergency	All Providers - Same day
Urgent	All Providers - 48 hours
Routine includes: Physical Health/ Preventative Adult & Early, Periodic, Screening, Diagnosis and Testing (EPSDT)	Primary Care Provider (PCP) - 21 days Specialist - 30 days
Behavioral Health	Routine SUD within 14 calendar days Pregnant and People Who Inject Drugs (PWID) 24 hours from assessment PWID 14 calendar days Urgent Mental Health (MH) assessed within 72 hours Routine MH assessed within 14 business days
OB	1st Trimester - 3 weeks 2nd Trimester - 2 weeks 3rd Trimester - 1 week High Risk - No specific standard. Please report average time for appointment.
After-Hours	24/7

In addition, all providers must:

- 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

Provider Directory

Each MCO must maintain an up to date Provider Directory which is made available to all members both in electronic and paper format. Provider types must include, at a minimum, physicians including specialists, vision, dental, hospitals, pharmacies, BH and LTSS providers. The required elements for each provider include:

1. Complete name
2. Address for all office locations, including street, city, county, and zip code
3. Phone number, including Text Telephone (TTY) phone line
4. Provider type
5. Specialty/services provided
6. Ages served
7. Group affiliations (i.e. affiliations through which the Participating Provider delivers services)
8. Hours of operation
9. After hours contact information
10. Website URL
11. Whether the Participating Provider will accept new Members
12. Cultural and linguistic capabilities, including languages spoken (e.g., Spanish, American Sign Language (ASL), etc.) by the Participating Provider or a skilled medical interpreter at the Participating Provider's office, and whether the Participating Provider has completed cultural competency training
13. Whether the Participating Provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment
14. Link to an interactive map with directions available

The State has asked the MCOs to also include the following elements as optional information that may increase member choice of provider:

1. Customer rating
2. Insurance plans accepted
3. Licensure/accreditation status
4. Service area listing
5. Special needs accommodations available
6. Whether public transportation is available in the service area

MCOs must notify members, within ten days of enrollment, of the availability and instructions for how to access the online provider directory including the link to the website address for the directory. This notice will also inform the member of their right to request a hard copy free of charge along with the phone number to call to make the request.

Evidence-Based 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.

- The policies, procedures and 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 Members

- Adopted in consultation with Participating Providers and reviewed and updated periodically as appropriate

Each MCO must have an internal approval process, including mechanisms to solicit input from its contracted provider network prior to adoption of the guideline. Guidelines are made available, without cost, by the MCO to members, prospective members and providers, and are posted on each MCO's website in an easy to find, easy to read format. The current guidelines for each plan can be found here:

Aetna Better Health: https://www.aetnabetterhealth.com/kansas/providers/guidelines

Sunflower Health Plan: https://www.sunflowerhealthplan.com/providers/resources/clinical-payment-policies.html

UnitedHealthcare Community Plan of Kansas : https://www.UHCCPprovider.com/en/health-plans-by-state/kansas-health-plans/ks-comm-plan-home/ks-cp-policies.html

Performance Measures

The State has identified a set of performance measures to monitor MCO performance that are published on the KanCare website. Data is presented and annually updated in a member- friendly format in order to assist members in comparing and selecting a Managed Care plan. The State chose to use a combination of nationally recognized measure sets whenever possible, including the National Committee for Quality Assurance (NCQA) HEDIS data, Consumer Assessment of Healthcare Providers and Systems (CAHPS) data, and Mental Health survey data.

The State used the CAHPS-HCBS Survey in 2018, 2019, and early 2020 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 National Outcomes Measurement System (NOMS), National Core Indicators (NCI), and National Core Indicators Aging and Disability (NCI-AD) and Mental Health survey. As performance measurement in home and community-based programs continues to evolve, the State may revise HCBS-specific performance measures 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.

KDHE and KDADS worked together to align the QMS goals with the 1115 demonstration waiver goals. QMS strategies address the specific needs of the population served and take 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 subsets of measures listed under each of the QMS goals selected are based on identified areas of opportunity and designed to achieve favorable outcomes in health status and experience of care. Additionally, the State will post, at a minimum, CAHPS (Adult, Child, and HCBS) data and all CMS required Medicaid Adult and Child Core Measures for each MCO to the KanCare website. 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.

The State has developed Specific, Measurable, Achievable, Realistic and Timely (SMART) strategies to help achieve the overall goals of the KanCare QMS. These goals and strategies are listed below:

Table 6.

Goal	SMART Strategy
1. Value-based models and purchasing strategies will further integrate services and eliminate the current silos between physical health services and behavioral health services, leading to improvements in quality, outcomes, and cost-effectiveness.	Increase the number of providers who qualified for value-based payment rate by 2% year over year (2019-2023).
2. Increasing employment and independent living supports for members who have disabilities or behavioral health conditions, and who are living and working in the community, will increase independence and improve health outcomes.	Reduce Hospital admissions and the use of crisis services by 25% by the end of three years (2019-2022), through increased use of employment and ILS services.
3. The use of telehealth (e.g., telemedicine, telemonitoring, and telementoring) services will enhance access to care for KanCare members living in rural areas. Specifically: A. Telemedicine will improve access to services such as speech therapy B. Telemonitoring will help members more easily monitor health indicators such as blood pressure or glucose levels, leading to improved outcomes for members who have chronic conditions. C. Telementoring can pair rural healthcare providers with remote specialists to increase the capacity for treatment of chronic, complex conditions.	Improve access to services by increasing the availability of telehealth services 2018-2023 (expecting a higher increase in 2020 than in subsequent years due to approval of additional procedure codes).
4. Removing payment barriers for services provided in Institutions for Mental Disease (IMDs) for members who have a primary diagnosis of a substance use disorder or co-occurring substance use disorder will result in improved member access to behavioral health services.	Decrease use of emergency room and hospital stays by increasing utilization of residential and outpatient BH services by 5% year over year (2019-2023).
5. Improve overall health and safety for KanCare members.	All MCOs are expected to achieve the National HEDIS 75th Quality Compass (QC) percentile for all reported HEDIS data. HEDIS measures falling below the 75th percentile the State has devised the following strategy aimed at reducing annually, by 10%, the gap between the 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. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI. (2019-2023).

Performance Improvement Projects

The Centers for Medicare and Medicaid Services requires Managed Care Organizations (MCOs) to conduct performance improvement projects (PIPs) that focus on both clinical and non-clinical areas each year (42 CFR 438330 and 4571240(b). A PIP is a pilot project designed to improve member health and quality of life. KanCare 2.0 requires each MCO to conduct at least three clinical and two non-clinical State-approved PIPs. The MCOs must conduct one of these PIP collaboratively, and one of the two non-clinical PIPS must be in the area of long-term-care. In addition, the MCOs must conduct a PIP EPSDT when the MCOs' overall rates drop below 85%. The focus of each PIP must be approved, in advance, by the State. PIP topics should address an area where the MCO has shown improvement is needed, especially those National HEDIS Measures that fall below the 75th percentile or other state priorities. With KanCare 2.0 the State required each MCO to implement a PIP which addresses a Social Determinant of Health (SDOH). Clinical PIPs should focus the quality and appropriateness of care 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 templates are 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 PIPs annually.

A member-friendly version of the current PIP topics and the MCOs' actions to achieve their goal can be found on the KanCare website at https://www.kancare.ks.gov/policies-and-reports/quality-measurement.

The following table represents the current KanCare 2.0 PIPs and the interventions the MCOs are using to improve the goals. Each PIP is assessed annually for successes, and changes are made to enhance effectiveness and improve impact.

*Some interventions are being adjusted due to face-to face interaction restrictions during Covid-19

Table 7.

