REVIEW OF KANCARE:
QUALITY AND ACCESS TO CARE

January 2018

LEAVITT
PARTNERS

INTRODUCTION

KanCare, the state of Kansas' managed Medicaid program, reached the end of its demonstration period under a 1115 CMS waiver at the end of 2017. CMS recently granted a one-year extension for the program, which contracts with three managed care organizations (MCOs) to provide health care for the state's Medicaid enrollees and covers more than 415,000 Kansans. Numerous reports have been published on KanCare, but a concise picture of the program's performance is still needed.

This effort summarizes the information in hundreds of pages of external quality reporting to draw out important findings about KanCare as it nears the end of its demonstration period. Leavitt Partners authored this secondary analysis report, with review from Kansas Health Institute (KHI). The analysis is based on detailed reports provided to CMS by the Kansas Foundation for Medical Care (KFMC) that include internally and externally sourced data from organizations such as the Kansas Department of Health and Environment (KDHE). This effort highlights KanCare's observed performance relative to its stated goals and commitments over the four completed operating years (2013 – 2016) since the program began in 2013.

This report, the second of three, focuses on health care quality and access to care for Kansas' Medicaid population. The first report focused on KanCare's success in controlling Medicaid costs and changing beneficiaries' utilization patterns, and the third will discuss the MCOs' efforts related to coordinating care and improvement projects.

KANCARE'S GOALS

Under KanCare, the state contracts with three health plans to provide Medicaid managed care services to beneficiaries—Amerigroup (a subsidiary of Anthem), Sunflower State Health Plan (a subsidiary of Centene Corp.), and United Healthcare of the Midwest. KanCare requires the MCOs to report quality and performance measures, and currently places up to 2% of their revenue at risk if they fail to meet quality benchmarks for physical health, behavioral health, and long-term care.

The Kansas Department of Health and Environment (KDHE) articulated four general goals that the state hopes to achieve through KanCare: (1) control Medicaid costs, (2) improve the quality of care, (3) provide integration and coordination of care, and (4) establish long-lasting reforms to sustain health improvements and provide a model for Medicaid reforms for other states. KanCare included quality and access objectives to improve coordination and integration of physical and behavioral health care, and to improve health outcomes in four specific treatment areas: diabetes, coronary artery disease, behavioral health, and prenatal care. This report presents quality measures related to these four treatment areas where possible, but no measures for coronary artery disease are reported in the annual and quarterly evaluations that Leavitt Partners has accessed and reviewed.

KDHE hypothesized that KanCare would improve care quality in two ways. First, it would hold MCOs accountable for outcomes and performance measures, and tie those measures to financial incentives. Second, KanCare would improve care quality by integrating and coordinating care to break down divisions among various sectors such as physical health, behavioral health, and long-term services and supports (LTSS).[1]

DATA SOURCES

This report draws from quarterly and annual reports required as part of the Section 1115 demonstration requirements. KDHE's Division of Health Care Finance compiles these reports, contracting with KFMC as the external quality review organization and section 1115 demonstration evaluator for much of the analysis and writing. The KDHE reports provide data on utilization, costs, quality metrics, and access measures for each completed year of KanCare, with some data running through the end of 2016. Leavitt Partners used these data to explore KanCare's effect on quality and access, drawing from the most recent reports that provided the data of interest in each category. Other data sources are cited as they appear in the report.

This report includes some survey-based measures, which have a margin of error based on sample design. On measures for which sampling methods were not reported, margins of error were calculated as if the samples were drawn using a simple random method. Where groups of surveys are combined, we conservatively report the highest

KanCare Pay-for-Performance Measures, 2013 – 2016[2]

CATEGORY	MEASURES	YEARS INCENTIVIZED			
		2013	2014	2015	2016
ADMINISTRATIVE/ OPERATIONAL	100% of clean claims processed within 20 days, 99% of non-clean claims in 45 days, 100% of all claims in 60 days	*		X	X
	Contractor meets all performance standards within 60 days from implementation date	X			
	90% provider credentials completed in 20 days, 100% completed in 30 days	X			
	98% of grievances are resolved within 20 days, 100% of grievances are resolved within 40 days	X			
	Contractor sends acknowledgement letter within 3 business days of receipt of appeal request	X			
	98% of all inquiries resolved within 2 business days from receipt, 100% of all inquiries resolved within 8 business days	X			
	Reduced claim turnaround times (NF, HCBS)			X	X
	98% of covered services must be accurately submitted via encounter within 30 days of claims paid date			X	X
	At least 98% of reported financials reflecting service payments match encounter record submitted by the MCO			X	X
PHYSICAL HEALTH	Comprehensive diabetes care, including HbA1c testing, HbA1c Poor Control (>9), HbA1c Adequate Control (<8), HbA1c Control (<7), eye exam, monitoring for nephropathy, blood pressure control (<140/90), and LDL-C screening		X	X	**
	Well child visits (4 or more in first 7 months)		X	X	
	Preterm births		X	X	
	Annual monitoring for patients on persistent medications		X	X	X
	Follow-up after hospitalization for mental illness		X	X	
	Childhood and adolescent immunizations				X
	Timeliness of prenatal care				X
BEHAVIORAL HEALTH	AIMS – Gained employment		X	X	X
	Participation in WORK program		X	X	X
	Increase in # of I/DD members employed		X	X	X
	SUD whose living arrangements improved		X	X	X
	SUD whose criminal justice involvement improved		X	X	X
	SUD whose drug and/or alcohol use decreased		X	X	X
	SUD whose self-help meeting attendance increased		X	X	X
	SUD whose employment status increased		X	X	X
	SPMI adults with increased access to services		X	X	X
	SED youth who had increased access to services		X	X	
	SPMI homeless with improvement in housing status		X	X	X
	Members utilizing inpatient psychiatric services		X	X	
PREVENTION/ INTERVENTION	Mammograms		X	X	
	Cervical cancer screening		X	X	X
	Adults' access to preventive/ambulatory health services		X	X	
	Flu shot, age 18-74		X	X	
	Comprehensive diabetes care for PD, I/DD, or SMI members (same as in physical health, plus smoking cessation)		X	X	
	Increase in # of primary care visits – Adults' access to preventive/ambulatory health services		X	X	
	Decrease in # of emergency room visits (HCBS)		X	X	
	Increase in use of annual dental visits (HCBS age 2+)		X	X	X
LONG-TERM CARE	Decreased Medicaid NF claims denied by MCOs		X		
	Medicaid NF residents with major injury from fall		X	X	
	% of members discharged from a NF who had a hospital admission within 30 days		X	X	X
	Increase in number of person-centered care homes (as recognized by PEAK) in Network		X	X	X

*Standard for 2013 was 100% of clean claims processed within 20 days, 99% of non-clean claims processed within 45 days, 100% of all claims are processed within 60 days.

