Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.13

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2013-12/31/2013)
Federal Fiscal Quarter: 1/2014 (10/13-12/13)

Table of Contents

I. Introduction

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

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare & Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017.

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

This five year demonstration will:

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

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

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;

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

This quarterly report is submitted pursuant to item #79 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued with regard to the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the fourth quarter known as of January 31, 2014.

Demonstration Population	Enrollees at Close of Qtr. (12/31/13)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	17,550	18,371	821
Population 2: ABD/SD Non Dual	29,030	29,851	821
Population 3: Adults	33,702	35,993	2,291
Population 4: Children	213,376	217,107	3,731
Population 5: DD Waiver	8,764	8,806	42
Population 6: LTC	21,192	22,317	1,125
Population 7: MN Dual	1,145	1,274	129
Population 8: MN Non Dual	993	1,133	140
Population 9: Waiver	4,267	4,352	85
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**330,019**	**339,204**	**9,185**

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 implementation activities, as well as the Section 1115 demonstration itself, is provided in the interest of transparency and engagement. In addition, the KanCare Advisor, the State's electronic implementation newsletter, is distributed to about 300 individual subscribers and various provider and consumer associations. Newsletters were distributed in the fourth quarter of the Demonstration Year on December 19, 2013. In addition to distribution to subscribers, the Advisor is also available on the KanCare website.

Open enrollment for the KanCare program was initiated during this quarter. In mid-November KDHE started mailing out Open Enrollment Packets for KanCare consumers. This was the first Open Enrollment Period for KanCare (after initial enrollment) and included most everyone that started in the KanCare program in January 2013. All the packets were delivered to the consumers before December 1st and members have until March 4th to change their KanCare MCO plan. Members who do not want to change their plan do not have to take any action and will remain in their current MCO. The Open Enrollment Packet can be found on the KanCare website.

During the fourth quarter, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: Oct 1 (9 attendees), November 12 (12 attendees), December 11 (10 attendees).

Also during this quarter, the state's Kancare Advisory Council held the first meeting of the newly appointed council on December 18, 2013, in Topeka at the State Capitol Building. The 2013 Advisory Council consists of 11 members. 2 legislative members representing the house and senate, 1 member representing mental health providers, 1 member representing CDDOs, 1 member representing physicians and hospitals, 2 members representing KanCare members, 1 member representing Prairie Band Potawatomi Nation, 1 member representing the developmentally disabilities community, 1 member former Kansas Senator, 1 member representing pharmacists. An additional member representing hospitals has also been appointed. The agenda for the council's December meeting:

I. Welcome – Dr. Susan Mosier
II. Introductions – Secretary Dr. Bob Moser
III. Update on KanCare
    a. KanCare Overview – Division Director Kari Bruffett
    b. Health Homes - Rebecca Ross
    c. Amerigroup Kansas – Laura Hopkins
    d. Sunflower State Health Plan – Jean Rumbaugh
    e. United Healthcare Community Plan – Tim Spilker
    f. Consumer and Specialized Issues Workgroup - Russell Nittler
    g. Provider and Operational Issues Workgroup - Paul Endacott
    h. Tribal Technical Advisory Group – Division Director Kari Bruffett
    i. I/DD Pilot - Secretary Shawn Sullivan
IV. Advisory Council Organizational Items
    a. Council Chair
    b. Future Meetings

V. Input from Council Members
VI. Next Meeting of KanCare Advisory Council – Wednesday, March 26, 2014, 2:00-3:30 p.m., Curtis State Office Building, Room 530
VII. Adjourn

Another innovative program option Kansas has been developing as part of the KanCare program relates to the use of Health Homes. A summary of that developing option follows:

Kansas intends to implement the Medicaid Health Homes State Plan option that will include two target populations that are covered within the KanCare program. The following briefly describes the state's work on this initiative.

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented July 2014
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, like CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012
- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services
    - Identifying the first target group, approximately 36,000 adults and children with SMI
    - Determining the goals for health homes and selecting quality measures, including eight required by CMS
    - Defining the provider qualifications and standards
    - Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
    - Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
    - Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
    - Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
    - Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
    - Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
    - Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures

and other components of the project
    - Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm)
    - Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
    - Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
    - Making presentations at various provider association conferences and meetings about the project
    - Holding an educational webinar for interested providers
- Tasks completed since the last report:
    - Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
    - Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
    - Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
    - Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
    - Scheduling through CCSR twice monthly webinars for providers interested in becoming HHPs
    - Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes
    - Setting dates for and sending out invitations for the Health Homes consumer tour (March 3-6 and 11-12)
    - Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
    - Creating an informational brochure to help inform consumers about Health Homes
    - Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Tasks still to complete include:
    - Refining the PMPM rate – draft rate is being reviewed internally
    - Developing program manuals for both SMI and chronic conditions (CC) Health Homes
    - Developing the components the State wants the health plans to include in their contracts with HHPs
    - Consulting with SAMHSA for the second, chronic conditions, SPA
    - Performing an operational readiness review of the MCOs
    - Developing reporting requirements
    - Final submission of both SPAs

In addition, routine and issue-specific meetings continued by state staff with a broad range of providers, associations, advocacy groups and other interested stakeholders. Examples of this include:

- Series of workgroup meetings between the Managed Care Organizations and the Community Developmental Disability Organizations (CDDO) to identify and address decision areas related to

the integration of long-term supports and services for IDD into KanCare.

- Targeted case manager and community service provider trainings in October.
- IDD KanCare Educational Tour for consumers in eight locations across Kansas.
- Care Coordination Summits with Nursing Facilities and Assisted Living Facilities.

- Series of behavioral health institution meetings to improve admission screening and gatekeeping functions.
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to improve coordination of transitions between inpatient and outpatient care.
- Regular ongoing meetings with KDADS stakeholders such as the Association of Community Mental Health Centers.
- KanCare's Provider and Operational Issues Workgroup
- KanCare's Consumer and Specialized Issues Workgroup

In the second quarter, Wichita State University's CSSR facilitators prepared a report and made five recommendations, which the State addressed and applied during third quarter activities. Additional activities occurred during the fourth quarter to continue stakeholder engagement.

The result of the activities related to the CCSR recommendations included the following activities:

- Additional training and clarification of care coordination and case management for integration of LTSS for IDD into KanCare in 2014.
- Consumer communication letters were edited by the Friends and Family Advisory Council and provided key
- Educational Tour was less about presentation and became more of a open house, question and answer venue for consumers and their support teams
- Consumer information is centralized in one location on the KDADS website (www.kdads.ks.gov) to make it easier for consumers, family and friends would be able to find information about IDD and KanCare (provider enhancements will occur in the next quarter)
- Lunch and Learn calls were added for both consumers and providers to ensure a forum for addressing key issues with the MCOs was consistently available. CCSR facilitates these calls.
- Weekly IDD Provider Bulletin began in December 2013 to provide IDD community service providers, targeted case managers, assessors, and CDDOS with up-to-date information about the KanCare, IDD issues, billing and claims, and other issues that arise on the twice weekly Lunch and Learn calls

A summary of 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:

Amerigroup participated in over 200 events for the fourth quarter, allowing them to spread their message regarding education of services and benefits of the KanCare program to thousands of Kansans. They continue to keep focused on building relationships and learning more about the value they can

bring to the community, especially with the I/DD population. Examples of marketing activities include exhibits at conferences, community held events, and meetings with key community partners. A sample of events they supported in fourth quarter include (but are not limited to):

- KDADS Friends and Family Tour for members on the I/DD waiver
- NAMI Conference
- Leading Age Nurse Leadership Conference
- Celebrating Healthy Families - Coalition of Hispanic Women Against Cancer

Outreach Activities: Fourth quarter activity has a continued focus on welcoming Amerigroup's newly enrolled members, gathering information about their members through the health risk assessment and reminding members about the importance of key services such as EPSDT. They continue to provide education to their members. Outreach activity is provided through a variety of means such as phone calls and mailings. Similar to last quarter, they have provided a variety of outreach educational topics. For example:

- They shared information regarding Amerigroup's nurse on call line to members who have utilized the emergency room for non-emergent services.

Advocacy Activities: Amerigroup's advocacy efforts continue to be broad based to support the needs of their general population, pregnant women, children, people with disabilities, and the elderly. Their staff is engaged at the local level with committees, coalitions, and boards of various non profit organizations that have a similar focus and mission. This quarter they participated in educating members, families, caregivers, targeted case managers, and providers on the implementation of HCBS services for members with intellectual and developmental disabilities. Amerigroup hopes that through their advocacy they are able to improve the quality of life of their members. They continue to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process.

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

Marketing Activities: Marketing staff visits with and maintains relationships with media representatives throughout the state. A media log is maintained and media inquiries are reported to the state. Social media sites have been developed and launched December 31. Maintaining the website is vital in educating members and providers on the plan and services.

