KMMC
KANCARE MEANINGFUL MEASURES COLLABORATIVE

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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*).

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.

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.

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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OCTOBER 2020

KMMCdata.org

ISSUE BRIEF

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

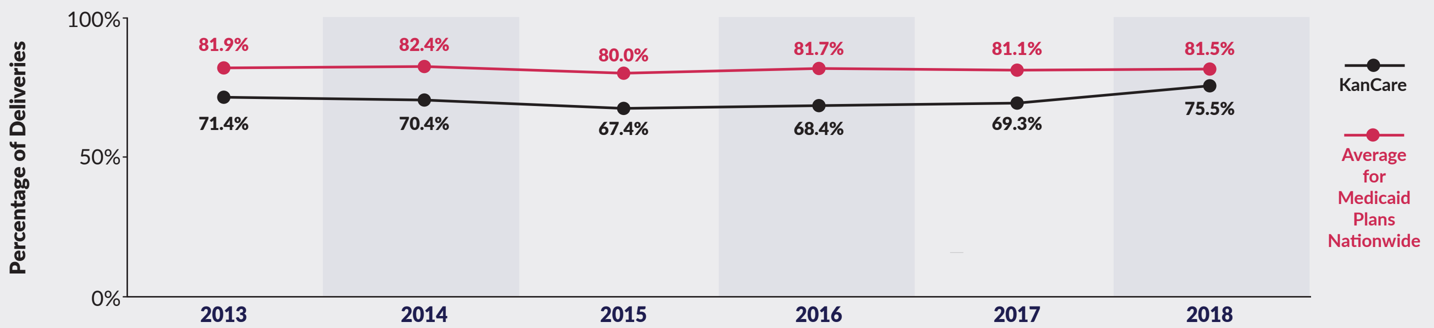
The Existing Meaningful Measures are from the Healthcare Effectiveness Data and Information Set (HEDIS) developed by the National Committee for Quality Assurance (NCQA) and are Centers for Medicare and Medicaid Services (CMS) core quality measures. The definitions of timeliness of prenatal care and postpartum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

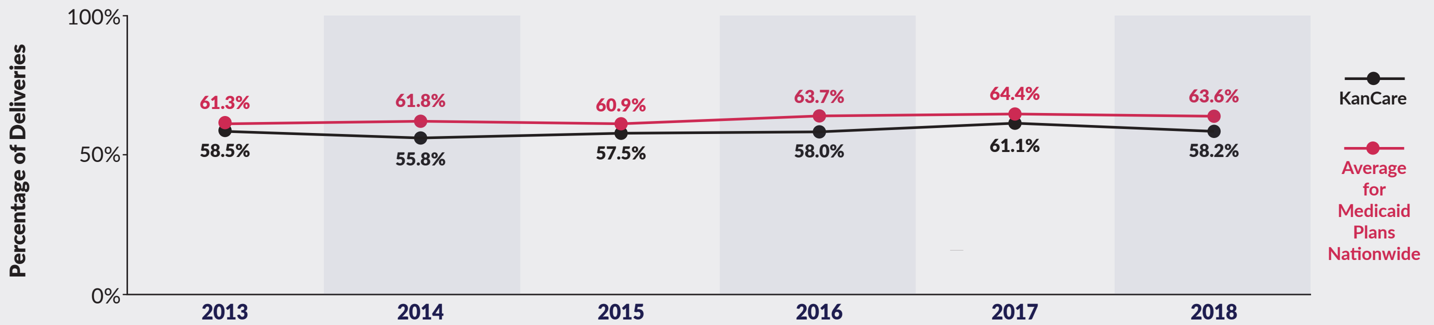
In 2018, 75.5 percent of deliveries in KanCare received timely prenatal care, compared to the average rate of 81.5 percent for Medicaid plans nationwide (*Figure 3*, page 3). Between 2013 and 2017, KanCare was consistently below the national average by 10.5-13.3 percentage points. In 2018, however, the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

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.

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

- 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.

New Meaningful Measures

- Measures from home and community-based services Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.
- Targeted case management measures.

Other Recommendations

- 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.

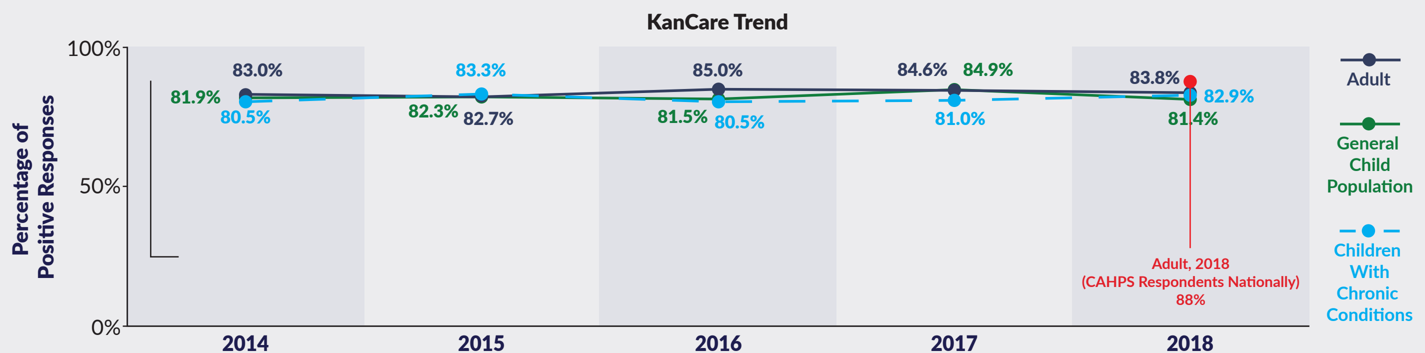
Understanding Data Sources for Existing Meaningful Measures

