KanCare Meaningful Measures Collaborative (KMMC) Meeting
Friday, September 10, 2021, 1:00PM-3:40PM
Zoom

Agenda Item: Welcome and Introductions

Aaron Dunkel, Chair of the KMMC Executive Committee, provided an overview of the meeting agenda and objectives, before asking all in attendance to introduce themselves.

Agenda item: Social Determinants of Health (SDOH) – SDOH memo

Jean Hall presented an update on the work of the Social Determinants of Health task group. The Stakeholder Working Group advised early consideration of social determinants of health (SDOH), and a task group was formed in 2020 to make recommendations. Research shows that SDOH can influence from 20 percent to 50 percent of health outcomes, making them a critical topic for the KMMC.

Building on the work of the initial task group, a specially formed task group started meeting in March 2021 to build consensus around standard data elements to recommend. The group put together a list of questions that would be asked of all KanCare participants, regardless of waiver status or type of coverage eligibility, covering housing, safety, food, transportation, technology, and employment. Many of the recommended questions were based on those that are already being used in the field and were drawn from existing instruments.

The group recommended that the questions be added to the initial Medicaid application to create a baseline measure. The group also recommended that KanCare members complete the health screening tool on an annual basis and that the recommended questions be included in the health screening tool. The group provided recommendations related to incentives to boost response rates and recommended a process by which members could be put in touch with resources. The recommendations can inform the next KanCare Request for Proposals (RFP).

Agenda Item: Sustainability

Kari Bruffett provided an update on the sustainability discussion started in the full KMMC in June, and continued by the Executive Committee in July, to focus on sustainability planning. In those meetings, KMMC members had affirmed a commitment to continue holding full KMMC meetings on a quarterly basis to maintain momentum. The discussion has also focused on engaging KMMC task team leads to facilitate work that will inform and support the KanCare waiver and procurement processes, with the acknowledgement that the work takes resources. As a result, a small working group was formed to identify resources for long-term sustainability. The group has met once and developed a plan to create a proxy budget for prospective proposals. If anyone has interest in contributing to the group, please contact Kari Bruffett.

Agenda Item: Report out from the Stakeholder Working Group (SWG)

Tami Allen, vice-chair of the Stakeholder Working Group, provided an update to the group of the last SWG meeting, conducted after the previous full KMMC meeting. The update focused on key issues and opportunities that had been identified for future work, including looking at

measures related to caregivers and families of Medicaid members, waiver waiting lists, best practices in other states related to I/DD waiver services, differences in availability of care related to geography, race and ethnicity, and timely enrollment. Tami also reported the group recognized consumer engagement has not had a clear focus on younger KanCare members and their families during previous rounds. The group had discussed options to engage more families, including collaborating with organizations that would be able to bring younger individuals to the consumer engagement group.

Agenda Item: Update from State

Sarah Fertig, Medicaid Director, provided an update on the "KanCare 3.0" procurement process and the major structural decisions facing the state. The current Section 1115 demonstration and current MCO contracts are all set to expire at the end of December 2023. She reported that KDHE will soon be able to announce the contractor who will help the state put together the RFP, lead the stakeholder engagement process, research best practices in other states, and assist in fine tuning the priorities and themes for KanCare 3.0. She said the agency plans for clear lines of communication. The tentative goal is for the MCO RFP to be released sometime in the first half of calendar year 2022.

Sarah also discussed considerations for either renewing the Section 1115 demonstration or potentially shifting to a different source of authority to operate the Medicaid program. Section 1115 demonstrations allow CMS to waive certain requirements that would normally apply to a Medicaid program to test new theories and new delivery systems. While the initial KanCare demonstration made sense for a Section 1115, she said, the state now has a more mature program, and some of the flexibilities that the current authority allows also come with constraints. An example she shared was the concept of budget neutrality, which is a key feature of a Section 1115 demonstration in which a state cannot cost CMS more in federal money than it would without the waiver. Investments in the program, including rate increases for select providers as directed by the Legislature, can cut into the budget neutrality cushion.

