GEOACCESS REPORTING REQUIREMENTS
UPDATED SEPTEMBER 8, 2020

I. Purpose

The Kansas Department of Health and Environment (KDHE) is the agency charged with ensuring that managed care organizations (MCOs) maintain sufficient provider networks to provide adequate access to covered services for all KanCare members in Kansas per 42 CFR §438.68, §438.206, §457.1218, and §457.1230. The KDHE, Division of Health Care Finance, has implemented a process to monitor the adequacy of the KanCare provider network. The Geographic Mapping Reports are one mechanism to provide information necessary to measure compliance with the network adequacy provisions of the Managed Care Final Rule.

The Geographic Mapping Reports are submitted to the State by the MCOs quarterly and are published by KDHE on the KanCare public website. This document has been created to provide specifications and requirements for these reports.

The Geographic Mapping Reports consist of 6 data sets, or sub-reports:

- **Maps by Specialties Report:** This report contains GeoAccess maps which show statewide coverage for specified provider types & specialties.
- **Mapped Provider Count Report:** This is a companion Excel report to the Maps by Specialties Report which shows—for each mapped specialty—the number of providers and locations, percent of members residing within the required radius of the provider, and mean distance in miles to provider by county type.
- **Specialty-Care Standards Report:** This report contains an Excel table which shows provider specialties with routine and/or urgent access standards; displays the number of providers contracted by county and identifies the percent of appointments not meeting the access standard.
- **NEMT Report:** This report contains two Excel tables that display various performance metrics for non-emergency medical transportation by county. The data for this report is drawn from claims and contact center data.
- **Unmapped Specialties Report:** This report contains an Excel table which lists the number of unique contracted and credentialed KanCare providers by specialty. This report only contains specialties for which no map is required.
- **Access and Availability Analysis Report:** This report compares data over the current reporting quarter and the previous quarter demonstrating the strength of network for each mapped provider type and includes basic network summary information in a Word document. The report will also include an analysis of any gaps in coverage along with actions the MCO is taking to address network weaknesses. The reporter is required to address the status of initiatives and areas of focus, such as foster care, as needed.

To ensure network adequacy standards are meaningful, KDHE has established processes to monitor and manage the Geographic Mapping Reports. If KDHE identifies that a MCO is struggling to meet network adequacy requirements, KDHE will propose an ad-hoc meeting with MCOs to understand the concern and efforts will be made to partner to find a resolution. Should non-compliance persist, KDHE may proceed with corrective action planning, as needed. Moreover, if a MCO does not come into compliance with the corrective action plan, KDHE may impose a financial penalty or sanction.

II. Effective Date

These requirements become effective beginning with the Q3-2019 report period, with initial reporting due October 2019.

III. Data Consistency

The State will cross verify the data in the GeoAccess Reports [Geo] and the PNtwk Report quarterly. Where the report data is inconsistent, the counts derived from the PNtwk Report will supersede the results listed in the GeoAccess reports. Therefore, the data collected for the Network Adequacy (Provider Network Report) should serve as the data source for the GeoAccess Reports. Please refer to the Network Adequacy (Provider Network Report) Reporting Requirements for more information about how that data is to be collected.

IV. Standards

The KanCare Network Adequacy Standards define time and distance requirements to determine if an MCO's provider network is adequate. Those standards can be found at the following location: https://www.kancare.ks.gov/policies-and-reports/network-adequacy

County Designations: When applying the access standards, MCOs are required to use the most recent available county designations defined in the report titled: "Kansas Annual Summary of Vital Statistics." For additional details, please reference the report, which is posted in the *Tables and Figures of Vital Events by Year and Subject* section under *Annual Summary Full Report*: http://www.kdheks.gov/phi/.

There are five county types described within the Geographic Mapping Reports, including:

a. Urban (n=6)
b. Semi-urban (n=10)
c. Densely-settled rural (n=21)
d. Rural (n=32)
e. Frontier (n=36)

*n=number of counties

V. Exceptions to Network Adequacy Standards:

MCOs that are unable to meet the State's network adequacy standards, as required in section 5.5.3. of their contract, may request an exception for a specific access to care gap in a specific region. To determine whether an exception is granted, the State may consider, but is not limited to, such factors as:

- Utilization patterns in the specific service area
- The number of Medicaid providers in that provider type/specialty practicing in service area
- The history of member complaints regarding access
- Specific geographic considerations

- Level of care needed by members for that county
- The proposed long-term plan by the MCO to address the access to care gap in its network
- The comprehensiveness of MCO's plan for addressing beneficiary needs in the short-run, including the MCO's process for assisting in finding services through out-of-network providers, or coordinating the use of telemedicine and other telecommunications technology, as applicable.

