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April 24, 2025

Mendy Jump
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Division of Health Care Finance
900 SW Jackson St., Room 900
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RE: KanCare Program Annual External Quality Review Technical Report for Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas, 2024-2025 Reporting Cycle

Dear Ms. Jump:

Enclosed, to review for KFMC errors and omissions, as guided by CMS regulations, is the draft KanCare Annual External Quality Review technical report for the 2024-2025 reporting cycle of Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas.

This report includes summaries of reports for the following activities: Performance Measure Validation (PMV) and Evaluation, Performance Improvement Project (PIP) Validation, CAHPS Health Plan 5.1H Survey Validation, KanCare Mental Health Consumer Perception Survey, Provider Satisfaction Survey Validation, Review of Compliance with Medicaid and CHIP Managed Care Regulations, Quality Assessment and Performance Improvement (QAPI) Review, and Network Adequacy Validation.

The format of the Annual Technical Report is based on requirements delineated in *42 CFR 438.364 External quality review results*. The Annual Technical Report summarizes reports (based on the CMS EQR protocols) submitted to the State throughout this reporting cycle.

Please feel free to contact me, bnech@kfmc.org, if you have any questions regarding this report.

Sincerely,

Elizabeth R. Nech
Beth Nech, MA
EQRO Senior Manager

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Enclosures

KanCare Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

Contract Number: 46100

Submission Date: April 24, 2025

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KanCare Program Annual External Quality Review Technical Report Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas 2024-2025 Reporting Cycle Submission Date: April 24, 2025

Introduction

KFMC Health Improvement Partners (KFMC), under contract with the Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), serves as the External Quality Review Organization (EQRO) for KanCare (Kansas Medicaid managed care). The goals of KanCare are to provide efficient and effective health care services and ensure coordination of care and integration of physical health (PH) and behavioral health (BH) services for children, pregnant women, and parents in the State's Medicaid and Children's Health Insurance Program (CHIP) programs. The Aetna Better Health of Kansas (Aetna, ABH, or ABHKS) KanCare managed care organization (MCO) contract was effective January 1, 2019 to December 31, 2024. Sunflower Health Plan (Sunflower or SHP) and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare, UHC, or UHCCP) have provided KanCare managed care services since January 2013.

As the EQRO, KFMC evaluated services provided in 2024-2025 by the MCOs, basing the evaluation on protocols developed by the Centers for Medicare & Medicaid Services (CMS), updated in February 2023. No KanCare MCO was exempt from external quality review. This report includes summaries of reports (submitted to the State May 2024 through April 2025) evaluating the following activities for each MCO.

- Performance Measure Validation (PMV) and Evaluation
- Performance Improvement Project (PIP) Validation
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Validation[1]
- Provider Survey Validation
- Review of Compliance with Medicaid and CHIP Managed Care Regulations (Compliance Review)
- Quality Assessment and Performance Improvement (QAPI) Review
- Network Adequacy Validation

KFMC also conducted a Mental Health (MH) Consumer Perception Survey to evaluate the KanCare program, reflecting combined MCO performance.

[1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

KFMC used and referenced the following CMS EQR Protocol worksheets and narratives in the completion of these activities[2]:

- EQR Protocol 1: Validation of Performance Improvement Projects
- EQR Protocol 2: Validation of Performance Measures
- EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations
- EQR Protocol 4: Validation of Network Adequacy
- EQR Protocol 6: Administration or Validation of Quality of Care Surveys
- EQR Appendix A: Information Systems Capabilities Assessment

KFMC completed individual reports for each activity throughout the 2024-2025 reporting cycle to provide the State and MCOs timely feedback on program progress. These individual reports contain more detail, and additional feedback beyond what is required, than is presented in the following activity summaries. This additional feedback includes suggestions for improvement that have no effect on compliance scores. See Appendix A for a list of the full reports (which are available upon request) for the activities conducted in accordance with the Code of Federal Regulations (CFR) §438.358.

In this Annual External Quality Review Technical Report, the summaries provided include objectives; technical methods of data collection; descriptions of data obtained; strengths and opportunities for improvement regarding quality, timeliness, and access to health care services; and recommendations for quality improvement. The conclusions and recommendations in the summaries that follow primarily focus on those related directly to improving health care quality, access, and timeliness; additional technical, methodological, and general recommendations to the MCOs may be included in the individual reports submitted to the State and MCOs. The Quality Management Strategy (QMS) section contains suggestions, based on the EQR findings, for how the State can target goals and objectives in the KanCare QMS.

Each section also contains an assessment of the degree to which the previous year's EQRO recommendations have been addressed. Appendix D contains details for this assessment, including definitions for the assessment scale used for all activities. To determine the degree to which previous recommendations were addressed, KFMC assessed activities completed, documentation received, and MCO progress updates received during the 2024-2025 review period for each EQR activity. Additional documentation or information received after the conclusion of the review period will be incorporated into the following year's assessment.

Most EQR-related activities require that findings be tied to access, quality, and timeliness of care. Table I.1 presents an overview of MCO-level strengths and opportunities for improvement identified via the external quality review activities conducted during the 2024-2025 reporting cycle. The "Domain" column indicates whether the strengths and opportunities are related to access, quality, or timeliness. The Mental Health Consumer Perception Survey and Network Adequacy Validation activities were conducted at the KanCare level and are not included in the table. Please see the individual activity sections for more detail regarding strengths and opportunities for improvement common among the MCOs.

[2] Centers for Medicare & Medicaid Services, *CMS External Quality Review (EQR) Protocols*, February 2023, OMB Control No. 0938-0786, Expires December 31, 2025.

Table I.1. MCO-Level Strengths and Opportunities for Improvement

MCO		Strengths (S*) and Opportunities (O*)	Domain
Performance Measure Validation			
ABH	S	High performance or notable mentions • Controlling High Blood Pressure • Hemoglobin A1c Control for Patients with Diabetes – HbA1c Control (<8%) • Postpartum Care • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics • Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years) – 7 Days	Access, Quality, Timeliness
	O	Low performance • Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18–64 Years) • Asthma Medication Ratio (5–18 Years and 19–64 Years) • Follow-up After Emergency Department Visit for Mental Illness (18–64 Years and 6–17 Years) • Childhood Immunization Status – Influenza	Access, Quality, Timeliness
SHP	S	High performance or notable mentions • Follow-Up After Emergency Department Visit for Mental Illness 7 and 30 Days (18–64 Years) and 30 Days (6–17 Years) • Controlling High Blood Pressure • Follow-up Care for Children Prescribed ADHD Medication – Continuation and Maintenance Phase • Follow-up After Hospitalization for Mental Illness (6–17 Years) • Prenatal and Postpartum Care • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents – BMI Percentile	Access, Quality, Timeliness
	O	Low performance • Initiation and Engagement of Substance Use Disorder Treatment (18–64 Years) – Initiation of Opioid Use Disorder and Total Initiation • Asthma Medication Ratio (5–18 Years) • Follow-up After Emergency Department Visit for Mental Illness – 7 Days (6–17 Years) • Substance use disorder treatment, total percent current smokers • Childhood Immunization Status – All antigens, except Hepatitis B, and Combination 10 • Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition and Physical Activity	Access, Quality, Timeliness
UHC	S	High performance or notable mentions • Follow-Up After Emergency Department Visit for Mental Illness – 7 Days and 30 Days (18–64 Years) • Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence – 7 Days and 30 Days (13-17 Years) • Controlling High Blood Pressure • Hemoglobin A1c for Patients with Diabetes – Poor HbA1c Control • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile (Total)	Access, Quality, Timeliness
	O	Low performance • Asthma Medication Ratio (5–11 Years) • Chlamydia Screening in Women (21–24 Years) • Initiation and Engagement of Substance Use Disorder Treatment (18–64 Years) • Follow-Up after Emergency Department Visits for Mental Illness – 7 Days (6–17 Years) • Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Nutrition and Physical Activity • Child and Adolescent Immunizations • Timeliness of Prenatal Care	Access, Quality, Timeliness

* S = Strength: High performance or notable mentions; O = Opportunity: Low performance

Table I.1. MCO-Level Strengths and Opportunities for Improvement

MCO		Strengths (S*) and Opportunities (O*)	Domain
Performance Improvement Project Validation			
ABH	S	Two PIPs were rated High Confidence (95% to 100%) and three were rated Confidence (90% to <95%).	Access, Quality, Timeliness
	O	Needed improvements were identified regarding interpretation of analyses, adherence to analytic plans, and various documentation details.	Access, Quality, Timeliness
SHP	S	Two PIPs were rated High Confidence (95% to 100%) and one was rated Confidence (90% to <95%).	Access, Quality, Timeliness
	O	One PIP received a rating of Low Confidence (80% to <90%).	Access, Quality, Timeliness
UHC	S	Two PIPs were rated High Confidence (95% to 100%) and two were rated Confidence (90% to <95%).	Access, Quality, Timeliness
	O	One PIP rated Low Confidence (80% to <90%).	Access, Quality, Timeliness
CAHPS Survey Validation			
ABH	S	The following ranks or rates were very high for at least one population • Ratings of Health Plan and Personal Doctor • Getting Care Quickly and Getting Needed Care • How Well Doctors Communicate and Having a Personal Doctor • Customer Service • Access to Prescription Medicines • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child Populations are adult, Medicaid (TXIX) general child (GC), CHIP (TXXI) GC, TXIX children with chronic conditions (CCC), and TXXI CCC.	Access, Quality, Timeliness
	O	Relatively low rates or ranks • Ratings of All Health Care (GC TXIX), Personal Doctor (GC TXIX and TXXI), and Specialist Seen Most Often (CCC TXIX) • Coordination of Care (adult) • Medical Assistance with Smoking and Tobacco Use Cessation: Discussing Cessation Medications and Discussing Cessation Strategies Decreasing five-year trendlines • Getting Care Quickly (CCC TXIX) and Getting Needed Care (CCC TXIX)	Access, Quality, Timeliness
SHP	S	The following ranks or rates were very high for at least one population • Ratings of All Health Care and Personal Doctor • Getting Care Quickly and Getting Needed Care • How Well Doctors Communicate and Having a Personal Doctor • Customer Service • Access to Prescription Medicines • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child	Access, Quality, Timeliness

* S = Strength: High performance or notable mentions; O = Opportunity: Low performance

Table I.1. MCO-Level Strengths and Opportunities for Improvement			
MCO	**Strengths (S*) and Opportunities (O*)**		**Domain**
CAHPS Survey Validation (Continued)			
SHP	O	Relatively low rates or ranks • Rating of Personal Doctor (GC TXXI) • Customer Service (GC TXIX and TXXI combined) • Family-Centered Care: Personal Doctor Who Knows Child (CCC TXXI) Decreasing five-year trendlines • Getting Care Quickly (GC TXIX, CCC TXIX and TXXI) • Getting Needed Care (adult, CCC TXXI) • Access to Prescription Medicines (CCC TXIX) • Access to Specialized Services (CCC TXIX and XXI combined) • Family-Centered Care: Personal Doctor Who Knows Child (CCC TXXI) • Rating of Mental or Emotional Health (GC TXXI) • Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers and Tobacco Users to Quit	Access, Quality, Timeliness
UHC	S	The following ranks or rates were very high for at least one population • Ratings of Health Plan and Personal Doctor • Getting Care Quickly • How Well Doctors Communicate and Having a Personal Doctor • Customer Service • Access to Prescription Medicines and Specialized Services • Family-Centered Care: Getting Needed Information and Personal Doctor Who Knows Child	Access, Quality, Timeliness
	O	Relatively low rates or ranks • Rating of All Health Care (GC TXIX and TXXI) and Personal Doctor (CCC TXXI) Decreasing five-year trendlines • Rating of All Health Care (GC TXXI, CCC TXIX and TXXI) and Personal Doctor (CCC TXXI) • Getting Care Quickly (GC TXIX, CCC TXXI) and Getting Needed Care (adult, CCC TXXI) • How Well Doctors Communicate (adult) • Customer Service (CCC TXIX and TXXI combined) • Access to Prescription Medicines (CCC TXXI) • Rating of Mental or Emotional Health (CCC TXXI) • Having a Personal Doctor (GC TXIX, CCC TXIX)	Access, Quality, Timeliness
Provider Survey Validation			
ABH	S	A single survey vendor was used for all MCOs, and the same survey processes were used across MCOs.	Quality
	O	By not applying a stratified random sampling method for the survey samples, the survey results could not be generalizable to Aetna's KanCare Provider Networks of Primary Care Providers (PCPs), specialists, BH providers and HCBS providers.	Quality
SHP	S	A single survey vendor was used for all MCOs, and the same survey processes were used across MCOs.	Quality
	O	By not applying a stratified random sampling method for the survey samples, the survey results could not be generalizable to Sunflower's KanCare Provider Networks of PCPs, specialists, BH providers and HCBS providers.	Quality
UHC	S	A single survey vendor was used for all MCOs, and the same survey processes were used across MCOs.	Quality
	O	By not applying a stratified random sampling method for the survey samples, the survey results could not be generalizable to UnitedHealthcare's KanCare Provider Networks of PCPs, specialists, BH providers and HCBS providers.	Quality
* S = Strength: High performance or notable mentions; O = Opportunity: Low performance			

Table I.1. MCO-Level Strengths and Opportunities for Improvement			
MCO	**Strengths (S*) and Opportunities (O*)**		**Domain**
Review of Compliance with Medicaid and CHIP Managed Care Regulations			
ABH	S	All subparts had a compliance score of 92% or above, with one subpart scoring 100% compliant.	Access, Quality, Timeliness
	O	Aetna had the greatest opportunity for improvement, primarily with documentation, within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
SHP	S	All subparts had a compliance score of 96% or above, with two subparts scoring 100% compliant.	Access, Quality, Timeliness
	O	Sunflower had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
UHC	S	All subparts had a compliance score of 96% or above, with two subparts scoring 100% compliant.	Access, Quality, Timeliness
	O	UnitedHealthcare had the greatest opportunity for improvement within Subpart D related to regulatory areas §438.214 *Provider Selection*, §438.228 *Grievance and Appeal Systems*, and §438.416 *Recordkeeping Requirements*.	Access, Quality, Timeliness
Quality Assessment and Performance Improvement Review			
ABH	S	Aetna's *2023 QAPI Program Evaluation* included information on expansion and addition of programs, processes, and operational activities to support initiatives. They also received a score of 100% and award from National Committee for Quality Assurance (NCQA) for Health Equity Accreditation.	Quality
	O	Five State requirements were partially met, and one was substantially met.	Quality
SHP	S	Sunflower's *2023 QAPI Program Evaluation* included information on the achievement of Health Equity Accreditation in the first quarter of 2023. Also, it continues to include a thorough analysis of their population characteristics, including maps and unique ways of breaking their population into groups (including grouping by product and language).	Quality
	O	One State requirement was substantially met.	Quality
UHC	S	UnitedHealthcare's *2023 QAPI Program Evaluation* reported that UHC achieved 4 Stars for the annual star rating in 2023. Also, they continue to have easy to follow activities for each objective as well as objectives for each goal. QAPI work plans continue to be well laid out and tie back to the QAPI program description and QAPI evaluation.	Quality
	O	Three State requirements were substantially met, and two requirements were partially met.	Quality
* S = Strength: High performance or notable mentions/O = Opportunity: Low performance			

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Summary of Individual EQR Components

1. Performance Measure Validation and Evaluation

Background/Objectives

KanCare MCOs are required to register with the National Committee for Quality Assurance (NCQA) and undergo an annual NCQA Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit™, which conveys sufficient integrity to HEDIS data used by consumers and purchasers to compare healthcare organization performance.[3] The State required Aetna, Sunflower, and UnitedHealthcare to report HEDIS Measurement Year (MY) 2023 data through the NCQA data submission portal. KFMC also evaluated the MCOs' performance of the Adult and Child Core Set measures to provide an understanding of the strengths and opportunities for improvement related to quality, timeliness, and access to care.

The PMV process had four main objectives:

- Evaluate the policies, procedures, documentation, and methods the MCO used to calculate the measures.
- Determine the extent to which reported rates are accurate, reliable, free of bias, and in accordance with standards for data collection and analysis.
- Verify measure specifications are consistent with the State's requirements.
- Ensure remeasurement rates are produced with methods and source data that parallel the baseline rates.

The objective of the performance measure evaluation was to provide an understanding of the strengths and opportunities for improvement of MCO performance related to quality, timeliness, and access to care. The evaluation focused on CMS Adult and Child Core Set HEDIS measures and included

- Comparison of the current year rates to
  - Prior year's rates,
  - Statewide aggregate (KanCare) rates, and
  - Quality Compass (QC) percentiles; and
- Analysis of trending across three to five prior years.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

Technical methods for the performance measure validation and evaluation activities are detailed in Appendix B.

Performance Measure Validation

In addition to the HEDIS Compliance Audit that NCQA requires of the MCOs, the State requires the EQRO to use an NCQA-Certified HEDIS Compliance Auditor to conduct its PMV. KFMC contracted with MetaStar, Inc. (MetaStar), an NCQA-Certified HEDIS Compliance Auditor that is independent of the HEDIS Compliance Auditors contracted by the KanCare MCOs. KFMC worked closely with MetaStar and the MCOs throughout the validation process.

[3] HEDIS® and NCQA HEDIS Compliance Audit™ are registered trademarks of the National Committee for Quality Assurance.

Performance Measure Evaluation

MCO data were aggregated for KanCare-level results. This report contains KanCare and MCO results for CMS 2024 (MY 2023) Adult and Child Core Set measures that include rates, rankings, and indicators for notable changes in rates.

- Adult Core Set (Table 1.1): 17 HEDIS measures, including 1 measure derived from the CAHPS surveys. The Plan All-Cause Readmissions (PCR) measure is risk-adjusted and reported according to observed versus expected hospital readmissions.
- Child Core Set (Table 1.2): 18 HEDIS measures.

Ranks are denoted, in order of worst to best performance: <5th, <10th, <25th, <33.33rd, <50th, ≥50th, >66.67th, >75th, >90th, and >95th. For example, a rate ranked <10th will be less than the Quality Compass national 10th percentile but not less than the 5th percentile. Note that, as QC percentiles are based on HEDIS rates from across the nation, some measures with high scores in Kansas may rank very low due to high scores nationwide. Due to the COVID-19 pandemic, NCQA advises caution when using MY 2020 data for rate comparisons.

An objective of the KanCare Quality Management Strategy is to improve HEDIS rates that are below the national 75th percentile by at least 10.00% of the difference between that rate and the performance goal (the goal is 100% or 0%, depending on the measure).[4] In alignment with this objective, Table 1.1 and Table 1.2 indicate measures that had a "gap-to-goal" percentage change of at least 10.00%. The tables also indicate changes of at least 3.0 percentage points per year (pp/y) averaged across three to five years and, for hybrid and survey measures, statistically significant changes from the prior year and statistically significant trendlines (see Appendix B for additional information).

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[4] State of Kansas, *KanCare 2.0 Quality Management Strategy*, December 9, 2021, www.kancare.ks.gov/home/showpublisheddocument/2046/638476547261200000.

Table 1.1. HEDIS Performance Measures (Measurement Year 2023) – Adult Core Set

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AAB *A*	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**								
	– 18–64 Years	45.79	≥50th	39.21 x	<33.33rd	49.06	>66.67th	46.67	≥50th
AMM *A*	**Antidepressant Medication Management**								
	– Effective Acute Phase Treatment	55.06	<25th	53.71	<25th	53.79	<25th	56.82	<33.33rd
	– Effective Continuation Phase Treatment	38.89	<33.33rd	38.72	<33.33rd	36.30	<25th	41.15	<50th
AMR *A*	**Asthma Medication Ratio**								
	– 19–50 Years	56.41	<33.33rd	49.57 x	<10th	61.95	<50th	55.60	<33.33rd
	– 51–64 Years	55.97	<25th	61.11 cx	<50th	57.14 c	<33.33rd	54.44	<25th
	– 19–50 and 51–64 Years	56.34	NA	51.12 x	NA	61.28	NA	55.38	NA
BCS *E*	**Breast Cancer Screening**	46.69	<25th	42.91 b	<25th	45.73	<25th	48.71	<33.33rd
CBP *H*	**Controlling High Blood Pressure**	70.54 ab cd	>75th	69.83 bc d	>75th	71.78 ab cd	>75th	69.83 b	>75th
CCS *H*	**Cervical Cancer Screening**	59.60	≥50th	55.23 d	<50th	57.66	≥50th	63.75	>75th
CHL *A*	**Chlamydia Screening in Women**								
	– 21–24 Years	55.20	<25th	57.24 b	<25th	55.69	<25th	53.41 x	<25th
COL *A*	**Colorectal Cancer Screening**	44.22	>75th	35.24	<50th	44.96	>75th	46.89	>75th
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (18+ Years)**								
	– 7 Days	31.23	>75th	32.71	>75th	32.66	>75th	29.37	>66.67th
	– 30 Days	44.56	>75th	45.21	>75th	45.16	>75th	43.76	>75th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method; "*C*" denotes CAHPS survey measures; "E" denotes measures reported using an electronic clinical data system.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator

Table 1.1. HEDIS Performance Measures (Measurement Year 2023) – Adult Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
FUH *A*	**Follow Up After Hospitalization for Mental Illness (18–64 Years)**								
	– 7 Days	44.14	>75th	40.76	>66.67th	49.09	>75th	41.97	>66.67th
	– 30 Days	65.43	>75th	62.32	>66.67th	68.29	>75th	64.75	>75th
FUM *A*	**Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years)**								
	– 7 Days	63.37	>95th	60.52 x	>90th	63.17	>90th	64.91	>95th
	– 30 Days	74.87	>95th	68.93 x	>75th	76.83	>95th	75.89 b	>95th
HBD *H*	**Hemoglobin A1c Control for Patients with Diabetes**								
	– HbA1c Control (<8%)	61.37 ab	>75th	61.07 ab	>75th	60.10 ab	>66.67th	62.53	>75th
	– Poor HbA1c Control *(lower rate is better)*	31.13 ab	≥50th	34.06 ab	<50th	33.33 ab	≥50th	28.22 b	>75th
IET *A*	**Initiation and Engagement of Substance Use Disorder Treatment**								
	Initiation (18–64 Years)								
	– Alcohol Use Disorder	37.18	<25th	40.58	<50th	34.29	<25th	37.38	<25th
	– Opioid Use Disorder	37.21	<5th	50.00 b	<25th	38.16 x	<10th	32.12	<5th
	– Other Drug Use Disorder	36.68	<25th	36.30	<25th	35.14	<25th	38.07	<33.33rd
	– Total	36.91	<10th	39.25	<25th	35.27	<10th	36.81	<10th
	Engagement (18+ Years)								
	– Alcohol Use Disorder	8.93	<50th	10.49	<50th	5.86	<25th	10.44	<50th
	– Opioid Use Disorder	15.17	<25th	24.19 b	<33.33rd	15.55	<25th	11.73	<10th
	– Other Drug Use Disorder	9.91	<50th	11.55	≥50th	6.86	<25th	11.26	≥50th
	– Total	10.40	<33.33rd	12.67	<50th	7.70	<25th	11.11	<50th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method; "*C*" denotes CAHPS survey measures.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Table 1.1. HEDIS Performance Measures (Measurement Year 2023) – Adult Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
MSC *C*	**Medical Assistance with Smoking and Tobacco Use Cessation †**								
	– Total % Current Smokers *(lower rate and ranking are better)*	27.92	≥50th	29.10	≥50th	29.46 x	>66.67th	25.60 d	≥50th
	– Advising Smokers to Quit	72.39	<50th	70.90	<33.33rd	72.93	<50th	73.17	<50th
	– Discussing Cessation Medications	52.63	<50th	47.34	<25th	55.56	>66.67th	54.55 b	≥50th
	– Discussing Cessation Strategies	44.43	<50th	40.43	<25th	47.19	≥50th	45.40	<50th
PPC *H*	**Prenatal and Postpartum Care**								
	– Postpartum Care	82.37 ab cd	≥50th	84.18 ab cd	>75th	81.51 ab cd	≥50th	82.00 d	≥50th
SAA *A*	**Adherence to Antipsychotic Medications for Individuals with Schizophrenia**	64.72	≥50th	65.38 b	≥50th	62.50	<50th	66.31	>66.67th
SSD *A*	**Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications**	80.27 b	<50th	77.08 b	<25th	81.99 b	≥50th	80.42 b	<50th

Risk-Adjusted Measure & Indicators*		KanCare			Aetna			Sunflower			UnitedHealthcare		
		O	E	O/E	O	E	O/E	O	E	O/E	O	E	O/E
PCR *A*	**Plan All-Cause Readmissions**												
	– Total (18–64 years)	10.00	10.96	0.91	10.89	11.12	0.98	10.12	11.16	0.91	9.23	10.58	0.87

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method; "*C*" denotes CAHPS survey measures. "O" means "observed," "E" means "expected," and ratios O/E less than 1.00 indicate better than expected performance.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.
† Total % Current Smokers is a one-year rate. The other MSC indicators are rolling two-year averages, with the pp change (b, x) being the difference between MY 2023 (2022-2023 average) and MY 2021 (2020-2021 average) and the average rate and rate of change (d) over five years calculated using one-year rates.

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Table 1.2. HEDIS Performance Measures (Measurement Year 2023) – Child Core Set

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

	Measures & Indicators*	KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
AAB *A*	**Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis**								
	– 3mo–17 Years	77.39 c	>66.67th	78.12 bc	>66.67th	76.98 c	≥50th	77.27 c	≥50th
ADD *A*	**Follow Up Care for Children Prescribed ADHD Medication**								
	– Initiation Phase	50.80	>75th	48.17	>66.67th	50.22	>75th	53.12	>75th
	– Continuation & Maintenance Phase	58.24	>66.67th	54.71	≥50th	60.20 b	>75th	58.29	>66.67th
AMB *A*	**Ambulatory Care – Emergency Department Visits/1000 MM** *(lower is better)*								
	– Ages Less Than 1 Year	988.21	≥50th	909.91 b	<50th	1044.10	>66.67th	1019.33	≥50th
	– Ages 1–9 Years	484.76	≥50th	457.86	<50th	494.61 b	≥50th	498.39	≥50th
	– Ages 10–19 Years	383.78	≥50th	364.64	≥50th	393.97	>66.67th	390.15	≥50th
	– Ages 19 Years and Less	459.84	NA	438.78	NA	471.64	NA	466.59	NA
AMR *A*	**Asthma Medication Ratio**								
	– Ages 5–11 Years	68.22 x	<33.33rd	67.95 xy	<33.33rd	68.93 x	<50th	67.96 x	<33.33rd
	– Ages 12–18 Years	62.52 x	<33.33rd	61.13 xy	<25th	66.74	<50th	60.59	<25th
	– Ages 5–18 Years	65.32 x	NA	64.39 xy	NA	67.77 x	NA	64.34	NA
APM *A*	**Metabolic Monitoring for Children and Adolescents on Antipsychotics**	43.16	>66.67th	42.68	>66.67th	43.58	>66.67th	43.04	>66.67th
APP *A*	**Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total)**	72.01	>75th	72.20 b	>75th	71.87 x	>75th	72.05	>75th
CHL *A*	**Chlamydia Screening in Women (16–20 Years)**	40.43	<25th	41.66	<25th	40.25	<25th	39.71	<25th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO child population rates, weighted by administrative denominator.

Table 1.2. HEDIS Performance Measures (Measurement Year 2023) – Child Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

	Measures & Indicators*	KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
CIS *H*	**Childhood Immunization Status**								
	– Diphtheria-Tetanus-Acellular Pertussis (DTaP)	68.08 z	<33.33rd	67.64 z	<33.33rd	68.37 yz	<50th	68.13 z	<33.33rd
	– Haemophilus Influenzae B (HiB)	82.19 bz	<50th	81.51 bz	<50th	81.75 z	<50th	83.21 bz	<50th
	– Hepatitis A	83.06 z	≥50th	82.97 z	≥50th	83.45 z	≥50th	82.73 z	≥50th
	– Hepatitis B	87.47 z	≥50th	85.89 z	<50th	89.05	>66.67th	87.10 z	≥50th
	– Inactivated Poliovirus Vaccine (IPV)	84.60 z	<50th	84.43 z	<50th	84.67 z	<50th	84.67	<50th
	– Influenza	33.94 wyz	<50th	34.79 wxz	<50th	34.31 yz	<50th	32.85 yz	<50th
	– Measles-Mumps-Rubella (MMR)	83.37 z	<50th	82.24 z	<33.33rd	84.18 z	<50th	83.45 z	<50th
	– Pneumococcal Conjugate	70.40 z	<50th	71.05 z	<50th	67.88 yz	<33.33rd	72.51 z	≥50th
	– Rotavirus	66.47 z	<50th	64.72 z	<33.33rd	67.64 z	<50th	66.67 x	<50th
	– Varicella-Zoster Virus (VZV)	82.96 z	<50th	82.00 z	<33.33rd	83.70 z	<50th	82.97 z	<50th
	– Combination 10 (all 10 antigens)	26.31 wyz	<50th	28.22 z	≥50th	25.30 yz	<50th	25.79 z	<50th
FUA *A*	**Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (13–17 Years)**								
	– 7 Days	30.04	>75th	28.95	>75th	25.97	>66.67th	34.44 b	≥90th
	– 30 Days	42.80	>75th	44.74	>75th	35.06 x	≥50th	47.78 b	≥90th
FUH *A*	**Follow Up After Hospitalization for Mental Illness (6–17 Years)**								
	– 7 Days	58.85	>75th	56.53	>75th	61.42	>75th	57.83	>75th
	– 30 Days	79.18	>75th	77.27	>66.67th	81.14 b	>75th	78.48	>75th
FUM *A*	**Follow Up After Emergency Department Visit for Mental Illness (6–17 Years)**								
	– 7 Days	65.32 x	>75th	63.00 x	>75th	71.24 x	>75th	60.45 x	>66.67th
	– 30 Days	81.36	>75th	76.50 x	>66.67th	85.62	≥90th	80.22	>75th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO child population rates, weighted by administrative denominator.

Table 1.2. HEDIS Performance Measures (Measurement Year 2023) – Child Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
IMA *H*	**Immunizations for Adolescents**					*Administrative*			
	– Human Papillomavirus (HPV)	30.12 z	<25th	29.68	<25th	32.60 n	<50th	27.98 z	<25th
	– Meningococcal	82.11	≥50th	81.75 z	≥50th	82.24 n	≥50th	82.24 b	≥50th
	– Tetanus-Diphtheria-Pertussis (Tdap)	82.63 z	<33.33rd	82.73	<50th	82.73 n	<50th	82.48	<33.33rd
	– Combination 1 (Meningococcal, Tdap)	81.29	≥50th	81.02	≥50th	81.51 n	≥50th	81.27 b	≥50th
	– Combination 2 (Meningococcal, Tdap, HPV)	29.79 z	<33.33rd	29.44	<25th	32.36 n	<50th	27.49 z	<25th
LSC *H*	**Lead Screening in Children**	55.43	<33.33rd	54.74 d	<33.33rd	55.23	<33.33rd	56.20 b	<33.33rd
PPC *H*	**Prenatal and Postpartum Care**								
	– Timeliness of Prenatal Care	84.39 ab	<50th	82.00 ab	<50th	81.75 bd	<33.33rd	88.56 x	>66.67th
TFC *A*	**Topical Fluoride for Children**								
	– 7 Days	12.53 n	NA	11.55 n	NA	13.61 n	NA	12.30 n	NA
	– 30 Days	26.66 n	NA	25.42 n	NA	27.69 n	NA	26.58 n	NA
W30 *A*	**Well-Child Visits in the First 30 Months of Life**								
	– First 15 Months	61.18	≥50th	62.24 c	≥50th	60.86	≥50th	60.49	≥50th
	– 15 Months–30 Months	65.29 b	<25th	67.15 b	<50th	65.26 b	<25th	63.98	<25th
WCC *H*	**Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total)**								
	– BMI Percentile	80.76 ab cd	<50th	77.37 cd	<50th	75.67 ab cd	<33.33rd	88.81 ab cd	>75th
	– Counseling for Nutrition	55.02 wx	<25th	62.77 cd	<25th	56.93 x	<25th	46.96 wx yz	<10th
	– Counseling for Physical Activity	52.46 wx	<25th	61.07 cd	<33.33rd	55.47 x	<25th	42.58 wx yz	<10th

* "*A*" denotes an administrative method of data collection was used; "*H*" denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Table 1.2. HEDIS Performance Measures (Measurement Year 2023) – Child Core Set (Continued)

Indicators of strength or improving rates, shown with green font or letters "a," "b," "c," and "d":
Quality Compass (QC) ranks >90th or >95th (i.e., rates above the 90th percentile)
"a" Statistically significant improvement from prior year (hybrid and survey methods only)
"b" At least 10.00% gap-to-goal improvement in rate from prior year based on a goal of 100% or 0%, depending on the measure
"c" Improving trend of at least 3.0 percentage points per year (pp/y) in rates over 3 to 5 years, depending on the measure
"d" Statistically significantly improving trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Indicators of opportunities for improvement or worsening rates, shown in purple font or letters "w," "x," "y," and "z":
QC ranks <10th or <5th (i.e., rates below the 10th percentile)
"w" Statistically significant worsening from prior year (hybrid and survey methods only)
"x" At least 10.00% gap-to-goal worsening in rate from prior year based on a goal of 100% or 0%, depending on the measure
"y" Worsening trend of at least 3.0 pp/y in rates over 3 to 5 years, depending on the measure
"z" Statistically significantly worsening trend over 3 to 5 years, depending on the measure (hybrid and survey methods only)

Other Indicators:
"n" Prior year's rates not available (measure was new or had a break in trend due to changes to the measure's technical specifications)
"NA" Quality Compass ranking was not available.

Measures & Indicators*		KanCare^		Aetna		Sunflower		UnitedHealthcare	
		Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank
WCV *A*	**Child and Adolescent Well-Care Visits**								
	– 3–11 Years	55.55	<50th	55.27 b	<50th	57.28	<50th	53.99	<33.33rd
	– 12–17 Years	50.53	<50th	49.64	<50th	52.89	≥50th	48.79	<50th
	– 18–21 Years	25.56	<50th	25.90	<50th	28.07	≥50th	22.79	<25th
	– 3–21 Years	50.63	<50th	50.29 b	<50th	52.64	≥50th	48.83	<50th

* *"A"* denotes an administrative method of data collection was used; *"H"* denotes a hybrid method.
^ The KanCare rate is the average of the MCO adult population rates, weighted by administrative denominator.

Conclusions Drawn from the Data

The MCOs calculated and submitted HEDIS rates for the 2023 measurement year. MetaStar evaluated each area requiring validation to instill confidence that the MCOs' information systems were configured appropriately and that performance measures were calculated correctly. Stratifications by race and ethnicity were not valid for any of the MCOs. Otherwise, all of Sunflower's and UnitedHealthcare's performance measures were found to be valid. The State requirement to include all KanCare members in HEDIS reporting was not met by Aetna—members with dual commercial/Medicaid enrollment and dual Medicaid/Medicare enrollment were excluded.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

Performance Measures

The following were considered when determining key strengths (refer to Table 1.1 and Table 1.2): measurement year 2023 rates above the Quality Compass 90th percentile, statistically significant improvements from 2022 (hybrid or survey methods only), at least 10.00% gap-to-goal improvement in rates from 2022 expressed as percentage points (pp) change, improvements averaging at least 3.0 pp/y since 2019 (depending on the measure), and statistically significantly improving trends (hybrid or survey methods only) since 2019 or 2021 (depending on the measure).

KanCare

While not all statistically significant trends, the MCOs have generally improved their HEDIS performance rates over the past three to five years. KanCare rates were above the 75th percentile for nine Adult and eight Child Core Set measure indicators (see Table 1.1 and Table 1.2). The Follow-Up After Emergency Department Visit for Mental Illness 7-Day and 30-Day Follow-Up (18–64 Years) indicators ranked >95th.

Seven KanCare rates for Adult Core Set measure indicators had improvements noted in Table 1.1, described below.

- Controlling High Blood Pressure, statistically significant 16.2% gap-to-goal improvement (5.7 pp) from 2022, statistically significantly improving trend of 3.4 pp/y from 2020
- Follow-up After Emergency Department Visit or Mental Illness (18–64 Years) 7 Days and 30 Days rates ranked above the 95th percentile
- Hemoglobin A1c Control for Patients with Diabetes – statistically significant improvement from 2022
  - HbA1c Control (<8%) – 18.9% gap-to-goal improvement (9.0 pp)
  - Poor HbA1c Control – 19.7% gap-to-goal improvement (7.7 pp decrease)
- Prenatal and Postpartum Care – Postpartum Care, statistically significant 25.9% gap-to-goal improvement (6.2 pp) from 2022, statistically significantly improving trend of 3.1 pp/y from 2019
- Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications – 16.4% gap-to-goal improvement (3.9 pp) from 2022

Five KanCare rates for Child Core Set measure indicators had improvements noted in Table 1.2, as shown below.

- Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (3 Months–17 Years), improving trend of 3.8 pp/y since 2019
- Childhood Immunization Status – Haemophilus Influenzae B (HiB), 10.5% gap-to-goal improvement (2.1 pp) from 2022
- Prenatal and Postpartum Care – Timeliness of Parental Care, statistically significant 20.3% gap-to-goal improvement (4.0 pp) from 2022
- Well-Child Visits in the First 30 Months of Life – 15 Months–30 Months, 11.6% gap-to-goal improvement (4.6 pp) from 2022
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
  - BMI Percentile, statistically significant gap-to-goal 22.4% (5.6 pp) increase from 2022 and statistically significantly improving trend of 5.1 pp/y from 2019

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The following were considered when determining key opportunities (refer to Table 1.1 and Table 1.2): measurement year 2023 rates below the Quality Compass 10th percentile; rates statistically significantly worse than in 2022 (hybrid and survey methods only); rates worse by at least 10.00% gap-to-goal from 2022; worsening trends of 3.0 pp/y or more since 2019 or 2021 (depending on the measure); and statistically significantly worsening trends (hybrid and survey methods only) since 2019 or 2021 (depending on the measure).

KanCare

For KanCare, one Adult Core Set measure indicator was below the 5th percentile, and one was below the 10th percentile (an additional seven Adult and five Child indicators ranked <25th).

No KanCare Adult Core Set measures had statistically significantly worsening rates, greater than 10% gap-to-goal worsening from 2022, or statistically significantly worsening trends since 2019.

Two KanCare child measures had a statistically significantly worsening rate from MY 2022. Three child measures had at least a 10.00% or greater gap-to-goal worsening. Two child measures (14 indicators) had a statistically significantly worsening trend from 2019.

- Statistically significantly worsening rate from MY 2022

  - Childhood Immunization Status – Influenza and Combination 10
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition and for Physical Activity
- At least a 10% gap-to-goal worsening from MY 2022
  - Asthma Medication Ratio – three indicators
  - Follow-Up After Emergency Department Visit for Mental Illness, members aged 6–17 years, 7 Days
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Counseling for Nutrition and for Physical Activity
- Statistically significantly worsening trend over three to five years
  - Childhood Immunization Status – all antigens and Combination 10
  - Immunizations for Adolescents – two antigens and Combination 2

Aetna

One Adult Core Set measure indicator was below the 10th percentile; nine more were below the 25th percentile. Five Child Core Set measure indicators were below the 25th percentile; none were below the 10th percentile.

The following Adult and Child Core Set measure indicators had rates that statistically significantly worsened from the prior year, worsened by 10.00% gap-to-goal or more from 2022 to 2023 (provided in pp), had a worsening trend of at least 3.0 pp/y, or had a statistically significantly worsening trend, from 2019 to 2023, depending on the measure, and are noted in Tables 1.1 and 1.2:

- Adult
  - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (18–64 Years), 8.8 pp (16.9% worsening gap-to-goal)
  - Asthma Medication Ratio
    - Ages 19–50 Years, 6.4 pp (14.5% worsening gap-to-goal)
    - Ages 51–64 Years, 4.4 pp (12.8% worsening gap-to-goal)
    - Ages 19–64, 6.1 pp (14.2% worsening gap-to-goal)
  - Follow-Up After Emergency Department Visit for Mental Illness (18–64 Years)
    - 7 Days, 3.8 pp (10.7% worsening gap-to-goal)
    - 30 Days, 6.6 pp (27.1% worsening gap-to-goal)
- Child
  - Asthma Medication Ratio – worsening trends are from 2020 to 2023
    - Ages 5–11 Years, 7.0 pp (27.9% worsening gap-to-goal), 4.6 pp/y
    - Ages 12–18 Years, 9.0 pp (30.0% worsening gap-to-goal), 3.8 pp/y
    - Ages 5–18 Years, 8.1 pp (27.2% worsening gap-to-goal), 4.3 pp/y
  - Childhood Immunization Status, statistically significantly worsening trends from 2019 to 2023
    - Diphtheria-Tetanus-Acellular Pertussis (DTaP), 1.8 pp/y
    - Haemophilus Influenzae B (HiB), 1.5 pp/y
    - Hepatitis A, 1.4 pp/y
    - Hepatitis B, 1.6 pp/y
    - Inactivated Poliovirus Vaccine (IPV), 1.7 pp/y
    - Influenza, 7.1 pp decrease from 2022 and 2.1 pp/y
    - Measles-Mumps-Rubella (MMR), 1.3 pp/y
    - Pneumococcal Conjugate, 1.6 pp/y

        - Rotavirus, 2.5 pp/y
        - Varicella-Zoster Virus (VZV), 1.3 pp/y
        - Combination 10, 1.7 pp/y
    - Follow-Up After Emergency Department Visit for Mental Illness (6–17 Years)
        - 7 Days, 4.7 pp (10.7% worsening gap-to-goal)
        - 30 Days, 4.0 pp (27.1% worsening gap-to-goal)
    - Immunizations for Adolescents
        - Meningococcal, 1.6 pp/y statistically significantly worsening trend from 2019

Sunflower

Initiation and Engagement of Substance Use Disorder (SUD) Treatment (18–64 Years), Initiation of Opioid Use Disorder (and 5.9 pp, 10.5% worsening gap-to-goal) and Total Initiation were below the 10th percentile. Ten more Adult and four Child Core Set measure indicators were below the 25th percentile. No Child Core Set measure indicators were below the 10th percentile.

The following Adult and Child Core Set measures worsened by 10.00% gap-to-goal or more (measured in pp), a worsening trend of at least 3.0 pp/y, or a statistically significantly worsening trend, from 2019 to 2023, depending on the measure, noted in Tables 1.1 and 1.2:

- Adult
    - Medical Assistance with Smoking and Tobacco Use Cessation – Total Percent Current Smokers, 2022-2023 average rate increased 5.5 pp from the 2020-2021 average rate
- Child
    - Rate decreased from 2022
        - Asthma Medication Ratio
            - Ages 5–11 Years, 9.8 pp (45.9% worsening gap-to-goal)
            - Ages 5–18 Years, 6.0 pp (22.8% worsening gap-to-goal)
        - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (Total), 3.6 pp (14.6% worsening gap-to-goal)
        - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (13–17 Years) – 30 Days, 8.4 pp (14.9% worsening gap-to-goal)
        - Follow-Up After Emergency Department Visit for Mental Illness (6–17 Years) – 7 Days, 2.6 pp (10.0% worsening gap-to-goal)
        - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total)
            - Counseling for Nutrition, 5.8 pp (15.7% worsening gap-to-goal)
            - Counseling for Physical Activity, 5.6 pp (14.4% worsening gap-to-goal)
    - Statistically significantly worsening trends from 2019 to 2022
        - Childhood Immunization Status
            - DTaP, 3.1 pp/y
            - HiB, 2.0 pp/y
            - Hepatitis A, 2.0 pp/y
            - IPV, 1.8 pp/y
            - Influenza, 3.3 pp/y
            - MMR, 1.9 pp/y
            - Pneumococcal Conjugate, 3.9 pp/y
            - Rotavirus, 2.7 pp/y

- VZV, 1.8 pp/y
- Combination 10 (all 10 antigens), 3.9 pp/y

UnitedHealthcare

Three Adult Core Set measure indicators were below the 10th percentile; three more were below the 25th percentile. Two Child Core Set indicator rates were below the 10th percentile; six were below the 25th percentile.

The following Adult and Child Core Set measures indicators had rates that statistically significantly worsened from the prior year, worsened by 10.00% gap-to-goal or more from 2022 to 2023 (provided in pp), had a worsening trend of at least 3.0 pp/y, or had a statistically significantly worsening trend from 2019 to 2023, depending on the measure, and are noted in Tables 1.1 and 1.2:

- Adult
  - Chlamydia Screening in Women (21–24 Years), 5.0 pp (12.1% worsening gap-to-goal)
- Child
  - Asthma Medication Ratio (Ages 5–11 Years), 4.2 pp (15.0% worsening gap-to-goal)
  - Childhood Immunization Status – statistically significantly worsening trends are from 2019 to 2023
    - DTaP, 2.3 pp/y
    - HiB, 1.3 pp/y
    - Hepatitis A, 1.3 pp/y
    - Hepatitis B, 1.4 pp/y
    - Influenza, 3.7 pp/y
    - MMR, 1.5 pp/y
    - Pneumococcal Conjugate, 1.6 pp/y
    - Rotavirus, 3.4 pp (11.4% worsening gap-to-goal)
    - VZV, 1.3 pp/y
    - Combination 10, 2.9 pp/y
  - Follow-Up After Emergency Department Visit for Mental Illness (6–17 Years)
    - 7 Days, 6.5 pp (19.6% worsening gap-to-goal)
  - Immunizations for Adolescents – statistically significantly worsening trends from 2019 to 2023
    - Human Papillomavirus (HPV), 2.7 pp/y
    - Combination 2, 2.5 pp/y
  - Prenatal and Postpartum Care – Timeliness of Prenatal Care, 2.0 pp (20.6% worsening gap-to-goal)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total) – statistically significant decrease and statistically significantly worsening trends from 2019 to 2023
    - Counseling for Nutrition, 12.7 pp, 3.8 pp/y
    - Counseling for Physical Activity, 13.6 pp, 3.4 pp/y

Technical Strengths

The following were areas of strength for HEDIS measure production and reporting. There were no technical strengths common to all MCOs.

Aetna

- Aetna continued to have strong processes in place to ensure accurate and complete receipt and processing of claims, enrollment, and provider data for HEDIS performance measurement. Aetna reported all organizational goals for accuracy and timeliness were met for the measurement period.

- Aetna maintained sufficient oversight of its claims processing vendors. A dedicated team ensured that vendor data were received and processed timely and completely.

Sunflower

- Sunflower once again used supplemental data from the Kansas Health Information Network (KONZA), an NCQA-certified Data Aggregator Validation organization.
- Sunflower continued to have strong processes in place to ensure accurate and complete receipt and processing of claims, enrollment, and provider data for HEDIS performance measurement. All organizational goals for accuracy and timeliness for Kansas were met for the measurement period.
- Sunflower improved its claims processing auto-adjudication rate to 95%.
- Sunflower successfully transitioned from ChangeHealthcare as its medical record review vendor following a cyber-security attack in February 2024 that prevented ChangeHealthcare from continuing with the project. Sunflower reallocated existing staff to medical record abstraction and completed the reviews on time with no issues.

UnitedHealthcare

- UnitedHealthcare continues to benefit from the support of its national plan for many aspects of HEDIS performance measure reporting, drawing on the extensive expertise of those within the corporate structure to achieve the goal of accurate and complete measure data.
- UnitedHealthcare used a vendor to conduct medical record abstraction. UnitedHealthcare adequately monitored vendor accuracy and progress and achieved 100% accuracy on the medical record re-abstraction.
- UnitedHealthcare improved its claims auto-adjudication rate to 84.6%.

Technical Opportunities for Improvement

The following were opportunities for improving HEDIS measure production and reporting.

Common Among the MCOs

Stratification of rates by race and ethnicity were not valid.

Aetna

- Aetna did not utilize Kansas-specific data sources such as direct electronic medical record data feeds and aggregated data from Kansas provider groups as supplemental data for HEDIS reporting.
- Members with dual commercial/Medicaid or dual Medicaid/Medicare enrollment were excluded from HEDIS reporting, contrary to State requirements.

Sunflower

No additional technical opportunities for improvement, other than the opportunity common to all MCOs, were noted.

UnitedHealthcare

- As was also noted in last year's report, UnitedHealthcare did not utilize Kansas-specific data sources such as direct electronic medical record data feeds and aggregated data from Kansas provider groups as supplemental data for HEDIS reporting.
- UnitedHealthcare's claims processing Overall Accuracy Rate for Kansas was 97.4%; UHCCP's goal of 98.5% was not met.

- The quantity billed for Current Procedural Terminology (CPT) code A0425 did not reflect miles traveled on encounters for ambulance service claims.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Please see Appendix D for KFMC's assessment of the MCOs' follow-up to the recommendations made as a result of the performance measure validation and evaluation process performed in 2024 (MY 2023).

Recommendations for Quality Improvement

Common Among the MCOs

Technical

1. Revise the HEDIS processes to more accurately report the rates stratified by race and ethnicity.

Performance Measures (Sunflower and UnitedHealthcare)

2. Review all HEDIS rates below the 75th percentile, as well as those above the 75th percentile with decreasing rates to identify opportunities for improvement.
3. Ensure the following areas are addressed through more focused efforts, such as assessing for health disparities and addressing barriers to associated care, etc.:
   - Initiation and Engagement of Substance Use Disorder Treatment
   - Topical Fluoride in Children
   - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (Total) – Counseling for Nutrition and for Physical Activity
   - Immunizations – Children and Adolescents
4. Continue or modify existing efforts, identified as partially addressed or in progress, for the previous recommendations noted in Appendix D.

Aetna

The recommendations below are in addition to the "Common Among the MCOs" recommendations.

Technical

1. Explore obtaining additional Kansas-specific data sources for supplemental data, such as direct electronic medical record data feeds from Kansas providers and aggregated data.
2. Include all KanCare members in HEDIS MY 2024 reporting.

Performance Measures

Given that 2024 is the last year of Aetna's contract with the State of Kansas, no performance measure recommendations are included in the report.

Sunflower

The recommendations below are in addition to the "Common Among the MCOs" recommendations.

Performance Measures

1. Ensure the following areas are addressed through more focused efforts, such as assessing for health disparities and addressing barriers to associated care, etc.

Recommendations for Quality Improvement (Continued)

UnitedHealthcare

The recommendations below are in addition to the "Common Among the MCOs" recommendations.

Technical

1. Explore obtaining additional Kansas-specific data sources for supplemental data, such as direct electronic medical record data feeds from Kansas providers and aggregated data.
2. Continue efforts to review claims processing error trends and provide additional training as appropriate to ensure claims processing accuracy goals are met.
3. Review provider billing of transportation by ambulance.

Performance Measures

4. Ensure the following areas are addressed through more focused efforts, such as assessing for health disparities and addressing barriers to associated care, etc.:
    - Chlamydia Screening in Women

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2. *Performance Improvement Project Validation*

Background/Objectives

The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. The objectives of KFMC's review were to determine if the PIP design was methodologically sound, validate the annual PIP results, evaluate the overall validity and reliability of the methods and findings, and to assess the evidence of improvement.

Technical Methods of Data Collection and Analysis

In 2024, regular interagency meetings occurred that included focused PIP discussions among staff from KDHE, Kansas Department for Aging and Disability Services (KDADS), KFMC, and each of the MCOs. KFMC provided feedback on initial and revised PIP methodologies, interventions, metric development and specifications, data analysis, and annual progress.

The PIP validations were conducted in accordance with the February 2023 Validating Performance Improvement Projects protocol worksheets and narrative provided by CMS. The evaluation includes review of the MCOs' annual reports submitted for the current and prior years (where applicable), along with their originally submitted approved PIP methodology worksheets. The MCOs' monthly data submitted to KFMC for populating into PIP Action Reports (PARs), along with the corresponding PAR metric specifications, were also reviewed.

Description of Data Obtained

Five of the fourteen PIPs validated during the 2024 to 2025 Reporting Cycle (RC) were based on HEDIS measures. For the various PIPs, sources of data included: claims, encounters, membership data, medical records, laboratory results, and immunizations identified through the Kansas Immunization Registry (KSWebIZ).

Overall Validity and Reliability of PIP

The first rating is determined based on KFMC's level of confidence (High Confidence: 95% to 100%, Confidence: 90% to <95%, Low Confidence: 80% to <90%, Little Confidence: below 80%) that the MCOs adhered to acceptable methodology for all phases of design and data collection, conducted accurate data analysis, assessed for statistical significance of any differences, and provided an interpretation of the PIP results.

The second rating determines whether the PIP produced significant evidence of improvement and has, or is on track to, reach the PIP's goal. As an assessment guide, KFMC uses a 12-point system. The MCO rating is based on KFMC's determination of progress made toward the PIP outcome goal, evidence that improvements are attributable to the PIP interventions, and evidence that improvements are sustainable. The net result is the *evaluation score*, which determines the level of overall confidence: High Confidence, 10 to 12 points; Confidence, 7 to 9 points; Low Confidence, 4 to 6 points; and Little Confidence, 3 points or fewer.

The two level of confidence ratings for each of the PIPs evaluated are included in Table 2.1 below.

Table 2.1. MCOs' PIP Topics and Validation Ratings			
PIP Topic	**Validation Status**	**Validation Rating**	**Evidence of Improvement**
Aetna			
EPSDT	Yes	90.4% – Confidence	Little Confidence
Pregnancy: Prenatal Care	Yes	92.4% – Confidence	High Confidence
Food Insecurity	Yes	92.6% – Confidence	Low Confidence
Long-Term Services & Supports (LTSS) Emergency Department (ED) Visits	Yes	95.4% – High Confidence	Little Confidence
Influenza Vaccination	Yes	95.4% – High Confidence	Little Confidence
Sunflower			
EPSDT	Yes	86.7% – Low Confidence	Little Confidence
Cervical Cancer Screening	Yes	89.8% – Confidence	High Confidence
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Yes	97.3% – High Confidence	Low Confidence
Mental Health Services for Foster Care version 2*	Yes	97.3% – High Confidence	Low Confidence
UnitedHealthcare			
EPSDT	Yes	90.7% – Confidence	Little Confidence
SMD (final year)	Yes	96.5% – High Confidence	High Confidence
Advanced Directives	Yes	88.5% – Low Confidence	Confidence
Housing (final year)	Yes	93.1% – Confidence	High Confidence
AMM	Yes	100.0% – High Confidence	Confidence
* Updated from Mental Health Services for Foster Care			

Themes of Recommendations for Quality Improvement

In assessing the EQRO recommendations for the fourteen PIPs, the main themes involved the MCOs' analysis of their data, overall consistency, and evidence of improvement. KFMC recommended for the MCOs to conduct exploratory analyses; ensure calculations and rounding are performed correctly and consistently; and that interpretations are supported by the presented data. Another recommendation theme for future annual reports was to make sure the approved materials are used for direction related to reporting, measurement adjustments, discontinuations, and continuous improvement.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Please see Appendix D for information regarding MCO progress on recommendations made in prior years' PIPs.

Aetna

EPSDT PIP

Background/Objectives

Aetna's stated aim for the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) PIP is to "achieve an EPSDT participation rate of 85 percent for ages 0–20 years, over a five-year period." The activity period for this PIP was October 1, 2022, to September 30, 2023. Aetna's multifaceted intervention strategy included the interventions listed below in Table 2.2.

Table 2.2. Aetna's EPSDT PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Interactive Voice Response (IVR) system calling campaign to remind and educate members/parents/guardians of the importance of EPSDT visits *(Implemented January 2022)*	• 1% (1,155/113,645) of members had a non-mobile phone number available to the plan. • 17% (197/1,155) of members for which the plan had a non-mobile phone number were unable to accept or receive an IVR call. • 18% (97/537) of members received EPSDT services within 90 days after the IVR phone call. • The percentage of members who received EPSDT services within 90 days after a warm transfer had a denominator less than 10.
Intervention 2: Text Message Campaign to provide educational messages to members/parents/guardians on health-related topics including EPSDT visits *(Implemented January 2022)*	• 8% (9,330/113,645) of members had an accurate mobile phone number in the MCO's databases. • The percentage of members with an EPSDT claim prior to the text campaign date was not calculated as defined within its measure specifications. • 23% (2,188/9,330) of members received EPSDT services within 90 days following the initial text message. . • The percentage of members who received EPSDT services without a text reminder was not reported due to vendor inconsistencies.
Intervention 3: Member incentives for completing well-care visits *(Implemented January 2019)*	• 9% (4,563/49,388) of members had an EPSDT service but did not receive a letter with details on how to claim their gift card incentive. • <1% (188/64,257) of members received a letter informing them that they earned a gift card but did not have an EPSDT service that qualified them for the gift card. • 47% (34,045/72,431) of members aged 0 to 12 years received a letter with details on how to claim their gift card incentive because EPSDT services were received. • 26% (10,780/41,214) of members aged 13 to 20 years received a letter with details on how to claim their gift card incentive because EPSDT services were received. • The percentage of members who had not received a letter with details on how to claim their gift card incentive because they did not complete an EPSDT service was not calculated as defined within its measure specifications.
Intervention 4: Use of Health Tag reminders on prescriptions filled at CVS pharmacies *(Discontinued March 2022)*	This intervention was discontinued, with State approval, before implementation.
Intervention 5: EPSDT-related webinars to educate providers/office staff on the EPSDT program and recommended screenings *(Implemented January 2022)*	• 20 persons attended, or participated, in the webinar. • The number of provider offices invited to the webinar was not provided. • 13 registrants did not attend the live webinar. • Survey results were suppressed due to low volume.
Intervention 6: Outreach calls to parents/guardians in Sedgwick County, aged 6–18, who identify as Black or Black non-Hispanic individuals, chose not to identify, or left the question blank on the enrollment form *(Implemented April 2022)*	• The MCO had an accurate phone number for 62% (2,912/4,698) of members aged 6 to 20. • 12% (360/2,912) of members aged 6 to 20 years received a successful outreach call by an EPSDT Coordinator. • 18% (66/360) of members aged 6 to 20 years who received a successful outreach call completed an EPSDT service within 90 days.

Conclusions Drawn from the Data

Tests for statistically significant differences between Remeasurement Year (RY) 3 and RY 4 Participation Rates were conducted for various subpopulations. There were several key findings:

- Significant decreases were detected across all age groups except for those members ages 1 to 2 (the

non-significant *p*-value reported for ages 6 to 9 appeared to have a typographical error that should have been *p*=.03).
- The rate decrease observed for members not in foster care was statistically significant.
- Changes were not significant for Intellectual/Developmental Disability (I/DD) or Serious Emotional Disturbance (SED) Waiver populations.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The analysis plan for the PIP Outcome Measure was well written and appropriate for the data.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- For one intervention, additional efforts were not made as indicated in the prior year's report.
- It appeared that various areas of the report were not updated from the prior year.
- Multiple calculations were incorrect, rounding errors were present throughout the report, and measure descriptions and numerator and denominator statements were not consistent for some outcome measures. There was also data missing from one intervention.

Recommendations for Quality Improvement
See Appendix C for details on the 16 recommendations made regarding opportunities for improvement in 2024.

Pregnancy: Prenatal Care PIP

Background/Objectives

Aetna identified two aims for the PIP:
- "To increase the median days between Aetna notification of the member's pregnancy and the date of delivery by 3% year over year reaching 198 median days by end of remeasurement year 4 (RY 4) or 2024."
- "To increase the Authenticated and Audited Final Hybrid HEDIS rate for the Timeliness of Prenatal Care (TOPC) measure from 72.0% in 2021 to 75.5% by end of RY 4 or 2024."

The activity period for this PIP was October 8, 2022, to October 7, 2023. The outcomes of Aetna's interventions, based on the 2024 evaluation, are provided in Table 2.3 below.

Table 2.3. Aetna's Pregnancy: Prenatal Care PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Texting campaign to female members aged 18–55 years *(Implemented December 2021 through December 2022)*	• 10 or fewer female members aged 18–55 who were identified as pregnant were notified about their $75 gift card incentive for completing a prenatal visit during their first trimester. • 6,041 female members aged 18–55 were unable to be contacted by the vendor due to not having the ability to receive a text. • Of 27,041 female members aged 18–55 who received a pregnancy-related text message, 0.04% (12) indicated that they were pregnant using the designated site.

Table 2.3. Aetna's Pregnancy: Prenatal Care PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 2: IVR campaign to female members aged 18–55 years *(Implemented December 2021 through December 2022)*	Results were deemed invalid for measuring intervention effectiveness.
Intervention 3: Telephonic care management outreach to newly enrolled members identified as pregnant in the State 834 eligibility file *(Implemented August 2020)*	• Of 2,524 female members identified as pregnant via the files from the State, 25% (636) received successful outreach within 14 business days of that information being loaded into Aetna's care management system. • Of 192 members who delivered during the measurement period and received successful outreach, 43% (82) attended a prenatal appointment within their first trimester or within 42 days of their enrollment.
Intervention 4: Incentives for providers to notify Aetna of member pregnancy *(Implemented September 2022)*	• 95 providers received an incentive for notifying Aetna of a member's pregnancy. • 783 notifications of pregnancy were sent to Aetna by providers (deduplicated to count members once per provider). • Of 4,785 female members who were pregnant during the measurement period and received care from a provider, 13% (617) had a notification of pregnancy sent to Aetna by their provider.
Intervention 5: Incentives for urgent care providers to notify Aetna of member pregnancy *(Discontinued prior to implementation)*	Discontinued in September 2022, resulting in no intervention activity.
Intervention 6: Incentives for members that receive prenatal and postpartum care *(Implemented March 2023)*	• 399 female members aged 18–55 who had an initial claim for a pregnancy-related service successfully received a text message notifying them of available incentives.
Intervention 7: Telephonic care management outreach to members identified as pregnant through claims data *(Implemented April 2023)*	• Of 916 members identified as pregnant through the claims-based report that had not yet received successful outreach, 8% (72) were successfully outreached by care management within 14 business days of Aetna's receipt of the report.
Intervention 8: Telephonic care management outreach to members identified as pregnant through Admission, Discharge, & Transfer (ADT) reporting *(Implemented April 2023)*	• Of 317 members identified as pregnant through the ADT-based report that had not yet received successful outreach, 26% (81) were successfully outreached by care management within 14 business days of Aetna's receipt of the report.

Conclusions Drawn from the Data

Based on the results presented, there has been considerable improvement made towards both aims:

- Increases made in Outcome Measure 1 from RY 3 to RY 4 for each age range, except for members aged 35 to 39, were statistically significant.
- The 2023 hybrid Timeliness of Prenatal Care rate (77.4%) was greater than the 2022 rate (73.5%) and above the targeted rate (75.5%).
- The 2023 rate for Outcome Measure 2 was 46.0%.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The 2023 hybrid Timeliness of Prenatal Care rate (77.4%) was greater than the 2022 rate (73.5%) and above the targeted rate (75.5%).

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Conclusions were not supported by the data, unclear language in technical specifications affected the reporting of outcome measures, one outcome measure was not updated per the narrative, and there were instances of process and outcome measures being calculated incorrectly.
- Language for the aims and the measures was inconsistent for all activities.
- For multiple interventions, guidance for how to document past activities was not followed.
- Further explanation was warranted for denominators reported in tables.
- Factors influencing the comparability and validity of measures did not include the extension of KanCare eligibility or members' access to care during the public health emergency.

Recommendations for Quality Improvement
See Appendix C for details on the 17 recommendations made regarding opportunities for improvement in 2024.

Food Insecurity PIP

Background/Objectives

The aim for this PIP is to "use member, provider, and community-facing interventions to reduce food insecurity reported in the annual Aetna Better Health - Health Care Equity (HCE) screening and the Food Insecurity Screening, for all targeted members through the end of the PIP." The activity period for this PIP was April 1, 2023, to March 31, 2024. Aetna's plan included the interventions listed in Table 2.4.

Table 2.4. Aetna's Food Insecurity PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Z-code project with outreach to select providers *(Implemented with provider education webinar in July 2021)*	• Of 2,980,518 claims in 2023, 0.06% (1,744) listed a Z-code identifying food insecurity. • Of 136,550 members in 2023, 0.70% (954) had claims with Z codes identifying food insecurity. • Of 954 members in 2023, 13.3% (127) were successfully contacted by Care Management (CM) for outreach within 14 days of CM being notified.
Intervention 2: Community Pharmacy Enhanced Service Network (CPESN) program with select pharmacies within Aetna's network *(Implemented July 2020)*	• Of the 150 members participating in the CPESN program, 7.3% (11) members were identified as having food insecurity on the HCE screening. • The percentage of those receiving successful outreach by Care Management was too low to be reported.
Intervention 3: IVR welcome call with Care Management follow-up as indicated *(Discontinued without implementation)*	Discontinuation of the intervention was approved April 24, 2022.
Intervention 4: Member webinar for members with diabetes and other chronic conditions to focus on education and options for healthy eating *(Implemented with initial webinar in 2023 Q1; discontinued December 2023)*	• The link for the educational webinar was sent to 11,693 members. • The number of members completing the survey was too low to report either outcome measure.
Intervention 5: Partnership with community providers to provide healthy food resources to communities identified as food deserts *(Implemented 2021 Q2)*	• Donations by Aetna in 2023 totaled $34,000.

Table 2.4. Aetna's Food Insecurity PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 6: Food Insecurity Screening via Short Message Service (SMS) or IVR *(Implemented 2022 Q3; launched 2023 Q1)*	Unable to provide process and outcome measure results due to data issues.
Intervention 7: Member Incentive for Engagement in Chronic Disease Care Management *(Implemented March 2024)*	No outcome data available.

Conclusions Drawn from the Data

Aetna's presentation and interpretation of the data were clear and organized. However, Aetna identified issues with the data they received from the vendor causing validity concerns with the data that was reported.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Aetna developed and implemented a Community Resource Directory. The directory was used by member-facing staff and contained community resources in one location.
- The Community Pharmacy Enhanced Service Network (CPESN) program was being redeveloped for implementation at a national level in other Aetna markets.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- There was an instance where the PIP Update process was not followed, and parts of the report did not adhere to established guidelines.
- Multiple measures and rates were calculated incorrectly, rounding errors were present, data were interpreted incorrectly, and some interpretations were not supported by the data.
- There were inconsistences between figure headings and data, measure descriptions and numerator and denominator statements, as well as process measure results and PAR results.

Recommendations for Quality Improvement

See Appendix C for details on the 9 recommendations made regarding opportunities for improvement in 2024.

Long-Term Services and Supports and Emergency Department Visits PIP

Background/Objectives

The aim for this PIP is to "decrease the use of emergency department visits by Home and Community Based Services (HCBS) members who are not in long term care for which the member was not subsequently admitted to a higher level of care by 4 visits per 100 members each MY over a three-year period." The activity period for this PIP was July 1, 2023, to June 30, 2024.

Aetna's intervention strategy included interventions listed below (Table 2.5) targeting members and caregivers. Two interventions were discontinued, and three new interventions were approved in the activity period.

Table 2.5. Aetna's LTSS ED Visits PIP Intervention Outcomes

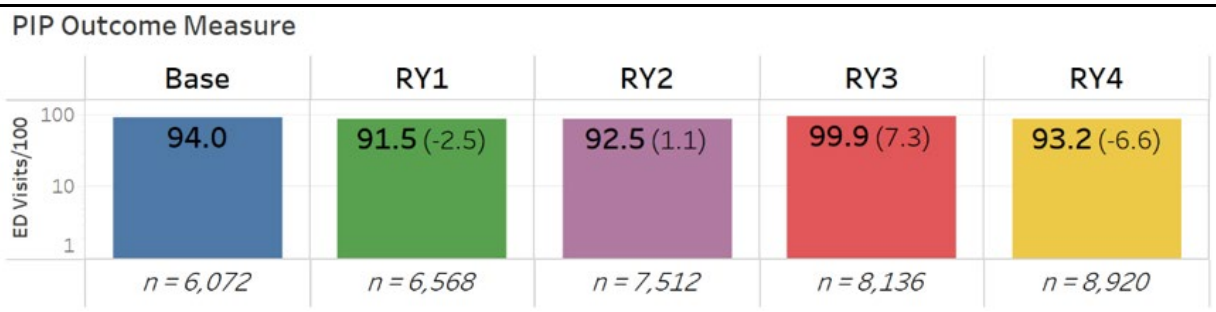
PIP Interventions	Outcomes
Intervention 1: Analyze and trend claims data for Emergency Department (ED) use to determine opportunities to decrease utilization of the ED for non-emergent (NE) conditions *(Implemented Quarter 4 2021)*	Discontinued in February 2023.
Intervention 2: Text messaging to educate members on where to seek appropriate care and provide access to the Aetna nurse line if they are unsure, measured up to 90 days after receiving the text. *(Implemented July 2021)*	• Percent of LTSS members on HCBS waivers who utilized the nurse line was 0.9% (74) for RY 3 and 0.8% (75) for RY 4. • 10 or fewer LTSS members on HCBS waivers with a NE ED visit called the nurse line up to 48 hours before the visit for both RY 3 and RY 4. • Percent of members in the PIP population with claims for NE ED visit within 90 days following receipt of the text message regarding the Nurse Line was 3.2% (33) for RY 3 and 2.9% (13) for RY 4. • Percent of members in the PIP population with claims for ED visit within 90 days following receipt of the text message regarding the Nurse Line was 28.1% (291) for RY 3 and 19.3% (85) for RY 4.
Intervention 3: Member education and resources in the form of face-to-face visit with distribution of refrigerator magnets with pertinent phone numbers and information (*Implemented December 2021*)	Discontinued in June 2023.
Intervention 4: Education and outreach to primary caregivers with information for decision making regarding use of ED, Nurse Help Line, etc. (*Implemented December 2021*)	Discontinued in June 2023.
Intervention 5: Service Coordinator outreach to members within 72 hours of notification to Aetna of discharge from ED for NE condition *(Implemented January 2022)*	• Percent of NE ED visits for the PIP population that were identified by matching ADT feed from the Kansas Health Information Network (KHIN) was 51.8% (483) for RY 3 and 9.0% (85) for RY 4. • Average number of days since last Service Coordinator (SC) contact for members in the PIP population who had NE ED visit that were identified using ADT feed from KHIN was 78.8 days for RY 3 and 90.8 days for RY 4. • Summary of key themes from SC data to better illustrate member justification for using ED versus alternatives found several themes regarding diagnosis. • Percent of NE ED visits for the PIP population identified by ADT feed from KHIN in which the members were successfully contacted within 3 business days following NE ED visit was 27.5% (133) for RY 3 and 12.9% (11) for RY 4.
Intervention 6: Coaching to non-professional caregivers who assist members receiving LTSS using an app provided by Careforth *(Implemented May 2023)*	• Percent of HCBS members that had a non-professional caregiver was 40.3% (3,280) for RY 3 and 40.2% (3,587) for RY 4. • 10 or fewer non-professional caregivers referred to Careforth consented to participate in the Careforth program for RY 3. Percent of non-professional caregivers who were referred to Careforth and consented to participate was 61.2% (82) for RY 4. • 10 or fewer non-professional caregivers in the Careforth program engaged for RY 3. Percent of non-professional caregivers who consented to participate and were engaged in Careforth was 47.8% (64) for RY 4. • 10 or fewer LTSS members with a non-professional caregiver enrolled in the Careforth program visited the ED within 6 months of caregiver enrollment in the Careforth program. Percent of members whose caregiver was enrolled in the Careforth program who had an ED visit within 6 months of program enrollment was 26.6% (17) for RY 4.

Table 2.5. Aetna's LTSS ED Visits PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 7: Addressing member's Social Determinants of Health (SDOH) and loneliness using an app provided by Pyx Health to decrease ED visits *(Implemented June 2022)*	• Percent of LTSS members referred to Pyx Health who consented to participate in the program was 2.9% (57) for RY 3 and 1.9% (11) for RY 4. • Percent of LTSS members on any waiver participating in the Pyx Health program who had an ED visit within 6 months of consenting to participate in the program was 56.1% (32) in RY 3 and RY 4 was suppressed per CMS Cell Suppression Policy.
Intervention 8: One-time education specific mailers sent to HCBS waiver members for specific conditions like respiratory, Urinary Tract Infection (UTI), and Musculoskeletal pain *(Implemented August/September 2023)*	• Percent of HCBS members who were randomly assigned to the intervention group and had a valid mailing address was 96.4% (820) for respiratory, 97.6% (700) for UTI, and 96.5% (1,038) for musculoskeletal pain. • Percent of HCBS members with a valid mailing address who were sent a brochure regarding a specific condition and had an ED visit for that specified condition within 6 months was 5.6% (46) for respiratory, 4.9% (34) for UTI, and 5.9% (61) for musculoskeletal pain for RY 4.

Conclusions Drawn from the Data

In RY 4 there were 93.2 Emergency Department (ED) visits per 100 HCBS waiver members. This was a non-significant decrease of 6.7 visits per 100 members compared to RY 3 (99.9 ED visits per 100 HCBS waiver members) and a decrease of 0.8 visits per 100 members compared to the Baseline (see Figure 2.1). Though there has not been much improvement from the Baseline, Aetna has adapted this PIP over the past several years to attempt a variety of approaches for reducing how often members on an HCBS waiver visit the emergency department.



From Aetna Figure 6

Figure 2.1. Emergency Department Visits per 100 HCBS Members, Outcome Measure Rates

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Aetna continued to adapt the PIP throughout the PIP cycle.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Past activity detail was not provided for several interventions.
- Metric descriptions appeared to be inconsistent with their numerator and denominator statements for PAR measures incorporated into the intervention plans.
- An intervention was not updated as expected from the previous annual report.

- There were wording inconsistencies between narrative and table labels, and column headings were not updated to reflect was what being reported in tables.
- Data and narrative for Process Measures were reported incorrectly.
- There was a major discrepancy between the PAR data and the data in the report.
- Not all comparisons and claims were appropriate or supported by the data.
- Sections were inconsistent on the reported information.

Recommendations for Quality Improvement
Given that 2024 is the last year of Aetna's contract with the State of Kansas, no recommendations were included in the report.

Influenza Vaccination PIP

Background/Objectives

Aetna's stated aim for the PIP is to "increase the influenza vaccination rate by 3 percentage points (pp) annually over the baseline year of 2019 for members ages 6 months to 17 years. The long-term goal is to meet Healthy People 2030 goal of increasing the proportion of people who get the flu vaccination every year to 70%." The activity period for this PIP was July 1, 2023, through June 30, 2024. Aetna's multifaceted education and outreach interventions are shown in Table 2.6.

Table 2.6. Aetna's Influenza Vaccination PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Texting Campaign (*Implemented update October 2022*)	• Of 79,626 members aged 6 months through 17 years whose contact was submitted to the vendor, the primary contact for 69.9% (55,124) successfully received the initial text message. • Of 48,505 members who had not received an influenza vaccine prior to the text message, 12.3% (5,981) received an influenza vaccination within 90 days of receipt of initial SMS/text message by their primary contact.
Intervention 2: Outreach Calls to Special Populations (*Implemented Mid-December 2021*)	• Of 617 members aged 6 months through 5 years with an asthma diagnosis who had a valid phone number and who had not received an influenza vaccination as of October 1 of the MY, 26.7% (165) were successfully outreached by an Aetna National Outreach team member. • Of 165 members aged 6 months through 5 years with an asthma diagnosis who had not received an influenza vaccination as of December 1 of the MY and who were successfully outreached by an Aetna National Outreach team member, 8.5% (14) received an influenza vaccination within 90 days of contact.
Intervention 4: Gaps in Care (GIC) Reports (*Implemented January and February 2022*)	• Of 50,309 members included on gaps in care reports sent to providers in RY 4, 8.8% (4,452) received an influenza vaccine within 90 days of a report.
Intervention 5: Member Incentives (*Implemented during 2019-2020 baseline period, suspended 2020-2021 due to vendor change; resumed with new vendor in third quarter of 2022*)	• Of 16,101 members aged 6 months through 17 years who received an influenza vaccination, 72.3% (11,640) were sent a letter with instructions that outlined how to claim a gift card incentive within the MY. • Of 4,454 members aged 6 months through 17 years who received an influenza vaccination identified via KSWebIZ, 10.9% (485) were sent a letter with instructions that outlined how to claim gift card within the MY.

Table 2.6. Aetna's Influenza Vaccination PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 6: Community Health Promotion Events Texting Campaign (*Implemented October 2022*)	• Of 2,745 members forwarded to the vendor mPulse, 31.4% (863) successfully received a text message for a community event. • Of the 863 members contacted, 10 or fewer opted out of receiving the 8 community event promotions. • Of the 767 members receiving a community event text message without an influenza vaccination prior to receiving the text, 9.5% (73) completed an influenza vaccine within 90 days of the text message. • Of the 1,713 members not receiving a community event text message without an influenza vaccination prior to the event, 7.5% (129) received an influenza vaccine within 90 days of the event.

Conclusions Drawn from the Data

Aetna aimed to increase the influenza vaccination rate by 3 pp annually for members aged 6 months to 17 years. However, the vaccination rate was 17.1% in RY 4, which is 0.8 pp lower than the rate in RY 3 (17.9%) and 11.9 pp below the baseline (29.0%). The annual report indicates a consistent decline in vaccination rates from the baseline to RY 4, suggesting that current efforts may be insufficient to meet Aetna's long-term goal of achieving a 70% vaccination rate by 2030.

To achieve the stated aim, Aetna implemented 5 interventions. Methodological issues related to the technical specifications of several interventions identified in the previous annual evaluation were resolved. Issues related to the relevance of certain messaging (e.g., the caller hold messaging for Intervention 2, which incorrectly referenced the COVID-19 public health emergency that ended in May 2023), as well as Aetna identifying a limitation as mask requirements and recommendations were found during this year's evaluation.

Chi-squared testing was conducted to evaluate the change in the PIP Outcome Measure from RY 3 to RY 4 and the impact of interventions on the influenza vaccination rate in RY 4 compared to RY 3. The statistical test for the PIP Outcome Measure showed the vaccination rate was significantly lower in RY 4 compared to RY 3. Testing used to evaluate the effectiveness of several interventions showed that members who received the interventions had statistically significantly greater vaccination rates than members in the comparison groups. An issue regarding the construction of the comparison group used to evaluate the effectiveness of Intervention 2 identified in the prior annual evaluation was not resolved and again led to conclusions not being supported by data or results of statistical testing.

To further investigate the impact of interventions on specific age groups, Aetna stratified members into three intervention groups based on age ranges (Under 5, 5 to 12, and 13 to 17). Aetna also conducted an exploratory analysis of vaccination data, stratifying it by vaccine source (claims and KSWebIZ) and across counties in Kansas. Further investigation into reasons behind counties having higher and lower vaccination rates may have provided valuable insight for further improvement and development of interventions. Finally, Aetna provided a detailed discussion on factors affecting the validity of the PIP and successes or shortcomings of each intervention and the overall PIP.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Aetna presented statistically significant results for Interventions 1, 4, and 6 conducted between RY 3 and RY 4.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Approved updates were not reflected (or separated) in past activities, thus were inconsistent in the presentation of data.
- Differing results in comparison years were not explained.
- The conclusion made between the intervention and comparison groups was not supported by the results.
- Some sections weren't updated from the prior annual report and were not applicable to this activity period.

Recommendations for Quality Improvement

Given that 2024 is the last year of Aetna's contract with the State of Kansas, no recommendations were included in the report.

Sunflower

EPSDT PIP

Background/Objectives

Sunflower's stated aim for this PIP is to "increase the EPSDT screening rate for KanCare members through a combination of provider, member, and community focus interventions over a five-year period. The effectiveness of the PIP will be measured by the percentage of KanCare members, ages 0 to 20, who receive at least one EPSDT screening within the measurement year (the Participation Rate). The goal is to achieve and maintain an 85% Participation Rate." The activity period for this PIP was January 1, 2023, to December 31, 2023, and remeasurement year was October 1, 2022, to September 30, 2023. This PIP included the six interventions listed in Table 2.7.

Table 2.7. Sunflower's EPSDT PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: mPulse text messaging campaign to members aged 6 to 20 years (*Implemented third quarter 2020; discontinued November 6, 2023*)	Unable to provide process measure results for last measurement period due to data issues.
Intervention 2: Warm phone call outreach to members on the SED Waiver (*Implemented second quarter 2020 with ages 6 to 20 years; January 2, 2023, with ages 4 to 20 years*)	• Results for Process Measure 1 RY 3 contain inconsistences. • Of 1,472 members in case management on the SED Waiver, 32% (476) completed an EPSDT visit within 90 days of receiving a call.

Table 2.7. Sunflower's EPSDT PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 3: Provider educational meetings *(Implemented March 2021 and October 2022 with five providers having 100 to 300 members 6 to 20 years of age; second and third quarter 2023 with ten providers having 100 to 1000 members 6 to 20 years)*	• One-on-one meetings were conducted with ○ 1 provider group in June 2023, ○ 5 provider groups in July 2023, ○ 2 provider groups in August 2023, and ○ 2 provider groups in September 2023. • Of 3,489 members aged 0–20 years who were attributed to a provider receiving this intervention and who had a claim for an office visit during the RY 3, 63% (2,199) received an EPSDT-related service during their office visit. • Of 7,015 members aged 0–20 years who were attributed to a provider receiving this intervention in the 12 months prior to the provider's in-person visit, 46% (3,227) received an EPSDT visit within those prior 12 months. • Of 5,601 members aged 0–20 years who were attributed to a provider receiving this intervention in the 12 months following the provider's in-person visit, 42% (2,374) received an EPSDT visit within those following 12 months.
Intervention 5: Internal staff trainings *(Implemented March 2021, August 2022; fourth quarter 2023; discontinued November 6, 2023)*	• 23 staff completed training
Intervention 6: Community events *(held in July, August, and October 2023)*	Outcome measure results for RY 2023 contain inconsistences.
Intervention 7: Proactive Outreach Management (POM) calls to members needing EPSDT services *(Implemented as monthly in second quarter 2023)*	Outcome measure results for RY 2023 contain inconsistences.

