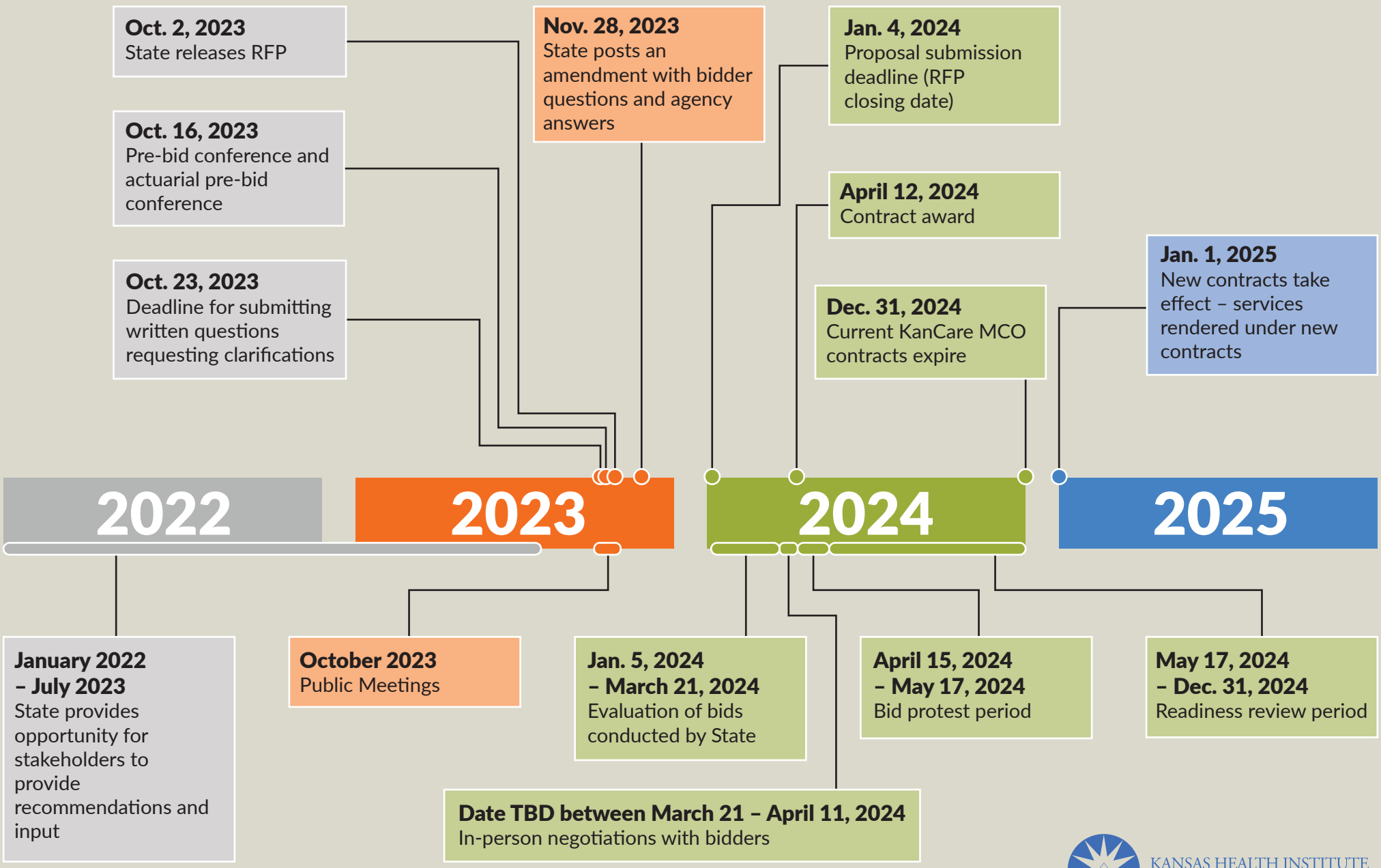
KanCare 3.0 Procurement Process and Timeline



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Source: Kansas Health Institute Analysis of Kansas Department of Health and Environment 2025 Request for Proposal documents.

Considerations for Decision-Makers Regarding the Upcoming Medicaid Managed Care Procurement Process

Introduction

The current procurement process regarding Kansas Medicaid and CHIP (KanCare) Managed Care contracts provides an opportunity to reflect and engage with stakeholders to ensure improved managed care performance and attention to racial and ethnic disparities in KanCare coverage and service provision. This summary includes observations, considerations, and recommendations for the request for proposal (RFP) and KanCare going forward.

Background

The REACH Healthcare Foundation, in collaboration with the Health Forward Foundation, hosted a discussion forum with nonpartisan facilitation support from the Kansas Health Institute on May 10, 2023. Participants included state agency leaders, providers, consumer advocates and subject matter experts who came together to identify and recommend improvements to strengthen managed care performance for children and adults that the State of Kansas could consider when developing the next Request for Proposal.

Prior to the forum, participants completed a survey to prioritize discussion topics and provide suggestions for improvements needed within those areas. The survey results were used to organize the discussion around six topics (presented in no particular order): 1) Network Adequacy, 2) Care Coordination, 3) Pregnancy Outcomes, 4) Social Determinants of Health and Health Equity, 5) Provider Innovations, and 6) Data Monitoring and Transparency.

During the forum, attendees participated in two rounds of discussions on their preferred topic(s). Each group shared observations and recommendations for improvement related to each topic area, which are summarized below along with relevant survey responses.

