KanCare Meaningful Measures Collaborative Report, 2019

August 26, 2019

(This page intentionally left blank.)

Table of Contents

Acknowledgments ... ii

Executive Summary ... iii

Introduction ... 1

Purpose ... 1

Structure ... 1

Participation ... 3

KMMC Process ... 3

Workplan ... 5

Stakeholder Working Group ... 6

Data Resources Working Group ... 7

Initial Priority Measures ... 8

Eligibility Determination ... 9

Network Adequacy ... 9

Health Care Utilization ... 11

Data Map ... 12

Developing Questions ... 12

Consumer Engagement ... 13

Framing Key Questions ... 15

Next Steps for Impact ... 17

Appendix A: Charter Statements ... A-1

Appendix B: KMMC Membership ... B-1

Appendix C: KMMC Meetings Timeline ... C-1

Appendix D: Consolidated Questions Crosswalk ... D-1

Acknowledgments

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

Supported by a grant from the REACH Healthcare Foundation.

Executive Summary

The KanCare Meaningful Measures Collaborative (KMMC) was created out of a desire to understand better how KanCare, the Kansas Medicaid program, is performing. Despite having been in existence for multiple years, there has been disagreement on how KanCare is performing and a desire for more timely and accessible data. The goal of the KMMC is not to evaluate the KanCare program, but instead to establish consensus around KanCare data and metrics by bringing together KanCare consumers, stakeholders, researchers and state staff.

This is the first report of the KMMC and is intended to capture the work-to-date of the collaborative. Additionally, this report describes the process by which the KMMC has sought to increase the visibility, credibility, validity and usefulness of information related to KanCare. This report also outlines the planned work of the KMMC to establish a shared understanding of KanCare.

Figure ES-1 (page iv) illustrates KMMC activities to date and anticipated upcoming activities.

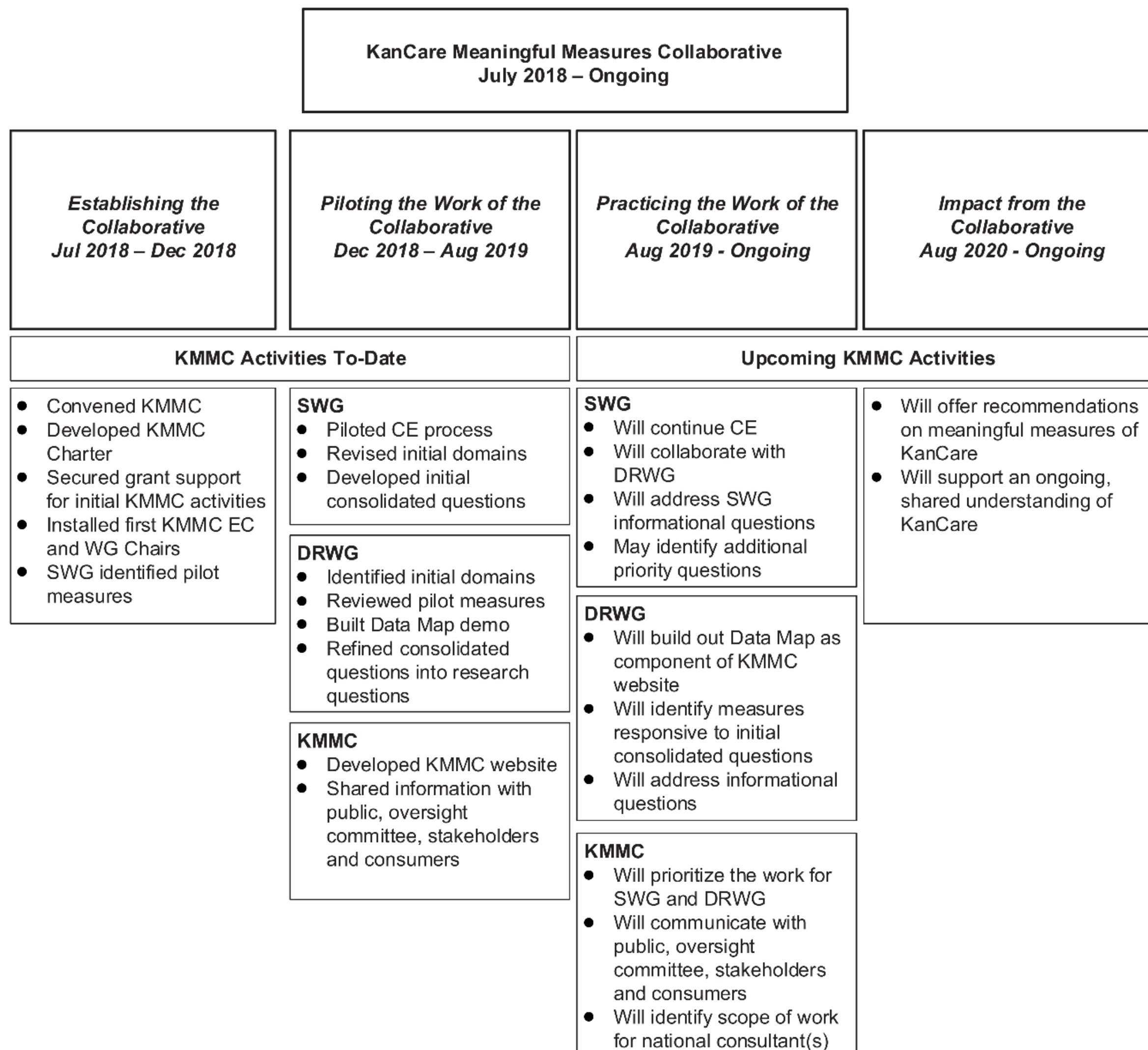
Activities to date included a pilot effort to analyze initial priority measures selected from state reports to the Robert G. (Bob) Bethell Joint Committee on Home and Community-Based Services and KanCare Oversight. These measures included those related to network adequacy, eligibility determinations and KanCare utilization measures related to inpatient stays, outpatient emergency room use, non-emergency medical transportation and home and community-based services. Through this pilot process, the KMMC was able to understand more about how the collaborative can function effectively and compile priority information on KanCare.

Other work-to-date has included the identification of domains of information related to KanCare and the identification of initial questions related to these domains. These domains include:

- Social Determinants of Health, Employment and Quality of Life;
- Quality and Outcomes;
- Access and Coordination of Care;
- Network Adequacy;
- Eligibility Determination, Enrollee Characteristics and Enrollee Satisfaction; and
- Utilization and Expenditures.

These domains were established via brainstorm by the Stakeholder Working Group (SWG) and the identification of initial themes through the consumer engagement process conducted by the SWG. The SWG drafted initial questions of interest which were sorted to form "Consolidated Questions." The initial consolidated questions (Tier 1) are described in *Figure ES-2* (page v). The ongoing work of the Data Resources Working Group (DRWG) is to pair consolidated questions with possible measures by which the questions might be assessed.

Figure ES-1. **KMMC Workplan**



Notes: EC is the Executive Committee; WG is Working Groups; SWG is the Stakeholder Working Group; CE is the Consumer Engagement process within the KMMC; DRWG is the Data Resources Working Group. "Upcoming KMMC Activities" are planned activities and might be subject to change as the work of the KMMC evolves.

Source: KanCare Meaningful Measures Collaborative, 2018-2019.

Figure ES-2. **Initial Consolidated Questions (Tier 1)**

Domain	Consolidated Question
Eligibility Determination, Enrollee Characteristics and Enrollee Satisfaction	**Enrollee Treatment.** Are KanCare enrollees satisfied with the way they are treated and the degree to which they understand and can make decisions about their services?
Eligibility Determination, Enrollee Characteristics and Enrollee Satisfaction	**Application Processing.** What are the barriers to having an application processed in a timely manner?
Quality and Outcomes	**Quality Assurance.** Are quality assurance measures in place to ensure that individuals receive the level of services they need?
Access and Coordination of Care	**Care Coordination.** Are care coordination services (i.e., any services to help coordinate care; not limited to managed care organizations [MCO]-defined services) available for consumers who need them? Are care coordination services effective for those who have received them?
Social Determinants of Health, Employment and Quality of Life	**Social Determinants.** What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health and their impact on enrollees?
Quality and Outcomes	**No Access.** What are the outcomes associated with individuals who cannot access care?
Quality and Outcomes	**Pregnancy Outcomes.** How does KanCare impact pregnancy outcomes (e.g., maternal mortality, infant mortality)?
Network Adequacy	**Network Adequacy.** What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?
Social Determinants of Health, Employment and Quality of Life	**Setting of Choice.** Does KanCare improve the ability of enrollees to live independently in the community setting of their choice?

Source: KanCare Meaningful Measures Collaborative, Stakeholder Working Group, 2018-2019.

(This page intentionally left blank.)

