Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 3.31.17

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2017-12/31/2017)
Federal Fiscal Quarter: 2/2017 (1/17-3/17)

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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 March 31, 2017.

Demonstration Population	Enrollees at Close of Qtr. (3/31/2017)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	15,142	16,016	874
Population 2: ABD/SD Non Dual	28,613	29,263	650
Population 3: Adults	51,202	55,771	4,569
Population 4: Children	231,179	248,901	17,722
Population 5: DD Waiver	8,893	8,945	52
Population 6: LTC	20,440	21,440	1,000
Population 7: MN Dual	1,277	1,360	83
Population 8: MN Non Dual	1,280	1,366	86
Population 9: Waiver	4,530	4,631	101
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**362,556**	**387,693**	**25,137**

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 March 7, 2017. No tribal representatives attended in person or by phone.

Also during this quarter, the KanCare Advisory Council met. 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 meeting took place on March 27, 2017 at the CSOB room 530. The agenda was as follows:

- I. Welcome
- II. Review and Approval of Minutes from Council Meeting, June 30, 2016
- III. KDHE Update – Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
- IV. KDADS Update – Tim Keck, Secretary, Kansas Department for Aging and Disability Services
- V. Updates on KanCare with Q&A
  - a. Amerigroup Kansas
  - b. Sunflower State Health Plan
  - c. United Healthcare Community Plan
- VI. Update from KanCare Ombudsman – Kerrie Bacon
- VII. Miscellaneous Agenda Items
  - a. Update on Jan 13 findings by CMS regarding KanCare
- VIII. KanCare Extension
- IX. Next Meeting of KanCare Advisory Council – June 13, 2017, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
- X. Adjourn

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
- KDADS-CDDO-Stakeholder Meetings (quarterly)
- WSU-Community Engagement Institute Special Projects (weekly meeting) including HCBS Access Guide, Policy Gap Analysis, and Capacity Building survey

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 finalized an interim electronic PDF version of the credentialing forms and it is now posted for provider use on all KanCare credentialing websites. This workgroup is continuing its work with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal, which will eventually incorporate many elements from the credentialing form. This Provider Enrollment Portal will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. Version one of the portal is complete and assessment is underway. The design has

been demonstrated to providers and MCO partners. Once this assessment of the design is complete, the first version of the portal will be revised and then operationalized by the end of 2017. The workgroup will be working with the Fiscal Agent to integrate the desired changes into the later version of this 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 February 28, 2017, at United Health Care in Overland Park, Kansas. The meeting consisted of a report from the KanCare Ombudsperson, Kerrie Bacon, and the balance of the meeting the group finished reviewing the current 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 suggestions from this meeting have already been shared with the KDHE employees that are working with Maximus on designing a new application. We did receive some feedback on the new KanCare web site and how not all items were appearing on the use of an I-Pad. The next meeting on 06/22/2017 will be at Sunflower Health Plan's office in Lenexa, 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 over 180 events for the first quarter of 2017. 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 first quarter:

- Giving Grove Training
- Grace Med Capital Family Clinic
- El Centro of Topeka

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 approximately 9,000 Kansans in the first 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:

- Youth Health Days Exhibit
- Point in Time Homeless Count Event
- KS Mission of Mercy
- Babies Jubilee

Advocacy Activities: Amerigroup's advocacy efforts for first quarter of 2017 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 first 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:

- Member Advisory Committee (HCBS and Teen)
- The Treehouse
- Wichita Public Schools Parent meeting
- Health Core Clinic Presentation
- Butler County CDDO TCM meeting

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:
Marketing Activities: Sunflower Health Plan marketing activities for the 1st Quarter 2017 included attending and/or sponsoring 48 member and provider events. Sunflower began distribution of new collateral focused on healthy behaviors and rewards for 2017, which includes the addition of targeted immunization to the healthy rewards program with the goal of increasing childhood and adolescent vaccination rates. Sunflower sponsored the Governor's Weight Loss Challenge and participated in the event at the Statehouse. Sunflower sponsored a professional conference for social workers and community health workers in Wichita and attended several other CHW meetings during Q1 to bring awareness to the role of CHWs in our communities.

Examples of marketing activities that generated support at sponsored events as well as KanCare visibility in the community include:

- Franklin Elementary School Health Fair
- Pioneer Electric and Pioneer Communications Area Health Fair
- Jewell County Health Fair
- No One Eats Alone middle school event
- 14th Annual POWER Conference for social workers
- USD 259 Hispanic Health Fair
- WYCO/KCK Community Baby Shower - Project HOPE
- Mercy & Truth Medical Mission - Member Clinic Day
- Red File/Jayhawk Area Agency on Aging

Outreach Activities: In addition to Sunflower Health Plan's participation in community events such as Baby Showers, Health Fairs and School Assemblies, the health plan's 1st quarter 2017 outreach activities involved efforts to get members vaccinated against influenza and to encourage members to make their regular doctor's visits based on periodicity or health status. There was also a strong focus on ESPDT screenings and HPV vaccinations. Interventions include phone calls, direct mail and home visits with members, as well as provider engagement strategies. Sunflower Health Plan's participation at community events resulted in a reach of more than 4,700 members and providers during the 1st quarter.

Additionally, Sunflower's MemberConnections community health worker team, which is separate from and complementary to the case management team, made 290 successful home visits during the 1st quarter to assist members with social service needs and coordination such as transportation; an additional 590 home visits were unsuccessful because the member was not home. Sunflower Health Plan partnered with Robinson Middle School in Wichita to organize a "No One Eats Alone Day" event to promote inclusion and anti-bullying among students. During this event, we reached more than 700 students and faculty. Sunflower Health Plan supported the Kansas Department for Aging & Disability Services this quarter for the agency's Red File distribution events in Topeka and Lawrence, which helps senior citizens and people with disabilities keep emergency and health information in one place in their home in the event emergency responders need to find it.

The health plan continued its outreach to increase flu vaccinations through the 1st Quarter, and this resulted in an increase year-over-year: The rate of Sunflower members vaccinated against the flu this season – through March 2017 – is 22.49%, though this is a very conservative report since many vaccinations occur in the hospital and other facility settings where the service is not billed (reported) as a separate service. This 2016-2017 rate is higher than the previous year's rate of 21%.

Other notable outreach activities (not all-inclusive):

- Mercy & Truth Medical Mission - Clinic Day
- Sunflower Provider Workshops
- Butler County Targeted Case Managers Lunch & Learn
- Treehouse Events for expectant mothers, English and Spanish sessions
- Point in Time (PIT) Homeless Count
- Community Health Fairs (e.g., those listed in the Marketing section above)
- Two (2) Community Baby Showers during this reporting period

Advocacy Activities: Sunflower Health Plan's 1st quarter advocacy activities centered on competitive employment for people with disabilities. Sunflower opened a funding opportunity to all Project SEARCH sites in Kansas to request financial support needed to send representatives to the national Project SEARCH conference in Pennsylvania. Additionally, Sunflower Health Plan delivered presentations in two elementary schools on the topic "defying the odds," which featured life lessons of a Sunflower Health Plan employee who has cerebral palsy.

Sunflower Health Plan staff participated in health alliance and coalition meetings during the 1st quarter to provide information to advocacy groups that are active in our communities.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding KanCare benefits and general health education. UnitedHealthcare also worked to develop newly designed and easier to understand welcome materials for new members. Plan staff completed 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. New members were sent ID Cards and new member welcome kits in a timely manner. UnitedHealthcare mailed members the HealthTalk Winter newsletter (a quarterly newsletter) 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, Federally Qualified Health Centers (FQHC's) and Community Based Organizations throughout the state that involved discussions around exploring innovative and collaborative opportunities. UnitedHealthcare also accepted RFP submissions for a Rural Health Community Grant. UHC plans to award the RFP to 4-5 Recipients in May to help non-profit groups provide whole person care to Kansas consumer in rural communities. Additional strategic endeavors continued to focus on working with providers to ensure accurate panel assignments and attribution, where appropriate.

Outreach Activities: UnitedHealthcare Community Plan participated in and/or supported 117 Member facing activities including 54 lobby sits at provider offices as well as 40 Events or Educational Opportunities to educate both consumers and providers. In Q1 UHC hosted two Community Baby Showers with Community Partners and FQHCs, one in Pittsburg and one in Dodge City. These Community Events were well received and provided pregnant and new moms with information about healthy pregnancies and deliveries, as well as child safe sleep, breast feeding and car seat installation. In addition, UHC helped organize a Wyandotte County Community Baby Shower in May in partnership with the Health Department and the other two MCO's. UnitedHealthcare also participated in 3 Baby Showers that were sponsored by other organizations. UnitedHealthcare leveraged bilingual Community Outreach Specialists that focused on activities targeted within assigned geographical areas across Kansas. These specialists are fluent in

both English and Spanish languages and effectively communicate with members with diverse cultural backgrounds. Additional Outreach Specialists supported activities in their respective territories. The Outreach Specialists regularly support one another working collaboratively to serve UHC Members. The key responsibility of the Outreach Specialist is to conduct educational outreach for members, community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. Of key importance is to meet members where they are and help understand their personal goals and how we can help them reach those goals. UnitedHealthcare educates Members and Providers on Value Added benefits and the features and benefits of KanCare. UnitedHealthcare also interacts with key provider offices and the provider community to assist with issue resolution. Several key outreach initiatives this quarter included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, and several health fairs and clinic days throughout the state. UnitedHealthcare also participated in a number of community stakeholder committee meetings in the first quarter of 2017. In particular, a lot of focus and support was given to the IRC (International Rescue Committee) that offers support to refugees in Kansas through the Wilson-Fish program. This population of refugees in Kansas is medically underserved and in need of help and support to get preventative medical care. UnitedHealthcare also sponsored and supported the Operation Red File program that is working to put folders on the refrigerators of Kansas Consumers so that EMT has all the data they need in the event of an emergency. One final key activity was the UHC Member Advisory Meeting. The Q1 meeting was held in Wichita and focused on member education and specifically new member welcome materials. The material was printed and attendees were asked to review and offer feedback and ideas. These materials had already been state approved, but not printed and mailed. UHC was able to make the changes suggested by members and the revised materials with the change incorporated will be printed. The rest of the Member Advisory Meeting focused on KanCare and UHC Value Added Benefits where members asked questions and offered ideas for benefits they would like to see added.

During the first quarter 2017, UnitedHealthcare staff personally met with:

- Approximately 5,504 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
- Approximately 783 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities
- More than 1,152 individuals from provider offices located throughout the State

Advocacy Activities: The UnitedHealthcare continued to support advocacy opportunities to support children, refugees and members with disabilities, and the individuals and agencies that support them.
-Throughout this quarter, UHC supported Disability Mentoring Day events, Brain Injury Advocacy Day, Youth Health Fairs and Family Advocacy days across the State. These events offer support for children and the waiver population and helped members and advocates learned 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.

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

- Hays Community Service Council
- Pratt County Community Health & Resource Council
- Thomas County Health Coalition
- Great Bend Interagency Committee
- Migrants Program Committee
- Cultural Relations Board
- Ford County Health Coalition
- Lifestyle Diabetes Coaches Training
- Tobacco Cessation Work Group
- Crawford County Health Department WIC
- Shawnee County Oral Health Coalition
- Douglas/Jefferson County Transition Council

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 24 was submitted to CMS on February 3, 2017. CMS requested additional information from the state on March 9, 2017. Responses were sent to CMS on March 20, 2017.