Discussion and Recommendations

The following section summarizes key issues of concern and associated recommendations for decision-makers to consider and incorporate into the procurement process, RFP evaluation, selection process, and the final contracts.

Network Adequacy

This topic includes, but is not limited to, the availability of providers and services. It also includes goals and measures related to **Network Adequacy**.

Key Issues

Participants identified the following key issues that need to be addressed regarding Network Adequacy:

- Provider reimbursement and payment structure is not adequate.
- There is a lack of availability and access to providers (e.g., specialty care, rural access).
- The contracting and credentialing process for providers is too cumbersome.
- There is a need for better coordination between Managed Care Organizations (MCOs), providers and the communities they serve.

Figure 1 summarizes issues, recommendations and measures related to Network Adequacy for consideration during the upcoming MCO procurement and contracting process.

Figure 1. **Summary of Network Adequacy Issues and Recommendations**

Issue	Recommendations and Measures
Provider Reimbursement and Payment Structure	• Reduce barriers to attract providers by increasing reimbursement rates.
Availability and Access to Providers (e.g., specialty care, rural access)	• Allow the provider network to be expanded to include additional types of providers — e.g., community health workers (CHWs), in-home therapists, doulas. • Enhance the provider network so that people in all areas of the state can access critical health care services, including specialized medical services and therapies. • Consider providing incentives for providers (e.g., training stipends) to assist with recruitment and retention. • Develop standards for MCO monitoring and compliance when network adequacy is not met. • Ensure the provider network list is kept up to date. • Evaluate access to care by measuring and analyzing utilization rates, provider retention rates and timeliness of service(s) provided.
Contracting and Credentialing Process	• Consider standardized credentialing and contracting across MCOs. • Consider a centralized credentialing process. • Consider establishing one application that is accepted by all MCOs and the state for contracting and credentialing. • Consider establishing a database of materials to minimize the administrative burden associated with this process.
MCO Coordination with Providers and the Communities They Serve	• Ensure MCO staff across the state are accessible to KanCare members. • Provide funding for health care organizations to have MCO staff in their facilities across the state. • Obtain more member feedback about network adequacy and what success looks like.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Care Coordination

This topic includes, but is not limited to, case management, the level of support provided for members, access to care connectors/case manager support, and any special considerations for consumers in waiver categories — e.g., individuals with intellectual and developmental disabilities (I/DD), home and community based services (HCBS).

Key Issues

Participants identified the following key issues that need to be addressed regarding **Care Coordination**:

- Access to care, including receiving timely care and the type of care needed, is a concern, especially for accessing specialty care and behavioral health care.
- The prior authorization process is cumbersome and inconsistent across MCOs, which could impact access to care.
- Case management challenges exist in several areas, including the lack of eligibility for these services among some KanCare populations including HCBS, frail elderly (FE), physical disability (PD), brain injury (BI), and children, as well as timeliness, cohesiveness and continuity, and the need for expanded and improved relationships with community partners.
- Improvements are needed regarding service delivery and accountability mechanisms when members do not receive the appropriate services according to their plans of care.
- Improvements are needed regarding MCO staff capacity to serve members in appropriate geographic settings, MCO staff knowledge of services and choices, training, and care coordination efforts.

Figure 2 summarizes issues, recommendations, and measures related to Care Coordination for consideration during the upcoming MCO procurement process and contracting process.

Figure 2. **Summary of Care Coordination Issues and Recommendations**

Issue	Recommendations and Measures
Access to Care	• Ensure that KanCare members have access to the right care at the right time. • Expand the availability of mental health providers to ensure access to mental health services. Options could include making a behavioral health specialist available via telemedicine or encouraging co-locating mental health providers in medical clinics where possible. • Ensure lists or databases of providers accepting patients are up to date and available.

Prior Authorizations	• The State of Kansas should consider:
	  ○ Standardizing the prior authorization process across all MCOs.
	  ○ Ensuring MCO contracts include transparency and accountability regarding the prior authorization process by clearly outlining procedures that require prior authorization, describing the appeals process, and requiring a third party to review complaints.

	○ Establishing stricter guidelines regarding prior authorizations, including the amount of time MCOs are allowed to respond to emergency, urgent and chronic care situations. ○ Minimizing the number of services, medications or procedures that require prior authorization.
Case Management	• Ensure comprehensive case management is timely, person-centered and offers choice of provider. • Case management should provide more cohesive services, including follow-up with KanCare members to ensure their needs are being met in addition to better relationships with community partners assisting clients. • Offer case management for HCBS, FE, PD and BI populations and all children to ensure they receive quality, person-centered care in the setting of their choice. • Use language that is clear and easy to understand for members and case managers to facilitate appropriate care.
Service Delivery	• Enhance accountability measures regarding service quality and delivery among providers and KanCare as a whole. Examples include: ○ The State of Kansas should develop and provide incentives and penalties for providers based on utilization rates (e.g., providers would receive incentive payment when their utilization is at least 80 percent). ○ Develop mechanisms to ensure members are receiving the services they need and better support to assist where needed if they are not receiving services. ○ Track and analyze complaints to ensure state-level review of common issues. • Improve transparency and communication around available services, costs, and complaints, and include the use of satisfaction surveys.
Staff Capacity	• Ensure MCO staff are provided with more training on provider choice and hours of care. • Consider allowing providers to have the option to manage care coordination outside of the MCO (e.g., community health workers). • Reduce caseloads and geographic coverage area for staff across the state.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Maternal and Child Health/Pregnancy Outcomes

This topic includes, but is not limited to, timely access to prenatal and postpartum care, measures for births and maternal health.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Maternal and Child Health/Pregnancy Outcomes**:

- Utilize best practices and pilots around maternal and child health.
- Collect and use disaggregated maternal and child health data to address disparities that exist in this area.
- Incorporate incentives for including safe sleep education in provided services.
- Provide support and referrals for members when postpartum coverage ends.
- Expand and improve MCO partnerships with communities to address maternal and child health needs of KanCare members.

