Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.16

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 4 (1/1/2016-12/31/2016)
Federal Fiscal Quarter: 1/2017 (10/16-12/16)

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.

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 five 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 with regard to 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 fourth quarter known as of December 31, 2016.

Demonstration Population	Enrollees at Close of Qtr. (12/31/2016)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	15,036	15,882	846
Population 2: ABD/SD Non Dual	28,485	29,118	633
Population 3: Adults	52,340	57,530	5,190
Population 4: Children	242,105	260,858	18,753
Population 5: DD Waiver	8,944	8,993	49
Population 6: LTC	20,583	21,390	807
Population 7: MN Dual	1,241	1,312	71
Population 8: MN Non Dual	1,235	1,307	72
Population 9: Waiver	4,497	4,672	175
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**374,466**	**401,062**	**26,596**

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.

During the 4th quarter, a Tribal Technical Advisory Group (TTAG) meeting with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations was held on November 1, 2016. None members attended in person or by phone.

Also during this quarter, the state's KanCare Advisory Council meeting and Annual Public Forum was held on December 1, 2016. The 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 December 1 meeting served primarily as the Annual Public Forum and the agenda was as follows:*

I. Welcome
II. KHI articles – KanCare renewal process and KanCare delivery on cost, not quality care
III. 2016 KanCare Public Forum
IV. Participant Q&A related to forum presentation
V. Next Meeting of KanCare Advisory Council – March 30, 2017, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m. *(NOTE: The meeting has since been moved to March 24, 2017)*
VI. Adjourn

A Summary of Annual Public Forum is attached to this report.

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)
- 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 9 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

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 in order to ease burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. The workgroup is currently working with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal. This 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. Version one of the portal is complete and assessment is underway. The design has been demonstrated to providers and MCO partners. Once this assessment is complete, the workgroup will be working with the Fiscal Agent to integrate the desired changes into the expanded Provider Enrollment Portal, while also including any necessary items from the new Managed Care Rules.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on December 15, 2016, at the Landon State Office Building in downtown Topeka, Kansas. The topics discussed were a follow up discussion about Nursing Hours on the HCBS TA waiver with an outcome that more nurses were needed in the medical system at large not just on the TA waiver. The work group also received an update on the KanCare Renewal and that the State had asked for an extension. KDHE encouraged people to watch the KanCare web site for updates on the KanCare Renewal. There was also a demonstration of the new and improved KanCare website. The workgroup then finished the rest of the meeting reviewing the KanCare application for medical assistance for the

Elderly and Persons with Disabilities. KDHE is planning on updating this application soon and wanted the workgroup's feedback. The entire application was not able to be reviewed in the remaining time. That review will be finished at the next meeting on 02/28/2017 at United HealthCare's offices in Overland Park, Kansas.

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 approximately 80 events for the fourth quarter of 2016. This included partner development, sponsorships, member outreach and advocacy. The Community Relations Representatives primary focus continues to be member education of services and how to get the most out of the KanCare program. They constantly look to develop strong partnerships across the state by enhancing existing relationships and building new ones.

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

- Interhab 2016 Power Up Conference
- Mayetta Boys and Girls Club
- Early Head Start Home Visitor Networking Presentation
- 2016 Workability Exhibit

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 continue with ongoing targeted outreach to improve member knowledge about the services available to them. They also reached out to members who appeared to be due for an annual checkup or needing 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 over 7,000 Kansans in the fourth quarter. 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, access to care, diabetes, well child visits, employment, high blood pressure, your PCP and you, and more. Amerigroup also met with members who participate in their adult, teen and foster care advisory groups to help assess their effectiveness and to improve various health related strategies, programs and systems of care. Below is a sampling of some of their outreach efforts this past quarter:

- Ks Community Baby Shower
- Clay Johnson Celebrity Weekend
- USD 500 Academy Exhibit
- West Middle School Fun Night
- Linn County Resource Fair
- Disability Mentoring Days -- Pittsburg

Advocacy Activities: Amerigroup' s advocacy efforts for fourth quarter 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 proactive 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 fourth quarter advocacy efforts remain similar to 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 and grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan.

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

- Giving Grove Meeting
- Child Start Health Services Advisory Committee Meeting
- Sedgwick County Health Department WIC Meeting
- Disability Mentoring Days – multiple locations across state

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

Marketing Activities: During the 4th quarter 2016, Sunflower's Marketing Department updated collateral for the New Member Welcome Packet to be used beginning 2017, and the health plan used sponsorships (funding support) with member and provider organizations to educate stakeholders for purposes of increased care coordination. Examples of 4th quarter 2016 marketing that generated support and attendance at sponsored events as well as health plan visibility in the community include:

- InterHab's annual PowerUp conference, Oct. 12-14, 2016
- Operation Red File, Oct. 17, 2016
- Children & Youth with Special Health Care Needs Stakeholder Meeting, Nov. 3, 2016
- Oral Health Kansas Conference, Nov. 4, 2016
- Special Olympics Healthy Athletes, Nov. 11, 2016
- Presented at the KanCare Ombudsman Member Lunch and Learn, Dec. 28, 2016

Sunflower also adjusted its CentAccount program to include member incentives for vaccinations and Health Risk Screening assessments. It also updated New Member Packets in both English and Spanish to include:

- Member Handbook
- Forms Book
- Benefits Booklet
- Magnet with Important Phone Numbers
- ID Card and Welcome Letter

Outreach Activities: In addition to regularly scheduled Adopt-a-School events and Baby Showers facilitated by Sunflower's MemberConnections department, the health plan's fourth quarter of CY 2016

outreach activities involved efforts to get members vaccinated against influenza and to get members seen for important preventive health screenings.

• Partnership with Quest/ExamOne to offer in-home testing to members who had not received testing with their PCP to assess their diabetes and effectiveness in the management of diabetes

• Telephone outreach to diabetic members in Case Management with successful outreach made to determine if an appointment was scheduled for routine diabetes care, or referred to Disease Management and/or provided educational information

• Outreach campaign with providers in November and December to enlist their assistance in getting members in who still needed their Hemoglobin A1c testing done

Advocacy Activities: Employment for persons with disabilities was the focus this quarter. Sunflower was awarded DisAbility Champion by the Greater Kansas City Business Leadership Network on November 2, 2016. Additionally, Sunflower and its partner, LifeShare, advocated for people with I/DD through a variety of stakeholder engagement opportunities, including the annual Disability Mentoring Day events to promote inclusion in the workplace and support for jobseekers with disabilities. Sunflower and LifeShare were able to sponsor and/or attend these special Disability Mentoring days:

- Oct. 18, 2016 – Humboldt, KS.
- Oct. 19, 2016 – Emporia, KS.
- Oct. 19, 2016 – Hutchinson, KS
- Oct. 20, 2016 – Lawrence, KS
- Oct. 20, 2016 – Wamego, KS
- Oct. 25, 2016 – Pratt, KS
- Oct. 27, 2016 – Fort Scott, KS
- Nov. 2, 2016 – Great Bend, KS
- Nov. 3, 2016 – Olathe, KS
- Nov. 16, 2016 – Neodesha, KS
- Nov. 17, 2016 – El Dorado, KS
- Nov. 30, 2016 – Pittsburg, KS
- Dec 1, 2016 – Dodge City, KS

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:

Marketing Activities: UnitedHealthcare Community Plan of Kansas' primary focus during this reporting period was continued emphasis on member, provider, and community education regarding benefits and health. UnitedHealthcare Community Plan participates in and supports a variety of community events, as well as engaged in member events and outreach. UnitedHealthcare focused on completing new member welcome calls, and Health Risk Assessments. UnitedHealthcare also engaged in other outreach calls to invite members to Community Baby Showers and Clinic Days. In Q4 UHC hosted a new event targeting the FE/PD Population to educate this population on being Happy and Healthy at Home. New members are sent ID Cards and new member welcome kits in a timely manner. UnitedHealthcare mails members the

HealthTalk newsletter each quarter with tips on living a healthier life. UnitedHealthcare delivers the quarterly Practice Matters Newsletter to Providers with information that is important for their support of UnitedHealthcare Members. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentation with key providers, hospitals and FQHC's throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional strategic endeavors continued to focus on working with providers to ensure accurate panel assignments and attribution, where appropriate. Additional work was done to learn more about the challenges of Rural Health. In December the Health Plan hosted an RFP Brainstorming session on Rural and Frontier Health with key stakeholders and organizations from across the State. Data gathered at this session is being used for the RFP that UHC is putting out in January 2017 where stakeholders can respond to acquire grant money to fund new programs to support Rural Health.

Outreach Activities: UnitedHealthcare leverages 2 Bilingual Community Outreach Specialists that focus on activities targeted within assigned geographical areas across Kansas. These specialists are fluent in both English and Spanish languages and effectively communicate with members. An additional Outreach Specialists was hired to support activities in South Central Kansas (Wichita and surrounding areas). The key responsibility of the Outreach Specialist is to conduct educational outreach to members, community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. 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, supported several health fairs and clinic days held throughout the state. UnitedHealthcare also participated in a number of community stakeholder committee meetings in the fourth quarter of 2016, UnitedHealthcare hosted two Community Baby Showers, in Olathe and Salina. These Community Events have been well received and provide pregnant and new moms with information about healthy pregnancies and deliveries, as well as child safe sleeping and car seat installation. In addition, UnitedHealthcare participated in four other Baby Showers hosted by other organizations. The Member Advisory Meeting held in Q4 in Olathe focused on member education and the NurseLine.

- During the fourth quarter of 2016, UnitedHealthcare staff personally met with approximately 8,603 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 fourth quarter 2016, UnitedHealthcare staff personally met with approximately 984 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.
- During the fourth quarter 2016, UnitedHealthcare staff personally met more than 664 individuals from provider offices located throughout the State.

Advocacy Activities: The UnitedHealthcare leverages one outreach specialist that has the additional focus of supporting members with disabilities, and the individuals and agencies that support them. This person

serves as a liaison between the community, members and the Health Plan. This outreach specialist divides her time between traditional outreach and supporting those with disabilities.

Throughout this quarter, UHC supported numerous Disability Mentor Day events across the State. These events offer support for the HCBS waiver population and helps members and disability advocates learn more about how to access and navigate their benefits with United Healthcare, including how care coordination is provided to those on Home and Community Based Waiver programs and where to go when they have questions. Health Plan staff continued to stress to members with disabilities the desire to support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. At events, it is not uncommon to meet individuals with a newly acquired disability who are in need of good referrals and basic information about programs and services available to them. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas.

In support of the consumers with developmental disabilities, this outreach specialist attended the 40th Annual Governor's Conference for Prevention of Child Abuse and Neglect. UHC also sponsored and spoke at the PowerUp! Conference supporting InterHab.

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 contract Amendment 23 was sent to CMS on July 27, 2016. This amendment instituted a 4% rate reduction to certain provider types. CMS requested additional information from the State on August 1, 2016 and September 26, 2016.

   Seven State Plan Amendments (SPA) addressing the 4% rate reduction were submitted with Amendment 23. CMS has issued a formal request for additional information (RAI) with responses due on March 15, 2017.

   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 service utilization, per each of the KanCare MCOs, by top three value added services and total for January-December 2016, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	4,229	$464,758
	Member Incentive Program	21,091	$393,225
	Mail Order OTC	11,301	$198,739
	Total of all Amerigroup VAS Jan- Dec 2016	***36,621***	***$1,056,722***
Sunflower	CentAccount Debit Card	83,066	$1,661,320
	Dental Visits for Adults	9,513	$313,161
	Smoking Cessation Program	389	$93,360
	Total of all Sunflower VAS Jan- Dec 2016	***92,968***	***$2,067,841***
United	Baby Blocks Program and Rewards	31,383	$666,581
	Adult Dental Services	1,126	$135,120
	Rewards for Preventive Visits & Health Actions	2,212	$110,990
	Total of all United VAS Jan- Dec 2016	***34,721***	***$912,691***

c. Enrollment issues: For the fourth quarter of calendar year 2016 there were 13 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 fourth quarter of calendar year 2016. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	10
KDHE - Administrative Change	43
WEB - Change Assignment	23
KanCare Default - Case Continuity	97
KanCare Default – Morbidity	271
KanCare Default - 90 Day Retro-reattach	101
KanCare Default - Previous Assignment	388
KanCare Default - Continuity of Plan	461
AOE – Choice	510
Choice - Enrollment in KanCare MCO via Medicaid Application	755
Change - Enrollment Form	292
Change - Choice	465
Change - Access to Care – Good Cause Reason	3
Change - Case Continuity – Good Cause Reason	3
Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	4
Total	**3426**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
CY16 4th quarter report

MCO	QOC (non HCBS, non Trans)	Customer Svcs	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (incl Riem.)	Trans (No Show)	Trans (Late)	Trans (Safety)	VAS	Billing/Fin Issues (non Trans)	Other
AMG	11	8	1	8	2	3	18	20	7	2	0	19	0
SUN	9	16	3	25	6	0	26	17	2	5	6	8	5
UHC	32	4	3	1	11	14	25	15	18	9	0	36	1
Total	52	28	7	34	19	17	69	52	27	16	6	63	6

MCOs' Appeals Database
Members – CY16 4th quarter report

Member Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**	**SFH requested**
MEDICAL NECESSITY DENIAL					
Criteria Not Met - DME	1 8 12	2	3 6	1 3 6	1 1
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	3 26	24	1 1	2 1	
Criteria Not Met - Medical Procedure (NOS)	3 22	1 1	9	2 12	
Criteria Not Met - Radiology	4	1	3		
Criteria Not Met - Pharmacy	15 73 44	1 12 2	12 39 26	2 22 16	2
Criteria Not Met - PT/OT/ST	12		7	5	1
Criteria Not Met - Dental	2 4 5	1	1 3	1 1 4	
Criteria Not Met or Level of Care - Home Health	1 3			1 3	1
Criteria Not Met - Hospice					

Criteria Not Met - Out of network provider, specialist or specific provider request	2			2	
Criteria Not Met – Inpatient Behavioral Health	2 20 3		2	2 18 3	
Criteria Not Met – Behavioral Health Outpatient Services and Testing	1 18		4	1 14	1
Level of Care - LTSS/HCBS	29 6	2 1	1 2	26 3	 4 1
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					
Ambulance (include Air and Ground)					
Other- Medical Necessity	7 11	1 2	1	6 8	
NONCOVERED SERVICE DENIAL					
Service not covered - Dental	1 1 1	 1		1	
Service not covered - Home Health	7			7	
Service not covered - Pharmacy				1	
Service not covered - Out of Network providers					
Service not covered - OT/PT/Speech					
Service not covered - DME	1		1		1
Service not covered - Behavioral Health					
Other - Noncovered service	 12 4	 1 1	 6 2	1 5 1	 4
Lock In	1 1		 1		
Billing and Financial Issues					
PRIOR AUTHORIZATION DENIAL					
Late notification					
No authorization submitted					
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **59** **191** **116**	 **5** **18** **31**	 **17** **78** **36**	 **37** **95** **49**	 **0** **13** **4**

MCOs' Appeals Database

Providers - CY16 4th 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	SFH requested
MEDICAL NECESSITY DENIAL					
Criteria Not Met - DME	1			1	1
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	28 35 105		5 18 37	23 17 68	9 17
Criteria Not Met - Medical Procedure (NOS)	2 7		1	2 6	1
Criteria Not Met - Radiology	7 1		6	1 1	1
Criteria Not Met - Pharmacy	42		40	2	1 1
Criteria Not Met - PT/OT/ST					
Criteria Not Met - Dental					
Criteria Not Met - Vision	21		14	7	
Criteria Not Met or Level of Care - Home Health	1		1		
Criteria Not Met - Hospice					
Criteria Not Met - Out of network provider, specialist or specific provider request					
Criteria Not Met – Inpatient Behavioral Health	5		1	4	
Criteria Not Met – Behavioral Health Outpatient Services and Testing	5		4	1	
Level of Care - LTSS/HCBS					
Level of Care - WORK					
Level of Care - LTC NF					
Level of Care - Mental Health					
Ambulance (include Air and Ground)	4				

	4		1	3	1
Other-medical necessity	4 3 2		3	1 3 2	 1
NONCOVERED SERVICE DENIAL					
Service not covered - Dental					
Service not covered - Vision					
Service not covered - Home Health	6		2	4	
Service not covered - Pharmacy					
Service not covered - Out of Network providers					
Service not covered - OT/PT/Speech	 3		 3		
Service not covered - DME					
Service not covered - Behavioral Health	1	1			
Other- not covered service	1 108	 1	1 36	 71	1 7
BILLING AND FINANCIAL ISSUES					
Claim Denied- contained errors	6978 77 12		3895 19 8	1981 58 4	1 41 4
Claim Denied- by MCO in Error	3357 3		1311 2	1822 1	9 6
PRIOR AUTHORIZATION DENIAL					
Late notification	12 16		1	11 16	 1
No authorization submitted	1 20 35		1 10 18	 10 17	
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **10432** **195** **276**	 **0** **0** **2**	 **5262** **70** **106**	 **3844** **125** **168**	 **10** **62** **31**

MCOs' Appeals Database

Provider Appeal Summary – CY16 4th quarter report

AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	Proceeded to SFH
Resolved at 1st Appeal Level	9901 0 276	0 0 2	5065 0 106	3581 0 168	0 0 31
Resolved at 2nd Appeal Level	531 195	0 0	197 70	263 125	43 18

State of Kansas Office of Administrative Fair Hearings

Members – CY16 4th quarter report

AMG-Red SUN-Green UHC-Purple	Withdrawn	Dismissed-Moot MCO Reversed decision	Dismissed – No Internal Appeal	Dismissed-No Adverse Action	Default Dismissal-Appellant did not respond/ appear	Dismissed-Untimely	OAH upheld MCO decision	OAH reversed MCO decision
Dental Denied/ Not Covered								
CT/MRI/X-Ray Denied								
DME Denied	1							1
Home Health hours Denied					1	1		2 1
Comm Psych Supt/ BH Svcs Denied					1			
LTSS/HCBS/Work PCA Hrs Denied	1	3		1	1		1	1
Pharm/Lab/Genetic Testing Denied								2
Inpt/Outpt/Observation Med Procedure Denied		1	1					
Specialist Ofc Visit/ Ambulance Denied								
TOTAL AMG – Red SUN – Green UHC – Purple	2	4	1	1	1 2	1	1	2 2 3

State of Kansas Office of Administrative Fair Hearings
Providers – CY16 4th quarter report

AMG-Red SUN-Green UHC-Purple	Withdrawn	Dismissed-Moot MCO Reversed decision	Dismissed – No Internal Appeal	Dismissed-No Adverse Action	Default Dismissal-Appellant did not respond/ appear	Dismissed-Untimely	OAH upheld MCO decision	OAH reversed MCO decision
Claim Denied (Contained Errors)	2	1		1				
Claim Denied by MCO in Error		2						
Recoupment								
DME Denied	1	2 2			1			
Dental Denied		1	1					
Radiology Denied			6 2					
Home Health/Hospice/ LTC Denied	1	1 2	1					
Air/Ambulance Charges		1						
Inpt/Outpt/Observation Med Procedure Denied – Facility Charges	10 1 10	8 8	1		1	1	1	
Inpt/Outpt/Observation Med Procedure Denied – Physician charges	1	6						
Mental Health HCBS/TCM Hrs Denied	3 1	3 1	1 1					
Pharm/Lab/Genetic Testing Denied		1 1		1	1			
TOTAL AMG – Red SUN – Green UHC - Purple	16 3 11	22 6 12	3 6 4	2	1 2	1	1	

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 Q4 of 2016, there were a total of 37 requests, which is a very large reduction in comparison to the 171 requests in third quarter of 2016. The Q3 numbers showed a sharp drop from the numbers as the quarter progressed, from July (83) to September (27), indicating that issues are being resolved. The final quarter statistics showed even further improvement.