- Email marketing system has been initiated to better inform providers and members of updates and happenings at the State and the plan. Database of email addresses has grown by 200% since inception.
- External newsletters were developed, posted on the website and distributed for Members and Providers.
- Presentations and informational sheets continually updated for population-specific presentations and events (i.e., new moms, IDD)
- Sponsorships and partnerships with local organizations continues to be a top priority, garnering relationship building and positive exposure (i.e., InterHab Conference, KAMU Conference, KACE conference and local health fairs)

Outreach Activities: Sunflower averages about 10 outreach events and presentations each week throughout the state. The calendar of events is submitted on a monthly basis to the state. MemberConnections staff make regular visits to local ADRCs, CDDOs, Nursing Facilities, Independent Living Resource Centers, etc. to make sure Sunflower is meeting the needs of the organization and their members.

Advocacy Activities: Sunflower is heavily involved with advocacy groups and works with them to educate community members on changes in KanCare and services offered by Sunflower. They continue to seek and utilization ways to share resources and maximize services to members. These include:

1. Sunflower State has actively participated in the I/DD Pilot Project and the implementation process of the DD inclusion plan. They have dedicated staff members who attend all rallies and meetings regarding this population and communicate with the organization. Welcome letters have been sent to and a special section of the website has been dedicated to this population.
2. Partnership initiated with the Disability Caucus and the Independent Living Resource Center in Sedgwick County to join forces in raising awareness on their program at locations across the state.
3. Monthly meetings held with health departments and CDDOs to find out best ways to partner and disseminate information.
4. Project and communications plans developed for DD and Health Home inclusions. Incorporates communications needs and event planning needs.
5. Plans in process for Adopt-A-School and Birthday party events beginning Q1 2014.
6. New Mom/Baby shower event held in Q3. 2014 plan for quarterly baby showers.
7. Promoting the Work Program. Coordinating symposium/disability caucus to feature the benefits of employment to those with developmental disabilities.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UnitedHealthcare's main activities have been focused on education with regard to the continued emphasis of health and benefit literacy regarding the UnitedHealthcare Community Plan of Kansas members. They did this through attendance at community events that attract their membership base, member welcome calls, mailings to those they could not reach by phone, and sending out the fourth Member Newsletter to their membership. UnitedHealthcare has also begun the process of contacting key Medicaid medical provider offices to provide them with education on the benefits that their members can achieve by completing their health screenings.

Outreach Activities: UnitedHealthcare has three outreach specialists focused on activities targeted within a geographic area of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, their work with KanCare and the benefits of their plan. They especially inform individuals about UnitedHealthcare's value added benefits. They also have a Provider Marketing Manager whose role is to work with key provider offices

throughout the State to assist them with issues regarding the transition to KanCare and to make sure they are educated on the benefits of UnitedHealthcare for members who visit their offices.

- During the fourth quarter of 2013, UnitedHealthcare staff personally met with 4,781 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.

- During the fourth quarter of 2013, UnitedHealthcare staff personally met with 523 individuals from community based organizations located throughout Kansas. These organizations work directly with UnitedHealthcare's members in various capacities.

- During the fourth quarter of 2013, UnitedHealthcare staff personally met with 838 individuals from provider offices located throughout the State.

Advocacy Activities: UnitedHealthcare's activities in advocacy are again focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with developmental disabilities. They have one Outreach Specialist focused specifically on working with individuals who touch Kansans with disabilities.

- Their outreach specialist to the disabled community personally visited with 96 advocates for the disabled in Kansas, providing them with education on KanCare and UnitedHealthcare benefits.

- The outreach specialist also worked in conjunction with the Empower Kansas steering committee on collecting more RFP's to award grantees in early 2014.

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, and a number of amendments have been submitted to CMS related to the three existing KanCare MCOs. As the State reported to CMS during monthly conference call updates, there have been a variety of concerns regarding systems and reporting issues, in line with expectations of a transition of this magnitude. Through a variety of accessible forums and input avenues, the State has been advised of these types of issues on an ongoing basis and worked 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. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues impacting timely and accurate reimbursement; and claims projects to assess and correct systemic issues.

   Kansas completed the periodic (first daily, then several times weekly, and then weekly) KanCare

Rapid Response calls with providers, members and advocates. Since that time, additional attention has been paid to evaluating the ongoing support activities and customer support performance of the MCOs. As that process came to a conclusion, Kansas conducted focused reviews of key infrastructure issues at each of the MCOs, to validate performance and help ensure strong performance as we shift to the longer term operation of the program. Based on experience in the first two quarters, the areas selected for more intensive desk review and onsite review included: customer service, provider credentialing, grievance/appeal management, prior authorization timeliness and accuracy, and TPL/client obligation/spend down processes. That focused review was conducted during the third quarter, and results of the review were developed and provided to the KanCare MCOs. Overall performance in the focused review met expectations, but also led to action items to enhance performance and compliance. Those focused review items are being incorporated into the comprehensive annual compliance reviews of the MCOs – which are being done in partnership between Kansas' External Quality Review Organization and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. Those annual reviews, which address both MCO regulatory requirements and many key state contract requirements, began in the fourth quarter of 2013 and will be completed in the first quarter of 2014.

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 used, per KanCare MCO's top three value-added services by reported value and total, January-December, 2013:

MCO	Value Added Service	Units	Value
Amerigroup	Member Incentive Program	10,102	$293,175
	Adult Dental Services	2,780	$262,734
	Mail Order OTC	7,163	$115,724
	Total of all Amerigroup VAS Jan-Dec 2013	*42,959*	*$989,122*
Sunflower	CentAccount debit card	75,060	$1,501,200
	SafeLink®/Connections Plus cell phones	10,923	$522,447
	Adult Dental Services	20,316	$397,721
	Total of all Sunflower VAS Jan-Dec 2013	*1,087,843*	*$3,074,781*
United	Additional Vision Services	26,865	$1,147,095
	Incentive Program for KAN Be Healthy Screening	47,559	$475,590
	Adult Dental Services	4,099	$212,870
	Total of all United VAS Jan-Dec 2013	*94,414*	*$2,206,242*
Combined Totals	**All MCOs - Jan-Dec 2013**	*1,225,216*	$6,270,145

c. Enrollment issues: For the fourth quarter of 2013, 1 American Indian/Alaska Native chose to not be enrolled in KanCare per the opt-out provision available to AI/AN members, for a total of 15 since January 1, 2013. The table below represents the enrollment reason categories for the fourth quarter of calendar year 2013 (months October, November and December). All KanCare eligible members are defaulted to a managed care plan.

Start Reasons	Total
Newborn assignment	9
Administrative change	20
WEB - Change Assignment	13
KanCare Default - Case Continuity	242
KanCare Default - Morbidity	533
KanCare Default - 90 Day Retro-reattach	254
KanCare Default - Previous Assignment	283
KanCare Default - Continuity of Plan	3249
Choice - Enrollment into KanCare MCO via Medicaid Application	662
Change - Enrollment Form	437
Change - Choice	815
Change - Access to Care - Good Cause Reason	27
Change - Case Continuity - Good Cause Reason	2
Assignment Adjustment Due to Eligibility	20
Total	**6,566**

d. Grievances, appeals and state hearing information

KDHE Grievance Data Base

Members – CY13 4th quarter report

MCO	Access	Pharmacy	Benefit and Billing	Quality of Care	Rights and Dignity	Eligibility	Spenddown	Authorization or Referral	Dental Billing
Amerigroup	7	19	38	2	0	40	34	3	0
Sunflower	13	40	34	0	1	36	16	2	0
United	13	21	32	2	0	46	6	9	1

Providers – CY13 4th quarter report

MCO	Access	Enrollment	Dental Billing	Pharmacy	Benefits and Billing	Eligibility	Spenddown	Authorization or Referral
Amerigroup	0	1	5	15	81	7	1	6
Sunflower	2	27	2	3	51	9	2	13
United	0	13	1	14	47	5	2	2

MCOs Database

Member Grievances – CY13 4th quarter report

MCO	Access	Quality	Benefits	Billing	Transportation	Pharmacy	Waiver Service	DME
Amerigroup	24	45	22	33	34	17	37	3
Sunflower	3	32	8	4	52	0	0	0
United	39	0	0	35	43	0	0	0

Member Appeals – CY13 4th quarter report

MCO	Access	Dental	Benefits	DME	Home Health	Pharmacy	Waiver Service	OT/PT/speech	Billing
Amerigroup	27	0	2	2	0	0	0	0	0
Sunflower	36	0	18	16	0	42	0	0	5
United	8	0	5	8	0	12	85	1	1

Provider Appeals – CY13 4th quarter report

MCO	Access	Benefits	Billing
Amerigroup	19	21	2,614
Sunflower	9	66	75
United	0	0	147

State of Kansas Office of Administrative Fair Hearings:

Members – CY13 4th quarter report

State Fair Hearings	MCO reversed decision before hearing	OAH reversed MCO decision	Appellant withdrew	Appellant did not appear	OAH affirmed MCO decision	Pending Decision
Amerigroup	2	0	1	0	4	0
Sunflower	8	0	3	2	3	0
United	2	0	1	0	3	0

Providers – CY13 4th quarter report

State Fair Hearings	MCO reversed decision before hearing	Appellant withdrew	Appellant did not appear	OAH reversed MCO decision	OAH affirmed MCO decision	Pending Decision
Amerigroup	57	6	0	3	6	22
Sunflower	9	7	0	0	15	0
United	8	1	0	0	7	0

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

f. Access: During the fourth quarter, the decrease in members' requests to change MCO plans continued. As discussed 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 the fourth quarter, KDHE received 156 member requests to change health plans, down from 225 requests in the third quarter. Seventeen of the 18 change requests approved in November are from the same provider group that had to that point declined to contract with one of the MCOs and announced they would stop seeing beneficiaries out of network. By December the provider group had signed contracts with all the Plans.