KanCare 2.0 Individual Performance Improvement Projects		
ABH	SHP	UHCCP
AIM Statement: Will member-, provider-, and community-facing interventions reduce food insecurity, reported in the annual ABH health screening, for all members through the end of the PIP?	**AIM Statement:** Increase the outpatient BH treatment access for out-of-home foster care youth ages 3 to 17 across the state for the duration of the PIP. Current Interventions:	**AIM Statement:** Will member, staff, and provider interventions improve the identification of members who are homeless or at risk of homelessness? Will the addition of member and

Will provider engagement increase the use on claims of Z-codes that enhance identification of food insecure members? Current Interventions: • Annual calls to members to identify those with food needs • Quarterly webinars for members with diabetes given by RN/Diabetic Educator. Focus will be on topics such as how to make and access healthy food choices, reading food labels and managing a chronic condition • Identify members who could benefit from pharmacy consultation. Partner with pharmacists who complete an assessment and send results to ABH. Care Managers then reach out to members to address food needs • Education and outreach to providers in food desert areas to increase provider use of billing codes that identify members with food needs. This intervention will first be piloted with 1 urban, 1 rural and 1 frontier provider. • Donations to food banks located in food deserts	• Access to MyStrength, a digital BH application used for BH self-management that can be used on a phone, tablet or computer • Evaluation of SED waiver eligibility to enhance services for children in foster care and waiting for placement in a Psychiatric Residential Treatment Facility • Expand Parent Management Training- Oregon Model, an Evidence-Based Practice, to the two new State Foster Care Contractors. Track the number of families who complete most of the modules • Pilot an expedited intake and treatment appointment process with 2 urban and 2 rural/frontier Federally Qualified Health Centers (FQHCs) • Open the BH portion of the provider portal to allow MH providers to upload BH documents. This access will allow the provider to guide their sessions and pick up in treatment where a previous provider left off	community housing resources lead to permanent housing for members who are homeless or at risk of homelessness? Current Interventions: • Provide temporary financial help for eligible members to get and/or keep housing • 10 units of transitional housing to serve medically complex members who are homeless and have high utilization in medical claims • Work with homeless shelters to identify members to connect them with services as needed • Provide financial support to add Community Health Workers at 2 urban and 1 rural health clinics to increase the use of billing codes to identify those who may have housing needs • Train UHCCP Care Management staff on identifying and assisting members with housing needs • Member services will ask housing status questions to any member who calls Member Services for assistance with transportation issues. Members who report housing needs will be referred to a Housing Specialist
AIM Statement: Use member- and provider-focused interventions to increase the average time between ABH notification of the member's	**AIM Statement:** Will the use of multifaceted outreach interventions targeting providers and female SHP members improve the annual cervical	**AIM Statement:** Increase adherence to treatment among adult members who begin treatment for major depression using antidepressant medication by using a targeted,

pregnancy to the date of delivery. Use member- and provider-focused interventions to increase the percent of pregnant women with the initial prenatal visit occurring within the first trimester (for current ABH members who become pregnant) or within 42 days of enrollment (for members who are pregnant at the time of enrollment) from 42.00 percent (2019) to 75.5 percent by the end of the PIP(modified, unaudited, HEDIS rates). Current Interventions: • $20 gift card to member for notifying ABH of pregnancy through interactive text message • $20 gift card to member for notifying ABH of pregnancy through interactive phone message • Direct phone calls to new members who are pregnant to offer enrollment in Promise Pregnancy Program. Calls are made within 3 days of ABH being notified of enrollment • $100 reward to BH and FQHC providers for notifying ABH of member's pregnancy • $25 reward to urgent care providers for notifying ABH of member's pregnancy	cancer screening rate each re-measurement year? Current Interventions: • Phone call reminders from case manager to women who are overdue for a screening • Bi-directional and Interactive text message reminders to women who are overdue for a screening • Co-branded letters with providers who have not transitioned to electronic record keeping. SHP will identify the members who are overdue for screenings and mail the reminder. • Reports to providers, who are not participating in SHP's performance incentive, listing assigned/attributed women who are overdue for a screening • Provider webinar focused on overcoming screening concerns of members with an Intellectual or Developmental Disability	culturally competent, and multifaceted education and outreach. Current Interventions: • Wellness-call within 21 calendar days of prescription being filled to provide medication coaching and discuss use of mental health app, outpatient therapy and enrollment into OCK program • Follow-up call within 14 calendar days of the initial call to discuss progress and questions since the initial call • Ensure members reached during the initial call complete an annual Health Screening Assessment
AIM Statement: Decrease the use of emergency departments by HCBS members who are not in long-term care, are not subsequently admitted to higher-level care (i.e. inpatient,	**AIM Statement:** Increase employment for members on the IDD, PD and BI waivers and those KanCare eligible members on the respective waiver waiting lists by 2% year over year for the	**AIM Statement:** The use of targeted, culturally competent education in members age 18 and older without a guardian with long term services and supports will lead to 50% of the

residential, etc.), and for selected primary diagnoses considered as non-emergent by 5 percentage points year over year, or approximately 2.5 visits per month, for the first year of the PIP. Current Interventions: • Refrigerator magnet with individualized phone numbers for non-ER care resources • Individual meeting with member and caregiver following non-urgent use of ER to discuss non-ER options • Text message reminders with non-ER options including use of Nurse Help Line • Quicker notification to ABH of member's use of the ER through the CareUnify notification system. Case Managers will then contact the member within 3 days to discuss non-ER options when appropriate. • Study trends of non-emergent ER use by members on the HCBS waivers	duration of the PIP by decreasing the barriers identified by providers and members. Current Interventions: • Mailers to members with employment-related information and assistance options in the member's community. Mailers will include the Employment Specialist's contact information as well. • Transportation to job interviews and job fairs • Partnering with employers to increase job opportunities for young adults in Project SEARCH • Rewards to day support providers to help members find and maintain competitive employment for members receiving services • Annual training for case managers on regional employment resources and employment incentive programs. Attendees will complete a pre and post survey to assure the training materials met the case manager's needs.	identified population having an executed Advanced Directives on file with UHCCP by the end of the PIP measurement period. Current Interventions: • Develop an easily understood Advance Directives form and a process to inform, document, store and track the sharing of the form with the member's primary care physician, care providers, family, and interested parties per the member's choice • Mail information about Advance Directives to members on the FE waiver in Sedgwick County 3 weeks prior to annual visit. This will allow members an opportunity to prepare for the conversation. • Assist members with completion of Advance Directives for members on the FE waiver in Sedgwick County during their annual visit • Train UHCCP Community Health Workers and Care Coordinators on the sensitivity of discussing Advance Directives • Collect and store completed Advance Directives in the UHCCP care management record (Community Care). Assist members with sharing their completed Advance Directives with at least one other person • Inform providers of the Advance Directives project
AIM Statement: Will multifaceted education and	**AIM Statement:** The use of a multifaceted intervention	**AIM Statement:** Direct outreach to members and

outreach interventions, targeting the member's care team (including providers and parents/guardians, as well as health departments) increase the influenza vaccination rates in children and adolescents during 2020 through 2023? Current Interventions: • $15 gift card to parent/guardian when child gets flu vaccination • Nurse will be available to give flu shots at four community health events • Up to four interactive reminder texts to parents or guardians until reply text is received that child has been vaccinated • Reminders on CVS prescription packages during flu season • Reports to providers of children who have not received a flu vaccination. Providers will then receive a survey to assess if reports were helpful in increasing flu vaccinations.	approach, targeting members 18-64 years of age with Schizophrenia or Schizoaffective Disorders and Diabetes and providers who serve this population will increase the compliance with annual LDL-C and Diabetes HbA1c testing by 3 percent year over year. Current Interventions: • Phone call reminders from case managers to members who are overdue for a HbA1c and LDL-C test • Reminder letters to members who are overdue for their HbA1c and LDL-C tests, using both SHP and the physician's letterhead with 5 pilot providers • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test	providers to bring rates of HbA1c and LDL testing back to, or exceed, the 2015 rates of over 70% over the next 3 years with annual progress of at least 3% Current Interventions: • Phone call reminders from Care Manager to members identified with complex medical needs and are overdue for a HbA1c and LDL-C test • Phone call reminders from Care Coordinators to members who are receiving waiver services and are overdue for a HbA1c and LDL-C test • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test
KanCare 2.0 Early Periodic Screening Diagnostic Treatment/ KAN Be Healthy PIP		
AIM Statement: Achieve an EPSDT participation rate of 85 percent for ages 0 – 20 years, over a five-year period. Current Interventions: • $25 each year for completing annual well visit - ages 13 to 20 years • $10 card and gift pack (including an activity book from Ted E. Bear, M.D.) each year for completing annual well visit - birth to 12 years	**AIM Statement:** Increase the EPSDT screening rate for KanCare members through a combination of provider, member, and community focus interventions over a five-year period. The effectiveness of the PIP will be measured by the percentage of KanCare members, ages 0 to 20, who receive at least one EPSDT screening within the measurement year. Current Interventions:	**AIM Statement:** Will the use of targeted interventions to UHCCPHealthcare members and providers improve the percentage of UHCCPCP KS members ages 0-20 who obtain at least one EPSDT visit during the measurement year? Improve EPSDT participation compliance rates to at least 85% over a five-year period. Current Interventions: • Phone call reminders to members who are 18-20 years old and overdue for a

