Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 3.31.18

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Temporary Extension Demonstration Year: 1 (1/1/2018-12/31/2018)
Federal Fiscal Quarter: 2/2018 (1/18-3/18)

Table of Contents

I. Introduction

KanCare is a managed care Medicaid program which serves the State of Kansas through a coordinated approach. The State determined that contracting with multiple managed care organizations will result in the provision of efficient and effective health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas, and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS).

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare & Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017.

KanCare is operating concurrently with the state's section 1915(c) Home and Community-Based Services (HCBS) waivers, which together provide the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, disabled, and some dual eligibles) across the state into a managed care delivery system to receive state plan and waiver services. This represents an expansion of the state's previous managed care program, which provided services to children, pregnant women, and parents in the state's Medicaid program, as well as carved out managed care entities that separately covered mental health and substance use disorder services. KanCare also includes a safety net care pool to support certain hospitals that incur uncompensated care costs for Medicaid beneficiaries and the uninsured, and to provide incentives to hospitals for programs that result in delivery system reforms that enhance access to health care and improve the quality of care.

This six-year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care; and
- Create a Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.

The KanCare demonstration will assist the state in its goals to:

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and
- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

This quarterly report is submitted pursuant to item #77 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued regarding the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the second quarter known as of March 31, 2018.

Demonstration Population	Enrollees at Close of Qtr. (3/31/2017)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,216	15,255	1,039
Population 2: ABD/SD Non-Dual	28,902	29,478	576
Population 3: Adults	50,470	54,634	4,164
Population 4: Children	231,431	240,855	9,424
Population 5: DD Waiver	9,048	9,102	54
Population 6: LTC	19,824	20,973	1,149
Population 7: MN Dual	1,172	1,315	143
Population 8: MN Non-Dual	897	1,004	107
Population 9: Waiver	4,562	4,603	41
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**360,522**	**377,219**	**16,697**

III. Outreach/Innovation

The KanCare website, www.kancare.ks.gov, is home to a wealth of information for providers, consumers, stakeholders and policy makers. Sections of the website are designed specifically around the needs of consumers and providers; and information about the Section 1115 demonstration and its operation is provided in the interest of transparency and engagement.

The KanCare Advisory Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists. The 1st quarter KanCare Advisory Council meeting took place on March 29, 2018 in Curtis State Office building room 530. The agenda was as follows:

- Welcome
- Review and Approval of Minutes from Council Meeting, December 19, 2017
- KDHE Update – Jon Hamdorf, Director and Medicaid Director, Division of Health Care Finance, Kansas Department of Health and Environment
- KDADS Update – Tim Keck, Secretary, Kansas Department for Aging and Disability Services
- Update from KanCare Ombudsman – Kerrie Bacon

- Updates on KanCare with Q&A
    - Amerigroup Kansas
    - Sunflower State Health Plan
    - UnitedHealthcare Community Plan
- Miscellaneous Agenda Items
    - Staffing of nursing hours and the TA Waiver
    - Update on KanCare 2.0
    - Status of the Advisory Council and Member Advocacy Group
- Adjourn

The next meeting of the Advisory Council is set for Wednesday, May 30th at 2:00pm in the same location.

The 1st quarter Tribal Technical Advisory Group (TTAG) occurred on February6, 2018 in Landon State Office Building Room 9E. There were 7 attendees present – 5 in person and 2 by phone. The next scheduled TTAG meeting is June 20, 2018 in the same location.

Other ongoing routine and issue-specific meetings continued by state staff engaging in outreach to a broad range of providers, associations, advocacy groups and other interested stakeholders. Examples of these meetings include:

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly) – ending this quarter
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Medicaid Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)

- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the nine subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings
- Monthly Nursing Facility Stakeholder Meetings
- KDADS-CDDO-Stakeholder Meetings (quarterly)
- WSU-Community Engagement Institute Special Projects (weekly meeting) including HCBS Access Guide, Policy Gap Analysis, and Capacity Building survey
- KDADS-CDDO Eligibility workgroup tasked to update IDD Eligibility policy and Handbook- policy work meetings ran from 6/22/17 to 1/10/18

In addition, Kansas is pursuing some targeted outreach and innovation projects, including:

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society. The agenda for this group is to analyze current enrollment and credentialing practices to ease burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. The workgroup finalized an interim electronic PDF version of the credentialing forms and it is now posted for provider use on all KanCare credentialing websites. This workgroup is continuing its work with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal, which will eventually incorporate many elements from the credentialing form. This Provider Enrollment Portal will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. The new provider enrollment portal is designed to be intelligent and intuitive. It supports provider application for all for all provider types and specialties in the Kansas Medical Assistance Program. The new Provider Enrollment Wizard will be available March 2018. Training sessions and labs for providers are occurring in February 2018, and members of the credentialing workgroup helped test the training application.

MCO Outreach Activities

A summary of this quarter's marketing, outreach and advocacy activities conducted by the KanCare managed care organizations – Amerigroup Kansas, Sunflower State Health Plan, and United Healthcare Community Plan – follows below.

Information related to Amerigroup Kansas marketing, outreach and advocacy activities:

Marketing Activities**:** Amerigroup participated in over 297 events for the first quarter of 2018. This included partner development, sponsorships, member outreach and advocacy.

The Community Relations Representatives primary focus continues to be assisting members with education on all the benefits provided by KanCare program. They constantly look to develop strong community partnerships across the state by enhancing existing relationships and building new ones.

Below is a sampling of activities Amerigroup supported in the first quarter:

- 2018 Together We Can Learn Conference
- Franklin Elementary School Health & Safety Event
- Kansas Project Eagle
- Rossville USD 321 Parent Resource Fair

Outreach Activities**:** Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They also reached out to members who appeared to be due for an annual checkup or need other medical services to help schedule their appointment with their provider to help improve their overall health.

The Community Relations Representatives participated in a variety of community events reaching approximately 10,500 Kansans in the first quarter of 2018. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: KAN Be Healthy screenings, transportation, diabetes, well child visits, employment, dental care, working with your PCPC, and more.

Below is a sampling of some of their outreach efforts this past quarter:

- Kansas Community Baby Showers
- Kansas Mission of Mercy (KMOM)
- Kansas Teen Mom Clinic
- Johnson County (Kansas) Mental Health Meeting

Advocacy Activities**:** Amerigroup' s advocacy efforts for first quarter of 2018 continue to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the elderly. The staff is proactively and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help the staff learn the needs of the communities they serve and how they can better serve these communities.

The first quarter advocacy efforts remain like those of the previous quarters. Amerigroup continues to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman, the grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan.

Amerigroup also met with members who participate in their adult advisory group to help assess their effectiveness and to improve various health related strategies, programs and systems of care.

Here are a few examples of their Advocacy Activities this past quarter:

- Member Advisory Committee
- Kansas Homeless Taskforce Meeting
- Family to Family Stake Holders Meeting
- Kansas Latino Health for All Coalition Meeting

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:

Marketing Activities: Sunflower Health Plan marketing activities for the 1st Quarter 2018 included attending and/or sponsoring 43 member and provider events. Sunflower introduced its new mascot, Sunny the Sunflower, and his Healthy Kids Club and began collecting subscriptions. The program will distribute activity books and kids' health books, and focus on health education for children. Sunny will attend community outreach events to connect with children to begin the healthy food and exercise conversation. During Q1 2018, Sunflower Health Plan sponsored local and statewide member and provider events such as:

- Mental Health Advocacy Day at the Capital
- Introduction to S.N.A.P
- School Resource Fair
- Sunflower Medicaid Members Advisory Group
- We All Eat event
- Life Patterns, Inc., Conference

Outreach Activities**:** Sunflower Health Plan's outreach activities for the first quarter of 2018 centered on prenatal and baby care, mental health and inclusion/anti-bullying. Sunflower Health Plan's participation at community events resulted in a reach of more than 5,600 members and providers during the first quarter.

Sunflower's direct mail marketing material for the first quarter included member postcards and customized letters addressing preventive health care gaps for important screenings and immunizations. Outreach activities also involved efforts to get members vaccinated against influenza and to encourage members to make their regular doctor's visits based on periodicity or health status. Interventions include phone calls, direct mail and home visits with members, as well as provider engagement strategies.

For the second year, Sunflower Health Plan partnered with Kansas middle schools to organize "No One Eats Alone" events to promote inclusion and anti-bullying among students. During this event, we reached more than 1,300 students and faculty at three middle schools.

Examples of notable member outreach activities this quarter:

- Participated in 6 Sunflower-member and community baby showers;
- Ten community partnership meetings aimed at furthering population health in the communities we serve;
- Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting, held in Lenexa, online and via phone;
- Sponsorship of and attendance at the Annual Black History and Scholarship Banquet in Wyandotte County;
- Our quality improvement department continued to make warm calls to members to encourage them to close care gaps.

Advocacy Activities**:** Sunflower Health Plan's advocacy efforts for Q1 2018 centered on competitive employment for people with disabilities. For the second year, Sunflower opened a funding opportunity to all Project SEARCH sites in Kansas to request financial support needed to send representatives to the national Project SEARCH conference. Sunflower participated in the following advocacy activities during Q1 2018:

- Behavioral Health Symposium

- Project SEARCH Statewide meeting
- Mental Health Advocacy Day at the Capital
- Community Action Teams for Fetal and Infant Mortality Review
- Health & Wellness Coalition, Wichita
- Health Alliance, Wichita
- Life Patterns Conference, supporting individuals with disabilities and their families

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding KanCare benefits and general health education. Plan staff completed new member welcome calls and Health Risk Assessments. New members were sent ID Cards and new member welcome kits in a timely manner. The UnitedHealthcare quarterly newsletter, HealthTalk changed to a digital format this winter. All members were mailed a postcard directing them online to view the newsletter that contained articles and tips on living a healthier life. UnitedHealthcare delivered the quarterly Community Connections Newsletter to Providers with information that is important for their support of UnitedHealthcare Members. Throughout the quarter, UnitedHealthcare hosted many meetings and presentations with key providers, hospitals, Federally Qualified Health Centers (FQHC's) and Community Based Organizations like Project Search, Families Together, Public Schools, Hannah's Promise, Head Start and Parents as Teachers and faith based organizations throughout the state that involved discussions around exploring innovative and collaborative opportunities.

Outreach Activities: UnitedHealthcare Community Plan participated in and/or supported 78 member facing activities, which included 28 lobby sits at provider offices as well as 26 events/Health Fairs or other educational opportunities for both consumers and providers. In Q1, UnitedHealthcare participated in and supported eight Baby Showers that were led by other organizations. UnitedHealthcare leveraged bilingual Community Outreach Specialists that focused on activities targeted within assigned geographical areas across Kansas. These specialists are fluent in both English and Spanish languages and effectively communicate with members with diverse cultural backgrounds. Additional Outreach Specialists supported activities in their respective territories. The Outreach Specialists regularly support one another working collaboratively to serve UHC Members. The key responsibility of the Outreach Specialist is to conduct educational outreach for members, community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. Of key importance is to meet members where they are and help understand their personal goals and how our team can help them reach those goals. UnitedHealthcare educates Members and Providers on Value Added Benefits and the features and benefits of KanCare. UnitedHealthcare also interacts with key provider offices and the provider community to assist with issue resolution. Several key outreach initiatives this quarter included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, and several health fairs. UnitedHealthcare staff partnered with Community Health Center of Southeast Kansas to offer an incentive to their patients who had not been seen by the clinic for 18+ months. UHC members were offered a $10 debit card to come into the office for a well visit. Additional incentive programs are in the works across the state. UnitedHealthcare also participated in many community stakeholder committee meetings during the first quarter of 2018.

UnitedHealthcare staff completed an outreach blitz called a swarm, where dozens of organizations in SE Kansas were visited over a two-day period. Goal of the swarm is to introduce the health plan to various organizations and brainstorm ways to collaborate and partner to find unique ways to support individuals

in the area with various needs including Social Determinants of Health (SDOH). The outcome of this swarm was several new relationships and ideas to support individuals in the rural areas of SE Kansas.

Finally, UHC hosted the Q1 Member Advisory Meeting in Wichita. The Health Plan finds it critical to host meetings in different parts of the state to hear from those in both urban and rural areas, but this strategy makes it challenging to have the same committee at each meeting. This advisory meeting focused on UHCs 2018 Value Added Benefit and on the best means for communicating with members.

During the first quarter 2018, UnitedHealthcare staff personally met with approximately 2,397 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.

During the first quarter 2018, UnitedHealthcare staff personally met with approximately 1,335 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities.

During the first quarter 2018, UnitedHealthcare staff personally met more than 512 individuals from provider offices located throughout the State.

Advocacy Activities: The UnitedHealthcare continued to support advocacy opportunities to support children and members with disabilities, and the individuals and agencies that support them.

Throughout this quarter, the team also worked closely with Health Plan Care Coordinators who support the waiver population. The Health Plan staff continued to stress to all members, including those with disabilities the desire to help support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. Staff will also meet consumers new to KanCare who are trying to understand their benefits. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas. Health Plan staff worked with the East Kansas Economic Opportunity Organization, the Douglas County Transition Council, Transformers and Self Advocate Coalition of Kansas to help support individuals in areas of training and job development. UHC advocate also served on the Project SEARCH advisory committee.

Health Plan members supported multiple committees and coalitions surrounding the challenges faced by consumers navigating the health care world. Examples of some of these committees/ conferences include:

- Self-Advocate Coalition of Kansas
- Hays Community Service Council
- Pratt County Community Health & Resource Council
- Thomas County Health Coalition
- Great Bend Interagency Committee
- Migrants Program Committee
- Cultural Relations Board
- Ford County Health Coalition
- Lifestyle Diabetes Coaches Training
- Tobacco Cessation Work Group
- Interhab Power Up! Conference
- Kickin' it with WIC
- Douglas/Jefferson County Transition Council

- Transformers Committee
- USD 259 Wichita Public Schools
- Council on Aging
- KIDS KS Infant Death & SIDS
- ECKAN
- Growing Futures
- Oral Health Kansas
- Parents as Teachers
- Wesley House
- Consulate of Mexico: Kansas City
- My Family Labette County
- Center of Grace
- InterHab
- Project Search
- Inclusion Connections

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and such issues are managed either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

KanCare Amendment 30 was submitted to CMS for review and approval on January 12, 2018. The Amendment replaced Attachment D in total and sections of Attachment G. The Amendment is effective January 1, 2018, pending CMS approval.

KanCare Amendment 31 was submitted to CMS for review and approval on January 30, 2018. The Amendment is for capitation rates effective January 1, 2018 through December 31, 2018, pending CMS approval. Each MCO capitation rates were negotiated.

KanCare Amendment 32 was submitted to CMS for review and approval on March 8, 2018. The Amendment replaced Attachment G. The Amendment is effective January 1, 2018, pending CMS approval.

Two State Plan Amendments (SPA) were approved as noted below:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
17-012	Payment of Medicare Part A and Part B Deductible/Coinsurance	12/19/2017	12/17/2017	1/29/2018
18-0003	FPL - CHIP yearly updates	2/05/2018	4/01/2018	2/22/2018

Five State Plan Amendments (SPA) were submitted:

SPA Number	Subject	Submitted Date	Proposed Effective Date	Approval Date
18- 001	RHC - Long Acting Reversible Contraceptives, payment methodology	3/02/2018	2/27/2018	
18-002	FQHC - Long Acting Reversible Contraceptives, payment methodology	3/02/2018	2/27/2018	
18-004	DMPEOS	3/12/2018	2/9/2018	
18-0005	CHIP Parity	3/23/2018	10/01/2017	
18-006	Inpatient hospital – readmission within 15 days	3/30/2018	1/01/2018	

Some additional specific supports to ensure effective identification and resolution of operational and reporting issues include activities described in Section III (Outreach and Innovation) above.