The following apply to exceptions:

1. When a gap in the provider network is identified, the exception request should be completed using the Exception Request Template.
2. Exceptions will not be permitted lightly and will only be granted in rare circumstances.
3. Where exception requests are approved, the State will monitor member access to the relevant provider types in the relevant regions on an ongoing basis and annually report the findings to CMS, as required.
4. Exception requests which are denied may be subject to the corrective action planning process whereas KDHE may impose a financial penalty or sanction.

VI. Report Certification

All reports covered in this document must have a certification/attestation included with the report meeting the following requirements[1]:

- The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data.
- Data must be certified by one of the following:
  1. The CONTRACTOR(S) Chief Executive Officer
  2. The CONTRACTOR(S) Chief Financial Officer
  3. An individual who has delegated authority to sign for, and who reports directly to, the CONTRACTOR(S)' Chief Executive Officer or Chief Financial Officer.

VII. Other items of note:

- Pediatric standards apply to KanCare members age 0- 20.
- Where distances are indicated, they are intended to be calculated as a radius from the provider's service location.
- Maps should only include providers serving the specific population noted for the map, i.e., maps for non-waiver services should exclude waiver-only providers; only psychiatric hospitals licensed to treat children should be displayed in pediatric psychiatrist map.
- CMHCs, PRTFs and RADAC are not to be included in BH standards or psychiatrist counts.

[1] *See* KanCare 2.0 RFP, Attachment H; *See also* KanCare 2.0 RFP § 5.14.3.A

VIII. Report Formatting Requirements

A. Maps by Specialties Report:

This report utilizes GeoAccess mapping software to create maps showing the location of providers and colored circles to represent the radius in miles from each location. The size of each circle corresponds to distance requirements identified in the network standards. The following specifications are requested to ensure consistency across plans:

- All provider types with a distance standard are required to be mapped.
- Consistent titles for maps: Please use the language in the "Provider Type" column of the KanCare Network Adequacy Standards table for map titles. When applicable, add whether the map refers to Adult or Pediatric Provider.
- Consistent font for headers and labels:
  - Map Title: Arial
  - Provider Counts: Arial
  - Map Foot Notes: Arial
  - County Labels: 7 point Arial (please ensure county label text boxes don't overlap one another on the maps)
  - Border States: 10 point Arial
- Consistent color scheme:
  - Adult
    - For Kansas background, use white.
    - For illustrating urban/semi-urban access standards, use pale blue (red=239, green=243, blue=255)
    - For illustrating densely-settled rural/rural/frontier access standards, use royal blue (red=107, green=174, blue=214)
    - For illustrating border state access standards use dark gray (red=156, green=156, blue=191)
    - For illustrating the provider location dot use dark blue (red=33, green=113 blue=181)
  - Pediatric
    - For Kansas background, use white.
    - For illustrating urban/semi-urban access standards, use peach (red=254, green=240, blue=217)
    - For illustrating densely-settled rural/rural/frontier access standards, use light orange (red=253, green=204, blue=138)
    - For illustrating border state access standards use medium orange (red=252, green=141, blue=89)
    - For illustrating the provider location dot use dark orange (red=215, green=48, blue=31)

  - HCBS
    - For Kansas background, use white.
    - For illustrating urban/semi-urban access standards, use light purple (red=242, green=154, blue=200)
    - For illustrating densely-settled rural/rural/frontier access standards, use lavender (red=158, green=154, blue=200)
    - For illustrating border state access standards use lilac (red=203, green=201, blue=226)
    - For illustrating the provider location dot use grape (red=106, green=81, blue=163)
  - Hospital/Ancillary/Pharmacy & Vision
    - For Kansas background, use white.
    - For illustrating urban/semi-urban access standards, use pale green (red=237, green=248, blue=233)
    - For illustrating densely-settled rural/rural/frontier access standards, use mint green (red=186, green=228, blue=179)
    - For illustrating border state access standards use jade green (red=116, green=196, blue=118)
    - For illustrating the provider location dot use forest green (red=35, green=139, blue=69)