The state is exploring what source of authority should be used for KanCare – Section 1115 authority, another authority (other states with Section 1115 demonstrations are moving to 1915(b) waivers for their managed care models, for example), or a hybrid approach – that would not disrupt the way the current Medicaid system operates.

Agenda Item: Recommendations

Wen-Chieh Lin opened the discussion, giving background for the recommendations and the plan to leverage the group's previous recommendations to support preparation for the upcoming KanCare procurement and waiver processes. Previous recommendations included seven priority areas: Pregnancy Outcomes, Care Coordination, Network Adequacy and Social Determinants of Health (SDOH) from last year, and Telehealth, Behavioral Health and Quality Assurance from this year. Because SDOH was discussed earlier in the meeting, the group reviewed the remaining six priority topics, starting with Pregnancy Outcomes.

Pregnancy outcomes

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

Discussion: Anna Purcell summarized the recommendations for pregnancy outcomes. The existing measures currently collected by MOCs include HEDIS measures on timeliness of prenatal care and postpartum care. The task group recommended collecting several new measures, e.g., birthweight, gestational age and infant mortality, identifying if disparities exist in these measures and exploring the use of the Pregnancy Risk Assessment Monitoring System (PRAMS) data.

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

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

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

Care Coordination

- Serious emotional disturbance (SED) waiver: Consider requiring an SED Waiver specific survey be completed by MCOs and explore the potential for the Child ECHO Behavioral Health survey to include a supplemental sample of children and youth receiving SED waiver services.
- HCBS CAHPS: Consider requiring the MCOs to complete the HCBS CAHPS survey (one already does), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination.
- HCBS CAHPS: Increase sample size for subgroup analysis by alternating years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys.

- National Core Indicator: Consider increasing resources for the National Core Indicator TM (NCI) and NCI-Aging and Disabilities TM (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. This approach will help pool resources together.

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

Approaches were suggested for collecting data from serious emotional disturbance (SED) waiver participants, members with targeted case management and other HCBS waivers. Suggestions included ways to increase the sample size for each type of waiver participant, considering alternate surveys and review overlaps between surveys to pool resources together. Please see Appendix B for details.

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

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

Network Adequacy

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

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

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

The group suggested that in the upcoming procurement process the state think outside the box and ask bidders how they will boost network adequacy across the state.

Telehealth

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

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

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

Another recommendation was to add a modifier to a claim or some other mechanism to understand how telehealth services were delivered, i.e., face to face over a video connection or audio only, to help assess the efficacy of those services.

The task group collectively decided that only once we are able to look at data provided through a program expectation, whether written into contracts or built into the overall management of the program, would we really be able to analyze and study the impact of telehealth on access and patient outcomes. Please see Appendix D for details.

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

Behavioral Health

- Access to telehealth: Developing a robust telehealth option for behavioral health services in KanCare with reasonable reimbursement attached will be key to the ongoing success of these services, which are often preferred by individuals receiving behavioral health treatment.
- Medicaid/CHIP Behavioral Health Core Set: Improve key quality measures including:

    - Adherence to antipsychotic medications for individuals with schizophrenia for members age 19 to 64
    - Initiation and engagement of alcohol and other drug abuse or dependence for members age 18 and older
- Mental health parity: Incorporate mental health parity expectations and reporting in the KanCare contracts.

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

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

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

Please see Appendix E for details.

Quality Assurance

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

Carrie Wendell-Hummel was not able to stay for the entire KMMC meeting. She submitted a document to summarize the recommendations on quality assurance. Please see Appendix F for details.

Next Steps: The KMMC will combine all recommendations into one document and include discussion and feedback after following up with the task team leads.

Agenda Item: Conferences

Kari Bruffett gave the group an update on the abstracts/proposals submitted for two conferences. The Kansas Telehealth Summit abstract has been accepted, but the Summit has been postponed until early 2022. The KMMC also submitted a panel proposal to the Home and Community-Based Services (HCBS) Conference (the ADvancing States national conference). [*Subsequent to the KMMC meeting, the KMMC was informed that the abstract was not chosen for the HCBS conference.]*

Agenda Item: Adjourn

The KMMC adjourned at 3:45PM, and the next full KMMC meeting is currently scheduled for November 12th at 1PM.

