Recommendations on Meaningful Measures of KanCare

From the KanCare Meaningful Measures Collaborative (KMMC)

April 2020

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Recommendation Summary

The Charter Statement of the KanCare Meaningful Measure Collaborative (KMMC) states that the purpose of the KMMC is to increase visibility, credibility, awareness and usefulness of information available about KanCare. The Data Resources Working Group (DRWG), as part of the KMMC, was tasked by the Charter with collaborating with the Stakeholder Working Group (SWG) to assess the data sources and methodology used to create new and existing meaningful measures and to recommend approaches to address limitations and gaps in existing data. This report includes a list of new and existing measures that have been identified as meaningful, as well as recommendations to address limitations in existing data, for the first four priority topics identified through the process described below. See *Figure 1* (page 2) for a summary of the recommendations by topic.

The SWG was responsible for identifying priority questions about KanCare while also engaging with KanCare members to inform priorities. Following the identification of priority questions, the DRWG conducted an initial scan of available measures. The SWG and DRWG collaborated to ensure stakeholder interest and measures aligned. Then, the KMMC Executive Committee directed the DRWG to work on three initial priorities: care coordination; pregnancy outcomes; and network adequacy. DRWG task groups formed to address each of these topics. Working documents from the task groups are available online here. Later, an additional task group formed due to high interest in a possible data source related to social determinants of health.

This document summarizes the work of the task groups in each of the priority topics. Each task group reviewed questions from the SWG, developed research questions, assessed the available data sources and corresponding technical information (e.g., methods, benchmarks, resources and limitations). Recommendations were developed regarding existing meaningful measures, new meaningful measures, and other topics (e.g., data limitations).

***Existing Meaningful Measures*:** These meaningful measures already exist across public KanCare reports. A summary report can be developed to gather these measures for each priority topic in one place and disseminate to the public.

New Meaningful Measures: These measures are not currently available in public KanCare reports and can be classified into three groups (bulleted below).

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

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

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

This document is arranged by the priority topics: network adequacy, care coordination, pregnancy outcomes and social determinants of health.

Figure 1. **Summary of KMMC Recommendations by Topic**

KMMC Topic & Stakeholder Questions	KMMC Recommendations
Network Adequacy. What is the network adequacy in KanCare, relative to a benchmark (e.g., contract standard)? If network adequacy is below the benchmark, why?	• *Existing Meaningful Measures:* Eleven existing measures that describe the KanCare network adequacy contract standards and member experiences were identified as meaningful. • *New Meaningful Measures:* New meaningful measures that assess adequate provider-to-enrollee ratios could be developed. • *Other Recommendations:* Sharing technical documentation, describing the network adequacy monitoring process and clarifying informational questions were also recommended. Detailed network adequacy recommendations on pg 5.
Care Coordination. Are care coordination services (i.e., any services to help coordinate care; not limited to MCO-defined services) available for consumers who need it? Are care coordination services effective for those who have received them?	• *Existing Meaningful Measures:* Sixteen existing measures for general care coordination and members receiving HCBS services were identified as meaningful. • *New Meaningful Measures:* Measures that will become available using new HCBS CAHPS data were identified as meaningful. • *Other Recommendations:* Recommendations on survey administration and representativeness were also developed. Detailed care coordination recommendations on pg 8.
Pregnancy Outcomes. How does KanCare impact pregnancy outcomes?	• *Existing Meaningful Measures:* Two existing process measures were identified as meaningful. • *New Meaningful Measures:* Six new outcomes measures (e.g., maternal mortality) that could be generated with claims data were identified as meaningful. • *Other Recommendations:* Recommendations pertaining to trend and subgroup analyses were also developed. Detailed pregnancy outcomes recommendations on pg 12.
Social Determinants of Health. What KanCare social determinants data do we have? What do the KanCare data tell us about the social determinants of health, and their impact on enrollees?	• *Existing Meaningful Measures:* None were identified. • *New Meaningful Measures:* New measures that capture information about the social determinants of health (SDOH) should be developed. One option to collect SDOH data would be via the currently used Health Screening Tool (HST), with modifications. • *Other Recommendations:* Recommendations focused on consistent collection of SDOH information by managed care organizations (MCO) across KanCare member groups, and incentives to encourage member responses. Detailed SDOH recommendations on pg 14.