Introduction

Purpose

The KanCare Meaningful Measures Collaborative (KMMC) was created out of a desire to better understand how KanCare, the Kansas Medicaid program, is performing. Despite having been in existence for multiple years, there has been disagreement on how KanCare is performing and a desire for more timely and accessible data. The goal of the KMMC is not to evaluate the KanCare program, but instead to establish consensus around KanCare data and metrics by bringing together KanCare consumers, stakeholders, researchers and state agency staff. The KMMC charter statements outline the following purposes for the KMMC:

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

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

Structure

Members of the KMMC participate in the Data Resources Working Group (DRWG) and the Stakeholder Working Group (SWG). The purpose of the DRWG is to provide methodologic and data analytic support for the KMMC and develop institutional knowledge assets for a sustainable infrastructure. The purpose of the SWG is to create an inclusive process that encompasses a variety of experiences, perspectives and individuals. Further, the purpose of the SWG is to identify and prioritize questions that will drive metrics to be analyzed or developed. Within the

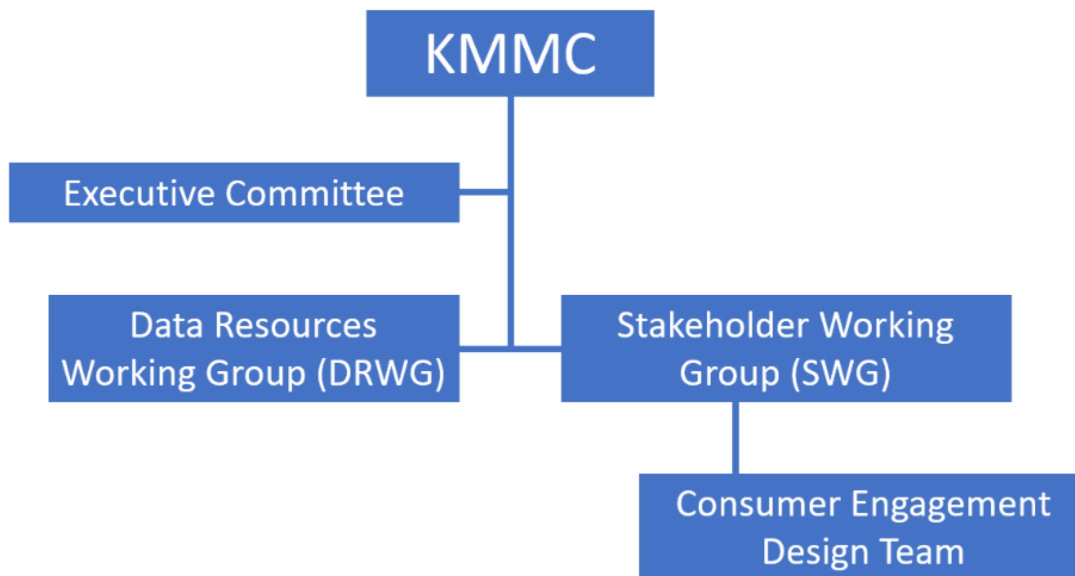
membership of the SWG, the Consumer Engagement Design Team functions to facilitate the engagement of the KMMC with a wider cross-section of KanCare consumers, beyond those who participate as members of the KMMC.

The KMMC functions under the leadership of an Executive Committee. The purposes of the Executive Committee include:

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

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

Figure 1. **Organization of the KMMC**



Source: KanCare Meaningful Measures Collaborative, 2018-2019.

Participation

The KMMC is comprised of KanCare consumers, advocacy organizations, provider associations, researchers, managed care organizations (MCOs) and state agency staff. A full list of the KMMC membership can be found in *Appendix B* (page B-1).

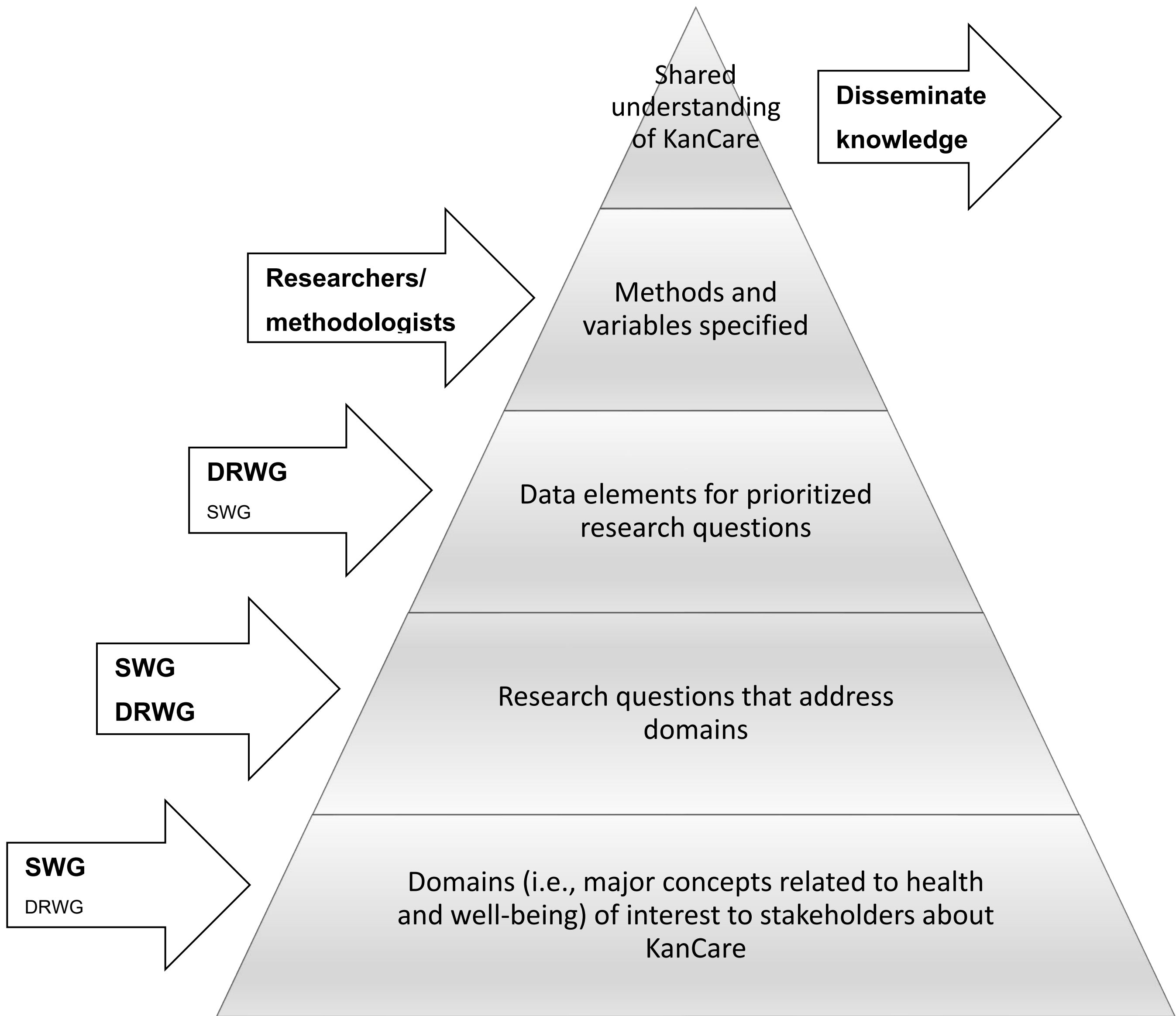
KMMC Process

The KMMC Process Pyramid (*Figure 2,* page 4) describes the collaborative process by which the KMMC plans to achieve its purpose. The base of the pyramid describes the identification of domains — the major concepts related to health and well-being — of interest to stakeholders and consumers of KanCare. After identification of these major concepts, the SWG and DRWG collaborate to refine areas of interest within these domains into researchable questions. After research questions have been drafted, measures that might help to answer these questions are identified. Researchers and those familiar with the technical aspects of these measures then assess the considerations for utilizing these measures. The top of the pyramid indicates a key intended outcome of this work — a shared understanding of KanCare. By collaboratively establishing the measures by which KanCare can be understood, the KMMC process seeks to share broadly knowledge of KanCare that is validated, trusted and credible.

Planning for the KMMC began in July 2018, when members came together to discuss the need to form the collaborative and how it would function. Planning continued through August 2018 and culminated in the adoption of a set of charter statements outlining the purpose, scope of work and structure of the KMMC (*Appendix A,* page A-1). The charter statements and plan for the KMMC were presented to the Robert G. (Bob) Bethell Joint Committee on Home and Community-Based Services and KanCare Oversight in August 2018.

Following the adoption of the charter statements, the KMMC began meeting regularly from October 2018 onward. Smaller groups, such as the Executive Committee, individual working groups and the Consumer Engagement Design Team, met as needed to complete their work. *Appendix C* (page C-1) offers a timeline of KMMC meetings through July 2019.