The majority of good cause requests (GCRs) during the Q4 of 2016 continue to be due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. KDHE and the MCOs issued educational materials or information late in 2016, including what could be added to member enrollment packets, to further explain what would be considered "good cause." Unfortunately, GCRs still occur due to providers advising patients to file GCRs to switch plans. Most of the GCRs in all quarters of 2016 are due to two clinics advising their patients to file GCRs when their clinics were terminated from MCO networks. 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. The GCR requests showed an overall downward trend from the requests at the beginning of 2015 through December 2015, but did increase in the first and second quarters of 2016.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2016, there were 0 state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	October	November	December
Total GCRs filed	18	12	7
Approved	2	2	1
Denied	9	5	4
Withdrawn (resolved, no need to change)	3	2	1
Dismissed (due to inability to contact the member)	4	3	1
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. Some of the provider numbers below shifted as a result of data clean up. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/31/16	# of Unique Providers as of 6/30/16	# of Unique Providers as of 9/30/16	# of Unique Providers as of 12/31/16
Amerigroup	15,802	16,410	16,623	16,886
Sunflower	20,389	20,647	20,734	21,391
UHC	21,290	22,133	24,321	23,778

MLTSS implementation and operation: In the fourth quarter, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list, as well as individuals on the HCBS-I/DD Program waiting list. All people on the waiting list for HCBS-PD waiver services through August 5, 2016 were sent an offer to begin receiving services. During this quarter, the number of new request exceeded the program capacity, resulting in movement on and off the waiting list. Additional details are included in section XIII below.

i. 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 DY4. A DSRIP Learning Collaborative was held on December 19, 2016, at Children's Mercy Hospital, with The University of Kansas Hospital, KFMC, and the State of Kansas in attendance.

j. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
   - The Serious Emotional Disturbance (SED) waiver is operating off an extension approved through March 23, 2017. Previously the State had withdrawn the submitted renewal request, to address concerns CMS expressed regarding mitigation of conflict of interest. The State is working closely with CMS to mitigate the conflict of interest concerns. The State has had technical assistance calls with CMS and continues to work on the concerns. The SED Waiver was submitted to CMS on 12-2-2016.
   - The Autism waiver is currently operating off an extension through March 25, 2016. CMS has required the state to remove three autism wavier services and provide them under the state plan as EPSDT services. The Autism Waiver was submitted to CMS on 11/23/16.

k. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met on November 17 and 18, 2016, to review the current state of KanCare and HCBS services.

- The committee received KanCare program updates from KDHE, including eligibility determinations, MCO financial status, KanCare opportunities and waiver integration project, and provider pharmacy issues.
- The committee received information from KDADS about state hospital issues, HCBS waiver and waiting list updates, and activities related to the HCBS Settings Rule.
- The committee also received presentations from each of the KanCare MCOs, received information from the KanCare Ombudsman, and took comments from stakeholders (with related responses from agency and MCO staff).

V. Policy Developments/Issues

General Policy Issues: Kansas addressed policy concerns related to managed care organizations and state requirements through weekly KanCare Policy Committee, biweekly 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 HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 12.31.16 is attached. Utilizing the HP-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 HP, the fiscal agent, to modify reports as needed in order 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	*2016-10*	*2016-11*	*2016-12*	*Grand Total*
Population 1: ABD/SD Dual	15,058	15,159	15,041	45,258
Population 2: ABD/SD Non Dual	28,694	28,604	28,492	85.790
Population 3: Adults	54,837	54,245	52,340	161,422

Sum of Member Unduplicated Count	Member Month			Totals
Population 4: Children	254,046	249,462	242,108	745,616
Population 5: DD Waiver	8,966	8,961	8,950	26,877
Population 6: LTC	20,921	20,862	20,742	62,525
Population 7: MN Dual	1,258	1,247	1,244	3,749
Population 8: MN Non Dual	1,249	1,237	1,235	3,721
Population 9: Waiver	4,528	4,540	4,498	13,566
Grand Total	**389,557**	**384,317**	**374,650**	**1,148,524**

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

VIII. Consumer Issues

Summary of consumer issues during the fourth quarter of 2016:

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 files.
Member authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to incomplete authorization requests, which were subsequently denied.	A few authorization and documentation requirements were relaxed, but there are lingering issues due to the process being largely a manual review process. And there are provider errors in billing which cause denials (incorrect dates, units, procedure codes, etc.).
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims.	This happens sporadically, and there are multiple causes.
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.	The State discussed this issue with all MCOs during the State on site reviews in 2016. All MCOs were instructed to report this information accurately as there is an existing field for Open/Closed panels. Also, the network adequacy report was revised to include a column for member count, and member capacity. We

Issue	Resolution	Action Taken to Prevent Further Occurrences
		have instructed the MCOs to submit this information for panel monitoring purposes.
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. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations. Also instructions for providers on how to submit requests for authorizations on retro eligible members.

Continued consumer support around the state was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 3,729 consumers. OEW also assisted in resolving 1,903 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 1,237 consumer phone calls.

During this quarter, OEW staff also participated in 6 community events providing Kan Care program outreach, education and information.

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. KDHE and KDADS have established the Medicaid Enterprise Leadership (MEL) team for comprehensive oversight and monitoring. The MEL team is a review, feedback and policy direction body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). The MEL 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. The MEL team 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 the MEL team's review of and feedback regarding the overall KanCare quality plan. This combined information assists the MEL 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 will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

The State values a collaborative approach that will allow 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 fourth quarter of 2016, some of the key quality assurance/monitoring activities have included:

- Quarterly 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.

- Finalization of the 2015 State contract on site audit. A final report issued for all MCOs. This audit is designed to assess the level to which each MCO performs duties of the contract and the quality of the services delivered to providers and members. The 2015 State Contract Review concentrated on compliance with the contract in effect. The 2015 State Contract Review was divided into two focus areas over two days; day one of the audit emphasized specific topics of interest within the KanCare contract identified by State subject matter experts and day two was the annual review of Health Homes for Serious Mental Illness (SMI). Two general methods, a desk review and an on-site review, involved the multiple approaches listed below to obtain data and evidence from internal systems and external stakeholders.

Desk Review	**On-site Review**
Policy and procedure review	In-person MCO staff interviews
Random samples of member and provider files to demonstrate application of policies	Use of two distinct teams of State subject matter experts for each day of the on-site
Random sample of recorded calls	System overview presentations by topic area
Member interviews	Presentation of one member file to demonstrate the elements of service delivery

Desk Review	On-site Review
Stakeholder interviews	Presentation of one provider file to demonstrate claims processing
Report analysis	Call Center shadowing

- 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 for 2016, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the fourth quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency.
- The 2016 Balanced Budget Act review and the annual State contract audit were performed conjointly during this timeframe. The audits assessed known compliance issues as well as findings from previous audits. Desk audits of samples and onsite visits were utilized to perform these audits. The final reports will be completed later this year.
- MFCU 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.
- Complex Case staffing of HCBS and Behavioral Health issues. Each MCO brings complex cases for State consideration, and the State provides technical assistance about program policies and alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- 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 Special Terms and Conditions.

- 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 procedure manual is in the draft stages, and once finalized it will be utilized to document this process. In the manual, protocols and interpretive guidelines have been established with the goal of ensuring consistency in the reviews.
- An HCBS Waiver Quality Review policy was in the final review stages. The policy addresses documentation requirements for compliance, required timelines for submission and review along with remediation and response processes. .
- During this quarter, the Quality Assurance team within KDADS team began their review of the 2015 documentation uploaded by the MCOs during the previous quarter. The MCOs were provided with the sample to upload for review for the 7/1/2016 – 9/30/2016 review period. The Quality Assurance team began their review of the 7/1/2016 – 9/30/16 review period.

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. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing: http://www.kancare.ks.gov/policies-and-reports/network-adequacy

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/mco-network-access.pdf?sfvrsn=2. 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.
2. HCBS Service Providers by County:

http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/hcbs-providers-by-waiver-service.pdf?sfvrsn=4, 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-December 2016:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	2.21%	184,550
Sunflower	0:18	1.79%	167,449
United	0:09	0.50%	160,153
HP – Fiscal Agent	0.00	0.10%	24,973

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:22	1.85%	83,865
Sunflower	0:11	0.86%	95,521
United	0:08	0.53%	63,919
HP – Fiscal Agent	0.00	0.0%	10,358

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 – CY16 3rd Quarter

Amerigroup 4th Quarter Grievance Trends		
Total # of Resolved Grievances	99	
Top 3 Trends		
Trend 1: Transportation (No Show)	20	20%
Trend 2: Billing/Financial Issues	19	19%
Trend 3: Transportation (incl. reimbursement)	18	18%

Sunflower 4th Quarter Grievance Trends		
Total # of Resolved Grievances	128	
Top 3 Trends		
Trend 1: Transportation (incl. reimbursement)	26	20%
Trend 2: Access to Service or Care	25	20%
Trend 3: Transportation (No Show)	17	13%

United 4th Quarter Grievance Trends		
Total # of Resolved Grievances	169	
Top 3 Trends		
Trend 1: Billing/Financial Issues	36	21%
Trend 2: Quality of Care (non HCBS)	32	19%
Trend 3: Transportation (incl. reimbursement)	25	15%

MCOs' Appeals Trends
Member/Provider – CY16 3rd Quarter

Amerigroup 4th Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	59		Total # of Resolved Provider Appeals	10432	
Top 3 Trends			Top 3 Trends		
Trend 1: Level of Care - LTSS/HCBS	29	49%	Trend 1: Claim Denied - contained Errors	6978	67%
Trend 2: Criteria Not Met - Pharmacy	15	25%	Trend 2: Claim Denied - by MCO in Error	3357	32%
Trend 3: Criteria Not Met - Radiology	4	7%	Trend 3: Criteria Not Met - Pharmacy	42	0%

Sunflower 4th Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	191		Total # of Resolved Provider Appeals	195	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	73	38%	Trend 1: Claim Denied - Contained Errors	77	39%
Trend 2: Criteria Not Met - Medical Procedure (NOS)	22	12%	Trend 2: Criteria Not Met - Inpt Admissions (non BH)	35	18%
Trend 3: Criteria not Met - Inpt Behavioral Health	20	10%	Trend 3: Criteria Not Met - Vision	21	11%

United 4th Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	116		Total # of Resolved Provider Appeals	276	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	44	38%	Trend 1: Other - Not covered service	108	39%
Trend 2: Criteria Not Met - Inpt Admissions (non BH)	26	22%	Trend 2: Criteria Not Met - Inpt Admissions (non BH)	105	38%
Trend 3: Other - Medical Necessity	11	9%	Trend 3: No Authorization submitted	35	13%

MCOs' SFH Reversed Decisions
Member/Provider – CY16 3rd Quarter

Amerigroup 4th Quarter					
Total # of Member SFH	3		Total # of Provider SFH	41	
OAH reversed MCO decision	2	67%	OAH reversed MCO decision	0	0%

Sunflower 4th Quarter					
Total # of Member SFH	13		Total # of Provider SFH	18	
OAH reversed MCO decision	2	15%	OAH reversed MCO decision	0	0%

United 4th Quarter					
Total # of Member SFH	4*		Total # of Provider SFH	31	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

* The four decisions reversed by OAH involved HCBS beneficiaries.

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 fourth quarter of 2016 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.

   Following updates to critical incident definitions and major updates and revisions to the AIR database, the testing phase is complete and provider training is underway. The development of an AIR training video is underway and will be posted to the KDADS website upon completion. AIR reporting access has expanded from a provider reporting tool to a public reporting tool.

Previous confidentiality concerns have been remedied through limits on historical information and a worklist assignment process to ensure MCOs are only able to access reports for their members.

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 2016 AIRS reports through the quarter ending December 31, 2016, follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	263	394	585	1134	2376
Pending Resolution	1	3	24	25	53
Total Received	264	397	609	1159	2429
APS Substantiations*	69	65	72	74	280

**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 State received approval of Attachment J on November 16. The third quarter HCAIP pool payments were made on November 4, 2016 and the fourth quarter HCAIP Pool payments were made on December 2, 2016. The LPTH/BCCH Pool third and fourth quarter payments were processed on November 10, 2016. The attached Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the third and fourth quarters.

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 fourth quarter of 2016, 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. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December, 2016, is attached.

b. Waiting List Management

PD Waiting List Management

For the quarter ending September 30, 2016:

- Current number of individuals on the PD Waiting List: 822
- Number of individuals added to the waiting list: 412
- Number of individuals removed from the waiting list: 594
    - 304 started receiving HCBS-PD waiver services
    - 15 were deceased
    - 275 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending December 31, 2016:

- Current number of individuals on the I/DD Waiting List: 3550
- Number of individuals added to the waiting list: 15
- Number of individuals removed from the waiting list: 28
    - 19 started receiving HCBS-I/DD waiver services
    - 9 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 8,918 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
III	Summary of Annual Public Forum
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 12.31.16
X(e)	Summary of KanCare Ombudsman Activities for QE 12.31.16
XI	KanCare Safety Net Care Pool Report for QE 12.31.16
XII	KFMC KanCare Evaluation Report for QE 12.31.16
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 12.31.16

XV. State Contacts

Dr. Susan Mosier, Secretary
Michael Randol, Division Director and Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3512 (phone)
(785) 296-4813 (fax)
Susan.Mosier@ks.gov
Michael.Randol@ks.gov

XVI. Date Submitted to CMS

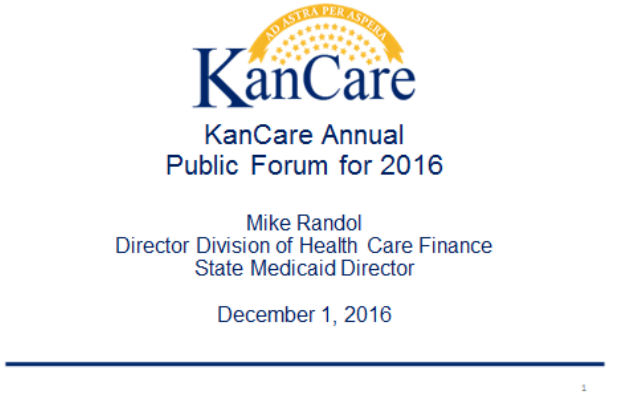
February 28, 2017

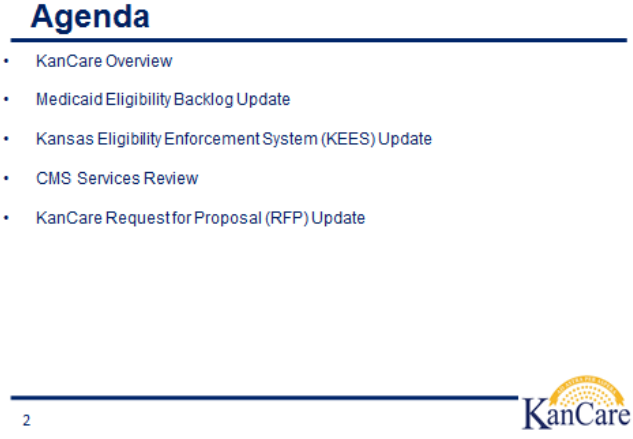
Summary of KanCare Annual Post Award Forum Held 12.01.16

The KanCare Special Terms and Conditions, at item #15, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. … The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC77, associated with the quarter in which the forum was held. The state must also include the summary of its annual report as required in STC78."

Consistent with this provision, Kansas held its 2016 KanCare Public Forum, providing updates and opportunity for input, on Thursday, December 1, 2016, from 3:00-4:00 pm at the Memorial Hall Auditorium, 2nd Floor, 120 SW 10th Avenue, Topeka, Kansas. The forum was published as a "Latest News – Upcoming Events" on the face page banner of the www.KanCare.ks.gov website, starting on October 25, 2016. A screen shot of the notice linked from the KanCare website face page banner is as follows:

At the public forum, approximately 28 KanCare program stakeholders (providers, members, and families) attended, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; and staff from the KanCare managed care organizations. A summary of the information presented by state staff is included in the following PowerPoint documents:





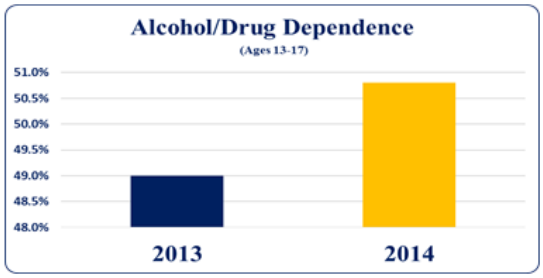
KanCare Goals

- Whole Person Care Coordination
- Clear Accountability
- Improved Health Outcomes
- Financial Sustainability

3

KanCare

Improved Alcohol/Drug Treatment

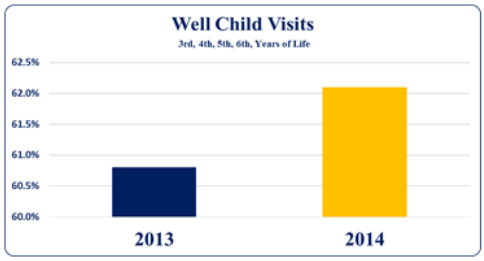


- **Alcohol/Drug Dependence**
  Initiation of treatment improved by 3.7% from 2013.

4

KanCare

Improved Well Child Visits

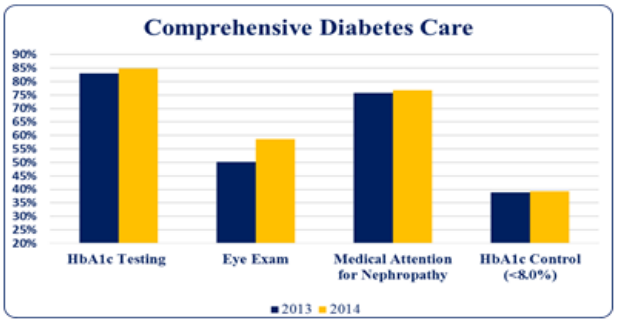


- **Well Child Visits**
  Children who attended their well child visit in the third, fourth, fifth, and sixth years of life increased 2.1% from 2013.