Conclusions Drawn from the Data

The Participation Rate indicates Sunflower is not making progress toward the PIP goal of reaching an 85% Participation Rate. The RY 3 rate (49.50%) was only 0.88 pp above the Baseline (48.62%).

The EPSDT Participation Rates by age group for the baseline (10/1/2017 to 9/30/2018) and RY 3 (10/1/2022 to 9/30/2023), along with the difference in percentages between rates showed increases in four of the age categories of over 4 pp from the baseline to RY 3 (see Figure 2.2).

Sunflower Table 36

EPSDT rates compared to baseline RMY 3 (10/1/2022 to 9/30/2023)			
Age range	**Baseline Rate**	**Rate**	**Difference (+/-)**
Under Age 1	90.44%	91.11%	+0.67%
Age 1 TO 2	73.51%	78.00%	+4.49%
Age 3 TO 5	61.46%	61.31%	-0.15%
Age 6 TO 9	41.50%	45.61%	+4.11%
Age 10 TO 14	41.95%	46.45%	+4.50%
Age 15 TO 18	33.16%	38.80%	+5.64%
Age 19 TO 20	12.36%	15.12%	+2.76%

Figure 2.2. Comparison of Baseline and RY 3 Participation Rates by Age Group

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- EPSDT Participation Rates have increased from baseline to RY 3 for six out of seven age groups.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Multiple values and interpretation of statistical analysis in the report were incorrect.
- Incorrect or contradictory statements were made within the narrative or between tables and narrative, and table titles and labels did not describe the data presented.
- Interpretation of changing rates did not mention factors known to impact comparability of rates between measurement periods.
- The technical specifications for the PIP outcome measure had not been updated to reflect the most recent specifications approved by the State.
- A clear distinction was not made between different measures in the report, and not all comparisons of measures were appropriate. Additionally, one outcome measure was not calculated according to technical specification.
- An intervention summary was not reported in accordance with the *PIP Instructional Guide*.

Recommendations for Quality Improvement
See Appendix C for details on the 30 recommendations made regarding opportunities for improvement in 2024.

Cervical Cancer Screening PIP

Background/Objectives

Sunflower's stated aim for the Cervical Cancer Screening (CCS) PIP is to "increase the HEDIS® hybrid CCS rate to 59.50% or higher over the duration of the PIP. The goal is to demonstrate a 5 pp improvement on the hybrid CCS final HEDIS® rate over the baseline CCS rate." Sunflower's multifaceted intervention approach during the activity period, January 2023 to December 2023, of this PIP included the interventions listed below in Table 2.8.

Table 2.8. Sunflower's Cervical Cancer Screening PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Monthly GIC reports to providers *(Implemented Fourth quarter 2020)*	Of 4,834 members listed on the pay-for-performance (P4P) provider GIC reports for 2023, • 12% (570) had a CCS within 180 days of the report's distribution. Of 263 members listed on the non-P4P provider GIC reports for 2023, • 13% (35) had a CCS within 180 days of the report's distribution.
Intervention 2: Interactive text messages to members through the mPulse platform *(Implemented Second quarter 2020)*	Approved to be discontinued on February 15, 2023, resulting in no intervention activity.
Intervention 3: POM phone call outreach to members *(Implemented Fourth quarter 2020)*	Measure results for MY 2023 contain inconsistences and are not trusted.
Intervention 6: Focused education campaign to I/DD members, their mental health provider, and their PCP or obstetrician/gynecologist (OB/GYN) *(Implemented September 2023)*	Of 348 CCS eligible I/DD members without a screening before the 9/14/2023 education campaign, • 3% (12) had a CCS within 90 days after the campaign, and • 4% (13) had a CCS within 120 days after the campaign.

Conclusions Drawn from the Data

Sunflower used two types of HEDIS CCS rates to assess progress of the PIP, hybrid rates that are based on claims and medical record review for a sample of members, and administrative rates that are primarily based on claims data (see Figure 2.3). The original goal of the PIP was to increase the hybrid CCS rate by 5 pp from the baseline (MY 2018) rate of 54.50% to 59.50%. Since the goal was exceeded for each of the first three years, Sunflower added a secondary goal, to increase an additional 2 pp annually. Since the administrative rates do not show an improvement of 2 pp from 2022 to 2023, an increase of 2 pp or greater in the hybrid rates appears unlikely.

From Sunflower Table 21

CCS Rates by Year (Hybrid)			
Measurement Years 2019 to 2023			
Year	Rate	Den	Num
2019	59.61%	411	245
2020	62.04%	411	255
2021	62.04%	411	255
2022	61.31%	411	252
2023	Not Available		

From Sunflower Table 20

CCS Rates by Year (Administrative)			
Measurement Years 2019 to 2023			
Year	Rate	Den	Num
2019	55.10%	13,499	7,438
2020	51.69%	16,774	8,670
2021	55.30%	19,705	10,896
2022	55.81%	21,711	12,117
2023*	55.32%	17,314	9,578

*Data not fully mature

Figure 2.3. Hybrid and Administrative CCS Rates by Year

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Sunflower sustained improvements with this PIP.
- Changes were made to improve the focused education intervention and was launched in September 2023 as planned.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Sunflower discussed a date period as unfinalized data but did not provide which measurement period this represented.
- Several *p*-values were incorrect.
- Table titles, numbering, descriptions, definitions, and labels were inconsistent with the associated narrative; some tables contained incorrect numerators, denominators, and rates.
- Description of statistical testing in an intervention was unclear and hard to identify which rate was being used for comparison; the evidence was also not presented clearly.
- An intervention summary was not provided in accordance with the *PIP Instructional Guide*.
- Data were reported inconsistently.

Recommendations for Quality Improvement

See Appendix C for details on the 17 recommendations made regarding opportunities for improvement in 2024.

Diabetes Monitoring for Members with Diabetes and Schizophrenia PIP

Background/Objectives

Sunflower's stated aim for the PIP is "the use of a multifaceted intervention approach, targeting Sunflower Health Plan members aged 18-64 years who have diagnoses of diabetes and schizophrenia or schizoaffective disorder and providers who serve this population will increase completion of annual Low-density Lipoprotein Cholesterol (LDL-C) and Diabetes HbA1c testing by 3 pp year over year." Sunflower's interventions implemented during the PIP activity period (January 1, 2023, through December 31, 2023) are listed below in Table 2.9.

Table 2.9. Sunflower's SMD PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Outreach calls to members who have not completed testing for both LDL-C and HbA1c *(Implemented November 2020)*	• Of the 797 members in RY 4 who had not completed testing for both LDL-C and HbA1c, 3.8% (30) successfully received a warm call reminding them to complete the outstanding LDL-C and HbA1c tests. • Of the 30 members who received a successful warm call in RY 4, ten or fewer completed their outstanding LDL-C and HbA1c tests within 90 days of the warm call.
Intervention 2: Sending monthly GIC reports to members' PCPs *(Implemented February 2021)*	• Of the 153 members in RY 4 who had not completed testing for both LDL-C and HbA1c and whose provider was participating in the GIC email campaign, 100% (153) were listed on a GIC report that was received by their provider. • Of the 153 members in RY 4 who had not completed testing for both LDL-C and HbA1c and whose provider was participating in the GIC email campaign and received a GIC report, 17.0% (26) had both the LDL-C and HbA1c tests completed within 90 days of their PCP receiving the GIC report identifying them.
Intervention 3: Co-branded letter campaign partnered with five community mental health centers (CMHCs) *(Implemented November 2020)*	• Of the 35 members in RY 4 who had not completed testing for both LDL-C and HbA1c prior to the date the co-branded letter was sent and whose CMHC was participating in the co-branded letter campaign, the co-branded letter was composed and posted to 100% (35) of CMHC participants. • Of the 35 members who had a co-branded letter composed and posted, ten or fewer resulted in the completion of outstanding LDL-C and HbA1c tests within 90 days of the letter's posted date.

Conclusions Drawn from the Data

PIP Outcome Measure 1 was the Administrative HEDIS Diabetes Monitoring for the Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) measure. Sunflower reported that 295 (68.13%) of 433 members meeting the denominator criteria for this measure completed both LDL-C and HbA1C tests in RY 4, which was 4.65 pp higher than the rate in RY 3 (63.48%) and 2.59 pp higher than the baseline rate (65.54%). PIP Outcome Measure 2 was a stratified version of the first PIP Outcome Measure by members who received an intervention (*Intervention group*) and those who did not (*No Intervention group*). Though Sunflower correctly interpreted the comparison that was conducted between the two groups (i.e., by stating that it was inconclusive), they did not indicate why. By design, the No Intervention group has a higher testing rate than the Intervention group since members who met numerator criteria at the time of an intervention were placed in the No Intervention group.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The logistic regression provided insight into the effectiveness of combinations of interventions, which can be built upon in the next annual report.
- Sunflower provided a thorough and detailed list of recommendations including utilization of data, limiting the number of interventions, effective use of the Plan-Do-Study-Act (PDSA) cycle, and team collaboration.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- A conclusion was made regarding testing that was not statistically meaningful.
- Adherence to the CMS policy on cell suppression remained an opportunity for improvement.
- Sunflower did not explain factors that affected the comparability of rates between the intervention and no intervention groups.
- Tables within the report contained both significant and non-significant variables, which was inconsistent with the provided narrative.

Recommendations for Quality Improvement
See Appendix C for details on the 7 recommendations made regarding opportunities for improvement in 2024.

Mental Health Services for Foster Care PIP, Version 2

Background/Objectives

Sunflower's Mental Health Services for Foster Care (MHFC) PIP (version 1) originated on August 1, 2020, with an aim to "increase the outpatient behavioral health treatment access for out-of-home foster care youth ages 3 to 17 across the state for the duration of the PIP." The goal of the PIP was a 2% increase of foster care members with a behavioral health diagnosis using behavioral health services year-over-year, by increasing expedited access and expansion of services available. Through the work of the PIP, Sunflower requested that the PIP be revamped to a new version due to different goals and annual targets. KDHE approved the request and MHFC version 2 began on August 1, 2023. The baseline for the new PIP was August 1, 2022 – July 31, 2023, and RY 1 was August 1, 2023 – July 31, 2024.

The aim for this PIP is to "keep foster care members in stable placement by reducing the number of visits/stays in higher level of care behavioral health services for the mental health out of home Foster Care youth aged 3-17 over a three year period; through utilization of outpatient mental health services a decrease will be realized by promoting utilization of outpatient mental health services through encouraging mental health services in a community setting, promoting evidence based practice training models to caregivers, and providing incentives to Community Mental Health Centers (CMHCs) to engage in care with high risk members."

Sunflower's interventions during the activity period (August 1, 2023 through July 31, 2024) targeted members, guardians, and providers see details in Table 2.10 below.

Table 2.10. Sunflower's Mental Health Services for Foster Care PIP, Version 2 Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: SED Waiver/Psychiatric Residential Treatment Facility (PRTF) *(Implemented 2021 Q2)*	• Of the 270 foster care members meeting PIP eligibility criteria who qualified for a PRTF stay and were placed on the waitlist for PRTF admission in RY 1, 24.8% (67) were admitted. • Of the 67 foster care members who were admitted to a PRTF after being placed on the waitlist in RY 1, 100% (67) received behavioral health services while on the waitlist. • Of the 37 foster care members meeting PIP eligibility criteria who were discharged from a PRTF in RY 1, 86.5% (32) received behavioral health services within 30 days of discharge (or prior to subsequent PRTF admission, whichever comes first). • Of the 37 foster care members meeting PIP eligibility criteria who were discharged from a PRTF in RY 1, 94.6% (35) received behavioral health services within 90 days of discharge. • Of the 54 foster care members meeting PIP eligibility criteria who qualified for a PRTF stay and who received outpatient behavior health services from the date of Prior Authorization Referral to date of admission in RY 1, 18.5% (10) stayed at a state institutional alternative (SIA), 31.5% (17) visited the ED, 61.1% (33) had an inpatient stay, and 98.1% (53) stayed at a PRTF.
Intervention 2: Parent Management Training, Oregon Model (PMTO), Program *(Implemented 2020 Q4)*	• 10 or fewer foster care members who were eligible to receive PMTO services participated in PMTO in RY 1. • 10 or fewer foster care members participated in PMTO and utilized SED waiver services in RY 1. • No foster care members who participated in PMTO and completed the required modules of PMTO utilized SED waiver services in RY 1. • 10 or fewer foster care members were eligible to receive PMTO services but did not participate and utilized SED waiver services in RY 1. • Of the 2,014 foster care members who were not eligible to participate in PMTO in RY 1, 19.1% (384) utilized SED waiver services.

Intervention 3: Value-Based Care Program with CMHCs *(Implemented 2021 Q2)*	• Of the 2,088 foster care members meeting PIP eligibility criteria in RY 1, 25.7% (536) were eligible for the value-based program.
	• For the 536 foster care members who were eligible for the value-based program in RY 1, there were
	  ○ 9.3 SIA stays per 100 members,
	  ○ 21.5 visits to the ED per 100 members,
	  ○ 55.4 inpatient stays per 100 members, and
	  ○ 16.8 PRTF stays per 100 members.
	• For the 1,552 foster care members who were not eligible for the value-based program in RY 1, there were
	  ○ 2.3 SIA stays per 100 members,
	  ○ 8.6 visits to the ED per 100 members,
	  ○ 18.6 inpatient stays per 100 members, and
	  ○ 4.5 PRTF stays per 100 members.

Conclusions Drawn from the Data

Sunflower's goals were to decrease the number of SIA stays, ED visits, inpatient stays, and Psychiatric Residential Treatment Facility (PRTF) stays for out of home foster care members aged 3 to 17 who receive behavioral health services. Sunflower met their goal for one measure, ED visits. Rates for stays or visits per 100 eligible foster care members are listed below:

- There were 4.1 SIA stays per 100 members in RY 1, which was 1.4 stays per 100 members higher than the baseline (2.7).
- There were 11.9 visits to the ED per 100 members in RY 1, which was 0.9 visits per 100 members lower than the baseline (12.8).

- There were 28.1 inpatient stays per 100 members in RY 1, which was 6.9 stays per 100 members higher than the baseline (21.2).
- There were 7.7 PRTF stays per 100 members in RY 1, which was 1.1 stays per 100 members higher than the baseline (6.6).

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Sunflower completed a thorough investigation into why their previous PIP was not as successful as intended. Due to the findings of that investigation, the previous PIP was redesigned into this current PIP.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Several results of statistical tests were interpreted inaccurately.

Recommendations for Quality Improvement
See Appendix C for details on the 12 recommendations made regarding opportunities for improvement in 2024.

UnitedHealthcare

EPSDT PIP

Background/Objectives

UnitedHealthcare's stated aim for this PIP was "Will the use of targeted interventions towards UHCCP members and providers improve the percentage of UHCCP members ages 0-20 who obtain at least one EPSDT screening during the measurement year? The aim for this PIP is to improve EPSDT screening compliance rates to at least 85% over a five-year period." The activity period for this PIP was October 1, 2022, to September 30, 2023. UnitedHealthcare's multi-faceted intervention approach targets both members and providers. The five interventions listed below in Table 2.11 have been implemented during the PIP.

Table 2.11. UnitedHealthcare's EPSDT PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Live calls to members who have not completed their EPSDT screening with a warm transfer option to schedule an appointment *(Implemented October 2020; August 2021; May 2022; May 2023)*	Percentage of members called that were confirmed to have an accurate phone number in 2023, 23% (118/507). Rates of successful calls in 2023: • Reached parent or guardian of the member with an accurate phone number who had not completed EPSDT screening, 92% (108/118) • Resulting in a warm transfer, 28% (30/108) • Resulting in an appointment within 90 days of the call, 11% (12/108) Fewer than 11 live call-referred appointments had a claim for EPSDT screening within 90 days of the call (too few to report). Percentage of members with an accurate phone number for a parent or guardian who were called in 2023 and had a claim for EPSDT screening within 90 days of the call, 35% (41/118).

Table 2.11. UnitedHealthcare's EPSDT PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
Intervention 2: Mailers to members who did not receive a live call to notify them of the need to complete an annual EPSDT screening *(Implemented October 2020; August 2021; May 2022; May 2023)*	Percentage of members aged 10–14 years with an EPSDT claim within 90 days of being sent a mailer: • 2022, 15% (306/2,000) • 2023, 17% (349/2,000)
Intervention 3: EPSDT GIC reports to their Foster Care Coordinator (CC) to assist in EPSDT screening gap closure for members in the foster care system (*Implemented quarterly starting fourth quarter 2020)*	Percentage of members who completed an EPSDT screening within 90 days of GIC report distribution: • 2023 Q1, 22.5% (615/2,735), was 1.5 pp greater than 2022 Q1, 21.0% (76/362), and 3.6 pp greater than 2021 Q1 baseline, 18.9% (148/782). • 2023 Q2, 23.8% (398/1,672), was 6.9 pp greater than 2022 Q2, 16.9% (194/1,149), and 4.0 pp greater than 2021 Q2 baseline, 19.8% (473/2,390). • 2023 Q3, 35.6% (407/1,143), was 11.3 pp greater than 2022 Q3, 24.3% (103/424), and 3.7 pp greater than 2021 Q3 baseline, 31.9% (500/1,567). • 2023 Q4, 27.7% (141/509), was 8.4 pp greater than 2022 Q4, 19.3% (543/2,811), and 5.0 pp greater than 2020 Q4 baseline, 22.7% (261/1,152). Percentage of members assigned to one of the 4 contractors who completed an EPSDT screening (October 1 to September 30 measurements): • 2020 (baseline), 52%–63% with an overall rate of 57% (1,586/2,738) • 2021, 76%–81% with an overall rate of 78% (2,031/2,608) • 2022, 71%–76% with an overall rate of 74% (2,074/2,819) • 2023, 77%–85% with an overall rate of 83% (1,719/2,083)
Intervention 4: EPSDT GIC reports to providers who do not participate in the provider incentive program, delivered by UnitedHealthcare's Clinical Practice Consultants *(Implemented quarterly starting fourth quarter 2020; discontinued November 6, 2023)*	Percentage of targeted provider groups who received GIC reports for members without an EPSDT screening: • 2023 Q1, 100% (59/59), equaled 2022 Q1, 100% (77/77), and equaled 2021 Q1 baseline, 100% (61/61). • 2023 Q2, 100% (53/53), equaled 202 2Q2, 100% (62/62), and 5 pp greater than 2021 Q2 baseline, 95% (57/60). • 2023 Q3, 100% (56/56), equaled 2022 Q3, 100% (54/54), and 5 pp greater than 2021 Q3 baseline, 95% (56/59). • 2023 Q4, 100% (45/45), equaled 2022 Q4, 100% (44/44), and equaled 2020 Q4 baseline, 100% (42/42). Proportion of providers responding to survey who responded that the GIC report was instrumental/helpful in increasing screening rate: • 2020, 44% (4/9) • 2021, 50% (4/8) • 2022, 45% (9/20) • 2023, 50% (7/14)

Table 2.11. UnitedHealthcare's EPSDT PIP Intervention Outcomes (Continued)	
PIP Interventions	**Outcomes**
	Percentage of members who completed an EPSDT screening within 90 days of GIC report delivery to provider: • 2023 Q1, 11.5% (1,965/17,092), was 0.0 pp different than 2022 Q1, 11.5% (1,929/16,738), and 0.3 pp less than 2021 Q1 baseline, 11.8% (1,432/12,099). • 2023 Q2, 17.6% (2,454/13,929), was 1.3 pp less than 2022 Q2, 18.9% (3,021/15,958), and 0.3 pp greater than 2021 Q2 baseline, 17.3% (2,131/12,332). • 2023 Q3, 12.2% (1,555/12,790), was 1.1 pp less than 2022 Q3, 13.3% (1,792/13,466), and 3.2 pp greater than 2021 Q3 baseline, 9.0% (1,091/12,110). • 2023 Q4, 10.4% (1,033/9,936), was 1.9 pp greater than 2022 Q4, 8.5% (913/10,700), and 0.6 pp greater than 2020 Q4 baseline, 9.8% (864/8,812).
Intervention 5: Incentive payments to providers for closing EPSDT GIC *(Implemented quarterly starting fourth quarter 2020)*	Percentage of provider groups eligible for the incentive who received the incentive for closing screening gaps: • 2020, 97% (125/129). • 2021, 94% (118/126). • 2022, 99% (94/95). • 2023, validated data not available at time of report. Percentage of members aged 6–20 years assigned to participating PCP who received EPSDT screening from any provider during calendar year: • 2020, 30% (14,683/49,396) • 2021, 51% (53,125/105,239) • 2022, 32% (22,040/19,253) • 2023, 30% (19,253/63,580)

Conclusions Drawn from the Data

UnitedHealthcare provided results of the Participation Rate, the percentage of members aged 0–20 years who obtained at least one EPSDT screening during the measurement period, as reported in Table 19 (see Figure 2.4). The Participation Rate for the baseline (10/1/2018 to 9/30/2019) was 48.3%. For RY 4 (10/1/2022–9/30/2023) the rate was 46.5%; a decrease of 1.8 pp from baseline and 1.1 pp from the prior year.

Table 19

EPSDT Participation Rates by Age					
Age Group	**Baseline** (10/1/2018 – 9/30/2019)	**Remeasure Yr1** (10/1/2019 – 9/30/2020)	**Remeasure Yr2** (10/1/2020 – 9/30/2021)	**Remeasure Yr3** (10/1/2021 – 9/30/2022)	**Remeasure Yr4** (10/1/2022 – 9/30/2023)
Under 1	91.13%	90.85%	93.30%	92.54%	90.98%
1-2	72.57%	72.53%	75.92%	76.30%	76.62%
3-5	59.02%	54.47%	61.00%	60.59%	59.14%
6-9	41.31%	38.04%	43.70%	42.54%	42.47%
10-14	42.64%	39.13%	45.11%	43.13%	42.73%
15-18	34.15%	34.16%	38.54%	36.04%	35.84%
19-20	10.01%	10.95%	16.66%	13.66%	12.97%
Total	**48.27%**	**45.76%**	**50.01%**	**47.60%**	**46.49%**

Figure 2.4. EPSDT Participation Rates by Age Group

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The overall EPSDT screening rate for Foster Care Gap in Care (GIC) Report intervention was 83% in RY 4.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Clarifying details were not included in the interventions, and UnitedHealthcare did not use consistent terminology throughout the report.
- One of the goals of the analytic plan cannot be assessed using the analyses that are currently implemented.
- Data was reported incorrectly.
- Factors known to impact the outcome measure were not included in the interpretation of measure results.
- It appeared that an area of the report was not updated from the prior year.
- A larger expansion of interventions is warranted to increase the Participation Rate following a proper evaluation of intervention effectiveness.

Recommendations for Quality Improvement
See Appendix C for details on the 17 recommendations made regarding opportunities for improvement in 2024.

Improving Diabetes Monitoring for Members with Diabetes and Schizophrenia PIP

Background/Objectives

UnitedHealthcare stated the aim for this PIP is to "employ direct outreach to members and providers to reach or exceed HbA1c and LDL-C testing rates of 66.82% by HEDIS measurement year 2023." The PIP activity period was January 1, 2023, through December 31, 2023. UnitedHealthcare's intervention strategy focused on employing direct outreach to members and providers to improve testing rates for HbA1c and LDL-C. The following interventions in Table 2.12 were implemented during this PIP.

Table 2.12. UnitedHealthcare's SMD PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: CM outreach to members on waivers *(Implemented June 2021)*	• Of 159 waiver members in 2023, 30.82% (49) received successful outreach from a care manager. • Of 49 waiver members in 2023 who received successful outreach from a care manager, 57.14% (28) received HbA1c/LDL-C testing within 90 days after the successful outreach.
Intervention 2: CM outreach to members in Whole Person Care Program (WPC) *(Implemented June 2021)*	• Of 109 members in the SMP PIP population in the WPC program during campaigns from 2021 through 2023, 21.10% (23) received successful outreach from the care management team. • Of 23 members who received successful outreach from the care management team during campaigns from 2021 through 2023, 60.87% (14) received HbA1c/LDL-C testing within 90 days after the successful outreach.

Table 2.12. UnitedHealthcare's SMD PIP Intervention Outcomes (Continued)	
PIP Interventions	**Outcomes**
Intervention 3: Gap in care distribution *(Implemented December 2020)*	• Of 456 members in the 2023 SMD PIP population, 47.59% (217) were included in a GIC report. • Of 456 members in the 2023 SMD PIP population, 31.58% (144) were included in a GIC report sent to both their primary care providers and Community Mental Health Center providers. • Of 217 members included in a GIC report, 56.22% (122) received HbA1c/LDL-C testing within 90 days of the GIC report being sent. • Of 60 members in the 2023 SMD PIP populations who were included in a GIC report and also identified as on a waiver or in WPC, 51.67% (31) received HbA1c/LDL-C testing within 90 days of the GIC report being sent. • Of 157 members in the 2023 SMD PIP population who were included in a GIC report and also identified as being neither a waiver nor WPC member, 57.32% (90) received HbA1c/LDL-C testing within 90 days of the GIC report being sent.

Conclusions Drawn from the Data

The outcome measure for the PIP is the audited administrative HEDIS SMD measure. The rate for 2023 was 71.27% (325/456). As shown in Figure 2.5, the 2023 rate increased 6.4 pp over the 2022 rate (64.87%) and is 9.56 pp above the baseline rate (61.71%). The 2023 rate is above the targeted testing rate (66.82%).

Table 13

SMD Rates - Total Population			
Measurement Year	**Denominator**	**Numerator**	**Rate**
2019 (Baseline)	397	245	61.71%
2020	434	252	58.06%
2021	452	274	60.62%
2022	427	277	64.87%
2023	456	325	71.27%

Numerator: *Members meeting the denominator criteria who have obtained both an LDL-C test and HbA1c test during the measurement year.*
Denominator: *UHCCP members between the ages of 18-64 as of December 31 of the measurement year with diagnoses of schizophrenia or schizoaffective disorder and diabetes with no more than one gap in enrollment of up to 45 days during the measurement year.*

Figure 2.5. HEDIS SMD Rates

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- UnitedHealthcare exceeded its goal for the PIP outcome measure of the HbA1c/LDL-C testing rate by 4.45 pp in MY 2023.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- A clear distinction was missing in measures.
- Incorrect *p*-values were shown in the report.

Recommendations for Quality Improvement
See Appendix C for details on the 3 recommendations made regarding opportunities for improvement in 2024.

Advanced Directives PIP

Background/Objectives

UnitedHealthcare stated the aim for this PIP is, "the use of targeted, culturally competent education to HCBS Waiver members ages 18 and over will lead to 25% of the identified population having an executed Advanced Directives (AD) on file with UHCCP by the end of the PIP measurement period. Year one is the baseline year, with a goal for of 3% year-over-year improvement." UnitedHealthcare's multifaceted intervention strategy was developed to provide targeted education and support to members in the HCBS Waiver regarding end-of-life planning. This PIP included four active interventions (Table 2.13) which focused on the development and provision of educational materials for members, providers, and staff during an activity period of January 1, 2023, to December 31, 2023.

Table 2.13. UnitedHealthcare's Advanced Directives PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 2: Provide AD training for UHCCP's Community Health Workers (CHW) and (CCs) *(Implementation since June of 2020)*	Percent of existing staff who completed training: • 100% (187/187); June 30, 2020 • 99% (193/194); June 30, 2021 • 100% (192/192); June 30, 2022 • 99% (178/180); June 30, 2023 Percent of new staff who completed training: • 100% (16/16); June 2020 – May 2021 • 100% (22/22); June 2021 – May 2022 • 94% (16/17); June 2022 – May 2023 • 92% (11/12); June 2023 – December 2023 Percent of adult HCBS members with AD: • 12% (8.15/67); 2020 • 15% (9.61/65); 2021 • 16% (10.10/63); 2022 • 16% (10.36/62.95); 2023
Intervention 3: Educate providers on the project *(implementation since October 1, 2021)*	UHC reviewed the AD bulletin and determined no updates were needed. The bulletin was not provided as an attachment or within an appendix of the report.
Intervention 5: AD mailer and education for new members on the Frail Elderly (FE) Waiver *(Implementation began on October 2020 with Sedgwick (SG) County and expanded to Statewide (KS)* [Kansas] *on November 1, 2022)*	Percent with AD on file within 90 days of enrollment: • 45% (64/142); October 1, 2020 – September 30, 2021 (SG) • 36% (56/156); October 1, 2021 – September 30, 2022 (SG) • 36% (207/581); November 1, 2022 – September 30, 2023 (KS) • 29% (52/182); October 1, 2023 – December 31, 2023 (KS)

Table 2.13. UnitedHealthcare's Advanced Directives PIP Intervention Outcomes (Continued)	
PIP Interventions	**Outcomes**
Intervention 6: Store completed ADs in UnitedHealthcare's care management record for new members on the Frail Elderly Waiver and its shared state with at least one provider *(Fourth quarter 2020 through December 2022; expanded from SG County to Statewide November 1, 2022)*	Stored ADs: • 104 to 186; September 30, 2020, to October 31, 2022 (SG) • 813 to 867; October 31, 2022, to December 31, 2023 (KS) Stored ADs shared by UnitedHealthcare with member's permission: • <2% (suppressed/156); July 31, 2021 (SG) • <2% (suppressed/186); October 31, 2022 (SG) • <2% (suppressed/834); July 31, 2023 (KS) • <2% (suppressed/867); December 31, 2023 (KS) Stored ADs shared by member: • <1% (suppressed/156); July 31, 2021 (SG) • 87% (162/186); October 31, 2022 (SG) • 93% (775/834); July 31, 2023 (KS) • 92% (799/865); December 31, 2023 (KS)

Conclusions Drawn from the Data

Over the course of this PIP, the percentage of ADs on file increased, from 12% to 16% in three years, which falls below the goal of 3 pp per year.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- Updates were being made to the adult HCBS Health Risk Assessment and the HCBS outreach tool that would help the care coordinators discuss ADs with members enrolled in the HCBS Waiver program and to follow up on initial discussions.
- Although UnitedHealthcare has fallen below the targeted rate of improvement of 3 pp per year, they have maintained a steady increase in the percentage of members with an AD on file enrolled in the HCBS Waiver program.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- For the second year in a row, UnitedHealthcare discussed the need for interventions to be expanded to other waivers.
- UnitedHealthcare did not interpret measure results with respect to the success of several interventions, and some evidence was unclear.
- UnitedHealthcare did not summarize prior analytic results in accordance with the *PIP Instructional Guide* and prior recommendations.
- The pp increase from the baseline to the current year is stated incorrectly twice.
- Opportunities exist to improve the technical writing. Various interventions lacked necessary details or were reported incorrectly.

Recommendations for Quality Improvement

See Appendix C for details on the 16 recommendations made regarding opportunities for improvement in 2024.

Housing PIP

Background/Objectives

UnitedHealthcare's stated aim for this PIP is to "assist members in maintaining or obtaining permanent housing through multilevel interventions. The goal is to achieve a Stable Housing rate of 80 percent annually." The interventions target members, providers, their staff, and community resources. The interventions listed below in Table 2.14 were conducted during the activity period of September 1, 2023, to August 31, 2024.

Table 2.14. UnitedHealthcare's Housing PIP Intervention Outcomes

PIP Interventions	Outcomes
Intervention 1: Staff training on homelessness and housing resources *(Implemented 2020 Q1)*	• Of the 97 CCs and CHWs who attended the annual housing training and completed the 60-day post training survey, 71.1% (69) reported the training helped them feel more confident in addressing members' housing-related needs. • Of 183 trained CCs and CHWs, 71.6% (131) referred at least one member to the Housing Navigator. • Of 183 trained CCs and CHWs, 58 scored 80% or above on the pre-training test and 147 scored 80% or above on the post-training test.
Intervention 2: Utilization of pilot of housing stabilization fund (HSF) *(Implemented 2020 Q2)*	• All 50 members who were referred for HSF in Year 4 were awarded HSF. • Of the 50 members awarded HSF in Year 4, 92.0% (46) maintained housing for a minimum of 90 days.
Intervention 3: Housing Bridge pilot to offer 10 units of transitional/permanent housing *(Discontinued 2023 Q3)*	• Of the 28 members eligible to participate in the Bridge Pilot, 89.3% (25) participated. • Average healthcare utilization for the 16 members who transitioned to permanent housing was $57,401.76 in the 12 months prior to Bridge Pilot participation and was $71,981.84 in the 12 months after starting Bridge Pilot participation. This was an increase of $14,580.08. • Of the 25 participating members from August 2020 through July 2024, 64.0% (16) transitioned to permanent housing.
Intervention 6: SDOH screening *(Implemented 2023 Q1)*	• From 5,888 SDOH real time offer (RTO) assessments completed, 1.4% (82) of members were identified as having housing related needs in Year 4. • Of 82 members identified as having housing related needs during an SDOH RTO assessment, 14.6% (12) were referred to WPC for support. • Of 12 members who were referred to WPC for support, 10 or fewer maintained housing after 90 days.

Conclusions Drawn from the Data

In Year 4, there were 67 out of 86 (77.91%) members who maintained stable housing, which is slightly below the goal of an 80% stable housing rate for these members. Though the goal was not achieved, UnitedHealthcare adapted this PIP well over the past four years by attempting several approaches to help members who experienced homelessness, or were at-risk for homelessness, achieve and maintain housing stability. The methodology described in the intervention plan lacked several updates suggested in the previous annual evaluation. One instance of this was for Outcome Measures 1 and 2 for the Housing Stabilization Fund (HSF) intervention which were combined for reporting purposes in analyzing the data, but this change was not reflected in the technical specifications for this intervention.

Strengths Regarding Quality, Timeliness, and Access to Health Care Service

- Educational training was put into standard practice to support member housing needs.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- Reporting instructions regarding intervention discontinuation were not followed.
- Outcome measures deviated from the technical specifications.
- A title of a table and its contents did not match, a table column heading did not match the narrative, and tables within an intervention contained inconsistent data.
- Consistent technical terminology was not used in several areas regarding technical specifications, analytic plans, and measure results.
- The reporting period for one intervention appeared to be inconsistent with the rest of the interventions.

Recommendations for Quality Improvement

UnitedHealthcare's Housing PIP activity ended on August 31, 2024. Therefore, no recommendations are included in this evaluation of their final Housing PIP report. UnitedHealthcare should review and apply the noted opportunities for improvement to continuing and future PIPs.

Antidepressant Medication Management PIP

Background/Objectives

UnitedHealthcare's stated aim for this PIP is to "increase adherence to treatment among adult members who begin treatment for major depression using antidepressant medication by using targeted, culturally competent, and multifaceted education and outreach. The goal is to increase the HEDIS® Antidepressant Medication Management (AMM) Effective Acute Phase Treatment indicator rate ("the AMM acute rate") annually by 3 percentage points, and to ultimately meet or exceed the Quality Compass (QC) 75th percentile over a three-year period."

The interventions listed below in Table 2.15 were conducted during the activity period of November 1, 2023, to October 31, 2024.

Table 2.15. UnitedHealthcare's AMM PIP Intervention Outcomes

PIP Interventions	Outcomes
Initial outreach calls to members *(Implemented February 2022)*	• All the 1,484 members who filled an initial prescription for antidepressant medication with a previous diagnosis of major depression within the past 5 years were attempted to be called in MY 3. • Of 1,484 members who filled an initial prescription for antidepressant medication with a previous diagnosis of major depression within the past 5 years, only 11.4% (169) were successfully called by Hospitality Assessment Reminder Center (HARC) staff within 14 calendar days of the generation of the HARC call list in MY 3. • Of 1,035 members from MY 1 to MY 3 successfully called by HARC staff within 14 calendar days of the generation of the HARC call list indicating a member had an initial prescription for antidepressant medication, 1.6% (16) opted into the One Care Kansas program.

Table 2.15. UnitedHealthcare's AMM PIP Intervention Outcomes (Continued)

PIP Interventions	Outcomes
	• Of 169 members in MY 3 who were successfully called by HARC staff within 14 calendar days of the generation of HARC call list indicating a member had an initial prescription for antidepressant medication, 40.2% (68) remained adherent with their antidepressant medication for at least 84 days. • Of 1,315 members in MY 3 who were not successfully called by HARC staff within 14 calendar days of the generation of HARC call list indicating a member had an initial prescription for antidepressant medication, 34.2% (450) remained adherent with their antidepressant medication for at least 84 days.
Follow-up outreach calls to members *(Implemented February 2022)*	• Of the 169 members who successfully completed a call from Intervention 1, 68.6% (116) were attempted to be called by HARC staff within 14 days of the completed call from Intervention 1. • Of the 169 members who successfully completed a call from Intervention 1, 28.4% (48) successfully completed a follow-up call within 14 days of the completed call from Intervention 1. • Of 48 members who were successfully called by HARC staff within 14 days of the successful Intervention 1 call, 50% (24) remained adherent with their antidepressant medication for at least 84 days. • Of 121 members who were not successfully called by HARC staff within 14 days of the successful Intervention 1 call, 36.4% (44) remained adherent with their antidepressant medication for at least 84 days.
Health Screening Tool completion *(Implemented February 2022)*	• Of 169 members who were successfully called by HARC staff within 14 calendar days of the generation of the HARC call list, 49.1% (83) completed a KS Health Screening Tool (HST) during the call. • Of 83 members who completed a KS HST during a successful call with HARC staff, 45.8% (38) remained adherent with their antidepressant medication for at least 84 days. • Of 86 members who did not complete a KS HST during a successful call with HARC staff, 34.9% (30) remained adherent with their antidepressant medication for at least 84 days.

Conclusions Drawn from the Data

UnitedHealthcare aimed to increase adherence to treatment among members aged 18 years and older who begin treatment for major depression using antidepressant medication. In MY 3, there were 1,137 out of 1,893 (60.1%) members who remained adherent with their antidepressant medication for at least 84 days, which is slightly higher than the goal of increasing 3 percentage points year over year. An increase from 50.3% (897/1,782) at baseline to 60.1% in M Y3 was seen during the cycle of this PIP. The goal of meeting or exceeding the Quality Compass 75th percentile was not met based on MY 2023 rankings for the AMM measure.

For each intervention, UnitedHealthcare conducted Fisher's exact test to determine if differences between intervention and control groups were statistically significant. Although the adherence rates were higher for the intervention groups, the test results showed there was no significant improvement in the adherence rate for the members in the intervention groups compared to their respective control group.

Statistical tests were also conducted to determine if the increases in the PIP Outcome Measure in MY 3 compared to the Baseline and MY 2 were statistically significant. Results indicated that both increases were statistically significant. Medicaid unwinding (the State's resumption of annual Medicaid eligibility reviews after the end of the continuous coverage requirement enacted due to the COVID-19 Public Health Emergency) was an external factor that likely substantially impacted the comparability of rates and the number of members impacted by the PIP, particularly for MY 3, but this was not mentioned in the report. Overall, the annual goal of the PIP was met, despite a lack of evidence of intervention effectiveness in the final year. This final annual report was presented well, and minimal issues were identified.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- UnitedHealthcare exceeded their targeted rate for a three-year period.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

- No major issues were noted in the report affecting the evaluation score.

Recommendations for Quality Improvement

UnitedHealthcare's AMM PIP activity ended October 31, 2024. Therefore, no recommendations are included in this evaluation of their final AMM PIP report. The MCO should review and apply the noted opportunities for improvement to continuing and future PIPs.

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3. *CAHPS Health Plan 5.1H Survey Validation*

Background/Objectives

CAHPS is a nationally standardized survey tool sponsored by the Agency for Healthcare Research and Quality (AHRQ) and co-developed with NCQA. The overall objective of the CAHPS survey is to capture accurate and complete information about consumer-reported experiences with health care. The HEDIS measures and the CMS Child and Adult Core Set measures include CAHPS Health Plan Survey measures. The State contractually required MCOs providing Kansas Medicaid (TXIX) and CHIP (TXXI) services through the KanCare program to survey representative samples of adult, general child (GC), and Children with Chronic Conditions (CCC) populations. The State required each MCO to separately sample and report results for children receiving TXIX and TXXI services.

CAHPS surveys are also required for NCQA accreditation of the MCOs. CAHPS data from health plans nationwide are submitted to NCQA, who then annually produces the Quality Compass that allows states and health plans to compare annual survey composite scores, ratings, and responses to many individual survey questions. The State also reports CAHPS data to CMS in an annual Children's Health Insurance Program Reauthorization Act (CHIPRA) report.

The 2024 CAHPS surveys (measurement year 2023) were conducted by Aetna, Sunflower, and UnitedHealthcare using the CAHPS 5.1H Adult Questionnaire (Medicaid) and CAHPS 5.1H Child Questionnaire (with CCC measure).

Technical Methods of Data Collection and Analysis/Description of Data Obtained

For the 2024 survey, each MCO contracted with NCQA-certified CAHPS survey vendors to assist with scoring methodology, fielding the survey, and presenting the calculated results. NCQA-certified vendors have ongoing NCQA oversight to ensure adherence to survey requirements. The three MCOs chose the mixed-mode mail/telephone/internet protocol for administering the surveys. This protocol includes an optional mailing of a prenotification postcard, an initial survey package mailing, mailing of a second survey package to non-respondents, reminder/thank-you postcard mailings after each survey mailing, and telephone follow-up to non-respondents. The survey packages include a cover letter, questionnaire, and postage-paid return envelope addressed to the survey vendor. The protocols specify three to six telephone follow-up attempts spaced at different times of the day and on different days of the week (within a survey, the maximum number of attempts must be the same for all members). For the internet methodology, a link to an online version of the survey is included in the cover letters. Aetna members who called to request a replacement survey were also given the option to complete the survey online. All surveys were fielded from February 2024 through May 2024.

The CAHPS tool and survey process have undergone extensive testing for reliability and validity. Detailed technical specifications are provided by NCQA for conducting the survey and processing results. Each MCO complied with the following NCQA requirements:

- Eligibility for each group required continuous enrollment in the MCO from July 1 to December 31, 2023, with no more than one gap of up to 45 days; enrollment on December 31, 2023; and enrollment when surveyed.
- Members eligible for each survey were
  - **Adults** – Age 18 years and older as of December 31, 2023;
  - **GC Populations** – Age 17 years or younger as of December 31, 2023; and

  - **CCC Populations** – A subset of the GC population identified as "CCC" using HEDIS requirements based on health criteria and specific survey answers.
- Minimum sample sizes were set by NCQA assuming an average 45% response rate for Medicaid product lines and targeting 411 responses were
  - **Adult Sample** – 1,350 adults;
  - **GC Sample** – 1,650 GC children; and
  - **CCC Supplemental Sample** – 1,840 children more likely to have a chronic condition, based on claims and encounter data, drawn from child records not selected for the GC sample. The sample size can be lower than 1,840 if fewer than 1,840 children are available for selection.

Four of the fifteen populations returned at least 411 complete and valid surveys in 2024 (TXIX GC, TXXI GC, and TXIX CCC for Aetna and TXXI GC for Sunflower). 2024 response rates ranged from 10.9% to 22.6%.

Conclusions Drawn from the Data Common Among the MCOs

With some exceptions, 2024 KanCare- and MCO-level survey results continued to demonstrate positive assessments by members of quality, timeliness, and access to healthcare. For the most part, global ratings, composite scores, and question percentages were at or above the 50th percentile. Declining rates for several metrics, particularly those surrounding coordination of care, are of concern. Additional measures should be taken by MCOs to improve this and other metrics (see Recommendations for Quality Improvement).

Tables and appendices in the full report include annual results for each survey question and composite questions related to access, timeliness, and quality of care by MCO and subgroup for 2020–2024, annual statistical comparisons by question, and annual QC rankings for composites, ratings, and questions.

In this summary report, Table 3.1 displays Health Plan, Health Care, Personal Doctor, and Specialist Seen Most Often ratings, and QC rankings by KanCare and MCO populations (adult, TXIX GC, TXXI GC, TXIX CCC, and TXXI CCC) for 2024. The global ratings are the percentage responding 8, 9, or 10 out of 10.

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Table 3.1. Global Ratings by MCO and Program (Rating 8+9+10) – 2024

Global Rating		Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
	MCO	%	Rank	%	Rank	%	Rank	%	Rank	%	Rank
Health Plan	ABH	79.5%	≥50th	85.8%	<50th	88.7%	>66.67th	84.4%	>66.67th	88.5%	**>90th**
	SHP	77.5%	<50th	86.5%	≥50th	89.1%	>75th	83.4%	≥50th	87.0%	>75th
	UHC	76.4%	<50th	86.7%	≥50th	**90.8%**	>75th	85.5%	>75th	88.1%	**>90th**
	KanCare	**77.7%**	**<50th**	**↓86.9%**		**≥50th**		**85.0%**		**>66.67th**	
Health Care	ABH	75.6%	<50th	84.8%	**<25th**	85.2%	<33.33rd	86.0%	≥50th	86.9%	>66.67th
	SHP	75.3%	<50th	86.8%	<50th	87.5%	≥50th	**↑89.5%**	>75th	89.1%	>75th
	UHC	74.3%	<50th	84.9%	**<25th**	84.4%	**<25th**	82.1%	<33.33rd	**↓**82.5%	<33.33rd
	KanCare	**75.0%**	**<50th**	**85.6%**		**<33.33rd**		**85.9%**		**≥50th**	
Personal Doctor	ABH	84.7%	≥50th	88.0%	**<25th**	87.9%	**<25th**	87.7%	<33.33rd	**89.9%**	≥50th
	SHP	85.5%	>75th	**89.7%**	<50th	87.2%	**<25th**	**89.8%**	≥50th	87.8%	<33.33rd
	UHC	85.4%	>66.67th	88.8%	<50th	**90.5%**	≥50th	**92.1%**	**>90th**	86.1%	**<25th**
	KanCare	**85.2%**	**>66.67th**	**88.8%**		**<50th**		**89.6%**		**≥50th**	
Specialist	ABH	85.4%	>75th	86.0%		<50th		82.9%	**<25th**	84%*	
	SHP	85.3%	>75th	88.8%		>66.67th		88.0%	≥50th	86.5%	<50th
	UHC	81.4%	<50th	89%*				85%*		83%*	
	KanCare	**83.9%**	**≥50th**	**87.9%**		**≥50th**		**85.2%**		**<50th**	

Note: The KanCare rate for the child surveys is the weighted average of the six subpopulations. The MCO-level general child ratings of specialist are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: Percentages 90% or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered *very high* and are shown in bold green font.
Relatively Low: For percentages less than 90%, KanCare rankings below the 50th percentile and subpopulation rankings below the 25th percentile were *relatively low* and are shown in bold purple font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.
*Fewer than 100 members responded; NCQA assigns "NA" rather than a QC ranking.

Table 3.2 displays scores and rankings for the composite measures of Getting Care Quickly, Getting Needed Care, Coordination of Care, How Well Doctors Communicate, and Customer Service for KanCare and MCO populations for 2024. A composite score is the average of its component questions' percentages.

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Table 3.2. Composite Scores by MCO and Program – 2024

Composite	MCO	Adult		General Child				Children with Chronic Conditions			
				Title XIX		Title XXI		Title XIX		Title XXI	
		Score	Rank	Score	Rank	Score	Rank	Score	Rank	Score	Rank
Getting Care Quickly	ABH	85.8	>75th	**90.1**	>66.67th	88.2	≥50th	**92.1**	>75th	**90.9**	≥50th
	SHP	83.1	>66.67th	89.2	≥50th	89.1	≥50th	**92.0**	>66.67th	**91.1**	≥50th
	UHC	↓84.3	>75th	89*		**90.4**	>75th	**92.4**	>75th	↓86.5	<33.33rd
	KanCare	**84.4**	**>75th**	**89.3**		**≥50th**		**91.7**		**>66.67th**	
Getting Needed Care	ABH	85.2	>75th	87.0	>75th	86.2	>66.67th	87.0	≥50th	**89.9**	**>90th**
	SHP	82.0	≥50th	89.2	>75th	**91.2**	**>95th**	89.4	>75th	89.4	>75th
	UHC	82.0	≥50th	86*		89.1	>75th	86.7	≥50th	86.6	≥50th
	KanCare	**83.0**	**≥50th**	**87.7**		**>75th**		**87.9**		**>75th**	
Coordination of Care	ABH	81.4	**<25th**	86.4		>66.67th		85.1	≥50th	81.5	<33.33rd
	SHP	87.2	>66.67th	84.2		<50th		86.4	>66.67th	84.8	≥50th
	UHC	86.8	>66.67th	82.9		<50th		85.3	≥50th	↓78*	
	KanCare	**85.2**	**≥50th**	**84.4**		**≥50th**		**84.9**		**≥50th**	
How Well Doctors Communicate	ABH	**92.5**	<50th	**95.9**	>75th	**96.0**	>75th	↑**97.0**	**>90th**	**96.1**	>75th
	SHP	**92.7**	<50th	**95.8**	>75th	**95.7**	>75th	↓**96.1**	>75th	**95.5**	>66.67th
	UHC	↓**90.7**	<25th	**96.5**	>75th	↑**98.2**	**>95th**	**94.9**	≥50th	**97.4**	**>95th**
	KanCare	**91.9**	**<33.33rd**	**96.2**		**>75th**		**96.0**		**>75th**	
Customer Service	ABH	**92.7**	**>95th**	**91.4**		>75th		**92.5**		>75th	
	SHP	**89.5**	≥50th	↓84.5		**<25th**		**90.4**		<50th	
	UHC	**90.7**	>66.67th	**93***				87.7		<50th	
	KanCare	**90.9**	**>75th**	↓**89.5**		**≥50th**		**90.1**		**<50th**	

Note: The KanCare score for the child surveys is the weighted average of the six subpopulations. The general child Coordination of Care and general child and children with chronic conditions Customer Service scores are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).

Very High: Scores 90 or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered *very high* and are shown in bold green font.

Relatively Low: For scores less than 90, KanCare rankings below the 50th percentile and subpopulation rankings below the 25th percentile were *relatively low* and are shown in bold purple font.

↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.

*Fewer than 100 members responded; NCQA assigns "NA" rather than a QC ranking.

Table 3.3 provides scores and rankings for composites specific to the CCC surveys: Access to Prescription Medicines, Access to Specialized Services, Coordination of Care for CCC, Family Centered Care: Getting Needed Information, and Family-Centered Care: Personal Doctor Who Knows the Child for 2024.

CAHPS questions related to access, timeliness, or quality of care that are not global ratings or composite questions (shown in Table 3.4, Table 3.5, and Table 3.6) include measures of

- Mental or emotional health,
- Having a personal doctor, and
- Smoking and tobacco use and cessation strategies (four questions).

Note that the total percent of adults that are current smokers is reported as a one-year rate and other questions related to tobacco use and cessation strategies are reported as two-year averages in Table 3.6.

Table 3.3. CCC Composite Scores by MCO and Program – 2024

Composite	MCO	Children with Chronic Conditions			
		Title XIX		Title XXI	
		Score	Rank	Score	Rank
Access to Prescription Medicines	ABH	**91.6**	>75th	**96.4**	**>95th**
	SHP	**91.2**	>75th	**92.7**	>75th
	UHC	**92.2**	>75th	**90.2**	≥50th
KanCare		**91.9**		**>75th**	
Access to Specialized Services	ABH	78.8		≥50th	
	SHP	75.3		≥50th	
	UHC	81.8		**>95th**	
KanCare		**78.6**		**≥50th**	
Coordination of Care for Children with Chronic Conditions	ABH	76.4		≥50th	
	SHP	75.3		<50th	
	UHC	74.3		<50th	
KanCare		**75.3**		**<50th**	
Family-Centered Care: Getting Needed Information	ABH	**92.0**	≥50th	**93.4**	>75th
	SHP	**↑97.6**	**>95th**	**94.9**	**>90th**
	UHC	89.4	<33.33rd	**94.2**	>75th
KanCare		**93.2**		**>75th**	
Family-Centered Care: Personal Doctor Who Knows Child	ABH	**91.3**	≥50th	**91.1**	<50th
	SHP	**91.7**	≥50th	89.3	**<25th**
	UHC	**92.7**	>66.67th	**91.4**	≥50th
KanCare		**91.7**		**≥50th**	

Note: The KanCare score is the weighted average of the six subpopulation scores. The Access to Specialized Services and Coordination of Care for Children with Chronic Conditions scores are weighted averages of the Title XIX and Title XXI populations (denominators were too small to report separately).
Very High: Scores 90 or greater, KanCare QC rankings above the 75th percentile, and subpopulation rankings above the 90th percentile were considered *very high* and are shown in bold green font.
Relatively Low: For scores less than 90, KanCare QC rankings below the 50th percentile and subpopulation rankings below the 25th percentile were *relatively low* and are in bold purple font.
↑↓Indicates a statistically significant increase or decrease compared to the prior year; $p<.05$.

Table 3.4. Non-Composite Question Related to Mental or Emotional Health – 2020 to 2024

CAHPS Question		Population	2024	2023	2022	2021	2020
Q30/Q54.	**In general, how would you rate your [your child's] overall mental or emotional health?** *("Excellent" or "Very Good")*	Adult	30.5%	30.9%	30.2%	30.7%	31.5%
		GC	66.9%	67.6%	66.9%	68.9%	68.1%
		CCC	36.9%	35.0%	35.3%	37.1%	38.1%

Note: Percentages are reported at the KanCare-level (the combined percentages weighted by MCO and program populations) because of the number of MCO-level scores being based on fewer than 100 responses.
There were no statistically significant changes compared to the prior year; $p<.05$.

Table 3.5. Non-Composite Question Related to Having a Personal Doctor – 2020 to 2024

CAHPS Question		Population	2024	2023	2022	2021	2020
Q10/Q25.	**A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you [Does your child] have a personal doctor?**	**Adult**	82.9%	84.8%	86.0%	87.2%	86.7%
		GC	84.3%	86.3%	86.4%	86.8%	87.5%
		CCC	**92.3%**	**93.3%**	**92.9%**	**93.2%**	**94.3%**

Note: Adult, GC and CCC percentages are combined percentages of MCO populations, weighted by MCO and program population size.
Very High: Percentages 90% or greater were considered *very high* and are shown in bold **green** font.
There were no statistically significant changes compared to the prior year; $p<.05$.

Table 3.6. Adult HEDIS Measures Related to Smoking and Tobacco Usage – 2024

Measure	KanCare		Aetna		Sunflower		UnitedHealthcare	
	%	Rank	%	Rank	%	Rank	%	Rank
Medical Assistance with Smoking and Tobacco Use Cessation (MSC)								
– Total % Current Smokers *(lower is better)*	**27.9%**	**≥50th**	29.1%	≥50th	29.5%	>66.67th	25.6%	≥50th
– Advising Smokers to Quit	**72.4%**	**<50th**	70.9%	<33.33rd	72.9%	<50th	73.2%	<50th
– Discussing Cessation Medications	**52.6%**	**<50th**	47.3%	**<25th**	55.6%	>66.67th	54.5%	≥50th
– Discussing Cessation Strategies	**44.4%**	**<50th**	40.4%	**<25th**	47.2%	≥50th	45.4%	<50th

Note: Adult percentages are combined percentages of MCO populations, weighted by MCO and program population size.
Relatively Low: For percentages less than 90%, KanCare rankings below the 50th percentile and subpopulation rankings below 25th percentile were *relatively low* and are in bold purple font (KanCare rank ≥50th and subpopulation rank >75th are in purple if lower is better).
No rates or averages increased or decreased statistically significantly compared to the prior year; $p<.05$.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

Outcomes

The following are areas of strength for KanCare identified by measures having very high KanCare rates (at least 90% or 90) or rankings (>75th or better). Also listed are demonstrations of improvement and MCO rates that were very high or ranked >90th or >95th.

Global Ratings

- **Rating of Health Plan**
  - GC – UHC TXXI (91%)
  - CCC – ABH TXXI (>90th), UHC TXXI (>90th)
- **Rating of All Health Care**
  - CCC – SHP TXIX (90%), significantly improved from 2023
- **Rating of Personal Doctor –** The KanCare CCC rate was 90%.
  - GC – SHP TXIX (90%), UHC TXXI (91%)
  - CCC – SHP TXIX (90%), UHC TXIX (92%, >90th), ABH TXXI (90%)

Composites

- **Getting Care Quickly** – The KanCare adult rank (>75th) and the KanCare CCC score (92) were *very high*.
  - GC – ABH TXIX (90), UHC TXXI (90)
  - CCC – ABH TXIX (92), SHP TXIX (92), UHC TXIX (92), ABH TXXI (91), SHP TXXI (91)
- **Getting Needed Care** – The KanCare GC and CCC ranks were both >75th.
  - GC – SHP TXXI (91, >95th)
  - CCC – ABH TXXI (90, >90th)
- **How well Doctors Communicate** – The KanCare adult score (92), KanCare GC score and rank (96, >75th), and the KanCare CCC score and rank (96, >75th) were *very high*.
  - Adult – ABH (93), SHP (93), and UHC (91)
  - GC – ABH TXIX (96), SHP TXIX (96), UHC TXIX (96), ABH TXXI (96), SHP TXXI (96), UHC TXXI (98, >95th) and significantly improved from 2023
  - CCC – ABH TXIX (97, >90th) and significantly improved from 2023, SHP TXIX (96), UHC TXIX (95), ABH TXXI (96), SHP TXXI (96), UHC TXXI (97, >95th)
- **Customer Service** – The KanCare adult score and rank (91, >75th), and the KanCare CCC score (90) were *very high*.
  - Adult – ABH (93, >95th), SHP (90), UHC (91)
  - TXIX & TXXI GC – ABH (91), UHC (93)
  - TXIX & TXXI CCC – ABH (93) and trending upward 1.1 points per year (p/y), SHP (90)

CCC Composites

- **Access to Prescription Medicines** – The KanCare CCC score and rank (92, >75th) were *very high*.
  - TXIX CCC – ABH (92), SHP (91), and UHC (92)
  - TXXI CCC – ABH (96, >95th), SHP (93), and UHC (90)

  Scores from 2020 to 2024 were all 90 or greater.
- **Access to Specialized Services**
  - TXIX & TXXI CCC – UHC (>95th)
- **Family-Centered Care: Getting Needed information** – The KanCare CCC score and rank remained *very high* (93, >75th).
  - TXIX CCC – ABH (92), and a statistically significant improvement for SHP (98, >95th)
  - TXXI CCC – ABH (93), SHP (95, >90th), and UHC (94)
- **Family-Centered Care: Personal Doctor Who Knows Child** – The KanCare CCC score (92) was *very high*.
  - TXIX CCC – ABH (91), SHP (92), and UHC (93)
  - TXXI CCC – ABH (91), UHC (91)

Non-Composite Questions

- **Having a Personal Doctor** – KanCare CCC rate remained *very high* (92%).
  - CCC – ABH TXIX (93%), SHP TXIX (95%), ABH TXXI (95%), SHP TXXI (94%), UHC TXXI (94%)
- **Smoking and Tobacco Usage** – UHC rates maintained an improving five-year trend (2.0 pp/y).

Technical

- Prior to sending the first survey packet, Aetna and Sunflower sent a postcard notification to all selected members. Aetna sent a third reminder postcard or questionnaire to non-respondents.
- Each MCO included an internet response option in addition to mail and phone response options. The internet link was included in the cover letters for the questionnaires.
- Aetna made up to six phone attempts to contact non-responding members (the maximum allowed).
- Vendor reports included the timeline for survey implementation.
- Analysis of survey results were clearly presented.
- Each MCO's vendor report included analyses of key drivers for the Rating of Health Plan and recommendations or resources for improving the ratings.
- Aetna's report included margins of error for global rating and composite questions.
- Each MCO's response rates were better than the corresponding average response rate for their vendor.

Opportunities for Improvement

Outcomes

Several measures for the KanCare adult and child populations, as well as for each MCO, indicated a need for improvement. *Relatively low* ranks, that is, below the 50th percentile (for KanCare rates) or the 25th percentile (for MCO ranks) for scores/rates below 90 or 90%, were considered opportunities for improvement. Rates with a statistically significant decrease from 2023 or with decreasing 2020–2024 trendlines were also considered opportunities for improvement.

Global Ratings

- **Rating of Health Plan –** KanCare adult rates ranked <50th, and KanCare GC rates statistically significantly decreased. Five-year trends were decreasing for KanCare GC (0.7 pp/y) and KanCare CCC (0.6 pp/y) rates.

- **Rating of All Health Care** – KanCare adult rates ranked <50th, and KanCare GC rates ranked <33.33rd. Trendlines were decreasing for KanCare GC (0.9 pp/y) and KanCare CCC (0.7 pp/y).
  - GC – ABH TXIX (<25th), UHC TXIX (<25th), UHC TXXI (<25th) with decreasing trendline (1.4 pp/y)
  - CCC – Decreasing trendline for UHC TXIX CCC (2.1 pp/y), statistically significant decrease and decreasing trendline for UHC TXXI (1.8 pp/y)
- **Rating of Personal Doctor** –The KanCare GC rate ranked <50th.
  - GC – ABH TXIX (<25th), ABH TXXI (<25th), SHP TXXI (<25th)
  - CCC – UHC TXXI (<25th) with decreasing trendline (1.4 pp/y)
- **Rating of Specialist Seen Most Often** – KanCare CCC scores ranked <50th.
  - CCC – ABH TXIX (<25th)

Composites

- **Getting Care Quickly –** Trendlines were decreasing for KanCare GC (1.1 p/y) and KanCare CCC (0.8 p/y).
  - Adult – Statistically significant decrease for UHC
  - GC – Decreasing trendlines for SHP TXIX (1.5 p/y) and UHC TXIX (1.4 p/y)
  - CCC – Decreasing trendlines for ABH TXIX (0.8 p/y), SHP TXIX (0.9 p/y), SHP TXXI (0.9 p/y), and UHC TXXI (2.0 p/y); statistically significant decrease for UHC TXXI
- **Getting Needed Care** – Trendlines were decreasing for KanCare adults (1.3 p/y) and KanCare CCC (0.8 p/y).
  - Adult – Decreasing trendlines for SHP (1.2 pp/y) and UHC (1.7 p/y)
  - CCC – Decreasing trendlines for ABH TXIX (1.7 p/y), SHP TXXI (1.1 p/y), and UHC TXXI (1.6 p/y)
- **Coordination of Care**
  - Adult – ABH (<25th)
  - CCC – Statistically significantly decrease for UHC TXXI
- **How Well Doctors Communicate**
  - Adult – UHC had a statistically significant decrease from 2023 and a decreasing trendline (0.7 p/y).
  - CCC – SHP had a statistically significant decrease from 2023.
- **Customer Service –** The KanCare GC score decreased statistically significantly from 2023.
  - TXIX & TXXI GC – SHP (<25th) with a statistically significant decrease
  - TXIX & TXXI CCC – Decreasing trendline for UHC (1.4 p/y)

CCC Composites

- **Access to Prescription Medicines**
  - Trendlines were decreasing for KanCare (0.7 p/y), and SHP TXIX (1.0 p/y), and UHC TXXI (1.4 p/y); however, KanCare and SHP TXIX scores remained ranked >75th in 2024.
- **Access to Specialized Services**
  - Trendlines were decreasing for KanCare (1.2 p/y) and SHP TXIX & TXXI (2.1 p/y)
- **Family-Centered Care: Personal Doctor Who Knows Child**
  - CCC – SHP TXXI (<25th) with downward trendline (0.8 p/y)

Non-Composite Questions

- **Rating of Mental or Emotional Health** – Only 30% of KanCare adult, 67% of KanCare GC, and 37% of KanCare CCC respondents rated their [their child's] overall mental or emotional health as *excellent* or *very good.* The 2020–2024 trendlines were declining for SHP TXXI GC rates (1.5 pp/y) and UHC TXXI CCC (3.0 pp/y).

- **Medical Assistance with Smoking and Tobacco Use Cessation**
  - **Smoking and Tobacco Usage** – The KanCare rate (28%) was above (worse than) the 50th percentile.
  - **Advising Smokers and Tobacco Users to Quit** – The KanCare rate (72%) ranked *relatively low* (<50th). Five-year trendlines were decreasing for KanCare (0.5 pp/y) and SHP (0.7 pp/y) rates.
  - **Discussing Cessation Medications** – The KanCare rate (53%) ranked <50th, and the ABH rate (47%) ranked <25th.
  - **Discussing Cessation Strategies** – The KanCare rate (44%) ranked <50th, and ABH rate (40%) ranked <25th.
- **Having a Personal Doctor** – The 2020–2024 trendlines were declining for KanCare adult (1.0 pp/y) and KanCare GC (0.7 pp/y) rates. There were also downward trends for UHC TXIX GC (1.5 pp/y) and UHC TXIX CCC (1.4 pp/y) rates.

Technical

- The targeted number of responses (411) was not obtained for 11 of the 15 survey populations.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Four of five recommendations made in the 2023 CAHPS Health Plan 5.1H Survey Validation report were still in progress. Please see Appendix D for more details.

Recommendations for Quality Improvement

Common Among the MCOs

In addition to the four recommendations from 2023 that are still in progress (see Appendix D for details), KFMC recommends the following.

1. The MCOs should conduct quality improvement activities to improve access to prescription medications and specialized services, particularly for children with chronic conditions. Root cause analysis could be conducted to identify the barriers for members.
2. Each MCO should work with contracted providers to improve member-provider communication and relationships. Provider education could include targeted topics to address these areas.

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4. KanCare Mental Health Consumer Perception Survey

Background/Objectives

Since 2010, KFMC has administered a mental health consumer perception survey to KanCare beneficiaries receiving services, as per the External Quality Review contract with the KDHE and the KDADS. Since 2021, KFMC has contracted with Press Ganey, formerly SPH Analytics, to administer the survey. KFMC provided operational oversight; Press Ganey analyzed survey data and produced the analysis included in this report.

The survey objectives were to assess the quality of behavioral health services by focusing on the patient's experiences with care.[5] Specific objectives of the survey include the following for adult and child populations.

Adult

- Determination of member ratings
  - Counseling and Treatment Overall
- Assessment of member perceptions
  - Getting Treatment Quickly
  - How Well Clinicians Communicate
  - Getting Treatment and Information from Health Plan
  - Being Informed about Treatment Options

Child

- Determination of member ratings
  - Child's Health Plan
  - Counseling and Treatment Overall
- Assessment of member perceptions
  - Getting Treatment Quickly
  - How Well Clinicians Communicate
  - Perceived Improvement
  - Getting Treatment and Information from Health Plan
  - Being Informed about Treatment Options

Technical Methods of Data Collection and Analysis/Description of Data Obtained

For 2024, the survey tool used was a modified version of the Experience of Care and Health Outcomes (ECHO) Survey. The sample included 13,100 KanCare members (5,550 adults and 7,550 children). KFMC created the sample frame from which Press Ganey selected the sample. The survey was administered using a one-wave, mail-only protocol. Adult members and parents or guardians of child members were mailed a survey and cover letter that included an internet option for the survey. A total of 521 adult surveys and 428 child surveys were returned or completed online. Additional details are provided in Appendix B.

Conclusions Drawn from the Data Common Among the MCOs

Adult Survey Results

Table 4.1 displays the summary rates of key measures and associated domains. In their reports, Press Ganey includes a key driver analysis regarding counseling and treatment that identifies certain measures as Power (relatively large impact and high performance), Retain (relatively small impact but above average performance), Opportunity (relatively large impact but below average performance), or Wait (relatively small impact and low performance). These are indicated in Table 4.1. KFMC also notes high rates (the five highest scoring key measures) and low rates (the five lowest scoring key measures) in the narrative following each table.

[5] Agency for Healthcare Research and Quality, Rockville MD. *Development of the CAHPS ECHO Survey*. www.ahrq.gov/cahps/surveys-guidance/echo/about/Development-ECHO-Survey.html. Content last reviewed May 2018.

Table 4.1. Summary Rates of Key Measures – Adult

Categories identified by Press Ganey as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).

Domain or Question	2024 Rate
Rating of Counseling and Treatment (Q28) (% 8, 9, or 10)	**69.9%**
Rating of Health Plan (Q53) (% 8, 9, or 10)	**77.4%†**
Getting Treatment Quickly (% Always or Usually)	**66.6%**
Q3. Got professional counseling on the phone when needed	56.3%‡
Q5. Saw someone as soon as wanted (when needed right away)	65.5%‡
Q7. Got appointment as soon as wanted (not counting times needed care right away)	78.1%‡
How Well Clinicians Communicate (% Always or Usually)	**89.4%**
Q11. Clinicians listened carefully to you	89.9%*
Q12. Clinicians explained things	87.2%*
Q13. Clinicians showed respect for what you had to say	89.7%*
Q14. Clinicians spent enough time with you	87.4%*
Q15. Felt safe with clinicians	92.2%*
Q18. Involved as much as you wanted in treatment	89.9%^
Informed about Treatment Options (% Yes)	**50.7%**
Q20. Told about self-help or support groups	43.2%
Q21. Given information about different kinds of counseling or treatment options	58.2%
Perceived Improvement (% Much better or A little better)	**55.0%**
Q31. Your ability to deal with daily problems, compared to one year ago	60.9%
Q32. Your ability to deal with social situations, compared to one year ago	48.8%
Q33. Your ability to accomplish things he/she want to do, compared to one year ago	52.1%
Q34. Rating of your problems or symptoms, compared to one year ago	58.3%
Prescription Medicines (% Yes)	
Q16. Took prescription medicines as part of treatment	88.4%
Q17. Told about side effects of medications	78.4%
Q24. Felt you could refuse a specific type of medicine or treatment	79.1%
Getting Treatment and Information from the Plan (% Not a problem)	**71.0%**
Q43. Problem with getting someone you are happy with since joining this health plan	61.6%
Q45. Problem with delays in counseling or treatment while waiting for approval	88.2%
Q46. Problem with getting counseling or treatment needed	76.8%†
Q48. Problem finding or understanding information in written materials/internet	52.0%
Q50. Problem getting the help needed when calling customer service	57.3%
Q52. Problem with paperwork from health plan	90.0%
Reasons for Counseling or Treatment (% Yes)	
Q54. Counseling was for personal problems, family problems, emotion, or mental illness	93.3%
Q55. Counseling was for alcohol or drug use	12.5%
Non-Domain Questions from Key Driver Analysis	
Q10. Seen within 15 minutes of appointment (% Always or Usually)	76.6%‡
Q29. Helped by the counseling or treatment you got (% A lot or Somewhat)	80.7%‡
Supplemental Questions (% Strongly Agree or Agree)	
Q64. I am happy with the friendships I have.	82.9%
Q65. I have people with whom I can do enjoyable things.	82.2%

Strengths Regarding Quality, Timeliness, and Access to Health Care Services – Adult

Key questions with high rates and questions identified as Power or Retain in the key driver analysis were considered strengths.

- Q11. Clinicians listened carefully to you (High, Power)
- Q12. Clinicians explained things (Power)
- Q13. Clinicians showed respect for what you had to say (High, Power)
- Q14. Clinicians spent enough time with you (Power)
- Q15. Felt safe with clinicians (High, Power)
- Q18. Involved as much as you wanted in treatment (High, Retain)
- Q52. Problem with paperwork from health plan (% Not a problem) (High)

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services – Adult

Key questions with low rates were considered opportunities for improvement, as well as the questions identified as Opportunity or Wait in the key driver analysis.

- Q3. Got professional counseling on the phone when needed (Low, Wait)
- Q5. Saw someone as soon as wanted (Wait)
- Q7. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q10. Seen within 15 minutes of appointment (Wait)
- Q20. Told about self-help or support groups (Low)
- Q29. Helped by the counseling or treatment you got (Wait)
- Q32. Your ability to deal with social situations, compared to one year ago (Low)
- Q33. Your ability to accomplish things he/she want to do, compared to one year ago (Low)
- Q46. Problem with getting counseling or treatment needed (Opportunity)
- Q48. Problem finding or understanding information in written materials/internet (Low)
- Q53. Rating of Health Plan (Opportunity)

Child Survey Results

Table 4.2 displays the summary rates of key measures and associated domains. In their reports, Press Ganey includes a key driver analysis that identifies certain measures as Power, Retain, Opportunity, or Wait. These are indicated in Table 4.2.

Table 4.2. Summary Rates of Key Measures – Child

Categories identified by Press Ganey as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).

Domain or Question	2024 Rate
Rating of Counseling and Treatment (Q29) (% 8, 9, or 10)	**73.3%†**
Rating of Child's Health Plan (Q54) (% 8, 9, or 10)	**80.6%**
Getting Treatment Quickly (% Always or Usually)	**63.9%**
Q3. Got professional counseling on the phone when needed	38.3%
Q5. Saw someone as soon as wanted (when needed right away)	71.5%‡
Q7. Got appointment as soon as wanted (not counting times needed care right away)	81.7%‡
Q11. Seen within 15 minutes of appointment	85.2%‡

Table 4.2. Summary Rates of Key Measures – Child (Continued)	
Categories identified by Press Ganey as key drivers of the Rating of Counseling and Treatment were Power (*), Retain (^), Opportunity (†), and Wait (‡).	
How Well Clinicians Communicate (% Always or Usually)	**92.5%**
Q12. Clinicians listened carefully to you	93.2%*
Q13. Clinicians explained things	94.4%*
Q14. Clinicians showed respect for what you had to say	94.5%*
Q15. Clinicians spent enough time with you	89.2%*
Q18. Involved as much as you wanted in treatment	91.0%*
Informed About Treatment Options (% Yes)	**74.1%**
Q22. Given information about different kinds of counseling or treatment options	68.0%
Q23. Given information about what you could do to manage your child's condition	80.2%
Getting Treatment and Information from the Plan (% Not a problem)	**75.7%**
Q44. Problem with getting someone your child is happy with since joining this health plan	61.7%‡
Q46. Problem with delays in counseling or treatment while waiting for approval	94.4%^
Q47. Problem with getting counseling or treatment child needed	75.2%‡
Q49. Problem finding or understanding information in written materials/internet	65.2%
Q51. Problem getting the help needed when calling customer service	64.9%
Q53. Problem with paperwork for child's health plan	92.6%‡
Perceived Improvement (% Much better or A little better)	**70.2%**
Q30. Helped by the counseling or treatment received (% A lot or Somewhat)	82.5%‡
Q32. Child's ability to deal with daily problems, compared to one year ago	76.1%
Q33. Child's ability to deal with social situations, compared to one year ago	68.5%
Q34. Child's ability to accomplish things he/she want to do, compared to one year ago	68.1%
Q35. Rating of your child's problems or symptoms, compared to one year ago	67.9%
Non-Domain Question from Key Driver Analysis (% Always or Usually)	
Q20. Family got the professional help you wanted for your child	88.5%*
Q21. Child had someone to talk to for counseling or treatment when he or she was troubled	85.8%*
Supplemental Questions (% Strongly Agree or Agree)	
Q71. I know people who will listen and understand me when I need to talk	95.4%
Q72. I have people with whom I can do enjoyable things	95.7%

Strengths Regarding Quality, Timeliness, and Access to Health Care Services – Child

Key questions with high rates and questions identified as Power or Retain in the key driver analysis were considered strengths.

- Q12. Clinicians listened carefully to you (Power)
- Q13. Clinicians explained things (High, Power)
- Q14. Clinicians showed respect for what you had to say (High, Power)
- Q15. Clinicians spent enough time with you (Power)
- Q18. Involved as much as you wanted in treatment (Power)
- Q20. Family got the professional help you wanted for your child (Power)
- Q21. Child had someone to talk to for counseling or treatment when troubled (Power)
- Q46. Problem with delays in counseling or treatment while waiting for approval (% Not a problem) (High, Retain)
- Q71. I know people who will listen and understand me when I need to talk (High)
- Q72. I have people with whom I can do enjoyable things (High)

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services – Child

Key questions with low rates were considered opportunities for improvement, as well as the questions identified as Opportunity or Wait in the key driver analysis.

- Q3. Got professional counseling on the phone when needed (Low)
- Q5. Saw someone as soon as wanted (when needed right away) (Wait)
- Q7. Got appointment as soon as wanted (not counting times needed care right away) (Wait)
- Q11. Child was seen within 15 minutes of appointment (Wait)
- Q29. Rating of Counseling and Treatment (% 8, 9, or 10) (Opportunity)
- Q30. Helped by the counseling or treatment received (Wait)
- Q35. Rating of your child's problems or symptoms, compared to one year ago (Low)
- Q44. Problem with getting someone for your child you are happy with (Low, Wait)
- Q47. Problem with getting counseling or treatment child needed (Wait)
- Q49. Problem finding or understanding information in written materials/internet (Low)
- Q51. Problem getting the help needed when calling customer service (% Not a problem) (Low)
- Q53. Problem with paperwork for child's health plan (Wait)

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

The State provided an update on the extent to which the 2023 recommendations were addressed. KFMC reviewed the updates and determined both recommendations are fully addressed. Please see Appendix D for more details.

Recommendations for Quality Improvement

Recommendations for the State

1. For adult members, monitor and explore methods to improve or continue improvement regarding,
   a. Access, quality, and timeliness of treatment;
   b. Members getting information about treatment options (information about self-help or support groups);
   c. Improved outcomes including member perceived improvement; and
   d. Member satisfaction with provider; and
   e. Accessing and understanding information in written materials or online.
2. For child members, monitor and explore methods to improve or continue improvement regarding,
   a. Access, quality, and timeliness of treatment;
   b. Improved outcomes including member perceived improvement;
   c. Member satisfaction with provider; and
   d. Accessing and understanding information, including getting needed help from customer service and problems with paperwork.

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5. *Provider Survey Validation*

Background/Objectives

The objective of the annual KanCare MCO provider survey is to assess how well each MCO is meeting its providers' expectations and needs, identifying strengths and areas for improvement. In July 2021, KDHE executed the KanCare MCO Contract Amendment 14, Section 5.9.11, specifying more detailed provider survey requirements in efforts to improve survey quality and increase consistency across the MCOs. One of the requirements is to submit results that are generalizable to the following four KanCare provider populations: Primary Care Providers (PCPs), specialists, BH providers, and HCBS providers. The MCOs must be in compliance with these requirements for their surveys. All three MCOs contracted with the Center for Applied Research and Evaluation (CARE) at Wichita State University's Community Engagement Institute (WSU-CEI), to develop and conduct the 2024 Provider Survey. The survey vendor developed a combined survey approach and a single survey instrument for the three MCOs. The MCOs' surveys were administered using a single web-based strategy, with primarily invitations sent through emails to providers for participation. In preparation for the 2024 survey, all three MCOs submitted the Survey Work Plan for State review prior to survey implementation. Two drafts of the MCOs' Survey Work Plan were reviewed, with feedback provided by the State and KFMC. KFMC noted the methodologic issues and advised the MCOs to apply steps for obtaining the generalizable results for the four provider types as required by the State. Due to time constraints, it was determined the needed changes to the methodology couldn't be corrected in time. The State did not approve the MCOs' methodology but allowed the survey to be implemented due to time restraints, with emphasis on submission of the 2025 survey methodology much earlier in the year to avoid such problems in the future. After completion of the survey, all three MCOs submitted the Survey Reports, prepared by the survey vendor, describing the survey methodology and the survey findings.

As the EQRO for the State of Kansas, KFMC completed a validation of the 2024 MCOs' Provider Surveys. The objective of KFMC's review described in this report is to validate the methodological soundness of the completed survey.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

KFMC used the February 2023 Validating Surveys Protocol worksheet and narrative, provided by CMS, to conduct the validation of Provider Surveys. The protocol is comprised of the following eight validation activities:

1. Review survey purpose, objectives, and audience
2. Review the work plan
3. Review the reliability and validity of the survey instrument
4. Review the sampling plan
5. Review the adequacy of the response rate
6. Review the quality assurance plan
7. Review the survey implementation
8. Review the survey data analysis and final report

Conclusions Drawn from the Data

As mentioned above, a combined survey approach was applied for the MCOs' surveys, therefore, validation conclusions are common for all MCOs. The key conclusions are described below:

Common Among the MCOs

- All three MCOs indicated their samples included KanCare network PCPs, specialists, BH clinicians, and HCBS providers.
- The 2024 MCO Provider Surveys did not fulfill the methodological and analytic requirements of State Contract Amendment 14. All three MCOs were unable to provide the results that could be generalizable to their respective KanCare provider networks comprised of the four required provider types, due to the following key issues:
  - Each MCO's survey was implemented by applying a single web-based mode using email addresses as the primary method to invite provider practices/locations of the four provider types to participate in the survey. A large proportion of practices/locations did not have valid email addresses, and only a few practices/locations without valid email addresses were invited via telephone to conduct the surveys. Therefore, the sample frames were formulated by applying a convenience sampling method. The total number of practices/locations included in the sample frame (those contacted by valid email address and those contacted by phone) of each MCO's survey represented a proportion of provider practices/locations of its eligible study population (84% of Aetna's; 78.6% of Sunflower's; and 36% of UnitedHealthcare's study population). As the proportions of the eligible practices/locations excluded from MCOs' sample frames were considerable (Aetna: 16%; Sunflower: 21.4%; and UnitedHealthcare: 64%), the sample frames were not representative of their respective study populations.
  - The survey samples were comprised of all the practices/locations that were selected in the MCOs' sample frames, which were formulated using a convenience sampling method as noted above. Therefore, the survey samples were also formulated by applying a convenience sampling method. By not applying a stratified random sampling method for the survey samples, the survey results could not be generalizable to MCOs' KanCare Provider Networks of PCPs, specialists, BH providers and HCBS providers. The number of provider practices/locations in the sample frames, the completed surveys needed, and the number of completed surveys achieved from the convenience sample are presented in Tables 5.1-5.3.