• Interactive text message, in the member's language preference, to parents/guardians of children who are overdue for a visit. System will ask for a response and transfer to member services all those who respond that they do not plan to go/make an appointment • Automated phone message to parents/guardians of children who are overdue for a visit. System will allow the member to warm transfer to customer service for assistance • A reminder message attached to prescriptions at all CVS pharmacies in Kansas. Reminder will be included on the first prescription filled during the quarter prior to the member's birthdate • Two provider education webinars. Strategies for adherence and difference between younger and older children will be covered	• Interactive text message reminder to parent/guardian or members who are overdue for a visit. System allows members to respond to and ask questions. • Two community outreach events where KAN Be Healthy visits can be completed onsite • Case Manager phone call reminder of annual visit for members on the SED waiver • Improve and coordinate tracking of EPSDT visits with contracted foster care agencies • In-person provider education visits to 5 large practices to discuss individual goals and barriers for their membership	visit, with the option to warm transfer to schedule an appointment • Mailing reminders to members without a known phone number. Mailer will include information detailing how members can obtain a phone through the health plan using UHCCPCP KS's value-added benefits (VAB) • Monetary incentive for providers who have over 50 members needing an EPSDT visit • Notification to contracted foster care agencies of those members who need an EPSDT visit • Reports of members who are due for a visit to providers who are not part of any other UHCCP EPSDT incentive program

COVID-19 Vaccination Collaborative PIP

AIM Statement: Increase COVID-19 vaccinations for KanCare members through a combination of provider, member, and community-focused interventions. The effectiveness of the PIP will be measured by the percentage of KanCare members, not living in a long-term care facility, who receive at least one dose of COVID-19 vaccine within the measurement period.

Current Interventions:

- Host two vaccine events in partnership with Health Departments and/or Federally Qualified Health Centers where members can get vaccinated
- Provide incentives for members who are vaccinated at either of the two vaccination events
- Outreach to members who have not received the COVID-19 vaccine in a variety of ways (texting, IVR calls and emails)
- Survey OCK providers to better understand what type of COVID-19 related communication/education would be most helpful
- Based on survey results, distribute quarterly communication to OCK providers focusing on COVID-19 topics such as mental health related needs and notification of vaccine related events throughout Kansas

External Quality Review

Kansas has a contracted with KFMC Health Improvement Partners to provide External Quality Review (EQR) activities. EQR activities are considered a core feature in the State's quality strategy. The State has incorporated the EQRO recommendations into the overall QMS. A table has been provided which details the State's response to each recommendation in the review, dissemination, and evaluation section of the QMS.

KFMC's final compliance review reports are distributed to KDHE, KDADS and MCO leadership for review. In 2020 KFMC implemented a Progress Tracking Tool that accompanies their compliance review reports. This tool documents each plan's rating for 2018 to the current year's rating, a progress update and the MCO's plan to address each of KFMC's recommendations. KFMC's findings are monitored for the degree to which the previous year's EQRO recommendations have been addressed and any opportunities for improvement KFMC identifies.

The EQRO is also available to provide technical assistance to the State's contracted Medicaid MCOs, much of which has focused on PIPs and performance measure reporting.

KanCare does not utilize the option for non-duplication of mandatory activities {described in 42 CFR 438.360(c)}. KanCare uses a combination of the EQRO activities listed below and the requirement for the MCO to be NCQA accredited with the LTSS designation. Each MCO's NCQA status is posted here.

The core services provided under this contract include:

- Validation of Information Systems Capabilities Assessment (ISCA) and Performance Measure Validation (PMV)
- Validation of PIPs
- CAHPS Health plan 5.0H Survey Validation
- 2020 Mental Health Consumer Perception Survey
- Provider Satisfaction Survey Validation
- Review of Compliance with Medicaid and CHIP Managed Care Regulations
- QAPI Review
- Network Adequacy Validation
  - 2020 and 2021 After-hours availability study
- Conduct Special Projects as requested
  - 2021 Review of Postpartum focused study

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, Emergency Department, 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.

The State's official TOC policy as well as the policy for transitioning from one MCO to another is posted at www.kancare.ks.gov/policies-and-reports/transition-of-care. Each contracted MCO is contractually obligated to follow the TOC policy.

MCOs are required to provide transition of care management for all KanCare Enrollees. Specialized care coordination is required for Enrollees whose health care needs are changing for a variety of reasons, including:

- Changing from one MCO to another
- Hospital (Ex: State hospital, Intermediate Care Facilities for Individuals with Intellectual Disabilities, etc.) to home or nursing facility
- Nursing facility to home/home to nursing facility
- Enrollee assignment to HCBS waiver
- Enrollee assignment of chronic care management moved from one provider to another
- Transition to or from KanCare eligibility
- Transitions for children in Foster Care

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.

KDHE has taken steps to identify and evaluate the age, race, ethnicity, sex, primary language, and the disability status for each member at the time of enrollment. Disability status means, at a minimum, whether the individual qualified for Medicaid based on a disability. The State of Kansas uses Social Security disability determination as its data source to determine disability status.

The State of Kansas does not define disability status for the CHIP population because disability status does not make a person eligible for CHIP. Only age and income are used to determine eligibility for CHIP.

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 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 for the coming year, 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.

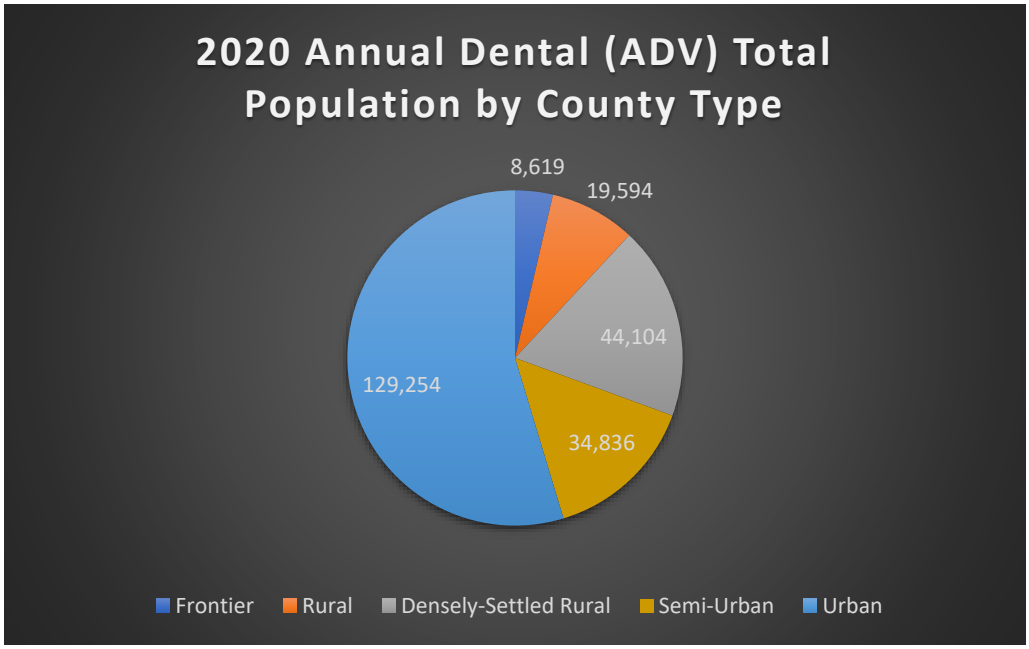
Contracted MCOs and their network providers and subcontractors that provide services to KanCare members participate in Kansas' efforts to deliver care in a culturally competent manner to all members. Additional information requirements specific to the Provider Directory include the capture of each provider's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

The participating MCOs provide Value Added Benefits (VABs) to their members. These VABs, in part, are an attempt to address and reduce Social Determinants of Health (SDOH) of members. Examples include free smartphones, transportation services, education advancement, smoking cessation, internet access, and more. These VABs are adjusted each year based on utilization and identified needs. All 2021 VABs can be found at https://www.kancare.ks.gov/consumers/benefits-services.