- Consistent symbols:
  - Symbol for Provider Locations: 10 point circle filled with the color indicated in the section above.
- Use of landscape orientation for maps
- Exclude landmarks, such as highways and water features
- Consistent scale, 45 miles per inch

Please provide a header on each page of the Maps by Specialties Report that includes:

- Report page numbers
- MCO name
- Report date

MAP ELEMENT	DEFINITION	DESCRIPTION
Map Header	This is the specific provider type, and where applicable, Adult or Pediatric descriptive text. Pediatric = Age 0-20. Adult >20.	• In a gray header stripe, indicate the title of the provider type included in the map. • Include “adult” or “pediatric” when applicable, to the title of each map to further describe provider type. • If the map is for a pediatric provider type, only include providers in the map who serve members aged 0-20. • HCBS maps should only include HCBS credentialed providers.

MAP ELEMENT	DEFINITION	DESCRIPTION
Map Footer	The footer will include unique counts of the number of providers and locations for each of the urban/rural/border state groups. A provider location is a service location (a permanent, physical office location or space belonging to or rented by the provider(s) for the exclusive purpose of providing services to patients.	Below the map, for each county type, please indicate the number of unique providers and provider locations using the format, "# providers at # locations."

B. Mapped Provider Count Report:

This report should be completed in Excel using the Mapped Provider Count Report Template. The *Report Detail-Attestation* tab should be completed by identifying the health plan, contact name and e-mail, report period start date, and—if a successive submission—the version number. Add the required certification/attestation. All other data on this tab will be automatically populated. Orange highlighting indicates that necessary data is missing.

This report includes two tabs for data:

- The *Mapped Provider Counts* tab includes all non-HCBS mapped data by provider specialty type.
- The *HCBS Mapped Providers* tab includes HCBS services that are mapped and should include providers for the provider type, specialty, and procedure codes identified.

Below are the fields included on both tabs.

FIELD	DEFINITION	DESCRIPTION
Provider Specialty Type (column A)	The provider type as listed in the KanCare Network Adequacy Standards. In some cases, this type is identified as Adult or Pediatric specialist.	• Specialty codes for each provider specialty type are listed in the KanCare Network Adequacy Standards.
# Unique Providers (column B)	The number of unique providers within the specialty type identified in column A.	• For a full definition of unique providers, please refer to the Network Adequacy Report Requirements.
# Unique Locations (column C)	The number of unique service locations associated with a provider in the specialty type identified in column A.	• For a full definition of unique locations, please refer to the Network Adequacy Report Requirements.

FIELD	DEFINITION	DESCRIPTION
Urban & Semi-Urban: Percent of Members within Access Standard (column D)	The percent of members residing in an urban or semi-urban county who are less than or equal to the identified driving time and linear distance from the nearest provider of the type listed in column A.	• Identify the percent of KanCare members whose residential address falls within a boundary from the nearest provider in the provider specialty type listed in column A. • Both time and distance must be met to consider the member within the access standard. • The numerator includes all members residing in an urban/semi-urban county who reside closer than the identified linear distance AND who are less than the identified driving distance from the nearest provider of the type identified in column A. • Where the specialty is categorized by adult or pediatric, the numerator and denominator must count only the applicable cohort.
Urban & Semi-Urban: Mean Distance from Member to Specialist (column E)	The average (mean) distance from urban/semi-urban member residence to provider service location.	• The population included should be consistent with column D.
Rural & Frontier: Percent of Members within Access Standard (column F)	The percent of members residing in a rural, densely settled rural, or frontier county who are less than or equal to the identified driving time and linear distance from the nearest provider of the type listed in column A.	• The same criteria identified for urban/semi-urban above should be used here, except rural, densely settled rural, and frontier counties should be used.
Rural & Frontier: Mean Distance from Member to Specialist (column G)	The average (mean) distance from rural/frontier member residence to provider service location.	• The population included should be consistent with column F.

C. Specialty-Care Standards Report:

This report should be completed in Excel using the Specialty-Care Standards Report Template. The *Report Detail-Attestation* tab should be completed by identifying the health plan, contact name and e-mail, report period start date, and—if a successive submission—the version number. Add the required certification/attestation. All other data on this tab will be automatically populated. Orange highlighting indicates that necessary data is missing.