   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. Responses were sent to CMS 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 services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-March, 2017 , follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	1,000	$142,611
	Member Incentive Program	5,377	$99,165
	Mail Order OTC	2,898	$51,805
	Total of all Amerigroup VAS Jan- March 2017	***10,085***	***$341,738***
Sunflower	CentAccount Debit Card	17,332	$188,145
	Dental Visits for Adults	2,277	$103,371
	Pharmacy Consultation	2,744	$85,726
	Total of all Sunflower VAS Jan- March 2017	***40,936***	***$478,689***
United	Rewards for Preventive Visits & Health Actions	9,700	$51,643
	Adult Briefs	448	$33,033
	Baby Blocks Program and Rewards	260	$31,200
	Total of all United VAS Jan- March 2017	***26,322***	***$229,171***

c. Enrollment issues: For the first quarter of calendar year 2017 there were 12 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the first quarter of calendar year 2017. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	2
KDHE - Administrative Change	59
WEB - Change Assignment	27
KanCare Default - Case Continuity	112
KanCare Default – Morbidity	239
KanCare Default - 90 Day Retro-reattach	99
KanCare Default - Previous Assignment	329
KanCare Default - Continuity of Plan	469
AOE – Choice	3486
Choice - Enrollment in KanCare MCO via Medicaid Application	896
Change - Enrollment Form	264
Change - Choice	399
Change - Access to Care – Good Cause Reason	1
Change - Case Continuity – Good Cause Reason	1

Enrollment Reason Categories	Total
Change – Due to Treatment not Available in Network – Good Cause	
Assignment Adjustment Due to Eligibility	8
Total	**6391**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
CY17 1st 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	10	9	11	16	4	3	17	33	4	3	1	23	3
SUN		30			11	1	38	13	9	5	5	10	2
UHC	38				10	1	18	16	25	5		37	2
Total	48	39	11	16	25	5	73	62	38	13	6	70	7

MCOs' Appeals Database
Members – CY17 1st quarter report

Member Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**
MEDICAL NECESSITY DENIAL				
Criteria Not Met - DME	15 14		10 5	5 9
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	1 26	1 25		1
Criteria Not Met - Medical Procedure (NOS)	3 14		2 7	1 7
Criteria Not Met - Radiology	2 4		1 2	1 2
Criteria Not Met - Pharmacy	18 59 49	3 2 1	14 27 26	1 30 22
Criteria Not Met - PT/OT/ST	15 1		11	4 1
Criteria Not Met - Dental	1 1 4			1 1 4

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Criteria Not Met or Level of Care - Home Health	2 1		1	1 1
Criteria Not Met - Hospice				
Criteria Not Met - Out of network provider, specialist or specific provider request	1		1	
Criteria Not Met – Inpatient Behavioral Health	3 35		7	3 28
Criteria Not Met – Behavioral Health Outpatient Services and Testing	3 7 3	1	1 4	2 3 2
Level of Care - LTSS/HCBS	17 3	4	8	5 3
Level of Care - WORK				
Level of Care - LTC NF				
Level of Care - Mental Health				
Ambulance (include Air and Ground)				
Other- Medical Necessity	10 10		2 2	8 8
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	2	1		1
Service not covered - Home Health	8		2	6
Service not covered - Pharmacy	1			1
Service not covered - Out of Network providers				
Service not covered - OT/PT/Speech				
Service not covered - DME	6		4	2
Service not covered - Behavioral Health				
Other - Noncovered service	10 9	2	5	5 7
Lock In	1			1
Billing and Financial Issues				
PRIOR AUTHORIZATION DENIAL				
Late notification				
No authorization submitted	1	1		
TOTAL AMG – Red SUN – Green UHC - Purple	48 186 126	8 3 30	26 81 35	14 102 61

MCOs' Appeals Database

Providers - CY17 1st quarter report (appeals resolved)

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
MEDICAL NECESSITY DENIAL				
Criteria Not Met - DME	1 4		1 1	3
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	19 31 99		8 16 25	11 15 74
Criteria Not Met - Medical Procedure (NOS)	5 5		4 2	1 3
Criteria Not Met - Radiology	10		9	1
Criteria Not Met - Pharmacy	48 1		48	1
Criteria Not Met - PT/OT/ST	1			1
Criteria Not Met - Dental	18		10	8
Criteria Not Met - Vision	34		29	5
Criteria Not Met or Level of Care - Home Health				
Criteria Not Met - Hospice				
Criteria Not Met - Out of network provider, specialist or specific provider request				
Criteria Not Met – Inpatient Behavioral Health	5 7		2	5 5
Criteria Not Met – Behavioral Health Outpatient Services and Testing	1 2			1 2
Level of Care - LTSS/HCBS	2		1	1
Level of Care - WORK				
Level of Care - LTC NF				
Level of Care - Mental Health				
Ambulance (include Air and Ground)	1		1	
Other-medical necessity	6 3		3 1	3 2
NONCOVERED SERVICE DENIAL				
Service not covered - Dental				
Service not covered - Vision				
Service not covered - Home Health	7 3	1	4 2	3

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Service not covered - Pharmacy	1			1
Service not covered - Out of Network providers				
Service not covered - OT/PT/Speech				
Service not covered - DME	1	1		
Service not covered - Behavioral Health	4		4	
Other- not covered service	151		21	130
BILLING AND FINANCIAL ISSUES				
Claim Denied- contained errors	6602 13 30		3989 7 26	2613 6 4
Claim Denied- by MCO in Error	2977 1		1191	1786 1
PRIOR AUTHORIZATION DENIAL				
Late notification	14 13		5 1	9 12
No authorization submitted	8 15	3	4 8	4 4
TOTAL AMG – Red SUN – Green UHC - Purple	**9,683** **152** **308**	**0** **0** **5**	**5,256** **80** **87**	**4,427** **72** **216**

MCOs' Appeals Database

Provider Appeal Summary – CY17 1st quarter report

AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Resolved at 1st Appeal Level	9192 308	4	5087 84	4105 220
Resolved at 2nd Appeal Level	491 152		169 80	322 72

State of Kansas Office of Administrative Fair Hearings

Members – CY17 1st 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
MEDICAL NECESSITY DENIAL								
Criteria Not Met - Durable Medical Equipment		1						1
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)								
Criteria Not Met - Medical Procedure (NOS)								
Criteria Not Met - Radiology								
Criteria Not Met - Pharmacy		1						
Criteria Not Met - PT/OT/ST					1			
Criteria Not Met - Dental		1						
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								
Criteria Not Met – Behavioral Health Outpatient Services and Testing								
Level of Care - LTSS/HCBS	1 2	1 1			1 1		2	1
Level of Care - WORK								
Level of Care - LTC NF								

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
Level of Care - Mental Health								
Ambulance (include Air and Ground)								
Other- Medical Necessity		1						
NONCOVERED SERVICE DENIAL								
Service not covered - Dental	1							
Service not covered - Home Health								
Service not covered - Pharmacy								
Service not covered - Out of Network providers								
Service not covered - OT/PT/Speech								
Service not covered - Durable Medical Equipment								
Service not covered - Behavioral Health								
Other - Noncovered service		2		2				
LOCK IN								
BILLING AND FINANCIAL ISSUES								
PRIOR AUTHORIZATION DENIAL								
Late notification								
No authorization submitted								
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	**3** **2**	**1** **6** **2**		**2**	**1** **2**		**2**	**1** **1**

State of Kansas Office of Administrative Fair Hearings

Providers – CY17 1st 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**
MEDICAL NECESSITY DENIAL								
Criteria Not Met - Durable Medical Equipment		1						
Criteria Not Met - Inpatient Admissions	1 2 11	1	5			1		
Criteria Not Met - Medical Procedure (NOS)								
Criteria Not Met - Radiology								
Criteria Not Met - Pharmacy			2					
Criteria Not Met - PT/OT/ST								
Criteria Not Met - Dental								
Criteria Not Met or Level of Care - Home Health								
Criteria Not Met - Hospice								
Criteria Not Met - Out of Network providers								
Criteria Not Met – Inpatient Behavioral Health								
Criteria Not Met – Behavioral Health Outpatient Services and Testing		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)		1						
Other-medical necessity						1		

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
NONCOVERED SERVICE DENIAL								
Service not covered - Dental								
Service not covered - Home Health								
Service not covered - Pharmacy								
Service not covered - Out of Network providers								
Service not covered - OT/PT/Speech								
Service not covered - Durable Medical Equipment								
Service not covered - Behavioral Health								
Other- not covered service			1					
BILLING AND FINANCIAL ISSUES	12 8 3	16 2 3	18 9 2	1	7 1	1 6	 2	
PRIOR AUTHORIZATION DENIAL								
Late notification								
No authorization submitted		1				1		
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	**13** **10** **14**	**16** **7** **3**	**18** **10** **9**	**1**	**7** **1**	**1** **9**	 **2**	

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 Q1 of 2017, 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 2016 statistics showed even further improvement.

The majority of good cause requests (GCRs) during the Q1 of 2017 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.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the first quarter of 2017, there were 2 state fair hearings filed for a denied GCR. One was eventually withdrawn, and the other is scheduled for a hearing in May. A summary of GCR actions this quarter is as follows:

Status	January	February	March
Total GCRs filed	14	10	33
Approved	1	1	1
Denied	8	7	23
Withdrawn (resolved, no need to change)	3	1	6
Dismissed (due to inability to contact the member)	2	1	3
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.

Quarter one of 2017, we have revised the provider pull to reflect the number of unique providers per name, NPI and city. Previously, we indicated unique providers by name and NPI, eliminating multiple records for providers who served in more than one city. Since Kansas is a highly rural state with many providers serving in multiple clinic locales, we felt a revision of this report would be a more accurate reflection of network capacity. The old method of calculation is listed first, then the new way:

KanCare MCO	# of Unique Providers as of 6/30/16	# of Unique Providers as of 9/30/16	# of Unique Providers as of 12/31/16	# of Unique Providers as of 3/31/17
Amerigroup	16,410	16,623	16,886	16,498/23,758
Sunflower	20,647	20,734	21,391	22,313/30,992
UHC	22,133	24,321	23,778	23,777/39,881

MLTSS implementation and operation: In the first quarter of 2017, 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. Kansas has offered services to 250 individuals on the HCBS-PD waiting list. **The percentage acceptance rate and** program positions are monitored monthly and Kansas projects that more offers will be sent to individuals on the HCBS-PD waiting list in the coming months. 114 individuals on the HCBS-IDD waiver wait list were offered funding in February 2017, with a 75% acceptance rate.

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. The State submitted the hospitals' DY4 Annual reports on March 1, 2017.

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 June 21, 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 SED Waiver was submitted to CMS on 12-2-2016.
   - The Autism waiver is currently operating off an extension through June 23, 2017. CMS has required the state to remove three autism waiver services and provide them under the state plan as EPSDT services. The Autism Waiver was submitted to CMS on 11/23/16. The State has continued to work with CMS to address requests for additional information during this extension period.

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 February 24, 2017, 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 3.31.17 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	*2017-01*	*2017-02*	*2017-03*	*Grand Total*
Population 1: ABD/SD Dual	15,384	15,307	15,152	45,843
Population 2: ABD/SD Non Dual	28,778	28,732	28,622	86,132
Population 3: Adults	52,819	51,571	51,204	155,594

Sum of Member Unduplicated Count	Member Month			Totals
Population 4: Children	240,234	233,144	231,182	704,560
Population 5: DD Waiver	8,930	8,917	8,906	26,753
Population 6: LTC	20,659	20,641	20,687	61,987
Population 7: MN Dual	1,306	1,290	1,289	3,885
Population 8: MN Non Dual	1,322	1,311	1,280	3,913
Population 9: Waiver	4,470	4,474	4,531	13,475
Grand Total	**373,902**	**365,387**	**362,853**	**1,102,142**

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

VIII. Consumer Issues

Consumer issues remain static. A summary of first quarter of 2017 consumer issues remains:

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

Issue	Resolution	Action Taken to Prevent Further Occurrences
		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.

Support and assistance for consumers around the state for KanCare was provided by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,242 consumers. OEW also assisted in resolving 2,061 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 1,408 consumer phone calls.

During this quarter, OEW staff also participated in 22 community events providing KanCare 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 first quarter of 2017, 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.
- 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 2017, 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.
- Compilation of the comprehensive 2016 annual compliance review 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.
- Ongoing analysis and workgroups reviewing the new Managed Care rules with the associated changes for quality.
- Medicaid Fraud Control Unit monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.

- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- 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 protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews.
- An HCBS Waiver Quality Review policy has been approved. 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 10/1/2016 through 12/31/2016 period. The MCOs were provided with the sample to upload for review for the 1/1/2017 through 3/31/17 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-March 2017:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:26	2.51%	49,286
Sunflower	0:22	1.30%	44,195
United	0:15	0.61%	46,159
HP – Fiscal Agent	0.00	0.0%	5,401

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:20	1.88%	23,999
Sunflower	0:15	1.26%	25,767
United	0:16	0.80%	20,925
HP – Fiscal Agent	0.00	0.0%	4,304

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 – CY17 1st Quarter

Amerigroup 1st Quarter Grievance Trends		
Total # of Resolved Grievances	137	
Top 3 Trends		
Trend 1: Transportation No Show	33	24%

Trend 2: Billing and Financial Issues (non-transportation)	23	17%
Trend 3: Transportation Issues - Including reimbursement (other than no show or safety)	17	12%

Sunflower 1st Quarter Grievance Trends		
Total # of Resolved Grievances	124	
Top 3 Trends		
Trend 1: Transportation (Including reimbursement)	38	31%
Trend 2: Customer Service	30	24%
Trend 3: Transportation (No Show)	13	10%

United 1st Quarter Grievance Trends		
Total # of Resolved Grievances	152	
Top 3 Trends		
Trend 1: QOC (non- HCBS, non-Transportation)	38	25%
Trend 2: Billing/Financial Issues (non-trans)	37	24%
Trend 3: Transportation (Late)	25	16%

MCOs' Appeals Trends
Member/Provider – CY17 1st Quarter

Amerigroup 1st Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	48		Total # of Resolved Provider Appeals	9683	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	18	38%	Trend 1: Claim Denied - contained errors	6602	68%
Trend 2: Level of Care - LTSS/HCBS	17	35%	Trend 2: Claim Denied - by MCO in Error	2977	31%
Trend 3: Criteria Not Met - Medical Procedure (NOS)	3	6%	Trend 3: Criteria Not Met - Pharmacy	48	0%

Sunflower 1st Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	186		Total # of Resolved Provider Appeals	152	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	59	32%	Trend 1: Criteria Not Met - Vision	34	22%
Trend 2: Criteria Not Met - Inpatient Behavioral Health	35	19%	Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	31	20%
Trend 3: Criteria Not Met - DME	15	8%	Trend 3: Criteria Not Met - Dental	18	12%

United 1st Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	126		Total # of Resolved Provider Appeals	308	
Top 3 Trends			Top 3 Trends		
Trend 1: Criteria Not Met - Pharmacy	49	39%	Trend 1: Other - not covered services	151	49%
Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	26	21%	Trend 2: Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	99	32%
Trend 3: Criteria Not Met - DME	14	11%	Trend 3: Claim Denied - contained errors		0%

MCOs' SFH Reversed Decisions
Member/Provider – CY17 1st Quarter

Amerigroup 1st Quarter					
Total # of Member SFH	3		Total # of Provider SFH	56	
OAH reversed MCO decision	1	33%	OAH reversed MCO decision	0	0%

Sunflower 1st Quarter					
Total # of Member SFH	14		Total # of Provider SFH	38	
OAH reversed MCO decision	1	7%	OAH reversed MCO decision	0	0%

United 1st Quarter					
Total # of Member SFH	6		Total # of Provider SFH	27	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

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

e. Summary of ombudsman activities for the first quarter of 2017 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.

