Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 9.30.17

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: 4/2017 (7/17-9/17)

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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 second quarter known as of September 30, 2017.

Demonstration Population	Enrollees at Close of Qtr. (9/30/2017)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,562	15,413	851
Population 2: ABD/SD Non Dual	28,718	29,529	541
Population 3: Adults	49,571	54,237	4,666
Population 4: Children	221,741	236,769	15,028
Population 5: DD Waiver	8,921	8,987	66
Population 6: LTC	20,296	20,853	557
Population 7: MN Dual	1,174	1,290	116
Population 8: MN Non Dual	1,133	1,246	113
Population 9: Waiver	4,298	4,483	185
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**350,414**	**372,537**	**22,123**

III. Outreach/Innovation

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

The KanCare Advisory Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists. No meeting took place this quarter. The meeting was cancelled due to having no agenda items to discuss.

KDHE and KDADS also held nine meetings September 13 and 15 with provider associations and advocacy groups to discuss how their input about KanCare was being used to develop the Request for Proposals (RFP) for new MCO contracts and the 1115 demonstration renewal application. Regular meetings with each group will occur quarterly throughout 2018 to provide updates and obtain their input as the State prepares to implement KanCare 2.0.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly) – ending this quarter
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Medicaid Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)
- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the 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
- KDADS-CDDO Eligibility workgroup tasked to update IDD Eligibility policy and Handbook-first meeting was 6/22/17

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 July 2018. 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 August 17, 2017, at Amerigroup Kansas, Inc. Overland Park, Kansas. The meeting consisted of a report from the KanCare Ombudsperson, Kerrie Bacon, and a continuation of the discussion of the redesign of the Elderly and Persons with Disabilities KanCare application. KDHE shared a draft copy of the new Elderly and Disabled application. KDHE accepted the group's feedback on the current draft version of the new application. David Torres, the Director of the Center for Health Literacy spoke to the group about some of the guiding principles they used in constructing the new application and was there to hear feedback. Russell Nittler gave a brief update on the upgrade of the KEES eligibility system that will now include the Department of Children and Families programs, such as Food Assistance and TAF cash assistance.

NASDDDS-KDADS-Stakeholder Engagement Meeting
On September 6, 2017, KDADS and National Association of State Directors of Developmental Disability Services (NASDDDS) hosted an engagement workday with IDD stakeholders to discuss Residential Supports such as Shared Living, Supported Living, and Supports in the Family Home, as well as Day Supports, Supported Employment and Community Live Engagement. 24 attendees from a variety of stakeholder groups and individuals attended this meeting. Stakeholder agencies represented included InterHab, Families Together, Kansas Council on Developmental Disabilities, CDDOs, providers of Shared Living and Residential services, WSU, MCOs, Disability Rights Center (DRC), Self-Advocate Coalition of Kansas (SACK), and Kansas University Center on Developmental Disabilities. The presentation and

discussion points were sent out after the meeting to the attendees, as well as a finalized version of the meeting's feedback summary from NASDDDs that included art by one of the participants.

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 280 events for the third 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 third quarter:

- Families Together Collaboration – Teen Booklet
- KYEA Mentor Meeting
- Olathe Community Health Forum Meeting
- St Francis Open House

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 37,000 Kansans in the third 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:

- Wyandotte Bethel Life Church Convey of Hope
- Kansas Food Bank
- Project Hope Baby Shower
- March of Dimes Bikers for Babies
- Boys and Girls South Central Kansas

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

The third 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:

- Safe Kids Coalition Meeting
- Member Advisory Committee (HCBS and Teen)
- Child Start Health Services Advisory Committee Meeting
- Employment Advisory Committee Meeting
- Finney County Community Health Coalition

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

Marketing Activities: During Q3 2017, Sunflower Health Plan sponsored local and statewide member and provider events as well as fundraisers for charitable organizations such as the United Way. Sunflower's direct mail marketing material for the second quarter included member postcards and customized letters addressing preventive health care gaps for important screenings and immunizations. Notable stakeholder programs and events for marketing during Q3 2017:

- United Way Employee Giving Campaign (with 82% employee participation)
- HPV Prevention: Education Breakfast, Overland Park
- Kansas Housing Conference
- Johnson County Mental Health Recovery Conference
- Saline County Back to School Fair
- Convoy of Hope back to school event in Wichita
- Topeka Breast Cancer Walk
- 14th Annual Remembrance Walk for Suicide Awareness and Prevention
- I/DD Provider Fair for Clients hosted by Council Community Members (CCM)
- Hutchinson Heart Walk
- Mid-West Ability Summit

Outreach Activities: Sunflower Health Plan's outreach activities for the 3rd Quarter 2017, centered on home visits, farmers markets and back-to-school events. The health plan also continued member outreach for tobacco cessation. Sunflower continued its work with individuals and community agencies to address the social determinants of health in Kansas communities. Examples of member outreach activities this quarter:

- Held six Farmers Market member programs during the quarter

- Participated in 10 community health events serving all populations, including North Central-Flint Hills Area Agency on Aging annual senior fair and a kids' dental clinic at First Care Clinic in Hays, KS.
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on August 23 in Wichita. The two main topics on the agenda were the CentAccount rewards program and the new member welcome packet.
- Community sponsored baby shower: Wyandotte County FIMR
- Invited members to two Clinic Days with Health Partnership Clinic in Shawnee and Ottawa to help close care gaps
- Sunflower volunteered at the Special Olympics Summer Games

Advocacy Activities: Sunflower Health Plan's advocacy efforts for Q3 2017 centered on supports for people with disabilities, oral health for the maternal & child health population and work to help all populations improve individual health literacy. The health plan's farmer's market voucher program also kicked off this quarter. Sunflower participated in the following advocacy activities during Q3 2017:

- Kansas Youth Empowerment Academy (KYEA) Leadership Forum
- KAY-Kansas Association for Youth Camp Activity supporting student leaders
- Kansas Youth Advisory Council (KYAC) Summer Conference "Unleash your Power - Be your own Superhero!"
- Topeka Independent Living Resource Center's 27th Americans with Disabilities Act Anniversary Celebration
- 3rd Annual Picnic in the Park for IDD members and their support teams
- Johnson County Mental Health - Recovery Conference
- Café Con Leche, Presented by the Hispanic Safety and Health Outreach Committee

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

Marketing Activities: UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding KanCare benefits and general health education. Plan staff completed new member welcome calls and Health Risk Assessments. 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 Summer newsletter (a quarterly newsletter) with tips on living a healthier life. UnitedHealthcare delivers the quarterly Community Connections 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 like Head Start and Parents as Teachers throughout the state that involved discussions around exploring innovative and collaborative opportunities.

UnitedHealthcare hosted 4 grant announcement events to recognize five organizations that received grant money as part of a Rural Health Community Grant program. Three of these events took place during National Health Center week in order to draw attention to the role FQHC's play in supporting Rural Health. Events were held in Pittsburg, Minneola, Wamego and Hutchinson Kansas to recognize the recipients: Southeast Kansas Independent Living, Community Health Center of Southeast Kansas, Minneola District Hospital, Reno County Health Department, and Community Health Ministry. The Health Plan put a lot of

focus on National Health Center Week. Events were held across the state to celebrate the great work done by FQHC's and Safety Net Clinics. Both Provider appreciation and Member events were held or sponsored by UHC. In addition, UHC awarded an additional grant to the Johnson County Mental Health Center to support a transportation pilot program. The reward event was held in September at the HCMHC office.

Outreach Activities: UnitedHealthcare Community Plan participated in and/or supported 119 member facing activities which included 53 lobby sits at provider offices as well as 43 events/Health Fairs or other educational opportunities for both consumers and providers. In Q2, UHC hosted a very successful Community Baby Shower with Community Partners in Parsons where more than 150 Consumers were in attendance. In addition, UHC helped organize the quarterly all MCO Wyandotte County Community Baby Shower. UnitedHealthcare also participated in and supported six additional 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. It is important 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 third quarter of 2017. In particular, a lot of focus and support was provided 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. UHC Advocates were key speakers and participants in IRC meetings in Wichita. Two Outreach Advocates completed Safe Sleep Training put on by KIDS KS Network. They are now certified Safe Sleep instructors that will be using their training to speak at both UHC and non-UHC events that focus on Mothers and Infants. In addition, a bi-lingual Advocate completed certification to train consumers on diabetes in-language. There was a shortage of Spanish speaking trainers, this advocate is helping to fill

Finally, UHC hosted the Q4 Member Advisory Meeting in Garden City. The Health Plan finds it critical to host meetings in different parts of the state in order to hear from those in both urban and rural areas. The meeting solicited feedback on Transportation, Telemedicine, and Value Added Benefits and allowed for open discussion on any topic of interest to the members.

- During the third quarter 2017, UnitedHealthcare staff personally met with approximately 10,701 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.
- During the third quarter 2017, UnitedHealthcare staff personally met with approximately 1,039 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities.
- During the third quarter 2017, UnitedHealthcare staff personally met more than 1.277 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, a UHC Advocate was a panel speaker at the FEAT Training in Lansing. This advocate also traveled to Salt Lake City, UT to speak on a Panel with regard to the role Managed Health Care play is supporting consumers with Intellectual and Developmental Disabilities. The team also works closely with Health Plan Care Coordinators who support the waiver population. The Health Plan staff continued to stress to all members, including those with disabilities the desire to help support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. 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. Or, to meet consumers new to KanCare who are trying to understand their benefits. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas.

Health Plan 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:

- International Rescue Committee (IRC)
- Self-Advocate Coalition of Kansas
- Hays Community Service Council,
- Pratt County Community Health & Resource Council
- Thomas County Health Coalition
- Great Bend Interagency Committee
- Migrants Program Committee
- Cultural Relations Board
- Ford County Health Coalition
- Lifestyle Diabetes Coaches Training
- Tobacco Cessation Work Group
- Mental Health Recovery Conference
- Kickin' it with WIC
- Wyandotte CDDO Provider Fair
- Douglas/Jefferson County Transition Council
- Transformers Committee
- Poverty Conference
- Parents University
- Meetings with youth in school
- KAMU Conference
- FIMR (Fetal and Infant Mortality Rate) Advocacy Group
- Family Employment Awareness Training

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and such

issues are managed either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

KanCare Amendment 26 was submitted to CMS for review and approval on August 9, 2017. The Amendments include an actuarial certification for a mid-year adjustment for the capitated rates for the period of July 1 – December 31, 2017. In addition, the amendments adjust the Pay for Performance (P4P) at-risk percentage to one percent (1%) of the capitated revenue and implement a TANF risk corridor for Amerigroup Kansas and Sunflower State Health Plan.

Six State Plan Amendments (SPA) were submitted as noted below:

SPA Number	Subject	Submitted Date	Effective Date
17-006	Frontis page	9/19/17	8/18/17
17-007	DRG outlier payment rates	9/19/17	8/18/17
17-008	ICF/IDD rates	9/19/17	8/18/17
17-009	Inpatient hospital rates	9/19/17	8/18/17
17-010	NF rates	9/19/17	7/01/17
17-011	Interim Hospital Billing	9/19/17	7/01/17

The state plan amendment 17-004, NADAC, submitted on June 16, 2017 with an effective date of April 1, 2017 was approved by CMS on July 21, 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-June, 2017, follows:

MCO	Value Added Service *Jan.-Sept. 2017*	Units YTD	Value YTD
Amerigroup	Adult Dental Care	2,610	$351,112
	Member Incentive Program	16,594	$318,180
	Mail Order OTC	6,018	$109,453
	Total of all Amerigroup VAS	***27,661***	***$895,078***
Sunflower	CentAccount Debit Card	59,644	$637,597
	Dental Visits for Adults	5,658	$271,880
	Pharmacy Consultation	7,426	$184,354
	Total of all Sunflower VAS	***123,764***	***$1,457,699***
United	Rewards for Preventive Visits & Health Actions	32,888	$97,825
	Adult Dental Services	1,615	$92,633
	Baby Blocks Program and Rewards	591	$70,920
	Total of all United VAS	***54,708***	***$585,025***

c. Enrollment issues: For the second quarter of calendar year 2017 there were 10 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 second quarter of calendar year 2017. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	1
KDHE - Administrative Change	61
WEB - Change Assignment	27
KanCare Default - Case Continuity	137
KanCare Default – Morbidity	216
KanCare Default - 90 Day Retro-reattach	183
KanCare Default - Previous Assignment	344
KanCare Default - Continuity of Plan	1214
AOE – Choice	371
Choice - Enrollment in KanCare MCO via Medicaid Application	1016
Change - Enrollment Form	375
Change - Choice	426
Change - Access to Care – Good Cause Reason	1
Change - Case Continuity – Good Cause Reason	1
Change – Due to Treatment not Available in Network – Good Cause	
Assignment Adjustment Due to Eligibility	11
Total	**4384**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
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MCO	QOC (non HCBS, non Trans)	Customer Svcs	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (incl Reim.)	Trans (No Show)	Trans (Late)	Trans (Safety)	No Driver Avail-able	VAS	Billing/Fin Issues (non Trans)	Other
AMG	9	11	2	12	2	14	19	11	6	3	4	8	39	1
SUN	17	22	4	14	7	17	25	13	27	9	4	4	9	2
UHC	24	12	0	9	6	6	27	27	37	12	2	4	64	1
Total	50	45	6	35	15	37	71	51	70	24	10	16	112	4

MCOs' Appeals Database

Members – CY17 3rd 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	1 37 6	 1	 13 3	1 24 2
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	1 2 28	1 22	 2 	 6
Criteria Not Met - Medical Procedure (NOS)	3 14		2 7	1 7
Criteria Not Met - Radiology	13 11		6 5	7 6
Criteria Not Met - Pharmacy	7 63 42	 6 2	7 35 23	 22 17
Criteria Not Met - PT/OT/ST	1			1
Criteria Not Met - Dental	9 5	 1	3 	6 4
Criteria Not Met or Level of Care - Home Health	3 1		1 	2 1
Criteria Not Met – Inpatient Behavioral Health	13 5		3 3	10 2
Criteria Not Met – Behavioral Health Outpatient Services and Testing	10 12 13		6 2 6	4 10 7
Level of Care - LTSS/HCBS	18 8	3 	10 	5 8
Other- Medical Necessity	1 2 7	 4	 2 	1 3
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	1 1	 1	 	1
Service not covered - Home Health	1			1
Service not covered - Pharmacy	2 2 3		2 1 3	 1
Service not covered - OT/PT/Speech	2	1		1
Service not covered – Durable Medical Equipment	1 4		 1	1 3

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Service not covered - Behavioral Health	1			1
Other - Noncovered service	1 10 17	 12	 7 2	2 3 3
Lock In	2 1		1	 1
Billing and Financial Issues				
AUTHORIZATION DENIAL				
Late submission by member/provider rep.	1			1
TOTAL AMG – Red SUN – Green UHC - Purple	 77 184 125	 5 6 43	 37 82 37	 35 96 45

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

MCO's Appeals Database

Member Appeal Summary – CY17 3rd quarter report

AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Total Number of Appeals Resolved	77 184 125	5 6 43	37 82 37	35 96 45
Percentage Per Category		7% 3% 34%	48% 45% 30%	45% 52% 36%

MCOs' Appeals Database

Provider Appeal Summary – CY17 3rd quarter report

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 – Durable Medical Equipment	2 6		2	 6

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	30 40 42		16 19 12	14 21 30
Criteria Not Met - Medical Procedure (NOS)	14 3		9 1	5 2
Criteria Not Met - Radiology	16		10	6
Criteria Not Met - Pharmacy	18		16	2
Criteria Not Met - PT/OT/ST	3		2	1
Criteria Not Met - Dental	2		2	
Criteria Not Met – Vision	37		22	15
Criteria Not Met - Hospice	2		2	
Criteria Not Met – Inpatient Behavioral Health	3 6		2 1	1 5
Criteria Not Met – Behavioral Health Outpatient Services and Testing	7 9 1		5 7	2 2 1
Level of Care - LTSS/HCBS	2 1		1	1 1
Level of Care - LTC NF	3		1	2
Ambulance (include Air and Ground)	2		1	1
Other-medical necessity	8		5	3
Change in attendant hours	1			1
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	10 2		5 1	5 1
Service not covered - Home Health	6 3		3	3 3
Service not covered - Pharmacy	1		1	
Service not covered – Durable Medical Equipment	1 12		1 2	 10
Service not covered - Behavioral Health	1		1	
Other- not covered service	2		1	1

PROVIDER Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
	11 20		5 2	6 18
BILLING AND FINANCIAL ISSUES				
Claim Denied- contained errors	116 126 282	 1	22 70 1	84 56 280
Claim Denied- by MCO in Error	344 39		114 39	198
PRIOR AUTHORIZATION DENIAL				
Late notification	12 118	 5	4 26	8 87
No authorization submitted	2 38 55		1 16 15	1 22 40
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **580** **436** **443**	 **5** **1**	 **210** **186** **70**	 **328** **245** **372**

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

MCO's Appeals Database

Provider Appeal Summary – CY17 3rd quarter report

AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
Reconsideration	10147 4575 27118		4153 3724 16396	4715 851 10722
Resolved at 2nd Appeal Level	580 436 443	 5 1	210 186 70	328 245 372
TOTAL	10727 5011 27561	 5 1	4363 3910 16466	5043 1096 11094
Percentage Per Category		 >0% >0%	41% 78% 60%	47% 22% 40%

State of Kansas Office of Administrative Fair Hearings

Members – CY17 3rd 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 - Medical Procedure (NOS)		1 1	2					
Criteria Not Met - Pharmacy			1 1					
Criteria Not Met - PT/OT/ST	1							
Level of Care - LTSS/HCBS	1 1 1	1						1
Level of Care - Mental Health					1		1	
Other- Medical Necessity							1	
NONCOVERED SERVICE DENIAL								
Service not covered - OT/PT/Speech							1	
Service not covered - Durable Medical Equipment		1						
LOCK IN					1			
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	1 2 1	2 2 1	1 4		1 1		2 1	1

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

State of Kansas Office of Administrative Fair Hearings
Providers – CY17 3rd 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 (Non-Behavioral Health)	2 15	4	3				2	
Criteria Not Met - Medical Procedure (NOS)		1						
Criteria Not Met - Radiology				1				
Criteria Not Met - Pharmacy	1	1	2 3					
Criteria Not Met – Behavioral Health Outpatient Services and Testing		1						
Ambulance (include Air and Ground)		1						
NONCOVERED SERVICE DENIAL								
Service not covered - Durable Medical Equipment	1							
Other - Noncovered service		1						
BILLING AND FINANCIAL ISSUES	2 1 3	8 5 1	1 3		1		1	
PRIOR AUTHORIZATION DENIAL								
Late notification							1	
TOTAL **AMG – Red** **SUN – Green** **UHC – Purple**	2 3 20	12 6 6	3 9	1	1		4	

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

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q2 of 2017, there were 101 requests to change health plans, and in Q3 2017, the volume reduced to 83 requests.

The majority of good cause requests (GCRs) are due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. 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. One fairly large pediatric practice dropped their contract with one MCO and sent letters to all their patients, advising them to send good cause requests to switch to a different MCO. 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 third quarter of 2017, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	July	August	September
Total GCRs filed	28	33	22
Approved	1	2	1
Denied	17	18	12
Withdrawn (resolved, no need to change)	8	5	5
Dismissed (due to inability to contact the member)	2	8	3
Pending	0	0	1

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, the way data was pulled was changed to reflect the number of unique providers per name, NPI and city. Previously, the report 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, this report was revised to be a more accurate reflection of network capacity. The MCOs continue to review and correct their data, which explains the changes in numbers:

KanCare MCO	# of Unique Providers as of 12/31/16	# of Unique Providers as of 3/31/17	# of Unique Providers as of 6/30/17	# of Unique Providers as of 9/30/17
Amerigroup	16,886	16,498/23,758	25,904	25,396
Sunflower	21,391	22,313/30,992	31,780	31,506
UHC	23,778	23,777/39,881	32,216	30,610

MLTSS implementation and operation: In the third 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 offered services to 300 people on the HCBS-PD waiver wait list in the month of September with a current acceptance rate of 46%. Kansas offered services to 409 people on June 21st with an acceptance rate of 52%.

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

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.