This report contains a tab for Home Health (provider type 05, provider specialty 050). The chart below shows the data to be included.

Note: Home health agencies may not provide care outside of 100 mile radius of the agency home office without a waiver from KDHE Health Facilities. More information can be found at the following link: http://www.kdheks.gov/bhfr/index.html.

FIELD	DEFINITION	DESCRIPTION
County (column A)	The Kansas County for which data is being reported.	Data is pre-populated. No data entry needed.
# of providers contracted to provide service in this county (column B)	This is the number of unique providers contracted to provide the service (identified in this county listed in column A.	For a full definition of unique providers, please refer to the Network Adequacy Report Requirements.
Routine Care: Percent of assessments not meeting standard (column C)	This is the percentage of assessments not meeting the standard (48 hours from authorization to delivery of service T1023). Calculated as: Numerator = Number not meeting standard Denominator = Total number of claims processed during the reporting quarter	• MCOs currently require prior authorization for Home Health Program Intake Assessments (Start of Care Assessments). • Measure is from date MCO authorizes service to date of first Home Health Program Intake Assessment (Start of Care Assessment) service claim (Procedure Code T1023). • Include any claim with the PT 05, PS 050, and PC T1023 combination processed during the reporting quarter. • Processed = paid and denied claims. • Exclude adjusted or corrected claims.

D. NEMT Report:

This report includes non-emergency transportation information by county for trips requested, scheduled, unaccommodated, and timeliness measures.

This report should be completed in Excel using the NEMT Report Template. The *Report Detail-Attestation* tab should be completed by identifying the health plan, contact name and e-mail, report period start date, and—if a successive submission—the version number. Add the required certification/attestation. All other data on this tab will be automatically populated. Orange highlighting indicates that necessary data is missing.

This report contains two tabs for data entry: Claims-Based Measures and Call Center Measures. On both tabs, Rows 7 through 12 contain aggregated totals by urban-rural designation and statewide totals.

Please note:

- When entering data, be mindful that Trips are counted from the county where the trip originated—this could be out-of-state and may not be the member's address.
- Each separate appointment or service for a member = one unique trip. So, one trip could be:
    - To/from provider roundtrip
    - Just to provider
    - Just from provider
- Claims-Based Access Standards-Includes Provider Type 26, Provider Specialties 263, 264, 265, 267. It excludes Procedure Codes A0080, A0090.

The table below shows the fields on the Claim-Based Access Standards tab.

FIELD	DEFINITION	DESCRIPTION
County/Peer Group (column A)	The Kansas county or urban-rural classification for which data is being reported.	Data is pre-populated. No data entry needed.
# claims processed for unique trips this quarter (column B)	This is the number of claims for unique trips that were processed during the reporting quarter.	• These trips may not have occurred during the reporting quarter • This measure is not service date driven • Processed =paid or denied • Do not include adjusted or corrected claims
of the unique trip claims processed this quarter, # which did not meet all applicable standards (column C)	Of the unique trips for which a claim was filed during the reporting quarter, this is the number of claims that did not meet all applicable standards.	Examples of "all applicable": • Member goes into labor on way to OB/GYN and is taken to ER instead; no standards apply—do not count this trip. • Member only needs a ride ***to*** the provider for their appointment and was delivered within the standard; the post appointment standard does not apply—do not count this trip.

FIELD	DEFINITION	DESCRIPTION
% trips which did not meet all applicable standards (column D)	This is a calculated field that displays the percentage of trips that did not meet all applicable standards.	Automatically calculates based on data in columns B and C.
# claims processed this quarter where request was not timely, yet transp was provided (Column E)	This is the number of claims processed during the reporting quarter where the request was not within the MCOs timeliness requirement, but the trip was provided.	This field gives credit for trips completed at the last minute.
of the claims processed this quarter, # of trips not requested timely which met all applicable standards (column F)	This is the number of claims processed during the reporting quarter where the request was not within the MCOs timeliness requirement, but the trip was provided ***and*** still met all applicable standards.	This field gives credit for trips completed timely at the last minute.
% of trips requested late and yet met standard (column G)	This is a calculated field that displays the percentage of trips for which a claim was processed, where the trip was not requested timely, yet met the standard.	Automatically calculates based on data in columns E and F.
For any county where % in column D is above 20% include explanation &/or steps taken to remedy or improve future performance (column H)	An explanation of the events impacting NEMT performance or steps taken by the MCO to remedy or improve future performance.	These might include, for example: • unexpected weather events, • a member calls the driver directly for transportation, • MCO is recruiting additional providers using the following methods, etc.