Figure 2. **KMMC Process Pyramid**



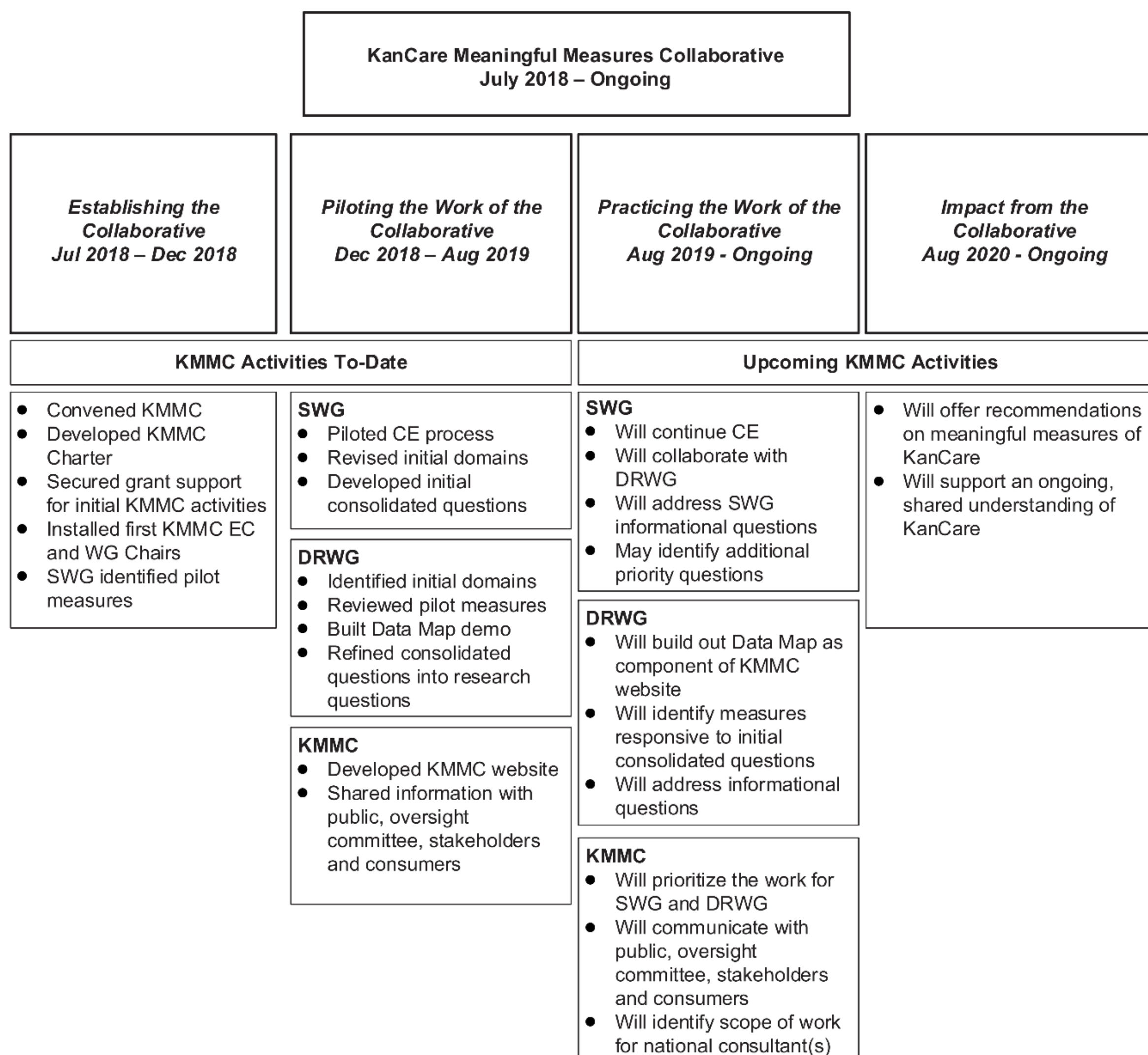
Note: DRWG is the Data Resources Working Group; SWG is the Stakeholder Working Group. The arrows to the left of the pyramid indicate parties responsible for that part of the process, with the name of dominant party bolded.

Source: KanCare Meaningful Measures Collaborative, 2018-2019.

Workplan

The KMMC outlined the following workplan tasks (*Figure 3*) as key to achieving the stated purpose of the group. This workplan outlines the upcoming work of the KMMC in the near-term and serves to highlight some of the activities completed by the group in its first year.

Figure 3. **KMMC Workplan**



Notes: EC is the Executive Committee; WG is Working Groups; SWG is the Stakeholder Working Group; CE is the Consumer Engagement process within the KMMC; DRWG is the Data Resources Working Group. “Upcoming KMMC Activities” are planned activities and might be subject to change as the work of the KMMC evolves.

Source: KanCare Meaningful Measures Collaborative, 2018-2019.

Stakeholder Working Group

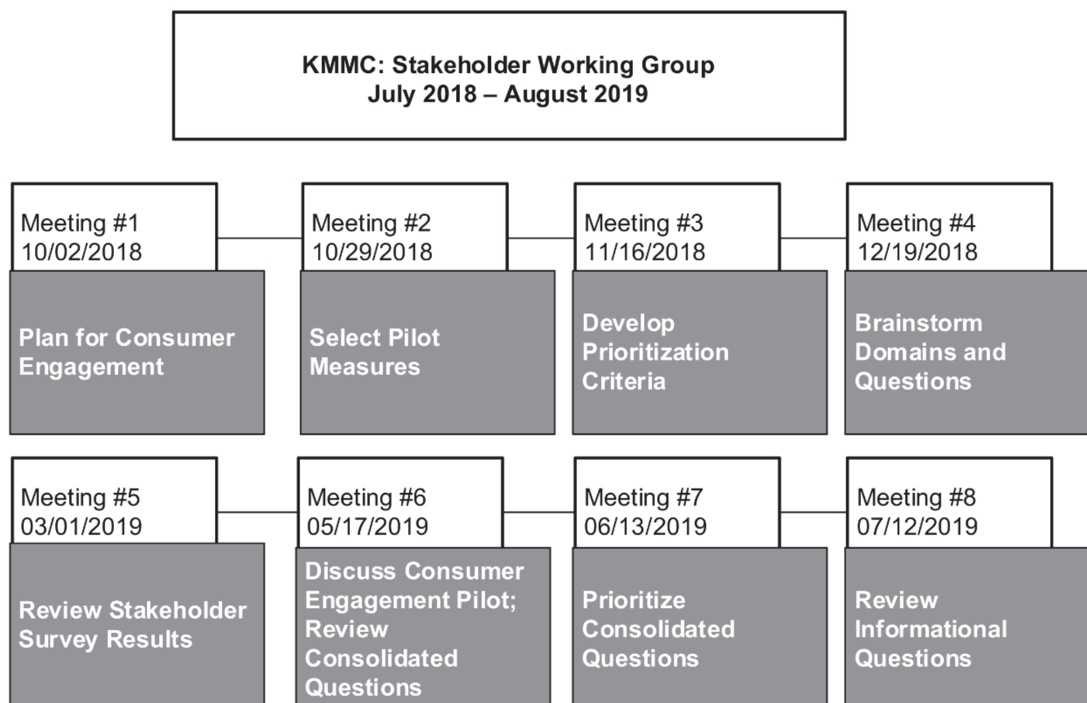
The Stakeholder Working Group (SWG) has two primary purposes:

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

The SWG engaged in multiple efforts over the last year to fulfill its stated purpose. To create an inclusive process, a subset of the SWG — the Consumer Engagement Design Team — developed and piloted an effort to engage KanCare consumers across the state. The goal of engaging consumers was to ensure that the eventual priorities put forward by the SWG also reflect the priorities of individuals receiving services from KanCare.

The SWG also has developed, refined and prioritized an initial set of "Consolidated Questions" (described in more detail on page 15) over the last year. The initial set of consolidated questions are now under review by the DRWG, who is assessing potential metrics to address the SWG priorities. See *Figure 4* for an overview of SWG efforts over the last year.

Figure 4. **Stakeholder Working Group Meeting Topics, July 2018-August 2019**



Source: KanCare Meaningful Measures Collaborative, Stakeholder Working Group, 2018-2019.