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

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

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 August 23, 2017, to review the current state of KanCare and HCBS services.
   - The committee received KanCare program updates from KDHE, including eligibility determinations, KanCare contracts re-procurement schedule, and MCO financial status.
   - 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 the State Budget Director on the Governor's budget priorities, presentations from each of the KanCare MCOs, 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, monthly KanCare Steering Committee and monthly joint and one-on-one meetings between KDHE, KDADS and MCO leadership. Policy changes are also communicated to MCOs through other scheduled and ad hoc meetings as necessary to ensure leadership and program staff are aware of the changes. All policies affecting the operation of the Kansas Medicaid program and MMIS are addressed through a defined and well-developed process that is inclusive (obtaining input from and receiving review by user groups, all affected business areas, the state Medicaid policy team, the state's fiscal agent and Medicaid leadership) and results in documentation of the approved change.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by DXC, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 9.30.17 is attached. Utilizing the DXC-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

General reporting issues: KDHE continues to work with DXC, the fiscal agent, to modify reports as needed 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	*2017-07*	*2017-08*	*2017-09*	*Grand Total*
Population 1: ABD/SD Dual	14,865	14,704	14,574	44,143
Population 2: ABD/SD Non Dual	28,774	28,719	28,733	86,226

Sum of Member Unduplicated Count	Member Month			Totals
Population 3: Adults	51,663	50,716	49,571	151,950
Population 4: Children	227,194	225,272	221,743	674,209
Population 5: DD Waiver	8,940	8,926	8,923	26,789
Population 6: LTC	20,260	20,283	20,358	60,901
Population 7: MN Dual	1,236	1,202	1,179	3,617
Population 8: MN Non Dual	1,187	1,155	1,134	3,476
Population 9: Waiver	4,600	4,456	4,298	13,354
Grand Total	**358,719**	**355,433**	**350,513**	**1,064,665**

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

VIII. Consumer Issues

Consumer issues remain static. A summary of second 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. Unfortunately, this has been a difficult system issue to resolve.
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

Issue	Resolution	Action Taken to Prevent Further Occurrences
		adequacy report was revised to include a column for member count, and member capacity. We have instructed the MCOs to submit this information for panel monitoring purposes. MCOS have begun to report using a new template in 2017, and have begun to actively collect and report this data in the quarterly reporting template. The State is also developing guidelines for the provider directory as mandated by CMS.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	Some of the MCO processes require manual intervention, which may lead to errors. Also some MCOs require a claim to be submitted and denied before they can implement the retroactive eligibility protocol. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations.

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 3,639 consumers during this quarter. OEW also assisted in resolving 2,363 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 1,466 consumer phone calls.

During this quarter, OEW staff also participated in 19 community events providing KanCare program outreach, education and information for schools, health departments, FQHC clinics, public health fairs, Latino and Asian Wellness groups, State School Nurses Conference, and State Immunization Conference.

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 third 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 automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan 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.

- Quarterly meetings with the EQRO along with the MCOs, KDADS and KDHE to discuss EQRO activities and concerns.
- 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.
- Monitor member or provider specific issues through a tracking database.
- 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. *HCBS Quality Review reports for CY 2013, 2014, 2015 and through September 2016 are attached to this report.*
- During this quarter, the Quality Assurance team within KDADS began their review of the 1/1/2017 through 3/31/207 period. January – June 2016 and July – September 2016 Quality Review reports were submitted and reviewed during this quarter's LTC Committee meetings.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data

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

- 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-2017.pdf?sfvrsn=6. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
- HCBS Service Providers by County: http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/hcbs-providers-by-waiver-service---2017.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-September 2017:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:23	2.59%	137,736
Sunflower	0:17	1.47%	129,601
United	0:13	0.53%	132,901
DXC – Fiscal Agent	0.00	0.0%	5,214

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:22	1.40%	69,251
Sunflower	0:11	1.09%	75,761
United	3:10	0.95%	68,009
DXC – Fiscal Agent	0.00	0.0%	12,556

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 3rd Quarter

Amerigroup 3rd Qtr. Grievance Trends

Total # of Resolved Grievances	141	
Top 5 Trends		
Trend 1: Billing/Financial Issues (Non Transportation)	39	28%
Trend 2: Transportation (Including Reimbursement)	19	13%
Trend 3: Quality of Care (HCBS)	14	10%
Trend 4: Access to Service or Care	12	9%
Trend 5: Customer Service and Transportation (no show)*	11	8%

*Customer Service and Transportation (no show) both had 11 grievances each.

Amerigroup Member Grievances:

- The top five Amerigroup member grievances account for 95 (76%) of the total 141 member grievances for CY2017 Qtr. 3
- The largest number of grievances submitted is Billing/Financial Issues (Non Transportation) of which 22 (56%) of the 39 grievances are for providers balance billing
- The fifth largest number of grievances submitted is Transportation (No Show) which is a decrease of 18 from CY2017 Qtr. 2
- Transportation grievances of 43 grievances for all five categories account for 31% of Amerigroup's member grievances this quarter which is a reduction of 15 from CY2017 Qtr. 2

Sunflower 3rd Qtr. Grievance Trends		
Total # of Resolved Grievances	174	
Top 5 Trends		
Trend 1: Transportation Late	27	16%
Trend 2: Transportation (including Reimbursement)	25	14%
Trend 3: Customer Service	22	13%
Trend 4: Quality of Care (HCBS)	17	10%
Trend 5: Quality of Care (non HCBS)	17	10%

Sunflower Member Grievances:

- The top five Sunflower member grievances account for 108 (62%) of the total 174 member grievances for CY2017 Qtr. 3
- The fourth largest number of grievances submitted is Quality of Care (non HCBS) which is an increase of 17 from CY2017 Qtr. 2. There were no grievances for this category in CY2017 Qtr. 1 or CY2017 Qtr. 2
- Transportation grievances of 78 grievances for all five categories account for 45% of Sunflower's member grievances this quarter which is a reduction of 3 from CY2017 Qtr. 2

United 3rd Qtr. Grievance Trends	
Total # of Resolved Grievances	230
Top 5 Trends	

Trend 1: Billing/Financial Issues	64	28%
Trend 2: Transportation Late	37	16%
Trend 3: Transportation (Including Reimbursement)	27	12%
Trend 4: Transportation No Show	27	12%
Trend 5: Quality of Care (non HCBS)	24	10%

United Member Grievances:

- The top five United member grievances account for 179 (78%) of the total 230 member grievances for CY2017 Qtr. 3
- The third largest number of grievances submitted is Transportation (Including Reimbursement) with 27 grievances this quarter a significant increase of 15 grievances from last quarter's
- The fourth largest number of grievances submitted is Transportation No Show with 27 grievances this quarter a significant increase of 16 grievances from last quarter
- Transportation grievances of 105 grievances for all five categories account for 46% of United's member grievances this quarter which is a significant increase of 60 from CY2017 Qtr. 2

MCOs' Appeals Trends
Member/Provider – CY17 3rd Quarter

Amerigroup 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	77		**Total # of Resolved Provider Appeals**	580	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Level of Care - LTSS/HCBS	18	23%	**Trend 1: Claim Denied - by MCO Error**	344	59%
Trend 2: Criteria Not Met - Radiology	13	17%	**Trend 2: Claim Denied - contained errors**	116	20%
Trend 3: Criteria Not Met - Inpatient Behavioral Health	13	17%	**Trend 3: Criteria Not Met – Inpatient Admissions (non-Behavioral Health)**	30	5%
Trend 4: Criteria Not Met – Behavioral health Outpatient Services and Testing	10	13%	**Trend 4: Criteria Not Met - Pharmacy**	18	3%
Trend 5: Criteria Not Met - Pharmacy	7	9%	**Trend 5: Criteria Not Met - Radiology**	16	3%

Amerigroup Member Appeals:

- The top five Amerigroup member appeals account for 51 (66%) of the total 77 member appeals for CY2017 Qtr. 3
- The second largest number of member appeals submitted is Criteria Not Met – Radiology with 13 member appeals this quarter a significant increase of 10 appeals from last quarter
- The third largest number of member appeals submitted is Criteria Not Met – Inpatient Behavioral Health with 13 member appeals this quarter a significant increase of 10 from last quarter

Amerigroup Provider Appeals:

- The top five Amerigroup provider appeals account for 524 (90%) of the total 580 provider appeals for CY2017 Qtr. 3
- The largest number of provider appeals submitted is Claims Denied – by MCO in Error with 344 appeals this quarter a significant decrease of 28 from last quarter
- The second largest number of provider appeals submitted is Claims Denied – Contained Errors with 116 appeals this quarter a significant decrease of 107 from last quarter

- The third largest number of provider appeals submitted is Criteria Not Met – Inpatient Admissions (Non-Behavioral Health) with 30 appeals this quarter a significant increase of 11 from last quarter
- The fourth largest number of provider appeals submitted is Criteria Not Met – Pharmacy with 18 appeals this quarter a significant decrease of 17 from last quarter

Sunflower 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	184		**Total # of Resolved Provider Appeals**	436	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	63	34%	**Trend 1: Claim Denied - contained errors**	118	27%
Trend 2: Criteria Not Met - DME	37	20%	**Trend 2: Late Notification**	118	27%
Trend 3: Criteria Not Met - Medical Procedure (NOS)	14	8%	**Trend 3: Criteria Not Met – Inpatient Admissions (Non-Behavioral Health)**	40	9%
Trend 4: Criteria Not Met – Behavioral Health Outpatient Services and Testing	12	7%	**Trend 4: No authorization submitted**	38	9%
Trend 5: Criteria Not Met - Radiology	11	6%	**Trend 5: Criteria Not Met - Vision**	37	8%

Sunflower Member Appeals:

- The top five Sunflower member appeals account for 137 (74%) of the total 184 member appeals for CY2017 Qtr. 3
- The second largest number of member appeals submitted is Criteria Not Met – DME with 37 member appeals this quarter a significant increase of 20 from last quarter

Sunflower Provider Appeals:

- The top five Sunflower provider appeals account for 351 (81%) of the total 436 provider appeals for CY2017 Qtr. 3
- The second largest number of provider appeals submitted is Late Notification with 118 appeals this quarter a significant increase of 81 from last quarter
- The third largest number of provider appeals submitted is Criteria Not Met – Inpatient Admissions (Non-Behavioral Health) with 40 appeals this quarter a significant increase of 10 from last quarter

United 3rd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	125		**Total # of Resolved Provider Appeals**	443	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	42	34%	**Trend 1: Claim Denied - contained errors**	282	64%
Trend 2: Criteria Not Met - Inpatient Admissions (Non Behavioral Health)	28	22%	**Trend 2: No authorization submitted**	55	12%
Trend 3: Other – Non-covered Service	17	14%	**Trend 3: Criteria Not Met - Inpatient Admissions (Non Behavioral health)**	42	9%
Trend 4: Criteria Not Met - Behavioral Health Outpatient Services and Testing	13	10%	**Trend 4: Claim Denied - by MCO in error.**	39	9%
Trend 5: Other – Medical Necessity	7	6%	**Trend 5: Other – Non-covered Service**	20	5%

United Member Appeals:

- The top five United member appeals account for 107 (86%) of the total 125 member appeals for CY2017 Qtr. 3

United Provider Appeals:

- The top five United provider appeals account for 438 (99%) of the total 443 provider appeals for CY2017 Qtr. 3
- The largest number of provider appeals submitted is Claim Denied – Contained Errors with 282 appeals this quarter a significant decrease of 96 from last quarter
- The second largest number of provider appeals submitted is No Authorization Submitted with 55 appeals this quarter a significant decrease of 19 from last quarter

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY17 3rd Quarter

- There were a total of 20 Member State Fair Hearings for all three MCOs. Two of the MCO decisions were reversed by OAH.
- There were a total of 67 Provider State Fair Hearings for all three MCOs. No decisions were reversed by OAH.

Amerigroup 3rd Qtr.					
Total # of Member SFH	5		**Total # of Provider SFH**	14	
OAH reversed MCO decision	0	0%	**OAH reversed MCO decision**	0	0%

Sunflower 3rd Qtr.					
Total # of Member SFH	11		**Total # of Provider SFH**	18	
OAH reversed MCO decision	1	9%	**OAH reversed MCO decision**	0	0%

United 3rd Qtr.					
Total # of Member SFH	4		**Total # of Provider SFH**	35	
OAH reversed MCO decision	1	25%	**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 second 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.

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

- Developing an automatic feed to pull APS and CPS reports into the AIR system
- Creating reports for each performance measure – specifically unexpected death, restraint, seclusion and restrictive interventions.
- Making final revisions to AIR, if needed, by KDADS IT
- Training MCO representatives once all system changes are in place
- Scheduling monthly meetings with each MCO to provide the appropriate amount of oversight of the AIR system, analyze trends and drill down in to any specific cases as necessary.

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

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 September 30, 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	1,903	1,776		5,289
Pending Resolution	0	0	0		0
Total Received	1,610	1,903	1,776		5,289
APS Substantiations*	58	93	114		265

**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 third quarter HCAIP UCC Pool payment was made September 29, 2017. The LPTH/BCCH Pool third quarter payment was made July 28, 2017.

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

XII. Demonstration Evaluation

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

For the quarter ending 9.30.17, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

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

a. Claims Adjudication Statistics

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

b. Waiting List Management

PD Waiting List Management

For the quarter ending September 30, 2017:

- Current number of individuals on the PD Waiting List: 1,211
- Number of individuals added to the waiting list: 420
- Number of individuals removed from the waiting list: 246
    - 148 started receiving HCBS-PD waiver services
    - 19 were deceased
    - 79 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending September 30, 2017:

- Current number of individuals on the I/DD Waiting List: 3,621
- Number of individuals added to the waiting list: 157
- Number of individuals removed from the waiting list: 126
    - 55 started receiving HCBS-I/DD waiver services
    - 4 were deceased
    - 67 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 9.30.17
IX	HCBS Quality Data Reports for October-December 2016
X(e)	Summary of KanCare Ombudsman Activities for QE 9.30.17
XI	KanCare Safety Net Care Pool Report for QE 9.30.17
XII	KFMC KanCare Evaluation Report for QE 9.30.17
XIII(a)	KDHE Summary of Claims Adjudication Statistics for January-December 2016

XV. State Contacts

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XVI. Date Submitted to CMS

January 9, 2018

DY 5
Start Date: 1/1/2017
End Date: 12/31/2017

Quarter 3
Start Date: 7/1/2017
End Date: 9/30/2017

	Total Expenditures	Total Member-Months
Jul-17	250,855,787.00	365,504
Aug-17	252,248,162.00	360,240
Sep-17	251,125,970.00	355,336
Q3 Total	754,229,919.00	1,081,080

	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
Jul-17									
Expenditures	$1,323,569	$37,338,784	$26,870,051	$53,194,731	$42,663,753	$73,319,084	$779,295	$2,380,053	$12,986,467
Member-Months	7,018	37,836	53,498	229,710	9,203	20,799	1,392	1,306	4,742
Aug-17									
Expenditures	$1,341,353	$37,436,213	$27,046,898	$52,648,195	$43,028,916	$75,117,259	$651,236	$2,142,079	$12,836,013
Member-Months	7,158	37,793	51,994	226,240	9,092	20,904	1,300	1,245	4,514
Sep-17									
Expenditures	1,287,866	36,213,588	28,432,574	51,715,369	42,945,146	74,801,966	704,961	2,187,104	12,837,396
Member-Months	6,859	37,304	51,190	222,993	9,014	20,925	1,348	1,259	4,444
Q3 Total									
Expenditures	$3,952,788	$110,988,585	$82,349,523	$157,558,295	$128,637,815	$223,238,309	$2,135,492	$6,709,236	$38,659,876
Member-Months	21,035	112,933	156,682	678,943	27,309	62,628	4,040	3,810	13,700
DY 5 - Q3 PMPM	$188	$983	$526	$232	$4,710	$3,565	$529	$1,761	$2,822

Home and Community Based Services Quality Review Report October – December 2016

September 18, 2017

KDADS HCBS Quality Review Report

Administrative Authority
PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Denominator: Number of Qualtiy Review reports
Review Period: 10/01/2016 - 12/31/2016
Data Source: Quality Review Reports to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	1
Denominator	1
FE	**100%**
Numerator	1
Denominator	1
IDD	**100%**
Numerator	1
Denominator	1
TBI	**100%**
Numerator	1
Denominator	1
TA	**100%**
Numerator	1
Denominator	1
Autism	**100%**
Numerator	1
Denominator	1
SED	**100%**
Numerator	1
Denominator	1

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2106
PD						
Statewide	25%	25%	25%	50%	100%	100%
FE						
Statewide	25%	25%	25%	50%	100%	100%
IDD						
Statewide	25%	25%	25%	50%	100%	100%
TBI						
Statewide	25%	25%	25%	50%	100%	100%
TA						
Statewide	25%	25%	25%	50%	100%	100%
Autism						
Statewide	25%	25%	25%	50%	100%	100%
SED						
Statewide	25%	25%	25%	50%	100%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 2: Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency
Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS
Denominator: Total number of waiver amendments and renewals
Review Period: 10/01/2016 - 12/31/2016
Data Source: Number of waiver amendments and renewals sent to KDHE

Compliance By Waiver	Statewide
PD	**N/A**
Numerator	0
Denominator	0
FE	**N/A**
Numerator	0
Denominator	0
IDD	**N/A**
Numerator	0
Denominator	0
TBI	**N/A**
Numerator	0
Denominator	0
TA	**N/A**
Numerator	0
Denominator	0
Autism	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	N/A	100%	100%	100%	N/A	N/A
FE						
Statewide	not a measure	100%	100%	100%	N/A	N/A
IDD						
Statewide	100%	100%	100%	100%	N/A	N/A
TBI						
Statewide	100%	100%	100%	100%	N/A	N/A
TA						
Statewide	100%	100%	N/A	100%	N/A	N/A
Autism						
Statewide	100%	100%	N/A	N/A	N/A	N/A
SED						
Statewide	100%	100%	N/A	N/A	N/A	N/A

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 3: Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Denominator: Number of waiver policy changes implemented by the Operating Agency
Review Period: 10/01/2016 - 12/31/2016
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	2
Denominator	2
IDD	**100%**
Numerator	3
Denominator	3
TBI	**100%**
Numerator	2
Denominator	2
TA	**100%**
Numerator	2
Denominator	2
Autism	**100%**
Numerator	2
Denominator	2
SED	**100%**
Numerator	2
Denominator	2

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	N/A	N/A	100%	100%	100%	100%
FE						
Statewide	N/A	N/A	100%	100%	100%	100%
IDD						
Statewide	100%	N/A	100%	100%	100%	100%
TBI						
Statewide	100%	N/A	100%	100%	100%	100%
TA						
Statewide	N/A	N/A	N/A	N/A	100%	100%
Autism						
Statewide	N/A	N/A	N/A	N/A	100%	100%
SED						
Statewide	N/A	N/A	N/A	N/A	100%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Administrative Authority
PM 4: Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Numerator: Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Denominator: Number of Long-Term Care meetings
Review Period: 10/01/2016 - 12/31/2016
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	3
Denominator	3
IDD	**100%**
Numerator	3
Denominator	3
TBI	**100%**
Numerator	3
Denominator	3
TA	**100%**
Numerator	3
Denominator	3
Autism	**100%**
Numerator	3
Denominator	3
SED	**100%**
Numerator	3
Denominator	3

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	Not a measure	45%	67%	75%	33%	100%
FE						
Statewide	100%	82%	50%	75%	33%	100%
IDD						
Statewide	Not a measure	91%	Not Available	75%	33%	100%
TBI						
Statewide	Not a measure	73%	Not Available	75%	33%	100%
TA						
Statewide	Not a measure	64%	Not Available	75%	33%	100%
Autism						
Statewide	Not a measure	91%	100%	75%	33%	100%
SED						
Statewide	Not a measure	100%	Not Available	75%	33%	100%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Level of Care
PM 1: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Numerator: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Denominator: Total number of enrolled waiver participants
Review Period: 10/01/2016 - 12/31/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**83%**
Numerator	5
Denominator	6
FE	**100%**
Numerator	15
Denominator	15
IDD	**100%**
Numerator	4
Denominator	4
TBI	**71%**
Numerator	5
Denominator	7
TA	**100%**
Numerator	4
Denominator	4
Autism	**100%**
Numerator	3
Denominator	3
SED	**97%**
Numerator	60
Denominator	62

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	64%	83%	96%	70%	100%	83%
FE						
Statewide	81%	91%	93%	100%	94%	100%
IDD						
Statewide	99%	94%	90%	100%	100%	100%
TBI						
Statewide	62%	89%	81%	89%	89%	71%
TA						
Statewide	97%	89%	100%	96%	86%	100%
Autism						
Statewide	82%	No Data	100%	100%	100%	100%
SED						
Statewide	99%	89%	88%	92%	85%	97%

Explanation of Findings:

The initial assessment tool was not completed and/or not provided for review.

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation: 1. Corrective action plan : Contractors shall provide a plan to the KDADS CSP Commissioner detailing how they will meet the intial assessment deadline AND provide all required documentation to quality reviewers. This particular measure only applies to initial assessments and initial access to service. It does not apply to annual re-assessments.

KDADS HCBS Quality Review Report

Level of Care
PM 2: Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Denominator: Number of waiver participants who received Level of Care redeterminations
Review Period: 10/01/2016 - 12/31/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**60%**
Numerator	48
Denominator	80
FE	**77%**
Numerator	58
Denominator	75
IDD	**70%**
Numerator	62
Denominator	89
TBI	**60%**
Numerator	27
Denominator	45
TA	**96%**
Numerator	45
Denominator	47
Autism	**85%**
Numerator	11
Denominator	13
SED	**96%**
Numerator	51
Denominator	53

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	47%	52%	64%	74%	69%	60%
FE						
Statewide	68%	70%	76%	80%	78%	77%
IDD						
Statewide	97%	74%	75%	79%	82%	70%
TBI						
Statewide	39%	50%	62%	67%	64%	60%
TA						
Statewide	94%	90%	86%	95%	54%	96%
Autism						
Statewide	68%	No Data	75%	74%	86%	85%
SED						
Statewide	93%	88%	94%	91%	71%	96%

Explanation of Findings:

The reassessment was not completed within the required timeframe or the assessment was not provided for review.