The table below shows the fields on the Call Center Measures tab.

Please note for this table:

- An urgent trip is one in which the beneficiary needs care within a relatively short period of time (which CMS defines as 12 hours) to avoid adverse consequences. For example, if a beneficiary has an ear infection with significant pain, CMS would view that as requiring treatment to avoid the adverse consequences of continued pain and perforation of the eardrum. The patient's condition would not meet the definition of emergency medical condition because immediate care is not needed to avoid placing the health of the individual in serious jeopardy.

FIELD	DEFINITION	DESCRIPTION
County/Peer Group (column A)	The Kansas county or urban-rural classification for which data is being reported.	Data is pre-populated. No data entry needed.

FIELD	DEFINITION	DESCRIPTION
total # of unique trips requested during this quarter (includes all requests) (column B)	This is the number of unique trips that were requested by the member.	• One call may be to schedule multiple unique trips—count each unique trip request. • Count whether the trip was requested timely, or not.
# trips requested timely and provider did not schedule transportation (excludes discharges/urgent trips) (column C)	Of the trips that were requested timely, the number of trips that were requested timely by the member and where the provider did not schedule transportation (excluding discharges and urgent trips).	Do not include urgent or discharge trips here.
for any trips requested timely and not scheduled provide explanation here (column D)	Where applicable, this is an explanation of the reasons that a trip was scheduled, but not completed.	• This may be left blank if there are no requests that apply. • Could be denied or no transportation available or some other arrangement was made.
# of discharge and urgent care trips requested and not scheduled this quarter (Column E)	This is the number of discharge and urgent care trips requested, but not scheduled (see definition of urgent trip above this table).	Unable to do the trip at all; this is regardless of any 3-hour window (which is not a state requirement)
for any discharge or urgent care trips unaccommodated provide explanation here (column F)	Where applicable, this is an explanation of the reasons that transportation was not provided for the discharge or urgent care trips.	• This may be left blank if there are no requests that apply • Explanation should be brief and grouped together. • Could be denied or no transportation available or some other arrangement was made
% unique trips unaccommodated (C+E)/# of unique trips requested (B) (column G)	This is a calculated field that displays the percentage of trips that were not accommodated.	• Numerator=unscheduled trips requested timely + unscheduled discharge and urgent trips requested this quarter • Denominator=total # of unique trips requested this quarter

E. Unmapped Specialties Report:

This report should be completed in Excel using the Unmapped Specialties Report Template. The *Report Detail-Attestation* tab should be completed by identifying the health plan, contact name and e-mail, report period start date, and—if a successive submission—the version number. Add the required certification/attestation. All other data on this tab will be automatically populated. Orange highlighting indicates that necessary data is missing.

This report contains three tabs for data entry:

1. Unmapped Specialties,
2. Mail, Pharmacy, and DME,
3. and HCBS.

The chart below shows the data to be included in the Unmapped Specialties tab.

FIELD	DEFINITION	DESCRIPTION
Provider Type (column A)	The provider type as listed in the KanCare Code Guide, Provider Type Specialty Code Crosswalk table.	No data entry required for this field.
Specialty (column B)	The specialty code and description as listed in the KanCare Code Guide, Provider Type Specialty Code Crosswalk table.	No data entry required for this field.
# of Unique Contracted KanCare Providers (column C)	This is the number of unique providers contracted by the MCO to provide services for the listed provider type and specialty.	
% Providers Required (column D)	This is the number of providers required under terms of the RFP (as required).	No data entry required for this field.
For any Specialty below # of providers required, include explanation &/or steps taken to remedy &/or recruiting efforts (Column E)	This is an explanation of the reason(s) for the gap in required providers (column D) and/or a description of the efforts taken to remedy the shortfall in providers (as required).	• This field is required when the number in column C is less than the number in column D. • This column may also be used, at the MCO's discretion, to explain recruiting efforts even when an access standard has not been defined or when an access standard is met.

The chart below shows the data to be included in the Mail, Pharmacy, and DME tab.