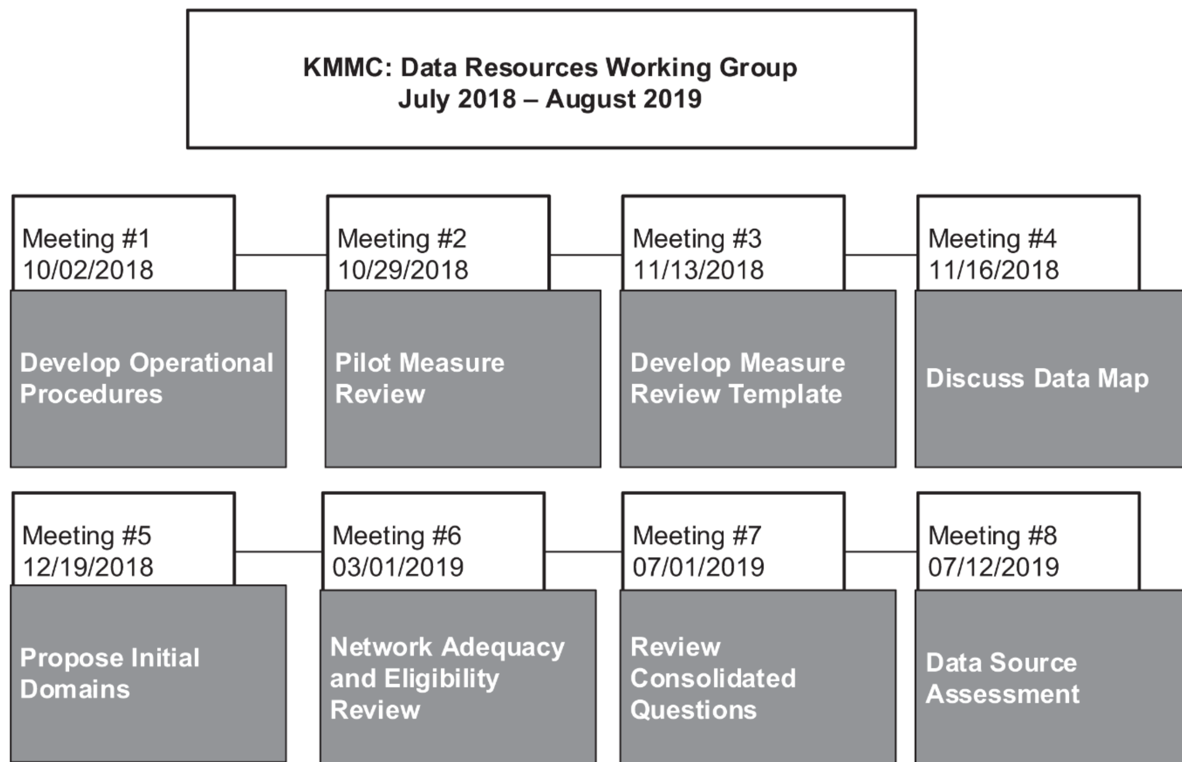
Data Resources Working Group

The Data Resources Working Group (DRWG) has two primary purposes:

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

The DRWG has met throughout the year (*Figure 5)* to develop and practice a process by which the analytical needs of the KMMC can be met.

Figure 5. **Data Resources Working Group Meeting Topics, July 2018-August 2019**



Source: KanCare Meaningful Measures Collaborative, Data Resources Working Group, 2018-2019.

Initial Priority Measures

To achieve the goal of increasing the shared understanding of KanCare, the SWG reviewed the measures presented to the Robert G. (Bob) Bethell Joint Committee on Home and Community-Based Services and KanCare Oversight (Bethell Committee) in August 2018 to identify initial priority measures the KMMC wanted to understand better or where additional clarity was needed. For example, one area of confusion highlighted by KMMC members was that not all measures presented to the Bethell Committee in August 2018 had a defined "unit" (e.g., days, claims).

From this review, the following initial priority measures were identified:

- Eligibility Determinations
    - Family Medical Applications
    - Elderly and Disabled Applications
    - Long-term Care Applications
- Network Adequacy
- Health Care Utilization
    - Home and Community-Based Services (HCBS) Utilization
    - Outpatient Emergency Room Utilization
    - Inpatient Utilization
    - Non-Emergency Medical Transportation (NEMT) Utilization

The DRWG then collaborated with the Kansas Department of Health and Environment (KDHE) to describe the technical aspects of these measures. They wanted to know:

- What data sources and methodology are used?
- Are the data sources and methodology used consistent with industry standards?
- Are benchmarks used or available for comparison?

- Are there alternative ways to present the information?
- Is it possible to stratify the existing measure by subcategories or subgroups?

While the KMMC did not make formal recommendations based on this pilot effort, more information about data and analysis that is possible increased stakeholder understanding of current KanCare measures.

Eligibility Determination

The eligibility determination information presented to the Bethell Committee is based on data from the Kansas Eligibility and Enforcement System (KEES). According to the federal regulation 42 CFR 435.912 (Timely Determination of Eligibility), the determination of Medicaid eligibility may not exceed 90 days for applicants on the basis of disability and 45 days for all other applicants. KDHE reports the number of new applications over 45 days to the Bethell Committee for three eligibility groups — family medical, elderly and disabled, and long-term care applicants.

New applications over 45 days are classified into two statuses: active and pending. Applications classified as active are applications ready to be processed, and they represent the true backlog in the eligibility determination. Applications classified as pending are applications with exceptions per federal regulation, and they often are waiting on information from applicants, providers or financial institutions.

Although states follow the same federal regulations for eligibility determination, processes vary across and within states. For example, some states utilize employees to process applications while others use a vendor. In addition to the three eligibility groups reported to the Bethell Committee, the KMMC confirmed that analysis could be conducted for subgroups based on member characteristics, such as demographics, residential location and program participation.

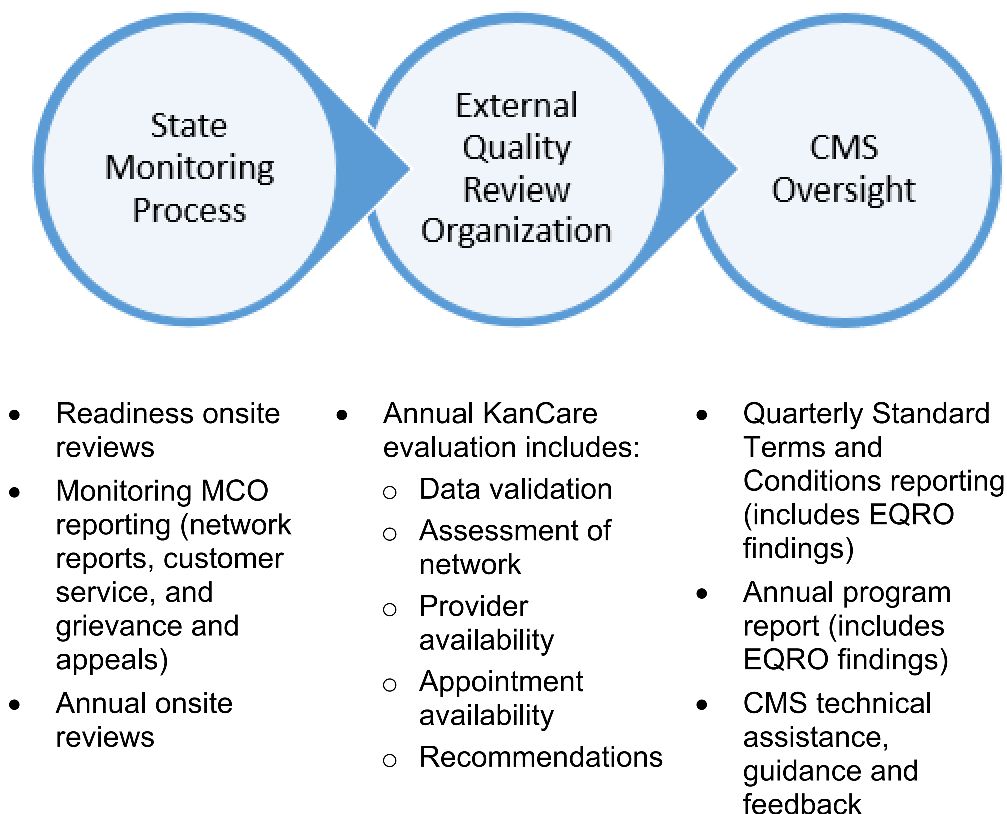
Network Adequacy

The Bethell Committee received updates on the number of unique providers participating in each KanCare managed care organization (MCO) network in the August 2018 presentation, *KanCare Executive Summary*. During its review of reported measures, SWG members asked for further information on network adequacy in KanCare.

KanCare network adequacy reporting is based on provider data submitted by MCOs. The state works with its External Quality Review Organization (EQRO) to review and summarize these data. KDHE establishes the network adequacy standards through environmental scans and the Centers for Medicare & Medicaid Services (CMS) Toolkit. The standards have been reviewed and approved by CMS. The established standards vary by provider specialty and rurality of county. More details regarding the standards and results can be found on the KanCare website at https://www.kancare.ks.gov/policies-and-reports/network-adequacy.

Network adequacy is subject to internal and external monitoring and oversight. *Figure 6* shows the network adequacy monitoring and evaluation processes used by the state, EQRO and CMS. While comparison with other states could be possible, geography varies across states and the standards established and approved by CMS could vary as well. If there is interest, the KMMC confirmed that subgroup analysis for network adequacy could be conducted by provider specialty and geographic location, as well as member demographics and program participation.

Figure 6. Network Adequacy Monitoring Overview



Source: KanCare, Personal Communication, February 28, 2019.

Health Care Utilization

The initial priority measures selected by the SWG included four categories of reported health care utilization including home and community-based services (HCBS), outpatient emergency room (ER), inpatient, and non-emergency medical transportation (NEMT). Member eligibility, enrollment and encounter data are used for analysis, which follows the algorithm established in the *KanCare Utilization Report Criteria*, available online at https://bit.ly/2Yt6UnO. Utilization category assignment (e.g., an emergency room visit) is based on eligibility, claims type, type of bill, place of service, diagnosis code, Diagnosis Related Group (DRG) code, procedure code, revenue code, provider type and provider specialty. The presentation to the Bethell Committee included high-level aggregated results reported by utilization category. *Figure 7* shows the criteria used to identify the four categories of health care utilization selected by the SWG and the units reported for each category of utilization.