As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period based solely on the member's preference, when other participating providers with that MCO are available within access standards, are denied as not having good cause. The MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the 4th quarter, there were no state fair hearings filed for a denied GCR.

Status	October	November	December
Total GCRs filed	40	50	66
Approved	2	18	3
Denied	21	6	10
Withdrawn (resolved, no need to change)	16	21	50
Dismissed (due to inability to contact the member)	1	5	3
Pending	0	0	0

There are still providers being added to the Plans' networks with much of the effort being focused on providers of I/DD services in preparation for readiness and service launch. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/26/13	# of Unique Providers as of 6/30/13	# of Unique Providers as of 9/12/13	# of Unique Providers as of 12/31/13
Amerigroup	11,746	16,706	16,891	17,352
Sunflower	10,006	13,016	14,478	15,404
UHC	11,105	14,738	15,893	18,010

In November and December, there was concern that one hospital and physician provider system in central Kansas had not contracted with one of the MCOs, and this particular provider system sent a letter to their KanCare patients advising them to change plans during their open enrollment period. However, the provider and the MCO were able to come to a contracting agreement late in December.

There are still provider confirmation issues around eligibility during the short time between when beneficiaries are deemed eligible for KanCare and when the MCOs and their subcontractors receive and load the eligibility files (within 24 hours for the MCOs and 48 hours

for subcontractors). KDHE and the MCOs continue to educate providers on preferred alternatives to confirm eligibility (calling the fiscal agent, or checking the KMAP website) and the fiscal agent call center processes escalated eligibility inquiries through the MCOs to the requesting provider.

g. Proposed changes to payment rates: Effective October 1, 2013, the KanCare capitation rates were adjusted to reflect the following rate updates:
    - Hospice Payment rates for FFY 2014;
    - PRTF per diem rate changes;
    - State institution Mental Health Rates for SFY 2014;
    - SNF rates;
    - DRG program changes;
    - GME cost factors.

h. MLTSS implementation and operation:
    - KDADS staff continued to hold a stakeholder workgroup that included MCO staff every two weeks to address the conversion of the SUD integrated data system to KDADS software. The workgroup is in the informational gathering stage with hopes of a 10/1/2014 implementation date.
    - During the fourth quarter, the State combined weekly Complex Case Staff meetings for behavioral health and home and community based services into bi-weekly meetings with KDADS staff for both units in attendance. These meetings allow the State to provide oversight and support to the MCOs when dealing with cases that require complex coordination, clarification of policies and procedures, or additional review before reaching a conclusion. The state has invited the Juvenile Justice Authority (JJA) and the Department for Children and Families (DCF) to attend these meetings when it involves cases in which they have primary responsibility to support the coordination or care for members more effectively.
    - The FMS Workgroup submitted a formal recommendation to change the financial management service from the Agency with Choice model to the Fiscal/Vendor Agent Model. This proposal includes a recommendation to retain information and referral activities under the fiscal agent approach but consider removing the requirement for the FMS provider to pay worker's compensation and unemployment. The recommendation is being reviewed by the Secretary of KDADS and will be considered in the first quarter of year two before a formal amendment will be submitted.
    - State staff attended the National Association for State Directors of Developmental Disability Services (NASDDDS) conference in November 2013. This annual training providers important information to State staff and connections with other states that are interested in improving their systems for those with IDD
    - The State, the Electronic Visit Verification (EVV) contractor and MCOs have partnered to

identify and resolve any lingering billing issues presented by providers. The EVV contractor works as a liaison with providers to ensure appropriate MCO authorizations that assure the integrity of service delivery and timely billing. Updates were made to the EVV system in July to accommodate MCO reporting requests. The EVV contractor has met with MCOs and providers to gather suggestions for future enhancements that will leverage additional savings to the State and its partners in their delivery of HCBS in Kansas. That proposal has been presented to the State. Additional updates to the system are expected over the next few months.

- The Program for All-Inclusive Care of the Elderly (PACE) has continued plans for expansion of PACE services to other counties in Kansas. KDADS and KDHE met to discuss possible terms of PACE contracted entities. One of the PACE organizations also met with CMS to reach an agreement on a Corrective Action Plan. PACE staff will continue to meet with CMS and KDHE in the first quarter of the second year of KanCare when a contract should be finalized and given to PaCE providers to sign.
- There were 384 Plans of Care (POC) Reduction requests in the fourth quarter of KanCare. The number of requests decreased significantly from the third quarter (949). The majority of the requests came from Sunflower State Health (203) and for the Physical Disability program (254). Generally the requests for reduction for PD were related to the standard application of existing policy related to the existence of a capable person in the home.

Total Requested	Total Approved	Total Denied	Under Review	Returned for More Info
384	305	11	20	48

i. Updates on the safety net care pool including DSRIP activities: Kansas proposed and CMS approved delaying the implementation of the DSRIP pool for one year to allow the State and CMS to focus on other critical activities related to Kansas' Section 1115 Demonstration waiver.

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

- The Traumatic Brain Injury (TBI) program and the Intellectual/Developmental Disability (IDD) program will be renewed in the first quarter of the second year.
- The HCBS programs will submit the amendments for consistent quality assurance measures in the first quarter of the second year.
- The IDD amendment was pending additional discussion after the integration of IDD on January 1, 2014 was postponed and a formal request for additional information was submitted to the State.
- HCBS staff continue participate in the following workgroups and steering committees to ensure consistency and listen to provider and consumer concerns, including but not limited

to:

- Autism Workgroup
- FMS Workgroup
- IDD KanCare Implementation Workgroup
- TA Workgroup
- MFP Workgroup
- MCO Technical Assistance
- HCBS Provider Forum (monthly)
- Friends and Family Advisory Council

- The State submitted a request in the third quarter to amend the HCBS-I/DD waiver to include quality measures in the waiver consistent with the QIS and CMS guidance and the integration of IDD LTSS into the KanCare 1115 Demonstration Project.
- The State began conducting National Core Indicators' surveys to develop a baseline of information for the NCI.

k. *Legislative activity:* The Robert G. Bethell Home & Community Based Services and KanCare Oversight Committee, a statutory joint committee, met in October and November to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The agendas for the two meetings were similar. The committee received reports from KDHE, KDADS, and the Ombudsman's office and asked questions of each in the morning before taking comments from stakeholders, including providers and beneficiaries. In the afternoon, the agencies provided additional information in response to concerns raised during the morning session, and the committee heard reports from each KanCare managed care organization. The committee also received testimony from the Kansas Insurance Department regarding implementation of the Federally Facilitated Marketplace.

V. Policy Developments/Issues

Earlier in 2013, the State had requested CMS approval to implement three changes to KanCare, effective January 1, 2014: (1) provide long term supports and services (LTSS) for individuals with intellectual or developmental disabilities through KanCare managed care plans; (2) establish three pilot programs to support employment and alternatives to Medicaid; and (3) change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool. The State received approval of the DSRIP Pool amendment, but to complete work on the details of the agreement regarding ID/DD LTSS, implementation of the rest of the amendment was postponed temporarily (approval for Feb. 1, 2014, implementation of ID/DD LTSS in KanCare ultimately was received in January).

Development of the billing pilot for IDD long-term supports and services revealed billing related issues in the fee-for-service system related to partial billing of whole units for Day Supports and Targeted Case Management. Training was conducted with community service providers. The Day Supports unit

changed from 1 unit = 1 day to 1 unit = 15 minutes. This change was made to ensure compliance with whole unit billing and continue to allow community service providers with the billing flexibility to which they were accustomed.

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. For the quarter ending December 2013 (DY1-Q4), the State removed the October payment amount/enrollment for September and input the January payment amount/enrollment for December. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent.

Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included. KDHE collected payment data for long-term services and supports and targeted case management for members on the I/DD HCBS waiver, services which are currently carved out from managed care but required to be included in Budget Neutrality reporting. In the fourth quarter, retroactive delivery payments increased reported expenditures for the Adults MEG.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	**Member Month**			**Totals**
MEG	*2013-10*	*2013-11*	*2013-12*	*Grand Total*
Population 1: ABD/SD Dual	17,719	17,622	17,563	52,904
Population 2: ABD/SD Non Dual	29,429	29,218	29,053	87,700
Population 3: Adults	33,094	33,376	33,704	100,174
Population 4: Children	210,945	212,203	213,382	636,530
Population 5: DD Waiver	8,681	8,736	8,769	26,186
Population 6: LTC	21,775	21,639	21,492	64,906
Population 7: MN Dual	1,214	1,168	1,158	3,540
Population 8: MN Non Dual	1,116	1,057	996	3,169

Population 9: Waiver	4,317	4,296	4,270	12,883
Grand Total	**328,290**	**329,315**	**330,387**	**987,992**

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

VIII. Consumer Issues

Summary of consumer issues during the fourth quarter of 2013:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established).	When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled.	Providers can confirm eligibility by directly accessing KMAP or calling customer service. Eligibility file load times have been reduced to 24 hours for MCOs and 48 hours for subcontractors.
Prescriptions and other services were delayed or denied for lack of a prior authorization.	• Some PA requirements were relaxed, upon guidance from State Program Managers and Pharmacist. • Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit. • MCO's PA processes were improved to provide more rapid decisions.	For Rx, the State's Pharmacist is monitoring MCOs' PA lists to assure that they aren't incorrectly requiring PAs.
Incorrect information was given to members and providers by customer service representatives.	• Instruction/correction of individual staff when issues were called to MCO's attention. • On occasion, MCO has covered services which were provided on the basis of incorrect information.	Ongoing education of CSRs to understand the eligibility information available to them, the services which are covered by KanCare, and correct routing of calls.
Incorrect application of spenddown, client obligation, and patient liability	MCO education to providers on how to properly apply claims to patient responsibility (spenddown).	State held a training session for MCO staff targeting these issues.
Services (such as prescription drugs) delayed due to eligibility files incorrectly showing TPL availability	MCOs work with eligibility staff to confirm that insurance is not in effect for the member, and to get file updated	Ongoing efforts to improve accuracy of eligibility TPL records

Members receive bills from providers for services that member feels should be covered by Medicaid	MCOs work with State and providers to determine whether: • claims are incorrectly being denied as non -covered • bills are being sent while claims are pending payment by the MCOs • member is obligated for payment, due to spenddown • or, provider is balance-billing Action is taken, as appropriate, according to the cause.	Ongoing system corrections by MCOs, to assure coverage is in compliance with State policies. Also, ongoing provider education.

In addition, related to consumer issues and supports: The state initiated, through our EQRO contractor, Mental Health consumer perception surveys which were mailed to members on August 21, 2013. A total of 16,302 surveys were mailed (10,640 youth and 5,662 adult). Reminder post cards were mailed September 9, 2013. The MCO member call centers received training regarding the survey prior to mailing, and the call centers were utilized to assist potential respondents with questions involving the survey. Surveys will be gathered for a period of approximately ten weeks. Also, KDADS Behavioral Health Services has hired two consumer affairs staff – one for youth and one for adults – to take the lead on member issues specific to Behavioral Health Services.

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 KanCare Interagency Monitoring Team (IMT) as an important component of comprehensive oversight and monitoring. The IMT is a review and feedback body that will meet in work sessions quarterly, focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS), consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. The IMT includes representatives from KDHE and KDADS, and operates under the policy direction of the KanCare Steering Committee which includes leadership from both KDHE and KDADS. Within KDHE, the KanCare Interagency Coordination and Contract Monitoring (KICCM) team, which facilitates the IMT, has the oversight responsibility for the monitoring efforts and development and implementation of the QIS.

These 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 and other KanCare contract requirements; external quality review findings and reports; the state's onsite review results; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and the IMT's review of and feedback regarding the overall KanCare quality plan. This combined information assists the IMT 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, it will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use. This comprehensive strategy was updated with additional operational details, and the MCO QAPIs for 2013 were finalized and approved in June 2013.

The State values a collaborative, race-to-the-top 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 operationalize; 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 has been completed (and as it recurs over time), as determined by the State of Kansas, the final details as to each measure will be communicated and will be binding upon each MCO. These operational adjustments and updates will not require contract amendments, but will be documented as part of the quality strategy or in related operational guidelines and will be binding upon and put into place by each MCO.

During the fourth quarter of KanCare operation, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program, with extensive work on customizing measures for the year two P4P measures which will be validated by the state's EQRO.
- Extensive interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate to the MCOs 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 receipt, distribution, review and feedback regarding submitted reports.
- Operationalizing the EQRO work plan for 2013 and into 2014, with the associated deliverables detail. One of the business meetings with the MCOs each month is dedicated to discussing EQRO activities, MCO requirements related to those activities, and timeline/action items to move all EQRO deliverables and related MCO deliverables along apace with good mutual understanding and clarity.

- Ongoing meetings of the KanCare Interagency Monitoring Team, with primary focus areas this quarter being the update of HCBS waiver performance measures and merging them with the KanCare comprehensive quality strategy, developing related HCBS waiver amendments, and preparation for the addition of I/DD waiver services into the KanCare program.
- During the third quarter, KDHE and KDADS collaborated to conduct a mid-year focused review of each MCO related to core operational issues, and ongoing reporting of the KKMAR activities/results. The review focused on core operational areas of the KanCare MCOs, to validate performance reports and to help ensure strong performance as the program shifted from the launch/initial implementation phase to the long-term/operational phase. Program management, contract monitoring and fiscal oversight staff from KDHE and KDADS obtained and assessed extensive documentation samples reflecting MCO performance and conducted related onsite reviews of these KanCare operational areas:

  - Customer Service – for both members and providers
  - Provider Credentialing – including timing and accuracy of related processes
  - Grievances and Appeals – for both members and providers
  - Prior Authorizations – including timing and accuracy of MCO and subcontractor decisions
  - Third Party Liability, Spend Down and Client Obligation – evaluating program integrity

  Findings from that focused review were presented to the MCOs, and related action items were incorporated into the comprehensive annual reviews underway as to each of the MCOs. Those reviews – a collaborative effort of the state's EQRO, KDHE and KDADS – are assessing MCO performance in all federal BBA-related areas and many state contractual/regulatory areas. The reviews, which include extensive documentation production, desk reviews and multi-track three-day onsite review components, started in the fourth quarter of 2013 and will be completed in the first quarter of 2014 (and related report of findings and recommendations in the second quarter of 2014).
- Facilitation of technical assistance activities for MCOs to address implementation and programmatic questions related to the HCBS waiver services. This weekly meeting allowed the State and the MCOs to touch-base and address any concerns or clarification needed related to each program.
- Facilitation of complex case staffing for cases involving individuals with multiple disabilities or complex needs. This weekly meeting for behavioral health and HCBS services allowed the State to work with the MCO to find creative solutions, apply policies to specific situations, and address issues identified by consumers, providers, the MCO, or the State for a specific consumer.
- Finalizing of revised HCBS waiver performance measures, to support the completed merger of HCBS waiver-based performance measures and practices within the comprehensive Kansas state quality strategy. During the fourth quarter, the IDD amendment for inclusion of those services into KanCare was finalized and extensive dialogue with CMS about that transition was conducted; and related amendments to the other HCBS waiver programs in Kansas were drafted for submission in early 2014.

- KDADS Quality Management Specialists (QMS) continued to provide quality oversight activities for the 1915(c) waiver programs. The activities include the following:
    - Conducting the National Core Indicators surveys for individuals with Intellectual/Developmental Disabilities (IDD). Over 400 surveys will be completed by the second quarter of the second year of KanCare.
    - Reviewing and investigating critical incidents involving HCBS consumers and providers that are submitted into the Adverse Incidents Reporting (AIR) system. Two providers had their licenses revoked for failure to comply with licensing standards
    - Meeting with Adult Protective Services (APS) to identify trends in the data and discuss the process related to crisis requests. QMS will continue working with APS workers to identify an individual's needs and ensure the appropriate services are accessed or offered as needed
    - Participating in the Long-Term Care meetings to report quality assurance activities to KDHE. QMS has continued quality assurance activities such as quality reviews of community service providers and contracted entities. These reviews provide important information about program integrity and quality services provided to aging and disabled individuals served by the HCBS programs.