Figure 3 summarizes issues, recommendations and measures related to Maternal and Child Health/Pregnancy Outcomes for consideration during the upcoming MCO procurement and contracting process.

Figure 3. **Summary of Maternal and Child Health/Pregnancy Outcomes Issues and Recommendations**

Issue	Recommendations and Measures
Best Practices	• Recognize and reimburse credentialed members of the health care team such as CHWs, home visitors, doulas and lactation consultants to improve access to culturally competent, quality and community-based care. • Require MCOs to adopt key evidence-based strategies around breastfeeding and postpartum care. • Encourage incorporation of community-based strategies and efforts around maternal and child health care, including pilots that focus on using CHWs, similar to those currently happening in the Kansas City metro area and Douglas County.
Disaggregated Data	• Stratify quality measures and other indicators of interest to Kansas for postpartum coverage extension by race, ethnicity, geography, and language, among others, as recommended by the Centers for Medicare and Medicaid Services (CMS). • Require MCOs to follow the Governor's Commission on Racial Equity and Justice 2021 report recommendation to collect and report Child Core Set measures disaggregated by race/ethnicity and service location for children ages 0-3.
Postpartum Care	• Ensure MCO case managers provide more support and coordination for services and resources to members when their postpartum coverage ends. • Require MCOs to increase postpartum care visits (PPC) through use of incentives, technology (text reminders, etc.) and home visits.

Safe Sleep	• Develop and implement incentives for incorporating safe sleep practices into services provided as unsafe sleep practices are a leading driver of infant mortality.
Community Partnerships	• Language in the 2018 KanCare 2.0 RFP requires contractors to coordinate with Women, Infants, and Children (WIC) Program, local health departments and other Title V programs in Section 5.1.5 (Cooperation with Other Agencies, Page 17). Maintain these references in the next RFP for MCO contract language. • Encourage MCOs to develop partnerships in the community between medical and non-medical entities to promote place-based care, as it is important in addressing social determinants of health and disparities.

Note: For additional key issues and recommendations related to this topic, see Appendix B, KanCare 3.0 Recommendations for Maternal and Child Health submitted by the Kansas Breastfeeding Coalition, Inc.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Social Determinants of Health and Health Equity

This topic includes, but is not limited to, services and resources that should be provided to address social determinants of health (non-medical factors that influence health outcomes). Examples include transportation, education, built environment, etc. Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health. According to the Centers for Disease Control and Prevention (CDC), achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Social Determinants of Health and Equity:**

- How KanCare, as a whole, defines and addresses equity and social determinants of health (e.g., transportation, childcare, housing, education, and other supports) for various populations, including racial/ethnic groups, those with disabilities, and those living in rural communities.
- Concerns exist specific to the I/DD population in Kansas.
    - Long-standing issues such as transportation and housing will continue to be barriers to inclusion for the I/DD population until addressed.
    - Access to behavioral health services, dental care and some preventive care remain unresolved for many Kansans with I/DD.
- Lack of integration of CHWs into the care team for those receiving services impacts social determinants of health and equity in KanCare.
- There is a lack of disaggregated data to understand and address disparities.

Figure 4 (page 7) summarizes issues, recommendations and measures related to Social Determinants of Health and Equity Issues for consideration during the upcoming MCO procurement and contracting process.

Figure 4. **Summary of Social Determinants of Health and Equity Issues and Recommendations**

Issue	Recommendations and Measures

Addressing Equity and Social Determinants of Health	• Require MCOs to provide robust plans and support for transportation, childcare and housing, as they impact members' ability to access care.
	• Encourage MCOs to invest in Kansas communities with the purpose of addressing systemic barriers for populations served by KanCare.
	• Provide specific additional support and resources for providers in areas where racially marginalized people are more clearly disadvantaged.
	• Require MCOs to provide anti-racist, culturally appropriate services. For example:
	  ○ MCO staff should be required to receive training on unconscious bias and racial and ethnic discrimination.
	  ○ MCOs should increase staffing with individuals who speak the languages of members they serve or provide appropriate translation services.

I/DD Population	• Encourage exploration and adoption of innovations that address social determinants of health, such as value-based reimbursement models, occurring elsewhere in the United States as it relates to individuals with I/DD.
Integration of CHWs	• Formal integration of CHWs into the care team is essential to addressing social determinants of health for KanCare members.
Disaggregated Data	• Data on services and outcomes should be disaggregated by race, gender, and ethnicity to identify disparities and target areas for improvement.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Provider Innovations

This topic includes, but is not limited to, potential innovations in provider types and services offered. This could include incentives for expanding the use of community health workers or other types of providers.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Provider Innovations:**

- Ability to use CHWs or other staff employed by health centers to provide services and provide care coordination.
- Efforts around modernization and utilizing strategies such as telemedicine to increase access to care.
- Adequacy of provider payment rates to see patients for services such as dental care or behavioral health needs.