The Cross-Agency Adverse Incident Management Team finalized critical incident definitions for the types of incidents to be monitored and reported in the AIR system and all were aligned with waiver performance measures. KDADS legal has approved the definitions and State and MCO representatives agreed upon roles and responsibilities for investigation and follow-up and four categories for tracking and trending this remediation.

The AIR training video and instructional webinar was completed and posted to the KDADS website for provider education. KDADS provided an informational memo for the MCOs to circulate to providers informing them of these resources and requiring reporting all critical incidents though the AIR system.

KDADS and the Department for Children and Families (DCF) cross-walked reporting fields in the AIR system and the protection reporting system to determine which need to be uploaded to the AIR system. Updates on this work and a demo of the AIR system were provided during team meetings and team members provided suggestions on the reporting structure and functionality.

Next steps include development of canned reports, reporting capabilities and a work plan for KDADS IT for AIR Revisions. The Critical Incident Policy is being finalized and will be submitted to the KDHE policy group and KDHE administrative staff for approval to post.

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 2017 AIRS reports through the quarter ending March 31, 2017 follows:

Critical Incidents	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**YTD**
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	1,610				1,610
Pending Resolution	0				0
Total Received	1,610				1,610
APS Substantiations*	58				58

**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 first quarter HCAIP UCC Pool payments will be made in late May or early June. The LPTH/BCCH Pool first quarter payments will be made in May.

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 first quarter of 2017, 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 March 31, 2017:

- Current number of individuals on the PD Waiting List: 1,004
- Number of individuals added to the waiting list: 430
- Number of individuals removed from the waiting list: 152
    - 114 started receiving HCBS-PD waiver services
    - 5 were deceased
    - 33 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending March 31, 2017:

- Current number of individuals on the I/DD Waiting List: 3,775
- Number of individuals added to the waiting list: 50
- Number of individuals removed from the waiting list: 92
    - 41 started receiving HCBS-I/DD waiver services
    - 51 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 8,881 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 3.31.17
X(e)	Summary of KanCare Ombudsman Activities for QE 3.31.17
XII	KFMC KanCare Evaluation Report for QE 3.31.17
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 3.31.17

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

May 31, 2017

DY5

Start Date: 1/1/2017
End Date: 12/31/2017

Quarter 1

Start Date: 1/1/2017
End Date: 3/31/2017

	Total Expenditures	Total Member-Months
Jan-17	$241,244,877	357,703
Feb-17	$241,097,963	357,213
Mar-17	$244,114,534	365,934
Q1 Total	$726,457,374	1,080,850

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Jan-17									
Expenditures	$1,389,487	$34,982,271	$26,634,084	$49,365,009	$41,251,320	$72,340,173	$711,961	$2,533,399	$12,037,173
Member-Months	7,371	37,109	52,970	222,528	9,075	21,224	1,393	1,465	4,568
Feb-17									
Expenditures	$1,406,306	$35,870,129	$25,946,758	$49,318,676	$41,216,930	$71,697,733	$808,220	$2,584,062	$12,249,149
Member-Months	7,502	37,644	53,125	220,504	9,044	21,623	1,594	1,508	4,669
Mar-17									
Expenditures	$1,495,968	$35,871,914	$26,492,604	$51,089,583	$41,545,617	$71,739,582	$825,382	$2,734,999	$12,318,885
Member-Months	7,876	37,971	54,433	227,220	9,006	21,553	1,598	1,546	4,731
Q1 Total									
Expenditures	$4,291,761	$106,724,314	$79,073,446	$149,773,268	$124,013,867	$215,777,488	$2,345,563	$7,852,460	$36,605,207
Member-Months	22,749	112,724	160,528	670,252	27,125	64,400	4,585	4,519	13,968
DY 5 - Q1 PMPM	$189	$947	$493	$223	$4,572	$3,351	$512	$1,738	$2,621

Note:

1. For DY5 Member-Months are CAP + RETRO combined.

KanCare Ombudsman Quarterly Report
Kerrie J. Bacon, KanCare Ombudsman
1st Quarter 2017 KDHE Report

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication and in person during the first quarter of 2017. First quarter is a decrease of 27% from last year. The decrease is still a significant increase compared to 2014 and 2015.

Contacts	**Qtr. 1**	**Qtr. 2**	**Qtr. 3**	**Qtr. 4**	**Comments**
2013	615	456	436	341	2013 does not include emails
2014	545	474	526	547	
2015	510	462	579	524	
2016	1130	846	687	523	
2017	825				
2017 Comparison to 2016	-27%				

To assist at the local level, the Ombudsman's office had the following assistance:

- Wichita satellite office opened in November 2015 and was staffed with volunteers from 10-5, Tuesday - Friday along with a ¾ time Project Coordinator who supervised the volunteers, assisted with phone coverage, and provided outreach. There are currently 7 Ombudsman volunteers and one Ombudsman VISTA volunteer (started in March) at the Wichita satellite office.
- Olathe satellite office opened in July 2016 and is currently staffed with volunteers Monday, Wednesday and Thursday, 10am – 1pm. There are currently 3 volunteers at the Olathe satellite office with three in various stages of training.

MCO related	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**
Amerigroup	92	46	45	31	60
Sunflower	92	57	59	46	65
UnitedHealthcare	66	47	37	31	53
Total	**250**	**150**	**141**	**108**	**178**

The KanCare Ombudsman webpage ***(www.kancare.ks.gov/kancare-ombudsman-office)*** is recently updated. The Resources page was updated to reflect the resource notebook that is used by the volunteers and staff and is now being provided on the website to make available to the Ombudsman Liaison Volunteers. Much of this information is mailed or emailed to KanCare members on an as needed basis.

Outreach by Ombudsman's office

- **Presentations:** (educational, networking, referrals, advertisement
- Life Centers of Kansas City (Leavenworth County), January 26, 2017
- Human Trafficking Conference booth; January 27, 2017
- Catholic Charities presentation; February 22, 2017
- POWER Conference booth; February 24, 2017
- Spoke at three Wichita State University classes about Ombudsman's office, February 2, 2017; March 6, 2017; March 7, 2017.
- Livable Neighborhoods Task Force meeting (Wyandotte County) February 23, 2017
- Wichita State University Public Health Fair; March 29, 2017
- KanCare Ombudsman Liaison Training Session; Kansas City, March 30, 2017
- **Publications:** Outreach post and/or article about the KanCare Ombudsman office services.
    - Livable Neighborhoods Neighborhood News (Wyandotte Co. newsletter) (January, February, March)
    - Senior Bluebook (KC, KS and KC, MO) January, February, March, 2017
    - Public Health Newsletter; February 2017
    - City of Wichita, District 2 (on-line); March 2017
- Friends and Family Advisory Council which met one time during the first quarter.
- 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 Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** is in its fourth quarter of providing assistance to KanCare members. Johnson County Satellite office is answering the phone and meeting with individuals on Mondays, Wednesdays, and Thursdays, 10:00am to 1:00pm.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been open over a year, providing assistance to KanCare members. The Southern Kansas Satellite Office is answering the phone and meeting with individuals Tuesdays through Fridays 10:00am to 5:00pm.
- Both Satellite offices are assisting consumers with filling out applications on the phone and by appointment, in person.
- Volunteer Applications are available on the ***recently updated*** KanCare Ombudsman webpage. www.KanCare.ks.gov/kancare-ombudsman-office.

Data by 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	Q1/17
Main	432	648
Johnson County	21	28
Wichita	70	149
Total	**523**	**825**

Contact Method	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
phone	862	644	507	394	687
email	265	191	174	125	125
letter	2	3	1	0	2
in person	0	8	3	3	11
online	1	0	2	1	0
Total	**1130**	**846**	**687**	**523**	**825**

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Caller Type	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Provider	179	110	100	71	117
Consumer	866	601	544	352	630
MCO employee	7	4	10	8	18
Other	78	131	33	92	60
Total	**1130**	**846**	**687**	**523**	**825**

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

	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Avg. Days to Resolve Issue	7	5	6	4	11
% files resolved in one day or less	49.6%	56%	54%	52%	34%
% files closed	77%	88%	87%	80%	88%

The most frequent calls regarding home- and community-based services (HCBS) waivers during the first quarter of 2017 was in regard to the intellectual/developmental disability waiver and then the physical disability and frail elderly 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	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
PD	48	22	13	9	40
I/DD	48	27	21	11	43
FE	23	19	10	7	30
Autism	1	2	2	1	3
SED	4	0	1	3	4
TBI	10	3	7	5	6
TA	10	9	4	4	8
MFP	8	5	3	0	2
PACE	0	0	0	0	0
Mental Health	8	6	3	2	5
Substance Use Disorder	0	0	0	0	0
Nursing Facility	47	27	16	27	65
Other	941	739	612	456	628
Total	**1148**	**859**	**692**	**525**	**834**

The Issue Categories listed below reflect the last five quarters in alphabetical order. The top five issues for each quarter are highlighted. The issues that carry across several quarters are Medicaid Eligibility Issues and Other. ***The Issue titles that are highlighted are newly added to help clarify assistance provided to members and potential members.*** History is only available for first quarter, 2017 so far for the new issues. There may be multiple issues for a member/contact.

Issues	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Access to Providers	7	6	9	13	14
Affordable Care Act	n/a	n/a	n/a	n/a	3
Appeals, Grievances	49	42	36	16	36
Billing	43	39	37	26	21
Care Coordinator Issues	7	3	6	4	5
Change MCO	15	3	0	6	3
Client Obligation	n/a	n/a	n/a	n/a	17
Dental	4	5	5	5	7
Division of Assets	n/a	n/a	n/a	n/a	2
Durable Medical Equipment	7	7	2	4	2
Estate Recovery	n/a	n/a	n/a	n/a	5
Guardianship Issues	0	1	2	2	3
HCBS Eligibility issues	45	33	21	9	46
HCBS General Issues	69	32	16	15	33
HCBS Reduction in hours of service	12	4	3	3	7
HCBS Waiting List issues	18	2	2	4	6
Housing issues	8	2	2	3	4

Issues	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Medicaid Application Assistance	n/a	n/a	n/a	n/a	46
Medicaid Coding	n/a	n/a	n/a	n/a	3
Medicaid Eligibility Issues	512	244	173	174	236
Medicaid Renewal	n/a	n/a	n/a	n/a	29
Medical Services	29	20	10	12	20
Moving to/from Kansas	n/a	n/a	n/a	n/a	5
Nursing Facility Issues	40	25	22	22	38
Other	332	377	381	224	274
Pharmacy	24	13	11	8	10
Questions for Conf Calls	0	0	1	2	0
Spenddown Issues	n/a	n/a	n/a	n/a	18
Thank you	72	85	114	100	235
Transportation	6	8	6	1	8
Unspecified	79	38	21	17	45
Total	1378	989	880	670	1181

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, potential member, provider or other caller to resolve an issue and what resources where provided. Highlighted titles in the Action Taken column indicate title changes or new categories to clarify assistance provided to members, potential members, providers, etc. History is only available for first quarter, 2017 so far for the new actions. Often multiple resources are provided to a member/contact.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Question/Issue Resolved	122	239	233	214	160
Used Contacts or Resources/Issues Resolved	463	394	313	166	494
Closed	198	313	111	17	65
Provided Resources to Member	361	239	115	88	203
Mailed/Email Resources	n/a	n/a	n/a	n/a	43
KDHE Contacts	214	97	97	111	134
DCF Contacts	6	2	1	4	1
MCO Contacts	48	43	44	31	33
MCO Referral	n/a	n/a	n/a	n/a	19
Clearinghouse Contact	n/a	n/a	n/a	n/a	73
Clearinghouse Referral	n/a	n/a	n/a	n/a	25
HCBS Team Contacts	28	21	12	5	29
HCBS Team Referral	n/a	n/a	n/a	n/a	7
CSP Mental Health Contacts	1	1	0	0	2
Other KDADS Contacts/Referral	53	16	44	38	49
State/Community Agency Referral	111	40	53	14	46
Disability Rights and/or KLS Referral	13	7	4	3	8
Total	**1618**	**1412**	**1027**	**691**	**1391**

Data by Managed Care Organization

The following charts provide the issue categories for the last five quarters by MCO. The top four issues are shaded. ***The Issue titles that are highlighted are newly added to help clarify assistance provided to members and potential members.*** History is only available for first quarter, 2017 so far for the new issues. There may be multiple issues for a member/contact.