Network Adequacy Recommendations

Stakeholder Questions:

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

Research Questions:

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

The KMMC recommends that meaningful measures in *Figure 2* (page 6) be considered for understanding the adequacy of the KanCare provider network. These measures consider the extent to which current contract standards are being met and how members have experienced when they need care. Most of these meaningful measures for Network Adequacy are available in public KanCare reports, including KanCare Network Adequacy Reporting and the KanCare Evaluation Annual Report. To better inform stakeholders regarding network adequacy, recommendations also include making technical documents available, describing the derivation of measures as part of these public reports, presenting the monitoring process and data, and clarifying informational questions. Specifically, the recommendations are:

Network Adequacy 1: Develop a summary report on network adequacy meaningful measures (*Figure 2*) in relation to contract standards as well as measures that capture the experience of KanCare members accessing care.

a. KanCare network adequacy standards: percent of members covered within the standards by provider type, geography and MCO.
b. Member experience: timely access to care as well as receiving services according to the service plan.

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

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

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

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

Network Adequacy 4: Provide information on the following questions.

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

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

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

Figure 2. **Meaningful Measures Related to Network Adequacy**

Meaningful Measures	**Data Source**	**Currently Reported?**
KanCare Network Adequacy Standards		
Percent of members covered within network adequacy standards by provider type, MCO and geography.	KanCare Network Adequacy Reporting	MCO Network Access May 2019
Number of counties with no provider access by provider type, geography and MCO.	KanCare Network Adequacy Reporting	KanCare Evaluation Annual Report 12.31.18 (Provider Network – GeoAccess, page 155-175 of PDF, Tables 36-37)
Number and percent of members not within access distance by provider type and MCO.	KanCare Network Adequacy Reporting	
Sufficient number of providers by provider type, MCO and geography to provide adequate coverage within defined time and distance standards.	*N/A*	*No*
Member Experience		
[Urgent/emergent care] In the last 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?	CAHPS	KanCare Evaluation Annual Report (page 175 of PDF, Table 42)
[Primary/preventive care] In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's	CAHPS	

office or clinic (how often did you get an appointment) as soon as you (your child) needed?		
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	CAHPS	
Children and Adolescents' Access to Primary Care Practitioners (for age 12-24 months; 25 months to 6 years; 7-11 years; and 12-19 years)	*HEDIS Measure*	*TBD*
Performance Measure 8 – Number and percent of waiver participants who received services in the type, scope, amount, duration and frequency specified in the service plan.	KDADS HCBS Quality Review Report	KanCare Quarterly Report to CMS (page 61 of PDF)
I was able to get all the services I thought I needed.	Mental Health Survey	KanCare Evaluation Annual Report (page 178-180 of PDF, Table 43)
My family got as much help as we needed for my child.	Mental Health Survey	
Services were available at times that were good for me (convenient for us/me).	Mental Health Survey	
My mental health providers returned my calls in 24 hours.	Mental Health Survey	

Care Coordination Recommendations

Stakeholder Question:

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

Research Questions:

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

In response to stakeholder and research questions the task group identified the meaningful measures described in *Figure 3* (page 10), which includes a combination of currently reported process measures and several measures where an opportunity may exist to capture the measure for additional member populations. The recommendations are sorted by each of the key populations receiving care coordination services that were identified by KanCare stakeholders. Specifically, the task group recommends the following opportunities to measure the availability and effectiveness of care coordination services be considered:

Overall:

Care Coordination 1: Develop a summary report on Care Coordination meaningful measures (*Figure 3*) in relation to general care coordination by providers, care coordination for HCBS waiver participants and targeted case management for intellectual/developmental disability waiver participants.

General Care Coordination by Providers:

Care Coordination 2. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the serious emotional disturbance (SED) waivers.
Care Coordination 3. The KMMC should consider monitoring the SUD Member Survey to see if changes to methodology make it a data source for meaningful measures.
Care Coordination 4. KanCare could consider increasing the number of HCBS CAHPS surveys conducted for each waiver to allow for sub-group analysis in regard to survey questions about providers.

MCO Care Coordination for KanCare consumers receiving HCBS Waiver services:

Care Coordination 5. KanCare could consider reviewing the reported information from the first data year of HCBS CAHPS Surveys to make recommendations on survey administration strategies, sampling needs or inclusion of additional questions.

Care Coordination 6. KanCare could consider conducting HCBS CAHPS survey by a hybrid approach (phone interview and in-person) as is seen in some peer states as a strategy to increase the number and representativeness of surveys completed.
Care Coordination 7. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the SED waivers.

Targeted Case Management for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) Waiver services:

Care Coordination 8. KanCare could consider opportunities to increase the number of I/DD waiver members participating in the HCBS CAHPS Survey to capture the experiences of those receiving targeted case management (TCM).