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-March 2018, follows:

MCO	Value Added Service Jan.-Mar. 2018	Units YTD	Value YTD
Amerigroup	Member Incentive Program	802	$634,195
	Adult Dental Care	890	$117,913
	Mail Order OTC	2,098	$38,959
	Total of All Amerigroup VAS	***4,071***	***$822,393***
Sunflower	CentAccount Debit Card	17,587	$190,551
	Pharmacy Consultation	2,809	$95,954
	Dental Visits for Adults	1,553	$87,172
	Total of all Sunflower VAS	***33,580***	***$475,355***
United	Additional Vision Services	949	$71,880
	Home Helper Catalog Supplies	1,143	$56,084
	Baby Blocks Program and Rewards	229	$27,480
	Total of all United VAS	***17,131***	***$217,116***

c. Enrollment issues: For the first quarter of calendar year 2018 there were 9 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the first quarter of calendar year 2018. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	0
KDHE - Administrative Change	31
WEB - Change Assignment	35
KanCare Default - Case Continuity	100

KanCare Default – Morbidity	225
KanCare Default - 90 Day Retro-reattach	153
KanCare Default - Previous Assignment	381
KanCare Default - Continuity of Plan	541
AOE – Choice	3179
Choice - Enrollment in KanCare MCO via Medicaid Application	1219
Change - Enrollment Form	357
Change - Choice	506
Change - Access to Care – Good Cause Reason	1
Change - Case Continuity – Good Cause Reason	0
Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	17
Total	**6745**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
CY18 1st quarter report

MCO	AMG	SUN	UHC	Total
QOC (non HCBS, Non Transportation)	8	12	35	55
Customer Service	11	12	10	33
Member Rights Dignity	3	2	3	8
Access to Service or Care	10	17	9	36
Non-Covered Services	2	2	6	10
Pharmacy	3	5	12	20
QOC (HCBS)	8	14	10	32
Value Added Benefits	7	8	2	17
Billing/Financial Issues (non-Transportation)	39	7	51	97
Transportation -Reimbursement	12	1	5	18
Transportation - No Show	13	17	13	43
Transportation - Late	12	21	17	50
Transportation - Safety	11	7	7	25
No Driver Available	2	1	1	4
Transportation - Other	27	20	22	69
Other			3	3
MCO Determined Not Applicable				

MCOs' Appeals Database
Members – CY18 1st quarter report

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined not Applicable
MEDICAL NECESSITY DENIAL					
Criteria Not Met – Durable Medical Equipment	1 28 16		1 14 4	 14 11	 1

Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	2 2 28	1 21		 2 4	1 3
Criteria Not Met - Medical Procedure (NOS)	8 15 3	1 1 2	3 7	4 7 1	
Criteria Not Met - Radiology	3 34		1 23	2 11	
Criteria Not Met - Pharmacy	9 51 58	 3	8 19 30	1 32 21	 4
Criteria Not Met - PT/OT/ST	8		5	3	
Criteria Not Met - Dental	2 2 2		 1	2 1 2	
Criteria Not Met or Level of Care - Home Health	3 2		3	 1	 1
Criteria Not Met – out of network provider, specialist or specific provider request	1 4		 2	1 1	 1
Criteria Not Met – Inpatient Behavioral Health	13 6 8		4 2	9 4 8	
Criteria Not Met – Behavioral Health Outpatient Services and Testing	4 3		1	3 2	 1
Level of Care - LTSS/HCBS	17 3 6	2 3	5 1 1	9 2 1	1 1
Level of Care – HCBS (change in attendant hours)	12	4	1	5	2
Other- Medical Necessity	2		2		
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	5 1 2			5 1 2	
Service not covered - Pharmacy	2			2	
Service not covered – Durable Medical Equipment	13		4	9	
Other - Noncovered service	2 14		2 10	 4	
Lock In	2 5		2 3	 2	
Billing and Financial Issues					
AUTHORIZATION DENIAL					
No authorization submitted	1 1	1		 1	
TOTAL **AMG – Red** **SUN – Green**	 **76** **190**	 **8** **2**	 **27** **92**	 **37** **96**	 **4**

UHC - Purple	**138**	**29**	**40**	**57**	**12**

** We removed categories from the above table that did not have any information to report for the quarter.*

MCO's Appeals Database

Member Appeal Summary – CY18 1st quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
Total Number of Appeals Resolved	76 190 138	8 2 29	27 92 40	37 96 57	4 12
Percentage Per Category		10% 1% 21%	36% 48% 29%	49% 51% 41%	5% 9%

MCOs' Reconsideration Database

Providers - CY18 1st quarter report (reconsiderations resolved)

PROVIDER Reconsideration Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
CLAIM DENIALS					
Hospital Inpatient (Non-Behavioral Health)	1511 512 789		563 425 355	682 78 434	266 9
Hospital Outpatient (Non-Behavioral Health)	712 870 1630		379 529 986	226 240 644	107 101
Pharmacy	117		41	58	18
Dental	1			1	
Vision	232		232		
Ambulance (Include Air and Ground)	65 13 83		40 11 51	16 2 32	9
Medical Professional (Physical Health not Otherwise Specified)	3604 864 8442		1777 181 5909	1376 683 2533	451
Nursing Facilities - Total	399 46		215 2	109 44	75
HCBS	683 823		417 715	170 108	96
Hospice	164 118 235		74 113 122	64 5 113	26
Home Health	282 16		155	104 16	23

Behavioral Health Outpatient and Physician	1111 1518		703 1098	317 420	91
Behavioral Health Inpatient	42 34		13 13	21 21	8
Out of network provider, specialist or specific provider	2645		1678	967	
Radiology	602 226 1365		203 42 863	383 171 502	16 13
Laboratory	225 487 1996		76 276 1321	129 172 675	20 39
PT/OT/ST	276 160 24		153 1 11	93 159 13	30
Durable Medical Equipment	750 240		308 186	367 54	75
Other	5		2	3	
Total Claim Denials	**10549** **4607** **18761**		**5119** **2713** **12407**	**4119** **1732** **6354**	**1311** **162**
BILLING AND FINANCIAL ISSUES					
Recoupment	1024		817	207	
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	599		371	228	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **10549** **4607** **20384**		 **5119** **2713** **13595**	 **4119** **1732** **6789**	 **1311** **162**

MCO's Appeals Database

Provider Reconsideration – Denied Claim Analysis – CY18 1st quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Claim Denied- MCO in Error**	**Claim Denied- Provider Mistake or, Incorrect Billing**	**Correctly Billed and Correctly Denied**	**Total**
CLAIM DENIALS				
MCO Reversed Decision on Reconsideration	3518 2713 7113	1601 3360	 1934	5119 2713 12407
MCO Upheld Decision on Reconsideration	2197	1922	 1732 6354	4119 1732 6354
Total Claim Denials	5715 2713 7113	3523 0 3360	 1732 8288	9238 4445 18761

MCOs' Appeals Database

Provider Appeal Summary – CY18 1st quarter report (appeals resolved)

PROVIDER Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
CLAIM DENIAL					
Hospital Inpatient (Non-Behavioral Health)	184 23 260		48 13 26	116 10 121	20 113
Hospital Outpatient (Non-Behavioral Health)	16 32 191	3	11 10 59	5 19 39	 93
Pharmacy	1		1		
Dental	4 9		3 7	1 2	
Vision	42 32		1 19	41 9	 4
Ambulance (Include Air and Ground)	12 2 11		9 2 4	3	 7
Medical Professional (Physical Health not Otherwise Specified)	183 20 286		70 9 20	96 10 106	17 1 160
Nursing Facilities - Total	24 5		10 1	12 1	2 3
HCBS	50 2		22	14 2	14
Hospice	6 2		3 1	1 1	2
Home Health	11 5 43		7 3 8	4 2 12	 23
Behavioral Health Outpatient and Physician	44 56		23 14	18 16	3 26
Out of network provider, specialist or specific provider	31	1	7	23	
Radiology	13 21 1	1	2 12 1	11 8	
Laboratory	17 18 32	1	3 7 5	14 10 2	 25
PT/OT/ST	17 7 3		7 4 2	6 2 1	4 1
Durable Medical Equipment	106 7	1	25 3	74 3	7
Other	8		7	1	
Total Claim Denials					

BILLING AND FINANCIAL ISSUES					
Recoupment	11 11		2	9 8	 3
ADMINISTRATIVE DENIAL					
Denials of Authorization (Unauthorized by Members)	187 46	2	60 17	100 29	25
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **928** **257** **907**	 **2** **7**	 **307** **114** **147**	 **525** **130** **307**	 **94** **6** **453**

Some categories from the above table that did not have any information to report for the quarter have been removed.

MCO's Appeals Database
Provider Appeal Summary – CY18 1st quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**MCO Determined Not Applicable**
Reconsideration	 10549 4607 20384		 5119 2713 13595	 4119 1732 6789	 1311 162
Resolved at 2nd Appeal Level	 928 257 907	 2 7	 307 114 147	 525 130 307	 94 6 453
TOTAL	11477 4864 21291	2 7	5426 2827 13742	4644 1862 7096	1405 168 453
Percentage Per Category		>1% >1% 0	47% 58% 65%	40% 38% 33%	12% 3% 2%

MCO's Appeals Database
Provider Appeal – Denied Claim Analysis – CY18 1st quarter report

AMG – Red **SUN – Green** **UHC – Purple**	**Claim Denied- MCO in Error**	**Claim Denied- Provider Mistake or, Incorrect Billing**	**Correctly Billed and Correctly Denied**	**Total**
CLAIM DENIALS				
MCO Reversed Decision on Appeal	128 6 21	117 53 118	 38 7	245 97 146
MCO Upheld Decision on Appeal	149	225 25	42 76 300	416 101 300
Total Claim Denials	277 6 21	342 78 118	42 114 307	661 198 446

**Due to system configuration errors, United HealthCare was unable to provide us data to populate this table.*

State of Kansas Office of Administrative Fair Hearings

Members – CY18 1st quarter report

AMG-Red SUN-Green UHC-Purple	Withdrawn	OAH Reversed MCO Decision	OAH Upheld MCO Decision	Dismissed Default Appellant's Favor	Dismissed Default Respondent's Favor	Dismissed Moot MCO Reversed Denial	Dismissed no Internal Appeal	Dismissed No Adverse Action	Dismissed Untimely
MEDICAL NECESSITY DENIAL									
Criteria Not Met – Durable Medical Equipment						1 1			
Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)							1 1		
Criteria Not Met - Medical Procedure (NOS)							1		
Criteria Not Met – Radiology							2		
Criteria Not Met - Pharmacy							5		
Criteria Not Met - PT/OT/ST							2		
Criteria Not Met – Dental							1		
Level of Care - LTSS/HCBS			1		1	1	1		
Level of Care - Mental Health							1		
Level of Care – HCBS (change in attendant hours)			1			1			
NONCOVERED SERVICE DENIAL									

Service not covered - Dental					1			1	
LOCK IN								1	
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**			1 1		2	3 1	1 12 2	1 1	

** We removed categories from the above table that did not have any information to report for the quarter.*

State of Kansas Office of Administrative Fair Hearings
Providers – CY18 1st quarter report

AMG-Red SUN-Green UHC-Purple	**Withdrawn**	**OAH Reversed MCO Decision**	**OAH Upheld MCO Decision**	**Dismissed Default Appellant's Favor**	**Dismissed Default Respondent's Favor**	**Dismissed Moot MCO Reversed Denial**	**Dismissed no Internal Appeal**	**Dismissed No Adverse Action**	**Dismissed Untimely**
CLAIM DENIAL									
Hospital Inpatient (Non-Behavioral Health)	1 4		1			1 3	5	1 6	4
Hospital Outpatient (Non-Behavioral Health)			1			2			
Pharmacy					1	1			
Ambulance (Include Air and Ground)						1			
Medical Professional (Physical Health not Otherwise Specified)	1					1 1			
Nursing Facilities - Total								1	
HCBS	2					3	1		
Hospice					1				
Home Health	1				3				
Behavioral Health	1					2		1	

Outpatient and Physician									
Radiology			2				1		
Laboratory							1		
Durable Medical Equipment	1				1	1	1	1	1
Other	1				1	2			
BILLING AND FINANCIAL ISSUES									
Recoupment	2 1								
ADMINISTRATIVE DENIALS									
Denials of Authorization (Unauthorized by Members)	1 4				1		3		1
TOTAL AMG – Red SUN – Green UHC – Purple	**9** **7** **5**		**4**		**1** **7**	**6** **6** **6**	**7** **5**	**3** **6** **1**	**5** **1**

** We removed categories from the above table that did not have any information to report for the quarter.*

e. Quality of care: Please see Section IX "Quality Assurance/Monitoring Activity" below.

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q3 2017, the volume reduced to 83 requests and, in Q4 2017, the number dropped to 47 requests.

Most of good cause requests (GCRs) are due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. GCRs still occur due to providers advising patients to file GCRs to switch plans. And as in previous quarters, GCRs filed after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers are available within access standards. In these cases, the MCOs are tasked with offering to assist the

member in scheduling an appointment with one of their participating providers. The remaining requests show varied reasons and causes for changing plans.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the first quarter of 2018, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	January	February	March
Total GCRs filed	6	8	29
Approved	1	0	1
Denied	4	7	21
Withdrawn (resolved, no need to change)	1	0	3
Dismissed (due to inability to contact the member)	0	1	4
Pending	0	0	0

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. All three MCOs have made a concerted effort to review, revise and update their network adequacy reports based upon State feedback. The networks are not changing significantly, but the network reports generated still require updates.

The chart below indicates unique providers by name, locale and NPI. Providers who serve multiple physical locations will be counted more than once:

KanCare MCO	# of Unique Providers as of 6/30/17	# of Unique Providers as of 9/30/17	# of Unique Providers as of 12/31/17	# of Unique Providers as of 3/31/18
Amerigroup	25,904	25,396	27,107	29,066
Sunflower	31,780	31,506	31,168	27,441
UHC	32,216	30,610	31,247	31,259

h. Payment Rates: New rates went into effect January 1, 2018 for plan year 2018.

i. Health plan financial performance that is relevant to the demonstration: All KanCare MCOs remain solvent.

j. MLTSS implementation and operation: In February 2018, Kansas offered services to 350 people on the HCBS PD Waiver waiting list. Of the 350 offers, 228 were accepted, for an overall acceptance rate of 65%.

During this quarter, the Money follows the Person (MFP) program continued its transition to sustainability services. New referrals to MFP concluded on June 30, 2017 KDADS sought input from stakeholders and MCO on a proposed policy to continue to encourage supports designed to move members to community based services. Effective July 1, 2017, rather than being referred to the MFP program, persons seeking to transition from institutions to HCBS are referred to their assigned MCO and applicable waiver program manager for review and approval. Members of the MFP program prior to June 30, 2017 will continue to receive supports during the 365 days post-transition.

k. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY5.

l. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):

- The State continues to work with stakeholders to formulate the most effective way to implement the Serious Emotional Disturbance (SED) waiver changes. The State is working closely with the MCOs and Community Mental Health centers to transition the plan of care creation in a smooth and efficient way. The State has continued to work with interested parties to identify a third-party contractor capable of completing a statistically significant sample of CAFAS assessments as the new waiver dictates.

- The State continues to work with the MCOs and interested providers to build capacity needs for the Autism Waiver (AU) and State Plan services.

m. *Legislative activity*: The Kansas legislature is currently debating two bills which could significantly affect the operations of KanCare. The first is Senate Bill 300 (SB 300) which would limit the current 1115 waiver demonstration proposal submitted to CMS. SB 300 requires the state to not make any changes to eligibility, increase access to behavioral health services and telehealth and only allow a demonstration period of 3 years. We will continue to work the legislature on SB 300.

   The second bill is Senate Bill 38 (SB 38) which would expand Medicaid in Kansas. SB 38 passed out of committee, but there is significant doubt this bill will receive a hearing on the Senate floor.

n. *Other Operational Issues*:

V. Policy Developments/Issues

General Policy Issues: Kansas addressed policy concerns related to managed care organizations and state requirements through weekly KanCare Policy Committee, monthly KanCare Steering Committee and monthly joint and one-on-one meetings between KDHE, KDADS and MCO leadership. Policy changes are also communicated to MCOs through other scheduled and ad hoc meetings as necessary to ensure leadership and program staff are aware of the changes. All policies affecting the operation of the Kansas Medicaid program and MMIS are addressed through a defined and well-developed process that is inclusive (obtaining input from and receiving review by user groups, all affected business areas, the state Medicaid policy team, the state's fiscal agent and Medicaid leadership) and results in documentation of the approved change.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by DXC, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 3.31.18 is attached. Utilizing the DXC-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

General reporting issues: KDHE continues to work with DXC, the fiscal agent, to modify reports as needed to have all data required in an appropriate format for efficient Section 1115 demonstration reporting. KDHE communicates with other state agencies regarding any needed changes.

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2018-1*	*2018-2*	*2018-3*	*Grand Total*
Population 1: ABD/SD Dual	14,518	14,390	14,237	43,145
Population 2: ABD/SD Non-Dual	28,962	28,942	28,925	86,829
Population 3: Adults	52,026	52,150	50,476	154,652
Population 4: Children	231,945	232,191	231,431	695,567
Population 5: DD Waiver	9,074	9,077	9,061	27,212
Population 6: LTC	20,298	20,189	20,078	60,565
Population 7: MN Dual	1,177	1,166	1,176	3,519
Population 8: MN Non-Dual	968	899	898	2,765
Population 9: Waiver	4,337	4,475	4,562	13,374
Grand Total	**363,305**	**363,479**	**360,844**	**1,087,628**

Note: Totals do not include CHIP or other non-Title XIX programs.

VIII. Consumer Issues

Consumer issues remain static. A summary of first quarter of 2018 consumer issues remains:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor. MCOs must report spenddown files to the State that track the spenddown

Issue	Resolution	Action Taken to Prevent Further Occurrences
		files. Unfortunately, this has been a difficult system issue to resolve.
Delays in HCBS services when the member transitions from one MCO to another, or from one setting to another.	There are many reasons this can occur. If the provider must report transition (like a nursing facility) sometimes they fail to turn in the correct forms. We require certain forms before we can switch the level of care coding in MMIS. Sometimes KDADS or KDHE failed to do something to switch the MMIS coding. Finally, the MCOs could fail to transfer service plans and other information when a member switches from one MCO to another.	MCOs are reviewing their notification processes to ensure that transitions go smoothly. An expedited review process is in place when level of care issues are found by MCOs – notice is sent to KDHE and KDADS to speed the process. Finally, provider reps stress to nursing facilities the importance in the level of care change forms.
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims, and providers get confused by the notifications. Providers also do not always look in provider look up tools for client obligation prior to rendering service. These things can impact the member.	This happens sporadically, and there are multiple causes. The MCOs and the State have jointly created a new training slide deck for training the providers.
Members sometimes find it difficult to find providers with open panels.	MCOs are working to correct provider network directory database issues. Also educating providers to reach out to MCOs when their directory information changes or if they add/subtract providers to the practice.	MCOs are instructed to report Open/Closed panels for all provider types. MCOS have begun to report this information in 2017, and to actively collect and report this data in the quarterly reporting template. The State is also developing guidelines for the provider directory to be implemented soon as mandated by CMS.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	Some of the MCO processes require manual intervention, which may lead to errors. Also, some MCOs require a claim to be submitted and denied before they can implement the retroactive eligibility protocol. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations.

During the first quarter of 2018, support and assistance for consumers around the state for KanCare was provided by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,111 consumers. OEW also assisted in resolving 1,712 issues involving such matters as urgent medical needs, obtaining correct information on applications and addressing gaps or errors in pending

applications/reviews with the KanCare Clearinghouse. These OEW staff assisted with 1,651 consumer phone calls.

During the first quarter of 2018, OEW staff participated in 16 community events providing KanCare program outreach, education and information to Schools, Health Departments, FQHC clinics, public health fairs, Latino and Asian Wellness groups, Community Baby showers, health care providers, advocates, and consumers.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. The KDHE and KDADS leadership team makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. This group directs the policy initiatives of the KanCare Steering Committee, which includes both executive and operational leadership from both KDHE and KDADS.

The following sources of information guide the ongoing review of and updates to the KanCare QIS:

Results of KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and leadership's review of and feedback regarding the overall KanCare quality plan. This combined information assists the leadership team and the MCOs to identify and recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, they are regularly reviewed and operational details are continually evaluated, adjusted and put into use.

The State values a collaborative approach that allows all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

During the first quarter of 2018, some of the key quality assurance/monitoring activities have included:

- Business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality

Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.

- Ongoing automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan.
- Meetings with the EQRO along with the MCOs, KDADS and KDHE to discuss EQRO activities and concerns.
- Compilation of the 2017 annual compliance reviews of the MCOs – which are done in partnership with KDADS, to review areas of State concern. Onsite audits are performed yearly, but the subsequent review and monitoring of any findings continue through the year.
- Medicaid Fraud Control Unit monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Monitor member or provider specific issues through a tracking database that is shared with MCOs and KDADS for weekly review.
- Attend various provider training and workshops presented by the MCOs. Monitor for accuracy, answer questions as needed.
- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Survey, Certification and Credentialing Commission (SCCC) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the MCO contracts.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. During this quarter, HCBS performance measures were reported to CMS via the 372 reporting process. A quality assurance protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews.