Figure 7. **KanCare Utilization Report Criteria for Select Measures**

Utilization Category	Criteria	Units Reported
Home and Community-Based Services Waivers	Waiver covered procedure codes and beneficiary assigned to these waivers on the 1st date-of-service of claim detail	Unit
Outpatient Emergency Room	Claim Type = C (crossover/Medicare outpatient) or O (outpatient) and revenue code = 450-459 (ER)	Claims
Inpatient	Claim Type = A (crossover/Medicare Part A) or I (inpatient)	Days
Non-Emergency Medical Transportation	Procedure codes NEMT and place of service code other than 41 (ambulance-land) or 42 (ambulance-air or water)	Claims

Source: KanCare Utilization Report Criteria, November 15, 2018.

These health care utilization measures can be compared between health plans and to other states because the *KanCare Utilization Report Criteria* follows commonly used methodology. However, these are descriptive statistics without risk adjustment for differences across populations. The KMMC confirmed that subgroup analysis could be conducted by member demographics, residential location and program participation.

Data Map

Another task identified in the early phase of the KMMC was the development of a Data Map of KanCare. The purpose of the Data Map is to provide a reference to interested individuals as to where specific information about KanCare is available. The Data Map will increase understanding of sources of data that exist to describe KanCare. The structure of the Data Map was determined by the domains of information defined by the SWG.

Additional functionalities are being added to the Data Map, which can be accessed via www.KMMCdata.org.

Developing Questions

The initial stages of developing questions that will lead to meaningful measures are the responsibility of the SWG. In October 2018, that group identified distinct KanCare consumer populations and information they were most interested in knowing about and from those populations. *Figure 8* provides a summary of the populations and subsets the SWG initially identified, with the goal of identifying approaches for engaging consumers and soliciting information that could be used to inform the selection of measures. Several population subsets were prioritized for initial focus for consumer engagement by the SWG in November 2018, and the group recommended that the KMMC work with organizations who have existing relationships with KanCare consumers to collect input.

Figure 8. **Consumer Groups Identified for Outreach by Stakeholder Working Group, 2018**

Population	**Subsets**
Children and Youth	• Foster care youth • Children and youth with special health care needs • Children with disabilities (included those who are medically stable) • Children on a waiver • Children who primarily need social supports • Youth in transition to adult services • Adolescents • Age 0-5 group • Children with behavioral health issues • Children diagnosed with Autism Spectrum Disorder • Children with Intellectual or Developmental Disabilities (I/DD) • Emancipated youth

Figure 8 (continued). **Consumer Groups Identified for Outreach by Stakeholder Working Group, 2018**

Population	Subsets
Adults (age 19-64)	• Adults with mental illness • Adults with substance use disorder • Pregnant women • Low-income adults (including parents) • Adults approaching age 65 • Former foster care youth (now adults)
Older Adults	• Nursing home residents • Residents of other adult residential facilities • Older adults on the Frail Elderly waiver • Assisted living residents • Senior Care Act beneficiaries • Older adults on private pay/spend down • Older adults dually eligible for Medicare and Medicaid • Older adults with a client obligation • Adults age 55 and older enrolled in PACE
People with Disabilities	• Individuals who self-direct their care • Waiver members • Those on a waiting list for HCBS • Guardians • People with disabilities dually eligible for Medicare and Medicaid • "Tier 0" individuals with I/DD • People who have a spend down or client obligation • Those in the Working Healthy or WORK programs • Adults age 55 and older enrolled in PACE • People with disabilities receiving care from an aging adult

Source: KanCare Meaningful Measures Collaborative, Stakeholder Working Group, 2018.

Consumer Engagement

The SWG established a Consumer Engagement Design Team, facilitated by the Community Engagement Institute at Wichita State University, to develop the pilot and the initial set of questions for consumer engagement. The KMMC consumer engagement pilot was conducted from February to March 2019, with three members of the KMMC volunteering to engage with current KanCare consumers. The Kansas Association of Centers for Independent Living (KACIL), Poetry for Personal Power, and the Self Advocate Coalition of Kansas (SACK) each asked KanCare consumers a set of seven standard questions, which they could supplement with questions of their own. KACIL engaged 29 consumers from across the state in one-on-one telephone interviews; Poetry for Personal Power engaged 19 consumers in Kansas City, Kansas, in one-on-one in-person interactions; and SACK engaged eight consumers in Garden City in a focus group. The populations in the pilot included older adults, people with disabilities,

and adults diagnosed with mental illness. *Figure 9* includes the standard questions and key response themes that emerged in the pilot. A more detailed summary of the pilot and responses received is available at www.KMMCdata.org, among the May 17, 2019, meeting materials.

Figure 9. **Consumer Engagement Pilot: Standard Questions and Key Response Themes, 2019**

Standard Questions	Response Themes
What matters to you about the KanCare program?	• Affordability and coverage of services • Respect and consumer treatment • Living in community, independence, quality of life • Communication • Transportation
What do you wish you knew more about KanCare?	• Availability of services • Communication
What problems have you experienced with KanCare?	• Affordability and coverage of services • Respect and consumer treatment • Transportation
What benefits have you experienced with KanCare?	• Affordability and coverage of services • Living in community, independence, quality of life • Transportation
If you were running the KanCare program for a week, what's the one thing you would need to know about the program?	*Note: Question did not elicit significant feedback*
If there's one thing you would change about KanCare services, what would it be?	• Communication
What is the best way to get ideas and opinions from people who use Medicaid/KanCare? How can we get more people involved?	• Consumer engagement/feedback: Word of mouth, surveys, waiting areas, group settings, telephone, email, flyers, door-to-door, go where self-advocates are; really listen to people, show them action
Other themes	• Services mentioned throughout: Transportation, caregivers, HCBS, home health, durable medical equipment, dental, eyeglasses, rehabilitation services, nutrition, prescriptions • Disparity of services: Distance to behavioral health services; HCBS/FMS services available in a county; telehealth or phone access; regional partnerships • Outcomes: Recovery-oriented outcomes are not the same as provider-oriented outcomes

Source: KanCare Meaningful Measures Collaborative, Consumer Engagement Pilot, February-March 2019.

The themes and responses were shared with the SWG, and the Consumer Engagement Design Team collaborated to refine the questions and outreach methods for the next round of consumer engagement in the summer and fall of 2019. Some funding is available to help support organizations engage with additional Medicaid populations and geographic areas.

Framing Key Questions

In a parallel process, the SWG began to develop an initial set of questions the group wanted to understand about KanCare, beginning with brainstorming during the SWG meeting in December 2018 and continuing with an online survey in January-February 2019. The questions could relate to specific domains (e.g., Quality of Care) used by the state in its KanCare reports or could be other questions of interest related to KanCare. In all, approximately 100 questions were submitted.

The survey also asked SWG members to select the domains they would ask the DRWG to address first. However, respondents noted that it was difficult to rank the 12 domains without seeing all questions submitted. At the March 2019 KMMC meeting, breakout sessions with a mixture of SWG and DRWG members were conducted to discuss questions in three domains — Access to Care, Coordination of Care and Social Determinants of Health. A key outcome was a recommendation for the SWG to consolidate domains and reframe questions to focus on information that was most important.

In response, in April 2019, SWG leadership sorted similar consumer engagement themes and individual SWG questions into groups. For each grouping, leadership drafted "Consolidated Questions" to draw together common ideas, which were reviewed and modified by the full SWG in May 2019. The SWG settled on 19 consolidated questions (*Figure 10*, page 16) grouped into five domains: Social Determinants of Health, Employment and Quality of Life; Quality and Outcomes; Access and Coordination of Care; Eligibility Determination, Enrollee Characteristics and Enrollee Satisfaction; and Utilization and Expenditures.

At the end of May 2019, the SWG completed a survey to assess the consolidated questions against a set of seven criteria previously developed by the SWG:

- Importance to consumers
- Importance to the SWG
- Desire for more clarity
- Number of people impacted

- Level of impact on the consumer
- Fiscal impact to the state/taxpayer
- Actionability

The survey results were then reviewed by the SWG on June 13, 2019. In that meeting, the SWG used the survey results to prioritize the consolidated questions by splitting them into two tiers. While all questions were considered important by the SWG, the consolidated questions in Tier 1 (nine questions total) represent the initial priority questions for review by the DRWG.

Appendix D includes a crosswalk of the consolidated questions, underlying consumer engagement themes and individual questions for context, and related informational questions, sorted by domain.

The DRWG is in the process of reviewing the Tier 1 consolidated questions, assessing existing measures and data sources that could address them, and, if necessary, restating them in a form that meaningful measures could help answer. As part of its July 12, 2019, meeting, the DRWG divided responsibility for reviewing the Tier 1 questions among DRWG members.