5

KanCare

Improved Diabetes Care



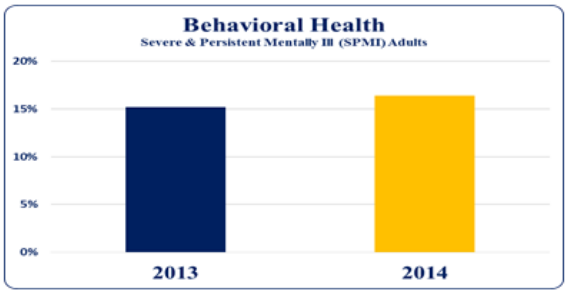
- **Comprehensive Diabetes Care**

  Diabetes Care measures have improved since 2013 and improved since old Medicaid measures in 2012.

6

KanCare

Improved Employment Status



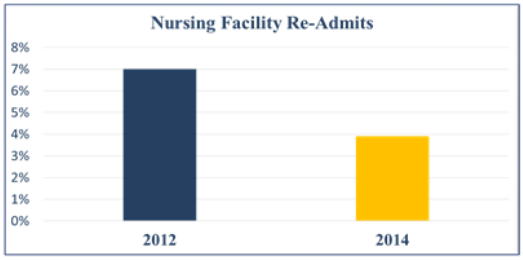
- **Behavioral Health**

  Severe and Persistent Mentally Ill adults (SPMI) competitively employed Q1 of 2014 increased by 1.3% into Q4 2014.

7

KanCare

Reduced NF Re-admits



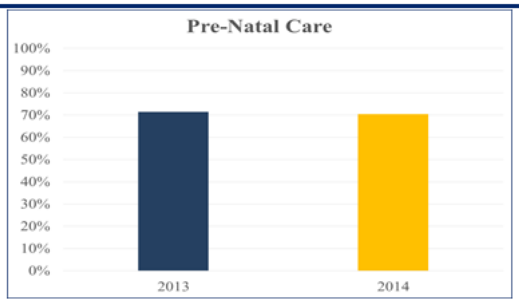
- **Nursing Facility Re-admits**

  The percentage of nursing facilities' (NF) Medicaid members readmitted to a hospital decreased by 44% from 2012 to 2014.

8

KanCare

Decrease in Pre-Natal Care



- Pre-Natal Care

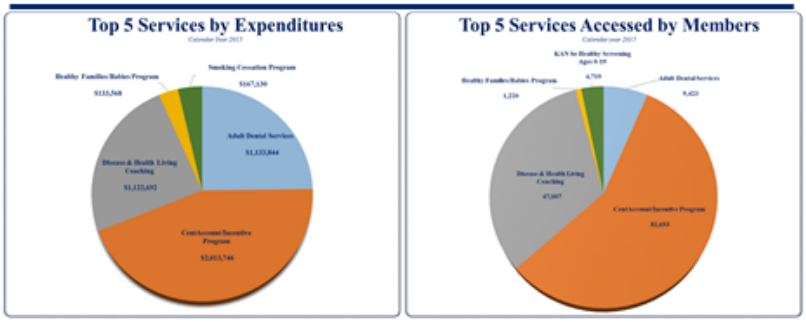
  Over 70% of pregnant women continue to get pre-natal care.

9

KanCare

KanCare New Services

At No Cost to the State



- In 2015, 133,012 members received value added services; this was an increase of 32% since 2014.
- Since the beginning of KanCare, members have been provided over $12 million dollars in total value of services **at no cost to the state.**
- These services were not available to members under old Medicaid.

10

KanCare

KanCare Utilization

- Members have used their Primary Care Physician 24% more with KanCare.
- Members are more likely to attend their appointments; Transportation up 33%.
- Costly inpatient hospital stays have been reduced by 23%.
- Emergency Room use down by 1%.

KanCare Utilization	
KanCare (2015) vs. Pre Kancare (2012)	
Type of Service	% Utilization Difference
Primary Care Physician	24%
Transportation	33%
Outpatient Non-ER	10%
Inpatient	-23%
Outpatient ER	-1%
Dental	32%
Pharmacy	7%
Vision	15%

11

KanCare

Waiver Utilization

- Waiver members have used their Primary Care Physician 80% more with KanCare.
- Members are more likely to attend their appointments; Non-Emergency transportation up 56%.
- Costly inpatient hospital stays have been reduced by 29%.
- Emergency Room use down by 7%

KanCare Waiver	Utilization
KanCare 2015 v. Pre KanCare 2012	
Type of Service	% Utilization Difference
Primary Care Physician	80%
Transportation	56%
Outpatient Non-ER	10%
HCBS Services	34%
Inpatient	-29%
Outpatient ER	-7%
Dental	36%
Pharmacy	2%
Vision	14%

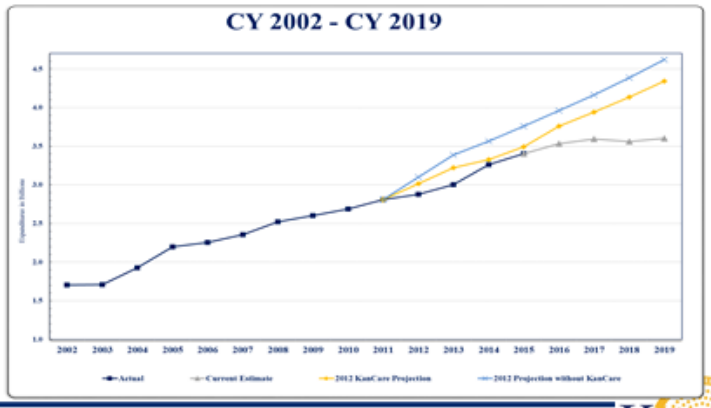
*SED, DD, PD, FE, Autism, TA, and TBI

12

KanCare

KanCare Cost Comparison

KanCare has produced more than $1.4B in savings to the state. A portion of these savings has allowed us to invest in eliminating the PD waiver, as of August 2016, and reducing the DD waiver waiting lists.



13

KanCare

If Waivers were to be Carved Out

- Two Scenarios:
  1. If State takes over care coordination services -
     - Over $180M in additional care and staffing costs would be incurred over 5 years.
     - Over 400 staff would be needed to perform services and manage recipients.
  2. If care coordination services go back to pre-KanCare levels -
     - Over $340M in additional care and staffing costs would be incurred over 5 years.

14

KanCare

Backlog Update

- Resolution Activities
  - System Update and Enhancements
  - Staffing Increases
  - Process Improvements

15 KanCare

Active Backlog

- Active backlog is approximately 800 as of last CMS report

Total number of Other applications and redeterminations	
	> 45 days
Unprocessed Applications - Total	1970
- Unprocessed Applications - Pended	482
- Unprocessed Applications - IROD <45	approx. 700
= Unprocessed Applications - Approx	788

16 KanCare

Active Backlog Calculation Factors

- The report appears to show 1,970 applications are backlogged.
- 482 of these are pended and awaiting additional information from applicant.
- Approximately 700 are designated "Information Received on Denial". or IROD.
  - If an individual applies and is denied, and then reapplies, the system reports the original application date, not the date of the new application.
- Remainder, or about 800, represents Active backlog.

17 KanCare

System Enhancements & Updates

- Since Go-Live, KDHE and the KEES Vendor (Accenture) have developed and implemented 17 major system enhancements to improve system performance across these functional areas:
  - Eligibility
  - Customer Service
  - Imaging
  - Data Entry
  - Registration

18 KanCare

Staffing

- Clearinghouse vendor (Maximus) added 40 temporary staff for calendar year 2016 with additional 70 staff added in July.
  - 50 of these staff are specifically trained to process Family Medical applications.
  - This additional staff will also mitigate federally facilitated marketplace applications (FFM) from creating backlog.
- State has augmented staff by 20 temporary workers.
  - 12 of these are for registering FFM applications during the ACA open enrollment period.
- Staff working overtime as needed.

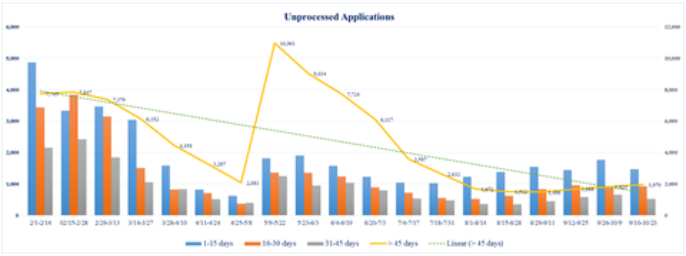
19 KanCare

Process Improvements

- Internal and external process reviews to identify work flow improvements:
  - Internal - continuously working to identify process improvement opportunities with state staff, Maximus and Accenture.
  - External — worked with process experts to assess workflow and identified and implemented a number of short-term and long-term improvements.
- Clearinghouse vendor installed a new call management system that better serves beneficiaries.
  - Since February 2016, the overall average speed to answer has declined from 27 minutes to about 46 seconds and the maximum wait time has declined from over 1 hour and 22 minutes to less than 11 minutes.

20 KanCare

Backlog Trend



KanCare

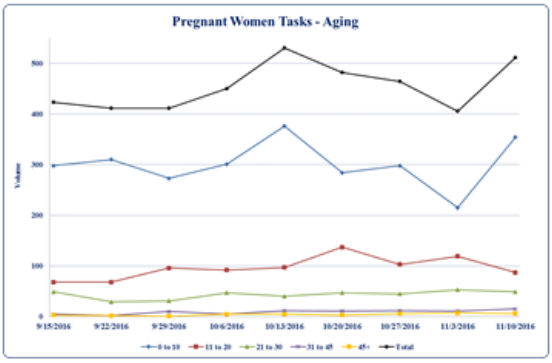
Backlog Reduction

- Trend has been consistent since March after some of the fixes were put into place.
- The increase in May was due to a reporting issue which was identified and rectified.
- Current reporting reflects all 45+ day and over applications which include:
  - Pended SSI
  - Information Received on Denial (IROD)
  - Pended waiting for additional information from applicant
  - Active Backlog over 45+ days

KanCare

Trends for Pregnant Women

- 70% of pregnant women cases are processed in less than 10 days.
- 96% of pregnant women cases are processed in less than 30 days.
- 4% of the cases are on hold waiting for additional information from the applicant.



KanCare

Pregnant Women Facts

- **Pregnant women who meet the criteria for presumptive eligibility, will receive coverage for prenatal and/or emergency room visits until a final determination has been completed.**
- Hospitals and clinics that have completed or scheduled training for the Presumptive Eligibility system:

  Children's Mercy Hospital
  Community Health Center of Southeast Kansas
  GraceMed Health Clinic
  Hunter Health Clinic
  Via Christi Regional Medical Center
  Stormont Vail Healthcare Inc.

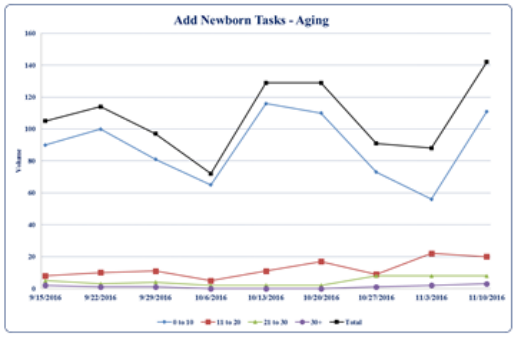
- These hospitals represent 12% of Medicaid births in 2015.
- We are in the process of enrolling and training additional hospitals in the Presumptive Eligibility System.

24

KanCare

Trends for Newborns

- 94% of all newborn cases are processed within 20 days.
- 78% of those are processed in less than 10 days.
- 6% are waiting additional information from the applicant.



25

KanCare

KanCare 2.0

- Extending request for proposal (RFP) development
  - Looking at exciting possibilities around potential future reforms
  - Identifying opportunities that will enhance KanCare's position as a model program for the nation
- Providing opportunities to greatly reduce provider burden and member satisfaction
  - Uniform credentialing requirement
  - Care Coordination services
    - Timing
    - Level of Interaction
    - Documentation
  - Value-Based Purchasing Guidance
  - More meaningful access to data to monitor and manage MCOs
- Currently working with vendor on drafting of RFP

26

KanCare

Thank You

27

KanCare

Kansas
Department for Aging
and Disability Services

KanCare Annual Public Forum for 2016

December 1, 2016

I/DD Waiting List: Current Efforts

IDD Waiting List Management

- 8,976 on the HCBS IDD Program as of 10/13/16
- Waiting List: 3,528
- 250 People offered services

PD Waiting List Management

- 6,210 on the HCBS PD Program as of 10/13/2016
- Waiting List 350
- Underserved wait list was eliminated in 2014
- The HCBS Monthly Summary is posted on the HCBS page at www.kdads.ks.gov

2

KanCare

Physical Disability Waitlist

Waitlist Accountability

- Agency continues to hear anecdotal stories that people did not get offers of service
- KDADS is trying to locate these individuals and encourage them contact us
- To date, we have not been contacted by anyone on waitlist who has not received services as expected when waitlist was cleared
- This not only a KDADS issue, this is a state issue that needs to be solved
- We want to partner with advocates and families in order to identify anyone not receiving services so we will be able to provide services to anyone who is eligible.

KanCare

Autism Services:

Waiver Renewal:

- Recently submitted autism waiver renewal application
- 62 currently receiving services; more children will get services because of transfer of some autism waiver services to the State Plan under the new waiver
- **Key Changes:**
- Three behavioral services transferred from waiver to the State Plan
- The goal is to work with families to provide the right plan of services and care
- We expect a significant reduction in proposed recipient list
- More children will receive early intervention Autism services

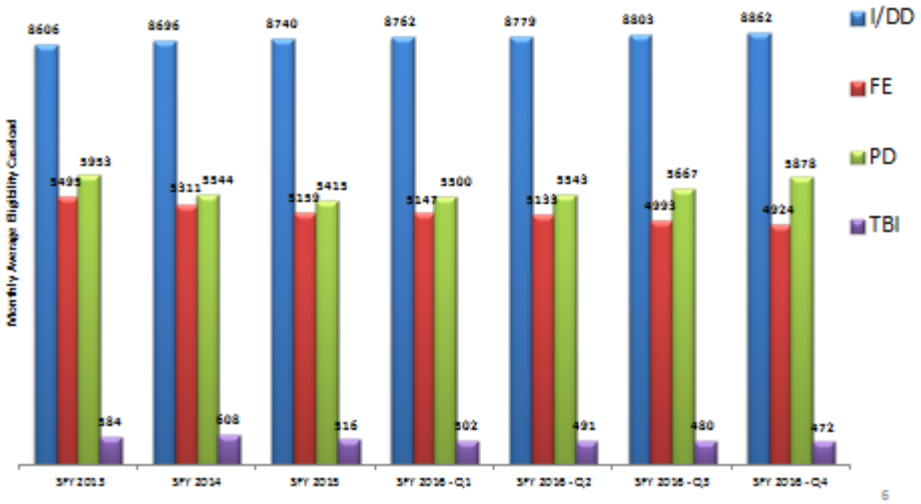
KanCare

Serious Emotional Disturbance:

- **Waiver Renewal:**
- KDADS is working on the waiver renewal application for the SED waiver
- CMS has approved a 90-day extension 2016 due to concerns about conflict of interest.
  - Currently the CMHC provides all eligibility determinations, plan of care development, and provision of services.
  - CMS has said the CMHC cannot continue to perform all these tasks.
  - KDADS is working with CMS to determine specifically what CMS will require to address conflict of interest.

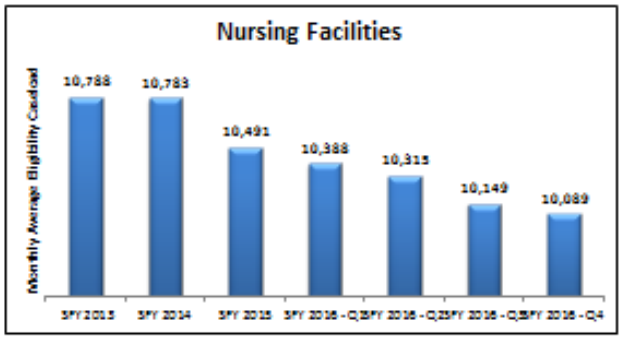
KanCare

Average Monthly Caseload for State Institutions and Long-Term Care Facilities



6

Average Census for Long-Term Care Facilities



7

After presentation of the update information from both KDHE and KDADS, participants were offered the opportunity to present questions or comments for discussion, either in writing or verbally. No questions or comments were presented, and the 2016 public forum was concluded.

DY 4
Start Date: 1/1/2016
End Date: 12/31/2016

Quarter 4
Start Date: 10/1/2016
End Date: 12/31/2016

	Total Expenditures	Total Member-Months
Oct-16	$243,636,000	378,213
Nov-16	$242,011,602	375,359
Dec-16	$246,641,421	373,216
Q4 Total	$732,289,024	1,126,788

ADMIN SUMMARY	
	Expenditures
DY4Q4	

	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
Oct-16									
Expenditures	$1,439,914	$36,675,336	$27,907,194	$54,401,209	$37,202,350	$70,847,543	$814,218	$2,052,516	$12,295,719
Member-Months	6,944	36,966	55,933	240,983	9,018	21,304	1,266	1,217	4,582
Nov-16									
Expenditures	$1,510,592	$36,196,867	$25,368,404	$53,097,654	$40,276,486	$70,248,079	$835,220	$2,130,273	$12,348,027
Member-Months	7,795	37,562	55,105	236,462	9,080	21,640	1,567	1,415	4,733
Dec-16									
Expenditures	$1,512,327	$36,850,564	$27,842,242	$53,820,027	$40,930,599	$70,716,867	$738,844	$2,217,196	$12,012,755
Member-Months	7,716	38,019	55,146	233,900	9,278	21,384	1,476	1,519	4,778
Q4 Total									
Expenditures	$4,462,833	$109,722,767	$81,117,840	$161,318,890	$118,409,435	$211,812,489	$2,388,282	$6,399,986	$36,656,501
Member-Months	22,455	112,547	166,184	711,345	27,376	64,328	4,309	4,151	14,093
DY 4 - Q4 PMPM	$199	$975	$488	$227	$4,325	$3,293	$554	$1,542	$2,601

Note:

1. DY4Q4: Decrease in Expenditures and Member-Months for Adults and Children due to eligibility discontinuance process.

KanCare Ombudsman Quarterly Report

KDHE

Kerrie J. Bacon, KanCare Ombudsman
4th Quarter Report

Accessibility of 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 the fourth quarter of 2016. Fourth quarter is basically flat to the average of the prior two years.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	Qtr. Avg. for 2014/2015 is 521
2016	1130	846	687	523	
% increase	117%	63%	32%	0.4%	

To assist with the increase in contacts, the Ombudsman's office had the following assistance:

- Wichita satellite office opened in November 2015 and was staffed with volunteers from 10-2, Monday- Friday along with a ¾ time Project Coordinator who supervised the volunteers, assisted with phone coverage, and provided outreach. There are currently 7 volunteers at the Wichita satellite office.
- During March of 2016, the Ombudsman's office added one part-time staff person assisting with phone calls and emails (10-12 hours/week) from the Governor's office.
- Johnson County satellite office opened in July 2016 and has been staffed with volunteers Monday and Thursday, 10am – 1pm. There are currently 4 volunteers at the Olathe satellite office.