Appendix A: Pregnancy Outcomes

The existing measures for pregnancy outcomes are timeliness of prenatal care and postpartum care. These are currently collected from each MCO as the existing HEDIS measures.
Recommendations for new measures would be to add birth weight, gestational age, and infant mortality information. Another recommendation was to identify if disparities exist in the measures and explore the use of PRAMS data. With these measures, a summary report or a dashboard can be developed to monitor measures on the pregnancy process and outcomes, and then conduct trend and subgroup analysis to identify subpopulations or geographic areas that are currently have poor outcomes and need continuous improvement.

Appendix B: Care Coordination

General Care Coordination by Providers:

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

Potential approaches:

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

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

Care Coordination3. KanCare could consider reviewing the reported information from the first data year of HCBS CAHPS Surveys to make recommendations on survey administration strategies, sampling needs or inclusion of additional questions.

Potential approaches:

- Consider requiring the MCOs to complete the HCBS CAHPS survey (one already does), stratified by waiver and including questions for both Targeted Case Management and MCO Care Coordination. The EQRO contract could include aggregation of the MCOs' results by waiver type, and an MCO comparison of the overall results (not by waiver, since there wouldn't be enough responses by MCO to compare).
- Other potential solutions to increasing responses for a statewide HCBS CAHPS survey could be to alternate years in which additional sampling is conducted for specific subgroups and to use the hybrid approach, with a combination of in-person and phone surveys, as seen in some states. KanCare could consider opportunities to increase the number of I/DD waiver members participating in the HCBS CAHPS Survey to capture the experiences of those receiving targeted case management (TCM).

- Consider increasing resources for the National Core Indicator ™ (NCI) and NCI-Aging and Disabilities ™ (NCI-AD) surveys by eliminating the HCBS CAHPS survey which has substantial overlap and fewer domains. By combining funding from the two types of surveys, potentially enough members would be surveyed to allow for the waiver stratification. The NCI surveys adults with intellectual or developmental disabilities (I/DD) and the NCI-AD surveys adults who receive supports because of a physical disability and/or an age-related disability. Consider adding supplemental questions (such as in the HCBS CAHPS survey) regarding Targeted Case Management versus MCO Care Coordination for the NCI survey.

Appendix C: Network Adequacy

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

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

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

Members are looking for real time information when they need care. Even though the network adequacy shows that providers are available in the geographic area, they might not be accepting new patients, the wait time for an open appointment is long or members might need to travel long distance. In these situations, members have had a difficult time finding information to communicate with MCOs and get their

needs met. Improving the information sharing to guide people through the process to have their needs met is another recommendation for network adequacy.

Appendix D: Telehealth

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

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

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

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

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

Only once the data collection is provided through the program, can analysis of telehealth's impact on access, patient outcomes, etc. be assessed.

Appendix E: Behavioral Health

Expectations for Kancare

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

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

- Care Coordination

- Network Adequacy
- Social Determinants of Health

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

For Behavioral Health specifically, the Recommendations include:

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

a) Prevalence of behavioral health disorders: proportion of KanCare members with mental health disorders, SUDs or co-occurring diagnoses of varying levels of severity.
b) Access to services: KanCare member ability to access services, with a focus on receiving services in a timely manner.

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

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

a.) Consistent definitions of homelessness should be used across populations.

Access to Telehealth

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

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

One way CMS measures quality of care in the Medicaid and CHIP programs is through two core sets of measures, one for children and one for adults. Each quality measure is accompanied by a

gauge that allows you to view Kansas's performance in comparison to other states reporting the measure. In federal fiscal year (FFY) 2019, Kansas voluntarily reported 17 of 21 frequently reported health care quality measures in the CMS Medicaid/CHIP Child Core Set. Kansas voluntarily reported 18 of 24 frequently reported health care quality measures in the CMS Medicaid Adult Core Set.