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation: Corrective Action Plan: Contractors will provide the KDADS CSP Commissioner with a training plan demonstrating how MCO care coordinators are trained to complete the following: (a) assure the annual reassessment is complete, timely, accurate, signed, on file and appropriately available to KDADS quality reviewers; (b) verify the reassessment was completed no more than 365 days since the last level of care assessment; (c) outline steps the MCO care coordinator is trained to take if a level of care assessment is more than 365 days old.

KDADS HCBS Quality Review Report

Level of Care
PM 3: Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
Numerator: Number of waiver participants whose Level of Care determinations used the approved screening tool
Denominator: Number of waiver participants who had a Level of Care determination
Review Period: 10/01/2016 - 12/31/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**78%**
Numerator	67
Denominator	86
FE	**91%**
Numerator	82
Denominator	90
IDD	**98%**
Numerator	91
Denominator	93
TBI	**73%**
Numerator	38
Denominator	52
TA	**100%**
Numerator	51
Denominator	51
Autism	**88%**
Numerator	14
Denominator	16
SED	**95%**
Numerator	59
Denominator	62

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	93%	84%	79%	79%	82%	78%
FE						
Statewide	88%	91%	91%	90%	95%	91%
IDD						
Statewide	97%	95%	99%	99%	98%	98%
TBI						
Statewide	64%	81%	79%	78%	77%	73%
TA						
Statewide	93%	98%	100%	100%	100%	100%
Autism						
Statewide	88%	No Data	90%	88%	88%	88%
SED						
Statewide	77%	79%	83%	89%	79%	95%

Explanation of Findings:

No current assessment provided for the review period or it was incomplete (assessment was not readable).

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation: Corrective Action Plan: Contractors will provide the KDADS CSP Commisioner with a training plan demonstrating how MCO care coordinators are trained to complete the following: (a) verify the correct initial or annual level of care assessment was done by the correct assessing entity; (b) that the assessment is complete, timely, accurate, signed, on file and appropriately available to KDADS quality reviewers.

KDADS HCBS Quality Review Report

Level of Care
PM 4: Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor
Numerator: Number of initial Level of Care (LOC) determinations made by a qualified assessor
Denominator: Number of initial Level of Care determinations
Review Period: 10/01/2016 - 12/31/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**79%**
Numerator	68
Denominator	86
FE	**90%**
Numerator	81
Denominator	90
IDD	**97%**
Numerator	90
Denominator	93
TBI	**73%**
Numerator	38
Denominator	52
TA	**100%**
Numerator	51
Denominator	51
Autism	**75%**
Numerator	12
Denominator	16
SED	**92%**
Numerator	57
Denominator	62

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	19%	68%	81%	80%	82%	79%
FE						
Statewide	24%	86%	91%	90%	96%	90%
IDD						
Statewide	92%	85%	96%	97%	96%	97%
TBI						
Statewide	57%	73%	83%	78%	77%	73%
TA						
Statewide	93%	100%	99%	100%	100%	100%
Autism						
Statewide	0%	No Data	57%	68%	65%	75%
SED						
Statewide	99%	71%	88%	88%	78%	92%

Explanation of Findings:

The current/applicable assessment tool was missing, so unable to determine if qualifed, the assessors name was not on the approved assessors listing, the assessment was not readable, or there was not a valid signature.

Remediation:

Until the missing documentation issues can be resolved this quality measure cannot be accurately evaluated or remediated.

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation: Corrective Action Plan: Contractors will provide the KDADS CSP Commissioner with a training plan demonstrating how MCO care coordinators are trained to complete the following: (a) how to verify that the assessor posessed necessary and current credentials/qualifications at the time of initial assessment; (c) that the assessment is complete, timely, accurate, signed, on file and appropriately available to KDADS quality reviewers.

KDADS HCBS Quality Review Report

PM 5: Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Denominator: Number of initial Level of Care determinations
Review Period: 10/01/2016 - 12/31/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**83%**
Numerator	5
Denominator	6
FE	**100%**
Numerator	15
Denominator	15
IDD	**100%**
Numerator	4
Denominator	4
TBI	**71%**
Numerator	5
Denominator	7
TA	**100%**
Numerator	4
Denominator	4
Autism	**100%**
Numerator	3
Denominator	3
SED	**95%**
Numerator	59
Denominator	62

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	73%	83%	96%	80%	84%	83%
FE						
Statewide	91%	90%	96%	88%	94%	100%
IDD						
Statewide	98%	95%	91%	98%	98%	100%
TBI						
Statewide	58%	81%	83%	76%	77%	71%
TA						
Statewide	93%	98%	100%	100%	50%	100%
Autism						
Statewide	89%	No Data	100%	88%	88%	100%
SED						
Statewide	99%	88%	87%	90%	83%	95%

Explanation of Findings:

Initial assessment was not provided for the review period or the assessment was not readable.

Remediation:

Until the missing documentation issues can be resolved this quality measure cannot be accurately evaluated or remediated.

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation: Corrective Action Plan: Contractors will provide the KDADS CSP Commissioner with a training plan demonstrating how MCO care coordinators are trained to complete the following: (a) verify the correct initial level of care assessment was done by the correct assessing entity; (b) verify that the assessor posessed necessary and current credentials/qualifications at the time of initial assessment; (c) that the assessment is complete, timely, accurate, signed, on file and appropriately available to KDADS quality reviewers; (d) assures care coordinators have demonstrated competency sufficient to determine whether the level of care criteria were correctly applied; (e) steps care coordinators are trained to take if they wish to challenge how the level of care criteria were applied.

KDADS HCBS Quality Review Report

Qualified Providers
PM 1: Number and percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Numerator: Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Denominator: Number of all new licensed/certified waiver providers
Review Period:
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs each have a process for credentialing newly enrolled providers, all MCOs lacked a process to monitor continued compliance with licensure, certification, and training of providers.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: The state is working to ensure that through KMAP, initial enrollment and credentialing needs can be accommodated. A gap analysis is being conducted to ensure the appropriate information can be collected and available to verify enrollment and credentialing. Further, the State will formalize a policy outlining expectations of MCOs for meeting these performance measures for all waivers by ensuring that MCOs are able to monitor provider compliance with provider qualifications. This policy will be drafted by December 2017 in order to be reviewed with MCOs for feedback.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
FE				
Amerigroup				5%
Sunflower				30%
United				N/A
Statewide	100%			9%
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	98%			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	91%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	93%			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
SED				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A

KDADS HCBS Quality Review Report

Qualified Providers
PM 2: Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Numerator: Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Denominator: Number of enrolled licensed/certified waiver providers
Review Period:
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs each have a process for credentialing newly enrolled providers, all MCOs lacked a process to monitor continued compliance with licensure, certification, and training of providers.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: The state is working to ensure that through KMAP, initial enrollment and credentialing needs can be accommodated. A gap analysis is being conducted to ensure the appropriate information can be collected and available to verify enrollment and credentialing. Further, the State will formalize a policy outlining expectations of MCOs for meeting these performance measures for all waivers by ensuring that MCOs are able to monitor provider compliance with provider qualifications. This policy will be drafted by December 2017 in order to be reviewed with MCOs for feedback.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	100%			0%
FE				
Amerigroup				12%
Sunflower				23%
United				0%
Statewide	Not a measure			11%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	98%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	89%			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	93%			0%
Autism				
Amerigroup				14%
Sunflower				0%
United				0%
Statewide	100%			4%
SED				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	100%			0%

KDADS HCBS Quality Review Report

Qualified Providers
PM 3: Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Numerator: Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Denominator: Number of all new non-licensed/non-certified providers
Review Period:
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs each have a process for credentialing newly enrolled providers, all MCOs lacked a process to monitor continued compliance with licensure, certification, and training of providers.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: The state is working to ensure that through KMAP, initial enrollment and credentialing needs can be accommodated. A gap analysis is being conducted to ensure the appropriate information can be collected and available to verify enrollment and credentialing. Further, the State will formalize a policy outlining expectations of MCOs for meeting these performance measures for all waivers by ensuring that MCOs are able to monitor provider compliance with provider qualifications. This policy will be drafted by December 2017 in order to be reviewed with MCOs for feedback.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	75%			N/A
FE				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	Not a measure			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	88%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	No Data			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	82%			N/A
SED				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	Not a measure			N/A

KDADS HCBS Quality Review Report

Qualified Providers
PM 4: Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Numerator: Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Denominator: Number of enrolled non-licensed/non-certified providers
Review Period:
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				3%
Sunflower				1%
United				0%
Statewide	75%			1%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	Not a measure			0%
IDD				
Amerigroup				0%
Sunflower				8%
United				0%
Statewide	Not a measure			2%
TBI				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	88%			3%
TA				
Amerigroup				13%
Sunflower				0%
United				0%
Statewide	No Data			4%
Autism				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	91%			2%
SED				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	89%			N/A

Explanation of Findings:

MCOs each have a process for credentialing newly enrolled providers, all MCOs lacked a process to monitor continued compliance with licensure, certification, and training of providers.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: The state is working to ensure that through KMAP, initial enrollment and credentialing needs can be accommodated. A gap analysis is being conducted to ensure the appropriate information can be collected and available to verify enrollment and credentialing. Further, the State will formalize a policy outlining expectations of MCOs for meeting these performance measures for all waivers by ensuring that MCOs are able to monitor provider compliance with provider qualifications. This policy will be drafted by December 2017 in order to be reviewed with MCOs for feedback.

KDADS HCBS Quality Review Report

Qualified Providers
PM 5: Number and percent of active providers that meet training requirements
Numerator: Number of providers that meet training requirements
Denominator: Number of active providers
Review Period:
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs each have a process for credentialing newly enrolled providers, all MCOs lacked a process to monitor continued compliance with licensure, certification, and training of providers.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: The state is working to ensure that through KMAP, initial enrollment and credentialing needs can be accommodated. A gap analysis is being conducted to ensure the appropriate information can be collected and available to verify enrollment and credentialing. Further, the State will formalize a policy outlining expectations of MCOs for meeting these performance measures for all waivers by ensuring that MCOs are able to monitor provider compliance with provider qualifications. This policy will be drafted by December 2017 in order to be reviewed with MCOs for feedback.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	99%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
Autism				
Amerigroup				20%
Sunflower				36%
United				0%
Statewide	No Data			11%
SED				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	88%			0%

KDADS HCBS Quality Review Report

Plan of Care
PM 1: Number and percent of waiver participants whose service plans address participants' goals
Numerator: Number of waiver participants whose service plans address participants' goals
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**80%**	**70%**	**96%**	**82%**
Numerator	28	16	24	68
Denominator	35	23	25	83
FE	**68%**	**75%**	**85%**	**75%**
Numerator	21	21	22	64
Denominator	31	28	26	85
IDD	**75%**	**54%**	**91%**	**69%**
Numerator	21	22	20	63
Denominator	28	41	22	91
TBI	**77%**	**67%**	**92%**	**78%**
Numerator	20	8	11	39
Denominator	26	12	12	50
TA	**76%**	**75%**	**75%**	**76%**
Numerator	19	12	6	37
Denominator	25	16	8	49
Autism	**0%**	**50%**	**75%**	**33%**
Numerator	0	2	3	5
Denominator	7	4	4	15
SED	**100%**	**90%**	**100%**	**97%**
Numerator	22	19	19	60
Denominator	22	21	19	62

Explanation of Findings:

The documentation reflecting the goal of the individual was not signed by the person/guardian/representative, the service plan was missing for the review period, the file was incomplete; goals were not documented or addressed in the service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation:
Corrective action plan : MCOs shall provide a training and development plan to the KDADS CSP Commissioner showing: (a) how they intend to document required signatures to show member participation in the service plan process; and, (b) how/where the service plan documents that the participant's assessed needs and capabilities are addressed.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		55%	33%	49%	69%	80%
Sunflower		57%	64%	55%	59%	70%
United		33%	49%	75%	96%	96%
Statewide	55%	50%	48%	59%	74%	82%
FE						
Amerigroup		50%	42%	45%	57%	68%
Sunflower		56%	51%	78%	71%	75%
United		45%	56%	73%	94%	85%
Statewide	Not a measure	50%	49%	66%	74%	75%
IDD						
Amerigroup		36%	32%	39%	59%	75%
Sunflower		56%	56%	58%	76%	54%
United		52%	41%	60%	81%	91%
Statewide	99%	49%	45%	53%	72%	69%
TBI						
Amerigroup		37%	41%	54%	48%	77%
Sunflower		37%	38%	92%	73%	67%
United		22%	55%	73%	71%	92%
Statewide	44%	34%	43%	67%	60%	78%
TA						
Amerigroup		50%	44%	62%	79%	76%
Sunflower		73%	85%	87%	81%	75%
United		64%	32%	65%	75%	75%
Statewide	93%	61%	54%	70%	79%	76%
Autism						
Amerigroup		84%	56%	43%	33%	0%
Sunflower		47%	50%	46%	67%	50%
United		63%	36%	0%	0%	75%
Statewide	58%	69%	49%	38%	38%	33%
SED						
Amerigroup		91%	99%	98%	97%	100%
Sunflower		92%	95%	100%	58%	90%
United		89%	100%	96%	100%	100%
Statewide	98%	90%	98%	98%	86%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 2: Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**77%**	**74%**	**92%**	**81%**
Numerator	27	17	23	67
Denominator	35	23	25	83
FE	**71%**	**79%**	**88%**	**79%**
Numerator	22	22	23	67
Denominator	31	28	26	85
IDD	**68%**	**68%**	**91%**	**74%**
Numerator	19	28	20	67
Denominator	28	41	22	91
TBI	**81%**	**75%**	**92%**	**82%**
Numerator	21	9	11	41
Denominator	26	12	12	50
TA	**76%**	**69%**	**75%**	**73%**
Numerator	19	11	6	36
Denominator	25	16	8	49
Autism	**0%**	**50%**	**75%**	**33%**
Numerator	0	2	3	5
Denominator	7	4	4	15
SED	**100%**	**90%**	**95%**	**95%**
Numerator	22	19	18	59
Denominator	22	21	19	62

Explanation of Findings:

Missing the service plan or assessment (s) for the review period, service plan was not signed and dated by the individual/guardian/representative, assessed needs and capabilities are not addressed in the service plan.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation:
Corrective action plan : MCOs shall provide a training and development plan to the KDADS CSP Commissioner showing; (1) how they intend to show required signatures to show member participation in the POC process; and, (2) how care coordinators are to document that the participant's assessed needs and capabilities are addressed as indicated in the level of care assessment.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		83%	55%	68%	81%	77%
Sunflower		90%	56%	57%	69%	74%
United		89%	68%	89%	96%	92%
Statewide	86%	87%	59%	70%	82%	81%
FE						
Amerigroup		79%	66%	75%	73%	71%
Sunflower		90%	53%	73%	68%	79%
United		88%	68%	78%	90%	88%
Statewide	87%	86%	61%	75%	77%	79%
IDD						
Amerigroup		85%	67%	59%	70%	68%
Sunflower		77%	36%	61%	69%	68%
United		72%	47%	69%	81%	91%
Statewide	99%	78%	48%	62%	72%	74%
TBI						
Amerigroup		67%	48%	58%	64%	81%
Sunflower		82%	28%	83%	87%	75%
United		70%	62%	73%	86%	92%
Statewide	72%	73%	45%	67%	74%	82%
TA						
Amerigroup		93%	58%	65%	75%	76%
Sunflower		98%	62%	80%	69%	69%
United		97%	58%	82%	75%	75%
Statewide	96%	96%	59%	73%	73%	73%
Autism						
Amerigroup		81%	59%	43%	17%	0%
Sunflower		50%	45%	42%	67%	50%
United		63%	21%	0%	25%	75%
Statewide	59%	68%	46%	36%	38%	33%
SED						
Amerigroup		91%	99%	98%	97%	100%
Sunflower		91%	92%	100%	58%	90%
United		89%	98%	96%	100%	95%
Statewide	92%	90%	97%	98%	86%	95%

KDADS HCBS Quality Review Report

Plan of Care
PM 3: Number and percent of waiver participants whose service plans address health and safety risk factors
Numerator: Number of waiver participants whose service plans address health and safety risk factors
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**80%**	**74%**	**92%**	**82%**
Numerator	28	17	23	68
Denominator	35	23	25	83
FE	**71%**	**79%**	**88%**	**79%**
Numerator	22	22	23	67
Denominator	31	28	26	85
IDD	**68%**	**68%**	**91%**	**74%**
Numerator	19	28	20	67
Denominator	28	41	22	91
TBI	**77%**	**75%**	**92%**	**80%**
Numerator	20	9	11	40
Denominator	26	12	12	50
TA	**76%**	**69%**	**75%**	**73%**
Numerator	19	11	6	36
Denominator	25	16	8	49
Autism	**0%**	**50%**	**75%**	**33%**
Numerator	0	2	3	5
Denominator	7	4	4	15
SED	**100%**	**90%**	**100%**	**97%**
Numerator	22	19	19	60
Denominator	22	21	19	62

Explanation of Findings:

Missing the service plan or assessments(s) for the review period, assessed health and safety risk factors are not addressed in the service plan, service plan was not signed and dated by the individual/guardian/representative.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation:
Corrective action plan : MCOs shall provide a training and development plan to the KDADS CSP Commissioner showing; (1) how they intend to show required signatures to show member participation in the POC process; and, (2) when/where/how the care coordinator documents the participant's health and safety risk factors in the service plan, including significant changes in condition.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		90%	44%	64%	81%	80%
Sunflower		89%	49%	62%	72%	74%
United		96%	67%	85%	96%	92%
Statewide	90%	91%	51%	70%	83%	82%
FE						
Amerigroup		92%	55%	77%	73%	71%
Sunflower		92%	50%	73%	68%	79%
United		95%	70%	75%	90%	88%
Statewide	Not a measure	93%	57%	75%	77%	79%
IDD						
Amerigroup		90%	61%	65%	70%	68%
Sunflower		97%	36%	62%	69%	68%
United		89%	45%	69%	81%	91%
Statewide	99%	93%	46%	65%	72%	74%
TBI						
Amerigroup		79%	45%	58%	64%	77%
Sunflower		91%	26%	92%	80%	75%
United		83%	64%	73%	86%	92%
Statewide	84%	84%	43%	69%	72%	80%
TA						
Amerigroup		96%	49%	69%	79%	76%
Sunflower		95%	61%	80%	75%	69%
United		94%	58%	82%	75%	75%
Statewide	96%	96%	54%	75%	77%	73%
Autism						
Amerigroup		79%	59%	40%	17%	0%
Sunflower		61%	45%	42%	67%	50%
United		86%	21%	0%	0%	75%
Statewide	64%	74%	46%	35%	31%	73%
SED						
Amerigroup		90%	99%	96%	97%	100%
Sunflower		89%	95%	100%	58%	90%
United		86%	100%	94%	100%	100%
Statewide	99%	88%	98%	97%	86%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 4: Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**83%**	**83%**	**96%**	**87%**
Numerator	29	19	24	72
Denominator	35	23	25	83
FE	**74%**	**79%**	**85%**	**79%**
Numerator	23	22	22	67
Denominator	31	28	26	85
IDD	**79%**	**73%**	**91%**	**79%**
Numerator	22	30	20	72
Denominator	28	41	22	91
TBI	**77%**	**75%**	**92%**	**80%**
Numerator	20	9	11	40
Denominator	26	12	12	50
TA	**76%**	**81%**	**75%**	**78%**
Numerator	19	13	6	38
Denominator	25	16	8	49
Autism	**0%**	**50%**	**75%**	**33%**
Numerator	0	2	3	5
Denominator	7	4	4	15
SED	**100%**	**90%**	**100%**	**97%**
Numerator	22	19	19	60
Denominator	22	21	19	62

Explanation of Findings:

Missing the service plan or assessment(s) for the review period, service plan was not signed and dated by the individual and/or representative/guardian, if applicable.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation:
Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing; (1) how they intend to show required signatures to show member participation in the POC process; and, (2) doument demonstrated competency and understanding of service plan development according to the processes in the approved waiver, including applicable state and/or federal rule changes that impact current waiver operations.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		88%	68%	69%	81%	83%
Sunflower		87%	69%	72%	69%	83%
United		85%	77%	87%	96%	96%
Statewide	80%	87%	70%	76%	82%	87%
FE						
Amerigroup		84%	76%	79%	80%	74%
Sunflower		88%	61%	90%	76%	79%
United		86%	79%	84%	94%	85%
Statewide	Not a measure	86%	71%	85%	83%	79%
IDD						
Amerigroup		80%	80%	70%	74%	79%
Sunflower		80%	59%	71%	80%	73%
United		82%	55%	69%	86%	91%
Statewide	98%	81%	64%	70%	80%	79%
TBI						
Amerigroup		76%	53%	59%	60%	77%
Sunflower		86%	43%	96%	80%	75%
United		77%	69%	82%	86%	92%
Statewide	64%	80%	53%	72%	70%	80%
TA						
Amerigroup		84%	68%	65%	79%	76%
Sunflower		97%	86%	87%	88%	81%
United		96%	58%	82%	75%	75%
Statewide	No Data	91%	72%	75%	81%	78%
Autism						
Amerigroup		74%	59%	43%	33%	0%
Sunflower		51%	50%	42%	67%	50%
United		65%	29%	0%	0%	75%
Statewide	55%	65%	49%	36%	38%	33%
SED						
Amerigroup		92%	99%	98%	97%	100%
Sunflower		90%	94%	98%	58%	90%
United		87%	98%	94%	100%	100%
Statewide	Not a measure	90%	97%	97%	86%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 5: Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan
Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**86%**	**83%**	**96%**	**88%**
Numerator	30	19	24	73
Denominator	35	23	25	83
FE	**71%**	**79%**	**88%**	**79%**
Numerator	22	22	23	67
Denominator	31	28	26	85
IDD	**79%**	**76%**	**91%**	**80%**
Numerator	22	31	20	73
Denominator	28	41	22	91
TBI	**73%**	**75%**	**92%**	**78%**
Numerator	19	9	11	39
Denominator	26	12	12	50
TA	**72%**	**81%**	**75%**	**76%**
Numerator	18	13	6	37
Denominator	25	16	8	49
Autism	**14%**	**50%**	**75%**	**40%**
Numerator	1	2	3	6
Denominator	7	4	4	15
SED	**95%**	**90%**	**100%**	**95%**
Numerator	21	19	19	59
Denominator	22	21	19	62