MCO related	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Amerigroup	53	69	63	45	92	46	45	31
Sunflower	96	92	72	62	92	57	59	46
UnitedHealthcare	75	47	52	32	66	47	37	31
Total	**224**	**208**	**187**	**139**	**250**	**150**	**141**	**108**

The KanCare Ombudsman webpage ***(www.kancare.ks.gov/kancare-ombudsman-office)*** is ***NEW and UPDATED***. It continues to provide information and resources to members of KanCare and consumers. It is updated on a regular basis.

Outreach by Ombudsman's Office

- Keynote speaker for Silver-haired Legislature, October 4, 2016
- Provided a report and testimony for the Robert Bethel Joint Committee on HCBS and KanCare Oversight, November 18, 2016
- Attended Consumer and Specialized Issues Workgroup meeting (KDHE), December 15, 2016
- **Publications:** Outreach post and/or article about the KanCare Ombudsman office services.
  - Livable Neighborhoods Neighborhood News (Wyandotte Co. newsletter) (October & November)
  - Active Age newsletter – Wichita, KS (October)
  - Shepherd's Center of Kansas City, KS (November)
  - 2Mas2KC Bilingual Newspaper (November)
  - Public Service Announcement (Voice: Daniel Lassley) went out to all Kansas City radio stations. (November)
  - Senior Bluebook (Kansas City, KS and Kansas City, MO) (December)
  - Center for Public Health Initiatives Newsletter, Wichita (December-January)
- **Local Churches:** These churches agreed to post our flyers and to provide members with KanCare Ombudsman office brochures.
  - Bethel Baptist Church, Wyandotte, KS (October)
  - Eighth Street Baptist Church, Wyandotte, KS (October)
  - First Baptist Church, Wyandotte, KS (November)
  - Mt Zion Baptist Church, Wyandotte, KS (November)
  - St. Marks United Methodist Church, Wichita, KS (October)
  - New Spring Church, Wichita, KS (October)
  - River Community Church, Wichita, KS (October)
  - All Saints Church, Wichita, KS (November)
- **Presentations:** (educational, networking, referrals, advertisement
  - Livable Neighborhoods Task Force meeting (Wyandotte Co.) (October)
  - InterHab Conference (October)
  - Social Work Classes presentations (WSU – 10/26 & 11/2)
  - K-State Research & Extension office (Linn Co.) (November)
  - Franklin County Aging and Disability Network monthly group meeting (December)
- **Educating Kansas Area Agencies on Aging about the KanCare Ombudsman office**: (networking, referrals, advertisement)
  - Wyandotte/Leavenworth Area Agency on Aging (November)
  - East Central Kansas Area Agency on Aging (November)
  - Northeast Kansas Area Agency on Aging (November)
  - Northeast Kansas Area Agency on Aging (November)
- Friends and Family Advisory Council which met six times during the 2016 year.

- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians, consumers and other interested parties. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed.

Outreach through the KanCare Ombudsman Volunteer Program

- The ***KanCare Ombudsman Johnson County Satellite Office*** is in its third quarter of providing assistance to KanCare members.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** completed a full year of providing assistance to KanCare members. Two of the volunteers at the site have been there since it opened and are charter volunteer members!
- Both Satellite offices are assisting consumers with filling out applications on the phone and by appointment in person.
- Volunteer Applications are available on the new and updated KanCare Ombudsman webpage: www.KanCare.ks.gov/kancare-ombudsman-office.

Data from Ombudsman's Office

The Ombudsman on-line tracker has been updated to include the main Ombudsman office and Ombudsman satellite offices covered by volunteers. ***Starting with the fourth quarter report,*** we are able to provide the number of contacts made to the main office and the Ombudsman's satellite offices across Kansas.

Contacts by Office	Q4/16
Main	432
Johnson County	21
Wichita	70
Total	**523**

The contact method for members to contact the Ombudsman's office has changed from 2015 to 2016. In 2015, contacts by phone were between 80% - 84%; by email they were between 16% - 19%. In 2016, contacts by phone were down and email contacts were up, percent to total. This held true even in fourth quarter, 2016 when actual contacts were similar to the average of the last two years.

Contact Method	Q1/15	%	Q2/15	%	Q3/15	%	Q4/15	%	Q1/16	%	Q2/16	%	Q3/16	%	Q4/16	%
phone	415	81%	378	82%	462	80%	438	84%	862	76%	644	76%	507	74%	394	75%
email	94	18%	82	18%	112	19%	83	16%	265	23%	191	23%	174	25%	125	24%
letter	1	0%	1	0%	0	0%	2	0%	2	0%	3	0%	1	0%	0	0%
in person	0	0%	1	0%	5	1%	1	0%	0	0%	8	1%	3	0%	3	1%
online	0	0%	0	0%	0	0%	0	0%	1	0%	0	0%	2	0%	1	0%
Total	**510**	**100%**	**462**	**100%**	**579**	**100%**	**524**	**100%**	**1130**	**100%**	**846**	**100%**	**687**	**100%**	**523**	**100%**

Caller Type	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Provider	111	94	102	93	179	110	100	71
Consumer	366	343	426	385	866	601	544	352
MCO employee	3	3	5	3	7	4	10	8
Other	30	22	46	43	78	131	33	92
Total	**510**	**462**	**579**	**524**	**1130**	**846**	**687**	**523**

Contact Information. The average number of days it took to resolve an issue during third quarter was six.

	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Avg. Days to Resolve Issue	7	7	11	6	7	5	6	4
% files resolved in one day or less	54%	38%	36%	45%	49.6 %	56%	54%	52%
% files closed	87%	88%	93%	83%	77%	88%	87%	80%

The most frequent calls regarding home- and community-based services (HCBS) waivers during the fourth quarter of 2016, most of 2016 and for all of 2015 were concerning the physical disability waiver and the intellectual/developmental disability waiver. Occasionally more than one option can be chosen, for example when mental health or substance abuse might be included in addition to a waiver or a nursing facility.

Waiver	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
PD	57	48	33	28	48	22	13	9
I/DD	35	25	29	28	48	27	21	11
FE	15	12	16	18	23	19	10	7
Autism	4	3	4	5	1	2	2	1
SED	1	7	5	4	4	0	1	3
TBI	10	9	7	9	10	3	7	5
TA	11	13	11	13	10	9	4	4
MFP	2	2	3	1	8	5	3	0
PACE	0	0	1	1	0	0	0	0
Mental Health	5	9	7	11	8	6	3	2
Substance Use Disorder	0	0	0	2	0	0	0	0
Nursing Facility	12	28	33	29	47	27	16	27
Other	512	320	443	391	941	739	612	456
Total	**664**	**476**	**592**	**540**	**1148**	**859**	**692**	**525**

The Issue Categories listed below reflect the last eight quarters in alphabetical order. The top five issues for each quarter are highlighted. The issues that carry across many quarters are Medicaid Eligibility Issues, Other and Billing. There may be multiple issues for a member/contact.

New issue categories were added at the beginning of first quarter to assist with lowering the number of “Other” and better identifying contacts/issues that are of concern to members. The new categories will be: Affordable Care Act, Client Obligation, Division of Assets, Estate Recovery, Medicaid Application Assistance (for help with filling out an application or answering questions on an application), Medicaid Coding, Medicaid Renewal, and Moving to/from Kansas. The new issues will be reflected in first quarter results.

Issues	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Access to Providers	3	11	1	12	7	6	9	13
Appeals, Grievances	42	33	47	26	49	42	36	16
Billing	36	40	41	30	43	39	37	26
Care Coordinators	10	8	9	8	7	3	6	4
Change MCO	8	4	10	9	15	3	0	6
Dental	7	5	1	4	4	5	5	5
Durable Medical Equipment	25	12	7	8	7	7	2	4
Guardianship Issues	5	1	2	1	0	1	2	2

Issues	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
HCBS Eligibility issues	11	15	24	30	45	33	21	9
HCBS General Issues	60	36	54	34	69	32	16	15
HCBS Reduction in hours of service	10	8	13	16	12	4	3	3
HCBS Waiting List issues	11	8	9	11	18	2	2	4
Housing issues	1	6	4	3	8	2	2	3
Medicaid Eligibility Issues	139	108	206	182	512	244	173	174
Medical Services	20	24	27	21	29	20	10	12
Nursing Facility Issues	15	34	34	29	40	25	22	22
Other	130	150	141	149	332	377	381	224
Pharmacy	25	33	14	20	24	13	11	8
Questions for Conf Calls	5	2	0	1	0	0	1	2
Thank you	14	15	11	12	72	85	114	100
Transportation	12	17	8	7	6	8	6	1
Unspecified	31	12	36	21	79	38	21	17
Total	620	582	699	634	1378	989	880	670

Action Taken to Resolve Issues by Ombudsman's Office

The Resource Category below shows what action was taken and what contacts were made on behalf of a member or potential member to resolve an issue and what resources where provided. A "Question/Issue is resolved" if it is answered without having to make a contact, refer to another resource, or provide a resource for assistance. If we "Use contacts or resources/issues to resolve" an issue, then one of the other categories below is also noted to indicate which agency or organization was accessed to find the help needed, which resource the member may have been referred to, and/or documents provided. Often multiple resources are provided to a member/contact.

Resource Category	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Question/Issue Resolved	84	61	65	58	122	239	233	214
Used Contacts or Resources/Issues Resolved	262	234	321	296	463	394	313	166
KDHE Contacts	95	77	124	87	214	97	97	111
DCF Contacts	20	13	25	37	6	2	1	4
MCO Contacts	79	73	48	62	48	43	44	31
HCBS Team Contacts	32	43	36	29	28	21	12	5
CSP Mental Health Team Contacts	0	1	0	2	1	1	0	0
Other KDADS Contacts	31	31	38	58	53	16	44	38
Provided Resources to Member	85	108	177	184	361	239	115	88

Resource Category	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Referred to State/Community Agency	22	54	75	72	111	40	53	14
Referred to DRC and/or KLS	26	16	19	5	13	7	4	3
Closed	14	29	60	72	198	313	111	17
Total	**750**	**740**	**988**	**962**	**1618**	**1412**	**1027**	**691**

Managed Care Organization Issues: by Category, by Quarter

Highlighted are the top four- five issues for each quarter over the last eight quarters for each managed care organization. The issues are sorted in alphabetical order. If there are more than four issues highlighted for a quarter, it is because there was a tie for the fourth place, so the additional issue(s) was included. There may be multiple issues for a member/contact.

Amerigroup

Issue Category - Amerigroup	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Access to Providers (usually Medical)	0	1	0	1	1	1	2	2
Appeals / Grievances	3	9	5	1	9	5	1	0
Billing	10	12	7	10	11	6	7	2
Care Coordinator Issues	1	3	3	3	4	1	3	1
Change MCO	2	1	4	2	1	1	0	0
Dental	2	0	0	11	0	0	1	1
Durable Medical Equipment	2	2	0	0	2	2	1	1
Guardianship	1	0	0	0	0	0	0	0
HCBS Eligibility issues	0	2	9	4	8	5	4	0
HCBS General Issues	14	12	12	3	13	3	3	3
HCBS Reduction in hours of service	0	0	5	6	6	1	1	1
HCBS Waiting List	2	2	3	2	0	0	0	1
Housing Issues	0	1	1	1	1	1	0	1
Medicaid Eligibility Issues	9	4	10	2	28	8	5	6
Medical Services	1	4	2	2	7	2	3	1
Nursing Facility Issues	2	1	5	5	2	1	0	1
Other	10	20	11	3	19	16	20	10
Pharmacy	1	4	2	1	3	1	0	2
Questions for Conference Calls/Sessions	0	0	0	4	0	0	0	0
Thank you.	0	0	1	1	6	4	9	5
Transportation	1	7	4	0	2	1	1	0
Unspecified	2	0	5	1	2	0	0	1
Total	**63**	**85**	**89**	**63**	**125**	**59**	**61**	**39**

Sunflower

Issue Category - Sunflower	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Access to Providers (usually Medical)	0	3	0	8	1	1	2	0
Appeals / Grievances	22	15	18	4	14	11	8	2
Billing	13	11	9	6	6	7	9	7
Care Coordinator Issues	2	3	3	2	2	1	1	2
Change MCO	3	1	3	6	3	1	0	1
Dental	1	3	0	1	1	2	0	0
Durable Medical Equipment	10	7	1	9	5	2	0	2
Guardianship	0	0	1	3	0	0	0	0
HCBS Eligibility issues	2	6	1	0	3	7	3	2
HCBS General Issues	22	9	10	0	15	9	1	5
HCBS Reduction in hours of service	4	4	4	7	0	3	1	0
HCBS Waiting List	0	0	2	1	1	0	0	0
Housing Issues	0	2	0	0	0	0	0	0
Medicaid Eligibility Issues	17	16	13	12	26	7	10	9
Medical Services	5	7	7	4	4	8	0	3
Nursing Facility Issues	3	3	3	0	3	3	2	1
Other	14	19	14	2	23	12	24	16
Pharmacy	7	16	5	2	4	1	4	4
Questions for Conference Calls/Sessions	1	0	0	0	0	0	0	0
Thank you.	4	3	5	1	7	6	8	11
Transportation	3	4	1	6	1	2	4	1
Unspecified	3	0	1	7	1	0	0	0
Total	**136**	**132**	**101**	**81**	**120**	**83**	**77**	**66**

UnitedHealthcare

Issue Category – UnitedHealthcare	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Access to Providers (usually Medical)	2	4	1	2	2	1	0	2
Appeals / Grievances	11	3	6	0	6	4	5	1
Billing	5	5	7	2	3	5	2	3
Care Coordinator Issues	5	2	2	9	0	0	2	1
Change MCO	2	1	1	0	3	0	0	4
Dental	2	1	0	1	1	3	2	0
Durable Medical Equipment	6	1	2	1	0	1	0	0

Issue Category – UnitedHealthcare	Q1/15	Q2/15	Q3/15	Q4/15	Q1/16	Q2/16	Q3/16	Q4/16
Guardianship	1	0	0	4	0	0	0	1
HCBS Eligibility issues	3	1	4	1	6	3	2	0
HCBS General Issues	11	6	7	3	11	5	2	3
HCBS Reduction in hours of service	4	2	2	1	2	0	0	2
HCBS Waiting List	3	0	1	0	2	1	1	0
Housing Issues	0	2	1	3	0	0	0	0
Medicaid Eligibility Issues	11	8	10	4	18	4	5	5
Medical Services	6	4	6	1	4	1	4	0
Nursing Facility Issues	4	4	4	0	2	1	2	2
Other	16	11	10	1	14	20	20	12
Pharmacy	8	6	2	0	7	2	4	0
Questions for Conference Calls/Sessions	1	0	0	1	0	0	0	0
Thank you.	2	1	0	1	5	8	6	9
Transportation	5	3	2	3	1	0	0	0
Unspecified	0	0	2	4	2	0	0	0
Total	**108**	**65**	**70**	**42**	**89**	**59**	**57**	**45**

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

- The Ombudsman Volunteer Coordinator, Lisa Churchill, and Ombudsman Project Coordinator, Percy Turner, will begin providing training to interested community service organizations regarding Medicaid. Trainings will be three one-hour trainings with topics such as: How to assist with Medicaid applications, Medicaid related resources, and KanCare programs and Home and Community Based Services overview. This is another way the Ombudsman's office is adding capacity to the Kansas Community.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 4 - QE December 2016

Health Care Access Improvement Pool

Paid 11/4/2016 and 12/2/2016

Hospital Name	HCAIP DY/QTR: 2016/4	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	95,035.00	41,615.83	53,419.17
Children's Mercy Hospital	503,261.00	220,377.99	282,883.01
Coffey County Hospital	38,899.00	17,033.87	21,865.13
Coffeyville Regional Medical Center	128,695.00	56,355.54	72,339.46
Doctors Hospital	2,854.00	1,249.77	1,604.23
Geary Community Hospital	215,789.00	94,494.00	121,295.00
Great Bend Regional Hospital	184,257.00	80,686.14	103,570.86
Hays Medical Center	488,354.00	213,850.22	274,503.78
Kansas Heart Hospital	55,943.00	24,497.44	31,445.56
Kansas Medical Center	28,789.00	12,606.70	16,182.30
Kansas Rehabilitation Hospital	2,630.00	1,151.68	1,478.32
Labette County Medical Center	140,559.00	61,550.79	79,008.21
Lawrence Memorial Hospital	478,828.00	209,678.78	269,149.22
McPherson Hospital	66,209.00	28,992.92	37,216.08
Meadowbrook Rehabilitation Hospital	64,246.00	28,133.32	36,112.68
Menorah Medical Center	369,986.00	162,016.87	207,969.13
Mercy Hospital - Independence	155,913.00	68,274.30	87,638.70
Mercy Hospital - Moundridge	12,957.00	5,673.87	7,283.13
Mercy Regional Health Center - Manhattan	390,793.00	171,128.25	219,664.75
Miami County Medical Center	99,626.00	43,626.23	55,999.77
Mid-America Rehabilitation Hospital	4,366.00	1,911.87	2,454.13
Morton County Hospital	14,369.00	6,292.19	8,076.81
Newton Medical Center	206,350.00	90,360.67	115,989.34
Olathe Medical Center	309,641.00	135,591.79	174,049.21
Overland Park Regional Medical Center	1,230,746.00	538,943.67	691,802.33
Pratt Regional Medical Center	59,551.00	26,077.38	33,473.62
Promise Regional Medical Center	212,956.00	93,253.43	119,702.57
Providence Medical Center	883,584.00	386,921.43	496,662.57
Ransom Memorial Hospital	130,036.00	56,942.76	73,093.24
Saint Catherine Hospital	437,738.00	191,685.47	246,052.53
Saint Francis Health Center	848,900.00	371,733.31	477,166.69
Saint John Hospital	146,645.00	64,215.85	82,429.15
Saint Luke's Cushing Memorial Hospital	223,592.00	97,910.94	125,681.06
Saint Luke's South Hospital	139,578.00	61,121.21	78,456.79
Salina Regional Health Center	378,500.00	165,745.15	212,754.85
Salina Surgical Hospital	7,562.00	3,311.40	4,250.60
Shawnee Mission Medical Center	1,566,830.00	686,114.86	880,715.14
South Central Kansas Regional Medical Center	96,270.00	42,156.63	54,113.37
Southwest Medical Center	196,511.00	86,052.17	110,458.83
Stormont-Vail Regional Health Center	2,110,878.00	924,353.48	1,186,524.52
Sumner Regional Medical Center	67,815.00	29,696.19	38,118.81
Susan B. Allen Memorial Hospital	227,581.00	99,657.72	127,923.28
Via Christi Hospital - Pittsburg	384,057.00	168,178.56	215,878.44
Via Christi Hospital - Wichita	3,859,393.00	1,690,028.19	2,169,364.81
Via Christi Hospital Wichita Saint Teresa	134,986.00	59,110.37	75,875.63
Via Christi Rehabilitation Hospital	61,845.00	27,081.93	34,763.07
Wesley Medical Center	2,749,708.00	1,204,097.13	1,545,610.87
Wesley Rehabilitation Hospital	4,916.00	2,152.72	2,763.28
Western Plains Medical Complex	248,224.00	108,697.29	139,526.71
Total	**20,466,751.00**	**8,962,390.26**	**11,504,360.74**

Safety Net Care Pool Report

Demonstration Year 4 - QE June 2016

Large Public Teaching Hospital\Border City Children's Hospital Pool

Paid 11/10/2016

Provider Name	LPTH/BCCH DY/QTR: 2016/4	State General Fund 1000 *	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,482,070.00	1,086,898.45	1,395,171.55
University of Kansas Hospital	7,446,207.00	3,260,694.05	4,185,512.95
Total	**9,928,277.00**	**4,347,592.50**	**5,580,684.50**

**IGT funds are received from the University of Kansas Ho*

Kansas Foundation for Medical Care, Inc

2947 SW Wanamaker Drive
Topeka, Kansas 66614-4193
Phone 785-273-2552
kfmc.org

February 20, 2017

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

RE: 2016 KanCare Evaluation Quarterly Report
Year 4, Quarter 4, October - December

Dear Ms. Ross:

Enclosed is the 4th Quarter 2016 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, Ph.D., MPA
Director of Quality Review & Epidemiologist

Enclosure

2016 KanCare Evaluation

Quarterly Report

Year 4, Quarter 4, October - December

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**February 20, 2017**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

Table of Contents

2016 KanCare Evaluation Quarterly Report

Year 4, Quarter 4, October - December

List of Tables

Tables:

KanCare Evaluation Quarterly Report
Year 4, Quarter 4, October – December 2016
February 20, 2017

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) on 8/24/2013; it was approved by CMS on 9/11/2013 and updated in March 2015. The Kansas Foundation for Medical Care, Inc. (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 and usefulness of the five-year KanCare demonstration managed care Medicaid program. Annual performance measures include baseline and cross-year comparisons; the first year of the KanCare demonstration, calendar year (CY) 2013, serves as a baseline year for most metrics. Data sources for assessing annual performance measures include administrative data, medical and case records, and consumer and provider feedback.