In addition, KDHE's KICCM staff conduct regularly occurring meetings with MCO staff, relevant cross-agency program management staff, and EQRO staff to work on KanCare operational details and ensure that quality activities are occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contact requirements. These meetings occur at least monthly, although during pre-launch, launch and initial implementation phase the meetings occurred daily, weekly and biweekly. Included in this work are reviews, revisions and updates to the QIS, including operational specifications of the performance measures (and pay for performance measures); reporting specifications and templates; LTSS oversight and plan of care review/approval protocols; and KanCare Key Management Activity reporting and follow up. All products are distributed to relevant cross-agency program and financial management staff, and are incorporated into updated QIS and other documents.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping:

Each MCO submits a monthly 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 monthly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
2. HCBS Service Providers by County: http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

Beginning in September, an additional report was submitted by each MCO that demonstrates, to KanCare administration, participation of providers who perform I/DD waiver services. This report will be closely monitored as we incorporate these services into KanCare.

b. Customer service reporting, including average speed of answer at the plans and call abandonment rates:

Member Call Top 5 Reasons					
Amerigroup	**Dec. 2013**	**Sunflower**	**Dec. 2013**	**United**	**Dec. 2013**
Find/change PCP	22.0%	PCP Change	12.5%	Benefits Inquiry	36%
Benefit Inquiry – regular or VAS	20.4%	Member Demographic Update	11.3%	Find / Change PCP	25%
Order ID card	6.2%	Eligibility Inquiry	8.3%	Order ID Card	8%
Claim or billing question	9.0%	ID Card Request	7.6%	Eligibility Inquiry	26%
Other	7.5%	Benefit - Medical Inquiry	3.8%	Care Management or Health Plan Program	3%
Other Member Customer Service Performance Results					
Member (Voice Portal & Live Agent)	**YTD 2013**	**Beneficiary Calls-**	**YTD 2013**	**Member Services**	**YTD 2013**
Total # Calls Offered	179,173	Total Offered	188,521	Total Offered	131,507
Total # Handled	178,730	Total Handled	187,082	Total Handled	130,443
Average seconds to answer	0.00006	Average seconds to answer	9	Average seconds to answer	4.49
Average length of call	3:55	Average length of call	5:18	Average length of call	05:24
Abandon Volume	443	Abandon Volume	1963	Abandon Volume	710
Abandon Rate	11.53%	Abandon Rate	1.0%	Abandon Rate	0.4%

Provider Call Top 5 Reasons					
Amerigroup	**Dec. 2013**	**Sunflower**	**Dec. 2013**	**United**	**Dec. 2013**
Authorization – new	24.9%	Claims Status	54.07%	Benefits Inquiry	19%

Claim status inquiry	29.7%	Adjustment	17.11%	Claim Status Inquiry	86%
Authorization – status	14.3%	Eligibility Inquiry	4.89%	Claim Denial Inquiry	14%
Claim denial inquiry	8.3%	Prior Authorization Status	2.49%	Update Demographic Information	.1%
Benefits inquiry	8.2%	Claims Submission Status	2.09%	Member Eligibility Inquiry	8%
Other Provider Customer Service Performance Results					
Provider (Voice Portal & Live Agent)	**YTD 2013**	**Provider Calls**	**YTD 2013**	**Provider Services**	**YTD 2013**
Total # Calls Offered	102,518	Total Offered	62,478	Total Offered	55,189
Total # Handled	102,080	Total Handled	61,977	Total Handled	55,044
Average seconds to answer	0.00011	Average seconds to answer	9	Average seconds to answer	2.67
Average length of call	0:04:37	Average length of call	6:41:10	Average length of call	07:50
Abandon Volume	8.26	Abandon Volume	486	Abandon Volume	150
Abandon Rate	0.41%	Abandon Rate	.8%	Abandon Rate	0.26%

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

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

e. Summary of ombudsman activities: The Office of Ombudsman continues to serve an important role as a resource to Kansas Medicaid consumers. The Ombudsman's office continues to be available in a timely and flexible manner. All phone calls are answered promptly and phone messages were returned within four hours. With the addition of the Ombudsman assistant, the Ombudsman has been proactive in reaching out to stakeholder groups to enhance collaboration and facilitate the input of members. The Ombudsman has researched and collaborated with others concerning resolution resources to improve the function of this important member resource.

   The number of concerns reflected in the Ombudsman Contact Log declined substantially from Q1-615, Q2-456, Q3-436 to Q4-341. The focus has shifted from general questions and referrals to specific member concerns. The subject matter of concerns has evolved to (in order of prevalence):

   1) Reductions in Service
   2) Eligibility
   3) Pharmacy/Transportation (these will be broken out separately next quarter)
   4) Billing/Client Obligation
   5) Status of Network
   6) Appeals/Grievances

The Ombudsman Contact Log is being refined to include a breakdown by MCO, geography and category of Medicaid service. The goal for the next quarter is to shift the focus from documentation to an interactive tool. With the planned addition of another full-time position during the next quarter, the goal is to provide a more personal level of service. During the next quarter member surveys will help focus the Ombudsman efforts to effectively meet member needs.

The Ombudsman continues to present to stakeholder groups and at KanCare public forums. Additionally, the Ombudsman actively participates in internal and external forums to enhance the visibility and understanding of the collective concerns and experiences of consumers. Due to the location and interaction with State program staff, there is direct feedback and exchange of information regarding concerns and effective approaches to resolution. Much of the utility of ombudsman is through the unique perspective gained through daily interactions between consumers, the State, the MCO's and many other stakeholder groups.

The ombudsman remains involved in various workgroups:

1) I/DD Waiver Pilot
2) KDADS Internal I/DD Workgroup
3) KDADS KanCare Weekly Workgroup
4) KDADS Friends and Family Steering Committee and Communication/Education Sub-committees
5) CMS Implementation Monitoring Meetings

In summary, the Ombudsman has been a responsive resource for KanCare members. With a focus on listening and providing support, members have a voice and the ability to influence outcomes. The Ombudsman will continue to adapt to meet member needs with a superior level of customer service.

As the first year of the KanCare program came to conclusion, the state assessed the Ombudsman program and ways to ensure that it be as accessible and effective as possible for KanCare members. In addition, the state had extensive discussions with CMS and with KanCare stakeholders regarding that resource. As a result, adjustments and clarifications about the Ombudsman office, including functions, accessibility, resources and data collection/reporting have been incorporated into the revised KanCare STCs and will be applied going forward.

f. Summary of MCO critical incident report: In the fourth quarter, critical incidents for individuals with IDD began to be submitted into the Adverse Incident Reporting (AIR) system. KDADS held trainings in the fourth quarter for CDDOs and IDD community service providers to familiarize them with the existing AIR system. Requests for enhancements to AIR were made that would allow CDDOs to have access to the system for their reporting requirements. This request is being reviewed by legal counsel to ensure HIPPA compliance. Critical incident summary:

Critical Incidents (All Providers)	1st Qtr			2nd Qtr			3rd Qtr	4th Qtr	YTD
	(AIR)	(KDADS)	Totals	(AIR)	(KDADS)	Totals	AIR Totals	AIR Totals	**TOTALS**
Total # Received	43	300	**343**	122	66	**190**	**131**	**167**	**841**
Total # Reviewed	36	247	**283**	101	66	**167**	**112**	**151**	**630**
Total # Pending	7	53	**60**	21	0	**21**	**8**	**16**	**N/A**
Total # Substantiated	NR	NR	NR	NR	51	**51**	**115**	**145**	**230**

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 Attachment Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the fourth quarter.

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

XII. Demonstration Evaluation

In the first quarter of the KanCare program, KDHE selected an evaluation entity – Kansas Foundation for Medical Care (KFMC) – and worked with that entity to develop an initial overview evaluation plan, obtain input on the evaluation design from a variety of stakeholder groups, and begin the development of a draft evaluation plan for submission to CMS. Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is to be completed by the Kansas Foundation for Medical Care, Inc., who will subcontract as needed for targeted review. Evaluation requirements are outlined in the Centers for Medicare & Medicaid Services Special Terms and Conditions document.

The draft 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 reviewed that feedback worked internally and with the external evaluator, MCOs and others to address that feedback. 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.

The timeline going forward will include:

- Adjustments to the evaluation plan will be completed and submitted for approval whenever relevant amendments to the 1115 waiver are submitted, and otherwise when modifications become necessary during the course of evaluating KanCare.
- Quarterly and Annual evaluation progress reports will be submitted.
- Draft evaluation report to be submitted 120 days after expiration of the demonstration.

For this fourth quarter report, KFMC has completed an initial analysis of a subset of the KanCare Evaluation design measures. The assessed subset of measures includes those which are reported quarterly, as follows:

1. Timely resolution of customer service inquiries.
2. Timeliness of claims processing.
3. Grievances
    a. Timely resolution of grievances.
    b. Compare/track the number of access related grievances over time, by population categories.
    c. Compare/track the number of grievances related to quality over time, by population.
4. Ombudsman's Office
    a. Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.
    b. Track the number and type of assistance provided by the Ombudsman's office.
5. Systems - Quantify system design innovations implemented by KanCare such as Person Centered Medical Homes (PCMH), Electronic Health Record (EHR) use, Use of Telehealth, and Electronic Referral Systems.