- Below is the timeline that the KDADS Quality Review Team follows regarding the quality review process.

HCBS Quality Review Rolling Timeline							
	FISC/IT	**SCC**	**MCO/Assess**	**SCC**	**FISC**	**SCC**	**CSP**
Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assess or Samples posted	MCO/Assessor Upload Period *(60 days)	Review of MCO data *(90 days)	Data pulled & Compiled (14 days)	Data & Findings Reviewed at LTC Meeting ***	Remediation Reviewed at LTC Meeting
01/01 – 03/31	4/1 – 4/15	4/16	4/16 – 6/15	5/16 – 8/15	8/30	October	November
04/01 – 06/30	7/1 – 7/15	7/16	7/16 – 9/15	8/16 – 11/15	11/30	January	February
07/01 – 09/30	10/1 – 10/15	10/16	10/16 – 12/15	11/16 – 2/15	3/2	April	May
10/01 – 12/31	1/1 – 1/15	1/16	1/16 – 3/15	2/16 – 5/15	5/30	July	August

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. KDHE uploads the provider raw data from the MCOs into a monitoring dashboard (still under construction) which has multipurpose report options and user configurable reporting. Currently, data supplied by the MCOs are used to generate two reports are published to the KanCare website monthly for public viewing: http://www.kancare.ks.gov/policies-and-reports/network-adequacy. KDHE hopes to post additional reports and dashboards for users to look at network information once we get the dashboard ready for public use.

- MCO Network Access:
  This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
- HCBS Providers by Waiver Service:
  Includes a network status table of waiver services for each MCO.

b. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers, January-March 2018:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:20	2.24%	47,097
Sunflower	0:15	1.37%	41,516
United	0:13	0.54%	44,063
DXC – Fiscal Agent	0.00	0.0%	5,405

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:22	1.74%	22,042
Sunflower	0:18	1.51%	24,408
United	0:15	.74%	24,984
DXC – Fiscal Agent	0.00	0.0%	4,867

c. A summary of MCO appeals for the quarter (including overturn rate and any trends identified) in addition to the information is included at item IV (d) above:

MCOs' Grievance Trends
Members – CY18 1st Quarter

Amerigroup 1st Qtr. Grievance Trends		
Total # of Resolved Grievances	168	
Top 5 Trends		
Trend 1: Billing and Financial issues (Non-Transportation)	39	23%
Trend 2: Transportation - Other	27	16%
Trend 3: Transportation - No Show	13	8%
Trend 4: Transportation Late	12	7%
Trend 5: Customer Service / Transportation - Safety	11	7%

Amerigroup Member Grievances:

- The top 5 Amerigroup member grievances account for 102 (61%) of all Amerigroup member grievances CY2018 Quarter 1.
- Amerigroup's transportation member grievances for all six categories account for 77 (46%) of Amerigroup's member grievances CY2018 Quarter 1 which is an increase of 20 (35%) from 57 transportation grievances in CY2017 Quarter 4.
- Amerigroup is providing additional detail so we can distinguish between Transportation – No Show and Transportation – No Driver Available.

Sunflower 1st Qtr. Grievance Trends		
Total # of Resolved Grievances	146	
Top 5 Trends		
Trend 1: Transportation - Late	21	14%
Trend 2: Transportation - Other	20	14%
Trend 3: Transportation - No Show	17	12%
Trend 4: Access to Service or Care	17	12%
Trend 5: Quality of Care HCBS	14	10%

Sunflower Member Grievances:

- The top 5 Sunflower member grievances account for 89 (61%) of all Sunflower member grievances CY2018 Quarter 1.
- Sunflower's transportation member grievances for all six categories account for 67 (46%) of Sunflower's member grievances CY2018 Quarter 1 which is a decrease of (28%) from 86 transportation grievances in CY2017 Quarter 4.

- Sunflower is providing additional detail so we can distinguish between Transportation – No Show and Transportation – No Driver Available.

United 1st Qtr. Grievance Trends		
Total # of Resolved Grievances	206	
Top 5 Trends		
Trend 1: Billing/Financial Issues (Non-Transportation)	51	25%
Trend 2: Transportation Late	35	17%
Trend 3: Transportation (No Show)	22	11%
Trend 4: Quality of Care (non HCBS)	17	8%
Trend 5: Transportation - Other	13	6%

United Member Grievances:

- The top 5 United member grievances account for 138 (67%) of all United member grievances CY2018 Quarter 1.
- United's transportation member grievances for all six categories account for 77 (37%) of United's member grievances CY2018 Quarter 1 which is an increase of 2 (3%) from 75 transportation grievances in CY2017 Quarter 4.
- United is providing additional detail so we can distinguish between Transportation – No Show and Transportation – No Driver Available.

MCO's Reconsideration Trends

Provider – CY2018 1st Quarter

Amerigroup 1st Qtr Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	10549	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	3604	34%
Trend 2: Hospital Inpatient (Non-Behavioral Health)	1511	14%
Trend 3: Behavioral Health Outpatient and Physician	1111	11%
Trend 4: Durable Medical Equipment	750	7%
Trend 5: Hospital Outpatient (Non-Behavioral Health)	712	7%

Amerigroup Provider Reconsiderations

- Starting CY2018 Quarter 1 the MCO's are providing provider reconsideration numbers by category.
- The top 5 Amerigroup provider reconsiderations account for 7,688 (73%) of all Amerigroup provider reconsiderations in CY2018 Quarter 1.

Sunflower 1st Qtr. Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	4607	
Top 5 Trends		
Trend 1: Hospital Outpatient (Non-Behavioral Health)	870	19%
Trend 2: Medical Professional (Physical Health not Otherwise Specified)	864	19%
Trend 3: HCBS	823	18%

Trend 4: Hospital Inpatient (Non-Behavioral Health)	512	11%
Trend 5: Laboratory	487	11%

Sunflower Provider Reconsiderations

- Starting CY2018 Quarter 1 the MCO's are providing provider reconsideration numbers by category.
- The top 5 Sunflower provider reconsiderations account for 3,556 (77%) of all Sunflower provider reconsiderations in CY2018 Quarter 1.

United 1st Qtr. Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	20384	
Top 5 Trends		
Trend 1: Medical Professional (Physical Health not Otherwise Specified)	8442	41%
Trend 2: Out of network provider, specialist or specific provider	2645	13%
Trend 3: Laboratory	1996	10%
Trend 4: Hospital Outpatient (Non-Behavioral Health)	1630	8%
Trend 5: Behavioral Health Outpatient and Physician	1518	7%

United Provider Reconsiderations

- Starting CY2018 Quarter 1 the MCO's are providing provider reconsideration numbers by category.
  The top 5 United provider reconsiderations account for 16,231 (80%) of all United provider reconsiderations in CY2018 Quarter 1.

MCOs' Appeals Trends
Member/Provider – CY18 1st Quarter

Amerigroup 1st Qtr Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	76		**Total # of Resolved Provider Appeals**	928	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Level of Care LTSS/HCBS	17	22%	Trend 1: Denials of Authorization (Unauthorized by Members)	187	20%
Trend 2: Criteria Not Met - Inpatient Behavioral Health	13	17%	Trend 2: Hospital Inpatient (Non-Behavioral Health)	184	20%
Trend 3: Level of Care - HCBS (Change in Attendant Hours)	12	16%	Trend 3: Medical Professional (Physical Health not Otherwise Specified)	183	20%
Trend 4: Criteria not Met - Pharmacy	9	12%	Trend 4: Durable Medical Equipment	106	11%
Trend 5: Criteria Not Met - Medical Procedure (NOS)	8	11%	Trend 5: HCBS	50	5%

Amerigroup Member Appeals:

- The top 5 Amerigroup member appeals account for 59 (78%) of all Amerigroup member appeals in CY2018 Quarter 1.

- The second largest number of member appeals submitted by Amerigroup involved Criteria Not Met – Inpatient Behavioral Health with 13 member grievances in CY2018 Quarter 1. This is a significant increase of 11 from CY2017 Quarter 4.

Amerigroup Provider Appeals:

- Starting CY2018 Quarter 1 we revised provider appeal categories to align with the categories the MCO's are submitting for claim denial reporting.
- The top 5 Amerigroup provider appeals account for 710 (77%) of all Amerigroup provider appeals in CY2018 Quarter 1.
- The largest number of provider appeals submitted by Amerigroup involved Denials of Authorization (Unauthorized by Members) with 187 provider grievances in CY2018 Quarter 1. This is a significant increase of 96 from CY2017 Quarter 4.
- The second largest number of provider appeals submitted by Amerigroup involved Hospital Inpatient (Non-Behavioral Health) with 184 provider grievances in CY2018 Quarter 1. This is a significant increase of 93 from CY2017 Quarter 4.
- The fourth largest number of provider appeals submitted by Amerigroup involved Durable Medical Equipment with 106 provider grievances in CY2018 Quarter 1. This is a significant increase of 93 from CY2017 Quarter 4.
- The fifth largest number of provider appeals submitted by Amerigroup involved HCBS with 50 provider grievances in CY2018 Quarter 1. This is a significant increase of 50 from CY2017 Quarter 4.

Sunflower 1st Qtr Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	190		Total # of Resolved Provider Appeals	257	
Top 5 Trends			Top 5 Trends		
Trend 1: Criteria Not Met - Pharmacy	51	27%	Trend 1: Denials of Authorization (Unauthorized by Members)	46	18%
Trend 2: Criteria Not Met - Radiology	34	18%	Trend 2: Vision	32	12%
Trend 3: Criteria Not Met - Durable Medical Equipment	28	15%	Trend 3: Hospital Outpatient (Non Behavioral Health)	32	12%
Trend 4: Criteria Not Met - Medical Procedure (NOS)	15	8%	Trend 4: Out of network provider, specialist or specific provider	31	12%
Trend 5: Other - Noncovered Service	14	7%	Trend 5: Hospital Inpatient (Non Behavioral Health)	23	9%

Sunflower Member Appeals:

- The top 5 Sunflower member appeals account for 142 (75%) of all Sunflower member appeals in CY2018 Quarter 1.
- The second largest number of member appeals submitted by Sunflower involved Criteria Not Met – Radiology with 34 member grievances in CY2018 Quarter 1. This is a significant increase of 21 from CY2017 Quarter 4.

Sunflower Provider Appeals:

- Starting CY2018 Quarter 1 we revised provider appeal categories to align with the categories the MCO's are submitting for claim denial reporting.
- The top 5 Sunflower provider appeals account for 164 (64%) of all Sunflower provider appeals in CY2018 Quarter 1.

- The largest number of provider appeals submitted by Sunflower involved Denials of Authorization (Unauthorized by Members) with 46 provider grievances in CY2018 Quarter 1. This is a significant increase of 15 from CY2017 Quarter 4.
- The fourth largest number of provider appeals submitted by Sunflower involved Out of network provider, specialist or specific provider with 31 provider grievances in CY2018 Quarter 1. This is a significant increase of 30 from CY2017 Quarter 4.

United 1st Qtr Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	138		Total # of Resolved Provider Appeals	907	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	58	42%	Trend 1: Medical Professional (Physical Health not Otherwise Specified)	286	32%
Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	28	20%	Trend 2: Hospital Inpatient (Non-Behavioral Health)	260	29%
Trend 3: Criteria Not Met - Durable Medical Equipment	16	12%	Trend 3: Hospital Outpatient (Non-Behavioral Health)	191	21%
Trend 4: Criteria Not Met - Inpatient Behavioral Health	8	6%	Trend 4: Behavioral Health Outpatient and Physician	56	6%
Trend 5: Level of Care - LTSS/HCBS	6	4%	Trend 5: Home Health	43	5%

United Member Appeals:

- The top 5 United member appeals account for 116 (84%) of all United member appeals in CY2018 Quarter 1.
- The largest number of member appeals submitted by United involved Criteria Not Met – Pharmacy with 58 member grievances in CY2018 Quarter 1. This is a significant increase of 10 from CY2017 Quarter 4.

United Provider Appeals:

- Starting CY2018 Quarter 1 we revised provider appeal categories to align with the categories the MCO's are submitting for claim denial reporting.
- The top 5 United provider appeals account for 836 (92%) of all United provider appeals in CY2018 Quarter 1.
- The second largest number of provider appeals submitted by United involved Hospital Inpatient (Non-Behavioral Health) with 260 provider grievances in CY2018 Quarter 1. This is a significant increase of 218 from CY2017 Quarter 4.
- The fourth largest number of provider appeals submitted by United involved Behavioral Health Outpatient and Physician with 56 provider grievances in CY2018 Quarter 1. This is a significant increase of 24 from CY2017 Quarter 4.
- The fifth largest number of provider appeals submitted by United involved Hospice with 43 provider grievances in CY2018 Quarter 1. This is a significant increase of 37 from CY2017 Quarter 4.

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY18 1st Quarter

- There was a total of 25 Member State Fair Hearings for all three MCOs. No decisions were reversed by Office of Administrative Hearings (OAH).
- There was a total of 79 Provider State Fair Hearings for all three MCOs. No decisions were reversed by OAH.

Amerigroup 1st Qtr					
Total # of Member SFH	8		Total # of Provider SFH	31	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

Sunflower 1st Qtr					
Total # of Member SFH	14		Total # of Provider SFH	30	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

United 1st Qtr					
Total # of Member SFH	3		Total # of Provider SFH	18	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

d. Enrollee complaints and grievance reports to determine any trends: This information is included at items IV (d) and X(c) above.

e. Summary of ombudsman activities for the first quarter of 2018 is attached.

f. Summary of MCO critical incident report: Shifting focus to opportunities for process and system improvement, the Cross-Agency Adverse Incident Management Team drafted a Critical Incident Form for MCOs to track MCO-specific critical incidents and document provider and MCO correspondence, collaboration and responses to each incident. The team made several suggestions to revise the types of critical incidents and current definitions of critical incidents collected in the Adverse Incident Reporting (AIR) database. An AIR timeline was developed and presented to the MCOs at the December Cross-Agency Adverse Incident Management Team meeting. Also, a review of the performance measures as they correspond to critical incidents was provided to the group to serve as a foundation for the work that needs to be completed. As a result, the Cross-Agency Adverse Incident Management Team agreed to devote more time to this project starting January 1, 2017 and meet bi-weekly until the appropriate processes and systems are in place.

Role and responsibility clarification for all parties will be prioritized and suggestions were made for reducing report duplication across the critical incident management system. The team began reassessing progress related to the applicable KanCare Special Terms and Conditions and documenting advancements by subject area and by agency.

KDADS has made significant progress on this project. Areas that are still being finalized include:

- Developing an automatic feed to pull APS and CPS reports into the AIR system
- Creating reports for each performance measure – specifically unexpected death, restraint, seclusion and restrictive interventions.

- Making final revisions to AIR, if needed, by KDADS IT
- Training MCO representatives once all system changes are in place
- Scheduling monthly meetings with each MCO to provide the appropriate amount of oversight of the AIR system, analyze trends and drill down in to any specific cases as necessary.

KDADS IT staff presented a demonstration of the AIR system for data element identification for future reporting requirements and preferences for canned reports and functionality. The system was revised to reflect the AIR policy revisions and assessed for performance measure reporting accuracy. Coordination meetings to leverage resources continue between KDADS' commissions and state agencies for full implementation. KDADS IT automation of the system to manage MCO-specific critical incidents in accordance with the AIR policy revisions is underway.

This team has met its goals, as stated in the STCs, to develop a statewide strategy for delineating and structuring multi-agency efforts by creating the Incident Reporting Guide. Also, the Adverse Incident Reporting system was built as a critical incident management reporting and monitoring system for the detection, prevention, reporting, investigation and remediation of critical incidents with design components to detect seclusion, restraint and medication management. The Adverse Incident Reporting system and accompanying AIR Memo and HCBS Adverse Incident Reporting and Management Policy have been finalized. This work is now with KDADS IT for operationalization of the system.

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2018 AIRS reports through the quarter ending March 31, 2018 follows:

Critical Incidents	**1st Qtr.**	**2nd Qtr.**	**3rd Qtr.**	**4th Qtr.**	**YTD**
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	2,096				
Pending Resolution	0				
Total Received	2,096				
APS Substantiations*	104				

**The APS Substantiations exclude possible name matches when no date of birth is identified. One adult may be a victim/alleged victim of multiple types of allegations. The information provided is for adults on HCBS programs who were involved in reports assigned for investigation and had substantiations during the quarter noted. An investigation may include more than one allegation.*

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: The Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The fourth quarter HCAIP UCC Pool payment was made December 7, 2017. The LPTH/BCCH Pool fourth quarter payment will be made in February 2018.

Disproportionate Share Hospital payments continue, as does support for graduate medical education.

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. KFMC developed and submitted quarterly evaluation reports, annual evaluation reports for 2013, 2014 and 2015, as well as a revised evaluation design in March 2015.

For the quarter ending 3.31.18, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (Claims Adjudication Statistics; Waiting List Management)

a. Post-award forums

No post-award forum was held this quarter.

b. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-March 2017, is attached.

c. Waiting List Management

PD Waiting List Management

For the quarter ending March 31, 2018:

- Current number of individuals on the PD Waiting List: 1,667
- Number of individuals added to the waiting list: 308
- Number of individuals removed from the waiting list: 434
    - 190 started receiving HCBS-PD waiver services
    - 22 were deceased
    - 222 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending March 31, 2018:

- Current number of individuals on the I/DD Waiting List: 3,630
- Number of individuals added to the waiting list: 156
- Number of individuals removed from the waiting list: 202
    - 51 started receiving HCBS-I/DD waiver services
    - 4 were deceased
    - 147 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 9,035 individuals.

d. Money Follows the Person

Kansas stopped taking new admissions to the MFP program 07/01/2017. The number of remaining MFP enrollees as of March 2018 is listed in the table below. The grand total is down from the 180 participants in December 2017 at the end of the previous quarter.