Table 5.1. Aetna Provider Survey: Completed Surveys Needed and Completed Surveys Achieved

Provider Type	Providers in Sample Frame	Completed Surveys Needed to Achieve Generalizability*	Completed Surveys Achieved^
Primary Care	749	255	166
Specialist Care	463	211	253
BH Care	1,348	300	566
HCBS Care	377	191	241
Total	2,938		

* These are the minimum required number of completed surveys to achieve results generalizable to the providers included in the sample frame who were invited to participate in the survey and not to all eligible providers identified in the study population.
^ The total number of completed surveys by provider type presented here are the results of the question asking, "*What is the primary type of healthcare service you provide?*"

Table 5.2. Sunflower Provider Survey: Completed Surveys Needed and Completed Surveys Achieved.

Provider Type	Providers in Sample Frame	Completed Surveys Needed to Achieve Generalizability*	Completed Surveys Achieved Using Convenience Sample^
Primary Care	343	182	166
Specialist Care	1,720	315	256
BH Care	1,403	302	569
HCBS Care	403	197	259
Total	3,869†		

* These are the minimum required number of completed surveys to achieve results generalizable to the providers included in the sample frame who were invited to participate in the survey and not to all eligible providers identified in the study population.
^ The total number of completed surveys by provider type presented here are the results of the question asking, "*What is the primary type of healthcare service you provide?*"
† The total number of provider practices/locations reported incorrectly in the Sunflower Health Plan Survey Report as 3,870.

Table 5.3. UnitedHealthcare Provider Survey: Completed Surveys Needed and Completed Surveys Achieved.

Provider Type	Providers in Sample Frame	Completed Surveys Needed to Achieve Generalizability*	Completed Surveys Achieved Using Convenience Sample^
Primary Care	282	163	169
Specialist Care	347	183	260
BH Care	872	267	564
HCBS Care	550	227	262
Total	2,051		

* These are the minimum required number of completed surveys to achieve results generalizable to the providers included in the sample frame who were invited to participate in the survey and not to all eligible providers identified in the study population.
^ The total number of completed surveys by provider type presented here are the results of the question asking, "*What is the primary type of healthcare service you provide?*"

- The survey reports noted the length of the survey as a barrier toward completion of the survey, due to asking the participants to complete surveys for all MCOs with whom they were contracted.
- The above-mentioned methodological issues and concerns were identified by KFMC and the State prior to survey implementation. The MCOs did not address these issues and concerns during survey implementation.
- Data quality assurance steps were described in the methodology sections of the survey reports. The survey vendor mentioned these steps were applied during data analysis and reporting of the results. However, various inaccuracies were seen in the calculations or reporting of the information related to minimum required completed surveys, minimum required response rates, actual response rates achieved, and actual number of completed surveys achieved. Also, discrepancies were seen in analysis and reporting of the results.
- The survey reports, described the analysis plan in the methodology section, noted all respondents were classified into four provider type groups on the basis of their response to the first question asking about the primary type of healthcare service they provide; this determined how they were represented in the data for the stratified analyses conducted for all other survey questions. However, in the stratified analysis of the survey question asking respondents to rate overall satisfaction with each MCO they currently work with, the data presented showed inconsistencies with the data shown for the initial question. In addition to this question, the inconsistencies were also seen from initial question's data with other survey questions for two of the MCOs. Reasons for this deviation were not provided.

- Due to non-representativeness of the sample frame to the study population, and application of a convenience sampling methodology for the formulation of sample frame and survey sample, the survey results could only be applied to the providers who were invited to participate in the survey.
- The survey reports presented the interpretations for most of the results in a manner that could be misinterpreted by the audience as applying to all KanCare providers in each MCO's network. The MCO reports noted the following interpretations regarding overall satisfaction in the examples below.
  - From Aetna's report, *"Over half of all providers (52%) of providers shared that overall they feel satisfied/completely satisfied with Aetna. Specialist had the lowest level of satisfaction at 45% and Behavioral Health providers had the highest level at 57%."*
  - From Sunflower's report, *"The majority of providers (64%) shared that overall they feel satisfied or completely satisfied with Sunflower Health Plan. HCBS was highest at 69%, and Specialists were the lowest at 53%."*
  - From UnitedHealthcare's report, *"The majority of providers (66%) shared that overall they feel satisfied or completely satisfied with United Healthcare. HCBS was highest at 78%, and Specialists were the lowest at 55%."*
  - These results should not be construed as the overall satisfaction with the MCOs by all the providers in their respective KanCare Provider Networks of four provider types (PCPs, specialists, BH and HCBS).

Technical Strengths

Common Among the MCOs

- The MCOs contracted with a single survey vendor that applied the same survey administration processes across the MCOs. This would have increased the possibility for comparisons between the MCOs, if there had not been the previously stated methodological issues.
- The study purpose/objectives for all three surveys were reasonably clear, measurable, and in accordance with State Contract Amendment 14.
- All three surveys were specific to KanCare providers as required by State Contract Amendment 14.
- The survey included four provider types as required by State Contract Amendment 14.
- The survey instrument included appropriate questions to measure the study purpose.
- The reliability and validity testing of the survey instrument was completed.
- The survey instrument included only one relative question as required by State Contract Amendment 14. This reduced the issues seen in prior years' surveys due to the possibility of varied understanding and responses when asked about satisfaction compared to other plans they work with, due to differences in the characteristics of the other health plans providers were contracting with.

Opportunities for Improvement

Common Among the MCOs

- Changes were made in the methodology and analyses during the MCOs' survey implementation. The reasons for deviations from the work plan were not provided.
- A considerable proportion of eligible provider practices/locations of the four provider types identified in the MCOs' study populations were not included in the sample frames of all three MCOs due to missing email addresses in their provider data files. Sample frames formulated from the study populations of the MCOs that exclude a considerable portion of eligible providers (those without email addresses in the MCOs' data files) are not representative of the study populations and MCOs' KanCare Provider Network of PCPs, specialists, BH providers, and HCBS providers.

- Based on the initial lists of practices/locations with valid email addresses for two of the MCOs, the work plan drafts indicated an availability of much larger sample frames for their survey implementation. However, the deduplication steps applied by the survey vendor to identify the practices/locations with unique email addresses, and phone numbers for those without valid email addresses, provided the sample frames comprised of a much smaller number compared to that described in the initial lists of these two MCOs.
- A stratified random sampling methodology and statistically significant samples for PCPs, specialists, BH, and HCBS provider populations were not used by the three MCOs. Instead, convenience samples were used (sample frames were used as survey samples).
- All three MCOs' surveys were administered using a single web-based strategy, with invitation for participation sent primarily to providers/practices for whom valid email addresses were available and to very few providers/practices without email addresses for whom a phone number was available. The practices/locations who received a survey invitation represented only 84% of Aetna's, 78.6% of Sunflower's, and 36% of UnitedHealthcare's eligible study populations.
- All three MCOs did not apply any corrective steps during the implementation of the survey to improve the representativeness of their sample frames by identifying additional eligible practices/ locations by using providers' mailing addresses and phone numbers contact information, and adding other modes of survey implementation, such as mail survey and telephone follow-up to nonrespondents of the mail survey and web-based survey, to obtain the generalizable results for the four provider types of the their KanCare Provider Networks.
- The stratified analyses of all survey questions should have used the total numbers of completed surveys as their denominators to calculate the satisfaction rates for different aspects of the MCOs' services. In all three MCOs' survey reports, data presented for the survey question asking respondents to rate overall satisfaction with each MCO they currently work with were inconsistent with the data for the provider types shown for the initial question, which was planned to be used for classifying the respondents into the four provider type groups. In addition to this question, the inconsistency from initial question's data was seen with a few other survey questions of Sunflower survey, and with all questions of Aetna survey. Reasons for this deviation were not provided.
- The results obtained from the stratified analyses were not generalizable to MCOs' complete provider networks of PCPs, specialists, BH and HCBS providers. However, the interpretations for most of the results for their surveys were presented in a manner that could be misinterpreted by the readers as applying to all KanCare providers in MCOs' Networks of four provider types (PCPs, specialists, BH providers, and HCBS providers).

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

The majority of the EQRO's provider survey recommendations have been repeated for multiple years with minimal improvement. Please see Appendix D for more details.

There were 15 previous year's recommendations common among the MCOs:

- Four recommendations were fully addressed by all three MCOs,
- Seven recommendations were partially addressed by all three MCOs, and
- Four recommendations were not addressed by all three MCOs.

Recommendations for Quality Improvement

Common Among Sunflower and UnitedHealthcare

1. Ensure all the requirements of the State Contract Amendment 14, Section 5.9.11 regarding the Provider Survey are fulfilled.
2. Implement the survey methodology and analytic plan approved by the State prior to the survey implementation or obtain written approval from the State for any revisions. Document, in the survey report, the rationale for revisions to the survey methodology during survey implementation.
3. Ensure generalizability of the survey findings to the intended study population:
    - Ensure the sample frame planned and used is representative of the study population of PCPs, specialists, BH providers and HCBS providers, by increasing email data completeness in the provider network files to substantially improve the sample frame numbers and adding other modes of identifying eligible providers (such as mailing addresses and phone numbers). Test and clean the provider contact information before sending the data files to the survey vendor for the formulation of the sample frame.
    - Apply stratified random sampling methodology (a type of probability sampling appropriate for meeting State Contract Amendment 14 requirements). Calculate the sample sizes for the four provider types by applying the following steps: 1) calculate the minimum required number of completed surveys by using the parameters specified in the State Contract Amendment (5% Margin of Error, and 95% Confidence Level); 2) determine the required number of providers needed to be invited for participating in the survey; and 3) calculate minimum required response rates to be achieved for the four required provider types.
    - Plan, implement, and report steps to increase the number of completed surveys or improve the response rate by each of the four provider types, such as: multi-modal strategy instead of single mode (e.g., mail, web-based, and phone follow-up of non-respondents of mail and web-based surveys) for notifications, surveying, and reminders; increasing the duration of the survey; updating and correcting provider contact information prior to the survey; finding new contact information for undeliverable surveys and resending; asking providers about issues related to their non-participation and taking steps to address these issues; and determining the reason for a large number of ineligible surveys.
    - Plan, apply and report corrective actions implemented during fielding of the survey if the number of completed surveys is less than the minimum required number by provider type, such as extending the survey cut-off date, or completing an extra provider phone follow-up for the provider types with low numbers of completed surveys.
4. Design and implement an analysis plan with appropriate statistical tests (if applicable) to obtain survey results generalizable to the MCO's KanCare Network of PCPs, specialists, BH providers and HCBS providers.
    - Ensure total sample frame size and those for the four provider types are correctly described. Ensure all response rates (minimum required and achieved) are calculated correctly.
    - Use the correct total number of completed surveys by provider type to analyze and report stratified analyses of all survey items for the four provider types.
    - Use and report caution in interpretation of the results when results are based on small numbers.
    - Ensure interpretations of the results are correctly reported.

Aetna

Given that 2024 is the last year of Aetna's contract with the State of Kansas, no recommendations for future actions were made for the next year's survey.

6. *Review of Compliance with Medicaid and CHIP Managed Care Regulations*

Background/Objectives

The Medicaid and CHIP Managed Care Regulations require performance of independent, external reviews of the quality, timeliness of, and access to care and services provided to Medicaid and CHIP beneficiaries by MCOs.[6] The objective of KFMC's review is to assess MCO compliance with federal standards. A full review is required every three years and may be completed over the course of the three years. Sunflower and UnitedHealthcare have provided KanCare managed care services since January 2013, and Aetna since January 2019. Aetna's contract with the State of Kansas ended December 31, 2024. KFMC reviewed MCO compliance with the Medicaid and CHIP Managed Care regulations updated November 13, 2020.

The current review period is 2022-2024, with KFMC conducting approximately one-half of the review in Years 1 (2022) and 2 (2023) for Sunflower and UnitedHealthcare, along with needed follow-up in Years 2 (2023) and 3 (2024). KFMC completed most of the full regulatory compliance review for Aetna in Year 1 (2022), along with needed follow-up in Years 2 (2023) and 3 (2024). KFMC's compliance review reports for the 2022 and 2023 reviews were submitted in January through March 2023 and 2024, respectively. KFMC's compliance review results for the reviews conducted in Years 1-3 (2022-2024) are included in this *2024-2025 Annual EQR Technical Report*.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

KFMC used Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations, from the CMS EQR Protocols, dated February 2023, to complete the reviews. In addition, KFMC compiled findings in a worksheet based on the EQR Protocol 3 documentation and reporting tool template developed by CMS.

The protocol involves completion of the following five activities:

- Activity 1: Establish Compliance Thresholds
- Activity 2: Perform Preliminary Review (Pre-Site Visit)
- Activity 3: Conduct MCO Site Visit
- Activity 4: Compile and Analyze Findings (Post-Site Visit)
- Activity 5: Report Results to the State

KFMC requested documentation from each MCO related to the federal regulations under review. Documentation provided included policies, procedures, manuals, and other materials related to the federal regulations, and case files for Coordination and Continuity of Care, Provider Selection, and Grievances and Appeals.

The following Medicaid Managed Care Regulatory Provisions were reviewed in Years 1 and 2 for the MCOs:

- Subpart B – State Responsibilities
- Subpart C – Enrollee Rights and Protections

[6] Managed Care, 42 C.F.R. §438 (2025). www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438?toc=1.

- Subpart D – MCO, PIHP [Prepaid Inpatient Health Plan] and PAHP [Prepaid Ambulatory Health Plan] Standards (requires compliance with Subpart F – Grievance and Appeal System)
- Subpart E – Quality Measurement and Improvement; External Quality Review

The regulatory areas were divided and categorized by year reviewed per MCO within the three-year review period (2022–2024), as displayed in Table 6.1.

Table 6.1. Standards Reviewed Timeframe (2022–2024)

Regulatory Standard	Reviewed by the EQRO					
	RC* 2022–2023			RC* 2023–2024		
	ABH	SHP	UHC	ABH	SHP	UHC
Subpart B – State Responsibilities						
§438.56 Disenrollment: Requirements and limitations	X				X	X
Subpart C – Enrollee Rights and Protections						
§438.100 Enrollee rights	X				X	X
§438.114 Emergency and poststabilization services	X				X	X
Subpart D – MCO, PIHP, and PAHP Standards						
§438.206 Availability of services	X	X	X			
§438.207 Assurances of adequate capacity and services	X	X	X			
§438.208 Coordination and continuity of care	X	X	X	X^		
§438.210 Coverage and authorization of services	X				X	X
§438.214 Provider selection	X	X	X			
§438.224 Confidentiality	X	X	X			
§438.228 Grievance and appeal systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	X				X	X
§438.402 General requirements	X	X	X		X†	X†
§438.404 Notice of adverse benefit determination	X				X	X
§438.406 Handling of grievances and appeals	X				X	X
§438.408 Resolution and notification	X				X	X
§438.410 Expedited resolution of appeals	X				X	X
§438.414 Information about the grievance and appeal system to providers and subcontractors	X				X	X
§438.416 Recordkeeping requirements	X				X	X
§438.420 Continuation of benefits while appeal and State fair hearing are pending	X				X	X
§438.424 Effectuation of reversed appeal resolutions	X				X	X
§438.230 Sub-contractual relationships and delegation	X	X	X			
§438.236 Practice guidelines	X	X	X			
§438.242 Health information systems	X				X	X
Subpart E – Quality Measurement and Improvement						
§438.330 Quality assessment and performance improvement program	X	X	X			

* Reporting Cycle (RC)
^ Additional Nursing Facility case review was completed for Aetna in Year 2 (2023).
† Regulatory component documentation reviewed in Year 1 (2022) and case review completed in Year 2 (2023) for Sunflower and UnitedHealthcare.

KFMC utilized the five-point rating compliance scoring (Fully Met [FM], Substantially Met [SM], Partially Met [PM], Minimally Met [MM], and Not Met [NM]) as defined in the EQR Protocol 3; results were compiled into a tabular format for reporting on each regulatory category. The individual MCO 2022 through 2024 *Review of Compliance with Medicaid and CHIP Managed Care Regulations* reports contain more detail and are available upon request.

KFMC applies a point system to calculate the compliance score for each regulatory component, subpart, and overall MCO compliance. Each component earns a compliance score in the following way: Fully Met

receives four points; Substantially Met receives three points; Partially Met receives two points; Minimally Met receives one point; and Not Met receives zero points. The *compliance score* for each regulation is a percentage calculated by dividing the total number of points earned by the components within that regulation by the total number of points possible for components within that regulation.

Conclusions Drawn from the Data

Compliance

Common Among the MCOs, Years 1–3 Reviews 2022 to 2024

For the areas reviewed for the MCOs, all three had the greatest opportunity for improvement in §438.214 *Provider Selection,* §438.228 *Grievance and Appeal Systems* (requires compliance with Subpart F *Grievance and Appeal System*), and §438.416 *Recordkeeping Requirements*. *Subpart B Disenrollment: Requirements and Limitations* is not included because the requirements are not applicable to the health plans.

Aetna, Years 1–3 Reviews 2022 to 2024

Aetna's full compliance review was completed in Year 1 (2022) with case review follow-up in Year 2 (2023). There were no additional regulatory areas remaining for review in Year 3 (2024). Overall, Aetna was 94% compliant with the federal regulatory requirements. *Subpart E Quality Measurement and Improvement; External Quality Review* scored the highest (100% Fully Met). Table 6.2 summarizes the 2022–2024 compliance review findings for Aetna.

Table 6.2. Summary of 2022–2024 Compliance Review – Aetna

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee rights^†	24	(18/24)	(6/24)	(0/24)	(0/24)	(0/24)	94% (90/96)
§438.10 Information requirements^							
§438.3(j) Standard contract requirements: Advance directives							
§438.114 Emergency and post-stabilization services†	5	(2/5)	(3/5)	(0/5)	(0/5)	(0/5)	85% (17/20)
SUBPART C TOTAL	**29**	**(20/29)**	**(9/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**92% (107/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.206 Availability of services†	17	(15/17)	(1/17)	(1/17)	(0/17)	(0/17)	96% (65/68)
§438.207 Assurances of adequate capacity and services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.2. Summary of 2022–2024 Compliance Review – Aetna

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.208 Coordination and continuity of care‡	11	(8/11)	(1/11)	(2/11)	(0/11)	(0/11)	89% (39/44)
§438.210 Coverage and authorization of services†	13	(11/13)	(2/13)	(0/13)	(0/13)	(0/13)	96% (50/52)
§438.214 Provider selection‡	5	(2/5)	(0/5)	(3/5)	(0/5)	(0/5)	70% (14/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228 Grievance and appeal systems^† (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General requirements‡	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and adequate notice of adverse benefit determination†	9	(7/9)	(2/9)	(0/9)	(0/9)	(0/9)	94% (34/36)
§438.406 Handling of grievances and appeals†	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.408 Resolution and notification†	15	(10/15)	(3/15)	(2/15)	(0/15)	(0/15)	88% (53/60)
§438.410 Expedited resolution of appeals†	3	(2/3)	(0/3)	(1/3)	(0/3)	(0/3)	83% (10/12)
§438.414 Information about grievance and appeal system to providers and subcontractors^† §438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.416 Recordkeeping requirements†	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.420 Continuation of benefits while appeal and State fair hearing are pending†	4	(3/4)	(1/4)	(0/4)	(0/4)	(0/4)	94% (15/16)

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.2. Summary of 2022–2024 Compliance Review – Aetna							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.424 Effectuation of reversed appeal resolutions†	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual relationships and delegation†	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice guidelines†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health information systems†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(97/119)**	**(13/119)**	**(9/119)**	**(0/119)**	**(0/119)**	**93% (445/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality assessment and performance improvement program†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
OVERALL COMPLIANCE	**162**	**(131/162)**	**(22/162)**	**(9/162)**	**(0/162)**	**(0/162)**	**94% (608/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Sunflower, Years 1–3 Reviews 2022 to 2024

Sunflower's full compliance review was completed in Years 1 and 2 (2022 and 2023), with follow-up in Year 3 (2024). There were no additional regulatory areas remaining for review in Year 3. Overall, Sunflower was 97% compliant with the federal regulatory requirements. *Subpart C – Enrollee Rights and Protections* and *Subpart E – Quality Measurement and Improvement; External Quality Review* scored the highest (100% Fully Met). Table 6.3 summarizes the 2022–2024 compliance review findings for Sunflower.

Table 6.3. Summary of 2022–2024 Compliance Review – Sunflower							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee rights^ §438.10 Information requirements^ §438.3(j) Standard contract requirements: Advance directives	24	(24/24)	(0/24)	(0/24)	(0/24)	(0/24)	100% (96/96)

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.3. Summary of 2022–2024 Compliance Review – Sunflower							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart C – Enrollee Rights and Protections (Continued)							
§438.114 Emergency and post-stabilization services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(29/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**100% (116/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.206 Availability of services†	17	(16/17)	(1/17)	(0/17)	(0/17)	(0/17)	99% (67/68)
§438.207 Assurances of adequate capacity and services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.208 Coordination and continuity of care†	11	(9/11)	(0/11)	(2/11)	(0/11)	(0/11)	91% (40/44)
§438.210 Coverage and authorization of services	13	(12/13)	(1/13)	(0/13)	(0/13)	(0/13)	98% (51/52)
§438.214 Provider selection†	5	(3/5)	(1/5)	(1/5)	(0/5)	(0/5)	85% (17/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228(a-b) Grievance and appeal systems^ (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General requirements‡	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and adequate notice of adverse benefit determination	9	(6/9)	(3/9)	(0/9)	(0/9)	(0/9)	92% (33/36)
§438.406 Handling of grievances and appeals	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§438.408 Resolution and notification	15	(12/15)	(3/15)	(0/15)	(0/15)	(0/15)	95% (57/60)
§438.410 Expedited resolution of appeals	3	(2/3)	(1/3)	(0/3)	(0/3)	(0/3)	92% (11/12)

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.3. Summary of 2022–2024 Compliance Review – Sunflower

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.414 Information about grievance and appeal system to providers and subcontractors^ §438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.416 Recordkeeping requirements	1	(0/1)	(0/1)	(1/1)	(0/1)	(0/1)	50% (2/4)
§438.420 Continuation of benefits while appeal and State fair hearing are pending	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.424 Effectuation of reversed appeal resolutions	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual relationships and delegation†	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice guidelines†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health information systems	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(102/119)**	**(13/119)**	**(4/119)**	**(0/119)**	**(0/119)**	**96% (455/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality assessment and performance improvement program†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
Overall Compliance	**162**	**(145/162)**	**(13/162)**	**(4/162)**	**(0/162)**	**(0/162)**	**97% (627/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

UnitedHealthcare, Years 1–3 Reviews 2022 to 2024

UnitedHealthcare's full three-year compliance review was completed in Years 1 and 2 (2022 and 2023), with follow-up in Year 3 (2024). There were no additional regulatory areas remaining for review in Year 3. Overall, UnitedHealthcare was 97% compliant with the federal regulatory requirements. *Subpart C – Enrollee Rights and Protections* and *Subpart E Quality Measurement and Improvement; External Quality Review* scored the highest (100% Fully Met). Table 6.4 summarizes the 2022–2024 compliance review findings for UnitedHealthcare.

Table 6.4. Summary of 2022–2024 Compliance Review – UnitedHealthcare

Federal Regulations	Component Compliance*						
	Components	FM (4 Points)	SM (3 Points)	PM (2 Points)	MM (1 Point)	NM (0 Points)	Compliance Score*
Subpart C – Enrollee Rights and Protections							
§438.100 Enrollee rights^ §438.10 Information requirements^ §438.3(j) Standard contract requirements: Advance directives	24	(24/24)	(0/24)	(0/24)	(0/24)	(0/24)	100% (96/96)
§438.114 Emergency and post-stabilization services	5	(5/5)	(0/5)	(0/5)	(0/5)	(0/5)	100% (20/20)
Subpart C Total	**29**	**(29/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**(0/29)**	**100% (116/116)**
Subpart D – MCO, PIHP and PAHP Standards							
§438.206 Availability of services†	17	(15/17)	(1/17)	(1/17)	(0/17)	(0/17)	96% (65/68)
§438.207 Assurances of adequate capacity and services†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.208 Coordination and continuity of care†	11	(8/11)	(1/11)	(2/11)	(0/11)	(0/11)	89% (39/44)
§438.210 Coverage and authorization of services	13	(12/13)	(1/13)	(0/13)	(0/13)	(0/13)	98% (51/52)
§438.214 Provider selection†	5	(2/5)	(2/5)	(1/5)	(0/5)	(0/5)	80% (16/20)
§438.224 Confidentiality†	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.228(a-b) Grievance and appeal systems^ (requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.402 General requirements‡	5	(4/5)	(1/5)	(0/5)	(0/5)	(0/5)	95% (19/20)
§438.404 Timely and adequate notice of adverse benefit determination	9	(7/9)	(2/9)	(0/9)	(0/9)	(0/9)	94% (34/36)
§438.406 Handling of grievances and appeals	2	(1/2)	(1/2)	(0/2)	(0/2)	(0/2)	88% (7/8)
§438.408 Resolution and notification	15	(15/15)	(0/15)	(0/15)	(0/15)	(0/15)	100% (60/60)
§438.410 Expedited resolution of appeals	3	(3/3)	(0/3)	(0/3)	(0/3)	(0/3)	100% (12/12)

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Table 6.4. Summary of 2022–2024 Compliance Review – UnitedHealthcare							
Federal Regulations	**Component Compliance***						
	Components	**FM (4 Points)**	**SM (3 Points)**	**PM (2 Points)**	**MM (1 Point)**	**NM (0 Points)**	**Compliance Score***
Subpart D – MCO, PIHP and PAHP Standards (Continued)							
§438.414 Information about grievance and appeal system to providers and subcontractors^ §438.10(g)(2)(xi) Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Enrollee handbook	1	(1/1)	(0/1)	(0/1)	(0/1)	(0/1)	100% (4/4)
§438.416 Recordkeeping requirements	1	(0/1)	(1/1)	(0/1)	(0/1)	(0/1)	75% (3/4)
§438.420 Continuation of benefits while appeal and State fair hearing are pending	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.424 Effectuation of reversed appeal resolutions	2	(2/2)	(0/2)	(0/2)	(0/2)	(0/2)	100% (8/8)
§438.230 Subcontractual relationships and delegation†	7	(7/7)	(0/7)	(0/7)	(0/7)	(0/7)	100% (28/28)
§438.236 Practice guidelines†	4	(4/4)	(0/4)	(0/4)	(0/4)	(0/4)	100% (16/16)
§438.242 Health information systems	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart D Total	**119**	**(104/119)**	**(11/119)**	**(4/119)**	**(0/119)**	**(0/119)**	**96% (457/476)**
Subpart E – Quality Measurement and Improvement; External Quality Review							
§438.330 Quality assessment and performance improvement program†	14	(14/14)	(0/14)	(0/14)	(0/14)	(0/14)	100% (56/56)
Subpart E Total	**14**	**(14/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**(0/14)**	**100% (56/56)**
Overall Compliance	**162**	**(147/162)**	**(11/162)**	**(4/162)**	**(0/162)**	**(0/162)**	**97% (629/648)**

* Number and percent of regulatory components that were: FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%)
^ And related provision(s)
† Regulatory component reviewed in Year 1 (2022)
‡ Regulatory component reviewed in Year 1 (2022) and case review follow-up completed in Year 2 (2023)

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

Common Among the MCOs

The MCOs' full three-year compliance reviews were completed in Years 1 and 2 (2022 and 2023), with follow-up in Year 3 (2024). No additional strengths were identified in Year 3. For Years 1 and 2, the following strengths were noted:

- Each MCO has staff who are knowledgeable.

- Aetna staff take the time to have personal conversations with their members; Sunflower staff listen to their members' needs and work to implement programs to meet those needs; and UnitedHealthcare staff continually advocate for their members.
- The MCOs are forward thinking and innovative related to aspects of member care and service delivery.
    - Aetna's innovations included culturally sensitive food bank food choices, focus on the foster care population, work force initiatives, collaboration with diverse community partners, and utilizing technology.
    - Sunflower's innovations included Start Smart for Your Baby/baby showers, and partnered with KDADS, the national Group Policy Research Associates, InterHab, and the Kansas Association for Community Mental Health Centers to provide the Sequential Intercept Model (only the second one in the nation), Pro Football Hall of Fame Event – April 2023 String Youth, Strong Communities, distribution of 21,000 bottles of water in 22 counties, local community engagement [i.e., clinics, recreation centers, schools, daycares, food banks, and libraries], employee donations to local charities, Farmer's Markets, Direct Support Professionals Social Media Campaign, Value Based Contract for Competitive Employment – I/DD, and Project ECHO [Extension for Community Healthcare Outcomes].
    - UnitedHealthcare's innovations included the Latina Leadership/Health Equity Event, funding food pantries, partnering with an organization called *United Women's Empowerment* that focuses on what the female population's experience is in the state, partnership with the Boys and Girls Club, back to school fairs, health fairs, lobby sits, community baby showers, Job Resource fair, Value Added Benefits presentations to Health Departments, and the doula program including coverage of doula services.

Aetna

Aetna's full compliance review was completed in Year 1 (2022) with case review follow-up in Year 2 (2023). Therefore, there were no additional strengths identified in Year 3. As a result of KFMC's 2022 and 2023 Compliance Reviews for Aetna, the following strengths were identified:

- In 2022, Aetna held a Women's Health gap day on a Saturday and women were able to get a mammogram and cervical cancer screening. A second day was added because of the large turnout.
- There were collaborative agreements between smaller independent behavioral health providers and the Community Mental Health Centers to reduce Emergency Department use.
- In 2022, Aetna assigned an Outreach Coordinator as a women's health specialist to focus on care gaps related to specific HEDIS® measures, and the Quality Practice Liaison position was created within Aetna to work with providers on quality improvement.
- During the last week of September 2022, Aetna submitted evidence to NCQA for the Health Equity Accreditation.
- In 2022, within the Provider Portal, Aetna developed a feature so providers can elect to automatically receive provider bulletins from Aetna, as well as Kansas Medical Assistance Program (KMAP) bulletins.
- In 2022, the Health Equity Committee developed a process to connect members to appropriate resources when Z codes are used on a claim.
- Aetna had an Annual Calendar of Strategies/Events (e.g., January is Neonatal month).
- Related to case review, the MCO record was consistent with the provider record in five of the six areas reviewed (2022).

Sunflower

- Digital Care Management, a new program in 2022, allowed members to interact with Sunflower staff via a mobile app that has a secure platform so that protected health information can be exchanged (protected and encrypted). There are programs within the platform that members can go through that have educational materials, videos, and surveys they can take that provides Sunflower real-time feedback between the member and the Care Manager.
- The Sunflower secure portal is an interactive process for providers and alerts them to provide additional documentation for the authorization during submission. This saves time and resources for all involved.
- Customer Service Representatives have access to Central Point, a centralized library where all the state specific processes and policies are housed. This allows staff easy access to information to answer questions from customers in real time.
- For outreach to rural providers, Sunflower had a provider breakfast in Hays. They also developed a Rural Health Advising Committee (first committee held September 8, 2023) where providers give feedback on how to better serve members and barriers they face. Sunflower staff stated it is important to meet providers where they are.
- Sunflower had a regional pilot training on conscious anti-racism that Sunflower leaders attended.
- Sunflower has focused on SDOH. Member-facing staff are required to take Health Equity and Cultural Humility training annually. For providers, Sunflower had a SDOH ECHO earlier in 2022, and was projected to start the Health ECHO in December 2022.
- In 2022, Sunflower was in the seventh year of being the statewide manager for the Project SEARCH program and it has a success rate, in Kansas, of about 70% achievement of competitive employment for individuals who participate.
- In 2023, Sunflower submitted materials to the Self Advocate Coalition of Kansas to review and provide feedback from their perspective on the understandability and readability of documentation.
- Sunflower has a quality audit program where each staff member is audited regularly according to a corporate rubric; feedback and coaching are then provided. Sunflower develops trainings based on the aggregate results on any areas that they would like to improve.
- Sunflower has a Utilization Management dashboard that the Utilization Management leaders review daily and sometimes multiple times a day.
- Sunflower recognizes the importance of employee engagement and satisfaction, and they reported having a low turnover rate, which creates a consistent atmosphere for members.
- Sunflower distributes staff across the State and has a "Hyper-local focus" which allows Sunflower to help meet members needs at a community level and not just with medical needs.

UnitedHealthcare

- UnitedHealthcare brings health equity into aspects of service delivery for members. This was evident in the case review KFMC completed in 2022.
- UnitedHealthcare has *Learn Source* and the *Care Management University* where trainings are available on health equity, diversity and inclusion, health equity university training (different badges that can be earned), trauma informed care, motivational interviewing, and many other topics.
- In 2023, UnitedHealthcare implemented the *Care Bridge* program to ensure members can access after-hours guidance through the use of a tablet.
- Maestro was described by UnitedHealthcare as a resource for members to easily find procedures, coverage, policies, and benefits. It was described as a decision tree with a built-in algorithm that members can use to get applicable information by answering a series of questions.
- In 2022, a *Member Experience Coordinator* position was created within UnitedHealthcare.

- UnitedHealthcare prioritizes health equity and social determinants of health, and in 2022, they expanded the educational series to include external speakers; they also developed the *Health Equity* series.
- In 2022, UnitedHealthcare created a quality assessment review tool to ensure they are compliant with requirements (*National Committee for Quality Assurance*, HCBS performance measures).

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The MCO's full three-year compliance review was completed in Years 1 and 2 (2022 and 2023). There were no additional opportunities identified in Year 3 (2024). The following are the opportunities identified from the 2022 and 2023 reviews.

Common Among the MCOs

As a result of KFMC's 2022 and 2023 Compliance Reviews for the MCOs, each of the three MCOs need to follow-up on KFMC's case review findings regarding the following:

- *Coordination and Continuity of Care – Care and Coordination of Services for all MCO, PIHP, and PAHP Enrollees*. (§438.208[b][1] and [b][3])
- Individual and Institutional Health Care Professional File Credentialing/Recredentialing findings. (§438.214[b][2] and [e])
- *Record Keeping Requirements* (grievance case review): The MCOs were provided a "Case Review Detail" document that outlined findings that needed addressed. (§438.416[b][2-3])

Aetna

As a result of KFMC's 2022 and 2023 Compliance Reviews for Aetna, the following opportunities were identified:

- *Handling of Grievances and Appeals – Special Requirements Acknowledgement of Verbal or Written Grievance)*: Timeframe to send grievance acknowledgement letters. (§438.406[b][1])
- Aetna needs to follow-up on KFMC's case review findings related to *Resolution and Notification – Grievance and Appeals*: Timeframe to send grievance resolution letters; verbal notice of an expedited resolution; and inclusion of the date of completion in the written notice of resolution for each level of the appeal. (§438.408[d][1], [d][2][ii], and [e][1])
- Language updates to the Aetna *Member Handbook* for the following:
  - *Disenrollment: Requirements and Limitations – Disenrollment Requested by the Enrollee*: Member's option to request disenrollment for cause, at any time. (§438.56[c][1])
  - *Standard Contract Requirements: Advance Directives*: Provide members with written information on advance directive policies and description of state law. (§438.3[j][3])
  - *Availability of Services – Delivery Network* (second opinion): Members getting a second opinion in-or out-of-network (§438.206[b][3])
- *Information on Advance Directives* (§422.128[b][1][i]), *Rules for Enrollees: Advance Directives* (§417.436[d][1][i][A]), and *Requirements for Providers* (§489.102[a]): Add Advance Directive regulatory language to Aetna policy and procedure.
- *Continuation of Benefits While the MCO Appeal and the State Fair Hearing are Pending*: Update Aetna policy and procedure and the *Provider Manual* with information related to continuation of benefits for Non-HCBS Waiver and HCBS Waiver services. (§438.420[a][i-ii])
- Aetna needs to follow-up on KFMC's grievance case review finding related to *Record Keeping Requirements.* (§438.416[b][3])
- *Information Requirements: Information for all Enrollees of MCO's – General Requirements*: Consistency is needed between documents related to provider termination. (§438.10[f][1]). Also, add the definition of post-stabilization to the *Provider Manual*. (§438.10[g][2][v])

- *Disenrollment*: Add to policy and procedure language related to disenrollment and reasons to disenroll for cause. (§438.56[c][1] and [d][2][iv])
- *Emergency and Poststabilization Services*: Add regulatory language to the *Provider Manual*. §438.114[d][2] and [e])
- *Coverage and Authorization of Services – Timeframe for Decisions: Standard Authorization Decisions* (§438.210[d][1][i-ii]) and *Timely and Adequate Notice of Adverse Benefit Determination: Timing of Notice* (§438.404[c][3]): in policy and procedure, the timeframe needs to be consistent with the regulation and State Contract Attachment D.
- *General Requirements: Filing Requirements – Authority to File – External Medical Review*: Add regulatory language to applicable documents related to External Independent Third-Party Review (EITPR) will be of no cost to the member. (§438.402[c][1][i][B][3])
- Aetna was to follow-up on KFMC's case review findings related to *Handling of Grievances and Appeals: Special Requirements* (Record keeping requirements): Educate staff on the timeframe to send Appeal Acknowledgement letters. (§438.406[b][1])
- *Resolution and Notification – Grievances and Appeals: Extension of Timeframes: Requirements following Extension* (§438.408[c][2]) and *Expedited Resolution of Appeals – Action Following Denial of a Request for Expedited Resolution* (§438.410[c][2]): Add regulatory language to the *Provider Manual* and *Member Handbook*.
- *Recordkeeping Requirements* (§438.416[b]): Complete the following:
  - Review the internal grievance and appeal system documentation to ensure consistency throughout the system.
  - Add regulatory language to policy and procedure.

Sunflower

As a result of KFMC's 2022 and 2023 Compliance Reviews for Sunflower, the following opportunities were identified:

- Follow-up to KFMC's 2023 case review findings was needed regarding the following:
  - *Handling of Grievance and Appeals – Special Requirements*: Revise Sunflower policy and procedure to include language that the information must be supplied sufficiently in advance of the appeal resolution. (§438.406[b][5])
  - *Resolution and Notification: Grievances and Appeals – Specific Timeframes-Standard Resolution of Appeals* (§438.408[b][2]) and *Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution* (§438.410[c][2]): Review appeal case review finding to ensure appeal was processed correctly.
- *Timely and Adequate Notice of Adverse Benefit Determination (Content of Notice)* (§438.404[b][6]), *Notice of Adverse Action* §438.210[c] and *Resolution and Notification: Grievance and Appeals – Content of Notice of Appeal Resolution* §438.408[e][2][ii-iii]: Re-educate staff to double check that the correct appeal resolution letter was sent to the member.
- *General Requirements - Filing Requirements (Authority to File)* (§438.402[c][1][ii] and State Contract sections 4.2.1.16.2 and 4.4.2.1.15.7, *Notice of Adverse Action* §438.210[c], *Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice* §438.404[b][3], and *Record Keeping Requirements* §438.416[b][6]):
  - Determine who filed the grievance and ensure all areas of the system are consistent. The internal system should include the name of who submitted the appeal.
  - Re-educate staff on most appropriate selection for who submitted the appeal and the requestor in True Care should be congruent with Prime (§438.402[c][1][ii]).

- *Resolution and Notification: Grievance and Appeals – Specific Timeframes-Standards Resolution of Appeals* (§438.408[c][2][ii]) and *Expedited Resolution of Appeals: Action Following Denial of a Request for Expedited Resolution* (§438.410[c][2][iii]): Update the *Member Handbook* language to include the member's right to file a grievance if they disagree with the decision to extend the timeframe.

UnitedHealthcare

As a result of KFMC's 2022 and 2023 Compliance Review for the MCOs, the following opportunities were identified:

- Revise language in the *Member Handbook* related to members getting a second opinion (§438.206[b][3]). In the Year 3 (2023) review, there were no opportunities for improvement identified specific to quality, access, or timeliness.
- *General Requirements: Filing Requirements – Authority to File* §438.402[c][1][i][B] and [c][1][ii]):
  - Update policy to include regulatory language related to external medical review.
  - Add language to the *Grievance and Appeal Process Letter Attachment*.
- *Handling of Grievances and Appeals (Special requirements)*: Re-educate staff on the timeframe requirements of sending the written acknowledgement for provider appeals (§438.406[b][1]).
- Follow-up to KFMC's 2023 grievance case review findings related to *General Requirements: Filing Requirements (Authority to File)* (§438.402[c][1][ii] and State Contract section 4.2.1.16.2 and 4.4.2.1.15.7, *Timely and Adequate Notice of Adverse Benefit Determination – Content of Notice* §438.404[b][3], and *Record Keeping Requirements* §438.416[b][6]: Determine the name of the person that filed the grievance, determine their relationship to the member, document the name in the system, and ensure the system consistently reflects who filed the grievance and submitted the appeal.
- *Record Keeping Requirements*: Re-educate staff that information entered in the internal UHC database should be double checked prior to finalization. Also, develop policy and procedure related to appropriate use of abbreviations and educate staff. If one already exists, re-educate staff on the policy (§438.416[b]).
- *Handling of Grievances and Appeals (Special requirements)*: Revise the *Provider Manual* to inform members of the grievance/appeal acknowledgement process and timeframes (§438.406[b][1]).

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Between July and September 2024, KFMC obtained from each MCO a series of updates to the progress tracking document that included KFMC's EQRO recommendations from 2020 to 2023 that were still in progress or less than fully addressed. KFMC provided each MCO with suggestions on how to bring outstanding recommendations into full compliance, and each MCO was given the opportunity to respond on their progress. The following are the summaries from the 2024 review.

Aetna

There are 32 recommendations (31 in 2022 and 1 in 2023) included in Appendix D. KFMC noted in 2024,

- Twenty-five recommendations moved to fully addressed (including 3 recommendations where components within the recommendation were unable to be addressed),
- Four were partially addressed,
- Two are unable to be addressed, and
- One was not addressed.

Sunflower

There are 19 recommendations (7 in 2022 and 12 in 2024) included in Appendix D. KFMC noted, in 2024,

- Sixteen moved to fully addressed, and
- Three were partially addressed.

UnitedHealthcare

There are 27 recommendations (2 in 2020, 17 in 2022, and 8 in 2023) included in Appendix D. KFMC noted, in 2024,

- Ten moved to fully addressed,
- Ten were partially addressed,
- Five were not addressed, and
- Two were in progress.

Recommendations for Quality Improvement

Since Year 3 (2024) was a follow-up year, no new recommendations were made. For any recommendations made in Year 1 (2022) or prior that were less than fully addressed, and recommendations made in Year 2 (2023), see Appendix D for details.

Aetna

Year 1 Full Review and Year 2 Follow-up Review

Based on the areas identified for improvement, KFMC made 55 recommendations:

- Twenty related to Credentialing/Recredentialing of Providers
- Thirteen related to Grievance, Appeal, and Notice of Adverse Benefit Determination
- Nine related to Coordination and Continuity of Care
- Eight related to Enrollee Rights and Protections
- Three related to Disenrollment
- Two related to Availability, Access, and Coverage of Services

Year 3 Review

Due to the full review being conducted in Year 1 and follow-up to case review within §438.208 *Coordination and Continuity of Care* in Year 2, no new recommendations were made.

Sunflower

Year 1 Review and Year 2 Review

Based on the areas identified for improvement, KFMC made 26 recommendations:

- Eight related to Coordination and Continuity of Care
- Six related to Credentialing/Recredentialing of Providers
- Twelve related to Grievance, Appeal, and Notice of Adverse Benefit Determination

Year 3 Review

Due to the full review being conducted in Years 1 and 2, no new recommendations were made.

UnitedHealthcare

Year 1 Review and Year 2 Review

Based on the areas identified for improvement, KFMC made 31 recommendations:

- Twelve related to Credentialing/Recredentialing of Providers
- Eight related to Coordination and Continuity of Care
- Ten related to Grievance, Appeal, and Notice of Adverse Benefit Determination

Recommendations for Quality Improvement

UnitedHealthcare (Continued)

Year 1 Review and Year 2 Review

- One related to Availability, Access, and Coverage of Services

Year 3 Review

Due to the full review being conducted in Years 1 and 2, no new recommendations were made.

Summary of 2022–2024 Compliance Review

Table 6.5 details a summary of the MCOs' overall 2022–2024 compliance review results for Subparts C, D, and E. *Subpart B – Disenrollment: Requirements and Limitations* is not included because for regulation §438.56 *Disenrollment: Requirements and Limitations*, the State, through its fiscal agent, is responsible for disenrollment, and the MCOs are not able to disenroll members. Therefore, these requirements are not applicable to the health plans.

Table 6.5. Summary of Compliance Review Results 2022–2024

Federal Regulation	Compliance Score		
	ABH	SHP	UHC
Subpart C – Enrollee Rights and Protections			
§438.100 Enrollee rights	94%	100%	100%
§438.114 Emergency and poststabilization services	85%	100%	100%
Subpart C Total	**92%**	**100%**	**100%**
Subpart D – MCO, PIHP and PAHP Standards			
§438.206 Availability of services	96%	99%	96%
§438.207 Assurances of adequate capacity and services	100%	100%	100%
§438.208 Coordination and continuity of care	89%	91%	89%
§438.210 Coverage and authorization of services	96%	98%	98%
§438.214 Provider selection	70%	85%	80%
§438.224 Confidentiality	100%	100%	100%
§438.228 Grievance and appeal systems (Requires compliance with Subpart F Grievance and Appeal System [§438.402 - §438.424])	75%	75%	75%
§438.402 General requirements	95%	95%	95%
§438.404 Notice of adverse benefit determination	94%	92%	94%
§438.406 Handling of grievances and appeals	100%	88%	88%
§438.408 Resolution and notification	88%	95%	100%
§438.410 Expedited resolution of appeals	83%	92%	100%
§438.414 Information about the grievance and appeal system to providers and subcontractors	100%	100%	100%
§438.416 Recordkeeping requirements	75%	50%	75%
§438.420 Continuation of benefits while appeal and State fair hearing are pending	94%	100%	100%
§438.424 Effectuation of reversed appeal resolutions	100%	100%	100%
§438.230 Sub-contractual relationships and delegation	100%	100%	100%
§438.236 Practice guidelines	100%	100%	100%
§438.242 Health information systems	100%	100%	100%
Subpart D Total	**93%**	**96%**	**96%**
Subpart E – Quality Measurement and Improvement; External Quality Review			
§438.330 Quality assessment and performance improvement program	100%	100%	100%
Subpart E Total	**100%**	**100%**	**100%**
OVERALL COMPLIANCE	**94%**	**97%**	**97%**

7. Quality Assessment and Performance Improvement Review

Background/Objectives

The QAPI approach is continuous, systematic, comprehensive, and data-driven. Implementing this approach allows organizations to improve on identified challenges as well as plan for future opportunities.[7] KFMC's objectives were to review completeness of each MCO's 2024 QAPI design, examine strengths, identify opportunities for improvement, and provide recommendations for improvement. Sunflower and UnitedHealthcare have provided KanCare managed care services since January 2013, and Aetna since January 2019. Aetna's contract with the State of Kansas ended December 31, 2024, therefore, no new recommendations are included in this report for this MCO.

Technical Methods of Data Collection and Analysis/Description of Data Obtained

The MCOs, in the administration of their QAPI programs, must comply with State Contract sections *5.2.2 Disenrollment*, *5.9. Quality Assessment and Performance Improvement*, *5.16.1 Reports and Audits* letter B, and *5.17.2 Contractor(s) Key Personnel* letter C, number 10.

For this review, KFMC assessed the MCO's QAPI evaluation, program description, work plans, and additional supporting documents submitted from the MCOs for compliance with the contract elements. Annually, the MCOs are to complete the *QAPI Checklist*. It is to accompany the QAPI work plan that is submitted November 30 of each year. See Appendix B for a detailed list of the documents reviewed.

Conclusions Drawn from the Data

Of the 30 requirements from the *QAPI Checklist*, KFMC identified the MCOs were less than fully compliant for 10 requirements, with the following ratings: Substantially met (ABH – 1, SHP – 1, and UHC – 3) and partially met (ABH – 5 and UHC – 2). See table 7.1 for a display of the requirements and ratings that were less than fully met.

Table 7.1. 2024 QAPI Review Requirements Less Than Fully Met–All MCOs

State Contract Requirement	Description	MCO	Rating*
5.2.2 Disenrollment, second letter B, number 2	Tracking the reason for disenrollment	ABH	PM
5.9.1 General Requirements, letter F	For members receiving LTSS, mechanisms used to compare services and supports received with those in the member's treatment/service plan.	UHC	PM
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter A	Use of the State specified guiding principles	UHC	SM
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter B	Use of the State specified goals	UHC	SM
5.9.3 QAPI Goal, Objectives, and Guiding Principles, letter C	Use of the State specified objectives	ABH	PM
		UHC	SM

[7] Centers for Medicare & Medicaid Services. *QAPI Description and Background*. www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapidefinition. Updated September 10, 2024. Accessed May 19, 2020.

Table 7.1. 2024 QAPI Review Requirements Less Than Fully Met–All MCOs (Continued)			
State Contract Requirement	**Description**	**MCO**	**Rating***
5.9.4 Performance Measures, letters A-B	Comply with the requirements in the QMS regarding performance measures for medical, BH and LTSS	ABH SHP	SM
5.9.6 Peer Review, letter A	Peer review process and Peer Review Committee	ABH	PM
5.9.11 Provider Satisfaction Survey	Provider Satisfaction Survey conducted with service Providers (methodology and annual summary).	UHC	PM
* FM = Fully Met (96%–100%), SM = Substantially Met (75%–95%), PM = Partially Met (50%–74%), MM = Minimally Met (25%–49%), and NM = Not Met (0%–24%).			

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

The following sections contain opportunities for the MCOs to make improvements that impact the compliance rating. Recommendations were made to address the areas where an MCO change is needed to be in full compliance with CFR *§438.330 Quality Assessment and Performance Improvement Program* and/or State KanCare 2.0 Contract requirements. See Appendix B for details on the QAPI compliance rating. Due to KanCare 3.0 implementation on January 1, 2025, recommendations made in this report related to future QAPI work plans and program descriptions are subject to change or may no longer be applicable in the 2025 review.

Common Among the MCOs

In the 2024 review, there were no areas of non-compliance that were common among the MCOs.

Aetna

Section 5.2.2 Disenrollment

5.2.2(B)(2) [Partially Met]: *Contractor Responsibilities: The Contractor(s) is also required to track the reason for the disenrollments for the Contractor(s)' Quality Assessment and Performance Improvement (QAPI) process.*

- There was discussion of "Member enrollment and disenrollment reconciliation" and "member disenrollment patterns" in the *2024 QAPI Program Description,* and the activity "Member Disenrollment Patterns" was included in the *2024 QAPI Work Plans.* However, there was no description of tracking the reason for disenrollment in the *2023 QAPI Program Evaluation*. In the 2023 report, KFMC made a suggested enhancement to include information on tracking the reason for disenrollment in future QAPI program evaluations.

Section 5.9.1 General Requirements

- *5.9.1(A)* [Fully Met]: *The State's QMS: The CONTRACTOR(S) shall comply with the State's QMS. The QMS includes, among other things, details on the State's expectations and requirements for quality activities and timeliness. The QMS is reviewed annually, at a minimum, and may be revised based on such review. If significant changes occur that impact quality activities or threaten the potential effectiveness of the QMS, as determined by the State, the QMS may be reviewed and revised more frequently. The CONTRACTOR(S) shall comply with any revisions to the QMS.*
  - In the *2024 QAPI Work Plans*, rows 123-127 include the KanCare 2.0 QMS Goals but they are listed as "Activities." In the 2023 report, KFMC made a suggested enhancement to revise the QAPI work plan, under the heading "KanCare Quality Management Strategy," to reflect that subsequent lines are QMS goals and not activities. However, Aetna did not make the revision.

- *5.9.1(G)* [Partially Met]: *Develop and implement mechanisms to identify Members who are enrolled in LTSS Waivers but who are not receiving any Waiver services.*
    - There was an activity to address this requirement in the *2024 QAPI Work Plans*. There was minimal information included related to the "LTSS Participation Rate" in the *2023 Long Term Support Services and Supports Program Evaluation* and *2023 QAPI Program Evaluation.* There was an exact citation of 5.9.1.(G) in the *2024 QAPI Program Description* and information was included on how members enrolled in LTSS programs are identified on the enrollment file sent from the state Medicaid agency or enrollment broker. However, in the aforementioned documents, there was no description provided of the process to identify members enrolled in LTSS Waivers but that are not receiving any waiver services. Therefore, this requirement is partially met. In the 2023 report, KFMC made a suggested enhancement to include in future QAPI program evaluations and program descriptions, information on the process to identify members enrolled in LTSS Waivers but are not receiving any waiver services.

- *5.9.1(N)(6)* [Partially Met]: *Develop an annual evaluation process to be completed within the first quarter of each new year from which findings and recommendation will be used to shape the annual QAPI program description and QAPI work plan. The QAPI evaluation should assess the extent to which the CONTRACTOR(S) met its goals and objectives and should include recommendations for continuous quality and service improvement.*
    - The *2024 QAPI Work Plans* included an activity related to the annual QAPI program evaluation. The *2024 QAPI Program Description* also detailed information related to the annual QAPI program evaluation process. The *2023 QAPI Program Evaluation* included findings and recommendations that were partially used to shape the *2024 QAPI Program Description* and *2024 QAPI Work Plans*. While there were changes noted from the *2022 QAPI Program Evaluation*, Aetna's identified areas for improvement in the *2023 QAPI Program Evaluation* continue to be referred to in a variety of ways (e.g., Actions planned for 2024, opportunities for improvement, opportunity/intervention, and planned changes for 2024). Using a consistent term would better help the reader identify the recommendations made. Also, it continues to be unclear which recommendations for improvement were selected for implementation in the next year (e.g., not all of them were displayed in a table with "Yes" or "No" to identify whether they were selected for implementation). Additionally, some of the recommendations detailed in the *2023 QAPI Program Evaluation* table with a "Yes" were not consistently included in the *2024 QAPI Program Description* or *2024 QAPI Work Plans*. The aforementioned areas for improvement were 2023 suggested enhancements.
    - Aetna described how they met their internally identified goals and objectives throughout the *2023 QAPI Program Evaluation*. Measures included findings and recommendations for continuous quality and service improvement.

<u>Section 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles</u>

- *5.9.3(A)* [Fully Met]: *Adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors* (see the State Contract for principles A.1-A.11).
    - The guiding principles were included in the *2024 QAPI Work Plans* and *2024 QAPI Program Description*. The *2023 QAPI Program Evaluation*, section "QAPI Goals and Objectives" includes State guiding principles A.1-A.11; however, the title of the section does not reflect this. In the

2023 report, KFMC made a suggested enhancement to revise the title of the section to also include "Guiding Principles."

- *5.9.3(C)* [Partially Met]: *Adopt, at a minimum, the following objectives to meet the established QAPI goals* (see the State Contract for objectives C.1-C.7).
  - The objectives, as listed in section 5.9.3(C) of the State Contract, are included in the *2023 QAPI Program Evaluation* and the *2024 QAPI Program Description*. However, objectives C.2, C.4, and C.5 were not included in the *2024 QAPI Work Plans*.

Section 5.9.4 Performance Measures

5.9.4(A-B) [Substantially Met]: *Comply with the requirements in the QMS regarding performance measures for medical, Behavioral Health and LTSS.*

- Aetna included assessment of all State required performance measures in the *2023 QAPI Program Evaluation* and *2024 QAPI Program Description*. The *2024 QAPI Work Plans* included information on multiple performance measures; however, the measures *Breast Cancer Screening (BCS-AD)* and *Chlamydia Screening in Women ages 16 to 24 (CHL)* were not included.

Section 5.9.6 Peer Review

5.9.6(A) [Partially Met]: *Peer Review Process and Peer Review Committee.*

- Aetna included information on the peer review process and Peer Review Committee in the *2023 QAPI Program Evaluation* and *2024 QAPI Program Description*. The *2024 QAPI Work Plans* did not include an activity that addressed this requirement. In 2022, KFMC made a suggested enhancement to include in the work plan information on the peer review process and Peer Review Committee. In 2023, Aetna added an activity to the work plan. However, in the review of the 2024 work plans, Aetna had since removed the activity.

Sunflower

Section 5.9.4 Performance Measures

5.9.4(A-B) [Substantially Met]: *Comply with the requirements in the QMS regarding performance measures for medical, Behavioral Health and LTSS.*

- SHP included assessment of performance measures in the *2024 QAPI Work Plans* and *2023 QAPI Program Evaluation*. However, in the *2024 QAPI Program Description*, there was brief mention of the *Breast Cancer Screening (BCS-AD)* measure. Also, the measure *Chlamydia Screening in Women ages 16 to 24 (CHL)* was not included. More robust information on the measures should be included in all QAPI documents.

UnitedHealthcare

Section 5.9.1 General Requirements

5.9.1(F) [Partially Met]: *Develop and implement mechanisms to compare services and supports received with those set forth in the Member's treatment/service plan for individuals enrolled in LTSS Waivers.*

- The *2023 QAPI Program Evaluation* and *2023 LTSS Program Evaluation* do not include information on comparing services and supports received with those set forth in the member's treatment/ service plan. In the QAPI review of 2022, KFMC made a suggested enhancement for UHC to include in future QAPI evaluations, mechanisms used to compare services and supports received with those in the member's treatment/service plan for members receiving LTSS. In 2023, UHC added language to the *2022 LTSS Program Evaluation*. However, in review of the *2023 LTSS Program Evaluation*, the language has since been removed.

The *2024 QAPI Program Description* referenced the *2024 LTSS Program Description* for specific details of the health plan's LTSS program. In the *2024 LTSS Program Description*, language was included on how UHC compares services and supports received with those in the member's person-centered service plan. In the *2024 QAPI Work Plans*, an activity was included.

Section 5.9.3 Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles

5.9.3(A) [Substantially Met]: *Adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors* (see the State KanCare 2.0 Contract for principles [A][1-11]).

- The *2023 QAPI Evaluation* and *2024 QAPI Program Description* included information on the State guiding principles. The *2024 QAPI Work Plans* included information on all of the State guiding principles except (A)(10-11). To the *2024 QAPI Work Plans*, UHC added the activity, "Review State QMS & State Contract Quality Assessment and Performance Improvement Goal, Objectives and Guiding Principles (5.9.3 A, B, C) annually, including compliance of both" (Activity tab, row 26). However, this does not address or demonstrate how UHC integrates guiding principles (A)(10-11) into the QAPI program or infuse them throughout the organization.

5.9.3(B) [Substantially Met]: *Adopt, at a minimum, the following goals within its QAPI program* (see the State KanCare 2.0 Contract for goals [B][1-6]).

- UHC's goals and objectives address most of the State Contract identified goals, however, the following were not included in the *2024 QAPI Work Plans*, "Objectives" tab:
  - UHC Goal A, fifth objective (row 8) states, "Support medically complex and fragile members through person-centered complex case management programs that improve the member experience" applies to requirement 5.9.3(B)(1). However, it continues to be missing the part of the State Contract goal related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports."
  - UHC Goal B, fourth objective (row 16) states, "Monitor the adequacy of the contracted network through analysis of access, availability, and out-of-network data and adjust the practitioner network, as appropriate, to meet diverse population needs" applies to requirement 5.9.3(B)(6). However, it continues to be missing the part of the goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members."

5.9.3(C) [Substantially Met]: *Adopt, at a minimum, the following objectives to meet the established QAPI goals* (see the State KanCare 2.0 Contract for objectives [C][1-7).

- In the *2023 QAPI Program Evaluation*, *2024 QAPI Program Description*, and *2024 QAPI Work Plans,* UHC did not include State-specified objective 5.9.3(C)(5) related to peer review in their program objectives,

Section 5.9.11 Provider Satisfaction Survey

5.9.11 [Partially Met]: *Provider Satisfaction Survey conducted with service Providers (methodology and annual summary).*

- The *2024 QAPI Work Plans* included information on the Provider Satisfaction Survey and annual summary. There was a brief mention of this requirement in the *2023 QAPI Program Evaluation* and *2024 QAPI Program Description*. In the *2023 QAPI Program Evaluation*, the survey was included in a

table related to the Physician Incentive Program. However, no details of the survey were included. In the *2024 QAPI Program Description*, the Provider Satisfaction survey was briefly mentioned in section "Functional Areas and Responsibilities," in the eighth bullet (page 5) that states, "UnitedHealthcare Marketing & Consumer Experience collect member and practitioner satisfaction information and assist in developing actions based on satisfaction results."

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

Common Among the MCOs

- The MCOs continued collaboration across departments to maximize quality assessment and coordinate quality improvement.
- The MCOs continue to be forward-thinking, innovative, and knowledgeable.
- Related to NCQA Accreditation,
  - Aetna had a score of 100% and an award for Health Equity Accreditation in 2022,
  - Sunflower achieved Health Equity Accreditation in the first quarter of 2023, and
  - UnitedHealthcare achieved 4 Stars for the annual star rating in 2023.

Aetna

- Aetna continues to make improvements to the QAPI program and required reporting.
- Aetna's QAPI program evaluation included information on
  - Continued expansion and addition of programs, processes, and operational activities to support initiatives;
  - Community Health Workers were introduced to support members; and
  - Maintaining an Accredited Health Plan Status with LTSS distinction.

Sunflower

- In the *2023 QAPI Program Evaluation*, Sunflower included a thorough analysis of their population characteristics, including maps and unique ways of breaking their population into groups (including grouping by product and language).
- Sunflower's workforce resides in the same communities and are reflective of the demographic characteristics of the Medicaid members they serve.

UnitedHealthcare

- UnitedHealthcare continues to have easy to follow activities for each objective as well as objectives for each goal.
- UnitedHealthcare's work plans continue to be well laid out and tie back to the QAPI program description and QAPI evaluation.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Prior to the writing of this report, the MCOs had the opportunity to provide updates to recommendations made in prior years that were still in progress or less than fully addressed (via the KFMC progress tracking tool). The findings are summarized below and are also detailed in Appendix D.

Aetna, Sunflower, and UnitedHealthcare

In 2024, the following was noted:

- For Aetna, three prior recommendations were fully addressed, one partially addressed, and one was not addressed.
- For Sunflower, all twenty-two prior recommendations were fully addressed.
- For UnitedHealthcare, seven prior recommendations were fully addressed and four were partially addressed.

Recommendations for Quality Improvement

Common Among the MCOs

In 2024, no recommendations were common to all MCOs.

Aetna, Sunflower, and UnitedHealthcare

Based on the areas identified for improvement, KFMC made one recommendation for Sunflower and five recommendations for UnitedHealthcare (see Appendix C). Due to Aetna's contract with the State of Kansas ending December 31, 2024, no new recommendations were made.

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8. *Network Adequacy Validation*

Background/Objectives

KanCare MCOs must maintain sufficient provider networks to deliver timely and accessible care to their members across the continuum of services. The contracts between KDHE and the KanCare MCOs specify requirements for provider access and availability, including after-hours access, appointment availability, and geo-access standards.[8] As part of the 2024 external quality review activities, KFMC validated data and methods used to assess and report MCO network adequacy. KFMC used and referenced Protocol 4: Validation of Network Adequacy of the CMS EQR Protocols (hereafter referred to as Protocol 4), revised February 2023.[9]

Per Activity One of Protocol 4, KFMC met with KDHE to define the scope of the validation for 2024. Findings and recommendations from past EQR network validation reports were considered when defining the scope of activities, as was Protocol 4, as well as other EQR activities, and the Medicaid and CHIP Managed Care Access, Finance, and Quality, Final Rule.[10] From 2020-2022 KFMC's primary network validation activity was after-hours access monitoring. KFMC's access monitoring has involved using MCO provider network reports, online provider directory reports, MCO online directories through their websites, and contacting providers after regular office-hours to assess after-hours access. This study had a primary objective to fulfill Protocol 4 through validation of selected time and distance standards that were agreed upon during the planning meeting with KDHE. Secondary objectives were to

- Determine if there is consistency between the provider information housed by each MCO, the Provider Network file, and the Kansas Modular Medicaid System (KMMS) provider data; and
- Review methodologies for appointment and after-hours studies, counting of unique providers and locations, and geo-access mapping.

Technical Methods of Data Collection and Analysis

Data Sources

Source data were obtained from the MCOs, the State, and other EQR activities:

- Data from KanCare MCOs
  - 2024 Q2 Mapped Provider Count Report – a report from each MCO submitted to the State detailing the number of unique participating providers and locations that KanCare members have access to
  - MCO network provider tables – an extract of MCO provider data that was used as source data for the 2024 Q2 Mapped Provider Count Report
  - Cleaned provider network file – a copy of the cleaned and deduplicated file used to derive the counts of unique providers and locations reported on the 2024 Q2 Mapped Provider Count Report

[8] KanCare Network Adequacy Standards. Updated September 22, 2022. Kansas Department of Health and Environment, Division of Health Care Finance. https://www.kancare.ks.gov/home/showpublisheddocument/2012/638476546047130000

[9] Centers for Medicare & Medicaid Services, *CMS External Quality Review (EQR) Protocols*, February 2023, OMB Control No. 0938-0786, Expires December 31, 2025.

[10] Centers for Medicare & Medicaid Services, *The Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, Final Rule*. May 10, 2024. https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance (Accessed January 21, 2024).

  - MCO process documentation – instructions, technical specifications, and coding steps for creating the cleaned provider network file from the network provider tables
  - Prior Mapped Provider Count Reports – quarterly reports from 2021 Q2 to 2024 Q3 were collected for additional analysis
  - 2024 Q2 Network Adequacy (Provider Network Reports) – Excel file listing providers who were participating, non-participating, and previously participating in the MCO's network
- Data from the State
  - KMMS tables – copies of KMMS provider, member, enrollment, and encounter tables routinely received by KFMC from the State for EQRO activities
  - PRN Files – an October 2024 version of the files routinely sent to the MCOs with updates to provider data
- Other EQR activities
  - 2023 ISCA reports and related documentation – An ISCA is conducted biannually to collect information to review the capabilities of the MCOs' information systems, processes, and data.

Validation of 2024 Q2 Mapped Provider Count Results

Calculation of Counts of Unique Providers and Locations

The MCOs' cleaned provider network files were used to confirm that the counts of unique providers and locations reported could be reproduced. Then, the process described by each of the MCOs' process documentation was followed to recreate their cleaned provider network files from the network provider tables, if they were provided.

Comparison of Mapped Provider Count Reports to the PRN and KMMS

To assess the consistency between MCO and State provider data, the 2024 Q2 Mapped Provider Count (MPC) Report records were compared to the PRN and KMMS reporting warehouse records. To facilitate the State's monitoring of the MCO provider networks, KDHE directed the MCOs to include providers' KMMS IDs in the Network Adequacy Reports. The KMMS ID is a unique identifier for records in the KMMS Providers table from the State. However, this field was sparsely populated in the data KFMC received from two of the MCOs. As an alternative to the KMMS ID, KFMC matched records using a combination of some address fields (i.e., primary address number, city, state, and zip code) and National Provider Identifiers (NPIs). Once records were matched between the provider network files and the PRN or KMMS tables, additional fields were compared.

A full description of the methodology is provided in Appendix B.

Review of MCO Access Monitoring Methodologies

Each MCO conducted annual monitoring to assess provider compliance with State contractual appointment standards and after-hours access. The monitoring occurred through a provider office appointment availability survey and a provider after-hours access survey. KFMC assessed the MCOs' methodologies, considering the State's specific template questions and EQR Protocol 4. KFMC also referenced EQR Protocol 6, Administration or Validation of Quality of Care Surveys, when assessing the survey methodologies and results. Each MCOs' access monitoring occurred by telephone.

Comparisons were made between sample size, unsuccessful attempts, compliance rates, days or hours to appointment, and after-hours access compliance to determine potential inconsistencies within each MCO's Annual Timeliness Report. Comparisons were also assessed among the MCOs' reports to identify differences in methods that could impact the State's interpretation of the reports.

KFMC reviewed each of the MCO's call scripts for both appointment availability monitoring calls as well as after-hours access survey calls. KFMC also reviewed the available data entry and call instructions. This review allowed for the identification of areas where uniformity and other improvements can be targeted.

Conclusions Drawn from the Data Common Among the MCOs

Validation of 2024 Q2 Mapped Provider Count Results

The intent of this validation activity was to assess the accuracy and completeness of the MCOs' MPC Reports by comparing them against the State's provider data housed in the KMMS. The network provider table records used as source data for the 2024 Q2 MPC Report were compared to the PRN and KMMS reporting warehouse records (as of July 2024).

Counts of Unique Providers and Locations

For Aetna, except for the count of unique occupational therapy providers, all provider counts were reproduced using their network provider table. The number of locations could not be reproduced for 31 of 50 specialty categories.

Using Sunflower's network provider table, KFMC successfully reproduced the counts for unique providers and locations for Sunflower.

For UnitedHealthcare, KFMC was able to reproduce UnitedHealthcare's counts of providers for a majority of specialties. Counts differed for adult general surgery, adult and pediatric ophthalmology, adult and pediatric pulmonary disease, hospital, lab, occupational therapy, optometry, physical therapy, speech therapy, and x-ray. KFMC was only able to reproduce the counts of unique locations for adult and pediatric dental primary care, hospitals, pharmacy, and x-ray. For other specialties, unique location counts based on latitude and longitude data included with the table provided in the MPC report were substantially lower than those reported by UnitedHealthcare. Unique location counts based on cleaned street address, city, state, and ZIP code were well over the values reported. From KFMC's analysis, how UnitedHealthcare calculated the number of unique locations reported was unclear for most specialties.

Matching Records for Individual Providers

Counts of 2024 Q2 Mapped Provider Count Report records for individual providers, stratified by MCO, are shown in Tables 8.1 and 8.2. The number and percentage of those records matched to the PRN or KMMS on primary address number, city, state, ZIP code, and provider type are shown. The following were general observations:

- Not matching on address was the primary reason records did not match using NPI.
- Though the matching criteria were generally less strict than the criteria used in KFMC's 2023 Network Adequacy Validation Report, the percentage of records that were able to be matched to either the PRN or KMMS was about the same. This indicates Sunflower and UnitedHealthcare have not made much progress on improving consistency between their data and the State's.
- Matching using KMMS IDs yielded much better results than matching using NPIs for Sunflower and UnitedHealthcare. Aetna's match rates were substantially worse than those using NPIs. This was driven by two related factors.
    - Aetna provided both the group KMMS ID and the practitioner KMMS ID for all records and was the only MCO to do so. From KFMC's analysis, it appeared Aetna struggled with populating the correct group KMMS ID for individuals in a group. Since records were matched on NPI and practitioner KMMS ID (for individuals), or group KMMS ID (for individuals in a group, groups, and facilities), this aspect of the analysis was perhaps stricter than necessary, but it should help

identify areas of improvement in data consistency for Aetna. The vast majority of records for individual providers that were not in a group had the correct practitioner KMMS ID populated.
  - Many records did not return the correct NPI, indicating an incorrect KMMS ID was provided.
- Some MCO records could only be matched to KMMS records that had an expired address, affiliation, or NPI. This indicates the MCOs may not have properly ingested some of the State's updates for providers into their systems.
- Many of the issues found when matching to PRN or KMMS records using NPIs persisted when using KMMS IDs.

Table 8.1. Locations Matched to the PRN or KMMS Using NPI – Individuals

Aetna	**N**	**%**
Records under evaluation	102,064	100%
Minus – No Match on location	504	<1%
Minus – Matched on location, not provider type code	84	<1%
Records Fully Matched to the PRN or KMMS	**101,476**	**>99%**
Sunflower	**N**	**%**
Records under evaluation	150,252	100%
Minus – No Match on location	48,911	33%
Minus – Matched on location, not provider type code	4,542	3%
Records Fully Matched to the PRN or KMMS	**96,799**	**64%**
UnitedHealthcare	**N**	**%**
Records under evaluation	93,768	100%
Minus – No Match on location	28,479	30%
Minus – Matched on location, not provider type code	217	<1%
Records Fully Matched to the PRN or KMMS	**65,072**	**69%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network file as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024.

Table 8.2. Locations Matched to the PRN or KMMS Using KMMS ID – Individuals

Aetna	**N**	**%**
Records under evaluation	101,380	100%
Minus – No KMMS ID populated	0	0%
Minus – No Match on NPI in the PRN or KMMS	10,657	11%
Minus – No Match on location	66,405	66%
Minus – Matched on location, not provider type code	19	<1%
Records Fully Matched to the PRN or KMMS	**24,299**	**24%**
Sunflower	**N**	**%**
Records under evaluation	150,252	100%
Minus – No KMMS ID populated	91,334	61%
Minus – No Match on NPI in the PRN or KMMS	5,822	4%
Minus – No Match on location	3,699	2%
Minus – Matched on location, not provider type code	2,102	1%
Records Fully Matched to the PRN or KMMS	**47,295**	**31%**
UnitedHealthcare	**N**	**%**
Records under evaluation	93,768	100%
Minus – No KMMS ID populated	41,358	44%
Minus – No Match on NPI in the PRN or KMMS	2,463	3%
Minus – No Match on location and provider type code	233	<1%
Minus – Matched on location, not provider type code	190	<1%
Records Fully Matched to the PRN or KMMS	**49,524**	**53%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

Counts of 2024 Q2 Mapped Provider Count Report records for individual providers, stratified by MCO, are shown in Table 8.3. The number and percentage of those records that could be verified on NPI, specialty code, or specialty category using the PRN or KMMS data are shown. Since the category is derived from the code, if specialty codes are verified then specialty categories are verified. Verifying specialty category is also less strict than verifying specialty code (sometimes substantially so).

The following were general observations:

- Many records indicated by the MCO as being for a primary care provider were not able to be verified on specialty category. For instance, KFMC found cases of providers categorized as PCPs whose specialty category could not be verified. This may indicate the MCOs misclassified providers as PCPs, or providers were contracted to provide primary care services without having the appropriate credentials.
- Psychiatry, general surgery, and cardiology specialty categories often did not have a corresponding record for a provider in PRN or KMMS records, raising concerns that the MCOs may not be reporting appropriate counts of providers for these categories.

Table 8.3. Specialties Verified Using NPI – Individuals

Aetna	**N**	**%**
Records with specialties under evaluation	102,064	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	0	0%
Minus – Matched Neither Specialty Code or Category	859	<1%
Records With Specialties Verified	**101,205**	**>99%**
Sunflower	**N**	**%**
Records with specialties under evaluation	150,252	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	4,078	3%
Minus – Matched Neither Specialty Code or Category	8,703	6%
Records With Specialties Verified	**137,471**	**91%**
UnitedHealthcare	**N**	**%**
Records with specialties under evaluation	93,768	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	2,229	2%
Minus – Matched Neither Specialty Code or Category	5,831	6%
Records With Specialties Verified	**85,708**	**91%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024.

Matching Records for Business Providers

Counts of 2024 Q2 Mapped Provider Count Report records for business providers, stratified by MCO, are shown in Tables 8.4 and 8.5. The following were general observations:

- Not matching on provider type code was the primary reason records did not match using NPI for Aetna. Not matching on address was the primary reason records did not match using NPI for Sunflower and UnitedHealthcare.
- Aetna correctly populated group KMMS IDs for businesses, which led to better match rates compared to individuals when matching to PRN or KMMS records using KMMS IDs. The rate was still lower than the match rate using NPIs because many KMMS IDs did not return the correct NPI and were excluded from further analysis.
- Many of the issues that were found when matching to PRN or KMMS records using NPIs persisted when using KMMS IDs.

Table 8.4. Locations Matched to the PRN or KMMS Using NPI – Businesses		
Aetna	**N**	**%**
Records under evaluation	22,270	100%
Minus – No Match on location	73	<1%
Minus – Matched on location, not provider type code	1,803	8%
Records Fully Matched to the PRN or KMMS	**20,394**	**92%**
Sunflower	**N**	**%**
Records under evaluation	6,538	100%
Minus – No Match on location	3,234	49%
Minus – Matched on location, not provider type code	288	4%
Records Fully Matched to the PRN or KMMS	**3,016**	**46%**
UnitedHealthcare	**N**	**%**
Records under evaluation	7,995	100%
Minus – No Match on location	4,278	54%
Minus – Matched on location, not provider type code	646	8%
Records Fully Matched to the PRN or KMMS	**3,071**	**38%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network (PRN) file as of October 2024, and Kansas Modular Medicaid System (KMMS) reporting warehouse tables as of 7/31/2024.

Table 8.5. Locations Matched to the PRN or KMMS Using KMMS ID – Businesses		
Aetna	**N**	**%**
Records under evaluation	22,009	100%
Minus – No KMMS ID populated	0	0%
Minus – No Match on NPI in the PRN or KMMS	1,454	7%
Minus – No Match on location	112	<1%
Minus – Matched on location, not provider type code	2,284	10%
Records Fully Matched to the PRN or KMMS	**18,159**	**83%**
Sunflower	**N**	**%**
Records under evaluation	6,538	100%
Minus – No KMMS ID populated	2,405	37%
Minus – No Match on NPI in the PRN or KMMS	91	1%
Minus – No Match on location	1,544	24%
Minus – Matched on location, not provider type code	204	3%
Records Fully Matched to the PRN or KMMS	**2,294**	**35%**
UnitedHealthcare	**N**	**%**
Records under evaluation	7,995	100%
Minus – No KMMS ID populated	4,806	60%
Minus – No Match on NPI in the PRN or KMMS	83	1%
Minus – No Match on location	157	2%
Minus – Matched on location, not provider type code	874	11%
Records Fully Matched to the PRN or KMMS	**2,075**	**26%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

Counts of 2024 Q2 MPC Report records for business providers, stratified by MCO, are shown in Tables 8.6 and 8.7. The number and percentage of those records that could be verified on NPI (for Table 8.6) or KMMS ID (for Table 8.7), specialty code, or specialty category using the PRN or KMMS data are shown. Specialties for business providers are expected to be location-specific, so specialty codes and categories were verified for records whose KMMS ID was either identified using NPI or supplied by the MCOs. Only business records that were matched on address and provider type to a PRN or KMMS record were compared on specialty code and category.

Table 8.6. Specialties Verified Using NPI – Businesses		
Aetna	**N**	**%**
Records Matched to the PRN or KMMS (on Address and Provider Type)	20,394	100%
No Match on Specialty Code or Category	9,141	45%
Records With Specialties Verified	**11,253**	**55%**
Sunflower	**N**	**%**
Records Matched to the PRN or KMMS	3,016	100%
No Match on Specialty Code or Category	5	<1%
Records With Specialties Verified	**3,011**	**>99%**
UnitedHealthcare	**N**	**%**
Records Matched to the PRN or KMMS	3,071	100%
No Match on Specialty Code or Category	90	3%
Records With Specialties Verified	**2,981**	**97%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network (PRN) file as of October 2024, and Kansas Modular Medicaid System (KMMS) reporting warehouse tables as of 7/31/2024.

For Aetna, the most common specialty categories that could not be verified for businesses were related to neurology, cardiology, psychiatry, plastic and reconstructive surgery, and general surgery, which accounted for 45% of mismatched categories when matching using NPI.

For Sunflower, the most common specialty categories that could not be verified for businesses were for behavioral health and psychiatry which, when combined, accounted for all specialty category mismatches.

For UnitedHealthcare, the most common specialty categories that could not be verified for businesses were related to allergy, hospital, general surgery, orthopedics, and primary care, which accounted for 85% of mismatched categories.

Table 8.7. Specialties Verified Using KMMS ID – Businesses		
Aetna	**N**	**%**
Records under evaluation	22,009	100%
Minus – No Full Match	3,850	17%
Minus – Matched Neither Specialty Code or Category	8,497	39%
Records Matched to the PRN or KMMS	**9,662**	**44%**
Sunflower	**N**	**%**
Records under evaluation	4,133	100%
Minus – No Full Match	1,839	44%
Minus – Matched Neither Specialty Code or Category	0	0%
Records Matched to the PRN or KMMS	**2,294**	**56%**
UnitedHealthcare	**N**	**%**
Records under evaluation	3,189	100%
Minus – No Full Match	1,114	35%
Minus – Matched Neither Specialty Code or Category	65	2%
Records Matched to the PRN or KMMS	**2,010**	**63%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

For Aetna, the most common specialty categories that could not be verified for businesses were related to neurology, cardiology, psychiatry, plastic and reconstructive surgery, and pulmonary disease—accounting for 45% of mismatched categories when matching using KMMS ID.

All group and facility records that were matched on location and provider type were also verified to have the correct specialty code or category for Sunflower when matching using KMMS ID.

For UnitedHealthcare, the most commonly mismatched categories were related to allergy, hospital, orthopedics, PCP, and psychiatry—accounting for 92% of mismatched categories. Most of these were for the allergy category.

Overall, specialty codes were usually able to be verified for individual providers, though there was a substantial portion for each MCO that could only be verified on specialty category, not code. For the purposes of this validation, this was considered acceptable. However, specialty data for these providers should be indicative of what a member would see in an online provider directory; this is concerning as not all specialties in a particular category are interchangeable, so this may mislead members into believing that certain specialty services are available in their area when that may not be the case. Of those business records that matched on location and provider type, most specialty codes were verified; however, a substantial portion of business records were not able to be matched on location and provider type. Further, there were NPIs provided by the MCOs for which no records could be found in the State's data. This indicates that members may be unable to find providers at locations listed in each MCO's online provider directory or that the State's data are not representative of the MCOs' full networks.

Review of MCO Access Monitoring Methodologies

Each MCO conducted appointment availability and after-hours access surveys in the third and fourth quarters of 2024 and submitted their Annual Timeliness Report using KDHE's template. The MCOs varied on the level of detail provided in the survey methodology and in their explanation of variances. However, all MCOs need to provide more detail. See Appendix B for more details.

Review of Appointment Availability and After-Hours Call Scripts

Two key findings emerged from this review. First, the MCOs all used different scripts to perform these survey calls to providers, making comparison difficult. Aetna utilized a single script for all calls across all provider types. The use of a single, non-detailed script severely limited Aetna's ability to capture needed information. Sunflower and UnitedHealthcare provided scripts that were tailored to specific provider types and the type of survey (appointment availability and after-hours).