Figure 5 (page 8) summarizes issues, recommendations and measures related to Provider Innovation for consideration during the upcoming MCO procurement and contracting process.

Figure 5. **Summary of Provider Innovation Issues and Recommendations**

Issue	Recommendations and Measures
Community Health Workers and other Support Staff	• Allow the use of CHWs or staff working in health centers to provide services and/or conduct care coordination and permit them to bill for their time. • CHWs and health center staff have strong relationships with patients, which could assist with addressing health needs and produce improved outcomes.
Modernization	• Create a more comprehensive data dashboard for providers to manage their patients. • Require more shared data between MCOs and providers to assist with access to care.
Provider Rates	• Establish provider incentives for seeing patients with disabilities, oral health needs and additional visits with health care providers that might be needed.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Data Monitoring and Transparency

This topic includes, but is not limited to, data collection, monitoring, and reporting of data by MCOs, state agencies and other related organizations. It also includes key issues related to transparency, including care coordination, case management, data collection and reporting, audits, etc.

Key Issues

Participants identified the following key issues that need to be addressed regarding **Data Monitoring and Transparency:**

- The need for more transparency and publicly available data to understand quality of care, satisfaction, cost of care, and other areas of interest.
- Improvements needed regarding the oversight and monitoring provided by state agencies responsible for KanCare.

Figure 6 summarizes issues, recommendations and measures related to Data Monitoring and Transparency issues for consideration during the upcoming MCO procurement and contracting process.

Figure 6. **Summary of Data Monitoring and Transparency Issues and Recommendations**

Issue	Recommendations and Measures
Transparency and Publicly Available Data	• The State of Kansas must improve its ability to access, interpret and publicly share data from the KanCare model. This includes web-based dashboards and similar technology that would improve transparency in KanCare. • Establish consistent measures across all MCOs that are reported consistently from all organizations. Ensure the focus is on data that can have a positive impact on outcomes of populations most impacted by social determinants of health.

	• Provide MCOs greater access to Clearinghouse information and capabilities so they can answer questions regarding renewals, due dates, updating information, eligibility verification, etc. • Require financial reporting by MCOs that shows profit margins for the companies, and what the difference is between their capitated rates and amounts paid for beneficiaries.
Suggested Indicators	• Disaggregated service data, outcome data, and cost data must be available to meaningfully compare plan performance and advocate for system improvements. • Include indicators to assess patient quality of care (e.g., hold times, hold times for peer-to-peer consults to look at administrative burden; number of denials outright by MCO on a quarterly basis; prior authorization response times; and designated contacts at MCOs for providers and patients.) • MCO contracts should require periodic reports from MCOs to highlight key indicators such as: o network capacity, o service delivery, o utilization, o ability to receive all recommended services, o hospitalization rates, o preventable hospital admissions, o service delivery setting (home, community or institutional), and o other measures to ensure person-centeredness and cost-effectiveness. • Reports should be routinely submitted to legislators to assist in assessing effectiveness and modifications needed and to the public to ensure cost savings are not based on reduced service delivery.
Oversight and Monitoring	• Require satisfaction surveys to be completed by an independent party. • Adopt representative governance for KanCare to ensure that all elements are focused on achieving the identified outcomes for populations served. Strategies to improve accountability in KanCare should be identified and presented to stakeholders early in the engagement process. • Allow the state's monitoring process to be reviewed, re-vamped and vetted publicly.

Source: Medicaid Managed Care Procurement Discussion Forum and Pre-Discussion Forum Survey, 2023.

Concluding Thoughts

The REACH Healthcare Foundation and Health Forward Foundation want to acknowledge the time commitment, contributions and input provided by participants, and thank the leaders of Kansas state government agencies who attended and provided additional insights during the discussion. It is our foundations' shared desire that the information be reflected on and fully considered in the procurement process and beyond.

KanCare provides health coverage to approximately 500,000 Kansans, serving as a critical vehicle for strengthening the health and well-being across multiple and overlapping, diverse populations – ultimately impacting the immediate and long-term health of Kansans overall. We acknowledge the State of Kansas' commitment to engaging with partners and its ongoing efforts to improve KanCare. We look forward to continuing to engage health providers and community members in these discussions as well as more collaboration with state agencies and communities in the future.

A special note of thanks to the Kansas Health Institute (KHI) for assistance with developing this summary material, and to Sheena L. Schmidt, KHI Senior Analyst and Kari Bruffett, KHI President and CEO, for survey development, facilitation and reporting assistance.

For additional information and questions regarding the summary provided, please contact Pattie Mansur, Director of Health Policy at the REACH Healthcare Foundation at pattie@reachhealth.org.

KanCare Meaningful Measures Collaborative

December 2, 2021

Recommendations to Support KanCare Procurement and Waiver Processes

Based on the feedback in the KanCare Meaningful Measures Collaborative (KMMC) full member meeting in June 2021, the Executive Committee recommended that KMMC leverage its previous recommendations to support the State of Kansas preparation of the upcoming KanCare procurement and waiver processes. Criteria to be considered when weighing the potential of each recommendation in this process includes:

- Relevance to the upcoming KanCare procurement and waiver processes.
- Components or approaches to a recommendation could be incorporated into future KanCare contracts or program evaluation plans.