Level of Care	Count
MFP DD	18
MFP FE	49
MFP PD	78
MFP TBI	4
TC MFP PD	3
Grand Total	152

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 3.31.18
X(e)	Summary of KanCare Ombudsman Activities for QE 3.31.18
XII	KFMC KanCare Evaluation Report for QE 3.31.18
XIII(a)	KDHE Summary of Claims Adjudication Statistics for January-March 2018

XV. State Contacts

Jeff Andersen, Secretary
Jon Hamdorf, Division Director and Medicaid Director
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Division of Health Care Finance
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Jeff.Andersen@ks.gov
Jonathan.Hamdorf@ks.gov

XVI. Date Submitted to CMS

June 8, 2018

DY6

Start Date: 1/1/2018

End Date: 12/31/2018

Quarter 1

Start Date: 1/1/2018

End Date: 3/31/2018

	Total Expenditures	Total Member-Months	PMPM
Jan-18	$266,587,125	366,081	
Feb-18	$275,165,255	373,190	
Mar-18	$269,809,985	373,647	
Q1 Total	$811,562,364	1,112,918	$ 729.22

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Jan-18									
Expenditures	$1,310,155	$39,328,585	$31,620,944	$61,306,601	$44,069,276	$71,770,268	$916,410	$2,273,026	$13,991,859
Member-Months	6,560	37,540	53,007	232,136	9,170	21,062	1,168	1,017	4,421
Feb-18									
Expenditures	$1,280,505	$39,265,891	$35,295,452	$63,648,614	$44,831,271	$73,529,223	$1,036,388	$2,205,817	$14,072,093
Member-Months	6,437	37,300	54,677	237,475	9,311	21,214	1,279	972	4,525
Mar-18									
Expenditures	$1,527,018	$36,921,726	$33,377,640	$63,177,158	$44,678,277	$72,698,436	$1,241,514	$1,663,505	$14,524,711
Member-Months	7,504	38,731	52,579	236,262	9,503	21,791	1,628	962	4,687
Q1 Total									
Expenditures	$4,117,678	$115,516,203	$100,294,036	$188,132,373	$133,578,823	$217,997,927	$3,194,312	$6,142,348	$42,588,663
Member-Months	20,501	113,571	160,263	705,873	27,984	64,067	4,075	2,951	13,633
DY 6 - Q1 PMPM	$200.85	$1,017.13	$625.81	$266.52	$4,773.40	$3,402.66	$783.88	$2,081.45	$3,123.94

KanCare Ombudsman Annual Report – Qtr1 2018

Kerrie J. Bacon, KanCare Ombudsman

Dashboard

- Contacts for the KanCare Ombudsman's office continue to increase.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Avg. qtr.
2017	825	835	970	**1,040**	918
2018	**1,214**				
2017 vs. 2018	47%				

- This report has added new information for response and closing data. Page 2. Both charts are reflecting the same time frame for number of days to respond and/or close contacts/cases.

	Q1/18
Avg. Days to close/resolve Issue	8
% files closed/resolved in 0-2 or less	60%
% of files closed/resolved in 3-7 days	17%
% of files closed/resolved in 7-30 days	12%
% of files closed/resolved in greater than 30 days	11%
% files closed	81%

	Q1/18
Avg. Days to Respond	1
% of contacts responded in 0-2 days	82%
% of contacts responded in 3-7 days	17%
% of contacts responded to in greater than 7 days	1%

- The notes and email history (page 6) reflect the calls and emails received and made by the KanCare Ombudsman's office.

	Q4/17	Q1/18
Notes History (number of notes about contacts made; correlates to number of actual contacts received.	2,122	2,251
Email History (all emails; contacts with beneficiaries; also includes office emails regarding assistance on cases)	1,490	1,389

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication, and in person during first quarter of 2018. The number of contacts the Ombudsman's office received continues to increase. The contacts have been increasing for the last 5 quarters. The increase from 4th quarter 2017 (1,040) to 1st qtr. 2018 (1,214) is 17%.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Avg. qtr.
2014	545	474	526	547	523
2015	510	462	579	524	519
2016	**1,130**	846	687	523	797
2017	825	835	970	**1,040**	918
2018	**1,214**				
2017 vs. 2018	47%				
2016 vs. 2018	7%				

There are now two charts showing contact response and contact resolution. The reason there are limited data for contact resolution is that once we are past the date of pulling information, the resolution information continues to change over time. The detail for resolving issues will be collected going forward.

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Avg. Days to close/resolve Issue	11	9	9	7	8
% files closed/resolved in 0-2 or less					60%
% of files closed/resolved in 3-7 days					17%
% of files closed/resolved in 7-30 days					12%
% of files closed/resolved in greater than 30 days					11%
% files closed	88%	92%	90%	83%	81%

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Avg. Days to Respond	1	1	2	2	1
% of contacts responded in 0-2 days	78%	80%	65%	69%	82%
% of contacts responded in 3-7 days	20%	19%	31%	22%	17%
% of contacts responded to in greater than 7 days	2%	1%	4%	9%	1%

Outreach by Ombudsman's office

Collaboration and education:

- Participated in Friends and Family Advisory Council meeting: (January 9, 2018)
- Staffed booth at the Wichita State Volunteer Fair on January 22, 2018 – approximately 450 attendees
- Indian Creek Library (Olathe, KS) (February 2, 2018)
- Participated in KanCare Long Term Care meeting: (February 8, 2018)
- Provided written testimony to Bob Bethell KanCare Oversight Committee: (February 16, 2018)
- Participated in KanCare Advisory Workgroup meeting (February 21, 2018)
- Keeler Women's Center (Kansas City, KS) (February 28, 2018)
- Staffed booth and networked with other organizations at the Wichita State Health Fair on February 28, 2018 – approximately 450 attendees
- Staffed booth at the Wichita State POWER Conference on March 2, 2018 – approximately 200 attendees
- KCDHH Deaf and Hard of Hearing Day at the Capital (Topeka, KS) (March 6, 2018)
- Participated in KanCare Long-Term Care meeting: (March 8, 2018)
- Attended the Quarterly VISTA Training and shared about the Ombudsman on March 8, 2018 – approximately 20 attendees
- Attended the TA HCBS Wavier Listening Session (Olathe, KS) (March 13, 2018)
- Provided information at the KanCare Advisory Council Meeting: (March 27, 2018)
- Displayed resources at the Wichita State Health Professions Career Day March 28, 2018 – approximately 75 attendees
- Provided KanCare Ombudsman information at KDHE Eligibility Training (Topeka, KS) (March 29, 2018)
- Life Patterns, HCBS Provider Event (Topeka, KS) (March 31, 2018)

Publications: Outreach, posts, and/or articles about the KanCare Ombudsman office services.

- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (Jan, Feb, March 2018)
- Library Main Administration to be distributed to all Wichita libraries (January 18, January 23, and January 30)
- New Spring Church (January 23)
- River Community Church (January 23)
- Tabernacle Bible Church (January23)
- Reflection Ridge Retirement Community (January11)
- Holiday Retirement (January 30)
- Presbyterian Manors (January 30)
- Future Healthcare Professionals at WSU (February 28)

- Summit Church (February 27)
- Midway Baptist Church (February 27)
- Calvary Baptist Church (February 27)
- Healthcare Sciences Program at NU (March7)
- HEALTH Organization at WSU (March13)
- Oxford Grand Retirement Community (March15)
- Submitted ombudsman outreach advertisement to the Community Health Worker newsletter (March21)
- Shepherd's Voice (Kansas City, KS) (March 2018)
- Livable Neighborhoods Task Force (Kansas City, KS) (March 2018)

Collaboration:

- Kansas Commission on the Deaf and Hard of Hearing (Topeka, KS) – working to bring ASL volunteers to our volunteer offices (February 2018)
- Refugee and Immigration Department of Catholic Charities (Wyandotte, Co.) – working to increase ability to direct and assist refugees and immigrants in accessing medical assistance programs in Kansas

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Northern Kansas Satellite Office (Olathe)*** has been aiding KanCare members since August 2016. The office has been answering the phone and meeting with individuals on Wednesdays (10-1), Thursdays (1-4), and Fridays (10-1). Two additional volunteers will be finishing their training on April 26th and will begin providing assistance to beneficiaries on a weekly basis. Two Education Resource and Information (ERI) volunteers, through St. Mary's College, have been assisting with developing resources for the Ombudsman's office.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been assisting KanCare members since November 2015. The office is answering the phone and meeting with individuals Monday (12-4), Tuesday (10-2), Thursday (10-12) and Friday (12-4). One additional volunteer will be finishing his training in May and well begin providing assistance to beneficiaries on a weekly basis.
- Both Satellite offices are assisting consumers with filling out applications on the phone and in person by appointment.

Data by Ombudsman's Office

Contacts by Office	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Main	648	639	759	718	772
Johnson County	28	81	51	62	68
Wichita	149	115	160	260	374
Total	**825**	**835**	**970**	**1,040**	**1,214**

Contact Method	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Email	125	127	143	122	112
Face-to-Face Meeting	11	5	6	8	7
Letter	2	0	0	0	2
ONLINE	0	0	0	0	0
Other	0	2	5	4	2
Telephone	689	701	816	906	1,091
TOTAL	**827**	**835**	**970**	**1,040**	**1,214**

Caller Type	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Consumer	631	661	773	862	1066
MCO Employee	18	9	11	6	6
Other type	61	53	45	50	46
Provider	117	112	141	122	96
TOTAL	**827**	**835**	**970**	**1,040**	**1,214**

The chart below shows the contact information and the work behind the scenes more clearly. Each time a person contacts the Ombudsman's office it is logged in the Notes History. When the same person contacts the office more than once, it would not necessarily show up under Caller Type or in the Total Contacts. It has been mentioned before that the total contacts are under-represented due to how the Ombudsman's office keeps track of those who contact the office. If we create a separate file each time a person calls, we would have to pull up several files when the person calls back to catch up on the situation, which is not efficient. The Notes History reflects the calls that are made between the Ombudsman's office and the beneficiary or representative. The information below provides a better understanding of the number of calls that come into the office. Email History is a combination of email contacts and work being done by the Ombudsman's office to assist those who contact the office.

	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18
Notes History (number of notes about contacts made; correlates to number of actual contacts received.	1,388	1,651	1,954	2,122	2,251
Email History (all emails; contacts with beneficiaries; also includes office emails regarding assistance on cases)	655	919	1,338	1,490	1,389

The most frequent calls regarding Home and Community-Based Services (HCBS) waivers and other long-term services and supports in the past five quarters were regarding nursing facility concerns, then the Intellectual Developmental Disability (I/DD) Waiver issues were second, the Physical Disability (PD) Waiver was third and the Frail Elderly Waiver issues were fourth. The calls continue to be high for nursing facilities due to eligibility issues for people waiting to get on Medicaid who are in a nursing facility or waiting to get in a nursing facility.

Waiver	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
PD	40	37	32	45	51	41
I/DD	43	28	52	77	29	46
FE	30	27	33	38	27	31
Autism	3	2	2	0	1	2
SED	4	4	5	5	9	5
TBI	6	8	7	6	7	7
TA	8	10	2	7	5	6
Working Healthy	0	0	1	3	5	2
MFP	2	1	0	0	1	1
PACE	0	0	1	1	0	0
Mental Health	5	5	2	5	2	4
SUB USE DIS	0	0	0	0	0	0
Nursing Facility	66	45	79	61	47	60
TOTAL	**207**	**167**	**216**	**248**	**184**	

The Issue Categories listed below reflect the past five quarters in alphabetical order. The top five issues for the quarters listed are highlighted. Issue categories by MCO are in Appendix A (pages 10-15). There may be multiple issues for a member/contact.

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Access to Providers (usually Medical)	14	14	13	10	2	11
Abuse/Neglect Complaints	0	0	0	2	10	2
Affordable Care Act Calls	3	6	5	5	15	7
Appeals/Fair Hearing questions/issues	0	0	21	23	45	18
Background Checks	0	0	0	2	4	1
Billing	21	33	17	19	40	26
Care Coordinator Issues	5	11	6	12	10	9
Change MCO	3	1	2	6	12	5
Choice Info on MCO	0	0	0	0	3	1
Client Obligation	17	36	37	33	53	35
Coding Issues	3	0	8	18	32	12
Consumer said Notice not received	0	0	0	1	16	3
Cultural Competency	0	0	0	0	0	0
Data Requests	0	0	3	5	3	2
Dental	7	9	7	6	10	8
Division of Assets	2	2	5	5	10	5
Durable Medical Equipment	2	9	4	3	1	4
Estate Recovery	6	5	6	4	11	6
Grievances Questions/Issues	36	33	29	9	28	27
Guardianship	3	1	3	4	3	3
HCBS Eligibility issues	46	50	58	62	46	52
HCBS General Issues	33	34	21	49	36	35
HCBS Reduction in Hours of Service	7	2	4	6	7	5
HCBS Waiting List	6	9	8	4	4	6
Health Homes	0	3	0	0	0	1
Help understanding mail	0	0	0	0	4	1
Housing Issues	4	6	7	0	7	5
Medicaid Application Assistance	45	55	162	179	185	125
Medicaid Coding	0	0	0	0	0	0
Medicaid Eligibility Issues	237	177	237	300	208	232
Medicaid Fraud	0	0	0	0	3	1
Medicaid General Issues/Questions	0	0	0	0	62	12
Medicaid info (status) update	0	0	0	4	210	43
Medicaid Renewal	29	43	38	61	103	55
Medical Services	20	20	11	9	23	17
Medicare related Issues	0	0	15	22	17	11
Medicare Savings Plan Issues	0	0	9	21	19	10
Moving to/from Kansas	5	7	6	9	16	9

Issue Category (continued)	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Nursing Facility Issues	40	26	23	21	21	26
Pain management issues	0	0	0	0	0	0
Pharmacy	11	9	10	13	16	12
Prior authorization issues	0	0	0	0	1	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Respite	0	0	0	0	0	0
Social Security Issues	0	0	1	4	9	3
Spend Down Issues	18	32	29	29	28	27
Transportation	8	9	12	5	16	10
Working Healthy	0	0	2	3	3	2
X-Other	275	315	241	187	214	246
Z Thank you.	238	319	416	433	556	392
Z Unspecified	44	36	61	75	79	59
TOTAL	**1,188**	**1,312**	**1,537**	**1,663**	**2,201**	

Action Taken to Resolve Issues by Ombudsman's Office

The chart on the next page shows action taken by the Ombudsman's office over the past five quarters. The ***"Resolved"*** section (in pink) explains how cases have been closed. For "Question/Issue Resolved," if a call is returned and the person has already received an answer and does not need help from the Ombudsman's office or the person called to just talk, then it is marked "Resolved" and then closed. The "Used Contacts or Resources" shows when resources are provided; explaining KanCare processes, providing phone numbers, sending information by way of mail or email, or using contacts or resources that are listed in the blue or green categories below. Our offices will contact those offices themselves, with the member, or refer the member to the organization. Once it is resolved, this is the section that is used. The "Closed" section is when a person contacts our offices and leaves a message and we are not able to get back in touch with them; either because the number left is a wrong number, there is no voice mail to leave a message and they don't call back, or messages are left and they don't return the call. After a month or so, the case is closed.

"Resources" (in yellow) provided to members can be in many forms: a phone number for an agency, explaining the process for filing a grievance, answering a question about estate recovery, walking someone through the spenddown calculation, offering to mail the Medicaid application, or client obligation explanation, etc. These are just a few examples of the resources provided verbally, mailed and emailed to potential members, members, family, and providers assisting members.

The balance of the Resource Category (in orange and blue) shows what action was taken and what contacts were made on behalf of a member, potential member, provider, or other caller to resolve an issue and what resources where provided. Often multiple resources are provided to a member/contact.

The orange lines are contacts that are typically made by the staff and volunteers of the Ombudsman's office to follow up on a call, email or visit. The blue lines show when contacts have been referred to agencies and/or organizations for further information.

Action Taken	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Question/Issue Resolved (No Resources)	163	81	73	99	101	103
Used Contact or Resources/Issue Resolved	504	601	685	707	760	651
Closed (No Contact)	91	75	110	85	95	91
Provided Resources	238	307	346	443	760	419
MAILED/EMAIL Resources	46	123	124	116	217	125
KDHE Contact	135	76	77	60	70	84
DCF Contact	1	4	8	1	3	3
MCO Contact	34	29	18	18	21	24
MCO Referral	19	34	33	29	39	31
Clearinghouse Contact	75	130	201	167	190	153
Clearinghouse Referral	26	104	142	142	245	132
HCBS Team Contact	30	23	24	28	26	26
HCBS Team Referral	7	12	18	19	14	14
CSP Mental Health Contact	2	0	1	0	0	1
Other KDADS Contact/ReferralL	49	41	46	88	87	62
State or Community AGENCY Referral	46	78	72	82	100	76
Disability Rights and/or KLS Referral	8	2	1	6	6	5
TOTAL	**1,474**	**1,720**	**1,979**	**2,090**	**2,734**	

APPENDIX A – information by Managed Care Organization (MCO)

Amerigroup

Using the 5-quarter average, the top four issues were Other, Medicaid eligibility, HCBS eligibility, and HCBS general issues. The top waiver issues were the PD, I/DD, and FE waivers. There may be multiple issues for a member/contact.