**Only A1c testing, retinal eye exam, medical attention for nephropathy, and HbA1c control (<8%) were used in 2016.

margin of error of any of the individual surveys. Generally, stratified sampling designs would have narrower margins of error and clustered designs would have higher margins of error. In all cases, differences are not statistically significant unless explicitly noted in the text or by symbols in the figures.

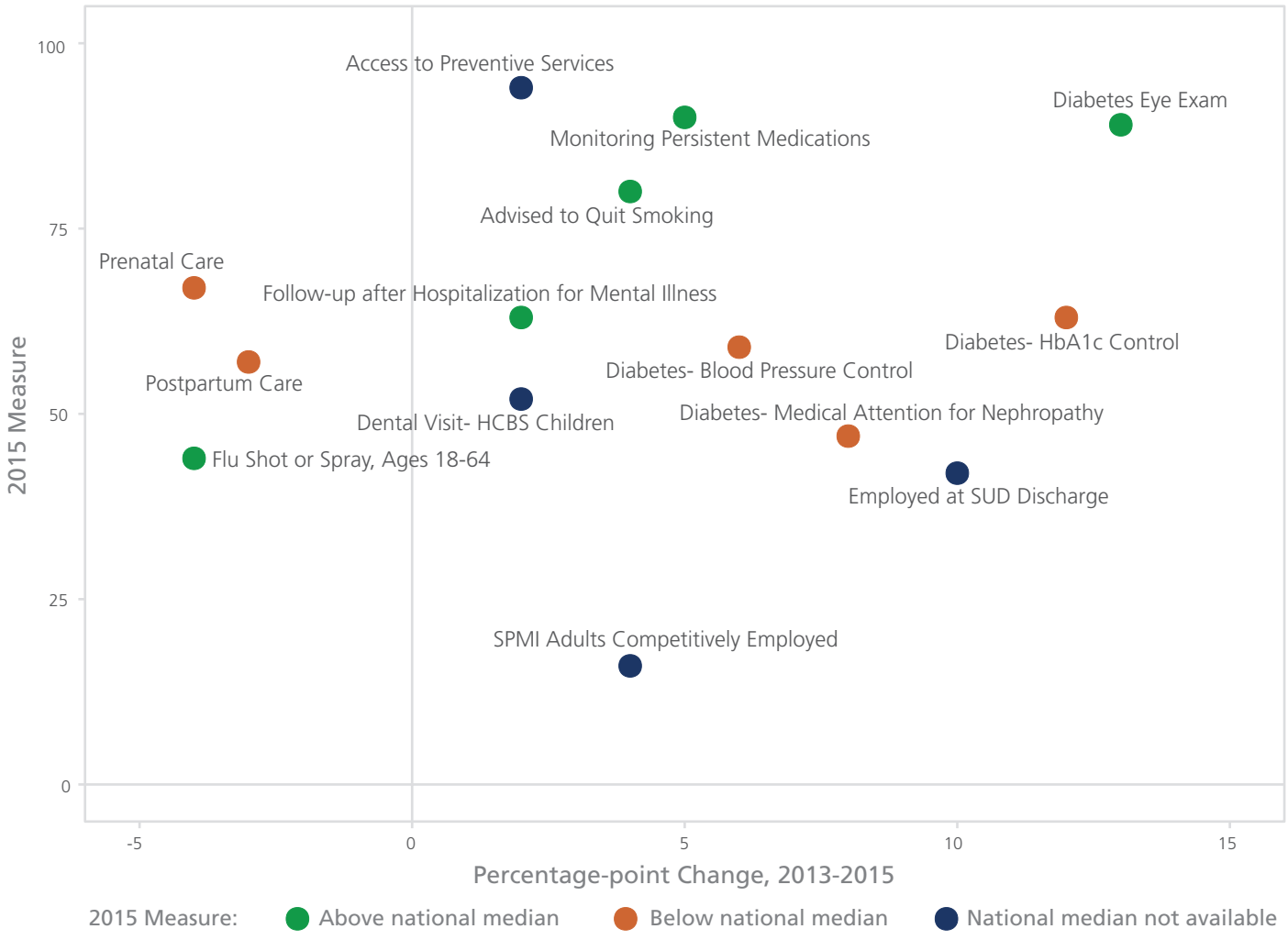
QUALITY OF CARE

PAY-FOR-PERFORMANCE MEASURES

MCOs' metrics on pay-for-performance (P4P) measures are important indicators of care quality in areas designated as of particular interest to the state. KanCare aims to improve care quality by holding two percent of MCOs' payments subject to their performance on specified P4P measures presented in the following table. Plans are first expected to achieve rates above the national median on these measures, and then improve by five percent each year after that. Once a measure has reached a ceiling specified by the state, it continues to be tracked but no longer functions as P4P.

P4P measures indicate how well the MCOs are doing with respect to diabetes management, tobacco cessation, substance use disorder (SUD) treatment, immunizations, prenatal and postpartum care, and other areas of importance to the state. Figure 1 shows the P4P measures that demonstrated meaningful changes from 2013 to 2015 (the most recent year for which data is available).

Figure 1. Pay-for-Performance Measures with Greater than +/- 2% Changes, 2013 – 2015



Source: Leavitt Partners analysis of KDHE reports.

Performance on the P4P measures related to the target treatment areas was mixed during the first three years of the program (those for which data was available in the 2016 reports).

IMPROVED PERFORMANCE

Looking at KanCare in the aggregate, most P4P measures improved from 2013 to 2015. The MCOs' management of diabetes care improved measurably on several metrics during the KanCare years, including eye exams for diabetes patients, HbA1c control, blood pressure control, and medical attention for nephropathy. The latter three measures indicated large improvements during the KanCare years but remained below the national median in 2015.

As KanCare aimed, utilization of inpatient psychiatric services decreased from 2013 to 2015, although there was no year in which all three MCOs decreased this metric by enough to meet P4P goals. Follow-up after hospitalization for mental illness increased to meet P4P goals in 2015. The percentage of deliveries that were preterm remained similar to 2013 levels, with some MCOs achieving the P4P target reductions in some years but not others.