The second finding of key importance is regarding the acceptance of an answering machine message instructing members to go to the nearest hospital or emergency room as compliant with providing after-hours access. Since the MCOs must meet NCQA standards, KFMC sought NCQA guidance on this issue and received the following response:

> *"The use of an answering machine with the message (directing members to the nearest hospital) described in your scenario does not meet the intent of NET 2, Element A, factor 3. The intent is that the organization ensures that PCP services include access to a live person at some point after hours to provide access for after-hours care. This doesn't mean that a live person is required to answer the phone, but could be, for example, a live person returns the member's call during after-hours or the member is referred to an answering service after hours and then receives a call from an appropriate practitioner during after-hours."*

KFMC noted the reporting template only has two response options to record answering machine messages, "no issues" and "directs the member to go to the closest hospital." As NCQA does not consider instructions to go to the nearest hospital or emergency room as adequate, and the definition of

no issues is open to varying interpretations by surveyors, KFMC recommends revisions to the reporting template. Revisions would include removing the response option of directing the member to the closest hospital and adding fields to more fully capture reasons for non-compliant answering machine messages.

Table 8.8 compares compliance rates reported by the MCOS to compliance rates calculated by KFMC withcalls that resulted in answering machines providing instructions to go to the nearest hospital removed from the numerator.

Table 8.8. Compliance Rates after Removing Answering Machines with Instructions to Go to the Nearest Hospital

	Aetna	Sunflower	UnitedHealthcare
Reported Compliance Rates	40.4% (203/502)	100.0% (321/321)	98.7% (911/923)
Compliance Rates after Removing Answering machine with instructions to go to the nearest hospital	30.9% (155/502)	78.2% (251/321)	96.3% (889/923)

Source: MCO Annual Timeliness Reports for 2024.

Improvement Activities

For the Annual Timeliness Reports, the State asks MCOs to not only report the outcome of their calls to providers in the current year but to also report efforts to correct non-compliance and describe their efforts to make improvements in several key areas. Appendix B provides a more detailed description of these findings.

Appointment Availability Survey Calls

A comparison of the MCOs' reported compliance rates are displayed in Table 8.9. There was wide variation in all rates among the three MCOs, except for PCP compliance with routine care appointment standards. Aetna's Emergency Care and Urgent Care results were noticeably lower compared to the other MCOs. With the exception of Routine Care for Pediatric PCPs (94.7%), Aetna had no category with compliance rates above 90%. In contrast, UnitedHealthcare reported almost all categories as 100% compliant, with none rating less than 96%. Sunflower and UnitedHealthcare reported identical numbers and percentages for all calls regarding Emergency Care and Urgent Care appointments, across all provider types, whereas Aetna's results varied. These wide variances suggest potential differences in scripts and call instructions not readily apparent from the information provided.

Table 8.9. Comparing MCO Reported Compliance to State Contractual Appointment Standards

Contact Type	Aetna	Sunflower	UnitedHealthcare
Provider Type	%	%	%
Emergency Care	**36.7%**	**57.8%**	**100.0%**
PCP Overall	59.7%	72.3%	100.0%
PCP Adults	58.6%	70.5%	100.0%
PCP Peds	68.4%	77.7%	100.0%
Specialists	39.3%	33.5%	100.0%
MH	0.0%	64.2%	100.0%
SUD	0.0%	54.4%	100.0%

Source: MCO Annual Timeliness Reports for 2024, Table 4.1a, Providers Surveyed in Compliance with State Contractual Appointment Standards

Table 8.9. Comparing MCO Reported Compliance to State Contractual Appointment Standards (Continued)			
Contact Type	**Aetna**	**Sunflower**	**UnitedHealthcare**
Provider Type	**%**	**%**	**%**
Urgent Care	**39.0%**	**57.8%**	**100.0%**
PCP Overall	60.8%	72.3%	100.0%
PCP Adults	58.6%	70.5%	100.0%
PCP Peds	78.9%	77.7%	100.0%
Specialists	45.2%	33.5%	100.0%
MH	0.0%	64.2%	100.0%
SUD	0.0%	54.4%	100.0%
Routine Care	**62.0%**	**78.1%**	**96.2%**
PCP Overall	84.0%	88.0%	86.2%
PCP Adults	82.7%	83.9%	84.4%
PCP Peds	94.7%	100.0%	96.1%
Specialists	88.9%	68.6%	100.0%
MH	0.0%	78.8%	100.0%
SUD	0.0%	69.2%	100.0%
Adult Physical	**64.2%**	**0.0%**	**84.4%**
EPSDT/Well-Child	**73.7%**	**0.0%**	**96.1%**
Source: MCO Annual Timeliness Reports for 2024, Table 4.1a, Providers Surveyed in Compliance with State Contractual Appointment Standards			

Table 10 summarizes the Median Number of Days Wait for Scheduled Appointment, as reported by each MCO in their Annual Timeliness Report. Sunflower reported notably longer wait times compared to the other two MCOs. Apparently, Sunflower did not calculate wait times in the same way as the other two MCOs; KFMC could not determine Sunflower's method from the documentation or scripts submitted.

Table 8.10. Comparing Median Number of Days Wait for Scheduled Appointments			
Contact Type	**Aetna**	**Sunflower**	**UnitedHealthcare**
Provider Type	**Days**	**Days**	**Days**
Emergency Care			
PCP	0.13	30	0.1
Specialists	0.94	80	0.3
MH	–	22	0.48
Urgent Care			
PCP	0.13	30	0.11
Specialists	1.04	80	0.8
MH	–	22	1.72
Routine Care			
PCP	1	48	14.72
Specialists	8	111	13.24
MH	–	32	7.09
Adult Physical	4	48	19.61
EPSDT/Well-Child	6.5	115	10.58
Source: MCO Annual Timeliness Reports for 2024, Table 4.2a, Median Number of Days Wait for Scheduled Appointments			

After-Hours Survey Calls

The difference in the compliance rates reported by Aetna for after-hours access compared to Sunflower and UnitedHealthcare is noteworthy. While Aetna reported 40.4% of their after-hours calls were compliant, Sunflower reported 100% and UnitedHealthcare reported 98.7% compliance. Though more information is needed to fully understand this discrepancy, such high compliance rates on the part of Sunflower and UnitedHealthcare are surprising.

See Appendix B for a more detailed description of this comparison.

Strengths Regarding Quality, Timeliness, and Access to Health Care Services

- The State and MCOs continue working towards improving the accuracy of the provider directory files. The State also remains committed to continuing to work with the MCOs on improving data quality and reporting.
- When populated, the KMMS ID for individuals in a group practice was usually for the individual practitioner, not their group practice; this is a notable improvement compared to KFMC's 2023 Network Adequacy Validation.

Opportunities for Improving Quality, Timeliness, and Access to Health Care Services

Validation of 2024 Q2 Mapped Provider Count Results

- Clearer documentation regarding the techniques used by Aetna and UnitedHealthcare to calculate the number of unique locations is needed. Most location counts could not be reproduced for either MCO.
- Missing KMMS ID was the primary reason records did not match using KMMS ID.
- When comparing using KMMS IDs, specialty code matches for business providers were relatively poor. Less than 65% of the business records for each MCO were able to have their specialty code or category verified.

Review of MCO Access Monitoring Methodologies

- Gaps in methodologic detail made it difficult to fully evaluate the methodology and interpret the survey results. Information gaps included sample frame counts by specialty type, sampling data sources, definition of provider in the sample (i.e., group practice, individual practitioner, or both), survey questions, counts for providers excluded from the survey, method for identifying strata for access indicators when providers overlap the adult and pediatric categories.
- The response options for answering machines were open to varying interpretation without detailed instructions (e.g., "answering machine message with no issues").
- There were potential variations in survey methodologies among the MCOs that can lead to different, or potentially invalid results, and misinterpretation of findings, (e.g., the use of potentially different survey questions).
- The Annual Timeliness Report template is not structured to allow MCOs to report calls that result in answering machines directing members to go to the nearest hospital as unacceptable.
- The State and MCOs should better define how wait times are calculated.

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Prior to the writing of this report, the MCOs had the opportunity to provide updates to recommendations made in prior years that were still in progress or less than fully addressed. The findings are summarized below. See Appendix D for more details.

In 2024, the following were noted:

- For the State, one recommendation was in progress.
- For Aetna, three were in progress, two were partially addressed, two were not assessed, and one was not addressed.
- For Sunflower, three were in progress, two were partially addressed, two were not assessed, and one was not addressed.

- For UnitedHealthcare, three were in progress, two were partially addressed, two were not assessed, and one was not addressed.

Recommendations for Quality Improvement

Recommendations for the State

1. As intended, the State should continue to review and work with the MCOs on accuracy of the various provider databases.
2. The State should review the Annual Timeliness Report template to ensure that call results are accurately categorized as unacceptable with regard to answering machines directing members to go to the nearest hospital.
3. KFMC recommends the State work with the MCOs to better define how wait times are calculated.

Recommendations for the KanCare MCOs

1. The MCOs should use findings from KFMC's Network Adequacy Validation report to work with providers to improve the accuracy and timely updating of provider information.
2. The MCOs should validate their provider data (e.g., NPIs, provider types, and specialties) against the State's records.
3. Sunflower and UnitedHealthcare should continue to prioritize populating KMMS IDs for individual, group, and facility providers.
4. Additional methodological detail is needed for the appointment availability and after-hours access provider surveys in all MCO Annual Timeliness Reports.
5. The MCOs should review and enhance their survey caller training and procedure manual specificity, regarding categorization of survey responses and unsuccessful attempt reasons. Review, and improve if needed, surveyor oversight, including inter-rater reliability testing.
6. The State, MCOs, and EQRO should review and discuss the potential variations in survey methodologies that could affect the measures and MCO comparisons, with the State making final determinations regarding methodological changes.

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9. Quality Management Strategy

The KanCare QMS, submitted to CMS on December 9, 2021, includes goals and objectives to improve "performance of our managed care partners and improving the quality of care our KanCare members receive."[11] In accordance with CFR §438.364(a)(4), KFMC compared our findings to the KanCare QMS to identify how the State can target goals and objectives, to better support improvement in the quality, timeliness, and access to health care services furnished to KanCare members. Table 9.1 contains the KanCare QMS goals and objectives and related to findings from KFMC's EQR activities completed in the 2024-2025 reporting cycle.

The State and KFMC developed a QAPI Checklist of MCO requirements, incorporated into the QAPI Review activity in 2022. One item on the QAPI Checklist (#2), requires MCO compliance with the State QMS. See the QAPI Review report section and Appendix B for more details.

Table 9.1. KanCare Quality Management Strategy and EQR Activities
Goal #1: Improve the delivery of holistic, integrated, person centered, and culturally appropriate care to all members
Objective 1.2: MCOs will annually submit a cultural competency plan which includes robust elements of a health equity strategy along with all elements required in the contract (5.5.4.B.)
The case review portion of the Compliance Review assessed MCO and provider member records for compliance with State and federal regulations related to care coordination. One requirement was for the MCO to document primary language and other cultural considerations in the *Service Plan.* KFMC reviewed this element in 2022 and made recommendations to include this information. This recommendation for one MCO is still in progress. Please see the Review of Compliance with Medicaid and CHIP Managed Care Regulations section of Appendix D for more details.
Goal #2: Increasing employment and independent living supports to increase independence and health outcomes
Objective 2.5: Each MCO will implement a Performance Improvement Project (PIP) that addresses SDOH

KFMC validated the following PIPs related to the social determinants of health:
• Aetna Food Insecurity, validation rating of 92.6% (Confidence)
  ○ All five active interventions were implemented.
  ○ Aetna collaborated with community organizations to provide healthy food resources to communities identified as food deserts and provided more than $34,000 in donations.
• Sunflower's Waiver Employment PIP was discontinued prior to this reporting cycle. The replacement SDOH PIP will not be implemented until 2025.
• UnitedHealthcare Housing, validation rating of 93.1% (Confidence)
  ○ Three of four interventions were implemented.
  ○ Of 86 members identified as homeless or at risk of homelessness who participated in the Housing Stabilization Fund (HSF), Bridge pilot or SDOH RTO interventions, 67 obtained permanent housing or maintained permanent housing within three months of identification.
For more details, see the Performance Improvement Project Validation section of this report.

Objective 2.6: Increase the rate of completed health screens
KFMC continues to follow up with the MCOs to ensure screening outreach attempts are documented and received updates during the 2024 reporting cycle. • UnitedHealthcare provided a chart demonstrating their improvement in completing HSTs and fully addressed the recommendation during the 2024-2025 reporting cycle.

[11] State of Kansas, *KanCare 2.0 Quality Management Strategy*, December 9, 2021, www.kancare.ks.gov/home/showpublisheddocument/2046/638476547261200000.

Table 9.1. KanCare Quality Management Strategy and EQR Activities (Continued)
Objective 2.9 Increase the rate of claims that use of Z-codes by 1% on claims year over year to better identify members with employment, housing, legal, food or health access needs
Aetna's Food Insecurity PIP included an intervention regarding Z-code outreach to providers. • A provider education webinar became available July 2021. • See Goal #2, Objective 2.5, and the Performance Improvement Project Validation section of this report for more details.
Goal #4: Removing payment barriers for services provided in Institutions for Mental Diseases (IMD's) for KanCare members will result in improved beneficiary access to Substance Use Disorder (SUD) treatment service specialists
Objective 4.3: Increase peer support utilization for BH services by 10% year over year
In 2024, KFMC administered the ECHO Survey to KanCare adults and children who had utilized mental health services. Of the adult respondents to the survey, 43.2% were told about self-help or support groups (Q20). For more details, please refer to the 2024 KanCare Mental Health Consumer Perception Survey section of this report.
Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)
The PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2023) – Adult Core Set.
Objective 4.6: Develop and implement direct testing or secret shopping activities for provider network validation
KFMC conducted provider network validation calls as part of the 2024 Network Adequacy Validation. For more detail within this report, please see the Network Adequacy Validation section.
Goal #5: Improve overall health and safety for KanCare members
State QMS Strategy: All MCOs are expected to achieve the National HEDIS 75th Quality Compass percentile for all reported HEDIS data. For HEDIS measures falling below the 75th percentile, the State strategy is aimed at reducing annually, by 10%, the gap between the baseline rate and 100%. Each measure that shows improvement equal to or greater than the performance target is considered achieved. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI. **Objective 5.1:** HbA1c good control (<8.0%) for members with diabetes **Objective 5.2a:** Well-Child Visits first 15 months (effective 2020, W15 became an indicator of W30) **Objective 5.2b:** Well-Child Visits 15–30 months (15-30-month period & name change in 2020) **Objective 5.3a:** Child and Adolescent Well-Care Visits (WCV) ages 3–11 **Objective 5.3b:** Child and Adolescent Well-Care Visits (WCV) ages 12–17 **Objective 5.3c:** Child and Adolescent Well-Care Visits (WCV) ages 18–21
Objective 5.7: Increase rates of selected Adult and Child Core measures by 5% annually: • Breast Cancer Screening (BCS-AD) • Chlamydia Screening in Women (CHL) ages 16 to 24
The PMV section of this report addresses the KanCare Quality Management Strategy objectives regarding HEDIS rates. Please see Table 1.1. HEDIS Performance Measures (Measurement Year 2023) – Adult Core Set and Table 1.2. HEDIS Performance Measures (Measurement Year 2023) – Child Core Set.

EQRO Suggestions for the State

1. Continue to support the MCOs throughout the PIP process, as they work with members to address health needs and improve outcomes.
2. Continue to support the MCOs towards increasing the number of members with a completed annual health screen.
3. Continue the assessment and improvement of member access to providers.
4. Continue to support the MCOs to improve State-required performance measures and continue targeting priority measures in the QMS.

End of written report

Appendix A

KanCare Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

List of KFMC EQR Technical Reports

Below is a list of reports on the required and optional EQR activities described in 42 CFR 438.358 that have been submitted by KFMC to the Kansas Department of Health and Environment during the 2024-2025 reporting cycle.

Performance Measure Validation

- Aetna — *2024 Validation and Evaluation of HEDIS MY 2023 Performance Measures of Aetna,* December 9, 2024
- Sunflower — *2024 Validation and Evaluation of HEDIS MY 2023 Performance Measures of Sunflower,* December 9, 2024
- UnitedHealthcare — *2024 Validation and Evaluation of HEDIS MY 2023 Performance Measures of UnitedHealthcare,* December 9, 2024

Performance Improvement Project Validation

- **Aetna**
  - *2024 Evaluation of Aetna, EPSDT PIP (*October 1, 2022, to September 30, 2023), July 10, 2024
  - *2024 Evaluation of Aetna, Pregnancy: Prenatal Care PIP (*October 8, 2022, to October 7, 2023), August 5, 2024
  - *2024 Evaluation of Aetna, Food Insecurity PIP (*April 1, 2023, to March 31, 2024), September 16, 2024
  - *2024 Evaluation of Aetna, Decreasing LTSS Emergency Department Visits PIP (*July 1, 2023, to June 30, 2024), November 21, 2024
  - *2024 Evaluation of Aetna, Influenza Vaccination PIP (*July 1, 2023, to June 30, 2024), January 22, 2025
- **Sunflower**
  - *2024 Evaluation of Sunflower, EPSDT PIP (January 1, 2023, to December 31, 2023),* July 18, 2024
  - *2024 Evaluation of Sunflower, Cervical Cancer Screening PIP (January 1, 2023, to December 31, 2023),* July 2, 2024
  - *2024 Evaluation of Sunflower, Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) PIP (January 1, 2023, to December 31, 2023),* January 6, 2025
  - *2024 Evaluation of Sunflower, Mental Health Services for Foster Care v2 PIP (August 1, 2023, to July 31, 2024),* January 6, 2025
- **UnitedHealthcare**
  - *2024 Evaluation of UnitedHealthcare, EPSDT PIP (January 1, 2023, to December 31, 2023),* July 23, 2024
  - *2024 Evaluation of UnitedHealthcare, Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) PIP, January 1, 2023, to December 31, 2023),* October 7, 2024

- *2024 Evaluation of UnitedHealthcare, Advanced Directives PIP (January 1, 2023, to December 31, 2023),* May 22, 2024
- *2024 Evaluation of UnitedHealthcare, Housing PIP (September 1, 2023, to August 31, 2024),* December 17, 2024
- *2024 Evaluation of UnitedHealthcare, Antidepressant Medication Management (AMM) PIP (November 1, 2023, to October 31, 2024),* April 4, 2025

CAHPS Health Plan 5.1H Survey Validation

- Aetna, Sunflower, UnitedHealthcare — *2024 CAHPS Health Plan 5.1H Survey Validation – Aetna Better Health of Kansas, Sunflower Health Plan, and UnitedHealthcare Community Plan of Kansas,* March 19, 2025. The 2024 CAHPS surveys were conducted by each MCO from February through May 2024

Mental Health Consumer Perception Survey

- KanCare — *2024 KanCare Mental Health Consumer Perception Survey,* February 19, 2025

Provider Survey Validation

- Aetna — *2024 Provider Satisfaction Survey Validaton*, March 24, 2025.
- Sunflower — *2024 Provider Satisfaction Survey Validaton* April 3, 2025.
- UnitedHealthcare — *2024 Provider Satisfaction Survey Validaton*, April 10, 2025.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

- Aetna — *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Aetna,* March 5, 2025
- Sunflower — *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of Sunflower,* February 4, 2025
- UnitedHealthcare — *2024 Review of Compliance with Medicaid and CHIP Managed Care Regulations of UnitedHealthcare,* February 5, 2025

Quality Assessment and Performance Improvement Review

- Aetna — *2024 QAPI Review of Aetna*, February 6, 2025
- Sunflower — *2024 QAPI Review of Sunflower*, March 10, 2025
- UnitedHealthcare — *2024 QAPI Review UnitedHealthcare*, February 25, 2025

Network Adequacy Validation

- KanCare — *2024 Network Adequacy Validation,* March 21, 2025

Appendix B

KanCare Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

2024 Methodologies

The following EQR Activity methodologies are included in Appendix B:

- PMV and Evaluation
- MH Consumer Perception Survey
- QAPI Review
- Network Adequacy Validation

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Performance Measure Validation and Evaluation

Performance Measure Validation Methods

MetaStar performed validation of the HEDIS MY 2023 performance measures according to CMS Protocol 2, Validation of Performance Measures.

Common Among the MCOs

The CMS Protocol 2 identified key types of data that should be reviewed as part of the validation process. MetaStar's review included the following types of data:

- Policies and procedures related to calculation of performance measures
- HEDIS Roadmaps (a NCQA HEDIS® Compliance Audit™ data collection tool), Information Data Submission System (IDSS) files, HEDIS Compliance Audit reports (prepared for the MCO-contracted audit that was concurrent with measure production), audited rates and support documents
- Records of MCO validation efforts, including run logs, error and issues logs, file layouts, and system flow diagrams
- Member-level data showing numerator and denominator inclusion status

Findings from virtual onsite interviews, provided documentation, system demonstrations and data output files, primary source verification, and review of data reports were compiled and analyzed. Additional follow-up was conducted by telephone and email.

As part of the PMV process and with approval from the State, the Timeliness of Prenatal Care and the Postpartum Care indicators of the HEDIS Prenatal and Postpartum Care (PPC) measure were reabstracted by MetaStar (30 records per indicator for each MCO). KFMC provided a randomly selected list of cases to the MCOs, and the MCOs provided the medical records for the reabstraction. MetaStar performed the reabstractions prior to the on-site interviews.

Prior to the virtual onsite, KFMC requested member-level files for 23 measures in order to conduct validations, such as comparing counts and rates in the MCO's IDSS files to corresponding values calculated from the KMMS. The measures requested are used by the State and KFMC for evaluation of the KanCare and SUD 1500 Demonstration programs and for the pay-for-performance incentive program. The validations served three purposes:

- Test the accuracy of the reported HEDIS measures
- Check that provider data and member demographic and enrollment data sent by the State are accurately stored in the MCOs' systems
- Assess the completeness of the encounter data sent by the MCOs

From the set of all member-level tables, the uniqueness of the Medicaid ID was tested (that is, verifying a Medicaid ID appeared only once per denominator). Within each MCO's records, the relationship between the Medicaid ID and MCO-defined identifiers was examined by checking for Medicaid IDs associated with multiple MCO-defined identifiers, and vice versa. For records showing the members' names and dates of birth, comparison to the names and dates of birth in KMMS were made.

Many HEDIS measures require that the member be enrolled with the MCO on a specific date, the *anchor date*, to be included in the denominator. KFMC checked that the members in the administrative denominator were enrolled on the anchor date for the following measures:

- Measures with December 31, 2023, anchor date
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
  - Cervical Cancer Screening (CCS)
  - Chlamydia Screening in Women (CHL)
  - Eye Exam for Patients with Diabetes (EED)
  - Use of Opioids from Multiple Providers (UOP)
  - Child and Adolescent Well-Care Visits (WCV)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)
- Measures anchored on the second birthday
  - Childhood Immunization Status (CIS)
  - Lead Screening in Children (LSC)

The eligible population criteria for CIS and Lead Screening in Children are the same. KFMC verified that the two measures had the same populations for each MCO. CIS, Immunizations for Adolescents (IMA) and WCV denominator criteria were then applied to KMMS demographic and MCO-assignment tables to estimate the denominators for the three measures.

The denominator for the Ambulatory Care Emergency Department Visits/1000 Mbr (AMB) measure is the total of member-months, which is a count that includes members once for each month they are enrolled. The total of member-months was compared to a corresponding count from KMMS. This comparison is used to check if members with dual Medicaid/Medicare enrollment or dual commercial/Medicaid enrollment are included in the HEDIS rates.

KFMC calculated rates for three HEDIS measures from KMMS data and compared results to the MCOs' rates (measurement years 2019-2023 for AAP and PPC, 2022-2023 for WCV). For AAP and WCV, corresponding rates were historically within two percentage points. The differences between KFMC-calculated rates and MCO rates were generally greater for the PPC indicators (not all of the data available to the MCOs for these rates are from claims that are submitted as encounters).

Race and ethnicity codes in KMMS were compared to values from the member-level tables for five measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA), Initiation and Engagement of Substance Use Disorder Treatment (IET), PPC, Pharmacotherapy for Opioid Use Disorder (POD), and WCV. Following the onsite visits, files comparing the MCOs' stratifications by race and ethnicity to stratifications obtained from KMMS reporting warehouse tables were sent to the State and MCOs.

Performance Measure Evaluation Methods

KFMC analyzed data for all HEDIS measures that are CMS Adult or Child Core Set measures to identify strengths and opportunities for improving access, timeliness, and quality of healthcare.

Common Among the MCOs

HEDIS measures may be classified by methods of data collection:

- Administrative Method – Measures are calculated from administrative data sources, including member and enrollment records, claims and encounters, and immunization registries.
- Hybrid Method – A sample of records meeting administrative measure criteria are sampled for medical record review.
- CAHPS® Survey – Rates are calculated from CAHPS survey responses.

For some measures for which either administrative or hybrid rates may be submitted to NCQA, the State required the hybrid methodology but allowed the MCOs to choose either method for the others. Numerator and denominator specifications for the HEDIS measures can be found in the *HEDIS Measurement Year 2023, Volume 2: Technical Specifications for Health Plans.*

Statewide KanCare program rates (labeled "KanCare" within this report) were calculated according to the types of data submitted by each MCO:

- Administrative – KanCare rates were created by dividing the sum of the numerators for each reporting MCO by the sum of denominators for those MCOs.
- Hybrid – KanCare rates for hybrid measures were averages weighted by the administrative denominators (from which the hybrid sample was drawn).
- Mixed Hybrid and Administrative – Where the MCOs did not report rates using the same method, KanCare rates were also averages weighted by the administrative denominators. For statistical testing of mixed KanCare rates, the administrative rates were treated as rates with denominator 411.
- CAHPS® Survey – KanCare rates for CAHPS survey measures were averages weighted by the counts of members meeting survey eligibility criteria.

KFMC compared HEDIS rates to national percentiles for all Medicaid and Children Health Insurance Program health plans made available through NCQA's Quality Compass®. MCO and KanCare rates were ranked using the QC percentiles. The ranks are denoted, in order of worst to best performance: $<5^{th}$, $<10^{th}$, $<25^{th}$, $<33.33^{rd}$, $<50^{th}$, $\geq 50^{th}$, $>66.67^{th}$, $>75^{th}$, $>90^{th}$, and $>95^{th}$. Note that, as QC percentiles are based on HEDIS rates from across the nation, some measures with high scores in Kansas may have very low QC rankings due to high scores nationwide. Due to the COVID-19 pandemic, NCQA advises caution when using MY 2020 data for rate comparisons.

Changes in MCO and KanCare rates and rankings across years 2019 to 2023 were assessed. For hybrid and CAHPS measures, annual changes between rates and the prior year's rates were tested for statistical significance using Fisher's exact for MCO rates and a weighted Pearson chi-square test for KanCare rates. Within this report, a *significant change* means the differences in rates was statistically significant with probability (*p*) less than 0.05. Note, statistical tests on administrative rates with very large denominators may report very small changes as statistically significant.

Changes in rates between 2022 and 2023 were also assessed using a *gap-to-goal* percentage change, which measures the change in rates relative to the potential for change. Identification of strengths and opportunities for improvement used gap-to-goal percentage changes of 10.00% or more as a threshold. The formula for the gap-to-goal percentage change is:

(2023 Rate – 2022 Rate) / (Goal Rate – 2022 Rate), where Goal Rate is 100% or 0%.

Slopes of trend lines were calculated using the ordinary least-squares method. Depending on data availability, three to five years were trended for KanCare, Aetna, Sunflower, and UnitedHealthcare. The slopes provide the *average rate of change* across the trending period in percentage points per year (pp/y). The slopes were tested to see if they were statistically significantly different from horizontal (i.e., significantly different from 0 pp/y) using Mantel-Haenszel chi-square (*p* less than 0.05 was considered significant). Average rates of change of at least 3.0 pp/y were also noted.

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Technical Methods of Data Collection and Analysis/Description of Data Obtained – KanCare Mental Health Consumer Perception Survey

Survey Instruments

From 2010 to 2020, an adapted version of the Mental Health Statistics Improvement Program (MHSIP) Survey instrument was used to gauge consumer perception of KanCare members. In 2021, the State made the decision to use the ECHO Survey tool. The ECHO Survey is the result of the merging of two surveys: MHSIP Survey and the Consumer Assessment of Behavioral Health Services (CABHS) Survey. Additional questions were added to both the adult and child ECHO tools (Q41 and Q42 for adults, Q71 and Q72 for children) to satisfy KDADS's block grant reporting requirements to the Substance Abuse and Mental Health Service Administration (SAMHSA). As a result, Kansas ECHO survey results may not be directly comparable to results from similar surveys conducted in other states.

The adult survey instrument used in 2021 was a version adapted by the vendor from the originally developed ECHO questionnaire. In 2022, the original ECHO survey tool was used, which added 25 questions to the adult survey. Trending is not available from 2021 to 2022 for the questions added to the 2022 tool.

KFMC contracted with Press Ganey to administer the Kansas ECHO Survey. Press Ganey is a certified CAHPS® vendor with experience administering the ECHO Survey since its development. Press Ganey also processed and analyzed the data and provided the final reports upon which this summary report is based. These vendor reports were provided to the State with the individual deliverable report. KFMC created the sample frames and provided them to Press Ganey.

Survey Population and Sampling Process

Members eligible to receive the survey were adult (ages 18 or older) and child (ages 17 or younger, family responding) populations enrolled in KanCare and residing in Kansas on the date of sample selection (June 15, 2024), continuously enrolled during the measurement period (June 1, 2023, through May 31, 2024), and who had received one or more mental health or substance use disorder services through one of the three MCOs during the measurement period.[1] See Table A-1 for the method of identifying mental health and substance use disorder services. A total of 30,084 adult members and 35,348 child members met the criteria. The sample frames were pulled from the June 2024 Medicaid Enrollment file, which included enrollment and demographic data (such as member name, age, phone number, and mailing address).

After receiving the sample frame files from KFMC, Press Ganey implemented a process of deduplication of the sample frames. The sample frames were deduplicated to one record per household. The resulting files included 15,007 eligible adult and 16,156 eligible child members.

The minimum number of survey responses required to obtain a 95% confidence level with a 5% margin of error was calculated for the adult (382) and child (382) populations. Samples were selected for the adult and child populations using simple random sampling. Surveys were mailed to 13,100 KanCare members, representing 5,550 adult and 7,550 child members.

[1] Age is calculated as of May 31, 2024. "Continuous enrollment" allows one gap of up to 45 days during the measurement period but requires enrollment on May 31, 2024.

Table B.1. Codes for Identifying Mental Health and Substance Use Disorder Services		
Type of Service	**Value Set**	**Steps**
Identification of Mental Health Services		
Institutional and professional encounters with mental health or intentional harm related primary diagnosis	Mental Health Diagnosis Intentional Self-Harm	Step 1 inclusion criteria
A visit with a mental health provider, identified by • Provider Type 11 – Mental Health, or • Provider Specialty ○ 096 – Psychiatric Nurse Practitioner ○ 107 – Licensed Clinical Addictions Counselor ○ 108 – Licensed Master's Level Psychologist ○ 109 – Licensed Clinical Psychotherapist ○ 339 – Psychiatrist	BH Outpatient Transitional Care Management Services Electroconvulsive Therapy Telephone Visit Visit Setting Unspecified + Outpatient POS Visit Setting Unspecified + Telehealth POS	Step 2 inclusion criteria
A Community Mental Health Center visit (POS = 53)	BH Outpatient Visit Setting Unspecified Electroconvulsive Therapy Transitional Care Management Services	Step 2 inclusion criteria
An intensive outpatient encounter or partial hospitalization	Partial Hospitalization or Intensive Outpatient Electroconvulsive Therapy + POS = 52 Visit Setting Unspecified + POS = 52	Step 2 inclusion criteria
A visit in a behavioral healthcare setting	Behavioral Healthcare Setting	Step 2 inclusion criteria
Psychiatric collaborative care management visit	Psychiatric Collaborative Care Management	Step 2 inclusion criteria
Notes: Value sets are from the HEDIS MY 2023 and MY 2024 technical specifications for the Follow-Up After Hospitalization for Mental Illness (FUH) measure. Identification was based on encounters meeting the Step1 inclusion criteria and one or more Step 2 inclusion criteria.		
Identification of Substance Use Disorder (SUD) Services		
Services on institutional and professional encounters with primary diagnosis code indicating SUD.	Alcohol Abuse and Dependence Opioid Abuse and Dependence Other Drug Abuse and Dependence	Step 1 inclusion criteria.
Pharmacy encounters with National Drug Code (NDC) indicating medication assisted treatment for SUD	Alcohol Use Disorder Treatment Medications Buprenorphine Implant Medications Buprenorphine Injection Medications Buprenorphine Naloxone Medications Buprenorphine Oral Medications Naltrexone Injection Medications Naltrexone Oral Medications	Step 1 inclusion criteria
Institutional and professional encounters with procedure or revenue codes indicating detoxification or screening and brief intervention services	Detoxification Codes for screening and brief intervention services: H0049, H0050, G0396, G397, 99408, 99409.	Step 2 exclusion criteria
Notes: Value sets are from the HEDIS MY 2023 & MY 2024 technical specifications for the Initiation and Engagement of Substance Use Disorder Treatment (IET) measure. Identification was based on encounters meeting one or more Step1 inclusion criteria. Encounters meeting Step 2 criteria were excluded from analysis.		

Survey Protocol

The survey methodology employed a mail-only distribution process consisting of a one-wave mail protocol. A survey with a cover letter and postage-paid return envelope was mailed to each adult in the sample and to the parent or guardian of each child in the sample. The cover letter provided a Quick Response (QR) code, as well as an internet Uniform Resource Locator (URL), username, and password so the member (or parent/guardian) could take the survey online, if desired. The tasks and timeframes employed were based on the standard NCQA protocol for administering surveys. Surveys were mailed July 19, 2024.

The cover letters for the 2024 Adult and Child ECHO Surveys included language in both English and Spanish; all mailed surveys were in English.

Survey Response Rates

A total of 949 valid surveys were returned: 521 adult surveys and 428 child surveys. Of the adult surveys received, 463 were completed by mail, and 58 were completed via the URL provided (58 in English, 0 in Spanish). For the child surveys, 339 were received by mail and 89 surveys were completed online (84 in English, 5 in Spanish). The adjusted response rates for the adult and child populations were 10.0% and 6.1%, respectively. A total of 872 surveys were undeliverable (337 adult and 535 child).

Data Processing and Analysis

Press Ganey processed all completed surveys and analyzed the results.

There are data limitations regarding the comparison of the KanCare adult and child ECHO survey results to Press Ganey's book of business. The ECHO Survey does not have national specifications for identifying the sample frames, such as criteria for identifying members receiving mental health services. Therefore, care must be used in interpreting the results of statistical testing between the KanCare rates and rates from the Press Ganey Book of Business.

Impact of the COVID-19 Pandemic

The pandemic did not impact the administration of this survey. However, the pandemic has affected mental health and access to services, both of which are factors in determining who was eligible to be surveyed. Comparing survey results between years should therefore be done with caution.

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Quality Assessment and Performance Improvement Review

MCO Documents Reviewed

For this review, KFMC assessed the following documents submitted from the MCOs for compliance with the State Contract QAPI elements:

- Common to the MCOs:
  - *2023 Member Satisfaction Survey – A Collaborative Point in Time Convenience Survey of Member Using Substance Use Disorder (SUD) Services* (Aetna, Sunflower, and UnitedHealthcare)
  - Follow-up to previous KFMC recommendations via the 2024 Progress Tracker (Aetna and UnitedHealthcare – 2022-2023; Sunflower – 2021-2023)
  - *2024 QAPI Checklist*
  - *2023 MCO Provider Satisfaction Survey* (Aetna and UnitedHealthcare November 2023 and Sunflower 2023)
- Aetna:
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement Annual Evaluation –2023* (throughout the report, referred to as *2023 QAPI Program Evaluation*)
  - *Aetna Better Health of Kansas Quality Assessment Performance Improvement 2024 Program Description* (throughout the report, referred to as *2024 QAPI Program Description*)
  - *2024 Aetna Better Health of Kansas QAPI Work Plans* dated May 31 and December 2, 2024 (throughout the report, referred to as *2024 QAPI Work Plans*)
  - *Aetna Better Health of Kansas CHIP Child Population 2024 (MY 2023)* CAHPS® *5.1H Medicaid with CCC Measure Member Experience Survey*
  - *Aetna Better Health of Kansas Adult Population 2024 (MY2023)* CAHPS® *5.1H Medicaid Member Experience Survey*
  - *Aetna Better Health of Kansas Child Population 2024 (MY2023)* CAHPS® *5.1H Medicaid with CCC Measure Member Experience Survey*
  - *Aetna 2023 Long Term Support Services and Supports* [sic] *Program Evaluation*
- Sunflower:
  - *Sunflower Health Plan 2023 Quality Improvement Program Evaluation, Report Period: January 1, 2023 – December 31, 2023* (throughout the report, referred to as the *2023 QAPI Program Evaluation*)
  - *Sunflower Health Plan 2024 Quality Program Description* (throughout the report, referred to as the *2024 QAPI Program Description*)
  - *Sunflower Health Plan 2024 QAPI Work Plans* dated May 31 and December 2, 2024 (throughout the report, referred to as the *2024 QAPI Work Plans*)
  - *MY 2023 CAHPS® Medicaid Child with CCC 5.1H Survey Sunflower Health Plan – Title 19 (Centene KS)*
  - *MY 2023 CAHPS® Medicaid Child With CCC 5.1H Survey Sunflower Health Plan – Title 21 (Centene KS)*
  - *MY 2023 CAHPS® Medicaid Adult 5.1H Survey Sunflower Health Plan (Centene KS)*
- UnitedHealthcare:
  - *2023 Quality Improvement & Population Health Management Annual Evaluation Report – UnitedHealthcare Plan of Midwest, Inc. (UnitedHealthcare Community Plan of Kansas* [*Date Completed: March 25, 2024, QMC Committee Approval: March 29, 2024]* (throughout the report, referred to as the *2023 QAPI Program Evaluation*)

- *2024 UnitedHealthcare QAPI Work Plans* dated May 31 and December 2, 2024 (throughout the report, referred to as the *2024 QAPI Work Plans*)
- *2024 Quality Improvement Population Health Program Description UnitedHealthcare Plan of Midwest, Inc. (UnitedHealthcare Community Plan of Kansas)* dated March 2024 (throughout the report, referred to as the *2024 QAPI Program Description*)
- *Population Health Management Annual Attachment - UnitedHealthcare Plan of the Midwest, Inc. (UnitedHealthcare Community Plan of Kansas*) dated March 7, 2024, QMC Committee Approval March 13, 2024
- *Long-Term Services & Support Care Management Program Evaluation UnitedHealthcare Community Plan of Kansas* dated April 22, 2024; Committee Approval June 3, 2024
- *Long-Term Services & Support Care Management Program Description UnitedHealthcare Community Plan of Kansas* dated March 13, 2024
- *UnitedHealthcare 2023 Complex Case Management (CCM) Satisfaction Survey*
- *UnitedHealthcare 2023 Health First Steps (HFS) Satisfaction Survey*
- UnitedHealthcare *Attachment A – PHM Program and Services*
- *UnitedHealthcare C&S* [Community and State] *Care Model Program Description Community Plan of Kansas* dated January 2024
- UnitedHealthcare *Attachment B – Health Equity Measures*
- UnitedHealthcare *Attachment C – National Committees*
- UnitedHealthcare *MY 2023 CAHPS® Medicaid Child with CCC 5.1H Survey*
- UnitedHealthcare *MY 2023 CAHPS® Medicaid Adult 5.1H Survey*

Required QAPI Reporting Elements from the KanCare Quality Management Strategy (QMS)

From the January 2022 KanCare QMS, the State advised (May 6, 2022) the MCOs are to report on the following elements in their QAPI Program Description and QAPI Program Evaluation:

- Objective 4.5: Achieve the National HEDIS® 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)
- Objective 5.1: HbA1c good control (<8.0%) for members with diabetes
- Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30)
- Objective 5.2b: Well-Child Visits 15-30 months (15-30-month period & name change in 2020)
- Objective 5.3a Child and Adolescent Well-Care Visits (WCV) ages 3-11
- Objective 5.3b Child and Adolescent Well-Care Visits (WCV) ages 12-17
- Objective 5.3c Child and Adolescent Well-Care Visits (WCV) ages 18-21

Per the State, "All MCOs are expected to achieve the HEDIS 75th QC percentile for all reported HEDIS data. HEDIS measures falling below the 75th percentile the State has devised the following strategy aimed at reducing annually, by 10%, the gap between the baseline rate and 100%. For example, if the baseline rate was 55%, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5%. Each measure that shows improvement equal to or greater than the performance target is considered achieved. For those measures which have exceeded the 90th QC percentile, plans are expected to maintain or improve their outcomes. MCOs are to assess and report their annual progress and goals for each measure below the 75th percentile in their QAPI."

MCO QAPI Requirements

In 2023, the State and KFMC met on April 11 and 17, and May 15, to discuss the items on the *QAPI Checklist* and determine what changes needed to be made to the requirements for the MCOs. On June 22, 2023, the State and KFMC met with the MCOs, presented the changes, and provided the new *QAPI Checklist* (included in this appendix, see page B-11). The State informed the MCOs of the expectation that the *QAPI Checklist* changes are to be incorporated, by the MCO, into the QAPI documents as follows:

- *2023 QAPI Work Plan* due from the MCOs November 30, 2023: The State determined there was not enough time for the MCOs to make the changes to the *2023 QAPI Work Plan* that was due May 31, 2023. Therefore, if the required items were not included in the QAPI work plan dated November 30, 2023, it would result in non-compliance and a recommendation would be made.
- *2023 QAPI Evaluation* (due from the MCOs April 29, 2024) and *2024 QAPI Program Description* (due from the MCOs August 31, 2024): The State determined there was not enough time for the MCOs to make the changes to the *2022 QAPI Evaluation* due April 29, 2023, and the *2023 QAPI Program Description* due August 31, 2023. Therefore, if the required items were not included in the *2022 QAPI Evaluation* (reviewed in the 2023 review) and *2023 QAPI Program Description* (reviewed in the 2023 review), it would result in suggested enhancements being made with the notation that if the items are not included in the *2023 QAPI Evaluation* and *2024 QAPI Program Description* (reviewed in the 2024 review), it will result in recommendations being made.

QAPI Compliance Rating

If the requirement was included in all of the QAPI documents (2023 program evaluation, 2024 program description, and 2024 work plans) and fully met, it was considered compliant for the 2024 review. The recommendations included in Appendix D were recommendations made in prior years. The MCO's updates to those recommendations are reviewed, and also factored into the overall 2024 compliance ratings. Since Aetna's contract ended with the State of Kansas on December 31, 2024, no new recommendations were made.

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QAPI Checklist

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
1.	Tracking the reason for disenrollment	5.2.2 Disenrollment – second Letter B, Number 2	**1. Is there evidence in the MCO QAPI Program that they are monitoring and reviewing disenrollment trends?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
2.	MCO Compliance with the State's QMS	5.9.1 General Requirements – Letter A	**1. Does the MCO acknowledge its intent to abide by the requirements of the State's QMS?** **2. Is there evidence that the QMS is reviewed at least annually, including the MCO's compliance of the State QMS?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
3.	Collected and reported performance measure data for members receiving LTSS	• 5.9.1 General Requirements – Letter D • CFR §438.330(b)(2) and (c)(1)(i-ii)	**1. Is there evidence that the MCO collects and reports performance measurement data, including performance measures for Members receiving LTSS related to:** • Quality of life • Rebalancing (definition and/or examples) Long-term Services and	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Supports (LTSS) Rebalancing Toolkit Fact Sheet | CMS • Community integration activities Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
4.	Detection of underutilization and overutilization of services	• 5.9.1 General Requirements – Letter E • CFR §438.330(b)(3)	**1. Is there evidence that the MCO has a mechanism to detect both underutilization and overutilization of services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
5.	For members receiving LTSS, mechanisms used to compare services and supports received with those in the member's treatment/ service plan	• 5.9.1 General Requirements – Letter F • CFR §438.330(b)(5)(i)	**1. Is there evidence that the MCO has a mechanism to compare services and supports received with those set forth in the Member's treatment/service plan for individuals enrolled in LTSS Waivers (Home and Community Based Services)?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
6.	Mechanisms to ID members enrolled in LTSS waivers but not receiving waiver services	5.9.1 General Requirements – Letter G	**1. Is there evidence that the MCO has a mechanism to identify Members who are enrolled in LTSS Waivers but who are not receiving any waiver services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
7.	Mechanisms to ID and address BH service needs and ensure Members receive the approved BH services	5.9.1 General Requirements – Letter H	**1. Is there evidence that the MCO has a mechanism to identify BH service needs of Members?** **2. Is there evidence that the MCO ensures that Members receive approved BH services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
8.	For Members receiving Special Health Care Needs, mechanisms to assess quality and appropriateness of care	• 5.9.1 General Requirements – Letter I • CFR §438.330(b)(4)	**1. Is there evidence that the MCO has a mechanism to assess quality and appropriateness of care for Members receiving SHCN?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
9.	For members receiving LTSS, mechanisms to assess the quality and appropriateness of care, including assessment of care between settings	• 5.9.1 General Requirements – Letter J • CFR §438.330(b)(5)(i)	**1. Is there evidence that the MCO has a mechanism in place to assess the quality and appropriateness of care for members that receive LTSS?** **2. Is there evidence that the MCO has a mechanism to assess the quality and appropriateness of care between settings for LTSS services?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • Member Survey for members receiving LTSS services • Credentialling and peer review of providers • Readmission rate of LTSS members	
10.	Adverse/Critical Incidents	• 5.9.1 General Requirements – Letter K • CFR §438.330(b)(5)(ii)	**1. Is there evidence that the MCO participates in efforts to prevent, detect, and remediate critical incidents, including identifying, tracking, and reviewing critical incidents to address potential and actual quality of care and/or health and safety issues?**	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: Report in the QAPI documents how the MCO tracks critical incidents and addresses issues identified.	
11.	For members receiving LTSS, results of efforts to support community integration reported to the State	5.9.1 General Requirements – Letter L	**1. Does the MCO report in the QAPI Evaluation (or LTSS Program Evaluation), at a minimum, the efforts to support community integration from Members using LTSS?** Documents Expected at a Minimum: QAPI Evaluation and/or LTSS Program Evaluation, QAPI Program Description and/or LTSS Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: Detail MCO activities that support community integration specifically for those members using LTSS.	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
12.	Evaluation of the impact and effectiveness of the MCO's QAPI	5.9.1 General Requirements – Letter M	**1. Is there evidence that the MCO has a process to evaluate the impact and effectiveness of the QAPI program?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • In the MCO QAPI Evaluation, include details of the impact and effectiveness of the QAPI program. • In the QAPI Program Description, MCO detail a process to evaluate the impact and effectiveness of its QAPI program. • In the QAPI Work Plan, MCO detail activity/ activities to evaluate the impact and effectiveness of its QAPI program.	
13.	Structure and staffing for QAPI	5.9.1 General Requirements – Letter N.1-4 (N4: Related NCQA Quality Improvement [QI] Committee Responsibilities, see related NCQA Annual Evaluation Guidelines and Program Description Requirements)	Review for evidence of the following: **1. The MCO has a QAPI unit within its organizational structure that is separate and distinct.** **2. The MCO employs sufficient, qualified staff and utilizes appropriate resources to achieve quality Outcomes.** **3. The MCO ensures the Chief Medical Officer (CMO) is responsible for oversight of the QAPI program.**	

QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
			e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		4. The MCO has an established Quality Committee Structure from the Board of Directors down to the local health plan that includes committees to address: **a. Quality management/quality improvement** **b. Service** **c. Delegation oversight** **d. Credentialing/recredentialing** **e. Peer review** **f. Member Advisory** **g. Subcommittees to address children or other special populations, as appropriate.** **5. All committees have a charter outlining the role, responsibility, membership and meeting frequency** **6. Membership of committees includes an appropriate mix of community Providers, Members and caregivers reflective of the services delivered and populations served.** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • QAPI Program Description to include a description of the QAPI organization	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			structure, including descriptions of the committees. • QAPI Evaluation to include any challenges or successes with the committees and staffing within the MCO. • QAPI Work Plan to include the committees and meeting timeframes/frequency. • The MCO to include a description of the various committees with their roles, responsibilities, membership, and meeting frequency.	
14.	Annual MCO QAPI work plan	• 5.9.1 General Requirements – Letter N.5 • Related NCQA QI Committee Responsibilities • Related NCQA QAPI Work Plan and Annual Evaluation Guidelines	**1. Is a current work plan(s) included in the submission?** **2. Does the work plan(s) include QAPI activities and a timeline for completion?** <u>Document Expected at a Minimum</u>: QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: The State/KFMC would not expect to see details of the QAPI Work Plan in the QAPI Program Description or QAPI Evaluation. The State expects the MCO to show whether the activity has been completed or continues to be in progress.	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
15.	Annual MCO QAPI evaluation	• 5.9.1 General Requirements – Letter N.6 • CFR §438.330(e)(1-2) • See related NCQA QAPI Work Plan Guidelines and NCQA Annual Evaluation Guidelines	**1. Is a current evaluation included in the submission?** **2. Is there evidence that the evaluation includes findings and recommendations that were used to shape the annual QAPI program description and QAPI Work Plan?** **3. Does the evaluation assess the extent that the MCO met its goals and objectives?** **4. Does the evaluation include recommendations for continuous quality and service improvement?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: Completion of the QAPI Evaluation should be included in the QAPI Program Description and should include the elements listed. The opportunities, as identified in the QAPI Evaluation, should be addressed in the subsequent year's QAPI Program Description and QAPI Work Plan.	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
16.	Integration and infusion of State identified guiding principles	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letter A.1-11 A. The CONTRACTOR(S) shall adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors: 1. Promote an organizational culture focused on continuous quality improvement, innovation, and service excellence at all levels of quality program design and implementation. 2. Empower staff excellence through hiring those who are Medicaid experienced and knowledgeable and investing in their development through relevant ongoing training, education, and mentorship. 3. Harness data from information systems and engage data analytic approaches to produce actionable information, which is consistent, timely, valid, and reliable and supports evidence-based decision making. 4. Utilize Rapid-Cycle Process Improvement methods to quickly identify, analyze and resolve operational inefficiency, improve the quality of care and improve the Member and Provider experience. 5. Focus on achieving year-over-year quantitative and qualitative improvements.	**1. Is there evidence of the Guiding Principles as listed in the State Contract, in at least one of the QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • The guiding principles do not need to be word for word or listed as guiding principles in the QAPI documents. This could be evidenced by the MCOs description of their QAPI programs throughout the documents. • The guiding principles should be consistent through all QAPI documents.	

QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
			e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
	6. Implement a system of measurement and monitoring to assure the health, safety, and welfare of Members. 7. Pursue innovative approaches, including the use of telehealth, e-visits and alternative payment arrangements, to expand access to quality care and services. 8. Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members. 9. Maximize the quality of life of all Members by addressing Social Determinants of Health and Independence and through delivery of culturally appropriate, integrated, holistic, evidenced based care and services. 10. Promote the highest level of independence, dignity, productivity and community inclusion or preservation and maintenance of dignity, privacy and individuality based on Member and representative choice, rights and goals of care. 11. Use person-centered models to collaborate with Members, caregivers, and family to achieve the highest level of Member self-actualization and success.		

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
17.	Incorporation of the State identified goals	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letter B.1-6 B. The CONTRACTOR(S) shall adopt, at a minimum, the following goals within its QAPI program. The CONTRACTOR(S) shall respond to how these goals will be incorporated into its QAPI program and into those of its delegates and Subcontractors: 1. The CONTRACTOR(S) shall develop performance measurement and performance improvement strategies to maximize health Outcomes and the quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports. 2. The CONTRACTOR(S) shall promote the highest level of Member independence, productivity, Wellness and functional ability in the most integrated and least restrictive setting through harnessing data to monitor and ensure the delivery of holistic, integrated, person-centered, and culturally appropriate care to all KanCare populations. 3. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Members, family	**1. Is there evidence the MCO's goals include the specified goals in the State Contract?** **2. Are the goals consistent through all QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • Within the MCO's listed goals, the goals as listed in the State contract need to be included. • The goals do not need to be word for word and the MCO can include more, MCO specific goals. • The goals should be consistent through all QAPI documents.	

QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
			e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
	members of Members, caregivers and other stakeholders in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance. 4. The CONTRACTOR(S) shall develop mechanisms to solicit regular feedback and recommendations from Providers, community-based organizations, Subcontractors and other network partners in order to monitor service quality and utilization and to develop strategies to improve Member Outcomes and quality improvement activities related to the quality of care and system performance. 5. The CONTRACTOR(S) shall use innovative strategies to improve access to and availability of services through the development of strong collaborative partnerships with Providers, Subcontractors and other network partners. 6. The CONTRACTOR(S) shall employ strategies to evaluate the ongoing efficiency and effectiveness of its Participating Providers and adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and services to all Members.		

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
18.	State identified seven objectives to meet established QAPI goals	5.9.3 QAPI Goals, Objectives, and Guiding Principles – Letters A.8 and C.1-7 A. Adopt the following guiding principles and respond to how it will integrate these principles into the QAPI program and infuse them throughout its organization and that of its delegates and Subcontractors: 8. Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members. C. Respond to how it will incorporate the following objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals: 1. Collect complete and accurate data on Members and Providers regarding service processes and Outcomes furnished through robust collection, analysis and reporting of data. 2. Maintain staff with the capacity and capability to provide and describe Kansas specific data at every level of collection, analysis, and reporting by the Plan, as well as, Participating Providers and vendors. 3. Develop capacity to analyze data, make information actionable, and implement interventions to demonstrate improved results.	**1. Is there evidence the MCO's objectives include the specified objectives in the State Contract?** **2. Are the objectives consistent through all QAPI documents?** <u>Documents Expected at a Minimum</u>: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan <u>NOTES – How the MCO can show compliance</u>: • Within the MCO's listed objectives, the objectives, as listed in the State contract, need to be included. • The objectives do not need to be word for word and the MCO can include more MCO specific objectives. • The objectives should be consistent through all QAPI documents.	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		4. Deploy Rapid-cycle Quality Improvement principles throughout the organization. 5. Develop strong Provider peer review mechanisms to evaluate the quality, appropriateness, and cost effectiveness of care delivered. 6. Adopt strategies to collect and integrate experience of care and satisfaction data from Members, caregivers, Participating Providers, and other network partners into the QAPI program. 7. Drive collaboration and innovation internally, across business units and externally with Members, caregivers, Participating Providers, stakeholders and community- based entities.		
19.	Performance Measures	• 5.9.4 Performance Measures – General Requirements and letters A-B • CFR §438.330(c)(2) • See related NCQA Data Collection Requirements • NCQA Requirements for MCO Practitioner/Provider Contracts Goal 5: Objective 5.7 State required Medicaid Child Core Measure Sets to be reported in the QAPI Program Description and QAPI Evaluation: • *Breast Cancer Screening (BCS-AD)*	**1. Is there evidence the MCO uses performance measure data in a rapid-cycle fashion to improve the integration of physical, behavioral, and LTSS service delivery and improve access and availability of LTSS and Behavioral Health Providers?** **2. Is there evidence the MCO uses data to improve the quality of care and services delivered to all populations?** **3. Does the MCO report in the QAPI Program Description and QAPI Evaluation, the State required Medicaid**	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		• *Chlamydia Screening in Women ages 16 to 24 (CHL)*	**Child Core Measure Sets (i.e., Breast Cancer Screening and Chlamydia Screening in Women ages 16 to 24)?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
20.	Clinical and Non-clinical Performance Improvement Projects	• 5.9.1 General Requirements – Letters B.1-2 and C • 5.9.5 Performance Improvement Projects – General Requirements and A-J • CFR §438.330(a)(1-2) and (b)(1)	**1. Is there evidence the MCO incorporates the PIPs and results into the QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: For the QAPI Review, the MCO should incorporate the PIPs and results into the QAPI Program Description and have activities that address the PIPs in the QAPI Work Plan.	
21.	Peer Review Process and Peer Review Committee	• 5.9.6 Peer Review – General Requirements and Letter A • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO has a Peer Review process and incorporates the data to improve the delivery of care and services?** **2. Is there evidence the MCO has a Peer Review Committee, chaired by the CMO or physician designee?**	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: The MCO should have the process detailed in the QAPI documents.	
22.	NCQA Accreditation	• 5.9.7 National Committee for Quality Assurance Accreditation – General Requirements and Letters A-B • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO is NCQA accredited?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: • MCO include language detailing they have a goal to maintain NCQA status. • Include the level of NCQA accreditation. • Include when the next NCQA accreditation will occur.	
23.	HEDIS data collection and reporting for population-specific HEDIS measures	• 5.9.8 HEDIS and CAHPS – General Requirements and Letters A-G • Related NCQA Data Collection and Quality Improvement (BH) • State QMS, Goal 4, Objective 4.5 and Goal 5, Objectives 5.1, 5.2a, 5.2b, 5.3a, 5.3b, and 5.3c	**1. Is there evidence the MCO incorporates HEDIS measures in their QAPI program?** **2. Are the required HEDIS measures evaluated in the QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
		State required HEDIS measures that the state requires be reported in the QAPI Program Description and QAPI Evaluation: • Objective 4.5: Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET) • Objective 5.1: HbA1c good control (<8.0%) for members with diabetes • Objective 5.2a: Well-Child Visits first 15 months (*effective 2020 name changed from W15 to W30) • Objective 5.2b: Well-Child Visits 15-30 months (15-30 -month period & name change in 2020) • Objective 5.3a Child and Adolescent Well-Care Visits (WCV) ages 3-11 • Objective 5.3b Child and Adolescent Well-Care Visits (WCV) ages 12-17 • Objective 5.3c Child and Adolescent Well-Care Visits (WCV) ages 18-21	NOTES – How the MCO can show compliance: In QAPI documents, include HEDIS reporting and ongoing analysis of the HEDIS data.	
24.	CAHPS Surveys	• 5.9.8 HEDIS and CAHPS – Letter G • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO incorporates the results from CAHPS Surveys in their QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
			NOTES – How the MCO can show compliance: Details on the MCOs administration of the CAHPS survey each year.	
25.	Adverse incident reporting, investigation, follow up, and data collection, analysis, tracking, and trending	• 5.9.9 Adverse Incident Reporting and Management System General Requirements – Letters A-F • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence that the MCO integrates data from the Adverse Incident Reporting and Management System, addressing how information will be used along with grievance data to improve the care and services delivered by network Providers, decrease incidents of abuse, neglect and exploitation, and prevent future incidents?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
26.	Member Satisfaction Survey Methodology, Survey, results, and incorporation into the QAPI program to improve care for members	• 5.9.10 Member Satisfaction Surveys – Letters A-E • Related NCQA Data Collection and Quality Improvement (BH)	**1. Is there evidence the MCO conducts Member satisfaction surveys and incorporates the results in to the QAPI program to improve care for Members?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
27.	Member satisfaction survey conducted with the KanCare SUD population and annual summary	• 5.9.10 Member Satisfaction Surveys – Letter F.1-2 (Amendment 14) • Related NCQA Data Collection and Quality Improvement (BH)	**1. Did the MCO administer the annual SUD Survey (Section 5.9.10.F)?** **2. If yes to #1, did the MCO submit the annual summary results to the State? (Section 5.9.10.F.2)** **3. Is there evidence the MCO incorporates the results of Member satisfaction surveys conducted with the KanCare SUD population and annual summary into the QAPI program?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan NOTES – How the MCO can show compliance: In QAPI documents, the MCO should include information detailing they have completed the survey. It would not be an expectation for the MCO to include information on what has been done to meet each of the contract requirements (Amendment 14).	

	QAPI Requirement	State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
28.	Provider Satisfaction Survey methodology, survey results report, and incorporation into the MCO QAPI program	• 5.9.11 Provider Satisfaction Surveys – Letters A-E (Amendment 14) • Related NCQA Data Collection and Quality Improvement (BH)	**1. Did the MCO complete the Provider Satisfaction Survey Methodology?** **2. If yes, did they submit it to the State for approval?** **3. Did the MCO administer the Provider Satisfaction Survey?** **4. If yes to #3, did the MCO submit the summary results to the State?** **5. Is there evidence the MCO incorporates the Provider satisfaction survey(s) methodology and results into the QAPI program to improve care for Members and the MCO service to its Participating Providers?** Documents Expected at a Minimum: QAPI Evaluation, QAPI Program Description, and QAPI Work Plan	
29.	Data received from Participating Providers	5.16.1 Reports and Audits – Letter B	**1. Is there evidence that the MCO ensures that data received from Participating Providers is accurate, complete, and timely?** Document Expected at a Minimum: QAPI Work Plan NOTES – How the MCO can show compliance: MCO activity in the QAPI Work Plan to verify the accuracy, completeness, and timeliness of the reports prior to submission to the State.	

QAPI Requirement		State QMS, State Contract Section and/or CFR §438.330 Quality Assessment and Performance Improvement Program	Reviewer Questions What the Reviewer Will Look for and in What Document(s)	Indicate the document, page number(s) and paragraph(s) where item is located
				e.g., Annual MCO Evaluation Report, page 4, paragraphs 2-6
30.	Information on the Quality Management Director that is exclusively dedicated to the KanCare program	5.17.2 CONTRACTOR(S) Key Personnel – Letter C.10	**1. Does the QAPI Program Description include information on the QM Director that is exclusively dedicated to the KanCare program?** Document Expected at a Minimum: QAPI Program Description	

Technical Methods of Data Collection and Analysis/Description of Data Obtained – Network Adequacy Validation

Validation of Time and Distance Standards – Validation of Mapped Provider Count Reports

KanCare *network adequacy standards* include minimum distances (expressed in miles or minutes) between a member's address and MCO network providers.[1] The minimum distances vary depending on provider category and specialty, age of member, and the population density of the county in which the member resides. The *network adequacy indicator* for the standards (a measure assessing the degree to which the standards are being met) reported quarterly by the MCOs to the State is the percent of members within the access standard. This appendix details the methodology and results of KFMC's validation of a set of indicators reported by Aetna, Sunflower, and UnitedHealthcare.

KFMC conducted this validation in accordance with the February 2023 Validation of Network Adequacy protocol worksheets and narrative provided by the CMS. The protocol outlines six activities for the validation and provides multiple questions for consideration:

- Activity 1: Define the Scope of the Validation
- Activity 2: Identify Data Sources for Validation
- Activity 3: Review Information Systems Underlying Network Adequacy Monitoring
- Activity 4: Validate Network Adequacy Monitoring Data, Methods, and Results
- Activity 5: Communicate Preliminary Findings to Managed Care Plans
- Activity 6: Submit Findings to State

Activity 1: Define the Scope of the Validation

In discussions with the State, the network adequacy standards to be evaluated were determined to be the time and distance measures reported on the Mapped Provider Counts tab of the MCOs' 2024 Q2 Mapped Provider Count (MPC) Reports.

The network adequacy indicator for the time and distance standards is the "percent of members within access standard." All three MCOs calculated distances from members to providers "as the crow flies," which was in line with the State's expectations. Travel time from member residence to provider location was not reported by the MCOs and, therefore, not part of the 2024 network adequacy validation.

The above indicator was not directly assessed. Rather, data used to calculate two additional metrics within the MPC Report were validated to assess the accuracy and completeness of the MCOs' reports. KFMC assumed that if the data used to calculate the following metrics was complete and accurate, then the percent of members within access standard was likely calculated correctly by the MCOs' standardized mapping software used to calculate the indicator. These two metrics were

- Number of unique providers, and
- Number of unique locations.

KFMC originally proposed to also examine claims data for providers who had at least one year of service to identify providers who had no claims in the six months prior to the end of the relevant quarter at a

[1] KanCare Network Adequacy Standards. www.kancare.ks.gov/home/showpublisheddocument/2012/638745144229798251. September 22, 2022.

specific service location. KFMC then planned to call the offices of selected providers to confirm that the provider was still practicing at the location and was in-network, to determine whether the provider was accepting new Medicaid patients, and to determine if the provider had existing Medicaid patients. The aim of this activity was to answer the following research question: "Do the MCOs have providers listed in their directories at service locations who are not providing services there?"

However, based on discussions with the State, the research question that motivated these activities was addressed. State guidance to KFMC was to eliminate the calls to providers from the 2024 Network Validation activities. KFMC committed to conducting the claims analysis and will provide a summary of these findings outside of this report.

State Technical Specifications for the Percent of Members Within Access Standard

The following technical terms were defined by the State for the network adequacy standards and indicators:

- **Adult Members** – KanCare members aged 21 years or older
- **Pediatric Members** – KanCare members aged 0–20 years
- **Adult Providers** – MCO network providers contracted to provide services to adult members
- **Pediatric Providers** – MCO network providers contracted to provide services to pediatric members
- **Urban/Semi-Urban County Type** – Urban counties are Douglas, Johnson, Leavenworth, Sedgwick, Shawnee, and Wyandotte; semi-urban counties are Butler, Crawford, Franklin, Geary, Harvey, Miami, Montgomery, Reno, Riley, and Saline.
- **Densely-Settled Rural/Rural/Frontier County Type** – All Kansas counties not classified as urban or semi-urban.
- **Border State Providers** – MCO network providers located in a state bordering Kansas.

The percent of members within an access standard was defined using the following criteria:

- **Denominator** – All KanCare members in the given age group residing in a county of the specified type
- **Numerator** – All KanCare members meeting denominator criteria who reside within the specified number of miles of at least one network provider contracted to provide services to members in the given age group

The State expects 100% of KanCare members to be covered under each of the specialties listed within the MPC Report. If an MCO is unable to meet this expectation for a particular specialty, the MCO may submit an exception request or may be subject to penalties or sanctions.

Affiliation of Group Practices and Practitioners

During the validation process, several questions arose related to the counting of groups and practitioners in groups. MCO network contracts with provider groups are commonly written so that all of the group's service locations and all of the group's practitioners become part of the MCO's provider network. The result of this is that a practitioner in a group will be an in-network provider when they see members at any of the group's locations. Within the State and MCO systems, practitioners are *affiliated* with a service location of a group when the system is set up for the group to submit a claim for services performed by the practitioner at that location. Groups with multiple service locations commonly affiliate their practitioners with all of the group's service locations, even if a practitioner may never provide services at some of these service locations. In this way, the group is ready to bill for services should a practitioner perform an occasional service at another location.

On November 1, 2024, KFMC met with the State to receive clarification on the network adequacy standards via three questions that were previously submitted along with examples from the MCOs' data submitted for validation:

- **Q1**: Is there an expectation that the MCOs only count practitioners at locations in which the practitioner is currently providing services?
  - The State indicated that this is not currently an expectation for the MCOs, though they are expected to only include providers who are currently contracted to provide services at a location (i.e., in-network) in their counts of unique providers and locations. The State acknowledged that not having an indicator in KMMS or the MCO systems to capture where a practitioner is currently practicing was a data limitation. This has the potential to inflate the total number of individual providers.
- **Q2**: For this report, should a provider be included in the specialty counts if they are not a practitioner? In other words, would it be acceptable for an MCO to include affiliated groups in their specialty counts in addition to the practitioners with those specialties?
  - The State indicated that MCOs can include both practitioners and the groups affiliated with those practitioners in their counts for the various provider specialties included in the MPC Report.
- **Q3**: Can a group be counted under a specialty if they do not have a practitioner with that specialty providing services at that location?
  - Based on the State's response to this and earlier questions, a group should not be counted under a particular specialty unless there is a practitioner with that specialty contracted to provide services at a location.

Activity 2: Identify Data Sources for Validation

Source data were obtained from the MCOs, the State, and other EQR activities:

- Data from KanCare MCOs
  - 2024 Q2 Mapped Provider Count Report – a report from each MCO submitted to the State detailing the number of unique participating providers and locations that KanCare members have access to.
  - MCO network provider tables – an extract of MCO provider data that was used as source data for the 2024 Q2 Mapped Provider Count Report.
  - Cleaned provider network file – a copy of the cleaned and deduplicated file used to derive the counts of unique providers and locations reported on the 2024 Q2 Mapped Provider Count Report.
  - MCO process documentation – instructions, technical specifications, and coding steps for creating the cleaned provider network file from the network provider tables.
  - Prior Mapped Provider Count Reports – quarterly reports from 2021 Q2 to 2024 Q3 were collected for additional analysis.
  - 2024 Q2 Network Adequacy (Provider Network Reports) – Excel file listing providers who were participating, non-participating, and previously participating in the MCO's network.
- Data from the State
  - KMMS tables – copies of KMMS provider, member, enrollment, and encounter tables are routinely received by KFMC from the State for EQR activities.
  - PRN Files – PRN files are routinely sent to the MCOs with updates to provider data. An October 2024 version was provided to KFMC.

- Other EQR activities
  - 2023 ISCA Reports and related documentation –ISCAs are conducted biannually to collect information to validate the capabilities of the MCOs' information systems, processes, and data.

Activity 3: Review Information Systems Underlying Network Adequacy Monitoring

From the latest ISCA (conducted during 2023), it was determined that each of the MCOs collect data for their network adequacy validation either from their internal provider data systems (QNXT for Aetna, Portico for Sunflower, and NDB for UnitedHealthcare) or from external vendors (dental, vision, pharmacy, and transportation for all three MCOs). No significant concerns were noted related to the MCOs' systems or processes for storing provider data. No significant systems upgrades, consolidations, or mergers were noted that would affect this year's validation.

Activity 4: Validate Network Adequacy Monitoring Data, Methods, and Results

The percentage of network provider table records (i.e., rows) populated for each variable deemed necessary for validation was calculated. For all records, the MCOs were expected to provide a KMMS ID for either the group or the individual practitioner (or both for practitioners in groups), an NPI where appropriate, a street address, city, state, ZIP code, provider type code, specialty code, and an indicator for ages that the provider serves.

KFMC requested cleaned provider network files from which the mapped provider and location counts were derived, the network provider table used as the source data table for the MPC Report, and instructions, technical specifications, or coding steps for creating the cleaned provider network file from the network provider table. Each of the MCOs had developed their own process for assessing network adequacy via the MPC Report. Each provided varying levels of detail regarding how the network provider tables and the cleaned provider network tables that KFMC requested were created.

Aetna provided a methodology document outlining the requirements for providers to be included in the MPC Report. Code was used to extract provider records that met the requirements, and Quest Analytics was used to generate both the maps and counts on the MPC Report. The counts reported were based on a deduplicated table of NPI, latitude, longitude, and the stratum identified by the provider's specialty code. After review of the documentation originally received, KFMC requested that Aetna provide a network provider table populated with KMMS IDs for practitioners and groups, fields not originally provided. An updated table was submitted; however, this updated table was not properly restricted to reflect the source data table used for the 2024 Q2 MPC Report. Both the originally submitted table and the updated table were compared to KMMS records and the PRN file provided by the State.

The methods described above were mostly sufficient to generate the data needed to calculate the number of unique providers and locations for providers in Aetna's Kansas network. One issue noted with the methodology documentation was the ambiguity related to the word "current." It was unclear if current referred to the date the report was generated, the start or end of the relevant quarter, or some other criteria. This ambiguity may have been responsible for some of the difficulty matching provider and location counts.

Sunflower provided detailed documentation regarding the processes followed to generate the tables KFMC requested for network adequacy validation. A process overview was received that outlined the steps taken to create the network provider table, referred to as the Geo Master Table (GMT), for the MPC Report. The GMT was created from Sunflower's electronic data warehouse, and the table

contained all information relevant to deciding whether a provider should be included in the MPC Report and under which specialties and locations they should be counted. The data table submitted with the MPC Report was generated from the GMT by deduplicating a filtered list of providers with a relevant three-digit specialty code, who had indicated they served the adult or pediatric population (or both), and whose contract with Sunflower had not been terminated.

Upon KFMC's request, Sunflower provided several additional pieces of documentation relevant to the MPC Report. These included a flow chart of their provider data system that indicated the PRN file received from the State was the source for most provider data in Sunflower's systems for the Kansas Medicaid market. The documentation submitted also included a data dictionary providing the general source of each element in the GMT as well as the query used to generate the cleaned provider network file from the GMT. This additional documentation allowed KFMC to follow Sunflower's process and reproduce the counts of unique providers and locations shown on the MPC Report for 2024 Q2 from the GMT records.

Following completion of this portion of the analysis, KFMC had two follow-up requests for Sunflower. The first was for an updated data dictionary that clearly stated the source of each element in the GMT (e.g., the PRN or provider rosters for certain demographic data). The second was for documentation describing the query logic used to restrict, clean, or join provider data at each stage in the creation of the GMT. This additional documentation ensured that KFMC had a complete picture of the process that Sunflower takes to collect, clean, and organize their provider data. The final piece of documentation was submitted to KFMC on November 14, 2024, and it provided the additional insight needed to complete the validation.

UnitedHealthcare provided detailed documentation of their processes. As with the other MCOs, KFMC requested a cleaned provider network table from which the counts of providers and locations could be derived. UnitedHealthcare included this in their submission of the GeoAccess reports for 2024 Q2. KFMC also requested the network provider table and the technical specifications for generating the cleaned provider network table from that network provider table. UnitedHealthcare provided detailed technical specifications and records for a sample of providers from several specialties. The sample was helpful for understanding each step described in the technical specifications.

Rather than the PRN file from the State being the primary data source for provider data as with the other two MCOs, UnitedHealthcare relies on an internal database to create the network provider table that is used as a source for the MPC Report. After rigorous cleaning and filtering of provider data, a cleaned file is compared to the PRN using several fields in an attempt to populate the KMMS ID prior to tables being populated into report templates. This may be a reason why UnitedHealthcare's population of KMMS IDs in the MPC Report table was relatively low. No other issues were noted with the methods described in the technical specifications for the report. UnitedHealthcare did not explicitly state how counts of providers and locations are derived from the cleaned provider network file, which may explain why some counts could not be reproduced.

Validation of 2024 Q2 Mapped Provider Count Results

Initial Observations

While reviewing the MPC Reports and preparing their records for analysis, the following observations were made.

Providers are assigned a KMMS ID at the time of enrollment in Kansas Medicaid and are enrolled as either individuals or businesses. These are subdivided into six enrollment types:

- **Individual Providers** – individuals, individuals in group practices, and other (rendering, prescribing, and ordering) providers
- **Business Providers** – group practices, facilities, and atypical providers

The two types of providers are distinguishable in the network provider tables and in KMMS by the name fields. For individual providers, the first and last names are populated; the business name field is populated for business providers.

Preliminary Analysis

The network provider table submitted by Aetna contained 125,535 records. Records with ancillary service provider types and NPIs associated with hospitals were removed because there are several ancillary services that hospitals offer that may not be properly reflected in the PRN or KMMS. Records for ancillary service providers not affiliated with hospitals were included in the analysis. After restricting to provider records that had specialties listed in the MPC Report and removing records with ancillary service provider types and NPIs associated with hospitals, 124,334 records remained (22,270 records for businesses and 102,064 records for individuals).

The table that Aetna originally submitted did not have columns for group or practitioner KMMS IDs. KFMC requested and received an updated version of the table with those IDs populated. All records in the updated table had either a group or practitioner KMMS ID (or both) populated; however, the updated table was not properly generated to reflect data used to create the deduplicated tables from the 2024 Q2 MPC Report, thus it contained a different number of records. MPC Reports from 2021 to 2024 were reviewed for notable changes or discrepancies. There was a substantial increase in the number of providers and locations reported on the Q1 MPC Report for 2023 compared to 2022 Q4. Narrative in Aetna's Access and Availability Report explained the increase by stating, "Through continued outreach to the rural providers and engaging them in discussions to determine who in their area provide specialty services, it has provided us information to approach individuals who are serving the remote areas but not registered in those locations." A simple linear trend line was fit to the reported provider and location counts from 2021 Q2 to 2024 Q3 to evaluate how provider and location counts changed over time. No concerns were raised by the trending results.

Since Aetna's provider data were based on data received from the State and no cross walking of these data elements was indicated, no concerns were noted regarding the methods for determining provider types and specialties.

The network provider table submitted by Sunflower contained 228,060 records. After restricting to provider records that had specialties listed in the MPC Report and removing records with ancillary service provider types and NPIs associated with hospitals, 156,790 records remained (6,538 records for businesses and 150,252 records for individuals). One column was provided for KMMS IDs, however only 40% (63,051) of the relevant records contained a KMMS ID. An NPI was provided for all appropriate providers. As with Aetna, counts of unique providers and locations reported by Sunflower were reviewed from 2021 to 2024. No concerns were raised by the trending results.

Use of KMMS IDs to update and maintain provider data is the ideal method to ensure data consistency and validity, but the percentage of records with a KMMS ID populated in Sunflower's data remained

relatively low. Sunflower's current processes for updating and maintaining provider data were explained in some detail and they indicated that a new process is being developed that may help with proper population of KMMS IDs in their provider database.

Sunflower indicated, when available, a provider's specialty was sourced from the PRN files, otherwise the provider's specialty was determined from the provider's taxonomy code using an internal crosswalk. Sunflower did not state if the crosswalk was approved by the State. The combination of poor population of KMMS IDs in Sunflower's data and the use of an internal crosswalk may explain issues related to matching provider specialty data highlighted later in this report.

The network provider table used by KFMC for validating UnitedHealthcare counts was the Raw Data table UnitedHealthcare submitted with their MPC Report. This dataset contained 131,453 records. After restricting to provider records that had specialties listed in the MPC Report and removing records with ancillary service provider types and NPIs associated with hospitals, 101,763 records remained (7,995 records for businesses and 93,768 records for individuals). One column was provided for KMMS IDs; however, only 55% (55,599) of the relevant records contained a KMMS ID. NPI, street address, city, state, ZIP code, provider type code, specialty code, and the indicator for ages served were populated in all records where appropriate. As with the other two MCOs, counts of unique providers and locations reported by UnitedHealthcare were reviewed from 2021 to 2024. No concerns were raised by the trending results.

As stated above, UnitedHealthcare indicated provider specialty data were maintained internally and not derived from the PRN. An internal, state-approved crosswalk was used to populate the provider specialties for the MPC Report. Since the crosswalk was approved by the State, it was not reviewed by KFMC.

Many of the issues highlighted in KFMC's 2023 Network Adequacy Validation Report (e.g., poor population of KMMS IDs, mid-level practitioners listed as physicians, issues with matching address data, etc.) persisted in the data that were reviewed for the 2024 report for all three MCOs. One improvement noted was that, when provided, Sunflower and UnitedHealthcare populated practitioner KMMS IDs for individuals in groups rather than their group's KMMS ID.

Analytic Plan

Here, a brief overview of the methods used for the validation is provided, followed by a detailed description of each step taken for the validation. First, the cleaned provider network files provided by each MCO were used to reproduce the counts of unique providers and locations reported. Second, the process described within each MCO's process documentation was followed to recreate their cleaned provider network files from the network provider tables, if provided. Third, the records in the network provider tables were matched to records in the PRN or KMMS tables to check for consistency between State and MCO records.

To verify that the cleaned provider network files could be used to reproduce the reported counts, KFMC conducted the following steps for each MCO:

1. Load the respective MCO's cleaned provider network file.
2. If provided, follow the MCO's process documentation for counting providers and locations from the cleaned provider network file. Otherwise, count providers based on deduplicated counts of NPI and specialty stratum. Note that a provider can have multiple codes in the same stratum. In these cases,

count the provider only once for the stratum. For locations, count distinct combinations of the latitudes and longitudes included in the deduplicated tables.

3. If the calculated counts differ from those reported by more than 1% (rounded to the nearest integer) or 1 provider or location, whichever is greater, make additional attempts to match the counts reported, including verification of correct classification of border state providers, additional cleaning of address information, counting a combination of address fields rather than latitude and longitude, using additional source data (e.g., 2024 Q2 Provider Network Report), and restricting provider records based on data received in the 2024 Q2 Provider Network Report (e.g., PCP status).

To verify the cleaned provider network files could be reproduced using the network provider tables, KFMC conducted the following steps for each MCO:

1. Load the MCO's network provider table.
2. Follow the MCO's technical specifications for filtering, cleaning, and deduplicating providers and locations to create a cleaned data table from which counts of unique providers and locations that should match the counts reported on the 2024 Q2 MPC Report may be calculated.
3. Verify that the provider NPIs and locations in the cleaned data table are the same as those in the cleaned provider network file.

To verify the provider data included in the 2024 Q2 MPC Report were consistent with the State's data, KFMC compared each MCO's network provider table against the PRN tables and the KMMS reporting warehouse tables. Since KMMS IDs were poorly populated, two methods were used to match the MCO network provider tables to the PRN and KMMS tables; the first method was based on NPI and the second on KMMS ID. Separate results are presented for individual and business providers. The basic steps were the same for both methods. Recall that Aetna's updated table contained records for providers beyond 2024 Q2, indicating the table was not properly created to reflect Aetna's 2024 Q2 MPC Report. Aetna's table had both practitioner and group KMMS IDs populated on every record; so, it was used for the KMMS ID comparison. In these steps, the KMMS ID refers to the identifier contained within the provider network files. The corresponding identifier in the PRN and KMMS tables is referred to as the *service location ID* (or *provider location ID* or *transaction ID*). The PRN file only contained providers active when the file was created—unlike the KMMS warehouse tables that also contain historical information for providers. This meant that changes to provider data made after 2024 Q2 would have caused issues with matching in the steps described below. To account for this, the reporting warehouse table received for the month of July was used for the validation of MCO data not found on the PRN. To maximize the chance of finding a matching address record in KMMS when comparing to records from each MCO, effective and end dates were not used to restrict provider data; rather, when multiple matches were found, a preference was given to those matches in KMMS that had the most dates for NPI, address, and affiliation within the acceptable range for 2024 Q2. If the only record that was able to be matched in KMMS had effective and end dates indicating the provider was not active during 2024 Q2, that record was considered a match. A breakdown of issues found with the matched records is included in the narrative below.