Amerigroup

Issue Category - Amerigroup	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Access to Providers (usually Medical)	1	1	2	2	3
Affordable Care Act	n/a	n/a	n/a	n/a	0
Appeals / Grievances	9	5	1	0	10
Billing	11	6	7	2	1
Care Coordinator Issues	4	1	3	1	1
Change MCO	1	1	0	0	1
Client Obligation	n/a	n/a	n/a	n/a	1
Dental	0	0	1	1	0
Division of Assets	n/a	n/a	n/a	n/a	0
Durable Medical Equipment	2	2	1	1	0
Estate Recovery	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	0	1
HCBS Eligibility issues	8	5	4	0	6
HCBS General Issues	13	3	3	3	11
HCBS Reduction in hours of service	6	1	1	1	2
HCBS Waiting List	0	0	0	1	1
Housing Issues	1	1	0	1	0
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0
Medicaid Eligibility Issues	28	8	5	6	8
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	4
Medical Services	7	2	3	1	5
Moving to/from Kansas	n/a	n/a	n/a	n/a	1
Nursing Facility Issues	2	1	0	1	1
Other	19	16	20	10	14
Pharmacy	3	1	0	2	1
Questions for Conference Calls/Sessions	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	2
Thank you.	6	4	9	5	23
Transportation	2	1	1	0	1
Unspecified	2	0	0	1	1
Total	**125**	**59**	**61**	**39**	**99**

Sunflower

Issue Category - Sunflower	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**
Access to Providers (usually Medical)	1	1	2	0	4
Affordable Care Act	n/a	n/a	n/a	n/a	0
Appeals / Grievances	14	11	8	2	5
Billing	6	7	9	7	3
Care Coordinator Issues	2	1	1	2	1
Change MCO	3	1	0	1	0
Client Obligation	n/a	n/a	n/a	n/a	3
Dental	1	2	0	0	0
Division of Assets	n/a	n/a	n/a	n/a	0
Durable Medical Equipment	5	2	0	2	0
Estate Recovery	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	0	0
HCBS Eligibility issues	3	7	3	2	3
HCBS General Issues	15	9	1	5	5
HCBS Reduction in hours of service	0	3	1	0	1
HCBS Waiting List	1	0	0	0	1
Housing Issues	0	0	0	0	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	1
Medicaid Coding Issues	n/a	n/a	n/a	n/a	2
Medicaid Eligibility Issues	26	7	10	9	14
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	6
Medical Services	4	8	0	3	5
Moving to/from Kansas	n/a	n/a	n/a	n/a	0
Nursing Facility Issues	3	3	2	1	2
Other	23	12	24	16	18
Pharmacy	4	1	4	4	4
Questions for Conference Calls/Sessions	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	2
Thank you.	7	6	8	11	20
Transportation	1	2	4	1	4
Unspecified	1	0	0	0	1
Total	**120**	**83**	**77**	**66**	**106**

UnitedHealthcare

Issue Category – UnitedHealthcare	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**
Access to Providers (usually Medical)	2	1	0	2	4
Affordable Care Act	n/a	n/a	n/a	n/a	0
Appeals / Grievances	6	4	5	1	3
Billing	3	5	2	3	3

Issue Category – UnitedHealthcare	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17
Care Coordinator Issues	0	0	2	1	3
Change MCO	3	0	0	4	2
Client Obligation	n/a	n/a	n/a	n/a	2
Dental	1	3	2	0	1
Division of Assets	n/a	n/a	n/a	n/a	0
Durable Medical Equipment	0	1	0	0	2
Estate Recovery	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	1	0
HCBS Eligibility issues	6	3	2	0	9
HCBS General Issues	11	5	2	3	2
HCBS Reduction in hours of service	2	0	0	2	2
HCBS Waiting List	2	1	1	0	0
Housing Issues	0	0	0	0	0
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0
Medicaid Eligibility Issues	18	4	5	5	7
Medicaid Renewal	n/a	n/a	n/a	n/a	1
Medical Services	4	1	4	0	3
Moving to/from Kansas	n/a	n/a	n/a	n/a	0
Nursing Facility Issues	2	1	2	2	2
Other	14	20	20	12	15
Pharmacy	7	2	4	0	0
Questions for Conference Calls/Sessions	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	0
Thank you.	5	8	6	9	11
Transportation	1	0	0	0	2
Unspecified	2	0	0	0	2
Total	**89**	**59**	**57**	**45**	**76**

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

The Ombudsman Volunteer Coordinator, Lisa Churchill, and Ombudsman Project Coordinator, Percy Turner, have begun providing training to interested community service organizations regarding Medicaid. Trainings will be two – 1.5 hour trainings with topics such as: 1) How to assist with Medicaid applications, and 2) KanCare programs and Home and Community Based Services overview. The feedback so far has been very positive. The registrations on-line are filling up and we are planning to also offer this as a webinar for those who may have difficulty getting away from the office to attend. This is another way the Ombudsman's office is adding capacity to the Kansas Community for KanCare/Medicaid assistance.

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

May 24, 2017

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

RE: 2017 KanCare Evaluation Quarterly Report
Year 5, Quarter 1, January - March

Dear Ms. Ross:

Enclosed is the 2017 Quarter 1 KanCare Evaluation Quarterly Report. If you have questions or corrections regarding this information, please contact me, jpanichello@kfmc.org or (785) 271-4138.

Sincerely,

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

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

Enclosures

2017 KanCare Evaluation

Quarterly Report

Year 5, Quarter 1, January - March

Contract Number: 11231

Program(s) Reviewed: KanCare Demonstration

Submission Date: May 24, 2017

Review Team: Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist

Prepared for:

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KanCare Evaluation Quarterly Report
Year 5, Quarter 1, January – March 2017
May 24, 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) in August 2013; it was approved by CMS in September 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 of the KanCare demonstration managed care Medicaid program. A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the first quarter (Q1) Calendar Year (CY) 2017 report include the following:

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

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

Quarterly and annual KanCare Evaluation topics and recommendations are discussed with MCO staff at quarterly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO and 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 Q1 CY2017, 99.6% of the 92,373 member customer service inquiries received by the MCOs and 99.97% of the 38,528 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 - Quarter 1, CY2015 to CY2017

	Quarter 1					
	Member Inquiries			Provider Inquiries		
	CY2015	CY2016	CY2017	CY2015	CY2016	CY2017
Number of Inquiries Received	103,160	102,747	92,373	49,252	48,921	38,528
Number Resolved within 2 Business Days	103,155	102,743	92,033	49,252	48,921	38,518
Number Not Resolved within 2 Business Days	5	4	340	0	0	10
% Resolved Within 2 Business Days	99.995%	99.996%	99.63%	100%	100%	99.97%
Number Resolved within 5 Business Days	103,160	102,747	92,265	49,252	48,921	38,519
Number Not Resolved within 5 Business Days	0	0	108	0	0	9
% Resolved within 5 Business Days	100%	100%	99.88%	100%	100%	99.98%
Number Resolved within 15 Business Days	103,160	102,747	92,368	49,252	48,921	38,522
Number Not Resolved within 15 Business Days	0	0	5	0	0	6
% Resolved within 15 Business Days	100%	100%	99.995%	100%	100%	99.98%

In Q1 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs met the contractual requirements to resolve 100% of inquiries within 15 business days: Amerigroup and Sunflower reported 100% of their member and provider inquiries were resolved within five business days. UnitedHealthcare reported 99.98% of member and provider inquiries were resolved within 15 days; five member inquiries and six provider inquiries in Q1 CY2017 were reported as not resolved within 15 business days.

Member Customer Service Inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2). Sunflower continued to add a category for Health Homes (which were discontinued as of July 1, 2016); the 36 customer service inquiries reported in Q1 CY2017 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, Q1 CY2016 to Q1CY2017

Member Inquiries	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
1. Benefit Inquiry – regular or VAS	21,924	22,319	21,652	18,152	**17,675**
2. Concern with access to service or care; or concern with service or care disruption	1,934	1,716	1,681	2,484	**1,889**
3. Care management or health plan program	1,597	1,584	1,363	1,177	**1,010**
4. Claim or billing question	6,416	6,381	5,557	4,838	**5,764**
5. Coordination of benefits	3,280	2,964	3,467	2,724	**3,075**
6. Disenrollment request	606	600	635	458	**463**
7. Eligibility inquiry	18,002	13,478	12,555	13,006	**15,475**
8. Enrollment information	3,203	2,396	2,558	2,632	**3,900**
9. Find/change PCP	12,893	12,488	12,906	8,586	**10,519**
10. Find a specialist	3,512	3,375	3,320	2,787	**2,794**
11. Assistance with scheduling an appointment	30	47	74	40	**58**
12. Need transportation	1,326	1,200	1,214	1,232	**1,353**
13. Order ID card	6,958	6,453	7,263	5,318	**6,894**
14. Question about letter or outbound call	1,322	1,961	1,338	1,143	**1,134**
15. Request member materials	1,083	1,119	976	920	**732**
16. Update demographic information	12,944	13,343	14,985	11,356	**13,821**
17. Member emergent or crisis call	699	687	597	676	**655**
18. Other	5,018	4,491	4,918	6,052	**5,162**
Total	**102,742**	**96,632**	**97,059**	**83,581**	**92,373**

- Benefit inquiries in Q1, as in previous quarters, had the highest percentage (19%) of member inquiries
- Of the 92,373 member customer service inquiries in Q1 CY2017, 47% were received by Sunflower, 33% by UnitedHealthcare, and 21% by Amerigroup.
- In Q1 CY2017, compared to the four previous quarter, the number of inquiries was lower in four of the 18 categories (*"Benefit inquiry – regular or VAS," "Care management or health plan program," "Question about letter or outbound call,"* and *"Request member materials"*) and was higher in two of the 18 categories ("*Enrollment information*" and "*Need transportation*").
- 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 six categories with over two-thirds of the inquiries reported by one MCO for nine 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:

- "*Update demographic information*" – 82% of 13,821 inquiries in Q1 CY2017 were reported by Sunflower (71% to 82% for last 10 quarters);
- "*Enrollment information*" – 73% of 3,900 inquiries were reported in Q1 CY2017 by Amerigroup (69% to 81% for the last 10 quarters);
- "*Concern with access to service or care; or concern with service or care disruption*" – 74% of 1,889 inquiries were reported in Q1 CY2017 by Sunflower (70% to 80% for last four quarters);
- "*Care management or health plan program*" – 79% of 1,010 inquiries in Q1 CY2017 were reported by Amerigroup (79% to 86% in last four quarters);
- "*Member emergent or crisis call*" – 99% of 655 inquiries in Q1 CY2017 were reported by Sunflower (99% to 99.8% in last 10 quarters); and
- "*Need transportation*" – 70% of 1,353 inquiries were reported in Q1 CY2017 by Amerigroup (77% in previous quarter).

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 quarterly STC and GAR reports. In the last five quarters, the number of access-related inquiries reported as "customer service inquiries" ranged from 1,681 to 2,484; the number of "access to service or care grievances" reported in STC reports for the same time period ranged from 15 to 44. The State should provide clear criteria to the MCOs for this category to ensure grievance and appeals contacts are not underestimated and 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). Sunflower again added a category for provider inquiries related to Health Homes; the four provider inquiries reported in Q1 CY2017 as related "*Health Homes*" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

- In Q1 CY2017, compared to the previous four quarters, the number of inquiries was lower in three of the 17 categories - "*Authorization – New*," "*Claim payment question/dispute*," and "*Other*."
- Of the 38,528 provider inquiries received by MCOs in Q1 CY2017, Amerigroup received 43%, Sunflower 42%, and UnitedHealthcare 15%.
- For providers, claim status inquiries were again the highest percentage (47%) of the 38,528 provider inquiries.

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 Q1 were reported by one MCO included:

- "*Authorization – New*" – 99% of 1,707 inquiries in Q1 CY2017 were reported by Amerigroup (98% to 99% for last 10 quarters);
- "*Authorization – Status*" – 73% of 2,497 inquiries in Q1 CY2017 were reported by Amerigroup (72% in previous quarter);
- "*Update demographic information*" – 97% of 684 inquiries were reported in Q1 CY2017 by Sunflower (91% to 99.5% in last 10 quarters);
- "*Coordination of benefits*" – 69% of 348 inquiries were reported in Q1 CY2017 by UnitedHealthcare (69% to 91% in last 10 quarters);
- "*Web support*" – 85% of 139 inquiries were reported in Q1 CY2017 by Sunflower (78% to 86% in last six quarters); and

- "*Recoupment or negative balance*" – 82% of 83 inquiries in Q1 CY2017 were reported by Sunflower (68% to 93% in last three quarters).