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the fourth quarter (Q4) CY2016 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 or AGP), Sunflower State Health Plan (Sunflower or SSHP), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare or UHC). 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 also 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% of all inquiries 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 counts, cumulative counts, and percentages 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. The call center reports also provide counts of customer service inquiries by inquiry type from members and providers each month.

Current Quarter and Trend over Time

In Q4 CY2016, 99.59% of the 83,581 member customer service inquiries received by the MCOs and 99.99% of the 37,278 provider customer service inquiries were resolved within two business days (see Table 1). During each quarter to date the two-day resolution rate exceeded 99.5%.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries, Q4 CY2016 compared to Q4 CY2015

	Member Inquiries		Provider Inquiries	
	Q4 CY2015	Q4 CY2016	Q4 CY2015	Q4 CY2016
Number of Inquiries Received	91,237	**83,581**	45,278	**37,278**
Number of Inquiries Resolved Within 2 Business Days	91,213	**83,237**	45,278	**37,274**
Number of Inquiries Not Resolved Within 2 Business Days	24	**345**	0	**4**
Percent of Inquiries Resolved Within 2 Business Days	99.97%	**99.59%**	100%	**99.989%**
Number of Inquiries Resolved Within 5 Business Days	91,237	**83,394**	45,278	**37,276**
Number of Inquiries Not Resolved Within 5 Business Days	0	**188**	0	**2**
Percent of Inquiries Resolved Within 5 Business Days	100%	**99.78%**	100%	**99.995%**
Number of Inquiries Resolved Within 15 Business Days	91,237	**83,538**	45,278	**37,278**
Number of Inquiries Not Resolved Within 15 Business Days	0	**43**	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	**99.95%**	100%	**100%**

In Q4 CY2016, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of inquiries within 15 business days: SSHP reported 100% of their member and provider inquiries were resolved within five business days; AGP reported 100% of their provider inquiries and 99.99% of their member inquiries were resolved within five days, and the three not resolved within five days were resolved within eight days. UHC reported 99.8% of member inquiries were resolved within 15 days; 43 member customer inquiries in Q4 CY2016 were reported as not resolved within 15 business days (37 in October and six in December).

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). SSHP added a category for Health Homes (which were discontinued beginning 7/1/2016); the 35 customer service inquiries reported in Q4 CY2016 as related to "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Table 2. Customer Service Inquiries from Members, CY2015 and CY2016

Member Inquiries	Q1-Q4 CY2016				CY2015	CY2016
	Q1	Q2	Q3	Q4		
1. Benefit Inquiry – regular or VAS	21,924	22,319	21,652	**18,152**	77,119	**84,047**
2. Concern with access to service or care; or concern with service or care disruption	1,934	1,716	1,681	**2,484**	7,101	**7,815**
3. Care management or health plan program	1,597	1,584	1,363	**1,177**	11,175	**5,711**
4. Claim or billing question	6,416	6,381	5,557	**4,838**	27,869	**23,192**
5. Coordination of benefits	3,280	2,964	3,467	**2,724**	12,444	**12,435**
6. Disenrollment request	606	600	635	**458**	2,371	**2,299**
7. Eligibility inquiry	18,002	13,478	12,555	**13,006**	55,717	**57,041**
8. Enrollment information	3,203	2,396	2,558	**2,632**	9,560	**10,789**
9. Find/change PCP	12,893	12,488	12,906	**8,586**	53,581	**46,873**
10. Find a specialist	3,512	3,375	3,320	**2,787**	15,249	**12,994**
11. Assistance with scheduling an appointment	30	47	74	**40**	148	**191**
12. Need transportation	1,326	1,200	1,214	**1,232**	6,223	**4,972**
13. Order ID card	6,958	6,453	7,263	**5,318**	26,038	**25,992**
14. Question about letter or outbound call	1,322	1,961	1,338	**1,143**	4,405	**5,764**
15. Request member materials	1,083	1,119	976	**920**	4,759	**4,098**
16. Update demographic information	12,944	13,343	14,985	**11,356**	51,491	**52,628**
17. Member emergent or crisis call	699	687	597	**676**	3,150	**2,659**
18. Other	5,018	4,491	4,918	6,052	22,598	**20,479**
Total	**102,742**	**96,632**	**97,059**	**83,581**	**390,998**	**379,989**

- In CY2016, there were 11,009 fewer member inquiries than in CY2015. Member inquiries related to "Benefit inquiry" had the highest increase in CY2016, with 6,928 more inquiries than in CY2015; "Find/change PCP" had the greatest decrease, with 6,708 fewer inquiries in CY2016.
- Benefit inquiries in Q4, as in previous quarters, had the highest percentage (21.7%) of member inquiries
- Of the 83,581 member customer service inquiries in Q4 CY2016, 46.3% were received by SSHP, 32.6% by UHC, and 21.1% by AGP.
- In Q4 CY2016, the total number of inquiries was lower than the previous seven quarters and lower in nine of the 18 categories ("Care management or health plan program," "Claim or billing question," "Coordination of Benefits," "Disenrollment request," "Find/change PCP, Order ID card," "Request member materials," and "Update demographic information"). One member inquiry category ("Concern with access to service or care; or concern with service or care disruption") was higher in Q4 than in the previous seven quarters.

- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO; three of the seven categories with over two-thirds of the inquiries reported by one MCO for eight or more quarters. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:
  - "Care management or health plan program" – 83.3% of 1,177 inquiries in Q4 CY2016 were reported by AGP. (CY2016: Q3 – 86.4%, Q2 – 82.1%);
  - "Concern with access to service or care; or concern with service or care disruption" – 80.2% of 2,484 inquiries were reported in Q4 CY2016 by SSHP. (CY2016: Q3 – 75.1%, Q2 – 69.7%);
  - "Member emergent or crisis call" – 99.3% of 676 inquiries in Q4 CY2016 were reported by SSHP. (CY2016: Q3 – 99.2%, Q2 – 99.6%, Q1 99.7%; CY2015: Q4 – 99.4%, Q3 – 99.4%, Q2 - 99.8%; Q1 – 99.7%; CY2014: Q4 – 99.7%);
  - "Update demographic information" – 78.2% of 11,356 inquiries in Q4 CY2016 were reported by SSHP. (CY2016: Q3 – 79.2%, Q2 – 78.9%, Q1 – 78.1%; CY2015: Q4 – 81.4%, Q3 – 82.1%, Q2 - 82.3%, Q1 – 82.1%; CY2014: Q4 – 71.0%);
  - "Enrollment information" – 77.9% of 2,632 inquiries were reported in Q4 CY2016 by AGP. (CY2016: Q3 – 69.3%, Q2 – 75.8%, Q1 – 85.4%; CY2015: Q4 – 80.5%, Q3 – 76.8%, Q2 - 76.4%, Q1 CY2015 - 76.6%; CY2014: Q4 – 80.5%);
  - "Need transportation" – 77.1% of 1,232 inquiries were reported in Q4 CY2016 by AGP (a 60% increase compared to the previous two quarters); and
  - "Other" – 66.6% of 6,052 inquiries were reported in Q4 CY2016 by SSHP.

The member customer service inquiry 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 STC and GAR reports. In Q4 CY2016, the MCOs received 2,484 inquiries in this category (up from 1,681 in Q3) that were in addition to the grievances and appeals reported by members. The number of inquiries categorized as "Other" in Q4 (6,052) was also higher than the previous five quarters. The State should provide clear criteria to the MCOs for this category to ensure grievance and appeals contacts are not misclassified as customer service inquiries.

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). SSHP added a category for provider inquiries related to Health Homes; the six customer service inquiries reported in Q4 CY2016 as related "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

- In CY2016, there were 7.1% fewer provider inquiries than in CY2015, including 11,227 fewer claims-related inquiries (in multiple categories – see Tables 4 and 5).
- In Q4 CY2016, the total number of inquiries was lower than the previous seven quarters and lower in 10 of the 17 categories ("Authorization – New," "Benefits Inquiry," "Claim denial inquiry," "Claim status inquiry," "Billing inquiry," "Coordination of benefits," "Member eligibility inquiry," "Verify/change participation status," and "Credentialing issues").
- Of the 37,278 provider inquiries received by MCOs in Q4 CY2016, AGP received 42.4%, SSHP 44.8%, and UHC 12.8%.
- For providers, claim status inquiries were again the highest percentage (46.8%) of the 37,278 provider inquiries.

Table 3. Customer Service Inquiries from Providers, CY2015 and CY2016

Provider Inquiries	Q1-Q4 CY2016				CY2015	CY2016
	Q1	Q2	Q3	Q4		
1. Authorization – New	1,942	1,812	1,870	**1,735**	8,359	**7,359**
2. Authorization – Status	2,773	2,373	2,599	**2,610**	9,790	**10,355**
3. Benefits inquiry	3,259	3,121	3,273	**2,215**	16,587	**11,868**
4. Claim denial inquiry	5,605	4,423	5,540	**3,920**	19,081	**19,488**
5. Claim status inquiry	23,613	21,685	20,682	**17,442**	83,068	**83,422**
6. Claim payment question/dispute	4,575	4,142	3,725	**3,948**	22,975	**16,390**
7. Billing inquiry	596	389	407	**317**	1,958	**1,709**
8. Coordination of benefits	373	396	429	**332**	3,675	**1,530**
9. Member eligibility inquiry	2,030	1,646	1,754	**1,389**	7,169	**6,819**
10. Recoupment or negative balance	66	85	75	**41**	852	**267**
11. Pharmacy/prescription inquiry	598	529	583	**475**	2,113	**2,185**
12. Request provider materials	71	40	34	**35**	189	**180**
13. Update demographic information	744	710	549	**554**	2,215	**2,557**
14. Verify/change participation status	345	258	249	**243**	1,268	**1,095**
15. Web support	182	103	99	**122**	852	**506**
16. Credentialing issues	231	162	157	**119**	805	**669**
17. Other	1,918	1,441	1,784	**1,781**	5,679	**6,924**
Total	**48,921**	**43,315**	**43,809**	**37,278**	186,635	**173,323**

As noted in previous quarterly reports, there are a number of 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 Q4 were reported by one MCO included:

- "Authorization – New" – 99.4% of 1,735 inquiries in Q4 CY2016 were reported by AGP. (CY2016: Q3 – 98.3%, Q2 – 99.0%, Q1 – 99.0%; CY2015: Q4 – 98.6%, Q3– 98.0%, Q2– 99.1%, Q1– 99.1%; CY2014: Q4 – 98.1%);
- "Authorization – Status" – 72.0% of 2,610 inquiries in Q4 CY2016 were reported by AGP;
- "Update demographic information" – 97.7% of 554 inquiries were reported in Q4 CY2016 by SSHP. (CY2016: Q3 – 95.3%, Q2 – 95.4%, Q1 – 95.3%; CY2015: Q4 – 93.7%, Q3 – 96.2%, Q2 - 91.4%, Q1 - 95.5%; CY2014: Q4 - 99.5%);
- "Coordination of benefits" – 75.0% of 332 inquiries were reported in Q4 CY2016 by UHC. (CY2016: Q3 – 79.5%, Q2 – 77.5%, Q1 – 73.7%; CY2015: Q4 – 87.9%, Q3– 85.5%, Q2 - 76.8%, Q1 - 90.7%; CY2014: Q4 - 91.0%);
- "Web support" – 86.1% of 122 inquiries were reported in Q4 CY2016 by SSHP (CY2016: Q3 – 82.8%, Q2 – 77.7%, Q1 – 81.9%; CY2015: Q4 – 84.0%
- "Recoupment or negative balance" – 92.7% of 41 inquiries in Q4 CY2016 were reported by SSHP (CY2016: Q1 – 68.2%); and
- "Other" – 74.7% of 1,781 inquiries in Q4 CY2016 were reported by SSHP. (CY2016: Q3 – 71.5%, Q2 – 64.7%, Q1 – 74.7%).

Of the 17 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 by MCO over the last seven quarters. Combining the seven claims-related inquiries, as shown in Table 5, may allow a better comparison over time overall and by MCO.

Table 4. Maximum and Minimum Numbers of Claims-Related Provider Inquiries by MCO by Quarter, CY2016

	CY2016							
	Q1		Q2		Q3		Q4	
	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,923	3	1,793	3	1,839	7	1,725	0
Authorization - Status	1,932	66	1,604	91	1,661	126	1,879	48
Benefits Inquiry	1,648	755	1,542	514	1,519	582	1,364	359
Claim Denial Inquiry	3,593	0	2,574	0	3,798	0	2,234	0
Claim Status Inquiry	14,458	2,473	12,825	2,751	11,845	2,911	10,047	1,367
Claim Payment Question/Dispute	2,276	293	1,955	311	1,745	346	2,275	148
Billing Inquiry	426	0	194	1	247	2	170	0

Amerigroup | UnitedHealthcare
Sunflower | Amerigroup & Sunflower

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, CY2015 and CY2016

	CY2015					CY2016				
	Q1	Q2	Q3	Q4	Q1-Q4	Q1	Q2	Q3	Q4	Q1-Q4
Amerigroup	16,035	16,441	15,433	14,974	**62,883**	16,373	14,967	14,479	14,354	**60,173**
Sunflower	11,454	12,614	12,249	14,191	**50,508**	18,706	16,182	15,255	13,544	**63,687**
UnitedHealthcare	14,224	11,622	11,638	10,945	**48,429**	7,284	6,796	8,362	4,289	**26,731**
Total	**41,713**	**40,677**	**39,320**	**40,110**	**161,820**	**42,363**	**37,945**	**38,096**	**32,187**	**150,591**

Based on the combined totals for the seven claims-related categories, MCOs more clearly differed over time in the number of claims-related inquiries. Comparing CY2015 and CY2016:

- The total number of claims-related provider inquiries decreased by 6.9% in CY2016.
- UHC reported the fewest claim-related provider inquiries in CY 2015 and CY2016 and decreased by 44.8% from 48,429 in CY2015 to 26,731 in CY2016. The number of UHC claims-related provider inquiries was 55% to 58% fewer than the number of claims-related provider inquiries reported in CY2016 by AGP and SSHP.
- AGP reported the highest number of claims-related provider inquiries in CY2015, and SSHP reported the highest number in CY2016.
  - The number of claims-related provider inquiries reported by AGP decreased 4.3% from 62,883 in CY2015 to 60,173 in CY2016.
  - The number of claims-related provider inquiries reported by SSHP increased 26.1% from 50,508 in CY2015 to 63,687 in CY2016.

Recommendations (Timely Resolution of Customer Service Inquiries)

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. In particular:

1. The State should provide clear criteria to the MCOs for the member customer service category "*Concern with access to service or care; or concern with service or care disruption*" to ensure grievance and appeals contacts are not misclassified as customer service inquiries.
2. Clear criteria for the seven claims-related provider customer service inquiry categories should be provided by the State, and consistent implementation by the three MCOs is needed, to allow better comparisons by MCO and assessment of inquiry trends over time.

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 that are 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." In Table 6, the numbers of excluded claims are listed by quarter for each of the claim categories – clean claims, non-clean claims, and all claims.

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.

Clean claims received in the middle or end of a month may be processed in that month or the following month. 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 Q4 CY2016 assesses timeliness of processing clean, non-clean, and all claims reports received through Q3 CY2016.

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether or not 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 time (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.

Beginning in 2015, timeliness of claims processing metrics were added to the State's pay-for-performance (P4P) incentive program. Metrics in 2015 through 2017 include incentives for the MCOs to

- Process 99.5% of clean claims within 20 days (instead of the contractually required 30 days);
- Process 99% of all claims within 60 days (instead of the contractually-required 90 days);

- Decrease TATs for Home- and Community-Based Services (HCBS) clean claims; and
- Decrease TATs for Nursing Facility clean claims.

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. In Table 6, the number and percentages of clean, non-clean, and all claims processed within these contractual time periods are summarized.