The State is working to reduce SDOH by identifying where SDOH exist. The first step in this process was to conduct research to identify populations that are impacted by SDOH. The State examined four measures; Annual Dental Visits (ADV), Postpartum Care (PPC), Adults' Access to Preventative/Ambulatory Health Services (AAP), and Child and Adolescent Well-Care Visits (WCV). The figures below include the four measures that the State examined and the resulting State response:

1. Annual Dental Visit Project:

   Figure 1.



The above data led the State to explore whether members in frontier counties have adequate dental network coverage. We discovered a potential health disparity for members in frontier counties due to a lack of dental providers. As a result, our Provider network team is working with MCOs to close coverage gaps, and we ask MCOs to document efforts to get new dentists from those areas into their networks.

Below are the GeoAccess maps for dental providers, both adult and pediatric, as of April 01, 2021. The entire set of GeoAccess maps are posted quarterly at www.kancare.ks.gov/policies-and-reports/network-adequacy.

Figure 2.

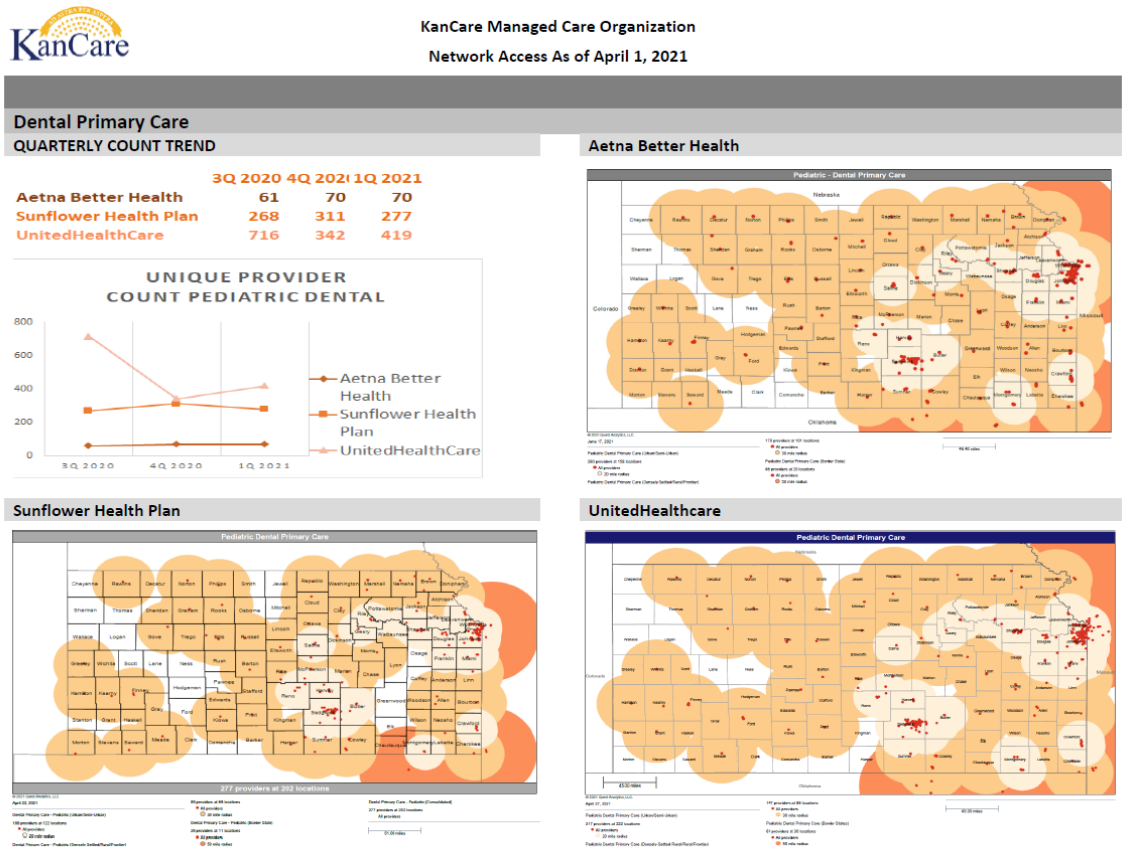
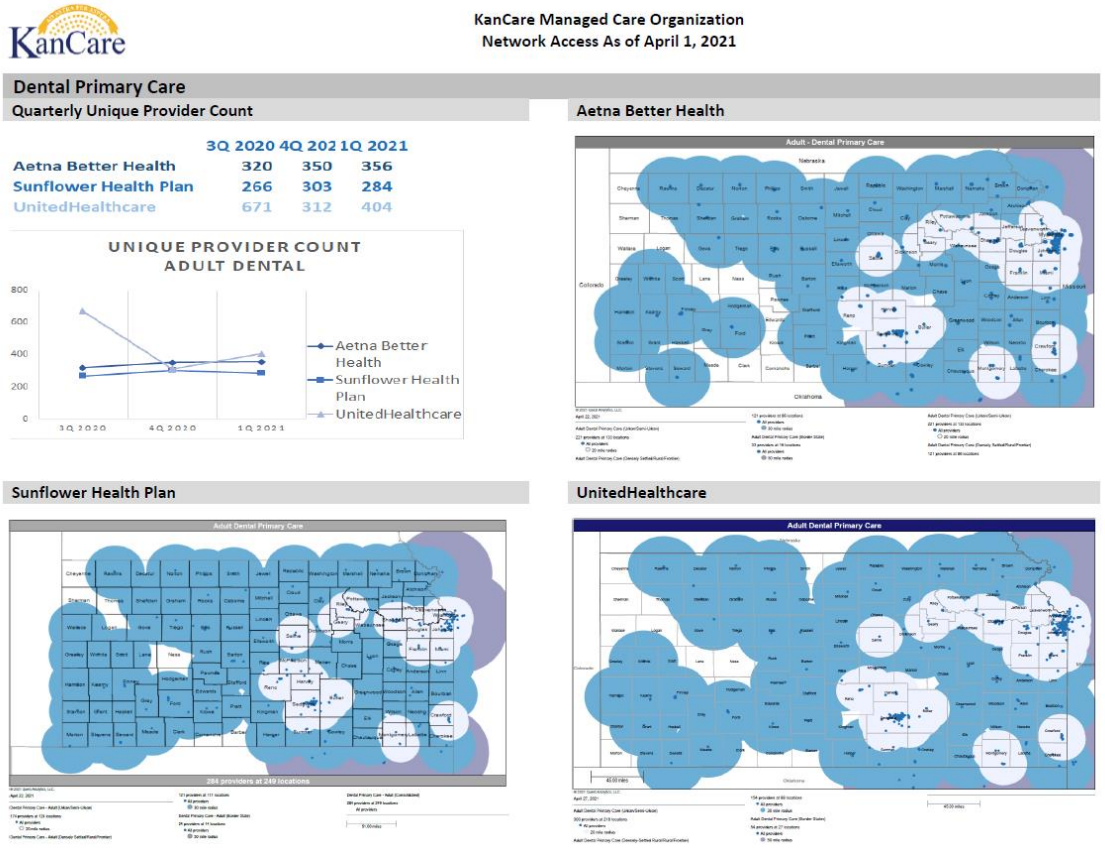
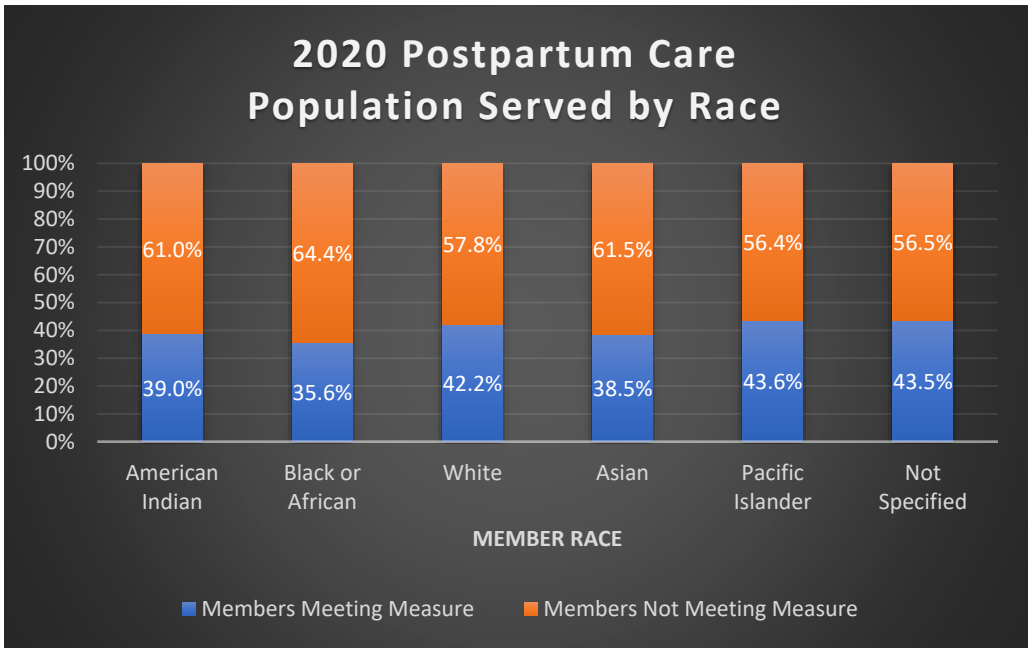