Table 3. Customer Service Inquiries from Providers, Q1 CY2016 to Q1 CY2017

Provider Inquiries	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
1. Authorization – New	1,942	1,812	1,870	1,735	**1,707**
2. Authorization – Status	2,773	2,373	2,599	2,610	**2,497**
3. Benefits inquiry	3,259	3,121	3,273	2,215	**2,811**
4. Claim denial inquiry	5,605	4,423	5,540	3,920	**5,127**
5. Claim status inquiry	23,613	21,685	20,682	17,442	**17,519**
6. Claim payment question/dispute	4,575	4,142	3,725	3,948	**3,537**
7. Billing inquiry	596	389	407	317	**367**
8. Coordination of benefits	373	396	429	332	**348**
9. Member eligibility inquiry	2,030	1,646	1,754	1,389	**1,695**
10. Recoupment or negative balance	66	85	75	41	**83**
11. Pharmacy/prescription inquiry	598	529	583	475	**535**
12. Request provider materials	71	40	34	35	**52**
13. Update demographic information	744	710	549	554	**684**
14. Verify/change participation status	345	258	249	243	**293**
15. Web support	182	103	99	122	**139**
16. Credentialing issues	231	162	157	119	**160**
17. Other	1,918	1,441	1,784	1,781	**974**
Total	**48,921**	**43,315**	**43,809**	**37,278**	**38,528**

Of the 17 provider customer service inquiry categories, seven are claims-related: "*Authorization – New*," "*Authorization – Status*," "*Benefit Inquiry*," "*Claim Denial Inquiry*," "*Claim Status Inquiry*," "*Claim Payment Question/Dispute*," and "*Billing Inquiry*." As shown in Table 4, the range of inquiries for these seven claims-related categories varied greatly, but consistently, by MCO. For the last 10 quarters, for example, Amerigroup has reported over 98% of the provider inquiries categorized as "*Authorization—New*"; Sunflower has reported 0% of the "*Claim Denial*" provider inquiries; and UnitedHealthcare has reported less than 3% of the "*Benefit Inquiry*" provider inquiries.

Combining the seven claims-related inquiries may allow a better comparison over time overall and by MCO. As shown in Table 5, the number of claims-related provider inquiries reported by the MCOs since January 2016:

- Sunflower provider inquiries decreased each quarter from 18,706 in Q1 CY2016 to 13,213 in Q1 CY2017;
- Amerigroup provider inquiries decreased each quarter from 16,373 in Q1 CY2016 to 14,354 in Q4, then increased in Q1 CY2017 to 15,015; and
- UnitedHealthcare reported 42% to 70% fewer provider inquiries than Amerigroup and Sunflower, with inquiries ranging from 4,289 (Q4) to 8,362 (Q3).

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO by Quarter - Q1 CY2016 to Q1 CY2017										
	CY2016								CY2017	
	Q1		Q2		Q3		Q4		Q1	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,923	3	1,793	3	1,839	7	1,725	0	1,695	0
Authorization - Status	1,932	66	1,604	91	1,661	126	1,879	48	1,816	134
Benefits Inquiry	1,648	755	1,542	514	1,519	582	1,364	359	1,550	431
Claim Denial Inquiry	3,593	0	2,574	0	3,798	0	2,234	0	3,070	0
Claim Status Inquiry	14,458	2,473	12,825	2,751	11,845	2,911	10,047	1,367	10,011	1
Claim Payment Question/Dispute	2,276	293	1,955	311	1,745	346	2,275	148	1,971	127
Billing Inquiry	426	0	194	1	247	2	170	0	241	1

Amerigroup | UnitedHealthcare
Sunflower | Amerigroup & Sunflower

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2016 to Q1 CY2017					
	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
Amerigroup	16,373	14,967	14,479	14,354	15,015
Sunflower	18,706	16,182	15,255	13,544	13,213
UnitedHealthcare	7,284	6,796	8,362	4,289	5,337
Total	42,363	37,945	38,096	32,187	33,565

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 underestimated and 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.

Table 6. Timeliness of Claims Processing, CY2016 by Quarter and Comparison to CY2015

	CY2016 Quarterly				Annual	
	Q1	Q2	Q3	Q4	CY2015	CY2016
Clean Claims						
Clean claims received in quarter	4,380,378	4,248,060	4,052,640	4,242,248	17,134,508	16,923,326
Number of claims excluded	263	88	61	709	2,750	1,121
Number of clean claims not excluded	4,380,115	4,247,972	4,052,579	4,241,539	17,131,758	16,922,205
Clean claims received within quarter processed within 30 days	4,378,159	4,246,507	4,050,603	4,239,788	17,122,506	16,915,057
Clean claims received within quarter not processed within 30 days	1,956	1,465	1,976	1,751	9,252	7,148
Percent of clean claims processed within 30 days	99.96%	99.97%	99.95%	99.96%	99.95%	99.96%
Non-Clean Claims						
Non-clean claims received in quarter	198,558	157,210	182,401	217,957	658,649	756,126
Number of claims excluded	2,974	1,434	1,344	1,372	3,722	7,124
Number of non-clean claims not excluded	195,584	155,776	181,057	216,585	654,927	749,002
Non-clean claims received within quarter processed within 60 days	195,335	155,608	180,909	211,621	653,753	743,473
Non-clean claims received within quarter not processed within 60 days	249	168	148	4,964	1,174	5,529
Percent of non-clean claims processed within 60 days	99.87%	99.89%	99.92%	97.71%	99.82%	99.26%
All Claims						
All claims received in quarter	4,578,936	4,405,270	4,235,041	4,460,205	17,793,157	17,679,452
Number of claims excluded	3,237	1,522	1,405	2,081	6,472	8,245
Number of claims not excluded	4,575,699	4,403,748	4,233,636	4,458,124	17,786,685	17,671,207
Number of all claims received within quarter processed within 90 days	4,575,552	4,403,630	4,233,492	4,457,945	17,785,983	17,670,619
Number of all claims received within quarter not processed within 90 days	147	118	144	179	702	588
Percent of all claims processed within 90 days	99.997%	99.997%	99.997%	99.996%	99.996%	99.997%

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include: adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date; claims from a providers under investigation for fraud or abuse; and/or claims under review for medical necessity.

Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements. To allow for claims lag, the KanCare Evaluation Report for Q1 CY2017 assesses timeliness of processing clean, non-clean, and all claims reports received through Q4 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 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) and
- Process 99% of all claims within 60 days (instead of the contractually-required 90 days).

Timeliness of Claims Processing by Claim Type and Date Received

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

For claims received in Q4 CY2016:

- **Clean claims**: 99.96% of 4,241,539 clean claims received in Q4 CY2016 were reported by the MCOs as processed within 30 days.
  - In Q4 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - Of the 1,751 clean claims not processed within 30 days – 1,383 (79%) were claims received by Sunflower; 259 (15%) were claims received by Amerigroup, and 109 (6%) were claims received by UnitedHealthcare.
  - As shown in Table 6, the number of clean claims excluded was lower in CY2016 (1,121) than in CY2015 (2,750). The number of excluded clean claims in Q4 (709), however, was much higher than the three previous quarters (61 to 263 per quarter); 690 of the 709 excluded claims were Amerigroup claims that met the exclusion criteria due to their assessment of claims by Amerigroup for potential fraud.
- **Non-clean claims**: 97.7% of 216,585 non-clean claims received in Q4 CY2016 were reported by the MCOs as processed within 60 days.
  - In Q4 CY2016, Amerigroup and UnitedHealthcare met the contractual requirement of processing at least 99% of the non-clean claims within 60 days. Sunflower processed only 96% of the non-clean claims received in Q4 within 60 days.
  - In Q4 CY2016, the numbers and percentages of non-clean claims not processed within 60 days (4,964) was higher than the previous 15 quarters. Of the 4,964 "non-clean claims" not processed within 60 days, 4,690 (95%) were claims received by Sunflower. Most of the claims not processed were not first-time claims, but were instead adjustments related to early implementation by Sunflower of the State 4% reduction policy whose provisions were updated. The adjusted claims not processed within 60 days were primarily vendor claims processed within the 90-day all-claims time period.
  - As indicated in Table 6, the number of "non-clean claims" excluded from the measure has increased from 3,722 in CY2015 to 7,124 in CY2016. In Q4 CY2016, 70% of the 1,372 excluded non-clean claims were claims reported by Sunflower. In November 2016, KFMC questioned Sunflower staff as to why their excluded claims counts have been so much higher than the MCOs. Sunflower staff reported that the excluded non-clean claims were primarily newborn claims that, under State criteria, may pend for 45 days. Sunflower staff acknowledged that these claims should, with few exceptions, be processed within 60 days.

- **All claims**: 99.996% of 4,458,124 "all claims" received in Q4 CY2016 were reported by the MCOs as processed within 90 days. In Q4 CY2016, none of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 179 claims not processed within 90 days – 98 (55%) were claims received by Sunflower; 73 (41%) were claims received by Amerigroup; and eight (5%) were claims received by UnitedHealthcare.

In the validation process for the claims-related metrics in the P4P in January 2017 (for 2015 and 2016 pay-for-performance metrics), KFMC found some criteria for reporting monthly and quarterly claims processing (Claims Overview Report) differ slightly from the criteria used for annual P4P reporting of claims processing. Use of the same criteria for the monthly, quarterly, and annual reporting would improve consistency in reporting and allow more complete monitoring of claims processing progress over time.

During the annual performance measure validation process it was also discovered that, while MCOs were generally following the State-defined monthly reporting criteria for claims processing, 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 the Claims Overview report for previous months, however, do not appear to have been revised by the MCOs to reflect these corrections.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,645,537 clean claims processed in Q1 CY2017 (includes claims received prior to Q1). Excluding 1,790,595 pharmacy claims (which are processed same day), there were 2,854,942 clean claims processed (4% more than the previous quarter). 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.

The average TAT for Total Services (excluding pharmacy claims) was 5.3 to 9.7 days in Q1 CY2017, compared with 5.0 to 9.9 days in Q4 CY2016. Amerigroup had the shortest total TAT (5.3 to 5.9), compared to Sunflower (8.6 to 9.7) and UnitedHealthcare (8.7 to 9.0).

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 Q1 CY2017 ranging from 7.5 to 14.7 days. Amerigroup had the shortest TAT in Q1 (7.5 to 8.4), compared to Sunflower (11.0 to 13.4) and UnitedHealthcare (12.0 to 14.7). Sunflower's monthly average decreased, however, from January (13.4) to March (11.0), while UnitedHealthcare's monthly average increased from January (12.0) to March (14.7).
- **HCBS** – HCBS claims had monthly TATs in Q1 ranging from 5.7 to 9.3 days. Amerigroup had the shortest TATs (5.7 to 6.6), compared to Sunflower (8.4 to 9.3) and UnitedHealthcare (6.8 to 7.4).
- **Nursing Facilities** – Nursing Facility claims had TATs ranging from 5.0 to 10.5 days in Q1. Amerigroup had the shortest TATs (5.0 to 5.9), and Sunflower had the longest TATs (9.4 to 10.5) in Q1. UnitedHealthcare's TATs ranged from 7.4 to 9.4 days in Q1.

- **Dental** - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q1 CY2016. Sunflower had the shortest TATs each month (6.0); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q1 CY2016 and the previous five quarters.
- **Behavioral Health** – Behavioral Health claims TATs ranged from 4.2 to 9.9 days in Q1 CY2017. Amerigroup had the shortest TATs (4.2 to 4.8), compared to Sunflower (8.3 to 9.9) and UnitedHealthcare (8.1 to 8.4).
- **Vision** – The average monthly TATs for Vision in Q1 ranged from 6.0 to 12.8 days. Amerigroup had the shortest TATs (6.0 to 7.0); Sunflower and UnitedHealthcare had TATs of 11.9 to 12.8 days in Q1.

