KMMC
KANCARE MEANINGFUL MEASURES COLLABORATIVE

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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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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. Please note that the KMMC is a volunteer effort of many stakeholders but is not an official activity of the KanCare program or the State of Kansas. Visit the KMMC website to learn more about the recommended Meaningful Measures: https://bit.ly/2Diax7B

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%

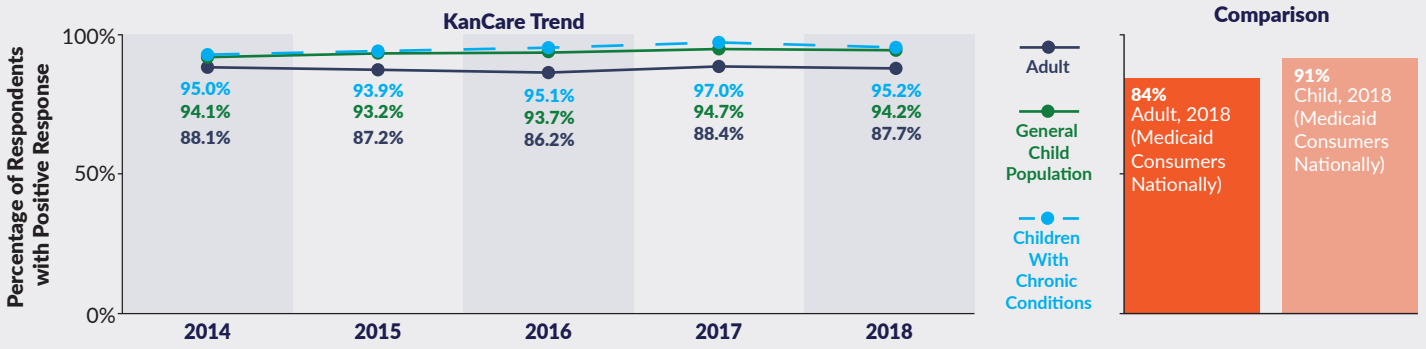
Note: This data is submitted by the MCOs and has not been validated by the state. Figure 2 also does not include all provider types reported by the MCOs (e.g., adult physical medicine/rehabilitation providers are reported, but not physical therapists). Standards vary by provider type and geography. For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

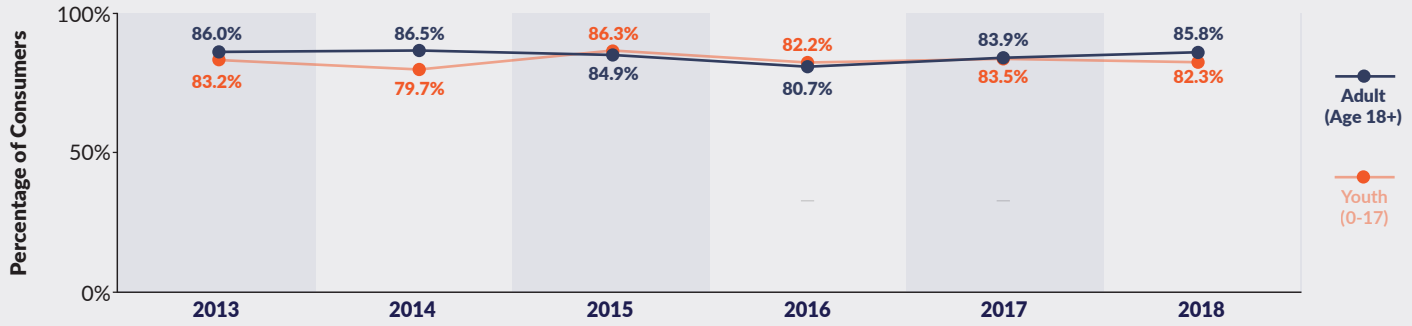
In the fourth quarter of 2019, all three MCOs reported that 100 percent of KanCare members were within the access standards for both adult and pediatric behavioral health providers (*Figure 2*). In contrast, only 64.1 percent of United Healthcare members in rural and frontier counties were within access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

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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.

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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.