KanCare plans demonstrated improvement on several other P4P measures during the first three years of the program. Monitoring for patients with persistent medications increased, almost 80% of adults who used tobacco reported that their provider advised them to quit, and more of them said their doctor had discussed strategies for quitting. The plans also reported an 8.6% increase in the percent of members receiving SUD services who were employed at time of discharge, and a 4% increase in the percent of members with a severe and persistent mental illness (SPMI) who were employed.

DECREASED PERFORMANCE

There were a few P4P measures which declined over the program period. Measures for timely prenatal and postpartum care decreased from 2013 to 2015, and only 43% of adults reported having received the flu vaccine in 2015. Kansas also tracks separate P4P measures for members with severe mental illness (SMI), intellectual/developmental disability, or a physical disability. In services for these enrollees, scores for several P4P measures decreased from 2013 to 2015. There were lower rates in screening for breast and cervical cancers for these populations, as well as for comprehensive diabetes care.

STATIC PERFORMANCE

Finally, MCOs' scores on several P4P measures demonstrated no large changes during the KanCare years. Well-child visits during the first seven months of life did not reach the improvement targets set by the state, but 2015 levels (67%) were comparable to 2013 levels. Adults' access to preventive and ambulatory health services remained high, near 95%. The percentage of SED youth with increased access to an increased level of services each year did not improve, remaining slightly above 5%. For nursing facility patients, the percentage of patients who had a fall with a major injury remained steady, as did the percent of hospital admissions after NF discharge.

CLAIMS PROCESSING P4P MEASURES

In 2013, the first year of KanCare, the MCOs' performance-based payments were based on process-based metrics including claims processing times, denial rates, provider credentialing times, customer service, grievances, and appeals. For the most part, plans met the criteria for these measures in 2013. For the 2015 performance year, in part due to complaints about processing times and claims backlogs, the following claims metrics were reinstated as P4P measures:

- Percent of clean claims paid or denied in 20 days: Achieve 99.5%
- Percent of all claims paid or denied in 40 days: Achieve 99%
- Average turnaround time (TAT) on HCBS claims: Maintain or decrease from CY 2014 rate (targets for the three MCOs ranged between 5.3 and 5.61 days)
- Average TAT on nursing facility claims: Maintain or decrease from CY 2014 rate (targets for the three MCOs ranged between 5.64 and 6.76 days)

KanCare MCOs are contractually obligated to process clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days of receipt. Clean claims

are those that can be paid or denied with no additional intervention. Non-clean claims include those requiring further documentation, out-of-network claims, claims within 30 days of the state providing updated rates/benefits/policies, claims from providers under investigation for fraud, and claims under review for medical necessity. KanCare's P4P standards of 20 and 40 days for clean and non-clean claims are intended to incentivize faster claims processing than the contractual standard.

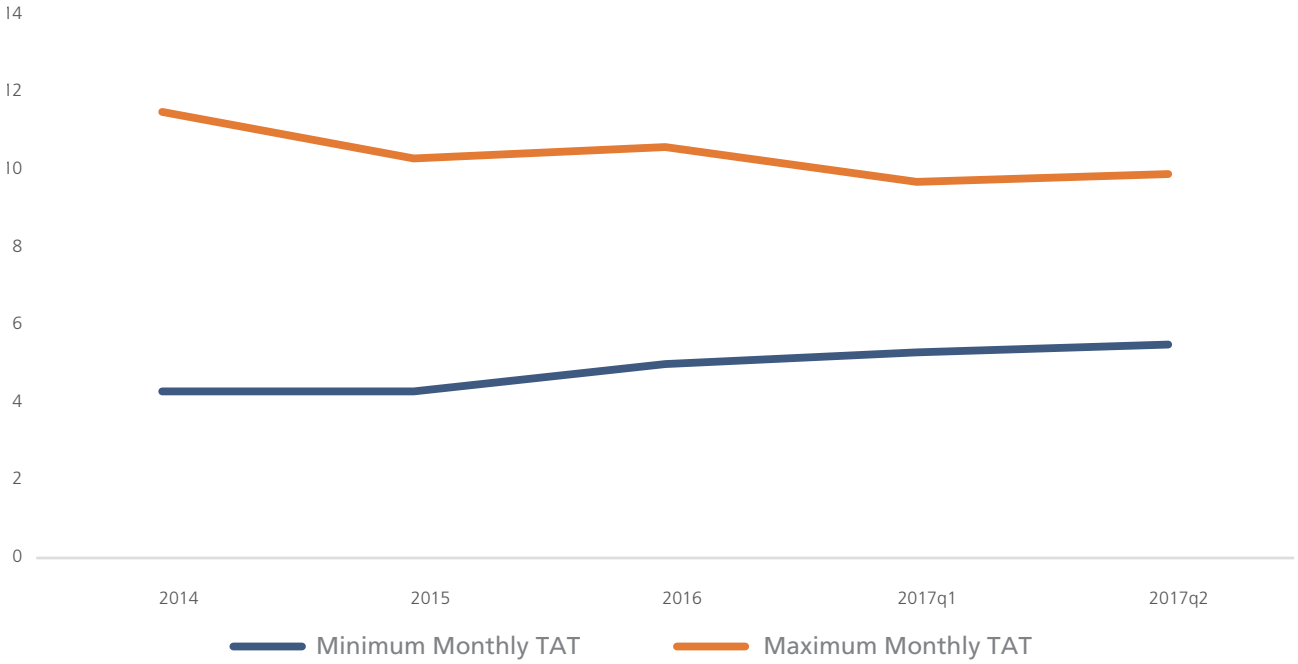
The most recently available KDHE reports do not indicate performance on these P4P measures, but do report performance relative to the contractual standards. In all quarters, over 99.99% of claims were processed within 90 days, and over 99.9% of clean claims were processed in 30 days or less. The only time fewer than 99.5% of non-clean claims were processed within 60 days was the fourth quarter of 2016, when 97.71% of non-clean claims were processed in the time allotted.

The KDHE reports do not provide average TATs program-wide, but the quarterly reports do show minimum and maximum monthly average TATs for the MCOs. Overall, variance in processing times appears to have been reduced, but no other trends are apparent in the available reports. In 2014, the minimum monthly average TAT for all claims was 4.3 days, and the maximum was 11.5. Overall average TATs appear to have converged to a narrower range in the second quarter of 2017, at which point monthly average TATs ranged from 5.3 to 9.7 (see Figure 2). For HCBS claims in the second quarter of 2017, monthly average TATs were between 5.7 and 9.3 days, compared to 3.2 and 15.6 days in 2014. For nursing facilities, monthly average TATs ranged from 4.3 to 11.5 in 2014, and from 5.0 to 10.5 in the second quarter of 2017.