Explanation of Findings:

Service plan was not signed & dated by the individual and/or representative/guardian, if applicable, or missing service plan for the review period.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing; (1) how they intend to show required signatures to show member participation in the POC process; and, (2) show required signatures to show member participation in the POC service planning process; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence showing the participant was not involved in the service planninig process.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		88%	70%	73%	84%	86%
Sunflower		87%	70%	72%	72%	83%
United		84%	79%	87%	86%	96%
Statewide	Not a measure	87%	72%	77%	81%	88%
FE						
Amerigroup		83%	78%	83%	70%	71%
Sunflower		86%	60%	89%	76%	79%
United		87%	83%	84%	94%	88%
Statewide	90%	85%	72%	85%	80%	79%
IDD						
Amerigroup		84%	76%	70%	74%	79%
Sunflower		82%	60%	70%	80%	76%
United		88%	51%	69%	86%	91%
Statewide	Not a measure	84%	63%	70%	80%	80%
TBI						
Amerigroup		73%	51%	64%	60%	73%
Sunflower		84%	45%	96%	80%	75%
United		80%	69%	77%	86%	92%
Statewide	Not a measure	78%	52%	74%	70%	78%
TA						
Amerigroup		83%	75%	67%	79%	72%
Sunflower		97%	86%	90%	75%	81%
United		97%	58%	82%	75%	75%
Statewide	Not a measure	91%	76%	76%	77%	76%
Autism						
Amerigroup		77%	59%	40%	33%	14%
Sunflower		53%	55%	46%	67%	50%
United		71%	36%	0%	0%	75%
Statewide	Not a measure	69%	52%	36%	38%	40%
SED						
Amerigroup		92%	98%	100%	97%	95%
Sunflower		90%	95%	98%	58%	90%
United		87%	99%	92%	100%	100%
Statewide	93%	90%	98%	97%	86%	95%

KDADS HCBS Quality Review Report

Plan of Care
PM 6: Number and percent of service plans reviewed before the waiver participant's annual redetermination date
Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**78%**	**83%**	**67%**	**76%**
Numerator	18	10	10	38
Denominator	23	12	15	50
FE	**53%**	**72%**	**79%**	**68%**
Numerator	8	13	11	32
Denominator	15	18	14	47
IDD	**80%**	**43%**	**57%**	**58%**
Numerator	12	9	8	29
Denominator	15	21	14	50
TBI	**36%**	**63%**	**40%**	**46%**
Numerator	4	5	2	11
Denominator	11	8	5	24
TA	**75%**	**75%**	**67%**	**74%**
Numerator	12	9	4	25
Denominator	16	12	6	34
Autism	**0%**	**50%**	**50%**	**33%**
Numerator	0	2	1	3
Denominator	3	4	2	9
SED	**94%**	**86%**	**81%**	**87%**
Numerator	16	18	13	47
Denominator	17	21	16	54

Explanation of Findings:

Service plan was not signed & dated by the individual and/or representative/guardian, if applicable, or missing service plan for the review period or prior service plan to determine timeliness, or service plan was not completed within specified waiver timelines.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing: (1) how they intend to show required signatures to show member participation in the POC process; and, (2) when/where/how MCO care coordinators will be trained on how to consistently review the participant's service plan before the waiver participant's annual redetermination date; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence showing participant's service plan was not reviewed before the participant's annual redetermination date.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		73%	67%	70%	63%	78%
Sunflower		82%	72%	69%	73%	83%
United		92%	73%	86%	92%	67%
Statewide	82%	82%	70%	75%	74%	76%
FE						
Amerigroup		81%	67%	66%	67%	53%
Sunflower		85%	57%	83%	75%	72%
United		90%	69%	83%	89%	79%
Statewide	81%	85%	64%	78%	77%	68%
IDD						
Amerigroup		75%	77%	65%	65%	80%
Sunflower		81%	66%	68%	75%	43%
United		91%	48%	50%	58%	57%
Statewide	97%	82%	66%	63%	68%	58%
TBI						
Amerigroup		65%	44%	60%	64%	36%
Sunflower		84%	40%	100%	88%	63%
United		77%	65%	79%	75%	40%
Statewide	60%	76%	47%	74%	74%	46%
TA						
Amerigroup		81%	78%	64%	91%	75%
Sunflower		94%	89%	86%	100%	75%
United		96%	59%	67%	80%	67%
Statewide	92%	89%	79%	71%	91%	74%
Autism						
Amerigroup		67%	52%	53%	0%	0%
Sunflower		43%	47%	31%	50%	50%
United		33%	38%	0%	0%	50%
Statewide	64%	57%	48%	32%	25%	33%
SED						
Amerigroup		89%	97%	93%	96%	94%
Sunflower		89%	91%	91%	42%	86%
United		83%	99%	88%	83%	81%
Statewide	80%	87%	96%	91%	76%	87%

KDADS HCBS Quality Review Report

Plan of Care
PM 7: Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**83%**	**100%**	**50%**	**83%**
Numerator	5	4	1	10
Denominator	6	4	2	12
FE	**50%**	**25%**	**100%**	**62%**
Numerator	2	1	5	8
Denominator	4	4	5	13
IDD	**50%**	**0%**	**33%**	**29%**
Numerator	1	0	1	2
Denominator	2	2	3	7
TBI	**83%**	**50%**	**50%**	**67%**
Numerator	5	2	1	8
Denominator	6	4	2	12
TA	**60%**	**50%**	**0%**	**50%**
Numerator	3	2	0	5
Denominator	5	4	1	10
Autism	**0%**	**0%**	**50%**	**20%**
Numerator	0	0	1	1
Denominator	2	1	2	5
SED	**100%**	**80%**	**100%**	**91%**
Numerator	6	8	6	20
Denominator	6	10	6	22

Explanation of Findings:

Prior service plan was not provided for review, uploaded incorrect timeframe for review period, service plan was missing, or service plans not signed & dated by the individual and/or their representative/Guardian, if applicable.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.
Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.
Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing: (1) how they intend to show required signatures to show member participation in the POC process; and, the participant's service plan before the waiver participant's annual redetermination date; and (2) how/when/where a documented change in needs results in a revised service plan, as needed, to address the change; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence showing a documented change in needs did not result in a revised service plan.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		20%	36%	56%	67%	83%
Sunflower		53%	58%	22%	67%	100%
United		50%	63%	78%	100%	50%
Statewide	75%	39%	53%	52%	80%	83%
FE						
Amerigroup		24%	71%	50%	25%	50%
Sunflower		39%	51%	100%	40%	25%
United		50%	47%	83%	75%	100%
Statewide	78%	38%	54%	82%	46%	62%
IDD						
Amerigroup		7%	60%	29%	0%	50%
Sunflower		38%	16%	20%	100%	0%
United		16%	30%	25%	33%	33%
Statewide	97%	23%	28%	25%	33%	29%
TBI						
Amerigroup		24%	42%	54%	50%	83%
Sunflower		54%	27%	100%	80%	50%
United		46%	50%	100%	N/A	50%
Statewide	53%	38%	38%	67%	67%	67%
TA						
Amerigroup		32%	73%	50%	100%	60%
Sunflower		54%	89%	73%	50%	50%
United		38%	43%	75%	N/A	0%
Statewide	92%	42%	75%	64%	60%	50%
Autism						
Amerigroup		10%	0%	25%	N/A	0%
Sunflower		17%	25%	100%	N/A	0%
United		0%	0%	0%	N/A	50%
Statewide	45%	11%	11%	14%	N/A	20%
SED						
Amerigroup		90%	90%	100%	92%	100%
Sunflower		83%	79%	93%	36%	80%
United		84%	93%	77%	88%	100%
Statewide	85%	86%	88%	89%	68%	91%

KDADS HCBS Quality Review Report

Plan of Care
PM 8: Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Numerator: Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**83%**	**87%**	**92%**	**87%**
Numerator	29	20	23	72
Denominator	35	23	25	83
FE	**65%**	**82%**	**92%**	**79%**
Numerator	20	23	24	67
Denominator	31	28	26	85
IDD	**75%**	**78%**	**91%**	**80%**
Numerator	21	32	20	73
Denominator	28	41	22	91
TBI	**73%**	**75%**	**92%**	**78%**
Numerator	19	9	11	39
Denominator	26	12	12	50
TA	**84%**	**75%**	**88%**	**82%**
Numerator	21	12	7	40
Denominator	25	16	8	49
Autism	**0%**	**50%**	**75%**	**33%**
Numerator	0	2	3	5
Denominator	7	4	4	15
SED	**100%**	**90%**	**89%**	**94%**
Numerator	22	19	17	58
Denominator	22	21	19	62

Explanation of Findings:

Service plan was not signed & dated b the individual and/or their representative/guardian, if applicable. Service Plan missing for the review period, log notes or documentation missing to make determination, information was uploaded for the incorrect time period (not the review period), service plan does not match documentation of services being received, log notes fail to indicate services received.

Remediation:

Until the missing signature issue is resolved this performance measure cannot be accurately measured or remediated.
Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.
Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing: (1) how they intend to show required signatures to show member participation in the POC process; and, the participant's service plan before the waiver participant's annual redetermination date; (2) how/when/where the care coordinator documents that the waiver participant received services in the type, scope, amount, duration, and frequency specified in the service plan; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence that shows the waiver participant did not receive services in the type, scope, amount, duration, and frequency specified in the service plan.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		94%	69%	73%	84%	83%
Sunflower		96%	72%	73%	72%	87%
United		96%	78%	89%	93%	92%
Statewide	85%	95%	72%	78%	83%	87%
FE						
Amerigroup		83%	76%	77%	80%	65%
Sunflower		96%	64%	92%	76%	82%
United		96%	79%	89%	87%	92%
Statewide	87%	92%	72%	87%	81%	79%
IDD						
Amerigroup		78%	84%	72%	74%	75%
Sunflower		97%	62%	74%	82%	78%
United		100%	59%	74%	86%	91%
Statewide	98%	92%	68%	74%	81%	80%
TBI						
Amerigroup		81%	55%	59%	60%	73%
Sunflower		95%	46%	96%	73%	75%
United		85%	71%	77%	86%	92%
Statewide	70%	87%	56%	71%	68%	78%
TA						
Amerigroup		98%	73%	73%	86%	84%
Sunflower		100%	86%	87%	81%	75%
United		96%	58%	82%	75%	88%
Statewide	100%	98%	74%	78%	83%	82%
Autism						
Amerigroup		89%	59%	47%	33%	0%
Sunflower		100%	55%	46%	67%	50%
United		50%	21%	0%	0%	75%
Statewide	50%	86%	49%	39%	38%	33%
SED						
Amerigroup		91%	99%	94%	93%	100%
Sunflower		96%	94%	94%	58%	90%
United		92%	99%	90%	96%	89%
Statewide	13%	93%	98%	93%	83%	94%

KDADS HCBS Quality Review Report

Plan of Care
PM 9: Number and percent of survey respondents who reported receiving all services as specified in their service plan
Numerator: Number of survey respondents who reported receiving all services as specified in their service plan
Denominator: Number of waiver participants interviewed by QMS staff
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

Data was not collected since customer interviews were not performed during this review period. Consumer (FE, PD, TA, AU) interviews were conducted beginning with the 1/1/17-3/31/17 quality reviews.

Remediation:

Not applicable at time of report.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		97%				
Sunflower		92%				
United		93%				
Statewide	Not a measure	94%				
FE						
Amerigroup		85%				
Sunflower		86%				
United		82%				
Statewide	87%	84%				
IDD						
Amerigroup		92%				
Sunflower		96%				
United		93%				
Statewide	Not a measure	94%				
TBI						
Amerigroup		81%				
Sunflower		88%				
United		83%				
Statewide	Not a measure	83%				
TA						
Amerigroup		89%				
Sunflower		84%				
United		85%				
Statewide	Not a measure	87%				
Autism						
Amerigroup		74%				
Sunflower		70%				
United		60%				
Statewide	Not a measure	71%				
SED						
Amerigroup						
Sunflower						
United						
Statewide	Not a measure	No Data				

KDADS HCBS Quality Review Report

Plan of Care
PM 10: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**74%**	**83%**	**96%**	**83%**
Numerator	26	19	24	69
Denominator	35	23	25	83
FE	**58%**	**75%**	**85%**	**72%**
Numerator	18	21	22	61
Denominator	31	28	26	85
IDD	**75%**	**73%**	**86%**	**77%**
Numerator	21	30	19	70
Denominator	28	41	22	91
TBI	**69%**	**75%**	**92%**	**76%**
Numerator	18	9	11	38
Denominator	26	12	12	50
TA	**68%**	**75%**	**75%**	**71%**
Numerator	17	12	6	35
Denominator	25	16	8	49
Autism	**0%**	**75%**	**75%**	**40%**
Numerator	0	3	3	6
Denominator	7	4	4	15
SED	**100%**	**95%**	**94%**	**97%**
Numerator	21	20	17	58
Denominator	21	21	18	60

Explanation of Findings:

Missing the documentation to show "choice" was reviewed with the individual, for the review period, choice is on the service plan, however, it was not signed, was not signed by the indivudual or guardian/representative, if applicable. Service plan does not include choice.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing: (1) how they intend to show required signatures to show member participation in the POC process; and, the participant's service plan before the waiver participant's annual redetermination date; and, (2) participant's record contains documentation indicating a choice of waiver service providers; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence that shows the participant was not given a choice of waiver service providers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		68%	56%	61%	75%	74%
Sunflower		58%	69%	72%	69%	83%
United		69%	73%	85%	89%	96%
Statewide	52%	65%	65%	72%	78%	83%
FE						
Amerigroup		68%	59%	70%	60%	58%
Sunflower		76%	59%	87%	79%	75%
United		77%	75%	80%	94%	85%
Statewide	56%	74%	63%	80%	78%	72%
IDD						
Amerigroup		51%	45%	63%	70%	75%
Sunflower		68%	42%	64%	73%	73%
United		75%	55%	67%	86%	86%
Statewide	99%	64%	46%	65%	75%	77%
TBI						
Amerigroup		54%	50%	49%	44%	69%
Sunflower		75%	40%	96%	80%	75%
United		70%	74%	77%	86%	92%
Statewide	44%	65%	52%	66%	62%	76%
TA						
Amerigroup		87%	65%	65%	71%	68%
Sunflower		84%	80%	80%	75%	75%
United		92%	58%	82%	75%	75%
Statewide	96%	86%	68%	73%	73%	71%
Autism						
Amerigroup		67%	67%	57%	50%	0%
Sunflower		44%	45%	46%	50%	75%
United		88%	21%	0%	0%	75%
Statewide	40%	63%	49%	44%	38%	40%
SED						
Amerigroup		94%	91%	98%	97%	100%
Sunflower		91%	72%	91%	58%	95%
United		84%	97%	85%	88%	94%
Statewide	98%	89%	88%	91%	82%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 11: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver services
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**66%**	**83%**	**84%**	**76%**
Numerator	23	19	21	63
Denominator	35	23	25	83
FE	**61%**	**75%**	**85%**	**73%**
Numerator	19	21	22	62
Denominator	31	28	26	85
IDD	**71%**	**73%**	**86%**	**76%**
Numerator	20	30	19	69
Denominator	28	41	22	91
TBI	**58%**	**75%**	**83%**	**68%**
Numerator	15	9	10	34
Denominator	26	12	12	50
TA	**76%**	**81%**	**50%**	**73%**
Numerator	19	13	4	36
Denominator	25	16	8	49
Autism	**0%**	**75%**	**75%**	**40%**
Numerator	0	3	3	6
Denominator	7	4	4	15
SED	**100%**	**95%**	**94%**	**97%**
Numerator	22	20	17	59
Denominator	22	21	18	61

Explanation of Findings:

Service plan was not signed by the individual or representative/guardian to indicate choice, missing the documentation to show "choice" was reviewed with the individual for the review period; "choice box" was not marked on the choice form and/or service plan, form isnot fully completed.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation: Corrective action plan : MCOs shall provide a corrective action training and development plan to the KDADS CSP Commissioner showing: (1) how they intend to show required signatures to show member participation in the POC process; and, the participant's service plan before the waiver participant's annual redetermination date; (2) participants whose record contains documentation indicating a choice of waiver services; and, (3) how MCO care coordinators will be trained and held accountable if there is identified evidence that shows the participant was not given a choice of waiver services.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		68%	53%	54%	72%	66%
Sunflower		72%	50%	68%	69%	83%
United		77%	73%	81%	89%	84%
Statewide	64%	72%	57%	67%	76%	76%
FE						
Amerigroup		67%	57%	70%	67%	61%
Sunflower		86%	47%	87%	79%	75%
United		85%	74%	78%	94%	85%
Statewide	59%	80%	57%	79%	80%	73%
IDD						
Amerigroup		55%	46%	65%	78%	71%
Sunflower		68%	35%	66%	73%	73%
United		77%	50%	62%	86%	86%
Statewide	No Data	66%	42%	65%	77%	76%
TBI						
Amerigroup		56%	50%	49%	52%	58%
Sunflower		80%	23%	96%	80%	75%
United		74%	67%	77%	86%	83%
Statewide	53%	68%	45%	66%	66%	68%
TA						
Amerigroup		86%	65%	65%	79%	76%
Sunflower		97%	53%	80%	75%	81%
United		94%	55%	65%	75%	50%
Statewide	96%	91%	60%	70%	77%	73%
Autism						
Amerigroup		79%	52%	57%	50%	0%
Sunflower		50%	27%	62%	50%	75%
United		88%	14%	0%	0%	75%
Statewide	55%	72%	35%	50%	38%	40%
SED						
Amerigroup		94%	92%	98%	97%	100%
Sunflower		91%	72%	91%	58%	95%
United		84%	97%	86%	88%	94%
Statewide	98%	89%	88%	92%	82%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 12: Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
Numerator: Number of waiver participants whose record contains documentation indicating a choice of community-based services
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**77%**	**83%**	**96%**	**84%**
Numerator	27	19	24	70
Denominator	35	23	25	83
FE	**65%**	**75%**	**85%**	**74%**
Numerator	20	21	22	63
Denominator	31	28	26	85
IDD	**71%**	**73%**	**86%**	**76%**
Numerator	20	30	19	69
Denominator	28	41	22	91
TBI	**65%**	**75%**	**92%**	**74%**
Numerator	17	9	11	37
Denominator	26	12	12	50
TA	**72%**	**81%**	**75%**	**76%**
Numerator	18	13	6	37
Denominator	25	16	8	49
Autism	**29%**	**75%**	**75%**	**53%**
Numerator	2	3	3	8
Denominator	7	4	4	15
SED	**100%**	**95%**	**95%**	**97%**
Numerator	22	20	18	60
Denominator	22	21	19	62

Explanation of Findings:

Choice is on the service plan but is not signed, missing the documentation to show "choice" as reviewed with the individual, for the review period, "choice box" was not marked on the choice for and/or Service plan.

Remediation:

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		76%	57%	61%	66%	77%
Sunflower		74%	67%	72%	69%	83%
United		80%	78%	83%	89%	96%
Statewide	Not a measure	76%	66%	72%	74%	84%
FE						
Amerigroup		67%	58%	74%	77%	65%
Sunflower		87%	56%	87%	79%	75%
United		85%	79%	78%	94%	85%
Statewide	65%	80%	63%	80%	83%	74%
IDD						
Amerigroup		47%	47%	65%	63%	71%
Sunflower		69%	41%	63%	73%	73%
United		78%	57%	71%	86%	86%
Statewide	No Data	64%	46%	66%	73%	76%
TBI						
Amerigroup		55%	51%	54%	40%	65%
Sunflower		79%	40%	96%	80%	75%
United		73%	74%	77%	86%	92%
Statewide	No Data	67%	52%	69%	60%	74%
TA						
Amerigroup		87%	65%	64%	75%	72%
Sunflower		98%	80%	80%	81%	81%
United		94%	55%	82%	75%	75%
Statewide	No Data	92%	68%	72%	77%	76%
Autism						
Amerigroup		86%	67%	77%	50%	29%
Sunflower		47%	59%	65%	67%	75%
United		75%	43%	20%	25%	75%
Statewide	No Data	72%	59%	64%	50%	53%
SED						
Amerigroup		94%	92%	98%	97%	100%
Sunflower		91%	72%	92%	58%	95%
United		85%	98%	87%	88%	95%
Statewide	99%	90%	89%	92%	82%	97%

KDADS HCBS Quality Review Report

Plan of Care
PM 13: Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**74%**	**83%**	**96%**	**83%**
Numerator	26	19	24	69
Denominator	35	23	25	83
FE	**65%**	**71%**	**85%**	**73%**
Numerator	20	20	22	62
Denominator	31	28	26	85
IDD	**68%**	**59%**	**86%**	**68%**
Numerator	19	24	19	62
Denominator	28	41	22	91
TBI	**62%**	**67%**	**92%**	**70%**
Numerator	16	8	11	35
Denominator	26	12	12	50
TA	**72%**	**81%**	**75%**	**76%**
Numerator	18	13	6	37
Denominator	25	16	8	49
Autism	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				
SED	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				

Explanation of Findings:

Missing the documentation to show "choice" was reviewed with the individual, for the review period, choice is on the service plan, however, it was not signed, form is signed but choice is not marked, service plan was not signed timely, "Choice box" was not marked on the choice form and/or service plan, form was not fully completed.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed.