The comparison between State and MCO records was completed using the following steps:

1. Load the respective MCO's network provider table. The table will include NPIs, KMMS IDs, name fields, address fields, provider type codes, and provider specialty codes.
2. Clean the data.
   a. Restrict records to only include specialties on the Mapped Provider Counts tab of the MPC Report.

   b. Exclude records that had an NPI associated with an acute care hospital and a specialty related to ancillary services (i.e., physical, occupational, or speech/hearing therapy, diagnostic x-ray, and independent or pathology lab).
   c. Exclude records with missing NPI (first method) or KMMS ID (second method).
   d. Identify the primary address number (aka, street number or house number). If the first character of Address Line 1 is numeric, then use the leading number of Line 1 as the primary address number. Otherwise, if the first character of the second address line is numeric, use the first number of Line 2 as the primary address number and interchange the contents of Line 1 and Line 2 (this interchanging often moves post office box numbers to the second line and the street address to the first line).
   e. Identify individual and business records based on the name fields.
   f. Add leading zeros stripped by Excel to ZIP codes and specialty codes.
   g. Add a unique record identifier.
3. Obtain the service location IDs corresponding to the network provider record.
   a. If using NPIs – crosswalk the NPIs to service location IDs using the PRN Provider NPIs table. An NPI may match to multiple service location IDs (NPIs no longer effective were included when checking KMMS records). Collect NPI effective and end dates for further analysis. Exclude NPIs not matched to a service location ID from further analysis.
   b. If using KMMS IDs – the service location ID is the KMMS ID. Use the KMMS ID to obtain an NPI from the Provider NPIs table. If the NPI provided did not match the NPI returned from either the PRN or KMMS tables, then remove the record from further analysis.
4. For each service location ID identified in Step 3, compare addresses from the provider network tables to each service location address available from the PRN or KMMS address tables. See Matching Addresses for details.
5. Compare specialty codes and categories from records in the provider network tables to records collected from the PRN or KMMS. For all records for individuals with an NPI, check specialties regardless of whether a full match was found for the provider's address information (since specialties for individuals are not expected to be location-specific). For business records that matched either a PRN record or KMMS record on location check specialties (since specialties for businesses are expected to be location-specific). See Matching Specialties for details.

Matching Addresses

This section provides details to Step 4 of the analytic plan. The first part explains how address information was obtained from the PRN or KMMS and cleaned in preparation for comparing to network provider table addresses. The second part details the algorithm for matching addresses.

Creating the Table of Addresses

The resulting *Table of Addresses* included these fields:

- KMMS ID and Service Location IDs – primary keys for the PRN and KMMS Providers tables
- NPI
- NPI Effective Date, End Date
- Affiliation Effective Date, End Date, if applicable
- Enrollment Type Code – indicates whether the provider was enrolled as a group (G), facility (F), individual (I), individual in a group (IG), or an ordering, rendering, or prescribing provider (O)
- Provider Type Code – two-digit code identifying the provider type (e.g., 01 – hospital)
- Address Service Location ID – the service location ID that was matched to the Address table
- Location Name

- Address Lines 1 and 2
- City, State, and ZIP code – stored in separate fields, five digits for ZIP code
- Primary Address Number – determined from Address Lines 1 and 2
- Primary Address – The address field used to determine the Primary Address Number
- Address Effective Date, End Date

The Table of Addresses was created as follows:

1. Using the service location IDs collected in Step 3 above, collect the following information from the PRN tables, or KMMS tables for those records that were not able to be matched to PRN data.
   a. Collect the provider type code and enrollment type code from the PRN Providers table.
   b. For records for practitioners in groups, Aetna provided the KMMS ID for both the individual practitioner and the group, so the following step was not needed. Sunflower and UnitedHealthcare provided practitioner KMMS IDs for individual providers and group KMMS IDs for business providers. For individuals in groups (enrollment type code IG), crosswalk the service location ID to the affiliations table to collect all affiliated service location IDs and their respective effective and end dates and use those IDs to collect the same service location address information detailed in Step 1.c for the affiliated groups. Note that this method does not guarantee that practitioners in groups have been affiliated to the correct group, only that the address listed for the practitioner is valid for at least one of their affiliated groups.
   c. For individuals (I), groups (G), ordering, rendering, or prescribing (O) providers, and facilities (F); collect all service location address information, including the address lines, city, state, and five-digit ZIP code from the addresses table using the service location IDs; determine the primary address number as above; and collect effective and end dates for all service location addresses associated with each service location ID. Normally, the service location ID is specific to a single service location address. Since this analysis includes expired address records as well, there may be more than one service location address tied to a single service location ID.

Criteria for Matching Addresses

Address data were cleaned prior to comparison. The relevant fields were converted to upper case and all non-alphanumeric characters were removed, including spaces. City, state, and ZIP code were concatenated. Provider type code was extracted from the MCOs' data for comparison along with the address information, since the provider type code was expected to be location-specific. Records that had the same NPI, primary address number, city, state, five-digit ZIP code, and provider type code were considered to have a *full match*. Records that had the same NPI, city, five-digit ZIP code, primary address number, state, but not provider type code were not a full match. If an MCO record was not matched to a PRN record on NPI, primary address number, city, state, and five-digit ZIP code, data were collected from KMMS tables for comparison. The same processes described in Step 1 under Matching Addresses were used to extract and compare information collected in KMMS. Those records that could not be fully matched to either the PRN or KMMS were excluded from further analysis. The analysis using KMMS IDs was similar, except that records were also matched using the KMMS IDs provided. These steps may return more than one match for a single record. Usually, these were cases where an individual was registered under codes I and IG or a business was registered multiple times at one location under a G or F code. These additional matches were maintained to collect as many specialties as possible for businesses for the comparison described in the following section. The count and percentage of records matched to either the PRN or KMMS tables was calculated and presented in Activity 5 below. Counts and percentages are based on unique record identifiers from each MCO's data created in Step 2 above.

Matching Specialties

This section provides details to Step 5 of the analytic plan. In addition to verifying specialty codes, the specialty category for providers was considered, that is, the specialty category that a provider would be counted under on the Mapped Provider Counts tab of the MPC Report. A single category can include multiple specialty codes (e.g., specialty codes 312 and 313 are in the cardiology category), thus verifying specialty category is less strict (sometimes substantially so) than verifying specialty code. Since the specialty category was determined from the specialty code, records that are verified on specialty code are also verified on specialty category. For individuals, there was not an expectation that the provider's specialty was location-specific. Thus, all specialties associated with an individual's NPI were extracted from the PRN or KMMS tables using the following method:

1. Extract all service location IDs associated with the NPI from the MCO's network provider tables. For business records that were able to be matched to a location, maintain the unique record identifier. If an individual provider's NPI was not matched to any record in the PRN or KMMS, exclude the provider's records from further analysis.
2. For each service location ID from Step 1, obtain the records from the specialties table having that service location ID. The records will contain the specialty code, effective date, and end date for each specialty.
3. Using the specialty codes, create a specialty category field based on the categories defined in the Network Adequacy Standards provided by the State. This is the *specialties table*.
4. Extract the specialty code from the MCO's network provider table, create a specialty category field similar to the previous step, match on the unique record identifier to the specialties table and create a flag to identify records where the specialty code could be verified. Create another flag to identify records where the specialty category could be verified.

The same process described in Steps 1 to 3 was used to extract and compare information from KMMS. For businesses, one difference was that the service location ID associated with the matched address information was used to extract the specialty codes for that location. Another difference was that those business records where the specialty code could not be verified had their service location IDs cross walked to the affiliations table to obtain individual providers affiliated with the business at that location. The individual providers' service location IDs were then used to extract specialties for the individuals at that business location to see if the group's specialty be found among the practitioners' specialties. As indicated in the Matching Addresses section above, businesses records without addresses matching between MCO and State data were excluded from this analysis. Since the unique record identifier was maintained for the location record that was matched to the PRN or KMMS records, it was used to verify the provider specialty code or category pulled from the State's tables matched the specialty code or category provided by the MCO. The percentage of records verified on specialty code and category were calculated and are presented in the following section.

Activity 5: Communicate Preliminary Findings to Managed Care Plans

The analytic plan described above was implemented for each of the MCOs with the objective of validating the counts of unique providers and locations on the 2024 Q2 Mapped Provider Counts Report. Using the MCOs' cleaned provider network tables, KFMC calculated counts of unique providers, stratified by specialty category.

For Aetna, all provider counts, except for the count of unique occupational therapy providers (313 reported compared to 309 calculated by KFMC), were reproduced using their network provider table. The discrepancy may be due to Aetna counting certain providers (e.g., hospitals) under multiple

specialties using the same NPI at a single location, which may not have been correctly reflected in the source data table or documentation provided. The source data table that Aetna provided included address information which KFMC cleaned, deduplicated, and geocoded; however, whether due to the use of a different geocoding database or lack of standardized formatting of addresses, the number of locations could not be reproduced for 31 of 50 specialty categories.

Using Sunflower's network provider table, the counts for unique providers and locations were successfully reproduced for Sunflower. One important piece that assisted in replicating the counts of unique locations for Sunflower was that Sunflower included in the source data table the latitude and longitude values returned for each provider in the source data table and reported count of distinct pairs of latitudinal and longitudinal values. This removed the limitation of KFMC not using the same geomapping software used by the MCOs. This information may be included in data requests for future network adequacy validation activities related to geomapping; alternatively, the KMMS ID that identifies the location of the provider could be requested if the MCOs make adequate progress in populating those data.

Not all counts of providers or locations could be reproduced using the cleaned provider network table UnitedHealthcare included with their MPC Report. To ensure that the methods described by UnitedHealthcare had been applied to the table included in the report, KFMC applied the steps described by UnitedHealthcare to the table, where possible. The 2024 Q2 Provider Network Report was used as another source for replicating the reported counts. Ultimately, KFMC was able to reproduce UnitedHealthcare's counts of providers for a majority of specialties. Counts differed for adult general surgery, adult and pediatric ophthalmology, adult and pediatric pulmonary disease, hospital, lab, occupational therapy, optometry, physical therapy, speech therapy, and x-ray. KFMC was only able to reproduce the counts of unique locations for adult and pediatric dental primary care, hospitals, pharmacy, and x-ray. For other specialties, unique location counts based on latitude and longitude data included with the table provided in the MPC Report were substantially lower than those reported by UnitedHealthcare. Unique location counts based on cleaned street address, city, state, and ZIP code were well over the values reported. From KFMC's analysis, it was unclear how UnitedHealthcare calculated the number of unique locations reported for most specialties. Since the table included in the MPC Report did not appear to be the fully cleaned provider network table from which the counts of providers and locations were derived, reasons why the counts of providers and locations were not able to be reproduced could not be determined. Based on their methodology documentation, UnitedHealthcare's counts of unique providers and locations would better reflect member access compared to the other two MCOs; UnitedHealthcare's method included groups in their counts only if there was not a practitioner within the group being counted.

Results for Individual Providers

Counts of 2024 Q2 Mapped Provider Count Report records for individual providers, stratified by MCO, are shown in Tables B2 and B3. The number and percentage of those records matched to the PRN or KMMS on primary address number, city, state, ZIP code, and provider type are shown. Recall that counts and percentages are based on unique record identifiers from each MCO's data. The following were general observations:

- Not matching on address was the primary reason records did not match using NPI.
- Though the matching criteria were generally less strict than the criteria used in KFMC's 2023 Network Adequacy Validation Report, the percentage of records that were able to be matched to either the PRN or KMMS was about the same. This indicates Sunflower and UnitedHealthcare have not made much progress on improving consistency between their data and the State's.

- Matching using KMMS IDs yielded much better results than matching using NPIs for Sunflower and UnitedHealthcare. Aetna's match rates were substantially worse than those using NPIs. This was driven by two related factors.
  - Aetna provided both the group KMMS ID and the practitioner KMMS ID for all records and was the only MCO to do so. This was appreciated; however, from KFMC's analysis, it appeared Aetna struggled with populating the correct group KMMS ID for individuals in a group. Since records were matched on NPI and practitioner KMMS ID (for individuals), or group KMMS ID (for individuals in a group, groups, and facilities), this aspect of the analysis was perhaps stricter than necessary, but it should help identify areas of improvement in data consistency for Aetna. The vast majority of records for individual providers that were not in a group had the correct practitioner KMMS ID populated.
  - As noted in last year's report, there were many records that did not return the correct NPI, indicating an incorrect KMMS ID was provided. These cases were not considered matches, but they would have improved Aetna's matching rate substantially if the correct KMMS ID had been provided.
- Some MCO records could only be matched to KMMS records that had an expired address, affiliation, or NPI. This indicates the MCOs may not have properly ingested some of the State's updates for providers into their systems.
- Many of the issues found when matching to PRN or KMMS records using NPIs persisted when using KMMS IDs.

Table B.2. Locations Matched to the PRN or KMMS Using NPI – Individuals

Aetna	N	%
Records under evaluation	102,064	100%
Minus – No Match on location	504	<1%
Minus – Matched on location, not provider type code	84	<1%
Records Fully Matched to the PRN or KMMS	**101,476**	**>99%**
Sunflower	**N**	**%**
Records under evaluation	150,252	100%
Minus – No Match on location	48,911	33%
Minus – Matched on location, not provider type code	4,542	3%
Records Fully Matched to the PRN or KMMS	**96,799**	**64%**
UnitedHealthcare	**N**	**%**
Records under evaluation	93,768	100%
Minus – No Match on location	28,479	30%
Minus – Matched on location, not provider type code	217	<1%
Records Fully Matched to the PRN or KMMS	**65,072**	**69%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network file as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024.

Table B.3. Locations Matched to the PRN or KMMS Using KMMS ID – Individuals

Aetna	N	%
Records under evaluation	101,380	100%
Minus – No KMMS ID populated	0	0%
Minus – No Match on NPI in the PRN or KMMS	10,657	11%
Minus – No Match on location	66,405	66%
Minus – Matched on location, not provider type code	19	<1%
Records Fully Matched to the PRN or KMMS	**24,299**	**24%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

Table B.3. Locations Matched to the PRN or KMMS Using KMMS ID – Individuals (Continued)		
Sunflower	**N**	**%**
Records under evaluation	150,252	100%
Minus – No KMMS ID populated	91,334	61%
Minus – No Match on NPI in the PRN or KMMS	5,822	4%
Minus – No Match on location	3,699	2%
Minus – Matched on location, not provider type code	2,102	1%
Records Fully Matched to the PRN or KMMS	**47,295**	**31%**
UnitedHealthcare	**N**	**%**
Records under evaluation	93,768	100%
Minus – No KMMS ID populated	41,358	44%
Minus – No Match on NPI in the PRN or KMMS	2,463	3%
Minus – No Match on location and provider type code	233	<1%
Minus – Matched on location, not provider type code	190	<1%
Records Fully Matched to the PRN or KMMS	**49,524**	**53%**
Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).		

Of Aetna's records for individual providers, over 99% matched to PRN or KMMS records on NPI. Not matching on address information was the most frequent cause of records not matching for Aetna's records.

Of Sunflower's records for individual providers, 64% matched to PRN or KMMS records on NPI. Not matching on address information was the most frequent cause of records not matching for Sunflower's records.

Of UnitedHealthcare's records for individual providers, 69% matched to PRN or KMMS records on NPI. Not matching on address information was the most frequent cause of records not matching for UnitedHealthcare's records.

Due to the issues outlined above, Aetna's match rates were significantly lower than the other two MCOs when matching using KMMS IDs. Matching to records using KMMS IDs was more reliable than using NPIs for the other two MCOs; of the 58,918 records for Sunflower and 52,410 records for UnitedHealthcare with a KMMS ID populated, 80% (47,295) and 94% (49,524) were matched to the PRN or KMMS tables, respectively. This underscores the need for all MCOs to properly populate KMMS IDs in their reports moving forward. If this issue is not addressed, the issues related to data consistency for Sunflower and UnitedHealthcare will continue.

Counts of 2024 Q2 Mapped Provider Count Report records for individual providers, stratified by MCO, are shown in Table B4. The number and percentage of those records that could be verified on NPI, specialty code, or specialty category using the PRN or KMMS data are shown. As specialties for individual providers are not expected to be location-specific, the analysis using KMMS IDs would have been essentially the same as using NPIs and, thus, was not conducted. Recall, since the category is derived from the code, if specialty codes are verified then specialty categories are verified. Verifying specialty category is also less strict than verifying specialty code (sometimes substantially so).

The following were general observations:

- Many records indicated by the MCO as being for a primary care provider were not able to be verified on specialty category. For instance, KFMC found cases of providers categorized as PCPs

whose specialty category could not be verified. This may indicate the MCOs misclassified providers as PCPs, or providers were contracted to provide primary care services without having the appropriate credentials.

- Psychiatry, general surgery, and cardiology specialty categories often did not have a corresponding record for a provider in PRN or KMMS records, raising concerns that the MCOs may not be reporting appropriate counts of providers for these categories.

Table B.4. Specialties Verified Using NPI – Individuals

Aetna	**N**	**%**
Records with specialties under evaluation	102,064	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	0	0%
Minus – Matched Neither Specialty Code or Category	859	<1%
Records With Specialties Verified	**101,205**	**>99%**
Full Matches (Verified Specialty Code and Category)	95,500	94%
Verified Specialty Category, not Code	5,705	6%
Sunflower	**N**	**%**
Records with specialties under evaluation	150,252	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	4,078	3%
Minus – Matched Neither Specialty Code or Category	8,703	6%
Records With Specialties Verified	**137,471**	**91%**
Full Matches (Verified Specialty Code and Category)	115,023	84%
Verified Specialty Category, not Code	22,448	16%
UnitedHealthcare	**N**	**%**
Records with specialties under evaluation	93,768	100%
Minus – No Match to the PRN NPI Table or the KMMS NPI Table	2,229	2%
Minus – Matched Neither Specialty Code or Category	5,831	6%
Records With Specialties Verified	**85,708**	**91%**
Full Matches (Verified Specialty Code and Category)	69,748	81%
Verified Specialty Category, not Code	15,960	19%

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024.

Aetna's most common mismatches based on the specialty code of the provider (59% of records where the specialty code could not be verified) were for psychiatric nurse practitioner, general surgeon, nephrologist, oncologist, and general internist. Aetna's most common mismatches based on the specialty category of the provider (70% of records where the specialty category could not be verified) were for primary care, psychiatry, general surgery, nephrology, and hematology/oncology.

Sunflower's most common mismatches for individuals based on the specialty code of the provider (62% of records where the specialty code could not be verified) were for general internist, general practitioner, nurse practitioner (other), licensed mental health professional, and psychiatrist. Sunflower's most common mismatches for individuals based on the specialty category of the provider (85% of records where the specialty category could not be verified) were for primary care, behavioral health, psychiatry, neurology, and cardiology.

UnitedHealthcare's most common mismatches for individuals based on the specialty code of the provider (60% of records where the specialty code could not be verified) were general internist, psychiatric nurse practitioner, general practitioner, OB/GYN, and general surgeon. UnitedHealthcare's most common mismatches for individuals based on the specialty category of the provider (75% of records where the specialty category could not be verified) were primary care, psychiatry, hematology/oncology, general surgery, and cardiology.

Results for Business Providers

Counts of 2024 Q2 Mapped Provider Count Report records for business providers, stratified by MCO, are shown in Tables B5 and B6. The number and percentage of those records matched to the PRN or KMMS on primary address number, city, state, ZIP code, and provider type are shown. The following were general observations:

- Not matching on provider type code was the primary reason records did not match using NPI for Aetna. Not matching on address was the primary reason records did not match using NPI for Sunflower and UnitedHealthcare.
- Aetna correctly populated group KMMS IDs for businesses, which led to better match rates compared to individuals when matching to PRN or KMMS records using KMMS IDs. The rate was still lower than the match rate using NPIs because many KMMS IDs did not return the correct NPI and were excluded from further analysis.
- Many of the issues that were found when matching to PRN or KMMS records using NPIs persisted when using KMMS IDs.

Table B.5. Locations Matched to the PRN or KMMS Using NPI – Businesses

Aetna	**N**	**%**
Records under evaluation	22,270	100%
Minus – No Match on location	73	<1%
Minus – Matched on location, not provider type code	1,803	8%
Records Fully Matched to the PRN or KMMS	**20,394**	**92%**
Sunflower	**N**	**%**
Records under evaluation	6,538	100%
Minus – No Match on location	3,234	49%
Minus – Matched on location, not provider type code	288	4%
Records Fully Matched to the PRN or KMMS	**3,016**	**46%**
UnitedHealthcare	**N**	**%**
Records under evaluation	7,995	100%
Minus – No Match on location	4,278	54%
Minus – Matched on location, not provider type code	646	8%
Records Fully Matched to the PRN or KMMS	**3,071**	**38%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network (PRN) file as of October 2024, and Kansas Modular Medicaid System (KMMS) reporting warehouse tables as of 7/31/2024.

Table B.6. Locations Matched to the PRN or KMMS Using KMMS ID – Businesses

Aetna	**N**	**%**
Records under evaluation	22,009	100%
Minus – No KMMS ID populated	0	0%
Minus – No Match on NPI in the PRN or KMMS	1,454	7%
Minus – No Match on location	112	<1%
Minus – Matched on location, not provider type code	2,284	10%
Records Fully Matched to the PRN or KMMS	**18,159**	**83%**
Sunflower	**N**	**%**
Records under evaluation	6,538	100%
Minus – No KMMS ID populated	2,405	37%
Minus – No Match on NPI in the PRN or KMMS	91	1%
Minus – No Match on location	1,544	24%
Minus – Matched on location, not provider type code	204	3%
Records Fully Matched to the PRN or KMMS	**2,294**	**35%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

Table B.6. Locations Matched to the PRN or KMMS Using KMMS ID – Businesses (Continued)		
UnitedHealthcare	**N**	**%**
Records under evaluation	7,995	100%
Minus – No KMMS ID populated	4,806	60%
Minus – No Match on NPI in the PRN or KMMS	83	1%
Minus – No Match on location	157	2%
Minus – Matched on location, not provider type code	874	11%
Records Fully Matched to the PRN or KMMS	**2,075**	**26%**

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

Counts of 2024 Q2 Mapped Provider Count Report records for business providers, stratified by MCO, are shown in Tables B7 and B8. The number and percentage of those records that could be verified on NPI (for Table B7 and KMMS ID for Table B8), specialty code, or specialty category using the PRN or KMMS data are shown. Specialties for business providers are expected to be location-specific, so specialty codes and categories were verified for records whose service location ID was identified using either NPI or KMMS ID supplied by the MCOs. Note that verification of specialty code implies verification of specialty category for that provider since the category is derived from the code. Verifying specialty category is also less strict than verifying specialty code (sometimes substantially so). Also, recall that only business records that were matched on address and provider type to a PRN or KMMS record were compared on specialty code and category.

Table B.7. Specialties Verified Using NPI – Businesses		
Aetna	**N**	**%**
Records Matched to the PRN or KMMS (on Address and Provider Type)	20,394	100%
No Match on Specialty Code or Category	9,141	45%
Records With Specialties Verified	**11,253**	**55%**
Matched on Specialty Code	8,739	78%
Matched on Specialty Category, not Code	1,048	9%
Matched on an Affiliated Specialty Code	1,248	11%
Matched on an Affiliated Specialty Category, not Code	218	2%
Sunflower	**N**	**%**
Records Matched to the PRN or KMMS	3,016	100%
No Match on Specialty Code or Category	5	<1%
Records With Specialties Verified	**3,011**	**>99%**
Matched on Specialty Code	2,932	97%
Matched on Specialty Category, not Code	41	1%
Matched on an Affiliated Specialty Code	0	0%
Matched on an Affiliated Specialty Category, not Code	38	1%
UnitedHealthcare	**N**	**%**
Records Matched to the PRN or KMMS	3,071	100%
No Match on Specialty Code or Category	90	3%
Records With Specialties Verified	**2,981**	**97%**
Matched on Specialty Code	2,714	91%
Matched on Specialty Category, not Code	240	8%
Matched on an Affiliated Specialty Code	12	<1%
Matched on an Affiliated Specialty Category, not Code	15	<1%

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024, Kansas Provider Network (PRN) file as of October 2024, and Kansas Modular Medicaid System (KMMS) reporting warehouse tables as of 7/31/2024.

For Aetna, specialty code mismatches were much more common for groups than facilities (55% versus 7%) when matching using NPI. The most common specialty codes that could not be verified for

businesses were for psychiatrist, neurologist, plastic surgeon, general surgeon, and pulmonary disease , which accounted for 37% of mismatched codes. The most common specialty categories that could not be verified for businesses were related to neurology, cardiology, psychiatry, plastic and reconstructive surgery, and general surgery, which accounted for 45% of mismatched categories.

For Sunflower, specialty code mismatches were more common for groups than facilities (7% versus 1%) when matching using NPI. The most common specialty codes that could not be verified for businesses were for CMHC partial hospitalization and psychiatric hospital. The most common specialty categories that could not be verified for businesses were for behavioral health and psychiatry which, when combined, accounted for all specialty category mismatches.

For UnitedHealthcare, specialty code mismatches were more common for groups than facilities (20% versus 5%) when matching using NPI. The most common specialty codes that could not be verified for businesses were for allergist, acute care hospital, general surgeon, orthopedic surgeon, and psychiatrist, which accounted for 84% of mismatched codes. The most common specialty categories that could not be verified for businesses were related to allergy, hospital, general surgery, orthopedics, and primary care, which accounted for 85% of mismatched categories.

Table B.8. Specialties Verified Using KMMS ID – Businesses

Aetna	**N**	**%**
Records under evaluation	22,009	100%
Minus – No Full Match	3,850	17%
Minus – Matched Neither Specialty Code or Category	8,497	39%
Records Matched to the PRN or KMMS	**9,662**	**44%**
Matched on Specialty Code	7,320	76%
Matched on Specialty Category, not Code	1,055	11%
Matched on an Affiliated Specialty Code	1,037	11%
Matched on an Affiliated Specialty Category, not Code	250	3%
Sunflower	**N**	**%**
Records under evaluation	4,133	100%
Minus – No Full Match	1,839	44%
Minus – Matched Neither Specialty Code or Category	0	0%
Records Matched to the PRN or KMMS	**2,294**	**56%**
Matched on Specialty Code	2,292	>99%
Matched on Specialty Category, not Code	2	<1%
Matched on an Affiliated Specialty Code	0	0%
Matched on an Affiliated Specialty Category, not Code	0	0%
UnitedHealthcare	**N**	**%**
Records under evaluation	3,189	100%
Minus – No Full Match	1,114	35%
Minus – Matched Neither Specialty Code or Category	65	2%
Records Matched to the PRN or KMMS	**2,010**	**63%**
Matched on Specialty Code	1,843	92%
Matched on Specialty Category, not Code	140	7%
Matched on an Affiliated Specialty Code	12	<1%
Matched on an Affiliated Specialty Category, not Code	15	<1%

Source: MCO Provider Network tables for 4/1/2024 to 6/30/2024 submitted by 7/31/2024 (except for Aetna, who submitted an updated table on 9/30/2024), Kansas Provider Network table as of October 2024, and Kansas Modular Medicaid System reporting warehouse tables as of 7/31/2024 (for Aetna, as of 9/30/2024).

For Aetna, specialty code mismatches were much more common for groups than facilities (64% versus 13%) when matching using KMMS ID. The most common specialty codes that could not be verified for businesses were for neurologist, psychiatrist, plastic surgeon, pulmonary disease, and general surgeon,

again accounting for 37% of records with mismatched codes. The most common specialty categories that could not be verified for businesses were related to neurology, cardiology, psychiatry, plastic and reconstructive surgery, and pulmonary disease, accounting for 45% of mismatched categories.

All group and facility records that were matched on location and provider type were also verified to have the correct specialty code or category for Sunflower when matching using KMMS ID.

For UnitedHealthcare, specialty code mismatches were more common for groups than facilities (18% versus 7%) when matching using KMMS ID. The most commonly mismatched codes were allergist, acute care hospital, orthopedic surgeon, psychiatrist, and oncologist, accounting for 88% of mismatched codes. The majority (62% of all mismatches) of these were for code 310 (allergist). The most commonly mismatched categories were related to allergy, hospital, orthopedics, PCP, and psychiatry—accounting for 92% of mismatched categories. Again, most of these were for the allergy category.

Conclusions

To check for consistency between the State's data and the data maintained by the MCOs, KFMC matched MCO records to PRN and KMMS tables using both NPI and KMMS ID and found several issues with the provider data used for reporting of network adequacy by each of the MCOs. Most notably, KFMC found providers being counted at locations at which they were not affiliated at any point during 2024 Q2 to provide services. This issue was brought to the State's attention who indicated that the MCOs should only be counting providers at locations in which they are currently contracted to provide services. Given that information, KFMC found several examples of providers being counted as in-network by the MCOs where KMMS indicated they were no longer affiliated (i.e., no longer set up to bill services) at that location. Further, KFMC found examples of providers being counted under incorrect provider types or specialties, based on records in the PRN or KMMS. These issues highlight several possible areas where data integrity and the validity of the 2024 Q2 MPC Reports submitted by each of the MCOs may be questioned.

Overall, specialty codes were usually able to be verified for individual providers, though there was a substantial portion for each MCO that that could only be verified on specialty category, not code. For the purposes of this validation, this was considered acceptable. However, specialty data for these providers should be indicative of what a member would see in an online provider directory; this is concerning as not all specialties in a particular category are interchangeable, so this may mislead members into believing that certain specialty services are available in their area when that may not be the case. Of those business records that matched on location and provider type, most specialty codes were verified; however, a substantial portion of business records were not able to be matched on location and provider type. Further, there were NPIs provided by the MCOs for which no records could be found in the State's data. This indicates that members may be unable to find providers at locations listed in each MCO's online provider directory or that the State's data are not representative of the MCOs' full networks.

Aetna and Sunflower both indicated the PRN file sent from the State to each of the MCOs was the source of truth for provider data included in the 2024 Q2 MPC Report. While this may be true, errors found during this validation indicate both MCOs may have errors in their methods of integrating the PRN file into their systems. UnitedHealthcare indicated the State's data are not necessarily the source of truth for provider data, rather an internal database is the source of truth for UnitedHealthcare's provider data.

To begin solving these issues, the MCOs must better populate and maintain KMMS IDs for providers as this would allow more reliable linking between the MCOs' internal provider database records to the PRN file sent by the State. KMMS IDs have historically been sparsely populated in the MCOs' reports; however, during the 2023 Network Adequacy validation, KFMC found that Aetna populated all records with a KMMS ID and the KMMS ID was successfully used to validate the data under evaluation with a 98% successful matching rate for participating and non-participating providers. Quality checks should be implemented at each stage of integration, if they are not already, to ensure the State's data are being properly integrated into each MCO's systems.

The State has indicated the Network Adequacy Standards used for the MPC Report will be updated to describe the report's intended contents more clearly. Currently, there is ambiguity that allows for each MCO to report counts of providers and locations in various ways that are still considered compliant even if they may not necessarily represent the State's intention.

Activity 6: Submit Findings to State

Overall Summary of Findings

The overall summary of findings is presented in the Validation of 2024 Q2 Mapped Provider Count Results subsection, in the body of the report.

Conclusions Drawn from the Data

Conclusions drawn from the data are summarized in the Conclusions section in the body of the report.

Limitations

- KMMS IDs were insufficiently populated for directly joining provider network records with PRN or KMMS tables.
- The street address fields are subject to data cleaning and standardization; thus, they are not suitable for matching to PRN or KMMS records. To account for this, records were compared on the primary address number instead of street address fields.
- Ancillary specialties for hospitals were not validated since these services may not be reflected in the State's data even if those services are offered at the hospital in question.
- NPIs are specific to people or businesses, but not to service locations. Therefore, joining provider network records to KMMS records using NPI returned results for multiple service locations. Consequently, issues identified through NPIs may be underrepresented. For example, this analysis did not verify whether the affiliation between practitioners and groups was correct.
- KFMC compared a PRN file received from the State to the KMMS warehouse tables used for the analysis described above. KFMC found several discrepancies between the two data sources and submitted a ticket to the State's fiscal agent to resolve these issues. Matching on a combination of PRN and KMMS data was used to mitigate the issues.
- KFMC's data request was not fulfilled by UnitedHealthcare. As described above, UnitedHealthcare provided a sample from their source data table of providers to illustrate each cleaning step described in its business requirements documentation. The data table submitted with the MPC Report did not appear to be the cleaned provider network file from which the counts on the report were derived.
- The database used for geocoding addresses (i.e., 2023 street lookup SAS geocoding dataset) differs from the database used by the MCOs (i.e., Quest Analytics).
- Linear trendlines used to assess data over multiple years may obscure changes that occur over short time scales and are susceptible to methodological changes that may impact the overall trend.

Review of MCO Access Monitoring Methodologies

Review of Appointment Availability and After-Hours Access Call Scripts

As an enhancement to KFMC's 2023 Network Adequacy Validation efforts, KFMC requested and received the call scripts and available instructions used by the MCOs' vendors to perform their appointment availability and after-hours access calls. Previous KFMC reviews of the Timeliness Reports indicated a lack of uniformity among MCO approaches to the surveys. Through assessing these scripts, a better understanding of where these discrepancies occur was achieved. KFMC's review of these scripts identified several areas of concern.

Assessing Reporting on Answering Machines and Answering Services

Aetna, Sunflower, and UnitedHealthcare, all indicated in their call scripts and instructions that answering machine messages instructing members to go to the nearest hospital or emergency room would be treated as passing and are therefore considered compliant in the Annual Timeliness Reports. KFMC sought NCQA guidance on this issue, due to their related accreditation requirements for MCOs. It is clear that NCQA does not consider such messages with instructions to go to the nearest hospital or emergency room as compliant with NCQA guidelines regarding after-hours access. KFMC recommends the reporting template be revised to allow calls resulting with such answering machine messages to be reported separately as non-compliant.

While Aetna and UnitedHealthcare completed after-hours calls to several provider types, including BH providers, Specialists, Obstetricians (OBs), and SUD providers, Sunflower only reported completed calls to PCPs. This makes comparisons difficult and efforts should be made to ensure that after-hours access is being monitored in provider types beyond those serving as PCPs. Limiting our comparison to just the PCPs, one area of note is that Sunflower reported a much higher percentage of calls resulting in answering machines than did either Aetna or UnitedHealthcare (see Table B9). It was not possible to determine from Sunflower's scripts or supporting documents why this may be the case. However, it should be noted that Sunflower's after-hours script is very brief and lacks details that distinguish answering machines from answering services.

Table B.9. PCP Calls Resulting in Acceptable Ratings Resulting from Answering Machines

	Aetna	Sunflower	UnitedHealthcare
Answering machine with instructions to go to the nearest hospital	8.1% 11	21.8% 70	3.8% 9
Answering machine message with no issues	8.1% 11	30.5% 98	30.5% 73
Total	**16.2%** **22**	**52.3%** **168**	**34.3%** **82**

Source: MCO Annual Timeliness Reports for 2024.

Comparing UnitedHealthcare's results to those of Sunflower and Aetna, it is striking that UnitedHealthcare reported 56.8% of all of their calls resulted in an acceptable response from an answering service while Sunflower reported only 0.6%, and Aetna reported 9.0% percent in this category. More work should be done to understand this variance among the MCOs, as a review of the scripts used by the MCOs' vendors did not shed light on the cause of such variances. One option for future validation efforts would be to work with the MCOs to better understand the improvement activities they undertook with their providers that are rated as non-compliant in the previous year's report.

Differences in Scripts

Aetna reported to KFMC they utilized the same script for both appointment availability calls and after-hours access calls. Additionally, Aetna reported they did not utilize specific scripts tailored to each of the provider types they survey. All MCOs should advise their vendor that use of a single script limits the ability of the callers to adequately capture necessary information.

Sunflower utilized appointment availability call scripts tailored to each provider type surveyed. These scripts were brief, but sufficient to allow for accurate calls and ratings of these calls. While the instructions provided to their callers would benefit from additional detail, the use of scripts specific to the provider type enhances the ability of the callers to adequately capture needed information.

Like Sunflower, UnitedHealthcare utilized call scripts that were specific to the provider type called. These scripts appeared sufficient and accurate. However, as was noted for both Aetna and Sunflower, it would be helpful to better understand the training provided to callers as this will allow for a better assessment of the overall uniformity of the methodology among the MCOs. More information about the training provided to the individuals who conduct these calls would help KFMC determine the overall efficacy of this process.

Aetna's Annual Timeliness Report

Aetna submitted their Annual Timeliness Report on October 31, 2024. Appointment availability survey calls occurred between August 22 and September 13, 2024, during provider office-hours of 9 a.m. to 5 p.m. on weekdays. Aetna reported after-hours survey calls were completed after 6 p.m. local time, Monday through Friday.

Aetna's Table 1, Description of Sample, displayed below in Figure B.1, reports information on the sample for appointment availability access monitoring and after-hours calls. The provider sample for 2024 is reported as containing 2,125 providers. However, on the Methodology tab of the report Aetna stated, "2,123 unique provider telephone numbers were included in the sample, which represented ALL available unique phone numbers in the Kansas provider universe." Aetna also reported a subgroup of specialty types (PCPs, oncologists, obstetrician/gynecologists, and behavioral health) were included and that other specialties were excluded.

Table 1: Description of Sample

Provider Groups

	PCP		Specialist		OB		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Provider Sample (number)	559	603	370	736	44	66	769	684	65	36	1807	2125
Providers Contacted	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(number)	559	603	370	736	44	66	769	684	65	36	1807	2125
Survey Completed	41.7%	30.0%	39.7%	18.3%	43.2%	25.8%	14.8%	16.2%	33.8%	33.3%	29.6%	21.5%
(number)	233	181	147	135	19	17	114	111	22	12	535	456
After-Hours Calls	22.4%	22.6%	33.2%	19.2%	100.0%	93.9%	18.9%	23.1%	100.0%	13.9%	27.8%	23.6%
(number)	125	136	123	141	44	62	145	158	65	5	502	502

Definitions	
Provider Sample	The total number of providers the surveyor determined was ideal to include in its survey.
Providers Contacted	The surveyor called and attempted to reach the provider. A minimum of 3 attempts should be made on different days and different times of day.
Survey Completed	The surveyor spoke with the provider or provider representative and the survey was completed.
After-Hours Calls	The surveyor attempted to contact the provider outside regular business hours as listed in the online provider directory. Includes successful and unsuccessful attempts.

If "Provider Sample" and "Providers Contacted" within each provider group are not equal, please provide an explanation.

N/A

Figure B.1. Description of Sample – Aetna

The data source and calculation for determining either the 2,123 or 2,125 unique provider telephone numbers was unclear. Aetna's Annual Timeliness Report noted, "provider offices that did not have a phone number populated were excluded." It was not clear what data source was being referenced for phone numbers, though Aetna reported that providers without a documented phone number in their system were excluded. Aetna should report the number of provider offices excluded from the survey, due to lack of telephone numbers. If Aetna was unable to identify the provider phone number, a member would not have access to the provider information through the provider directory either, which may limit the member's access to key specialty services.

In addition to questions regarding follow-up from the previous year, the Methodology tab of the Annual Timeliness Report template asked how many of the non-compliant providers from the prior year were included in the survey sample this year, as well as what actions were taken with all non-compliant providers from the prior year who are currently in the network. Aetna did not report any information in response to these questions on the Methodology tab of the report.

Figure B.2 displays Aetna's Tables 2.1.a. and 2.1.b, Provider Sample in Compliance with State Contractual Appointment Standards, and provides appointment availability results for those in the provider sample noted in Figure 5.1. In addition to results for PCP (overall), Specialist, MH, SUD, and OB provider types; Aetna stratified the PCP results by those serving adults and those providing pediatric services. It wasn't clear what provider specialties were within the Specialist provider stratum, other than oncologists, since it was previously noted other specialties were excluded. Information is needed regarding how Aetna determined the categorization of providers with overlapping specialties, such as those providing both adult and pediatric PCP services, or MH and SUD services.

Table 2.1.a.: Provider Sample in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Provider Sample	559	603	534	572	25	27	370	736	769	684	65	36	1763	2059
Emergency Care	24.9%	17.9%	24.2%	16.6%	40.0%	48.1%	17.0%	7.2%	7.2%	0.0%	20.0%	0.0%	15.3%	7.8%
(number)	139	108	129	95	10	13	63	53	55		13		270	161
Urgent Care	26.1%	18.2%	25.5%	16.6%	40.0%	55.6%	15.4%	8.3%	6.9%	0.0%	15.4%	0.0%	15.1%	8.3%
(number)	146	110	136	95	10	15	57	61	53		10		266	171
Routine Care*	36.0%	25.2%	35.0%	23.4%	56.0%	66.7%	30.8%	16.3%	11.4%	0.0%	26.2%	0.0%	23.8%	13.2%
(number)	201	152	187	134	14	18	114	120	88		17		420	272
Adult Physical	N/A		28.8%	18.2%	N/A		N/A		N/A		N/A		N/A	
(number)			154	104										
EPSDT/Well-Child	N/A		N/A		52.0%	51.9%	N/A		N/A		N/A		N/A	
(number)					13	14								

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Table 2.1.b.: Provider Sample in Compliance with State Contractual Appointment Standards

	OB	
	2023	2024
	% (n)	
Provider Sample	44	66
OB 1st Trimester	31.8%	15.2%
(number)	14	10
OB 2nd Trimester	34.1%	16.7%
(number)	15	11
OB 3rd Trimester	31.8%	13.6%
(number)	14	9
OB High Risk	N/A	
(number)		

"N/A" - reporting does not apply to category

Figure B.2. Provider Sample in Compliance with State Contractual Appointment Standards – Aetna

Aetna reported a decline in compliance rates across all provider types except Pediatric PCPs. For Mental Health and SUD providers Aetna reported 0.0% compliance in all categories for 2024.

Figure B.3. displays Aetna's Table 3, Most Common Reasons for Not Being Able to Survey Offices, which reports 2,125 providers were contacted, 456 surveys were completed, and 1,669 surveys were not completed; however, 1,064 providers were not surveyed. According to the template the Total Not Surveyed should be equal to the number reported in the Survey Not Completed row.

Table 3: Most Common Reasons for Not Being Able to Survey Offices

	PCP		Specialist		OB		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Providers Contacted	559	603	370	736	44	66	769	684	65	36	1807	2125
a. Survey Completed	233	181	147	135	19	17	114	111	22	12	535	456
b. Survey Not Completed	326	422	223	601	25	49	655	573	43	24	1272	1669
Refused to Participate	0.4%	0.3%	0.3%	0.3%	0.0%	0.0%	0.5%	0.0%	0.0%	0.0%	0.4%	0.2%
(number)	2	2	1	2	0	0	4		0		7	4
Unable to Contact After 3 Attempts	48.8%	44.3%	50.8%	47.4%	50.0%	53.0%	77.8%	0.0%	56.9%	0.0%	61.9%	30.6%
(number)	273	267	188	349	22	35	598		37		1118	651
Technical Problems*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0		0		0	0
Moved, No Updated Information	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0		0		0	0
Incorrect Phone Number	8.4%	23.7%	14.1%	32.3%	4.5%	15.2%	6.9%	0.0%	7.7%	0.0%	8.8%	18.4%
(number)	47	143	52	238	2	10	53		5		159	391
Other*	0.7%	1.0%	0.3%	1.6%	2.3%	0.0%	0.0%	0.0%	1.5%	0.0%	0.4%	0.8%
(number)	4	6	1	12	1	0	0		1		7	18
Total Not Surveyed	58.3%	69.3%	65.4%	81.7%	56.8%	68.2%	85.2%	0.0%	66.2%	0.0%	71.4%	50.1%
(number **should** equal Row 9)	326	418	242	601	25	45	655	0	43	0	1291	1064

*Additional information required - See below

KFMC note: Row 9 is the Survey Not Completed row.

Figure B.3. Most Common Reasons for Not Being Able to Survey Offices – Aetna

Discrepancies occurred under every provider type except Specialists. These discrepancies included:

- The PCP column where 422 surveys were not completed but 418 providers were not surveyed.
- The OB column where 49 surveys were not completed but 45 providers were not surveyed.
- The MH column where 573 surveys were not completed but 0 providers were not surveyed.
- The SUD column where 24 surveys were not completed but 0 providers were not surveyed.

While the numbers and percentages may be incorrect, of the 1,064 providers not surveyed in 2024, unsuccessful attempts for 651 (61%) providers were due to the caller being unable to contact the provider after three attempts, and 391 (37%) were due to incorrect phone numbers. The Other category was used to capture phone number changes and reaching business or government entities. It is unclear why such calls were not categorized as incorrect phone numbers.

It should also be noted that Aetna did not report any actions related to Improvement Activities (For Year 2024) related to Table 3.

Appointment Availability

Figure B.4 displays Aetna's Table 4.1.a, Providers Surveyed in Compliance with State Contractual Appointment Standards. Aetna's results were noticeably lower compared to the other MCOs. With the exception of Routine Care for Pediatric PCPs (95% of 19), no category was reported above 90% compliance with contractual appointment standards.

Table 4.1.a.: Providers Surveyed in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Survey Completed	233	181	219	162	14	19	147	135	114	111	22	12	516	439
Emergency Care	59.7%	59.7%	58.9%	58.6%	71.4%	68.4%	42.9%	39.3%	48.2%	0.0%	59.1%	0.0%	52.3%	36.7%
(number)	139	108	129	95	10	13	63	53	55		13		270	161
Urgent Care	62.7%	60.8%	62.1%	58.6%	71.4%	78.9%	38.8%	45.2%	46.5%	0.0%	45.5%	0.0%	51.6%	39.0%
(number)	146	110	136	95	10	15	57	61	53		10		266	171
Routine Care*	86.3%	84.0%	85.4%	82.7%	100.0%	94.7%	77.6%	88.9%	77.2%	0.0%	77.3%	0.0%	81.4%	62.0%
(number)	201	152	187	134	14	18	114	120	88		17		420	272
Adult Physical	N/A		70.3%	64.2%	N/A		N/A		N/A		N/A		N/A	
(number)			154	104										
EPSDT/Well-Child	N/A		N/A		92.9%	73.7%	N/A		N/A		N/A		N/A	
(number)					13	14								

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Figure B.4. Providers Surveyed in Compliance with State Contractual Appointment Standards – Aetna

Figure B.5 displays Aetna's Tables 4.2.a, 4.2.b, and 4.2.c, Median Number of Days Wait for Scheduled Appointments, which report the median number of days that Aetna members had to wait to receive various types of care. The median number of days a member had to wait for a routine care visit was one day for a PCP and eight days for a Specialist. No information on wait time was provided for Mental Health providers. The median number of days a member had to wait for an OB appointment was four days. This wait time for an OB appointment was reported as the same across all trimesters as well as for member experiencing High Risk pregnancies.

Table 4.2.a.: Median Number of Days Wait for Scheduled Appointment

	PCP		Specialist		MH	
	2023	2024	2023	2024	2023	2024
Survey Completed	233	181	147	135	114	111
	Median Number of Days					
Emergency Care*	0.04	0.13	0.85	0.94	0.25	
Urgent Care	0.08	0.13	1.92	1.04	1	
Routine Care	1	1	5	8	2	
Adult Physical	2	4	N/A			
EPSDT/Well-Child	0	6.5				

*Report in decimal form to the nearest hour (e.g., 7 hrs is equivalent to 0.29 days)
"N/A" - reporting does not apply to category

Table 4.2.b.: Median Number of Days Wait for Scheduled Appointment

	OB	
	2023	2024
Survey Completed	19	17
	Median Number of Days	
OB 1st Trimester	4	4
OB 2nd Trimester	4	4
OB 3rd Trimester	4	4
OB High Risk*	4	4

*No specific standard - Please report average time for appointment

Table 4.2.c.: Median Number of Days Wait for Scheduled Appointment

	BH	
	2023	2024
Survey Completed	22	12
	Median Number of Days	
SUD	4	
PWID	1	
Pregnant Drug User*	0.69	
Other Behavioral Health Services	0.79	

*Report in decimal form to the nearest hour (e.g., 7 hrs is equivalent to 0.29 days)

Figure B.5. Median Number of Days Wait for Scheduled Appointment – Aetna

After-Hours Access

For after-hours calls, a random sample of 502 unique telephone numbers were selected for outreach. The proportions by specialty were a little different than the appointment availability sample, with the after-hours sample having 136 PCPs, 141 Specialist, 62 OBs, and 163 Behavioral Health providers. Figure B.6 displays Aetna's Table 5, After-Hours Access Compliance, which reports that of the 502 calls completed by Aetna, 40.4% were compliant.

Of the 203 compliant calls, 52.2% (106) were answered by answering machines, with 45.3% (48) of answering machines having instructions to go to the nearest hospital. Removing such calls would reduce Aetna's overall compliance from 40.4% (203) to 30.9% (155). Of the 141 reported non-compliant calls, 74.5% were due to the combined issues of the phone ringing continuously, disconnecting, or quitting ringing. Incorrect telephone numbers (31) and fax machine numbers (5) accounted for the remaining reported non-compliant calls.

Table 5: After-Hours Access Compliance

	PCP		Specialist		OB		BH*		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)	
After-Hours Calls	125	136	123	141	44	62	210	163	502	502
Compliant										
Acceptable Responses										
Answering Service	8.8%	8.8%	11.4%	10.6%	6.8%	16.1%	2.9%	4.9%	6.8%	9.0%
(number)	11	12	14	15	3	10	6	8	34	45
Triage/Nurse Line	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Intended/On-call provider	3.2%	5.1%	3.3%	2.8%	0.0%	0.0%	2.9%	1.8%	2.8%	2.8%
(number)	4	7	4	4	0	0	6	3	14	14
Message with contact number	12.8%	13.2%	7.3%	3.5%	18.2%	6.5%	10.0%	6.7%	10.8%	7.6%
(number)	16	18	9	5	8	4	21	11	54	38
Answering Machine										
Instructions to go to the nearest hospital	10.4%	8.1%	13.0%	3.5%	20.5%	17.7%	9.5%	12.9%	11.6%	9.6%
(number)	13	11	16	5	9	11	20	21	58	48
Other answering machine message with no issues	15.2%	8.1%	20.3%	14.2%	15.9%	16.1%	2.9%	10.4%	11.4%	11.6%
(number)	19	11	25	20	7	10	6	17	57	58
Percent Compliant	50.4%	43.4%	55.3%	34.8%	61.4%	56.5%	28.1%	36.8%	43.2%	40.4%
Total Compliant	63	59	68	49	27	35	59	60	217	203
Non-Compliant										
No Answer										
Disconnect/Quits ringing	7.2%	5.9%	7.3%	8.5%	2.3%	4.8%	8.6%	8.0%	7.4%	7.2%
(number)	9	8	9	12	1	3	18	13	37	36
Rings continuously	18.4%	13.2%	13.0%	10.6%	18.2%	14.5%	16.7%	16.6%	16.3%	13.7%
(number)	23	18	16	15	8	9	35	27	82	69
Number no longer in service	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Provider unknown to number called	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Other Unacceptable										
Fax Machine	0.0%	0.7%	0.0%	1.4%	0.0%	0.0%	1.0%	1.2%	0.4%	1.0%
(number)	0	1	0	2	0	0	2	2	2	5
Provider no longer at location	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Instructions to call 911	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Wrong number	2.4%	11.8%	4.1%	2.8%	2.3%	6.5%	1.9%	4.3%	2.6%	6.2%
(number)	3	16	5	4	1	4	4	7	13	31
Percent Non-Compliant	28.0%	31.6%	24.4%	23.4%	22.7%	25.8%	28.1%	30.1%	26.7%	28.1%
Total Non-Compliant	35	43	30	33	10	16	59	49	134	141

*BH = MH + SUD

Improvement Activities (For Year 2024)

Reason (Non-Compliant)	Number of Providers	Action	Outcome
Non Compliant Providers from 2023 survey	1291	All Non-Compliant providers were contacted by phone and/or email by Provider Reps to provide education	Education/ Training provided

Figure B.6. After-Hours Access – Aetna

Sunflower's Annual Timeliness Report

Sunflower submitted their Annual Timeliness Report on October 31, 2024. As noted in KFMC's report last year, distinctions between the results of the appointment availability survey and the after-hours access survey were needed. Sunflower's report stated, "Vendor conducted study in the 3rd Quarter of 2023 and 1st Quarter of 2024. Vendor provided outbound contact services during the hours of 9am to 9pm local time between Monday and Thursday." However, there was no additional detail provided that would allow for differentiation between appointment availability and after-hours calls.

Regarding the sample for appointment availability access monitoring and after-hours calls, Sunflower reported the entire network was sent to the vendor. Figure B.7 displays Sunflower's Table 1, Description of Sample, which reports 1,563 PCPs, 1,190 Specialists, 162 OBs, 1,439 Mental Health providers, and 654 SUD providers were sampled in 2024. There were no calculation errors found in Table 1. However, Sunflower noted in the sample related portion of the report, "The entire network was sent to the vendor. The vendor chooses the sample based on the goals provided per provider type. Kansas' goal is to reach 90% of providers passing all appointment standards." Sunflower identified the numbers of providers contacted were 441 (PCP), 322 (Specialist), 55 (OB), and 471 (BH providers).

Table 1: Description of Sample

	Provider Groups											
	PCP		Specialist		OB		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Provider Sample (number)	2800	1563	2033	1190	323	162	1447	1439	464	654	7067	5008
Providers Contacted	17.7%	28.2%	20.8%	27.1%	28.8%	34.0%	20.5%	21.0%	18.3%	25.8%	19.7%	25.7%
(number)	496	441	422	322	93	55	297	302	85	169	1393	1289
Survey Completed	17.7%	28.2%	20.8%	27.1%	28.8%	34.0%	20.5%	21.0%	18.3%	25.8%	19.7%	25.7%
(number)	496	441	422	322	93	55	297	302	85	169	1393	1289
After-Hours Calls	11.8%	20.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.7%	6.4%
(number)	330	321	0	0	0	0	0		0		330	321

Definitions	
Provider Sample	The total number of providers the surveyor determined was ideal to include in its survey.
Providers Contacted	The surveyor called and attempted to reach the provider. A minimum of 3 attempts should be made on different days and different times of day.
Survey Completed	The surveyor spoke with the provider or provider representative and the survey was completed.
After-Hours Calls	The surveyor attempted to contact the provider outside regular business hours as listed in the online provider directory. Includes successful and unsuccessful attempts.

If "Provider Sample" and "Providers Contacted" within each provider group are not equal, please provide an explanation.

The entire network was sent to the vendor. The vendor chooses the sample based on the goals provided per provider type. Kansas' goal is to reach 90% of providers passing all appointment standards. It was determined the following were needed to determine the sample: PCP = 441, SPC = 322, OBGYN = 55, BH = 471

Figure B.7. Description of Sample – Sunflower

Figure B.8 displays the section of the Annual Timeliness report that asks about actions taken with non-compliant providers from the prior year. Sunflower reported no direct activities with non-compliant providers. There is an expectation that MCOs are actively working with their provider network to improve compliance, and this should be addressed in 2025.

Did your sample include those providers who were non-compliant in 2023?
How many providers were non-compliant the prior year and how many of them were contacted?
Yes, the entire network was sent to the vendor so it is possible providers non-compliant in 2023 were included in this years sample.
Please describe actions taken with those providers found non-compliant in 2023.
Were actions taken with all non-compliant providers from the prior year who are currently in network?
While we did not contact non-compliant providers directly, we are reevaluating the processes and procedures around these audits and how to address failures.

Figure B.8. Activities with Non-Compliant Providers – Sunflower

Figure B.9 displays Sunflower's Tables 2.1.a and 2.1.b., Provider Sample in Compliance with State Contractual Appointment Standards, which provides results for the following provider types: PCP (overall, adult, and pediatric), Specialist, MH, SUD, and OB.

Table 2.1.a.: Provider Sample in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Provider Sample	2800	1563	1546	1319	1254	244	2033	1190	1447	1439	464	654	6744	4846
Emergency Care	12.5%	20.4%	15.7%	17.6%	8.5%	35.7%	10.9%	0.0%	7.1%	0.0%	5.0%	0.0%	10.3%	6.6%
(number)	349	319	243	232	106	87	221		103		23		696	319
Urgent Care	12.5%	20.4%	15.7%	17.6%	8.5%	35.7%	10.9%	0.0%	14.4%	0.0%	10.8%	0.0%	12.3%	6.6%
(number)	349	319	243	232	106	87	221		208		50		828	319
Routine Care*	14.0%	23.5%	17.6%	20.9%	9.6%	37.7%	15.8%	0.0%	19.0%	0.0%	11.6%	0.0%	15.5%	7.6%
(number)	393	368	272	276	121	92	322		275		54		1044	368
Adult Physical	N/A		0.0%	0.0%	N/A		N/A		N/A		N/A		N/A	
(number)														
EPSDT/Well-Child	N/A		N/A		0.0%	0.0%	N/A		N/A		N/A		N/A	
(number)														

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Table 2.1.b.: Provider Sample in Compliance with State Contractual Appointment Standards

	OB	
	2023	2024
	% (n)	
Provider Sample	323	162
OB 1st Trimester	0.0%	22.2%
(number)		36
OB 2nd Trimester	0.0%	18.5%
(number)		30
OB 3rd Trimester	0.0%	16.0%
(number)		26
OB High Risk	N/A	
(number)		

"N/A" - reporting does not apply to category

Figure B.9. Provider Sample in Compliance with State Contractual Appointment Standards – Sunflower

While Aetna reported a decline in compliance rates across nearly all provider types, Sunflower reported an increased rate of compliance for PCPs.

Last year, KFMC noted that Sunflower's report contained errors in Table 3, Most Common Reasons for Not Being Able to Survey Offices (not displayed). The template instructions state that Row 9, Survey Not Completed, should equal Row 23, Total Not Surveyed, and Sunflower's report did not demonstrate this. This issue was corrected in the 2024 Annual Timeliness Report, and Table 3 appeared to be populated

correctly. Among the 3,719 providers called but not surveyed, 59.8% (2,224) were not reached because of technical or other problems. Examination of Table 3, Most Common Reasons for Not Being Able to Survey Offices, Improvement Activities (For Year 2024) section, displayed below in Figure B.10, revealed that the descriptions for these categories were brief, including Vendor Hold Times, Providers Who are Busy at the Time the Vendor Called, and Asked to Call Back at a Later Time.

Almost all remaining reasons, 36.5%, were related to data inaccuracies, including incorrect phone numbers (914) and the provider having moved with no updated information (445). Only 3.7% (136) of calls were categorized as Refused to Participate. Though Sunflower did populate a portion of the Improvement Activities (For Year 2024) section, there were no actions listed related to the 1,047 providers who fell into the Other category. It is unknown whether any return calls were attempted with providers that asked to be called back at a later time.

Improvement Activities (For Year 2024)

Reason	Number of	Action	Outcome
Refused to Participate	136	Meeting with provider to discuss expectations and barriers to completing the survey.	
Unable to Contact After 3 Attempts	0		
Technical Problems*	1177	Ensuring provider data and numbers are accurate to reduce technical errors.	
Moved, No Updated Information	445	Update provider data in our systems to remove these providers.	
Incorrect Phone Number	914	Update provider data in our systems.	
Other*	1047		

*Additional information required - See below

If data is entered into category "Other" and/or category "Technical Problems", please use the text box below to provide a detailed explanation of the reason for not being able to survey the offices.

"Technical" covers vendor hold times. "Other" covers providers who are busy at the time the vendor called, and asked to call back at a later time.

Figure B.10. Improvement Activities (For Year 2024) – Sunflower

Appointment Availability

Figure B.11 displays Sunflower's Tables 4.1.a and 4.1.b., Providers Surveyed in Compliance with State Contractual Appointment Standards. In 2023, Sunflower did not identify the number of providers surveyed for the adult PCP and pediatric PCP specialties and did not provide percentages associated with the compliance numbers. This oversight has been corrected and the missing 2023 data was included in the 2024 report. No errors were found in these tables for 2023 or 2024.

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Table 4.1.a.: Providers Surveyed in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Survey Completed	496	441	336	329	160	112	422	322	297	302	85	169	1300	1234
Emergency Care	70.4%	72.3%	72.3%	70.5%	66.3%	77.7%	52.4%	33.5%	34.7%	64.2%	27.1%	54.4%	53.5%	57.8%
(number)	349	319	243	232	106	87	221	108	103	194	23	92	696	713
Urgent Care	70.4%	72.3%	72.3%	70.5%	66.3%	77.7%	52.4%	33.5%	70.0%	64.2%	58.8%	54.4%	63.7%	57.8%
(number)	349	319	243	232	106	87	221	108	208	194	50	92	828	713
Routine Care*	79.2%	88.0%	81.0%	83.9%	75.6%	100.0%	76.3%	68.6%	92.6%	78.8%	63.5%	69.2%	80.3%	78.1%
(number)	393	388	272	276	121	112	322	221	275	238	54	117	1044	964
Adult Physical	N/A		0.0%	0.0%	N/A		N/A		N/A		N/A		N/A	
(number)														
EPSDT/Well-Child	N/A		N/A		0.0%	0.0%	N/A		N/A		N/A		N/A	
(number)														

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Table 4.1.b.: Offices Surveyed in Compliance with State Contractual Appointment Standards

	OB	
	2023	2024
	% (n)	
Survey Completed	93	55
OB 1st Trimester	0.0%	65.5%
(number)		36
OB 2nd Trimester	0.0%	54.5%
(number)		30
OB 3rd Trimester	0.0%	47.3%
(number)		26
OB High Risk	N/A	
(number)		

"N/A" - reporting does not apply to category

Figure B.11. Providers Surveyed in Compliance with State Contractual Appointment Standards – Sunflower

Figure B.12 displays Sunflower's Tables 4.2.a, 4.2.b, and 4.2.c, Median Number of Days Wait for Scheduled Appointments, which report the median number of days that Sunflower members had to wait to receive various types of care. The median number of days a member had to wait for a routine care visit was 48 days for a PCP, 111 days for a Specialist, and 32 days for a Mental Health Provider. Each of these represent an increase in wait times compared to times reported in the 2023 Annual Timeliness Report. Sunflower also reported that all OB wait times increased for each trimesters.

Table 4.2.a.: Median Number of Days Wait for Scheduled Appointment

	PCP		Specialist		MH	
	2023	2024	2023	2024	2023	2024
Survey Completed	496	441	422	322	297	302
	Median Number of Days					
Emergency Care*	30	30	61	80	21	22
Urgent Care	30	30	61	80	21	22
Routine Care	47	48	80	111	31	32
Adult Physical	47	48	N/A			
EPSDT/Well-Child	111	115				

*Report in decimal form to the nearest hour (e.g., 7 hrs is equivalent to 0.29 days)
"N/A" - reporting does not apply to category

Table 4.2.b.: Median Number of Days Wait for Scheduled Appointment

	OB	
	2023	2024
Survey Completed	93	55
	Median Number of Days	
OB 1st Trimester	20	21
OB 2nd Trimester	20	21
OB 3rd Trimester	7	13
OB High Risk*	7	13

*No specific standard - Please report average time for appointment

Table 4.2.c.: Median Number of Days Wait for Scheduled Appointment

	BH	
	2023	2024
Survey Completed	85	169
	Median Number of Days	
SUD	80	80
PWID	80	80
Pregnant Drug User*	80	80
Other Behavioral Health Services	80	80

*Report in decimal form to the nearest hour (e.g., 7 hrs is equivalent to 0.29 days)

Figure B.12. Median Number of Days Wait for Scheduled Appointment – Sunflower

Sunflower's 2022 Annual Timeliness Report noted the health plan "considers the third appointment availability to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect available urgent appointments or appointments available due to cancellations for a given day, which may not represent average accessibility." It was not clear whether Sunflower's compliance rates in 2023 were based on third available or average appointment availability as scripts were not available for review. To better assess this issue in 2024, KFMC requested and received the survey questions used to conduct this survey. From the scripts provided, it did not appear that Sunflower was still employing the third appointment available approach. However, median numbers of days wait for scheduled appointments reported by Sunflower in Tables 4.2.a–4.2.c, displayed in Figure B.12, were noticeably longer than those reported by the other MCOs, suggesting Sunflower may be measuring these indicators differently from the other MCOs.

After-Hours Access

Related to after-hours sampling, Sunflower stated, "AH is done using completed PCP audits so we have a full picture of how that provider performs." Sunflower reported completing 441 PCP audits but only attempting 321 after-hours calls to PCPs (see Figure B.7). Also, in Sunflower's Annual Timeliness Report, under After-Hours Calls Definitions on the Sample Size sheet, Sunflower noted successful and unsuccessful attempts were included. In Figure B.13, which displays Sunflower's Table 5, After-Hours Access Compliance, none of the 321 calls were reported as non-compliant.

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Table 5: After-Hours Access Compliance

	PCP		Specialist		OB		BH*		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)	
After-Hours Calls	330	321	0	0	0	0	0	0	330	321
Compliant										
Acceptable Responses										
Answering Service	0.6%	0.6%							0.6%	0.6%
(number)	2	2							2	2
Triage/Nurse Line	3.0%	22.7%							3.0%	22.7%
(number)	10	73							10	73
Intended/On-call provider	36.4%	8.1%							36.4%	8.1%
(number)	120	26							120	26
Message with contact number	18.5%	16.2%							18.5%	16.2%
(number)	61	52							61	52
Answering Machine										
Instructions to go to the nearest hospital	16.7%	21.8%							16.7%	21.8%
(number)	55	70							55	70
Other answering machine message with no issues	24.8%	30.5%							24.8%	30.5%
(number)	82	98							82	98
Percent Compliant	100.0%	100.0%							100.0%	100.0%
Total Compliant	330	321	0	0	0	0	0	0	330	321
Non-Compliant										
No Answer										
Disconnect/Quits ringing	0.3%	0.0%							0.3%	0.0%
(number)	1								1	0
Rings continuously	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Number no longer in service	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Provider unknown to number called	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Other Unacceptable										
Fax Machine	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Provider no longer at location	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Instructions to call 911	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Wrong number	0.0%	0.0%							0.0%	0.0%
(number)									0	0
Percent Non-Compliant	0.3%	0.0%							0.3%	0.0%
Total Non-Compliant	1	0	0	0	0	0	0	0	1	0

*BH = MH + SUD

Improvement Activities (For Year 2024)

Reason (Non-Compliant)	Number of Providers	Action	Outcome

Figure B.13. After-Hours Access – Sunflower

Sunflower reported a very high percentage of unsuccessful call attempts (74.3% of 3,719 calls). Recall, that Sunflower only called PCPs who completed an audit; thus, Sunflower had screened out PCPs who would have been non-compliant for reasons such as number no longer in service, fax machine, or wrong number. Sunflower did not report any non-compliant calls for their after-hours survey. For comparison, Sunflower reported 8.9% (445) of their appointment availability calls were categorized as Moved, No Updated Information. Sunflower also reported 18.3% (914) of their appointment availability calls were categorized as Incorrect Phone Number. KFMC would have expected similar percentages of calls to fall into the categories of Wrong Number and Provider No Longer at Location for after-hours calls; however, none were reported in Table 5, displayed as Figure B.13.

As with Aetna and UnitedHealthcare, removing those calls that resulted in reaching answering machines with instructions to go to the nearest hospital would result in a dramatic reduction in Sunflower's compliance percentage. Calls resulting in such messages accounted for 21.8% (70) of all of Sunflower's compliant calls. Removing such calls would reduce Sunflower's overall compliance from 100.0% to 78.2%. UnitedHealthcare also reported a compliance rate of 98.7%.

Lastly, regarding Figure B.13, Sunflower did not populate Table 5 except for the column pertaining to PCPs. Other populations should be surveyed to allow for consistent comparisons across provider types and MCOs. Finally, Sunflower did not populate the Improvement Activities (For Year 2024) section of Table 5. Efforts should be made to update this report with improvement activities in the future as this will ensure continuous improvement efforts are acknowledged and learned from.

UnitedHealthcare's Annual Timeliness Report

UnitedHealthcare submitted the Annual Timeliness Report on October 31, 2024. UnitedHealthcare stated, "Based on previous years' survey data, an anticipated frequency of 85% was used to estimate the sample size. Confidence limits of ±5% were estimated to allow for reasonably precise results while keeping sample sizes manageable." The sample frame included 4,692 PCPs, 1,334 Specialists, 525 OBs, 1,045 MH providers, and 81 SUD providers.

Regarding the sample for appointment availability access monitoring and after-hours calls, Figure B.14 displays UnitedHealthcare's Table 1, Description of Sample. Their sample contained 923 providers (239 PCPs, 215 Specialists, 180 OBs, 208 MH providers, and 81 SUD providers). UnitedHealthcare reported the same samples were used for the appointment availability and after-hours access surveys. For the after-hours survey, the MH and SUD provider populations were combined into 280 providers in Behavioral Health.

Table 1: Description of Sample

	Provider Groups											
	PCP		Specialist		OB		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
Provider Sample (number)	237	239	215	215	178	180	200	208	80	81	910	923
Providers Contacted	100.0%	100.0%	100.0%	97.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%
(number)	237	239	215	210	178	180	200	208	80	81	910	918
Survey Completed	84.8%	79.1%	93.0%	93.5%	84.8%	57.8%	86.0%	100.0%	98.8%	100.0%	88.2%	84.8%
(number)	201	189	200	201	151	104	172	208	79	81	803	783
After-Hours Calls	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
(number)	237	239	215	215	178	180	200	208	80	81	910	923

Definitions	
Provider Sample	The total number of providers the surveyor determined was ideal to include in its survey.
Providers Contacted	The surveyor called and attempted to reach the provider. A minimum of 3 attempts should be made on different days and different times of day.
Survey Completed	The surveyor spoke with the provider or provider representative and the survey was completed.
After-Hours Calls	The surveyor attempted to contact the provider outside regular business hours as listed in the online provider directory. Includes successful and unsuccessful attempts.

If "Provider Sample" and "Providers Contacted" within each provider group are not equal, please provide an explanation.

100% of providers in the sample were contacted except for 5 ophthalmologist providers(1 TIN) in the specialist category. The surveyor attempted to contact this office 3 different days at various times of the day. The surveyor was on extended holds or reached voicemail during these attempts. The Provider Relations team will outreach to this provider group and educate on standards related to appointment setting.

Figure B.14. Description of Sample – UnitedHealthcare

UnitedHealthcare detailed their outreach efforts to providers and specified activities related to each provider type found to be non-compliant in 2023. No issues were identified in this section of UnitedHealthcare's Annual Timeliness Report.

Table 2.1.a, Provider Sample in Compliance with State Contractual Appointment Standards, displayed in Figure B.15, provides results for the following provider types: PCP (overall, adult, and pediatric), Specialist, MH, SUD, and OB.

Table 2.1.a.: Provider Sample in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Provider Sample	237	239	237	210	237	230	215	215	200	208	80	81	732	743
Emergency Care	84.0%	79.1%	75.9%	76.2%	84.0%	78.3%	93.0%	93.5%	86.0%	100.0%	98.8%	100.0%	88.8%	91.4%
(number)	199	189	180	160	199	180	200	201	172	208	79	81	650	679
Urgent Care	84.0%	79.1%	75.9%	76.2%	84.0%	78.3%	93.0%	93.5%	86.0%	100.0%	98.8%	100.0%	88.8%	91.4%
(number)	199	189	180	160	199	180	200	201	172	208	79	81	650	679
Routine Care*	84.4%	68.2%	76.4%	64.3%	84.4%	75.2%	93.0%	93.5%	77.0%	100.0%	98.8%	100.0%	86.5%	87.9%
(number)	200	163	181	135	200	173	200	201	154	208	79	81	633	653
Adult Physical	N/A		76.4%	64.3%	N/A		N/A		N/A		N/A		N/A	
(number)			181	135										
EPSDT/Well-Child	N/A		N/A		84.4%	75.2%	N/A		N/A		N/A		N/A	
(number)					200	173								

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Table 2.1.b.: Provider Sample in Compliance with State Contractual Appointment Standards

	OB	
	2023	2024
	% (n)	
Provider Sample	178	180
OB 1st Trimester	84.8%	57.8%
(number)	151	104
OB 2nd Trimester	82.0%	57.8%
(number)	146	104
OB 3rd Trimester	84.8%	57.8%
(number)	151	104
OB High Risk	N/A	
(number)		

"N/A" - reporting does not apply to category

Figure B.15. Provider Sample in Compliance with State Contractual Appointment Standards – UnitedHealthcare

Though UnitedHealthcare reported most provider types have maintained a relatively stable level of compliance, there is a substantial decline in the compliance of OB providers across all trimesters. This decline should be investigated and addressed.

UnitedHealthcare's Table 3, Most Common Reasons for Not Being Able to Survey Offices, shown in Figure B.16, indicates 62.1% (87) of 140 surveys not completed were categorized as Other.

Of the 87 calls in the Other category, 31 were for PCPs and 56 were for OBs. Within these provider types, the reasons for not completing the survey were reported in Figure B.17.

All 87 of the calls categorized as Other represent calls to providers who were likely inappropriately listed in provider directories due to outdated or incorrect information. Despite this, it should also be noted

that UnitedHealthcare did a much better job of capturing the reasons that calls were rated as Other, or as Technical Problems, compared to Aetna and Sunflower.

Table 3: Most Common Reasons for Not Being Able to Survey Offices

	PCP		Specialist		OB		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Providers Contacted	237	239	215	215	178	180	200	208	80	81	910	923
a. Survey Completed	201	189	200	201	151	104	172	208	79	81	803	783
b. Survey Not Completed	36	50	15	14	27	76	28	0	1	0	107	140
Refused to Participate	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0	0	0
Unable to Contact After 3 Attempts	0.0%	0.0%	0.0%	2.3%	0.0%	0.0%	3.5%	0.0%	0.0%	0.0%	0.8%	0.5%
(number)	0	0	0	5	0	0	7	0	0	0	7	5
Technical Problems*	4.6%	0.0%	2.8%	4.2%	1.1%	8.9%	0.0%	0.0%	0.0%	0.0%	2.1%	2.7%
(number)	11	0	6	9	2	16	0	0	0	0	19	25
Moved, No Updated Information	5.5%	7.9%	2.3%	0.0%	2.2%	2.2%	4.0%	0.0%	1.3%	0.0%	3.4%	2.5%
(number)	13	19	5	0	4	4	8	0	1	0	31	23
Incorrect Phone Number	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4.0%	0.0%	0.0%	0.0%	0.9%	0.0%
(number)	0	0	0	0	0	0	8	0	0	0	8	0
Other*	5.1%	13.0%	1.9%	0.0%	11.8%	31.1%	2.5%	0.0%	0.0%	0.0%	4.6%	9.4%
(number)	12	31	4	0	21	56	5	0	0	0	42	87
Total Not Surveyed	15.2%	20.9%	7.0%	6.5%	15.2%	42.2%	14.0%	0.0%	1.3%	0.0%	11.8%	15.2%
(number **should** equal Row 9)	36	50	15	14	27	76	28	0	1	0	107	140

*Additional information required - See below

Figure B.16. Most Common Reasons for Not Being Able to Survey Offices – UnitedHealthcare

If data is entered into category "Other" and/or category "Technical Problems", please use the text box below to provide a detailed explanation of the reason for not being able to survey the offices.

Technical Problems (25):
- OB (16): Provider is unable to bring up appt calendar without a members name/DOB
- Specialists (9): Provider is unable to see appointment availability without a referral

Other Problems (87):
OB (56):
- 26: Provider is a specialist (maternal/fetal medicine, abortion clinic, laborist/hospitalist only)
- 21: Provider does not take Medicaid
- 9: Provider group doing Locum deliveries only

PCP (31)
- 19: Provider is a specialist (not a PCP)
- 8: Provider Retired
- 4: Misc: Group listed instead of a provider name, Provider is now acting CEO of clinic (2), Provider has not yet started wtih clinic

Figure B.17. Provider Types for "Other" Category – UnitedHealthcare

Appointment Availability

Regarding Tables 4.1.a and 4.1.b, Providers Surveyed in Compliance with State Contractual Appointment Standards, displayed in Figure B.18, UnitedHealthcare reported extremely high levels of compliance.

For all areas except Routine Care for Adult PCPs (84.4%), Pediatric PCPs (96.1%), Adult Physical (84.4%) and EPSDT/Well-child (96.1%), provider compliance with contractual appointment standards were 99.0% or above. Figure B.18 shows the Adult and Pediatric PCPs sample sizes were similar—160 providers serving adults compared to 180 providers serving pediatric members. However, the total number of PCPs is 189, and it is not clear how UnitedHealthcare identified the adult and pediatric subcategories.

Tables 4.2.a., 4.2.b, and 4.2.c., Median Number of Days Wait for Scheduled Appointments (not displayed), reported the median number of days that UnitedHealthcare members had to wait to receive

various types of care. There were no errors or significant changes reported from prior years. However, UnitedHealthcare did not populate the Improvement Activities (For Year 2024) section of this table.

Table 4.1.a.: Providers Surveyed in Compliance with State Contractual Appointment Standards

	PCP (Overall)		PCP (Adults)		PCP (Peds)		Specialist		MH		SUD		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)		% (n)		% (n)	
Survey Completed	201	189	182	160	201	180	200	201	172	208	79	81	652	679
Emergency Care	99.0%	100.0%	98.9%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%
(number)	199	189	180	160	199	180	200	201	172	208	79	81	650	679
Urgent Care	99.0%	100.0%	98.9%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%
(number)	199	189	180	160	199	180	200	201	172	208	79	81	650	679
Routine Care*	99.5%	86.2%	99.5%	84.4%	99.5%	96.1%	100.0%	100.0%	89.5%	100.0%	100.0%	100.0%	97.1%	96.2%
(number)	200	163	181	135	200	173	200	201	154	208	79	81	633	653
Adult Physical	N/A		99.5%	84.4%	N/A		N/A		N/A		N/A		N/A	
(number)			181	135										
EPSDT/Well-Child	N/A		N/A		99.5%	96.1%	N/A		N/A		N/A		N/A	
(number)					200	173								

*Excludes Adult Physical and EPSDT/Well-Child
"N/A" - reporting does not apply to category

Table 4.1.b.: Offices Surveyed in Compliance with State Contractual Appointment Standards

	OB	
	2023	2024
	% (n)	
Survey Completed	151	104
OB 1st Trimester	100.0%	100.0%
(number)	151	104
OB 2nd Trimester	96.7%	100.0%
(number)	146	104
OB 3rd Trimester	100.0%	100.0%
(number)	151	104
OB High Risk	N/A	
(number)		

"N/A" - reporting does not apply to category

Figure B.18. Appointment Availability – UnitedHealthcare

It appears this section of the report was simply overlooked. UnitedHealthcare provided details related to their Improvement Activities in Tables 4.1.a and 4.1.b, Providers Surveyed in Compliance with State Contractual Appointment Standards, displayed in Figure B.18. UnitedHealthcare should make efforts to engage with its provider network to ensure appointment wait times remain in compliance. All improvement activities should be fully detailed in future reports in each section where appropriate.

After-Hours Access

In Table 5, After-Hours Access Compliance, displayed Figure B.19, UnitedHealthcare reported that of the 923 After-Hours calls completed, 98.7% (911) were compliant with access standards.

Of the 911 compliant calls, 20.9% (191 calls) were responded to by a provider answering service. Notable improvements over last year's report were found in the number of calls that were responded to by an answering machine with instructions to go to the nearest hospital—289 (31.8%) in 2023 versus 22 (2.4%) in 2024. Though UnitedHealthcare's improvement related to answering machines instructing members to go to the nearest hospital was substantial, their call scripts and instructions continued to treat such responses as acceptable. When the calls that resulted in answering machines with instructions to go to the nearest hospital were removed, the UnitedHealthcare compliance rate dropped from 98.7% to 96.3%.

Similar to Sunflower, UnitedHealthcare reported a surprisingly low number of non-compliant calls. Only 12 non-compliant calls were reported by UnitedHealthcare, all related to calls to PCP offices. KFMC

compared UnitedHealthcare's appointment availability results in Table 3, Most Common Reasons for Not Being Able to Survey Offices, displayed in Figure B.16, for the categories Moved, No Updated Information, and Incorrect Phone Number to the category results for Provider No Longer at Location and Wrong Number reported in Table 5, After-Hours Access Compliance, displayed in Figure B.19. KFMC expected similar percentages of calls to fall into these somewhat similar categories. UnitedHealthcare reported 2.5% (23) of all providers unable to be surveyed as Moved, No Updated Information in Table 3, whereas 0.9% (8) calls were reported as Provider No Longer at Location in Table 5.