KFMC's quarterly report is attached. The state will review this KanCare Evaluation Quarterly Report, with specific attention to the related recommendations, and will take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (I/DD Pilot Project; Implementation of I/DD)

a. KanCare I/DD Pilot Program: IDD Pilot billing began through the MCOs on October 1, 2014. This process revealed billing related matters. Pilot updates are being added to the website monthly. Recent fourth quarter updates are highlighted below and the full report can be found on the KDADS website at: http://www.kdads.ks.gov/CSP/IDD/KanCare_Imp/DD_Pilot_Activities.html. The following information was provided to IDD providers in December 2013. It was subsequently included in an IDD Provider Bulletin in the first quarter of the second year of KanCare.

Billing and Claims Updates

Through the IDD KanCare Pilot there have been four common claims and billing issues identified. The State has been working with the MCOs to ensure these identified issues do not cause payment disruption when HCBS/IDD long-term supports and services and Targeted Case Management services are implemented into KanCare. The identified issues and the plan are described below.

- **Missing Authorizations**

Due to the complexity of the Pilot Billing process in coordinating the Fee-for-service system with the MCO systems, there were issues with missing Plans of Care files being transmitted to the MCOs. To ensure the plan of care transition does not cause a payment delay, the MCOs will not automatically deny claims for missing HCBS/DD Plan of Care authorizations. Instead, there will be review processes in place prior to or after the claim is paid that will ensure a valid authorization is on file. As the Authorization systems are validated by MCOs, the State and the MCOs will work to turn this edit back on.

- **Date Span Billing**

  When billing MCOs for unit services that are equal to one day, providers are required to have the number of units billed match the date span. Each MCO has training opportunities for providers that need clarity around date span billing. For implementation, MCOs will be relaxing their span edit. All MCOs will provide education to providers and work with the State to phase this edit back into the process at an appropriate time.

- **Third Party Liability (TPL)**

  KDHE continues to reach out to insurance carriers in an attempt to secure blanket denials for service codes in order to assist providers in submitting claims with TPL involved. Efforts have been successful in obtaining some blanket denials, but the State cannot obtain blanket denials from all carriers. Another avenue for obtaining blanket denials is through providers themselves.

  KDHE asks providers who receive a blanket denial from a carrier for service(s), to share them with the State so they may published for all providers to use.

  Providers can submit all blanket denials to KDHE via fax at (785) 296-4813 or via email to josterhaus@kdheks.gov.

- **Client Obligation**

  Issues around the appropriate deduction of client obligation amounts from payments were identified during the pilot. The MCOs have made appropriate process changes to accurately assign client obligation amounts to claims to follow the State's HCBS process. In addition, MCOs will adjust claims for any retroactive client obligation changes made by the State.

b. KanCare Implementation for IDD LTSS: Provider updates are available on the KDADS website at www.kdads.ks.gov. Provider updates include:

- Day long weekly meetings with the MCOs and the State began during the third quarter to ensure policies and procedures were in place for the IDD LTSS. These discussions continued during the fourth quarter and included discussions with stakeholders, technical staff from HP, KDADS, KDHE, and the MCOs to ensure system readiness when IDD integrated into KanCare.
- Providers were trained on the AIR Reporting system and will begin using it to report critical incidents for individuals with IDD in the fourth quarter. Currently, reports for critical incidents for individuals with IDD are submitted by the CDDO to the Statewide Oversight Committee for review, tracking and trending. On January 1, 2014, all critical incidents will

be reported in AIR for all HCBS consumers.

- Providers attended training and question and answer sessions hosted by the State to address contracting and credentialing concerns, present pilot updates, and prepare providers for changes coming on January 1, 2014.
- The I/DD Pilot Committee identified needed changes to the current billing and claims process that included a system change to a 15 minute billing unit for Day Supports to be effective on January 1.

Readiness Reviews

- The KDADS Community Services and Programs Commission (CSP) Home and Community Based Services (HCBS) Division, the Operating Agency, in conjunction with the Kansas Department of Health and Environment (KDHE) Division of Health Care Finance, the Medicaid Agency, has completed the Readiness Review for integrating the long-term supports and services for individuals with intellectual and developmental disabilities into KanCare on January 1, 2014. Our review was performed in accordance with CMS guidance for Managed Long Term Supports and Services released in May 2013 and the IDD Legislative Proviso language.

- The State conducted Readiness Reviews for IDD LTSS integration into KanCare in November 2013. The half-day review sessions included KDADS and KDHE staff reviewing key areas identified below:
    - Member Management/Case Management
    - Staff Capacity (Care Coordinators, Member Services, Member Representatives)
    - Grievances, Appeals, Critical Incidents and Protections
    - Proviso Requirements/Related Policies
    - Timely Claims Payment and Data Transfer
    - Provider Contracting and Credentialing
    - LTSS Quality Management

- The following issues were identified as having the greatest relevance to HCBS-IDD KanCare Integration:
    - IDD Pilot: There are more than 25% of Pilot claims submitted denied for a number of reasons including span billing. Provider education and system readiness are critical to integration and such concerns should be addressed and significantly decreased prior to January 1st. Weekly monitoring will continue to address denials and ensure that appropriate billing and claims processes are in place to minimize financial impacts on providers and avoid service impacts on members.

    - Claims and Billing: General concerns, across all three health plans, have been identified related to the issue of claims and billing following January 1, 2014, specifically surrounding the following issues:

        1. Span Billing
        2. Third Party Liability/Blanket Denials

3. Prior Authorizations
4. Client Obligation

Specific concerns regarding client obligation, overpayments, and incorrect assignments of client obligation have been identified for Amerigroup. These concerns will be specifically monitored, and the health plan should provide detailed plans for addressing these concerns.

- Non-specific concerns: The health plans have completed limited activities related to competitive employment and outreach in this area. Employment is a key area for HCBS-IDD LTSS under KanCare and will be monitored throughout the first 180 days. While this is not critical for implementation, it is important for program sustainability and increased independence.

- Noted Readiness Review results from each MCO
  - Amerigroup's Readiness Review was held on November 5, 2013. Additional Information was requested and due no later than November 19, 2013. KDADS requested the following information for review:
    1. Policies and Procedures related to the legislative proviso and the MCO and KDADS QMS ride-a-long process and expectations
    2. Billing and Claims report demonstrating the percentage of corrected claims and appealed claims, the timeline for new and improved client obligation process ready for KanCare integration, and information about the ability of providers to now submit EOB's and claims for TPL electronically as well as providing a weekly report for IDD pilot claims paid and denied
    3. Communication plans and Care Coordination processes for interpreting the information on the Person-Centered Support plan and integrating it into the Integrated Service Plan

  - United's Readiness Review was held on November 12, 2013, Additional Information was requested and due no later than November 26, 2013. KDADS requested the following information for review:
    - Policies and procedures related to the process and interaction between care coordination and targeted case management, the internal task management tool demonstrating communication between care coordinator and intake staff, and a description of the Care Coordination and KDADS QMS Ride-a-long expectations for all IDD staff
    - Billing and claims information related to a report indicating % of corrected claims and appealed claims, Standard Operating Procedures for billing and claims processing, and notification to providers that EOBs can be handled electronically
    - IDD Communication Plan that indicates what education opportunities are in person, online, etc. and ensures universal use of the term "Integrated Service Plan" (ISP) to help with system education and identifies TCM training

and outreach opportunities

- Sunflower's Readiness Review was held on November 19, 2013. Additional Information was requested and due no later than December 4, 2013. KDADS requested the following information for review:
    1. Workflows and plans for tracking provider issues including a copy of their implementation Workplan (internal tool) and more information about the LifeShare process or plan to increase employment
    2. Policies & Manuals related fraud waste and abuse, IDD Training Manual for staff and/or care coordinators, and Key sections of manuals related to proviso requirements
- The requested information and documents were submitted timely and accepted for review. Upon review of the following documents, the Health Plan complied with the request no concerns were identified.