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

- Adherence to Antipsychotic Medications for Individuals with Schizophrenia: Ages 19 to 64
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment: Age 18 and Older
- Breast Cancer Screening: Ages 50 to 74

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

Components for the Kancare procurement process:

- One obvious area for change is incorporating these as quality improvement measures

Specifically – bidders should be asked two important questions –

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

Finally – it is time to know what they are doing to prepare KanCare for the Federal reporting that Kansas has not been requiring of the MCOs. CMS says that they will have to complete the Medicaid managed care report at 42 CFR § 438.66.

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

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Mental Health Parity – a quick note:

States are quickly changing their expectations for compliance with Federal Mental Health Parity laws and the courts are hastening this reform.

Kansas should incorporate mental health parity expectations and reporting in the Kancare contracts.

Mental Health Quality Measures

The Child Health Toolbox contains concepts, tips, and tools for evaluating the quality of health care for children.

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Overview

The lack of reliable and useful quality measures for mental and behavioral health services has been frequently cited by State policymakers. This section tries to address these concerns through a review of two national mental health initiatives that target or include children's mental health needs.
In addition to these resources, there are two products developed under the Child and Adolescent Health Measurement Initiative (CAHMI) with measures related to child behavioral health:

- Young Adult Health Care Survey (YAHCS).

Includes behavioral screens for 14-18-year-olds including preventive screening and counseling on risky behaviors and on emotional health and relationship issues.

- Promoting Health Development Survey (PHDS).

Includes related measures including parental guidance on child development.

Online Resources:

- Information on YAHCS.
- Information on PHDS.
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Experience of Care and Health Outcomes Survey (ECHO™): The ECHO™ survey collects consumers' assessments about their behavioral health treatment, including mental health and chemical dependency services. There are both adult and child versions of the ECHO™ survey.

National Inventory of Mental Health Quality Measures: Developed by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH), this is a searchable database of

over 300 measures for quality assessment and improvement in mental health and substance abuse care.

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Experience of Care and Health Outcomes Survey (ECHO™)

Experience of Care and Health Outcomes Survey (ECHO™) collects consumers' assessments about their behavioral health treatment, including mental health and chemical dependency services. The ECHO™ survey is designed for use by consumers, clinicians, managed behavioral health care organizations (MBHOs), health care plans, purchasers, States, and Federal agencies. The format and design of the ECHO™ survey is consistent with the widely used CAHPS. Its contents were largely derived from two pre-existing instruments for behavioral health care quality assessment:

- The Mental Health Statistics Improvement Program.
- The Consumer Assessment of Behavioral Health Services surveys.

There are both adult and child versions of the ECHO™ survey.

Online Resources:

- Information on CAHPS 3.0.
- For more information on the Mental Health Statistics Improvement Program, go to: https://depts.washington.edu/pbhjp/projects-programs/page/mental-health-statistics-improvement-program-mhsip-surveys
- For the ECHO™ surveys, go to: https://www.ahrq.gov/cahps/surveys-guidance/echo/index.html

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Child Measures Included

Separate versions of the child survey have been developed for MBHOs and managed care organizations (MCOs). Items assess consumer experience with specialty behavioral health, including care for mental or emotional illness, substance abuse, family problems, and developmental conditions. The MBHO version contains 58 items and the MCO version contains 69 items. The ECHO™ survey assesses several aspects of care, including:

- Getting treatment and counseling quickly.
- Communications with clinicians.
- Information provided by clinicians on medication side effects.

- Family involvement in care.
- Information about self-help groups and treatment options.
- Cultural competency of providers of care.
- Treatment effectiveness.
- Health plan administrative and office staff services.

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Users

The ECHO™ survey is targeted to children who currently use mental health, behavioral health, and/or chemical dependency services. MBHOs, MCOs, and State Medicaid agencies are the intended users of the ECHO™ survey. It is expected that the child version, like the adult version of ECHO™, will be used over time to assess the performance of contracted MCOs and to compare performance across plans and subsets of the child population (e.g., children enrolled in Medicaid versus children enrolled in a State Children's Health Insurance Program (SCHIP).