Recommended Remediation:
1. Corrective action plan : MCOs shall provide a corrective action plan showing how they intend to show required signatures to show member participation in the POC process.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		64%	58%	68%	78%	74%
Sunflower		73%	68%	70%	69%	83%
United		77%	78%	83%	89%	96%
Statewide	Not a measure	71%	66%	73%	79%	83%
FE						
Amerigroup		64%	59%	75%	77%	65%
Sunflower		84%	59%	87%	76%	71%
United		77%	79%	80%	94%	85%
Statewide	65%	75%	64%	81%	82%	73%
IDD						
Amerigroup		34%	47%	63%	63%	68%
Sunflower		61%	39%	59%	64%	59%
United		77%	57%	64%	76%	86%
Statewide	No Data	53%	46%	61%	67%	68%
TBI						
Amerigroup		50%	50%	54%	56%	62%
Sunflower		85%	43%	96%	73%	67%
United		70%	74%	77%	86%	92%
Statewide	No Data	66%	52%	69%	66%	70%
TA						
Amerigroup		82%	56%	64%	64%	72%
Sunflower		98%	82%	80%	75%	81%
United		100%	58%	82%	75%	75%
Statewide	No Data	90%	64%	72%	69%	76%
Autism	**Self-direction is not offered for this waiver**					
Amerigroup						
Sunflower						
United						
Statewide						
SED	**Self-direction is not offered for this waiver**					
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 1: Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes
Numerator: Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 2: Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures
Numerator: Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken
Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 4: Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**83%**	**83%**	**96%**	**87%**
Numerator	29	19	24	72
Denominator	35	23	25	83
FE	**68%**	**82%**	**88%**	**79%**
Numerator	21	23	23	67
Denominator	31	28	26	85
IDD	**82%**	**78%**	**86%**	**81%**
Numerator	23	32	19	74
Denominator	28	41	22	91
TBI	**81%**	**75%**	**92%**	**82%**
Numerator	21	9	11	41
Denominator	26	12	12	50
TA	**76%**	**81%**	**75%**	**78%**
Numerator	19	13	6	38
Denominator	25	16	8	49
Autism	**0%**	**50%**	**25%**	**20%**
Numerator	0	2	1	3
Denominator	7	4	4	15
SED	**5%**	**0%**	**0%**	**2%**
Numerator	1	0	0	1
Denominator	22	21	19	62

Explanation of Findings:

Review of ANE was on the Service plan, which was not signed & dated by the individual and/or their representative/guardian, if applicable; the form or documentation was not provided, "box" was not marked on the form that information was provided.

Remediation:

This performance measure is achieved through the integrated service plan. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.
2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

Steps still left to complete remediation:

1. Draft revised integrated support plan policy. Expected completion date: September 2017.
2. Public comment on integrated support plan policy. Expected completion date: October 2017. Responsible party: KDADS (CSP)
3. Finalize policy and get approval from KDHE AD staff. Expected completion: November 2017. Responsible party: KDADS (CSP), KDHE.
4. Operationalization of policy. Expected completion: January 2018. Responsible party: MCOS and TCMs.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		51%	19%	51%	81%	83%
Sunflower		88%	72%	72%	72%	83%
United		90%	80%	79%	96%	96%
Statewide	65%	72%	53%	67%	83%	87%
FE						
Amerigroup		59%	16%	51%	70%	68%
Sunflower		86%	62%	87%	79%	82%
United		92%	80%	85%	94%	88%
Statewide	80%	78%	50%	75%	81%	79%
IDD						
Amerigroup		23%	6%	41%	70%	82%
Sunflower		87%	59%	71%	80%	78%
United		100%	56%	71%	86%	86%
Statewide	99%	68%	42%	62%	78%	81%
TBI						
Amerigroup		30%	12%	46%	56%	81%
Sunflower		94%	45%	88%	87%	75%
United		80%	76%	81%	86%	92%
Statewide	57%	63%	34%	63%	70%	82%
TA						
Amerigroup		61%	38%	73%	79%	76%
Sunflower		99%	86%	87%	81%	81%
United		97%	61%	82%	75%	75%
Statewide	86%	82%	57%	78%	79%	78%
Autism						
Amerigroup		62%	8%	30%	14%	0%
Sunflower		33%	29%	35%	50%	50%
United		43%	14%	0%	0%	25%
Statewide	90%	50%	16%	27%	24%	20%
SED						
Amerigroup		88%	64%	45%	10%	5%
Sunflower		80%	53%	27%	29%	0%
United		78%	63%	29%	13%	0%
Statewide	89%	82%	60%	34%	17%	2%

KDADS HCBS Quality Review Report

Health and Welfare
PM 5: Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames
Numerator: Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver
Denominator: Number of participants' reported critical incidents
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 6: Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures
Numerator: Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver
Denominator: Number of reported critical incidents
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 7: Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Numerator: Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Denominator: Number of restraint applications, seclusion or other restrictive interventions
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 8: Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator: Number of unauthorized uses of restrictive interventions
Review Period: 10/01/2016 - 12/31/2016
Data Source:

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

AIR policy/procedures still in the development process.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance
measure the following remediation steps have taken place:
1. Established a reporting system to capture all adverse/critical incidents. The "Adverse Incident Reporting" system has received 5,722 reports from August 1, 2016 to August 1, 2017. This is a difference of 1,303 reports from the previously reported timeframe of August 1, 2016 to May 2, 2017.
2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.
3. The adverse incident policy has been finalized following the public comment session and is being presented at the KanCare Policy Team Meeting August 1, 2017. Expected completion
October 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.
4. All system changes have been identified. In process of finalizing definitions related to some of the Performance Measures specifically "unexpected death," "identification of preventable causes," "appropriate follow up measures" and "unauthorized use of restrictive interventions." Meeting with legal, management team and Program Integrity is scheduled for August 11th. Complete and to IT: August 2017.
5. Complete AIR system modifications to operationalize AIR policy. Expected completion 10/1/2017. Responsible Party: KDADS FISC Commission.
6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC
Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup						
Sunflower						
United						
Statewide						
FE						
Amerigroup						
Sunflower						
United						
Statewide						
IDD						
Amerigroup						
Sunflower						
United						
Statewide						
TBI						
Amerigroup						
Sunflower						
United						
Statewide						
TA						
Amerigroup						
Sunflower						
United						
Statewide						
Autism						
Amerigroup						
Sunflower						
United						
Statewide						
SED						
Amerigroup						
Sunflower						
United						
Statewide						

KDADS HCBS Quality Review Report

Health and Welfare
PM 9: Number and percent of waiver participants who received physical exams in accordance with State policies
Numerator: Number of HCBS participants who received physical exams in accordance with State policies
Denominator: Number of HCBS participants whose service plans were reviewed
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

This data was not collected as part of the MCO reviews that were conducted.

Remediation:

KDADS program staff will engage with MCOs to clarify documentation requirements for quality review.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		78%				
Sunflower		81%				
United		88%				
Statewide	Not a measure	82%				
FE						
Amerigroup		89%				
Sunflower		97%				
United		97%				
Statewide	Not a measure	95%				
IDD						
Amerigroup		91%				
Sunflower		99%				
United		99%				
Statewide	Not a measure	97%				
TBI						
Amerigroup		84%				
Sunflower		94%				
United		93%				
Statewide	Not a measure	90%				
TA						
Amerigroup		100%				
Sunflower		100%				
United		97%				
Statewide	Not a measure	100%				
Autism						
Amerigroup		100%				
Sunflower		92%				
United		100%				
Statewide	Not a measure	98%				
SED						
Amerigroup		54%				
Sunflower		55%				
United		46%				
Statewide	Not a measure	52%				

KDADS HCBS Quality Review Report

Health and Welfare
PM 10: Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan
Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
Denominator: Number of waiver participants with a red flag designation
Review Period: 10/01/2016 - 12/31/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**83%**	**74%**	**96%**	**84%**
Numerator	29	17	24	70
Denominator	35	23	25	83
FE	**65%**	**79%**	**88%**	**76%**
Numerator	20	22	23	65
Denominator	31	28	26	85
IDD	**75%**	**66%**	**91%**	**75%**
Numerator	21	27	20	68
Denominator	28	41	22	91
TBI	**81%**	**75%**	**92%**	**82%**
Numerator	21	9	11	41
Denominator	26	12	12	50
TA	**76%**	**75%**	**75%**	**76%**
Numerator	19	12	6	37
Denominator	25	16	8	49
Autism	**0%**	**100%**	**25%**	**33%**
Numerator	0	4	1	5
Denominator	7	4	4	15
SED	Not a waiver performance measure			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Amerigroup		59%	53%	64%	78%	83%
Sunflower		77%	49%	60%	72%	74%
United		64%	80%	81%	93%	96%
Statewide	Not a measure	67%	58%	68%	81%	84%
FE						
Amerigroup		61%	62%	74%	77%	65%
Sunflower		72%	56%	63%	82%	79%
United		76%	81%	78%	94%	88%
Statewide	59%	70%	65%	71%	84%	76%
IDD						
Amerigroup		67%	61%	61%	63%	75%
Sunflower		58%	32%	52%	67%	66%
United		70%	58%	60%	81%	91%
Statewide	Not a measure	64%	47%	56%	69%	75%
TBI						
Amerigroup		46%	49%	53%	64%	81%
Sunflower		68%	42%	75%	93%	75%
United		56%	74%	76%	71%	92%
Statewide	Not a measure	56%	52%	63%	74%	82%
TA						
Amerigroup		75%	54%	80%	79%	76%
Sunflower		91%	58%	70%	94%	75%
United		86%	63%	82%	75%	75%
Statewide	Not a measure	83%	57%	77%	83%	76%
Autism						
Amerigroup		77%	44%	37%	43%	0%
Sunflower		53%	27%	54%	100%	100%
United		38%	7%	0%	0%	25%
Statewide	Not a measure	64%	30%	38%	53%	33%
SED	Not a waiver performance measure					
Amerigroup						
Sunflower						
United						
Statewide						

Explanation of Findings:

The BUP is on the service plan or own form, however, it is not signed and/or dated by the individual, their representative/guardian, if applicable; missing the BUP for the review period; BUP does not address all of the identified health and safety risks, staffing and/or *red flags (*FE only), BUP is not individualized to the individual.

Remediation:

This performance measure is achieved through the integrated service plan. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.
2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

Steps still left to complete remediation:

1. Draft revised integrated support plan policy. Expected completion date: September 2017.
2. Public comment on integrated support plan policy. Expected completion date: October 2017. Responsible party: KDADS (CSP)
3. Finalize policy and get approval from KDHE AD staff. Expected completion: November 2017. Responsible party: KDADS (CSP), KDHE.
4. Operationalization of policy. Expected completion: January 2018. Responsible party: MCOS and TCMs.

KDADS HCBS Quality Review Report

Financial Accountability
PM 1: Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Numerator: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Denominator: Total number of provider claims
Review Period: 07/01/2016 - 9/30/2016
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
HCBS Waivers	**95%**
Numerator	269,735
Denominator	285,073

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
All HCBS Waivers						
Statewide	not a measure	90%	88%	94%	95%	95%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

Financial Accountability
PM 2: Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Numerator: Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Denominator: Total number of capitation (payment) rates
Review Period: 10/01/2016 - 12/31/2016
Data Source: KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	24
Denominator	24
FE	**100%**
Numerator	24
Denominator	24
IDD	**100%**
Numerator	48
Denominator	48
TBI	**100%**
Numerator	12
Denominator	12
TA	**100%**
Numerator	12
Denominator	12
Autism	**100%**
Numerator	12
Denominator	12
SED	**100%**
Numerator	12
Denominator	12

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016	Oct-Dec 2016
PD						
Statewide	not a measure	100%	100%	100%	100%	100%
FE						
Statewide	not a measure	100%	100%	100%	100%	100%
IDD						
Statewide	not a measure	100%	100%	100%	100%	100%
TBI						
Statewide	not a measure	100%	100%	100%	100%	100%
TA						
Statewide	not a measure	100%	100%	100%	100%	100%
Autism						
Statewide	not a measure	100%	100%	100%	100%	100%
SED						
Statewide	not a measure	100%	100%	100%	100%	100%

Explanation of Findings:

Remediation:

KanCare Ombudsman KDHE Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
3rd[d] Quarter 2017 Report

Executive Summary Dashboard

Contacts by Office	Q2/17	Q3/17
Main	639	759
Johnson County	81	51
Wichita	115	160
Total	**835**	**970**

Contact Method	Q2/17	Q3/17
Email	127	143
Face-to-Face Meeting	5	6
Letter	0	0
ONLINE	0	0
Other	2	5
Telephone	701	816
Total	**835**	**970**

	Q2/17	Q3/17
Avg. Days to Resolve Issue	9	9
% files resolved in one day or less	44%	34%
% files closed	92%	90%

Top five issues for third quarter (without Other):

Issues	Q3/17
Medicaid Eligibility Issues	237
Medicaid Application Assistance	162
HCBS Eligibility issues	58
Medicaid Renewal	38
Client Obligation	37

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 third quarter of 2017. Third quarter has an increase over first and second quarters of 2017 and a 41% increase over third quarter last year.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	*2014/2015 avg. is 520*
2016	1,130	846	687	523	2016 avg. is 797
2017	825	835	970		*2017 avg. to date is 877*
2016 vs. 2017	-27%	-1%	41.2%		

The average number of contacts for the Ombudsman's office has received increased by almost 300 calls per quarter from 2014/2015 to 2016; from 520 to 797 contacts on average per quarter. Third quarter the office received almost 1000 contacts and is on trend to do the same or more fourth quarter. This increase is can be contributed in part to the outreach by the Ombudsman staff, Lisa Churchill, Volunteer Coordinator and Percy Turner, Project Coordinator. Lisa has been providing KanCare/Medicaid 101 training and KanCare Application training 1-3 times a month since first quarter to providers to help them better understand KanCare and let them know about the Ombudsman's office services so they can refer people they work with to this office if they are having issues with KanCare. Consequently, the cases are more complicated and take more time than in the past. Percy has been providing outreach to the county Public Health Clinics across Kansas for the past year.

In the chart below, on the "*% files resolved in one day or less" line,* the percentages are down in 2017 compared to 2016. This trend is due to the more complicated contacts the office is receiving compared to last year and is reflected in these numbers.

	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Avg. Days to Resolve Issue	7	5	6	4	11	9	9
% files resolved in one day or less	49.6%	56%	54%	52%	34%	44%	34%
% files closed	77%	88%	87%	80%	88%	92%	90%

Outreach by Ombudsman's office

Presentations: (educational, networking, referrals)

- Third Quarter Public Health Region Meeting in Chanute, KS (July 13, 2017)
- 2017 Kansas Conference on Poverty (July 19-20, 2017)
- Public Health Quarterly meetings: 8/2017 (Hutchinson 8/2, Oakley 8/10, Garden City 8/9, and Topeka 8/29)
- Oak Creek Senior Living/Assisted Living Facility, presentation to residents in Topeka (August 16, 2017)
- Attended the KanCare Consumer Specialized Issues Workgroup and provided quarterly report for review; August 17, 2017.
- Sedgwick County Developmental Disability Community Council meeting 8/18
- 2017 Midwest Ability Summit in Kansas City (August 19, 2017)
- Provided quarterly report on the Ombudsman's office for the Robert Bethell HCBS and KanCare Oversight Committee Meeting, August 23, 2017
- WSU Volunteer Fair 8/28
- Locations Posting KanCare Ombudsman Information: Outreach post about the KanCare Ombudsman office services.
    - 50 + Center (September 2017)
    - Olathe Public Library (September 2017)
    - Church of Harvest (September 2017)
    - First Baptist Church of Olathe (September 2017)
    - St. Paul's Catholic Church (September 2017)
    - Legacy Christian Church (September 2017)
- Public Health Quarterly meetings 9/2017 (Beloit-9/6)
- KanCare All MCO Provider outreach meetings 2 sessions 9/13
- All MCOs/HCBS Training/Outreach (Olathe, KS) (September 20, 2017)
- All MCOs/HCBS Training/Outreach (Hays, KS) (September 27, 2017)
- St. Mary's University (Kansas City, KS) (September 28, 2017)
- Provided testimony on the Ombudsman's office for the KanCare Advisory Council; October 17, 2017
- KanCare Ombudsman Liaison Training Sessions (educational, networking, referrals, increase capacity)
    - Aledade, Inc. in Salina, KS (July 7, 2017)
    - Wyandotte/Leavenworth AAA (July 17, 2017)
    - El Centro in Wyandotte County (August 31, 2017)
    - Northwestern KS CDDO (DSNWK), in Hill City, KS (Graham Co.) (Sept. 22, 2017)

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

- Senior Bluebook Magazine (Kansas City, KS and Kansas City, MO) (July and August 2017)
- The Communicator (Wyandotte/Leavenworth AAA Publication) (July and August 2017)
- Livable Neighborhood Task Force (Wyandotte Co. Publication) (September 2017)
- Information posted in the newsletters of the:
    - McConnel AFB retirees (8/2017)
    - Bel Aire Senior Center (8/2017, updated 9/2017)
    - Pine Valley Christian Church (9/2017)
    - Volunteer ICT (posted on their website 9/2017)
    - St James Church (provided publication information and flyers) (Sept 2017)

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** has been providing assistance to KanCare members for almost a year and a half. Johnson County Satellite office is answering the phone and meeting with individuals on Wednesdays (10-1), Thursdays (10-4), and Fridays (10-1). In November, three volunteers are beginning training in Olathe to work in the office and three volunteers will begin training in November to assist with creating additional resources.
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been open two years, providing assistance to KanCare members. The Southern Kansas Satellite Office is answering the phone and meeting with individuals Monday through Thursday 10:00am to 2:00pm.
- Both Satellite offices are assisting consumers with filling out applications on the phone and by appointment, in person.

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.

The reason for the variance in the numbers in the satellite offices is when volunteers start or end their time with the Ombudsman's office. For example, in Johnson County there were two volunteers for some time, then there were four, then it dropped back to three. You can see the number of calls taken reflected the number of volunteers available to take those calls. Something similar happened in Wichita between first, second and third quarters.

Contacts by Office	Q4/16	Q1/17	Q2/17	Q3/17
Main	432	648	639	759
Johnson County	21	28	81	51
Wichita	70	149	115	160
Total	523	825	835	970

Contact Method	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
phone	862	644	507	394	687	701	816
email	265	191	174	125	125	127	143
letter	2	3	1	0	2	0	0
in person	0	8	3	3	11	5	6
online	1	0	2	1	0	0	0
other	0	0	0	0	0	2	5
Total	**1,130**	**846**	**687**	**523**	**825**	**835**	**970**

Caller Type	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Provider	179	110	100	71	117	112	141
Consumer	866	601	544	352	630	661	773
MCO employee	7	4	10	8	18	9	11
Other	78	131	33	92	60	53	45
Total	**1,130**	**846**	**687**	**523**	**825**	**835**	**970**

The most frequent calls regarding home and community-based services (HCBS) waivers during the third quarter of 2017 was in regard to the intellectual developmental disability waiver, then the frail elderly waiver and physical disability waiver were almost tied for second and third.

The increase in ***I/DD calls*** seemed to be partly due to the Clearinghouse working on cases where people were no longer on SSI and sending notices to close the member out of Medicaid. Many families/providers thought they were exempt from having to reapply because they were an adult disabled child; however, if SSI was dropped the *financial information* would need to be updated so a new application would be necessary.

The increase in ***Nursing Facility calls*** was a combination of Medicaid eligibility/renewal, concern about abuse/neglect, and estate recovery.

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**	**Q2/17**	**Q3/17**
PD	48	22	13	9	40	37	32
I/DD	48	27	21	11	43	27	52
FE	23	19	10	7	30	27	33
Autism	1	2	2	1	3	2	2
SED	4	0	1	3	4	4	5
TBI	10	3	7	5	6	8	7
TA	10	9	4	4	8	10	2
WH	0	0	0	0	0	0	1
MFP	8	5	3	0	2	1	0
PACE	0	0	0	0	0	0	1
Mental Health	8	6	3	2	5	5	2
Substance Use Disorder	0	0	0	0	0	0	0
Nursing Facility	47	27	16	27	65	45	79
Other	941	739	612	456	628	677	754
Total	**1,148**	**859**	**692**	**525**	**834**	**843**	**970**

The Issue Categories listed below reflect the last seven quarters in alphabetical order. The top six issues for each quarter are highlighted. Six are listed this time due to the last two issues being almost a tie at 37 and 38 (Client Obligation and Medicaid Renewal). The issues that carry across several quarters are Medicaid Eligibility Issues, Other and HCBS Eligibility Issues (besides Thank You).