- Pilot Information related to a report IDD-specific Valued Added Benefits that identifies what has been used to date, the overall adjudication rate is 85% as well as providing a weekly report for IDD pilot claims paid and denied
    - IDD-specific Value Added Benefits – generic report # and what worked.
    - Claims Billing (weekly updates)
    - Auto-Adjudication Data: Overall adjudication rate is 85% and more rate information specific to DD and HCBS services as well as providing a weekly report for IDD pilot claims paid and denied

Education and Engagement

- Stakeholder Engagement and Communication
    - Targeted Case Manager Informational Memorandum (201309) – October 2013
    - Consumer KanCare Information Letter – sent October 15, 2013
    - Provider Guidance & Information – sent November 15, 2013
    - Consumer Informational Brochure – provided in December 2013
    - Consumer Letter about IDD Delay – December 27, 2013
    - Lunch and Learn Calls (started the week of December 9th)
        - Consumer calls are held weekly at noon on Wednesdays
        - Provider calls held twice weekly at 11:00 on Mondays and Fridays

- Consumer Engagement:
    - Increased Consumer engagement activities in the fourth quarter include greater communication directly with consumers, friends and family through letters, brochures, and online tools. In the first quarter of year two of KanCare, additional access tools will be allowed.
    - The State continued Consumer Education Tours during the fourth quarter of KanCare. The last week of education tours expanded previous outreach activities and focused on trying to reach individuals in places they were already comfortable at. KDADS worked

with the Friends and Family Advisory Council to identify changes to the previous Educational Tour process. These tours included 8 locations over 4 days and were held either at a CDDO, a community service provider, or local community location to encourage a less intimidating opportunity for individuals to meet with their MCO and ask direct questions from the MCO and State. The State will consider additional options for meeting consumers in their community to answer questions as they arise. Despite the addition of evening times, attendance remained low with an average of less than 10 individual consumers and/or family and friends. The Newton event was the best attended Consumer education event with over 100 attendees; the majority of the attendees were consumers, family and friends.

- December 6th – Dodge City (11:30 am to 12:30 am) & Garden City (5:30 to 7:00 pm)
- December 7th – Newton (10:00 am to 12:00 pm) & Wichita (4:00 pm to 6:00 pm)
- December 8th – Hays (10:00 am to 12:00 pm) & Salina (4:00 pm to 6:00 pm)
- December 9th– Lenexa (10:00 am to 12:00 pm) & Lawrence (4:00 pm to 6:00 pm)

- Provider Engagement: Several trainings across the State have been hosted and include the creation of Provider-focused Frequently Asked Questions, Policy Clarification memorandum. Additional trainings are planned to education providers on the workflows, update policies and develop communication protocols between the entities.
  - Contracting and credentialing reporting is due weekly to KDADS. This process informs the State about the status of contracts for IDD providers. The MCOs identified a group of providers, mostly limited license providers and targeted case managers, who are declining to contract because they are only contracting with one other MCO. Some have declined to contract or remained unresponsive to contracting and credentialing efforts. The numbers should increase after IDD go-live and when a contract is developed with Interhab.
  - Targeted Case Management trainings were held on October 7th, 8th, 9th, 10th, 11th, and 14th. Over 600 targeted case managers and agencies attended the trainings. The focus of the training was to review the TCM components as identified in the CMS Final Rule established in 2008 and finalized in 2011. The new Prior Authorization web application was introduced for TCMs to use in order to request additional units. A number of "system gaps" were identified by the TCMs. Answers to the questions were posted online and made available to TCMs.
  - Community Service Provider trainings were held on October 3rd and 8th. These trainings were held in Wichita and Topeka. Over 350 providers attended the trainings, which focused on changes to Day Supports billable units, AIR Training, and other IDD-related topics. MCOs attended and presented information about Care Coordination and billing.

- State staff presented information about KanCare at the Interhab Conference. They covered a variety of topics including Health Homes and Targeted Case Management in Managed Care. KDADs held a 2 hour question and answer session for providers during the conference.

XIV. Enclosures/Attachments

Section VI refers to the KanCare Budget Neutrality Monitoring spreadsheet, which is attached.

Section XI refers to the Safety Net Care Pool Report, which details sources of funding for pool payments applicable to this quarter, per STC 67(b). It is attached.

Section XII refers to the KFMC "2013 KanCare Evaluation Quarterly Report" related to the assessment KanCare performance measures reported quarterly. That report is attached.

XV. State Contacts(s)

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XVI. Date Submitted to CMS

February 28, 2014

KanCare BN Monitoring
DY 1, Q1-Q4

DY 1
Start Date: 1/1/2013
End Date: 12/31/2013

	Total Expenditures	Total Member-Months
DY1Q1	551,219,424.24	979,907
DY1Q2	561,553,531.67	979,006
DY1Q3	615,970,528.35	980,896
DY1Q4	657,017,751.91	987,992
DY1 Total	2,385,761,236.17	3,927,801

(actuals)

	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
DY1Q1									
Expenditures	11,820,828.17	83,365,882.52	37,508,648.01	117,749,154.42	94,909,142.82	160,873,260.89	4,005,540.87	5,098,329.12	35,888,637.42
Member-Months	52,847	85,951	94,778	633,754	26,136	65,712	3,636	3,534	13,559
PCP	0	0	0	0	0	0	0	0	0
DY1Q2									
Expenditures	12,021,095.74	87,856,425.67	39,590,922.31	125,151,359.00	102,863,865.76	159,822,442.76	4,089,361.03	4,968,313.42	36,199,688.52
Member-Months	53,055	87,338	96,765	627,644	26,349	65,730	3,823	4,560	13,742
PCP	(65,051.75)	(2,400,217.79)	(698,151.79)	(6,620,191.78)	(232,611.03)	(606,434.10)	(4,575.82)	(120,604.86)	(262,103.62)
DY1Q3									
Expenditures	13,190,367.76	95,539,177.99	43,709,968.63	132,805,882.58	102,996,267.16	183,243,140.15	4,776,346.96	5,996,100.66	39,315,632.80
Member-Months	52,826	87,537	98,025	631,064	26,018	65,324	3,606	3,264	13,232
PCP	(33,309.66)	(1,241,357.82)	(365,445.62)	(3,351,547.66)	(111,565.53)	(303,243.48)	(2,465.11)	(61,965.67)	(131,455.79)
DY1Q4									
Expenditures	13,281,236.97	96,145,932.42	95,278,930.96	134,911,356.99	95,817,386.27	177,720,775.44	4,624,613.17	5,876,627.35	38,985,911.98
Member-Months	52,904	87,700	100,174	636,530	26,186	64,906	3,540	3,169	12,883
PCP	(33,232.87)	(1,276,873.17)	(370,574.65)	(3,335,108.85)	(114,019.70)	(300,862.43)	(2,388.32)	(61,568.26)	(130,391.39)
DY1 Total									
Expenditures	50,181,934.36	357,988,969.82	214,654,297.85	497,310,904.70	396,128,465.75	680,449,079.23	17,486,432.78	21,695,231.76	149,865,919.92
Member-Months	211,632	348,526	389,742	2,528,992	104,689	261,672	14,605	14,527	53,416
DY 1 PMPM	237.12	1,027.15	550.76	196.64	3,783.86	2,600.39	1,197.29	1,493.44	2,805.64

Note: Population 3 - Adults Reported expenditures are significantly higher due to the inclusion for this quarter of retroactive delivery payments.

KanCare BN Monitoring DY1-Q4

DY 1
Start Date: 1/1/2013
End Date: 12/31/2013

Quarter 4
Start Date: 10/1/2013
End Date: 12/31/2013

	Total Expenditures	Total Member-Months
Oct-13	187,042,242.41	328,290
Nov-13	248,531,042.37	329,315
Dec-13	227,069,486.77	330,387
PCP:	(5,625,019.64)	
Q4 Total	657,017,751.91	987,992

(Actual/Estimate)

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Oct-13									
Expenditures	4,417,556.55	31,801,430.88	14,757,527.52	44,336,369.33	14,479,131.24	60,770,939.41	1,554,926.57	1,969,114.65	12,955,246.26
Member-Months	17,719	29,429	33,094	210,945	8,681	21,775	1,214	1,116	4,317
Nov-13									
Expenditures	4,429,399.67	32,619,138.63	59,809,635.06	45,726,839.27	30,786,468.04	58,378,699.27	1,552,683.07	2,153,104.52	13,075,074.84
Member-Months	17,622	29,218	33,376	212,203	8,736	21,639	1,168	1,057	4,296
Dec-13									
Expenditures	4,434,280.75	31,725,362.91	20,711,768.38	44,848,148.39	50,551,786.99	58,571,136.76	1,517,003.53	1,754,408.18	12,955,590.88
Member-Months	17,563	29,053	33,704	213,382	8,769	21,492	1,158	996	4,270
PCP									
Expenditures	(33,232.87)	(1,276,873.17)	(370,574.65)	(3,335,108.85)	(114,019.70)	(300,862.43)	(2,388.32)	(61,568.26)	(130,391.39)
Q4 Total									
Expenditures	13,248,004.10	94,869,059.25	94,908,356.31	131,576,248.14	95,703,366.57	177,419,913.01	4,622,224.85	5,815,059.09	38,855,520.59
Member-Months	52,904	87,700	100,174	636,530	26,186	64,906	3,540	3,169	12,883
DY 1 - Q4 PMPM	250.4159	1,081.7453	947.4350	206.7086	3,654.7532	2,733.4902	1,305.7132	1,834.9824	3,016.0305