OTHER GENERAL QUALITY MEASURES

In addition to P4P measures, KanCare plans report quality measures based on patient surveys and claims data. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, designed to assess members' experience with access, timeliness, and quality of health care, indicate that enrollees' general satisfaction with their health plans in 2016 ranged from 61% of adults to 74% of general child enrollees (according to their parents). As Table 1 shows, satisfaction with the health plans has increased for adults, children, and children with chronic conditions since 2014. (Margins of error differ by year and

Figure 2: Range of Monthly Average Claims Turnaround Times



Source: KDHE quarterly reports.

population, but all are below 2.41; see the note for Table 1 for details.)

KanCare members' satisfaction in 2016 was at or above the national median for all reported areas except personal doctors for children with chronic health conditions. This marked improvement from 2014, when KanCare members' satisfaction was below the national median in several more categories: specialists and health plans for adults, personal doctors and specialists for children, and personal doctors, specialists, and health plans for children with chronic conditions. Nationally, Medicaid enrollees tend to rate their satisfaction very highly; in a 2013 nationwide survey they gave their Medicaid programs an average 7.9 out of 10 rating, with almost half rating their program a 9 or a 10.[3]

In CAHPS surveys, slightly fewer patients reported discussing preventive health care with their provider in 2016 than in 2014, but 93% of adults and 95% of children's parents agreed that their provider clearly explained their or their child's health status.

KDHE also reports Healthcare Effectiveness Data and Information Set (HEDIS) measures, clinically based quality measures calculated from claims data and medical records which are tracked nationally by the National Committee for Quality Assurance (NCQA). These measures can be compared over time and relative to the national median. In 2015, KanCare MCOs performed better than the national median plan on 10 out of 24 measures reported by KDHE, worse on 12 measures, and had mixed results for 2 of the measures.

Leavitt Partners obtained Quality Compass data for 2017 (based on measurements taken in 2016) to examine the full range of HEDIS quality measures, including those not reported by KDHE.[a] On the full set of 101 HEDIS measure components for "effectiveness of care," there were 51 measures on which at least one KanCare MCO scored above the national median in 2016. All three MCOs scored above the median on 18 measurement components, including a number of KanCare P4P measures such as adult flu vaccinations, follow-up after hospitalization for mental illness within 7 and 30 days, and monitoring for those on antipsychotic medication. Each MCO individually scored above the national median on at least 32 measures (up to 39). NCQA awarded all three KanCare MCOs a "commendable" accreditation status, a level achieved by just under half of MCOs in the 2016 NCQA data. Data limitations prevent determining the relative performance of KanCare MCOs compared to other states' Medicaid managed care organizations.

a Leavitt Partners obtained data from 2014-2016, but only one MCO submitted measurements to NCQA for years other than 2016. This report does not discuss changes in HEDIS scores over time based on the Quality Compass data, since such analysis would be based on only one MCO.

Table 1. CAHPS Measures of General Satisfaction, 2014-2016

	ADULTS			GENERAL CHILDREN			CHILDREN W/CHRONIC CONDITIONS		
SATISFACTION WITH...	2014	2015	2016	2014	2015	2016	2014	2015	2016
Health Care	53	51	54	69	69	71	65	65	66
Personal Doctor	64	67	68	73	73	76	72	73	74
Specialist	65	66	67	70	69	70	69	68	73
Health Plan	55	58	61	71	72	74	63	67	67

Source: KanCare 2.0 waiver application.

Note: Cells show percent of respondents who gave a 9 or 10 on a scale of 1-10, where 10 represents the highest level of satisfaction. This table was reproduced from the KanCare waiver renewal application document. Colored text indicates whether the satisfaction measures are above or below the national median that year. Assuming that respondents are sampled using simple random sampling and that general children and children with chronic conditions in both Medicaid and CHIP are sampled together, the margins of error for the surveys range from 2.26 to 2.41 for adults and 1.00 to 1.18 for children.

In addition to the declines in P4P measures of prenatal and postpartum care discussed above, HEDIS scores show declines in initiation and engagement in treatment for alcohol and other drug dependencies, and physical activity counseling for adolescents. These decreases have kept Kansas below the national median on these measures. Still, KanCare plans showed improvement in several areas for which they scored higher than the national median in 2015, including meaningful improvement in most diabetes care metrics; the percent of children receiving well-child visits; BMI assessments for children, adolescents, and adults, and counseling for nutrition and physical activity for children. Most other measures remained substantially unchanged from 2013 to 2015.

MENTAL HEALTH

The three KanCare MCOs provide mental health services directly (Amerigroup) or through subcontractors (Sunflower with Cenpatico and United Healthcare with Optum). The National Outcome Measurement System (NOMS) measures assess quality of care for mental health patients (and a family member/caregiver for youth) each year to assess their satisfaction with, access to, and participation in mental health care services. Figure 3 shows general satisfaction results for 2016 and the percent change in satisfaction from 2013 to 2016 for five categories of respondents: adults, general youth and their families, and youth enrolled in the Serious Emotional Disturbance (SED) waiver and their families.

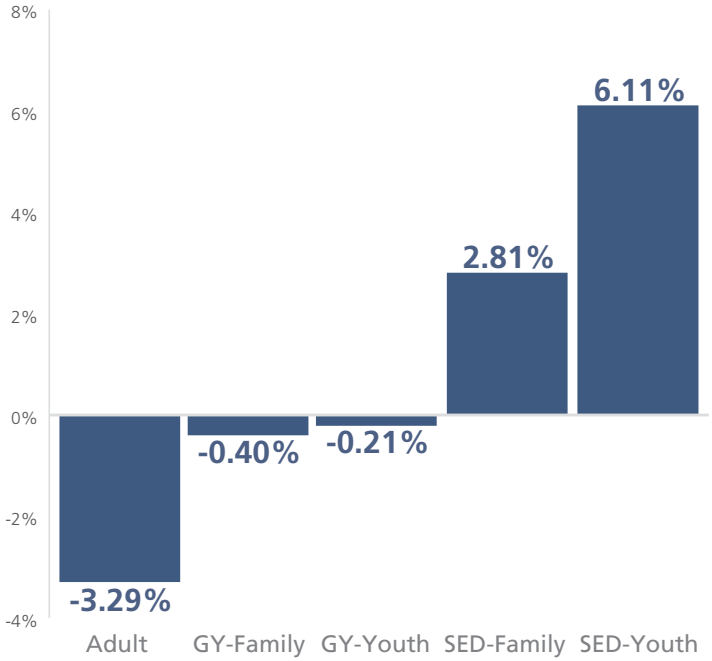
Changes over the program period varied considerably across populations, with adults responding worse on general satisfaction and SED youth responding more positively. Statistical tests for differences in these survey measures indicate that only the decline in general adult satisfaction approaches significance. Generally, adults reported lower satisfaction with and access to mental health services over time (latter measure not shown), though adults had higher satisfaction levels to begin with. SED youth and families reported statistically insignificant increases in satisfaction and access. General youth satisfaction levels did not change meaningfully from 2013 to 2016.