Figure 10. **Consolidated Questions by Tier, as Developed by the Stakeholder Working Group**

Consolidated Questions (Tier 1)
Enrollee Treatment. Are KanCare enrollees satisfied with the way they are treated and the degree to which they understand and can make decisions about their services?
Application Processing. What are the barriers to having an application processed in a timely manner?
Quality Assurance. Are quality assurance measures in place to ensure that individuals receive the level of services they need?
Care Coordination. Are care coordination services (i.e., any services to help coordinate care; not limited to managed care organizations [MCO]-defined services) available for consumers who need them? Are care coordination services effective for those who have received them?
Social Determinants. What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health and their impact on enrollees?
No Access. What are the outcomes associated with individuals who cannot access care?
Pregnancy Outcomes. How does KanCare impact pregnancy outcomes (e.g., maternal mortality, infant mortality)?
Network Adequacy. What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?
Setting of Choice. Does KanCare improve the ability of enrollees to live independently in the community setting of their choice?

Figure 10 (continued). **Consolidated Questions by Tier, as Developed by the Stakeholder Working Group**

Consolidated Questions (Tier 2)
Quality of Care. What quality of care measures currently are available?
Wait Lists. What impact on outcomes are associated with wait lists and high vacancy rates?
Disparities. Does KanCare reduce disparities related to health outcomes?
Service Location. Where are KanCare services provided, and to which consumers?
Total Cost of Care. Does the total cost of care for members vary based on location of service and how the services are accessed?
High-Cost Drivers. For high-cost drivers, is KanCare making a difference?
Levels of Care. Have levels of care for individuals in nursing facilities changed pre KanCare compared to post KanCare?
Funding Distribution. How are funding/costs associated with KanCare distributed?
Employment. What impact does KanCare have on employment?
Utilization. How is utilization measured, and how can it be stratified?

Source: KanCare Meaningful Measures Collaborative, Stakeholder Working Group, June 2019.

From the original list of individual questions, 32 informational questions have been extracted. The informational questions are focused on KanCare processes or understanding current services and are not focused on measurement. Examples of informational questions include, “What services are available that facilitate employment opportunities for adults with significant disabilities?” and “How does KanCare select performance measures related to quality of care?” The informational questions also are included in *Appendix D*, sorted by domain.

Next Steps for Impact

The KMMC is moving into the “practicing” phase of the collaborative. This will include additional work on behalf of the DRWG to refine the initial priority consolidated questions posed by the SWG and define metrics — existing or new — that can address the SWG priorities. Consumer engagement will be expanded to additional consumers across the state and additional priorities also might be identified by the SWG. All of which will contribute to the identification of meaningful measures for the KanCare program, and the ultimate goal of a shared understanding of KanCare.

(This page intentionally left blank.)

Appendix A: Charter Statements

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

Purpose:

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

Scope of Work:

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

Membership:

Composed of the collective membership of:

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

Operating Process:

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

KMMC Executive Committee

Purpose:

- Approve the metrics to be developed through the Collaborative, based on the recommendations forwarded by the Stakeholder Working Group (SWG)
- Approve the data sources and methodology used to report those metrics based on the recommendations of the Data Resources Working Group (DRWG)
- Document for public reporting the process employed to identify and measure selected metrics

Scope of Work:

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

Membership:

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

Operating Process:

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

KMMC Data Resources Working Group (DRWG)

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

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

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

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

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

KMMC Stakeholder Working Group (SWG)

Purpose:

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

Scope of Work:

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

Membership:

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

Operating Process:

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

Appendix B: KMMC Membership

Table B-1. **KMMC Membership List**

Name	Organization	SWG	DRWG	EC
Scott Brunner	Aetna Better Health of Kansas	X		
Keith Wisdom	Aetna Better Health of Kansas			
Susan Yeager-Chowning	Aetna Better Health of Kansas		X	
Kyle Kessler	Association of Community Mental Health Centers of Kansas		X	X
Sue Murnane	Association of Community Mental Health Centers of Kansas	X		
Stuart Little	Behavioral Health Association of Kansas	X		
Annette Graham	Central Plains Area Agency on Aging	X		X
Denise Cyzman	Community Care Network of Kansas	X		X
Terri Kennedy	Community Care Network of Kansas		X	
Jamie Price	Community Living Opportunities	X		
Timothy Crain	Consumer	X		
Kendra Sambrana	Consumer	X		
Mike Burgess	Disability Rights Center of Kansas		X	
Rocky Nichols	Disability Rights Center of Kansas	X		
Nick Wood	Interhab		X	
Sean Gatewood	KanCare Advocates Network	X		X
Kerrie Bacon	KanCare Ombudsman			
Emily Fetsch	Kansas Action for Children			
Tate Mullen	Kansas Action for Children			
John Wilson	Kansas Action for Children			
Barb Conant	Kansas Advocates for Better Care		X	
Mitzi McFatrich	Kansas Advocates for Better Care	X		
Audrey Schremmer	Kansas Association of Centers for Independent Living; Three Rivers Inc	X		
Steve Gieber	Kansas Council on Developmental Disabilities		X	
Craig Knutson	Kansas Council on Developmental Disabilities	X		
Jeff Schroeder	Kansas Council on Developmental Disabilities			
Kevin Robertson	Kansas Dental Association	X		
Janis DeBoer	Kansas Department for Aging and Disability Services			
Caitlin Fay	Kansas Department for Aging and Disability Services		X	
Amy Penrod	Kansas Department for Aging and Disability Services			
Brad Ridley	Kansas Department for Aging and Disability Services			
Melissa Warfield	Kansas Department for Aging and Disability Services		X	X
Liz Long	Kansas Department of Health and Environment		X	
Kolloh Nimley	Kansas Department of Health and Environment		X	

Table B-1 (continued). **KMMC Membership List**

Name	Organization	SWG	DRWG	EC
Adam Proffitt	Kansas Department of Health and Environment		X	X
Sarah Good	Kansas Foundation for Medical Care, Inc.		X	X
John McNamee	Kansas Foundation for Medical Care, Inc.		X	
Lynne Valdivia	Kansas Foundation for Medical Care, Inc.	X		
Cindy Luxem	Kansas Health Care Association	X		
Kari Bruffett	Kansas Health Institute	X		
Carlie Houchen	Kansas Health Institute		X	
Wen-Chieh Lin	Kansas Health Institute		X	
Sydney McClendon	Kansas Health Institute	X		
Robert St. Peter	Kansas Health Institute		X	
Jane Kelly	Kansas Home Care and Hospice Association	X		
Chad Austin	Kansas Hospital Association	X		
Audrey Dunkel	Kansas Hospital Association		X	
Tish Hollingsworth	Kansas Hospital Association			X
Jon Rosell	Kansas Medical Society	X		X
Amy Campbell	Kansas Mental Health Coalition	X		
Aaron Dunkel	Kansas Pharmacists Association		X	X
Amanda Gaulke	Kansas State University			
Ross Milton	Kansas State University			
Ben Schwab	Kansas State University		X	
Steve Kearney	Kearney and Associates			
Rachel Monger	LeadingAge Kansas	X		
Debra Zehr	LeadingAge Kansas			
Laura Boswell	Minds Matter, LLC		X	
Janet Williams	Minds Matter, LLC	X		
Tanya Dorf Brunner	Oral Health Kansas	X		
Kathy Keck	Parent	X		X
Julianna Sellers	Poetry for Personal Power			
Corinna West	Poetry for Personal Power	X		
Les Sperling	Recovery PRN LLC			
Rachel Marsh	Saint Francis Ministries	X		
Vickie McArthur	Saint Francis Ministries			
Kelly Smith	Self Advocate Coalition of Kansas			
Jason Barrett	Self Advocate Coalition of Kansas	X		X
Stephanie Sanford	Self Advocate Coalition of Kansas			
Mark Hinde	Southwest Developmental Services	X		
Kim Anderson	Sunflower Health Plan			
Jim Gardner	Sunflower Health Plan			
Susan Hood	Sunflower Health Plan		X	
Trisa Hosford	Sunflower Health Plan			
Stephanie Rasmussen	Sunflower Health Plan			
Cris Speaks	Sunflower Health Plan			
Michael Stephens	Sunflower Health Plan			
Mike Oxford	Topeka Independent Living Resource Center	X	X	

Table B-1 (continued). **KMMC Membership List**

Name	Organization	SWG	DRWG	EC
Chris Gard	United Healthcare			
Audrey Masoner	United Healthcare			
Anna Purcell	United Healthcare	X	X	
Kevin Sparks	United Healthcare			
Jeff Stafford	United Healthcare			X
David Slusky	University of Kansas, Department of Economics			
Jean Hall	University of Kansas, Institute for Health and Disability Policy Studies		X	X
Martha Hodgesmith	University of Kansas, Institute for Health and Disability Policy Studies	X		
Noelle Kurth	University of Kansas, Institute for Health and Disability Policy Studies		X	
Carrie Wendel-Hummell	University of Kansas, School of Social Welfare		X	
Edward Ellerbeck	University of Kansas Medical Center, Department of Population Health		X	
Tami Gurley-Calvez	University of Kansas Medical Center, Department of Population Health		X	
Monte Coffman	Windsor Place			
Tara Gregory	Wichita State University, Community Engagement Institute			
Scott Wituk	Wichita State University, Community Engagement Institute	X		

Note: SWG is the Stakeholder Working Group; DRWG is the Data Resources Working Group; EC is Executive Committee.