Table 7. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Comparison of Current and Previous Quarter and Annual Monthly Ranges

Service Category	Current and Previous Quarter		Annual Monthly Ranges		
	Q4 CY2016	Q1 CY2017	CY2014	CY2015	CY2016
Hospital Inpatient	7.3 to 17.0	**7.5 to 14.7**	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4
Hospital Outpatient	4.0 to 10.4	**4.5 - 10.1**	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
Dental	7.0 to 13.0	**6.0 to 13.0**	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0
Vision	7.0 to 12.6	**6.0 to 12.8**	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7
Non-Emergency Transportation	9.6 to 13.7	**11.4 to 14.0**	10.9 to 18	10.4 to 16	9.0 to 14.4
Medical (Physical health not otherwise specified)	4.2 to 9.9	**4.7 to 9.4**	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7
Nursing Facilities	4.6 to 10.6	**5.0 to 10.5**	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0
HCBS	5.7 to 9.7	**5.7 to 9.3**	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8
Behavioral Health	4.1 to 9.8	**4.2 to 9.9**	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7
Total Claims (Including Pharmacy)	4,451,645	**4,645,537**	16,763,501	17,820,402	17,820,402
Total Claims (Excluding Pharmacy)	2,754,223	**2,854,942**	10,370,998	10,999,807	10,999,807
Average TAT (Excluding Pharmacy)	**5.0 to 9.9**	**5.3 to 9.7**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**

Recommendations (Timeliness of Claims Processing)

1. The State should provide additional direction to the MCOs as to appropriate processing times newborn claims. If newborn claims are not to be excluded from the 90-day processing requirement for "all claims," additional direction should be provided as to whether previous quarterly reports should be updated to include processing of newborn claims within the 90-day time period.
2. To promote consistency in reporting by MCOs, the State should consider revising the criteria for the Claims Overview quarterly reports to better correspond to the criteria used in the P4P reporting for the claims metrics.
3. The State should provide guidance to the MCOs as to whether corrections should be made in any of the data for prior months where vendors' claims processing reporting did not follow State reporting criteria.
4. 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.

Grievances

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

- 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.
- 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 in the quarter, and counts of grievances by category type. The report includes space where MCOs are to provide a brief summary of trends identified in grievances by category and any actions taken to prevent recurrence.

Data Sources

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report. The number of grievances received and resolved each quarter is also reported in the STC quarterly report. Since 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 are based on the MCOs’ contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days (via an extension request). The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as “received” each quarter does not (and is not expected to) equal the number of grievances “resolved” during the quarter (see Table 8).

Table 8. Timeliness of Resolution of Grievances - Q1 CY2016 to Q1 CY2017

	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
Grievances received in quarter	456	453	452	406	412
Grievances resolved in quarter*	437	465	446	395	412
Grievances resolved within 30 business days*	433	452	387	395	410
Percent resolved within 30 business days	99.1%	97.2%	86.8%	100%	99.5%
Grievances not resolved within 30 business days	4	13	59	0	2
Grievances resolved within 60 business days*	436	465	446	395	412
Percent resolved within 60 business days*	99.8%	100%	100%	100%	100%
Grievances closed in quarter not resolved in 60 business days*	1	0	0	0	0

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

In Q1 CY2017, 99.5% (410) of the 412 grievances reported by the MCOs as resolved in Q1 were reported as resolved within 30 business days, and 100% were reported to be resolved within 60 business days.

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 412 grievances in Q1 CY2017 (see Table 9). In the STC report, the MCOs reported that 340 of the 412 were resolved within the quarter.

Table 9. Number of Grievances Received by Category, Q1 CY2016 to Q1 CY2017*

	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
Transportation	176	125	172	166	**191**
Claims/Billing Issues	90	86	48	70	**62**
Quality of Care or Service	36	34	28	43	**24**
Access to Service or Care	44	34	41	41	**15**
Health Plan Administration	16	10	20	15	**24**
Customer Service	27	30	48	30	**39**
Member Rights/Dignity	12	17	16	5	**9**
Benefit Denial or LImitation	10	8	10	14	**19**
Service or Care Disruption	14	7	2	5	**9**
Clinical/Utilization Management	5	1	2	1	**6**
Other	12	23	21	16	**14**
Total Grievances Received	**442**	**375**	**408**	**406**	**412**

*Reported in quarterly STC Reports

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names.

- 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*."
  - "*Benefit Denial or Limitation*" and "*Service or Care Disruption*" would seem to be describing appeals rather than grievances.
  - "*Clinical/Utilization Management*" and "*Health Plan Administration"* would seem to be categorized in the GAR report as *"Customer Services."*
- Categories with similar wording, but that may be interpreted differently, include:
  - "*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.

- "*Claims/Billing Issues*" (STC) and "*Billing and Financial Issues*" (GAR) – "*Claims/Billing Issues*" may potentially be misinterpreted to include appeals related to claims.

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. Table 10 summarizes the numbers and categories of grievances resolved in Q1 CY2017 as reported in the GAR and STC reports. Of 404 grievances resolved in Q1 CY2017, 137 (34%) were reported by Amerigroup, 124 (31%) by Sunflower, and 143 (35%) by UnitedHealthcare.

Table 10. Comparison of Grievance Categories in STC and GAR Reports, Q1 CY2017

Grievance Categories	STC Report*	GAR Report^
Customer Service	39	39
Member Rights/Dignity	9	11
Access to Service or Care	15	16
Other	14	7
Transportation-Related	191	
Transportation Issues - including reimbursement (other than no show or safety)		73
Transportation Late		37
Transportation No Show		59
Transportation Safety		13
Claims/Billing Issues	62	
Billing and Financial Issues (non-transportation)		69
Quality of Care or Service	24	
Quality of Care - non-HCBS/non-transportation		46
Quality of Care - HCBS		5
Health Plan Administration	24	
Clinical/Utilization Management	6	
Pharmacy Issues		23
Value-added Benefits		6
Service or Care Disruption	9	
Benefit Denial or Limitation	19	
Total	412	404

*STC reports categorize grievances received in the quarter.
^GAR reports categorize grievances resolved in the quarter.

Whereas prior to Q2 CY016, transportation-related grievances were categorized as "*Timeliness*," "*Availability," "Attitude/Service of Staff," Quality of Care or Service," "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, promote better consistency in MCO reporting, and should also allow better tracking of progress in addressing specific transportation-related grievances, such as transportation safety and "no shows." (Note: The "*Transportation Issues*" category specifically excludes "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 as many as 20% of the grievances that, as described by the MCOs in the Q1 GAR report, and in comparison to the grievance category definitions, may be misclassified, including:

- 14 grievances categorized as "*Customer Service*," but, based on their descriptions, could be "*Access to Service or Care*," "*Quality of Care (non-HCBS),*" "*Pharmacy,*" "*Member Rights/Dignity*," or "*Billing and Financial Issues*";
- 23 "grievances" categorized as "*Access to Service or Care*," "*Quality of Care (non- HCBS)*," "*Pharmacy*," "*Customer Service*," and "*Other*," that may more appropriately be categorized and reported as "appeals";
- 25 grievances categorized as "*Quality of Care (non-HCBS)*" that, based on their descriptions, may be better categorized as "*Customer Service*," "*Access to Service or Care," "Transportation Issues," "Other," "Member Rights/Dignity,"* or may more appropriately be categorized as appeals;
- 9 grievances categorized as general "Transportation Issues" that, based on their descriptions, should more appropriately be categorized as "*Transportation Late*" or "*Transportation No Show.*"

In past GAR reports, UnitedHealthcare provided little to no detail describing the grievances and resolutions. In the Q1 CY2017 GAR report, the resolutions again primarily indicated resolution letters were sent, and the grievance descriptions for over half of the grievances (75 of 143) were too limited to determine whether the grievances were or were not categorized correctly. Of the 68 with limited detail, 15 (22%) appear to be categorized incorrectly.

Table 11 reports the types of grievances resolved in Q1 CY2017 in total and by waiver and the number of members reporting grievances, as categorized by the MCOs. Table 12 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 over 75% due to 20 additional grievances (46 as categorized by the MCOs and 26 based on the grievances as described by the MCOs). Table 12 also adds an "*Appeals*" category to show the number of grievances that may potentially be better categorized as appeals. Table 12 also includes an additional grievance – based on the grievance description, there were actually two categories of grievances described by the member; MCOs have been advised by KDHE to document each grievance separately, even if the grievances are communicated by the member during one contact.

Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 182 transportation-related grievances, up from 164 in the previous quarter. Of the 182 transportation-related grievances, 57 (31%) were reported by Amerigroup, 65 (36%) were reported by Sunflower, and 60 (33%) were reported by UnitedHealthcare. The number of "No Show" "Late" transportation grievances continued to be high, with 59 "No Show" grievances (compared to 52 in Q4) and 37 "Late" grievances in Q1 (44 based on grievance descriptions), compared to 27 in Q4. Of concern again in Q1 is the number of Amerigroup grievances (categorized as "*Transportation Issues*") indicating the transportation vendor was unable to provide the member with transportation, despite the member contacting ahead of time appropriately. Also of concern is the number of "Transportation – Safety" grievances (13 in Q1, 16 in the previous quarter).

Table 11. Comparison by Waiver of Grievances Resolved in Q1 CY2017*, 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	69	62	10	10	1	2	4	1	1	1
Access to Service or Care	16	14	6	6		2	1	1	1	1
Quality of Care (non-HCBS)	46	43	11	11	3		5	1	1	1
Quality of Care - HCBS	5	5	5	5	2		2			1
Customer Service	39	39	25	25	6	3	12	1	1	2
Pharmacy Issues	23	22	4	4	1		1	2		
Member's Rights/Dignity	11	11	4	4	1		3			
Value-Added Benefit	6	5	1	1			1			
Transportation Issue	73	69	18	18	5	2	10			1
Transportation Safety	13	11	7	6	2		5			
Transportation No Show	59	57	30	29	7	1	18	1		3
Transportation Late	37	37	15	15	3	1	8	1	1	1
Other	7	6	3	2			1			2
Total	**404**	**381**	**139**	**136**	**31**	**11**	**71**	**8**	**5**	**13**

*Includes grievances received in Quarter 4 CY2016 resolved in Quarter 1 CY2017.
^No grievances were categorized in Quarter 1 for Autism Waiver members.

Table 12. Comparison by Waiver of Grievances Resolved in Q1 CY2017, based on MCO Grievance Details

	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	71	62	14	13	1	3	4	2	1	3
Access to Service or Care	17	17	7	7	1	1	2	1	0	2
Quality of Care (non-HCBS)	26	26	7	7	3		2	1	0	1
Quality of Care - HCBS	5	5	5	5	1		3			1
Customer Service	36	36	16	16	4	0	9	0	2	1
Pharmacy Issues	25	23	8	7	1		4	2	1	
Member's Rights/Dignity	9	9	3	3	2		1			
Value-Added Benefit	7	6	1	1			1			
Transportation Issue	67	64	16	16	5	1	9			1
Transportation Safety	14	12	8	7	3		5			
Transportation No Show	60	58	30	29	7	1	18	1		3
Transportation Late	44	44	17	17	2	2	10	1	1	1
Other	2	2	0	0						
Appeal-related	*22*	*20*	*8*	*8*	*1*	*3*	*4*			

Higher count based on grievance descriptions vs. MCO category
Lower Count based on Grievance Descriptions vs. MCO Category
Appeal-related - potentially misclassified as grievances
No change in count

As shown in Table 13, the percentage of transportation-related grievances was higher among waiver members (50% in Q1) compared to the total population (45% in Q1). Of the 404 grievances in Q1, 139 (34%) were from members receiving waiver services.

Table 13. Transportation-Related Grievances Resolved in Q3 CY2016 to Q1 CY2017, by Waiver

	# Grievances			# Transportation Related			% Transportation Related		
	CY2016		CY2017	CY2016		CY2017	CY2016		CY2017
	Q3	Q4	Q1	Q3	Q4	Q1	Q3	Q4	Q1
Physical Disability (PD)	65	63	71	33	47	41	51%	75%	58%
Frail Elderly (FE)	23	24	31	16	15	17	70%	63%	55%
Intellectual/Developmental Disability (I/DD)	17	13	11	4	2	4	24%	15%	36%
Traumatic Brain Injury (TBI)	18	10	13	5	5	5	28%	50%	38%
Serious Emotional Disturbance (SED)	7	8	8	2	2	2	29%	25%	25%
Technology Assisted (TA)	0	4	5	NA	0	1	NA	0%	20%
Autism	2	0	0	2	NA	NA	100%	NA	NA
No Waiver	314	274	265	123	86	112	39%	31%	42%
Waiver Members Total	132	122	139	62	71	70	47%	58%	50%
All Members Total	446	396	404	185	157	182	41%	40%	45%

The number and percentage of transportation-related grievances received from waiver members was higher in Q1 CY2017 than the five previous quarters. Of the 139 grievances received from 136 waiver members in Q1, 70 (58.2%) were transportation-related.

- Physical Disability (PD) Waiver members had the most grievances in Q1, with 69 members reporting 71 grievances, 41 (58%) transportation-related.
- Frail Elderly (FE) Waiver members (31) reported 31 grievances in Q1, up from 24 in the previous quarter; 17 (50%) of the 31 grievances were transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members (11) in Q1 reported 11 grievances, four (36%) that were transportation-related.
- Traumatic Brain Injury (TBI) Waiver members (12) reported 13 grievances, five (42%) transportation-related.
- Technology Assistance Waiver members (5) reported five grievances in Q1, one transportation-related.
- Serious Emotional Disturbance (SED) Waiver members (8) reported eight grievances in Q1, two (25%) transportation-related.