Figure 3.



2. Postpartum Care Project:

Figure 4.



The State has had a Timeliness of Prenatal Care Pay for Performance measure since 2016. The MCOs showed above expected rates of meeting this performance measure. Since the measure was exceeding expectations, the State decided to add Postpartum Care as a Pay for Performance measure.

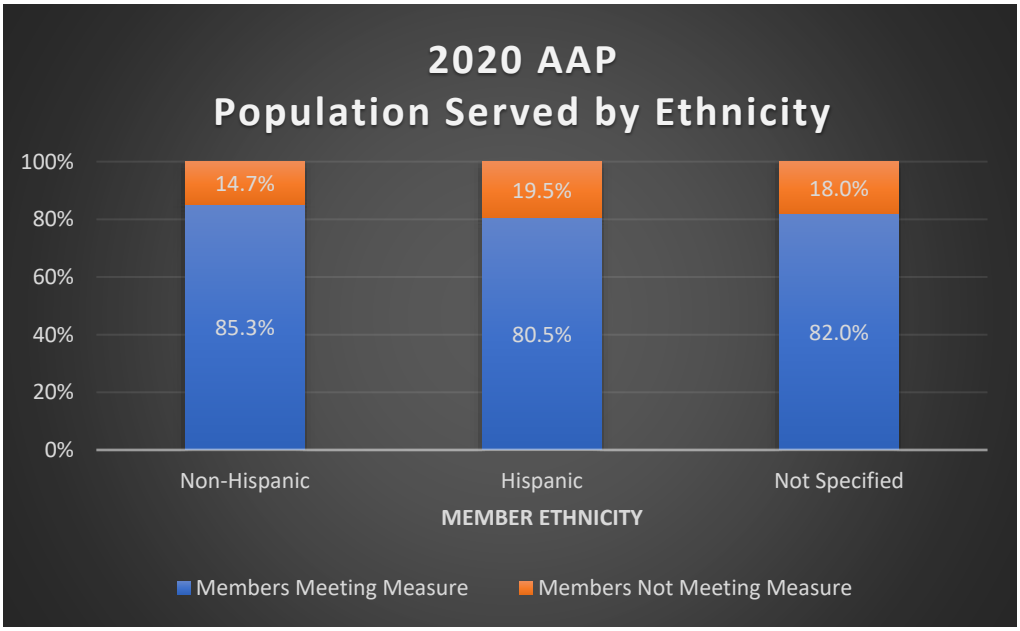
The data above shows the disparity in races is low (6%) for KanCare members. The State did find Kansas had HEDIS rates that have been below the 50th percentile and below the 25th percentile in 2019 for postpartum care. For this reason, The State has added focus on increasing the postpartum care (PPC) rate for all women who give birth by implementing in 2020 a pay for performance incentive to increase women's likelihood of receiving a postpartum visit. This is a project where the state withholds a portion of the MCOs payment in order to incentivize the MCOs to improve rates. Postpartum was chosen after reviewing factors such as the number of members impacted, lack of progress over time, and low HEDIS scores.

Table 8.

Postpartum Care		
	HEDIS Total	**Quality Compass Ranking**
2018	58%	<25th
2019	67%	<25th
2020	76%	Data not yet available
Prenatal Care		
	HEDIS Total	**Quality Compass Ranking**
2018	75%	<25th
2019	84%	<33rd
2020	80%	Data not yet available

3. Adults' Access to Preventive/Ambulatory Health Services (AAP) Project:

Figure 5.



The 2020 CAHPS survey asked multiple questions regarding provider access ratings. Some questions included:

- How often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?
- When you needed care right away, how often did you get care as soon as you needed?

The State maintained a rating above the 75th percentile of the Quality Compass since 2018 for Adults receiving care as soon as they needed. Since 2019 we have scored above the 90th percentile of the Quality Compass when adults were asked if they were able to get an appointment for preventive care as soon as they needed.

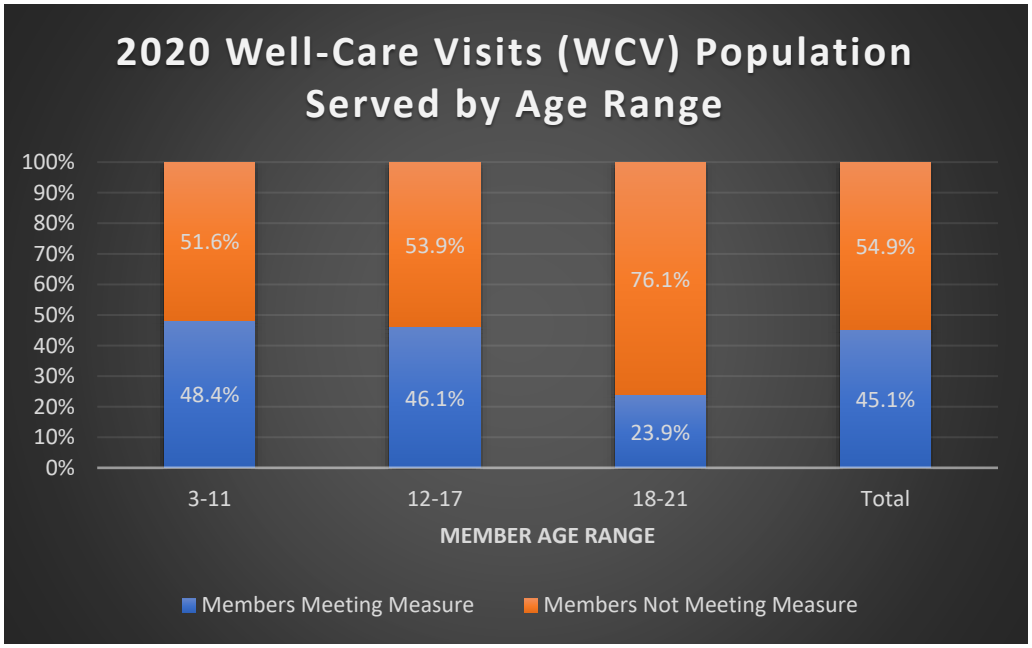
From 2016 to 2020, the KanCare adult Getting Care Quickly scores increased an average of 0.8 p/yr. (p< .01) The 2020 score for each MCO was 88. The ABH and SHP adult scores ranked > 90th, and the UHCCP score, which was 0.8 points higher, ranked >95th.