The highlighted issues on the left were added in third quarter. Issues added recently have an n/a listed during history that is not available. There may be multiple issues for a member/contact.

Issues	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Access to Providers	7	6	9	13	14	14	13
Affordable Care Act	n/a	n/a	n/a	n/a	3	6	5
Appeals, Grievances	49	42	36	16	36	33	0
Billing	43	39	37	26	21	33	17
Care Coordinator Issues	7	3	6	4	5	11	6
Change MCO	15	3	0	6	3	1	2
Client Obligation	n/a	n/a	n/a	n/a	17	35	37
Coding Issues	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	8
Data Requests	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	3
Dental	4	5	5	5	7	9	7
Division of Assets	n/a	n/a	n/a	n/a	2	2	5
Durable Medical Equipment	7	7	2	4	2	9	3
Estate Recovery	n/a	n/a	n/a	n/a	5	5	6
Grievances Questions/Issues	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	29
Guardianship Issues	0	1	2	2	3	1	3
HCBS Eligibility issues	45	33	21	9	46	48	58
HCBS General Issues	69	32	16	15	33	34	21
HCBS Reduction in hours of service	12	4	3	3	7	2	4
HCBS Waiting List issues	18	2	2	4	6	9	8
Housing issues	8	2	2	3	4	6	7
Medicaid Application Assistance	*n/a*	n/a	n/a	n/a	*n/a*	*54*	162
Medicaid Eligibility Issues	512	244	173	174	*236*	*177*	237
Medicaid Renewal	n/a	n/a	n/a	n/a	*29*	*43*	38
Medical Services	29	20	10	12	20	23	11
Medicare related Issues	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	15
Medicare Savings Plan Issues	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	9
Moving to/from Kansas	n/a	n/a	n/a	n/a	5	7	6
Nursing Facility Issues	40	25	22	22	38	25	23
Other	332	377	381	224	274	323	241
Pharmacy	24	13	11	8	10	9	10
Questions for Conf. Calls	0	0	1	2	0	0	0
Social Security Issues	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	1
Spenddown Issues	n/a	n/a	n/a	n/a	18	32	29
Transportation	6	8	6	1	8	9	12
Working Healthy	*n/a*	n/a	n/a	n/a	*n/a*	*n/a*	2
z-Thank you	72	85	114	100	235	318	413
z-Unspecified	79	38	21	17	45	39	61
Total	**1,378**	**989**	**880**	**670**	**1,132**	**1,317**	**1512**

KanCare Ombudsman

Action Taken to Resolve Issues by Ombudsman's Office

The ***"Resolved"*** section explains how cases have been closed. If a call is returned and the person has already received an answer and does not need help from the Ombudsman's office, then it is marked "Resolved" and closed. The ***"Used Contacts or Resources"*** shows how we resolved the cases; using contacts or resources that are listed in the blue or green categories below. Our offices will contact those offices themselves, with the member, or refer the member to the organization. Once it is resolved this is the section that is used. The **"Closed"** section is when a person contacts our offices and leaves a message and we are not able to get back in touch with them; either because the number left is a wrong number, there is no voice mail to leave a message and they don't call back, or messages are left and they don't return the call. After a month or so, the case is closed.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Question/Issue Resolved	122	239	233	214	160	78	72
Used Contacts or Resources/Issues Resolved	463	394	313	166	494	601	682
Closed	198	313	111	17	65	69	99

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

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Provided Resources to Member	361	239	115	88	203	305	330
Mailed/Email Resources	n/a	n/a	n/a	n/a	43	123	123

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. A few new categories were created during first quarter of 2017. History is not available before then. Often multiple resources are provided to a member/contact.

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

You will note the high number of contacts for the Clearinghouse for Q3/17. Volunteers and staff do 3 way calls with members and family and the Clearinghouse. When the members call and have questions regarding their Medicaid that we cannot answer it is the best way to get the problems clarified. Our staff have a knowledge base to understand what questions to ask and direct the conversation to a more positive outcome. This can be time consuming, but worth the time to get problems resolved.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
KDHE Contacts	214	97	97	111	134	76	75
DCF Contacts	6	2	1	4	1	4	7
MCO Contacts	48	43	44	31	33	29	18
MCO Referral	n/a	n/a	n/a	n/a	19	34	33
Clearinghouse Contact	n/a	n/a	n/a	n/a	73	129	200
Clearinghouse Referral	n/a	n/a	n/a	n/a	25	104	141
HCBS Team Contacts	28	21	12	5	29	23	24
HCBS Team Referral	n/a	n/a	n/a	n/a	7	12	18
CSP Mental Health Contacts	1	1	0	0	2	0	1
Other KDADS Contacts/Referral	53	16	44	38	49	41	46
State/Community Agency Referral	111	40	53	14	46	78	71
Disability Rights and/or KLS Referral	13	7	4	3	8	3	1

Next Steps for Ombudsman's Office

KanCare Ombudsman Liaison Training Program

The focus for the next six months will be to get both Volunteer offices at better coverage with volunteers to assist with the increase in call volume.

Data by Managed Care Organization

The following charts provide the issue categories for the last six quarters by MCO. The top four issues are shaded (more may be shaded if there was a tie for the last number). There may be multiple issues for a member/contact.

Amerigroup

Issue Category - Amerigroup	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Access to Providers (usually Medical)	1	1	2	2	3	7	2
Affordable Care Act	n/a	n/a	n/a	n/a	0	0	0
Appeals/Fair Hearing questions/issues	9	5	1	0	10	4	4
Billing	11	6	7	2	1	5	3
Care Coordinator Issues	4	1	3	1	1	4	0
Change MCO	1	1	0	0	1	0	0
Client Obligation	n/a	n/a	n/a	n/a	1	7	4
Coding Issues	n/a	n/a	n/a	n/a	n/a	n/a	3
Data Requests	n/a	n/a	n/a	n/a	n/a	n/a	0
Dental	0	0	1	1	0	0	1
Division of Assets	n/a	n/a	n/a	n/a	0	0	0
Durable Medical Equipment	2	2	1	1	0	1	0
Estate Recovery	n/a	n/a	n/a	n/a	0	1	0
Grievances Questions/Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	0	1	0	0
HCBS Eligibility issues	8	5	4	0	6	7	7
HCBS General Issues	13	3	3	3	11	10	3
HCBS Reduction in hours of service	6	1	1	1	2	0	0
HCBS Waiting List	0	0	0	1	1	2	0
Housing Issues	1	1	0	1	0	1	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0	0	0
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0	0	0
Medicaid Eligibility Issues	28	8	5	6	8	5	10
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	4	7	3
Medical Services	7	2	3	1	5	7	1
Medicare related Issues	n/a	n/a	n/a	n/a	n/a	n/a	2
Medicare Savings Plan Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Moving to/from Kansas	n/a	n/a	n/a	n/a	1	0	0
Nursing Facility Issues	2	1	0	1	1	3	0
Other	19	16	20	10	14	21	11
Pharmacy	3	1	0	2	1	2	2
Social Security Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Spenddown Issues	n/a	n/a	n/a	n/a	2	5	2
Transportation	2	1	1	0	1	1	3
Z-Thank you.	6	4	9	5	23	31	13
Z-Unspecified	2	0	0	1	1	1	1
Total	**125**	**59**	**61**	**39**	**99**	**132**	**76**

Sunflower

Issue Category - Sunflower	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Access to Providers (usually Medical)	1	1	2	0	4	3	2
Affordable Care Act	n/a	n/a	n/a	n/a	0	1	0
Appeals/Fair Hearing questions/issues	14	11	8	2	5	8	1
Billing	6	7	9	7	3	6	5
Care Coordinator Issues	2	1	1	2	1	2	1
Change MCO	3	1	0	1	0	0	0
Client Obligation	n/a	n/a	n/a	n/a	3	4	4
Coding Issues	n/a	n/a	n/a	n/a	n/a	n/a	1
Data Requests	n/a	n/a	n/a	n/a	n/a	n/a	0
Dental	1	2	0	0	0	1	1
Division of Assets	n/a	n/a	n/a	n/a	0	0	0
Durable Medical Equipment	5	2	0	2	0	2	1
Estate Recovery	n/a	n/a	n/a	n/a	0	0	1
Grievances Questions/Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	0	0	0	1
HCBS Eligibility issues	3	7	3	2	3	10	10
HCBS General Issues	15	9	1	5	5	6	3
HCBS Reduction in hours of service	0	3	1	0	1	1	1
HCBS Waiting List	1	0	0	0	1	1	0
Housing Issues	0	0	0	0	1	1	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	1	0	3
Medicaid Coding Issues	n/a	n/a	n/a	n/a	2	0	0
Medicaid Eligibility Issues	26	7	10	9	14	8	13
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	6	5	8
Medical Services	4	8	0	3	5	3	5
Medicare related Issues	n/a	n/a	n/a	n/a	n/a	n/a	1
Medicare Savings Plan Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Moving to/from Kansas	n/a	n/a	n/a	n/a	0	1	0
Nursing Facility Issues	3	3	2	1	2	1	0
Other	23	12	24	16	18	19	11
Pharmacy	4	1	4	4	4	3	1
Social Security Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Spenddown Issues	n/a	n/a	n/a	n/a	2	4	4
Transportation	1	2	4	1	4	3	1
Z-Thank you.	7	6	8	11	20	25	31
Z-Unspecified	1	0	0	0	1	0	1
Total	**120**	**83**	**77**	**66**	**106**	**118**	**112**

United Healthcare

Issue Category - UnitedHealthcare	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17	Q3/17
Access to Providers (usually Medical)	2	1	0	2	4	2	0
Affordable Care Act	n/a	n/a	n/a	n/a	0	0	0
Appeals/Fair Hearing questions/issues	6	4	5	1	3	3	4
Billing	3	5	2	3	3	7	3
Care Coordinator Issues	0	0	2	1	3	1	4
Change MCO	3	0	0	4	2	1	1
Client Obligation	n/a	n/a	n/a	n/a	2	2	3
Coding Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Data Requests	n/a	n/a	n/a	n/a	n/a	n/a	0
Dental	1	3	2	0	1	3	2
Division of Assets	n/a	n/a	n/a	n/a	0	0	1
Durable Medical Equipment	0	1	0	0	2	2	1
Estate Recovery	n/a	n/a	n/a	n/a	0	1	0
Grievances Questions/Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Guardianship	0	0	0	1	0	0	1
HCBS Eligibility issues	6	3	2	0	9	6	3
HCBS General Issues	11	5	2	3	2	4	5
HCBS Reduction in hours of service	2	0	0	2	2	0	2
HCBS Waiting List	2	1	1	0	0	0	0
Housing Issues	0	0	0	0	0	0	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0	1	1
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0	0	0
Medicaid Eligibility Issues	18	4	5	5	7	7	9
Medicaid Renewal	n/a	n/a	n/a	n/a	1	1	6
Medical Services	4	1	4	0	3	3	0
Medicare related Issues	n/a	n/a	n/a	n/an	n/a	n/a	2
Medicare Savings Plan Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Moving to/from Kansas	n/a	n/a	n/a	n/a	0	0	0
Nursing Facility Issues	2	1	2	2	2	2	1
Other	14	20	20	12	15	17	13
Pharmacy	7	2	4	0	0	1	0
Social Security Issues	n/a	n/a	n/a	n/a	n/a	n/a	0
Spenddown Issues	n/a	n/a	n/a	n/a	0	1	6
Transportation	1	0	0	0	2	2	2
Z-Thank you.	5	8	6	9	11	22	29
Z-Unspecified	2	0	0	0	2	0	4
Total	**89**	**59**	**57**	**45**	**76**	**89**	**104**

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 3 - YE 2015

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

Paid dates 1/1/2015 through 12/31/2015

Hospital Name	YE 2015 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	7,473,102.00	3,253,601.78	4,219,500.22
University of Kansas Hospital	22,419,309.00	9,760,806.66*	12,658,502.34
Total	**29,892,411.00**	**13,014,408.44**	**16,878,002.56**

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 5 - Quarter 3
Large Public Teaching Hospital/Border City Children's Hospital Pool
Paid date 7/28/2017

Provider Name	DY/QTR: 2017/3	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	616,034	269,761	346,273
University of Kansas Hospital	1,848,103	809,824*	1,038,819
Total	2,464,137	1,079,046	1,385,091

*IGT funds are received from the University of Kansas Hospital

Kansas Foundation for Medical Care, Inc

800 SW Jackson St., Suite 700
Topeka, Kansas 66612-1265
Phone 785-273-2552
kfmc.org

November 27, 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 3, July - September

Dear Ms. Ross:

Enclosed is the 2017 Quarter 3 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

Kansas Foundation for Medical Care, Inc.

URAC ACCREDITED Independent Review Organization: Comprehensive Expires 07/01/2018

2017 KanCare Evaluation

Quarterly Report

Year 5, Quarter 3, July - September

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**November 27, 2017**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

AD ASTRA PER ASPERA KanCare

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Year 5, Quarter 3, July - September

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KanCare Evaluation Quarterly Report
Year 5, Quarter 3, July – September 2017
November 27, 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 third quarter (Q3) 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 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 number and category of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end. Unlike the Ombudsman's Office reports that include the number of contacts and the number of individual issues addressed during the contacts, the MCO monthly customer service call center reports specify only the number of inquiries and not the number of monthly contacts. Reporting both the number of contacts and number of inquiries is necessary for accurate trend analysis by MCO and for aggregating results. An MCO reporting twice as many inquiries than another MCO, for example, may actually have had the same number of contacts, but may be reporting only one inquiry for each contact even if the contact addressed multiple topics.

Current Quarter and Trend over Time

In Q3 CY2017, 99.1% of the 79,473 member inquiries received by the MCOs and 99.7% of the 39,586 provider inquiries were resolved within two business days (see Table 1). The aggregate two-day resolution rate has been above 99.0% in each quarter to date. Of the 713 customer service inquiries from members not resolved within two business days in Q3, 704 were reported by UnitedHealthcare.

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries - Quarter 3, CY2015 to CY2017

	Quarter 3					
	Member Inquiries			Provider Inquiries		
	CY2015	CY2016	CY2017	CY2015	CY2016	CY2017
Number of Inquiries Received	99,007	97,059	79,473	45,365	43,809	39,586
Number Resolved within 2 Business Days	99,002	96,683	78,759	45,365	43,796	39,448
Number Not Resolved within 2 Business Days	5	376	713	0	13	138
% Resolved Within 2 Business Days	99.99%	99.61%	99.10%	100%	99.97%	99.65%
Number Resolved within 5 Business Days	99,007	96,876	79,098	45,365	43,796	39,575
Number Not Resolved within 5 Business Days	0	183	375	0	13	11
% Resolved within 5 Business Days	100%	99.81%	99.53%	100%	99.97%	99.97%
Number Resolved within 15 Business Days	99,007	97,046	79,387	45,365	43,809	39,583
Number Not Resolved within 15 Business Days	0	13	86	0	0	3
% Resolved within 15 Business Days	100%	99.99%	99.89%	100%	100%	99.99%

In Q3 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. All but one of 375 member inquiries not resolved within five business days in Q3 CY2017 were reported by UnitedHealthcare.

Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.7% of member inquiries and 99.99% of provider inquiries were resolved within 15 days; 86 member inquiries and three provider inquiries in Q3 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).

Table 2. Customer Service Inquiries from Members, Q1 CY2016 to Q3 CY2017

Member Inquiries	CY2016				CY2017		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
1. Benefit Inquiry – regular or VAS	21,924	22,319	21,652	18,152	17,675	17,216	**16,143**
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	1,978	**1,827**
3. Care management or health plan program	1,597	1,584	1,363	1,177	1,010	1,001	**1,140**
4. Claim or billing question	6,416	6,381	5,557	4,838	5,764	5,398	**4,830**
5. Coordination of benefits	3,280	2,964	3,467	2,724	3,075	3,280	**3,098**
6. Disenrollment request	606	600	635	458	463	524	**424**
7. Eligibility inquiry	18,002	13,478	12,555	13,006	15,475	14,420	**13,077**
8. Enrollment information	3,203	2,396	2,558	2,632	3,900	3,234	**3,086**
9. Find/change PCP	12,893	12,488	12,906	8,586	10,519	9,554	**9,413**
10. Find a specialist	3,512	3,375	3,320	2,787	2,794	3,043	**3,043**
11. Assistance with scheduling an appointment	30	47	74	40	58	88	**119**
12. Need transportation	1,326	1,200	1,214	1,232	1,353	1,594	**1,821**
13. Order ID card	6,958	6,453	7,263	5,318	6,894	6,190	**4,521**
14. Question about letter or outbound call	1,322	1,961	1,338	1,143	1,134	2,253	**1,045**
15. Request member materials	1,083	1,119	976	920	732	751	**661**
16. Update demographic information	12,944	13,343	14,985	11,356	13,821	12,568	**10,572**
17. Member emergent or crisis call	699	687	597	676	655	371	**321**
18. Other	5,018	4,491	4,918	6,052	5,162	5,085	**4,332**
Total	**102,742**	**96,632**	**97,059**	**83,581**	**92,373**	**88,548**	**79,473**

- The number of inquiries from members in Q3 was the lowest number since MCOs began reporting in Q2 2014.
- Benefit inquiries in Q3, as in previous quarters, had the highest percentage (20%) of member inquiries.
- Of the 79,473 customer service inquiries from members in Q3 CY2017, 41% were received by Sunflower, 38% by UnitedHealthcare, and 21% by Amerigroup.
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two-thirds of the reported inquiries were from one MCO include:
  - *Update demographic information*: 76% of 10,572 inquiries in Q3 CY2017 were reported by Sunflower (71%–82% for last 12 quarters);

  - *Enrollment information*: 71% of 3,086 inquiries were reported in Q3 CY2017 by Amerigroup (69%–81% for the last 12 quarters);
  - *Concern with access to service or care; or concern with service or care disruption*: 67% of 1,827 inquiries were reported in Q3 CY2017 by Sunflower (67%–80% for the last six quarters);
  - *Care management or health plan program*: 75% of 1,140 inquiries in Q3 CY2017 were reported by Amerigroup (74%–86% in the last six quarters);
  - *Member emergent or crisis call*: 98% of 321 inquiries in Q3 CY2017 were reported by Sunflower (99%–99.8% in the last 12 quarters); and
  - *Need transportation*: 68% of 1,821 inquiries were reported in Q3 CY2017 by Amerigroup (66%–77% in the last four quarters).
- Sunflower continued to add a category for Health Homes; the 45 customer service inquiries reported in Q3 CY2017 as related to "Health Homes" (which were discontinued in July 2016) were added to the "*Other"* category for consistency in reporting aggregated counts for the three MCOs.

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 GAR reports. In response to the EQRO recommendation that "*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*," KDHE is revising the Customer Services Inquiries report template to remove this category in future monthly reports. In training provided to MCO staff in September 2017, KDHE stressed the importance of forwarding all inquiries that could potentially meet grievance or appeal criteria to MCO staff responsible for following up with members to resolve grievances and initiate appeal processes. While the new template may not be instituted until early 2018, KDHE staff are anticipating that the number of inquiries listed in this category will decrease in Q4 in response to the September training.

Provider Customer Service Inquiries

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

- Of the 39,586 provider inquiries received by MCOs in Q3 CY2017, Amerigroup received 41%, Sunflower 48%, and UnitedHealthcare 11%.
- Claim status inquiries were again the highest percentage (51%) of the 39,586 provider inquiries.
- Seven provider inquiries reported by Sunflower in Q3 CY2017 as related "*Health Homes*" were added to the "*Other*" category for consistency in reporting aggregated counts and percentages for the three MCOs.

As noted in previous quarterly reports, there are several categories where aggregated data primarily reflect one MCO rather than all three over time. Categories where two-thirds or more of the provider inquiries in Q3 were reported by one MCO included:

- *Authorization—New*: 99% of 1,332 inquiries in Q3 CY2017 were reported by Amerigroup (98%–99% for the last 12 quarters);
- *Authorization—Status*: 68% of 2,360 inquiries in Q3 CY2017 were reported by Amerigroup (73%–74% in the previous two quarters);
- *Update demographic information*: 96% of 426 inquiries were reported in Q3 CY2017 by Sunflower (91%–99.5% in the last 12 quarters);
- *Benefits inquiry*: 73% of 1,980 inquiries were reported in Q3 CY2017 by Amerigroup; and
- *Claim payment question/dispute*: 74% of 4,095 inquiries were reported in Q3 CY2017 by Sunflower (69% in Q2 CY2017).