Other:

Care Coordination 9. The KMMC should review data available related to administrative care coordination to identify which to include in the list of meaningful measures related to care coordination.
Care Coordination 10. The KMMC should review evaluation data related to OneCare Kansas to identify which to include in the list of meaningful measures related to care coordination.

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

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

Figure 3. **Meaningful Measures Related to Care Coordination**

Meaningful Measures	Data Source	Currently Reported
General Care Coordination by Providers		
Percent of respondents with positive response to, "How often was it easy to get the care, tests, or treatment you (your child) needed?"	CAHPS	2018 KanCare Evaluation Annual Report, (page 147 of PDF, Table 30)
Percent of respondents with positive response to, "How often did you (your child) get an appointment to see a specialist as soon as you (your child) needed?"		
Percent of respondents with positive response to, "Personal doctor seemed informed and up-to-date about your (your child's) care received from other providers."		
CC7. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	CAHPS Survey – Children with Chronic Conditions Supplemental Questions	2018 KanCare Evaluation Annual Report, (page 146 of PDF, Table 30)
CC18. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?		
CC27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child? (Refers to treatment or counseling for an emotional, developmental, or behavioral problem)	CAHPS Survey – Children with Chronic Conditions Supplemental Questions	Reported by MCOs to state, but not included in annual evaluation report.
HEDIS gaps in care reports that capture follow-up visits and transitions in care: • Follow-Up After Mental Health Hospitalization • Initiation and Engagement of Alcohol and Other Drug Dependence • Anti-Depressant Medication Management • Follow-up Care for Children Prescribed ADHD Medicine • Annual Monitoring for Patients on Persistent Medications • Preventive care measures	HEDIS measure	HEDIS Comparison Data Files – Anticipated HEDIS Scorecard
MCO Care Coordination for KanCare Consumers Receiving HCBS Waiver Services		
Do you know who your MCO Care Coordinator is?	HCBS CAHPS Survey	Expected – April 2020
Could you contact them when needed?		
Work with you when asked for help getting or fixing equipment?		

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

Pregnancy Outcomes Recommendations

Stakeholder Question: How does KanCare impact pregnancy outcomes?

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

The task group identified the meaningful measures described in *Figure 4* (page 13), which includes a combination of currently reported process measures and a set of new clinical outcome measures to be developed and derived from claims data. A potential data source is also identified; however, some limitations prevent its immediate application in the analysis. Specifically, the task group recommends to:

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

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

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

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

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

Considerations:

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

Additionally, as this work moves toward action the group noted the need for additional technical information related to the measures in *Figure 4* (below). For example, the group would be interested to provide input on the development of algorithms for birth weight categories, such as "normal," "low birthweight" and "extremely low birthweight." Additionally, for some of the *Clinical Outcome Measures*, such as infant mortality, there are multiple approaches by which peer states have built similar measures.

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

Figure 4. **Meaningful Measures Related to Pregnancy Outcomes**

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

Social Determinants of Health Recommendations

Stakeholder Question:

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

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

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

HSTs and HRAs are currently conducted by KanCare managed care organizations (MCOs) to inform care delivery. *Figure 5* (page 16) illustrates the relationship and differences between the HST and HRA. Currently, all three KanCare MCOs utilize the same HST but different HRAs. The DRWG task group considered opportunities for the data gathered through these tools to provide information about the SDOH among KanCare members. The DRWG task group acknowledged that the HST, as it is currently administered, does not fully align with the domains of the SDOH as outlined by Healthy People 2020 (see *Figure 6*, page 16).

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

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

HST Data Content

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

a. The group noted that multiple social determinants questions are included in the current HST. Key determinant topics are missing from the current HST, however, including

information about transportation, social and community context, and the neighborhood and built environment.

b. For an example of a state that requires collection of a core set of SDOH screening questions in its Medicaid Managed Care program, see North Carolina.