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.

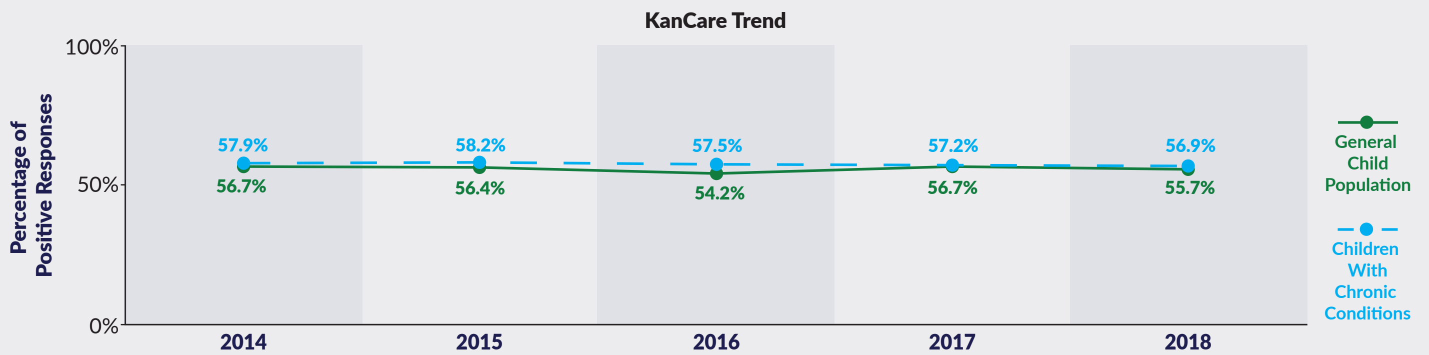
HEDIS measures are developed by NCQA to measure health care performance and are derived from administrative data (e.g., claims data) alone or a combination use of administrative data and chart reviews.

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

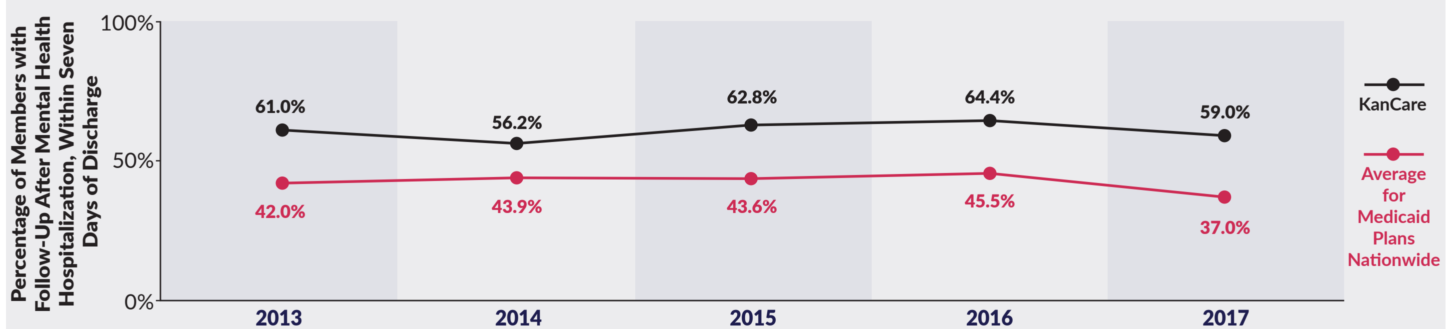
Consumers who complete the CAHPS survey are asked whether they or their child received care from a doctor or other health providers besides their personal doctor. For those who respond "Yes," that they or their child had received care from another doctor, they were asked, "how often did your (child's) 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