Table 5: After-Hours Access Compliance

	PCP		Specialist		OB		BH*		Total	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
	% (n)		% (n)		% (n)		% (n)		% (n)	
After-Hours Calls	237	239	215	215	178	180	280	289	910	923
Compliant										
Acceptable Responses										
Answering Service	47.7%	12.6%	87.4%	75.8%	66.3%	39.4%	70.0%	90.0%	67.6%	56.8%
(number)	113	30	188	163	118	71	196	260	615	524
Triage/Nurse Line	0.0%	5.9%	0.0%	24.2%	0.0%	0.0%	0.0%	4.2%	0.0%	8.5%
(number)	0	14	0	52	0	0	0	12	0	78
Intended/On-call provider	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	5.9%	0.0%	1.8%
(number)	0	0	0	0	0	0	0	17	0	17
Message with contact number	0.0%	42.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.9%
(number)	0	101	0	0	0	0	0	0	0	101
Answering Machine										
Instructions to go to the nearest hospital	52.3%	3.8%	12.6%	0.0%	33.7%	7.2%	27.9%	0.0%	31.8%	2.4%
(number)	124	9	27	0	60	13	78	0	289	22
Other answering machine message with no issues	0.0%	30.5%	0.0%	0.0%	0.0%	53.3%	0.0%	0.0%	0.0%	18.3%
(number)	0	73	0	0	0	96	0	0	0	169
Percent Compliant	100.0%	95.0%	100.0%	100.0%	100.0%	100.0%	97.9%	100.0%	99.3%	98.7%
Total Compliant	237	227	215	215	178	180	274	289	904	911
Non-Compliant										
No Answer										
Disconnect/Quits ringing	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Rings continuously	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.0%	0.2%	0.0%
(number)	0	0	0	0	0	0	2	0	2	0
Number no longer in service	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Provider unknown to number called	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Other Unacceptable										
Fax Machine	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Provider no longer at location	0.0%	3.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.9%
(number)	0	8	0	0	0	0	0	0	0	8
Instructions to call 911	0.0%	1.7%	0.0%	0.0%	0.0%	0.0%	1.4%	0.0%	0.4%	0.4%
(number)	0	4	0	0	0	0	4	0	4	4
Wrong number	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
(number)	0	0	0	0	0	0	0	0	0	0
Percent Non-Compliant	0.0%	5.0%	0.0%	0.0%	0.0%	0.0%	2.1%	0.0%	0.7%	1.3%
Total Non-Compliant	0	12	0	0	0	0	6	0	6	12

*BH = MH + SUD

Figure B.19. After-Hours Access – UnitedHealthcare

No calls were reported as Incorrect Phone Number or Wrong Number in either table. While UnitedHealthcare's results seem somewhat consistent, more work is required to understand why Aetna's non-compliant call percentage was so much higher than that reported by Sunflower or UnitedHealthcare. Examination of call scripts and instructions did clarify why Sunflower and UnitedHealthcare have such extremely low levels on non-compliance compared to Aetna.

Appendix C

KanCare Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

2024 Recommendations

The following EQR Activity recommendations are included in Appendix C:

- PIP Validation
- QAPI Review

2024 PIP Recommendations
Aetna
EPSDT
1. Include the IVR call script in the appendices or provide additional details related to the calls in Activity 5.1.a. 2. Modify Intervention 1 to include additional outreach to members who are in foster care or provide an explanation as to why the additional efforts to reach them were not implemented. 3. Update the numerator statements for Intervention 3, Outcome Measures 1 and 2, to reflect the intended calculations. 4. Update Activity 5.6.a to clearly describe the prioritization of Intervention 6 outreach calls and any limitations to the number of members outreached. 5. Specify if the emailed flyer will be available in Spanish. 6. Clearly define *successfully received email* in Activity 5.7.c. 7. Report deviations from or updates to the technical specifications in Activity 5.c for the relevant intervention. 8. Edit table titles to match the data presented (e.g., Tables 20, 25, and 27). 9. Ensure that measures are calculated correctly. 10. Define the verification process in Activity 5.1.a and include the call script for Intervention 1 in an appendix. 11. Include all process and outcome measures defined in Activity 5.c or provide rationale for deviating from the analytic plan. 12. Conduct root cause analysis for low rates. Report how root cause analysis was performed and any relevant results. 13. When writing the annual report, ensure distinctions are made between past and current events or conditions. 14. Use technical terms consistently to improve clarity and reader comprehension (e.g., “non-mobile number” and “intervention group”). 15. Verify consistency between the analytic plans and the activities where the analyses are presented. 16. Ensure that rounding is performed consistently and correctly throughout the report.
Pregnancy: Prenatal Care
1. Update the outcome measure to be consistent with the measure description provided. 2. Report intervention 1, 2, and 3 activities that were completed in accordance with the *PIP Instructional Guide*. 3. Report intervention 4 activities that were completed in accordance with the *PIP Instructional Guide*. 4. Report deviations from or updates to the technical specifications in Activity 5.c for the relevant intervention. 5. Verify that the process and outcome measures are calculated correctly for Intervention 2. 6. Provide an explanation for the large changes in the denominators reported in Table 11. 7. Ensure that rounding is performed correctly. 8. Define the term *newly identified* so that the outcome measure for Intervention 7 may be reported as intended. 9. Consider updating Activities 5.7.c and 5.7.d to include the alternative outcome measure reported for Intervention 7. 10. Define the term *newly identified* so that the outcome measure for Intervention 8 may be reported as intended. 11. Consider updating Activities 5.8.c and 5.8.d to include the alternative outcome measure reported for Intervention 8. 12. Restate the aim statement verbatim in Activity 6 to avoid the potential for misinterpretations. 13. In Activity 6.2, update the heading of Outcome Measure 1 of the PIP to better reflect the measure being reported. 14. Express differences in percentages using percentage points to improve clarity and prevent readers from misinterpreting the result as relative changes. 15. Verify the results of statistical tests and ensure that *p*-values are reported accurately. 16. Discuss the impact that the extension of KanCare eligibility and members’ access to care during the public health emergency had on the comparability and validity of measures. 17. In Activity 9, ensure conclusions drawn are supported by the data.

2024 PIP Recommendations
Aetna (Continued)
Food Insecurity
1. Update Activity Period in the Demographic Information table with the approved dates. 2. Refer to the *PIP Instructional Guide* for direction related to interventions and measurement adjustments or discontinuations. 3. Ensure that interpretations and conclusions are supported by data. 4. Review the technical specifications for Process Measure 3 in Activity 5.6.c and reported results in Activity 8.6.b for clarity and consistency. 5. Ensure measures are calculated correctly, reported accurately, and rounding is performed consistently. 6. When writing the annual report, ensure distinctions are made between past and current events or conditions. 7. Review figure, table labels, and content for accuracy. 8. Provide appropriate reasons for inconsistencies between PAR and intervention measures. 9. Follow the CMS Cell Suppression Policy when reporting small counts, including counts in report tables and narrative.
Long-Term Services and Supports and Emergency Department Visits
Given that 2024 is the last year of Aetna's contract with the State of Kansas, no recommendations were made.
Influenza Vaccination
Given that 2024 is the last year of Aetna's contract with the State of Kansas, no recommendations were made.
Sunflower
EPSDT
1. Update Activity 5.7.a to define the criteria for inclusion in intervention 7. 2. Update Activity 5.7.a to clarify whether the POM calls are made to members or parents/guardians. 3. Correct the typographical error in the Non-POM Call Numerator statement. 4. Specify if the emailed flyer will be available in Spanish. 5. Clearly define *successfully received email* in Activity 5.8.c. 6. Double check rates in all tables for intervention 8. 7. Verify the accuracy of interpretations related to the results of statistical tests in Activity 8. 8. Ensure alignment between data tables and measure descriptions in Activity 8. 9. Unless additional insight is gained, do not report analytic results for both sets of measurement periods in Activity 8.2. 10. Be judicious on statistical testing of intervention measures. 11. Clearly indicate which measurement periods are used for any statistical analysis. 12. Ensure that interpretations align with the results presented within tables for Activity 8, intervention 1. 13. Provide interpretations of all reported data tables for Activity 8, intervention 1. 14. Review the technical specifications for the Process Measure in Activity 5.2.c and reported results in Activity 8.2 for clarity and consistency. 15. Include discussion on the impact of changes in the targeted population of the intervention on process and outcome measure rates. 16. Verify alignment between values reported within the data tables and narrative. 17. Ensure alignment between narrative and measure descriptions. 18. Include discussion of impacts to rate comparisons due to changes to the panel size criteria used to determine providers targeted for Intervention 3. 19. In Activity 8.2 of future reports, summarize the results of Outcome Measure 2 for Intervention 4 in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*.

2024 PIP Recommendations
Sunflower
EPSDT (Continued)
20. Calculate measures according to the technical specifications or provide rationale for deviating from the specifications. Provide complete technical specifications for all reported measures. Follow the CMS cell suppression policy when reporting small counts, including counts in report tables and narrative. 21. Ensure all reported values are correctly calculated. 22. Ensure all reported values are supported by the presented evidence. 23. Report measures in accordance with the technical specifications and analytic plans in Activity 5 or provide an explanation for the deviations. Update Activity 5 as needed. 24. Overall, ensure that changes in rates are calculated correctly and reported accurately. 25. Verify that table titles describe the data being reported. 26. When comparing measures between interventions, ensure that the measures are similarly defined. 27. Consistently refer to the PIP outcome measure as the "Participation Rate." 28. Update the technical specifications for the PIP outcome measure and recalculate Participation Rates reported in previous years to reflect the updated specifications. 29. Include an explanation of the impact of extended KanCare coverage during the COVID-19 PHE on the Participation Rate in Activities 9.1 and 9.2. 30. Ensure that interpretations of analytic results are supported by data.
Cervical Cancer Screening
1. Update measurement year labels within the introduction of Activity 8.2 to match those used within the intervention sections of Activity 8.2. 2. Update significance testing discussion and notations within the introduction of Activity 8.2 to correspond with the testing and notations used within the data tables of Activity 8.2. 3. Explain why Outcome Measure 4 baseline data is not available for non-P4P providers but is available for other non-P4P measurements. 4. Use consistent measurement period labels for intervention 1. 5. Provide correct interpretation of significance for all *p*-values. 6. Clarify which rates are being tested in Table 10 "Intervention 1 Non-P4P vs Control Group." 7. Correct the title of Table 11 to match its presented data. 8. Provide clear interpretation to what extent measure results indicate the success or failure of Intervention 1. 9. Refer to the *PIP Instructional Guide* for direction related to reporting of discontinued measures. The technical specifications and reported analysis are expected to be consistent. 10. Use consistent measurement period labels for intervention 3. 11. Correct inconsistencies with the presented number of CCS eligible members who have not completed their cervical cancer screening per HEDIS criteria. 12. Ensure the title for Table 15 aligns with the contents of the table. 13. Ensure the labels and interpretations for Table 16 align with the contents of the table. 14. Assess the appropriateness of the definition of the control group. 15. Verify table numbering in Activities 9 and 10. 16. Ensure that *p*-values are calculated correctly. 17. Conduct exploratory analyses (e.g., basic comparative analysis, chi-squared test for independence, logistic regression) to quantify the impact of members receiving multiple interventions on the PIP outcome measure. If the results of those analyses are fruitful, update the analytic plan in Activity 7 and report the results of the analyses in Activity 9.

2024 PIP Recommendations
Sunflower (Continued)
Diabetes Monitoring for Members with Diabetes and Schizophrenia
1. Ensure that statements in Activities 5 and 8 are consistent. Provide the details for actions taken as a result of a PDSA cycle in Activity 5 for prior years. 2. Ensure that the statements made on statistical testing in Activity 7 are correct. 3. Use the same data cutoff date across remeasurement years to ensure consistency and comparability of measure calculations. 4. Follow CMS cell suppression guidelines for reporting of small numbers. 5. Adjust the second PIP Outcome Measure so that members who completed testing prior to the start of interventions are excluded from the no intervention group. This would allow for a better comparison to be made since the rates between these two groups are expected to be similar. 6. Correct the statement regarding the removal of non-significant variables from the logistic regression model. 7. Ensure repeated points in the narrative are consistent throughout the report.
Mental Health Services for Foster Care
1. Verify that all links are formatted correctly and updated prior to submission of the annual report. 2. Consider implementing the recommended changes discussed in the Summary of Findings section above for Intervention 2, PMTO Training Program. 3. Clarify the difference, or lack thereof, between the variations of the term "KVC" used in several activities. 4. Follow the CMS Cell Suppression guidelines for reporting of small numbers. 5. Verify consistency between the results of statistical tests in tables and the interpretation of those results in the narrative. 6. Tables 1 and 2 may be updated to provide more relevant context for the PIP (i.e., Table 1: Sunflower members in out-of-home foster care aged 3 to 17; Table 2: Sunflower members in out-of-home foster care aged 3 to 17 receiving behavioral health services). 7. Ensure that rounding is performed correctly and consistently throughout the report. 8. Include the targeted rates for the PIP Outcome Measures in Activity 2. 9. Ensure that goals are stated consistently throughout the report. 10. Ensure that conclusions drawn are supported by data or statistical test results. 11. Revisit the technical specifications to ensure that they completely detail the criteria used to calculate the PIP Outcome Measures. 12. Consider creating an aggregate PIP Outcome Measure and corresponding targeted rate for measuring progress.
UnitedHealthcare
EPSDT
1. Clarify in Activity 5.1.a and 5.1.c that live calls were made to members aged 19–20 and to parents/guardian of members aged 10–14 versus directly to the member. 2. Include details of the MCO collaborative intervention in Activity 5 of next year's report. 3. Reidentify the control group and reevaluate the effectiveness of Intervention 1. 4. Add additional detail to the calculation of the numerator for Process Measure 1a for Intervention 1. 5. Follow the CMS Cell Suppression Policy when reporting small counts, including counts in report tables and narrative. 6. Ensure that changes in rates are calculated correctly and reported accurately. 7. Include factors known to impact rates in the interpretation of measure results. 8. Reidentify the control group and reevaluate the effectiveness of Intervention 2. 9. Confirm the quarterly Outcome Measure 1 rates for Intervention 3 were calculated using equivalent data cutoff periods and allowance for claims lag or describe the differences.

2024 PIP Recommendations
UnitedHealthcare
EPSDT (Continued)
10. Clarify the analytic plan in Activity 5.3 to explain how foster care members assigned to multiple or no foster care contractors are handled in Outcome Measure 1 calculations. 11. Conduct a root cause analysis to identify reasons for the success of Intervention 3 that may be used to design interventions for additional populations. 12. Include an explanation of the impact of extended KanCare coverage during the COVID-19 PHE on the Participation Rate in Activities 9.1 and 9.2. 13. Consistently refer to the PIP outcome measure as the "Participation Rate." 14. Update the technical specifications for the Participation Rate provided in Appendix 1. 15. Update the analytic plan in Activity 7.2 to align with the goals stated. 16. Refer to the *PIP Instructional Guide* guidance for simplifying future reporting of analysis related to the PIP outcome measure. 17. Use the insight gained from evaluating the effectiveness of interventions to guide further expansion.
Improving Diabetes Monitoring for Members with Diabetes and Schizophrenia
1. Restate the PIP population (Activity 3) in accordance with the *PIP Instructional Guide*. 2. Correctly calculate and report the *p*-values resulting from chi-square tests. 3. Exploratory analyses are encouraged; however, when results are meaningful, the report should present how the findings were used to improve PIP interventions and to further evaluate the PIP. See the *PIP Instructional Guide* for further guidance regarding exploratory analysis.
Advanced Directives
1. Clarify whether the outcome measure for Intervention 2 was calculated as of 90 days after the training deadline or 90 days after each individual completed the training. 2. Provide the technical specifications and analytic plan for Intervention 6, Process Measure 4. 3. Verify the periods displayed in Tables 4 and 5 for Intervention 2. 4. For clarity to the reader, refrain from using the term activity when representing dates except when referencing the PIP's activity periods. 5. For Intervention 2, if trainings are not being completed for new staff in the established timeframe, the MCO should evaluate the related barriers or process issues to implementing the intervention. 6. Provide an appropriate description of the outcome measure for Intervention 2. 7. For the measure results in Intervention 2, provide an interpretation of the success of the intervention. 8. Provide the AD bulletin used for Intervention 3 as an attachment or within an appendix of the report. 9. Refer to the *Conducting Performance Improvement Project Worksheet Instructional Guide* for direction related to reporting of discontinued measures. The technical specifications and reported analysis are expected to be consistent. 10. Calculate Intervention 5's measures according to the technical specifications and clearly present the measure results consistently with those calculations. 11. Provide interpretation to what extent measure results indicate Intervention 5's success or failure. 12. Provide interpretation to what extent the results for Intervention 6 indicate its success or failure. 13. Expand the relevant interventions to other waiver populations. 14. Update the analytic plan in Activity 7.2 to focus on two areas: a. Assessing the overall success of the PIP b. Directing the expansion of the interventions and gauging the amount of effort needed to reach the targeted rate (to be conducted early in the activity period) 15. Review the stated increase of the PIP outcome measure from the baseline to the current year to ensure it is accurately reported. 16. Provide more robust evidence that the statewide expansion of Interventions 5 and 6 led to increases in the number of members with an AD on file receiving FE Waiver services by reporting the total number of members receiving FE Waiver services statewide, as in Process Measure 2 for Intervention 6.

2024 PIP Recommendations
UnitedHealthcare (Continued)
Housing
UnitedHealthcare's Housing PIP activity ended on August 31, 2024. Therefore, no recommendations are included in this evaluation of their final Housing PIP report. UnitedHealthcare should review and apply the noted opportunities for improvement to continuing and future PIPs.
Antidepressant Medication Management
UnitedHealthcare's AMM PIP activity ended October 31, 2024. Therefore, no recommendations are included in this evaluation of their final AMM PIP report. The MCO should review and apply the noted opportunities for improvement to continuing and future PIPs.

State Contract Area and QAPI Checklist Requirement	2024 QAPI Review Recommendations
Common Among the MCOs	
In 2024, there were no recommendations that were common to all MCOs.	
Aetna	
Aetna's contract with the State of Kansas ended December 31, 2024, therefore, no new recommendations were included in the report.	
Sunflower	
5.9.4 Performance Measures, letters A-B (2024 QAPI Checklist Requirement 19)	1. In future QAPI program descriptions include information on the measures *Breast Cancer Screening (BCS-AD)* and *Chlamydia Screening in Women ages 16 to 24 (CHL)*. (State KanCare 2.0 Contract)
UnitedHealthcare	
5.9.1 General Requirements, letter F (2024 QAPI Checklist Requirement 5)	1. In future QAPI program evaluations and/or LTSS program evaluations, include information on mechanisms used to compare services and supports received with those in the member's treatment/service plan for members receiving LTSS. (State KanCare 2.0 Contract, Section 5.9.1[F])
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter A *Guiding Principles* (2024 QAPI Checklist Requirement 16)	2. In future QAPI work plans, State KanCare 2.0 Contract-specified guiding principles (A)(10-11) of section 5.9.3(A) should be included to demonstrate how the QAPI program addresses them. (State KanCare 2.0 Contract)
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter B *Goals*, numbers 1 and 6 (2024 QAPI Checklist Requirement 17)	3. In future QAPI work plans, to the "Objectives" tab, incorporate the following missing elements of the State KanCare 2.0 Contract-specified goals of section 5.9.3(B) to demonstrate how the QAPI program addresses them (2022 and 2023 Recommendation): a. Add to UHC Goal A, fifth objective (row 8), the part of the State Contract-specified goal(s) related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports." (State KanCare 2.0 Contract, Section 5.9.3[B][1]) b. Add to UHC Goal B, fourth objective (row 16), the part of the State Contract-specified goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members." (State KanCare 2.0 Contract, Section 5.9.3[B][6])
5.9.3 QAPI Goals, Objectives, and Guiding Principles, letter C *Objectives,* number 5 (2024 QAPI Checklist Requirement 18)	4. In future QAPI documents, in the UHC "Program Objectives," State KanCare 2.0 Contract-specified objective (C)(5) of section 5.9.3(C) should be included to demonstrate how the QAPI program addresses it. (State KanCare 2.0 Contract)
5.9.11 Provider Satisfaction Survey (2024 QAPI Checklist Requirement 28)	5. In future QAPI program evaluations and program descriptions, include information on the Provider Satisfaction survey methodology and survey results. (State KanCare 2.0 Contract)

Appendix D

KanCare Program Annual External Quality Review Technical Report

2024-2025 Reporting Cycle

Degree to Which the Previous Year's EQRO Recommendations Have Been Addressed

Based on documentation provided for review, the 2024 completion status of previous recommendations was scored using the following scale:

- Fully Addressed – Documentation clearly indicated all aspects of the recommendation were applied.
- Partially Addressed – Some parts of the recommendation were applied; issues remain.
- Not Addressed – Documentation did not indicate any part of the recommendation was applied.
- In Progress – Review indicated efforts to meet the recommendation are active.
- No Longer Applicable – Changing circumstances rendered the recommendation not applicable.
- Unable to Address – MCO is not able to obtain/provide documentation to address recommendation.

Performance Measure Validation and Evaluation

Follow-Up to Previous Recommendations (2024)		2024 Completion Status
Common Among the MCOs		
Performance Recommendations		
1.	The MCOs should prioritize improvement efforts towards the following HEDIS measures: • Antidepressant Medication Management • Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment • Breast Cancer Screening • Child and Adolescent Well-Care Visits • Well-Child Visits in the First 30 Months of Life • Chlamydia Screening in Women	See MCO sections below
2.	Review all HEDIS rates below the 75th percentile, as well as those above the 75th percentile with decreasing rates, to look for opportunities for improvement. • **KFMC Update:** For MY 2023, of 77 measures, 12 of Aetna's measure indicators ranked above the 75th percentile (10 in MY 2022); 15 of Sunflower's ranked above the 75th percentile (unchanged from MY 2022); and 19 of UnitedHealthcare's ranked above the 75th percentile (17 in MY 2022). ○ Considering only those indicators (73) common between the two measurement years, for which Quality Compass rankings were available for both years, ▪ Aetna. The rankings of 26 (36%) indicators were unchanged; 30 (41%) improved, and 17 (23%) worsened in MY 2023 compared to MY 2022. In MY 2023, 12 of these indicators ranked greater than the 75th percentile (compared to 10 in MY 2022). For MY 2022, Aetna had two indicators ranked <10th and two ranked <5th; three of these improved to <25th and one improved to <33rd. For both measurement years, 36% of indicators were ranked above the 50th percentile. ▪ Sunflower. The rankings of 32 (44%) indicators were unchanged; 20 (27%) improved, and 21 (29%) worsened in MY 2023 compared to MY 2022. In MY 2023, 14 of these indicators ranked greater than the 75th percentile (unchanged from MY 2022). For MY 2022, Sunflower had no indicators ranked below the 10th percentile; in MY 2023, one indicator was ranked <10th. For both measurement years, 49% of indicators were ranked above the 50th percentile. ▪ UnitedHealthcare. The rankings of 41 (56%) indicators were unchanged; 21 (29%) improved, and 11 (15%) worsened in MY 2023 compared to MY 2022. In MY 2023, 18 of these indicators ranked greater than the 75th percentile (16 in MY 2022). For MY 2022, UnitedHealthcare had three indicators ranked <10th and one ranked <5th; one of these improved to <25th. The proportion of rates that ranked above the 50th percentile improved from 43% in MY 2022 to 52% in MY 2023.	In Progress

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Common Among the MCOs		
Performance Recommendations (Continued)		
3.	Continue or modify existing efforts identified as partially addressed, or in progress, for the previous recommendations (MY 2022 report, Appendix C).	Included in the MCO sections below
Aetna		
Technical Recommendations		
1.	Continue with plans to begin capturing multiple race and ethnicity codes when more than one code is included for members on the State 834 enrollment file. **KFMC Update:** Aetna is capturing all race and ethnicity codes from the 834 files.	Fully Addressed
2.	Review the State Race and Ethnicity Health Insurance Portability and Accountability Act (HIPAA) Crosswalk table and update the race and ethnicity data mapping into the HEDIS reporting system to ensure that race and ethnicity are accurately stratified. **KFMC Update:** The mapping approved by the National HEDIS auditor was inconsistent with race and ethnicity codes from the 834 file. In particular, members with multiple races were not mapped to the multiple races stratum.	Not Addressed
Performance Recommendations		
3.	Aetna should prioritize improvement efforts towards the following HEDIS rates: • **Antidepression Medication Management** **KFMC Update:** The rates for both indicators improved more than 4.5 pp. The Effective Acute Phase Treatment rate rank was <25th, an improvement from <10th in MY 2022. The Effective Continuation Phase Treatment rate ranked <33.33rd, an improvement from <25th in MY 2022. • **Initiation and Engagement of Substance Use Disorder (SUD) Treatment – Opioid Use Disorder** **KFMC Update:** Both rates had a gap-to-goal increase greater than 10.0% over the prior year. ○ The Initiation rate for Opioid Use Disorder increased from 35.4% to 50.0% and ranked <25th, an improvement from <5th in MY 2022, with a gap-to-goal improvement of 22.7%. ○ The Engagement rate for Opioid Use Disorder increased from 13.6% to 24.2% and ranked <33.33rd, an improvement from <10th in MY 2022, with a gap-to-goal improvement of 12.3%.	In Progress

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna	
Performance Recommendations (Continued)	
• **Breast Cancer Screening** **KFMC Update:** In MY 2023, the administrative measure, Breast Cancer Screening (BCS), was replaced by the electronic clinical data systems (ECDS) measure BCS-E. The BCS-E rate increased 6.6 pp (10.4% gap-to-goal improvement) from MY 2022 to MY 2023 (Aetna reported both BCS and BCS-E in MY 2022). Although the rate ranks <25th, it improved from <5th in MY 2022. • **Child and Adolescent Well-Care Visits** **KFMC Update:** The ranking for all rates improved to below the 50th percentile. ○ For ages 3–11, the rate increased from 49.7% to 55.3%, 5.6 pp (11.0% gap-to-goal improvement) and was previously ranked <25th. ○ For ages 12–17, the rate increased from 44.7% to 49.6%, almost 5.0 pp, and was previously ranked <33.33rd. ○ For ages 18–21, the rate increased from 17.9% to 25.9 %, almost 8.0 pp, and was previously ranked <25th. • **Well-Child Visits in the First 30 Months of Life – 15 Months–30 Months** ○ **KFMC Response:** The rate (67.2%) increased 6.3 pp (16.2% gap-to-goal improvement) from the prior year and ranked <50th, which was an improvement from <25th in MY 2022. • **Chlamydia Screening in Women** **KFMC Update:** Despite improvements, the rates for both indicators remain below the 25th percentile. ○ Ages 16–20 years – The rate increased from 38.1% to 41.7%, an improvement of 3.6 pp; the rank improved from <10th in MY 2022. ○ Ages 21–24 years – The rate increased from 50.7% to 57.2%, an increase of 6.5 percentage points (13.2% gap to goal improvement) with no change in rank from the prior year.	

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna		
Performance Recommendations (Continued)		
	• **Ambulatory Care – Emergency Dept Visits/1000 Members for ages less than 1 year through 19 years** **KFMC Update:** All ratios improved (decreased); the largest reduction (108.1 fewer visits/1000 members) was for members aged less than one year. The ratios for members from birth to nine years of age ranked <50th. For members aged 10–19 years, the ratio was ranked ≥50th. There were no Quality Compass rankings for these indicators in MY 2022. • **Prenatal and Postpartum Care – Timeliness of Prenatal Care** ○ **KFMC Update:** The rate increased 8.5 pp from the prior year (32.1% gap-to-goal improvement). The rate is ranked <50th, which is an improvement from <25th in MY 2022. • **Medical Assistance with Smoking and Tobacco Use Cessation– Discussing Cessation Medications and other Cessation Strategies** **KFMC Update:** With the exception of Discussing Cessation Strategies, the rates and rankings of the indicators improved. ○ Total % Current Smokers rate (29.1%) rank improved to ≥50th from >75th (lower rate and rank are better). ○ Advising Smokers to Quit rate (75.3%) rank improved to ≥50th from <25th. ○ Discussing Cessation Medications rate (50.0%) rank improved to <50th from <25th. ○ Discussing Cessation Strategies rate (40.0%) rank worsened to <25th from <33.33rd.	
Sunflower		
Technical Recommendations		
1.	Continue with plans to incorporate each of the race and ethnicity codes submitted for each member in the 834 enrollment file. **KFMC Update:** All race codes need to be considered to correctly identify the stratum of members with multiple races.	Partially Addressed
2.	Review the State Race and Ethnicity HIPAA Crosswalk table and update the race and ethnicity data mapping into the HEDIS reporting system to ensure that race and ethnicity are correctly stratified. **KFMC Update:** Although progress is being made, stratification by race and ethnicity were not consistent with data from the 834 files for MY 2023.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower (Continued)		
Performance Recommendations		
3.	Sunflower should prioritize improvement efforts towards the following HEDIS rates: • **Antidepressant Medication Management** **KFMC Update:** The rates (decrease less than 0.5 pp) and ranking for the indicators remained relatively unchanged. o Effective Acute Phase Treatment, 53.8%, ranking below the 25th percentile o Effective Continuation Phase Treatment, 36.3%, ranking below the 25th percentile. • **Initiation and Engagement of Substance Use Disorder (SUD) Treatment** **KFMC Update:** The rates for all indicators decreased from the prior year. • Initiation of SUD Treatment ▪ Alcohol Use Disorder, 34.3%, 2.1 pp decrease, unchanged ranking of below the 25th percentile ▪ Opioid Use Disorder, 38.2%, 5.9 pp decrease (more than 10.0% gap to goal worsening), ranking decreased to below the 10th percentile from below the 25th percentile ▪ Other Drug Use Disorder, 35.1%, 2.0 pp decrease, unchanged ranking of below the 25th percentile ▪ Total Initiation, 35.3%, 2.5 pp decrease, ranking decreased to below the 10th percentile from below the 25th percentile • Engagement of SUD Treatment ▪ Alcohol Use Disorder, 5.9%, 3.5 pp decrease, ranking decreased to below the 25th percentile from below the 50th percentile ▪ Opioid Use Disorder, 15.6%, 2.5 pp decrease, unchanged ranking of below the 25th percentile ▪ Other Drug Use Disorder, 6.9%, 3.2 pp decrease, ranking decreased to below the 25th percentile from below the 50th percentile ▪ Total Engagement, 7.7%, 3.1 pp decrease, ranking decreased to below the 25th percentile from below the 33.33rd percentile • **Breast Cancer Screening** **KFMC Update:** In MY 2023, the administrative measure, Breast Cancer Screening (BCS), was replaced by the electronic clinical data systems (ECDS) measure, BCS-E. Sunflower reported both rates in MY 2022. The MY 2023 screening rate (45.7%) decreased 4.1 pp from MY 2022. The rate ranks below the 25th percentile, a decrease from below the 50th percentile in MY 2022.	In Progress

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower	
Performance Recommendations (Continued)	
• **Child and Adolescent Well-Care Visits** **KFMC Update:** Rates improved for all age categories from the prior year. ○ 3–11 Years: 57.3%, 2.2 pp increase, ranking below the 50th percentile unchanged ○ 12–17 Years: 52.9%, 1.9 pp increase, ranking at or above the 50th percentile unchanged ○ 18–21 Years: 28.1%, 5.6 pp increase, ranking improved from at or above the 50th percentile from below the 50th percentile • **Well-Child Visits in the First 30 Months of Life** **KFMC Update:** While there was no change in the rate for members up to 15 months, the rate for members aged 15 Months–30 Months improved. ○ Up to 15 Months: 60.9%, ranking remained unchanged at or above the 50th percentile • 15 Months–30 Months: 65.3%, an increase of 4.0 pp (10.3% gap to goal improvement), ranking unchanged at below the 25th percentile • **Chlamydia Screening in Women** **KFMC Update:** The screening rates for women aged 16–20 years remained relatively unchanged for women aged 16–20 but did increase for women aged 21–24 years. Both rates were below the 25th percentile, unchanged from MY 2022. ○ Ages 16–20 Years, 40.3% (less than 0.4 pp decrease) ○ Ages 21–24 Years, 55.7% (1.2 pp increase) • **Continue existing improvement efforts for Prenatal and Postpartum Care** **KFMC Update.** The rates for both indicators improved from the prior year. ○ Postpartum Care: 81.5%, an increase of 9.5 pp (33.9% gap to goal improvement), ranking improved to at or above the 50th percentile from below the 25th percentile ○ Timeliness of Prenatal Care: 81.8%, an increase of 5.8 pp (24.2% gap to goal improvement), ranking improved to below the 33.33rd percentile from below the 25th percentile	

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower	
Performance Recommendations (Continued)	
• **Immunizations – Childhood, Adolescent (HPV)** **KFMC Update:** The Immunizations for Adolescents (IMA) – Human Papillomavirus (HPV) rate improved 1.7 pp from the prior year. The rate for most Childhood Immunization Status (CIS) antigens were relatively unchanged. The rates for Diphtheria-Tetanus-Pertussis and Hepatitis A showed a slight improvement (1.5 pp), while the rates for Influenza (5.8 pp), Rotavirus (1.7 pp), and Combination 10 (6.1 pp) decreased. ○ IMA – The rates and rankings between MY 2022 and MY 2023 are not comparable. In MY 2022, Sunflower reported rates from administrative data and in MY 2023, reported rates from hybrid data. ○ CIS – The rankings for DTaP, Haemophilus Influenza B (HiB), and Rotavirus improved to below the 50th percentile from below the 33.33rd percentile; rankings for the other antigens remained unchanged—above the 66.67th percentile for Hepatitis B; at or above the 50th percentile for Hepatitis A; below the 50th percentile for Inactivated Poliovirus Vaccine, Influenza, Measles-Mumps-Rubella, and Varicella-Zoster Vaccine; below the 33.33rd percentile for Pneumococcal Conjugate. • **Ambulatory Care – Emergency Department Visits/1000 Members (ages <1, 1–9 Years, and Total)** **KFMC Response:** The ratios improved for members aged 19 years and less. Quality Compass rankings were not available in MY 2022. ○ Ages < 1 year: 1044.10, decrease of 95.0 visits/1000 members, ranking above the 66.67th percentile ○ Ages 1–9 Years: 494.61, decrease of 55.7 visits/1000 members (10.1% gap to goal improvement), ranking at or above the 50th percentile ○ Ages 10–19 Years: 393.97, decrease of 13.2 visits/1000 members, ranking above the 66.67th percentile ○ Ages 19 Years and Less: 471.64, a decrease of 37.5 visits/1000 members • **Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence (18+ Years)** **KFMC Response:** The rates for both indicators improved from the prior year. The ranking for both improved to above the 75th percentile from above the 66.67th percentile. ○ 7 Days 32.7%, 3.9 pp ○ 30 Days 45.2%, 3.2 pp	

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower		
Performance Recommendations (Continued)		
	• **Hemoglobin A1c Control for Patients with Diabetes – Poor HbA1c Control** **KFMC Response:** The rate of 33.3% was a 7.6 pp improvement from the prior year. The ranking increased to at or above the 50th percentile from below the 50th percentile. • **Medical Assistance with Smoking and Tobacco Use Cessation -- Discussing Cessation Medications and Advising Smokers to Quit** **KFMC Response:** Total % of Current Smokers had a 22.8% gap-to-goal worsening (5.5 pp) from the prior year and ranked above the 66.67th percentile (lower rate and rank and better). KFMC compared the 2020-2021 rates to the 2022-2023 rates for the indicators other than the percentage of current smokers and tobacco users. Since the recommendation was focused on discussing cessation medications (improved) and advising smokers to quit (worsened), KFMC considers this recommendation to still be in progress. ○ Total % Current Smokers, (lower is better) 29.5%, 5.5 pp higher than MY 2022 ○ Advising Smokers to Quit, 72.9%, ranked <50th, 1.2 pp decrease from 2021-2022 ○ Discussing Cessation Medications, 55.6%, rank unchanged at >66.67th ○ Discussing Cessation Strategies, 47.2%, rank worsened from >75th, decreased 2.2 pp from 2021-2022	
UnitedHealthcare		
Technical Recommendations		
1.	Explore obtaining additional Kansas-specific data sources for supplemental data, such as direct electronic medical record data feeds from Kansas providers and aggregated data. **KFMC Update:** The data were not used as additional supplemental data sources.	Not Addressed
2.	Review the State Race and Ethnicity HIPAA Crosswalk table and update the race and ethnicity data mapping into the HEDIS reporting system to ensure that race and ethnicity are accurately stratified. **KFMC Update:** Race and ethnicity mapping into the HEDIS reporting system was not changed. UnitedHealthcare's processing of the race and ethnicity codes transmitted on the 834 file for uploading into the HEDIS reporting system did not capture all race and ethnicity information.	Not Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
UnitedHealthcare		
Technical Recommendations (Continued)		
3.	Review provider billing of transportation by ambulance and commercial van. **KFMC Update:** Usage of T2003 and A0425 with T2003 has been addressed. UnitedHealthcare was still not capturing the number of miles traveled for trips by ambulance (procedure codes A0426–A0425). For almost 100% of UHC-paid claims for ambulance service, the quantity billed on service lines with procedure code A0425 indicated only one mile was travelled.	Partially Addressed
Performance Recommendations		
4.	UnitedHealthcare should prioritize improvement efforts for the following HEDIS rates: • **Antidepressant Medication Management** **KFMC Update:** The rates for both indicators were relatively unchanged from the prior year (increased less than one percentage point). The rankings for both indicators were also unchanged—Effective Acute Phase Treatment below the 33.33rd percentile and Effective Continuation Phase Treatment below the 50th percentile. • **Breast Cancer Screening** **KFMC Update:** In MY 2023, the administrative measure, Breast Cancer Screening (BCS), was replaced by the electronic clinical data systems (ECDS) measure, BCS-E. United Healthcare has reported both rates since MY 2020. The screening rate (48.7%) improved one percentage point from MY 2022 and remains ranked below the 33.33rd percentile. • **Child and Adolescent Well-Care Visits** **KFMC Update:** The rates for all age groups improved, with the largest increase for members 18–21 years of age. ○ 3–11 Years: 54.0%, 3.4 pp, rank improved to below the 33.33rd percentile from below the 25th percentile ○ 12–17 Years: 48.8%, 3.3 pp, rank improved to below the 50th percentile from below the 33.33rd percentile ○ 18–21 Years: 22.8%, 4.1 pp, rank remained unchanged at below the 25th percentile	In Progress

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Initiation and Engagement of Substance Use Disorder (SUD) Treatment** **KFMC Update:** The Initiation and Engagement rates for Opioid Use Disorder decreased from the prior year, and Other Drug Use Disorder improved. Engagement for Alcohol Use Disorder also improved. ○ Initiation ▪ Alcohol Use Disorder 37.4% unchanged, ranking unchanged at below the 25th percentile ▪ Opioid Use Disorder 32.1%, 1.5 pp decrease, ranking unchanged at below the 5th percentile ▪ Other Drug Use Disorder 38.1%, 1.0 pp increase, ranking improved to below the 33.33rd percentile from below the 25th percentile ▪ Total 36.8% unchanged, ranking unchanged at below the 10th percentile ○ Engagement ▪ Alcohol Use Disorder 10.4%, 2.1 pp increase, ranking improved to below the 50th percentile from below the 33.33rd percentile ▪ Opioid Use Disorder 11.7%, 1.6 pp decrease, ranking unchanged at below the 10th percentile ▪ Other Drug Use Disorder 11.3%, 1.7 pp increase, ranking improved to at or above the 50th percentile from below the 50th percentile ▪ Total 11.1%, 1.2 pp increase, ranking improved to below the 50th percentile from below the 25th percentile • **Well-Child Visits in the First 30 Months of Life** **KFMC Update:** The rate for members up to 15 months (60.5%) was unchanged and remained at or above the 50th percentile. For members between 15 and 30 months, the rate (64.0%) increased 3.8 pp (9.6% gap to goal improvement), but the rank was unchanged at below the 25th percentile. • **Chlamydia Screening in Women** **KFMC Update:** ○ Ages 16–20 Years: 39.7%, 1.0 pp decrease, rank unchanged at below the 25th percentile ○ Ages 20–24 Years: 53.4%, 5.0 pp decrease, 12.1% gap to goal worsening, rank decreased to below the 25th percentile from below the 33.33rd percentile	

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Metabolic Monitoring for Children and Adolescents on Antipsychotics** **KFMC Update:** The Total rate increased 1.5 pp, with the ranking unchanged from above the 66.67th percentile. • **Ambulatory Care – Emergency Department Visits/1000 Members (ages <1, 1–9 Years, and Total)** **KFMC Response:** The ratio of emergency department visits showed improvement from the prior year, with the greatest improvement for members less than one year old. Quality Compass rankings were not available for MY 2022. For MY 2023, each age stratum ranked at or above the 50th percentile. ○ Ages Less than 1 year: 1019.3, decrease of 80.3 visits/1000 members ○ Ages 1–9 Years: 498.4, decrease of 43.5 visits/1000 members ○ Ages 10–19 Years: 390.2, decrease of 7.4 visits/1000 members ○ Ages 19 Years and Less: 466.6, a decrease of 28.6 visits/1000 members • **Medical Assistance with Smoking and Tobacco Use Cessation – Discussing Cessation Strategies and Advising Smokers to Quit** **KFMC Response:** For other than the Total % of Current Smokers, KFMC analyzed rolling two-year averages—for MY 2023, the rates are averaged for 2022 and 2023 and compared to rates averaged for MY 2020 and 2021. The rate for Advising Smokers to Quit increased almost 2 pp from 2020-2021; the rate ranked <50th. Discussing Cessation Strategies also increased by 3.7 pp from 2020-2021 and ranked <50th.	

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare	
Performance Recommendations (Continued)	
• **Immunizations – Childhood, Adolescent** **KFMC Response:** ○ Childhood vaccination rates improved for Haemophilus Influenzae B (HiB) (3.4 pp), Pneumococcal (2.2 pp), Diphtheria-Tetanus-Acellular Pertussis (DTaP) (1.5 pp), and Measles-Mumps-Rubella (MMR) (1.0 pp); rates worsened for Influenza (4.1 pp), Rotavirus (3.4 pp), and Combination 10 (5.8 pp). ▪ The ranking for the Pneumococcal Conjugate (2.2 pp increase) rate improved to at or above the 50th percentile from below the 50th percentile, and for HiB (16.8% gap to goal improvement), to below the 50th percentile from below the 33.33rd percentile. ▪ The rankings for Rotavirus (11.4% gap to goal worsening and 3.4 pp decrease) and Combination 10 decreased from at or above the 50th percentile to below the 50th percentile. ▪ Rankings were unchanged for the other antigens: below the 33.33rd percentile for DTaP, below the 50th percentile for Inactivated Poliovirus Vaccine, Influenza, MMR, and Varicella-Zoster Virus, and at or above the 50th percentile for Hepatitis A and Hepatitis B.	

Performance Improvement Projects

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – EPSDT		
1.	Update Activity 5 to align technical specifications and analytic plans with analysis to be reported in Activity 8.2. **Aetna Response:** (Aetna did not provide a response.) **KFMC Response:** The issue was resolved for Intervention 1.	Fully Addressed
2.	Following the transition to a new vendor, the intervention technical specifications and analysis plan should be updated to be consistent with any changes made in the data collection. **Aetna Response:** Updated in 2024 report in applicable sections. **KFMC Response:** The technical specifications were not updated to reflect what Aetna measured. While it was indicated that the vendor could track receipt of gift cards, Aetna did not report on that.	Not Addressed
3.	Verify the numerators for Outcome Measure 2 and Process Measure 2 are calculated according to their technical specifications. **Aetna Response:** Data was fixed in Activity 8.2. **KFMC Response:** Process Measure 2 was calculated as defined. Although Outcome Measure 2 results were suppressed, based upon Aetna's narrative the measure was not calculated as defined.	Partially Addressed
4.	Verify calculated values displayed in tables are correct (e.g., Tables 10 and 11). **Aetna Response:** Data was fixed in Activity 8.2. **KFMC Response:** The presented data for Process Measures 1 and 2 were calculated correctly.	Fully Addressed
5.	Ensure descriptions of the intent of measures are clear and accurate. **Aetna Response:** Measure descriptions were repeated in Activity 8.2. **KFMC Response:** Aetna provided the measure's name and definition prior to all measure result tables.	Fully Addressed
6.	Verify measurement periods are consistent with available data (e.g., Outcome Measure 2). **Aetna Response:** Data was fixed in Activity 8.2. **KFMC Response:** Measurement periods were consistent with available data for reported measures; Aetna did not report results for Outcome Measure 2 due to vendor issues.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – EPSDT (Continued)		
7.	Report the measures as they were defined in the methodology or redefine the measures to be consistent with the data reported. **Aetna Response:** Data was fixed in Activity 8.2. **KFMC Response:** Aetna no longer incorrectly filtered the data prior to measure calculations. There were still inconsistencies between measure numerator descriptions in Activity 5.c and data reported in Activity 8.2 due to a change in vendors.	Partially Addressed
8.	When a table contains multiple rows of data and a total, the total should be the actual sum of the row values. If it is not, an explanation for the discrepancy should be provided. **Aetna Response:** Data was fixed in Activity 8.2.3. **KFMC Response:** As the data tables in Intervention 3 did not include total rows, no issues were identified.	Fully Addressed
9.	In the next annual report, update the measure technical specifications and the analysis plan to be consistent with any changes made following the November 2022 transition of vendors. **Aetna Response:** Updated in 2024 report in applicable sections. **KFMC Response:** Activities 5.3.c and 5.3.d were appropriately updated.	Fully Addressed
10.	In the next annual report, provide the results for Outcome Measure 4d for RY 3, or provide an explanation for its omission. **Aetna Response:** Results could not be provided for Intervention 5 measures because not enough surveys were completed in RY 4. **KFMC Response:** An appropriate explanation was provided for not reporting the measure.	Fully Addressed
11.	Because this intervention is geared toward provider education, exclude Aetna staff from the reported survey results or report their responses separately. **Aetna Response:** (Aetna did not provide a response.) **KFMC Response:** Because participation was low, Aetna was unable to provide any survey results.	Fully Addressed
12.	Consistently refer to the PIP outcome measure as the "Participation Rate." **Aetna Response:** (Aetna did not provide a response.) **KFMC Response:** The PIP outcome measure was consistently referred to as the "Participation Rate" throughout the report.	Fully Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Aetna PIP – Pregnancy: Prenatal Care		
1.	Provide details of the incentive payment structure in the next annual report. **Aetna Response:** Fully addressed **KFMC Response:** Aetna provided details of the incentive payment structure.	Fully Addressed
2.	Use standard language of reporting measure as defined or provide an explanation for deviation. **Aetna Response:** Fully addressed **KFMC Response:** Standard language was used and explanations for deviations from the technical specifications were provided where applicable.	Fully Addressed
3.	Include technical specifications for all reported measures, including PAR measures not completely defined in Activity 5. **Aetna Response:** Fully addressed. Added in Appendix E **KFMC Response:** Aetna included the technical specifications for all reported measures, including PAR measures, in the report.	Fully Addressed
4.	Use consistent terminology for defining measures and describing measure results (e.g., Intervention 1, Tables 3 and 7). **Aetna Response:** Fully addressed **KFMC Response:** Referenced tables are now called Tables 5 and 9 in this annual report. Consistent terminology was used throughout the intervention's Activity 8.	Fully Addressed
5.	If numerators are suppressed, suppress percentages instead of reporting them as 0%. **Aetna Response:** Fully addressed **KFMC Response:** When numerators were suppressed in tables, so were the associated percentages.	Fully Addressed
6.	Provide discussion concerning the cause of Table 9's large changes in denominator. **Aetna Response:** Fully addressed in Activity 8.2 **KFMC Response:** PAR data for ABH_PC_2a is now contained in Table 11. Aetna discussed why the 2022 Q4 was so much larger than the previous quarters, but the information provided was not sufficient.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Pregnancy: Prenatal Care (Continued)		
7.	Use consistent terminology for defining measures and describing measure results (e.g., Intervention 2, Tables 8 and 12). **Aetna Response:** Fully addressed **KFMC Response:** Referenced tables are now called Tables 10 and 14 in this annual report. Consistent terminology was used throughout the intervention's Activity 8.	Fully Addressed
8.	Provide dates for events that affect interpretation of the data. **Aetna Response:** Fully addressed throughout report **KFMC Response:** Aetna provided appropriate dates.	Fully Addressed
9.	Create or modify PAR measures to correspond with changes to interventions' processes or goals. **Aetna Response:** Fully addressed **KFMC Response:** PAR measures were modified to correspond with changes to interventions' processes or goals.	Fully Addressed
10.	Write table titles that match the reported data (e.g., Table 15). **Aetna Response:** Fully addressed **KFMC Response:** Referenced table is now called Table 16 in this annual report. The table's title matched the data being reported.	Fully Addressed
11.	Revise PARs to reflect the current population targeted for Intervention 4 and include historic data. **Aetna Response:** Fully addressed **KFMC Response:** The technical specifications provided in Aetna's Appendix E updated the population targeted for Intervention 4 and Aetna included relevant historic data.	Fully Addressed
12.	Update the aim statement to indicate more clearly the projected PIP end date and the second aim's baseline rate and outcome measure. **Aetna Response:** Fully addressed – The aim statement was updated following the annual report, submitted in an update tool, and approval was received on 10/5/2023. **KFMC Response:** The aim statement was updated accordingly.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Pregnancy: Prenatal Care (Continued)		
13.	Define the PIP population in Activity 3 as "female members with a pregnancy during the activity period." **Aetna Response:** Fully addressed - The population was updated following the annual report, submitted in an update tool, and approval was received on 10/5/2023. **KFMC Response:** The population was updated accordingly.	Fully Addressed
14.	In Activity 6.1, repeat the aim statement and provide non-technical descriptions for each of the PIP's outcome measures. In Activity 6.2 provide complete technical specifications for each of the PIP's outcome measures, in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. **Aetna Response:** Fully addressed **KFMC Response:** The aim statement was not repeated verbatim. Non-technical descriptions of the PIP outcome measures and their technical specifications were provided in the appropriate activities.	Partially Addressed
15.	Review, and revise as needed, the technical specifications for PIP Outcome Measure 1 (Median Days from Notification to Delivery). **Aetna Response:** Fully addressed. Added in Appendix E **KFMC Response:** The complete technical specifications for PIP Outcome Measure 1 were included in Activity 6.2.	Fully Addressed
16.	In Activity 9.2, discuss the impact of the policy changes that extended Medicaid coverage. **Aetna Response:** (ABH did not seem to address this.) **KFMC Response:** Aetna did not provide a discussion on the impact of policy changes that extended Medicaid coverage.	Not Addressed
17.	Reevaluate the success of the PIP and its interventions based on revised measurements. **Aetna Response:** Partially addressed due to some interventions being discontinued. **KFMC Response:** The success of all relevant interventions was reassessed.	Fully Addressed
18.	Ensure conclusions drawn are supported by the data. **Aetna Response:** (ABH did not seem to address this.) **KFMC Response:** Conclusions drawn were generally supported by the data, however a conclusion regarding the hybrid HEDIS TOPC rate was not.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Food Insecurity		
1.	Update the denominator statements for Process Measure 7 and Outcome Measure 1 to reflect the intended measurements. **Aetna Response:** Updated **KFMC Response:** This was corrected.	Fully Addressed
2.	Mention that the Z59.4 diagnosis code became non-billable on October 1, 2022, when codes Z59.41 and Z59.48 became effective. **Aetna Response:** Updated **KFMC Response:** This information was provided.	Fully Addressed
3.	Define and consistently use a notation for the group diagnosis codes identifying food insecurity. **Aetna Response:** Updated **KFMC Response:** The notation for the group diagnosis codes identifying food insecurity was defined and consistently used throughout the report.	Fully Addressed
4.	Ensure table titles reflect the data presented (e.g., correct or remove the date range in the titles of Figures 11–17). **Aetna Response:** Updated **KFMC Response:** Table titles were updated to reflect the data presented.	Fully Addressed
5.	Update Tables 2 and 3 headers to appropriately match the data that is included. Include a notation when changes occurred within the criteria used to pull data for the table. **Aetna Response:** Updated **KFMC Response:** Table 2 was updated to include all group diagnosis codes identifying food insecurity. The headers used in Tables 3 and 4 (both formerly Table 3) matched the data presented.	Fully Addressed
6.	Provide appropriate reasons for inconsistencies between PAR and intervention measures. **Aetna Response:** Updated **KFMC Response:** Appropriate reasons were provided for inconsistencies between PAR and intervention measures.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Food Insecurity (Continued)		
7.	Ensure table titles reflect the data presented (e.g., Figure 18). **Aetna Response:** Updated **KFMC Response:** All table titles relevant to this intervention now reflect the data presented.	Fully Addressed
8.	Provide appropriate reasons for inconsistencies between PAR and intervention measures. **Aetna Response:** Updated **KFMC Response:** There were notable differences between PAR data and data reported for Process Measure 1 that warranted explanation.	Not Addressed
9.	Follow the CMS cell suppression policy throughout the report. **Aetna Response:** Updated **KFMC Response:** There are several instances where data was not appropriately suppressed (e.g., the narrative provided at the beginning of Intervention 4, Tables 5 and 6, and Figure 27).	Not Addressed
10.	Correct the headers in Figures 19–23 and 26 to match the data presented. **Aetna Response:** Updated **KFMC Response:** The title of Figure 25 (formerly Figure 26) incorrectly indicated that Outcome Measure 2 was stratified by county.	Partially Addressed
11.	In Activity 6.1, repeat the aim statement and provide non-technical descriptions for each of the PIP outcome measures in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. **Aetna Response:** Updated **KFMC Response:** The aim statement was repeated, and suitable non-technical descriptions were provided for each of the PIP outcome measures.	Fully Addressed
12.	Ensure conclusions are supported by the data (e.g., incorrect percentage stated in Activity 9.3). **Aetna Response:** Updated **KFMC Response:** No evidence was provided to support the claim that "some members are willing to complete surveys in the hopes of being provided with assistance."	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – LTSS-Emergency Department Visits		
1.	For clarity, revise the technical specifications and analytic plans for measures ABH_ED_2a, ABH_ED_2b, ABH_ED_3a, and ABH_ED_4a to remove discrepancies between metric descriptions and numerator and denominator statements. **Aetna Response:** Fully addressed **KFMC Response:** The discrepancy between the denominator (number of unique LTSS members…) and the numerator (number of visits per unique member…) remained in ABH_ED_2a and ABH_ED_2b.	Not Addressed
2.	Specify the method for calculating annual rates for measures defined using PAR technical specifications. **Aetna Response:** Fully addressed **KFMC Response:** This information was included in Activity 5.2.c.	Fully Addressed
3.	Continue to update the technical specifications and analytic plans for Intervention 8 as the details become known. **Aetna Response:** Fully addressed **KFMC Response:** No updates to the technical specifications for Intervention 8 were made. No diagnosis codes used to identify the specified conditions were added to the technical specifications.	Not Addressed
4.	Verify the denominators for the Outcome Measure 1 and Alternate Outcome Measure for Intervention 2. Provide an explanation for any discrepancies. **Aetna Response:** Fully addressed **KFMC Response:** No discrepancies were noted.	Fully Addressed
5.	Reevaluate causes of discrepancies between Process Measure 2 (ABH_ED_2a) data reported in Tables 4 and 7. **Aetna Response:** Fully addressed **KFMC Response:** No discrepancies were noted.	Fully Addressed
6.	Include the full question from the text survey evaluating Intervention 3 in Activity 5.3. Update the technical specifications, analytic plan, and presentation of results for Process Measures 1 and 2 to reflect the responses more clearly to the question. **Aetna Response:** Intervention discontinued; no longer applicable **KFMC Response:** This intervention was discontinued.	No Longer Applicable

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – LTSS-Emergency Department Visits (Continued)		
7.	Ensure Intervention 4 rates were calculated according to the technical specifications and that wording related to measures is consistent between Activities 5.3 and 8. **Aetna Response:** Intervention discontinued; no longer applicable **KFMC Response:** This intervention was discontinued.	No Longer Applicable
8.	Include the full question from the text survey evaluating Intervention 4 in Activity 5.3. Update the technical specifications, analytic plan, and presentation of results for Process Measures 1 and 2 to reflect more clearly the responses to the question. **Aetna Response:** Intervention discontinued; no longer applicable **KFMC Response:** This intervention was discontinued.	No Longer Applicable
9.	Verify the terms *median* and *mean* are being used correctly. Clarify technical specifications and reporting of results where *average* refers to a measure of central tendency other than the arithmetic mean. **Aetna Response:** Fully addressed **KFMC Response:** Aetna defined average as a mean value and verified that it was being used correctly.	Fully Addressed
10.	Calculate Outcome Measure 1 for Intervention 5 according to its technical specifications. **Aetna Response:** Fully addressed **KFMC Response:** Aetna calculated Process Measure 1 according to its technical specifications.	Fully Addressed
11.	Specify the method for calculating annual rates in the analytic plans for measures defined using PAR technical specifications for monthly rates. **Aetna Response:** Fully addressed **KFMC Response:** Aetna specified the method for calculating rates. The only difference between the annual and PAR rates appears to be the definitions of the measurement periods used.	Fully Addressed
12.	Update the heading of tables for Intervention 7 to better describe the data they contain. **Aetna Response:** Fully addressed **KFMC Response:** Aetna updated the headings of tables for Intervention 7 to better describe the data they contain.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Influenza Vaccination		
1.	Revise Activity 5.2 to clearly indicate the target population for Intervention 2. **Aetna Response:** Fully addressed **KFMC Response:** The intervention description, measure description, and denominators were updated to clarify the target population.	Fully Addressed
2.	Provide appropriate explanations for inconsistencies between PAR and annual report results. **Aetna Response:** Fully addressed **KFMC Response:** The discrepancies between PAR data and annual report for the process measure were explained.	Fully Addressed
3.	In intervention 1, texting campaign, calculate measures according to the technical specifications, or clearly indicate how and why they deviated from the specifications. **Aetna Response:** Fully addressed **KFMC Response:** No deviations between the technical specifications and the measures reported were noted.	Fully Addressed
4.	In intervention 2, outreach calls to special populations, calculate measures according to the technical specifications, or clearly indicate how and why they deviated from the specifications. **Aetna Response:** Fully addressed **KFMC Response:** No deviations between the technical specifications and the measures reported were noted.	Fully Addressed
5.	Submit necessary updates for approval to properly correct the error found in technical specifications of the Process Measure ABH_Influ_2a so annual report and PAR measures are calculated the same. **Aetna Response:** Fully addressed **KFMC Response:** The necessary updates were submitted to correct the error found in the technical specifications of Process Measure ABH_Influ_2a and the annual report and PAR measures were calculated the same way.	Fully Addressed
6.	Provide appropriate explanations for inconsistencies between PAR and annual report results. **Aetna Response:** Fully addressed **KFMC Response:** No major discrepancies were found between the PAR and annual report results.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Aetna PIP – Influenza Vaccination (Continued)		
7.	Review the technical specifications for Intervention 5 measures; following the PIP Update process if changes are warranted. **Aetna Response:** Fully addressed **KFMC Response:** Changes were warranted and the technical specifications for Intervention 5 measures were updated following the PIP Update process.	Fully Addressed
8.	Reevaluate the effectiveness of outreach calls to children diagnosed with asthma (Intervention 2). **Aetna Response:** Fully addressed **KFMC Response:** The comparison group includes members vaccinated between October 1 and December 1 of the measurement year while the intervention group includes only members who were not vaccinated as of December 1 of the measurement year. The comparison and intervention groups are not expected to have similar rates, thus statistical testing conducted between the two groups is not a valid method for establishing effectiveness of the intervention.	Not Addressed
9.	Continue to report evidence of effectiveness of the PIP to supplement the results of the PIP outcome measure. **Aetna Response:** Fully addressed **KFMC Response:** Evidence of the effectiveness of the PIP was reported to supplement the results of the PIP outcome measure in Activity 9.	Fully Addressed
10.	Ensure that interpretations of analysis results are supported by the data. **Aetna Response:** Fully addressed **KFMC Response:** There was an instance of a misinterpretation of the statistical test results in Activity 9 (e.g., the interpretation of the results of statistical testing for Intervention 2).	Not Addressed
11.	Investigate the completeness of the claim and immunization registry data. The goal would be to determine the extent to which influenza vaccinations are not being reported to KSWebIZ or billed by providers. **Aetna Response:** Fully addressed **KFMC Response:** Although Aetna's annual report showed that most vaccination claims data were included in KSWebIZ, the investigation for completeness of data or rationale for not conducting the suggested analysis was not provided.	Not Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT		
1.	If an intervention goal is added, it should be included in intervention measures. **Sunflower Response:** Partially addressed: Intervention goal added per previous KFMC recommendation but not used for this report, intervention discontinued. **KFMC Response:** Goal added, but not reported since intervention was discontinued.	Fully addressed
2.	Intervention descriptions should be consistent with responses to "Follow-up to Previous Recommendations." **Sunflower Response:** Partially addressed: Intervention goal not used for this intervention during this reporting period, intervention discontinued. All other intervention descriptions are consistent as recommended. **KFMC Response:** Goal is consistent with responses to "Follow-up to Previous Recommendations".	Fully Addressed
3.	When citing limitations to a successful intervention, provide a clear description of those limitations. **Sunflower Response:** Fully addressed: Limitations are discussed within the Study portion of the PDSA cycle. **KFMC Response:** All limitations were clearly described.	Fully Addressed
4.	Correctly label tables and data columns (Tables 6, 8, 15, 18, and 19) **Sunflower Response:** Fully addressed: Table headers and columns appropriately labeled. **KFMC Response:** Table headers are appropriately labeled.	Fully Addressed
5.	Ensure the conclusions are supported by the analytic results. **Sunflower Response:** Fully addressed: Analytic results and conclusions aligned. **KFMC Response:** Interpretations of the analytic results were not always supported by the analytic results in this intervention.	Partially Addressed
6.	Provide an explanation for the large difference in denominators for Process Measure 1 between RMY 1 and RMY 2 and between PT 2 and PT 3. **Sunflower Response:** Fully addressed: Discussed changes made by the vendor in 2022 that affected the denominator. **KFMC Response:** The Study phase of the PDSA cycle provided sufficient insight into the observed changes in denominators for Process Measure 1.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT (Continued)		
7.	Use consistent and standard statistical nomenclature when reporting results so that the interpretation is clear (*p*-values and odds). **Sunflower Response:** Fully addressed: Instead of R-software statistical significance symbolic notation conventions, we created a column for each data summary table where statistical testing is applicable. The column indicated the statistical test used and the *p*-value findings. **KFMC Response:** The actions in Sunflower's response were found to be appropriate to address the issue.	Fully Addressed
8.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Fully addressed: All statistical analysis interpretations are accompanied by a *p*-value in the data summary tables where statistical tests are applicable. **KFMC Response:** Interpretations of the analytic results appeared appropriate.	Fully Addressed
9.	Compare the (combined) EPSDT screening rate of members attributed to the participating provider groups to the control group to analyze the impact of the intervention. **Sunflower Response:** Fully addressed: No control group was established for this PIP. Hence, efficacy of interventions was not studied. Instead, we demonstrated EPSDT rate trends to show EPSDT performance for interventions. **KFMC Response:** Sunflower's approach was appropriate.	Fully Addressed
10.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Fully addressed: All statistical analysis interpretations are accompanied by a *p*-value in the data summary tables where statistical tests are applicable. **KFMC Response:** Interpretations of the analytic results appeared appropriate.	Fully Addressed
11.	Ensure that numerator and denominator columns are properly labeled. **Sunflower Response:** Not addressed: No analysis done for this intervention due to approved discontinuation. **KFMC Response:** A summary of prior results was not provided in accordance with the instructional guide.	Not Addressed
12.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Not addressed: No analysis done for this intervention due to approved discontinuation. **KFMC Response:** The interpretation of the results provided in Activity 5.4.a were supported by reported in the prior report.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT (Continued)		
13.	Verify the accuracy of the pre- and post-training score rates and the percentage point change. **Sunflower Response:** Partially addressed: Pre and post training testing did not occur for the intervention for this reporting period, data reported where completed or marked as N/A in report. **KFMC Response:** KFMC agrees with Sunflower's status.	Partially Addressed
14.	Report the measures as defined in the methodology or update the methodology to reflect what was reported in Activity 8.2. **Sunflower Response:** Fully addressed: The measures performed reviewed and align with methodology. **KFMC Response:** No inconsistencies were found between the reported measurements and the defined measures.	Fully Addressed
15.	Update the annual targeted rates for the PIP outcome measure. **Sunflower Response:** Fully addressed: Annual targets for the overall PIP outcome updated to reflect previous years' actual performance. **KFMC Response:** This was updated in Table 2.	Fully Addressed
16.	Include qualifications of each PIP role and all staff involved in the PIP in future reports. **Sunflower Response:** Fully addressed: All staff qualifications included in table 4. **KFMC Response:** Sunflower listed all staff involved with the PIP and their qualifications in Table 4.	Fully Addressed
17.	Use consistent abbreviations and acronyms throughout the report (RY1, RY2, RMY 1, RMY 2). **Sunflower Response:** Fully addressed: RMY used consistently in all data reports, as well as Points with dates included. **KFMC Response:** Sunflower consistently used RMY to represent the intervention's measurement period and Year/PT to represent the PIP reporting period within Activity 8.2.	Fully Addressed
18.	Ensure analysis results described in the report narrative are consistent with the data presented in tables. **Sunflower Response:** Fully addressed: Most statistical analysis interpretations are respective of process and outcome measures table. **KFMC Response:** Some inconsistencies were found between the report's narrative and data tables.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT (Continued)		
19.	Accurately describe data being tested or measured and how the results are being interpreted. **Sunflower Response:** Fully addressed: Each table provides statistical analysis, when needed, and attempted to provide clear results. Each intervention provides a section of "Data Findings, Performance Assessment, and Follow-up." **KFMC Response:** Sunflower's approach described within their response was mostly sufficient in Activity 8.2, but SHP occasionally described a measure incorrectly or did not include a measure within the intervention's section of "Data Findings, Performance Assessment, and Follow-up."	Partially Addressed
20.	Ensure all data and statistical interpretations are verified for accuracy and clarity in future reports. **Sunflower Response:** Fully addressed: Data and statistical analysis were checked for accuracy. Each table provides statistical analysis, when needed and attempted to provide clear results. **KFMC Response:** Interpretations of statistics within Activity 8.2 generally did not indicate changes as statistically significant. Also, the chi-squared test of independence was incorrectly interpreted to have the ability to calculate percentage point and rate change values, not just the identification of a statistically significant change between rates. Several change-of-rate calculations were incorrect in Activity 9.1.	Partially Addressed
21.	For the statistical testing, report rounded *p*-values for values from 0.01 through 0.99 and using ranges (e.g., $p<.001$, $p<.01$, and $p>.99$) otherwise. **Sunflower Response:** Fully addressed: All *p*-values are now reported on the hundredths (1/100) place. **KFMC Response:** Sunflower reported *p*-values as instructed, however there were instances of *p*-values being calculated incorrectly.	Fully Addressed
22.	Redesign tables in Activities 8.2 and 9.1 to improve the clarity of the contents and purpose so that the reader can more readily understand the data and test results that are presented. **Sunflower Response:** Fully addressed: Tables reviewed and updated to provide clear information and consistency throughout report. **KFMC Response:** Tables within Activity 8.2 clearly presented their contents and purpose.	Fully Addressed
23.	Provide a detailed analytic comparison of the baseline to remeasurement EPSDT Participation Rates in Activity 9.1 and a less technical interpretation of the results in Activity 9.3. **Sunflower Response:** Fully addressed: Statistical analysis are interpreted accordingly for both 9.1 and 9.3. **KFMC Response:** The discussion was detailed and well-organized, and the writing style was appropriate for the intended audience.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT (Continued)		
24.	Review technical writing in Activities 8.2 and 9.1 of statistical results for clarity, accuracy, and correct interpretation. **Sunflower Response:** Fully addressed: Reviewed writing and had leadership review of report prior to submitting report. **KFMC Response:** The chi-square test of independence was incorrectly interpreted to have the ability to calculate a percentage point and rate change values, not just the identification of a statistically significant change between rates. An inappropriate comparison between two process measures was made in Activity 9.1.	Partially Addressed
25.	Results and analysis specific to an intervention's process and outcome measures should be provided in Activity 8.2, rather than in Activity 9. Analysis against a control group is described in intervention methodologies (Activity 5). This analysis is presented in Activity 9 and should be described in Activity 7. **Sunflower Response:** Fully addressed: No control group for this year. Hence, latter half of comment is addressed. Section 8.2 includes statistical tests and interpretations for each process and outcome measures tables for each intervention where multiple measurement periods are shown. **KFMC Response:** Activity 8.2 contains results and analyses specific to the interventions' process and outcome measures. No control group was used with the interventions and was removed from the interventions' methodologies in Activity 5.	Fully Addressed
26.	Provide a description of how Sunflower intends to meet the PIP outcome goal, EPSDT Participation Rate greater than 85% (e.g., annual rate improvement targets). **Sunflower Response:** Fully addressed: An outline of both member and provider interventions that will be utilized to reach the goal of an overall 85% EPSDT screening participation is included. **KFMC Response:** Annual improvement targets of 1.00 percentage points were stated in Activity 2. These goals indicate Sunflower does not foresee reaching 85% within 5 years.	Partially Addressed
27.	Provide an interpretation of the rate change from RMY 1 to RMY 2 in Activity 10.1. **Sunflower Response:** Fully addressed: Changes in overall rates discussed including possible contributing factors. **KFMC Response:** Sunflower adequately discussed rate changes from RMY 1 to RMY 2 and from RMY 2 to RMY 3 in Activity 10.1.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – EPSDT (Continued)		
28.	Include a summary of the impact of the interventions on the PIP outcome measure, including their impact on achieving the PIP Goal of an 85% Participation Rate, in Activity 10.1. **Sunflower Response:** Fully addressed: Discussion is included for each active intervention within this PIP with reflection on the effect of each intervention on the overall PIP goal of 85% EPSDT screening participation. **KFMC Response:** An appropriate summary of the impact of each intervention on the PIP outcome measure and on achieving the PIP Goal was provided in Activity 10.1.	Fully Addressed
Sunflower PIP – Cervical Cancer Screening		
1.	In Activity 8.2, provide data, comparisons, and significance testing of CCS closure rates between initiative and the non-initiative groups consistent with the analytic plans described in Activities 5 for Interventions 1, 2, and 3. **Sunflower Response:** Fully addressed: This intervention was discontinued and new methodology for remaining interventions. Reviewed analytic plans in Activity 5 and 8 for each intervention. **KFMC Response:** While Intervention 2 was discontinued and had no results to be presented in the annual report, the analysis of Interventions 1 and 3 followed the analytic plan outlined in Activity 5 for each of the interventions.	Fully Addressed
2.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Fully addressed: Analytic team reviewed comments and presented data analysis with evidence where needed. **KFMC Response:** Interpretations of the analytic results appeared appropriate.	Fully Addressed
3.	Update the analytic plan in Activity 5.1.d, redefining the control group criteria and adjusting for any impacts on analysis and trending due to requested changes to the intervention. **Sunflower Response:** Fully addressed: Control group is defined and updated to reflect new methodology and interventions. **KFMC Response:** The control group is discussed within Activity 5.1.d and defined within Activity 8.2.1 prior to Tables 10 and 11.	Fully Addressed
4.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Fully addressed: This intervention was discontinued, data analyst worked to use evidence to support results for other interventions. **KFMC Response:** No intervention results were provided due to discontinuation of the intervention. Appropriate discussion of past activities was provided in Activity 5.4.	Fully Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Sunflower PIP – Cervical Cancer Screening (Continued)		
5.	Ensure all calculations are correct. **Sunflower Response:** Fully addressed: Data team and analytics reviewed data and worked on calculations; data checked by analytic manager to verify information. **KFMC Response:** Except for one *p*-value, calculations appeared correct.	Fully Addressed
6.	Ensure all calculations are correct. **Sunflower Response:** Data team and analytics reviewed data and worked on calculations; data checked by analytic manager to verify information. **KFMC Response:** Discrepancies were seen between Process Measures 1 and 2.	Partially Addressed
7.	Ensure that the evidence is properly labeled. **Sunflower Response:** Fully addressed: Analytic team reviewed this for proper data and label. **KFMC Response:** Inconsistent usage of measurement period label RMY 1 and Tables 15 and 16 were labeled incorrectly.	Partially Addressed
8.	Ensure that the interpretation of the analytic results is supported by the evidence. **Sunflower Response:** Fully addressed: Reviewed prior years report for data and worked to address analysis on each intervention with evidence. **KFMC Response:** Table 16's discussion includes statistical analysis that was not conducted using the data presented in the data table.	Partially Addressed
9.	Suppress data in accordance with the CMS cell suppression policy, including suppressing in a way that the suppressed data cannot be reconstructed. **Sunflower Response:** Fully addressed: All tables in section 8.2 are in accordance with CMS cell suppression policy. **KFMC Response:** Data was presented in accordance with CMS cell suppression policy.	Fully Addressed
10.	Ensure table titles and labels align with the contents of the table. **Sunflower Response:** Fully addressed: Activity 5 discontinued for this annual report. Reviewed labels and contents of all tables in report. **KFMC Response:** Issues were cited with several tables in the report.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – Cervical Cancer Screening (Continued)		
11.	For the statistical testing, report rounded *p*-values for values from 0.01 through 0.99 and report ranges (e.g., $p<.001$, $p<.01$, and $p>.99$) otherwise. **Sunflower Response:** Fully addressed: Removed symbolic notation of *p*-values and listed them out where statistical analysis was performed. **KFMC Response:** Sunflower reported *p*-values as instructed, however there were instances of *p*-values being calculated incorrectly.	Fully Addressed
12.	Revise the contents of Activity 6 in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. **Sunflower Response:** Fully addressed: Revised Activity 6 and added Appendix C, D to refer to for general guidelines **KFMC Response:** Activity 6 included all necessary components indicated in the *PIP Instructional Guide.*	Fully Addressed
13.	Reference the *Conducting Performance Improvement Project Worksheet Instructional Guide* for ways to judiciously reduce the reporting of exploratory analysis and year-over-year trending analysis. **Sunflower Response:** Not addressed in Activity 10.2's Table 15 of the MCO's Annual Report **KFMC Response:** Reported exploratory analysis and year-over-year trending only included results that added value to the report.	Fully Addressed
14.	Clarify the data cutoff dates for the CCS administrative and hybrid rates in Activity 7. **Sunflower Response:** Not addressed in Activity 10.2's Table 15 of the MCO's Annual Report **KFMC Response:** Sunflower provided data cutoff dates.	Fully Addressed
15.	Ensure that counts, rates, and *p*-values are calculated correctly. **Sunflower Response:** Not addressed in Activity 10.2's Table 15 of the MCO's Annual Report **KFMC Response:** The analysis was improved from the prior report. However, there were still several errors related to the analyses conducted within Activities 8 and 9.	Partially Addressed
16.	In the listing of staff participating in the PIP, include title, qualifications, and responsibilities. **Sunflower Response:** Not addressed in Activity 10.2's Table 15 of the MCO's Annual Report **KFMC Response:** Sunflower provided title, qualifications, and responsibilities for staff participating in the PIP.	Fully Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Sunflower PIP – Cervical Cancer Screening (Continued)		
17.	Provide an early indication of the PIP's effectiveness based on the administrative CCS rate. **Sunflower Response:** Not addressed in Activity 10.2's Table 15 of the MCO's Annual Report **KFMC Response:** No indication of the PIP's effectiveness, based on the administrative CCS rate, was provided.	Not Addressed
18.	Include interpretations of statistical significance in addition to rejection/non-rejection of the null hypothesis in Activities 8.2 and 9. **Sunflower Response:** Partially addressed: Interpreted the statistical analysis to state if increase or decrease between the two categories being compared (whether measurement period rates or control/intervention comparisons) **KFMC Response:** KFMC agrees with Sunflower's response.	Partially Addressed
19.	Ensure the content of the data tables are correct and match the narrative content (e.g., ensure tables indicate the correct intervention). **Sunflower Response:** Fully addressed: Reviewed all tables and labels for this annual report. **KFMC Response:** Tables within Activities 8 and 9 were labeled and titled incorrectly.	Partially Addressed
20.	Provide correct interpretations of statistical results that will be meaningful to the reader (e.g., discuss rates and differences in rates instead of odds ratios). **Sunflower Response:** Fully addressed: Analytic team reviewed prior years findings and report and conducted analysis for each intervention with interpretation listed. **KFMC Response:** Interpretation of statistical analysis was included.	Fully Addressed
Sunflower PIP – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)		
1.	Interpret statistical test results that are not statistically significant as being inconclusive. **Sunflower Response:** Fully addressed: Rephrased "no significance: to "inconclusive" where needed. **KFMC Response:** All instances of non-significant statistical test results were labeled as inconclusive. This issue is addressed.	Fully Addressed
2.	As requested by the State, follow CMS cell suppression guidelines for reporting of small numbers. **Sunflower Response:** Fully address: CMS cell suppression guidelines have been followed when necessary. **KFMC Response:** In Tables 1 and 3, small numerators were suppressed per CMS policy. However, the rate and denominators were provided, and the suppressed values could be derived.	Not Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD) (Continued)		
3.	Since receipt of emails is not tracked, update measure definitions in Activity 5.2.c and the corresponding narrative to reflect emails being sent as the trigger event. **Sunflower Response:** Fully addressed: This has been updated to state emails sent as recommended. **KFMC Response:** Definitions in Activity 5.2 and the corresponding narrative were updated.	Fully Addressed
4.	Provide the current aim statement in Activity 2, rather than just the original statement and descriptions of revisions. **Sunflower Response:** Fully addressed: Corrected this and added correct AIM Statement. **KFMC Response:** The aim statement was updated.	Fully Addressed
5.	In Activity 3, clarify that the continuous enrollment criterion applies to the PIP outcome measures and not the PIP population or interventions' measures. **Sunflower Response:** Fully addressed: Statement updated for clarity. **KFMC Response:** The continuous enrollment criteria was clarified to indicate that it only applies to the PIP outcome measures.	Fully Addressed
6.	Ensure conclusions are supported by the data. **Sunflower Response:** Fully addressed: Each statistical test performed for applicable data summary tables are accompanied by a narrative above the tables. **KFMC Response:** The stated conclusions were appropriate for the data and results of statistical testing.	Fully Addressed
7.	Explain factors that affect comparability of rates (e.g., timing of interventions, characteristics of members within strata). **Sunflower Response:** Fully addressed: Section added for additional factors in 9.c. **KFMC Response:** This recommendation applies to all rates in the report but was created for the comparisons made between the intervention and no intervention groups in Activity 9.a. While the statistical results were interpreted correctly, the factors that affected the comparability of rates (which led to inconclusive results) were not discussed in either Activity 9.a or Activity 9.c. See the previous annual evaluation for further details.	Partially Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Sunflower PIP – Mental Health for Foster Care		
1.	Review the guidance outlined in the *Conducting Performance Improvement Project Worksheet Instructional Guide* when writing annual reports to ensure required elements are included in PIP annual reports. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** All required elements were present in the report.	Fully Addressed
2.	Interpret each intervention's effectiveness based upon the measures results. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** Sunflower provided an interpretation of the effectiveness of the intervention based upon the measures results.	Fully Addressed
3.	Review data tables for clarity and accuracy. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** No issues were found in data tables in this year's annual report.	Fully Addressed
4.	Provide complete technical specifications for all reported measures. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** Sunflower provided complete technical specifications for all reported measures.	Fully Addressed
5.	Provide interpretation of the intervention's success or failure based upon the measure results. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** Sunflower provided an interpretation of the effectiveness of the intervention based upon the measure results.	Fully Addressed
6.	Follow the CMS cell suppression policy when reporting small counts, including counts in report tables and narrative. Consider aggregating data across multiple measurement periods or strata. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** Sunflower suppressed reporting of small counts except in Table 11. The aggregations of the baseline and RMY 1 numbers for outcome measures were not provided.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – Mental Health for Foster Care (Continued)		
7.	Report measures in accordance with the technical specifications and analytic plans in Activity 5 or provide an explanation for the deviations. Update Activity 5 as needed. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** No discrepancies between the technical specifications and the analytic plan were noted.	Fully Addressed
8.	Review data tables for clarity and accuracy. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** The baseline was defined, and data tables were presented clearly.	Fully Addressed
9.	Provide complete technical specifications for all reported measures. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** Complete technical specifications for all reported measures were provided.	Fully Addressed
10.	Report measures in accordance with the technical specifications and analytic plans in Activity 5 or provide an explanation for the deviations. Update Activity 5 as needed. **Sunflower Response:** [Sunflower did not address this recommendation in section 10.d of their annual report] **KFMC Response:** This intervention was discontinued.	No Longer Applicable
11.	Refer to the *Conducting PIP Worksheet Instructional Guide* for the information on providing follow-up to each EQRO recommendation made in previous years' PIP annual validation reports as outlined in Activity 10.2. **Sunflower Response:** Fully addressed: Reviewed instructional guide for this section and applied feedback as directed. **KFMC Response:** Sunflower provided a table containing follow-up to each applicable EQRO recommendation made in the previous year's PIP annual validation report. Sunflower did not include recommendations from Activities 5 & 8 in the aforementioned table as these recommendations were addressed during the MHFC version 2 PIP methodology approval process.	Fully Addressed
12.	For clarity, word the aim statement the same throughout the report. **Sunflower Response:** Fully addressed: AIM statement updated with Version 2 and same throughout report. **KFMC Response:** Sunflower provided a consistent aim statement throughout the report.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Sunflower PIP – Mental Health for Foster Care (Continued)		
13.	Submit changes to the technical specifications for measures, including changes to code listings, for review by the State and KFMC using the PIP Update process. **Sunflower Response:** Fully addressed: These were updated and approved with new PIP, new technical specifications approved 11/17/2023. **KFMC Response:** Sunflower submitted and received approval for a PIP Update form to change to the technical specifications for measures.	Fully Addressed
14.	Conclusions should be drawn that are supported by the data. **Sunflower Response:** Fully addressed: Conclusions and data reviewed with data analyst for report. **KFMC Response:** There were several instances where the conclusions drawn were not supported by the data such as the Interpretation of Analysis Results section in Activity 9.a. The interpretation of the statistical test results was not correct. Inpatient stays increased significantly for the eligible population, which is the opposite of the desired outcome, but Sunflower indicated that the rate improved.	Not Addressed
UnitedHealthcare PIP – EPSDT		
1.	The Outcome Measure 1 denominator should be updated to reflect the age range targeted in the intervention. **UnitedHealthcare Response:** Fully addressed **KFMC Response:** UHCCP split the single outcome measure into three by age group to account for comparison between interventions and the PIP outcome measure. This decision was appropriate and useful to the reader.	Fully Addressed
2.	Revise the analysis plan (Activity 5.1.d) to indicate the percentage of live call-referred appointments that resulted in an EPSDT claim within 90 days will be calculated using multi-year measurement periods. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** Activity 5.1.d was appropriately revised to indicate the outcome measure's multi-year measurement periods.	Fully Addressed
3.	The 2021 annual PIP report stated that the 2021 Q4 rate was based on partial data due to claims lag. Those reported values and the ones seen in the 2022 annual PIP report were the same. Please verify that those values were updated according to the same claims lag allowance as the other quarters. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UHCCP did not address this concern and no adjustments were made to the 2021 Q4 Outcome Measure 1 data.	Not Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – EPSDT (Continued)		
4.	UnitedHealthcare stated in Activity 5.3.c that their goal is to see an increase of 3 pp quarter-over-quarter in the number of foster care members who complete their annual EPSDT screening, but in Activity 8.2, that their goal is an increase of 3 pp year-over-year with corresponding quarterly data. Although both have the same meaning, the same terminology should be used in every location. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** The goal was updated to the same wording in both activities.	Fully Addressed
5.	Clarify the analytic plan in Activity 5.3 to explain how foster care members assigned to multiple or no foster care contractors are handled in Outcome Measure 1 calculations. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UHCCP provided no clarifications.	Not Addressed
6.	Clarify the description of providers targeted for Intervention 4 (GIC reports to providers not participating in the incentive program) and refer to them consistently throughout the report. **UnitedHealthcare Response:** Fully addressed **KFMC Response:** UHCCP consistently referred to the targeted providers as those not participating in the incentive Community Plan Primary Care Provider Incentive (CP-PCPi) program.	Fully Addressed
7.	Ensure consistency when using abbreviations and acronyms (Since CP-PCPi is an acronym for Community Plan Primary Care Provider Incentive, replace occurrences of "CP-PCPi Incentive" with either "CP-PCP Incentive" or "CP-PCPi.) **UnitedHealthcare Response:** Fully addressed **KFMC Response:** The full CP-PCPi acronym is used consistently through the annual report.	Fully Addressed
8.	Replace the use of "in the EPSDT measure" with a clearer statement that will indicate whether the member component is based on those members missing closures concerning their annual EPSDT screenings or if it is based on the members who should receive an annual EPSDT screening and may or may not already done so. **UnitedHealthcare Response:** Fully addressed **KFMC Response:** UHCCP made the appropriate revisions.	Fully Addressed