Table 6. Timeliness of Claims Processing Q1 CY2015 to Q3 CY2016

	CY2015				CY2016		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Clean Claims							
Number of clean claims received in quarter	4,286,318	4,289,698	4,293,070	4,265,406	4,380,378	4,248,060	**4,052,640**
Number of claims excluded	0	149	332	2,269	263	88	**61**
Number of clean claims not excluded	4,286,318	4,289,549	4,292,738	4,263,137	4,380,115	4,247,972	**4,052,579**
Number of clean claims received within quarter processed within 30 days	4,285,468	4,286,617	4,289,231	4,261,301	4,378,159	4,246,507	**4,050,544**
Number of clean claims received within quarter **not** processed within 30 days	850	2,932	3,507	1,836	1,956	1,465	**2,035**
Percent of clean claims processed within 30 days	**99.980%**	**99.932%**	**99.918%**	**99.957%**	**99.955%**	**99.966%**	**99.950%**
Non-Clean Claims							
Number of non-clean claims received in quarter	180,925	164,617	150,266	176,809	198,558	157,210	**182,401**
Number of claims excluded	352	306	1,310	1,849	2,974	1,434	**1,344**
Number of non-claims not excluded	180,573	164,311	148,956	174,960	195,584	155,776	**181,057**
Number of non-clean claims received within quarter processed within 60 days	180,544	164,251	148,753	174,079	195,335	155,608	**180,909**
Number of non-clean claims received within quarter **not** processed within 60 days	29	60	203	881	249	168	**148**
Percent of non-clean claims processed within 60 days	**99.984%**	**99.963%**	**99.864%**	**99.496%**	**99.873%**	**99.892%**	**99.918%**
All Claims							
Number of claims received in quarter	4,467,243	4,454,315	4,443,336	4,442,215	4,578,936	4,405,270	**4,235,041**
Number of claims excluded	352	455	1,642	4,118	3,237	1,522	**1,405**
Number of claims not excluded	4,466,891	4,453,860	4,441,694	4,438,097	4,575,699	4,403,748	**4,233,636**
Number of claims received within quarter processed within 90 days	4,466,812	4,453,606	4,441,634	4,437,802	4,575,552	4,403,620	**4,233,492**
Number of claims received within quarter **not** processed within 90 days	79	254	60	307	147	118	**144**
Percent of claims processed within 90 days	**99.998%**	**99.994%**	**99.999%**	**99.993%**	**99.997%**	**99.997%**	**99.997%**

For claims received in Q3 CY2016:

- **Clean claims**: 99.950% of 4,052,579 clean claims received in Q3 CY2016 were reported by the MCOs as processed within 30 days.
  - In Q3 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q3 CY2016, the number of clean claims not processed within 30 days (2,035) increased compared to the three previous quarters.
  - Of the 2,035 clean claims not processed within 30 days – 920 (45.2%) were claims received by AGP; 740 (36.4%) were claims received by SSHP, and 375 (18.4%) were claims received by UHC.

- **Non-clean claims**: 99.918% of 181,057 non-clean claims received in Q3 CY2016 were reported by the MCOs as processed within 60 days.
  - In Q3 CY2016, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q3 CY2016, the numbers and percentages of non-clean claims not processed within 60 days (148) was lower than the previous three quarters (ranging from 168 to 881) but higher than in Q1 (29) and Q2 (60) CY2015.
  - Of the 148 "non-clean claims" not processed within 60 days - 124 (83.8%) were claims received by AGP, 15 (10.1%) were claims received by SSHP; and nine (6.1%) were claims received by UHC.
  - As indicated in Table 6, the number of "non-clean claims" excluded from the measure has increased from 306 (0.2% of non-clean claims) in Q2 CY2016 to 2,974 (1.5% of non-clean claims) in Q1 CY2016. In Q3 CY2016, 75.0% of the 1,344 excluded non-clean claims were claims reported by SSHP. In November 2016, KFMC questioned SSHP staff as to why their excluded claims counts have been so much higher than the MCOs. SSHP staff reported that the excluded non-clean claims were primarily newborn claims that, under State criteria, may pend for 45 days. SSHP staff agreed that these claims should actually not be excluded, as these claims should, with few exceptions, be processed within 60 days. SSHP indicated they plan to revise future reports to correct this error.
- **All claims**: 99.997% of 4,233,636 "all claims" received in Q3 CY2016 were reported by the MCOs as processed within 90 days. In Q3 CY2016, none of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 144 claims not processed within 90 days – 127 (88.2%) were claims received by AGP; 13 (9.0%) were claims received by SSHP; and four (2.8%) were claims received by UHC.

In the validation process for the claims-related metrics in the P4P in January 2017 (for 2015 and 2016 P4P metrics), KFMC found that, while MCOs were reporting timeliness of claims processing correctly, one or more of each MCO's vendors were not correctly reporting timeliness of claims processing. Instead of reporting the number of claims received each month (and number/percent of the claims received that month that were processed within the time parameters), some vendors were reporting the monthly number of claims processed in the month that had been processed within the required time parameters. As vendor claims are to be included in claims processing timeliness, MCOs worked with the vendors to correct the reporting and submitted revised P4P data to the State and to the EQRO (KFMC) for validation. Data reported in Table 6, however, has not yet been revised by the MCOs to reflect these corrections.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,451,645 clean claims processed in Q4 CY2016 (includes claims received prior to Q4). Excluding pharmacy claims (which are processed same day) there were 2,754,223 clean claims processed.

The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.0 to 9.9 days in Q4 CY2016, compared with 5.8 to 10.6 days in Q3 CY2016.

It should be noted that the average TAT monthly ranges reported in Table 7 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed. Also, the average TATs reported for "Total Claims" are weighted averages calculated after excluding pharmacy claims, as pharmacy claims for each of the MCOs are processed "same day."

Table 7. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Q1 to Q4 CY2016 and Monthly Ranges by Year - CY2014 to CY2016

Service Category	Q1 to Q4, CY2016				Monthly Ranges by Year		
	Q1	Q2	Q3	Q4	CY2014	CY2015	CY2016
Hospital Inpatient	8.1 to 15.1	7.1 to 12.4	8.3 to 18.2	**7.3 to 17.0**	5.0 to 19.2	6.4 to 15.9	**7.1 to 18.4**
Hospital Outpatient	4.8 to 10.5	4.3 to 9.5	4.4 to 12.9	**4.0 to 10.4**	3.6 to 12.8	3.5 to 10.8	**4.0 to 12.9**
Pharmacy	same day	same day	same day	**same day**	same day	same day	**same day**
Dental	7.0 to 13.0	7.0 to 13.0	6.0 to 13.0	**7.0 to 13.0**	2.0 to 21.0	4.0 to 13.1	**6.0 to 13.0**
Vision	9.0 to 12.7	7.0 to 12.0	7.0 to 11.9	**7.0 to 12.6**	7.0 to 12.5	9.0 to 12.5	**7.0 to 12.7**
Non-Emergency Transportation	9.0 to 14.0	9.5 to 14.4	9.7 to 13.5	**9.6 to 13.7**	10.9 to 18	10.4 to 16	**9.0 to 14.4**
Medical (Physical health not otherwise specified)	4.4 to 9.9	4.4 to 8.9	4.9 to 10.7	**4.2 to 9.9**	3.3 to 10.6	3.4 to 10.5	**4.2 to 10.7**
Nursing Facilities	5.6 to 9.0	4.7 to 9.0	4.8 to 9.7	**4.6 to 10.6**	4.3 to 11.5	4.1 to 9.7	**4.6 to 9.0**
HCBS	5.8 to 9.7	6.0 to 8.7	7.8 to 10.8	**5.7 to 9.7**	3.2 to 15.6	4.1 to 10.2	**5.7 to 10.8**
Behavioral Health	4.2 to 10.3	4.2 to 9.3	4.5 to 11.7	**4.1 to 9.8**	3.4 to 8.6	2.7 to 10.5	**4.1 to 11.7**
Total Claims (Including Pharmacy)	4,409,846	4,315,854	4,469,354	**4,451,645**	16,763,501	17,820,402	**17,820,402**
Total Claims (Excluding Pharmacy)	2,646,703	2,622,624	3,045,520	**2,754,223**	10,370,998	10,999,807	**10,999,807**
Average TAT (Excluding Pharmacy)	**5.3 to 10.0**	**5.2 to 9.1**	**5.8 to 10.6**	**5.0 to 9.9**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**

The average TAT for processing clean claims for individual service types again varied by service type and by MCO.

- **Hospital Inpatient** – Hospital Inpatient claims had TATs in Q4 CY2016 ranging from 7.3 to 17.0 days, a decrease compared to Q3 CY2016 (8.3 to 18.2). AGP had the shortest TATs in Q4 (7.3 to 10.2 days), compared to SSHP (11.1 to 12.3 days) and UHC (10.8 to 17.0 days).
- **Dental** - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q4 CY2016. SSHP had the shortest TATs each month (7.0 days); AGP and UHC had TATs of 13.0 days in Q4 CY2016 and the previous four quarters.
- **Nursing Facilities** – Nursing Facility claims had TATs ranging from 4.6 to 10.6 days in Q4. AGP had the shortest TATs (4.6 to 6.0 days). SSHP had the longest (9.3 to 10.6 days) in Q4, an increase compared to 83 (8.8 to 9.7 days), Q2 (8.6 to 9.0 days) and Q1 (7.5 to 9.0 days). UHC's TATs in Q4 (7.4 to 7.7 days) were a decrease compared to in Q3 (7.6 to 8.8 days).
- **HCBS** – HCBS claims had monthly TATs in Q4 ranging from 5.7 to 9.7 days. AGP had the shortest TATs (5.7 to 7.6 days), compared to SSHP (8.2 to 9.7 days) and UHC (6.6 to 8.2 days).
- **Behavioral Health** (BH) – BH claims TATs ranged from 4.1 to 9.8 days in Q4 CY2016. AGP had the shortest TATs (4.1 to 5.2 days), compared to SSHP (8.4 to 9.8 days) and UHC (8.3 to 9.0 days).
- **Non-Emergency Transportation** (NEMT) - Clean claims for NEMT had monthly average TATs ranging from 9.6 to 13.7 days in Q4. AGP had the longest TATs in Q4, ranging from 12.0 to 13.7 days, compared to 9.6 to 9.9 for SSHP and 9.7 to 10.0 for UHC.
- **Vision** – The average TATs were consistently a week or longer in Q4 and previous quarters for all of the MCOs. In Q4 CY2016, the average monthly TATs ranged from 7.0 to 12.6 days. AGP had the shortest TAT (7.0 to 8.0 days), and SSHP had the longest TAT (12.0 to 12.6 days).

Recommendations (Timeliness of Claims Processing)

1. MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

2. The State should provide additional direction to the MCOs as to whether corrections (example: SSHP mistakenly excluding newborn claims from the 60-day and 90-day processing requirements) should be made in previous quarterly reports when errors in interpreting reporting criteria are identified.

Grievances

Performance measures for grievances include: Track the Timely Resolution of Grievances; Compare/Track the Number of Access-Related Grievances over time, by population categories; and Compare Track the Number of Quality Related Grievances over time, by population.

Grievances are reported and tracked on a quarterly basis by MCOs in two separate reports:

- The Special Terms and Conditions (STC) Quarterly Report tracks the number of grievances received in the quarter, the total number of the grievances received in the quarter that were resolved, and counts of grievances by category type. The report includes space for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.
- The Grievance and Appeal (GAR) 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 description and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Data Sources

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report described above. The number of grievances received and resolved each quarter is also reported in the STC quarterly report. Beginning in Q2 CY2016, grievances and appeals are to be reported using updated categories. KDHE staff provided training to MCO staff to clarify criteria for each category and provided more detailed grievance and appeal criteria definitions and examples in the reporting template to promote more accurate and consistent reporting. A number of categories (including “Criteria Not Met – DME,” “Criteria Not Met – Medical Procedure,” and “Level of Care Dispute”) are now to be tracked as “appeals” instead of “grievances.”

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation is 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 equal the number of grievances “resolved” during the quarter (see Table 8).

Current Quarter Compared to Previous Quarters

In Q4 CY2016, 100% (395) of the 395 grievances reported by the MCOs as resolved in Q4 CY2016 were reported as resolved within 30 business days.

There were fewer grievances reported by MCOs as received in Q4 CY2016 than the three previous quarters, and fewer grievances reported in CY2016 than in the three previous years. The number of grievances not resolved within 30 days was highest in CY2016 (76); however, in Q4 CY2016 the MCOs reported that all grievances were resolved within 30 days, compared to 59 not resolved within 30 days in Q3 CY2016.

Table 8. Timeliness of Resolution of Grievances - Q1 to Q4 CY2016 and CY2013 to CY2016

	Q1 to Q4, CY2016				CY2013 to CY2016			
	Q1	Q2	Q3	Q4	CY2013	CY2014	CY2015	CY2016
Number of grievances received in quarter	456	453	452	406	1,786	2,287	2,021	1,767
Number of grievances resolved in quarter*	437	465	446	395	1,723	2,307	2,046	1,743
Number of grievances closed in quarter resolved within 30 business days*	433	452	387	395	1,723	2,283	2006	1,667
Percent of grievances closed in quarter resolved within 30 business days	99.1%	97.2%	86.8%	100%	100%	99.0%	98.0%	95.6%
Number of grievances in quarter not resolved within 30 business days	4	13	59	0	0	24	40	76
Number of grievances closed in quarter resolved within 60 business days*	436	465	446	395	1,723	2,299	2,035	1,742
Percent of grievances closed in quarter resolved within 60 business days	99.8%	100%	100%	100%	100%	99.7%	99.5%	99.9%
Number of grievances closed in quarter not resolved within 60 business days*	1	0	0	0	0	8	11	1

*The number of grievances resolved in the quarter and the number and percent of grievances resolved in the quarter include grievances received in the previous quarter.

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

All Grievances

In the STC and GAR reports, MCOs reported they received 406 grievances in Q4 CY2016. In the STC report, the MCOs reported that 336 of the 406 were resolved within the quarter (see Table 9).

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the revised GAR Reason Summary Table has 13 categories (see Table 9).

- Five categories are the same in both reports – "Access to Service or Care," "Customer Service," "Member Rights/Dignity," "Transportation" (four subcategories in the GAR report), and "Other."
- Two categories in the GAR Report not in the STC report are "Pharmacy Issues" and "Value-Added Benefit."
- Four categories in the STC report not in the GAR report are "Benefit Denial or Limitation," "Service or Care Disruption," "Clinical/Utilization Management," and "Health Plan Administration."
- Two categories with similar wording, but that may be interpreted differently, include:
  - "Claims/Billing Issues" (STC) and "Billing and Financial Issues" (GAR) – "Claims/Billing Issues" may potentially be misinterpreted to include appeals related to claims; and
  - "Quality of Care or Service" (STC) and "Quality of Care/non-HCBS" and "Quality of Care/ HCBS" (GAR) – In past GAR reports, "Quality of Service" has included a wide range of grievances – from not receiving a value-added rewards card timely to reports of perceived malpractice.

Table 9. Number of Grievances in STC Reports by Category, CY2015 to CY2016

	Q1 to Q4, CY2015				Q1 to Q4, CY2016				CY2015	CY2016
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Total grievances received in quarter	667	480	427	404	442	420	452	**406**	1,978	**1,720**
Grievances resolved of those received in the quarter	573	420	366	379	407	357	391	**336**	1,738	**1,491**
Transportation	251	245	192	182	176	125	172	**166**	870	**639**
Claims/Billing Issues	217	56	44	62	90	86	48	**70**	379	**294**
Quality of Care or Service	53	40	57	22	36	34	28	**43**	172	**141**
Access to Service or Care	34	33	35	42	44	34	41	**41**	144	**160**
Health Plan Administration	13	19	11	9	16	10	20	**15**	52	**61**
Customer Service	49	67	36	42	27	30	48	**30**	194	**135**
Member Rights/Dignity	14	15	17	13	12	17	16	**5**	59	**50**
Benefit Denial or LImitation	24	10	12	8	10	8	10	**14**	54	**42**
Service or Care Disruption	6	4	3	6	14	7	2	**5**	19	**28**
Clinical/Utilization Management	4	2	0	2	5	1	2	**1**	8	**9**
Other	2	27	20	16	12	23	21	**16**	65	**72**
Total Grievances	**667**	**480**	**427**	**404**	**442**	**375**	**408**	**406**	**1,978**	**1,631**

Table 10. Grievance Categories - STC and GAR Reports

STC Categories	GAR Report Categories
Claims/Billing Issues	Billing and Financial Issues
Access to Service or Care	Access to Service or Care
Quality of Care or Service	Quality of Care (non-HCBS)
	Quality of Care - HCBS
Customer Service	Customer Service
Transportation	Transportation Issue
	Transportation Safety
	Transportation No Show
	Transportation Late
Other	Other
Member Rights/Dignity	Member's Rights/Dignity
	Pharmacy Issues
	Value-Added Benefit
Benefit Denial or LImitation	
Clinical/Utilization Management	
Health Plan Administration	
Service or Care Disruption	

Using the same categories in both reports and/or providing guidance, criteria, and examples for the STC report categories would promote consistency and allow more complete assessment of grievances received and resolved over time. The STC categories should also be reviewed to assess whether any of

the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.

Table 11 summarizes the numbers and categories of grievances resolved in Q4 CY2016 as reported in the GAR reports and illustrates the revisions in grievance categories beginning in Q2 CY2016.

Table 11. Comparison of Grievances Resolved, Q1 CY2015 to Q4 CY2016*

	CY2015				CY2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Billing and Financial Issues						108	52	**61**
Claims/Billing Issues	227	86	63	77	97			
Quality of Care - non-HCBS/non-transportation						42	46	**74**
Quality of Care - HCBS						11	8	**3**
Quality of Care or Service	40	56	96	71	65			
Attitude/Service of Staff	116	144	138	120	108			
Customer Service						41	49	**24**
Member's Rights/Dignity						14	12	**5**
Access to Service or Care						50	77	**34**
Pharmacy Issues	9	10	3	11	9	20	24	**19**
Other	23	33	35	33	17	9	14	**6**
Value-added Benefit						6	9	**6**
Transportation - Late						22	27	**27**
Transportation - No Show						39	59	**52**
Transportation - Safety						14	7	**16**
Transportation - Other Issues						47	62	**69**
Availability	83	99	82	83	79			
Timeliness	86	83	24	26	31			
Lack of Information from Provider	3	5	5	2	2			
Level of Care Dispute	5	4	2	8	4			
Prior or Post Authorization	5	3	7	6	1			
Accessibility of Office	3	1	1	2	4			
Criteria Not Met - Medical Procedure	6	6	2	1	2			
Criteria Not Met - Durable Medical Equipment	2	2	1	-	2			
Criteria Not Met - Inpatient Hospitalization	2	-	1	-	-			
HCBS	12	-	7	3	-			
Sleep Studies	-	-	1	-	-			
Sterilization	-	1	1	1	-			
Overpayments	-	-	-	-	1			
Quality of Office, Building	-	-	-	1	-			
"AOR"	13	9	7	12	10			
Total	**635**	**542**	**542**	**457**	**432**	**423**	**446**	**396**

* As reported in quarterly grievance (GAR) reports.

Whereas prior to Q2 CY016, transportation-related grievances were categorized as "Timeliness," "Availability," "Attitude/Service of Staff," Quality of Care or Service," "Other," "Lack of Information from Provider," "Accessibility of Office," and "Level of Care," the revised GAR template now has specifically-defined transportation categories: "Transportation – No Show," "Transportation – Safety," "Transportation – Late," and "Transportation Issues – including reimbursement (other than no show or safety)." Adding these transportation categories to the GAR report should allow better comparisons with STC reports and promote better consistency in MCO reporting. The revised categories, where reported by MCOs and using the revised criteria, should also allow better tracking of progress is addressing specific transportation-related grievances, such as transportation safety and "no shows." (Note: The "Transportation Issues" category specifically excluded "no show" and "safety" in the category description. "Transportation – Late" was later designated as a separate tracking category but was not added to the exclusions in the "Transportation Issues" category description.)