FIELD	DEFINITION	DESCRIPTION
Provider Type (column A)	The provider type as listed in the KanCare Code Guide, Provider Type Specialty Code Crosswalk table.	No data entry required for this field.
Specialties (column B)	This identifies the specialties for which provider counts are included.	No data entry required for this field.

FIELD	DEFINITION	DESCRIPTION
# of Counties with Contracted providers (column C)	This is the number of counties for which at least one provider of the type identified in column B has been contracted.	This is an integer.
Out of 105 (column D)	This column identifies the total count of Kansas counties for comparison with column C.	No data entry required for this field.
For any Specialty below 105 counties of coverage, include list of which counties do not have providers and explanation &/or steps taken to remedy &/or recruiting efforts (Column E)	This is an explanation of the reason(s) for the gap in required providers (column D) and/or a description of the efforts taken to remedy the shortfall in providers (as required).	• This field is required when the number in column C is less than the number in column D. • This column may also be used, at the MCO's discretion, to explain recruiting efforts even when an access standard has not been defined or when an access standard is met.

The chart below shows the data to be included in the HCBS tab.

FIELD	DEFINITION	DESCRIPTION
Provider Service and Procedure Code (column A)	This is the provider service and procedure code for which data is reported.	No data entry required for this field.
# of Counties with 2 contracted HCBS providers (column B)	This is the number of counties for which at least two providers of the service identified in column A have a current contract during the reporting period.	This is an integer.
Out of 105 (column C)	This column identifies the total count of Kansas counties for comparison with column B.	No data entry required for this field.
For any Service below 105 counties of 2 contracted HCBS providers, include list of which counties do not have 2 providers and explanation &/or steps taken to remedy &/or recruiting efforts (Column D)	This is an explanation of the reason(s) for the gap in required providers (column C) and/or a description of the efforts taken to remedy the shortfall in providers (as required).	• This field is required when the number in column B is less than the number in column C. • This column may also be used, at the MCO's discretion, to explain recruiting efforts even when an access standard has not been defined or when an access standard is met.

F. Access and Availability Analysis Report:

This report should be completed in Word using the Access and Availability Analysis Report Template. The *Report Detail-Attestation* page should be completed by identifying the health plan, contact name and e-mail, report period start and end date, and version number. Add the required certification/attestation.

This report is a Word document that contains a narrative analysis of the status of the MCO provider network and the efforts taken by the MCO to develop and strengthen its network. Although some items in this report may contain threads from previous reporting, each narrative should be unique to the activities occurring in the reporting quarter.

The report contains the following sections:

1. Network Strengths

a. Overall Strength of Network: This section includes a broad summary of the strength of the MCOs KanCare network when comparing the GEO Access Report for the two most recent quarters.

b. Network Highlight: This section includes a detailed narrative that highlights a specific area of strength and growth in the MCOs KanCare provider network when comparing the GEO Access Report for the two most recent quarters.

2. Network Opportunities

a. Missed Standards-Approved Exceptions (where applicable): For provider network exceptions that have been approved by the State, provide an updated status and detailed plan for resolution of the network gap. For each area covered under the approved exception that missed the requirement, please include:

INFORMATION	DESCRIPTION
Provider type	Identify the provider type as listed in the KanCare Code Guide, Provider Type Specialty Code Crosswalk table.
Access standard not met	Identify the specific access standard for which the exception applies.
Time period	Identify the time period covered under the exception.
Measurement tool(s) used	Identify and describe the measurement tool(s) used by the MCO.
Degree to which the standard was not met	Identify the current quarterly result compared with the standard.
Counties impacted	Identify the Kansas counties impacted by the network gap.
% of membership impacted	Identify the prevalence of members who are impacted by the network gap.
Who, what, when, where of both short-term and long-term resolution plan	Consists of a detailed narrative addressing essential elements of the MCO's plans to resolve the network gap. Be sure to identify all parties responsible and accountable for overseeing and executing the plan. Include time-tables for resolution and actions taken toward resolution during the quarter.

b. Other Identified Opportunities: Include a narrative detailing at least one network adequacy improvement initiative or project being implemented during the quarter which was designed to address:

- A gap in network coverage, or
- An evolution or change in healthcare that better addresses member needs,
- A KanCare 2.0 requirement or consideration, or
- A State initiative.