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
UnitedHealthcare PIP – EPSDT (Continued)		
9.	Update the analytic plan in Activity 7.2 to reflect the analysis reported in Activity 9.1 (control group, trending by age). **UnitedHealthcare Response:** Fully addressed **KFMC Response:** UHCCP did include all the analyses presented in Activity 9.1 in the analytic plan.	Fully Addressed
10.	Update the analytic plan to include testing for key drivers influencing changes in Participation Rates that includes participation in interventions as factors. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** The recommended analysis was not completed and no rationale for its exclusion was provided.	Not Addressed
11.	Ensure that the interpretation of the impact of the interventions is supported by the evidence, and ensure appropriate conclusions are drawn. **UnitedHealthcare Response:** Fully addressed **KFMC Response:** Incidences cited in the prior report were corrected. The improvement in race and ethnicity rates stated in Activity 9.3 was not supported by the data. The improper construction of the control group used to evaluate the effectiveness of Interventions 1 and 2 led to their effectiveness being overstated.	Partially Addressed
12.	Consistently refer to the PIP outcome measure as the "Participation Rate." **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UHCCP updated some, but not all (e.g., Table 21), references to the PIP outcome measure.	Partially Addressed
13.	In future annual reports, refer to historical data regarding when members receive their EPSDT screenings or the differences in Participation Rates among the different age groups. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UHCCP referenced historical data in the discussion of outcome measure results for Intervention 2, but no reference to historical data was provided in the discussion of outcome measure results for Intervention 1.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD)		
1.	Include a summary of activities conducted in previous activity periods under the subheading of "Completed in Prior Activity Periods", per the *Conducting Performance Improvement Project Worksheet Instructional Guide.* **UnitedHealthcare Response:** Fully addressed. UHCCP reviewed the instructional guide and the feedback from the previous evaluation report. UHCCP added narrative regarding continuous enrollment criteria mentioned in the previous evaluation report. **KFMC Response:** Full descriptions of activities conducted in previous activity periods were provided.	Fully Addressed
2.	Provide explanations for inconsistencies between PAR and annual report results. **UnitedHealthcare Response:** Fully addressed. Narrative has been added to Activity 8.b to further explain how data suppression and the combining of data impacts the ability to compare data within this report and PAR data. **KFMC Response:** Explanations were provided, and the PAR data was not reported to avoid possible misinterpretations.	Fully Addressed
3.	Verify the conflicting counts of the number of members listed on the GIC report. **UnitedHealthcare Response:** Fully addressed. UHCCP corrected the count of members who were on a waiver or WPC within this report. **KFMC Response:** The count of the number of members listed on the GIC report is now consistent throughout the annual report.	Fully Addressed
4.	Restate the PIP population (Activity 3) in accordance with the *Conducting Performance Improvement Project Worksheet Instructional Guide*. **UnitedHealthcare Response:** Fully addressed. UHCCP reviewed the instructional guide and the feedback from the previous evaluation report. UHCCP added narrative regarding continuous enrollment criteria mentioned in the previous evaluation report. **KFMC Response:** UHCCP added narrative regarding continuous enrollment criteria. However, this was a clarification of the population for the outcome measure. There was still not a clear distinction between the PIP population and the population for the outcome measure. Activity 3 needs to define the PIP population that is broader than the population for the outcome measure.	Not Addressed
5.	Correctly calculate and report the *p*-values resulting from chi-square tests. **UnitedHealthcare Response:** Fully addressed. UHCCP examined the approach used for this annual report to reflect accurate values. **KFMC Response:** Several *p*-values were incorrectly calculated in Activity 9.a.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Diabetes Monitoring for Members with Diabetes and Schizophrenia (SMD) (Continued)		
6.	For exploratory analyses presented in Activity 9.3, include interpretations of how results relate to the evaluation of the PIP or to the potential for improving interventions. **UnitedHealthcare Response:** Fully addressed. UHCCP revised approach of data presentation and analysis (Activity 9.c) within this annual report. **KFMC Response:** UHCCP found that urban populations had lower testing rates than their less-densely settled counterparts. This along with the discussion presented in Activity 9.c provided some indication that interventions may have been less effective for this population; however, these results were not discussed in relation to the evaluation of the PIP or how the interventions may be improved to address the lower rates in urban areas.	Partially Addressed
UnitedHealthcare PIP – Advanced Directives		
1.	Revise the Outcome Measure's technical specifications for clarity and to reduce technical writing problems. **UnitedHealthcare Response:** Measure specifications have been updated. The labeling of tables has been updated. **KFMC Response:** This was updated accordingly.	Fully Addressed
2.	Provide additional detail to the analytic plans so that measures are calculated according to specifications and results can be more easily interpreted. **UnitedHealthcare Response:** Analytic plans have been updated to more accurately reflect how these measures are being reported. **KFMC Response:** Measure specifications were updated, however the analytic plan indicating that "90 days post training, data was pulled…" remains unclear.	Partially Addressed
3.	Define terms not readily understood by the intended audience that are used in measure specifications and analytic plans. Use consistent terminology for technical writing. **UnitedHealthcare Response:** Measure specifications have been updated. The labeling of tables has been updated. **KFMC Response:** Clarification was provided at the end of Activity 4.	Fully Addressed
4.	Define terms not readily understood by the intended audience that are used in measure specifications and analytic plans. Use consistent terminology for technical writing. **UnitedHealthcare Response:** Measure specifications have been updated. The labeling of tables has been updated. **KFMC Response:** Clarification was provided.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Advanced Directives (Continued)		
5.	Inform the reader that FE Waiver eligibility begins at age 65. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** This was provided in Activity 3.1.	Fully Addressed
6.	Update process measure technical specifications to reflect the expanded intervention population and add directions to the analytic plan for reporting statewide and Sedgwick County rates. **UnitedHealthcare Response:** Technical specifications were updated to reflect the expansion of the intervention statewide and to reflect how this intervention is currently being measured. **KFMC Response:** Process measure technical specifications were updated, but directions for reporting statewide and Sedgwick County rates were not added to the analytic plan. See KFMC's response to Item 15 for further explanation.	Partially Addressed
7.	Rewrite the technical specifications and analytic plans for the intervention outcome measure to reflect rates intended to be reported. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** Technical specifications were updated, but analytic plans were not updated.	Partially Addressed
8.	Revise the technical specifications for Process Measure 2 to improve clarity. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** Technical specifications were updated.	Fully Addressed
9.	Add technical specifications for Process Measure 4 to Activity 5.6.c. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** Not updated.	Not Addressed
10.	Verify that data in narrative agrees with data in tables. **UnitedHealthcare Response:** UHCCP was more careful about drawing conclusions from available data during this reporting period. **KFMC Response:** While it no longer applies to this intervention, the same issue was noted in other areas of the report.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Advanced Directives (Continued)		
11.	Be consistent between the technical specifications for the AD training outcome measure and how results are calculated and reported. **UnitedHealthcare Response:** The description of the numerator and denominator for the outcome measure was not consistent with how it was calculated. This has been updated. Consistent with KFMC's recommendation, UHCCP plans to retire this measure, as the rate for this measure was the same as the overall PIP outcome measure. **KFMC Response:** The technical specifications have been updated and the outcome measure are presented based upon those new specifications.	Fully Addressed
12.	Revise the column headings in the report tables for the AD training results so they are clear and appropriate based on the content of the columns. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UnitedHealthcare provides additional background within 5.2.c for the outcome measure's table and updated the headers to better reflect the data contained within its results table.	Fully Addressed
13.	Refer to the Instructional Guide for direction related to reporting of discontinued measures. The technical specifications and reported analysis are expected to be consistent. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UnitedHealthcare did not, as instructed, provide analytic results of the discontinued measure. They stated the intervention was discontinued and the date its discontinuation was approved. Per the Instructional Guide, page 15, version 2/10/2022, "After the first year and for discontinued interventions: • Detailed analytic results from prior years are not needed if they were inconclusive, incomplete, or replaced by current year's analytic findings. If prior results help show the challenges or successes of the outcome of the intervention then include them in this activity, but perhaps without as much detail as originally presented."	Not Addressed
14.	Conduct and report results of root cause analysis for underperforming measure results. **UnitedHealthcare Response:** UHCCP acknowledges that a formal root cause analysis should have been completed for Intervention 4 prior to requesting that this intervention be discontinued. UHCCP did complete an investigation of the reason for the poor performance on the Intervention 5 outcome measure and has made recommendations regarding this measure moving forward. **KFMC Response:** Root cause analysis were provided for other intervention outcome measures.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Advanced Directives (Continued)		
15.	Continue to report rates for Sedgwick County. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** The rates for measurement periods during the pilot of the intervention were kept in the report, but Sedgwick County rates were not provided separately from the Statewide rates for measurement periods after the expansion. This recommendation (and the recommendation in Item 6) is based on text on page 10 ("For the next annual report, consider displaying the Sedgwick County rate for October 2022 to September 2023 in Table 13. Monitoring Sedgwick County rates may provide data on upper bounds for rates earlier that would be obtained from statewide rates.") and page 16 ("For interventions that expanded from Sedgwick County to statewide, monitoring Sedgwick County rates may provide data on upper bounds for rates earlier that would be obtained from statewide rates.").	Partially Addressed
16.	When rates differ significantly between those provided in the annual report and in PAR Snapshots for the same measure, provide an explanation for the difference. **UnitedHealthcare Response:** UHCCP updated the process for collecting data for reporting of the member denominator for PAR rates, which has resulted in a closer alignment between PAR and annual report rates. **KFMC Response:** The PARs were sufficiently aligned with the intervention measures.	Fully Addressed
17.	Use a date for the measurement period of point-in-time measures. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** The appropriate measurement periods have been updated to point-in-time dates.	Fully Addressed
18.	Incorporate recommendations for improving the writing of the annual report into next year's report. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** UnitedHealthcare made progress on incorporating recommendations into this report.	Fully Addressed
19.	Include qualifications of each PIP role and all staff involved in the PIP in future reports. **UnitedHealthcare Response:** UHCCP has updated Activity 7.3 to include qualifications of staff positions as well as all staff positions involved with the PIP. **KFMC Response:** Activity 7.3 included the required components.	Fully Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Advanced Directives (Continued)		
20.	Reassess the analytic plan for the PIP outcome measure—changes to the regression model and stratified analysis are warranted (e.g., stratify PIP outcome measure rates by members receiving FE Waiver services and members receiving non-FE Waiver services, and use weighted averages of FE and non-FE PIP outcome measure rates to forecast progress towards the PIP outcome measure goal.) **UnitedHealthcare Response:** UHCCP followed KFMC's recommendation to update the plan to compare FE Waiver members to members on other HCBS Waivers. **KFMC Response:** The analytic plan for the PIP outcome measure (i.e., Activity 7.2) was not updated to include the additional analyses provided in Activity 9.1.	Not Addressed
21.	Review the *Conducting Performance Improvement Project Worksheet Instructional Guide* for guidance on the content and organization for the 2023 annual report, including follow-up to prior recommendations. **UnitedHealthcare Response:** (UHCCP did not provide a response.) **KFMC Response:** Summaries of prior year's activities were moved from Activity 8.1 to Activity 5. Short descriptive names for interventions were consistently used in section titles. Staff qualifications were added to Activity 7.3. Follow-up was not provided for each EQRO recommendation made in the previous years' PIP annual validation report. Guidance on reporting analysis for discontinued measures was not followed.	Partially Addressed
UnitedHealthcare PIP – Housing		
1.	Correct or explain the inconsistency between Tables 2, 4, and 6 in the count of CCs and CHWs who scored 80% or better on the post-training test for Year 3. **UnitedHealthcare Response:** Yes, when reviewing the data provided on annual report, the correct number is 146 CC + 26 CHW leading to a total of 172, not 173. We apologize for this mathematical error. **KFMC Response:** UnitedHealthcare did not update the correct sum in Table 5.	Not Addressed
2.	For clarity, provide rationale for any deviations from the technical specifications (e.g., aggregation of outcome measures). **UnitedHealthcare Response:** Thank you for the recommendation, we added language on this year's report (page 31) to provide clarity. **KFMC Response:** The outcome measure in 8.b deviated from the technical specifications in Activity 5.c. In activity 8.2.b, UnitedHealthcare stated that members from the two outcome measures were aggregated, but UnitedHealthcare did not provide any rationale for why this was done.	Not Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – Housing (Continued)		
3.	Report intervention process and outcome measures according to the technical specification and analytic plan or explain how and why deviations were made (e.g., Outcome Measure 1 for Intervention 3). **UnitedHealthcare Response:** Our apologies for not catching that before. In year 3 we reported on total claims and not on the average cost. We have corrected the way we reported health care utilization in this year report, and we are sharing the values as an average utilization by dividing total claims by 16 individuals. **KFMC Response:** The updated narrative and reporting was insightful, however one aspect identified in the prior annual evaluation was not addressed "For comparisons between years, the measure was defined as the average utilization for 12 months after beginning the program divided by the average utilization for the 12 months before beginning the program." No ratio was reported for Outcome Measure 1 and no rationale was provided to justify this decision in this year's annual report.	Partially Addressed
4.	Use consistent terminology within the technical specifications, analytic plans, and reporting of results. **UnitedHealthcare Response:** Language added to section 5.6.c and new table added to section 8. **KFMC Response:** In the prior annual evaluation, it was stated that "The title of Table 37 … is not a technically correct description of the outcome measure." The table's title was not updated to accurately reflect the outcome measure being reported.	Not Addressed
5.	Follow through with developing the additional outcome measure for Intervention 6 that was discussed in Activity 5.6.c. Submit the technical specification for review using the PIP Update process. **UnitedHealthcare Response:** Language added to section 5.6.c and new table added to section 8. **KFMC Response:** The new measure was developed and reported.	Fully Addressed
6.	Use consistent technical terminology throughout the report where writing relates to technical specifications, analytic plans, and measure results. **UnitedHealthcare Response:** An MCO response was not provided. **KFMC Response:** While there was improvement in use of consistent terminology, issues were noted regarding technical terms used in Activity 8.6.b compared to Activity 5.6.c.	Partially Addressed

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
UnitedHealthcare PIP – AMM		
1.	Provide cutoff dates of the intervention measures; mature data may then be reported in subsequent annual reports. **UHCCP Response:** The date of the data extraction has been included in Activity 8. **KFMC Response:** UnitedHealthcare included cutoff dates in Activity 8.	Fully Addressed
2.	Determine and report the denominator for Outcome Measure 2 consistent with the methodology in Activity 5.1.c. **UHCCP Response:** The methodology was reviewed, and data is reported accordingly. **KFMC Response:** The denominator reported in Activity 8.b for outcome measure 2 was consistent with the methodology described in Activity 5.1.c.	Fully Addressed
3.	Include a non-technical description of the PIP outcome measure in Activity 6.1. **UHCCP Response:** A non-technical description of the PIP outcome measure was provided in Activity 6.a. **KFMC Response:** A non-technical description of the PIP outcome measure was provided in Activity 6.a.	Fully Addressed
4.	Verify chi-square and Fisher's exact statistical tests are correctly performed. **UHCCP Response:** UHCCP met with KFMC in October of 2024 to receive feedback and guidance on approach to statistical testing within the PIPs. The approach used for statistical tests within this report was done in response to this meeting. **KFMC Response:** UnitedHealthcare performed Fisher's exact test correctly.	Fully Addressed
5.	In Activity 10.1, provide a discussion, in layman's terms, of the interventions and their impact on the PIP outcome measure. **UHCCP Response:** Discussion was provided with consideration of layman's terminology. **KFMC Response:** UnitedHealthcare provided discussion in layman's terms of the interventions and their impact on the PIP Outcome Measure in Activity 10.a.	Fully Addressed

CAHPS Health Plan 5.1H Validation

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Common Among All MCOs		
1.	MCOs should conduct root cause analysis to identify the reasons for, and identify next steps to address, the decline in providing urgent and routine care quickly for KanCare members. **KFMC 2024 Update:** The KanCare general child and KanCare CCC rates continued to have downward five-year trends.	In Progress
2.	All MCOs should continue to expand their care coordination efforts, particularly for children with chronic conditions, including primary care physicians being informed and up to date about the care children receive from other doctors and health providers. Encouraging providers to discuss with the parents and guardians (or the youth themselves) whether their children receive care or services elsewhere, request releases of information, and establish bi-directional ongoing communication with the other providers. The MCOs could assist providers in identifying members' other sources of care, for the provider to use in flagging medical records as prompts for initiation of coordination of care discussions (e.g., similar to gap-in-care communications). **KFMC 2024 Update:** Regarding the Coordination of Care score, the KanCare adult score decreased to its lowest point in five years, the KanCare GC score increased (non-significantly) from 2023, the KanCare CCC score was steady, and each KanCare score ranked ≥50th. The score for the Coordination of Care for Children with Chronic Conditions composite increased and now ranks <50th.	In Progress
3.	MCOs should further review their processes for encouraging providers to assess and respond to members' mental health and emotional health issues, and for encouraging members to access mental health or substance use disorder services. **KFMC 2024 Update**: The KanCare adult and general child percentages of respondents indicating their [their child's] mental or emotional health was excellent or very good marginally have been relatively unchanged—no statistically significant changes between years and no trendlines statistically significantly different from horizontal.	In Progress
4.	MCOs should continue efforts to reduce smoking and tobacco use and to promote cessation. Consider methods to address providers' missed opportunities to discuss cessation medications and other strategies while advising smoking cessation (e.g., MCO supplying communication materials and identifying resources for providers to use, or for referrals). **KFMC 2024 Update**: The KanCare percent of current smokers and tobacco users and the three HEDIS MSC indicators have been relatively unchanged from 2020 to 2024 with no trendlines being statistically significantly different from horizontal.	In Progress
5.	MCOs should continue efforts to increase the number of people receiving flu vaccinations yearly. **KFMC 2024 Update:** The 2024 surveys did not include a flu vaccination question. The flu vaccination rate ranked >75th in 2023; the recommendation was considered to be addressed.	Fully Addressed

KanCare Mental Health Consumer Perception Survey

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Common Among the MCOs		
1.	For adult members, monitor and explore methods to improve or continue improvement regarding a. Access, quality, and timeliness of treatment; b. Members getting information about treatment options (information about self-help or support groups); c. Improved outcomes including member perceived improvement; and d. Member satisfaction with provider. **2024 KDADS Response:** **a. Access, Quality, and Timeliness:** By opening the Peer Support Service codes (H0038 and H0038HQ) to any Medicaid provider, Peer Support Services are becoming available at more and more provider organizations, increasing access and timeliness of treatment. Quality of treatment, for Peer Support Services, is being addressed via updates and expansion of Peer Support Trainings through ongoing projects with several partnering organizations and Peer stakeholder groups. Kansas has been awarded several Transformation Transfer Initiative (TTI) Awards over several years to develop and provide additional and specialized trainings for Peers working in Crisis Services. Consumer Run Organization (CRO) budgets were increased by 15% this fiscal year. This increases the ability of all CROs to provide Peer Support Services at no cost to its members and their communities. CRO staff routinely visit the State Hospitals and Nursing Facilities for Mental Health (NFMHs) to provide Peer Support Services and connect with individuals who will be discharging. Connecting with these individuals increases access and timeliness of treatment. CROs also make referrals to other treatment providers like Clubhouses and Certified Community Behavioral Health Clinic (CCBHCs). Clubhouses were awarded additional funding from the Community Mental Health Services Block Grant (MHBG) to provide services to individuals residing within or at risk of admitting to the State Hospitals, State Institutional Alternatives (SIAs), NFMHs, and other inpatient facilities. These services include Step-up services (increase in intensity of services), step-down services (decrease in intensity of services), and discharge planning services. Clubhouses are also tasked with collaborating with other provider organizations including, but not limited to, the inpatient facilities, CCBHCs, CROs, and Substance Use Treatment Providers, whenever appropriate. Additionally, KDADS saw increases in access to treatment, specifically the timeliness of intake and the availability of clinical hours, due to the implementation of CCBHC model of care across the State. In 2024, all 26 CMHCs in Kansas had been, at minimum, provisionally certified in the CCBHC model. Most completed community needs assessments and addressed hours of availability and/or implemented an open access model that has improved the clinic's ability to provide same-day appointments and services. Additionally, telehealth continued to grow in utilization by clinics.	Fully Addressed

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
***Common Among the MCOs* (Continued)**	
KDADS also is partnering with 5 Federally Qualified Health Centers (and look-a-likes) and RHCs to implement the Psychiatric Collaborative Care Model into primary care clinics across Kansas. This model helps with identification, brief interventions, and appropriate referrals to care for individuals identified through primary care as experiencing behavioral health concerns. This implementation is allowing Kansas to work towards a "no wrong door" model of care to continue to increase access and timeliness of treatment. • **Data-Driven Monitoring:** KDADS Behavioral Health Services (BHS) Commission Quality Assurance team assesses compliance with CCBHC criteria regarding time to nine required services, quality measures and care coordination to improve treatment adherence rates. • **Regular Audits:** KDADS BHS Quality Assurance Team conducts periodic chart audits to assess adherence to clinical guidelines, treatment plan development, and documentation standards. • **Risk Management:** KDADS Surveying, Licensing, and Credentialing (Team works with the quality assurance team to track Adverse Incident Reports (AIRs). Together we proactively identify and mitigate potential risks to service quality, such as errors, adverse outcomes, and/or safety concerns. **b. Member Information and Choice:** Outreach conducted by CROs and Clubhouses increases education about the Peer Support Groups and activities that are offered by their organizations. Most of these organizations have digital and physical informational items, like websites, Facebook pages, and pamphlets. The "work-ordered day" of the Clubhouses teach valuable life skills that are directed by members with minimal staff involvement. Clubhouses are structured with minimal staff and could not function without its members. Additionally, KDADS has promoted and provided information materials around CCBHCs. KDADS has also noted that several CCBHCs have increased marketing of services through the model. • **Education and Training:** KDADS Survey, Certification and Credentialing Commission partners with the quality assurance team to review licensed providers' staff members are adequately trained on to deliver culturally competent, age-appropriate, person-centered, and family centered treatment options using evidence-based practices including Assertive Community Treatment (ACT), Cognitive Behavioral Therapy (CBT), Medication Assisted Treatment (MAT), and Individual Placement and Support (IPS) Supported Employment. • **Resource Development:** KDADS Behavioral Health Services program teams collaborate with the Association of Community Mental Health Centers of Kansas (ACMHCK) to develop and disseminate clear, concise, and culturally sensitive information materials for community mental health centers members. • **Feedback Mechanisms:** KDADS Behavioral Health Services employs constituent resource liaisons and diversion coordinators who actively engage Kansans including MCO members who are seeking care from a KDADS-licensed provider. KDADS uses this feedback to improve services across the continuum of behavioral health and integrated care in every region across the state.	

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Common Among the MCOs (Continued)		
	c. Improved Outcomes: CROs and Clubhouses are required to submit quarterly reporting. Both report on membership (including young adult), attendance, increasing connection/reducing stigma, and types of services provided/activities completed. **Outcome Measurement:** KDADS BHS Quality Assurance team utilizes standardized behavioral health quality measures to track clinical progress and identify areas for improvement in treatment effectiveness. Outcomes measures include: Adult Inpatient Admission Rate, Adult Inpatient 30-Day Readmission Rate, Adult Penetration Rate (Per capita number of adults with SPMI served by the CMHC), Children and Adolescent Penetration Rate (Per capita number of children/adolescents with SED served by the CMHC, Adult Therapeutic Intervention Rate, Children and Adolescent Therapeutic Intervention Rate, Child In Need of Care (CINC) Penetration Rate, and more. • **Data Analysis and Reporting:** KDADS BHS Commission has partnered with ACMHCK on a data warehouse initiative to gather claims and encounter data to identify trends, areas of concern, and to inform quality improvement initiatives. • **Performance Improvement Projects:** KDADS BHS Commission supports data-driven performance improvement projects aimed at enhancing clinical outcomes and addressing identified gaps in care. In 2024, the BHS Quality Assurance Team conducted onsite quality assurance reviews to improve provider performance across 18 licensed Community Mental Health Centers (CMHCs) seeking full CCBHC certification across Kansas. **d. Member Satisfaction:** • **Complaint Resolution:** KDADS has a robust system for promptly investigating and resolving member complaints and concerns. • **Provider Feedback:** KDADS Quality Assurance Team gathers feedback from providers on their experiences and challenges to identify areas for improvement in clinical practice and support. **KFMC Response:** KFMC considers this recommendation fully addressed. Any area that continues to be an opportunity for improvement will result in a recommendation based on current survey results.	
2.	For child members, monitor and explore methods to improve or continue improvement regarding e. Access, quality, and timeliness of treatment; f. Improved outcomes including member perceived improvement; g. Member satisfaction with provider; and h. Accessing and understanding information, including getting needed help from customer service **2024 KDADS Response:** **e. Access to Services:** The CCBHC and Quality Assurance teams have worked to provide resources and tools to the provider system on better tracking,	Fully Addressed

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Common Among the MCOs (Continued)	
identification of needs, and understanding the resources available to centers (billing codes, leveraging the CCBHC Prospective Payment System (PPS), increased funding for crisis, etc.) to improve the quality and access to timely treatment for adolescents. The CCBHC team has worked with the youth services team to implement requirements for serving youth ages 0-5 and work on access to screenings for waiver conditions. • KDADS supports a comprehensive continuum of care including prevention, early intervention, outpatient, intensive case management, and community integration programs. • Mobile Response Stabilization Services (MRSS) and Crisis Respite Centers ensure immediate access to crisis care. • Specialized programs like Therapeutic Preschools and Partial Hospitalization Programs target specific needs, ensuring tailored and localized access. **Quality of Treatment:** • Programs like the Kansas Prevention Collaborative and targeted efforts such as evidence-based interventions (e.g., Parent Management Training) focus on enhancing the quality of behavioral health services. • KDADS partners with other state agencies to establish high standards, like certification for CMHCs and crisis stabilization units. **Timeliness of Care:** • Crisis services, including the 988 helpline and 24/7 mobile response teams, ensure swift intervention during behavioral health emergencies. • Coordination with managed care organizations and targeted case management speeds up access to ongoing support and ensures continuity of care. **f. Improved Outcomes:** 1. Decrease reliance on State Mental Health Hospitals (SMHHs) as a safety net service provider and establish and support alternative community programing; 2. Decrease admissions to SMHHs of individuals who could be stabilized in the community in 10 days or less by connecting individuals to services/resources in their home communities; 3. Increase 24-hour community diversion options for individuals with co-occurring mental health and substance use disorders; 4. Increase 24-hour community options for individuals who are homeless or at risk of becoming homeless, have self-care failure issues or are at risk for adult/child protective services; 5. Reduce the utilization of the SMHHs and Psychiatric Residential Treatment Facilities 6. Crisis Centers provide 23-hour observation, longer stays up to 10 days if warranted, sobering beds and Detox or referrals to Detox. 7. Currently KDADS has 7 Crisis Centers in operations and 2 under development	

Follow-Up to Previous Recommendations (2023)	2024 Completion Status
***Common Among the MCOs* (Continued)**	
g. Member Satisfaction with Provider Stepping Up for Youth: Kansas State Task Force on Improving Behavioral Health Services for Youth with Justice Experiences is a comprehensive initiative aimed at enhancing behavioral health services for justice-involved youth in Kansas. The primary goal is to identify, implement, and expand best practices that improve community-based services, foster cross-system collaboration, ensure efficient resource utilization, and enhance outcomes for youth with behavioral health needs within the juvenile justice system. The task force includes representatives from Kansas Department of Corrections (KDOC), KDADS, Department for Children and Families (DCF), judiciary members, legislators, law enforcement, education, mental health organizations, advocacy groups, and community corrections. **h. Accessing and Understanding Information** Through the Quality Assurance work, particular attention has been given to how foster youth and youth crisis services are being delivered by CCBHCs. KDADS has worked to increase consumer understanding of crisis services (including how to access those services), clinic understanding of the MRSS model for crisis services, and increase the tracking and awareness of foster youth within the CCBHC system. **KFMC Response:** KFMC considers this recommendation fully addressed. Any area that continues to be an opportunity for improvement will result in a recommendation based on current survey results.	

Provider Survey Validation

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Common Among the MCOs		
1.	**Ensure all the requirements of the State Contract Amendment 14, Section 5.9.11 regarding MCO's Provider Satisfaction Survey are fulfilled** **KFMC Response:** All three 2024 MCOs' Provider Survey did not fulfill all the requirements of the State Contract Amendment 14, Section 5.9.11 related to the survey methodology, implementation, quality assurance, data analysis and reporting. The needed changes related to the methodological issues and concerns noted by the State and KFMC in the review of the proposed 2024 MCOs' survey work plan were not made prior to the survey implementation. The State did not approve the MCOs' methodology, but allowed the survey to be implemented due to time restraints, with the emphasis on submitting the Work Plan much earlier in the year to avoid such problems in the future. The practices/locations of the four required provider types selected for the sample frames were only those with valid email addresses available to the MCOs and a very few practices/locations with an available phone number that did not have an email address. This represented only 84%, 78.6%, and 36% of the total number of provider practices/locations of the four provider types identified as the study populations for Aetna, Sunflower and UnitedHealthcare, respectively. Therefore, the survey sample frames were not representative of the study populations of the three MCOs and did not fulfill the State Contract Amendment 14 requirement. The sample frames, which were formulated using convenience survey methodology, were used as the survey samples, thus, the survey samples were not drawn by applying stratified random sampling methodology. Therefore, the State Contract Amendment 14 requirement to use statistically significant sample sizes of PCPs, specialists, BH and HCBS provider populations (four required provider types) was not fulfilled by the three MCOs. The surveys were implemented by applying only a single web-based mode using email addresses as the primary distribution method to invite the practices/locations to participate in the surveys. As mentioned above, a few practices/locations with valid phone numbers that did not have valid email addresses were contacted by phone to complete the surveys. The total number of these practices/locations in the study populations and the number included in the sample frames were not mentioned. The survey reports noted some of these practices /locations contacted by phone requested to email the survey link; however, it was not clear why MCOs did not have their valid email address in their records. Other modalities such as a mail survey mode to reach those without email addresses, and a telephone follow-up survey mode to reach nonrespondents of mail and web-based surveys, were not used to achieve survey results generalizable to the four provider types in the MCOs' KanCare Provider Networks. The vendor mentioned data quality assurance steps were applied in data analysis and reporting of the results; however, a few inconsistencies were seen in reporting of the data and analysis results. The MCOs' surveys fulfilled some requirements of the State Contract Amendment 14. The study purpose/objectives were clear, measurable, and in accordance with State Contract Amendment 14. The surveys were specific to KanCare providers and included the four required provider types. The survey instrument included appropriate questions to measure the study purpose. The reliability and validity testing of the survey instrument was done. The survey instrument included only one relative question, as required by State Contract Amendment 14.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
***Common Among the MCOs* (Continued)**		
2.	**Implement the survey methodology and analytic plan approved by the State prior to the survey implementation or obtain written approval from the State for any revisions. Document, in the Survey Report, the rationale for revisions to the survey methodology during survey implementation** **KFMC Response:** The needed changes related to the methodological issues and concerns noted by the State and KFMC in the review of the proposed 2024 MCOs' survey work plan were not made prior to survey implementation. Therefore, the State did not approve the MCO's survey methodology, but allowed the survey to be implemented due to time restraints, with the emphasis on submitting the Work Plan much earlier in the year to avoid such problems in the future. Based on the initial lists of practices/locations with valid email addresses for two of the MCOs, the work plan drafts indicated an availability of much larger sample frames for their survey implementation. However, the deduplication steps applied by the survey vendor to identify the practices/locations with unique email addresses, and phone numbers for those without valid email addresses, provided the sample frames comprised of a much smaller number compared to that described in the initial lists of these two MCOs. The stratified analyses of all survey questions should have used the total numbers of completed surveys as their denominators to calculate the satisfaction rates for different aspects of the MCOs' services. In all three MCOs' survey reports, data presented for the survey question asking respondents to rate overall satisfaction with each MCO they currently work with were inconsistent with the data for the provider types shown for the initial question, *"What is the primary type of healthcare service you provide?",* which was planned to be used for classifying the respondents into the four provider type groups. In addition to the overall satisfaction rate question, inconsistency from the initial question's data was seen with a few other survey questions from the Sunflower survey, and with all questions from the Aetna survey. Reasons for this deviation were not provided.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
3.	**Ensure all the respondents identified through "Other, specify" who cannot be classified in one of the four required provider type groups are excluded from the survey analysis** **KFMC Response:** The question, *"What is the primary type of healthcare service you provide?"* was asked to classify survey respondents in one of the four required provider type groups. One of the response options for the question was "Other, please specify." The respondents identified through *"Other, specify"* who could not be classified in one of the four required provider type groups were excluded from the MCOs' survey analyses.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
***Common Among the MCOs* (Continued)**		
4.	**Conduct reliability and validity testing of the Survey Instrument with the target population of the survey, such as the MCOs' provider advisory committees. Access these groups to identify potential reasons for non-participation in the survey and suggestions for improvement** **KFMC Response:** The work plan noted procedures such as survey retesting through the MCOs' Provider Advisory Councils (PACs) and through cognitive interviewing with experts in the field were applied for the reliability and validity testing of the instrument for the target population. The survey reports did not describe asking the PACs about potential reasons for non-participation in the survey and suggestions for improvement.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
5. •	**Ensure generalizability of the survey findings to the intended study population** Include only PCPs, specialists, BH providers and HCBS providers, i.e., the four required provider types, in the study population and sample frame. Ensure the sample frame planned and used is representative of the study population, by substantially increasing email data completeness in the provider network files to substantially improve the sample frame numbers and adding other modes of identifying eligible providers. **KFMC Response:** The study populations and survey frames of all three MCO surveys only included the four required provider types. As mentioned above, the sample frames planned and used were not representative of the study populations. The study population composition of each provider type was defined as "provider location," instead of "individual practitioners." This resulted in inclusion of more practices with valid email addresses in the sample frames of the three surveys; however, these still only represented 84%, 78.6%, and 36% of the total number of provider practices/locations of the four provider types identified as the study populations for Aetna, Sunflower, and UnitedHealthcare surveys, respectively. The deficiency in the availability of valid email addresses from the provider network files were still seen, as the survey vendor reported some of the email invitations sent to the provider practices/locations bounced back due to invalid addresses. Also, the survey vendor noted, *"Based on automatic responses received back from the survey, it appeared that a large number of surveys went to billing organizations who may not have been able to answer the questions in the survey."* Thus, the MCOs did not check addresses and take steps to get appropriate email addresses before sending the email lists to the survey vendor. Other modalities such as a mail survey mode to reach those without email addresses, and telephone follow-up for the non-respondents of mail and web-based modes, were not used to achieve survey results generalizable to the four provider types in the MCOs' KanCare Provider Networks.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
***Common Among the MCOs* (Continued)**		
•	Apply stratified random sampling methodology (a type of probability sampling appropriate for meeting State Contract Amendment 14 requirements). Calculate the sample sizes needed using clearly described sample size calculation parameters. These calculated sample sizes would be the required minimum number of completed surveys by the four provider types. Ensure using and achieving these calculated sample sizes during survey implementation. Establish minimum required response rates to be achieved for the four required provider types. **KFMC Response:** The sample frames, which were formulated using convenience survey methodology, were used as the survey sample; thus, the survey samples were not drawn by applying stratified random sampling methodology, and statistically significant sample sizes of PCPs, specialists, BH and HCBS provider populations (four required provider types) were not used. The minimum required number of completed surveys by the four provider types were calculated using sample size calculation parameters. The required minimum number of completed surveys by the four provider types were established. However, it should be noted the sample frames were not representative of the study populations and the samples of provider types were not drawn by applying stratified random sampling methodology. Therefore, by achieving these minimum required number of completed surveys and the response rates, the survey results still were not generalizable to the study populations and MCOs' KanCare Provider Networks of four provider types.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Plan, implement, and report steps to increase the number of completed surveys or improve the response rate by each of the four provider types, such as: multi-modal strategy instead of single mode (e.g., mail, phone, and web-based) for notifications, surveying, and reminders; increasing the duration of survey; frequency and number of reminders; updating and correcting provider contact information prior to survey and throughout the survey – resending survey after researching and finding new contact information; asking the providers the issues related to their non-participation and taking steps to address these issues, and determining the reason for a large number of ineligible surveys. **KFMC Response:** The MCOs implemented and reported certain steps to increase the number of completed surveys or improve the response rate by each of the four provider types. The survey vendor sent follow up emails (a minimum of five) to those who had not completed the survey. The survey vendor provided the MCOs with weekly response rates, information regarding bounce backs, refusals, and non-completions to assist in their outreach. The MCOs followed up, as needed, to unresponsive providers to encourage survey completion. This included phone calls, mailings, or office visits. Additionally, MCOs sent a variety of communications to publicize the survey and its value. These included: an MCO branded provider bulletin to indicate the survey launched; provider facing teams alerted providers that the survey had launched and followed-up with providers who had not completed the survey; MCO Provider Relations (PR) representatives alerted providers of the survey and its value during meetings; and MCO PR representatives added a segment to their email signature block regarding the provider survey. Thus, the MCOs made various efforts maximize the response rate and number of completed surveys. The MCOs did not apply a multi-modal strategy (e.g., mail, phone, and web-based) to conduct the survey and only relied on a single mode web-based survey. The survey reports did not report any steps applied by MCOs for researching and finding new contact information after	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
***Common Among the MCOs* (Continued)**		
	receiving the list of non-valid emails from the survey vendor. The survey reports did not describe the MCOs' attempts for asking the providers (and addressing) the issues related to their non-participation, or for determining the reason for a large number of ineligible surveys.	
•	Plan, apply and report corrective actions implemented during fielding of the survey if the number of completed surveys is less than the minimum expected number by provider type, such as extending the survey cut-off date, or completing an extra provider phone follow-up for the provider types with low numbers of completed surveys. **KFMC Response:** The minimum number of completed surveys was achieved by three provider types for Aetna, two provider types for Sunflower, and all four provider types for UnitedHealthcare. However, due to the application of a convenience sampling methodology for the sample frames and survey samples, with non-representativeness of the sample frames to the study populations, the survey results could only be applied to the providers in the sample frames, and were not generalizable to all of the four provider types. The MCOs did not apply any corrective steps to improve the representativeness of their sample frames, such as identifying additional eligible practices/locations by seeking correct email addresses and phone numbers or adding other modes of survey implementation (e.g., mail survey with telephone follow-up to non-respondents of the mail and web-based survey).	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
6. •	**Design and implement an analysis plan with appropriate statistical tests (if applicable) to obtain survey results generalizable to the UnitedHealthcare's KanCare Network of PCPs, specialists, BH providers and HCBS providers populations** All respondents identified through the "Other, specify" response option, who could not be classified in one of the four required provider types, should be excluded from the survey analysis. **KFMC Response:** As mentioned above, the respondents identified through "Other, specify" who could not be classified in one of the four required provider type groups were excluded from the MCOs' survey analyses.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Calculate and report response rates in addition to the completed responses; also, conduct and report non-response analysis. **KFMC Response:** The response rates were calculated and reported for all three MCOs. However, the response rates were inaccurately calculated for two or more provider types for all the three MCOs. Non-response analysis was conducted and reported for the three MCOs.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
***Common Among the MCOs* (Continued)**		
•	Conduct and report stratified analyses of all survey items for the four provider types. **KFME Response:** The stratified analyses of all survey items, except for those in the *"General Section of the Survey Instrument,"* were conducted and reported for the four provider types. The stratified analyses of all survey questions should have used the total number of completed surveys as their denominators to calculate the satisfaction rates for different aspects of the MCOs' services. In all three MCOs' survey reports, data presented for the survey question asking respondents to rate overall satisfaction with each MCO they currently work with were inconsistent with the data for the provider types shown for the initial question, which was planned to be used for classifying the respondents into the four provider type groups. In addition to this question, the inconsistency from initial the question's data was seen with a few other survey questions of the Sunflower survey, and with all questions of the Aetna survey. Reasons for this deviation were not provided.	Partially Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Create and use sampling weights in the analyses. **KFMC Response:** Sampling weights were not used in the data analysis for all three MCOs' surveys.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Include numerator and denominator counts in the data tables presented in Survey Report. **KFMC Response:** The numerator and denominator counts were presented in the data tables in all MCOs' survey reports.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Include numerators and denominators used for analyzing the data for each survey item (overall and stratified analyses results). **KFMC Response:** The numerators and denominators used for analyzing the data for each survey item were included in MCOs' survey reports.	Fully Addressed: • Aetna • Sunflower • UnitedHealthcare
•	Use and report caution in interpretation of the results when results are based on small numbers. **KFMC Response:** The caution in the interpretation of results due to non-representativeness of the sample frames to the study populations, and non-generalizability to the MCOs' KanCare Provider Networks of four provider types was not mentioned. The interpretations for the results were presented in a manner that could be misinterpreted by the readers as applying to all providers in each MCO's KanCare Provider Network of four provider types.	Not Addressed: • Aetna • Sunflower • UnitedHealthcare

Compliance Review

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Common Among the MCOs				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
1.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: Elements documented in the Service Plan **Aetna**: • Review the internal Aetna process to ensure the following required elements are documented in the Service Plan or a separate specified location (KanCare 2.0 Contract, Section 5.4.4.1 *Plans of Service*) [2022 Recommendation 14]: a. Any services authorized including a detailed description of the amount, scope, and duration of services needed to help meet identified needs or to achieve goals. (LTSS – Nursing Facility [NF] cases; KanCare 2.0 Contract, Section 5.4.4.1.D.3) b. The pharmacy and number. (BH, LTSS – HCBS, and Special Health Care Needs [SHCN] – Title V cases; KanCare 2.0 Contract, Section 5.4.4.1.D.9) c. Primary language being included. (LTSS – NF cases; KanCare 2.0 Contract, Section 5.4.4.1.D.10) d. Eligibility start and end date. (PH, LTSS – NF, and SHCN – Title V cases; KanCare 2.0 Contract, Section 5.4.4.1.D.17) e. Developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting. (PH cases; KanCare 2.0 Contract, Section 5.4.4.1.F) f. Member's preferred method of receiving a copy of their service plan (paper or electronic). (PH, BH, SHCN – Technical Assistance [TA] Waiver and Title V, and LTSS – HCBS and NF cases; KanCare 2.0 Contract, Section 5.4.4.1.I) **KFMC 2023 Update:** ABH submitted the document *Care Plan Development and Updating- Enhanced Version ICM and LTSS* that fully addressed the following: • Letter a: Items 20-22, 24-27, and 33-34. KS LTSS Service Plan, items 24, 26, 27, and 36. • Letter b: Page 4, item 1, lists Pharmacy in the care team participation. • Letter c: Page 7, item 7, has a field for spoken language and written language. • Letter e: Page 1, section "Signatures on Service Plan Letters." • Letter f: Page 7, item 7, has a field for preferred method of receiving the service plan. Letter d: In Progress, as ABH submitted an Information Technology ticket to add a field for the eligibility start and end dates to the Service Plan. For this element to be fully addressed, ABH needs to submit evidence of the finalized Service Plan to demonstrate the changes made. **KFMC 2024 Update:** Related to letter d, the ABH update states, "This item remains incomplete at this time due to IT project backlog." Aetna's contract with the State of Kansas ended December 31, 2024, therefore this recommendation is unable to be addressed.	ABH/ SHP/UHC New	ABH/UHC In Progress SHP Partially Addressed	ABH Unable to Address SHP Fully Addressed UHC In Progress

Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs			
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower: • Review the internal Sunflower process to ensure the following required elements are documented in the Service Plan or a separate specified location (KanCare 2.0 Contract, Section 5.4.4.1 *Plans of Service*) [2022 Recommendation 1]: a. Description of the member's goals, strategies to meet goals and desired health, functional and quality of life outcomes. For youth members, inclusion of their family's goals and strategies shall be incorporated into the Plan of Service. (PH and SHCN – TA – Waiver; KanCare 2.0 Contract, Section 5.4.4.1.D.1) b. Member's identified strengths, preferences, and any identified needs including psycho-social needs and needs related to social determinants of health and independence such as housing or financial assistance. (PH and SHCN – TA Waiver; KanCare 2.0 Contract, Section 5.4.4.1.D.2) c. Risk factors, including a member's understanding of risk factors and potential adverse consequences, member's plans to respond to adverse consequences, and additional measures in place to minimize them, when needed. (PH, SHCN – TA Waiver, and SHCN – Title V; KanCare 2.0 Contract, Section 5.4.4.1.D.4) d. Level of Service Coordination (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.5) e. Medication list with date and dosages (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.8) f. Pharmacy and number (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.9) g. Primary language (SHCN – Title V; KanCare 2.0 Contract, Section 5.4.4.1.D.10) h. Date of next Service Coordination (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.13) i. Date of annual reassessment (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.14) j. Patient liability and/or client obligation information including information about providers to whom the member has paid (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.16) k. Any specialized communication needs including interpreters or special devices required by the member. This includes an identification of any reading challenges. (SHCN – TA Waiver; KanCare 2.0 Contract, Section 5.4.4.1.D.18) l. Member's physical environment and any modifications necessary to ensure the member's health and safety. (PH; KanCare 2.0 Contract, Section 5.4.4.1.D.20) m. Service coordinator name and direct contact information along with appropriate off-hours contact information. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.22) n. Member given a choice of paper or electronic Plan of Service prior to development of the plan. A completed Plan of Service must be provided to the member prior to services beginning. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.I)			

Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs			
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower (Continued): **KFMC 2023 Update**: In letters a-n below, the documents detailed were provided by SHP. a. Kansas Department for Aging and Disability Services approved *Personal Interest Inventory (PII)/Support Plan* and *CC.CM.02 Care Coordination Care Management Policy* demonstrated how member's goals are made and where they are in the Service Plan. b. Health Risk Assessments (HRAs), PII/Support Plan, TA Waiver specific needs assessment, and *CC.CM.02 Care Coordination Care Management Policy* demonstrated the member's strengths, preferences, and needs are assessed and documented appropriately. c. HRAs, *CC.CM.02 Care Coordination Care Management Policy*, and *LTSS WP_PCSP* [Person-Centered Service Plan] policy demonstrated that members are assessed for risk factors, their understanding of risk factors and potential adverse consequences, member's plans to respond to adverse consequences, and additional measures in place to minimize them, when needed. d. From KFMC's inquiry about the expectations of the service plan including the level of service coordination, on September 20, 2023, KDHE confirmed section 5.4.5 of the KanCare 2.0 Contract is on hold based on State policy *M2019-078 Prohibiting Implementation of New Eligibility or Programmatic Changes Before 7-1-2019* (KDHE provided). Therefore, letter d is no longer applicable. However, the *CC.CM.02 Care Coordination Care Management Policy* and *LTSS_WP_PCSP* policy described their levels of service coordination and how it is determined. e. HRAs (examples), the PII/Support Plan, the *CC.CM.02 Care Coordination Care Management Policy*, and the *Nursing Facility Work Process* demonstrated how SHP obtains and documents the member's medication list and consistently updates it, and where in SHP's record the medication list is documented. f. The PCSP demonstrated where the member's preferred pharmacy and contact information is documented. g. HRA examples demonstrated when primary language of the member is asked and documented. h. LTSS – NF: SHP stated, "A note template is being developed to document that the next visit is to occur in the following calendar year." For all of the other review categories, SHP provided the Work Process *CC.CM.02*, and an example of the note in the Care Plan to demonstrate how the date of next service coordination is documented. In order for this element to be fully addressed, SHP needs to submit the note template that documents the next service coordination date. i. LTSS-NF: SHP stated, "A note template is being developed to document that the next visit is to occur in the following calendar year." For PH/SHCN-Title V and BH, no explanation of how the date of annual reassessment is documented in the member's record. For LTSS-HCBS and SHCN-TA Waiver, the *PCSP Work Process* documents how often the annual or semi-annual assessment is completed for each waiver. For this element to be fully addressed, SHP needs to submit the note template that documents the next annual reassessment date.			

Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs			
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower (Continued): j. For PH, BH, SHCN-Title V, and LTSS-NF, no explanation of how patient liability and/or client obligation information is documented in the member's record. For LTSS-HCBS and SHCN-TA Waiver, the PCSP (in the document *KFMC Continuity of Care Response*) demonstrated how it is documented if a member has a client obligation. For this recommendation to be fully addressed, SHP needs to provide documentation and explanation for PH, BH, SHCN-Title V, and LTSS-NF of how patient liability and/or client obligation information is documented (i.e., screenshots of the KMAP system and SHP system). k. PII/Support Plan (in the *KFMC Continuity of Care Response*, pages 13 and 40), demonstrated how the communication needs of the member is documented in the plan. l. HRA examples (see *CCMA.HRA* and *KS HRA KA*) demonstrated how the member's physical environment is assessed and documented and how any modification needs are assessed. m. SHP provided a brief explanation of how the service coordinator name and direct contact information is documented for the member, however, the referenced letter in the explanation for BH was not provided, therefore, it is partially addressed. For all other categories, SHP provided a *Member welcome letter, KFMC Continuity of Care Response,* and *Supporting documents for LTSS-NF Feedback* that showed examples of how the member is given their service coordinator name and contact information, as well as off-hours contact information. For this recommendation to be fully addressed, SHP needs to provide the letter referenced for BH. n. SHP provided a brief explanation of how choice is given to the member for the member's preference for a paper or electronic Plan of Service and that the completed Plan of Service was provided to the member prior to services beginning, however, for the PH, BH, and SHCN-Title V categories, evidence of documentation was not provided, therefore, it is partially addressed. All other review categories are fully addressed as SHP provided the *PCSP Work Process*, section "E. Providing a Finalized Person Centered Service Plan" which covers how the member will be provided the final PCSP. For this recommendation to be fully addressed, SHP needs to provide evidence of how the member's preference for paper or electronic Plan of Service is documented in the member record (i.e., screenshots of the internal system showing the field where preference is documented). **KFMC 2024 Update**: h-i. Fully Addressed: SHP provided a *Note Template Case Management/Care Coordination* and *Annual Visit Completed* template that demonstrates how the service coordinators would document the next service coordination date/annual reassessment date. j. Fully Addressed: SHP provided an explanation as to why patient liability and/or client obligation information may not be documented in the member's record. Sunflower also provided a *Note Template Case Management/Care Coordination* document that outlines how spenddown is documented in the member record. m. Fully Addressed: SHP provided an example of the letter members receive with their service coordinators name and direct contact information and after-hours information.			

Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs			
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower (Continued): n. Fully Addressed: SHP provided a *Note Template Case Management/Care Coordination* that demonstrates how the service coordinators would document the member's preferred method to receive their Plan of Service in the member record. **UnitedHealthcare**: • Review the internal UnitedHealthcare process to ensure the following required elements are documented in the Service Plan or a separate specified location (KanCare 2.0 Contract, Section 5.4.4.1 *Plans of Service*) [2022 Recommendation 2]: a. The level of service coordination. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.5) b. The medication list with date and dosages. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.8) c. The pharmacy and number. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.9) d. Primary language. (LTSS – NF cases; KanCare 2.0 Contract, Section 5.4.4.1.D.10) e. Dates of next service coordination. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.13) f. Date of annual reassessment. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.14) g. The service coordinator name and direct contact information along with appropriate off-hours contact information. (All six case review categories; KanCare 2.0 Contract, Section 5.4.4.1.D.22) h. Developed and signed by and distributed to all relevant parties within thirty (30) days of the interdisciplinary team meeting. (SHCN – TA Waiver cases; KanCare 2.0 Contract, Section 5.4.4.1.F) **KFMC 2023 Update:** For letter a, KFMC inquired with the State about the expectations of the service plan including the level of service coordination. On September 20, 2023, KDHE provided KFMC confirmation that Section 5.4.5 "Service Coordination Stratification Levels and Contact Schedules" of the KanCare 2.0 Contract is on hold based on State *Policy M2019-078 Prohibiting Implementation of New Eligibility or Programmatic Changes Before 7-1-2019*. KDHE provided the referenced policy. Therefore, letter a is no longer applicable. For letters b-g, UHC reports that they are "reviewing the most appropriate location to document this requirement, as this impacts multiple care coordination populations." For letter h, UHC needs to submit the referenced processes that align with this requirement. Also, provide documentation of the date this was reinforced with UHC staff and what method was used. **KFMC 2024 Update:** For letters b-h, UHC stated the PCSP documents will need to be updated to reflect the changes in the *KanCare 3.0* contract. Therefore, they are waiting for State instruction and will not incorporate all changes until then. Upon completion, UHC needs to provide KFMC documentation of when the changes were made and provide a template PCSP reflecting the changes. This recommendation is in progress.			

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Common Among the MCOs				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
2.	Case Review related to §438.208(b)(1) Coordination and continuity of care: **Aetna**: • Aetna should educate providers on the following (2022 Recommendation 16 and **2023 Recommendation 3**): a. Ask if the member received services elsewhere. (PH, BH, and SHCN – Title V) b. Providers should have contact with other service providers. (PH, BH, LTSS – HCBS, SHCN – TA Waiver and Title V) c. The provider should acknowledge test results. (PH, BH, and SHCN – TA Waiver) d. Follow-up should be documented by the provider. (BH) e. The provider should have follow-up of all results and inform the member of the results. (PH, BH, and SHCN – TA Waiver) f. Providers need to include evidence that that the referral took place. (BH) g. Providers need to include in consult or referral notes that the consult occurred. (PH) h. In the record, there needs to be evidence of continuity of care in the provider setting. (SHCN – TA Waiver and Title V) **i. Follow-up, next steps or plans for each encounter should be documented by the provider.** **KFMC 2023 Update:** ABH provided a Provider Bulletin that covers all the education in the recommendation. The bulletin is being reviewed internally and then will go through the KDHE approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved bulletin. **KFMC 2024 Update:** a-h. Fully Addressed: ABH submitted the approved finalized bulletin. i. Not Addressed: ABH did not provide evidence of progress made for letter i of the recommendation. **Sunflower**: • Sunflower should educate providers on the following (2022 Recommendation 4): a. Ask if the member received services elsewhere. (PH) b. Providers should have contact with other service providers. (PH) c. The provider should acknowledge test results. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) d. Follow-up of all results should be documented by the provider. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) e. The provider should have follow-up of all results and inform the member of the results. (PH, BH, LTSS – HCBS, LTSS – NF, SHCN – TA Waiver, and SHCN – Title V) f. Providers need to include evidence that that the consult services took place. (PH, BH, LTSS – HCBS, and SHCN – TA Waiver) g. Consult or referral notes should be included in the record. (PH, BH, SHCN – TA Waiver, and SHCN – Title V)	ABH/SHP/ UHC New	ABH/SHP/ UHC In Progress	ABH/UHC Partially Addressed SHP Fully Addressed

Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs			
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
Sunflower (Continued): **KFMC 2023 Update**: SHP provided their *2023 Medicaid Provider Orientation* that included (slide 30) a summarization of how providers can facilitate coordination of care, including referrals. However, the list does not include all of the specific areas identified in this recommendation (a-g), and SHP reported that new slides are being developed to be included in the presentation. SHP needs to provide the approved revised Medicaid Provider Orientation that addresses letters a-g. **KFMC 2024 Update**: SHP provided the *2024 Medicaid Provider Orientation* with all of the stated changes from the 2023 Progress Update. This recommendation is fully addressed. **UnitedHealthcare**: • UnitedHealthcare should educate providers on the following (2022 Recommendation 5): a. Ask if the member received services elsewhere. (PH and BH) b. Providers should have contact with other service providers. (PH and BH) c. The provider should acknowledge test results. (BH) d. Follow-up of all results should be documented by the provider. (PH and BH) e. The provider should have follow-up of all results and inform the member of the results. (PH and BH) f. Providers need to include evidence that that the referral took place. (PH, BH, LTSS – NF, and SHCH – Title V) g. Consult or referral notes should be included in the record. (PH and LTSS – NF) **KFMC 2023 Update:** UHC reported that they "will send out communication to providers reminding them of this requirement" for all elements of this recommendation. For this recommendation to be fully addressed, UHC needs to send to KFMC, for review, education materials that were used, the date/s the communication was sent to providers, and what method was used to send the communication. **KFMC 2024 Update:** UHC advised they perform an annual audit of provider records called the *MRR* [Medical Record Review] *Audit*. Medical records are reviewed along with confirmation of test results and referral arrangements. Results are presented to providers after the audit. UHC submitted the *Coordination of Care Checklist*, *Coordination of Care Flyer*, and *Provider Administrative Guide (Care Provider Manual)* to address recommendations a-g. From that review, KFMC determined letters a-c and f-g were fully addressed and letters d-e were partially addressed. KFMC noted the following: • *Coordination of Care Checklist (for Provider)* addressed recommendations f-g. • *Coordination of Care Flyer*, section "Guidelines for Effective Communication," addressed recommendation a.			

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Common Among the MCOs				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
	• *Provider Administrative Guide (Care Provider Manual)* fully addressed letters b and c of the recommendation, and partially addressed letters d and e. To fully address letters d and e of the recommendation, UHC needs to add information that follow-up of all results should be documented by the provider for all members and inform the members of the results.			
Aetna				
	2022 Recommendations: Subpart B – State Responsibilities			
3.	§438.56(c)(1) Disenrollment: Requirements and Limitations – Disenrollment Requested by the Enrollee: • In Aetna policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* include the following (2022 Recommendation 1): a. Regulatory language stating members may request disenrollment for cause, at any time. b. The additional three reasons to disenroll for cause that are detailed in the *Member Handbook*: "If you no longer qualify for Medicaid under one of the eligible categories; If you transfer to an eligibility category that is not included in the benefits; and Renewing your insurance." **KFMC 2023 Update:** ABH provided policy *4500.86 Member Disenrollment/Disruptive Member Transfer* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed
4.	§438.56(d)(2)(iv) Disenrollment: Requirements and Limitations – Procedures for Disenrollment-Cause for Disenrollment: • Include in policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* the regulatory language that states, "For enrollees that use Medicaid Managed Long Term Services and Supports, the enrollee would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the MCO, PIHP, or PAHP and, as a result, would experience a disruption in their residence or employment." (2022 Recommendation 3) **KFMC 2023 Update:** ABH provided policy *4500.86 Member Disenrollment/Disruptive Member Transfer* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *4500.86 Member Disenrollment/Disruptive Member Transfer* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Aetna (Continued)				
	2022 Recommendations: Subpart C – Enrollee Rights and Protections			
5.	§438.10(f)(1) Information requirements: Information for all enrollees of MCO's – General requirements: • For consistency with the *Member Handbook* and the *Member Notification for Provider Terminations Desktop Process*, in policy and procedure *7000.40 Member Transition,* section "Policy," sub-section "Notification of Practitioner or Provider Group Termination Requirements," include the word "written" to identify written notice of termination is provided to members affected by the termination of a practitioner or practice group in the statements below. (2022 Recommendation 4) a. "Health plan notifies members affected by the termination of a practitioner or practice group in general, family, or internal medicine or pediatrics **at least ten (10) calendar days prior** to the effective termination date [bold in original]." (Page 1) b. "If a practitioner notifies the health plan of termination **less than ten (10) days prior** to the effective date, the health plan notifies the affected members as soon as possible, but **no later than ten (10) calendar days after** receipt of the notification [bold in original]." (Page 2) **KFMC 2023 Update:** ABH provided policy *7000.40 Member Transition – Kansas Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *7000.40 Member Transition– Kansas Amendment* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed
6.	§438.10(f)(1) Information requirements: Information for all enrollees of MCO's – General requirements: • Provide consistency between the *Member Notification for Provider Terminations Desktop Process* and policy and procedure *7000.40 Member Transition,* as the policy and procedure details member notification will be sent in "at least ten (10) calendar days prior to the effective termination date" or "no later than ten (10) calendar days after receipt of the notification" and the Desktop Process details "Members will be notified no more than 15 calendar days from the date of issuance." (2022 Recommendation 5) **KFMC 2023 Update:** ABH provided policy *7000.40 Member Transition – Kansas Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *7000.40 Member Transition– Kansas Amendment* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart C – Enrollee Rights and Protections (Continued)			
7.	§422.128(b)(1)(i) Information on advance directives; §417.436(d)(1)(i)(A) Rules for enrollees: Advance directives; and §489.102(a)(1)(i) Requirements for providers (related provision to §438.10[g][2][xii] Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities – Enrollee handbook and §438.3[j] Standard contract requirements: Advance directives): • Add to Aetna policy and procedure *7800.70 Advance Directives Corporate Policy,* section "Focus/Disposition: Scope," fourth bullet, the words "in state law." It would read, "Members are notified of any changes as soon as possible but no later than ninety (90) days after the effective date of the change **in state law**." (2022 Recommendation 8) **KFMC 2023 Update:** ABH provided policy *7500.90 Advance Directives Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *7500.90 Advance Directives Amendment* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed
8.	§422.128(b)(1)(i) Information on advance directives; §417.436(d)(1)(i)(A) Rules for enrollees: Advance directives; and §489.102(a)(1)(i) Requirements for providers (related provision to §438.10[g][2][xii] Information requirements: Information for enrollees of MCOs, PIHPs, PAHPs, and PCCM entities – Enrollee handbook and §438.3[j] Standard contract requirements: Advance directives): • Add to Aetna policies and procedures *4500.70 Advance Directives* and *7800.70 Advance Directives Amendment* or *7800.70 Advance Directives Corporate Policy* the regulatory language that states, "Providers may contract with other entities to furnish this information but remain legally responsible for the ensuring that the requirements of this section are met." (KanCare 2.0 Contract, Section 5.10.2 *Advance Directives*, letter B, number 1) (2022 Recommendation 9) **KFMC 2023 Update:** ABH provided policy *7500.90 Advance Directives Amendment* that was updated to include the recommended regulatory language. Currently, the updated policy is going through ABH's approval process; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *7500.90 Advance Directives Amendment* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
9.	Case Review related to §438.208(b)(1) Coordination and Continuity of Care: • Review the internal Aetna process to ensure the Service Plan has the following completed (KanCare 2.0 Contract, Sections 5.4.4.1 *Plans of Service* and 5.4.4.2 Person Centered Service Planning) [2022 Recommendation 15; **2023 Recommendation 2**]: a. Signed and approved. (PH, and SHCN – Title V cases; KanCare 2.0 Contract, Sections 5.4.4.1.G and 5.4.4.2.C) b. Signed by the Member, their MCO service coordinator, community service coordinator, and any providers that were present during the development of the Plan of Service. (PH and SHCN – Title V cases; KanCare 2.0 Contract, Section 5.4.4.1.G.2) c. Signatures being obtained from, at a minimum, the service coordinator, the community service coordinator, and Member prior to implementation unless an extraordinary circumstance prevented signatures from being obtained. (PH cases; KanCare 2.0 Contract, Section 5.4.4.1.G.3) d. Signed by the Member, guardian, or legal representative, the MCO service coordinator, the community service coordinator, and all providers listed on the PCSP. (PH and SHCN – Title V; KanCare 2.0 Contract, Section 5.4.4.2.C.2) e. Distributed to all attendees within 14 days of the development of the plan. (SHCN – Title V cases; KanCare 2.0 Contract, Section 5.4.4.2.H) **f. The medication list with date and dosages. (KanCare 2.0 Contract, Section 5.4.4.1.D.8)** **g. Dates of next service coordination contact. (KanCare 2.0 Contract, Section 5.4.4.1.D.13)** **h. Date of annual reassessment. (KanCare 2.0 Contract, Section 5.4.4.1.D.14)** **i. Reviewed during every contact with the member and updated with new signatures as needed. (KanCare 2.0 Contract, Section 5.4.4.1.H)** **KFMC 2023 Update:** a-d. Fully addressed: Pages 1-2, section "Signatures on Service Plan Letters," outlines the requirements of signatures on the Service Plan. e. Partially addressed: Page 2, section "Signatures on Service Plan Letters," subsection "LTSS" states, "**Service Plan Letter** must be sent to/shared with the member/legal representative and PCP (at minimum). It must also be shared with any ICT [Interdisciplinary Care Team] member of the member's choosing." However, no time frame was stated. For this element to be fully addressed, ABH needs to provide evidence that the Service Plan is distributed within 14 days of the development of the plan. **KFMC 2024 Update:** e. Fully Addressed: For October 2023 through March 2024, ABH provided the average turnaround times between PCSP create date and the letter being sent. All months had average turnaround times within the 14-day requirement. f-i. Fully Addressed: ABH provided evidence of a training held in June 2024, to educate staff on elements f-i of the recommendation. Also, ABH submitted a sample service plan that details elements f-i of the recommendation.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
10.	Case Review related to §438.208(b)(1) Coordination and continuity of care: • Aetna should review the case identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (PH Title 19 Member 9) (2022 Recommendation 17) **KFMC 2023 Update:** ABH provided a brief explanation of outreach for PH Title 19 Member 9, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence of either follow-up done with the member and/or outreach/education done with the provider. **KFMC 2024 Update:** ABH submitted evidence of outreach attempts, including notes, to the member from ABH case workers. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
11.	Case Review related to §438.208(b)(1) Coordination and continuity of care: • Aetna should review the case and determine appropriate follow-up, if needed (e.g., MCO follow-up regarding the specific case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (LTSS – NF Member 7) (2022 Recommendation 18 and **2023 Recommendation 4**) ○ 2022 Sample Selection: LTSS – NF Member 7 ○ **2023 Sample Selection: LTSS – NF Members 4 and 9** **KFMC 2023 Update:** ABH provided a brief explanation of outreach for LTSS – NF Member 7, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence of either follow-up done with the member and/or outreach/education done with the case management staff. **KFMC 2024 Update:** LTSS – NF Member 7 (2022 sample selection): Fully Addressed. ABH provided the outreach to the member. LTSS – NF Members 4 and 9 (2023 sample selection): Not Addressed. ABH did not provide progress to address this element of the recommendation.	New	Not Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
12.	Case Review related to §438.208(b)(1) Coordination and continuity of care: • Aetna should review the case identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Aetna details for the member in a separate, secure document. (SHCN – Title V Member 20) (2022 Recommendation 19) **KFMC 2023 Update:** ABH provided a brief explanation of outreach for SHCN – Title V Member 20, but no evidence was provided. For this recommendation to be fully addressed, ABH needs to provide evidence (i.e., documentation such as case management notes) of the parent declining services. **KFMC 2024 Update:** ABH submitted visit and assessment history for SHCN – Title V Member 20 that details visit history and plan of care. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
13.	§438.210(d)(1)(i-ii) Coverage and authorization of services: Standard authorization decisions (Also applies to Subpart F §438.404[c][3] Timely and adequate notice of adverse benefit determination: Timing of notice [Standard service authorization decisions]): • In Aetna policy and procedure *7100.05 Prior Authorization,* section "Extension of Decision Times for Non-urgent Pre-service Decisions," second paragraph, change the time frame of "fifteen (15) for NOA [Notice of Action] additional calendar days" to "fourteen (14) calendar days" to be consistent with the regulation and KanCare 2.0 Contract Attachment D Section 4.3.3.2.1 that details "fourteen (14) calendar days." (2022 Recommendation 21) **KFMC 2023 Update:** ABH submitted policy amendment *7200.03 UM timeliness Standards and Decision Notification Amendment* that includes the recommended regulatory language. ABH reported, currently, this policy amendment is under internal review; therefore, this recommendation is In Progress. For this recommendation to be fully addressed, ABH needs to submit the finalized approved policy. **KFMC 2024 Update:** ABH provided the approved finalized policy and procedure *7200.03 UM Timeliness Standards and Decision Notification Amendment* that includes the recommended regulatory language. This recommendation is fully addressed.	New	In Progress	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
14.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the "Disclosure of Ownership and Controlling Interest and Management Statement" for Providers 1 through 15. (2022 Recommendation 24) **KFMC 2023 Update:** ABH provided an explanation of how the Disclosure of Ownership and Controlling Interest is collected and reviewed, however, the attachments that ABH referred to could not be found in the ABH file upload. The only case that details the Disclosure of Ownership form is Provider 3 (pages 94-108). For this recommendation to be fully addressed, ABH needs to show how the Disclosure of Ownership and Controlling Interest and Management Statement is verified/assessed for credentialing. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where' [MCO NAME] provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing." **KFMC 2024 Update:** ABH provided the Disclosure of Ownership and Controlling Interest for the remaining providers on the case list. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
15.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the National Plan and Provider Enumeration System (NPPES) check that was completed on Providers 1, 2, 4-7, 9, 12, 13, and 15. (2022 Recommendation 25) **KFMC 2023 Update:** For Providers, 1, 2, 4, 6, 7, 9, 12, 13, and 15, ABH provided the NPPES check that was completed. The document provided for Provider 5 was blank; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that the NPPES was completed for Provider 5 (the document needs to have the provider's name on it). **KFMC 2024 Update:** The ABH update stated the needed document was not able to be opened due to a firewall issue and updates were implemented to prevent the issue from happening again. Due to the firewall issue, the evidence the NPPES was ran for Provider 5 and is not able to be submitted since they are not able to restore the document. Aetna is unable to provide the documentation for Provider 5, therefore this case is unable to be addressed.	New	Partially Addressed	Fully Addressed (9 cases) and Unable to Address (1 case)

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
16.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) to any person with an ownership or control interest or who is an agent or managing employee of the provider check that was completed for Providers 2, 4-9, 12, 13, and 15. (2022 Recommendation 27) **KFMC 2023 Update:** For Providers, 2, 4, 7, 8, 9, 12, and 15, ABH provided the OIG LEIE check that was completed. The documents provided for Providers 5 and 6 were blank, and Provider 13 was not provided; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that the OIG LEIE check was completed for Providers 5, 6, and 13 (the document needs to have the provider's name on it). **KFMC 2024 Update:** The ABH update stated the needed document was not able to be opened due to a firewall issue and updates were implemented to prevent the issue from happening again. Due to the firewall issue, the evidence the OIG LEIE check was completed for Providers 5 and 6 and is not able to be submitted since they are not able to restore the document. Aetna is unable to provide the documentation for Providers 5 and 6, therefore these cases are unable to be addressed.	New	Partially Addressed	Fully Addressed (8 cases) and Unable to Address (2 cases)
17.	Individual Health Care Professional File Credentialing/Recredentialing Case Review related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the General Services Administration's System for Awards Management (GSA–SAM) check that was completed for Providers 5, 7, 9, 12, and 15. (2022 Recommendation 28) **KFMC 2023 Update:** For Providers, 7, 9, 12, and 15, ABH provided the GSA-SAM check that was completed. The document provided for Provider 5 was blank; therefore, this recommendation is partially addressed. For this recommendation to be fully addressed, ABH needs to provide evidence that GSA-SAM check was completed for Provider 5 (the document needs to have the provider's name on it). **KFMC 2024 Update:** In the ABH update, explanation was provided that the GSA-SAM is checked monthly after the initial credentialling of a provider, therefore, a GSA-SAM check is not necessary during recredentialling. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
18.	Individual Health Care Professional File Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide detail regarding the significant delay between when the credentialing was approved and when the provider was notified by letter for Providers 7, 11, and 12. (2022 Recommendation 29) **KFMC 2023 Update:** For Providers 7, 11, and 12, ABH provided an explanation of the significant delay between when the credentialling was approved and when the provider was notified, however, no evidence was provided to support the reported update. For this recommendation to be fully addressed, ABH needs to provide documentation of the update (i.e., a process flow or work process of the automation). **KFMC 2024 Update:** In the ABH update, the Desktops *PRMS QuickBase Work Queues (Credentialing Record Table)* and *Credentialing Approval Letter* were submitted. They describe the steps that move the credentialing applications forward to improve the timeliness of notification. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
19.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the notification to the provider of the credentialing decision for Provider 1. (2022 Recommendation 30) **KFMC 2023 Update:** The file provided was for Individual Provider 1, but the file needed is Institutional Provider 1. For this recommendation to be fully addressed, ABH needs to provide the notification to the provider of the credentialling decision for Institutional Provider 1. **KFMC 2024 Update:** In the ABH update, ABH stated they are unable to address this recommendation, as they are not able to provide the notification to the provider of the credentialing decision for Provider 1. This was due to not having a central repository at the time of credentialing for the provider. ABH made updates to their credentialling process to remediate this recommendation. This recommendation is unable to be addressed.	New	Not Addressed	Unable to Address
20.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the attestation of correctness for Provider 2. (2022 Recommendation 31) **KFMC 2023 Update:** ABH stated the evidence for the attestation of correctness is in the uploaded attachments, however, the attachments were not found. For this recommendation to be fully addressed, ABH needs to provide the attachments for Institutional Provider 2. **KFMC 2024 Update:** The files submitted for this recommendation were for Individual Provider 2, not Institutional Provider 2. This recommendation continues is not addressed. In March 2025, ABH provided a second submission for Institutional Provider 2; however, it did not include the attestation of correctness. This recommendation continues to be not addressed.	New	Not Addressed	Not Addressed