HST Data Collection

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

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

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

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

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

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

HST Data Utilization

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

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

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

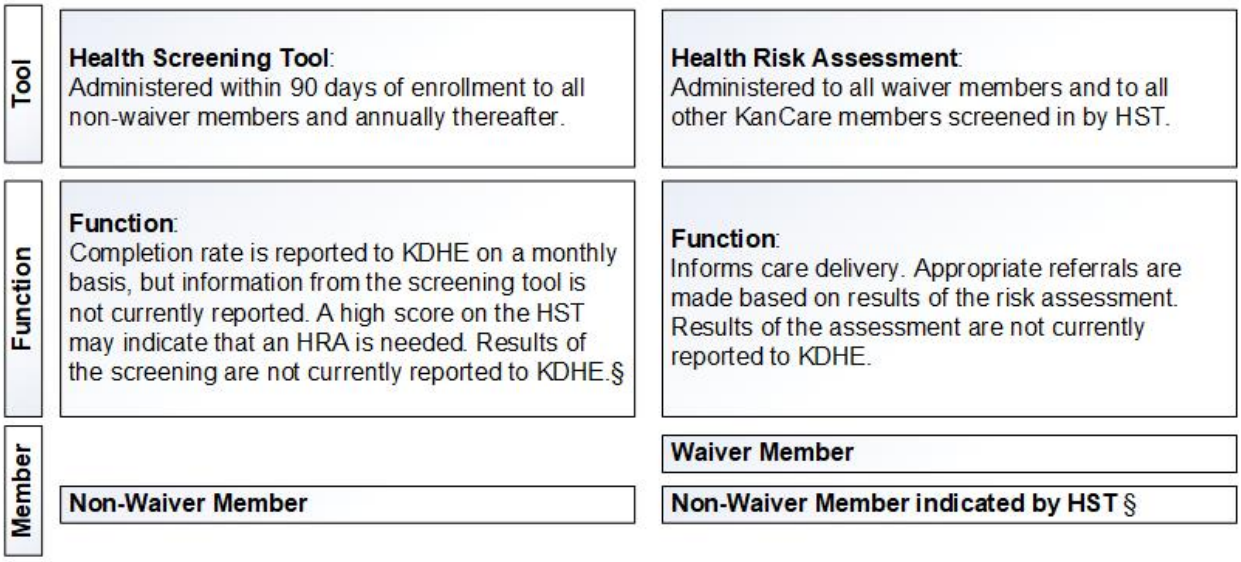
Considerations:
The task group recommended the HST to collect SDOH data, with the above improvements, because it is an existing tool currently administered by all three MCOs. Some raised concerns about whether the HST is the best tool to collect SDOH data long-term, in part due to potential resource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

The group discussed considerations and opportunities for future work regarding SDOH, with a focus on other avenues to collect SDOH data. For example, the group discussed the use of z-codes reported in claims data to capture SDOH data, once fully adopted. The use of z-codes is

nascent, and they have not yet been widely adopted. Further, the group referenced other sources of information that are currently available, such as information on Kansas Health Matters and community health centers, some of which collect information on why consumers miss appointments. For Kansas Health Matters and other public or community health data sources, the group noted that this information is available by various geographic areas but can often not be sorted by health care payer or provide measures at the individual member level.

Additional task group background information:

Figure 5. **Health Screening Tool (HST) and Health Risk Assessment (HRA) Process**



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

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

Figure 6, below, organizes questions from the current HST by each determinant area. As can be seen, some determinant areas lack questions completely, or include minimal questions that do not address all issues under the determinant area. Further, should it become possible to aggregate and report responses by question, these measures may be among the most meaningful.

Figure 6. **Meaningful Measures from a Crosswalk Health Screening Tool (HST) and Social Determinants of Health**

Meaningful Measures
Economic Stability *Key issues include: Employment, Housing instability; Food insecurity; Poverty*
32: Do you have a regular, safe place where you sleep and store your things?

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

Source: Social Determinants of Health from Healthy People 2020

Appendix A. Meaningful Measures and Recommendations

Figure A-1. **Existing Meaningful Measures**

Meaningful Measures	Data Source	Currently Reported?
Network Adequacy		
KanCare Network Adequacy Standards		
Percent of members covered within network adequacy standards by provider type, MCO and geography.	KanCare Network Adequacy Reporting	MCO Network Access May 2019
Number of counties with no provider access by provider type, county type and MCO.	KanCare Network Adequacy Reporting	KanCare Evaluation Annual Report 12.31.18 (Provider Network – GeoAccess, page 155-175 of PDF, Tables 36-37)
Number and percent of members not within access distance by provider type and MCO.	KanCare Network Adequacy Reporting	
Member Experience		
[Urgent/emergent care] 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?	CAHPS	KanCare Evaluation Annual Report (page 175 of PDF, Table 42)
[Primary/preventive care] In the last 6 months, how often did you get (when you made) an appointment for a check-up or routine care (for your child) at a doctor's office or clinic (how often did you get an appointment) as soon as you (your child) needed?	CAHPS	
How often did you get an appointment (for your child) to see a specialist as soon as you needed?	CAHPS	
Children and Adolescents' Access to Primary Care Practitioners (for age 12-24 months; 25 months to 6 years; 7-11 years; and 12-19 years)	*HEDIS Measure*	*TBD*
Performance Measure 8 – Number and percent of waiver participants who received services in the type, scope, amount, duration and frequency specified in the service plan.	KDADS HCBS Quality Review Report	KanCare Quarterly Report to CMS (page 61 of PDF)
I was able to get all the services I thought I needed.	Mental Health Survey	KanCare Evaluation Annual Report (page 178-180 of PDF, Table 43)
My family got as much help as we needed for my child.	Mental Health Survey	
Services were available at times that were good for me (convenient for us/me).	Mental Health Survey	
My mental health providers returned my calls in 24 hours.	Mental Health Survey	
Care Coordination		
General Care Coordination by Providers		