Access-Related Grievances

Of 412 grievances categorized in the STC report as received in Q1 CY2017, 15 (4%) were categorized as "*Access to Service or Care*" (see Table 9); and, of 404 grievances resolved in Q1 CY2017, 16 (4%), were categorized by the MCOs in their GAR reports as "*Access to Service or Care*."

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

- Amerigroup reported 11 access-related grievances received in Q1 CY2017 (compared to 10 in Q4 CY2016). As identically described in 10 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 Amerigroup to perform key services for our members*."
- Sunflower reported one access-related grievances received in Q1. In the STC trend summary, Sunflower again reported only the percentage of access-related grievances of the total for the quarter, *"Access to Service or Care consists of 0.83% (1/120) of all total grievances resolved this quarter."*
- UnitedHealthcare reported three access-related grievances received in Q1. These were described, as in the previous 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 previous quarterly STC reports UnitedHealthcare report that "access to service or care" grievances were tracked *monthly*." Beginning in Q4 CY2016, UnitedHealthcare reported they track and trend access to service and care "*quarterly*."

All of the 16 grievances in the Q1 GAR report categorized as "*Access to Service or Care*" were reported by Amerigroup. Based on the grievance descriptions, one may more appropriately be categorized as "*Billing and Financial Issues*" and eight may meet criteria to be considered "appeals." Two grievances categorized as "Customer Service" and one categorized as "*Quality of* Care (non-HCBS)" may be better categorized as "*Access to Service or Care*."

Six of the grievances categorized by Sunflower as "*Customer Service*" and one grievances categorized by UnitedHealthcare as "*QOC*" may more appropriately be categorized as "*Access to Service or Care*." Due to the lack of detail provided by UnitedHealthcare for most grievance descriptions and resolutions, it is not possible to assess whether most of the grievances have been categorized incorrectly.

Of the 16 grievances reported in the GAR report as "*Access to Service or Care*" by 14 members in Q1 CY2017, six grievances (38%) were from six members receiving waiver services, including: one member receiving TBI waiver services, two members receiving I/DD waiver services, one member receiving SED Waiver services, one member receiving PD waiver services, and one member receiving TA waiver services.

Quality-Related Grievances

In Q1 CY2017, 24 (6%) of 412 grievances received were categorized in the STC report as being related to "*Quality of Care or Service*." In the MCO Q1 GAR reports, 51 (13%) of 404 grievances reported as resolved were categorized as Quality of Care (QOC), 10 as "*Quality of Care (non-HCBS),"* five as "*Quality of Care – HCBS*," and 36 (by UnitedHealthcare) as "*Quality of Care.*" (UnitedHealthcare did not report whether or not these 36 grievances were HCBS-related, as had been directed by the State. One grievance, however, was categorized as "*Quality of Care HCBS*," so the 36 were assumed to be "*Quality of Care (non/HCBS)*.")

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

- Amerigroup reported receiving 10 QOC grievances in Q1 CY2017 (compared to 10 in Q4 and six in Q3 CY2016). As in previous STC reports, Amerigroup 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."*
- Sunflower reported three QOC grievances received in Q4 (eight in Q4 and Q3 CY2016), and that, "*Quality of Service or Care grievances accounts for 2.50% (3/120) of all total grievances for this quarter."*
- UnitedHealthcare reported 11 QOC grievances received in Q1. 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.*"

Based on descriptions in the GAR report, over half of the grievances categorized as "*Quality of Care (non –HCBS)"* and "*Quality of Care*" may not be correctly categorized.

- Amerigroup categorized 10 grievances resolved in Q1 as "*Quality of Care (non-HCBS)"* and three as "*Quality of Care - HCBS*." Based on the grievance descriptions, four of the "*Quality of Care (non-HCBS)"* grievances may have been more correctly categorized as "*Access to Care or Service*," "*Customer Service*," *Member Rights/Dignity*," and/or "*Transportation Issues*"; and, three additional grievances may be more correctly categorized as "*Quality of Care (non-HCBS)"* – one "*Billing and Financial Issues*" and two "*Member Rights/Dignity*" grievances.
- Sunflower categorized no grievances as "*Quality of Care (non-HCBS)"* and one as "*Quality of Care – HCBS."* Based on the grievance descriptions, the grievance categorized as "*Quality of Care – HCBS" may more appropriately be categorized as* "*Quality of Care (non-HCBS)";* three grievances categorized as "*Customer Service*" may be more correctly categorized as "*Quality of Care"* (two non-HCBS and one HCBS).
- UnitedHealthcare characterized 36 grievances in Q1 as "*Quality of Care"* and one as "*Quality of Care HCBS."* Due to the lack of detail provided by UnitedHealthcare 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, 22 grievances categorized as "*Quality of Care*" would seem to be more correctly be categorized as "*Customer service*" (13), "*Access to service or care*" (1), "*Member Rights/Dignity*" (1), "*Other*" (2), or may be more appropriately categorized as appeals instead of grievances (5).

Of 51 grievances reported in the GAR report as QOC by 48 members in Q4, 16 grievances (31%) were from 16 members receiving waiver services, including: two members receiving TBI Waiver services, five members receiving FE Waiver services, one member receiving SED Waiver services seven members receiving PD waiver services, and one member receiving TA Waiver services.

Recommendations (Grievances)

1. UnitedHealthcare 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.
    - MCOs should review transportation-related grievances to ensure those related to no-show, lateness, or safety issues are categorized appropriately.
    - Grievances referred to the QOC staff should be categorized as "*Quality of Care (non-HCBS)"* or "*Quality of Care HCBS*."
    - Each grievance should be categorized separately, even if the grievances are reported during one contact by phone or mail.
4. The State should review the grievances KFMC has identified as potentially misclassified to evaluate whether additional examples, grievance and appeal descriptions, and follow-up training should be provided to MCO staff routinely categorizing grievances.
5. 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.
6. 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.
7. 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.
8. 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)."
9. UnitedHealthcare should identify whether QOC grievances are or are not HCBS-related.
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," errors in scheduling, and lack of vendor availability of transportation.

Ombudsman's Office

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

Data Sources

The primary data source in Q1 CY2017 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

Ombudsman Office assistance is provided by the Ombudsman (Kerrie Bacon), a Volunteer Coordinator, a Project Coordinator, and trained volunteers at satellite offices, including (as of March) one VISTA volunteer. Information (as well as volunteer applications) is also available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office). The Ombudsman's Office is located in Topeka, with satellite offices in Wichita and Olathe (Johnson County).

- The Wichita satellite office is staffed with a Project Coordinator available and seven volunteers who provide onsite assistance from 10 a.m. to 5 p.m. Tuesday through Friday.

- The Olathe satellite office is currently staffed with three volunteers providing onsite assistance from 10 a.m. to 1 p.m. Mondays, Wednesdays, and Thursdays.

Beginning this quarter, the Volunteer Coordinator and Project Coordinator have begun providing training to community service organizations regarding Medicaid. The two 1.5-hour trainings focus on how to assist with Medicaid applications and an overview of KanCare programs and HCBS. Future plans include offering these trainings as webinars for those unable to attend in person.

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

The Ombudsman's office tracks contacts by contact method, caller type, by specific issues, and whether the contacts are MCO-related. Beginning in Q1 CY2017 the Ombudsman's Office also began tracking and reporting the number of contacts by whether they were made to the satellite offices or to the main office in Topeka (see Table 14). In Q1 CY2017, 178 of 825 contacts were MCO-related. While the number of contacts was an increase compared to 523 in Q4 CY2016, a higher volume of contacts in Q1 each year is common due to the annual re-enrollment period; the number of contacts in Q1 CY2017 was lower than the 1,130 contacts in Q1 CY2016.

Table 14. Ombudsman's Office Contacts - All and MCO-Related, CY2016 to Q1 CY2017

	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
All Contacts	**1,130**	**846**	**687**	**523**	**825**
*Main office**				*432*	*648*
*Olathe satellite office**				*21*	*28*
*Wichita satellite office**				*70*	*149*
MCO-Related Contacts	**250**	**150**	**141**	**108**	**178**
% MCO-Related Contacts	**22.1%**	**17.7%**	**20.5%**	**20.7%**	**21.6%**

* Contacts by location began to be tracked and reported beginning in Q4 CY2016.

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.

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts, including the number of issues that are MCO-related (see Table 15). The most frequently reported issues quarterly to date have been "*Medicaid Eligibility Issues*" and HCBS-related issues. Beginning in Q1 CY2017, additional issue categories have been added, including "*Client*

Obligation,” “Medicaid Renewal,” “Medicaid Application Assistance,” “Medicaid Coding,” “Moving to/from Kansas,” and “*Spenddown Issues*.”

Table 15. Issues tracked by Ombudsman's Office - All and MCO-Related, CY2016 to Q1 CY2017

	CY2016								CY2017	
	Q1		Q2		Q3		Q4		Q1	
	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related
Medicaid Eligibility Issues	512	72	244	19	173	20	174	20	236	29
Appeals, Grievances	49	29	42	20	36	14	16	3	36	18
Medical Services	29	15	20	11	10	7	12	4	20	13
Billing	43	20	39	18	37	18	26	12	21	7
Durable Medical Equipment	7	7	7	5	2	1	4	3	2	2
Pharmacy	24	14	13	4	11	8	8	6	10	5
HCBS - Total	144	67	71	37	42	18	31	17	92	43
HCBS General Issues	69	39	32	17	16	6	15	11	33	18
HCBS Eligibility Issues	45	17	33	15	21	9	9	2	46	18
HCBS Reduction in Hours of Service	12	8	4	4	3	2	3	3	7	5
HCBS Waiting List	18	3	2	1	2	1	4	1	6	2
Care Coordinator Issues	7	6	3	2	6	6	4	4	5	5
Transportation	6	4	8	3	6	5	1	1	8	7
Nursing Facility Issues	40	7	7	5	22	4	22	4	38	5
Housing Issues	8	1	2	1	2	0	3	1	4	1
Access to Providers	7	4	6	3	9	4	13	4	14	11
Change MCO	15	7	3	2	0	0	6	5	3	3
Dental	4	2	5	5	5	3	5	1	7	1
Client Obligation*									17	6
Medicaid Renewal*									29	11
Spenddown Issues*									18	4
Medicaid application assistance*									46	1
Medicaid Coding*									3	2
Moving to/from Kansas*									5	1
Other^	411	61	415	48	402	64	241	39	319	51
Total Issues - All & MCO-Related	1,450	383	957	220	807	190	599	141	1,028	270

* Categories added in Q1 CY2017
^Includes issues categorized as "Other" and "Unspecified"

The Ombudsman’s Office also reports contact issues by waiver-related type. As shown in Table 16, the number of waiver-related contacts, which had dropped to 40 in Q4 CY2016, increased to 136 but was slightly lower than in Q1 CY2016. The most frequent waiver-related issues were related to the I/DD Waiver (43 in Q1), PD Waiver (40 in Q1), and FE Waiver (30 in Q1).

Table 16. Waiver-Related Inquiries to Ombudsman, Q1 CY2016 to Q1 CY2017					
Waiver	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
Intellectual/Developmental Disability (I/DD)	48	27	21	11	**43**
Physical Disability (PD)	48	22	13	9	**40**
Technology Assisted (TA)	10	9	4	4	**8**
Frail Elderly (FE)	23	19	10	7	**30**
Traumatic Brain Injury (TBI)	10	3	7	5	**6**
Serious Emotional Disturbance (SED)	4	0	1	3	**4**
Autism	1	2	2	1	**3**
Money Follows the Person (MFP)	8	5	3	0	**2**
Total	**152**	**87**	**61**	**40**	**136**

The GAR report, which included details of grievances and appeals and resolution details and dates, is submitted to KDHE, but not to the Ombudsman's Office. Tracking of resolutions of issues from KanCare members who contact the Ombudsman's Office could potentially be enhanced by review by the Ombudsman of the grievance details provided by the MCOs to the State in the quarterly GAR reports.

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 Q1 CY2017, 99.6% of the 92,373 member customer service inquiries and 99.97% of the 38,528 provider customer service inquiries received by the MCOs were resolved within two business days.
- In Q1 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs met the contractual requirements to resolve 100% of inquiries within 15 business days: Amerigroup and Sunflower reported 100% of their member and provider inquiries were resolved within five business days. UnitedHealthcare reported 99.98% of member and provider inquiries were resolved within 15 days; five member inquiries and six provider inquiries in Q1 CY2017 were reported as not resolved within 15 business days.
- The criteria used by the MCOs to categorize member and provider inquiries continue to vary by MCO. As a result, aggregated data for certain categories are more representative of only one of the MCOs rather than all three.