Table 3. Customer Service Inquiries from Providers, Q1 CY2016 to Q3 CY2017							
Provider Inquiries	CY2016				CY2017		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
1. Authorization – New	1,942	1,812	1,870	1,735	1,707	1,561	**1,332**
2. Authorization – Status	2,773	2,373	2,599	2,610	2,497	2,351	**2,360**
3. Benefits inquiry	3,259	3,121	3,273	2,215	2,811	2,730	**1,980**
4. Claim denial inquiry	5,605	4,423	5,540	3,920	5,127	5,245	**4,876**
5. Claim status inquiry	23,613	21,685	20,682	17,442	17,519	20,320	**20,718**
6. Claim payment question/dispute	4,575	4,142	3,725	3,948	3,537	3,910	**4,095**
7. Billing inquiry	596	389	407	317	367	337	**330**
8. Coordination of benefits	373	396	429	332	348	283	**202**
9. Member eligibility inquiry	2,030	1,646	1,754	1,389	1,695	1,634	**1,490**
10. Recoupment or negative balance	66	85	75	41	83	40	**53**
11. Pharmacy/prescription inquiry	598	529	583	475	535	499	**496**
12. Request provider materials	71	40	34	35	52	42	**33**
13. Update demographic information	744	710	549	554	684	655	**426**
14. Verify/change participation status	345	258	249	243	293	243	**186**
15. Web support	182	103	99	122	139	101	**99**
16. Credentialing issues	231	162	157	119	160	147	**153**
17. Other	1,918	1,441	1,784	1,781	974	940	**757**
Total	**48,921**	**43,315**	**43,809**	**37,278**	**38,528**	**41,038**	**39,586**

Of the 17 provider inquiry categories, seven are claims-related: *Authorization—New*, *Authorization—Status*, *Benefit Inquiry*, *Claim Denial Inquiry*, *Claim Status Inquiry*, *Claim Payment Question/Dispute*, and *Billing Inquiry*. As shown in Table 4, the range of inquiries for these seven claims-related categories varied greatly, but consistently, by MCO. For the last 11 quarters, for example, Amerigroup has reported over 98% of the provider inquiries categorized as *Authorization—New,* and Sunflower has reported 0% of the *Claim Denial* provider inquiries.

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO - Q3 CY2016 to Q3 CY2017										
	CY2016				CY2017					
	Q3		Q4		Q1		Q2		Q3	
	Max	Min	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,839	7	1,725	0	1,695	0	1,546	1	1,323	1
Authorization - Status	1,661	126	1,879	48	1,816	134	1,741	172	1,615	267
Benefits Inquiry	1,519	582	1,364	359	1,550	431	1,762	441	1,441	181
Claim Denial Inquiry	3,798	0	2,234	0	3,070	0	3,646	0	3,114	0
Claim Status Inquiry	11,845	2,911	10,047	1,367	10,011	1	12,903	670	12,779	466
Claim Payment Question/Dispute	1,745	346	2,275	148	1,971	127	2,688	74	3,010	34
Billing Inquiry	247	2	170	0	241	1	217	0	182	0

Amerigroup
Sunflower
UnitedHealthcare

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

- UnitedHealthcare reported 42% to 70% fewer provider inquiries than Amerigroup and Sunflower, with inquiries ranging from 4,289 (Q4 CY2016) to 8,362 (Q3 CY2016).
- The overall number of claims-related provider inquiries were lower in Q1–Q3 CY2017 compared to Q1–Q3 CY2016.
- Sunflower provider inquiries decreased each quarter from 18,706 in Q1 CY2016 to 13,213 in Q1 CY2017, and then increased to 16,787 and 16,604 in Q2 and Q3 CY2017;
- Amerigroup provider inquiries have been relatively comparable in number from since Q2 CY2016.

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2016 to Q3 CY2017

	CY2016				CY2017		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Amerigroup	16,373	14,967	14,479	14,354	15,015	14,663	14,813
Sunflower	18,706	16,182	15,255	13,544	13,213	16,787	16,604
UnitedHealthcare	7,284	6,796	8,362	4,289	5,337	5,004	4,274
Total	42,363	37,945	38,096	32,187	33,565	36,454	35,691

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

- *The MCOs should ensure all staff responding to customer service inquiries are categorizing the inquiries based on State-specified criteria.*
  Follow-up response: In the Fall of 2017, KDHE staff provided training to MCO staff and discussed reporting criteria with customer service managers at MCO site visits.
- *After additional MCO training is completed, the State should consider reviewing a sample of customer service inquiries categorized as "concern with access to service or care; or concern with service or care disruption" to ensure contacts that should be categorized as grievances and appeals are not instead reported as customer service inquiries.*
  Follow-up response: KDHE is updating the Customer Service Inquiries reporting template to exclude this category.
- *MCOs should include the State-specified member and provider customer service inquiries in the drop-down menu options available to customer service staff responding to member inquiries.*
  Follow-up response: Drop-down menu options used by Kansas MCOs are based on their corporate tracking systems used in multiple states. KDHE has worked with the MCOs to develop crosswalks of State reporting criteria and MCO dropdown menu options to more accurately evaluate MCO reporting of customer service inquiries.
- *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.*
  Follow-up response: KDHE is updating the Customer Service Inquiries reporting template to exclude this category.

Recommendations (Timely Resolution of Customer Service Inquiries)

1. The State should implement the revised Customer Service Inquiries reporting template (that excludes the *"Concern with access to service or care; or concern with service or care disruption"* reporting option) by Q1 CY2018, if possible.
2. The State should consider reviewing a sample of inquiries categorized to date as *"Concern with access to service or care; or concern with service or care disruption"* to ensure those that have met grievance or appeal criteria have had appropriate follow-up.
3. The State should consider requiring MCOs to report the monthly number of contacts in addition to the monthly number of issues addressed during each contact to better ensure consistency in reporting and to better analyze the numbers and types of member and provider inquiries 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 excluded from the measures include "*claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues*" and "*any claim which cannot be processed due to outstanding questions submitted to KDHE*."

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

Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements. To allow for claims lag, the KanCare Evaluation Report for Q3 CY2017 assesses timeliness of processing clean, non-clean, and all claims reports received through Q2 CY2017 (see Table 6).

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether these claims were processed in a timely manner as defined by the type of claim and State-specified timelines. The report also includes average turnaround times (TAT) for processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.

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.

Table 6. Timeliness of Claims Processing, Q1 CY2016 to Q2 CY2017						
	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
Clean Claims						
Clean claims received in quarter	4,380,378	4,248,060	4,052,640	4,242,248	4,332,165	4,192,588
Number of claims excluded	263	88	61	709	445	720
Number of clean claims not excluded	4,380,115	4,247,972	4,052,579	4,241,539	4,331,720	4,191,868
Clean claims received within quarter processed within 30 days	4,378,159	4,246,507	4,050,603	4,239,788	4,329,950	4,190,829
Clean claims received within quarter not processed within 30 days	1,956	1,465	1,976	1,751	1,770	1,039
Percent of clean claims processed within 30 days	99.96%	99.97%	99.95%	99.96%	99.96%	99.98%
Non-Clean Claims						
Non-clean claims received in quarter	198,558	157,210	182,401	217,957	238,370	152,537
Number of claims excluded	2,974	1,434	1,344	1,372	1,617	1,193
Number of non-clean claims not excluded	195,584	155,776	181,057	216,585	236,753	151,344
Non-clean claims received within quarter processed within 60 days	195,335	155,608	180,909	211,621	235,719	150,733
Non-clean claims received within quarter not processed within 60 days	249	168	148	4,964	1,034	611
Percent of non-clean claims processed within 60 days	99.87%	99.89%	99.92%	97.71%	99.56%	99.60%
All Claims						
All claims received in quarter	4,578,936	4,405,270	4,235,041	4,460,205	4,570,535	4,345,125
Number of claims excluded	3,237	1,522	1,405	2,081	2,062	1,913
Number of claims not excluded	4,575,699	4,403,748	4,233,636	4,458,124	4,568,473	4,343,212
Number of all claims received within quarter processed within 90 days	4,575,552	4,403,630	4,233,492	4,457,945	4,568,285	4,343,082
Number of all claims received within quarter not processed within 90 days	147	118	144	179	188	130
Percent of all claims processed within 90 days	99.997%	99.997%	99.997%	99.996%	99.996%	99.997%

For claims received in Q2 CY2017:

- **Clean claims**:
  - None of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - 99.98% of 4,191,868 clean claims received in Q2 CY2017 were reported by the MCOs as processed within 30 days.
  - Of the 1,039 clean claims not processed within 30 days – 82 (8%) were claims received by Amerigroup; 535 (51%) were claims received by Sunflower; and 422 (41%) were claims received by UnitedHealthcare.
- **Non-clean claims**:
  - 99.6% of 151,344 non-clean claims received in Q2 CY2017 were reported by the MCOs as processed within 60 days.
  - In Q2 CY2017, Amerigroup and Sunflower met the contractual requirement of processing at least 99% of the non-clean claims within 60 days. UnitedHealthcare met the requirement in April and May, but reported they processed only 95.5% of non-clean claims in June.

  - Of the 611 non-clean claims not processed within 60 days – 136 were claims received by Amerigroup; 13 were claims received by Sunflower; and 462 were claims received by UnitedHealthcare.
- **All claims**:
  - 99.997% of 4,343,212 "all claims" received in Q2 CY2017 were reported by the MCOs as processed within 90 days.
  - UnitedHealthcare reported they met the requirement of processing 100% of claims within 90 days. Amerigroup reported that 99.993% of all claims were processed within 90 days, and Sunflower reported 99.998% were processed within 90 days.
  - Of the 130 claims not processed within 90 days – 93 were claims received by Amerigroup, and 37 were claims received by Sunflower.

In 2015 and 2016, the State's pay-for-performance program included incentives to process 99.5% of clean claims within 20 days (instead of the contractually required 30 days) and to process 99% of all claims within 60 days (instead of the contractually-required 90 days). During the annual performance measure validation process for the claims-related P4P claims metrics, KFMC found some differences by each of the MCOs in interpretation of reporting criteria for claims processing timeliness. MCOs each made corrections in their reporting processes that will now allow more accurate aggregation of the three MCOs' quarterly claims data. The claims data reported in Table 6 for 2017, however, have not yet been updated to reflect the criteria revisions.

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

- *MCOs should update their monthly claims processing reports for 2017 and annual totals for 2016 to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days).*
  Follow-up response: Staff from KDHE and the MCOs are in agreement with revising the criteria for the Claims Overview monthly reports to better correspond to the criteria used by the MCOs when reporting claims processing data for the validated P4P claims-related metrics. This recommendation is in process.
- *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.*
  Follow-up response: The time periods for correcting monthly Claims Overview reports are under review by KDHE staff. This recommendation is in process.
- *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.*
  Follow-up response: KDHE staff are considering revisions to the Claims Overview monthly report that will ensure appropriately tracking and reporting of timeliness in processing of newborn claims. This recommendation is in process.

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

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

clean claims (60 days), and all claims (90 days). The State should provide guidance to the MCOs as to the time periods for which claims data should be updated.

2. The State should provide additional direction to the MCOs as to appropriate reporting of 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 which monthly reports should be updated to include processing of newborn claims previously excluded from the 90-day processing requirement.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,090,819 clean claims were processed in Q3 CY2017 (includes claims received prior to Q3). Excluding 1,445,711 pharmacy claims (which are processed same-day), there were 2,645,108 clean claims processed in Q3.

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		
	Q2 CY2017	Q3 CY2017	CY2014	CY2015	CY2016
Hospital Inpatient	6.0 to 15.6	**10.3 to 12.9**	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4
Hospital Outpatient	4.7 to 9.8	**5.4 to 9.8**	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	6.0 to 13.0	**7.0 to 13.0**	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0
Vision	6.0 to 12.0	**6.0 to 12.7**	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7
Non-Emergency Transportation	11.0 to 13.0	**11.0 to 13.4**	10.9 to 18	10.4 to 16	9.0 to 14.4
Medical (Physical health not otherwise specified)	5.0 to 9.8	**6.0 to 8.8**	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7
Nursing Facilities	4.3 to 9.6	**4.8 to 10.0**	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0
HCBS	6.4 to 9.1	**6.8 to 9.3**	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8
Behavioral Health	3.8 to 9.6	**4.6 to 9.4**	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7
Total Claims (Including Pharmacy)	4,439,117	**4,090,819**	16,763,501	17,820,402	17,820,402
Total Claims (Excluding Pharmacy)	2,716,577	**2,645,108**	10,370,998	10,999,807	10,999,807
Average TAT (Excluding Pharmacy)^	**5.5 to 9.9**	**6.4 to 9.0**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**

*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.
^Average TATs are weighted averages calculated after excluding pharmacy claims.

The average TAT for Total Services (excluding pharmacy claims) was 6.4 to 9.0 days in Q3 CY2017, compared with 5.5 to 9.9 days in Q2 and 5.3 to 9.7 days in Q1. Amerigroup overall TAT of 6.4–7.2 days was again shortest, compared to Sunflower (8.5–9.0) and UnitedHealthcare (8.7–8.9).

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

- **Hospital Inpatient** had TATs in Q3 CY2017 ranging from 10.3 to 12.9 days, (compared to 6.0–15.6 days in Q2). UnitedHealthcare had the biggest decrease from Q2 (14.5–15.6 days) to Q3 (10.7–12.9 days.
- **Medical** claims had monthly TATs in Q3 ranging from 6.0 to 8.8 days.
- **Nursing Facilities** claims had TATs ranging from 4.8 to 10.0 days in Q3.

- **Dental** claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q3 CY2017. Sunflower had the shortest TATs (7.0 to 8.0 days); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q2 CY2016 and the previous seven quarters.
- **Behavioral Health** claims TATs ranged from 4.6 to 9.4 days in Q3 CY2017. Amerigroup had the shortest TATs (4.6 to 5.7 days), compared to Sunflower (8.1 to 9.1 days) and UnitedHealthcare (8.6 to 9.4 days).
- **Vision** – The average monthly TATs for Vision in Q3 ranged from 6.0 to 12.7 days. Amerigroup had the shortest monthly TATs (6.0 days), compared to Sunflower (12.0 days) and UnitedHealthcare (12.0 to 12.7 days).

Grievances

Data Sources

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

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation are based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days (via an extension request). The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not (and is not expected to) equal the number of grievances "resolved" during the quarter (see Table 8).

Table 8. Timeliness of Resolution of Grievances - Q3 CY2016 to Q3 CY2017

	CY2016		CY2017		
	Q3	Q4	Q1	Q2	Q3
Grievances received in quarter	452	406	412	458	541
Grievances resolved in quarter*	446	395	412	447	546
Grievances resolved within 30 business days*	387	395	410	441	543
Percent resolved within 30 business days	86.8%	100%	99.5%	98.7%	99.5%
Grievances not resolved within 30 business days	59	0	2	6	3
Grievances resolved within 60 business days*	446	395	412	446	546
Percent resolved within 60 business days*	100%	100%	100%	99.8%	100%
Grievances closed in quarter not resolved in 60 business days*	0	0	0	1	0

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

In Q3 CY2017, 99.5% (543) of the 546 grievances reported by the MCOs as resolved in Q3 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 September 2017, KDHE staff provided follow-up training to MCO staff to clarify criteria for each grievance and appeal category and increased staff review and response to MCOs related to apparent misclassifications. In Q3, with the increased KDHE staff review and input, there has been noticeable progress in reporting of grievances and appeals. While in past quarters, 30% or more of the grievances appeared to be categorized incorrectly (based on grievance descriptions and resolution details), in Q3 only 8% (43) of the grievances appeared to be misclassified (see Table 9). Seven additional grievances were also identified where members noted more than one grievance during their contact to the MCO, and one grievance was excluded as a duplicate, bringing the total number of grievances to 552 for the quarter. KDHE plans to schedule follow-up training to MCO staff to provide additional instruction and examples to further improve MCO comparability in categorizing grievances and appeals

Table 9. Comparison of Grievances as Categorized by MCOs and Based on Grievance Descriptions Q3 CY2017*

	As categorized by MCOs		Based on Grievance Descriptions	
	# grievances	# members	# grievances	# members
Billing and Financial Issues	112	106	110	104
Access to Service or Care	36	36	47	47
Quality of Care (non-HCBS)^	48	46	59	56
Quality of Care - HCBS	37	35	20	20
Customer Services	43	39	41	38
Pharmacy Issues	15	14	14	13
Member's Rights/Dignity	6	6	5	5
Value-Added Benefit	16	14	16	14
Transportation Issues	71	65	73	66
Transportation Safety	24	23	25	24
Transportation No Show	51	47	52	48
Transportation Late	70	61	72	62
Transportation No Driver Available	10	8	10	8
Other	4	4	8	6
Benefit denial or limitation#	1	1		
Health Plan Administration#	2	2		
Total	546	507	552	511

*Includes grievances received in Quarter 2 CY2017 resolved in Quarter 3 CY2017
^Includes 22 grievances categorized by UnitedHealthcare only as "Quality of Care"
#UnitedHealthcare added categories for grievances that should have been categorized using the State-specified categories.

Of the 552 grievances resolved in Q3 CY2017, 141 (26%) were reported by Amerigroup, 174 (32%) by Sunflower, and 231 (42%) by UnitedHealthcare. There were 24% more grievances reported in Q3

compared to Q2. UnitedHealthcare had the highest increase with 34% more grievances in Q3 compared to Q2. UnitedHealthcare also had the highest number of grievances in Q3 (234), 93 more than Amerigroup and 57 more than Sunflower.

Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 232 transportation-related grievances, up from 164 to 199 previous three quarters. Of the 232 transportation-related grievances, 44 (19%) were reported by Amerigroup, 80 (30%) were reported by Sunflower, and 108 (47%) were reported by UnitedHealthcare. The number of "No Show," "Late," transportation grievances continued to be high, with 52 "No Show" grievances and 72 "Late" grievances in Q3. Of concern, too, is the number of *Transportation – Safety* grievances (25 in Q3, up from 22 in Q2 and 13 in Q1. In Q3 MCOs also began reporting the number of transportation grievances due to no driver being available for the member, with 10 reported this quarter.

Of 552 grievances in Q3 (based on grievance descriptions), 199 (36%) were from 181 members receiving waiver services, up from 164 (148 members) in Q2 and 139 grievances (136 members) in Q1. Table 10 shows the number of grievances by category and by waiver group.

Table 10. Grievances Reported by Waiver Members Resolved in Q3 CY2017*

	Number of Grievances by Waiver Type^					
	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	5	1	12	2	1	2
Access to Service or Care		3	9	2	1	
Quality of Care (non-HCBS)		1	9	1	2	
Quality of Care - HCBS	4	2	10	2		1
Customer Service	2	7	8	1		1
Pharmacy Issues		2		1		
Member's Rights/Dignity			1		1	
Value-Added Benefit	3	1	3			
Transportation Issues	5	3	12	1	1	2
Transportation Safety	2		8			1
Transportation No Show	7		16			1
Tran sportation No Driver Available		2	4			
Transportation Late	5	3	19			2
Other		1	3			
Total	33	26	114	10	6	10

*Counts are based on grievances as described by MCOs.
^There were no grievances reported in Quarter 3 for Autism Waiver members.

As shown in Table 11, the percentage of transportation-related grievances was higher among waiver members in Q1–Q3 (48%–50%) compared to members not receiving waiver services (39%–42%). Of 199 grievances received from 181 waiver members in Q3, 94 (47%) were transportation-related, the highest in two years.

Table 11. Transportation-Related Grievances Resolved in Q1 to Q3 CY2017, by Waiver									
	# Grievances			# Transportation Related			% Transportation Related		
	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Physical Disability (PD)	71	90	114	41	51	59	58%	57%	52%
Frail Elderly (FE)	31	27	33	17	14	19	55%	52%	58%
Intellectual/Developmental Disability (I/DD)	11	28	26	4	7	8	36%	25%	31%
Traumatic Brain Injury (TBI)	13	6	10	5	4	6	38%	67%	60%
Serious Emotional Disturbance (SED)	8	9	10	2	1	1	25%	11%	10%
Technology Assisted (TA)	5	3	6	1	2	1	20%	67%	17%
Autism	0	1	0	NA	0	NA	NA	0%	NA
Waiver Member Grievances	139	164	199	70	79	94	50%	48%	47%
Non- Waiver Member Grievances	265	291	352	112	120	138	42%	41%	39%
All Member Grievances	404	455	552	182	199	232	45%	44%	42%

- Physical Disability (PD) Waiver members had the most grievances in Q3, with 102 members reporting 114 grievances, 59 transportation-related. This was an increase compared to the prior two quarters (Q2 - 90 grievances, 51 transportation-related; Q1 - 71 grievances, 41 transportation-related).
- Frail Elderly (FE) Waiver members (30) reported 33 grievances in Q3; 19 of the 33 grievances were transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members (24) in Q3 reported 26 grievances, comparable to Q2 (28 grievances) and higher than in Q1 (11 grievances); eight transportation-related.
- Traumatic Brain Injury (TBI) Waiver members (9) reported 10 grievances in Q3; six transportation-related.
- Technology Assistance (TA) Waiver members (6) reported six grievances in Q3; one transportation-related.
- Serious Emotional Disturbance (SED) Waiver members (10) reported 10 grievances in Q3, one transportation-related.

Access-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Access to Service or Care* criteria are those where "*Appointment availability, no providers available within distance standards, timeliness to get appointment, complaints about non-covered services (other than pharmacy), MCO system issue error – (eligibility not updated, TPL not current, processing error) difficulty finding HCBS provider*."

Of 552 grievances as categorized by MCOs in the Q3 GAR report, 36 were categorized as *Access to Service or Care.* Based on grievance descriptions, however, there were 47 in Q3 that may more appropriately meet the criteria for the *Access to Service or Care* category.