Despite the revised categories and the addition by KDHE of criteria descriptions and examples by category, KFMC identified over 55 grievances that, as described by the MCOs in the Q4 GAR report, and in comparison to the grievance category definitions, appear to be potentially misclassified, including:

- 18 "Customer service" grievances categorized as QOC (17), and "Access to Service or Care" (1);
- 13 "Access to service or care" grievances categorized as QOC (10), "Billing or Financial Issues" (1), "Customer Service" (1), and "Other' (1);
- Eight QOC grievances categorized as "Access to Service or Care" (6), "Customer Service" (2);
- Three "Billing and financial issues" grievances categorized as QOC (2), and "Customer Service" (1); "
- Four "Value added benefit" grievances categorized as QOC(3) and "Other" (1); and
- Transportation-related grievances:
    - Nine "Transportation – Late" grievances categorized as "Transportation Issues – including reimbursement (other than no show or safety)" (7), "Member rights/dignity" (1), and "Access to Service or Care" (1);
    - Three "Transportation Issues" grievances categorized as QOC (1), "Member rights/dignity" (1), and "Customer Service" (1);
    - One "Transportation – No Show" categorized as "Transportation – Late"; and
    - One "Transportation – Safety" categorized as "Transportation Issues."

UHC again this quarter included very limited descriptions of grievances resolved: most grievance descriptions simply said, "A grievance was received regarding [*billing, the quality of service, a transportation issue*, etc.], four included no details about the grievance, and 74% of the resolution descriptions (125 of 169) were limited to documentation that a letter was sent to the member, together making it impossible to determine for most of the grievances whether they were categorized appropriately. Of the UHC grievance descriptions that did include a limited amount of detail, at least 28 seemed to be categorized incorrectly, including 26 of the 54 UHC categorized as "Quality of Care" (QOC).

Table 12 reports the types of grievances resolved in Q4 CY2016 in total and by waiver and the number of members reporting grievances, as categorized by the MCOs.

Table 13 and Table 14 show the impact on these counts after categorizing the grievances based on the descriptions provided by the MCOs in the GAR report. The category most impacted by the potentially incorrect categorizing is QOC, potentially inflated by a third due to24 additional grievances. Conversely, "Customer Service" may have been under-reported by 13 grievances.

Table 12. Comparison by Waiver for Grievances Resolved in Q4 CY2016*, as Categorized by MCOs

	All members		Waiver members		Number of Grievances by Waiver Type^					
	# grievances	# members	# grievances	# members	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	61	60	7	7	3	1	1	2		
Access to Service or Care	34	31	8	7	1	1	2	1	2	1
Quality of Care (non-HCBS)	74	68	19	17	2	5	7	2	1	2
Quality of Care - HCBS	3	3	3	3		2	1			
Customer Service	24	24	3	3	2			1		
Pharmacy Issues	19	19	3	3			1		1	1
Member's Rights/Dignity	5	5	2	2			2			
Value-Added Benefit	6	4	2	2		1	1			
Transportation Issue	69	63	26	22	5		18	1		2
Transportation Safety	16	16	10	10	2		8			
Transportation No Show	52	52	21	21	6	2	10			3
Transportation Late	27	26	14	13	2		11	1		
Other	6	6	4	4	1	1	1			1
Total	396	377	122	114	24	13	63	8	4	10

*Includes grievances received in Quarter 3 CY2016 resolved in Quarter 4 CY2016.
^No grievances were categorized in Quarter 4 for Autism Waiver members.

Table 13. Comparison by Waiver of Grievances Resolved in Q4 CY2016* based on MCO Grievance Descriptions#

	All members		Waiver members		Number of Grievances by Waiver Type^					
	# grievances	# members	# grievances	# members	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	63	62	8	8	3	1	1	3		
Access to Service or Care	36	33	12	11	2	3	3	1	2	1
Quality of Care (non-HCBS)	50	46	10	9	1	1	5	2	0	1
Quality of Care - HCBS	3	3	3	3		2	1			
Customer Service	37	36	8	7	2	3	1	0	1	1
Pharmacy Issues	19	19	3	3			1		1	1
Member's Rights/Dignity	2	2	1	1			1			
Value-Added Benefit	10	8	3	3		1	2			
Transportation Issue	65	58	24	20	5		16	1		2
Transportation Safety	16	16	9	9	2		7			
Transportation No Show	53	53	22	22	6	2	11			3
Transportation Late	35	35	16	16	2		13	1		
Other	7	7	3	3	1	0	1			1
Total	396	378	122	115	24	13	63	8	4	10

* Includes grievances received in Quarter 3 CY2016 resolved in Quarter 4 CY2016.
# Shaded areas are those where counts differed based on descriptions of grievances and grievance resolutions in the GAR report.
^ No grievances were categorized in Quarter 4 for Autism Waiver members.

Table 14. Comparison by Waiver of Grievances Resolved in Q4 CY2016* - Difference in Grievance Categories Reported by MCOs Compared to MCO Grievance Descriptions

	All members		Waiver members		Number of Grievances by Waiver Type^					
	# grievances	# members	# grievances	# members	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	2	2	1	1				1		
Access to Service or Care	2	2	4	4	1	2	1			
Quality of Care (non-HCBS)	-24	-22	-9	-8	-1	-4	-2		-1	-1
Quality of Care - HCBS										
Customer Service	13	12	5	4		3	1	-1	1	1
Pharmacy Issues										
Member's Rights/Dignity	-3	-3	-1	-1			-1			
Value-Added Benefit	4	4	1	1			1			
Transportation Issue	-4	-5	-2	-2			-2			
Transportation Safety			-1	-1			-1			
Transportation No Show	1	1	1	1			1			
Transportation Late	8	9	2	3			2			
Other	1	1	-1	-1		-1				

Higher Count based on Grievance Descriptions vs. MCO Category

Lower Count based on Grievance Descriptions vs. MCO Category

Of 396 grievances resolved in Q4 CY2016, 99 (25.0%) were from AGP members, 128 (32.3%) from SSHP members, and 164 (41.4%) from UHC members.

Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 164 transportation-related grievances received from 157 members. Of the 164 transportation-related grievances, 67 (40.1%) were reported by SSHP, 50 (29.9%) were reported by UHC, and 47 (28.7%) were reported by AGP. The number of "No Show" "Late" transportation grievances continued to be high, with 52 "No Show" grievances in Q4 (compared to 59 in Q3) and 27 "Late" grievances in Q4 and Q3. Also of note in Q4 is the number of AGP grievances categorized as "Transportation Issues" that described eight where transportation as "not scheduled" and two that referred to errors in scheduling that were in addition to 18 "Transportation – Late" and 15 "Transportation – No Show" grievances. Also of concern is the increased number of "Transportation – Safety" grievances, which increased from seven in Q3 to 16 in Q4.

As shown in Table 15, the percentage of transportation-related grievances was higher among waiver members (58.2% in Q4) compared to the total population (41.4% in Q4). Of the 396 grievances in Q4, 122 (30.8%) were from members receiving waiver services.

In past quarters, billing-related grievances were the most frequently reported grievances. In Q4, based on the MCO categorization, QOC was the second most frequently reported grievance, with 76 grievances (19.2% of the 396 grievances). This may be due, however, to errors in categorizing the grievances this quarter; based on the grievance descriptions there were more "Billing and Financial Issues" (63 grievances) than QOC grievances (53 grievances).

An additional error was noted in the number of duplicate entries reported by SSHP. Of the 128 grievances reported, four grievances (one "Access to service or care," two "Value added benefit," and one QOC) included exact entries to other grievances, all differing by internal tracking numbers, two differing by the last digit of the Medicaid ID, and one reporting completely different Medicaid ID numbers.

Table 15. Transportation-Related Grievances Resolved in Q3 and Q4 CY2016, by Waiver

	# Grievances		# Members Reporting Grievances		# Transportation Related		% Transportation Related	
	Q3	Q4	Q3	Q4	Q3	Q4	Q3	Q4
Physical Disability (PD)	**65**	**63**	**54**	**58**	**33**	**47**	50.8%	**74.6%**
Frail Elderly (FE)	**23**	**24**	**21**	**23**	**16**	**15**	69.6%	**62.5%**
Intellectual/Developmental Disability (I/DD)	**17**	**13**	**17**	**12**	**4**	**2**	23.5%	**15.4%**
Traumatic Brain Injury (TBI)	**18**	**10**	**7**	**10**	**5**	**5**	27.8%	**50.0%**
Serious Emotional Disturbance (SED)	**7**	**8**	**7**	**8**	**2**	**2**	28.6%	**25.0%**
Technology Assisted (TA)	**0**	**4**	**0**	**3**	**0**	**0**	NA	**0%**
Autism	**2**	**0**	**2**	**0**	**2**	**0**	100%	**NA**
Waiver Members Total	132	**122**	108	**114**	62	**71**	47.0%	**58.2%**
All Members Total	446	**396**	412	**377**	185	**157**	41.5%	**39.6%**

The number and percentage of transportation-related grievances received from waiver members was higher in Q4 CY2016 than the four previous quarters. Of the 122 grievances received from 114 waiver members in Q4, 71 (58.2%) were transportation-related, compared to 61 (47.0%) in Q3, 46 (26.4%) in Q2 and 37 (34.6%) in Q1 CY2016. In CY2015, 47.6% of 538 waiver-related grievances were transportation related.

- Physical Disability (PD) Waiver members had the most grievances in Q4, with 58 members reporting 63 grievances, 47 (74.6%) transportation-related. In Q3 CY2016, 54 PD waiver members reported 65 grievances, 33 (50.8%) transportation-related.
- Frail Elderly (FE) Waiver members reported 24 grievances (23 members) in Q4, 15 (62.5%) transportation-related. In Q3 CY2016, 23 grievances were reported by 21 members, 16 (69.6%) transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members in Q4 reported 13 grievances (12 members), two (15.4%) transportation-related. In Q3 CY2016, 17 members reported a grievance, four (23.5%) transportation-related.
- Traumatic Brain Injury (TBI) Waiver members reported 10 grievances (10 members), five (50%) transportation-related. In Q3 CY2016, seven members reported 18 grievances, five (27.8%) transportation-related.
- Serious Emotional Disturbance (SED) Waiver members reported eight grievances (eight members) in Q4, two (25%) transportation-related. In Q3 CY2016, seven members reported a grievance, two (28.6%) transportation-related.
- Technology Assistance Waiver members reported four grievances (three members) in Q4, none transportation-related.
- In Q4 CY2016, the MCOs did not report receiving grievances from Autism Waiver members. In Q3 CY2016, two grievances were reported, both transportation-related.

Access-Related Grievances

Of 406 grievances categorized in the STC report as received in Q4 CY2016, 41 (10.1%) were categorized as "Access to Service or Care" (see Table 9); and, of 396 grievances resolved in Q4 CY2016, 34 (8.6%), were categorized by the MCOs in their GAR reports as "Access to Service or Care." MCOs reported 77 access-related grievances (17.3% of 446) in the Q3 CY2016 GAR report. While it would initially appear there were less than half as many access-related grievances in Q4 compared to Q3, the KanCare Q3 Evaluation reported that at least 45 of the 77 were not access-related.

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence."

- AGP reported 10 access-related grievances received in Q4 CY2016. As identically described in nine previous STC reports, the summary of trends and actions to prevent recurrence was: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continues to monitor our network to identify service gaps and work with providers to contract with AGP to perform key services for our members*."
- SSHP reported 25 access-related grievances received in Q4. In the STC trend summary, SSHP reported, *"Access to Service or Care consists 20% (25/1125) of all total grievances resolved this quarter."*
- UHC reported six access-related grievances received in Q4. These were described in this quarter's STC report as, "*The MCO tracks and trends access to service and care grievances quarterly. Grievances related to the availability of network providers are used as part of geo access studies to identify potential network gaps. For grievances related to appointment availability, the provider offices are contacted to review appointment availability standards."* In the previous four quarterly STC reports UHC report that "access to service or care" grievances were tracked *monthly*." This quarter, UHC reported they track and trend access to service and care "*quarterly*."

In the Q4 GAR report, SSHP categorized 25 resolved grievances as "Access to Service or Care." In Q3, SSHP reported 67 "access" grievances; but, based on grievance descriptions, up to 45 of the 67 were misclassified, including 27 clearly transportation-related. Based on grievance descriptions in Q4, potentially misclassified four grievances as "Access to Service or Care" that would appear to be better categorized as QOC/non-HCBS (2), "Transportation – Late" (1), and "Other" (1). Three grievances that would seem to be more correctly categorized as access-related were categorized as QOC/non-HCBS (1), "Customer Service" (1), and "Other" (1).

AGP categorized eight grievances resolved in Q4 as "Access to Service or Care." Based on the grievance descriptions, one would have been more correctly categorized as "Customer Service," and one more correctly as an appeal. Two grievances categorized as "Billing and Financial Issues" and QOC/non-HCBS may be better categorized as "Access to Service or Care."

UHC characterized one grievance in Q4 as "Access to Service or Care." Due to the lack of detail provided by UHC for most grievance descriptions and resolutions, it is not possible to assess whether most of the grievances have been categorized incorrectly. Of the few that included descriptions, the one grievance categorized as "Access to Service or Care" appeared instead to be a QOC grievance, and three grievances categorized as QOC would seem to be more correctly categorized as "Access to Service or Care."

Of 34 grievances reported in the GAR report as "Access to Service or Care" by 31 members in Q4 CY2016, eight grievances (23.5%) were from seven members receiving waiver services, including: one member receiving TBI waiver services, one member receiving FE services, one member receiving I/DD waiver services, one member receiving SED services, two members receiving PD waiver services (two grievances), and one member receiving TA waiver services (two grievances). Of the eight grievances, the grievance from the I/DD waiver member would seem to be more appropriately categorized as an appeal, as it is described as requesting an appeal due to decreased hours, and the resolution detail refers to appeals staff having left the member a voice message requesting a return call.

Quality-Related Grievances

In Q4 CY2016, 43 (10.6%) of 406 grievances received were categorized in the STC report as being related to "Quality of Care or Service" (QOC). In the MCO Q4 GAR reports, 77 (19.4%) of 396 grievances reported as resolved were categorized as QOC, 20 as "Quality of Care (non-HCBS)," three "Quality of Care – HCBS," and 54 as "Quality of Care" (UHC did not report whether or not the QOC grievance was HCBS-related, as had been directed by the State). Based on descriptions in the GAR report, up to one third of the grievances categorized as "Quality of Care (non –HCBS)" and "Quality of Care" were not correctly categorized. (This also raises questions as to the percentage of the 43 QOC grievances reported in the STC report in Q4 incorrectly categorized.)

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence."

- AGP reported receiving 10 QOC grievances in Q4 (compared to six in Q3). As in previous STC reports, AGP summarized this quarter's grievance with the following language: "*Members felt they received inappropriate treatment from their treating provider*. *These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action."*
- SSHP reported eight QOC grievances received in Q4 (eight in Q3), and that, "*Quality of Service or Care grievances accounts for 6.40% (8/125) of all total grievances for this quarter."*
- UHC did not provide descriptions of the 25 QOC grievances received in Q4 (up from 14 in Q3). As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians' offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"

In the GAR report AGP categorized 11 grievances resolved in Q4 as QOC/non-HCBS and three as QOC/HCBS. Based on the grievance descriptions, two QOC/non-HCBS grievances would have been more correctly categorized as "Access to Service" and one potentially as "Other."

SSHP categorized nine resolved grievances in Q4 as QOC/non-HCBS. Based on grievance descriptions, one of the nine would seem to be more correctly categorized as "Access to service or care." Four grievances that would seem to be more correctly categorized as QOC were categorized as "Access to service or Care" (2) and "Customer Service" (2).

UHC characterized 54 grievances in Q4 as "QOC." Due to the lack of detail provided by UHC for most grievance descriptions and resolutions, it is not possible to assess whether most of the grievances have been categorized incorrectly. Of those that included descriptions, 26 grievances categorized as QOC

would seem to be more correctly be categorized as "Customer service" (17), "Access to service or care" (3), "Billing and financial issues" (2), "Transportation Issues (1), and "Value added benefit" (3).

Of 77 grievances reported in the GAR report as QOC by 71 members in Q4, 22 grievances (28.6%) were from 20 members receiving waiver services, including: two members receiving TBI waiver services (two grievances), two members receiving FE services (two grievances), six members receiving I/DD waiver services (seven grievances), two members receiving SED services (two grievances), seven members receiving PD waiver services (eight grievances), and one member receiving TA waiver services. Based on the grievance descriptions, there would seem instead to be 53 grievances reported by 49 members, with only 13 grievances from 12 members receiving waiver services: one TBI Waiver member (instead of two), one FE Waiver member (instead of two), three I/DD Waiver members (instead of six), two SED Waiver members (no difference), five PD Waiver members (instead of seven), and no TA Waiver members (instead of one).

Recommendations (Grievances)

1. UHC should provide more detailed descriptions of the grievances resolved each quarter. Resolution details should not be limited to verification that a letter of resolution was sent.
2. MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.
3. MCOs should ensure their staff categorize grievances using the revised categories and criteria. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.
4. MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
5. The State should consider using the same grievance and appeals categories in the STC and GAR reports to promote consistency and allow more complete assessment of grievances over time.
6. The STC report categories should be reviewed to assess whether any of the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.
7. Due to the addition of the "Transportation Late" category, the State should update the Grievance definition of the "Transportation Issues" category to include "late" as an exclusion, i.e. "(other than no show, safety, or late)."
8. UHC should identify whether QOC grievances are or are not HCBS-related. UHC staff should review the revised category criteria, particularly QOC, due to the many grievances mistakenly categorized.
9. SSHP should provide additional clarification for grievances where all details except the tracking number are exact; if duplicates, these should be removed from the list/counts, and, if errors, should be corrected.
10. The State should work with the MCOs to identify corrective actions to address the high number of transportation grievances related to safety, "no show," late," and errors in scheduling.

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 Q4 CY2016 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

The Ombudsman Office staff includes the Ombudsman, a part-time assistant, and a full-time volunteer coordinator.

The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral as needed, to the Ombudsman or other State agency staff through the KanCare Ombudsman Volunteer Program. Recruitment of volunteers began in June 2015. The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers then receive three weeks of in-person mentoring by the Ombudsman and program coordinator. Volunteers provide assistance by phone and by appointment in person with filling out applications. In Q4 CY2016, the Wichita satellite office had seven volunteers and a Project Coordinator available to provide onsite assistance from 10a.m. to 2p.m. Monday through Friday. A second satellite office, opened in July 2016 in Olathe (Johnson County), is currently staffed with four volunteers providing onsite assistance from 10a.m. to 1p.m. Mondays and Thursdays. Plans are underway for the Ombudsman Volunteer Coordinator to provide one-hour trainings to interested community service organizations on topics such as "How to assist with Medicaid applications," "Medicaid-related resources," and "KanCare programs and Home and Community-Based Services overview."