Percent of respondents with positive response to, "How often was it easy to get the care, tests, or treatment you (your child) needed?"	CAHPS	2018 KanCare Evaluation Annual Report, (page 147 of PDF, Table 30)
Percent of respondents with positive response to, "How often did you (your child) get an appointment to see a specialist as soon as you (your child) needed?"		
Percent of respondents with positive response to, "Personal doctor seemed informed and up-to-date about your (your child's) care received from other providers."		
CC7. In the last 6 months, did you get the help you needed from your child's doctors or other health providers in contacting your child's school or daycare?	CAHPS Survey – Children with Chronic Conditions Supplemental Questions	2018 KanCare Evaluation Annual Report, (page 146 of PDF, Table 30)
CC18. In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?		
CC27. Did anyone from your child's health plan, doctor's office, or clinic help you get this treatment or counseling for your child? (Refers to treatment or counseling for an emotional, developmental, or behavioral problem)	CAHPS Survey – Children with Chronic Conditions Supplemental Questions	Reported by MCOs to state, but not included in annual evaluation report.
HEDIS gaps in care reports that capture follow-up visits and transitions in care: • Follow-Up After Mental Health Hospitalization • Initiation and Engagement of Alcohol and Other Drug Dependence • Anti-Depressant Medication Management • Follow-up Care for Children Prescribed ADHD Medicine • Annual Monitoring for Patients on Persistent Medications • Preventive care measures	HEDIS measure	HEDIS Comparison Data Files – Anticipated HEDIS Scorecard
MCO Care Coordination for KanCare Consumers Receiving HCBS Waiver Services		
Do you know who your MCO Care Coordinator is?	HCBS CAHPS Survey	Expected – April 2020
Could you contact them when needed?		
Work with you when asked for help getting or fixing equipment?		
Help in getting changes in service, or help getting places or finding a job?		
Rating of help received from MCO Care Coordinator.		
Would you recommend this care coordinator?		
Proportion of people whose case manager/care coordinator talked to them about services that might help with their unmet needs and goals (if have unmet needs and goals and know they have case manager/care coordinator)	National Core Indicators – Aging and Disabilities Adult	NCI-AD, Kansas State Reports, 2015-2019; 2018-2019 Kansas Report

Proportion of people who felt comfortable and supported enough to go home (or where they live) after being discharged from a hospital or rehabilitation facility in the past year	Consumer Survey	(Graph 19, page 49 of PDF; Graphs 26-28, page 52-53 of PDF)
Proportion of people who had someone follow up with them after being discharged from a hospital or rehabilitation facility in the past year		
Proportion of people who know how to manage their chronic condition(s).		
Targeted Case Management (TCM) for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) Waiver Services		
NOTE: HCBS CAHPS Survey measures are collected for TCM, but caution should be taken making any comparisons as the sample size is small.	*HCBS CAHPS Survey*	*Expected – April 2020*
Pregnancy Outcomes		
Process Measures		
Timeliness of prenatal care – What percentage of deliveries received a prenatal care visit as a member of the organization in the first trimester, on the enrollment start date, or within 42 days of enrollment in the organization?	MCO Performance Outcome	KanCare Annual Report (page 109 of PDF, Table 2)
Postpartum care – What percentage of deliveries had a postpartum visit on or between 21 and 56 days after delivery?	HEDIS measures	KanCare Annual Report (page 109 of PDF, Table 2)