On measures of patient engagement and treatment outcomes, adults and general youth had lower scores in 2016 than in 2013 for participation in treatment planning, functioning, and health outcomes. Adults also reported lower appropriateness and quality of services (down 6% from 2013 to 2016), along with lower social connectedness. Each of these measures for adults is statistically significant, but general youth changes are not significant. Crisis management scores were 2% to 3% lower for all populations, but these results are not significant. Still, improvement was evident in mental health services for SED youth, who reported greater participation in treatment planning and improved functioning over time (result for participation in planning is statistically significant).

SUBSTANCE USE DISORDER SURVEY RESULTS

Measures are mixed for quality of care in SUD services during the KanCare period. NOMS measures assess quality of care for patients receiving SUD treatment services including improvement in living arrangements, reduction in arrests and drug and alcohol use, attendance at self-help meetings prior to discharge, and employment status. Slightly smaller percentages of people discharged from

Figure 3: Mental Health - Changes in Satisfaction, 2013 – 2016



Source: KDHE reports

Note: Statistical tests for differences in these survey measures indicate that only the decline in general adult satisfaction approaches statistical significance.

SUD services had stable living situations or were abstinent from substances in 2016 (96.9% and 90.8%, respectively) than in 2013 (99.1% and 94.2%). There was a 20.9% reduction from 2013 to 2016 in the percent of KanCare members attending self-help programs while in SUD treatment. However, there was an 8.6% increase in the percent of people employed at their time of discharge.

PROVIDER SURVEY

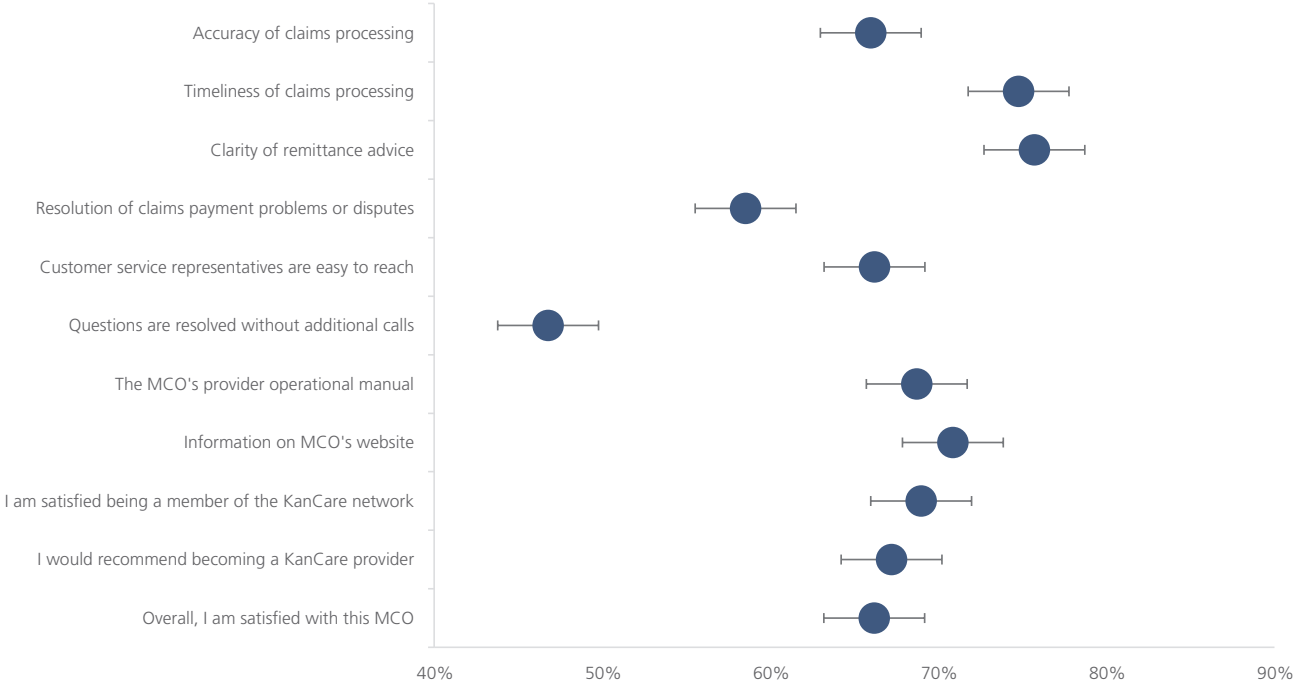
Another important measure of quality comes from surveys of providers offering services through the program about their satisfaction with the MCOs. Providers' responses allow the state to assess how well MCOs are meeting the needs of their providers and identify areas for improvement. In a 2016 survey commissioned by KDHE, around two-thirds of all providers reported being satisfied with the MCOs, and similar percentages reported satisfaction with KanCare network membership and willingness to recommend becoming a KanCare network provider (see Figure 4; the margin of sampling error on this survey was +/- 3%.).

Areas where providers reported the highest satisfaction included the timeliness of processing claims and remittance (reimbursing for services), and 58.5% of providers reported satisfaction with the resolution process for payment problems or disputes. Slightly fewer than half of providers, 46.8%, reported that they could get problems resolved without having to follow-up or make additional calls. Previous surveys commissioned by KFMC and performed by researchers at Wichita State University in 2013 and 2014 do show improvement on most of these metrics from KanCare's early days.[4] Still, other surveys captured some providers' dissatisfaction with the KanCare program and their perception that it had not improved quality and coordination of care.[5]

ACCESS

Beneficiaries' access to health care is an important indicator of KanCare's effectiveness in delivering Medicaid benefits. Access can be thought of objectively (service availability) and subjectively (time and effort it takes beneficiaries to access needed care). Considering these

Figure 4. Provider Survey - Satisfaction with MCOs, 2016



Source: KFMC-provided data.