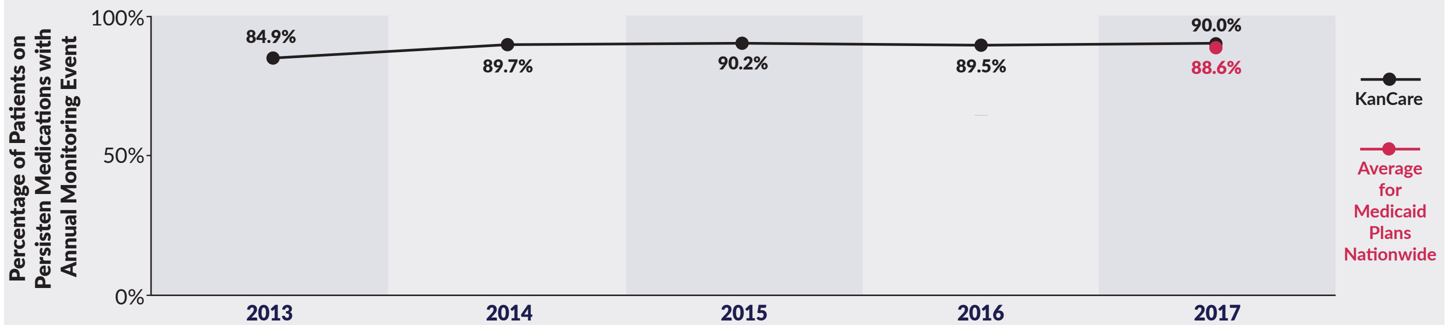
Two existing HEDIS measures identified as meaningful for understanding general care coordination in KanCare are presented in this brief:

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%

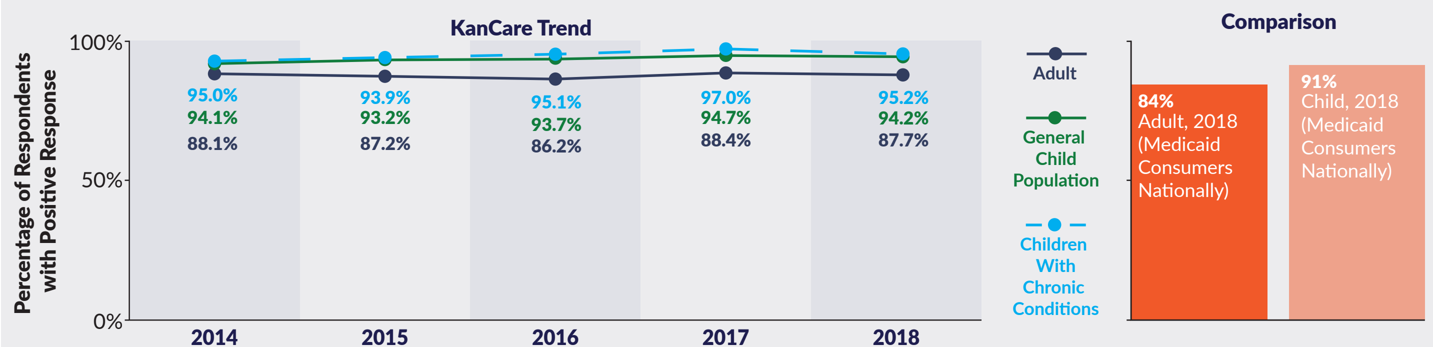
Note: This data is submitted by the MCOs and has not been validated by the state. Figure 2 also does not include all provider types reported by the MCOs (e.g., adult physical medicine/rehabilitation providers are reported, but not physical therapists). Standards vary by provider type and geography. For 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*.

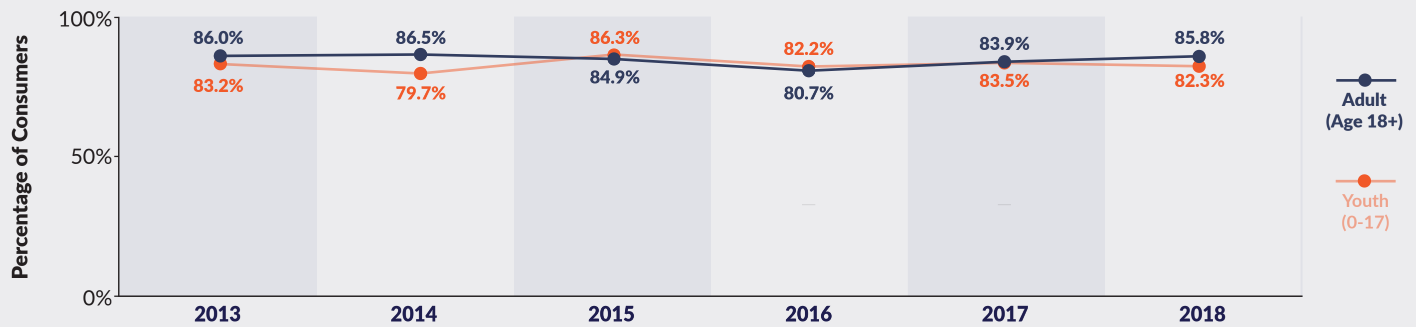
In the fourth quarter of 2019, all three MCOs reported that 100 percent of KanCare members were within the access standards for both adult and pediatric behavioral health providers (*Figure 2*). In contrast, only 64.1 percent of United Healthcare members in rural and frontier counties were within access 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.