Figure A-2. **New Meaningful Measures**

Meaningful Measures	Data Source	Currently Reported
Network Adequacy Standards Measure		
Sufficient number of providers by provider type, MCO and geography to provide adequate coverage within defined time and distance standards.	N/A	No
Targeted Case Management (TCM) for KanCare consumers receiving Intellectual/Developmental Disability (I/DD) Waiver Services		
NOTE: HCBS CAHPS Survey measures are collected for TCM, but caution should be taken making any comparisons as the sample size is small.	HCBS CAHPS Survey	Expected – April 2020
Clinical Outcome Measures		
Birth weight	Claims	No
Gestational age	Claims	No
Infant mortality	Claims	No
NAS diagnosis at birth	Claims	No
NICU admission at birth	Claims	No
Maternal mortality (statewide)	Vital Statistics	Yes

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

Source: Social Determinants of Health from Healthy People 2020

Figure A-3. **Summary of All Recommendations by Priority Area**

Network Adequacy
Network Adequacy 1: Develop a summary report on network adequacy meaningful measures in relation to contract standards as well as measures that capture the experience of KanCare members accessing care. a. KanCare network adequacy standards: percent of members covered within the standards by provider type, geography and MCO. b. Member experience: access to care in time and receive services according to the service plan. **Network Adequacy 2:** Make technical documents available and provide the derivation of measures as part of public reports. a. Technical documents on how the KanCare network adequacy standards are established and how the standards compared to those used by other entities or organizations, e.g., CMS, NCQA, other states or private insurance. b. Cross-reference referred documents and reports with links and consistent titles.

c. Calculation formulas or derivation processes for measures that are presented in public reports, e.g. % covered in the KanCare Managed Care Organization Network Access table.
Network Adequacy 3: Describe the KanCare network adequacy monitoring process and utilize data collected for program improvement. a. Documents on the monitoring process and, when issues arise, actions could be taken to address the issues. b. Approaches regarding data collection, analysis and applications, e.g., "secret shopper." c. Consider utilizing the program monitoring data to help identify areas for continuous improvement.
Network Adequacy 4: Provide information on the following questions. a. When is the network determined to be inadequate? How often is the network determined to be inadequate? What are the main reasons? What indicates that a review of the network is required? b. What will KanCare MCOs do when members do not have access to care/services as required by the contract for network adequacy? What adjustments do they make to get KanCare members access when there are gaps?
Care Coordination
General Care Coordination by Providers:
Care Coordination 1: Develop a summary report on Care Coordination meaningful measures in relation to general care coordination by providers, care coordination for HCBS waiver participants and targeted case management for intellectual/developmental disability waiver participants.
Care Coordination 2. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the SED waivers.
Care Coordination 3. The KMMC should consider monitoring the SUD Member Survey to see if changes to methodology make it a data source for meaningful measures.
Care Coordination 4. KanCare could consider increasing the number of HCBS CAHPS surveys conducted for each waiver to allow for sub-group analysis in regard to survey questions about providers.
MCO Care Coordination for KanCare Consumer Receiving HCBS Waiver Services:
Care Coordination 5. KanCare could consider reviewing the reported information from the first data year of HCBS CAHPS Surveys to make recommendations on survey administration strategies, sampling needs or inclusion of additional questions.
Care Coordination 6. KanCare could consider conducting HCBS CAHPS survey by a hybrid approach (phone interview and in-person) as is seen in some peer states as a strategy to increase the number and representativeness of surveys completed.
Care Coordination 7. KanCare could consider opportunities to develop measures that capture perception of services particularly of members on the SED waivers.
Targeted Case Management for KanCare Consumers Receiving Intellectual/Developmental Disability (I/DD) Waiver Services:
Care Coordination 8. KanCare could consider opportunities to increase the number of I/DD waiver members participating in the HCBS CAHPS Survey to capture the experiences of those receiving targeted case management (TCM).
Other:
Care Coordination 9. The KMMC should review data available related to administrative care coordination to identify which to include in the list of meaningful measures related to care coordination.

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

Pregnancy Outcomes

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

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

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

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

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

Social Determinants of Health

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

SDOH 2. KanCare should consider utilizing a core set of questions in the Health Screening Tool (HST) to capture key SDOH information.

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

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

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

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

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

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

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

SDOH 6. To build consensus among stakeholders on the value of this information, KanCare should consider providing information on how the HST instrument was developed, as the KMMC recommends that tool(s) be validated.
SDOH 7. The HST data should be reported back to KanCare and able to be linked with other KanCare data for analysis and reporting.
SDOH 8. With these recommendations implemented, KDHE and other partners should consider opportunities to utilize data to inform program design regarding the SDOH.