As delineated in the CMS Kansas Special Terms and Conditions (STC), revised in January 2014, data the Ombudsman's Office track 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.

The Ombudsman's office tracks contacts by contact method, caller type, and by specific issues. The Ombudsman's Office is also required to track contacts by geographic area; trends by geography, however, are not included in the Ombudsman's quarterly reports. According to Kerrie Bacon, Ombudsman, callers' cities are often tracked, but many of the calls to the office are too short to gather additional demographic data and/or the callers prefer to not provide identifying information.

In Q1 CY2016, the number of contacts to the Ombudsman's office was more than double that of the previous quarter; in Q1 there were 1,130 total contacts, compared with 462 to 579 in the previous eight quarters, primarily due to requests for assistance related to Medicaid eligibility. By Q4 CY2016, the number of contacts dropped 53.7% to 523; and, the number of MCO-related contacts dropped by 56.8% from 250 in Q1 CY2016 to 108 in Q4 (see Table 16). In CY2016, 20.4% of the contacts were MCO-related (649 of 3,186), compared to 36.5% in CY2015 (758 of 2,075) and 42.5% in CY2014 (890 of 2,092).

Table 16. Ombudsman's Office Contacts - All and MCO-Related, Q1 to Q4 CY2016 and CY2014 to CY2016

	Q1 to Q4, CY2016				CY2014	CY2015	CY2016
	Q1	Q2	Q3	Q4			
All Contacts	1,130	846	687	523	2,092	2,075	3,186
MCO-Related Contacts	250	150	141	108	890	758	649
% MCO-Related Contacts	22.1%	17.7%	20.5%	20.7%	42.5%	36.5%	20.4%

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts. Table 17 includes the counts of issue types, comparing quarterly and annual C2016 data. The top two issues quarterly in CY2016 were "Medicaid Eligibility Issues" and HCBS-related issues. In Q4 CY2016, however, there were 31 HCBS-related issues compared to 71 in Q2 and 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2, and then to 173 in Q3 and 174 in Q4.

The Ombudsman's Office also tracks and reports the number of the issues that are MCO-related (Table 17) and the timing to resolve the issues for those who contact the Ombudsman's Office each quarter.

Table 17. Issues Submitted to Ombudsman's Office - All and Percentage MCO-Related, CY2016

	Q1		Q2		Q3		Q4		Q1-Q4	
	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related
	#	%	#	%	#	%	#	%	#	%
Medicaid Eligibility Issues	512	14.1%	244	7.8%	173	11.6%	174	11.5%	1,103	11.9%
Appeals, Grievances	49	59.2%	42	47.6%	36	38.9%	16	18.8%	143	46.2%
Medical Services	29	51.7%	20	55.0%	10	70.0%	12	33.3%	71	52.1%
Billing	43	46.5%	39	46.2%	37	48.6%	26	46.2%	145	46.9%
Durable Medical Equipment	7	100%	7	71.4%	2	50.0%	4	75.0%	20	80.0%
Pharmacy	24	58.3%	13	30.8%	11	72.7%	8	75.0%	56	57.1%
HCBS										
HCBS General Issues	69	56.5%	32	53.1%	16	37.5%	15	73.3%	132	55.3%
HCBS Eligibility Issues	45	37.8%	33	45.5%	21	42.9%	9	22.2%	108	39.8%
HCBS Reduction in Hours of Service	12	66.7%	4	100%	3	67%	3	100%	22	77.3%
HCBS Waiting List	18	16.7%	2	50.0%	2	50.0%	4	25.0%	26	23.1%
Care Coordinator Issues	7	85.7%	3	66.7%	6	100%	4	100%	20	90.0%
Transportation	6	66.7%	8	37.5%	6	83.3%	1	100%	21	61.9%
Nursing Facility Issues	40	17.5%	7	71.4%	22	18.2%	22	18.2%	91	22.0%
Housing Issues	8	12.5%	2	50.0%	2	0.0%	3	33.3%	15	20.0%
Access to Providers	7	57.1%	6	50.0%	9	44.4%	13	30.8%	35	42.9%
Change MCO	15	46.7%	3	66.7%	0	0%	6	0%	24	58%
Dental	4	50.0%	5	100%	5	60%	5	20.0%	19	57.9%
Other	332	16.9%	377	12.7%	381	16.8%	224	5.4%	1,314	13.7%
Total Issues & Percent MCO-Related	1,227	25.3%	847	21.6%	742	23.2%	549	17.7%	3,365	22.7%

Tracking of resolutions of issues from KanCare members may be enhanced by review by the Ombudsman of the grievance details provided by the MCOs to the State in the quarterly GAR reports.

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 18, the number of waiver-related contacts dropped to 40 in Q4 CY2016, a 73.7% decrease compared to Q1 CY2016 (152 contacts), a 54% decrease compared to Q2 (87 contacts), and a 34.4% decrease from Q3. From Q3 CY2014 through Q4 CY2016, the number of waiver-related inquiries ranged from 40 this quarter (Q4 CY2016) to 152 in Q1 CY2016. The most frequent waiver-related issues were from KanCare members receiving Intellectual/Developmental Disability (I/DD) Waiver services; of 40 waiver-related inquiries in Q4 CY2016, 11 were from members receiving I/DD Waiver services.

Table 18. Waiver-Related Inquiries to the Ombudsman's Office, CY2015 to CY2016

Waiver	CY2015					CY2016				
	Q1	Q2	Q3	Q4	Q1-Q4	Q1	Q2	Q3	Q4	Q1-Q4
Intellectual/Developmental Disability (I/DD)	35	25	29	28	117	48	27	21	**11**	107
Physical Disability (PD)	57	48	33	28	166	48	22	13	**9**	92
Technology Assisted (TA)	11	13	11	13	48	10	9	4	**4**	27
Frail Elderly (FE)	15	12	16	18	61	23	19	10	**7**	59
Traumatic Brain Injury (TBI)	10	9	7	9	35	10	3	7	**5**	25
Serious Emotional Disturbance (SED)	1	7	5	4	17	4	0	1	**3**	8
Autism	4	3	4	5	16	1	2	2	**1**	6
Money Follows the Person (MFP)	2	2	3	1	8	8	5	3	**0**	16
Total	**135**	**119**	**108**	**106**	**468**	**152**	**87**	**61**	**40**	**340**

Recommendations (Ombudsman's Office)

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports.

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q4 CY2016, 99.59% of the 83,581 member customer service inquiries and 99.99% of the 37,278 provider customer service inquiries received by the MCOs were resolved within two business days. All three MCOs in Q4 CY2016 met contractual requirements for resolving at least 98% of customer service inquiries within five business days.
- All three MCOs met the contractual requirement to resolve 100% of provider inquiries within 15 days. Two of the three MCOs (AGP and SSHP) met the contractual requirements to resolve 100% of member inquiries within 15 business days: SSHP reported 100% of their member and provider inquiries were resolved within five business days; and, AGP reported 100% of their provider inquiries and 99.99% of their member inquiries were resolved within five days, and the three not resolved within five days were resolved within eight days. UHC reported 99.8% of member inquiries were

resolved within 15 days; 43 member customer inquiries (37 in October and six in December) were 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.
- **Member customer service inquiries**
  - In CY2016, there were 11,009 fewer member inquiries than in CY2015. The number of benefit inquiries increased by 6,928 in CY2016 and had the highest percentage of member inquiries each quarter (21.7% of member inquiries in Q4 CY2016).
  - Of the 83,581 member customer service inquiries in Q4 CY2016, 46.3% were received by SSHP, 32.6% by UHC, and 21.1% by AGP.
  - Benefit inquiries were the highest percentage (21.7%) of member inquiries in Q4.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO; three of the seven with over two-thirds of the inquiries reported by one MCO for eight or more quarters. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:
    - "Care management or health plan program,"
    - "Concern with access to service or care; or concern with service or care disruption,"
    - "Member emergent or crisis call,"
    - "Update demographic information,"
    - "Enrollment information," and
    - "Need transportation".
  - The member customer service inquiry 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 STC and GAR reports. In Q4 CY2016, the MCOs received 2,484 contacts in this category that were in addition to the grievances and appeals reported by members.
- **Provider customer service inquiries**
  - In CY2016, there 7.1% fewer provider inquiries reported, compared to CY2015, including 11,227 fewer claims-related inquiries (in multiple categories).
  - Of the 37,278 provider inquiries received by MCOs in Q4 CY2016, AGP received 42.3%, SSHP 44.8%, and UHC 12.8%. UHC reported 55% to 58% fewer claims-related provider inquiries than AGP and SSHP in CY2016; the number of UHC claims-related inquiries decreased 44.8% from CY2015 to CY2016.
  - For providers, "Claim status" inquiries were again the highest percentage (46.8%) of the 37,278 provider inquiries.
  - Categories where two thirds or more of the provider inquiries in Q4 were reported by only one MCO included:
    - "Authorization – New,"
    - "Authorization – Status,"
    - "Coordination of benefits,"
    - "Web support,"
    - "Recoupment or negative balance," and
    - "Other."
  - 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 Q3 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,052,579 clean claims received in Q3 CY2016, 99.95% were processed within 30 days. Of the 2,035 clean claims not processed within 30 days, 920 (45.2%) were claims received by AGP; 740 (36.4%) were claims received by SSHP; and 375 (18.4%) were claims received by UHC.
  - In Q3 CY2016, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 181,057 non-clean claims received in Q3 CY 2016, 99.918% were processed within 60 days. Of the 148 non-clean claims not processed within 60 days, 124 (83.8%) were claims received by AGP, 15 (10.1%) were claims received by SSHP; and nine (6.1%) were claims received by UHC.
  - Of 4,233,636 "all claims" received in Q3 CY2016, 99.997% were processed within 90 days. Of the 144 claims not processed within 90 days, 127 (88.2%) were claims received by AGP; 13 (9.0%) were claims received by SSHP; and four (2.8%) were claims received by UHC.
  - The number of claims excluded from the non-clean claims processing time continued to be high in Q3, with 75% of the 1,344 excluded claims reported by SSHP.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q4 CY2016, the MCOs reported processing of 4,451,645 clean claims (including 1,697,422 pharmacy claims).
  - In Q4 CY2016, the average TAT for total services (excluding pharmacy claims) was 5.0 to 9.9 days, compared to 5.8 to 10.6 days in Q3 CY2016.
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - **Hospital Inpatient** – Hospital Inpatient claims had TATs in Q4 CY2016 ranging from 7.3 to 17.0 days, a decrease compared to Q3 CY2016 (8.3 to 18.2). AGP had the shortest TATs in Q4 (7.3 to 10.2 days), compared to SSHP (11.1 to 12.3 days) and UHC (10.8 to 17.0 days).
    - **Dental** - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q4 CY2016. SSHP had the shortest TATs each month (7.0 days); AGP and UHC had TATs of 13.0 days in Q4 CY2016 and the previous four quarters.
    - **Nursing Facilities** – Nursing Facility claims had TATs ranging from 4.6 to 10.6 days in Q4. AGP had the shortest TATs (4.6 to 6.0 days). SSHP had the longest (9.3 to 10.6 days) in Q4, an increase compared to 83 (8.8 to 9.7 days), Q2 (8.6 to 9.0 days) and Q1 (7.5 to 9.0 days). UHC's TATs in Q4 (7.4 to 7.7 days) was a decrease compared to in Q3 (7.6 to 8.8 days).
    - **HCBS** – HCBS claims had monthly TATs in Q4 ranging from 5.7 to 9.7 days. AGP had the shortest TATs (5.7 to 7.6 days), compared to SSSHP (8.2 to 9.7 days) and UHC (6.6 to 8.2 days).
    - **Behavioral Health** (BH) – BH claims TATs ranged from 4.1 to 9.8 days in Q4 CY2016. AGP had the shortest TATs (4.1 to 5.2 days), compared to SSHP (8.4 to 9.8 days) and UHC (8.3 to 9.0 days).
    - **Non-emergency transportation** (NEMT) - Clean claims for NEMT had monthly average TATs ranging from 9.6 to 13.7 days in Q4. AGP had the longest TATs in Q4, ranging from 12.0 to 13.7 days, compared to 9.6 to 9.9 for SSHP and 9.7 to 10.0 for UHC.
    - **Vision** – The average TATs were consistently a week or longer in Q4 and previous quarters for all of the MCOs. In Q4 CY2016, the average monthly TATs ranged from 7.0 to 12.6 days.

AGP had the shortest TAT (7.0 to 8.0 days), and SSHP had the longest TAT (12.0 to 12.6 days).

Grievances

- MCOs reported receiving 406 grievances in Q4 CY2016, which was fewer grievances than the three previous quarters. The total number of grievances received in CY2016 (1,631) was also lower than in the three previous years.
- There were fewer grievances reported by MCOs as received in Q4 CY2016 than the three previous quarters, and fewer grievances reported in CY2016 than in the three previous years. The number of grievances not resolved within 30 days was highest in CY2016 (76); however, in Q4 CY2016 the MCOs reported that all grievances resolved in Q4 were resolved within 30 days, compared to 59 not resolved within 30 days in Q3 CY2016.
- Of the 396 grievances reported as resolved in Q4
  - 99 (25.0%) were from AGP members, 128 (32.3%) from SSHP members, and 164 (41.4%) from UHC members.
  - 34 (8.6%) grievances from 31 members were categorized in the GAR report as "Access to service or care." Eight of the 34 grievances were from seven members receiving TBI, FE, I/DD, SED, PD, and TA waiver services.
  - 77 grievances (19.4%%) were categorized as QOC, 20 as "Quality of Care (non-HCBS)," three "Quality of Care – HCBS," and 54 as "Quality of Care" (UHC did not report whether or not the QOC grievance was HCBS-related, as had been directed by the State). Based on grievance descriptions, up to one third of the grievances categorized as QOC were not correctly categorized. 22 of the 77 grievances (28.6%) were from members receiving TBI, FE, I/DD, SED, PD, and TA waiver services.
- UHC again this quarter provided only limited descriptions of grievances and grievance resolutions in the GAR report, making it difficult to assess whether other grievances are categorized appropriately. Many of those that included detail were incorrectly categorized, including 26 of the 54 grievances UHC categorized as "Quality of Care."
- Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 164 transportation-related grievances received from 157 members. Of the 164 transportation-related grievances, 67 (40.1%) were reported by SSHP, 50 (29.9%) were reported by UHC, and 47 (28.7%) were reported by AGP. The number of "No Show" "Late" transportation grievances continued to be high, with 52 "No Show" grievances in Q4 (compared to 59 in Q3) and 27 "Late" grievances in Q4 and Q3. Of note in Q4 is the number of AGP grievances categorized as "Transportation Issues" that described eight where transportation as "not scheduled" and two that referred to errors in scheduling that were in addition to 18 "Transportation – Late" and 15 "Transportation – No Show" grievances. Also of concern is the increased number of "Transportation – Safety" grievances, which increased from seven in Q3 to 16 in Q4.
- Of 396 grievances reported as resolved by MCOs in Q4 CY2016, 122 (30.8%) were reported by 114 members receiving waiver services.
- KFMC identified over 55 grievances that, based on grievance descriptions were categorized incorrectly. Other errors include duplicate entries, missing grievance descriptions, and incomplete resolution details.
- Grievance categories differ in the STC and GAR reports. Using the same categories in both reports would allow better comparisons over time of grievances received and resolved each quarter.
- Descriptions by AGP and UHC in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 33 grievances in the category that quarter.

Ombudsman's Office

- As of Q4 CY2016, the Wichita satellite office had seven volunteers and a Project Coordinator available to provide onsite assistance from 10a.m. to 2p.m. Monday through Friday. A second satellite office, opened in July 2016 in Olathe (Johnson County), is currently staffed with four volunteers providing onsite assistance from 10a.m. to 1p.m. Mondays and Thursdays.
- Plans are underway for the Ombudsman Volunteer Coordinator to provide one-hour trainings to interested community service organizations on topics such as "How to assist with Medicaid applications," "Medicaid-related resources," and "KanCare programs and Home and Community-Based Services overview."
- In Q4 CY2016, 20.7% (108 of 523) of the contacts were MCO-related. The number of MCO-related contacts was lower in Q4 than the three previous quarters (ranged from 141 to 250). In CY2016, 20.4% of the contacts were MCO-related (649 of 3,186), compared to 36.5% in CY2015 (758 of 2,075) and 42.5% in CY2014 (890 of 2,092).
- The top two issues quarterly in CY2016 were "Medicaid Eligibility Issues" and HCBS-related issues. In Q4 CY2016, however, there were 31 HCBS-related issues compared to 71 in Q2 and 144 in Q1 CY2016. The number of "Medicaid Eligibility Issues" also dropped from 512 in Q1 CY2016 to 244 in Q2, and then to 173 in Q3 and 174 in Q4.
- The number of waiver-related contacts dropped to 40 in Q4 CY2016, a 73.7% decrease compared to Q1 CY2016 (152 contacts), a 54% decrease compared to Q2 (87 contacts), and a 34.4% decrease from Q3. The most frequent waiver-related issues were from KanCare members receiving Intellectual/Developmental Disability (I/DD) Waiver services (11 of 40 waiver-related inquiries in Q4 CY2016).

Recommendations Summary

Timely Resolution of Customer Service Inquiries

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. In particular:

1. The State should provide clear criteria to the MCOs for the member customer service category "*Concern with access to service or care; or concern with service or care disruption*" to ensure grievance and appeals contacts are not misclassified as customer service inquiries.
2. Clear criteria for the seven claims-related provider customer service inquiry categories should be provided by the State, and consistent implementation by the three MCOs is needed, to allow better comparisons by MCO and assessment of inquiry trends over time.

Timeliness of Claims Processing

1. MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.
2. The State should provide additional direction to the MCOs as to whether corrections (example: SSHP mistakenly excluding newborn claims from the 60-day and 90-day processing requirements) should be made in previous quarterly reports when errors in interpreting reporting criteria are identified.

Grievances

1. UHC should provide more detailed descriptions of the grievances resolved each quarter. Resolution details should not be limited to verification that a letter of resolution was sent.
2. MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided

where resolution details are blank or do not include enough detail to determine grievance resolution.

3. MCOs should ensure their staff categorize grievances using the revised categories and criteria. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.
4. MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
5. The State should consider using the same grievance and appeals categories in the STC and GAR reports to promote consistency and allow more complete assessment of grievances over time.
6. The STC report categories should be reviewed to assess whether any of the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.
7. Due to the addition of the "Transportation Late" category, the State should update the Grievance definition of the "Transportation Issues" category to include "late" as an exclusion, i.e. "(other than no show, safety, or late)."
8. UHC should identify whether QOC grievances are or are not HCBS-related. UHC staff should review the revised category criteria, particularly QOC, due to the many grievances mistakenly categorized.
9. SSHP should provide additional clarification for grievances where all details except the tracking number are exact; if duplicates, these should be removed from the list/counts, and, if errors, should be corrected.
10. The State should work with the MCOs to identify corrective actions to address the high number of transportation grievances related to safety, "no show," late," and errors in scheduling.

Ombudsman's Office

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports.

End of report