Note: Whiskers represent the margin of sampling error for these results, which is +/- 3%.

measures together provides a broader picture to help evaluate both objective and subjective access to health care for KanCare beneficiaries. Access to health care is much less straightforward to measure than cost, utilization, or even quality, but Leavitt Partners analysts summarized information on several measures included in the KDHE reports to approximate KanCare enrollees' access to Medicaid services.

NETWORK SIZE AND ADEQUACY

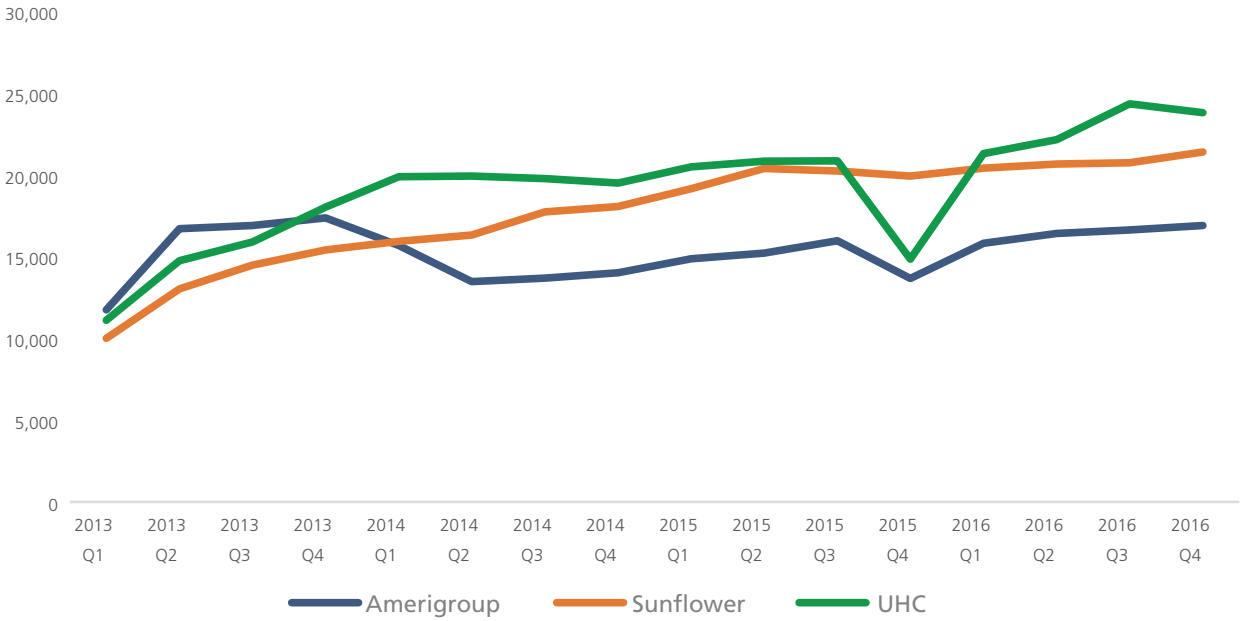
One way to measure access is to look at network size, approximated by how many providers each MCO has contracted with. The three MCOs' network sizes increased significantly in the first year of the program, with network sizes remaining generally stable after that (see Figure 5). The fact that all three MCOs are gaining more provider contracts is a good initial sign for beneficiaries' access.

Another measure of access is the time or distance patients in certain areas must travel to see a type of provider. Lower distances and times equal greater access. KanCare has established access standards based on distance for various service types (e.g., primary care, neurosurgery, hospitals, dental care, retail pharmacy, etc.), as well as separate, county-based standards for HCBS services.

Figure 6 shows the number of counties without any access to a given specialty or service type to demonstrate how access has changed in Kansas from 2012 to 2016. There were sizeable gains in the first year of the program in access to specialist physicians like neurosurgeons, podiatrists, neurologists, and plastic surgeons. Also during that first year, some counties saw declines in access to some specialties, including gastroenterology and allergy, compared to 2012. Still, all 16 urban and semi-urban counties had access up to the standards set in MCO contracts with the state in both 2012 and 2013, and by 2016 overall access had increased tremendously in terms of counties served by specialists. In that year, all counties had the same or better coverage for all but two specialties (cardiology and allergy). In some cases, especially in rural areas, the lack of a KanCare specialist in a county may be because there is no specialist serving that county.

There were some urban counties without access to certain services in 2016 that had not lacked them before; three urban or semi-urban counties lacked a plastic surgeon accepting KanCare, one lacked a neonatologist, and one lacked an allergy specialist. Because urban counties are more densely populated, when these counties lack a specialist there are relatively more beneficiaries without