Previous recommendations included seven priority areas: (1) Pregnancy Outcomes, (2) Care Coordination, (3) Network Adequacy and (4) Social Determinants of Health (SDOH) from the full recommendation report in 2020, (5) Telehealth, (6) Behavioral Health and (7) Quality Assurance from the full recommendation report 2021. Since there is an ongoing effort related to SDOH, this summary focused on the remaining six priority areas.

The task group leader for each priority area reviewed previous recommendations and identified areas that meet the criteria described above. Results were presented and discussed in the KMMC full member meeting in September 2021. This document includes the summary from the task groups and the discussion in the KMMC quarterly meeting (September 2021) for each priority area.

Pregnancy Outcomes

Task Group Summary

- Summary report or dashboard: Develop a summary report or a dashboard to monitor measures on pregnancy including health care process and clinical outcomes.
- Trend and subgroup analysis: Conduct analysis to monitor changes over time and identify subpopulation and geographic areas at risk of poor outcomes for continuous improvement.

The existing measures for pregnancy outcomes are timeliness of prenatal care and postpartum care. These are currently collected from each managed care organization (MCO) as the existing HEDIS measures. This task group recommends adding new measures: birth weight, gestational age, and infant mortality information. Another recommendation was to identify if disparities or inequities exist in the measures and explore the use of Pregnancy Risk Assessment Monitoring System (PRAMS) data. With these measures, a summary report or a dashboard can be developed to monitor measures on the pregnancy including health care process and clinical outcomes, and then conduct trend and subgroup analysis to identify subpopulations or geographic areas that are currently have poor outcomes and need continuous improvement.

KMMC Quarterly Meeting, September 10, 2021

Anna Purcell summarized the recommendations for pregnancy outcomes. The existing measures currently collected by MCOs include HEDIS measures on timeliness of prenatal care and postpartum care. The task group recommended collecting several new measures, e.g., birth weight, gestational age and infant mortality, identifying if disparities exist in these measures and exploring the use of the PRAMS data.

For the upcoming procurement process, the recommendation is to include a summary report or a dashboard to monitor measures on the pregnancy process and outcomes, and then conduct trend and subgroup analysis to identify subpopulations or geographic areas with poor outcomes for continuous improvement. Please see the *Task Group Summary* above for details.

KMMC members discussed the timeliness of data to inform the program, health plans and providers to manage potential risks. Currently, the information would be delayed due to the lag in claims data (a provider has 180 days to submit a claim). Also, a portion of maternity claims in Kansas are globally billed, meaning that all services are bundled together and not submitted until the baby is delivered. Additionally, HEDIS measures must be fully audited before MCOs release that information.

Therefore, an alternate approach could be considered if we want a more timely, actionable dashboard with the known caveats. A longer-term approach could leverage the data for predictive modeling to help identify factors associated with increased risk for poor outcomes. If providers can receive the information in advance, it might provide the opportunity to mitigate risk.

Care Coordination

Task Group Summary

- Serious emotional disturbance (SED) waiver: Consider requiring an SED Waiver-specific survey be completed by MCOs and explore the potential for the Child ECHO Behavioral Health survey to include a supplemental sample of children and youth receiving SED waiver services.
- HCBS CAHPS: Consider requiring the MCOs to complete the HCBS CAHPS survey (one MCO already does this), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination.
- HCBS CAHPS: Increase sample size for subgroup analysis by alternating years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys.
- National Core Indicator: Consider increasing resources for the National Core Indicator TM (NCI) and NCI-Aging and Disabilities TM (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. This approach will help pool resources together.

General Care Coordination by Providers:

Care Coordination 1. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the serious emotional disturbance (SED) waiver.

Potential approaches:

- Consider requiring an SED Waiver-specific survey be completed by MCOs; this could involve development of a survey questionnaire all MCOs would use to allow for comparisons and potential aggregation. Aggregation and comparisons could be completed through a coordinated MCO effort, similar to the SUD survey. Alternatively, the comparisons and aggregation could be added to the EQRO contract, similar to what occurs with the CAHPS Health Plan surveys.
- Explore the potential for the Child ECHO Behavioral Health survey (currently subcontracted to be conducted by an NCQA certified survey vendor through the EQRO contract) to include a supplemental sample of children and youth receiving SED Waiver services selected from the records not already selected for the general child ECHO survey. Responses of all children/youth from the general child survey that receive SED Waiver services would be combined with responses from the supplemental sample. This could parallel the process used for the CAHPS children with chronic conditions module.

Care Coordination 2. KanCare could consider increasing the number of HCBS consumer surveys conducted for each waiver to allow for sub-group analysis in regard to survey questions about providers.

Care Coordination 3. KanCare could consider reviewing the reported information from the first data year of HCBS CAHPS Surveys to make recommendations on survey administration strategies, sampling needs or inclusion of additional questions.

Potential approaches:

- Consider requiring the MCOs to complete the HCBS CAHPS survey (one MCO already does), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination. The EQRO contract could include aggregation of the MCOs' results by waiver type, and an MCO comparison of the overall results (not by waiver, since there wouldn't be enough responses by MCOs to compare).
- Other potential solutions to increasing responses for a statewide HCBS CAHPS survey could be to alternate years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys, as seen in some states. KanCare could consider opportunities to increase the number of I/DD waiver members participating in the HCBS CAHPS Survey to capture the experiences of those receiving targeted case management (TCM).
- Consider increasing resources for the National Core Indicator™ (NCI) and NCI-Aging and Disabilities ™ (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. By combining funding from the two types of surveys, potentially enough members would be surveyed to allow for the waiver stratification. The NCI surveys adults with intellectual or developmental disabilities (I/DD) and the NCI-AD surveys adults who receive supports because of a physical disability and/or an age-related disability. Consider adding supplemental questions (such as in the HCBS CAHPS survey) regarding Targeted Case Management versus MCO Care Coordination for the NCI survey.