In the 2021 CAHPS report the EQRO recognized that the "Overall Observation" showed the composite scores for getting urgent and routine care quickly again show strengths for the KanCare program. The KanCare adult score ranked >90th for the second year in a row. The MCO child composite scores in 2020 for Getting Care Quickly ranged from 90 to 97. The MCO child composite scores in 2020 for Getting Care Quickly ranged from 90 to 97.

for the last three years, over 91% of parents surveyed reported they were able to get an appointment for urgent and for routine care as soon as they needed it.

4. Child and Adolescent Well-Care Visits Project:

Figure 6.



One method the State uses to target efforts on encouraging members to receive well-care visits is to require MCOs to develop and implement a PIP on EPSDT Screening and Community outreach when overall CMS 416 rates drop below eighty-five percent (85%). The overall rates in 2019 were 72% and in 2020 were 69% (decrease possibly due to Covid-19). The State, EQRO and MCOs collaboratively decided the aim of these PIPs would focus on increasing participation rates (#10 Form CMS-416) to simplify measurement, impact those members with no EPSDT participation and spotlight efforts toward older

members (age 6-20) where improvement was most needed. MCOs submit participation rates for the following age groups quarterly:

- All ages
- 6-20
- 5 and below
- Under 1
- 1-2
- 3-5
- 6-9
- 10-14
- 15-18
- 19-20

Each group is aggregated and presented in a snapshot format showing how close or far they are to the aim of 85%. This allows the teams to quickly detect if a particular age group is improving or declining and adjust interventions accordingly. The State, EQRO and MCO PIP teams meet monthly to discuss agenda topics such as interventions that appear to be ineffective, adjustments to interventions based on results, improvements to processes and documentation, etc.

Each MCO is required to have five interventions for each PIP.

Some of the current interventions used to address the EPSDT PIP include:

- Interactive text message reminders to member
- Gift cards to incentivize members to attend appointments
- Phone call reminders to members who have children that are overdue for a visit. This system will allow the member to warm transfer to customer service for assistance

Corrective Action Plan and 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 quality improvement program. If an MCO has inadequate quality performance a remediation plan will be established. This is the State's preferred method of working with the MCOs to maintain compliance. If the remediation plan is unsuccessful, the State may then impose a Corrective Action Plan (CAP). There will be, at times, a need for KanCare Leadership to impose CAPs if there is a catastrophic inability to perform operational tasks, sanctions, and even contract termination if the expected quality improvement 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 can request the MCO terminate those contracts should they not be responsive to a CAP or improvements to performance.

Over the past three years Kansas did not implement any intermediate sanctions with the three MCOs. However, Kansas did implement a CAP with ABH. ABH was awarded the contract to provide KanCare services as a new MCO in the State beginning in 2019. During the transition period there were several readiness tasks where ABH needed additional time to implement. As a result, ABH was placed on a CAP during portions of 2019 and 2020. ABH was able to satisfactorily resolve these readiness tasks and the CAP was removed.

In cases of noncompliance or where the MCO did not demonstrate adequate performance, CAPs will require clearly stated objectives, the individual/department responsible, and timeframes to remedy the deficiency. CAPs may include, but are 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 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.

Other systems to monitor compliance include:

- Both KDHE and KDADS have defined quality units within each of their respective organizations responsible for the day-to-day oversight and monitoring activities.
- The KDADS 1915(c) waiver quality monitoring is defined within the parameters of the individual waiver. Waiver activities and quality measures are monitored by both the quality team and the operational team within KDHE-DHCF as the single state agency.
- 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 review process is designed to facilitate ongoing quality improvement 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.

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
- Results of each MCO's performance under the State's P4P program
- 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
  - Utilization Management timeliness of decision making and rates of service utilization reports
  - Evaluation of each MCOs Quality Assessment and Performance Improvement Program
  - GeoAccess reports and Network Adequacy reports
  - Timeliness of appointment reports
  - SUD and BH survey reports
  - Provider Satisfaction survey report
  - Trending reports for HCBS waiver assurance measures
  - Progress of PIPs

Special Healthcare Needs and Long-Term Support Services

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:

- 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 program or Other Employment Programs
- KanCare utilizes a Health Screening tool that identifies members who may be at risk, these members receive a Health Risk Assessment to determine the need for service coordination. Each MCO is required to complete a Health Screen annually for all members. Screenings include questions related to Social Determinants of Health and Independence, such as housing instability, food insecurity, and unemployment/under employment

The following are the steps the MCOs use to identify members with LTSS or special health care needs:

- The MCOs are required to annually complete a health screening with each member to identify those who may need LTSS or who have special health care needs
- The MCOs must utilize a State developed health screen and scoring algorithm
- The MCOs must make reasonable efforts (three [3] attempts via phone and then follow up by mail within ten [10] business days from date of enrollment for new members) to contact member in person, by phone, or by mail to complete health screening. If unable to reach the member, the MCOs must attempt screening again, at a minimum, every ninety (90) days or following HCBS waiver requirements. The MCOs must use methods beyond the typical phone and mail to reach the member, including hard-to-reach members, but not limited to, contacting through a provider or other community partner, etc.
- All members who meet a total score threshold, or an elevated score within at least one of four sections of the health screen tool (Health Status, Health Condition, Health Lifestyle, Home/Employment), indicates a need for a Health Risk Assessment (HRA)
- The MCOs must complete a State approved HRA tool within 30 days of the completion of the health screen (or as directed by HCBS waiver or State policy for LTSS and BH)
- Members with LTSS and BH needs must be assessed within 14 days of enrollment
- The HRA will determine the type of needs assessment warranted by the member's health status and the next steps in the process based on member's needs identified in the assessment
- The MCOs report their completion rates via the KanCare Report Administration

Service coordination requirements include that the MCOs will be responsible for Service Coordination and continuity and continuation of care by establishing a set of Member-centered, goal-oriented, culturally relevant, and logical steps to ensure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Case Management, disease management, discharge planning, and transition planning are elements of Service Coordination for Members across all Providers and settings. Service Coordination shall also assist Members with addressing Social Determinants of Health and Independence.

The MCOs shall develop and implement a comprehensive Service Coordination program that meets the following goals and objectives:

- Supports person-centered care
- Intervenes along a continuum of need from Preventive Care to addressing acute, complex, and chronic needs
- Integrates Behavioral Health, physical health, and LTSS needs with an emphasis on the integration of treatment for co-occurring mental health and substance use disorders (SUDs)
- Improves health outcomes for the entire population
- Addresses the Social Determinants of Health and Independence, including housing, adequate nutrition, adequate environmental conditions, transportation and other social determinants.
- Increases access to community based LTSS
- Allows for maximum access to community supports
- Supplements but does not supplant natural supports
- Provides for conflict-free Case Management, service delivery and assessment as directed by Federal and State law, as well as State policy (per 42 CFR § 431.301(c)(1)(vi) and 42 CFR § 441.730(b))

- Ensures that all populations, depending on their needs, receive the appropriate level of Service Coordination
- Consists of Case Management, and Service Coordination functions and activities
- Ensures appropriate face-to-face monitoring or telehealth, depending on needs of the member

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 also submit a revised QMS at any point there is a significant change as a result of our ongoing review and evaluation. A significant change will encompass major program changes (i.e., new program, new populations) or a change in any of the KanCare QMS goals or strategies.

The State, along with its EQRO, evaluates the effectiveness of the QMS as part of the annual 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 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, are used to identify any needed improvements 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, Ombudsman, and public input into the review and evaluation of the QMS on an ongoing basis. This is achieved through the 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 and tribal input that will then be incorporated into the QMS and evaluated by the KanCare QMS team. The State will Submit a copy of the initial strategy for CMS comment and feedback prior to adopting it in final. The State will make the final copy of the QMS available here.