- **Member customer service inquiries**
  - 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 Q1 CY2017, the MCOs received 1,889 contacts in this category that were in addition to the grievances and appeals reported by members.
  - Of the 92,373 member customer service inquiries in Q1 CY2017, 47% were received by Sunflower, 33% by UnitedHealthcare, and 21% by Amerigroup.
  - Benefit inquiries were the highest percentage (19%) of member inquiries in Q1.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO; three of the six with over two-thirds of the inquiries reported by one MCO for nine 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*."
- **Provider customer service inquiries**
  - Of the 38,528 provider inquiries received by MCOs in Q1 CY2017, Amerigroup received 43%, Sunflower 42%, and UnitedHealthcare 15%.
  - For providers, "*Claim status*" inquiries were again the highest percentage (47%) of provider inquiries.
  - Categories where two-thirds or more of the provider inquiries in Q1 were reported by only one MCO included:
    - "*Authorization – New*,"
    - "*Authorization – Status*,"
    - "*Coordination of benefits*,"
    - "*Update demographic information*,"
    - "*Web support*," and
    - "*Recoupment or negative balance*."
  - Of the 17 provider inquiry categories, seven are focused on claims; the range of inquiries for each of the seven varied greatly by MCO. The combined total number of inquiries for these seven categories may allow better comparison of overall claims-related inquiries.

Timeliness of Claims Processing

- **Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days**
  - In Q4 CY2016, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,241,539 clean claims received in Q4 CY2016, however, 99.96% were processed within 30 days. Of the 1,751 clean claims not processed within 30 days, 1,383 (79%) were claims received by Sunflower; 259 (15%) were claims received by Amerigroup; and 109 (6%) were claims received by UnitedHealthcare.
  - In Q4 CY2016, Amerigroup and UnitedHealthcare met the contractual requirement of processing at least 99% of the non-clean claims within 60 days. Sunflower processed only 96% of the non-clean claims received in Q4 within 60 days.

- In Q4 CY2016, the numbers and percentages of non-clean claims not processed within 60 days (4,964) was higher than the previous 15 quarters. Of the 4,964 "non-clean claims" not processed within 60 days, 4,690 (95%) were claims received by Sunflower. Most of the claims not processed were not first-time claims, but were instead adjustments related to early implementation by Sunflower of the State 4% reduction policy whose provisions were updated. The adjusted claims not processed within 60 days were primarily vendor claims processed within the 90-day all-claims time period.
  - The number of "non-clean claims" excluded from the measure has increased from 3,722 in CY2015 to 7,124 in CY2016. In Q4 CY2016, 70% of the 1,372 excluded non-clean claims were claims reported by Sunflower. In November 2016, KFMC questioned Sunflower staff as to why their excluded claims counts have been so much higher than the MCOs. Sunflower staff reported that the excluded non-clean claims were primarily newborn claims that, under State criteria, may pend for 45 days. Sunflower staff acknowledged that these claims should, with few exceptions, be processed within 60 days.
  - Of 4,458,124 "all claims" received in Q4 CY2016, 99.996% were processed within 90 days. None of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 179 claims not processed within 90 days – 98 (55%) were claims received by Sunflower; 73 (41%) were claims received by Amerigroup; and eight (5%) were claims received by UnitedHealthcare.
  - The criteria for reporting monthly and quarterly claims processing (Claims Overview Report) differ somewhat from the criteria used for annual P4P reporting of claims processing. Use of the same criteria for the monthly, quarterly, and annual reporting would improve consistency in reporting and allow more complete monitoring of claims processing progress over time.
  - During the annual performance measure validation process it was discovered that, while MCOs were generally following the State-defined monthly reporting criteria for claims processing, one or more of each MCO's vendors were not correctly reporting timeliness of claims processing. 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 for previous months in the Claims Overview Report, however, do not appear to have been revised by the MCOs to reflect these corrections.
- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q1 CY2017, the MCOs reported processing of 4,645,537 clean claims (including 1,790,595 pharmacy claims).
  - The average TAT for Total Services (excluding pharmacy claims) was 5.3 to 9.7 days in Q1 CY2017, compared with 5.0 to 9.9 days in Q4 CY2016. Amerigroup had the shortest total TAT (5.3 to 5.9), compared to Sunflower (8.6 to 9.7) and UnitedHealthcare (8.7 to 9.0).
  - 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 Q1 CY2017 ranging from 7.5 to 14.7 days. Amerigroup had the shortest TAT in Q1 (7.5 to 8.4), compared to Sunflower (11.0 to 13.4) and UnitedHealthcare (12.0 to 14.7). Sunflower's monthly average decreased, however, from January (13.4) to March (11.0), while UnitedHealthcare's monthly average increased from January (12.0) to March (14.7).
    - **Dental** - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q1 CY2016. Sunflower had the shortest TATs each month (6.0); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q1 CY2016 and the previous five quarters.

- **Nursing Facilities** – Nursing Facility claims had TATs ranging from 5.0 to 10.5 days in Q1. Amerigroup had the shortest TATs (5.0 to 5.9), and Sunflower had the longest TATs (9.4 to 10.5) in Q1. UnitedHealthcare's TATs ranged from 7.4 to 9.4 days in Q1.
- **HCBS** – HCBS claims had monthly TATs in Q1 ranging from 5.7 to 9.3 days. Amerigroup had the shortest TATs (5.7 to 6.6), compared to Sunflower (8.4 to 9.3) and UnitedHealthcare (6.8 to 7.4).
- **Behavioral Health** – Behavioral Health claims TATs ranged from 4.2 to 9.9 days in Q1 CY2017. Amerigroup had the shortest TATs (4.2 to 4.8), compared to Sunflower (8.3 to 9.9) and UnitedHealthcare (8.1 to 8.4).
- **Vision** – The average monthly TATs for Vision in Q1 ranged from 6.0 to 12.8 days. Amerigroup had the shortest TATs (6.0 to 7.0); Sunflower and UnitedHealthcare had TATs of 11.9 to 12.8 days in Q1.

Grievances

- In Q1 CY2017, 99.5% (410) of the 412 grievances reported by the MCOs as resolved in Q1 CY2017 were reported as resolved within 30 business days, and 100% were reported to be resolved within 60 business days.
- In Q1 CY2017, 99.5% (410) of the 412 grievances reported by the MCOs as resolved in Q1 CY2017 were reported as resolved within 30 business days, and 100% were reported to be resolved within 60 business days.
- Of the 404 grievances reported as resolved in Q1
  - 137 (34%) were reported by Amerigroup, 128 (31%) by Sunflower, and 143 (35%) by UnitedHealthcare.
  - 16 (4%) grievances were categorized in the GAR report as "*Access to service or care*"; all were reported by Amerigroup. Six of the 16 grievances were from 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" (UnitedHealthcare 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, I/DD, SED, PD, and TA waiver services.
- UnitedHealthcare 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.
- Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 182 transportation-related grievances, up from 164 the previous quarter. The number of "*Transportation No Show*" and "*Transportation Late*" grievances continued to be high, with 59 "No Show" grievances and 37 "Late" grievances in Q1. Of concern again in Q1 is the number of Amerigroup grievances (categorized as "*Transportation Issues*") indicating the transportation vendor was unable to provide the member with transportation, despite the member contacting ahead of time appropriately. Also of concern is the number of "Transportation – Safety" grievances (13 in Q1, 16 in the previous quarter).
- Of 404 grievances reported as resolved by MCOs in Q1 CY2017, 139 (34%) were reported by members receiving waiver services.
- Based on grievance descriptions, KFMC estimated over 20% of the grievances reported in Q1 may be categorized incorrectly, including 22 grievances that may be more appropriately categorized as "appeals."

- 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 Amerigroup and UnitedHealthcare 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

- Ombudsman's Office assistance is available at the main office in Topeka, two satellite offices (Wichita and Olathe), and on the Ombudsman's Office website. As of Q1 CY2017, the Wichita satellite office had a Project Coordinator and seven volunteers (including one VISTA volunteer) available to provide onsite assistance from 10 a.m. to 5 p.m. Tuesday through Friday. The Olathe satellite office in Q1 had three volunteers providing onsite assistance from 10a.m. to 1p.m. Mondays, Wednesdays, and Thursdays.
- The Ombudsman's Office has begun providing two 1.5-hour trainings to interested community service organizations focused on how to assist with Medicaid applications and on overviews of KanCare programs and HCBS.
- In Q1 CY2017, 21.6% (178 of 825) of contacts tracked by the Ombudsman's Office were MCO-related. Beginning in Q1, the Ombudsman's Office began tracking contacts by whether they were made to the main office or to the satellite offices.
- The most frequently reported issues continue to be those related to Medicaid eligibility and HCBS. In Q1, the Ombudsman's Office expanded the list of categories to improve reporting and tracking of trends.
- The most frequent waiver-related issues were related to the I/DD Waiver (43 in Q1), PD Waiver (40 in Q1), and FE Waiver (30 in Q1).

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 underestimated and 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. The State should provide additional direction to the MCOs as to appropriate processing times newborn claims. If newborn claims are not to be excluded from the 90-day processing requirement for "all claims," additional direction should be provided as to whether previous quarterly reports should be updated to include processing of newborn claims within the 90-day time period.
2. To promote consistency in reporting by MCOs, the State should consider revising the criteria for the Claims Overview quarterly reports to better correspond to the criteria used in the P4P reporting for the claims metrics.

3. The State should provide guidance to the MCOs as to whether corrections should be made in any of the data for prior months where vendors' claims processing reporting did not follow State reporting criteria.
4. 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.

Grievances

1. UnitedHealthcare 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.
   - MCOs should review transportation-related grievances to ensure those related to no-show, lateness, or safety issues are categorized appropriately.
   - Grievances referred to the QOC staff should be categorized as "*Quality of Care (non-HCBS)"* or "*Quality of Care HCBS*."
   - Each grievance should be categorized separately, even if the grievances are reported during one contact by phone or mail.
4. The State should review the grievances KFMC has identified as potentially misclassified to evaluate whether additional examples, grievance and appeal descriptions, and follow-up training should be provided to MCO staff routinely categorizing grievances.
5. 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.
6. 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.
7. 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.
8. 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)."
9. UnitedHealthcare should identify whether QOC grievances are or are not HCBS-related.
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," errors in scheduling, and lack of vendor availability of transportation.

Ombudsman's Office

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance and appeal resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances and appeals.
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.

KDHE Summary of Claims Adjudication Statistics –

January through December 2016 – KanCare MCOs

AMERIGROUP Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	9,402	$369,127,365	1,458	$63,534,746	15.51%
Hospital Outpatient	84,233	$221,049,909	10,024	$25,327,600	11.90%
Pharmacy	526,630	$40,261,462	156,809	Not Applicable	29.78%
Dental	32,822	$8,790,949	2,148	$617,853	6.54%
Vision	19,662	$5,373,960	3,440	$1,189,630	17.50%
NEMT	26,673	$969,727	121	$4,482	0.52%
Medical (physical health not otherwise specified)	483,078	$303,902,726	57,482	$37,724,782	11.90%
Nursing Facilities-Total	22,649	$53,108,886	2,558	$4,507,963	11.29%
HCBS	50,609	$28,791,496	2,989	$1,738,784	5.91%
Behavioral Health	162,112	$21,333,225	16,355	$2,066,993	10.09%
Total All Services	1,417,870	$1,052,709,706	253,384	$136,712,833	17.87%

SUNFLOWER Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	11,305	$422,749,190	2,674	$121,464,435	23.65%
Hospital Outpatient	92,211	$226,355,607	14,242	$33,563,195	15.45%
Pharmacy	803,029	$78,150,835	241,960	$45,040,844	30.13%
Dental	38,393	$9,675,949	3,205	$717,739	8.35%
Vision	24,347	$5,757,321	2,997	$751,565	12.31%
NEMT	39,662	$1,054,040	504	$18,760	1.27%

KDHE Summary of Claims Adjudication Statistics –
January through December 2016 – KanCare MCOs

SUNFLOWER Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Medical (physical health not otherwise specified)	523,898	$260,489,195	56,863	$36,318,498	10.85%
Nursing Facilities-Total	36,242	$78,643,535	3,631	$11,282,339	10.02%
HCBS	163,043	$63,639,558	7,059	$2,625,334	4.33%
Behavioral Health	168,778	$26,315,533	14,186	$2,404,628	8.41%
Total All Services	1,900,908	$1,172,830,764	347,321	$254,187,339	18.27%

UNITED Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	7,689	$286,658,100	1,571	$73,578,896	20.43%
Hospital Outpatient	82,594	$213,204,397	14,406	$36,285,892	17.44%
Pharmacy	460,954	$59,292,662	103,811	$27,446,237	22.52%
Dental	34,494	$9,162,189	2,599	$711,149	7.53%
Vision	21,140	$4,230,766	2,004	$404,853	13.11%
NEMT	43,821	$1,125,795	711	$19,613	1.62%
Medical (physical health not otherwise specified)	23,515	$61,289,684	3,874	$12,181,525	16.47%
Nursing Facilities-Total	23,969	$62,271,597	3,933	$12,306,183	16.41%
HCBS	90,928	$22,665,093	3,843	$990,116	4.23%
Behavioral Health	58,548	$24,253,909	2,967	$3,427,355	5.07%
Total All Services	847,652	$744,154,192	139,719	$167,351,818	16.48%