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Access to Providers (usually Medical)	3	7	2	2	1	3
Abuse / neglect complaints	0	0	0	0	1	0
Affordable Care Act Calls	0	0	0	0	1	0
Appeals/Fair Hearing questions/issues	0	0	2	3	2	1
Background Checks	0	0	0	1	1	0
Billing	1	5	3	2	7	4
Care Coordinator Issues	1	4	0	3	3	2
Change MCO	1	0	0	1	4	1
Choice Info on MCO	0	0	0	0	0	0
Client Obligation	1	7	4	3	8	5
Coding Issues	0	0	3	2	5	2
Consumer said Notice not received	0	0	0	1	2	1
Cultural Competency	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0
Dental	0	0	1	0	3	1
Division of Assets	0	0	0	0	0	0
Durable Medical Equipment	0	1	1	0	0	0
Estate Recovery	0	1	0	1	0	0
Grievances Questions/Issues	10	4	4	0	3	4
Guardianship	1	0	0	0	0	0
HCBS Eligibility issues	6	7	7	10	6	7
HCBS General Issues	11	10	3	8	4	7
HCBS Reduction in hours of service	2	0	0	2	6	2
HCBS Waiting List	1	2	0	1	0	1
Health Homes	0	2	0	0	0	0
Help understanding mail	0	0	0	0	1	0
Housing Issues	0	1	1	0	0	0
Medicaid Application Assistance	0	0	0	1	3	1
Medicaid Coding	0	0	0	0	0	0
Medicaid Eligibility Issues	8	5	10	18	11	10
Medicaid Fraud	0	0	0	0	0	0

Issue Category (continued)	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Medicaid General Issues/questions	0	0	0	0	6	1
Medicaid info (status) update	0	0	0	0	11	2
Medicaid Renewal	4	7	3	8	8	6
Medical Services	5	7	1	0	4	3
Medicare related Issues	0	0	2	3	1	1
Medicare Savings Plan Issues	0	0	0	1	0	0
Moving to / from Kansas	1	0	0	1	0	0
Nursing Facility Issues	1	4	0	0	1	1
Pain management issues	0	0	0	0	0	0
Pharmacy	1	2	2	1	1	1
Prior authorization issues	0	0	0	0	0	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Respite	0	0	0	0	0	0
Social Security Issues	0	0	0	0	1	0
Spend Down Issues	2	5	2	4	4	3
Transportation	1	1	3	0	3	2
Working Healthy	0	0	0	0	0	0
X-Other	14	19	11	6	18	14
Z Thank you.	23	31	13	26	37	26
Z Unspecified	1	1	1	0	2	1
TOTAL	**99**	**133**	**79**	**109**	**169**	

Waiver	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
PD	12	9	3	12	5	8
I/DD	9	2	6	8	3	6
FE	3	6	3	7	4	5
Autism	1	1	0	0	0	0
SED	1	3	2	1	4	2
TBI	2	2	3	1	1	2
TA	2	4	2	1	0	2
Working Healthy	0	0	1	0	0	0
MFP	0	0	0	0	0	0
PACE	0	0	0	0	0	0
Mental Health	1	1	2	0	0	1
Nursing Facility	2	3	2	0	3	2
WAIVER TOTAL	**33**	**31**	**24**	**30**	**20**	

Sunflower

Using the 5-quarter average, the top four issues were Other, Medicaid eligibility, HCBS eligibility, and HCBS general issues. The top waiver issues were the PD, I/DD, and FE waivers. There may be multiple issues for a member/contact.

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Access to Providers (usually Medical)	4	3	2	3	1	3
Abuse / neglect complaints	0	0	0	0	2	0
Affordable Care Act Calls	0	1	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	1	1	0	0
Background Checks	0	0	0	0	1	0
Billing	3	6	5	9	8	6
Care Coordinator Issues	1	2	1	6	2	2
Change MCO	0	0	0	3	3	1
Choice Info on MCO	0	0	0	0	0	0
Client Obligation	3	5	4	5	5	4
Coding Issues	2	0	1	3	7	3
Consumer said Notice not received	0	0	0	0	1	0
Cultural Competency	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0
Dental	0	1	1	1	3	1
Division of Assets	0	0	0	0	1	0
Durable Medical Equipment	0	2	1	2	1	1
Estate Recovery	0	0	1	0	0	0
Grievances Questions/Issues	5	8	1	3	2	4
Guardianship	0	0	1	0	0	0
HCBS Eligibility issues	3	10	10	6	8	7
HCBS General Issues	5	6	3	9	12	7
HCBS Reduction in hours of service	1	1	1	0	1	1
HCBS Waiting List	1	1	0	1	0	1
Health Homes	0	0	0	0	0	0
Help understanding mail	0	0	0	0	0	0
Housing Issues	1	1	1	0	1	1
Medicaid Application Assistance	1	0	3	2	2	2
Medicaid Coding	0	0	0	0	0	0
Medicaid Eligibility Issues	14	8	13	14	8	11
Medicaid Fraud	0	0	0	0	0	0

Issue Category (continued)	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Medicaid General Issues/questions	0	0	0	0	7	1
Medicaid info (status) update	0	0	0	0	7	1
Medicaid Renewal	6	5	8	6	3	6
Medical Services	5	3	5	1	4	4
Medicare related Issues	0	0	1	1	0	0
Medicare Savings Plan Issues	0	0	0	1	2	1
Moving to / from Kansas	0	1	0	0	1	0
Nursing Facility Issues	2	1	0	1	1	1
Pain management issues	0	0	0	0	0	0
Pharmacy	4	3	1	0	2	2
Prior authorization issues	0	0	0	0	0	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Respite	0	0	0	0	0	0
Social Security Issues	0	0	0	1	1	0
Spend Down Issues	2	4	4	3	0	3
Transportation	4	3	1	1	2	2
Working Healthy	0	0	0	0	0	0
X-Other	18	19	11	15	8	14
Z Thank you.	20	25	31	32	49	31
Z Unspecified	1	0	1	2	0	1
TOTAL	**106**	**119**	**113**	**132**	**156**	

Waiver	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
PD	7	8	8	8	13	9
I/DD	8	4	10	12	5	8
FE	4	5	3	6	5	5
Autism	1	0	1	0	0	0
SED	0	1	0	0	0	0
TBI	1	2	0	1	1	1
TA	2	2	0	1	2	1
Working Healthy	0	0	0	1	1	0
MFP	0	1	0	0	1	0
PACE	0	0	0	0	0	0
Mental Health	1	1	0	0	0	0
Substance Use Dis	0	0	0	0	0	0
Nursing Facility	4	6	3	3	4	4
TOTAL	**28**	**30**	**25**	**32**	**32**	

UnitedHealthcare

Using the 5-quarter average, the top issues were Other, Medicaid eligibility, and HCBS eligibility. The top waiver issues were the PD, I/DD, and FE waivers. There may be multiple issues for a member/contact.

Issue Category	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Access to Providers (usually Medical)	4	2	0	2	0	2
Abuse / neglect complaints	0	0	0	1	0	0
Affordable Care Act Calls	0	0	0	0	0	0
Appeals/Fair Hearing questions/issues	0	0	3	2	4	2
Background Checks	0	0	0	0	0	0
Billing	3	7	3	0	6	4
Care Coordinator Issues	3	1	4	1	4	3
Change MCO	2	1	1	2	2	2
Choice Info on MCO	0	0	0	0	0	0
Client Obligation	2	2	3	5	8	4
Coding Issues	0	0	0	3	2	1
Consumer said Notice not received	0	0	0	0	0	0
Cultural Competency	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0
Dental	1	3	2	0	0	1
Division of Assets	0	0	1	0	1	0
Durable Medical Equipment	2	2	1	0	0	1
Estate Recovery	0	1	0	0	0	0
Grievances Questions/Issues	3	3	4	0	3	3
Guardianship	0	0	1	0	0	0
HCBS Eligibility issues	9	6	3	7	5	6
HCBS General Issues	2	4	5	5	4	4
HCBS Reduction in hours of service	2	0	2	0	0	1
HCBS Waiting List	0	0	0	0	0	0
Health Homes	0	0	0	0	0	0
Help understanding mail	0	0	0	0	0	0
Housing Issues	0	0	1	0	1	0
Medicaid Application Assistance	0	1	1	2	4	2
Medicaid Coding	0	0	0	0	0	0
Medicaid Eligibility Issues	7	7	9	19	11	11
Medicaid Fraud	0	0	0	0	0	0
Medicaid General Issues/questions	0	0	0	0	4	1
Medicaid info (status) update	0	0	0	0	4	1
Medicaid Renewal	1	1	6	6	7	4

Issue Category (continued)	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
Medical Services	3	3	0	2	2	2
Medicare related Issues	0	0	2	1	0	1
Medicare Savings Plan Issues	0	0	0	1	4	1
Moving to / from Kansas	0	0	0	0	1	0
Nursing Facility Issues	2	2	1	2	0	1
Pain management issues	0	0	0	0	0	0
Pharmacy	0	1	0	3	4	2
Prior authorization issues	0	0	0	0	1	0
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Respite	0	0	0	0	0	0
Social Security Issues	0	0	0	0	0	0
Spend Down Issues	0	1	6	2	3	2
Transportation	2	2	2	1	6	3
Working Healthy	0	0	0	0	0	0
X-Other	15	17	13	12	9	13
Z Thank you.	11	22	30	33	46	28
Z Unspecified	2	0	4	4	1	2
TOTAL	76	89	108	116	147	

Waiver	Q1/17	Q2/17	Q3/17	Q4/17	Q1/18	5 Qtr. Avg.
PD	8	3	5	4	7	5
I/DD	5	2	6	9	2	5
FE	7	3	5	6	4	5
Autism	0	1	0	0	0	0
SED	1	0	0	0	1	0
TBI	2	1	2	0	1	1
TA	0	1	0	2	0	1
Working Healthy	0	0	0	0	2	0
MFP	0	0	0	0	0	0
PACE	0	0	0	0	0	0
Mental Health	0	1	0	2	0	1
SUB USE DIS	0	0	0	0	0	0
Nursing Facility	5	2	6	3	3	4
TOTAL	**28**	**14**	**24**	**26**	**20**	

Kansas Foundation for Medical Care, Inc.
800 SW Jackson, Suite 700
Topeka, Kansas 66612
Phone 785-273-2552
Fax: 785-273-0237
www.kfmc.org
ACCREDITED
Independent Review Organization: Comprehensive Review (Internal & External)
Expires 07/01/2018

May 25, 2018

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: 2018 KanCare Evaluation Quarterly Report
Year 6, Quarter 1, January - March

Dear Ms. Ross:

Enclosed is the 2018 Quarter 1 KanCare Evaluation Quarterly Report. If you have questions or corrections regarding this information, please contact me, jpanichello@kfmc.org or (785) 271-4138.

Sincerely,

Janice D. Panichello, PhD, MPA
Director of Quality Review & Epidemiologist

CC Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE

Kansas Foundation for Medical Care, Inc.

URAC ACCREDITED
Independent Review Organization: Comprehensive Review (Internal & External)
Expires 07/01/2018

2018 KanCare Evaluation

Quarterly Report

Year 6, Quarter 1, January - March

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**Mary 25, 2018**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

Table of Contents

2018 KanCare Evaluation Quarterly Report

Year 6, Quarter 1, January - March

List of Tables

KanCare Evaluation Quarterly Report
Year 6, Quarter 1, January – March 2018
May 25, 2018

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) in August 2013; it was approved by CMS in September 2013 and updated in March 2015. The Kansas Foundation for Medical Care (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

The KanCare Evaluation Design includes over 100 annual performance measures developed to measure the effectiveness of the KanCare demonstration managed care Medicaid program. A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the first quarter (Q1) Calendar Year (CY) 2018 report include the following:

- Timely resolution of customer service inquiries
- Timeliness of claims processing
- Grievances
  - Track timely resolution of grievances
  - Compare/track the number of access-related grievances over time, by population categories.
  - Compare/track the number of grievances related to quality over time, by population.
- Ombudsman's office
  - Track the number and type of assistance provided by the Ombudsman's office.
  - Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.

KanCare healthcare services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

Quarterly and annual KanCare Evaluation topics and recommendations are discussed with MCO staff at quarterly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO, and at project-specific site visits at the MCO offices in Lenexa and Overland Park, Kansas.

Timely Resolution of Customer Service Inquiries

Quarterly tracking and reporting of timely resolution of customer service inquiries in the KanCare Evaluation are based on the MCOs' contractual requirements to resolve 95% of all inquiries within two business days of inquiry receipt, 98% of all inquiries within five business days, and 100% within 15 business days.

Data Sources

The data sources for the KanCare Quarterly Evaluation Reports are monthly call center customer service reports MCOs submit to KDHE. In these reports, MCOs report the monthly number and category of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end.

Unlike the Ombudsman's Office reports that include the number of contacts and the number of individual issues addressed during the contacts, the MCO monthly customer service call center reports do not specifically report whether the number of reported inquiries represents all inquiries from all monthly contacts. Reporting both the number of contacts and number of inquiries is necessary for accurate trend analysis by MCO and for aggregating results. An MCO reporting half as many inquiries as another MCO may have had the same number of contacts but may be reporting only one inquiry for each contact even if the contact addressed multiple topics. UnitedHealthcare, for example, confirmed in February 2018 that each contact equals one inquiry, with only the "primary inquiry" categorized; according to KDHE staff, Amerigroup and Sunflower reported categorizing multiple inquiries per contact if the contact includes more than one inquiry. The quarterly aggregated comparisons over time, including this quarterly report, have, to date, likely been based on consistent processes but may have been based on underreported inquiry counts.

In April 2018, KDHE staff provided training sessions for staff at each MCO that focused on revisions to the monthly Customer Service Report template. These revisions, which included several modifications to the member and provider inquiry categories, will become effective in August (for July reporting). MCOs have been directed to separately provide inquiry counts in June and July using the current and updated categories as test runs; KDHE staff will then make adjustments in the template, where indicated.

Current Quarter and Trend over Time

In Q1 CY2018, 98.3% of the 83,519 customer service member inquiries reported by the MCOs and 99.99% of the 36,515 provider inquiries were resolved within 2 business days (see Table 1).

As shown in Table 1, the number of member and provider customer service inquiries reported in Q1 has decreased each year. However, the number of member customer service inquiries not resolved within 2, 5, and 15 business days in Q1 each year has greatly increased: within 2 business days – from 5 in Q1 CY2015 to 1,402 in Q1 CY2018; within 5 business days – from 0 in Q1 CY2015 to 331 in Q1 CY2018; and within 15 business days – from 0 in Q1 CY2015 to 52 in CY2018. Over 99% of the member inquiries not resolved within 2 days in Q1 CY2017 and Q1 CY2018, and 100% of those not resolved within 5 days and 15 days, were inquiries reported by UnitedHealthcare.

Since UnitedHealthcare categorized only the "primary inquiry" from each contact, the total number of inquiries received is likely higher, and the number of inquiries not resolved is also, as a result, unclear.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries - Quarter 1, CY2015 to CY2018								
	Quarter 1							
	Member Inquiries				Provider Inquiries			
	CY2015	CY2016	CY2017	CY2018	CY2015	CY2016	CY2017	CY2018
Number of Inquiries Received	103,160	102,747	92,373	83,519	49,252	48,921	38,528	36,515
Number Resolved within 2 Business Days	103,155	102,743	92,033	82,117	49,252	48,921	38,518	36,511
Number Not Resolved within 2 Business Days	5	4	340	1,402	0	0	10	4
% Resolved Within 2 Business Days	99.995%	99.996%	99.63%	98.32%	100%	100%	99.97%	99.99%
Number Resolved within 5 Business Days	103,160	102,747	92,265	83,188	49,252	48,921	38,519	36,512
Number Not Resolved within 5 Business Days	0	0	108	331	0	0	9	3
% Resolved within 5 Business Days	100%	100%	99.88%	99.60%	100%	100%	99.98%	99.99%
Number Resolved within 15 Business Days	103,160	102,747	92,368	83,467	49,252	48,921	38,522	36,513
Number Not Resolved within 15 Business Days	0	0	5	52	0	0	6	2
% Resolved within 15 Business Days	100%	100%	99.995%	99.94%	100%	100%	99.98%	99.99%

In Q1 CY2018, all three MCOs met contractual requirements to resolve 95% of customer service inquiries within 2 business days and to resolve at least 98% within 5 business days.

- Of the 1,402 customer service inquiries from members in Q1 not resolved within 2 business days, 5 were reported by Amerigroup and 1,397 were reported by UnitedHealthcare. The 4 provider inquiries not resolved within 2 business days were also reported by UnitedHealthcare.
- The 331 customer service inquiries from members that were not resolved within 5 business days were reported by UnitedHealthcare.

Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.94% of member inquiries and 99.99% of provider inquiries were resolved within 15 days; 52 inquiries from members and 2 provider inquiries in Q1 CY2018 were reported as not resolved within 15 business days.

Member Customer Service Inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2).

- *Benefit inquiries* in Q1, as in previous quarters, had the highest percentage (21%) of member inquiries.
- Of the 83,519 customer service inquiries from members in Q1 CY2018, 40% were reported by Sunflower, 39% by UnitedHealthcare, and 21% by Amerigroup.
- The category *Concern with access to service or care; or concern with service or care disruption* seems to potentially describe contacts tracked as grievances or appeals in the State's quarterly GAR reports. MCOs reported 2,380 inquiries in this category, compared to only 516 reported grievances in Q1. To address this, KDHE has removed this category beginning in July 2018, is adding a category *Expression of dissatisfaction*, has updated category descriptions, and is working with MCO staff to ensure inquiries meeting grievance criteria receive appropriate follow-up.

Table 2. Customer Service Inquiries from Members, Q1 CY2017 to Q1 CY2018					
Member Inquiries	CY2017				CY2018
	Q1	Q2	Q3	Q4	Q1
1. Benefit Inquiry – regular or VAS	17,675	17,216	16,143	16,913	**17,539**
2. Concern with access to service or care; or concern with service or care disruption	1,889	1,978	1,827	2,016	**2,380**
3. Care management or health plan program	1,010	1,001	1,140	962	**937**
4. Claim or billing question	5,764	5,398	4,830	4,277	**5,011**
5. Coordination of benefits	3,075	3,280	3,098	2,708	**2,986**
6. Disenrollment request	463	524	424	344	**418**
7. Eligibility inquiry	15,475	14,420	13,077	13,064	**14,211**
8. Enrollment information	3,900	3,234	3,086	3,021	**2,619**
9. Find/change PCP	10,519	9,554	9,413	9,875	**10,207**
10. Find a specialist	2,794	3,043	3,043	2,819	**3,168**
11. Assistance with scheduling an appointment	58	88	119	113	**98**
12. Need transportation	1,353	1,594	1,821	1,700	**1,455**
13. Order ID card	6,894	6,190	4,521	3,537	**6,198**
14. Question about letter or outbound call	1,134	2,253	1,045	1,617	**2,975**
15. Request member materials	732	751	661	667	**1,056**
16. Update demographic information	13,821	12,568	10,572	10,347	**7,259**
17. Member emergent or crisis call	655	371	321	286	**331**
18. Other	5,162	5,085	4,332	3,731	**4,671**
Total	**92,373**	**88,548**	**79,473**	**77,997**	**83,519**

- As in previous quarters, there are categories where two-thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where two-thirds or more of the reported inquiries were from one MCO include:
  - *Update demographic information*: 64% of 7,259 inquiries in Q1 CY2018 were reported by Sunflower (71%–82% for last 14 quarters);
  - *Enrollment information*: 69% of 2,986 inquiries were reported in Q1 CY2018 by Amerigroup (66%–81% for the last 14 quarters);
  - *Care management or health plan program*: 69% of 937 inquiries in Q1 CY2018 were reported by Amerigroup (69%–86% in the last 8 quarters);
  - *Member emergent or crisis call*: 100% of 331 inquiries in Q1 CY2018 were reported by Sunflower (98%–100% in the last 14 quarters);
  - *Concern with access to service or care; or concern with service or care disruption:* 66.5% of 2,380 Sunflower (65%–80% for the last nine quarters); and
  - *Need transportation*: 64% of 1,455 inquiries were reported in Q1 CY2018 by Amerigroup (64%–77% in the last 6 quarters).
- Sunflower continued to add a category for *Health Homes*; the 54 customer service inquiries reported in Q1 CY2018 as related to *Health Homes* (which were discontinued in July 2016) were added to the *Other* category for consistency in reporting aggregated counts for the three MCOs.