Figure 5. Number of Provider Contracts by MCO, 2013-2016

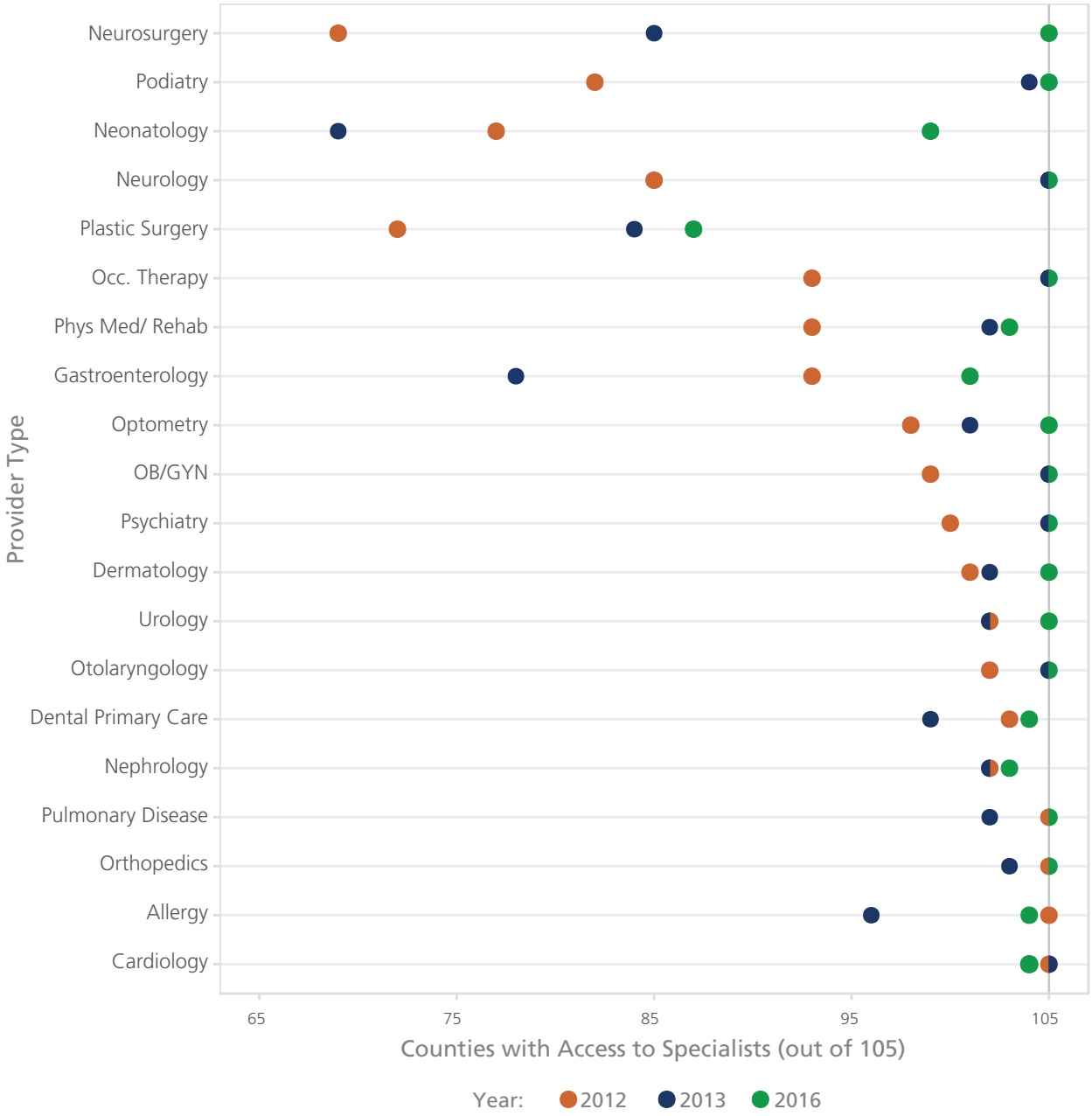


Source: KDHE reports

access. Table 6 (in Appendix A) displays deficiencies in geographic access for 2016, both in terms of members and counties.

In addition to general medical services, KanCare established access standards for home and community-based services (HCBS) by requiring that members in each county have at least two in-network HCBS providers to choose from. In all counties, at least one MCO met that standard for all HCBS service categories reported by KDHE, except for speech therapy for autism waiver members and adult day care. One MCO has one or more adult day

Figure 6: Geographic Access by Provider Type, 2012, 2013, and 2016



Source: KDHE reports

Note: Specialties for which all counties had access in 2012 and for which there were no changes through 2016 are excluded from this table. Excluded specialties and facility types include hospitals, primary care, general surgery, hematology/oncology, internal medicine, ophthalmology, physical therapy, x-rays, labs, and retail pharmacy.

care providers in all counties. The annual reports indicate substantial variation in HCBS access measures for the three MCOs. Over time, no clear trends emerge in terms of increasing or decreasing access.

PERCEIVED ACCESS

CAHPS surveys ask patients to report on their experience in accessing and receiving health care. In addition to questions related to quality and satisfaction, the surveys also ask patients how much difficulty they experienced in trying to access care. The most basic access-related question, asked of adults both about themselves and their children, reads: "In the last six months, how often was it easy to get the care, tests, or treatment you (your child) needed?" Positive responses to this question over the period from 2014-2016 ranged from 87.2% to 88.1% for adults (+/-2.41%), and from 91.9% to 93.4% (+/-1.13%) for their children. These are all above the national median, and the 2016 adult numbers are above the 95th percentile. By comparison, positive responses were given 75.9% (+/-2.31%) of the time for adults and 79% (+/-1.18%) for children in 2012, before KanCare began. This general survey-based measure seems to corroborate the trend observed in the geographic data of modest gains in access over the KanCare program period.

Perceived access remained stable, statistically speaking, in the areas of mental health and substance use disorders (SUD). The number of youth with mental health issues whose families reported being able to get needed services during a crisis was 89.5% in 2011 (+/-4.7%) and 83.8% in 2016 (+/-5.1%), but this change is not statistically significant and could be due to sampling variability. Other mental health measures have also remained largely stable.

Table 2, recreated from KDHE's 2016 annual report, shows negative trends in access issues for SUD members during the program, with the percentage placed on a waiting list growing each year from 2014 (12%) to 2016 (21%). The contractual quality standard for wait-times in KanCare is three weeks (the NCQA standard is four weeks), but the percentage of those on waiting lists reporting wait times of longer than three weeks jumped from 26.1% in 2014 to 42.1% in 2016. This means that 8.8% of SUD patients were on waiting lists for longer than three weeks in 2016 (with a margin of error of +/- 5%).

Providers also reported their perceptions of patient access in surveys conducted by each of the MCOs and their behavioral health subcontractors, where applicable. Table 3 shows doctors' reported satisfaction with the availability

Table 2. SUD Access, 2014-2016

	2014	2015	2016
Thinking back to your first appointment for your current treatment, did you get an appointment as soon as you wanted? ("Yes" responses)	92%	88%	84%
In the last year, did you need to see your counselor right away for an urgent problem? ("Yes" responses)	29%	26%	28%
If yes: How satisfied are you with the time it took you to see someone? ("Very satisfied" and "Satisfied" responses)	98%	79%	94%
Were you seen within 24 hours, 24 to 48 hours, or did you have to wait longer than 48 hours? (">48 hours" responses)	11%	19%	16%
Is the distance you travel to your counselor a problem or not a problem? ("Not a Problem" responses)	89%	88%	88%
Were you placed on a waiting list? ("Yes" responses)	12%*	16%*	21%
If you were placed on a waiting list, how long was the wait? (Percent of "3 weeks or longer" responses)	26%*	46%*	42%

*The total number of SUD patients on waiting lists in 2014 and 2015 was less than 30, so these numbers may not be significant. The margin of error for the overall sample is +/- 5%, and is larger for questions dealing with subsets of respondents.

Source: Leavitt Partners Analysis of KDHE reports.

of specialists for their patients. Trends in doctors' opinions differ by MCO but in most cases, levels of dissatisfaction in 2016 were, if anything, lower than for previous years. Overall, 42% (+/-7.7%) of providers were very or somewhat satisfied with specialist availability in 2016, and there does not appear to have been much improvement over time in this measure.

Table 3. Provider Perceptions of Access to Specialty Care

YEAR	VERY OR SOMEWHAT SATISFIED*	NEUTRAL	VERY OR SOMEWHAT DISSATISFIED
2014**	42%	43%	16%
2015	50%	36%	15%
2016	42%	45%	12%

Source: Leavitt Partners analysis of KDHE reports.