KMMC Quarterly Meeting, September 10, 2021

Lynne Valdivia presented the priority topic of Care Coordination. Measures on care coordination tend to focus on the data around consumer satisfaction, i.e., consumer feedback around care management and needs. However, KMMC stakeholders would like to have more specific data for waiver participants.

Approaches were suggested for collecting data from serious emotional disturbance (SED) waiver participants, members with targeted case management and other HCBS waivers.

Suggestions included ways to increase the sample size for each type of waiver participant, considering alternate surveys and review overlaps between surveys to pool resources together. Please see *Task Group Summary* above for details.

KMMC members discussed how recommendations could be included in the KanCare and waiver process. Some of these measures could be for KanCare overall and others could be related to potential RFP and eventual contracts. For example, if the state wants to require each MCO to conduct the HCBS CAHPS, it could be included in the RFP.

Another suggestion discussed was that MCOs should report the number of children who receive care coordination services and have been offered the SED waiver. MCOs contributing their data to a universal platform was also discussed.

Network Adequacy

Task Group Summary

- Network Adequacy Reporting: Continue to strengthen the standardized and systemized reporting from MCOs.
- Monitoring process: Formulate and utilize program monitoring data to help identify areas for continuous improvement.
- HCBS waivers: Conduct analysis to measure the adequacy of waiver service provider availability for waiver participants.
- Consumer Information: Improve information sharing in responding to common questions from consumers and informing consumers regarding the process when issues related to provider availability arise.

Members regularly have questions about where to find information and how measures on the network advocacy website are calculated. The KanCare Network Adequacy website has been changed a couple times and provides a rich set of information. The information provides a snapshot on a quarterly basis. MCOs provide the data to KanCare for further processing to generate the information for the public. A recommendation is for KanCare to continue strengthening consistent reporting across MCOs.

Additional measures for HCBS providers could be considered in the procurement process. Currently, only two types of HCBS providers (adult day care and day supports) are included in the report. Expanding the list of measures for the reporting would be very helpful for monitoring the workforce shortage.

Although evaluation or monitoring efforts have been put in place, the information has not been available to the public. If data can be collected systematically for these programs, e.g., secret shoppers, analyses can be conducted to help identify certain geographic areas or certain types of populations that might need additional support.

Members are looking for real-time information when they need care. Even though the network adequacy shows that providers are available in the geographic area, they might not accept new patients, the wait time for an open appointment is long, or members might need to travel long distance. In these situations, members have had a difficult time finding information to communicate with MCOs and get their needs met. Improving the information sharing to guide people through the process to have their needs met is another recommendation for network adequacy.

KMMC Quarterly Meeting, September 10, 2021

Wen-Chieh Lin summarized the recommendations on Network Adequacy. The KanCare network adequacy website has been changed to provide more information. MCOs provide the data to KanCare for further processing for the website.

The recommendations for the upcoming procurement process include continuing and strengthening consistent reporting across MCOs; making data collection for monitoring efforts, e.g., secret shoppers, more systematic for analysis; expanding the number of measures on HCBS providers; and improving information sharing with members regarding what they can do when they encounter issues with provider availability. Please see the Task Group Summary above for details.

KMMC members suggested that in the upcoming procurement process the state seek more innovative approaches to solving these issues and ask bidders how they will boost network adequacy across the state.

Telehealth

Task Group Summary

- Develop measures to track the telehealth concepts outlined in Figure 2 (page 8 of the recommendation report in 2021), to understand factors influencing consumer access and provider ability to administer telehealth services in KanCare.
- In addition to measuring access of telehealth services, KanCare could adopt measures from the other three domains outlined by the National Quality Forum in its telehealth framework, including: a) Financial Impact/Cost b) Experience and c) Effectiveness.
- Develop a way to track whether telehealth services are provided via video or audio-only modalities, such as by adding a modifier to claims to indicate how the service was delivered. Audio-only modalities should also continue in order to make telehealth services accessible to those who cannot access video-only services.
- Only once the data collection is provided through the program, can analysis of telehealth's impact on access, patient outcomes, etc. be assessed.

The recommendations developed for the 2021 report had the KanCare procurement process in mind, since this area is one that is not currently monitored or incentivized in the current program. As it relates to the recommendations to be discussed, Recommendations 1, 2 and 4 are included:

Telehealth 1: Develop measures to track the telehealth concepts outlined in Figure 2 (page 8 of the recommendation report in 2021), to understand factors influencing consumer access and provider ability to administer telehealth services in KanCare.

Telehealth 2: In addition to measuring access of telehealth services, KanCare could adopt measures from the other three domains outlined by the National Quality Forum in its telehealth framework, including:

a) Financial Impact/Cost
b) Experience
c) Effectiveness

Telehealth 4: Develop a way to track whether telehealth services are provided via video or audio-only modalities, such as by adding a modifier to claims to indicate how the service was delivered. Audio-only modalities should also continue to make telehealth services accessible to those who cannot access video-only services.

Only once the data collection is provided through the program, can analysis of telehealth's

impact on access, patient outcomes, etc., be assessed.

KMMC Quarterly Meeting, September 10, 2021

Sarah Irsik-Good noted that the Telehealth task group developed a set of recommendations for how to build a data set to start answering questions. The group outlined those concepts in a specific table as shown on page 8 of the recommendation report in 2021.

In addition to measuring access, a recommendation was discussed to adopt measures from the other three domains identified by the National Quality Forum including financial impact and cost, the experience of those receiving and providing telehealth services, and effectiveness of clinical and operational systems.

Another recommendation was to add a modifier for claims submissions or develop a new reporting mechanism to understand how telehealth services were delivered, i.e., face to face, over a video connection, or audio only, to help assess the efficacy of those services.

The task group collectively decided that only once we are able to collect data for the KanCare program, whether data collection was written into MCO contracts or built into the overall evaluation of the program, would we really be able to analyze and study the impact of telehealth services on access and patient outcomes.

KMMC members discussed the increased use of telehealth, service modes (i.e., video or audio-only), and types of technology barriers. In-depth studies were suggested to better understand access issues from the patient perspective when telehealth services are provided.

Behavioral Health

Task Group Summary

- Access to telehealth: Developing a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement attached will be key to the ongoing success of these services, which are often preferred by individuals receiving behavioral health treatment.
- Medicaid/CHIP Behavioral Health Core Set: Improve key quality measures including:
    - Adherence to antipsychotic medications for individuals with schizophrenia for members age 19 to 64
    - Initiation and engagement of alcohol and other drug abuse or dependence for members age 18 and older
- Mental health parity: Incorporate mental health parity expectations and reporting in the KanCare contracts.

Kansas has the opportunity to incorporate greater expectations of their KanCare contracts in the next round of requests. Our group is hopeful that the recommendations relating to behavioral health will rank high for quality improvement measures and the collection of meaningful data.

For individuals with mental health or substance use disorder needs, the recommendations for all KanCare participants are very important:

- Care Coordination
- Network Adequacy
- Social Determinants of Health

To this end, seeking managed care organizations with the capacity to meet quality measures in these areas is just as important if not more. This requires more than passive reporting of the current situation, but an action plan to improve these measures.

For Behavioral Health specifically, the recommendations include:

Behavioral Health 1: Develop a summary report of meaningful measures for behavioral health that include information on the prevalence of behavioral health disorders (Figure 3, page 12) and access to services (Figure 4, page 12) in the recommendation report in 2021.

a) Prevalence of behavioral health disorders: proportion of KanCare members with mental health disorders, SUDs or co-occurring diagnoses of varying levels of severity.

b) Access to services: KanCare member ability to access services, with a focus on receiving services in a timely manner.

Behavioral Health 2: Explore the ability to incorporate additional metrics related to the effectiveness of prevention efforts in the state, including a focus on children in the child welfare system or at-risk of entering the child welfare system.

Behavioral Health 3: Identify and report additional information on the extensiveness of homelessness within the behavioral health population in KanCare, expanding beyond information currently reported for those with serious and persistent mental illness (SPMI). Consistent definitions of homelessness should be used across populations.

Access to Telehealth

One of the most promising developments in access to care is telehealth. Providers report that the opening of telehealth opportunities, along with parity pay, has increased access for many individuals whether they lack transportation, need to care for children, or simply struggle with other barriers to making appointments.

Requiring a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement attached will be key to the ongoing success of these services, which are often preferred by individuals receiving behavioral health treatment.

Quality of Care

One way CMS measures quality of care in Medicaid and CHIP programs is through two core sets of measures, one for children and one for adults. Each quality measure is accompanied by a gauge that allows you to view Kansas's performance in comparison to other states reporting the measure. In federal fiscal year (FFY) 2019, Kansas voluntarily reported 17 of 21 frequently reported health care quality measures in the CMS Medicaid/CHIP Child Core Set. Kansas voluntarily reported 18 of 24 frequently reported health care quality measures in the CMS Medicaid Adult Core Set.

Within the reported measures, Kansas mostly falls within the range of the bottom quartile, the median, and the top quartile of the 37 reporting states. In a few categories, Kansas exceeds these measures. Unfortunately, there are three adult quality measures where Kansas falls below the bottom quartile:

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia: Ages 19 to 64
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment:

Age 18 and Older

- Breast Cancer Screening: Ages 50 to 74

(Source: https://www.medicaid.gov/state-overviews/stateprofile.html?state=kansas)

Components for the KanCare procurement process

One obvious area for change is incorporating these as quality improvement measures. Specifically, bidders should be asked two important questions:

1. How would the bidder be able to contribute to the meaningful data collection and publication?
2. How has the bidder improved the outcomes proposed by this group and what practices have they implemented as an entity (not put upon their providers) to improve the six areas within these recommendations?

Finally, it is time to know what the state needs to prepare KanCare for the Federal reporting that Kansas has not been requiring of the MCOs. CMS says that they will have to complete the Medicaid managed care report in accordance with 42 CFR § 438.66.

CMS says that they will have to complete and submit the Medicaid managed care report directly to CMS. States will have to explain how they are going to accomplish this reporting in waiver renewals. https://www.medicaid.gov/federal-policy-guidance/downloads/cib06282021.pdf

Mental Health Parity – a quick note

States are quickly changing their expectations for compliance with Federal Mental Health Parity laws and the courts are hastening this reform. Kansas should incorporate mental health parity expectations and reporting in the KanCare contracts.

KMMC Quarterly Meeting, September 10, 2021

Amy Campbell presented recommendations for behavioral health. The task group came up three sets of recommendations as shown on page 11 of the Recommendation Report 2021. The recommendations for the upcoming KanCare procurement process include a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement to ensure the ongoing success of these services; reporting key quality measures on the adherence to antipsychotic medications and the initiation and engagement of substance use disorder treatment; and incorporate mental health parity expectations and reporting.

Specifically, Amy said bidders should be asked two important questions:

1. How would the bidder be able to contribute to meaningful data collection and publication?
2. How has the bidder improved the outcomes proposed by this group and what practices have they implemented as an entity (not put upon their provider networks) to improve the six areas of recommendations?

Quality Assurance

Task Group Summary

- Tracking whether HCBS consumers are receiving the services they need and are qualified to receive, and developing benchmarks and more robust systems of accountability.
- HCBS Service Plan Performance Measures: Develop benchmark goals and incentives, as well as additional measures.
- Consumer interview and record review methodologies: Ensure validation and Representativeness.
- HCBS CAHPS: Increase sample size for subgroup analysis.
- Direct care workers: Measure their availability for adequate workforce and access.
- AuthentiCare: Explore the potential for measuring authorized and fulfilled hours for direct care.
- HCBS person-centered care: Ensure adequate hours are authorized and fulfilled.

Carrie Wendell-Hummel (KU Center for Research on Aging and Disability Options) was not able to stay for the entire KMMC meeting. She submitted a document below to summarize the recommendations on quality assurance. Carrie revisited these recommendations in light of the upcoming KanCare procurement process. Note, she did not have an opportunity to discuss these recommendations with other members of the task group, and so this is just a starting point for KMMC consideration.

Overview of prior recommendations:

- Based on stakeholder input, the research question we identified was, "Are Home and Community Based Services (HCBS) populations receiving the level of services needed?" This includes all 7 waivers in Kansas.
- We identified several measures that help answer this question, including the HCBS CAHPS (Client Assessment of Healthcare Providers and Systems) survey, NCI-AD (National Core Indicators- Aging and Disability) survey, record review, and customer interviews. We made recommendations around expanding CAHPS and NCI-AD, as these survey measures were not available across all waivers and sample sizes are too small to support comparisons or subgroup analysis.
- We also recommended new measures be developed, including the need to measure the availability of direct care workers and exploring the potential for using other data sources, such as APS/CPS data (adult and child protective services), MCO member surveys, and AuthentiCare data.

This is a key quality measure, as concerns about waiver consumers not receiving all authorized services have only grown during the pandemic, which is largely driven by direct support workforce shortages in which consumers struggle to find and retain good personal care attendants. Based on both reports from the field and ongoing research by Carrrie's team at KU, it's clear that these workforce shortages have also only grown during the pandemic. However, as these are longstanding concerns, we cannot expect these issues to go away after the pandemic. Unmet care needs place HCBS consumers at great risk of institutionalization, hospitalization, and other adverse health outcomes. Thus, with the importance of this quality measure in mind during the KanCare procurement process, the following next steps are recommended:

1. Program administrators need to know more about how the related performance measures operate in the current KanCare contracts. KMMC previously identified 6 performance measures related to this question. What are the benchmark goals for each measure and what are the incentives for reaching these benchmarks? This would provide a useful starting point to consider whether these incentives should be updated, including whether any of the additional identified measures should be included as performance measures.
2. Take a deeper dive into consumer interview and record review methodologies to ensure these are valid and representative measures, especially considering the predominance of these data sources in current performance measures.
3. We previously discussed the need for larger CAHPS sample sizes to allow for subgroup analysis. Thinking about sample size needs in light of MCO procurement and accountability, a larger sample size is also needed to support comparisons across geographic regions, as this may impact access to services more than waiver type.
4. We noted a need to measure the availability of direct care workers. This remains an important and key recommendation in light of KanCare procurement, and thus needs further refinement. There may be overlap or lessons from KMMC recommendations on provider network adequacy that could be carried over to this recommendation.
5. We noted the potential of using AuthentiCare as a source of meaningful data. AuthentiCare supports payroll for consumers and direct support workers, so it is a rich source of data on the number of direct care hours authorized and the number filled. Previously, we did not take a deep dive into AuthentiCare as a potential data source, but this would be a timely moment to explore this further and make more specific recommendations.
6. Finally, we never addressed whether HCBS person-centered care plans are

authorizing an appropriate number of hours in the first place, and thus, we should revisit data sources with this question in mind. There are growing concerns among advocates about consumers who are only awarded one hour of care per week, even though they meet the institutional level of care standard. Further, in exploring how the MCO contracts could better ensure that care hours are filled, we need to make sure there's not a perverse incentive to increase the proportion of filled hours by reducing the number of authorized hours.

Combined, the above-mentioned data, if collected in a valid and representative way, can track whether HCBS consumers are receiving the services they need and are qualified to receive, and thus also be used to develop benchmarks and more robust systems of accountability in MCO contract requirements. As thinking about our prior recommendations in light of KanCare procurement brings forth new questions and potentially shifts the priority of some of our recommendations, it is recommended that the QA taskforce reconvene to consider these and other KMMC member recommendations.