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 in continuous monitoring and improvement activities that ultimately impact the quality of services and reinforce positive change.

The table below indicates the recommendations from the EQRO after reviewing the Kansas 2018 QMS and the corresponding responses from the State.

Table 9.

EQRO Recommendations for 2018 QMS		
Recommendation #	**Recommendation**	**State Response**
1	The objective should be clearly stated and should be designed as SMART objectives.	The revised QMS includes goals and objectives that are Specific, Measurable, Attainable/Achievable, Relevant and Time-Bound (SMART)
2	Continue to include in the next version of the KanCare 2.0 Quality Management Strategy quality of care and quality of life measures including addressing health disparities	The State is including goals and objectives in the revised QMS that address improving the delivery of holistic, integrated, person centered, and culturally appropriate care to all members, increasing employment and independent living supports to increase independence and health outcomes, and Improving overall health and safety for KanCare members. We have included a section describing the State's initiatives to address health disparities as well as SDOHs.
3	KDADS should continue their efforts to establish a data source and data collection process to initiate the continuous collection and utilization of NOMS data in the future.	KDADS continues to work with providers to align data collection for NOMS with Provider electronic health record systems and allow for less duplicate entry through Application Programming Interface connections with new state systems. KDADS has issued a Request for Proposal to contract for a statewide Electronic Health Record for state hospitals and SUD providers.
4	Ensure MCOs' Quality Assessment Performance Improvement (QAPI) plans include specific strategies for how they will address the KanCare 2.0 QMS objectives.	Each MCO's QAPI is due to the state on August 31 each year through the KRA site. The State will review each submission to ensure that the QAPIs adequately address the QMS objectives. The KRA site will allow the state to provide feedback and request more information as needed, as well as document the feedback and information requests. The state will review and assess the QAPIs submitted by the MCOs to ensure that their projects align with the State's QMS goals and strategies. Additionally, the State will obtain data from the MCOs from several sources, including HEDIS, KRA, MDS, KDADS quality review report, claims data, etc. This data will provide additional

		evidence the State needs in order to monitor MCO progress on QMS objectives.

EQRO Evaluation of 2020 KanCare QMS

KanCare Quality Initiatives

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 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 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 program embraces 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.

After the EQRO review of the previous QMS and after receiving input from multiple stakeholders, opportunities for improvement have been identified.

Crisis Response Claims

One identified quality initiative is Objective 1.3: Increase the number of crisis response claims that occur in the community setting, including in the member's home. The intent of Objective 1.3 is to increase responses, increase timeliness, and to be more person-centered. Preference is for Mobile Crisis Intervention to be provided in person, at the preferred location of the individual or family (home, school, or other community-based setting) by a Licensed Qualified Mental Health Professional. This code can be reimbursed for individuals ages 0-20.

Increase Use of Z Codes

Another quality initiative that was discovered is related to Objective 2.9: Increase the rate of claims that use Z codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs. The State believes that Covid-19 played a significant role in the decrease of the use of Z codes from 2019-2020. The State is working to understand how we can encourage providers to utilize Z codes on a consistent basis so that the State can more accurately track the data provided in the Z codes. The State intends to consult with providers, provider associations, and the quality steering committee for suggestions. ABH's reducing food insecurity PIP has an intervention where providers are partnering with a university to increase utilization of Z codes (Z59 category) to identify members who may have food insecurity. UHCCPCP has a housing PIP with an intervention that funds a community

health worker in RHCs to increase use of Z codes (Z59.0, Z59.1, Z59.8, Z59.9) to identify those that may have housing needs.

Address Dental Health Disparities

The State has discovered a potential health disparity for members in frontier counties due to a lack of dental providers. As a result, our Provider network team is working with MCOs to close coverage gaps and we ask MCOs to document efforts to get new dentists from those areas into their networks.

The State has recently increased the rates paid to dental providers to encourage more dentists to accept KanCare patients. The rationale is that increasing the rates on these specified dental codes will potentially improve access to care and improve health outcomes for members requiring extensive and specialized dental care. This is especially important for pediatric members.

Postpartum Care HEDIS Rates

The State has had a pay for performance project with our MCOs for PPC rates since 2020. This is a project where the state withholds a portion of the MCO's payment in order to incentivize the MCOs to improve rates. PPC was chosen after reviewing factors such as the number of members impacted, lack of progress over time, and low HEDIS scores.

Maternal Postpartum Study

The State began a project in 2021, in partnership with the EQRO, to study the maternal postpartum Medicaid coverage extension. Seeing an opportunity to extend Medicaid coverage for women who qualified due to pregnancy from 60 days after delivery to 12 months after delivery, KDHE requested a study to characterize and quantify the postpartum services that have been provided through KanCare during this Covid-19 extended eligibility period. This study will help the State determine whether to continue this coverage period once the Covid-19 delayed discontinuance policy has expired.

The study questions for the project are:

> What are the typical postpartum medical and behavioral health services provided through KanCare to adult women in the 3rd to 12th month after delivery (classified by type and quantity of services)?
>
> Assuming KanCare continues to extend postpartum coverage, what is the expected sum of claim payments (per year) that would be made by KanCare MCOs to providers for medical and behavioral health services provided in the 3rd to 12th month after delivery?

The initial measures being used to answer the study questions are:

- Prevalence rate of most frequently used primary and secondary diagnoses categories coded on claims during the 3rd to 12th month postpartum period
- Incidence rate of most frequently used primary and secondary diagnoses categories coded on claims during the 3rd to 12th month postpartum period that were not coded on the member's claims from 8 months prior to delivery through 2 months after delivery
- Average number of outpatient or professional visits (days of service)
- Average number of days of inpatient hospital stay
- Number of days' supply, by National Drug Code (NDC) description, for prescriptions dispensed during the 3rd to 12th month postpartum period

- Number of days' supply, by NDC description, for prescriptions dispensed during the 3rd to 12th month postpartum period that were not dispensed from 8 months prior to delivery through the second month after delivery
- Total amount paid by MCOs
- Total amount paid by other insurances

Ongoing commitment to quality improvement 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 supports Kansans to 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: Crosswalk

	42 CFR § 438.340 Reference #	Description	QMS page reference
1	438.340(b)(1)	State-defined network adequacy standards developed in accordance with 438.68 (e.g., time and distance and LTSS provider standards).	22
2	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).	22
3	438.340(b)(1)	State's approach to adoption and dissemination of evidence-based clinical practice guidelines in accordance with 438.236.	24
4	438.340(b)(2)	Developing goals and objectives for continuous quality improvement, which must be measurable and take into consideration the health status of all populations served by MCOs.	8
5	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.	25
6	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.	27
7	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.	33
8	438.340(b)(5)	Description of the State's TOC policy required under 438.62(b)(3).	33

	42 CFR § 438.340 Reference #	Description	QMS page reference
9	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). For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status.	34
10	438.340(b)(7)	Appropriate use of intermediate sanctions that, at a minimum, meet the requirements of 42 CFR part 438, subpart I.	41
11	438.340(b)(8)	The mechanisms implemented by the State to comply with 438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	43
12	438.340(b)(9)	The information required under 438.360(c) (relating to non-duplication of EQR activities)	33
13	438.340(b)(10)	The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.	45
14	438.340(c)(1)	Make the strategy available for public comment before submitting the strategy to CMS for review	20
15	438.340(c)(1)(i)	Obtaining input from the Medical Care Advisory Committee (established by 431.12 of this chapter), beneficiaries, and other stakeholders.	20, 45
16	438.340(c)(1)(ii)	If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in § 438.310(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy.	20
17	438.340(c)(2)	Review and update Quality Strategy no less than once every three years.	45

	42 CFR § 438.340 Reference #	Description	QMS page reference
18	438.340(c)(2)(i)	This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.	45
19	438.340(c)(2)(ii)	The State must make the results of the review available on the Web site required under § 438.10(c)(3).	20, 45
20	438.340(c)(2)(iii)	Updates to the quality strategy must take into consideration the recommendations provided pursuant to 438.364(a)(4).	45
21	438.340(c) & 438.340(c)(3)(i)	Submit a copy of the initial strategy for CMS comment and feedback prior to adopting it in final.	45
22	438.340(c)(3)(ii)	Submit a copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	45
23	438.340(d)	The State must make the final quality strategy available on the Web site required under 438.10(c)(3).	45