Comparisons and Trends

ECHO™ results provide statistically significant comparisons when produced for multiple MHBOs and MCOs, provided that comparable populations are used.

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Benchmarking and Databases

The National CAHPS Benchmarking Database (NCBD) is developing a national database of ECHO™ results.

Online Resource: Information on the CAHPS database.

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Service Delivery and Units of Analysis

ECHO™ was designed to assess the performance of MBHO and MCO service delivery systems.

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Length-of-Enrollment Requirements

Twelve months of continuous eligibility is recommended when selecting the target population for the child version of the ECHO™ survey. The principles of good survey techniques suggest that individuals be surveyed who have had sufficient enrollment to achieve the desired effects of what is being measured. For example, no minimum length of enrollment requirements may be required for assessing whether members understand their basic rights for due process within a plan. However, when assessing whether a member received appropriate preventive or followup care, a minimum of 12 months of continuous enrollment is necessary. Because ECHO™ measures are based in part on the premise that MBHOs and MCOs are accountable for providing defined services to enrolled members, the minimum period of enrollment is designed to give plans a reasonable opportunity to fulfill that responsibility prior to measurement.

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Data Issues

ECHO™ can be administered by:

- Telephone.
- Mail.
- A combination of both. To maximize response rates, administration by mail with telephone followup is recommended.

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Sample Sizes

The CAHPS family of surveys requires a sample large enough to yield 300 completed questionnaires. Larger sample sizes may be required to get valid information on specific subpopulations. The CAHPS Survey and Reporting Kit proposes several sampling alternatives that can be applied to the child version of ECHO™.

Online Resource: For more information on the CAHPS Survey and Reporting Kit, go to: http://www.ahrq.gov/cahps/surveys-guidance/cg/instructions/index.html.

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Resource and Burden Issues

Credible survey data require close attention to proper sampling methods and adherence to survey administration protocols. These take time and money. Senior-level agency responsibility and sufficient staff resources are needed to ensure useful results.

This survey requires a minimal burden and cost for those conducting the survey. There is also a minimal burden for those responding to the survey with respect to length and reading level.
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Development Process

The group that developed the ECHO™ survey included behavioral health consumers, clinicians, and behavioral health policy experts, including representatives from CAHPS®, the National Committee for Quality Assurance (NCQA), NCQA's Behavioral Health Measure Advisory Panel, the Mental Health Statistics Improvement Program, the Evaluation Center at the Human Services Research Institute, the Washington Circle Group, the American Managed Behavioral Health Care Association, and the National Alliance for the Mentally Ill.

Online Resource: For more information on the group that developed the ECHO™ survey, go to: https://www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html

In 1998, the Evaluation Center at the Human Services Research Institute and AHRQ funded the Harvard Medical School CAHPS® study team to determine whether two existing instruments for assessing behavioral health plan performance could be combined into a single instrument. The Consumer Assessment of Behavioral Healthcare Services (CABHS) and the Mental Health Statistics Improvement Program (MHSIP) surveys were compared with respect to eight factors:

- Response rates.
- Characteristics of respondents versus non-respondents.
- Respondent burden, understanding, and perceived utility.
- Structure of survey.
- Distribution of survey response (e.g., missing data, inapplicable items).
- Data validity.
- Internal consistency.
- How well survey items discriminate among plans.

A pilot phase was conducted to test each survey instrument as well as a combined instrument. Results were reviewed by the CAHPS instrument development team and were used to develop a single survey combining the best features of each instrument. A draft ECHO™ survey was field tested by MCOs. In June, 2003 the adult version of ECHO™ was approved under the CAHPS version 3.0 family of surveys. Approval of the child version is pending.
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Criteria Used

In designing the final child and adult versions of ECHO™, several criteria were essential. The survey needed to be:

- **Meaningful** to individuals who have used behavioral health services and to plans and staff for quality improvement efforts.
- **Applicable** to different types of plans, including commercial, Medicaid and Medicare, and health systems (managed care and fee-for-service) plans.
- **Appropriate** for consumers with a range of mental health service needs, including those with severe mental illness.
- **Easy to understand** for diverse demographic and racial/ethnic groups and different levels of education.
- **Easy to administer** in different modes (mail or telephone) with minimal effect on survey responses.