Provider Customer Service Inquiries

The MCOs categorize provider customer service inquiries in their monthly call center reports by 17 provider service inquiry categories (see Table 3).

- Of the 36,515 provider inquiries in Q1 CY2018, Amerigroup reported 44%, Sunflower 46%, and UnitedHealthcare 11%. The total number and percentages of provider inquiries from each MCO, however, may be inaccurate due to UnitedHealthcare reporting only one primary inquiry from each contact.
- Claim status inquiries were again the highest percentage (53%) of the 36,515 provider inquiries.

Table 3. Customer Service Inquiries from Providers, Q1 CY2017 to Q1 CY2018

Provider Inquiries	CY2017				CY2018
	Q1	Q2	Q3	Q4	Q1
1. Authorization – New	1,707	1,561	1,332	1,333	**1,392**
2. Authorization – Status	2,497	2,351	2,360	1,988	**1,930**
3. Benefits inquiry	2,811	2,730	1,980	1,801	**2,280**
4. Claim denial inquiry	5,127	5,245	4,876	4,503	**4,815**
5. Claim status inquiry	17,519	20,320	20,718	18,585	**19,320**
6. Claim payment question/dispute	3,537	3,910	4,095	3,210	**2,374**
7. Billing inquiry	367	337	330	263	**261**
8. Coordination of benefits	348	283	202	167	**133**
9. Member eligibility inquiry	1,695	1,634	1,490	1,626	**1,608**
10. Recoupment or negative balance	83	40	53	64	**64**
11. Pharmacy/prescription inquiry	535	499	496	542	**477**
12. Request provider materials	52	42	33	32	**47**
13. Update demographic information	684	655	426	448	**702**
14. Verify/change participation status	293	243	186	168	**261**
15. Web support	139	101	99	83	**38**
16. Credentialing issues	160	147	153	127	**160**
17. Other	974	940	757	684	**653**
Total	**38,528**	**41,038**	**39,586**	**35,624**	**36,515**

As noted in previous quarterly reports, there are several categories where aggregated data primarily reflect one MCO rather than all three over time. Categories where two-thirds or more of the provider inquiries in Q1 were reported by one MCO included:

- *Authorization—New*: 98% of 1,392 inquiries in Q1 CY2018 were reported by Amerigroup (98%–99% for the last 14 quarters);
- *Authorization—Status*: 77% of 1,930 inquiries in Q1 CY2018 were reported by Amerigroup (69%–74% in the previous 4 quarters);
- *Update demographic information*: 97% of 702 inquiries were reported in Q1 CY2018 by Sunflower (91%–99.5% in the last 14 quarters);
- *Benefits inquiry*: 81% of 2,280 inquiries were reported in Q1 CY2018 by Amerigroup (73%–76% in the previous 2 quarters).

Of the 17 provider inquiry categories, seven are claims-related: *Authorization—New*, *Authorization—Status*, *Benefit Inquiry*, *Claim Denial Inquiry*, *Claim Status Inquiry*, *Claim Payment Question/Dispute*, and *Billing Inquiry*. As shown in Table 4, the range of inquiries for these seven claims-related categories varied greatly, but consistently, by MCO. For the last 12 quarters, for example, Amerigroup has reported over 98% of the provider inquiries categorized as *Authorization—New,* and Sunflower has reported 0% of the *Claim Denial* provider inquiries.

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO - Q1 CY2017 to Q1 CY2018

	CY2017								CY2018	
	Q1		Q2		Q3		Q4		Q1	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,695	0	1,546	1	1,323	1	1,324	0	1,369	0
Authorization - Status	1,816	134	1,741	172	1,615	267	1,367	266	1,492	97
Benefits Inquiry	1,550	431	1,762	441	1,441	181	1,376	107	1,847	96
Claim Denial Inquiry	3,070	0	3,646	0	3,114	0	2,811	0	3,190	0
Claim Status Inquiry	10,011	1	12,903	670	12,779	466	11,267	569	12,085	313
Claim Payment Question/Dispute	1,971	127	2,688	74	3,010	34	2,092	28	1,265	25
Billing Inquiry	241	1	217	0	182	0	146	0	155	0

Amerigroup UnitedHealthcare
Sunflower

Combining the seven claims-related inquiries may allow a better comparison over time overall and by MCO (see Table 5).

UnitedHealthcare again reported less than one-third as many provider inquiries than Amerigroup and Sunflower, which may be due to differences in provider inquiry tracking and reporting.

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2017 to Q1 CY2018

	CY2017				CY2018
	Q1	Q2	Q3	Q4	Q1
Amerigroup	15,015	14,663	14,813	13,715	14,445
Sunflower	13,213	16,787	16,604	14,187	14,206
UnitedHealthcare	5,337	5,004	5,024	3,781	3,721
Total	33,565	36,454	36,441	31,683	32,372

The revised customer service inquiry template will include detailed criteria for categorizing claims. MCOs will be reporting inquiry counts and resolutions in June and July based on the revised categories in addition to current categories. This will allow KDHE staff to assess whether additional revisions are needed in the categories and definitions prior to implementation of the revised template in August.

Follow-up on Previous Recommendations (Timely Resolution of Customer Service Inquiries)

- *MCOs should report all inquiries from each contact and not limit reporting and categorization of inquiries to one primary inquiry.*
  Follow-up response: The number of provider inquiries reported by UnitedHealthcare was comparable to previous quarters (approximately one-fourth as many inquiries as reported by Amerigroup and Sunflower).
- *After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs.*
  Follow-up response: The State provided training in April 2018 to MCOs on the revised Customer Service Inquiries template. The revised template will be implemented in August (for July reporting), with preliminary testing in June and July.
- *The State should consider requiring the MCOs to track the number of customer service inquiries that are forwarded for review as grievances or appeals.*
  Follow-up response: The revised Customer Service Report template adds a *category Expression of Dissatisfaction* to both the member and provider category lists. KDHE staff anticipate the number of inquiries reported in this category each quarter will be relatively comparable to the number of grievances reported each quarter.
- *As the Health Homes program ended in July 2016, Sunflower should evaluate reasons for continuing to receive inquiries each month related to Health Homes or should determine if these are misclassified (potentially questions related to home health care).*
  Follow-up response: Sunflower again this quarter reported 54 customer service inquiries from members related to Health Homes.

Recommendations (Timely Resolution of Customer Service Inquiries)

1. UnitedHealthcare should report all inquiries from each contact and not limit reporting and categorization of inquiries to one primary inquiry.
2. As the Health Homes program ended in July 2016, Sunflower should evaluate reasons for continuing to receive inquiries each month related to Health Homes or should determine if these are misclassified (potentially questions related to home health care).
3. After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs. Of particular focus should be ensuring inquiries that meet grievance or appeal criteria are being appropriately forwarded for follow-up and tracking as grievances or appeals.

Timeliness of Claims Processing

Claims, including those of MCO vendors, are to be processed within 30 days if "clean" and within 60 days if "non-clean"; all claims, except those meeting specific exclusion criteria, are to be processed within 90 days. Claims excluded from the measures include "*claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues*" and "*any claim which cannot be processed due to outstanding questions submitted to KDHE*."

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; claims from providers where the updated rates, benefits, or policy

changes were not provided by the State 30 days or more before the effective date; claims from a providers under investigation for fraud or abuse; and/or claims under review for medical necessity.

Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements. To allow for claims lag, the KanCare Evaluation Report for Q1 CY2018 assesses timeliness of processing clean, non-clean, and all claims reports received through Q4 CY2017 (see Table 6 for annual and quarterly aggregated claims processing counts by claim type for CY2017).

Table 6. Timeliness of Claims Processing - CY2017

	CY2017				
	Q1	Q2	Q3	Q4	Total
Clean Claims					
Clean claims received in quarter	4,331,085	4,289,623	4,216,700	4,141,115	16,978,523
Number of claims excluded	242	343	362	183	1,130
Number of clean claims not excluded	4,330,843	4,289,280	4,216,338	4,140,932	16,977,393
Clean claims received within quarter processed within 30 days	4,328,106	4,285,879	4,214,069	4,125,063	16,953,117
Clean claims received within quarter not processed within 30 days	2,737	3,401	2,269	15,869	24,276
Percent of clean claims processed within 30 days	99.94%	99.92%	99.95%	99.62%	99.86%
Non-Clean Claims					
Non-clean claims received in quarter	230,131	166,333	181,989	198,106	776,559
Number of claims excluded	1,174	1,193	2,005	491	4,863
Number of non-clean claims not excluded	228,957	165,140	179,984	197,615	771,696
Non-clean claims received within quarter processed within 60 days	228,092	163,503	178,459	197,359	767,413
Non-clean claims received within quarter not processed within 60 days	865	1,637	1,545	256	4,303
Percent of non-clean claims processed within 60 days	99.62%	99.01%	99.15%	99.87%	99.44%
All Claims					
All claims received in quarter	4,561,216	4,455,956	4,398,689	4,339,221	17,755,082
Number of claims excluded	1,416	1,536	2,367	674	5,993
Number of claims not excluded	4,559,800	4,454,420	4,396,322	4,338,547	17,749,089
Number of all claims received within quarter processed within 90 days	4,559,302	4,453,939	4,396,198	4,338,003	17,747,442
Number of all claims received within quarter not processed within 90 days	498	481	124	544	1,647
Percent of all claims processed within 90 days	99.989%	99.989%	99.997%	99.987%	99.991%

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether these claims were processed in a timely manner as defined by the type of claim and State-specified timelines. The report also includes average turnaround times (TAT) for

processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.

In 2017, KFMC validated MCO claims processing timeliness related to the State's pay-for-performance program that included incentives in 2016 for MCOs to process 99.5% of clean claims within 20 days (instead of the contractually required 30 days) and to process 99% of all claims within 40 days (instead of the contractually-required 90 days). In the validation process, the State clarified several definitions in the technical specifications for reporting clean and non-clean claims processing. In the monthly Claims Overview reports, Sunflower and UnitedHealthcare updated their monthly claims counts to reflect these clarified specifications. The counts reported in this KanCare quarterly report reflect those changes.

Timeliness of Claims Processing by Claim Type and Date Received

The MCOs are contractually required to process 100% of clean claims within 30 days; 99% of non-clean claims within 60 days; and 100% of all claims within 90 days.

For claims received in Q4 CY2017:

- **Clean claims**:
  - None of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - 99.6% of 4,140,932 clean claims received in Q4 CY2017 were reported by the MCOs as processed within 30 days.
  - Of the 15,869 clean claims not processed within 30 days – 13,940 (88%) were claims received by Amerigroup; 1,510 (10%) by Sunflower; and 419 (3%) by UnitedHealthcare. The number of clean claims not processed within 30 days was the highest in four years. Amerigroup reported, *"…the volume of increase [corrected claims receipts] exceeded expectations and staff capacity. Additionally, a series of unrelated system issues (system upgrades, for example) impacted the application used by Amerigroup to process these claims. The Corrected Claims issues have now been rectified, receipts are returning to normal expectations, staffing has been addressed and system issues have been resolved."* Initial claims reports for January and February 2018 confirm the numbers of Amerigroup clean claims processed within 30 days have returned to previous lower levels.
- **Non-clean claims**:
  - 99.9% of 197,615 non-clean claims received in Q4 CY2017 were reported by the MCOs as processed within 60 days.
  - In Q4 CY2017, all three MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - Of the 256 non-clean claims not processed within 60 days – 64 were claims received by Amerigroup; 157 were claims received by Sunflower; and 35 were claims received by UnitedHealthcare.
- **All claims**:
  - 99.99% of 4,338,547 "all claims" received in Q4 CY2017 were reported by the MCOs as processed within 90 days.
  - Of the 544 claims not processed within 90 days – 35 were claims received by Amerigroup, 495 were claims received by Sunflower, and 14 were claims received by UnitedHealthcare.

Due to the high volume and same-day processing of pharmacy claims, questions were raised at KanCare legislative public meetings about the impact of pharmacy claims on the reported 99.95% processing rate within 30 days for clean claims. To assess the impact of pharmacy claims on the clean claims processing

rate, KFMC calculated processing rates excluding pharmacy claims (see Table 7). In the first three quarters of CY2017, the clean claims processing rate decreased by .03% to 0.05% when excluding pharmacy claims. In Q4, which, for unusual factors noted above, had the highest number to date of clean claims not processed within 30 days, the processing rate decreased by 0.21% (from 99.62% to 99.41%) after excluding pharmacy claims. The annual percentage decreased by 0.09% (from 99.86% to 99.77%) after excluding pharmacy claims.

Table 7. Timeliness of Clean Claims Processing - CY2017, Excluding Prescriptions

	CY2017				
	Q1	Q2	Q3	Q4	Total
Clean Claims					
Clean claims received in quarter	4,331,085	4,289,623	4,216,700	4,141,115	16,978,523
Number of pharmacy claims (excluded)	1,790,595	1,722,540	1,445,711	1,456,248	6,415,094
Number of other claims excluded	242	343	362	183	1,130
Number of clean claims not excluded	2,540,248	2,566,740	2,770,627	2,684,684	10,562,299
Clean claims (not excluded) processed within 30 days	2,537,511	2,563,339	2,768,358	2,668,815	10,538,023
Clean claims not processed within 30 days	2,737	3,401	2,269	15,869	24,276
Percent of clean claims processed within 30 days (excluding pharmacy)	99.89%	99.87%	99.92%	99.41%	99.77%
Percent of clean claims processed within 30 days (including pharmacy)	*99.94%*	*99.92%*	*99.95%*	*99.62%*	*99.86%*

Follow-up on Previous Recommendations (Timeliness of Claims Processing by Claim Type and Date Received)

- *To address concerns about the impact of pharmacy claims (which are high volume and processed same-day) on claims processing timeliness, the State should consider requiring the MCOs to report the number of pharmacy claims included in the clean claims and all claims rates (reported on the Claims Contract Standard tab of the monthly Claims Overview Report).*
  Follow-up response: The number of pharmacy claims processed each month are reported in other sections of the Claims Overview Report. As these claims are processed same-day, adequate data are available to determine the clean claims processing percentages that exclude pharmacy claims.
- *MCOs should update their monthly claims processing reports for 2017 and annual totals for 2016 to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days). The State should provide guidance to the MCOs as to the time periods for which claims data should be updated.*
  Follow-up response: Sunflower and UnitedHealthcare have updated their 2017 monthly claims processing counts.

Recommendations (Timeliness of Claims Processing by Claim Type and Date Received)

1. Amerigroup should update their monthly claims processing reports for 2017, and all three MCOs should update their annual totals for 2016, to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days).

Average Turnaround Time for Processing Clean Claims

As indicated in Table 8, the MCOs reported 4,408,439 clean claims were processed in Q1 CY2018 (includes claims received prior to Q1). Excluding 1,586,923 pharmacy claims (processed same-day), there were 2,821,516 clean claims processed in Q1.

The average TAT for Total Services (excluding pharmacy claims) was 7.1–10.8 days in Q1 CY2018, the highest average monthly ranges to date.

Table 8. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Comparison of Current and Previous Quarter and Annual Monthly Ranges*

Service Category	Current and Previous Quarter		Annual Monthly Ranges			
	Q4 CY2017	Q1 CY2018	CY2014	CY2015	CY2016	CY2017
Hospital Inpatient	9.7 to 13.0	**10.4 to 14.3**	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4	6.0 to 15.6
Hospital Outpatient	5.8 to 10.1	**5.8 to 10.6**	3.6 to 12.8	3.5 to 10.8	4.0 to 12.9	4.5 to 10.1
Pharmacy	same day	**same day**	same day	same day	same day	same day
Dental	6.0 to 8.0	**6.0 to 13.0**	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0	6.0 to 13.0
Vision	5.0 to 15.1	**4.0 to 17.1**	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7	5.0 to 15.1
Non-Emergency Transportation	10.9 to 13.0	**10.7 to 13.0**	10.9 to 18	10.4 to 16	9.0 to 14.4	10.9 to 14.0
Medical (Physical health not otherwise specified)	6.5 to 9.4	**6.5 to 10.0**	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7	4.7 to 9.8
Nursing Facilities	5.2 to 9.3	**5.8 to 8.7**	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0	4.3 to 10.5
HCBS	6.4 to 12.2	**7.1 to 19.4**	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8	5.7 to 12.2
Behavioral Health	5.4 to 9.7	**4.9 to 14.9**	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7	3.8 to 9.9
Total Claims (Including Pharmacy)	4,126,949	**4,408,439**	16,763,501	17,820,402	17,820,402	17,302,422
Total Claims (Excluding Pharmacy)	2,670,701	**2,821,516**	10,370,998	10,999,807	10,999,807	10,887,328
Average TAT (Excluding Pharmacy)^	**6.7 to 9.5**	**7.1 to 10.8**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**	**5.3 to 9.9**

*The average TAT monthly ranges reported in Table 8 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed.
^Average TATs are weighted averages calculated after excluding pharmacy claims.

The widest average monthly ranges in Q1 by MCO were

- **HCBS** – Average monthly TATs for HCBS clean claims were the widest range to date, ranging from 7.1–19.4 days. Amerigroup's TATs in Q1 were the longest (12.5–19.4 days), compared to 8.7–8.9 days for Sunflower and 4.1–7.6 days for UnitedHealthcare.
- **Behavioral Health** – Behavioral Health claims also had wide average TATs in Q1, ranging from 4.9 to 14.9. Amerigroup had the shortest average TATs (4.9–7.2 day) and Sunflower the longest average TATs (10.9–14.9 days). UnitedHealthcare's average TATs were 9.3–10.1 days in Q1.
- **Vision** – Vision claim TATs ranged from 4.0–5.0 days for Amerigroup, 14.0–15.0 days for Sunflower, and 8.7–17.1 days for UnitedHealthcare.
- **Dental** – TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0–13.0 days in Q1.

Grievances

Data Sources

Grievances are reported and tracked on a quarterly basis by MCOs in the Grievance and Appeal (GAR) report. The report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 business days, and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of grievance resolved, including narratives of grievance descriptions and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation are based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days (via an extension request). The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not (and is not expected to) equal the number of grievances "resolved" during the quarter (see Table 9).