Table B-2. **KMMC Leadership**

Executive Committee	Data Resources Working Group (DRWG)	Stakeholder Working Group (SWG)
Aaron Dunkel (Chair)	Adam Proffitt (Co-Chair)	Audrey Schremmer (Chair)
Adam Proffitt (Interim Vice Chair)	Melissa Warfield (Co-Chair)	Denise Cyzman (Vice Chair)

(This page intentionally left blank.)

Appendix C: KMMC Meetings Timeline

Date	Meeting(s)
July 2018	• KMMC Planning (7/3) • KMMC Planning (7/20)
August 2018	• KMMC Planning (8/3) • KMMC Planning (8/13) • Bethell Presentation (8/20)
October 2018	• KMMC (10/2) • KMMC (10/29)
November 2018	• DRWG (11/13) • KMMC (11/16)
December 2018	• Consumer Engagement Design Team (12/14 & 12/18) • KMMC (12/19) • Executive Committee (12/19)
January 2019	• Consumer Engagement Design Team (1/14)
February 2019	• Bethell Presentation (2/15) • Executive Committee (2/19)
March 2019	• KMMC (3/1)
April 2019	• Consumer Engagement Design Team (4/25)
May 2019	• Executive Committee (5/2) • KMMC (5/17)
June 2019	• SWG (6/13) • Consumer Engagement Design Team (6/14) • Executive Committee (6/26)
July 2019	• DRWG (7/1) • KMMC (7/12) • Executive Committee (7/18)

(This page intentionally left blank.)

Appendix D: Consolidated Questions Crosswalk

Table D-1. **Domain: Social Determinants of Health, Employment and Quality of Life**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
77. What are (competitive, integrated) employment levels of Kansans with disabilities pre and post KanCare? Are people aware of employment supports available to them? Are providers reimbursed at a rate that supports services that promote competitive, integrated employment?	1. **Employment.** What impact does KanCare have on employment?	No Change.
78. Would we also want to know how many individuals on Medicaid are employed or going to training/school — to answer the question or debunk the myth presented by several legislators?		
80. How many folks are employed already in Kansas receiving the benefits?		
67. Are people achieving their vision of a "good life" under KanCare?	2. **Setting of Choice.** Does KanCare improve the ability of enrollees to live independently in the community setting of their choice? 3. **Quality Assurance.** Are quality assurance measures in place to ensure that individuals receive the level of services they need?	No Change.
68. Quality of life measures should assess the delay of complications from life either through conditions, disorders, disease or aging. I do not know enough about the data set to propose a specific question.		
51. Are people with more significant disabilities more likely to remain in nursing homes vs. in the community? Has this changed from pre KanCare trends?		
33. What are the health care conditions that are impacted by personal care assistance; i.e., capability to self-administer drugs.		
10. How does the number of individuals self-directing their care compare to pre KanCare?		
5. For individuals deemed eligible for HCBS in home supports, what is the number of approved plans of care with 20 or fewer hours per week attendant care services?		
88. Does KanCare/HCBS support community involvement and social supports?		
Consumer Engagement Theme: Living in Community, Independence, Quality of Life		

Table D-1 (continued). **Domain: Social Determinants of Health, Employment and Quality of Life**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
89. How do social determinants of health (SDOH; such as income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviors, access to health services, biology and genetic endowment, gender and culture) impact health outcomes/treatment/enrollment/etc.?	4. **Social Determinants.** What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health and their impact on enrollees?	No Change.
90. Do enrollees have access to safe housing? Do enrollees need help finding work (combine social determinants with employment domain)? Do enrollees have access to a network of caring friends or family? If not, what would help?		
91c. Are there differences in rates/frequencies for various SDOH by region of the state, rural/urban, etc.		
92b. Are there regional differences in SDOH data and how is this being communicated?		
93. How available is transportation in your community to social activities, church, etc.? (In other words, not medical appointments.) How available is safe and affordable housing?		
94. What housing data are available to compare to the chronic conditions metrics? (What is the relationship between housing status and chronic conditions?)		
95. Financial hardships around older Americans who need services.		
Consumer Engagement Theme: Transportation		

Informational Questions for Social Determinants of Health, Employment and Quality of Life:

66. What services are available in KanCare to help enrollees avoid institutionalization or loss of independence? Do MCOs have financial incentives to limit enrollee’s ability to stay in a home environment?

74. What services are available that facilitate employment opportunities for youth?

75. What services are available that facilitate employment opportunities for adults with significant disabilities?

76. What services are available to facilitate employment opportunities for adults?

76b. What additional services would help enrollees find employment?

91. What data are being collected for SDOH?

91b. How do providers use the data to support provision of health care? What about the health plans? KanCare — at the state agency level?

92. What data are being collected as SDOH and how are the data being used to support patients in their care?

Table D-2. **Domain: Quality and Outcomes**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
54. How does quality of care differ from rural to urban?	5. **Quality of Care.** What quality of care measures currently are available?	No Change.
86. How are key chronic health conditions compared and contrasted between different disabilities?	6. **Disparities.** Does KanCare reduce disparities related to health outcomes?	No Change.
87. How are key chronic health conditions compared across rural and urban?		
Consumer Engagement Theme: Outcomes (recovery-oriented outcomes and provider-oriented outcomes are not the same)		
81. What is the frequency of low-weight births?	7. **Pregnancy Outcomes.** How does KanCare impact pregnancy outcomes (e.g., maternal mortality, infant mortality)?	No Change.
82. How does the frequency of low-weight births relate to when eligible mothers began receiving health care?		
83. What are the outcomes associated with low-weight births?		
84. What are the inputs associated with low-weight births? How does racism relate to low-weight births/preterm births/infant mortality?		
85. How many babies are born with neonatal abstinence syndrome?		
85b. It would be good to have maternal mortality information, as well.		
85c. Overall mortality and premature death — all ages is good to know; how does this compare to the general population?		
N/A	N/A	8. **No Access.** What are the outcomes associated with individuals who cannot access care?

Informational Questions for Quality and Outcomes:

52. What Healthcare Effectiveness Data and Information Set (HEDIS) or other quality metrics are tracked by the KanCare program? What portion of provider or MCO profit is void if those entities fail to meet quality standards? What accreditation or credentialing is done for the KanCare program? How does this compare to other state Medicaid programs?

53. There are so many more questions related to quality of care, it is hard to know where to start. I would be interested in knowing how KanCare selects their performance measures related to quality of care — are we truly measuring what is most important?

55. What are the quality of care definitions?

Table D-3. **Domain: Access and Coordination of Care**

<table>
<tr><th>SWG Questions from Surveys (03/01/2019 and 06/13/2019)</th><th>Draft Consolidated Questions (04/12/2019)</th><th>SWG Approval/ Modifications (05/17/2019)</th></tr>
<tr><td>35. Perhaps a question around the high user patients...is it because of their health condition, social determinants, lack of primary care, lack of transportation, lack of effective case management? (What factors are related to high utilizers?)</td><td rowspan="4">9. High-Cost Drivers. For high-cost drivers, is KanCare making a difference?</td><td rowspan="4">No Change.</td></tr>
<tr><td>27. Definitely feel we should always look at whether access to emergency care is decreasing as consumers have improved access to primary care providers.</td></tr>
<tr><td>60. How many and for what reasons are people re-admitted to the hospital for the same health event?</td></tr>
<tr><td>60b. How long does it take for an individual on Medicaid to be seen by their primary care provider post discharge from hospital, emergency department (ED), specialty care, physical therapy (PT), etc.</td></tr>
<tr><td>41. How do beneficiaries manage if they are not receiving services? (waiting lists)</td><td rowspan="3">10. Wait Lists. What impact on outcomes are associated with wait lists and high vacancy rates?</td><td rowspan="3">No Change.</td></tr>
<tr><td>49. What is the vacancy rate on plans of care; for example, 60 hours of services approved each week but only 30 covered? Factors for the vacancy</td></tr>
<tr><td>Consumer Engagement Theme: Availability of Services</td></tr>
</table>

Table D-3 (continued). **Domain: Access and Coordination of Care**

SWG Questions from Surveys (03/01/2019 and 06/13/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
37b. How does reported network adequacy relate to individuals' experiences accessing care?		
38. What is the percentage of individuals in different counties on home and community-based services (HCBS) waivers over time?		
43. What percentage of individuals receiving HCBS report access to adequate health and dental services?		
45. Equity of care. (Does access to/quality of care vary by demographic?)		
46. How does access to care in Kansas compare to other state Medicaid plans? How do the reimbursements in Kansas compare to other state Medicaid plans?		
47. What is the true network adequacy for providers serving KanCare? For example, how many dentists do we truly have that provide dental services to individuals on KanCare? What is the available panel spots for patients seeking care — do they really have choice? Do we have sufficient level of Behavioral Health Consultants to meet the full need — and if not, why are plans not willing to credential new providers because their "networks are full?"	11. **Network Adequacy.** What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?	No Change.
48. Do patients have access to the care/services they need within the area as required by network adequacy? The number of available panel spots for patients seeking care.		
48b. Do all patients have a choice of providers? Do MCO limits on credentialing providers (behavioral health) limit access to care?		
Consumer Engagement Theme: Availability of Services		
Consumer Engagement Theme: Disparity of Services		