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
21.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the Disclosure of Ownership and Controlling Interest and Management statement for Providers 2, 3, 7, 8, and 10-14. (2022 Recommendation 32) **KFMC 2023 Update:** ABH provided a brief explanation but did not specify for what provider/s the explanation was for. Also, there were no documents submitted as evidence. For this recommendation to be fully addressed, ABH needs to show how the Disclosure of Ownership and Controlling Interest and Management Statement is verified/assessed for credentialing. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where' [MCO NAME] provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing." **KFMC 2024 Update:** In the ABH update, ABH stated they are unable to address this recommendation, as they are not able to provide the notification to the provider of the credentialing decision for Providers 7, 8, and 10-14 due to not having a central repository at the time of credentialing for the provider. To remediate this issue, ABH updated their credentialing process. The Disclosure of Ownership was submitted for Providers 2 and 3. This recommendation is fully addressed for Providers 2 and 3. Aetna is not able to address the recommendation for Providers 7, 8, and 10-14.	New	Not Addressed	Fully Addressed (2 cases) and Unable to Address (7 cases)
22.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the NPPES check that was completed for Providers 2, 3, 7, 8, 10, 11, 13, and 14. (2022 Recommendation 33) **KFMC 2023 Update:** The files provided were for the Individual Providers, but the files needed are Institutional Providers 2, 3, 7, 8, 10, 11, 13, and 14. For this recommendation to be fully addressed, ABH needs to provide the notification to the provider of the credentialling decision for Institutional Providers 2, 3, 7, 8, 10, 11, 13, and 14. **KFMC 2024 Update:** ABH submitted evidence that the NPPES check was completed for Institutional Providers 2, 3, 7, 8, 11, and 13. The file submitted for Institutional Provider 10 was not able to be opened and no document was submitted for Institutional Provider 14. The recommendation is partially addressed.	New	Not Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
23.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the OIG LEIE to any person with an ownership or control interest or who is an agent or managing employee of the provider check that was completed for Provider 2. (2022 Recommendation 34) **KFMC 2023 Update:** The file provided was for Individual Provider 2, but the file needed is Institutional Provider 2. For this recommendation to be fully addressed, ABH needs to provide the OIG LEIE for Institutional Provider 2. **KFMC 2024 Update:** ABH submitted evidence of the OIG LEIE being checked for Institutional Provider 2. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
24.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the GSA-SAM check that was completed for Providers 2, 3, 7, 8, 10, 11, and 14. (2022 Recommendation 35) **KFMC 2023 Update:** The files provided were for Individual Providers 2, 3, 7, 8, 10, 11, and 14, but the files needed are Institutional Providers 2, 3, 7, 8, 10, 11, and 14. For this recommendation to be fully addressed, ABH needs to provide the GSA-SAM check for Institutional Providers 2, 3, 7, 8, 10, 11, and 14. **KFMC 2024 Update:** In the ABH update, explanation was provided that the GSA-SAM is checked monthly after the initial credentialing of a provider, therefore, a GSA-SAM is not necessary during recredentialing. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
25.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide documentation of Malpractice insurance/professional liability insurance for Providers 1-4. (2022 Recommendation 36) **KFMC 2023 Update:** The files provided were for Individual Providers 1-4, but the files needed are Institutional Providers 1-4. For this recommendation to be fully addressed, ABH needs to provide documentation of malpractice insurance/professional liability insurance for Institutional Providers 1-4. **KFMC 2024 Update:** ABH provided documentation of the Malpractice insurance/professional liability insurance for Institutional Providers 1-4. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
26.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, for initial credentialing files, provide the date of receipt of the application for Providers 1, 4, 9, and 15. (2022 Recommendation 38) **KFMC 2023 Update:** The files provided were for Individual Providers 1, 4, 9, and 15, but the files needed are for the Institutional Providers 1, 4, 9, and 15. For this recommendation to be fully addressed, ABH needs to provide documentation of the date of receipt of the application for Institutional Providers 1, 4, 9, and 15. **KFMC 2024 Update:** ABH provided the date of receipt of the applications for Institutional Providers 4, 9, and 15. KFMC was not able to open the file submitted for Institutional Provider 1. This recommendation is partially addressed.	New	Not Addressed	Partially Addressed
27.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide a copy of the insurance policy for Provider 11. (2022 Recommendation 40) **KFMC 2023 Update:** The file provided was for Individual Provider 11, but the file needed is Institutional Provider 11. For this recommendation to be fully addressed, ABH needs to provide a copy of the insurance policy for Institutional Provider 11. **KFMC 2024 Update:** ABH provided proof of insurance for Institutional Provider 11. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
28.	§438.214(e) Provider selection: State requirements: • Credentialing decisions should be communicated to the provider within 60 days of the completed application being received. (Individual Health Care Professional Providers 6 and 13) [2022 Recommendation 41] **KFMC 2023 Update:** ABH provided the Approval letters for Individual Health Care Professional Providers 6 and 13; however, there was no explanation as to why the credentialling decision was communicated outside of the 60-day timeframe. For this recommendation to be fully addressed, ABH needs to provide evidence and remediation (i.e., staff education) as to why it took longer than 60 days to communicate the decision. **KFMC 2024 Update:** ABH submitted Desktops *PRMS QuickBase Work Queues (Credentialing Record Table)* and *Credentialing Approval Letter* that describe the steps that move the credentialing applications forward to improve the timeliness of notification. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Aetna (Continued)				
	2022 Recommendations: Subpart F – Grievance and Appeal System			
29.	§438.408(c)(2) Resolution and Notification: Grievances and appeals – Extension of timeframes-requirements following extension and §438.410(c)(2) Expedited resolution of appeals: Action following denial of a request for expedited resolution: • In the *Member Handbook*, related to Aetna extending the timeframes not at the request of the member, in the section "Grievance Extension" and the section "Appeals," subsection "If we need more information," add the following regulatory language (2022 Recommendation 46): a. Make reasonable efforts to give the enrollee prompt oral notice of the delay. b. Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe. Specific to the section "Appeals," subsection "If we need more information," inform the enrollee of the right to file a grievance if he or she disagrees with that decision. **KFMC 2023 Update:** ABH submitted the request to add the recommended regulatory language to the *Member Handbook*. For this recommendation to be fully addressed, ABH needs to provide the updated approved *Member Handbook*. **KFMC 2024 Update:** ABH submitted the approved finalized *Member Handbook* with the recommended changes. This recommendation is fully addressed.	New	In Progress	Fully Addressed
30.	Appeal Case Review related to §438.408(e)(1) Resolution and notification: Grievance and appeals – Content and notice of appeal resolution: • Include the date of completion in the written notice of resolution for each level of the appeal (Members 1-30). (2022 Recommendation 49) **KFMC 2023 Update:** ABH provided member letter templates for the written notice of resolution that include the date of completion; however, the letters need KDHE approval before finalizing. For this recommendation to be fully addressed, ABH needs to provide the final approved letter templates. **KFMC 2024 Update:** ABH submitted the final approved letter templates that include the date of completion, as well as the approval from the State. This recommendation is fully addressed.	New	In Progress	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Aetna				
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)				
31.	§438.420(a)(i-ii) Continuation of benefits while the MCO appeal and the State fair hearing are pending: Definition: • Related to continuation of benefits for Non-HCBS Waiver and HCBS Waiver services, complete the following (2022 Recommendation 54): a. Add distinction to the Aetna appeal resolution letters, between continuation of benefits for Non-HCBS Waiver and HCBS Waiver services. b. In the section "Continuation of Benefits" in the *Provider Manual*, include language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*. c. In Aetna policy and procedure *3100.70 Enrollee Appeals,* section "Request for Continued Benefits During Appeals Process," include language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook.* **KFMC 2023 Update:** a. Not Addressed: ABH did not provide an updated Appeal Resolution Letter Template to demonstrate the recommended regulatory language had been added. For this to be fully addressed, ABH needs to provide an approved updated letter template that has a distinction between continuation of benefits for Non-HCBS Waiver and HCBS Waiver services. b. Fully Addressed: ABH provided an updated *Provider Manual* that includes language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*. c. Fully Addressed: ABH provided policy *3100.70 Enrollee Appeals*. Section "Request for Continued Benefits During Appeals Process," (pages 12-13) includes language on continuation of benefits for Non-HCBS Waiver and HCBS Waiver services that is consistent with the *Member Handbook*. **KFMC 2024 Update:** a. Fully Addressed: ABH submitted the approved updated letter templates that have a distinction between continuation of benefits for non-HCBS Waiver and HCBS Waiver services.	New	Partially Addressed	Fully Addressed
2023 Recommendations: Subpart D – MCO, PIHP and PAHP Standards				
32.	Case Review Related to §438.208(b)(3) Coordination and continuity of care: • Re-educate staff that a health screen should be completed or an attempt to contact the member should be made within 90 days of enrollment or every other year. (2023 Recommendation 5) **KFMC 2024 Update:** ABH submitted the presentation done with all service coordinators. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
Sunflower				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards			
3.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: For ease of reference for members and providers, for any applicable elements listed above (see Common to the MCOs recommendation 1) that are not included in the Service Plan or PCSP, make a reference in the Service Plan/PCSP indicating where the information can be located. (2022 Recommendation 2) **KFMC 2023 and 2024 Updates**: See the KFMC 2023 and 2024 Updates in "Common to the MCOs," Recommendation 1.	New	Partially Addressed	Fully Addressed
4.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: Review the internal Sunflower process to ensure that the PCSP documents the following (2022 Recommendation 3): a. Distributed to all attendees within fourteen (14) days of the development of the plan. (LTSS – HCBS cases; KanCare 2.0 Contract 5.4.4.2.H) b. Signed and approved. (PH and LTSS – HCBS cases; KanCare 2.0 Contract, Section 5.4.4.2.C) c. Signed by the member, guardian, or legal representative, the MCO service coordinator, the community service coordinator, and all providers listed on the PCSP. (PH and LTSS – HCBS cases; KanCare 2.0 Contract, 5.4.4.2.C.2) d. Signed by the service coordinator, the community service coordinator, and member prior to implementation. (PH and LTSS – HCBS cases; KanCare 2.0 Contract, Section 5.4.4.1.C.3) **KFMC 2023 Update**: a. The SHP *PCSP Work Process* (page 13) details the member is given the finalized plan and the Care Manager confirms receipt of the plan, however, no timeframe is listed. This element is In Progress. For this element to be fully addressed, SHP needs to submit the approved revised process that reflects specific distribution of the plan within 14 days of development. b-d. For LTSS – HCBS, SHP submitted the *PCSP Work Process* that describes the member signature requirements (pages 8-12). For PH, SHP explained how the verbal consent of the member is obtained, but no SHP internal process was submitted, therefore, these elements are partially addressed. **KFMC 2024 Update**: a. Fully Addressed: SHP submitted the *PCSP Work Process*. On page 11, section "E. Providing a Finalized Person Centered Service Plan," letter b states, "The final PCSP will be provided to the member according to the method based on their preferred communication preferences, within fourteen (14) days of the development of the plan." b-c. Fully Addressed: SHP submitted the *PCSP Work Process* that addressed the required signatures.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Sunflower				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
5.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: Sunflower should review the cases identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided Sunflower details for each member in a separate and secure document (2022 Recommendation 5): a. PH TXIX: Members 1, 2, 4, 5, 7, 9, 10, 13, 15, and 17; PH TXXI: Members 1, 3, 4, 5, 6, 8, 9, 10, 11, and 14 b. BH TXIX: Members 8, 9, and 16; TXXI Members 2, 5, 7, 8, 9, 10, 11, and 14 c. LTSS – HCBS Members 6, 9, and 11 d. LTSS – NF Members 2 and 10 e. SHCN – Title V Member 22 **KFMC 2023 Update**: Overall, in the update provided, SHP addressed most of the members noted in the recommendation, however, no documentation was provided. The following members were not addressed and/or the explanation did not adequately address the recommendation: PH TXIX Member 9; BH TXIX Member 8; BH TXXI Members 2, 7, 8, and 9; LTSS – HCBS Member 9; and SHCN – Title V Member 22. SHP reports they are in progress of addressing the issues identified for PH TXXI Member 8 and LTSS – NF Member 10. For this recommendation to be fully addressed, SHP needs to provide documentation of the outreach attempts (i.e., screenshots of the system that tracks texts or mailers sent with date stamps), provide staff and provider education materials, and address the concerns made for those members not adequately addressed. KFMC provided SHP a sperate document via the Secure File Transfer Protocol (SFTP) for detailed explanation of the cases. **KFMC 2024 Update**: From the documentation submitted, KFMC noted the following: • PH TXIX and TXXI, BH TXIX, LTSS – HCBS, LTSS – NF, and SHCN – Title V: Fully Addressed – SHP submitted the requested documentation. • BH TXXI: Partially Addressed – SHP provided an explanation for the reason there was no documentation for Members 2 and 7 and provided the outreach documentation for Members 8 and 9. No additional documentation of the outreach attempts was submitted for Members 5, 10, 11, and 14; therefore, this element of the recommendation is partially addressed. For this element to be fully addressed, SHP needs to provide documentation of the outreach attempts (i.e., screenshots of the system that tracks texts or mailers sent with date stamps) for BH TXXI Members 5, 10, 11, and 14.	New	Partially Addressed	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Sunflower				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
6.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: In the 2023 follow-up review, provide notification of credentialing decision letter for Providers 1, 8, and 14. (2022 Recommendation 10) **KFMC 2023 Update**: SHP provided explanation of why the notification of credentialing decision letter was not sent to the listed Institutional providers and stated that SHP processes have been updated to send notification of approval. For this recommendation to be fully addressed, SHP needs to provide documentation of the process change (i.e., the written work process, a policy and procedure, and/or the email template for notification of approval of recredentialing). **KFMC 2024 Update**: SHP submitted the email template and the work process to send email notification of approval or recredentialling for practitioners. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
7.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: In the 2023 follow-up review, provide State Uniform HCBS Supplemental Form for Provider 3. (2022 Recommendation 13) **KFMC 2023 Update**: SHP did not provide the document to KFMC, and it was not noted as a missing document when KFMC confirmed the number of uploaded documents (KFMC SFTP), therefore, this recommendation is not addressed, as KFMC was unable to review the State Uniform HCBS Supplemental Form for Provider 3. **KFMC 2024 Update**: SHP submitted evidence that the documentation was reviewed for the State Uniform HCBS Supplemental Form for Provider 3. This recommendation is fully addressed.	New	Not Addressed	Fully Addressed
2023 Recommendations: Subpart F – Grievance and Appeal System				
8.	Grievance Case Review Related to §438.402(c)(1)(ii) General requirements: Filing requirements (Authority to rile) and KanCare 2.0 Contract Section 4.2.1.16.2; §438.210(c) Notice of adverse action; §438.404(b)(3) Timely and adequate notice of adverse benefit determination – Content of notice; and §438.416(b)(6) Recordkeeping requirements: For the identified cases, review the internal system documentation and determine who filed the grievance and ensure all areas of the internal system are consistent (Members 11, 17, and 19). KFMC will provide Sunflower details for the members in a separate, secure document. (2023 Report Recommendation 1) **KFMC 2024 Update**: SHP submitted documentation of who filed the grievance for Members 11, 17, and 19. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Sunflower				
	2023 Recommendations: Subpart F – Grievance and Appeal System (Continued)			
9.	Appeal Case Review Related to §438.402(c)(1)(ii) General requirements: Filing requirements (Authority to file) and KanCare 2.0 Contract Sections 4.2.1.16.2 and 4.4.2.1.15.7; §438.404(b)(3) Timely and adequate notice of adverse benefit determination – Content of notice; and §438.416(b)(6) Recordkeeping requirements: For the identified case, the name of the individual submitting the appeal should be identified in the internal system (Member 23). KFMC will provide Sunflower details for the member in a separate, secure document. (2023 Report Recommendation 2) **KFMC 2024 Update**: SHP provided documentation, from their internal system, of the name of the individual submitting the appeal for Member 23. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
10.	Appeal Case Review Related to §438.402(c)(1)(ii) General requirements: Filing requirements (Authority to file) and KanCare 2.0 Contract Section 4.4.2.1.15.7): Re-educate staff on the most appropriate selection to choose for who submitted the appeal (Members 6 and 23). KFMC will provide Sunflower details for the members in a separate, secure document. (2023 Report Recommendation 3) **KFMC 2024 Update**: SHP submitted the training that was provided to the Appeal and Grievances Staff regarding the findings for Members 6 and 23. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
11.	Appeal Case Review Related to §438.402(c)(1)(ii) General requirements: Filing requirements (Authority to file) and KanCare 2.0 Contract Section 4.4.2.1.15.7): Re-educate staff that the requestor in TruCare should be congruent with PRIME (Members 7 and 9). KFMC will provide Sunflower details for the members in a separate, secure document. (2023 Report Recommendation 4) **KFMC 2024 Update**: SHP submitted the training that was provided to the Appeal and Grievances Staff regarding the findings for Members 7 and 9. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
12.	Appeal Case Review Related to §438.404(b)(6) Timely and adequate notice of adverse benefit determination (Content of notice); §438.210(c) Notice of adverse action; and §438.408(e)(2)(ii-iii) Resolution and notification: Grievances and appeals – Content of notice of appeal resolution: Re-educate staff to double check that the correct appeal resolution letter was sent to the member (Member 30). (2023 Report Recommendation 5) **KFMC 2024 Update**: SHP submitted the training that was provided to the Appeal and Grievances Staff regarding the findings for Member 30. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Sunflower				
	2023 Recommendations: Subpart F – Grievance and Appeal System (Continued)			
13.	§438.406(b)(5) Handling of grievances and appeals: Special requirements (Member's request of case file during appeal): In Sunflower policy and procedure *KS.QI.11 Appeal and Grievance System Description*, section "Member Requests for Appeal Documents," specify that if members make a request for documentation, the information must be supplied sufficiently in advance of the appeal resolution. (2023 Report Recommendation 6) **KFMC 2024 Update**: SHP submitted the policy *Appeal and Grievance System Description*, with the requested change. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
14.	Appeal Care Review Related to §438.408(b)(2) Resolution and notification: Grievances and appeals – Specific timeframes-Standard resolution of appeals; §438.410(c)(2) Expedited resolution of appeals: Action following denial of a request for expedited resolution: Review this case and advise if the appeal should have been processed since Sunflower identified that an Authorized Representative form was not needed to review this appeal (Member 5). (2023 Report Recommendation 7) **KFMC 2024 Update**: SHP stated a review was completed and that the Authorized Representative form was not needed for the appeal to be reviewed. SHP submitted the training that was provided to the Appeal and Grievances staff regarding the findings for Members 5. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
15.	§438.408(c)(2)(ii) Resolution and notification: Grievances and appeals (Extension of timeframes: Requirements following extension) and §438.410(c)(2)(iii) Expedited resolution of appeals: Action following denial of a request for expedited resolution: Update language in the *Member Handbook*, in the section "Appeals Basics" to include language detailing the member has the right to file a grievance if he or she disagrees with the decision to extend the timeframes not at the request of the member. (2023 Report Recommendation 8) **KFMC 2024 Update**: The SHP *Member Handbook* was submitted with the updated language. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
16.	Grievance Case Review Related to §438.416(b)(2) Recordkeeping requirements: SHP should review the cases identified to determine the correct grievance date and address as appropriate to ensure the grievance date is consistent throughout the internal system and grievance acknowledgement/resolution letters (e.g., changes to the internal system to capture the accurate date and/or staff education) (Members 5, 7, 9, 13, 14, 16, and 23-25). KFMC will provide Sunflower details for the members in a separate, secure document. (2023 Report Recommendation 9) **KFMC 2024 Update**: For Members 9, 14, 16, and 23, SHP submitted new documentation to demonstrate when the grievance was received, and the case was closed. These cases are fully addressed. There were no documents or explanation submitted for Members 5, 24, and 25. The files submitted for Members 7 and 13 are for Members 9 and 14, respectively. For this recommendation to be fully addressed, SHP needs to provide evidence of the grievance date and/or remediation for the discrepancy of the dates for Members 5, 7, 13, 24, and 25. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
Sunflower				
	2023 Recommendations: Subpart F – Grievance and Appeal System (Continued)			
17.	Grievance Case Review Related to §438.416(b)(2) Recordkeeping requirements: Grievance receipt date, subcontractor review date, and grievance resolution date needs to be clear in the internal Sunflower system (Members 11 and 12). (2023 Report Recommendation 10) **KFMC 2024 Update**: SHP provided screenshots of their internal system for Members 11 and 12, as well as a template update, to demonstrate that the date of the vendor review is documented in their system. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed
18.	Grievance Case Review Related to §438.416(b)(3) Recordkeeping requirements: Provide evidence of the dates the grievance was reviewed to make a determination (Members 11, 12, 19, 22-24, 26, 27, 29, and 30). (2023 Report Recommendation 11) **KFMC 2024 Update**: SHP submitted additional documentation to demonstrate the dates the grievances were reviewed for Members 11, 19, 24, 26, 27, 29, and 30. These cases are fully addressed. The file submitted for Member 12 is the file for Member 19, therefore, there is no documentation submitted for Member 12. Within the documents for Members 22 and 23, SHP stated that the cases are still under investigation. For this recommendation to be fully addressed, SHP needs to submit the evidence of the dates the grievance was reviewed for Member 12 and provide explanation of why Members 22 and 23 continue to be under investigation. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed
19.	Appeal Case Review Related to §438.416(b)(2) Recordkeeping requirements: For the identified case, review the internal system documentation and determine and identify the date the appeal was filed (Member 23). (2023 Report Recommendation 12) **KFMC 2024 Update**: SHP provided documentation for Member 23 detailing when the appeal was filed. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status				
		2020	2021	2022	2023	2024
UnitedHealthcare						
	2020 Recommendation: Subpart D – MCO, PIHP and PAHP Standards					
3.	Case Review Related to §438.208 Coordination and continuity of care: Findings from case review conducted. • With future record requests, include member services' documentation of all outreach attempts for health screenings for members in the request; KFMC will ensure this is included as a request element. (2020 Recommendation 24) **KFMC 2022 Update:** Documentation of Health Screening Tool (HST) outreach attempts was not provided in records reviewed by KFMC. **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For a fully addressed rating, UHC will need to provide documentation (i.e., screenshots of the Community Care or HST that is mentioned). **KFMC 2024 Update:** UHC submitted the document *CR_1_8_9_HST Outreach Documentation_ 07242024.pdf*, which included a screenshot of the *CommunityCare* system that shows the documentation of the HST outreach attempts. This recommendation is fully addressed.	New	Substantially Addressed	In Progress	Partially Addressed	Fully Addressed
4.	Case Review Related to §438.208 Coordination and continuity of care: Case review that included review of health screens. • Identify and implement strategies to increase health screens of members in the BH and PH populations. (2020 Recommendation 25) **KFMC 2022 Update:** UHC did provide documentation outlining the remediation plan to increase the completion of health screens of members, however completion rates remain low, therefore KFMC will continue to monitor this recommendation. **KFMC 2023 Update:** According to UHC's narrative, good progress is being made towards this recommendation being fully addressed. For this recommendation to be fully addressed, UHC needs to submit documents providing evidence of their increase in HST completion (i.e., a screenshot of the spreadsheet document with clear labeling). The documentation submitted was not clearly labeled; therefore, KFMC could not verify what the numbers submitted signified. **KFMC 2024 Update:** UHC provided a chart that clearly demonstrates their improvement in completing HSTs. The aforementioned, along with the narrative submitted in previous updates, fully addressed this recommendation.	New	In Progress	In Progress	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
5.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: • For ease of reference for members and providers, for any applicable elements listed above (2022 Recommendation 2) that are not included in the Service Plan or PCSP, make a reference in the Service Plan/PCSP indicating where the information can be located. (2022 Recommendation 3) **KFMC 2023 Update:** UHC's Summer 2023 update stated they are in the process of updating the PCSP document. Upon completion, UHC needs to provide documentation of when the changes were made and provide a template PCSP reflecting the changes. **KFMC 2024 Update:** In UHC's update, they stated that the Service Plan and PCSP documents will need to be updated to reflect the changes in the *KanCare 3.0* contract. Therefore, they are waiting for State instruction and will not incorporate all changes until then. Upon completion, UHC needs to provide KFMC documentation of when the changes were made and provide a template PCSP reflecting the changes. This recommendation is in progress.	New	In Progress	In Progress
6.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: • Review the internal UnitedHealthcare process to ensure the PCSP is distributed to all attendees within fourteen (14) days of the development of the plan. (BH, LTSS – NF, and SHCN – TA Waiver cases; KanCare Contract, Section 5.4.4.2.H) (2022 Recommendation 4) **KFMC 2023 Update:** UHC's Summer 2023 update states that their processes and procedures align with the recommendation, however, no policies and procedures or Standard Operating Procedures (SOPs) were provided. For this recommendation to be fully addressed, UHC needs to submit documents (i.e., policies and procedures, training documents, SOPs etc.) for KFMC to review. **KFMC 2024 Update:** UHC provided policies and procedures *KSCL-0029 - Frail Elderly, Physical Disability, Technology Assisted, Autism and Brain Injury Person Centered Service Plan* and *KSCL – 0028 - Person Centered Service Plan Intellectual and Developmental Disability Person Centered Service Plan*. The language within these policies does not specify the timeframe of fourteen (14) days for distribution to all attendees of the PCSP interdisciplinary team. For a fully addressed rating, UHC needs to include within the policies and procedures the distribution timeframe specified in the KanCare 2.0 Contract. This recommendation is partially addressed.	New	Not Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
7.	Case Review Related to §438.208(b)(1) Coordination and continuity of care: • UnitedHealthcare should review the cases identified for potential follow-up and address as appropriate (e.g., MCO follow-up regarding the case or general provider education). KFMC provided United details for the following cases in a secure separate document (2022 Recommendation 6): a. PH TXIX Members 3, 4, 5, 8, 9, 18, and 20; PH TXXI Members 2, 4, 5, 12, 18, and 20 b. BH TXIX Members 1, 3, 6, 11, 12, 13, 16, and 17; Replacement cases 4 and 5; BH TXXI Members 1, 2, 3, 4, 5, 8, 13, 14, 15, 19, and 20; Replacement cases 2, 3, 5, and 6 c. LTSS – HCBS Members 12 and 18 d. LTSS – NF Members 5, 6, 10, and 15 e. SHCN – TA Waiver Members 17 and 18 f. SHCN – Title V Members 1, 6, 10, 16, 28, 30, 31, 32, 34, and 35 **KFMC 2023 Update:** The original secure document, as referenced in the recommendation was uploaded by KFMC to the KFMC SFTP site on 2/14/2023, along with an email notification from KFMC to UHC, however no receipt confirmation was received from UHC. On 9/20/2023, the secure document was reuploaded by KFMC for UHC's reference along with the original email informing them of the upload. **KFMC 2024 Update:** a. KFMC noted the following for PH TXIX Member 20 and PH TXXI Members 12, 18, and 20: • PH TXIX Member 20: Partially Addressed – UHC provided the medical records from the primary care provider; however, UHC did not provide the plan of care. • PH TXXI Members 12 and 18: Fully Addressed – UHC provided an explanation as to why a Service Plan was not submitted. • PH TXXI Member 20: Partially Addressed – UHC stated there were no hospitalizations; however, pages 7 and 10 of the documentation submitted, in 2022, details information on hospitalization/discharge. Pages 1 and 2 detail Care Coordination and Community Health Worker outreach. The HRA has a started date/time; however, under "Completed On" it states, "NA." It is not clear if the HRA was fully completed and whether there is a "Total Score Received," as it states "0." For this element of the recommendation to be fully addressed, UHC needs to advise if the 2021 HRA was completed. b. KFMC noted the following for BH TXIX Members 16 and 17: BH TXIX Members 16 and 17: Partially Addressed – UHC stated that provider education on thorough note taking would be completed. For this element of the recommendation to be fully addressed, UHC needs to provide evidence of provider education (date completed). c. KFMC noted the following for LTSS – HCBS Members 12 and 18:	New	Not Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status 2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
	• LTSS – HCBS Member 12: Fully Addressed – UHC provided an explanation as to why questions in the PII were not addressed. • LTSS – HCBS Member 18: Partially Addressed – UHC stated that their process was updated to require that member goals be listed on the PII. For this element of the recommendation to be fully addressed, UHC needs to provide the process that was updated to require that member goals be listed on the PII. d. KFMC noted the following for LTSS – NF Members 5, 6, 10, and 15: Fully Addressed – See the last paragraph in this section. e. KFMC noted the following for SHCN – TA Waiver Members 17 and 18: Fully Addressed – UHC stated that staff education was completed on the need to obtain signatures from the Member/Legal Rep and care coordinator. f. KFMC noted the following for SHCN – Title V Members 1, 28, and 30: • SHCN – Title V Member 1: Not Addressed – UHC provided an HRA from 2020, however, the request was for an updated one after the member was hospitalized in 2021. In order for this element of the recommendation to be fully addressed, UHC needs to address appropriate follow-up, such as staff education or process updates for when an HRA should be completed, and which one is appropriate to complete. • SHCN – Title V Members 28 and 30: Fully Addressed – UHC stated that staff education was completed on the need to obtain signatures timely (Member 28) and document ambulatory needs (Member 30). For the remaining cases, UHC did not have HST outreach well documented. UHC addressed HST outreach in recommendations 1 and 2 above, as well as recommendations 8 and 9 below and they were fully addressed. (PH TXIX Members 3, 4, 5, 8, 9, and 18; PH TXXI Members 2, 4, and 5; BH TXIX Members 1, 3, 6, 11, 12, and 13, and Replacement cases 4 and 5; BH TXXI Members 1, 2, 3, 4, 5, 8, 13, 14, 15, 19, and 20, and Replacement cases 2, 3, 5, and 6; LTSS – NF Members 5, 6, 10, and 15; and SHCN – Title V Members 6, 10, 16, 31, 32, 34, and 35).			
8.	Case Review related to §438.208(b)(3) Coordination and continuity of care: • In the 2023 follow-up review, provide the process for documenting all HST outreach attempts. (2022 Recommendation 7) **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For this recommendation to be fully addressed, UHC needs to provide documentation (i.e., policy and procedure, SOPs, screenshots of the Community Care system, HST or of the IVR vendor system that captures all contact attempts mentioned by UHC). **KFMC 2024 Update:** UHC submitted process flows for the *Icario HST* and the *Pediatric HST* as well as screen shots of where UHC staff document HST outreach attempts and HRA completion is noted. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
9.	Case Review Related to §438.208(b)(3) Coordination and continuity of care: • A health screen should be completed or an attempt to contact the member within 90 days of enrollment or every other year (PH, BH, LTSS – NF, and SHCN – Title V) (2022 Recommendation 8) **KFMC 2023 Update:** UHC's response is informative and describes how contact attempts are tracked, however, no evidence of the tracking was provided. For this recommendation to be fully addressed, UHC needs to provide documentation (i.e., policy/procedure, SOPs, screenshots of the Community Care system, HST, or of the IVR vendor system that captures all contact attempts mentioned by UHC). **KFMC 2024 Update:** UHC provided screenshots of how outreach attempts are documented and a report example of health screening outreach attempts to members. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
10.	Case Review Related to §438.208(b)(3) Coordination and continuity of care: • For eligible members, UnitedHealthcare should include documentation of the need for a yearly HST reassessment (PH). (2022 Recommendation 9) **KFMC 2023 Update:** UHC provided a thorough explanation on how the need for a yearly HST reassessment is documented, however, for this recommendation to be fully addressed, UHC needs to submit documentation to support how they are addressing the recommendation (i.e., screenshots of the IVR system, policy & procedure, or SOP that demonstrates the process). **KFMC 2024 Update:** UHC provided multiple documents to demonstrate how HST and HRA are determined to be completed through workflows. Also, UHC submitted policies pertaining to the annual outreach for the HST, as well as the HST Business Requirements for the implementation and ongoing monitoring of the HST process. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
11.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide explanation of delay in provider notification (provider notified >60 days) for Provider 7 (6/14/2022 original sample selection). (2022 Recommendation 11) **KFMC 2023 Update:** For Individual Health care Provider 7, from the documentation UHC submitted, the initial application date is detailed as 7/6/2021, with most verification happening on 10/5/2021. UHC states the credentialing process was delayed due to the provider not providing admitting privileges at a participating hospital. That information was received on 11/5/2021, with the credentialing decision being made by UHC the same day. In order for this recommendation to be fully addressed, UHC needs to provide explanation of why there was more than 60 days between receiving the initial application (7/6/2021) and sending the email requesting additional information (11/3/2021). **KFMC 2024 Update:** UHC stated in their explanation that the "Application Received Date" was 9/27/2021 and the "Credentialing Decision Date" was 11/5/2021, which matches the file submitted. In the original review, the "Attestation Date" had been used as the application date when the "Application Received Date" should have been used. Therefore, the credentialing decision was communicated to the provider within the required timeframe of 60 days. This recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
12.	Individual Health Care Professional File Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide documentation of the "Disclosure of Ownership and Controlling Interest and Management Statement" for all reviewed providers. (2022 Recommendation 13) **KFMC 2023 Update:** UHC provided a thorough explanation, however, no evidence was submitted of UHC verifying the Disclosure of Ownership had been completed. For this recommendation to be fully addressed, UHC needs to provide documentation on how they would verify the Disclosure of Ownership was completed through KMAP. 9/29/2023 response from the State pertaining to the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where 'UHC provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing."	New	Partially Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
	KFMC 2024 Update: UHC submitted two of the fifteen files needed for the Individual Health Care Provider file selection. The Disclosure of Ownership was submitted for Individual Health Care Providers 5 and 7. The other documentation submitted was for Providers not on the sample list. For this recommendation to be fully addressed, UHC needs to submit the Disclosure of Ownership for the remainder of the Individual Health Care Professional files. KFMC will provide, in a separate document, the names of the Individual Health Care Professionals. This recommendation is partially addressed.			
13.	Individual Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide an explanation of why there would be a span of six months between credentialing dates (Provider 5, 6/14/2022 original sample selection). (2022 Recommendation 15) **KFMC 2023 Update:** UHC's explanation stated they were compliant because there was no more than 36 months between credentialing and recredentialing dates. However, since providers are recredentialed every 36 months, it is not clear why a provider would be initially credentialed and then recredentialed within a short time period of six months. UHC will need to provide KFMC explanation of the reason. **KFMC 2024 Update:** KFMC's question regarding why the time between credentialing and recredentialing was only 6 months when providers are recredentialed every 36 months was not addressed. The file submitted details the "Previous Credentialing Approval Date" was 5/14/2021 and the "Recredentialing Date" was 11/12/2021. UHC needs to provide KFMC an explanation of the reason why there was only 6 months between credentialing and recredentialing for this provider (e.g., what warranted the provider to go through recredentialing with 6 months of being credentialed?). This recommendation is partially addressed.	New	Partially Addressed	Partially Addressed
14.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the signed attestation of correctness for Providers 3, 7, 10, and 14. (2022 Recommendation 16) **KFMC 2023 Update:** UHC provided the attestations for the Individual Health Care Professional cases, not the Institutional Health Care Provider files. For this recommendation to be fully addressed, UHC will need to provide the signed attestation of correctness for Institutional Health Care Providers 3, 7, 10, and 14. **KFMC 2024 Update:** UHC provided the attestations for the Individual Health Care Provider files, not the Institutional Health Care Provider files. **For this recommendation to be fully addressed, UHC needs to provide the signed attestation of correctness for Institutional Health Care Providers 3, 7, 10, and 14.** KFMC will provide, in a separate document, the names of the Institutional Health Care Professionals. This recommendation was not addressed.	New	Not Addressed	Not Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
15.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide the Disclosure of Ownership and Controlling Interest for Providers 1, 2, 3, 4, 6, 8, 12, 14, and 15. (2022 Recommendation 17) **KFMC 2023 Update:** UHC provided a thorough explanation, however, no evidence was submitted of UHC verifying the Disclosure of Ownership had been completed. For this recommendation to be fully addressed, UHC needs to provide documentation on how they would verify the Disclosure of Ownership was completed through KMAP. 9/29/2023 response from the State pertaining the need for the MCOs to verify the Disclosure of Ownership form, "While the CMS requirement for provider revalidation is to revalidate every five years, Kansas has chosen to make revalidations due every three years to align with MCO credentialing. During the initial enrollment and revalidation process, the Disclosure of Ownership and Controlling Interest is screened before being approved in KMAP and passed to the MCOs for credentialing. However, to make sure it's clear, where 'UHC provided a response that this document is not needed because it is reviewed by KDHE during their credentialing.' KMAP is responsible for enrollment only. The MCOs do the credentialing. The necessary Disclosure of Ownership/Controlling Interest information is collected, reviewed, and then passed to the MCOs from the enrollment process for the MCOs to use during credentialing." **KFMC 2024 Update:** UHC submitted the Disclosure of Ownership for Institutional Health Care Providers 1 and 3. For this recommendation to be fully addressed, UHC needs to provide the Disclosure of Ownership for Institutional Health Care Providers 2, 4, 6, 8, 12, 14, and 15. KFMC will provide, in a separate document, the names of the Institutional Health Care Professionals. This recommendation is partially addressed.	New	Partially Addressed	Partially Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)			
16.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide evidence of the following, for Institutional Health Care Provider 14 (2022 Recommendations 18a-c): a. NPPES, OIG/LEIE and GSA-SAM being checked. (Also applies to §438.214[d]) (2022 Recommendations 18a and 20) b. Entity that credentialed the provider, Medicare/Medicaid Program participation, and that all information used for credentialing was less than 180 days old. c. Review the file completeness, as there were only four documents submitted (Drug Enforcement Administration certificate, commercial liability insurance, proof of Kansas permit and licensure) and it is unknown if the provider was being credentialed or recredentialed or who completed it. **KFMC 2023 Update:** The documents provided for Institutional Health Care Provider 14 did not include an Aperture checklist during the 2022 Review of UHC. For this recommendation to be fully addressed, UHC needs to provide evidence that the items listed in the recommendation were verified by UHC. **KFMC 2024 Update:** UHC did not submit a recredentialing file in the original file submission. Rather, the only documents submitted were the *Registrant Verification for the Drug Enforcement Administration*, *Certificate of Liability Insurance*, *Kansas Board of Pharmacy* license verification, and *Pharmacy Certificate of Renewal of Permit*. KFMC did not receive evidence that the NPPES, OIG/LEIE and GSA-SAM were checked, and no Aperture checklist was included in the original file submission. This recommendation was not addressed.	New	Not Addressed	Not Addressed
17.	Institutional Health Care Professional Files Credentialing/Recredentialing Case Review Related to §438.214(b)(2) Provider selection: • In the 2023 follow-up review, provide evidence of the malpractice insurance for Providers 6, 7, 14, and 15. (2022 Recommendation 19) **KFMC 2023 Update:** The Health Care Providers that are referenced in UHC's response are the Individual Health Care Provider files, not the Institutional Health Care Provider files that are referenced in the recommendation. **KFMC 2024 Update:** The files submitted for this recommendation are for Institutional Health Care Providers 4, 5, 12, and 13, not the Institutional Health Care Provider files that are referenced in the recommendation. KFMC will provide, in a separate document, the names of the Institutional Health Care Professionals. This recommendation was not addressed.	New	Not Addressed	Not Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
UnitedHealthcare				
2022 Recommendations: Subpart D – MCO, PIHP and PAHP Standards (Continued)				
18.	§438.214(e) Provider selection – State requirements: • Credentialing decisions should be communicated to the provider within 60 days of the completed application being received. (Provider 7, 6/14/2022 original sample selection). (2022 Recommendation 21) **KFMC 2023 Update:** For Individual Health Care Provider 7, from the documentation UHC submitted, the initial application date is detailed as 7/6/2021, with most verification happening on 10/5/2021. UHC states the credentialing process was delayed due to the provider not providing admitting privileges at a participating hospital. That information was received on 11/5/2021, with the credentialing decision being made by UHC the same day. For this recommendation to be fully addressed, UHC needs to provide explanation why there was more than 60 days between receiving the initial application (7/6/2021) and sending the email requesting additional information (11/3/2021). **KFMC 2024 Update:** UHC stated in their explanation that the "Application Received Date" was 9/27/2021 and the "Credentialing Decision Date" was 11/5/2021, which matches the file submitted. In the original review, the "Attestation Date" had been used as the application date when the "Application Received Date" should have been used. Therefore, the credentialing decision was communicated to the provider within the required timeframe of 60 days and this recommendation is fully addressed.	New	Partially Addressed	Fully Addressed
2022 Recommendations: Subpart F – Grievance and Appeal System				
19.	§438.402(c)(1)(i)(B) General requirements: Filing requirements (Authority to file - External medical review): • Add the regulatory language related to external medical review in the United policy *UCSMM 07.12 Appeal Process and Record Documentation*, table column "State/Federal Medicaid Rules." (2022 Recommendation 22) **KFMC 2023 Update:** UHC reports they are currently working with their Corporate Administration on making the change to fully address this recommendation. **KFMC 2024 Update:** UHC provided the updated policy and procedure *UCSMM 07.12 Appeal Process and Record Documentation*, which included the regulatory language related to external medical review. This recommendation is fully addressed.	New	In Progress	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)			
20.	§438.402(c)(1)(ii) General requirements: Filing requirements (Authority to file) and Adequate notice of adverse benefit determination – Content of notice; and §438.416(b)(6) Recordkeeping requirements • Review the cases identified to determine the name of the person that filed the grievance and address as appropriate to ensure the system consistently reflects who filed the grievance (e.g., staff education). KFMC will provide UHC details for the members in a secure separate document (Members 16, 21, 22, 29, and 30). (KanCare 2.0 Contract, Section 4.2.1.16.2) [2023 Recommendation 1] **KFMC 2024 Update:** For Members 21 and 29, UHC provided an explanation as to how the name of the person that filed the grievance was documented in the file. For Members 16, 22, and 30, UHC stated additional training and education of staff will be completed. For this recommendation to be fully addressed, UHC needs to submit the date the training and education to staff was completed, as well as a staff roster of who attended. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed
21.	§438.402(c)(1)(ii) General requirements – Filing requirements (Authority to file) and §438.404(b)(3) Timely and adequate notice of adverse benefit determination: Content of notice • Review who filed the grievance and determine their relationship to the member and ensure it is documented in the internal system (Member 30). (KanCare 2.0 Contract, Section 4.2.1.16.2) [2023 Recommendation 2] **KFMC 2024 Update:** UHC stated additional training and education of staff will be completed, specifically related to this case. For this recommendation to be fully addressed, UHC needs to submit the date the training and education to staff was completed, as well as a staff roster of who attended. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed
22.	§438.402(c)(1)(ii) General requirements – Filing requirements (Authority to file) and §438.404(b)(3) Timely and adequate notice of adverse benefit determination – Content of notice • For the identified cases, review internal system documentation and determine who submitted the appeal and ensure all areas of the internal system are consistent (Members 7, 13, 18, and 19). (KanCare 2.0 Contract, Section 4.4.2.1.15.7) [2023 Recommendation 3] **KFMC 2024 Update:** UHC provided an explanation that the parent/guardian could also be documented as authorized representative in their system, per Attachment D of the KanCare 2.0 Contract. This recommendation is fully addressed.	Not Yet Reviewed	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
UnitedHealthcare				
2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)				
23.	§438.406(b)(1) Handling of grievances and appeals – Special requirements • In the UHC *2023 Care Provider Manual*, sections "Member grievance" and "Member appeals," page 105, where the grievance and appeal process is explained, add language to inform members of the grievance/appeal acknowledgement process and timeframe. (KanCare 2.0 Contract, Section 5.2 "Provider Grievance Process," subsection 5.2.1.4 and Section 5.4.7 "Provider Appeals Process," subsection 5.4.7.1.5) (2023 Recommendation 4) **KFMC 2024 Update:** The UHC *2024 Care Provider Manual* was reviewed and no changes from the UHC *2023 Care Provider Manual* were noted. For this recommendation to be fully addressed, UHC needs to submit evidence that the *Care Provider Manual* is updated to include the timeframe a grievance and appeal is acknowledged after receipt for the member. This recommendation was not addressed.	Not Yet Reviewed	New	Not Addressed
24.	§438.406(b)(1) Handling of grievances and appeals – Special requirements • For provider appeals, re-educate staff that the health plan is to send written acknowledgement of an appeal receipt within ten (10) calendar days of the date the health plan received the appeal request. (Member 27) (2023 Recommendation 5) **KFMC 2024 Update:** UHC did not provide an explanation for Member 27 in the submitted documents. For this recommendation to be fully addressed, UHC needs to provide evidence that they re-educated staff that the health plan is to send written acknowledgement of an appeal receipt within ten (10) calendar days of the date the health plan received the appeal request. This recommendation was not addressed.	Not Yet Reviewed	New	Not Addressed
25.	Case review Related to §438.416(b)(2) Recordkeeping requirements: • UHC should review the cases identified to determine the correct grievance date and address as appropriate to ensure the grievance date is consistent throughout the internal system and grievance acknowledgement letter (e.g., changes to the internal system to capture the accurate date and/or staff education). KFMC will provide UHC details for the members in a secure separate document (Members 29 and 30). (2023 Recommendation 6) **KFMC 2024 Update:** UHC submitted an explanation as to why the dates where different between the system and the acknowledgement letter, which fully addressed the recommendation.	Not Yet Reviewed	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations: Subpart F – Grievance and Appeal System (Continued)			
26.	Grievance issues not related to an element on the review tool for §438.416(b) Recordkeeping requirements: • Re-educate staff that information entered in the internal UHC database should be double checked prior to finalization (Members 6, 13, and 19). KFMC will provide UHC details for the members in a secure separate document. (2023 Recommendation 7) **KFMC 2024 Update:** UHC stated that additional training and education of all appeal and grievance staff will be completed pertaining to the accuracy of record entries and not using abbreviations in documentation. For this recommendation to be fully addressed, UHC needs to submit the date the training and education to staff was completed, as well as a staff roster of who attended. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed
27.	Grievance issues not related to an element on the review tool for §438.416(b) Recordkeeping requirements: • Develop a policy and procedure outlining the appropriate use of abbreviations with an approved abbreviation list and educate staff. If such policy and procedure exists, re-educate staff on the importance to use only approved abbreviations in documentation. (2023 Recommendation 8) **KFMC 2024 Update:** UHC stated that additional training and education of all appeal and grievance staff will be completed pertaining to the accuracy of record entries and not using abbreviations in documentation. For this recommendation to be fully addressed, UHC needs to submit the date the training and education to staff was completed, as well as a staff roster of who attended. This recommendation is partially addressed.	Not Yet Reviewed	New	Partially Addressed

Quality Assessment and Performance Improvement Review

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Common Among the MCOs				
	2022 Recommendation			
1.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors (State KanCare 2.0 Contract; 2022 QAPI Checklist Number 22; 2023 QAPI Checklist Number 17): • ABH – Incorporate the State-specified goals listed in the State Contract section 5.9.3(B) in the QAPI program documents. (2022 Recommendation 2) • SHP and UHC – In future QAPI documents, incorporate the State-specified goals listed in the State Contract section 5.9.3(B) to demonstrate how the QAPI program addresses them. (2022 Recommendations 2 [SHP] and 3 [UHC]) • SHP – In future QAPI work plans, include State Contract-specified goals (B)(1-6) of section 5.9.3(B) to demonstrate how the QAPI program addresses them. (2023 Recommendation 8) • UHC – In future QAPI work plans, incorporate the following missing elements of the State Contract-specified goals of section 5.9.3(B) to demonstrate how the QAPI program addresses them (2023 Recommendation 5): a. Add to UHC internal Goal A, row 8 Objective, the part of the State-specified goal(s) related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports." (Section 5.9.3[B][1]) b. Add to UHC Internal Goal B, row 16 Objective, the part of the State-specified goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members." (Section 5.9.3[B][6]) **KFMC Update:** • <u>ABH</u> ○ <u>2023 Review</u>: The State-specified goals were incorporated into the *2023 QAPI Work Plan* (dated November 30, 2023) and the *2023 QAPI Program Description.* The *2022 QAPI Program Evaluation* included goals 5.9.3(B)(1-5) but did not include goal 5.9.3(B)(6). ○ <u>2024 Review</u>: The *2023 QAPI Program Evaluation* included goal 5.9.3(B)(6). • <u>SHP</u> ○ <u>2023 Review</u>: The QAPI documents do not include the State Contract-specified goals and the one SHP goal included in the program description was not included in the other documents. ○ <u>2024 Review</u>: In the *2024 QAPI Work Plan* dated December 2, 2024, SHP added State Contract-specified goals (B)(1-6) of section 5.9.3(B). The recommendation is fully addressed.	New	ABH Partially Addressed SHP/UHC Not Addressed	ABH/SHP Fully Addressed UHC Partially Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Common Among the MCOs				
	2022 Recommendation (Continued)			
	• UHC ○ 2023 Review: The *2023 QAPI Work Plans* did not include the following requirements of the State-specified goals listed in the KanCare 2.0 Contract, Section 5.9.3(B) to demonstrate how the QAPI program addresses them: ▪ UHC internal Goal A, row 8 Objective (work plan) states, "Support medically complex and fragile members through person-centered complex case management programs that improve the member experience." However, it is missing the part of the State Contract goal related to "…quality of life for all Members to achieve the highest level of dignity, independence, and choice through the delivery of holistic, person-centered, and coordinated care and the promotion of employment and independent living supports." ▪ UHC Internal Goal B, row 16 Objective (work plan) states, "Monitor the adequacy of the contracted network through analysis of access, availability, and Out-of-network (OON) data and adjust the practitioner network, as appropriate, to meet diverse population needs." However, it is missing the part of the State Contract goal related to "…adopt innovative and strategic partnerships with its Participating Providers to improve the delivery of quality care and service to all Members." ○ 2024 Review: The State Contract-identified goals 5.9.3(B)(1) and (B)(6) were added to the *2024 QAPI Program Description* and *2023 QAPI Program Evaluation*. However, they were not added to the *2024 QAPI Work Plans*, on the "Objectives" Tab (rows 8 and 16). Also, UHC did not submit documentation for the progress tracker related to the work plan. For the work plan, KFMC had the same findings as noted in 2023 (see bullets directly above). The recommendation was partially addressed.			
Aetna				
	2022 Recommendation			
2.	5.9.1(N)(6) General Requirements – Structure and Staffing: Develop an annual evaluation process: • Use consistent definitions for the terms Goals, Objectives, and Activities across all three documents (QAPI work plans, program description, and program evaluation). (State KanCare 2.0 Contract; 2022 QAPI Checklist Number 16; 2022 Recommendation 3) **KFMC Update:** • 2023 Review: The goals continue to not be consistent across the three QAPI documents, as the *2023 QAPI Work Plan* (dated November 30, 2023) and *2023 QAPI Program Description* included the goals listed in the State Contract section 5.9.3(B)(1-6). The *2022 QAPI Program Evaluation* included goals 5.9.3(B)(1-5) but did not include goal 5.9.3(B)(6). • 2024 Review: In the *2023 QAPI Program Evaluation*, section "QAPI Goals and Objectives," subsection "Aetna Better Health Organizational Goals," (page 186) ABH incorporated goal 5.9.3.B.6 into the list of goals.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2023	Completion Status 2024
Aetna			
	2023 Recommendations		
3.	5.9.1(G) Mechanisms to ID [identify] members enrolled in LTSS waivers but not receiving waiver services: • Include activities in future QAPI work plans to address mechanisms to identify members enrolled in LTSS Waivers but not receiving waiver services. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 6; Recommendation 1) **KFMC Update:** • 2024 Review: Row 64 "LTSS – Monitor/Measure Participation Rates" in the *2024 QAPI Work Plans* addressed this recommendation.	New	Fully Addressed
4.	5.9.3(C) State identified seven objectives to meet established QAPI goals: • In future QAPI work plans, State Contract-specified objectives C.2 and C.4 of section 5.9.3(C) should be included to demonstrate how the QAPI program addresses them. (Also, 5.9.1[N][6]; State KanCare 2.0 Contract; QAPI Checklist Number 18; Recommendation 2) **KFMC Update:** • 2024 Review: ABH advised they made updates to the goals/objectives to "create consistency throughout the Trilogy documents 5.9.3 C" in the work plan. KFMC noted the following in the *2024 QAPI Work Plans*: ○ 5.9.3(C)(2): Partially Addressed. KFMC noted, row 7 "QAPI Work Plan: Review of accomplished vs planned activities outlined on the work plan" states, "Quarterly evaluation of ongoing progress on QI [Quality Improvement] activities: Staff member responsible for each activity." However, none of the activities address maintaining staff capacity and capability. ○ 5.9.3(C)(4): Not Addressed. KFMC is not able to find an activity that relates to deploying Rapid-cycle Quality Improvement principles throughout the organization. ○ 5.9.3(C)(5): Not Addressed. KFMC is not able to find an activity that relates to provider peer review.	New	Partially Addressed
5.	5.9.4(A-B) Performance Measures: • In future QAPI work plans, include information on the following measures (State KanCare 2.0 Contract; QAPI Checklist Number 19; Recommendation 3): a. *Breast Cancer Screening (BCS-AD)* b. *Chlamydia Screening in Women ages 16 to 24 (CHL)* **KFMC Update:** • 2024 Review: ABH did not add an activity to the *2024 QAPI Work Plans* related to the performance measures *Breast Cancer Screening (BCS-AD)* and *Chlamydia Screening in Women ages 16 to 24 (CHL)*.	New	Not Addressed

	Follow-Up to Previous Recommendations	Completion Status			
		2021	2022	2023	2024
Sunflower					
	2021 Recommendation				
2.	5.16.1(B) Reports and Audits – Steps Contractor must take to ensure that data received from Participating Providers is accurate and complete (State KanCare 2.0 Contract): • In future QAPI work plans, program descriptions, and evaluations, include information related to MCO's review of all reports submitted to the State. (2021 Recommendation 2) • Include information in the QAPI documents on review and oversight of data collection, ensuring complete and accurate data from participating providers, and Sunflower's review of all reports submitted to the State. (2022 QAPI Checklist Number 35; 2022 Recommendation 5) • In future QAPI work plans, for the SHP objective "Data received from Participating Providers" in column D, include an activity that SHP completes to ensure that data received from Participating Providers is accurate and complete. (2023 QAPI Checklist Number 29; 2023 Recommendation 21) **KFMC Update:** • 2022 Review: Information related to review of all reports for timeliness, accuracy, and completeness prior to submission to the State (State Contract, section 5.16.1[B]) was not added to the *2021 QAPI Evaluation, 2022 QAPI Work Plans,* or *2022 QAPI Program Description*. • 2023 Review: In 2023, the State determined the MCO is not required to include this information in the QAPI evaluation or program description. However, it is required to be in the QAPI work plan. In the *2023 QAPI Work Plans*, SHP added a row "Data received from Participating Providers." However, column E "Activity" did not include an activity that SHP completes to achieve this requirement. Rather, it detailed the State Contract requirement. Therefore, the recommendation is partially addressed. • 2024 Review: In the *2024 QAPI Work Plans*, row 94 "Data received from Participating Providers," Column E "Activity," SHP included seven activities that SHP completes to achieve this requirement. The recommendation is fully addressed.	New	Not Addressed	Partially Addressed	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
Sunflower				
	2022 Recommendations			
3.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt through which the Contractor shall meet the established QAPI goals and incorporate the objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals (State KanCare 2.0 Contract; 2022 QAPI Checklist Number 23; 2023 QAPI Checklist Number 18): • In future QAPI documents, use the State-specified objectives listed in the State Contract section 5.9.3(C) to demonstrate how the QAPI program addresses them. (2022 Recommendation 3) • In future QAPI work plans, include State Contract-specified objectives (C)(1-7) of section 5.9.3(C) to demonstrate how the QAPI program addresses them. (2023 Recommendation 13) **KFMC Update:** • 2023 Review: The QAPI documents do not include the State Contract-specified objectives listed in State Contract section 5.9.3(C). • 2024 Review: In the *2024 QAPI Work Plans*, SHP included State Contract-specified objectives C.1-C.7 of section 5.9.3(C). The recommendation is fully addressed.	New	Not Addressed	Fully Addressed
4.	5.9.10(F) Contractor to annually conduct a member satisfaction survey with the KanCare SUD population and incorporate questions, as needed, into their survey instrument as instructed by KDADS or KDHE: • In future QAPI documents, include the KanCare SUD population and annual summary. (State KanCare 2.0 Contract; 2022 QAPI Checklist Number 32; Recommendation 4) **KFMC Update**: • 2023 Review: The 2022 QAPI Evaluation included information on the KanCare SUD Survey. In the *2023 QAPI Work Plans*, SHP added a line that addressed the SUD survey. The 2023 QAPI Program Description did not include information on the SUD survey. • 2024 Review: To the *2024 QAPI Program Description*, SHP included information on the collaboration with the other MCOs to administer the BH SUD survey and analysis of results. The recommendation is fully addressed.	New	Partially Addressed	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2023	Completion Status 2024
Sunflower			
	2023 Recommendations		
5.	5.9.1(E) Detection of underutilization and overutilization of services: • In future QAPI work plans, include an activity that SHP completes to achieve detection of underutilization and overutilization of services. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 4; Recommendation 1) **KFMC Update:** • 2024 Review: SHP added to the *2024 QAPI Work Plans*, column "E. Activity" activities that are completed to achieve detection of underutilization and overutilization of services. The recommendation is fully addressed.	New	Fully Addressed
6.	5.9.1(F) For members receiving LTSS, mechanisms used to compare services and supports received with those in the member's treatment/service plan: • In future QAPI work plans, include an activity that SHP completes to develop and implement mechanisms used to compare services and supports received with those in the member's treatment/service plan. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 5; Recommendation 2) **KFMC Update:** • 2024 Review: SHP added to the *2024 QAPI Work Plans*, column "E. Activity" seven activities that are completed to ensure enrolled LTSS members are receiving services outlined in their service plan. The recommendation is fully addressed.	New	Fully Addressed
7.	5.9.1(N)(6) Annual MCO QAPI evaluation: • In future QAPI work plans, include the SHP internal Quality Program objectives that are detailed in the *2022 QAPI Program Evaluation*. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 16; Recommendation 3) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plan* (dated December 2, 2024), row 77, SHP added an activity that details the internal Quality Program Objectives that were detailed in the *2023 QAPI Program Evaluation*. The recommendation is fully addressed.	New	Fully Addressed
8.	5.9.1(N)(6) Annual MCO QAPI evaluation: • Include in future QAPI work plans, the priorities and recommendations that were selected for implementation in the prior year QAPI program evaluation. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 15; Recommendation 4) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plan* (dated December 2, 2024), row 77, SHP added an activity that details the priorities and recommendations that were detailed in the *2023 QAPI Program Evaluation*. The recommendation is fully addressed.	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status 2023	Completion Status 2024
Sunflower			
	2023 Recommendations (Continued)		
9.	5.9.3(A) Integration and infusion of State identified guiding principles: • In future QAPI work plans, include State Contract-specified guiding principles (A)(2), (A)(4-5), (A)(7), and (A)(10-11) of section 5.9.3(A) to demonstrate how the QAPI program addresses them. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 16; Recommendation 5) **KFMC Update:** • 2024 Review: To the *2024 QAPI Work Plans*, SHP included all of the State-identified Guiding Principles A1-11. The recommendation is fully addressed.	New	Fully Addressed
10.	5.9.3(A)(8) Integration and infusion of State identified guiding principles – Develop a transparent and collaborative environment with Members, Providers and other stakeholders to promote best in class health care service delivery to Members. • In future QAPI work plans, for guiding principle 5.9.3(A)(8), include detail on a transparent and collaborative environment with providers and other stakeholders. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 16; Recommendation 6) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plan* dated December 2, 2024, for guiding principle 5.9.3(A)(8), SHP added language that includes detail on developing a transparent and collaborative environment with providers and other stakeholders. The recommendation is fully addressed.	New	Fully Addressed
11.	5.9.3(A) Integration and infusion of State identified guiding principles: • In future QAPI work plans, include an activity that SHP completes for integration and infusion of the State identified guiding principles. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 16; Recommendation 7) **KFMC Update:** • To the *2024 QAPI Work Plan* dated December 2, SHP added seven activities that are completed to achieve the guiding principles. The recommendation is fully addressed.	New	Fully Addressed
12.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors: • In future QAPI work plans, clearly state QAPI program goals and use them consistently. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 17; Recommendation 9) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP added the State Contract-specified goals (B)(1-6) of section 5.9.3(B) and they were used consistently. The recommendation is fully addressed.	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2023	Completion Status 2024
Sunflower			
	2023 Recommendations (Continued)		
13.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors: • In future QAPI work plans, use the term "goals" as defined in the State Contract, section 5.9.3(B). (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 17; Recommendation 10) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP used the term "goals" as defined in the State Contract, section 5.9.3(B). The recommendation is fully addressed.	New	Fully Addressed
14.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors: • In future QAPI work plans, use the term "goals" consistently. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 17; Recommendation 11) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP used the term "goals" consistently. The recommendation is fully addressed.	New	Fully Addressed
15.	5.9.3(B) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Goals Contractor to adopt within its QAPI program and incorporate the goals into its QAPI program and into those of its delegates and Subcontractors: • In future QAPI work plans, for the SHP objective "Incorporation of the State identified goals" in column D, include an activity that SHP completes to achieve this requirement. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 17; Recommendation 12) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plan* dated December 2, 2024, SHP included activities that are completed to achieve the goals. Also, SHP added in column "I. Comments," details of what has been completed related to each activity. The recommendation is fully addressed.	New	Fully Addressed
16.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt within its QAPI program and incorporate the objectives into its QAPI program and identify any additional objective it will use to meet the QAPI goals: • In future QAPI work plans, clearly state QAPI program objectives and use them consistently. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 18; Recommendation 14) **KFMC 2024 Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP clearly stated the QAPI program State-identified objectives and used them consistently. The recommendation is fully addressed.	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status 2023	Completion Status 2024
Sunflower			
	2023 Recommendations (Continued)		
17.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt within its QAPI program and incorporate the objectives into its QAPI program and identify any additional objective it will use to meet the QAPI goals: • In future QAPI work plans, use the term "objectives," as defined in the State Contract, section 5.9.3(C). (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 18; Recommendation 15) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP used the term "objectives," as defined in the State Contract, section 5.9.3.C. The recommendation is fully addressed.	New	Fully Addressed
18.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt within its QAPI program and incorporate the objectives into its QAPI program and identify any additional objective it will use to meet the QAPI goals: • In future QAPI work plans, use the terms "objectives" and "activities" consistently. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 18; Recommendation 16) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, SHP used the terms "objectives" and "activities" consistently. The recommendation is fully addressed.	New	Fully Addressed
19.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt within its QAPI program and incorporate the objectives into its QAPI program and identify any additional objective it will use to meet the QAPI goals: • In future QAPI work plans, for the SHP objective "State identified seven objectives to meet established QAPI goals," in column D, include an activity that SHP completes to achieve this requirement. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 18; Recommendation 17) **KFMC Update:** • 2024 Review: In the *2024 QAPI Work Plans*, for the SHP Objective "State identified seven objectives to meet established QAPI goals," in column E, SHP included activities completed to achieve these requirements. Also, column "I. Comments" included details on what was completed. The recommendation is fully addressed.	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2023	Completion Status 2024
Sunflower			
	2023 Recommendations (Continued)		
20.	5.9.7 National Committee for Quality Assurance Accreditation – General Requirements: • In future QAPI work plans, for the SHP objective "NCQA Accreditation" in column D, include activities related to SHP's NCQA Accreditation, the level of accreditation, and/or when the next accreditation will occur. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 22; Recommendation 18) **KFMC Update:** • 2024 Review: To the *2024 QAPI Work Plans*, row "NCQA Accreditation," column "D. Objective," SHP added four activities that SHP completes to achieve this requirement. The recommendation is fully addressed.	New	Fully Addressed
21.	5.9.8 HEDIS and CAHPS – General Requirements: • In future QAPI work plans, include information on the following identified HEDIS requirements (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 23; Recommendation 19): a. *Achieve the National HEDIS 75th percentile for Opioid abuse or dependence: Age 13+, Initiation of AOD Treatment (IET)*. [Objective 4.5] b. *HbA1c good control (<8.0%) for Members with diabetes* [Objective 5.1] c. *Well-Child Visits first 15 months (effective 2020 name changed from W15 to W30)* [Objective 5.2a] d. *Well-Child Visits 15-30 months (15-30-month period & name change in 2020)* [Objective 5.2b] e. *Child and Adolescent Well-Care Visits (WCV) ages 3-11* [Objective 5.3a] f. *Child and Adolescent Well-Care Visits (WCV) ages 12-17* [Objective 5.3b] g. *Child and Adolescent Well-Care Visits (WCV) ages 18-21* [Objective 5.3c] **KFMC Update:** • 2024 Review: To the *2024 QAPI Work Plans*, row "Achieve the National HEDIS 75th percentile for…," SHP added the QMS required HEDIS measures. The recommendation is fully addressed.	New	Fully Addressed
22.	5.9.8 HEDIS and CAHPS – General Requirements: • In future QAPI work plans, for the SHP objective "Healthcare Effectiveness Data and Information Set (HEDIS) data collection and reporting for population-specific HEDIS measures," include the State QMS required HEDIS measures Goal 4, Objective 4.5 and Goal 5, Objectives 5.1, 5.2a-b, and 5.3a-c. (State KanCare 2.0 Contract; 2023 QAPI Checklist Number 23; Recommendation 20) **KFMC Update:** • 2024 Review: SHP no longer has the objective "Healthcare Effectiveness Data and Information Set (HEDIS) data collection and reporting for population-specific HEDIS measures" in the *2024 QAPI Work Plans*. However, the work plans include the row "Achieve the National HEDIS 75th percentile for…" that include the QMS required HEDIS measures. The recommendation is fully addressed.	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status		
		2022	2023	2024
UnitedHealthcare				
	2022 Recommendations			
2.	5.9.1(A) General Requirements – The State's QMS: The Contractor will comply with the State's QMS. • In future QAPI documents, include information on how UHC complies with the State QMS. (KanCare 2.0 Contract; 2022 QAPI Checklist Number 2; 2022 Recommendation 1) **KFMC Update:** • 2023 Review: The *2023 QAPI Work Plans* included the activity "Review State QMS annually, including compliance of the QMS." The *2022 QAPI Evaluation* and *2023 Program Description* did not include details of how UHC complies with the State QMS. In the *2023 Program Description*, within the list of "Responsibilities of the QMC," oversight and approval of the QI PHM PD, QI PHM WP, and QI PHM Eval was listed. However, showing evidence of compliance with the State QMS requires more than listing these items in the program description. • 2024 Review: UHC added information to the *2024 Quality Improvement Population Health Program Description* (QAPI program description), *2023 Quality Improvement & Population Health Management Annual Evaluation Report* (QAPI program evaluation), and the *2024 Population Health Management Work Plans* (QAPI work plans). The recommendation was fully addressed.	New	Partially Addressed	Fully Addressed
3.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt through which the Contractor shall meet the established QAPI goals and incorporate the objectives into its QAPI program and identify any additional objectives it will use to meet the QAPI goals (KanCare 2.0 Contract): • In future QAPI documents, use the State-specified objectives listed in the State Contract section 5.9.3(C) to demonstrate how the QAPI program addresses them. (2022 QAPI Checklist Number 23; 2022 Recommendation 4) • In future QAPI work plans, in the UHC "Program Objectives," State Contract-specified objectives (C)(1-5) and (C)(7) of section 5.9.3(C) should be included to demonstrate how the QAPI program addresses them. (2023 QAPI Checklist Number 18; 2023 Recommendation 7) **KFMC Update:** • 2023 Review: In the QAPI documents, UHC did not include in their program objectives the following State-specified objectives listed in the State Contract section 5.9.3(C): ○ 5.9.3(C)(1-3), (C)(5), and (C)(7) were not included in the *2022 QAPI Evaluation*, *2023 QAPI Program Description*, and *2023 QAPI Work Plans*. ○ 5.9.3(C)(4) was not included in the *2022 QAPI Evaluation* or the *2024 QAPI Work Plans*. ○ 5.9.3(C)(6) was not included in the *2023 QAPI Program Description*. ○ 5.9.3(C)(7) was not included in the *2022 QAPI Evaluation* or *2023 QAPI Program Description*. • 2024 Review: In all three QAPI documents, UHC added information to address C.1, C.3, C.4, C.6, and C.7. However, there was no information added in any of the QAPI documents for C.5 related to peer review.		Partially Addressed	Partially Addressed

Follow-Up to Previous Recommendations		Completion Status 2023	Completion Status 2024
UnitedHealthcare			
	2023 Recommendations		
4.	5.2.2(B)(2) and 5.9.1(A) Disenrollment and MCO Compliance with the State's QMS: • In future QAPI documents, reference, as applicable, committee meeting activities that are used to provide evidence of compliance with the State's QAPI requirements. (KanCare 2.0 Contract; 2023 QAPI Checklist Numbers 1-2; 2023 Recommendation 1) **KFMC Update:** • 2024 Review: UHC added language to the *2023 QAPI Program Evaluation* and *2024 QAPI Program Description* related to monitoring, tracking, and trending disenrollment and on how they comply with the State QMS. The recommendation was fully addressed.	New	Fully Addressed
5.	5.9.1(N)(6) Annual MCO QAPI Evaluation: • In future QAPI work plans, in the column "Comments/Status/Previous Issue Update," include the QAPI evaluation recommendations that will be implemented that year and/or include a new activity row within the work plan. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 15; 2023 Recommendation 2) **KFMC Update:** • 2024 Review: The *2023 QAPI Evaluation* included findings and recommendations that were used to shape the *2024 QAPI Program Description* and *2024 QAPI Work Plans*, as all of the UHC identified recommendations from the findings detailed in the *2023 QAPI Evaluation* were included in the *2024 QAPI Program Description* and *2024 QAPI Work Plans*. The recommendation was fully addressed.	New	Fully Addressed
6.	5.9.1(N)(6) Annual MCO QAPI Evaluation: • In future QAPI work plans, describe activities that UHC will do to improve HEDIS goals that are identified in the prior year QAPI evaluation. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 15; 2023 Recommendation 3) **KFMC Update:** • 2024 Review: To the work plan, row 13 "Complete the annual QI Program Evaluation. Obtain Committee feedback and approval," in column K "Comments/Status/Previous Issue Update," UHC added information on the following that were outlined and reviewed in the *2023 QAPI Program Evaluation*: ○ "UHCCP KS will focus on the following HEDIS measures throughout 2024, which are state-assigned P4P measures: IET (AOD - Initiation), WCC (BMI %ile - Total), CHL, PPC (Prenatal), PPC (Postpartum), LSC , and PCE (Systemic Corticosteroid)." ○ "UHCCP will focus on the following HEDIS measures that scored < 10th %ile on the QC and had a negative YOY [Year-Over-Year] change: IMA and IET total." ○ "UHCCP will focus on the following state-required HEDIS Measures: Breast Cancer Screening (BCS), HbA1c good control (<8.0%) for members, with diabetes, Well Child Visits in the First 15 Months (W30), Well Child Visits for Age 15-30 Months (W30), Well Child Visits (WCV) – ages 3-11, Well Child Visits (WCV) – ages 12-17, and Well Child Visits (WCV) – ages 18-21." The recommendation was fully addressed.	New	Fully Addressed

Follow-Up to Previous Recommendations		Completion Status 2023	Completion Status 2024
UnitedHealthcare			
	2023 Recommendations (Continued)		
7.	5.9.3(A) Integration and infusion of State identified guiding principles: • In future QAPI work plans, State Contract-specified guiding principles (A)(2), (A)(10), and (A)(11) of section 5.9.3(A) should be included to demonstrate how the QAPI program addresses them. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 16; 2023 Recommendation 4) **KFMC Update:** • 2024 Review: ○ A.2: Fully Addressed: Guiding principal A.2 was added to the work plan on the Objectives Tab (line 34). ○ A.10 and A.11: Not Addressed: Work Plan – Activity Tab: Line 26, UHC added the activity, "Review State QMS & State Contract Quality Assessment and Performance Improvement Goal, Objectives and Guiding Principles (5.9.3 A, B, C) annually, including compliance of both." However, this does not address or demonstrate how UHC integrates guiding principles A.10 and A.11 into the QAPI program or infuse them throughout the organization.	New	Partially Addressed
8.	5.9.3(C) Quality Assessment and Performance Improvement Goal, Objectives, and Guiding Principles – Objectives Contractor to adopt within its QAPI program and incorporate the objectives into its QAPI program and identify any additional objective it will use to meet the QAPI goals: • In future QAPI documents, ensure that UHC "Program Objectives" are consistent across the documents. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 18; 2023 Recommendation 6) **KFMC Update:** • 2024 Review: In all three QAPI documents, UHC added information to address C.1, C.3, C.4, C.6, and C.7. However, there was no information added in any of the QAPI documents for C.5 related to peer review. The recommendation was partially addressed.	New	Partially Addressed
9.	5.9.4(A-B) Performance Measures: • In future QAPI work plans, include information on the measure *Breast Cancer Screening (BCS-AD)*. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 19; 2023 Recommendation 8) **KFMC Update:** • 2024 Review: UHC added the measure *Breast Cancer Screening (BCS-AD)* to the QAPI work plans. The recommendation was fully addressed.	New	Fully Addressed
10.	5.9.7 National Committee for Quality Assurance Accreditation – General Requirements: • In future QAPI work plans, include information on NCQA Accreditation and LTSS Distinction. (KanCare 2.0 Contract; 2023 QAPI Checklist Number 21; 2023 Recommendation 9) **KFMC Update:** • 2024 Review: UHC added an NCQA Accreditation and LTSS Distinction activity to the 2024 QAPI work plans. The recommendation was fully addressed.	New	Fully Addressed

	Follow-Up to Previous Recommendations	Completion Status 2023	Completion Status 2024
UnitedHealthcare			
	2023 Recommendations (Continued)		
11.	5.9.8 HEDIS and CAHPS – General Requirements: • In future QAPI work plans, include information on how UHC addresses the HEDIS measure *Breast Cancer Screening (BCS-AD)* and State QMS, Goal 5, Objectives 5.1, 5.2a-b, and 5.3a-c. (2023 QAPI Checklist Number 23; 2023 Recommendation 10) **KFMC Update:** • 2024 Review: UHC added, to the 2024 work plans, an activity that included information on how UHC addresses the HEDIS measure *Breast Cancer Screening (BCS-AD)* and State QMS, Goal 5, Objectives 5.1, 5.2a-b, and 5.3a-c. The recommendation was fully addressed.	New	Fully Addressed

Network Adequacy Validation

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Recommendations for Quality Improvement		
1.	As intended, the State should continue to review and work with the MCOs on accuracy of the various provider databases. **2024 KDHE Response:** KDHE will continue to review and work with the MCOs on the accuracy of their provider databases. **2024 KFMC Update:** The State has recognized a continued need for improvements to provider databases. Efforts aimed at improving the data bases are ongoing.	In Progress
2.	KanCare MCOs should inform providers that all pre-recorded messages must be high-quality, informative, and provide callers with certainty that they have reached the practice whose number they dialed. A member should, at minimum, have a means for leaving a message and should be told when to expect a return call. **2024 Aetna Response:** Outreach was completed to providers during 1st quarter of 2024 and information for A&A requirements was provided. **2024 Sunflower Response:** This is on our 2025 workplan. We are also working with our communication team to add this to Medicaid training that will be submitted to the state for review. **2024 UnitedHealthcare Response:** As identified by the MCO Annual Timeliness Report survey, United coaches providers whose messages are identified as lacking. UHC is in the process of adding specific recommendations on pre-recorded messages and network adequacy standards to existing provider training. **2024 KFMC Update:** This recommendation was *not assessed* in the 2024 report. KFMC intends to resume calls to providers in 2025 and progress toward addressing this recommendation will be evaluated at that time.	Not Assessed in 2024 ABH, SHP, UHC
3.	KanCare MCOs should use findings from KFMC's Network Adequacy Validation report to work with providers to improve the accuracy (of names, in particular) and timely updating of directory files. **2024 Aetna Response:** Outreach was completed to providers during 1st quarter of 2024 and information for A&A requirements was provided. **2024 Sunflower Response:** This is included in Medicaid Provider training. Provider Data and Enrollment Updates indicate how to update their provider record information. A bulletin was released on 9/25/24 indicating the importance of updating provider information. We are also adding this to Provider Orientation.	Not Assessed in 2024 ABH, SHP, UHC

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Recommendations for Quality Improvement (Continued)		
	2024 UnitedHealthcare Response: Providers must submit name updates to their data and need to update both KMMS and UHC data. We do recognize that this means providers must update information in two different places. Per the DXC and MCO Provider JSON file with business rules posted on KMAP name is categorized as Pend for PE review. Pend for PE Review is defined as: ADD/CHANGE WILL BE VALIDATED BY DXC. This means that this change will not be accepted until DXC [Gainwell] can validate. On the United side, a provider frequently is contracted for more than just Medicaid and we would need provider to use existing channels like www.uhcprovider.com for demographic updates. **2024 KFMC Update:** This recommendation was *not assessed* in the 2024 report. The 2024 report focused on the accuracy and completeness of the Mapped Provider Counts Report and did not include an assessment of the accuracy of names in the data that was evaluated. Provider directories will be assessed again in KFMC's future Network Adequacy Validation efforts.	
4.	KanCare MCOs should validate their provider data (e.g., NPIs, provider types, and specialties) against the State's records. **2024 Aetna Response:** ABH of Kansas system is locked to the state system and updates nightly to mirror the state record for the provider. Our information reflects the current information on state files. **2024 Sunflower Response:** Sunflower crosswalks the provider's credentialed taxonomy (Affiliation's taxonomy UDA) to the Provider Type and Provider Specialty. Special rules for Taxonomy of 103K00000S and 101YP1600X are applied as these taxonomies map to three (3) different Provider Types and Provider Specialties on the State's PRN. **2024 UnitedHealthcare Response:** UHC updates follow the guidance on DXC and MCO Provider JSON file. **2024 KFMC Update**: Partially Addressed. Specialty codes for over 75% (over 90% for specialty categories) of individual providers matched, however location specific business specialty codes did not match to the State's records well for any of the MCOs.	Partially Addressed ABH, SHP, UHC
5.	Sunflower and UnitedHealthcare should prioritize populating KMMS IDs for participating individual, group, and facility providers. **2024 Sunflower Response:** The KMMS ID listed in the PNtwk is matched by TIN, NPI, and first four characters of the Address. The Provider Name is the Tax ID Name listed in the Business Entity table. **2024 UnitedHealthcare Response:** Provider records were established prior to the introduction of the KMMS IDs. Additionally provider data is shared across similar lines of business like DSNP. Since our members can have both a Medicaid policy and a DSNP policy and have claims process under both at the same time, it is important that our providers would have a identifier that can be universal under both records. **2024 KFMC Update:** Not Addressed. Of the records evaluated, only 40% for Sunflower and 55% for UnitedHealthcare had a KMMS ID populated.	Not Addressed SHP and UHC

	Follow-Up to Previous Recommendations (2023)	2024 Completion Status
Recommendations for Quality Improvement (Continued)		
6.	Aetna should populate effective and end date fields in its network reports. **2024 Aetna Response:** This has been updated and added. **2024 KFMC Update:** Not Addressed. Aetna did not correctly populate the effective or end date fields in its Q2 or Q3 2024 network reports.	Not Addressed ABH
7.	For individuals in a group practice, KanCare MCOs should provide the NPI and KMMS ID of the individual, not the group. **2024 Aetna Response:** This was added in the 2024 survey. **2024 Sunflower Response:** The KMMS ID listed in the PNtwk: The Practitioner's NPI for Practitioner records and Provider's NPI for Provider records. **2024 UnitedHealthcare Response:** This is contradictory to guidance from KDHE related to Geo and Network Adequacy reports. Previous guidance indicates that counts should tie between GEO and Network Adequacy and UHC counts were inflated due to reporting individuals and groups at the same location, our instructions were to report the group location. United is requesting this recommendation be directed to KDHE and any updates be made to the Network Adequacy and Geo Access standards documents. **2024 KFMC Update:** Partially Addressed. Of the records for individuals in a group that had a KMMS ID populated, they were usually for the individual, not the group. This allowed for a high percentage of individual records to be matched to the correct location for that provider. However, many records for Sunflower and UnitedHealthcare did not have a KMMS ID populated.	Partially Addressed ABH, SHP, UHC
8.	Additional methodological detail is needed for the appointment availability and after-hours access provider surveys in all MCO Annual Timeliness Reports. **2024 Aetna Response:** This was added in the 2024 survey. **2024 Sunflower Response:** This is on the 2025 workplan. We will include this on the 2025 MCO Annual Timeliness Report template. **2024 UnitedHealthcare Response:** The current TIME report meets the standards outlined in the 2025 MCO Annual Timeliness Report v2.1. United is requesting this recommendation be directed to KDHE and any updates be made to the MCO Annual Timeliness Report. **2024 KFMC Update:** This recommendation is *in progress*. The MCOs have provided some additional detail in these reports. However, all MCOs should enhance their efforts to provide clear and thorough methodological detail regarding their sampling processes in particular.	In Progress ABH, SHP, UHC

Follow-Up to Previous Recommendations (2023)		2024 Completion Status
Recommendations for Quality Improvement (Continued)		
9.	The MCOs should review and enhance their survey caller training and procedure manual specificity, regarding categorization of survey responses and unsuccessful attempt reasons. Review, and improve if needed, surveyor oversight, including inter-rater reliability testing. **2024 Aetna Response:** This was added to the results from our survey for 2024 for our review **2024 Sunflower Response:** This is on the 2025 workplan. We are drafting an Access and Availability Standards bulletin and provider training and will be making necessary changes to the vendor's audit call script. Regarding training, the vendor hires resources with experience in contracting and data management and three months of training is conducted after onboarding. **2024 UnitedHealthcare Response:** The current TIME report meets the standards outlined in the 2025 MCO Annual Timeliness Report v2.1. United is requesting this recommendation be directed to KDHE and any updates be made to the MCO Annual Timeliness Report. **2024 KFMC Update:** This recommendation is *in progress*. The MCOs have provided call scripts and other documentation to aid in KFMC's 2024 review and have provided limited descriptions of call procedures in their Annual Timeliness Reports. KFMC determined that additional details related to caller training and inter-rater reliability testing is needed to fully assess this recommendation.	In Progress ABH, SHP, UHC
10.	The State, MCOs, and EQRO should review and discuss the potential variations in survey methodologies that could affect the measures and MCO comparisons, with the State making final determinations regarding methodological changes. **2024 Aetna Response:** This was discussed for the 2024 survey. **2024 Sunflower Response:** This is on our 2025 workplan and we would welcome discussion with the state on potential options to reduce methodologies across MCOs. **2024 UnitedHealthcare Response:** UHC agrees. **KFMC Update:** This recommendation is *in progress*. KFMC and the State have been in discussions related to improvement of the survey and reporting processes. These conversation will continue in 2025 and will include discussions related to the design of the Annual Timeliness Report.	In Progress ABH, SHP, UHC

Appendix E

KanCare Program Annual External Quality Review Technical Report

2024–2025 Reporting Cycle

List of Abbreviations and Acronyms

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
AAP	Adults' Access to Preventive/Ambulatory Health Services (HEDIS measure)
AD	Advanced Directives
ADHD	Attention Deficit Hyperactivity Disorder
Aetna, ABH, or ABHKS	Aetna Better Health of Kansas
AHRQ	Agency for Healthcare Research and Quality
ADT	Admission, Discharge, and Transfer
AMM	Antidepressant Medication Management (HEDIS measure)
BCS-AD	Breast Cancer Screening
BH	Behavioral Health
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CC	Care Coordinator
CCC	Children with Chronic Conditions
CCS	Cervical Cancer Screening (HEDIS measure)
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program (Title XXI)
CHL	Chlamydia Screening in Women
CHW	Community Health Worker
CIS	Childhood Immunization Status
CM	Care Management
CMHC	Community Mental Health Center
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CPESN	Community Pharmacy Enhanced Service Network
CP-PCPi	Community Plan Primary Care Provider Incentive
CRO	Consumer Run Organization
DTaP	Diptheria, Tetanus, and Acellular Pertussis Vaccine (Children's Immunization Status HEDIS measure antigen)
ECDS	Electronic Clinical Data Systems
ECHO	Experience of Care and Health Outcomes (ECHO Survey)
ED	Emergency Department
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
EQR	External Quality Review
EQRO	External Quality Review Organization
FE	Frail Elderly
FM	Fully Met
GC	General Child CAHPS survey population
GIC	Gaps in Care
GMT	Geo Master Table
GSA-SAM	Government Services Administration's System for Award Management
HARC	Hospitality Assessment Reminder Center
HbA1c	Glycated Hemoglobin

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
HCBS	Home and Community-Based Services
HCE	Health Care Equity
HEDIS	Healthcare Effectiveness Data and Information Set
HiB	Haemophilus Influenzae B (Children's Immunization Status HEDIS measure antigen)
HIPAA	Health Insurance Portability and Accountability Act
HPV	Human Papillomavirus (Immunizations for Adolescents HEDIS measure antigen)
HRA	Health Risk Assessment
HSF	Housing Stabilization Fund
HST	Health Screening Tool
ID	Identify/Identification
I/DD	Intellectual/Developmental Disability
IET	Initiation of AOD Treatment
IPV	Inactivated Poliovirus Vaccine (Children's Immunization Status HEDIS measure antigen)
ISCA	Information Systems Capabilities Assessment
IVR	Interactive Voice Response
KDADS	Kansas Department for Aging and Disability Services
KDHE-DHCF	Kansas Department for Health and Environment, Division of Health Care Finance
KFMC	KFMC Health Improvement Partners
KHIN or KONZA	Kansas Health Information Network
KMAP	Kansas Medical Assistance Program
KMMS	Kansas Modular Medicaid System
KSWebIZ	Kansas Immunization Registry
LDL-C	Low-density Lipoprotein Cholesterol
LEIE	List of Excluded Individuals/Entities
LTSS	Long-Term Services and Supports
MCO	Managed Care Organization
MetaStar	MetaStar, Inc.
MH	Mental Health
MHFC	Mental Health for Foster Care
MM	Minimally Met (Compliance Review)
MMR	Measles-Mumps-Rubella (Children's Immunization Status HEDIS measure antigen)
MPC	Mapped Provider Count
MY	Measurement Year
NCQA	National Committee for Quality Assurance
NE	Non-Emergent
NF	Nursing Facility
NM	Not Met
NPI	National Program Identifier
NPPES	National Plan & Provider Enumeration System

List of Abbreviations and Acronyms	
Abbreviation/Acronym	**Description**
OBGYN	Obstetrician/Gynecologist
OIG	Office of the Inspector General
PAHP	Prepaid Ambulatory Health Plan
PARs	PIP Action Report
PCP	Primary Care Physician/Provider
PCSP	Person-Centered Service Plan
PII	Personal Interest Inventory
PH	Physical Health
PIHP	Prepaid Inpatient Health Plan
PII	Personal Interest Inventory
PIP	Performance Improvement Project
PM	Partially Met
PMTO	Parent Management Training, Oregon Model
PMV	Performance Measure Validation
POM	Proactive Outreach Management
POS	Place of Service
pp	Percentage Points
pp/y	Percentage Points Per Year
PPC	Prenatal and Postpartum Care (HEDIS measure)
p/y	Points Per Year
PRTF	Psychiatric Residential Treatment Facility
QAPI	Quality Assessment and Performance Improvement
QC	Quality Compass (NCQA)
QI	Quality Improvement
QMS	Quality Management Strategy
RC	Reporting Cycle
RY	Remeasurement Year
SDOH	Social Determinants of Health
SED	Serious Emotional Disturbance
SFTP	Secure File Transfer Protocol
SG	Sedgwick County
SHCN	Special Health Care Needs
SIA	State Institutional Alternative
SM	Substantially Met
SMD	Diabetes Monitoring for People with Diabetes and Schizophrenia
SMHH	State Mental Health Hospitals
SMS	Short Message Service
SOP	Standard Operating Procedure

List of Abbreviations and Acronyms	
Abbreviation/Acronym	***Description***
SUD	Substance Use Disorder
Sunflower or SHP	Sunflower Health Plan
TA	Technical Assistance
Tdap	Tetanus, Diptheria toxoids, and Pertussis Vaccine
TXIX	Title 19 (Medicaid)
TXXI	Title 21 State Child Health Insurance Programs (CHIP)
UnitedHealthcare, UHC, or UHCCP	UnitedHealthcare Community Plan of Kansas
UTI	Urinary Tract Infection
VZV	Varicella-Zoster Virus (Children's Immunization Status HEDIS measure antigen)
WCV	Child and Adolescent Well-Care Visits (HEDIS measure)
WPC	Whole Person Care Program