Note: Rows may not sum to 100 due to rounding. For margins of error, we take the maximum confidence interval for all surveys in each year, assuming each survey used simple random sampling. The margins of error are 10.7% in 2014, 7.4% in 2015, and 7.7% in 2016.

*The percentages shown are aggregations of surveys fielded separately by the three MCOs. Providers may have responded to more than one MCO provider survey.

**For 2014, there were errors in the UnitedHealthcare general provider survey and the Cenpatico behavioral health survey (Cenpatico is Sunflower's behavioral health subcontractor). These two groups are therefore excluded from the 2014 results.

Table 4. Claims Denial Rates, 2014 and 2016

	PERCENT CLAIMS DENIED	
KanCare - Service Type	2014	2016
Hospital Inpatient	20%	16%
Hospital Outpatient	15%	14%
Pharmacy	23%	20%
Dental	9%	7%
Vision	15%	12%
NEMT	0%	1%
Medical (physical health not otherwise specified)	13%	12%
Nursing Facilities - Total	9%	13%
HCBS	5%	5%
Behavioral Health	8%	8%
Total All Services	16%	14%

Source: Leavitt Partners analysis of KDHE reports.

CLAIMS ADJUDICATION

Access could be adversely impacted through high denial rates of certain types of claims. Leavitt Partners' first report on KanCare cost and utilization reports definite shifts in utilization relative to 2012. These shifts have not coincided with higher rates of claims denial in any particular category.[6] In fact, claims adjudication data in the KDHE reports show that claims denial rates from 2014 to 2016 were largely unchanged across categories, and may have actually decreased in some categories such as vision and hospital inpatient care (all by at least 3%; see Table 4).

CONCLUSIONS

This report focused on care quality and access to care during KanCare's four completed operating years from 2013 to 2016, specifically the program's performance in improving health outcomes for several specific treatment areas and improving coordination and integration of care. In its proposal for the program, the state hypothesized that it could improve quality of care by holding MCOs accountable for outcomes and performance measures tied to financial incentives.

During the program period, KanCare plans demonstrated improvement in P4P quality related to diabetes management, tobacco use, monitoring chronic medications, and SUD services, with slight decreases in performance for prenatal care, postpartum checkups, and flu shots. No measures were reported for coronary artery disease, an area the state had targeted for improvement under the program.

The KanCare MCOs scored higher than the national median for diabetes care and preventive services such as well-child visits, BMI assessments, and nutrition counseling, and lower than the national median in measures of importance to the state such as timeliness of prenatal and postpartum care and initiation and engagement in treatment for alcohol and drug dependencies. Quality measures show mixed results for mental health care and SUD services, with some patient populations experiencing improvement in some

measures and others seeing declines. Generally, both beneficiaries' and providers' satisfaction with the health plans rose slightly over the program period, with room for improvement in some areas.

In terms of access, MCO provider networks have grown overall during the KanCare years, with significant gains in access to specialists in many counties. Patient perceptions of their access to general care under KanCare are above the national median, but there was a negative trend in perceived access to SUD services. Fewer than half of providers say they are satisfied with patient access to specialists, but their satisfaction with specialist access has grown slightly during the program period.

Data on claims denials do not show signs of any undue efforts to deny access to certain kinds of care. If anything, claims denial rates have decreased slightly in general.

Claims processing and turnaround time metrics remained fairly consistent over the observed time period. Turnaround times in particular appear to have become less variable over time.

BIBLIOGRAPHY

1. Kansas Department of Health and Environment Division of Health Care Finance. Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.2013.

2. The information in this table was compiled from several sources, including, State of Kansas. KanCare Program Medicaid State Quality Strategy. 2014 Sep.; KDHE reports; and information provided to Leavitt Partners by the three KanCare MCOs.

3. Michael L. Barnett and Benjamin D. Sommers. A National Survey of Medicaid Beneficiaries' Experiences and Satisfaction With Health Care. JAMA Intern Med. 2017 Sep;177(9):1378–81.

4. KanCare Provider Experience Survey. 2014 Jan. and 2014 Oct. Provided to Leavitt Partners by Kansas Department of Health and Environment Division of Health Care Finance.

5. Leavitt Partners. Understanding KanCare's Challenges [Internet]. 2016 Nov. Available from: http://www.khi.org/news/article/report-kancare-delivered-on-cost-not-quality-of-care

6. Leavitt Partners. Review of KanCare: Cost and Utilization [Internet]. 2017 Nov. Available from: http://www.kamhp.org/news-resources/news/kamhp-2017-report-review-of-kancare-cost-and-utilization

APPENDIX A

Table 6. Geographic Access Measures by Members, CY 2016

SPECIALTY TYPE	CONTRACTUAL STANDARD DISTANCE, IN MILES (URBAN/RURAL)	MEMBERS W/O ACCESS (FARTHER THAN CONTRACTUAL DISTANCE)	
		MEMBERS	PERCENT
Neonatology	25/100	77,774	19.7%
Plastic and Reconstructive Surgery	25/100	65,020	16.5%
Physical Medicine/ Rehab	25/100	37,906	9.6%
Allergy	25/100	34,204	8.7%
Gastroenterology	25/100	31,130	7.9%
Podiatry	25/100	28,828	7.3%
Dermatology	25/100	27,145	6.9%
Neurosurgery	25/100	26,948	6.8%
Nephrology	25/100	22,520	5.7%
Hematology/Oncology	25/100	15,959	4.0%
Cardiology	25/100	12,016	3.0%
Dental Primary Care	20/30	9,687	2.5%
Otolaryngology	25/100	8,060	2.0%
Pulmonary Disease	25/100	7,425	1.9%
OB/GYN	15/60	6,623	1.7%
Occupational Therapy	30/30	4,653	1.2%
Retail Pharmacy	10/30	3,779	1.0%
Lab	30/30	3,014	0.8%
X-ray	30/30	3,014	0.8%
Psychiatrist	15/60	2,842	0.7%
Urology	25/100	2,686	0.7%
Neurology	25/100	2,328	0.6%
Optometry	30/30	1,766	0.4%
Orthopedics	25/100	1,432	0.4%
Hospitals	30/30	1,372	0.3%
Opthalmology	25/100	302	0.1%
Physical Therapy	30/30	78	0.02%

Source: KDHE reports.

Note: Specialties for which all members had access in 2016 are excluded from this table. Excluded specialties and facility types include primary care, general surgery, internal medicine, and retail pharmacy.

LEAVITT

PARTNERS