Table 9. Timeliness of Resolution of Grievances - Q1 CY2017 to Q1 CY2018 and CY2013 to CY2017

	CY2017				CY2018	CY2013 to CY2017				
	Q1	Q2	Q3	Q4	Q1	2013	2014	2015	2016	2017
Grievances received in quarter	412	458	541	506	516	1,786	2,287	2,021	1,767	1,917
Grievances resolved in quarter*	412	447	546	507	498	1,723	2,307	2,046	1,743	1,912
Grievances resolved within 30 business days*	410	441	543	498	486	1,723	2,283	2006	1,667	1,892
Percent resolved within 30 business days	99.5%	98.7%	99.5%	98.2%	97.6%	100%	99.0%	98.0%	95.6%	99.0%
Grievances not resolved within 30 business days	2	6	3	9	12	0	24	40	76	20
Grievances resolved within 60 business days*	412	446	546	505	488	1,723	2,299	2,035	1,742	1,909
Percent resolved within 60 business days*	100%	99.8%	100.0%	99.6%	98.0%	100%	99.7%	99.5%	99.9%	99.8%
Grievances closed in quarter not resolved in 60 business days*	0	1	0	2	10	0	8	11	1	3

*Grievances resolved in the quarter include grievances received in the previous quarter.

In Q1 CY2018, 97.6% (486) of the 498 grievances reported by the MCOs as resolved in Q1 were reported as resolved within 30 business days.

- The number of grievances not resolved within 60 days (10) is the highest in five years.
- UnitedHealthcare resolved 195 of 195 grievances within 30 days and was the only MCO in Q1 to meet the contractual requirement to resolve 98% of grievances within 30 business days and 100% within 60 business days.
- Amerigroup resolved 155 of 162 (95.7%) grievances within 30 days and 157 (96.9%) within 60 days. The 7 grievances (from 5 members) not resolved within 30 days were all transportation-related. The 5 grievances (from 3 members) that were not resolved within 60 days were resolved within 70–107 days.

- Sunflower resolved 136 of 141 (96.5%) grievances within 30 days. The 5 grievances not resolved within 30 or 60 days were from one member on the TA Waiver. Four of the five grievances were related to *Access to Service or Care* and one *Customer Service* grievance. The five grievances were resolved within 70–183 days.

Compare/Track the Number of Grievances, Including Access-Related and Quality-Related Grievances, Over Time, by Population Categories

All Grievances

In March 2018, KDHE staff updated the grievance template and provided follow-up training to MCO staff to clarify criteria for each grievance and appeal category. The updated Grievance Report template includes new categories and updated descriptions. Two added categories are *Non-Covered Services* and *MCO Determined Not Applicable*.

In Q1, with increased KDHE staff review and input, there has been noticeable progress in reporting of grievances and appeals. While in past quarters, 30% or more of the grievances appeared to be categorized incorrectly (based on grievance descriptions and resolution details), in Q1 13% (68) of the grievances appeared to be misclassified (see Table 10).

An additional 25 grievances were identified where members noted more than one grievance during their contact to the MCO, one grievance was a duplicate, and one grievance was recategorized as an appeal, bringing the total number of grievances to 522 for the quarter.

Table 10. Comparison of Grievances as Categorized by MCOs and Based on Grievance Descriptions Q1 CY2018*

	As categorized by MCOs		Based on Grievance Descriptions	
	# grievances	# members	# grievances	# members
Billing and Financial Issues	92	87	97	92
Access to Service or Care	46	40	44	38
Quality of Care (non-HCBS)	55	51	57	54
Quality of Care - HCBS	21	21	19	18
Customer Service	45	42	38	35
Pharmacy Issues	21	21	21	20
Member's Rights/Dignity	4	4	11	11
Value-Added Benefit	14	13	17	16
Transportation - Other	56	54	67	65
Transportation - Reimbursement	31	30	18	18
Transportation Safety	23	21	24	22
Transportation No Show	29	27	45	41
Transportation Late	57	52	50	45
Transportation No Driver Available	2	2	3	3
Other	0	0	3	3
Non-Covered Services	2	2	8	8
Not Applicable	0	0	0	0
Appeals #			*1*	*1*
Total	498	467	522	489

*Includes grievances received in Quarter 4 CY2017 resolved in Quarter 1 CY2018
Appeals are not included in total counts.

Of the 522 grievances resolved in Q1 CY2018, 169 (32%) were reported by Amerigroup, 148 (28%) by Sunflower, and 205 (39%) by UnitedHealthcare.

Some grievances clearly fit the definition of more than one category. For example, this quarter three grievances included members saying transportation drivers "*made racial comments*," "*driver discriminating and being racist to the member*," and "*driver calling her racial names, saying racial comments the entire ride, and racial slurs*." These meet the definitions of both *Transportation – Other* and *Member Rights Dignity*. MCOs have been advised that, where members report multiple grievances in one contact, MCOs are to report each grievance. In these instances, however, there was one grievance related to *Member Rights Dignity* that occurred during *Transportation (Other).* Should this be one grievance or two? If one grievance, which category should be used? Where there is only one grievance, it may be helpful to provide MCOs with a hierarchy that helps prioritize categorization where there is one grievance clearly meeting two definitions.

The 62 grievances potentially categorized incorrectly in Q1 include:

- 14 *Transportation – Other* categorized as *Transportation Issues – Reimbursement;*
- 9 *Transportation – No Show* categorized as *Transportation - Late* (6) and *Transportation – Other* (3);
- 10 *Quality of Care (non-HCBS)* categorized as *Quality of Care HCBS* (4), *Customer Service* (3), *Access to Service or Care* (2), and *Member Rights Dignity* (1);
- 4 *Quality of Care – HCBS* categorized as *Quality of Care (non-HCBS)* (3) and *Access to Service or Care* (1);
- 6 *Access to Service or Care* categorized as *Quality of Care HCBS (1), Pharmacy Issues (1), Customer Service* (3), and *Billing & Financial Issues (1);*
- 5 *Billing & Financial Issues* categorized as *Access to Service or Care (2)*, *Quality of Care (non-HCBS) (2),* and *Customer Service (1);*
- 3 *Member Rights Dignity* categorized as *Access to Service or Care (1), Customer Service (1)*, and *Quality of Care (non-HCBS) (1)*; and
- 4 *Non-Covered Services* categorized as *Access to Service or Care (2)*, *Billing & Financial Issues (1)*, and *Customer Service (1).*

Transportation-related grievances continued to be the most frequently reported grievances – 207 in Q1 CY2018, 182–232 in 2017. Of the 207 transportation-related grievances, 82 (37%) were reported by Amerigroup, 75 (33%) were reported by Sunflower, and 67 (30%) were reported by UnitedHealthcare.

The number of *Transportation - No Show* and *Transportation - Late* grievances continued to be high, with 45 "*No Show*" grievances, three "*No Driver Available*" grievances, and 50 "*Late*" grievances in Q1. Of concern, too, is the number of *Transportation – Safety* grievances (24 in Q1). In follow-up, the State is now requiring the MCOs to send monthly NEMT reports, in addition to quarterly reports, to promote quicker follow-up and resolution of transportation-related issues.

Of 522 grievances in Q1 (based on grievance descriptions), 189 (36%) were from 170 members receiving waiver services (see Table 11); 333 grievances (64%) were from 319 members not receiving waiver services.

Table 11. Grievances Reported by Waiver Members Resolved in Q1 CY2018*										
	Waiver Members								Non-Waiver	
	FE	I/DD	PD	SED	TA	TBI	Grievances	Members	Grievances	Members
Billing and Financial Issues	4	7	2		3	2	18	17	79	75
Access to Service or Care	2	3	5	1	6	2	19	14	25	24
Quality of Care (non-HCBS)		4	8	4			16	14	41	40
Quality of Care - HCBS	7	3	6				16	15	3	3
Customer Service	3	1	10		1	3	18	16	20	19
Pharmacy Issues	1	2		1			4	4	17	16
Member's Rights/Dignity		1	4				5	5	6	6
Value-Added Benefit	3	2	3				8	7	9	9
Transportation - Other	5		23		1		29	28	38	37
Transportation - Reimbursement	1	2	2	2			7	7	11	11
Transportation Safety	1	1	5	2			9	8	15	14
Transportation No Show	3		10		1	1	15	13	30	28
Transportation No Driver Available			2				2	2	1	1
Transportation Late	3		16		1	1	21	18	29	27
Other	1						1	1	2	2
Non-Covered Service						1	1	1	7	7
Total	34	26	96	10	13	10	189	170	333	319

*Counts are based on grievances as described by MCOs.

As shown in Table 12, the percentage of transportation-related grievances was higher among waiver members in the last five quarters (44%–50%) compared to members not receiving waiver services (37%–42%).

Table 12. Percentage of Transportation-Related Grievances Resolved in Q1 CY2017 to Q1 CY2018, by Waiver/non-Waiver										
	# Grievances					% Transportation Related				
	Q1	Q2	Q3	Q4	Q1	Q1	Q2	Q3	Q4	2017
Physical Disability (PD)	71	90	114	103	96	58%	57%	52%	57%	60%
Frail Elderly (FE)	31	27	33	29	34	55%	52%	58%	50%	38%
Intellectual/Developmental Disability (I/DD)	11	28	26	26	26	36%	25%	31%	23%	12%
Traumatic Brain Injury (TBI)	13	6	10	10	10	38%	67%	60%	30%	20%
Serious Emotional Disturbance (SED)	8	9	10	18	10	25%	11%	10%	39%	40%
Technology Assisted (TA)	5	3	6	5	13	20%	67%	17%	20%	23%
Waiver Member Grievances	139	163	199	191	189	50%	48%	47%	47%	44%
Non- Waiver Member Grievances	265	291	352	336	333	42%	41%	39%	38%	37%
All Member Grievances	404	455	552	529	522	45%	44%	42%	41%	40%

In Q1, of 189 grievances reported by 170 waiver members, 83 (44%) were transportation-related; 40% of the 207 transportation-related grievances in Q1 were reported by members receiving waiver services.

- Physical Disability (PD) Waiver members – 91 members reported 96 grievances in Q1, 58 transportation-related; 18% of the 522 total grievances reported in Q1 were from PD Waiver members.
- Frail Elderly (FE) Waiver members (29) reported 34 grievances in Q1, 13 transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members (25) in Q1 reported 26 grievances, three transportation-related.
- Serious Emotional Disturbance (SED) Waiver members (8) reported 10 grievances in Q1, four transportation-related.
- Traumatic Brain Injury (TBI) Waiver members (8) reported 10 grievances in Q1, two transportation-related.
- Technology Assistance (TA) Waiver members (9) reported 13 grievances in Q1; three transportation-related.

Access-Related Grievances

The Q1 Grievance Report template includes a revised definition for grievances to be categorized as *Access to Service or Care* (revisions noted as strike-out): "*Appointment availability, no providers available within distance standards, timeliness to get appointment, ~~complaints about non-covered services (other than pharmacy),~~ MCO system issue error – (eligibility not updated, TPL not current, processing error) difficulty finding HCBS provider*." The revision reflects the addition of *Non-Covered Service* as a separate grievance category beginning in Q1.

Of 522 grievances, as categorized by MCOs in the Q1 Grievance Report, 44 met the category criteria.

- The 44 *Access to Service or Care* grievances in Q1 include six grievances categorized by the MCOs as *Customer Service* (3), *Pharmacy Issues* (1), *Billing & Financial Issues* (1), and *Quality of Care HCBS* (1).
- Nine grievances categorized by the MCOs as *Access to Service or Care* may more appropriately meet the criteria for: *Quality of Care (non-HCBS)* (2 referred to MCO QOC); *Non-Covered Service* (2 – orthodontics and dental fillings for an adult); *Quality of Care HCBS* (1 – member not given medications ordered for her); *Member Rights Dignity* (1 – handicap accessibility at a provider office); *Billing & Financial Issues* (2); and *Other* (or not applicable) (1 – no longer eligible for Medicaid).

Of the 44 *Access to Service or Care* grievances (received from 38 members), 19 were reported by 14 members receiving waiver services:

- 6 grievances from 2 TA Waiver members,
- 5 grievances from 5 PD Waiver members,
- 3 grievances from 2 IDD Waiver members,
- 2 grievances from 2 FE Waiver members,
- 2 grievances from 2 TBI Waiver members, and
- 1 grievances from an SED Waiver member.

Quality-Related Grievances

Quality of Care (QOC) grievance definitions were also revised beginning in Q1 CY 2018 (revisions noted with underlining):

- *QOC (non-HCBS, non-Transportation)*: "*Provider/<u>Clinical</u> Staff error or neglect in delivery of any health care <u>or dental</u> services, e.g., someone is hurt, or it is determined necessary to forward to the QOC department for investigation. Additional examples: someone is dropped during transfer, doctor*

operates on wrong site, wrong medication administered, neglect, includes rudeness of provider, complaints about being put in Lock-in, includes complaints from members regarding providers refusing to see them."

- *QOC HCBS*: "*HCBS Provider/Clinical Staff error or neglect in delivery of any HCBS services, e.g., mistreatment of member, not providing service as specified in support plan or plan of care, includes rudeness of provider, complaints about being put in Lock-in, includes complaints from members regarding providers refusing to see them."*

The revised definitions reflect additional effort by the State to track grievances and appeals from members receiving HCBS services. The revised QOC grievance definitions, however, have a degree of overlap, as both include "*complaints about being put in Lock-in*" and "*complaints from members regarding providers refusing to see them."*

The *QOC HCBS* category was initially created to track issues specifically related to HCBS services quality of care. The *QOC non-HCBS* category was to track quality issues experienced by members that were unrelated to whether they receive waiver services. KDHE is considering categorizing all QOC grievances experienced by HCBS members as *QOC HCBS* whether or not specific services referenced in the grievance are HCBS-related. KFMC sees value in separately tracking the number of *QOC HCBS* and *QOC (non-HCBS)* grievances by waiver (see Table 11); in Q1, 16 of 19 (84%) *QOC HCBS* grievances were reported by Waiver members (7 FE, 3 I/DD, and 6 PD), and 16 of 57 (28%) *QOC (non-HCBS)* grievances were from Waiver members (4 I/DD, 8 PD, and 4 SED). Separately tracked and reported counts based on whether they are related to HCBS services, however, can then be combined; in Q1, for example, 84% of the *QOC HCBS* grievances and 28% of the *QOC non-HCBS* grievances were from Waiver members; 42% of the combined QOC grievances were reported by Waiver members.

As described by MCOs in the Q1 Grievance Report, 19 grievances (from 18 members) met the category criteria for *QOC HCBS*.

- The 19 *QOC HCBS* grievances in Q1 include four grievances categorized by the MCOs as *Access to Service or Care* (1) and *QOC non-HCBS* (3).
- Three grievances categorized by the MCOs as *QOC HCBS* may more appropriately meet the criteria for *Access to Service or Care* (or *Appeal* – night care no longer provided), *Appeal* (respite hours cut), and *Customer Service* (dissatisfaction with member services). Three additional grievances may have been incorrectly categorized by the MCOs as *QOC HCBS*, as the members are not listed in the Grievance Report (or in the MMIS system) as receiving waiver services.

In Q1, 57 grievances from 54 members met criteria for QOC *(non-HCBS, non-transportation)*.

- The 57 *QOC non-HCBS* grievances in Q1 include 10 grievances categorized by the MCOs as *Access to Service or Care* (2 grievances referred by the MCO for QOC staff follow-up that were related to dissatisfaction with physicians); *Customer Service* (3 – provider refusing to see member, condescending attitude of provider toward member, and no preauthorization submitted for medications); *Member Rights Dignity* (1); and *QOC HCBS* (4 grievances related to x-ray request, medication change, antianxiety medication request, and qualifications of person conducting a psychiatric review).
- Seven grievances categorized by the MCOs as *QOC non-HCBS* may more appropriately meet the criteria for: *Billing & Financial* (2), *Pharmacy issue* (1), *Member Rights Dignity* (2), *Non-Covered Service* (1), and *Customer Service* (1).

Follow-up on Previous Recommendations (Grievances)

- *MCOs should continue to make it a high priority to ensure transportation is available timely and consistently for members.*
  Follow-up response: The numbers of *Transportation – Late* and *Transportation – No Shows* grievances have continued to be high. The State, however, is now requiring the MCOs to send monthly NEMT (non-emergency medical transportation) reports, in addition to quarterly NEMT, to allow for quicker follow-up and resolution of issues.
- *UnitedHealthcare should categorize grievances using only the State-specified categories.*
  Follow-up response: UnitedHealthcare reported grievances in Q1 using only the State-specified categories.
- *KFMC recommends categorizing grievances based on consideration of both the initial description and the resolution.*
  Follow-up response: At the Q1 training, the State advised the MCOs to consider both the initial description and the resolution when categorizing grievances.
- *The State should consider renaming Customer Services as Customer Service.*
  Follow-up response: The State revised the *Customer Services* category to *Customer Service*.

Recommendations (Grievances)

1. The State should continue to require MCOs to report QOC grievances separately for HCBS-related services and for QOC grievances not related to HCBS. MCOs should ensure each quarterly Grievance Report identifies accurately and completely all members receiving HCBS Waiver services.
2. The State should consider developing a hierarchy of priority categories where one grievance meets criteria for two grievance categories.
3. MCOs and the State should compare Customer Service Reports and Grievance Reports each quarter to assess whether customer service inquiries counts for *Expression of dissatisfaction* are relatively comparable to the number of grievances reported.

Ombudsman's Office

- ***Track the Number and Type of Assistance Provided by the Ombudsman's Office.***
- ***Evaluate Trends Regarding Types of Questions and Grievances Submitted to the Ombudsman's Office.***

Data Sources

The primary data source in Q1 CY2018 is the quarterly KanCare Ombudsman Quarterly Report.

Current Quarter and Trend over Time

Ombudsman Office assistance is provided by the Ombudsman (Kerrie Bacon), a Volunteer Coordinator, a Project Coordinator, and trained volunteers at satellite offices. Information (as well as volunteer applications) is also available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office and is provided to members by mail and email as-needed.

The Ombudsman's Office is located in Topeka, with satellite offices in Wichita and Olathe (Johnson County). Assistance is provided by phone and in person, by appointment, including assistance completing Medicaid applications.