Table D-3 (continued). **Domain: Access and Coordination of Care**

<table>
<tr><th>SWG Questions from Surveys (03/01/2019 and 06/13/2019)</th><th>Draft Consolidated Questions (04/12/2019)</th><th>SWG Approval/ Modifications (05/17/2019)</th></tr>
<tr><td>40. Have levels of care for individuals in nursing facilities changed pre KanCare compared to post KanCare?</td><td>N/A.</td><td>12. Levels of Care. Have levels of care for individuals in nursing facilities changed pre KanCare compared to post KanCare?</td></tr>
<tr><td>22. Are there common characteristics associated with children/youth entering psychiatric treatment residential facilities (PRTF)? Who's being screened out from entering PRTFs?</td><td rowspan="6">13. Care Coordination. Are care coordination services available for consumers who need this service? Are care coordination services available based on individuals' level of need?</td><td rowspan="6">13. Care Coordination. Are care coordination services (i.e., any services to help coordinate care; not limited to managed care organizations [MCO]-defined services) available for consumers who need them? Are care coordination services effective for those who have received them?</td></tr>
<tr><td>56. Who is helping children/youth with behavioral health conditions receive services, such as getting into psychiatric residential treatment facilities (PRTF)?</td></tr>
<tr><td>59. I think there are a lot of questions surrounding coordination of care, especially with regard to long-term services and supports (re: I/DD waiver). Is coordination of care best implemented on an MCO level or on a local level via a targeted case manager like in the I/DD waiver?</td></tr>
<tr><td>61. Who is ensuring follow-up visits when transitioning between types of care (for example; inpatient, specialty care or post-partum)?</td></tr>
<tr><td>64. It might be important to determine how many of the youth with behavioral health conditions are in state custody (Department for Children and Families/Corrections) and who helps coordinate THOSE services vs. youth with behavioral health conditions NOT in custody, etc.</td></tr>
<tr><td>39. How do results provided in the Mental Health Survey correlate to services provided?</td></tr>
</table>

Informational Questions for Access and Coordination of Care:

37. How is network adequacy reported?

50. I have shared some comments with KHI staff regarding information that is put into the UB-04 claim that might be helpful in identifying a number of issues, including access to care. The source of admission (did the patient walk in, were they brought in by ambulance, etc.) and the discharge disposition (did the patient go home, were they transferred to another facility, did they go to a nursing home, did they go to a psychiatric facility, etc.) might be used to help identify access issues. However....I don't know if the source of admission or the discharge disposition is a field that is included in the encounter data that the MCOs report to KDHE.

57. Who is assisting individuals with significant disabilities and/or seniors on HCBS to complete Medicaid annual reassessments?

58. What KanCare populations receive coordination of care services? Who makes that determination? Do MCOs limit member access to waiver programs?

6. Do MCOs do anything to limit KanCare eligibility? How does the Kansas eligibility determination process compare with other state Medicaid plans?

62. How are cases coordinated for children and adults with multiple physical and mental health conditions?

63. What is the "help" that is being provided regarding PRTF admission and continuing service therein?

65. Who helps an elder if they want to leave an institution?

6/13. Who holds MCOs accountable for network inadequacy?

6/13. Participation in certain KanCare services; particularly the HCBS Frail Elderly and Brain Injury Waivers, has dropped significantly from pre KanCare numbers. What systems are in place to ensure access to these services hasn't been adversely affected by KanCare processes, eligibility evaluations, rules etc.

Table D-4. **Domain: Eligibility Determination, Enrollee Characteristics and Enrollee Satisfaction**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
44. Cultural knowledge of medical providers.	14. **Enrollee Treatment.** Are KanCare enrollees satisfied with the way they are treated and the degree to which they understand and can make decisions about their services?	No Change.
69. Are enrollees treated with respect by providers and MCOs?		
70. Do enrollees feel safe when receiving care?		
71. Do enrollees feel that providers and MCOs are available to answer their questions?		
9. How aware of their benefits are KanCare enrollees?		
17. How many youths transitioning into adulthood reapply for services once they reach adulthood?		
6/13: How easy is it to access and understand KanCare Services?		
6/13: Are people getting informed about community-based supports like peer support that are alternatives to the mainstream model?		
6/13: Are people getting informed consent? (i.e., do people know that many medical treatments do more harm than good?)		
Consumer Engagement Theme: Living in Community, Independence, & Quality of Life		
Consumer Engagement Theme: Respect/Consumer Treatment		
Consumer Engagement Theme: Communication		
2. If the application is taking more than 45 days, what are the reason(s) for the delays.	15. **Application Processing.** What are the barriers to having an application processed in a timely manner?	No Change.
3. What are the barriers to completing application review within the allowed time frame?		
4. What are the patient characteristics for those that take longer than 45 days? For example, are there more patients in a certain geographic area, indicating a need for eligibility outreach? Is there a higher volume of patients with applications for patients for certain waivers, etc.		
8. How many are processed with no changes from year to year, especially those in long-term care services?		
57b. How many individuals receiving HCBS fail to complete reassessments in a timely manner?		

Informational Questions for Eligibility Determination, Enrollee Characteristics, Enrollee Satisfaction:

1. KDHE regularly reports "applications/reviews that take longer than 45 days" to the Legislature. What data is included when this is reported?

6. Do MCOs do anything to limit KanCare eligibility? How does the Kansas eligibility determination process compare with other state Medicaid plans?

7. How does the data rank the factors that impact the eligibility determination?

11. Demographics (race/ethnicity, income, etc.)

12. How do enrollees break down by county or state legislative district? What are ages, genders, languages spoken and types of members in various areas of the state? What are the various personas of the enrollees? (e.g., child, mom, elderly)

13. What are the characteristics of the persons enrolled in KanCare, including age, race, gender, education, employment, income, etc.

14. What are the characteristics of the persons enrolled in KanCare in addition to income? Age, race, gender, education, employment and at what capacity are they employed (and so on).

15. Rank the common characteristics by age, geographic area and diagnosis.

16. How many enrollees are from other ethnic origins?

69. How is enrollee satisfaction currently measured? Is there independent data collection of consumer satisfaction of MCO services?

70. When a consumer has a complaint, is there an independent source of support to assist with filing a complaint?

Table D-5. **Domain: Utilization and Expenditures**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
29. Not sure how to phrase it, but there should be some type of breakdown of health care expenditures vs. waiver expenditures. For example, on the I/DD waiver there is roughly a $140M difference between capitated payments to MCOs and payments to HCBS service providers. How much of this goes to health care expenditures, and what are those expenditures?	16. **Utilization.** How is utilization measured, and how can it be stratified?	No Change.
31. Total cost of care as it relates to the lines of business offered by the MCOs and the varied service providers. Geographic data related to the expenditures to determine the ancillary costs of patients being required to travel for care.		
32. Break down of the dollars spent on various health care expenditures.		
19. Can utilization be stratified for different groups?		
23. How are services consumed and in what proportion by different types of KanCare members?	17. **Service Location.** Where are KanCare services provided, and to which consumers?	No Change.
26. Where are services provided in KanCare (e.g., schools)?		
21. What is the current utilization of Early and Periodic Screening, Diagnostic and Treatment (EPSDT; e.g., characteristics of individuals receiving services, types of services)?		
20. Prior to the upcoming expansion of telehealth services, what is the current utilization of telehealth services, and who's accessing them?		
25. Geographic location of all telehealth use.		
24. What is the current utilization of screening, brief intervention, and referral to treatment (SBIRT) as well as the additional characteristics?		
42. SBIRT: look at adequacy of network related to utilization — are people able to receive services, including specialty services — close to home?		
Consumer Engagement Theme: Affordability/Coverage of Services		
Consumer Engagement Theme: Availability of Services		
Consumer Engagement: Communication		

Table D-5 (continued). **Domain: Utilization and Expenditures**

SWG Questions from Survey (03/01/2019)	Draft Consolidated Questions (04/12/2019)	SWG Approval/ Modifications (05/17/2019)
28. What opportunities exist for KanCare to share costs with other programs (e.g., dual special need plans with Medicare)?	18. **Funding Distribution.** How are funding/costs associated with KanCare distributed?	No Change.
36. Health care related program in Kansas: Determining what funding Kansas receives and who administers it.		
Consumer Engagement Theme: Affordability/Coverage of Services		
30. Compare total cost of care — as well as specific costs of care (inpatient, outpatient, lab, etc.) — for individuals receiving primary through community health centers (FQHC) as compared to care from traditional primary care providers. This type of analysis could be used in other ways, depending on what is helpful to know. For example, total cost of care, and cost of care for the various service lines analyzed by MCO, by rural/urban, etc. If members are unable to receive services close to home (e.g., specialty services), what does this do to total cost of care?	19. **Total Cost of Care.** Does the total cost of care for members vary based on location of service and how the services are accessed?	No Change.
31b. Geographic data related to the expenditures to determine the ancillary costs of patients being required to travel for care.		

Informational Questions for Utilization and Expenditures:

18. How is utilization measured and calculated (particularly inpatient utilization)?

34. How are health care expenditures defined?

(This page intentionally left blank.)