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More Information and User Support
Online Resource: To download the ECHO™ surveys, go to:
https://www.ahrq.gov/cahps/surveys-guidance/echo/instructions/index.html
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National Inventory of Mental Health Quality Measures

This is a searchable database of over 300 measures for quality assessment and improvement in mental health and substance abuse care. Measures included in the database have been developed by government agencies, researchers, clinical and professional organizations, accreditors, health systems and facilities, employer purchasers, consumer coalitions, and commercial organizations. Information about the measures' clinical rationale and evidence base was developed by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH), with funding from AHRQ.

The inventory can be searched by the following specifications:

- Diagnosis, including major depressive disorder, personality disorders, schizophrenia, and substance abuse dependence.
- Special populations, including child/adolescent and dual diagnosis.
- Data source, such as administrative claims, medical record, and survey.
- Evidence level, which is a rating by AHRQ as to the level of evidence.

- Treatment, including medication, psychotherapy, and case management.
- Domain of quality, such as access, prevention, and treatment.
- Clinical setting, such as inpatient, outpatient, home, and community.
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Results of an indicator search of the database include a description of the measure, appropriate data sources to use for the numerator and denominator of rates, and the developer of the measure.

Child and adolescent measures include:

- Access to child specialty care for depression.
- Family involvement in attention-deficit hyperactivity disorder (ADHD).
- Stimulant medication treatment for ADHD.
- Antipsychotic treatment for childhood psychosis.
- Completion of treatment for substance abuse.
- Referral to post-detoxification services.

Online Resource: For more information on CQAIMH, including a guide to using the database, a directory of measures, and project publications, go to the CQAIMH Web site at http://www.cqaimh.org/index.html

Appendix F: Quality Assurance

Overview of prior recommendations:

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

Carrie Wendel-Hummell (KU Center for Research on Aging and Disability Options) revisited these recommendations in light of the upcoming KanCare procurement process. Note, she did not have an

opportunity to discuss these recommendations with other members of the taskforce, and so this is just a starting point for KMMC consideration.

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

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

proportion of filled hours by reducing the number of authorized hours.

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

Appendix F: Quality Assurance

Overview of prior recommendations:

Based on stakeholder input, the research question we identified was, "Are Home and Community Based Services (HCBS) populations receiving the level of services needed?" This includes all 7 waivers in Kansas.

We identified several measures that help answer this question, including the HCBS CAHPS (Client Assessment of Healthcare Providers and Systems) survey, NCI-AD (National Core Indicators- Aging and Disability) survey, record review, and customer interview. We had made recommendations around expanding CAHPS and NCI-AD, as these survey measures were not available across all waivers and sample sizes are too small to support comparisons or subgroup analysis.

We also recommended new measures be developed, including the need to measure the availability of direct care workers and exploring the potential for using other data sources, such as APS/CPS data (adult and child protective services), MCO member surveys, and AuthentiCare data.

Carrie Wendel-Hummell (KU Center for Research on Aging and Disability Options) revisited these recommendations in light of the upcoming KanCare procurement process. Note, she did not have an opportunity to discuss these recommendations with other members of the taskforce, and so this is just a starting point for KMMC consideration.

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

It would help to know more about how the related performance measures operate in the current KanCare contracts. KMMC previously identified 6 performance measures related to this question. What are the benchmark goals for each measure and what are the incentives for reaching these benchmarks? This would

provide a useful starting point to consider whether these incentives should be updated, including whether any of the additional identified measures should be included as performance measures.

Take a deeper dive into consumer interview and record review methodologies, to ensure these are valid and representative measures, especially considering the predominance of these data sources in current performance measures.

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