Appendix B: Acronyms

AAP-Adults' Access to Preventative/Ambulatory Health Services

ABH-Aetna Better Health of Kansas

ADAP-AIDS Drug Assistance Program

ADV-Annual Dental Visits

AI/AN-American Indians and Alaska Natives

AIR-Adverse Incident Reporting

AOD-Alcohol or Other Drug

APM-Alternative Payment Model

ASL-American Sign Language

AU-Autism Waiver

BH-Behavioral Health

BI-Brain Injury Waiver

CAHPS-Consumer Assessment of Healthcare Providers and Systems

CAP-Corrective Action Plan

CCC-Children with Chronic Conditions

CFR-Code of Federal Regulations

CHIP-Children's Health Insurance Program

CMS-Centers for Medicare & Medicaid Services

DCF-Kansas Department for Children and Families

DHCF-Division of Health Care Finance

DME-Durable Medical Equipment

DSRIP-Delivery System Reform Incentive Payment

ELMB-Expanded Low Income Medicare Beneficiary

EPSDT-Early and Periodic Screening, Diagnostic and Treatment

EQR-External Quality Review

EQRO-External Quality Review Organization

FE-Frail Elderly Waiver

FFS-Fee for Service

FQHC-Federally Qualified Health Center

HbA1c-Glycated hemoglobin

HCBS-Home and Community Based Services

HEDIS-Healthcare Effectiveness Data and Information Set

IDD-Intellectual/Developmental Disability Waiver

IET-Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

ILS-Independent Living Support

IMD-Institutions for Mental Disease

ISCA-Information Systems Capabilities Assessment

I/T/U-Indian Health Programs, Tribal Governments, and Urban Indian Organizations

KDADS-Kansas Department for Aging and Disability Services

KDHE-Kansas Department of Health & Environment

KFMC-KFMC Health Improvement Partners (the EQRO)

KMMS-Kansas Modular Medicaid System

KRA-Kansas Report Administration

LDL-C Low-density lipoprotein cholesterol

LMB-Low Income Medicare Beneficiary

LTSS-Long-Term Services and Supports

MCAC-Medical Care Advisory Committee

MCO-Managed Care Organization

MDS-Minimum Data Set

MH-Mental Health

NCI-National Core Indicators

NCI-AD-National Core Indicators Aging and Disability

NCQA-National Committee for Quality Assurance

NDC-National Drug Code

NF-Nursing Facility

NFMH-Nursing Facilities for Mental Health

NOMS-National Outcomes Measurement System

OCI-Operation Community Integration

OCK-OneCare Kansas

P4P-Pay for Performance

PACE-Program of All-Inclusive Care for the Elderly

PCP-Primary Care Provider

PD-Physical Disability Waiver

PH-Physical Health

PIL-Protected Income Level

PIP-Performance Improvement Project

PMV-Performance Measure Validation

PPC-Postpartum Care

PWID-People Who Inject Drugs

QAPI-Quality Assurance and Performance Improvement

QMB-Qualified Medicare Beneficiary

QMS-Quality Management Strategy

RN-Registered Nurse

SDOH-Social Determinants of Health

SED-Serious Emotional Disturbance Waiver

SHP-Sunflower Health Plan

SMART- Specific, Measurable, Achievable, Realistic and Timely

SOBRA-Sixth Omnibus Budget Reconciliation Act

SSA-Social Security Act

STC-Special Terms and Conditions

STEPS-Supports and Training for Employing People Successfully

SUD-Substance Use Disorder

TA-Technology Assisted Waiver

TB-Tuberculosis

TIN-Tax Identification Number

TOC-Transition of Care

TTY-Text Telephone

UHCCP-United HealthCare Community Plan of Kansas

VAB-Value Added Benefits

VBP-Value Based Purchasing

WCV-Child and Adolescent Well-Care Visits

Appendix C: List of Figures and Tables

Figures

Tables

Appendix D: Public Comments

QMS Feedback	
There were nine questions/comments on the 2021 KanCare Quality Management Strategy.	
General Questions/Comments Summary	**State Response**
Stakeholder suggested: for Goal 1.3 Improve Mobile Crisis Intervention Response claims by providing community setting or in the home crisis intervention by licensed mental health professionals.	The State agrees and added language to Objective 1.3 to clarify that the services are to be provided by Licensed Qualified Mental Health Professionals.
Stakeholder suggested: Goal 1, objective 1.3: would like there to be clarification that the objective is to increase the percentage (rather than number) of crisis response claims that occur in the community/home setting (vs. other settings such as office). This clarification is sought to ensure that there is no conflict with the second goal related to reducing use of crisis services by 25%.	The State agrees that the intention of objective 1.3 is to increase the percentage of crisis response claims that occur in the community/home setting, rather than the number of claims submitted. The State changed the language of objective 1.3 to clarify the objective.
Stakeholder suggested: Goal 2, objectives 2.7, 2.8: Also related to this 2nd goal, there are objectives related to increasing enrollment with OCK and increasing claims. Stakeholder wondered if there will be discussions regarding additional infrastructure for this program to support the providers in continued participation as OCK providers.	The State will discuss these concerns in the Quality Steering Committee meetings.

Goal 4: Stakeholder would like to see further clarification of the goal related to IMD, as the objectives (e.g. reducing antipsychotic medication in NF) do not seem to tie to the goal (remove payment barriers for services provided in IMD…improved beneficiary access to SUD treatment specialists). Stakeholder reported that it seems there are perhaps more than one goal wrapped up in these objectives that could be delineated so as to align more directly.	The State agrees with the feedback. As a result, the State moved objective 4.4 (Reduction in use of antipsychotic medications in nursing homes < or = 12%) to goal number 5 (Improve overall health and safety for KanCare members), it is now objective 5.6.
Goal 5, objective 5.5: Stakeholder would like to clarify how Level of Care evaluation is defined. If defined as the assessment conducted by the responsible for determination of eligibility (ADRCs, CDDOs, etc.), then the MCOs do not have authority over those agencies to improve compliance. Stakeholder also expressed: while this objective is clearly tied to the goal of improving overall health and safety for members, it does not seem aligned with the stated strategy to achieve HEDIS Quality Compass 75th percentile.	The State appreciates this feedback. As a result of this feedback, the State clarified Goal 5 strategy and objective 5.5.
Stakeholder asked about the qualification requirements of interpretation services offered by providers, which are listed in online provider directories.	The state reviewed the related CFR (42 CFR § 438.10(h)(1)(iv)(vii)) and the State complies. The State will consider additional clarification in upcoming contract revisions.
Stakeholder asked about the wide variables in the Evidence Based Clinical Practice Guidelines provided by the MCOs.	The State appreciates the feedback and shared the stakeholder's suggestions with the KDHE clinical team.

Stakeholder asked about the qualifications of the EQRO and where to find EQRO reports.	KFMC is the current KanCare EQRO. KFMC is fully accredited by URAC (Independent Review Organization - External Review certification) through June 01, 2024 and has been certified by the Kansas Insurance Department (Independent Review Organization certification) since May 8, 2017. KFMC also meets independence and competence requirements as evaluated and certified by CMS National Quality Improvement Innovation Contractor contract award dated January 28, 2019. Annual Technical Reports are posted on the KanCare website here: https://www.kancare.ks.gov/policies-and-reports/quality-measurement/external-quality-review-reports. Annual Technical Reports include the results from the following evaluations: ISCA and PMV, PIP Validation, CAHPS Health Plan 5.0H Survey Validation, 2020 Mental Health Consumer Perception Survey, Provider Satisfaction Survey Validation, Review of Compliance with Medicaid and CHIP Managed Care Regulations, QAPI Review, and Network Adequacy Validation.
Stakeholder asked about the possibility of State requiring MCOs to utilize a centralized database to capture SDOH data.	The State included objective 2.9 in the QMS to increase the rate of claims that use of Z codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs.