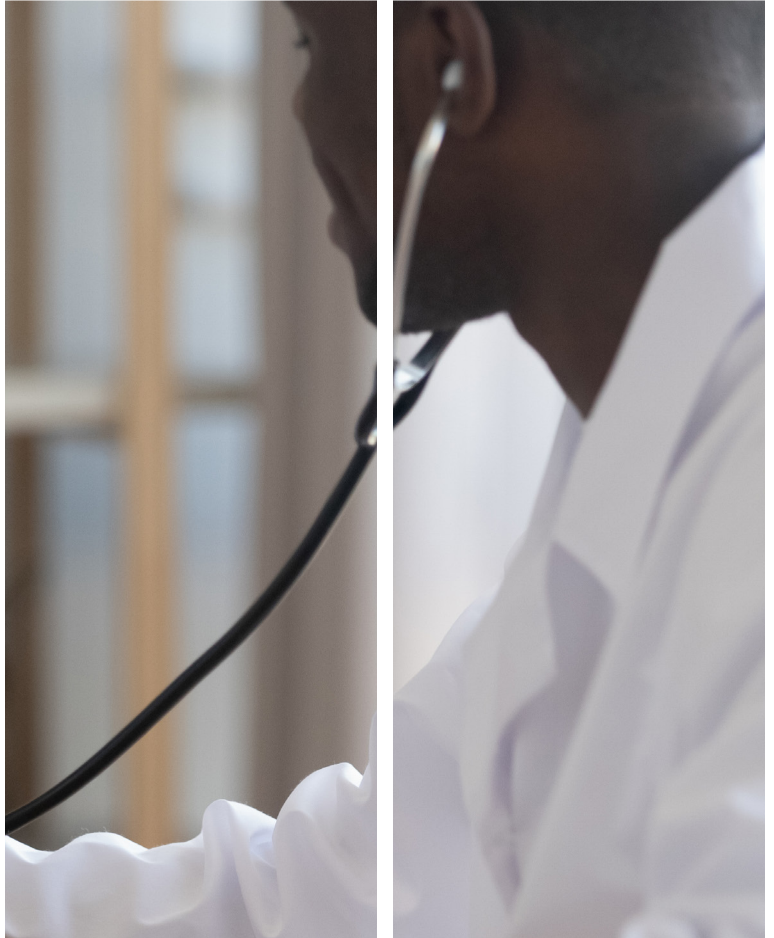
KMMC

KANCARE MEANINGFUL MEASURES COLLABORATIVE



ANNUAL REPORT

OCTOBER 2020

KMMC
KANCARE MEANINGFUL MEASURES COLLABORATIVE

KANCARE MEANINGFUL MEASURES COLLABORATIVE ANNUAL REPORT, 2020

OCTOBER 2020

Acknowledgments

The KanCare Meaningful Measures Collaborative is grateful for the valuable input and support of its membership. The full list of members can be found in Appendix A (page A-1).

Supported by a grant from the REACH Healthcare Foundation.

Table of Contents

Executive Summary iii

Introduction 1

Purpose 1

Structure 2

Participation 3

KMMC Process 3

Cycle 1 6

Network Adequacy Recommendations 9

Care Coordination Recommendations 12

Pregnancy Outcomes Recommendations 16

Social Determinants of Health Recommendations 19

Existing Measures Reports 23

Cycle 2 24

Consumer Engagement 24

Key Findings 25

SWG Membership Engagement 25

Next Steps 29

Appendix A: Membership List A-1

Appendix B: KMMC Charter Statements B-1

Appendix C: KMMC Meetings Timeline C-1

Appendix D: Short Reports on Meaningful Measures in KanCare D-1

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Executive Summary

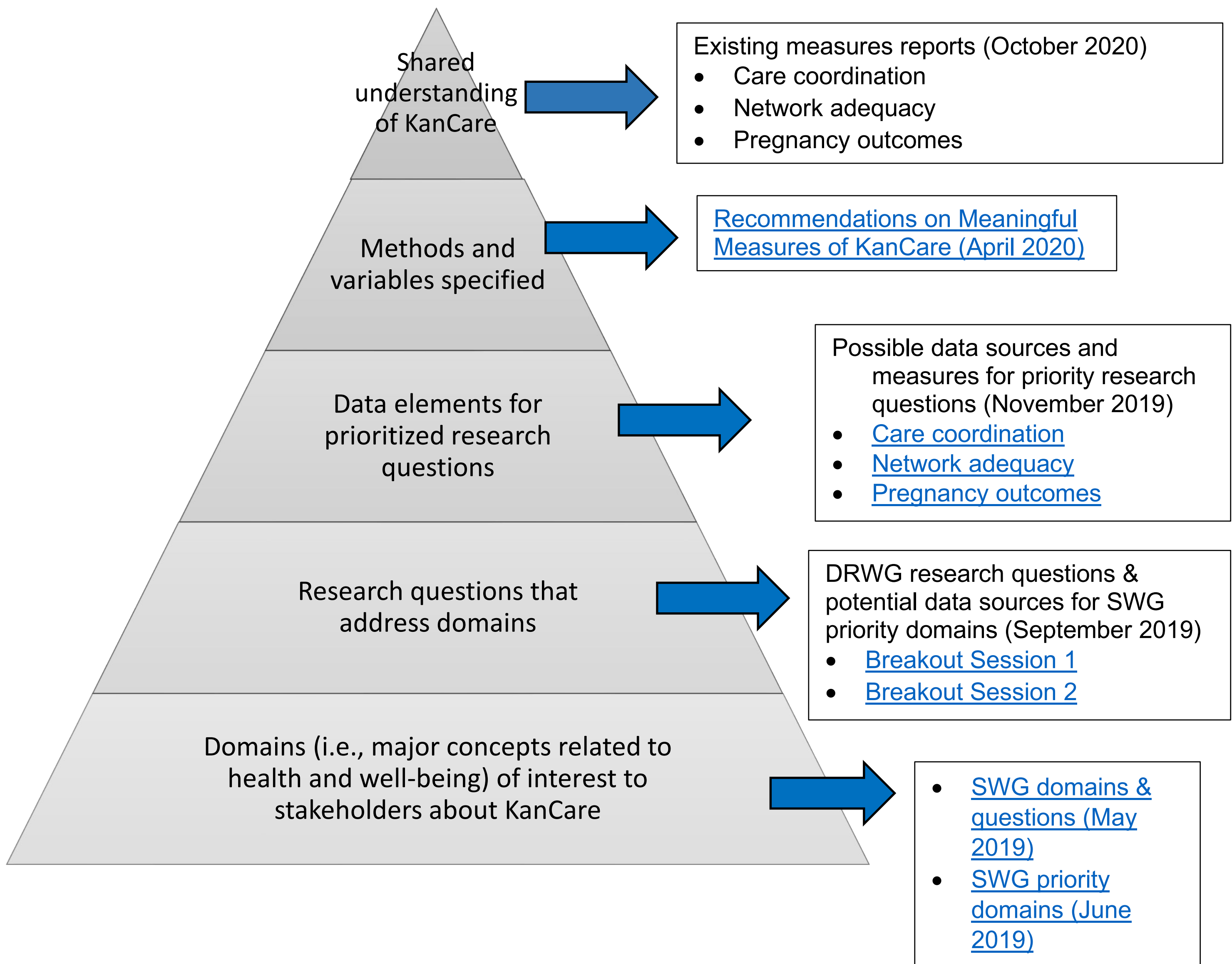
The KanCare Meaningful Measures Collaborative (KMMC) was formed by KanCare stakeholders, researchers, and state agency staff in 2018 to establish consensus on the data and metrics available for the KanCare program, the comprehensive Medicaid managed care program in Kansas. This document is the second report from the KMMC and captures the activities and achievements of the KMMC between August 2019 and July 2020, as well as highlights the collaborative process by which the group operates.

This report describes the work completed by the KMMC throughout one complete cycle of effort (see *Figure ES-1,* page iv, for a visual representation of the cycle and outputs of this process). Further, this report describes potential priorities that will be pursued during a second cycle of KMMC activity. Each KMMC cycle begins with consumer engagement in collaboration with the KMMC Stakeholder Working Group (SWG) to identify priorities. These priorities are then shared with the KMMC Data Resources Working Group (DRWG). The groups exchange information continuously to write research questions, identify and prioritize possible measures, and develop recommendations. Recommendations in the first cycle of KMMC work fell into three categories: existing meaningful measures, new meaningful measures, and other recommendations to improve methodology or reporting (see *Figure ES*-2, page v). All recommendations were made with the goal of increasing the visibility, credibility and usefulness of data related to KanCare, as well developing a shared understanding of the KanCare program.

The KMMC recommendations from the first cycle of effort focus on the initial priority topics of network adequacy, care coordination, pregnancy outcomes and social determinants of health. *Figure ES-3* (page vi), summarizes the recommendations by topic and comes from the April 2020 report by the KMMC, *Recommendations on Meaningful Measures of KanCare* (available here: https://bit.ly/2YVa4QK). In addition, the KMMC drafted reports on the existing meaningful measures to summarize the data and metrics currently available for evaluating network adequacy, care coordination and pregnancy outcomes in KanCare. Those reports can be found in *Appendix D* (page D-1) or on kmmcdata.org as standalone products.

In a second cycle of work, the KMMC SWG members are currently identifying additional priority topics. This work began with consumer engagement and has continued as SWG members have provided additional input and insight on how work could be prioritized. Lastly, this report summarizes the initial steps the KMMC is considering as to how the COVID-19 pandemic and related response efforts should inform the work completed in the second cycle of KMMC work.

Figure ES-1. **KMMC Cycle 1: Process and Associated Products**



Note: DRWG stands for "Data Resources Working Group." SWG stands for "Stakeholder Working Group." "Breakout Session 1" includes research questions and data sources for the following domains: Quality Assurance, Care Coordination, No Access, Pregnancy Outcomes and Setting of Choice. "Breakout Session 2" includes research questions and data sources for the following domains: Enrollee Treatment, Application Processing, Social Determinants and Network Adequacy.

Source: KanCare Meaningful Measures Collaborative, 2020.

Figure ES-2. **Categories of Cycle 1 KMMC Recommendations**

Existing Meaningful Measures

- These measures already exist across public KanCare reports.

New Meaningful Measures

- These measures are not currently available in public KanCare reports and can be classified into three groups:
- Data are available but require additional resources to construct the measures.
- Data are not available but could be adapted from measures developed elsewhere.
- Data are not available and measures have not been developed elsewhere.

Other Recommendations

- Further study and investment in these areas are strongly encouraged to address data limitations and other issues related to methodology.

Source: This figure comes directly from the [meaningful measures reports](), October 2020.

Figure ES-3. **Summary of Cycle 1 KMMC Recommendations by Topic, April 2020**

KMMC Topic & Stakeholder Questions	KMMC Recommendations
Network Adequacy. What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?	• *Existing Meaningful Measures:* Eleven existing measures that describe the KanCare network adequacy contract standards and member experiences were identified as meaningful. • *New Meaningful Measures:* New meaningful measures that assess adequate provider-to-enrollee ratios could be developed. • *Other Recommendations:* Sharing technical documentation, describing the network adequacy monitoring process and clarifying informational questions were also recommended.
Care Coordination. Are care coordination services (i.e., any services to help coordinate care; not limited to MCO-defined services) available for consumers who need it? Are care coordination services effective for those who have received them?	• *Existing Meaningful Measures:* Sixteen existing measures for general care coordination and members receiving HCBS services were identified as meaningful. • *New Meaningful Measures:* Measures that will become available using new home and community based services (HCBS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) data were identified as meaningful. • *Other Recommendations:* Recommendations on survey administration and representativeness were also developed.
Pregnancy Outcomes. How does KanCare impact pregnancy outcomes?	• *Existing Meaningful Measures:* Two existing process measures were identified as meaningful. • *New Meaningful Measures:* Six new outcomes measures (e.g., maternal mortality) that could be generated with claims data were identified as meaningful. • *Other Recommendations:* Recommendations pertaining to trend and subgroup analyses were also developed.
Social Determinants of Health. What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health, and their impact on enrollees?	• *Existing Meaningful Measures:* None were identified. • *New Meaningful Measures:* New measures that capture information about the social determinants of health (SDOH) should be developed. One option to collect SDOH data would be via the currently used Health Screening Tool (HST), with modifications. • *Other Recommendations:* Recommendations focused on consistent collection of SDOH information by managed care organizations (MCO) across KanCare member groups, and incentives to encourage member responses.

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Introduction

The KanCare Meaningful Measures Collaborative (KMMC) was formed by KanCare stakeholders, researchers, and state agency staff in 2018 to establish consensus on the data and metrics available for the KanCare program, the comprehensive Medicaid managed care program in Kansas. This is the second report from the KMMC and captures the activities and achievements of the KMMC between August 2019 and July 2020, as well as highlights the collaborative process by which the group operates. Where possible, text and figures from KMMC documents developed throughout the year have been included. For example, figures pulled from prior KMMC documents are labeled in the source as, "this figure comes directly from X," with a link to the corresponding document for more information. The first annual report of the KMMC can be accessed here.

Purpose

From the inception of KanCare in 2013, there has been disagreement over how KanCare is performing and a desire for more timely and accessible data. The goal of the KMMC is not to evaluate the KanCare program, but instead to establish consensus around KanCare data and metrics by bringing together KanCare consumers, stakeholders, researchers and state agency staff. The KMMC charter statements outline the following purposes for the KMMC:

- Increase the visibility, credibility, validity and usefulness of information broadly available about KanCare;
- Establish consensus on metrics that already exist, and new metrics that can be created, to better understand the performance of the KanCare program in relation to the whole person;
- Identify the best data sources, the appropriate methods and the most effective way to report the metrics;
- Establish a transparent process that transcends administrations and individuals; and
- Over time, build capacity in Kansas to generate and use the appropriate data for program management, program evaluation, policy development and accountability.

Additional information on the KMMC scope of work and purpose can be found in the KMMC charter statements (*Appendix B*, page B-1). This collaborative effort is supported by a grant from the REACH Healthcare Foundation and is facilitated by the Kansas Health Institute (KHI).

Structure

Members of the KMMC participate in the Data Resources Working Group (DRWG) and the Stakeholder Working Group (SWG). The SWG identifies and prioritizes questions that are analyzed through an inclusive process that encompasses a variety of experiences, perspectives and individuals. Within the membership of the SWG, the Consumer Engagement Design Team functions to facilitate the engagement of the KMMC with a wider cross-section of KanCare consumers, beyond those who participate as members of the KMMC.

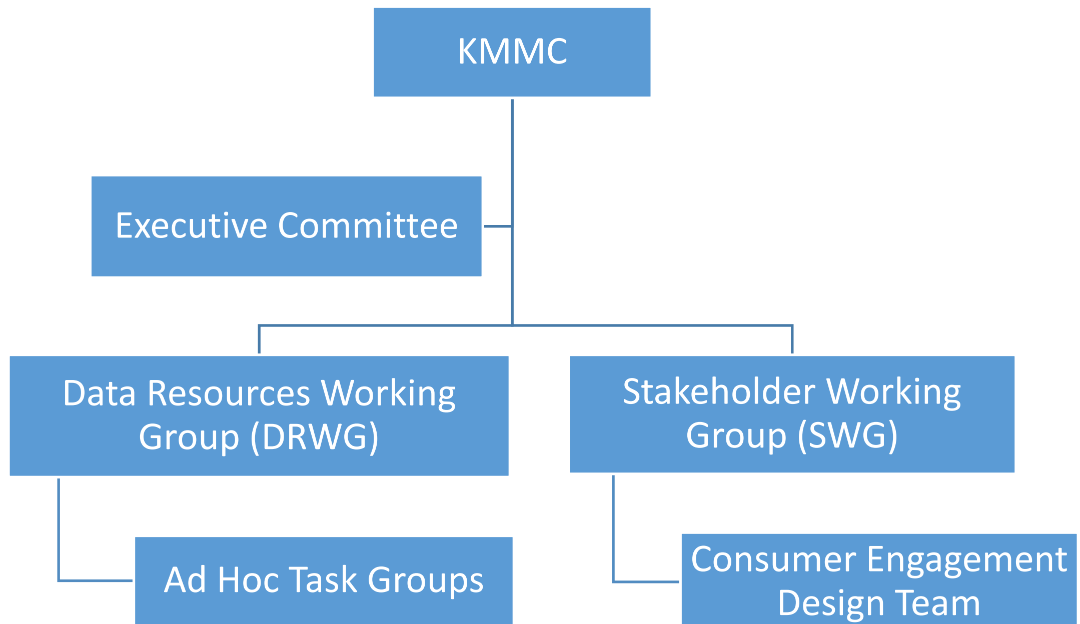
The DRWG provides methodologic and data analytic support for the KMMC and develops institutional knowledge for a sustainable infrastructure. Members of the DRWG form ad hoc Task Groups to work on each KMMC priority identified by the SWG. For example, Task Groups reviewed data and measures related to the KMMC priorities of network adequacy, pregnancy outcomes, care coordination and social determinants of health.

The KMMC is led by an Executive Committee whose purpose is to:

- Approve the metrics to be developed through the collaborative, based on the recommendations forwarded by the SWG;
- Approve the data sources and methodology used to report those metrics based on the recommendations of the DRWG; and
- Document for public reporting the process employed to identify and measure selected metrics.

Decisions made by the Executive Committee are sent to the entire KMMC, referred to as the Committee-of-the-Whole, for ratification. The charter statements define Executive Committee roles for consumers, stakeholders and research representatives, as well as representatives from state agencies. *Figure 1* (page 3) illustrates the organizational structure of the KMMC.

Figure 1. **Organization of the KMMC**



Source: KanCare Meaningful Measures Collaborative, 2020.

Participation

The KMMC is comprised of KanCare consumers, advocacy organizations, provider associations, researchers, MCOs and state agency staff. Members volunteer their time and expertise and decide to participate in either the DRWG or the SWG. Additionally, members may be appointed to the Executive Committee by the KMMC Committee-of-the-Whole. A full list of the KMMC membership can be found in *Appendix A* (page A-1), and a timeline of meetings and presentations provided by the KMMC in the last year can be found in *Appendix C* (page C-1).

KMMC Process

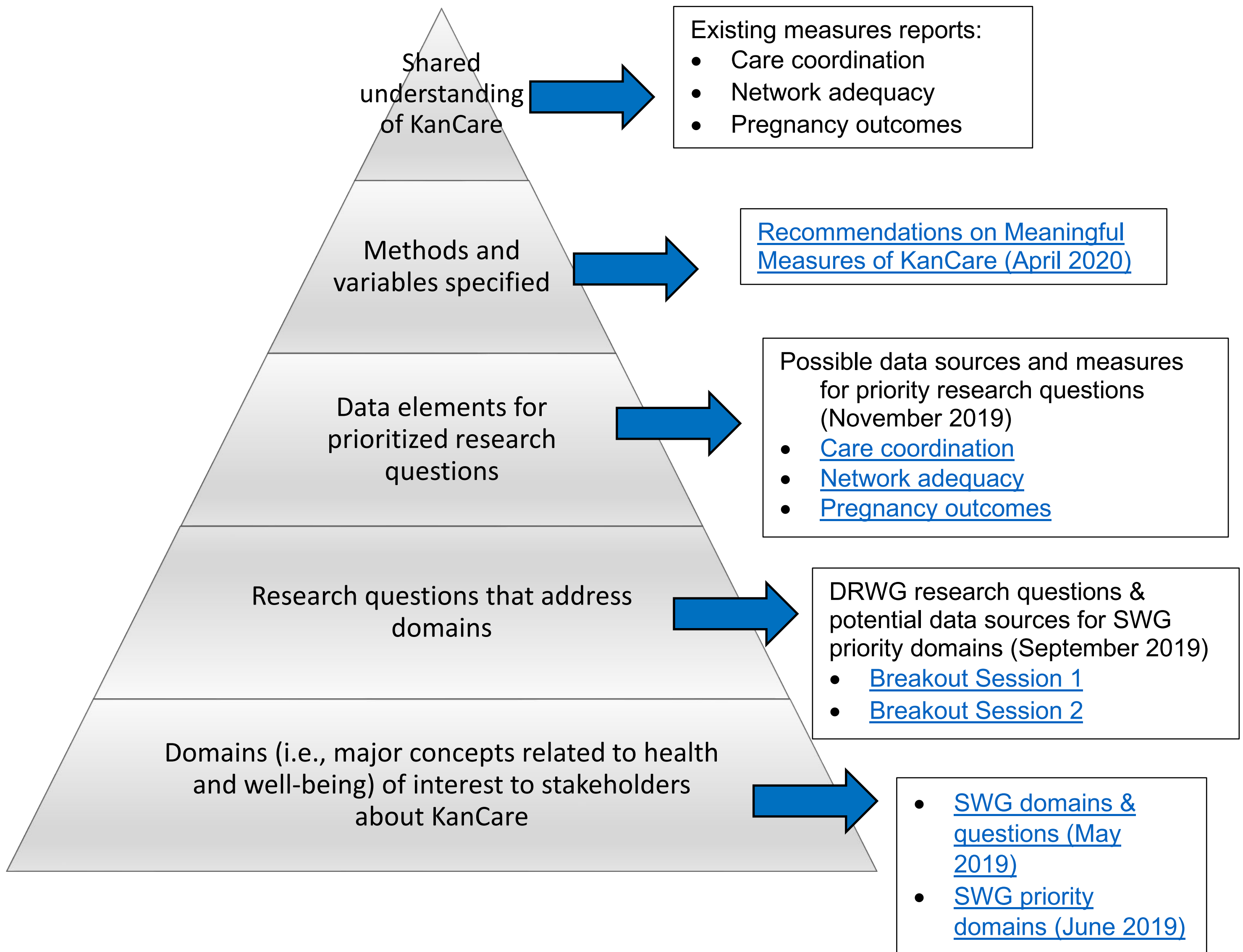
The KMMC Process Pyramid (*Figure 2*, page 5) describes the collaborative process by which the KMMC seeks to achieve its purpose. The KMMC moves through this process in cycles, with a cycle concluding once the collaborative has completed each section of the pyramid. Thus far, one cycle of work has been completed, with a second cycle currently underway. *Figure 2* highlights the products completed during each step of the process in the first cycle of KMMC work.

The base of the pyramid describes the identification of domains — the major concepts related to health and well-being — of interest to stakeholders and consumers of KanCare. After identification of these major concepts by the SWG, the DRWG and SWG collaborate to refine areas of interest within these domains into researchable questions. After research questions have been drafted, data elements — including potential data sources, measures, methodology and variables — that might help to answer these questions are identified by DRWG Task Groups. Using the data elements identified, the Task Group then creates specific recommendations about meaningful measures of KanCare, which are reviewed by the Committee-of-the-Whole. Throughout this process, the KMMC Executive committee provides leadership as to the feasibility and other considerations around the work.

The top of the pyramid indicates a key intended outcome of this work: a shared understanding of KanCare. By collaboratively establishing the measures by which KanCare can be understood, the KMMC process seeks to broadly share knowledge of KanCare that is validated, trusted and credible. To achieve this aim, cycles of work conclude with the dissemination of information that was compiled throughout the collaboration.

For more detailed information on scope, responsibility and other guiding principles please see the KMMC Charter Statements in *Appendix B* (page B-1). The following sections provide additional detail on how the process has been implemented during the first two cycles of KMMC work, the second of which is still underway.

Figure 2. **KMMC Cycle 1: Process and Associated Products**



Note: DRWG stands for "Data Resources Working Group." SWG stands for "Stakeholder Working Group." "Breakout Session 1" includes research questions and data sources for the following domains: Quality Assurance, Care Coordination, No Access, Pregnancy Outcomes and Setting of Choice. "Breakout Session 2" includes research questions and data sources for the following domains: Enrollee Treatment, Application Processing, Social Determinants and Network Adequacy.

Source: KanCare Meaningful Measures Collaborative, 2020

Cycle 1

The first cycle of KMMC work began in the fall of 2018 and concluded in April 2020 with the culmination of recommendations from the KMMC. Initial work completed in cycle 1 was highlighted in the *KanCare Meaningful Measures Collaborative Report, 2019*, including the identification of nine priority topics and corresponding questions (referred to previously *Tier 1 Consolidated Questions*) by the SWG. Since the publication of the previous report, the Executive Committee selected four of the nine topics for work by the DRWG, including: network adequacy, care coordination, pregnancy outcomes and social determinants of health. These topics were selected for several reasons, including availability of existing data and measures, stakeholder interest and potential for impact due to KMMC work on the topic.

Four DRWG task groups formed to refine the stakeholder topics and questions into research questions, identify potential data sources, and recommend meaningful measures of KanCare. Once data sources and all potential measures for a given topic were identified, the task groups used the following criteria to identify a subset of measures considered to be meaningful.

- Feasibility of assessing the measures
    - Data access
    - Data collection frequency
    - Data quality
- Existence of any industry standard or benchmark related to the measure
- Level of resources required to produce the measures

The work of the task groups was ratified by the Committee-of-the-Whole and culminated in a report titled, *Recommendations on Meaningful Measures of KanCare*, which was released in April 2020. The remaining text in this *Cycle 1* section is excerpted from that report and includes the original SWG topics and questions, a list of new and existing measures identified as meaningful by the KMMC, and recommendations to address limitations in existing data for four initial priority topics. Initial priorities included network adequacy, care coordination, pregnancy outcomes and social determinants of health. See *Figure 3* (page 8) for a summary of the recommendations by priority.

Within each priority topic, recommendations were sorted into one of three categories: existing meaningful measures, new meaningful measures and other recommendations.

***Existing Meaningful Measures*:** These meaningful measures already exist across public KanCare reports. Summary reports have been developed to gather these measures for each priority topic in one place and disseminate to the public.

New Meaningful Measures: These measures are not currently available in public KanCare reports and can be classified into the following three groups:

- Data are available in KanCare but require additional resources to construct the measures.
- Data are not available in KanCare but could be adapted from existing measures developed for the federal program or in other states.
- Data are not available in KanCare and measures have not been developed for the federal program or in other states.

Methodology for these new meaningful measures can be developed to ensure consistency and transparency.

Other Recommendations: Further study on these items is strongly encouraged to address data limitations and other issues related to methodology.

Figure 3. **Summary of KMMC Recommendations by Topic**

KMMC Topic & Stakeholder Questions	KMMC Recommendations
Network Adequacy. What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?	• *Existing Meaningful Measures:* Eleven existing measures that describe the KanCare network adequacy contract standards and member experiences were identified as meaningful. • *New Meaningful Measures:* New meaningful measures that assess adequate provider-to-enrollee ratios could be developed. • *Other Recommendations:* Sharing technical documentation, describing the network adequacy monitoring process and clarifying informational questions were also recommended.
Care Coordination. Are care coordination services (i.e., any services to help coordinate care; not limited to MCO-defined services) available for consumers who need it? Are care coordination services effective for those who have received them?	• *Existing Meaningful Measures:* Sixteen existing measures for general care coordination and members receiving HCBS services were identified as meaningful. • *New Meaningful Measures:* Measures that will become available using new HCBS CAHPS data were identified as meaningful. • *Other Recommendations:* Recommendations on survey administration and representativeness were also developed.
Pregnancy Outcomes. How does KanCare impact pregnancy outcomes?	• *Existing Meaningful Measures:* Two existing process measures were identified as meaningful. • *New Meaningful Measures:* Six new outcomes measures (e.g., maternal mortality) that could be generated with claims data were identified as meaningful. • *Other Recommendations:* Recommendations pertaining to trend and subgroup analyses were also developed.
Social Determinants of Health. What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health, and their impact on enrollees?	• *Existing Meaningful Measures:* None were identified. • *New Meaningful Measures:* New measures that capture information about the social determinants of health (SDOH) should be developed. One option to collect SDOH data would be via the currently used Health Screening Tool (HST), with modifications. • *Other Recommendations:* Recommendations focused on consistent collection of SDOH information by MCO across KanCare member groups, and incentives to encourage member responses.

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Network Adequacy Recommendations

According to the National Association of Insurance Commissioners, “network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract.” Network adequacy was selected as a priority by the KMMC because the ability to access providers and services when needed underpins health outcomes and other topics of interest to the KMMC.

The stakeholder questions described below were the initial questions posed by SWG members. The research questions were created by DRWG task group members from the initial stakeholder questions and used to develop the recommendations outlined below.

Stakeholder Questions:

- What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)?
- If network adequacy is below the benchmark, why?

Research Questions:

- What is the current measure for network adequacy in KanCare relative to a benchmark (e.g., contract standard)?
- Overall, do KanCare members feel they have adequate access to care and services?

The KMMC recommends that meaningful measures in *Figure 4* (page 11) be considered for understanding the adequacy of the KanCare provider network. These measures consider the extent to which current contract standards are being met and how members have experienced when they need care. Most of these meaningful measures for Network Adequacy are available in public KanCare reports, including KanCare Network Adequacy Reporting and the KanCare Evaluation Annual Report. To better inform stakeholders regarding network adequacy, recommendations also include making technical documents available, describing the derivation of measures as part of these public reports, presenting the monitoring process and data, and clarifying informational questions. Specifically, the recommendations are:

Network Adequacy 1: Develop a summary report on network adequacy meaningful measures (*Figure 4*, page 11) in relation to contract standards as well as measures that capture the experience of KanCare members accessing care.

a. KanCare network adequacy standards: percent of members covered within the standards by provider type, geography and MCO.

b. Member experience: timely access to care as well as receiving services according to the service plan.

Network Adequacy 2: Make technical documents available and provide the derivation of measures as part of public KanCare reports.

a. Provide access to technical documents on how the KanCare network adequacy standards are established and how the standards compared to those used by other entities or organizations, e.g., Centers for Medicare and Medicaid Services (CMS), National Committee for Quality Assurance (NCQA), other states or private insurance.
b. Cross-reference referred documents and reports with links and consistent titles.
c. Ensure the transparency of calculation formulas or derivation processes for measures that are presented in public KanCare reports, e.g. percentage covered in the KanCare Managed Care Organization Network Access table.

Network Adequacy 3: Describe the KanCare network adequacy monitoring process and utilize data collected for program improvement.

a. Publish documents on the monitoring process and the process to act when issues arise.
b. Provide more information regarding data collection, analysis and applications for monitoring efforts, e.g., *secret shopper.*
c. Utilize program monitoring data to help identify areas for continuous improvement.

Network Adequacy 4: Provide information on the following questions.

a. When is the network determined to be inadequate? How often is the network determined to be inadequate? What are the main reasons? What indicates that a review of the network is required?
b. What will KanCare MCOs do when members do not have access to care/services as required by the contract for network adequacy? What adjustments do they make to get KanCare members access when there are gaps?

Considerations:
The group discussed the following considerations and opportunities for future work regarding network adequacy. A challenge identified for network adequacy meaningful measures is the balance between individual-level network adequacy needs (e.g., a KanCare consumer being able to find a provider when they need one) and effective program-level measurement. To address this challenge, reports could list not only provider types, but also the waiver members who may be served by each provider type. This may allow for additional clarity when individuals access network adequacy reports.

An opportunity for future work noted by the group was developing additional network adequacy measures for personal care attendants that capture availability of services at the attendant level rather than the agency level.

Figure 4. **Meaningful Measures Related to Network Adequacy**

Meaningful Measures	**Data Source**	**Currently Reported?**
KanCare Network Adequacy Standards		
Percent of members covered within network adequacy standards by provider type, MCO and geography.	KanCare Network Adequacy Reporting	Geo-Access Map (4th Quarter, 2019)
Number of counties with no provider access by provider type, geography and MCO.	KanCare Network Adequacy Reporting	2018 KanCare Evaluation Annual Report (Provider Network – GeoAccess, page 155-175 of PDF, Tables 36-37)
Number and percent of members not within access distance by provider type and MCO.	KanCare Network Adequacy Reporting	
Sufficient number of providers by provider type, MCO and geography to provide adequate coverage within defined time and distance standards.	*N/A*	*No*
Member Experience		
[Urgent/emergent care] In the last six months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	CAHPS	2018 KanCare Evaluation Annual Report (page 175 of PDF, Table 42)
[Primary/preventive care] In the last six months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	CAHPS	
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	CAHPS	
Children and Adolescents' Access to Primary Care Practitioners (for age 12-24 months; 25 months to 6 years; 7-11 years; and 12-19 years)	*Healthcare Effectiveness Data and Information Set (HEDIS) Measure*	*TBD*
Performance Measure 8 – Number and percent of waiver participants who received services in the type, scope, amount, duration and frequency specified in the service plan.	KDADS HCBS Quality Review Report	KanCare Quarterly Report to CMS, Quarter Ending 9.30.19 (page 63 of PDF)

Figure 4 (continued). **Meaningful Measures Related to Network Adequacy**

Meaningful Measures	Data Source	Currently Reported?
***Member Experience* (continued)**		
I was able to get all the services I thought I needed.	Mental Health Survey	2018 KanCare Evaluation Annual Report (page 178-180 of PDF, Table 43)
My family got as much help as we needed for my child.	Mental Health Survey	
Services were available at times that were good for me (convenient for us/me).	Mental Health Survey	
My mental health providers returned my calls in 24 hours.	Mental Health Survey	

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Care Coordination Recommendations

According to the Agency for Healthcare Research and Quality (AHRQ), "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." Care coordination was selected as a priority by the KMMC due to the impact of care coordination on health outcomes and the number of readily available measures assessing care coordination in KanCare.

The stakeholder questions described below were the initial questions posed by SWG members. The research questions were created by DRWG task group members from the initial stakeholder questions and used to develop the recommendations outlined below.

Stakeholder Question:

- Are care coordination services (i.e., any services to help coordinate care; not limited to MCO-defined services) available for consumers who need it?
- Are care coordination services effective for those who have received them?

Research Questions:

1. General Provider Care Coordination – How well do providers assist KanCare members in managing their care? Do providers organize communication and cooperation among the member and others responsible for different aspects of the member's care?
2. MCO Care Coordination for KanCare consumers receiving home and community based services (HCBS) Waiver services – How well do MCO Care Coordinators assist KanCare HCBS Waiver members in managing their care?

3. Targeted Case Management for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) Waiver services – How well do Targeted Case Managers assist KanCare I/DD Waiver members in managing their care?

In response to stakeholder and research questions the task group identified the meaningful measures described in *Figure 5* (page 15), which includes a combination of currently reported process measures and several measures where an opportunity may exist to capture the measure for additional member populations. The recommendations are sorted by each of the key populations receiving care coordination services that were identified by KanCare stakeholders. Specifically, the task group recommends the following opportunities to measure the availability and effectiveness of care coordination services be considered:

Overall:

Care Coordination 1: Develop a summary report on Care Coordination meaningful measures (*Figure 5,* page 15) in relation to general care coordination by providers, care coordination for HCBS waiver participants and targeted case management for intellectual/developmental disability waiver participants.

General Care Coordination by Providers:

Care Coordination 2. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the serious emotional disturbance (SED) waivers.

Care Coordination 3. The KMMC should consider monitoring the substance use disorder (SUD) Member Survey to see if changes to methodology make it a data source for meaningful measures.

Care Coordination 4. KanCare could consider increasing the number of HCBS CAHPS surveys conducted for each waiver to allow for sub-group analysis in regard to survey questions about providers.

MCO Care Coordination for KanCare consumers receiving HCBS Waiver services:

Care Coordination 5. 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.

Care Coordination 6. KanCare could consider conducting HCBS CAHPS survey by a hybrid approach (phone interview and in-person) as is seen in some peer states as a strategy to increase the number and representativeness of surveys completed.

Care Coordination 7. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the SED waivers.

Targeted Case Management (TCM) for KanCare consumers receiving I/DD Waiver services:

Care Coordination 8. 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 TCM.

Other:

Care Coordination 9. The KMMC should review data available related to administrative care coordination to identify which to include in the list of meaningful measures related to care coordination.

Care Coordination 10. The KMMC should review evaluation data related to OneCare Kansas to identify which to include in the list of meaningful measures related to care coordination.

Considerations:

The group discussed the following considerations and opportunities for future work regarding care coordination. Regarding recommendations about opportunities to expand the subgroups by which CAHPS or HCBS CAHPS surveys may be examined (e.g., *Care Coordination Recommendation 4*), the group recognized the high resources required to increase sampling. One solution the group discussed was alternating years in which additional sampling is conducted for specific subgroups.

Additionally, the group noted that it may be helpful to understand how the various CAHPS surveys differentiate between the services that might be referred to as “care coordination” in survey interviews with members. An initial review of the HCBS CAHPS instrument (available here), indicates that interviewers refer to the providers by either program-specific language or the language used by the member being interviewed. Additionally, the interview protocol uses both role titles and examples of services provided to ensure that the member being interviewed understands to which care provider the interviewer is referring.

Figure 5. **Meaningful Measures Related to Care Coordination**

<table>
<tr><th>Meaningful Measures</th><th>Data Source</th><th>Currently Reported</th></tr>
<tr><td>General Care Coordination by Providers</td><td></td><td></td></tr>
<tr><td>Percent of respondents with positive response to, How often was it easy to get the care, tests, or treatment you (your child) needed?</td><td rowspan="3">CAHPS</td><td rowspan="3">2018 KanCare Evaluation Annual Report, (page 147 of PDF, Table 30)</td></tr>
<tr><td>Percent of respondents with positive response to, How often did you (your child) get an appointment to see a specialist as soon as you (your child) needed?</td></tr>
<tr><td>Percent of respondents with positive response to, Personal doctor seemed informed and up-to-date about your (your child's) care received from other providers.</td></tr>
<tr><td>CC7. In the last six months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?</td><td rowspan="2">CAHPS Survey – Children with Chronic Conditions Supplemental Questions</td><td rowspan="2">2018 KanCare Evaluation Annual Report, (page 146 of PDF, Table 30)</td></tr>
<tr><td>CC18. In the last six months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?</td></tr>
<tr><td>CC27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child? (Refers to treatment or counseling for an emotional, developmental, or behavioral problem)</td><td>CAHPS Survey – Children with Chronic Conditions Supplemental Questions</td><td>Reported by MCOs to state, but not included in annual evaluation report.</td></tr>
<tr><td>HEDIS gaps in care reports that capture follow-up visits and transitions in care:
• Follow-Up After Mental Health Hospitalization
• Initiation and Engagement of Alcohol and Other Drug Dependence
• Anti-Depressant Medication Management
• Follow-up Care for Children Prescribed ADHD Medicine
• Annual Monitoring for Patients on Persistent Medications
• Preventive care measures</td><td>HEDIS measure</td><td>HEDIS Comparison Data Files – Anticipated HEDIS Scorecard</td></tr>
</table>

Figure 5 (continued). **Meaningful Measures Related to Care Coordination**

Meaningful Measures	Data Source	Currently Reported
MCO Care Coordination for KanCare Consumers Receiving HCBS Waiver Services		
Do you know who your MCO Care Coordinator is?	HCBS CAHPS Survey	Expected – April 2020
Could you contact them when needed?		
Work with you when asked for help getting or fixing equipment?		
Help in getting changes in service, or help getting places or finding a job?		
Rating of help received from MCO Care Coordinator.		
Would you recommend this care coordinator?		
Proportion of people whose case manager/care coordinator talked to them about services that might help with their unmet needs and goals (if have unmet needs and goals and know they have case manager/care coordinator)	National Core Indicators – Aging and Disabilities Adult Consumer Survey	NCI-AD, Kansas State Reports, 2015-2019; 2018-2019 Kansas Report (Graph 19, page 49 of PDF; Graphs 26-28, page 52-53 of PDF)
Proportion of people who felt comfortable and supported enough to go home (or where they live) after being discharged from a hospital or rehabilitation facility in the past year		
Proportion of people who had someone follow up with them after being discharged from a hospital or rehabilitation facility in the past year		
Proportion of people who know how to manage their chronic condition(s).		
Targeted Case Management (TCM) for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) Waiver Services		
NOTE: HCBS CAHPS Survey measures are collected for TCM, but caution should be taken making any comparisons as the sample size is small.	*HCBS CAHPS Survey*	*Expected – April 2020*

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Pregnancy Outcomes Recommendations

In 2018, the KanCare program covered nearly 4 in 10 births in Kansas. Pregnancy outcomes was selected as a priority by the KMMC because few measures are currently reported to understand outcomes related to pregnancies, making it difficult to understand the impact that KanCare is having on the large number of women and infants covered by the program during and after a pregnancy.

The stakeholder questions described below were the initial questions posed by SWG members. The research questions were created by DRWG task group members from the initial stakeholder questions and used to develop the recommendations outlined below.

Stakeholder Question: How does KanCare impact pregnancy outcomes?

Research Question: Have members enrolled in KanCare shown improved pregnancy outcomes?

The task group identified the meaningful measures described in *Figure 6* (page 18), which includes a combination of currently reported process measures[1] and a set of new clinical outcome measures[2] to be developed and derived from claims data. A potential data source is also identified; however, some limitations prevent its immediate application in the analysis. Specifically, the task group recommends to:

Pregnancy Outcomes 1. Develop a summary report on pregnancy process and clinical outcome measures.

a. Current reported process measures: timeliness of prenatal care and postpartum care.
b. New clinical outcome measures: birth weight, gestational age, infant mortality, maternal mortality, neonatal abstinence syndrome (NAS) diagnosis at birth and neonatal intensive care unit (NICU) admission at birth.

Pregnancy Outcomes 2. Work toward the ability to monitor changes over time and to identify disparities on measures specified in *Pregnancy Outcomes Recommendation 1*.

a. Trend analysis to monitor changes over time
b. Stratified/subgroup analysis, when data permit, by race/ethnicity and by geographic region to identify potential disparities.

Pregnancy Outcomes 3. Continue to explore the use of the Pregnancy Risk Assessment Monitoring System (PRAMS) data, acknowledging that, as of January 2020, Kansas only has two years of data available for analysis and the small sample of KanCare members provides a significant limitation.

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[1] According to the Agency for HealthCare Research and Quality (AHRQ), "process measures indicate what a provider does to maintain or improve health, either for healthy people or for those diagnosed with a health care condition."
[2] According to the Agency for HealthCare Research and Quality (AHRQ), "outcome measures reflect the impact of the health care service or intervention on the health status of patients."

Considerations:

The group discussed that this topic may be a top priority for early action since approximately 39 percent of births in Kansas in 2018 were paid for by KanCare. Additionally, the group indicated interest in additional measures that may be helpful in identifying and responding to disparities in pregnancy outcomes, as indicated in *Pregnancy Outcomes Recommendation 2.* For example, the Kansas Healthcare Collaborative has prioritized work on early-elective deliveries.

Additionally, as this work moves toward action the group noted the need for additional technical information related to the measures in *Figure 6*. For example, the group would be interested to provide input on the development of algorithms for birth weight categories, such as *normal*, *low birthweight* and *extremely low birthweight.* Additionally, for some of the *Clinical Outcome Measures*, such as infant mortality, there are multiple approaches by which peer states have built similar measures.

Finally, the group discussed the importance of tracking maternal mortality, but indicated that the number of maternal deaths in KanCare may make this not a statistically meaningful measure. In lieu of a KanCare-specific maternal mortality measure, the group could monitor findings from the Kansas Maternal Mortality Review Committee and examine maternal mortality at the state level.

Figure 6. **Meaningful Measures Related to Pregnancy Outcomes**

Meaningful Measures	Data Source	Currently Reported
Process Measures		
Timeliness of prenatal care – What percentage of deliveries received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization?	HEDIS measure; MCO Performance Outcome	2018 KanCare Evaluation Annual Report (page 109 of PDF, Table 2)
Postpartum care – What percentage of deliveries had a postpartum visit on or between 21 and 56 days after delivery?	HEDIS measure	
Clinical Outcome Measures		
Birth weight	*Claims*	*No*
Gestational age	*Claims*	*No*
Infant mortality	*Claims*	*No*
NAS diagnosis at birth	*Claims*	*No*
NICU admission at birth	*Claims*	*No*
Maternal mortality (statewide)	*Vital Statistics*	*Yes*

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Social Determinants of Health Recommendations

SDOH – the conditions in which people are born, grow, live, work and age – have a significant impact on the health of individuals. SDOH include factors related to economic stability, education, social and community context, health and health care, and neighborhood and built environment. KanCare members might be at increased risk of negative health outcomes due to SDOH, such as economic instability, which has been linked to poorer health outcomes.

While the network adequacy, care coordination and pregnancy outcome recommendations – described above – each have some data and measures currently reported for the KanCare program, data related to the SDOH for KanCare members are scarce. The KMMC prioritized SDOH to explore options and make recommendations related to existing data collection methods by which SDOH data could be made available. The group took this approach due to recognition of the high level of resources needed to develop new measures and collection methods. This topic was of high interest to stakeholders, and the questions bulleted below were the initial questions posed by SWG members.

Stakeholder Question:

- What KanCare social determinants data do we have?
- What do the KanCare data tell us about the social determinants of health and their impact on enrollees?

KMMC recommends that steps be taken to capture information about the SDOH for KanCare members. This recommendation is intended to inform proper care delivery and referral to services. Additionally, this information may inform programmatic decision-making related to reimbursement for services related to the social determinants, as is currently occurring in some states.

KMMC members identified SDOH as a high priority area. Specifically, SWG members wanted to know “What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health and their impact on enrollees?” In initial analyses by DRWG members, the DRWG noted the very limited amount of data currently available about the SDOH of KanCare members. The Charter Statement for the KMMC instructs the DRWG to, “Assess the data sources and methodology used to create new and existing metrics” and to “Recommend approaches to address limitations and gaps in existing data.” With that directive in mind, a task group formed to assess the currently used HST and HRA as potential data sources for understanding KanCare enrollee SDOH.

HSTs and HRAs are currently conducted by KanCare MCOs to inform care delivery. *Figure 7* (page 22) illustrates the relationship and differences between the HST and HRA. Currently, all three KanCare MCOs utilize the same HST but different HRAs. The DRWG task group considered opportunities for the data gathered through these tools to provide information about the SDOH among KanCare members. The DRWG task group acknowledged that the HST, as it is currently administered, does not fully align with the domains of the SDOH as outlined by Healthy People 2020 (see *Figure 8*, page 23).

Given the high level of interest in SDOH and the direction from the KMMC Charter Statement to assess both existing and new metrics, the following recommendations have been made as possible steps toward the goal of regularly assessing the SDOH among KanCare members:

SDOH 1. The KMMC strongly recommends that data source(s) related to the SDOH be pursued. One option by which this information may be accessed is by assessing the information currently collected in the HST. If this tool is utilized to assess the social determinants of KanCare members, the group puts forward the following additional recommendations and considerations.

HST Data Content

SDOH 2. KanCare should consider utilizing a core set of questions in the HST to capture key SDOH information.

a. The group noted that multiple social determinants questions are included in the current HST. Key determinant topics are missing from the current HST, however, including information about transportation, social and community context, and the neighborhood and built environment.
b. For an example of a state that requires collection of a core set of SDOH screening questions in its Medicaid Managed Care program, see North Carolina.

HST Data Collection

SDOH 3. KanCare should consider modifying the HST protocol to ensure consistent information is collected across all KanCare member groups.

a. For example, currently waiver members may receive only the full HRA rather than be screened into the HRA by the HST. One option may be to have a core set of questions related to the SDOH that is included in whichever tool is most appropriate for each KanCare member.

SDOH 4. To allow for high-quality information to be shared, KanCare should consider specifications for tool administration and data collection methodology across MCOs.

a. For example, ensuring that the data collection approach is consistent across MCOs can contribute to greater confidence in the data.

SDOH 5. KanCare should consider providing appropriate incentives to ensure an adequate response rate to the HST and data that are representative of the entire KanCare population.

a. Currently, specific populations (e.g., those with a case manager) appear more likely to complete the HST than others. Incentives may encourage KanCare members to complete the HST.

HST Data Utilization

SDOH 6. To build consensus among stakeholders on the value of this information, KanCare should consider providing information on how the HST instrument was developed, as the KMMC recommends that tool(s) be validated.

SDOH 7. The HST data should be reported back to KanCare and able to be linked with other KanCare data for analysis and reporting.

SDOH 8. With these recommendations implemented, KDHE and other partners should consider opportunities to utilize data to inform program design regarding the SDOH.

Considerations:
The task group recommended the HST to collect SDOH data, with the above improvements, because it is an existing tool currently administered by all three MCOs. Some raised concerns about whether the HST is the best tool to collect SDOH data long-term, in part due to potential resource needs and member burden required to obtain a larger set of HST responses. Additionally, KMMC members highlight the importance of convening health services directors, population health directors or the equivalent designee from each MCO to detail the technical aspects of gathering SDOH information from the HST.

The group discussed considerations and opportunities for future work regarding SDOH, with a focus on other avenues to collect SDOH data. For example, the group discussed the use of z-codes reported in claims data to capture SDOH data, once fully adopted. The use of z-codes is nascent, and they have not yet been widely adopted. Further, the group referenced other sources of information that are currently available, such as information on Kansas Health Matters and community health centers, some of which collect information on why consumers

miss appointments. For Kansas Health Matters and other public or community health data sources, the group noted that this information is available by various geographic areas but can often not be sorted by health care payer or provide measures at the individual member level.

Additional task group background information:

Figure 7. **Health Screening Tool (HST) and Health Risk Assessment (HRA) Process**

Tool	**Health Screening Tool**: Administered within 90 days of enrollment to all non-waiver members and annually thereafter.	**Health Risk Assessment**: Administered to all waiver members and to all other KanCare members screened in by HST.
Function	**Function**: Completion rate is reported to KDHE on a monthly basis, but information from the screening tool is not currently reported. A high score on the HST may indicate that an HRA is needed. Results of the screening are not currently reported to KDHE.§	**Function**: Informs care delivery. Appropriate referrals are made based on results of the risk assessment. Results of the assessment are not currently reported to KDHE.
Member		**Waiver Member**
	Non-Waiver Member	**Non-Waiver Member indicated by HST** §

§ ***Thresholds for HRAs***: (1) An activated automatic trigger will result in an HRA. (2) A total score of twenty-three (23) or more will result in an HRA. (3) Within the four (4) sections of the Tool, an HRA will result if a Member meets any of the threshold scores listed below, even if their overall score does not meet twenty-three (23): a) Health Status – A score of nine (9) or more results in an HRA. b) Health Conditions – A score of five (5) or more results in an HRA. c) Health Lifestyle – A score of six (6) or more results in an HRA. d) Home/Employment – A score of four (4) or more results in an HRA.

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

As part of their review, the DRWG task group cross-walked the current HST with the SDOH as defined by Healthy People 2020. According to Healthy People 2020, there are five determinant areas, and each determinant area has underlying key issues. For example, one determinant area is Economic Stability, with underlying key issues such as employment, housing stability and food insecurity.

Figure 8 (page 23) organizes questions from the current HST by each determinant area. As can be seen, some determinant areas lack questions completely, or include minimal questions that do not address all issues under the determinant area. Further, should it become possible to aggregate and report responses by question, these measures may be among the most meaningful.

Figure 8. **Meaningful Measures from a Crosswalk Health Screening Tool (HST) and Social Determinants of Health**

Meaningful Measures
Economic Stability *Key issues include: Employment, Housing instability; Food insecurity; Poverty*
32: Do you have a regular, safe place where you sleep and store your things?
33: What is your Employment Status?
36: Are you currently receiving supports for healthy eating? (Supplemental Nutrition Assistance Program (SNAP), Food Stamps, Special Supplemental Food Program for Women, Infants and Children (WIC), etc.)
Education *Key issues include: Early childhood education and development; Enrollment in higher education; High school graduation; Language and literacy*
37: What is your highest level of education?
Social and Community Context *Key issues include: Civic participation; Discrimination; Incarceration; Social cohesion*
Gap in current HST tool.
Health and Health Care *Key issues include: Access to health care; Access to primary care; Health literacy*
2: Have you seen a Primary Care Provider (PCP) in the last twelve months?
8: Have you seen a dentist in the last twelve months?
9: Have you had a flu shot in the last twelve months?
10: Are you up to date on your immunizations?
11: Have you had an eye exam in the last twelve months?
30: Have you had a Well Child/Well Woman/Well Man exam in the past twelve months?
35: How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?
Neighborhood and Built Environment *Key issues include: Access to foods that support healthy eating patterns; Crime and violence; Environmental conditions; Quality of housing*
31: Because difficult relationships can cause health problems, we are asking all of our patients the following question: Does a partner, or anyone at home, hurt, hit, or threaten you?

Source: This figure comes directly from the Recommendations on Meaningful Measures of KanCare, April 2020.

Existing Measures Reports

Following the completion of the cycle 1 recommendations described in the preceding section, the KMMC compiled the "existing meaningful measures" into short reports, which are new as of the release of this report and can be found in *Appendix D* (page D-1). The existing measures reports are intended to facilitate a shared understanding of KanCare via meaningful measures that are already available and reported.

Cycle 2

The KMMC has begun a second cycle of work following the completion of recommendations regarding network adequacy, care coordination, pregnancy outcomes and the social determinants of health. The first step in this process involves the SWG identifying a new set of priority topics and questions. According to the KMMC Charter Statements, the SWG has two primary purposes:

- Create an inclusive process that encompasses a variety of experiences, perspectives and individuals; and
- Identify and prioritize questions that will drive metrics to be analyzed or developed.

To fulfill its stated purposes, the SWG process involves engaging both its membership and KanCare consumers across the state.

Consumer Engagement

In the spring of 2019, the SWG established a Consumer Engagement Design Team (design team), facilitated by the Community Engagement Institute at Wichita State University, to develop a consumer engagement pilot. The KMMC pilot was conducted from February to March 2019, and more information can be found in the *KanCare Meaningful Measures Collaborative Report, 2019*.

Building on the spring 2019 consumer engagement pilot, the KMMC conducted additional consumer engagement from August-November 2019. The purpose was to engage KanCare members regarding their experiences with KanCare, to inform the KMMC's prioritization efforts, direction and focus. Five organizations partnered in the effort, and input was gathered from over 135 Kansas consumers using listening sessions, telephone and in-person interviews, and included mothers, mental health consumers, older adults and individuals contacted by managed care organizations (MCOs). Regardless of the format, consumers were asked a consistent set of nine interview questions, such as "What matters to you (or people receiving similar services to you) about the KanCare program?" Consumer responses were then synthesized and grouped into common themes by the design team.

Below are key findings from the August-November 2019 effort. The full set of findings and interview questions can be found in the *KMMC Consumer Engagement Report*.

Key Findings

Several of the primary themes from the spring 2019 consumer engagement pilot emerged again during the August-November 2019 consumer engagement. Specifically, the following themes highlighted in spring 2019 appeared frequently in consumers' responses in the fall of 2019:

- Affordability/Coverage of Services
- Availability of Services
- Communication

While mentioned less frequently, the following themes from the consumer engagement pilot were also identified again in consumer engagement efforts from August-November 2019:

- Transportation
- Living in Community, Independence, Quality of Life

Finally, while there were examples of the following items, they were not mentioned as often as in the consumer engagement pilot:

- Respect/Consumer Treatment
- Disparities
- Outcomes

Additionally, the design team reviewers noted that there were multiple consumer responses related to eligibility for KanCare. Reviewers agreed that while this issue could be related to some of the existing themes, it was distinct, mentioned frequently and important enough to note separately. Also, given the open-ended nature of the questions, important issues might not have come up that would have been prioritized if consumers had been presented with a list of issues to consider.

The findings from the August-November 2019 round of consumer engagement were presented to the SWG during its February 2020 meeting, to inform its selection of a new set of priority topics.

SWG Membership Engagement

The SWG convened in February 2020 to begin assessing potential KMMC priority topics for the second round of work. The group began by reviewing the priorities that had been developed but

not selected during the first cycle of work. The SWG then modified this list based on SWG member input and the consumer engagement findings.

Following the February 2020 meeting, SWG members completed a survey to assess each of the priority topics using previously established criteria. The survey was intended to provide an initial prioritization of the priority topics, which would then be ratified by the SWG. It was available from February 26-March 23. SWG members were asked to rate each topic on a scale of 1-5 using a set of eight criteria previously developed and approved by the SWG (*Figure 9*). The full set of SWG questions and survey results can be found in *Figure 10*. The topics are sorted in order of priority according to the survey results.

Figure 9. **Stakeholder Working Group Prioritization Criteria**

Importance	Feasibility
1. Importance to consumers	7. Regularly available information
2. Importance to the SWG	8. Actionability
3. Desire for more clarity	
4. Number of people impacted	
5. Level of impact on consumer	
6. Fiscal impact.	

Source: This figure comes directly from the May 15, 2020 KMMC Meeting Slides.

Figure 10. **Stakeholder Working Group Questions and Initial Survey Results**

Topic	Summed Average Criteria Score
Quality assurance. Are quality assurance measures in place to ensure that individuals receive the level of services they need?	33.9
Access. Where are KanCare services provided, and to which consumers? What are the outcomes associated with individuals who cannot access care?	33.0
Setting of choice. Does KanCare improve enrollees' ability to live independently in the community setting of their choice?	32.9
Communication. How effectively does KanCare communicate with members? Are members satisfied with the degree to which they understand and can make decisions about their services?	32.7
Wait lists. What impact on outcomes are associated with wait lists and high vacancy rates?	32.4
Disparities. Does KanCare reduce disparities related to health outcomes? (e.g., geography, race/ethnicity, disability type)	31.6
Cost of Care. How are funding/costs associated with KanCare distributed? Does the total cost of care for members vary based on location of service and how the services are accessed? For high-cost drivers, is KanCare making a difference?	31.0
Eligibility. What are the barriers to having an application processed in a timely manner? How many annual renewals are processed with no changes from year to year? How do standards for eligibility affect health outcomes?	30.9
Levels of care. Have levels of care for individuals in nursing facilities changed pre-KanCare compared to post-KanCare?	29.4
Enrollee Treatment. Are KanCare enrollees satisfied with the way they are treated?	28.5
Employment. What impact does KanCare have on employment?	26.4

Note: The “summed average criteria score” column refers to a sum of the average criteria score for each question. Scores could range from 8-40, with higher scores indicating a higher priority question.
Source: This figure comes directly from the May 15, 2020 KMMC Meeting Slides.

The survey results were reviewed by the full KMMC during its May 2020 meeting. Given the COVID-19 pandemic, KMMC members were asked to consider whether any changes were needed to the current set of questions to reflect COVID-19 concerns, whether certain questions would have scored higher in light of COVID-19, and whether any questions needed to be added due to COVID-19. Input from KMMC members included:

- Related to the SWG topic, 'Communication': access to phones, broadband or other technology to allow for utilization of services remotely. The group discussed that the technology must exist and be available in a quantity that allows for the needs of all members of the household to be met.
- Related to the SWG topic, 'Disparities': The group discussed accessibility of broadband as a potential disparity to explore. There may be data in the American Community Survey (ACS) on broadband access that could be analyzed by insurance status. Disparities by race/ethnicity and geography related to COVID-19 and access to care were also raised.
- Potential new topics in light of COVID-19:
  - Literacy, health literacy and technology literacy
  - Emergency management
  - Measures that could explain what is happening during COVID-19 with the delivery of in-home care.
- The KMMC raised a number of issues related to the safe delivery of self-directed in-home care, including personal protective equipment (PPE) and the adequacy of emergency plans in the face of the challenges presented by COVID-19.

It was also discussed that a COVID-19-specific product from the KMMC might be a way to address some of the ideas identified. In the coming months, the KMMC will be finalizing prioritization of the set of questions and deciding on next steps for effort, which may include COVID-19-related work.

Next Steps

As the KMMC approaches the end of its second year, the short- and long-term effects of COVID-19 present a challenge for the group. Resources for many of the partners involved in the collaborative have been stretched thin, and well-established measures of program effectiveness may be compromised by the effects of the pandemic. However, despite these challenges, the work of the KMMC may be more valuable than ever. There may be new opportunities to use the collaborative processes developed over the last two years to focus on measures that can shine a light on the response to COVID-19 – what was effective, what issues may have been exposed and what we can learn together to improve KanCare. These and other issues — once prioritized by the SWG and Executive Committee — will likely be considered via DRWG task groups, similar to the first cycle of work.

Additionally, in the coming year the KMMC will explore issues related to long-term sustainability of the collaborative, as well as consider ways to infuse a national perspective into the process — all of which will contribute to the identification of meaningful measures for the KanCare program, and the ultimate goal of a shared understanding of KanCare.

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Appendix A: Membership List

Name	Organization
Keith Wisdom	Aetna
Kyle Kessler	Association of Community Mental Health Centers of Kansas
Lori Marshall	Association of Community Mental Health Centers of Kansas
Stuart Little	Behavioral Health Association of Kansas
Annette Graham	Central Plains Area Agency on Aging
Terri Kennedy	Community Care Network of Kansas
Jonathan Smith	Community Care Network of Kansas
Jamie Price	Community Living Opportunities
Timothy Crain	Consumer
Kendra Sambrana	Consumer
Mike Burgess	Disability Rights Center of Kansas
Rocky Nichols	Disability Rights Center of Kansas
Tami Allen	Families Together, Inc.
Nick Wood	Interhab
Sean Gatewood	KanCare Advocates Network
Kerrie Bacon	KanCare Ombudsman
Heather Braum	Kansas Action for Children
Barb Conant	Kansas Advocates for Better Care
Mitzi McFatrich	Kansas Advocates for Better Care
Audrey Schremmer	Kansas Association of Centers for Independent Living
Steve Gieber	Kansas Council on Developmental Disabilities
Craig Knutson	Kansas Council on Developmental Disabilities
Jeff Schroeder	Kansas Council on Developmental Disabilities
Kevin Robertson	Kansas Dental Association
Caitlin Fay	Kansas Department for Aging and Disability Services
Amy Penrod	Kansas Department for Aging and Disability Services
Brad Ridley	Kansas Department for Aging and Disability Services
Melissa Warfield	Kansas Department of Health and Environment
Liz Long	Kansas Department of Health and Environment
Sarah Good	Kansas Foundation for Medical Care, Inc.
John McNamee	Kansas Foundation for Medical Care, Inc.
Lynne Valdivia	Kansas Foundation for Medical Care, Inc.
Cindy Luxem	Kansas Health Care Association
Kari Bruffett	Kansas Health Institute
Carlie Houchen	Kansas Health Institute
Wen-Chieh Lin	Kansas Health Institute
Sydney McClendon	Kansas Health Institute
Robert St. Peter	Kansas Health Institute
Phillip Steiner	Kansas Health Institute
Jane Kelly	Kansas Home Care and Hospice Association
Chad Austin	Kansas Hospital Association
Audrey Dunkel	Kansas Hospital Association
Tish Hollingsworth	Kansas Hospital Association
Jerry Slaughter	Kansas Medical Society
Amy Campbell	Kansas Mental Health Coalition

Aaron Dunkel	Kansas Pharmacists Association
Amanda Gaulke	Kansas State University
Ross Milton	Kansas State University
Ben Schwab	Kansas State University
Steve Kearney	Kearney and Associates
Rachel Monger	LeadingAge Kansas
Debra Zehr	LeadingAge Kansas
Laura Boswell	Minds Matter, LLC
Janet Williams	Minds Matter, LLC
Erica Bates	Minds Matter, LLC
Tanya Dorf Brunner	Oral Health Kansas
Kathy Keck	Parent
Julianna Sellers	Poetry for Personal Power
Matt Spezia	Poetry for Personal Power
Sheri Hall	Poetry for Personal Power
Rachel Marsh	Saint Francis Ministries
Kelly Smith	Self-Advocate Coalition of Kansas
Jason Barrett	Self-Advocate Coalition of Kansas
Stephanie Sanford	Self-Advocate Coalition of Kansas
Mark Hinde	Southwest Developmental Services
Kim Anderson	Sunflower Health Plan
Susan Beaman	Sunflower Health Plan
Trisa Hosford	Sunflower Health Plan
Stephanie Rasmussen	Sunflower Health Plan
Scott Latimer	Sunflower Health Plan
Ami Hyten	Topeka Independent Living Resource Center
Anna Purcell	United Healthcare
Jeff Stafford	United Healthcare
David Slusky	University of Kansas Department of Economics
Carrie Wendel-Hummell	University of Kansas School of Social Welfare
Jean Hall	University of Kansas Institute for Health and Disability Policy Studies
Martha Hodgesmith	University of Kansas Institute for Health and Disability Policy Studies
Noelle Kurth	University of Kansas Institute for Health and Disability Policy Studies
Tami Gurley-Calvez	University of Kansas Medical Center, Department of Population Health
Ed Ellerbeck	University of Kansas Medical Center, Department of Population Health
Drew Roberts	University of Kansas Medical Center, Department of Population Health
Monte Coffman	Windsor Place
Tara Gregory	Wichita State University, Community Engagement Institute
Jennifer Pacic	Wichita State University, Community Engagement Institute
Scott Wituk	Wichita State University, Community Engagement Institute

Appendix B: KMMC Charter Statements

KanCare Meaningful Measures Collaborative (KMMC)
Charter Statements
Approved 8/13/2018

Purpose:

- Increase the visibility, credibility, validity and usefulness of information broadly available about KanCare
- Establish consensus on metrics that already exist, and new metrics that can be created, to better understand the performance of the KanCare program in relation to the whole person.
- Identify the best data sources, the appropriate methods and the most effective way to report the metrics
- Establish a transparent process that transcends administrations and individuals
- Over time, build capacity in Kansas to generate and use the appropriate data for program management, program evaluation, policy development, and accountability

Scope of Work:

- Engage stakeholders in a collaborative process to identify high priority metrics
- Engage data experts in defining and reporting the high priority metrics
- Elevate visibility and usefulness of metrics already available
- Build on existing efforts to create KanCare metrics
- Streamline additional data reporting by health plans, providers, consumers, etc.
- Present available data in an actionable way and incorporate context where needed
- Effectively communicate the products of the Collaborative

Membership (composed of the collective membership of):

- Executive Committee
- Stakeholder Working Group (SWG)
- Data Resources Working Group (DRWG)

Operating Process:

- Operate as an autonomous, collaborative effort
- Facilitated by KHI
- Ratify metrics approved by the Executive Committee
- Decisions by consensus, with use of survey tools or other prioritization mechanisms to ensure all voices are heard. Voting may be used when necessary
- Seek funding for core activities from foundations or member groups
- Develop effective communications with a broad audience over time, including:
    - KanCare consumers
    - General public
    - Stakeholder organizations
    - Legislative entities, especially the Bethell Oversight Committee

KMMC Executive Committee

Purpose:
- Approve the metrics to be developed through the Collaborative, based on the recommendations forwarded by the SWG
- Approve the data sources and methodology used to report those metrics based on the recommendations of the DRWG
- Document for public reporting the process employed to identify and measure selected metrics

Scope of Work:
- Prioritize the metrics identified by the SWG, taking into consideration the assessment of feasibility and the necessary capacity to generate the metric as determined by the DRWG
- Send approved metrics to the Collaborative (as a committee of the whole) for ratification
- Provide guidance and accountability to ensure the Collaborative remains focused on and fulfills its purpose

Membership:
- Consumer representatives: 3 members
- Stakeholder representatives: 5 members
- State agency representatives: 4 members
- Research representatives: 3 members

Operating Process:
- Facilitated by KHI, who will not be a member of the Executive Committee
- Executive Committee will use a matrix to ensure that key groups are represented fairly within the group of nominees:
    - Stakeholder representatives will be nominated by the SWG
    - Research representatives will be non-state agency representatives nominated by the DRWG
    - Consumer representatives will be selected by the Executive Committee following a nomination process among consumers and consumer groups
    - State agency representatives will be determined by the agencies
- Decisions by consensus, with use of survey tools or other prioritization mechanisms to ensure all voices are heard. Voting may be used when necessary
- Chair and vice chair elected by membership of Executive Committee on a rotating basis

KMMC Data Resources Working Group (DRWG)

Purpose:

- Provide methodology and data analytics support for the KMMC
- Develop the institutional knowledge assets for a sustainable infrastructure

Scope of Work:

- Collaborate closely with the SWG in discussing and prioritizing metrics
- Assess the feasibility of creating new metrics
- Assess the data sources and methodology used to create new and existing metrics
- Assess the resources needed to generate the prioritized metrics
- Produce selected prioritized metrics and translate them into information
- Provide context behind the underlying data, the analytic approach and the application of the information generated
- Recommend approaches to address limitations and gaps in existing data
- Validate metrics generated by other groups
- Develop policies and procedures for the appropriate access to and use of data by relevant parties

Membership:

- State agencies
- Researchers, analysts, stakeholders (including KHI)

Operating Process:

- Co-chaired by DHCF and KDADS
    - Data governance and confidentiality sole responsibility of state agencies
    - Supported by subject matter experts from research community, analysts, stakeholders, and other state agencies
- Processes to be developed:
    - Communication with SWG and selection of stakeholders on the DRWG
    - Review and assessment of measures, methodology, data interpretation and reporting

Potential Funding for Activities

- Existing state and federal funding sources support many of these activities
- Additional federal funding opportunities
- Funding opportunities among stakeholder groups
- Research grant proposals

KMMC Stakeholder Working Group (SWG)

Purpose:

- Create an inclusive process that encompasses a variety of experiences, perspectives and individuals
- Identify and prioritize questions that will drive metrics to be analyzed or developed

Scope of Work:

- Assess the range of currently available metrics in close collaboration with the Data Resources Working Group
- Identify gaps in the current set of metrics
- Consider the work of other groups, in Kansas and nationally, that have proposed metrics for Medicaid in general and KanCare in particular
- Determine which metrics will help advance understanding of the KanCare program and forward them to the Executive Committee
- As existing and new metrics are developed and reported, review for continued usefulness and consider new questions as necessary

Membership:

- Membership to be broad-based and inclusive, including representation of the consumer perspective
- Formal membership limited to one person per organization with no limits to the number of organizations or total attendees
- Working Group could create subcommittees as needed, but the preference is for most discussions to be at the full committee level

Operating Process:

- Facilitated by KHI or a similar partner
- Chair and vice chair elected by membership of SWG on a rotating basis
- Decisions by consensus, with use of survey tools or other prioritization mechanisms to ensure all voices are heard. Voting may be used when necessary

Appendix C: KMMC Meetings Timeline

Date	Meetings
August 2019	• Bethell Committee (8/26)
September 2019	• KMMC (9/6)
October 2019	• No Meetings
November 2019	• KMMC (11/1) • Bethell Committee (11/18)
December 2019	• No Meetings
January 2020	• House Health & Human Services Committee (1/22)
February 2020	• SWG (2/12) • DRWG (2/17) • Bethell Committee (written testimony; 2/28)
March 2020	• KMMC (3/2)
April 2020	• No Meetings
May 2020	• KMMC (5/15)

Note: Ad hoc task group meetings and consumer engagement design team meetings not included.

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Appendix D: Short Reports on Meaningful Measures in KanCare

KANCARE MEANINGFUL MEASURES COLLABORATIVE

KMMC
KANCARE MEANINGFUL MEASURES COLLABORATIVE

OCTOBER 2020

The KanCare Meaningful Measures Collaborative (KMMC) was created out of a desire to better understand how KanCare is performing.

KanCare is the state's comprehensive managed care program that combines Medicaid and the Children's Health Insurance Program (CHIP). While it has been in existence since 2013, there are differing views of how well the program is meeting its goals from the perspective of the state, the consumers enrolled in the program and other key stakeholders. There is a shared desire for more timely and accessible data that can show how well the program is meeting the needs of Kansans.

KMMC is a coalition of KanCare consumers, stakeholders, researchers and state staff whose goal is not to evaluate the KanCare program, but instead to establish consensus around which data and metrics are most needed to better understand the performance of the program.

Meaningful Measures

Hundreds of metrics are produced each year from KanCare data, many to meet federal requirements or to include in the KanCare evaluation reports. While all of these data are important, the sheer volume of information can make it difficult for stakeholders to find key metrics that help them to better understand how KanCare is performing. Furthermore, some important outcome measures are not publicly reported, making it difficult to know how well KanCare is meeting the needs of vulnerable Kansans.

One purpose of KMMC is to establish consensus around a smaller set of measures — Meaningful Measures — that are important to KanCare stakeholders. Additionally, KMMC seeks to foster understanding of current KanCare data and to build capacity to generate and use data effectively, even across administrations. Ultimately, these purposes seek to ensure that taxpayer funds are being invested effectively and efficiently in KanCare so that the program appropriately serves its more than 400,000 members.

Working Groups

Members of KMMC participate in one of two working groups:

- The Stakeholder Working Group, comprised of individuals with a variety of experiences and perspectives with KanCare, help identify and prioritize questions about the performance of the program.
- The Data Resources Working Group, comprised of experts in measurement and data analysis, assesses data sources for feasibility, comparability and other key attributes and identifies measures that can be used to answer the questions raised by the Stakeholder Working Group. In examining data sources and metrics, this working group develops recommendations for Meaningful Measures and places them into three categories: Existing Meaningful Measures, New Meaningful Measures and Other Recommendations (*right*).

Each KMMC cycle begins with consumer engagement to identify priorities. These priorities are then discussed by the Stakeholder Working Group and shared with the Data Resources Working Group. The two groups exchange information continuously to identify and prioritize possible Meaningful Measures and develop recommendations.

Through this process, KMMC members have identified nine initial priority topic areas — Enrollee Treatment, Quality Assurance, Care Coordination, Social Determinants of Health, Access to Health Care, Pregnancy Outcomes, Network Adequacy and Setting of Choice.

Existing Meaningful Measures

These measures already exist across public KanCare reports.

New Meaningful Measures

These measures are not currently available in public KanCare reports and can be classified into three groups:

- Data are available but require additional resources to construct the measures.
- Data are not available but could be adapted from measures developed elsewhere.
- Data are not available and measures have not been developed elsewhere.

Other Recommendations

Further study and investment in these areas are strongly encouraged to address data limitations and other issues related to methodology.

Learn More

KMMC has published three reports to highlight a subset of the Existing Meaningful Measures identified for three priority topic areas — Pregnancy Outcomes, Care Coordination and Network Adequacy. These reports are intended to provide examples of the work of KMMC, and may not provide a full picture of KanCare performance in any given area. Information on data sources also is presented for each topic, to support interpretation of the metrics presented.

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KANCARE MEANINGFUL MEASURES COLLABORATIVE

ISSUE BRIEF

OCTOBER 2020

KMMCdata.org

PREGNANCY OUTCOMES: MEANINGFUL MEASURES IN KANCARE

KanCare covered nearly four in ten (39 percent) births in Kansas in 2018, the latest year for which data were available, and pregnant women and other parents comprised 12.9 percent of the more than 400,000 individuals enrolled in KanCare each month.

The KanCare Meaningful Measures Collaborative (KMMC) has identified pregnancy outcomes as one of its priority topic areas. In particular, stakeholders who selected the topic were interested to better understand how KanCare impacts pregnancy outcomes. This brief highlights Existing Meaningful Measures reported on pregnancies covered under KanCare and provides information on other available data that could address gaps in the information currently reported on pregnancy outcomes.

The data are reported as *examples* of the information currently available; therefore, this brief does not seek to interpret the data or to address the programmatic implications of the findings.

Instead, it focuses on opportunities to improve the quality of information available on the topic with the assumption that meaningful data collection and analysis are foundational to all work to improve outcomes for those whose pregnancies are covered by KanCare.

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Figure 1. **Examples of Meaningful Measures for Pregnancy Outcomes**

Existing Meaningful Measures	New Meaningful Measures	Other Recommendations
• Timeliness of prenatal care. • Postpartum care.	• Birth weight. • Gestational age. • Infant mortality.	• Identify if disparities exist in measures. • Explore use of the Pregnancy Risk Assessment Monitoring System (PRAMS) data.

Note: Check out the full set of recommendation for pregnancy outcomes here: https://bit.ly/2Diax7B.

Figure 2. **Definitions of Existing Meaningful Measures for Pregnancy Outcomes**

Timeliness of Prenatal Care
The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization.

Postpartum Care
The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

Source: National Committee for Quality Assurance

Meaningful Measures for Pregnancy Outcomes

Meaningful Measures identified by KMMC address questions posed by KanCare stakeholders. For pregnancy outcomes, the Meaningful Measures include existing process measures that are already reported and a new set of clinical outcomes measures that could be derived from claims data (*Figure 1*).

Two existing process measures that were identified as critical to understanding pregnancy outcomes in KanCare were timeliness of prenatal care and postpartum care. Prenatal care is care received prior to giving birth, while postpartum care refers to health care visits after giving birth. Receiving prenatal and postpartum care can impact health outcomes for new mothers and infants.

Understanding the Existing Meaningful Measures

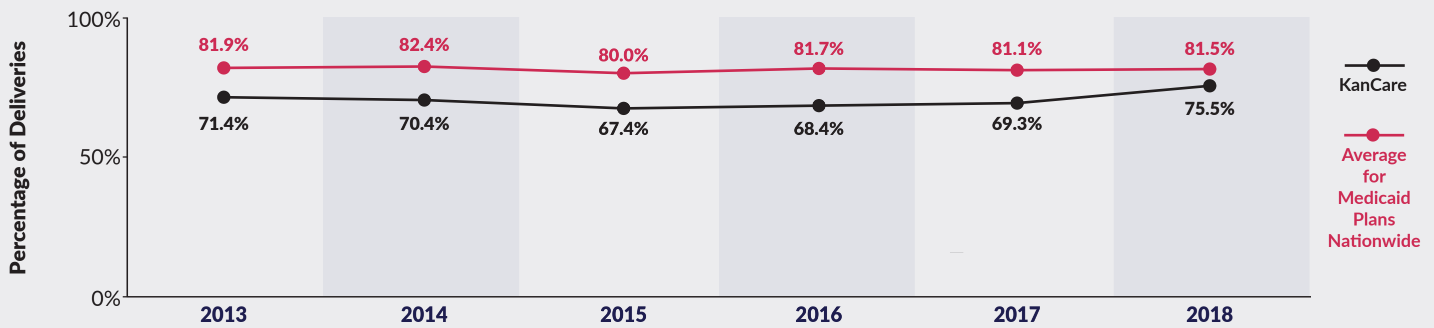
The Existing Meaningful Measures are from the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA) and are Centers for Medicare and Medicaid Services (CMS) core quality measures. The definitions of timeliness of prenatal care and postpartum care according to NCQA are outlined in *Figure 2*.

The latest available data on the performance of the KanCare managed care organizations (MCOs) on both measures has been aggregated and is provided in *Figures 3 and 4*. For comparison, the average performance of Medicaid plans across the U.S. also is provided.

Timeliness of Prenatal Care

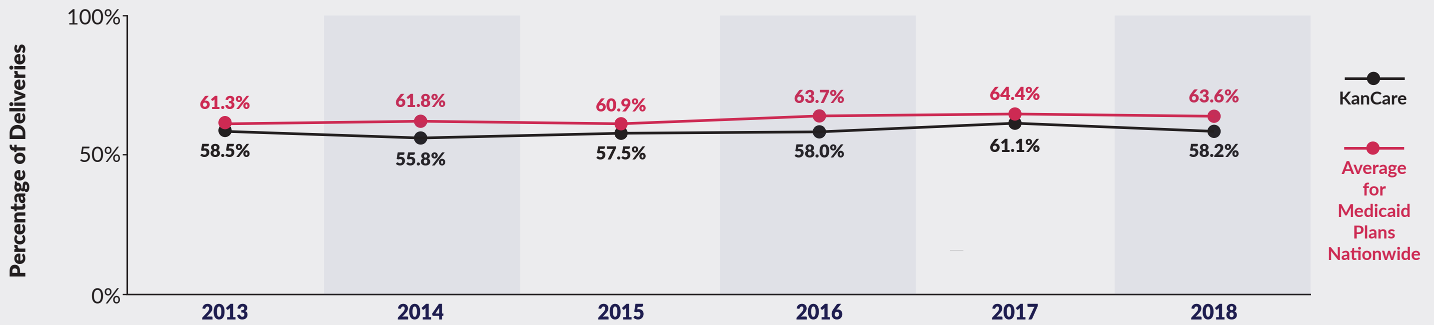
In 2018, 75.5 percent of deliveries in KanCare received timely prenatal care, compared to the average rate of 81.5 percent for Medicaid plans nationwide (*Figure 3*, page 3). Between 2013 and 2017, KanCare was consistently below the national average by 10.5-13.3 percentage points. In 2018, however, the difference

Figure 3. **Percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date or within 42 days of enrollment in the organization**



Source: KanCare data for 2013-2017 was reported by the Kansas Foundation for Medical Care and is available in Table 2 (page 109) in the 2018 KanCare evaluation report, available here: https://bit.ly/2XCDGB4. The 2018 KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table B2 (page 112) in the KanCare Program Annual External Quality Review Technical Report, available here: https://bit.ly/2Ec07Xl. The Medicaid plan data was calculated by NCQA and is available here: https://bit.ly/31k4Opu.

Figure 4. **Percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery**



Source: KanCare data was calculated by the Kansas Foundation for Medical Care and is available in Table 2 (page 109) in the 2018 KanCare evaulation report, available here: https://bit.ly/2XCDGB4. The 2018 KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table B1 (page 108) in the KanCare Program Annual External Quality Review Technical Report, available here: https://bit.ly/2Ec07Xl. The Medicaid plan data was calculated by NCQA and is available here: https://bit.ly/31k4Opu.

between KanCare and Medicaid plans nationwide was only 6.0 percentage points.

Postpartum Care

In 2018, 58.2 percent of deliveries in KanCare received a postpartum visit, compared to the average rate of 63.6 percent for Medicaid plans nationwide (*Figure 4*). Between 2013 and 2018, the difference between KanCare and Medicaid plans across the U.S. remained stable.

Considerations

Timeliness of prenatal care and postpartum care are key Meaningful Measures to understand how KanCare is performing for nearly 40 percent of all births in Kansas. Of note, between 2017 and 2018, the percentage of deliveries in KanCare with a timely prenatal visit increased by 6.2 percentage points.

While these measures are essential, they may not be sufficient to provide a comprehensive picture, as they do not describe the outcomes of KanCare pregnancies. Outcome measures related to pregnancy are key to knowing not just how care was delivered but how that care impacted the health of the mother and baby. Meaningful outcome measures identified by KMMC members include birth weight, infant mortality and gestational age, among others. Although these outcome measures are not currently available to the public, they can be derived from health insurance claims data. Reporting and further analyzing these meaningful process and outcome measures would help providers, health plans, KanCare and policymakers identify at risk populations and areas, as well as approaches to improving health care delivery and outcomes related to pregnancy.

ABOUT THIS ISSUE BRIEF

This brief is based on work completed by the KanCare Meaningful Measures Collaborative (KMMC) task group on pregnancy outcomes. It was written by Kansas Health Institute staff who support the work of the KMMC and the task groups. It is available online at http://bit.ly/KMMC2020.

KANCARE MEANINGFUL MEASURES COLLABORATIVE

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OCTOBER 2020
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ISSUE BRIEF

CARE COORDINATION: MEANINGFUL MEASURES IN KANCARE

According to the Agency for Healthcare Research and Quality, "Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care."

The KanCare Meaningful Measures Collaborative (KMMC) has identified care coordination as a priority topic area. In particular, stakeholders who selected the topic were interested to better understand whether care coordination is available for consumers who need it, as well as whether care coordination services are effective for those who receive them.

This brief provides information on some of the data that are available related to care coordination in KanCare and also offers recommendations to address gaps in the information reported. Data are included as *examples* of information currently available; therefore, this brief does not seek to interpret the data or to address the programmatic implications of the findings. Instead, it focuses on opportunities to improve the quality of information available on the topic with the assumption that meaningful data collection and analysis are foundational to all work to improve care coordination for KanCare members.

Meaningful Measures for Care Coordination

The types of services referred to as 'care coordination' can differ. To assess the availability and efficacy of care coordination in KanCare, KMMC examined measures for three distinct types of care coordination:

1. General care coordination for all KanCare consumers;
2. Care coordination for KanCare consumers receiving home and community-based services (HCBS); and
3. Targeted case management (TCM) for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) waiver services.

Some Meaningful Measures for care coordination identified by KMMC are already publicly reported and are described in this brief, while others could be developed but are not yet available. Additionally, many measures identified as meaningful for HCBS waiver services and TCM are available for the first time in 2020.

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Figure 1. **Examples of Meaningful Measures for Care Coordination**

Existing Meaningful Measures	New Meaningful Measures	Other Recommendations
• Personal doctor seemed informed and up-to-date about your (you child's) care received from other providers. • Proportion of people who felt comfortable and supported enough to go home (or where they live) after being discharged from a hospital or rehabilitation facility in the past year.	• Measures from home and community-based services Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. • Targeted case management measures.	• Develop measures for member experience on the Serious Emotional Disturbance (SED) waiver. • Monitor substance use disorder (SUD) member survey for changes in sampling.

Note: Check out the supplemental tables to see the other Existing Meaningful Measures selected for care coordination not reported in this brief. The full set of recommendation for care coordination, including those in the "other recommendations" category, are here: https://bit.ly/2Diax7B.

This brief highlights a subset of the existing measures selected for general care coordination that are reported in the *2018 KanCare Evaluation Report* with supplemental tables reporting the other Existing Meaningful Measures selected for care coordination. *Figure 1* shows examples from the full set of Meaningful Measures and recommendations on care coordination.

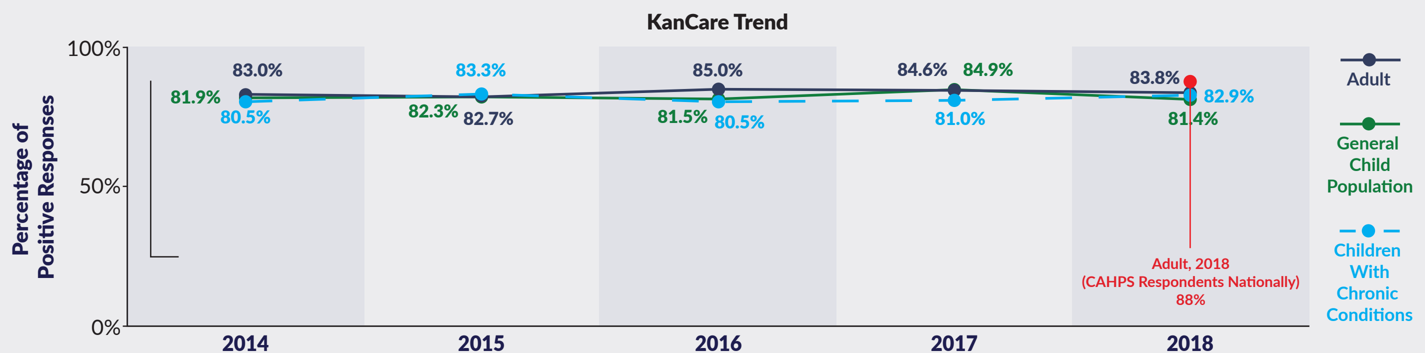
Understanding Data Sources for Existing Meaningful Measures

In this brief, two data sources underpin the Existing Meaningful Measures presented for general care coordination in KanCare: the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Healthcare Effectiveness Data and Information Set (HEDIS).

CAHPS measures capture consumer experiences in a variety of settings and are derived from consumer survey responses . The CAHPS program was developed by the Agency for Healthcare Research and Quality (AHRQ), and each KanCare managed care organization (MCO) is required to conduct the CAHPS Health Plan Survey via third-party survey vendors and submit the results to the National Committee for Quality Assurance (NCQA). In the KanCare evaluation reports, CAHPS measures are reported for the adult population, general child population and for children with chronic conditions. Due to the current required sample size of the CAHPS survey in Kansas, CAHPS measures cannot be reported for each waiver population or other sub-groups (e.g., geography, race/ethnicity). Increasing the sample size of CAHPS was of high interest to KMMC members, to be able to assess differences in consumer experience.

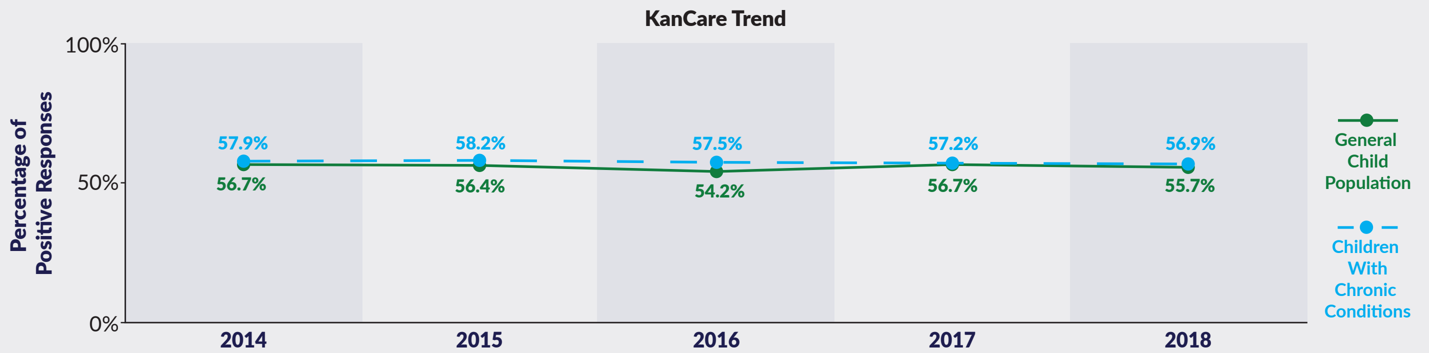
HEDIS measures are developed by NCQA to measure health care performance and are derived from administrative data (e.g., claims data) alone or a combination use of administrative data and chart reviews.

Figure 2. **Percent of KanCare or National respondents with positive response to: In the last 6 months, how often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?**



Source: The KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table 30 (page 147) in the 2018 KanCare evaluation report: https://bit.ly/2XCDGB4. The national consumer data was reported by the Agency for Healthcare Research and Quality and is available here: https://bit.ly/35LrzGV. Data is voluntarily submitted and is not restricted to Medicaid consumers. Children's national data not available.

Figure 3. **Percent of KanCare respondents with positive response to: In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**



Source: The KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table 30 (page 146) in the 2018 KanCare evaluation report: https://bit.ly/2XCDGB4.

Definitions of the Existing Meaningful Measures presented in this brief follow. The performance of KanCare MCOs on each of the measures has been aggregated and is provided in *Figures 2-5*. Where possible, national rates on the same measures have been provided for comparison. The most recently available data has been used throughout the brief.

Select Existing Meaningful Measures

CAHPS Measures

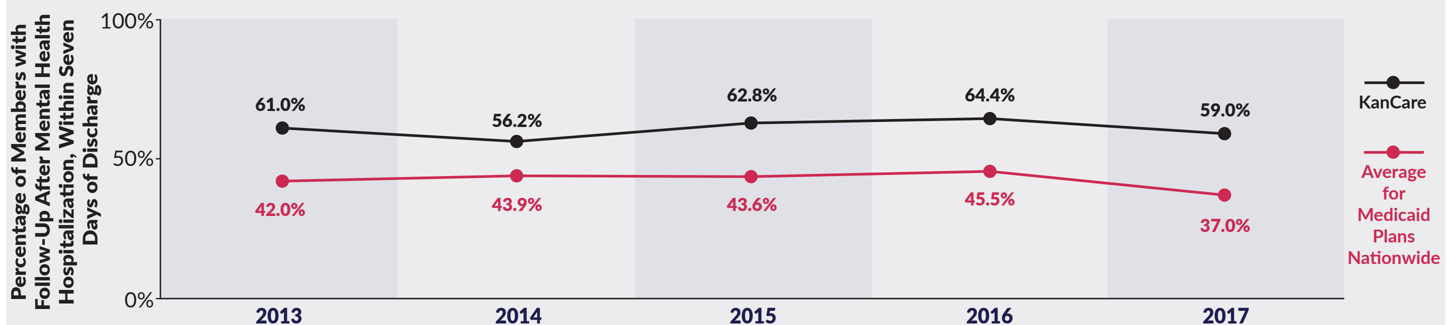
Consumers who complete the CAHPS survey are asked whether they or their child received care from a doctor or other health providers besides their personal doctor. For those who respond "Yes," that they or their child had received care from another doctor, they were asked, "how often did your (child's) personal doctor seem informed and up-to-date about the care you (your child) got from these doctors or other health providers?" In 2018, approximately 8 in 10 individuals in KanCare, regardless of population (i.e., adult, general child or children with chronic conditions) felt that their personal doctor seemed informed and up-to-date (*Figure 2*). This is compared to 88 percent of adults nationally, regardless of insurer type.

Consumers who complete the CAHPS survey are asked whether their child received care from more than one kind of health provider or used more than one kind of service. For those who responded "Yes," that their child had received care from more than one kind of provider or used more than one kind of service, they are asked, "in the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?" In 2018, 55.7 percent of the general child population and 56.9 per-cent of the children with chronic conditions population felt that there had been coordination among these different providers or services.

HEDIS Measures

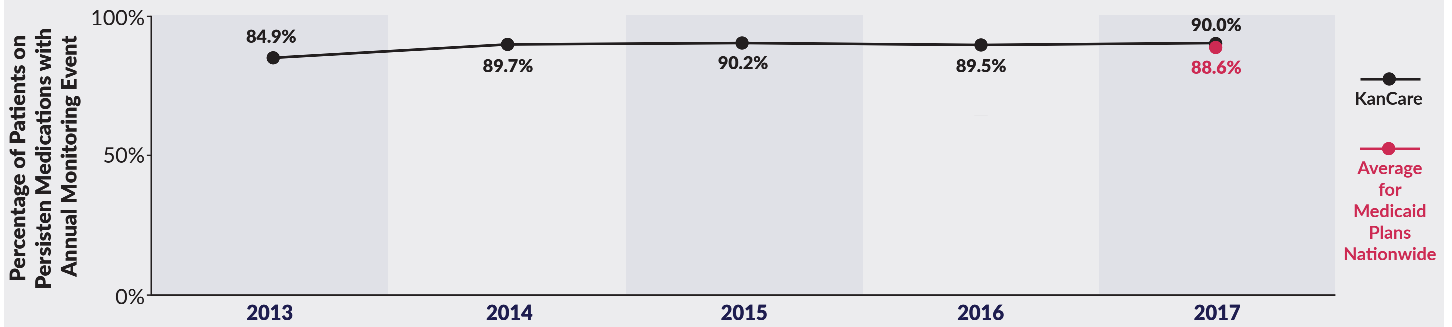
Two existing HEDIS measures identified as meaningful for understanding general care coordination in KanCare are presented in this brief:

Figure 4. **Follow-Up After Hospitalization for Mental Illness, Within Seven Days of Discharge**



Source: The KanCare data was calculated by the Kansas Foundation for Medical Care and is available in Table 2 (page 109) in the 2018 KanCare evaluation report: https://bit.ly/2XCDGB4. The Medicaid plan nationwide data was reported by NCQA and is available here: https://bit.ly/31pJqPY.

Figure 5. **Annual Monitoring for Patients on Persistent Medications**



Source: The KanCare data was calculated by the Kansas Foundation for Medical Care and is available in Table 2 (page 110) in the 2018 KanCare evaluation report: https://bit.ly/2XCDGB4. The 2018 KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table B1 (page 108) in the KanCare Program Annual External Quality Review Technical Report, available here: https://bit.ly/2Ec07Xl. The Medicaid plan nationwide data for 2018, the only year available, was reported by NCQA and is available here: https://bit.ly/2XwY2eX.

1. *Follow-Up After Mental Health Hospitalization, Within Seven Days of Discharge*: Assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within seven days of discharge.

2. *Annual Monitoring for Patients on Persistent Medications*: Assesses adults age 18 years and older who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and received at least one therapeutic monitoring event for the therapeutic agent during the measurement year. Specific therapeutic agents include: angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARB) and diuretics.

In 2017, 59.0 percent of adults and children with KanCare who were hospitalized for treatment of a mental health illness or intentional self-harm received follow-up care within seven days of discharge, compared to 37.0 percent for Medicaid plans nationwide (*Figure 4*).

In 2018, 90.4 percent of adults who received an ambulatory medication therapy received at least one medication monitoring event during the year, compared to the average rate of 88.6 percent for Medicaid plans nationwide (*Figure 5*).

Considerations

Among many of the measures presented in this brief, KanCare performance on care coordination largely appears to be similar to national benchmarks. While a number of existing measures related to care coordination have been designated as "meaningful" by KMMC stakeholders, stakeholders highlighted that these measures are only reliable for the KanCare population as a whole and do not capture the lived experience of specific KanCare populations. KMMC members indicated a high level of interest in measures that assess how care is coordinated for members of individual KanCare waivers or for others with complex needs, as well as differences in care coordination by other sub-groups, such as those living in urban or rural areas. This would require sampling for these populations, increasing the overall sample size for some current measures.

Additionally, there are no measures that capture the full range of services that care coordination can entail. For example, targeted case management (TCM) is considered a distinct service from MCO care coordination, but measures may focus on one and not the other, or may not adequately distinguish between them. Stakeholders have interest in understanding how effectively care is coordinated for those who receive TCM as well as for those who do not. More specific information on the KMMC's recommendation related to KanCare data and measures can be found here: https://bit.ly/2Diax7B.

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ISSUE BRIEF

NETWORK ADEQUACY: MEANINGFUL MEASURES IN KANCARE

According to the National Association of Insurance Commissioners, "Network adequacy refers to a health plan's ability to deliver the benefits promised by providing reasonable access to enough in-network primary care and specialty physicians, and all health care services included under the terms of the contract."

The ability to access providers and services when needed leads to improved health outcomes; therefore, the KanCare Meaningful Measures Collaborative (KMMC) has identified network adequacy as one of its priority topic areas. In particular, stakeholders who selected the topic were interested to better understand the network adequacy in KanCare relative to a benchmark, and if network adequacy were below the benchmark, the reason(s) why.

This brief provides information on some of the data that are available related to network adequacy in KanCare and also offers recommendations to address gaps in the information reported. Data are included as *examples* of the information currently available, but this brief does not seek to address programmatic implications of those findings. Instead, it focuses on opportunities to improve the quality of information available on the topic with the assumption that meaningful data collection and analysis are foundational to all work to improve the KanCare network.

Meaningful Measures for Network Adequacy

When identifying Meaningful Measures for network adequacy in KanCare, KMMC considered measures that highlight both the extent to which current contract standards are being met and the consumer experience of accessing care. The former assesses whether the number and the location of providers in the network meet pre-established distance and time standards to provide services to KanCare members. While contract standards describe the presence of providers, member experience measures whether services are available when members need care.

This brief highlights a subset of measures already reported that shed light on KanCare network adequacy according to contract standards and member experiences. Existing managed care organization (MCO) contract data was used to understand the network adequacy relative to contract standards, while consumer survey responses were used to understand member experiences. The complete set of

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Figure 1. **Examples of Meaningful Measures for Network Adequacy**

Existing Meaningful Measures	New Meaningful Measures	Other Recommendations
• Percentage of members covered within network adequacy standards by provider type, managed care organization (MCO) and geography. • Percentage of KanCare respondents with positive response to: In the last six months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?	• Sufficient number of providers by provider type, MCO and geography to provide adequate coverage within defined time and distance standards.	• Make technical documents available and provide the derivation of measures part of public reports. • Describe the network adequacy monitoring process. • Describe options available when the KanCare network is not able to meet an identified need.

Note: Check out the supplemental tables to see other Existing Meaningful Measures selected for network adequacy not reported in this brief. Check out the full set of recommendation for network adequacy here: https://bit.ly/2Diax7B.

Existing Meaningful Measures can be found here, and examples are shown in *Figure 1*. The full set of Recommendations can be found here.

Understanding Data Sources for Existing Meaningful Measures

The data sources underlying the Existing Meaningful Measures presented in this brief include contract data reported by MCOs (e.g., how many members are within access standards) and survey data. The survey data reported in this issue brief come from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey for Families and Adult Consumer Survey.

In KanCare, MCOs are required to submit data for quarterly KanCare network adequacy reports. MCOs need to meet specific access standards in order for their networks to be considered "adequate." The access standards are currently defined by miles and travel time, and standards differ by provider type and where consumers live. For example, the access standard for primary care providers is 20 miles/40 minutes of travel time for consumers who live in urban and semi-urban counties, while it is 30 miles/45 minutes of travel time for consumers living in rural and frontier counties. Time to provider, rather than just miles to provider, is a new addition to the contract standard and recognizes that distance alone does not define the accessibility of the network of providers.

Access standards for home and community-based services (HCBS) differ by service type. For example, some services use time and distance standards, while others rely on the number of days to receive first service or a minimum number of providers serving a county.

CAHPS measures capture consumer experiences in a variety of settings and are derived from consumer survey responses. The CAHPS program was developed by the Agency for Healthcare Research and Quality (AHRQ), and each KanCare MCO is required to conduct the CAHPS Health Plan Survey and submit the results to the National Committee for Quality Assurance (NCQA). CAHPS surveys are administered by third-party survey vendors via phone and mail. In the *2018 KanCare Evaluation Annual Report*, CAHPS measures are reported for the adult population, general child population and for children with chronic conditions.

The MHSIP survey tools for adults and youth are used to ask consumers in KanCare about their experiences receiving mental health services. The MHSIP was a task force formed through a branch of the Substance Abuse and Mental Health Services Administration (SAMSHA) that initially developed consumer surveys to assess mental health plans. The survey is administered to a random sample of KanCare consumers who received at least one mental health service in the six months preceding the survey.

Select Existing Meaningful Measures

KanCare Network Adequacy Standards

One metric to assess network adequacy is to examine the percentage of members within the contractual access standards by provider type, MCO and geography (urban/semi-urban and rural/frontier). The data for this

Figure 2. **Percentage of KanCare Members Within Access Standards by Select Provider Types, MCO and Geography, Fourth Quarter, 2019**

Provider Type	Aetna Better Health		Sunflower Health Plan		United Healthcare	
	Urban/ Semi-Urban	Rural/ Frontier	Urban/ Semi-Urban	Rural/ Frontier	Urban/ Semi-Urban	Rural/ Frontier
Adult Primary Care Providers	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%
Pediatric Primary Care Providers	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%
Obstetrics/Gynecology	100.0%	98.1%	99.9%	98.0%	98.3%	96.7%
Adult Behavioral Health Providers	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Pediatric Behavioral Health Providers	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Adult Physical Medicine/ Rehabilitation Providers	99.9%	83.9%	100.0%	98.8%	93.4%	64.1%
Pediatric Physical Medicine/ Rehabilitation Providers	100.0%	75.1%	100.0%	98.5%	93.4%	64.1%

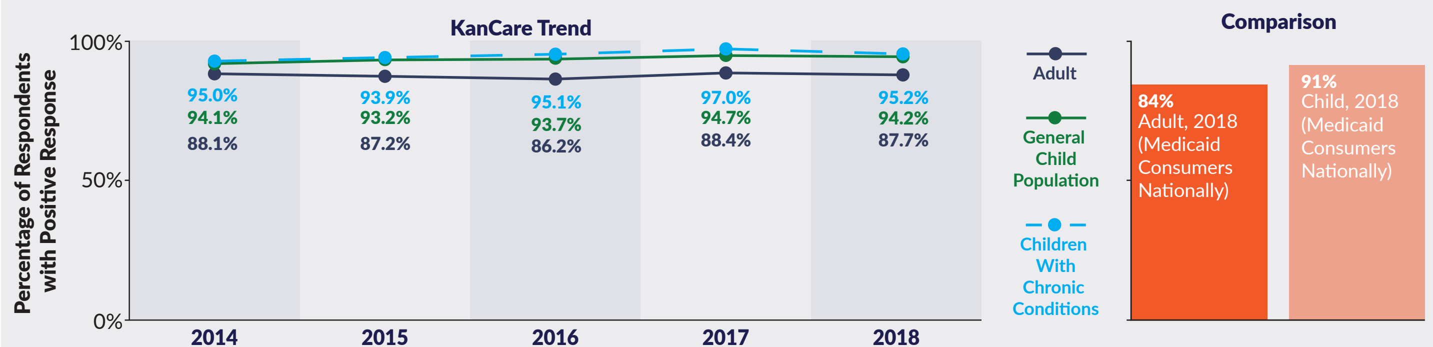
Note: This data is submitted by the MCOs and has not been validated by the state. Figure 2 also does not include all provider types reported by the MCOs (e.g., adult physical medicine/rehabilitation providers are reported, but not physical therapists). Standards vary by provider type and geography. For adult and pediatric primary care providers, the access standards are 20 miles/40 minutes for urban and semi-urban counties, and 30 miles/45 minutes for rural and frontier counties. For obstetrics/gynecology providers, the access standards are 15 miles/30 minutes for urban and semi-urban counties, and 60 miles/90 minutes for rural and frontier counties. For adult and pediatric behavioral health providers, the access standards are 30 miles/60 minutes for urban and semi-urban counties, and 60 miles/90 minutes for rural and frontier counties. For adult and pediatric physical medicine/rehabilitation providers, the access standards are 30 miles/60 minutes for urban and semi-urban counties, and 90 miles/135 minutes for rural and frontier counties.

Source: KanCare Managed Care Organizations, Geo-Access Maps For 4th Quarter, 2019: https://bit.ly/3kmSIVg

metric is submitted by the MCOs and was not validated by the state, and *Figure 2* highlights a subset of the provider types reported (e.g., adult physical medicine/rehabilitation providers are reported as an example in *Figure 2*, but not physical therapists). Information on the percentage of members within access standards for all reported provider types can be found in the *Geo-Access Maps For 4th Quarter, 2019*.

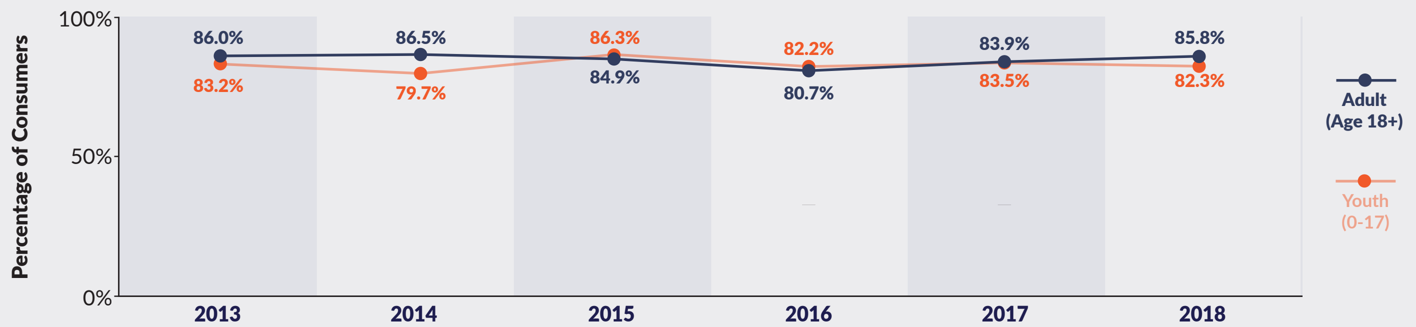
In the fourth quarter of 2019, all three MCOs reported that 100 percent of KanCare members were within the access standards for both adult and pediatric behavioral health providers (*Figure 2*). In contrast, only 64.1 percent of United Healthcare members in rural and frontier counties were within access standards for adult physical medicine/rehabilitation providers, compared to 93.4 percent of United Healthcare members in urban and semi-urban counties. For Sunflower Health Plan and Aetna Better Health, members within access standards for adult physical medicine/rehabilitation providers ranged from 83.9 percent to 100 percent. MCOs that are unable to meet a specific network adequacy standard, for example due to the number of providers in a specific region, may request an exception. The State determines whether an exception is granted and works with MCOs to identify solutions to assist members.

Figure 3. **Percentage of KanCare respondents and Medicaid respondents nationwide with positive response to: In the last 6 months, when you (your child) needed care right away, how often did you (your child) get care as soon as you (he or she) needed?**



Source: The KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table 42 (page 175) in the 2018 KanCare evaluation report: https://bit.ly/2XCDGB4. The Medicaid nationwide data was reported by the Agency for Healthcare Research and Quality and is available here: https://bit.ly/2DrAYrn.

Figure 4. **Percentage of Mental Health Consumers Who Felt They Were Able to Access Needed Services**



Note: The adult survey asked respondents to answer yes or no to the following statement: "I was able to get all the services I thought I needed." The youth question asked families to respond yes or no to the following statement: "My family got as much help as we needed for my child."
Source: The KanCare data was reported by the Kansas Foundation for Medical Care and is available in Table 43 (page 178) in the 2018 KanCare evaluation report: *https://bit.ly/2XCDGB4.*

Member Experience

While contract standards are an important way to assess network adequacy, understanding the consumer experience can provide additional information on where a network is working and where it might have gaps. For example, a network provider may be available in the county where a member lives, but if the provider is not accepting new KanCare patients, a KanCare member may be unable to obtain needed care. Member experience measures provide additional insight as to whether the provider network is adequate for ensuring that providers are available when members need care.

Consumers who complete the CAHPS survey are asked whether they had an illness, injury or condition that needed care right away in a clinic, emergency room or doctor's office within the last six months. Of consumers who answered "yes"— they had a condition that required immediate care — 87.7 percent of adults indicated that they were able to get care as soon as they thought they needed it, which was similar to the national average of 84 percent for adults with Medicaid nationwide in 2018 (*Figure 3*). Similarly, 94.2 percent of the general child population in KanCare and 95.2 percent of KanCare children with a chronic condition were able to get care when they needed it, compared to 91 percent of Medicaid children nationwide.

In 2018, more than eight out of every 10 (85.8 percent) adult mental health consumers felt that they were able to access all of the services they thought they needed (*Figure 4*). Families asked whether they were able to get as much help as they needed for their child responded similarly, with 82.3 percent of families able to access needed help.

Considerations

Despite dozens of existing measures that stakeholders have recognized as meaningful, the adequacy of the KanCare network continues to be challenging to understand. In November 2018, the Centers for Medicare and Medicaid Services (CMS) released a notice of proposed rulemaking to modify network adequacy guidelines. These forthcoming rules could be valuable in clarifying best practices for assessing network adequacy. With the expectation of eventual changes to national rules, the network adequacy contracting standards have continued to evolve. For example, the contract standard is currently written to include both distance and time of travel to a provider. The expected final rule from CMS may allow for the standard to be defined by something other than time or distance. Additionally, as standards continually evolve, stakeholders will have to consider which standards were in place at the time in order to interpret measures.

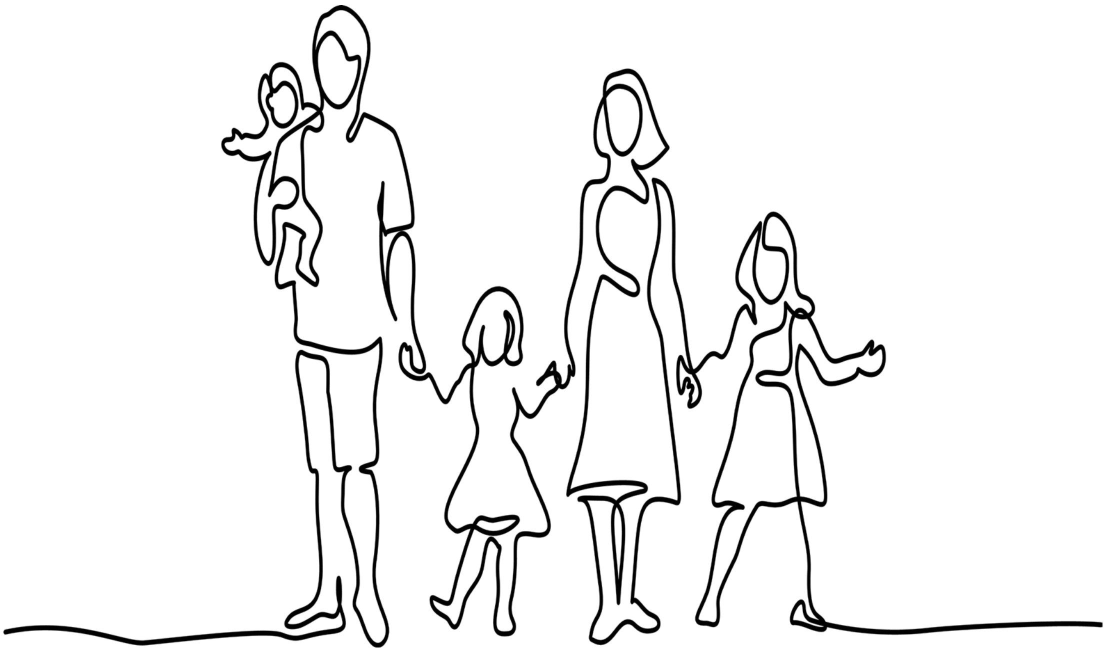
KanCare stakeholders may be interested in clarifying not only when a provider is recorded to be available to serve a county or region but also when that provider has space in their practice to meet the level of demand KanCare members require. KMMC members indicated a high level of interest in information regarding network adequacy, suggesting that there may be opportunities to improve communication around the measures currently available and the processes in place for ensuring members' needs can be met.

ABOUT THIS ISSUE BRIEF

This brief is based on work completed by the KanCare Meaningful Measures Collaborative (KMMC) task group on network adequacy. It was written by Kansas Health Institute staff who support the work of the KMMC and the task groups. It is available online at http://bit.ly/KMMC2020.

KANCARE MEANINGFUL MEASURES COLLABORATIVE
The KMMC is comprised of stakeholders — including KanCare consumers, advocates, providers, state agency staff, researchers and others — from across Kansas, who volunteer their time and effort to participate in the collaborative. Supported by a grant from the REACH Healthcare Foundation. Learn more at KMMCdata.org.

The KanCare Meaningful Measures Collaborative (KMMC) was created out of a desire to better understand how KanCare is performing. KanCare is the state's comprehensive managed care program that combines Medicaid and the Children's Health Insurance Program (CHIP). While it has been in existence since 2013, there are differing views of how well KanCare is meeting its goals from the perspective of the state, the consumers enrolled in the program and other key stakeholders. One purpose of KMMC is to establish consensus around a set of measures — Meaningful Measures — that are important to better understanding KanCare performance. Visit the KMMC website to learn more about the recommended Meaningful Measures: https://bit.ly/2Diax7B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