As delineated in the CMS Kansas Special Terms and Conditions (STC), revised in January 2014, the Ombudsman's Office data to be tracked include date of incoming requests (and date of any change in status); the volume and types of requests for assistance; the time required to receive assistance from the Ombudsman (from initial request to resolution); the issue(s) presented in requests for assistance; the health plan involved in the request, if any; the geographic area of the beneficiary's residence; waiver authority if applicable (I/DD, PD, etc.); current status of the request for assistance, including actions taken by the Ombudsman; and the number and type of education and outreach events conducted by the Ombudsman.

Volunteer assistance has been a critical factor in helping meet the high demand for assistance. The Olathe satellite office currently has four volunteers, and the Wichita office has three volunteers. A new volunteer position, Education and Resource Information (ERI) volunteer, created in 2017, engages students from the St. Mary's College Health Information Management Program. After background checks and completion of a 30-hour volunteer training, students complete 120 hours of volunteer work. Two ERI volunteers, through St. Mary's College have been assisting with developing resources for the Ombudsman's Office.

A wide variety of resources are available on the KanCare Ombudsman website, including forms, fact sheets, application and documentation checklists, information on where to find additional assistance, information on applying for eligibility and renewal, and grievance and appeal process.

The Ombudsman's Office tracks contacts by contact method, caller type, by specific issues and by location (main office or satellite office). Notes and email history from previous contacts were added in 2017, which has improved the level of assistance provided.

The number of contacts has increased each quarter of 2017 and again increased in Q1 2018.
In Q1 CY2018, the Ombudsman's Office tracked 1,214 contacts, compared to 827 in Q1 CY2017.

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts, including the number of issues that are MCO-related (see Table 13). In Q1, 340 (22%) of 1,543 issues (excluding 658 issues categorized as thank you, unspecified, and those with no MCO-related issues) in contacts to the Ombudsman's Office were MCO-related. The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.

Table 13. MCO-Related Issues tracked by Ombudsman's Office - Q1 CY2017 to Q1 CY2018

	CY2017								CY2018	
	Q1		Q2		Q3		Q4		Q1	
	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related
Medicaid Eligibility Issues	237	**29**	177	**20**	237	**32**	300	**51**	208	**30**
Medicaid Info (status) update	^	^	^	^	^	^	4	**0**	210	**22**
Medicaid Renewal	29	**11**	43	**13**	38	**17**	61	**20**	103	**18**
Medicaid General Issues/Questions	^	^	^	^	^	^	^	^	62	**17**
Medicaid Application Assistance	45	**1**	55	**1**	162	**4**	179	**5**	185	**9**
HCBS - Total	92	**43**	95	**47**	91	**34**	121	**49**	93	**46**
HCBS General Issues	*33*	*18*	*34*	*20*	*21*	*11*	*49*	*22*	*36*	*20*
HCBS Eligibility Issues	*46*	*18*	*50*	*23*	*58*	*20*	*62*	*23*	*46*	*19*
HCBS Reduction in Hours of Service	*7*	*5*	*2*	*1*	*4*	*3*	*6*	*2*	*7*	*7*
HCBS Waiting List	*6*	*2*	*9*	*3*	*8*	*0*	*4*	*2*	*4*	*0*
Appeal/Fair Hearing questions/issues	^	^	^	^	21	**6**	23	**6**	45	**6**
Grievances Questions/Issues	36	**18**	33	**15**	29	**9**	9	**3**	28	**8**
Billing	21	**7**	33	**18**	17	**11**	19	**11**	40	**21**
Client Obligation & Spenddown Issues	35	**10**	68	**24**	66	**23**	62	**22**	81	**28**
Coding Issues	3	**2**	0	**0**	8	**4**	18	**8**	32	**14**
Transportation	8	**7**	9	**6**	12	**6**	5	**2**	16	**11**
Medical Services	20	**13**	20	**13**	11	**6**	9	**3**	23	**10**
Care Coordinator Issues	5	**5**	11	**7**	6	**5**	12	**10**	10	**9**
Change MCO & Choice Info on MCO	3	**3**	1	**1**	2	**1**	6	**6**	15	**12**
Medicare-related issues	^	^	^	^	24	**5**	43	**8**	36	**7**
Pharmacy	11	**5**	9	**6**	10	**3**	13	**4**	16	**7**
Dental	7	**1**	9	**4**	7	**4**	6	**1**	10	**6**
Notice not received	^	^	^	^	^	^	1	**1**	16	**3**
Abuse/neglect complaints	^	^	^	^	^	^	2	**1**	10	**3**
Social Security Issues	^	^	^	^	1	**0**	4	**1**	9	**2**
Nursing Facility Issues	40	**5**	26	**7**	23	**1**	21	**3**	21	**2**
Housing Issues	4	**1**	6	**2**	7	**3**	0	**0**	7	**2**
Access to Providers	14	**11**	14	**12**	13	**4**	10	**7**	2	**2**
Moving to/from Kansas	5	**1**	7	**1**	6	**0**	9	**1**	16	**2**
Background Checks	^	^	^	^	^	^	2	**1**	4	**2**
Durable Medical Equipment	2	**2**	9	**5**	4	**3**	3	**2**	1	**1**
Help Understanding Mail	^	^	^	^	^	^	^	^	4	**1**
Prior Authorization Issues	^	^	^	^	^	^	^	^	1	**1**
Other	280	**47**	323	**56**	251	**36**	197	**33**	239	**38**
Total Issues - All & MCO-Related*	**897**	**222**	**948**	**258**	**1,046**	**217**	**1,139**	**259**	**1,543**	**340**
% MCO-Related*		**25%**		**27%**		**21%**		**23%**		**22%**

^Category added at a later date

*Excludes in Q1: Unspecified (79 in Q1; 3 MCO-related), Thank You (556 in Q1; 132 MCO-related), and categories with no MCO-related issues (Estate Recovery - 11, Guardianship - 3, Data requests - 3, Medicaid Fraud - 3, and Working Healthy - 3)

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 14, there were 129 waiver-related contacts in Q1, 58 MCO-related. The most frequent waiver-related issues in Q1 were related to the PD Waiver (51), followed by the I/DD Waiver (29), and FE Waiver (27). The number and percentage of MCO-related inquiries was lower in Q1 CY2018 compared to Q1 in CY2016 and CY2017.

Table 14. Waiver-Related Inquiries to Ombudsman - Q1 CY2016 to CY2018

Waiver	Q1					
	2016		2017		2018	
	all	MCO-related	all	MCO-related	all	MCO-related
Intellectual/Developmental Disability	48	28	43	22	29	10
Physical Disability	48	31	40	27	51	25
Technology Assisted	10	9	8	4	5	2
Frail Elderly	23	15	30	14	27	13
Traumatic Brain Injury	10	6	6	5	7	3
Serious Emotional Disturbance	4	3	4	2	9	5
Autism	1	0	3	2	1	0
Total	**144**	**92**	**134**	**76**	**129**	**58**

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- All three MCOs met contractual requirements to resolve at least 95% of inquiries within 2 business days and at least 98% of inquiries within 5 days.
- In Q1 CY2018, 98.3% of the 83,519 customer service member inquiries and 99.99% of the 36,515 provider inquiries were resolved within two business days. Of 1,402 member inquiries not resolved within two business days in Q1, 1,397 were reported by UnitedHealthcare. The 331 member inquiries not resolved within 5 business days were also reported by UnitedHealthcare
- Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.94% of member inquiries and 99.99% of provider inquiries were resolved within 15 days; 52 inquiries from members and 2 provider inquiries in Q1 CY2018 were reported as not resolved within 15 business days.
- The criteria used by the MCOs to categorize member and provider inquiries continue to vary by MCO. As a result, aggregated data for certain categories are more representative of only one of the MCOs rather than all three.
- KDHE has updated to the customer service reporting template, including inquiry categories. Initial training was provided in April 2018 to MCO staff. The revised template will be implemented beginning in July, with initial testing in May and June.
- The number of member and provider customer service inquiries reported in Q1 has decreased each year. However, the number of member customer service inquiries not resolved within 2, 5, and 15 business days in Q1 each year has greatly increased: within 2 business days – from 5 in Q1 CY2015 to 1,402 in Q1 CY2018; within 5 business days – from 0 in Q1 CY2015 to 331 in Q1 CY2018; and within 15 business days – from 0 in Q1 CY2015 to 52 in CY2018. Over 99% of the member inquiries not resolved within 2 days in Q1 CY2017 and Q1 CY2018, and 100% of those not resolved within 5 days and 15 days, were inquiries reported by UnitedHealthcare.
- Member customer service inquiries
  - Of the 83,519 customer service inquiries from members in Q1 CY2018, 40% were reported by Sunflower, 39% by UnitedHealthcare, and 21% by Amerigroup.
  - Benefit inquiries were the highest percentage (21%) of member inquiries in Q1.

  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template.
  - Sunflower continued to report receiving inquiries related to Health Homes (54 in Q1) despite the program's discontinuance in July 2016.
  - The category *Concern with access to service or care; or concern with service or care disruption* seems to potentially describe contacts tracked as grievances or appeals in the State's quarterly GAR reports. MCOs reported 2,380 inquiries in this category, compared to only 516 reported grievances in Q1. To address this, KDHE has removed this category beginning in July 2018, is adding a category *Expression of dissatisfaction*, has updated category descriptions, and is working with MCO staff to ensure inquiries meeting grievance criteria receive appropriate follow-up.
- Provider customer service inquiries
  - Of the 36,515 provider inquiries received by MCOs in Q1 CY2018, Amerigroup reported 44%, Sunflower 46%, and UnitedHealthcare 11%.
  - Claim status inquiries were again the highest percentage (53%) of provider inquiries.
  - Of the 17 provider inquiry categories, seven are focused on claims; the range of inquiries for each of the seven varied greatly by MCO. The combined total number of inquiries for these seven categories may allow better comparison of overall claims-related inquiries.

Timeliness of Claims Processing

Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days

- In Q4 CY2017, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,40,932 clean claims received in Q4 CY2018, 99.6% were processed within 30 days. Of the 15,869 clean claims not processed within 30 days – 13,940 (88%) were claims received by Amerigroup; 1,510 (10%) were claims received by Sunflower; and 419 (3%) were claims received by UnitedHealthcare. The number of clean claims not processed within 30 days was the highest in four years. Initial claims reports for January and February 2018 confirm the numbers of Amerigroup clean claims processed within 30 days have returned to previous lower levels.
- All three MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days; 99.9% of 197,615 non-clean claims were reported to be processed within 60 days.
- Of 4,338,547 "all claims" received in Q4 CY2017, 99.99% were processed within 90 days.
- To assess the impact of pharmacy claims on the clean claims processing rate, KFMC calculated processing rates excluding pharmacy claims. In the first three quarters of CY2017, the clean claims processing rate decreased by .03% to 0.05% when excluding pharmacy claims. In Q4, which had the highest number to date of clean claims not processed within 30 days, the processing rate decreased by 0.21% (from 99.62% to 99.41%) after excluding pharmacy claims. The annual percentage decreased by 0.09% (from 99.86% to 99.77%) after excluding pharmacy claims.

Turnaround time (TAT) ranges for processing clean claims

- In Q1 CY2018, the MCOs reported 4,408,439 clean claims were processed (including 1,586,923 pharmacy claims).
- The average TAT for Total Services (excluding pharmacy claims) was 7.1 to 10.8 days in Q1 CY2018, the highest average monthly ranges to date.

- The average TAT for processing clean claims for individual service types again varied by service type and by MCO. Average monthly ranges were widest in Q1 for claims for HCBS (7.1 to 19.4 days) and Behavioral Health (4.9 to 14.9 days).

Grievances

- In Q1 CY2018, 97.6% of 498 grievances reported by the MCOs as resolved in Q1 were reported as resolved within 30 business days and 98% were resolved within 60 days. The number of grievances not resolved within 60 days (10) is the highest in five years.
- UnitedHealthcare resolved 195 of 195 grievances within 30 days and was the only MCO in Q1 to meet the contractual requirement to resolve 98% of grievances within 30 business days and 100% within 60 business days.
- Amerigroup resolved 155 of 162 (95.7%) grievances within 30 days and 157 (96.9%) within 60 days. The 7 grievances (from 5 members) not resolved within 30 days were all transportation-related. The 5 grievances (from 3 members) that were not resolved within 60 days were resolved within 70–107 days.
- Sunflower resolved 136 of 141 (96.5%) grievances within 30 days. The 5 grievances not resolved within 30 or 60 days were from one member on the TA Waiver. Four of the five grievances were related to *Access to Service or Care* and one *Customer Service* grievance. The five grievances were resolved within 70–183 days.
- In March 2018, KDHE staff updated the grievance reporting template and provided follow-up training to MCO staff to clarify criteria for each grievance and appeal category.
- Of 522 grievances resolved in Q1 CY2018, 169 (32%) were reported by Amerigroup, 148 (28%) by Sunflower, and 205 (39%) by UnitedHealthcare.
- In Q4 there were 44 *Access to Service or Care* grievances, 57 *Quality of Care (non-HCBS, non-transportation)* grievances, and 19 *Quality of Care-HCBS* grievances.
- Transportation-related grievances continued to be the most frequently reported grievances, with 207 in Q1. The number of *Transportation No Show, Transportation - Late,* and *Transportation – Safety* grievances continued to be high, with 45 *Transportation – No Show* grievances (plus three no-shows due to *No Driver Available*), 50 *Transportation – Late* grievances, and 24 *Transportation – Safety* grievances in Q1.
- In Q1, 189 (36%) grievances were from 170 members receiving waiver services; 44% of the grievances reported by waiver members were transportation-related (compared to 37% of those not receiving waiver services).

Ombudsman's Office

- Ombudsman's Office assistance is available at the main office in Topeka, two satellite offices (Wichita and Olathe), and on the Ombudsman's Office website.
- Beginning in Q4, students from St. Mary's College, after completing Ombudsman volunteer training, began providing volunteer assistance, including development of resources for beneficiaries by two students in Q1 CY2018.
- In Q1 CY2018, the Ombudsman's Office tracked 1,214 contacts, compared to 827 in Q1 CY2017.
- In Q1, 340 (22%) of 1,543 issues (excluding 658 issues categorized as thank you, unspecified, and those with no MCO-related issues) in contacts to the Ombudsman's Office were MCO-related.
- The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.
- The most frequent waiver-related issues in Q1 were related to the PD Waiver (51), I/DD Waiver (29), and FE Waiver (27). Approximately half of the waiver-related issues (58 of 129) were MCO-related.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

1. UnitedHealthcare should report all inquiries from each contact and not limit reporting and categorization of inquiries to one primary inquiry.
2. As the Health Homes program ended in July 2016, Sunflower should evaluate reasons for continuing to receive inquiries each month related to Health Homes or should determine if these are misclassified (potentially questions related to home health care).
3. After implementation of the revised customer service inquiry template, the State should monitor to ensure comparable categorization of inquiries by each of the MCOs. Of particular focus should be ensuring inquiries that meet grievance or appeal criteria are being appropriately forwarded for follow-up and tracking as grievances or appeals.

Timeliness of Claims Processing by Claim Type and Date Received

1. Amerigroup should update their monthly claims processing reports for 2017, and all three MCOs should update their annual totals for 2016, to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days).

Grievances

1. The State should continue to require MCOs to report QOC grievances separately for HCBS-related services and for QOC grievances not related to HCBS. MCOs should ensure each quarterly Grievance Report identifies accurately and completely all members receiving HCBS Waiver services.
2. The State should consider developing a hierarchy of priority categories where one grievance meets criteria for two grievance categories.
3. MCOs and the State should compare Customer Service Reports and Grievance Reports each quarter to assess whether customer service inquiries counts for *Expression of dissatisfaction* are relatively comparable to the number of grievances reported.

KDHE Summary of Claims Adjudication Statistics –

January through March 2018 – KanCare MCOs

AMERIGROUP Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	8,977	$404,292,008	1,376	$94,572,138	15.33%
Hospital Outpatient	86,311	$227,558,071	9,599	$24,525,053	11.12%
Pharmacy	515,781	$42,230,245	153,315	Not Applicable	29.72%
Dental	32,870	$9,645,093	3,132	$1,131,862	9.53%
Vision	18,570	$5,345,508	2,398	$808,143	12.91%
NEMT	32,326	$1,233,317	141	$7,541	0.44%
Medical (physical health not otherwise specified)	487,311	$253,375,565	61,136	$37,807,801	12.55%
Nursing Facilities-Total	21,550	$58,080,422	2,521	$7,722,697	11.70%
HCBS	73,608	$45,632,720	4,199	$4,009,926	5.70%
Behavioral Health	145,768	$19,957,204	12,919	$1,626,934	8.86%
Total All Services	1,423,072	$1,067,350,152	250,736	$172,212,094	17.62%

SUNFLOWER Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	8,672	$361,503,745	1,992	$94,884,544	22.97%
Hospital Outpatient	83,738	$205,309,207	10,046	$29,172,736	12.00%
Pharmacy	589,473	$72,593,709	216,691	$39,456,602	36.76%
Dental	37,090	$10,299,663	3,632	$748,874	9.79%
Vision	24,594	$6,076,081	4,760	$1,157,437	19.35%
	38,526	$1,064,503	1,000	$22,811	2.60%
NEMT	427,835	$215,081,293	60,043	$39,409,718	14.03%
Medical (physical health not otherwise specified)	33,028	$75,607,663	2,592	$8,866,751	7.85%
Nursing Facilities-Total	143,305	$74,220,399	7,521	$3,620,878	5.25%
HCBS	213,790	$33,086,134	19,079	$3,534,670	8.92%
Behavioral Health	1,600,051	$1,054,842,396	327,356	$220,875,020	20.46%
Total All Services	8,672	$361,503,745	1,992	$94,884,544	22.97%

UNITED Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	7,112	$285,084,660	1,476	$60,533,294	20.75%
Hospital Outpatient	83,927	$221,828,159	15,952	$43,620,407	19.01%
Pharmacy	481,669	$79,142,634	122,826	$45,284,190	25.50%
Dental	36,575	$10,740,602	4,523	$1,632,345	12.37%
Vision	20,268	$4,805,654	4,858	$1,121,741	23.97%
NEMT	1,128	$261,503	678	$171,541	60.11%
Medical (physical health not otherwise specified)	40,755	$1,125,764	509	$13,365	1.25%
Nursing Facilities-Total	442,011	$227,211,658	71,337	$50,044,204	16.14%
HCBS	23,608	$66,086,252	3,502	$9,798,446	14.83%
Behavioral Health	93,852	$41,468,119	2,965	$1,842,199	3.16%
Total All Services	152,098	$38,784,154	10,546	$4,583,121	6.93%