- Based on the GAR report criteria, two grievances categorized as *Access to Service or Care* may more appropriately be categorized as *Quality of Care (non HCBS, non-Transportation)* and one as *Transportation Issues*.
- Based on grievance descriptions, 14 grievances categorized as *Customer Services* (4), *Pharmacy Issues* (3), *Member Rights/Dignity* (1), *Quality of Care HCBS* (2), *Billing and Financial Issues* (1),

Quality of Care (1), and *Health Plan Administration* (2) (category added by UnitedHealthcare) may be better categorized as *Access to Service or Care*.

Although the number of access-related grievances in Q3 (47 grievances) was much higher than in Q1 and Q2 (13 and 16 grievances, respectively), this seems to be due to more accurate categorization of grievances by the MCOs. The State also clarified that "access-related" grievances should include grievances where members report providers refuse to continue to provide them with services and to grievances related to "lock-in" (where under certain circumstances members are required to use one specific pharmacy) that were previously often categorized as pharmacy issues or customer services.

Quality-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Quality of Care (non-HCBS, non-Transportation)* criteria are those where "*Provider/Staff error or neglect in delivery of any health care services, e.g., someone is hurt, or it is determined necessary to forward to the QOC department for investigation. Additional examples: someone is dropped during transfer, doctor operates on wrong site, wrong medication administered, neglect*."

Definitions and examples in the GAR report of grievances meeting *Quality of Care - HCBS* criteria are those where "*Provider/Staff error or neglect in delivery of any HCBS services, e.g., mistreatment of member, not providing service as specified in support plan or plan of care."*

Of 552 grievances categorized in the Q3 GAR report,47 were categorized by the MCOs as *Quality of Care (non-HCBS, non-Transportation)* or (by UnitedHealthcare) as *Quality of Care; and,* 37 were categorized as *Quality of Care – HCBS*. As described in the GAR report, 59 meet the criteria for *Quality of Care (non-HCBS, non-Transportation)* and 20 as *Quality of Care – HCBS.* Based on grievance descriptions:

- 12 grievances categorized as *Quality of Care – HCBS* should have been categorized as *Quality of Care (non-HCBS, non-Transportation).* This was primarily due to a mistakenly categorizing quality of care grievances received from members receiving waiver services as *Quality of Care – HCBS* even if the grievance was not related to HCBS services.
- 5 grievances categorized by the MCOs as *Quality of Care HCBS* may more appropriately be categorized as Access to Service or Care (2), Customer Services (2), and Other (1).
- 1 grievance categorized as *Quality of Care (non-HCBS, non-Transportation)* should have been categorized as *Quality of Care – HCBS.*
- 2 grievances categorized as *Quality of Care* may more appropriately be categorized as *Access to Service or Care* (1) and *Customer Services* (1).
- 2 grievances categorized as *Access to Service or Care* may be better categorized *as Quality of Care – (non-HCBS, non-Transportation).*

Follow-up on Previous Recommendations (Grievances)

- *MCOs should review transportation-related grievances to ensure those related to no-show, lateness, safety issues, and lack of provider availability are categorized appropriately.*
  Follow-up response: Based on grievance descriptions, transportation-related grievance categories, with only a few exceptions, have been categorized much more accurately than in prior quarters.
- *Each grievance should be categorized separately, even if the grievances are reported during one contact by phone or mail.*
  Follow-up response: Two of the MCOs this quarter have implemented this change, as demonstrated in their Q3 reporting. According to KDHE staff, one of the MCOs indicated they are not able to report more than one grievance if the grievance is already categorized as resolved. In the review of

grievance descriptions, there were seven additional potential grievances related to late transportation (members reporting more than one late transportation), rudeness of staff, and member discrimination based on religious beliefs.

- *Drop-down menus used by MCO staff categorizing grievances should be reviewed and updated to include the State-specified categories for classifying grievances and appeals.*
  Follow-up response: KDHE staff are working with the MCOs to create crosswalks to better compare State-specified categories with MCO corporate-directed drop-down menu categories.
- *UnitedHealthcare should identify whether QOC grievances are or are not HCBS-related.*
  Follow-up response: UnitedHealthcare again this quarter added a generic "Quality of Care" category and did not report any grievances as being specifically "non-HCBS, non-transportation related."

Recommendations (Grievances)

1. MCOs should make it a higher priority to ensure transportation is available timely and consistently for members.
2. The State should review the grievance categories to determine if additional examples should be included and to determine if additional categories may be needed.
3. UnitedHealthcare should categorize grievances using only the State-specified categories.

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 Q3 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. Information (as well as volunteer applications) is also available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office and is provided to members by mail and email as-needed.

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

The Ombudsman's office tracks contacts by contact method, caller type, by specific issues, by location (main office or satellite office). In Q3 CY2017, the Ombudsman's Office tracked 970 contacts, 41% more

than in Q3 CY2016. 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 12). In Q3, 218 (20%) of 1,079 issues addressed in 970 contacts to the Ombudsman's Office were MCO-related. The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.

Table 12. Issues tracked by Ombudsman's Office - All and MCO-Related, Q1 to Q3 CY2017

	CY2017								
	Q1			Q2			Q3		
	All	MCO Related	% MCO Related	All	MCO Related	% MCO Related	All	MCO Related	% MCO Related
Medicaid Eligibility Issues	236	29	12%	177	20	11%	**237**	**32**	**14%**
Medicaid Renewal	29	11	38%	43	13	30%	**38**	**17**	**45%**
Medicaid Application Assistance	46	1	2%	54	1	2%	**162**	**4**	**2%**
HCBS - Total	92	43	47%	93	47	51%	**91**	**34**	**37%**
HCBS General Issues	*33*	*18*	*55%*	*34*	*20*	*59%*	*21*	*11*	**52%**
HCBS Eligibility Issues	*46*	*18*	*39%*	*48*	*23*	*48%*	*58*	*20*	**34%**
HCBS Reduction in Hours of Service	*7*	*5*	*71%*	*2*	*1*	*50%*	*4*	*3*	**75%**
HCBS Waiting List	*6*	*2*	*33%*	*9*	*3*	*33%*	*8*	*0*	**0%**
Appeals, Grievances	36	18	50%	33	15	45%	**0**		
Appeals/Fair Hearing Questions/Issues								**9**	**31%**
Grievances Questions/Issues							**29**	**0**	
Medical Services	20	13	65%	23	13	57%	**11**	**6**	**55%**
Billing	21	7	33%	33	18	55%	**17**	**11**	**65%**
Durable Medical Equipment	2	2	100%	9	5	56%	**3**	**2**	**67%**
Pharmacy	10	5	50%	9	6	67%	**10**	**3**	**30%**
Care Coordinator Issues	5	5	100%	11	7	64%	**6**	**5**	**83%**
Transportation	8	7	88%	9	6	67%	**12**	**6**	**50%**
Nursing Facility Issues	38	5	13%	25	6	24%	**23**	**1**	**4%**
Housing Issues	4	1	25%	6	2	33%	**7**	**3**	**43%**
Access to Providers	14	11	79%	14	12	86%	**13**	**4**	**31%**
Change MCO	3	3	100%	1	1	100%	**2**	**1**	**50%**
Dental	7	1	14%	9	4	44%	**7**	**4**	**57%**
Client Obligation	17	6	35%	35	13	37%	**37**	**11**	**30%**
Spenddown Issues	18	4	22%	32	10	31%	**29**	**12**	**41%**
Medicare-related issues							**15**	**5**	**33%**
Coding Issues	3	2	67%	0	0	0%	**8**	**4**	**50%**
Moving to/from Kansas	5	1	20%	7	1	14%	**6**	**0**	**0%**
Other*	319	51	16%	373	61	16%	**316**	**44**	**14%**
Total Issues - All & MCO-Related	**933**	**226**	**24%**	**996**	**261**	**26%**	**1,079**	**218**	**20%**

* Includes issues categorized as "Other," "Affordable Care Act," Estate Recovery," "Guardianship," and "Unspecified"

The increase in the number of contacts in Q3 is attributed in part to be due to an increase in outreach to providers and public health clinics by the Ombudsman's Office Volunteer Coordinator and Project Coordinator to let them know services available through the Ombudsman's Office for KanCare members. In Q3, the Ombudsman's Office responded to 162 requests for Medicaid application assistance, up from 54 reported in Q2.

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 13, there were 133 waiver-related contacts in Q3. The most frequent waiver-related issues in Q3 were related to the I/DD Waiver (52), FE Waiver (33), and PD Waiver (32).

Table 13. Waiver-Related Inquiries to Ombudsman, Q1 CY2016 to Q3 CY2017

Waiver	CY2016				CY2017		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Intellectual/Developmental Disability (I/DD)	48	27	21	11	43	27	**52**
Physical Disability (PD)	48	22	13	9	40	37	**32**
Technology Assisted (TA)	10	9	4	4	8	10	**2**
Frail Elderly (FE)	23	19	10	7	30	27	**33**
Traumatic Brain Injury (TBI)	10	3	7	5	6	8	**7**
Serious Emotional Disturbance (SED)	4	0	1	3	4	4	**5**
Autism	1	2	2	1	3	2	**2**
Money Follows the Person (MFP)	8	5	3	0	2	1	**0**
Total	**152**	**87**	**61**	**40**	**136**	**116**	**133**

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.

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. The State should consider making the quarterly GAR reports 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, where applicable.

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q3 CY2017, 99.1% of the 79,473 customer service inquiries from members and 99.7% of the 39,586 provider customer service inquiries received by the MCOs were resolved within two business days.
- In Q3 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days.
- Amerigroup and Sunflower met the contractual requirements to resolve 100% of inquiries within 15 business days. UnitedHealthcare reported 99.7% of member inquiries and 99.99% of provider inquiries were resolved within 15 days; 86 member inquiries and three provider inquiries in Q3 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 number of inquiries from members in Q3 was the lowest number since MCOs began reporting in Q2 2014.
  - Of the 79,473 customer service inquiries from members in Q3 CY2017, 41% were received by Sunflower, 38% by UnitedHealthcare, and 21% by Amerigroup.
  - 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 "GAR" grievance reports KDHE is revising the Customer Services Inquiries template to exclude the member inquiry category *"concern with access to service or care; or concern with service or care disruption."* In training to MCO staff in September 2017 and onsite meetings with MCO customer service managers, KDHE stressed the importance of forwarding inquiries that potentially meet grievance or appeal criteria to appropriate MCO staff for follow-up.
  - Benefit inquiries were the highest percentage (20%) of member inquiries in Q3.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. 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 39,586 provider inquiries received by MCOs in Q3 CY2017, Amerigroup received 41%, Sunflower 48%, and UnitedHealthcare 11%.
  - Claim status inquiries were again the highest percentage (51%) of provider inquiries.
  - Categories where two-thirds or more of the provider inquiries in Q3 were reported by only one MCO included: *Authorization – New*, *Authorization – Status*, *Update demographic information*, *Benefits inquiry,* and *Claim payment question/dispute*.
  - 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. In the last three quarters, for example, UnitedHealthcare reported 60-70% fewer overall claims-related provider inquiries than Amerigroup and Sunflower during the same reporting periods.

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 Q2 CY2017, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,191,868 clean claims received in Q1 CY2017, however, 99.98% were processed within 30 days. Of the 1,039 clean claims not processed within 30 days – 82 (8%) were claims received by Amerigroup; 535 (51%) were claims received by Sunflower; and 422 (41%) were claims received by UnitedHealthcare.
- In Q2 CY2017, Amerigroup and Sunflower met the contractual requirement of processing at least 99% of the non-clean claims within 60 days. UnitedHealthcare met the requirement in April and May, but reported they processed only 95.5% of non-clean claims in June.
- Of 4,343,212 "all claims" received in Q2 CY2017, 99.997% were processed within 90 days. UnitedHealthcare reported they met the requirement of processing 100% of claims within 90 days. Amerigroup reported that 99.993% of all claims were processed within 90 days, and Sunflower reported 99.998% were processed within 90 days.
- In 2015 and 2016, the State's pay-for-performance program included incentives to process 99.5% of clean claims within 20 days (instead of the contractually required 30 days) and to process 99% of all claims within 60 days (instead of the contractually-required 90 days). During the annual performance measure validation process for the claims-related P4P claims metrics, KFMC found some differences by each of the MCOs in interpretation of reporting criteria for claims processing timeliness. MCOs each made corrections in their reporting processes that will now allow more accurate aggregation of the three MCOs' quarterly claims data. The claims data reported to date for 2017, however, have not yet been updated to reflect the criteria revisions.

Turnaround time (TAT) ranges for processing clean claims

- In Q3 CY2017, the MCOs reported processing of 4,090,819 clean claims (including 1,445,711 pharmacy claims).
- The average TAT for Total Services (excluding pharmacy claims) was 6.4 to 9.0 days in Q3 CY2017, compared with 5.5 to 9.9 days in Q2 and 5.3 to 9.7 in Q1. Amerigroup overall TAT of 6.4 to 7.2 was again shortest, compared to Sunflower (8.5 to 9.0) and UnitedHealthcare (8.7 to 8.9).
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - **Hospital Inpatient** claims had TATs in Q3 CY2017 ranging from 10.3 to 12.9 days, (compared to 6.0 to 15.6 days in Q2). UnitedHealthcare had the biggest decrease from Q2 (14.5 to 15.6 days) to Q3 (10.7 to 12.9 days.
    - **Medical** claims had monthly TATs in Q3 ranging from 6.0 to 8.8 days.
    - **Nursing Facility** claims had TATs ranging from 4.8 to 10.0 days in Q3.
    - **Dental** claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 7.0 to 13.0 days in Q3 CY2017. Sunflower had the shortest TATs (7.0 to 8.0 days); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q2 CY2016 and the previous seven quarters.
    - **Behavioral Health** claims TATs ranged from 4.6 to 9.4 days in Q3 CY2017. Amerigroup had the shortest TATs (4.6 to 5.7 days), compared to Sunflower (8.1 to 9.1 days) and UnitedHealthcare (8.6 to 9.4 days).
    - **Vision** - The average monthly TATs for Vision in Q3 ranged from 6.0 to 12.7 days. Amerigroup had the shortest monthly TATs (6.0 days), compared to Sunflower (12.0 days) and UnitedHealthcare (12.0 to 12.7 days).

Grievances

- In Q3 CY2017, 99.5% (543) of 546 grievances reported by the MCOs as resolved in Q3 CY2017 were reported as resolved within 30 business days, and 100% were reported to be resolved within 60 business days.
- KDHE has increased staff review and response to MCOs related to apparent misclassification of grievances and appeals, provided training to MCO staff in September, and plan to provide additional training and direction to promote more accurate and consistent reporting.
- Of the 552 grievances reported by MCOs as resolved in Q3:
  - 141 (26%) were reported by Amerigroup, 177 (32%) by Sunflower, and 234 (42%) by UnitedHealthcare.
  - There were 24% more grievances reported in Q3 compared to Q2. UnitedHealthcare had the highest increase with 34% more grievances in Q3 compared to Q2. UnitedHealthcare also had the highest number of grievances in Q3 (234), 93 more than Amerigroup and 57 more than Sunflower.
  - 36 grievances were categorized in the GAR report as *Access to service or care*. Based on grievance descriptions, however, there were 47 in Q3 that met the criteria for the *Access to Service or Care* category.
  - 85 grievances were categorized by MCOs as being related to quality of care: 26 as *Quality of Care (non-HCBS, non-Transportation),* 37 *Quality of Care – HCBS*, and 22 as *Quality of Care.* (UnitedHealthcare did not report whether the 22 quality of care grievances were or were not HCBS-related, as had been directed by the State.) Based on grievance descriptions, however, there were 79 grievances related to quality of care: 59 *Quality of Care (non-HCBS, non-Transportation)* and 20 *Quality of Care – HCBS.*
- Transportation-related grievances continued to be the most frequently reported grievances.
  - MCOs reported resolution of 232 transportation-related grievances, up from 164 to 199 the previous three quarters.
  - The number of *Transportation No Show, Transportation - Late,* and *Transportation – Safety* grievances continued to be high, with 52 *Transportation – No Show* grievances, 72 *Transportation – Late* grievances, and 25 *Transportation – Safety* grievances in Q3.
  - In Q3 MCOs also began reporting the number of transportation grievances due to no driver being available for the member, with 10 reported this quarter.
- In Q3, 199 (36%) grievances were from 181 members receiving waiver services, up from 164 (148 members) in Q2 and 139 grievances (136 members) in Q1; 47% of the grievances reported by waiver members were transportation-related.

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.
- In Q3 CY2017, the Ombudsman's Office tracked 970 contacts, 41% more than in Q3 CY2016.
- In Q3, 218 (20%) of 1,079 issues addressed in 970 contacts to the Ombudsman's Office were MCO-related.
- The most frequently reported MCO-related issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues.
- The most frequent waiver-related issues were related to the I/DD Waiver (52 in Q3), PD Waiver (32 in Q2), and FE Waiver (33 in Q2).

Recommendations Summary

Timely Resolution of Customer Service Inquiries

1. The State should implement the revised Customer Service Inquiries reporting template (that excludes the *"Concern with access to service or care; or concern with service or care disruption"* reporting option) by Q1 CY2017, if possible.
2. The State should consider reviewing a sample of inquiries categorized to date as *"Concern with access to service or care; or concern with service or care disruption"* to ensure those that have met grievance or appeal criteria have had appropriate follow-up.
3. The State should consider requiring MCOs to report the monthly number of contacts in addition to the monthly number of issues addressed during each contact to better ensure consistency in reporting and to better analyze the numbers and types of member and provider inquiries over time.

Timeliness of Claims Processing

1. MCOs should update their monthly claims processing reports for 2017 and annual totals for 2016 to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days). The State should provide guidance to the MCOs as to the time periods for which claims data should be updated.
2. The State should provide additional direction to the MCOs as to appropriate reporting of 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 which monthly reports should be updated to include processing of newborn claims previously excluded from the 90-day processing requirement.

Grievances

1. MCOs should make it a higher priority to ensure transportation is available timely and consistently for members.
2. The State should review the grievance categories to determine if additional examples should be included and to determine if additional categories may be needed.
3. UnitedHealthcare should categorize grievances using only the State-specified categories.

Ombudsman's Office

1. The State should consider making the quarterly GAR reports 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, where applicable.

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	27,267	$1,253,418,911.92	3,981	$241,423,361.92	14.60%
Hospital Outpatient	248,091	$664,578,517.19	30,562	$74,194,567.91	12.32%
Pharmacy	1,421,903	$113,171,055.47	375,768	Not Applicable	26.43%
Dental	98,870	$27,435,193.54	6,805	$1,885,162.44	6.88%
Vision	60,336	$16,194,192.58	9,719	$2,922,019.78	16.11%
NEMT	85,898	$3,254,725.91	369	$19,189.14	0.43%
Medical (physical health not otherwise specified)	1,423,893	$845,786,492.32	172,770	$115,980,677.35	12.13%
Nursing Facilities-Total	68,790	$167,852,896.93	4,157	$12,714,032.16	6.04%
HCBS	144,811	$92,288,461.53	7,851	$6,436,633.78	5.42%
Behavioral Health	494,337	$67,864,328.93	43,145	$5,747,620.46	8.73%
Total All Services	4,074,196	$3,251,844,776.32	655,127	$461,323,264.94	16.08%

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	29,216	$1,163,215,799	6,722	$318,260,113	23.01%
Hospital Outpatient	256,935	$656,944,382	38,693	$103,586,257	15.06%
Pharmacy	1,869,693	$235,875,874.44	777,411	$140,150,716.14	41.58%
Dental	113,711	$29,332,249.22	11,139	$2,183,619.28	9.80%
Vision	70,752	$16,528,995.15	8,501	$2,025,127.81	12.02%
NEMT	122,653	$3,359,911.99	1,730	$51,680.90	1.41%
Medical (physical health not otherwise specified)	1,303,343	$650,502,284	152,967	$104,340,766	11.74%
Nursing Facilities-Total	99,037	$223,181,904	8,969	$28,209,133	9.06%
HCBS	437,419	$221,906,196	17,206	$9,581,236	3.93%
Behavioral Health	548,096	$82,793,083	47,254	$8,002,573	8.62%
Total All Services	4,850,855	$3,283,640,679	1,070,592	$716,391,221	22.07%

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	21,188	786,582,845	4,807	215,211,703	22.69%
Hospital Outpatient	239,699	655,155,577	46,981	146,112,867	19.60%
Pharmacy	1,342,794	$95,180,556.00	308,894	$71,206,295.99	23.00%
Dental	106,042	$29,136,848.61	8,316	$2,353,502.83	7.84%
Vision	62,164	$12,639,676.54	5,937	$1,217,218.55	9.55%
NEMT	135,629	$3,569,237.48	1,958	$53,171.73	1.44%
Medical (physical health not otherwise specified)	1,356,404	675,743,895	192,909	165,136,632	14.22%
Nursing Facilities-Total	71,058	189,266,040	10,334	30,824,203	14.54%
HCBS	309,266	111,705,727	16,366	7,033,950	5.29%
Behavioral Health	317,453	94,854,594	20,797	12,701,902	6.55%
Total All Services	3,961,697	$2,653,834,997	617,299	$651,851,445	15.58%