Safety Net Care Pool Report

Demonstration Year 1 - QE December 2013

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

Paid 10/03/13

Provider Name	4th Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.00	1,073,386.55	1,417,647.45
University of Kansas Hospital	7,473,103.00	3,220,160.08*	4,252,942.92
Total	**9,964,137.00**	**4,293,546.63**	**5,670,590.37**

*IGT funds are received from the University of Kansas Hospital.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 1 - QE December 2013

Health Care Access Improvement Pool
Paid 10-03-2013

Hospital Name	HCAIP DY/QTR: 2013/4	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	30,671.00	13,216.13	17,454.87
Children's Mercy Hospital South	132,777.00	57,213.61	75,563.39
Coffey County Hospital	22,627.00	9,749.97	12,877.03
Coffeyville Regional Medical Center, Inc.	85,286.00	36,749.74	48,536.26
Cushing Memorial Hospital	121,790.00	52,479.31	69,310.69
Galichia Heart Hospital LLC	36,289.00	15,636.93	20,652.07
Geary Community Hospital	108,555.00	46,776.35	61,778.65
Hays Medical Center, Inc.	372,360.00	160,449.92	211,910.08
Hutchinson Hospital Corporation	290,353.00	125,113.11	165,239.89
Kansas Heart Hospital LLC	30,369.00	13,086.00	17,283.00
Kansas Medical Center LLC	46,231.00	19,920.94	26,310.06
Kansas Rehabilitation Hospital	6,315.00	2,721.13	3,593.87
Kansas Surgery & Recovery Center	4,845.00	2,087.71	2,757.29
Labette County Medical Center	90,809.00	39,129.60	51,679.40
Lawrence Memorial Hospital	223,485.00	96,299.69	127,185.31
Memorial Hospital, Inc.	42,455.00	18,293.86	24,161.14
Menorah Medical Center	207,647.00	89,475.09	118,171.91
Mercy - Independence	47,986.00	20,677.17	27,308.83
Mercy Health Center - Ft. Scott	82,851.00	35,700.50	47,150.50
Mercy Hospital, Inc.	3,238.00	1,395.25	1,842.75
Mercy Reg Health Ctr	170,151.00	73,318.07	96,832.93
Miami County Medical Center	57,668.00	24,849.14	32,818.86
Mid-America Rehabilitation Hospital	17,574.00	7,572.64	10,001.36
Morton County Health System	35,477.00	15,287.04	20,189.96
Mt. Carmel Medical Center	207,215.00	89,288.94	117,926.06
Newman Memorial County Hospital	127,347.00	54,873.82	72,473.18
Newton Medical Center	123,877.00	53,378.60	70,498.40
Olathe Medical Center	366,180.00	157,786.96	208,393.04
Overland Park Regional Medical Ctr.	585,432.00	252,262.65	333,169.35
Pratt Regional Medical Center	57,255.00	24,671.18	32,583.82
Providence Medical Center	396,597.00	170,893.65	225,703.35
Ransom Memorial Hospital	73,654.00	31,737.51	41,916.49
Saint Catherine Hospital	172,436.00	74,302.67	98,133.33
Saint Francis Health Center	619,423.00	266,909.37	352,513.63
Saint John Hospital	99,674.00	42,949.53	56,724.47
Saint Luke's South Hospital, Inc.	121,260.00	52,250.93	69,009.07
Salina Regional Health Center	263,395.00	113,496.91	149,898.09
Salina Surgical Hospital	654.00	281.81	372.19
Select Specialty Hospital - Kansas City	5,211.00	2,245.42	2,965.58
Select Specialty Hospital - Wichita	5,734.00	2,470.78	3,263.22
Shawnee Mission Medical Center, Inc.	707,194.00	304,729.89	402,464.11
South Central KS Reg Medical Ctr	21,471.00	9,251.85	12,219.15
Southwest Medical Center	117,325.00	50,555.34	66,769.66
Specialty Hospital of Mid America	374.00	161.16	212.84
Stormont Vail Regional Health Center	943,679.00	406,631.28	537,047.72
Summit Surgical LLC	775.00	333.95	441.05
Sumner Regional Medical Center	27,744.00	11,954.89	15,789.11
Susan B. Allen Memorial Hospital	114,300.00	49,251.87	65,048.13
Via Christi Hospital St Teresa	161,582.00	69,625.68	91,956.32
Via Christi Regional Medical Center	1,465,595.00	631,524.89	834,070.11
Via Christi Rehabilitation Center	17,203.00	7,412.77	9,790.23
Wesley Medical Center	1,000,422.00	431,081.84	569,340.16
Western Plains Medical Complex	125,521.00	54,087.00	71,434.00
Prairie View Inc.	104,616.00	45,079.03	59,536.97
Marillac Center, Inc.	94,293.00	40,630.85	53,662.15
	10,395,247.00	**4,479,311.93**	**5,915,935.07**

KanCare Evaluation Quarterly Report
4th Quarter 2013

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**February 25, 2014**
Review Team:	**Janice Panichello, Ph.D., MPA, AICP, EQRO Manager/Epidemiologist** **Lynne Valdivia, RN, BSN, MSW, Vice President of Program Management & Development** **Cissy McKinzie, CPM, CQA, Quality Review Coordinator**

Prepared for:

Table of Contents
4th Quarter 2013 KanCare Evaluation Quarterly Report

Table of Contents
4th Quarter 2013 KanCare Evaluation Quarterly Report

2013 KanCare Evaluation Quarterly Report
Year 1, Quarter 4, October-December 2013
February 25, 2014

Background / Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF) submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) on August 24, 2013, and it was approved on September 11, 2013. The Kansas Foundation for Medical Care, Inc., (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

The KanCare Evaluation Design includes over 100 annual performance measures developed to measure the effectiveness and usefulness of the five-year KanCare demonstration managed care Medicaid program. Annual performance measures include baseline and cross-year comparisons; the first year of the KanCare demonstration, calendar year (CY) 2013, serves as a baseline year. Data sources for assessing annual performance measures include administrative data, medical and case records, and consumer and provider feedback.

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures in this fourth quarter (Q4), CY2013, report include the following:

1. Timely resolution of customer service inquiries.
2. Timeliness of claims processing.
3. Grievances
    a. Timely resolution of grievances.
    b. Compare/track the number of access related grievances over time, by population categories.
    c. Compare/track the number of grievances related to quality over time, by population.
4. Ombudsman's Office
    a. Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.
    b. Track the number and type of assistance provided by the Ombudsman's office.
5. Systems - Quantify system design innovations implemented by KanCare such as Person Centered Medical Homes (PCMH), Electronic Health Record (EHR) use, Use of Telehealth, and Electronic Referral Systems.

KanCare health care 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 (United). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs will be combined, wherever possible, to better assess the overall impact of the KanCare program.

Preliminary review of the following findings has occurred with KDHE, and they will be working to remedy the issues addressed.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

Quarterly tracking and reporting of timely resolution of customer service inquiries in the KanCare Evaluation is based on the MCOs' contractual requirements to resolve 95% of all inquiries within 2 business days of inquiry receipt, 98% of all inquiries within five (5) business days, and 100% of all inquiries within 15 business days.

DATA SOURCE

Timeliness of resolution of customer service inquiries is reported by each MCO in Pay for Performance (P4P) reports submitted to KDHE on a monthly basis. The customer service P4P reports track resolution of customer service inquiries within two (2) business days and within eight (8) business days. To be eligible for P4P payments, 98% of all inquiries must be resolved within 2 business days of receipt and 100% of all inquiries must be resolved within 8 business days from receipt date.

A separate monthly report, the KanCare Key Management Activities Report (KKMAR), reports the monthly and cumulative percentage of member and provider inquiries resolved within 2, 5, 8, 15, and greater than 15 days, as well as the percentage of inquiries pending.

In Table 1 below, the quarterly numbers of inquiries resolved within 2 business days are based on monthly data from the customer service P4P report. Percentages reported in the KKMAR were then used to calculate the number of inquiries resolved and not resolved within 5 business days and 15 business days.

Table 1 - Timeliness of Resolution of Customer Service Inquiries

	Q1	Q2	Q3	Q4	Total
Number of Inquiries Received	**261,286**	**181,427**	**157,547**	**146,374**	**746,634**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	745,246
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	1,259
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.81%
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	746,520
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	114
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.98%
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	746,634
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%

CURRENT QUARTER AND TREND OVER TIME

As shown in Table 1, the number of customer service inquiries received by the MCOs has decreased significantly over time. In Q1, the MCOs received a total of 261,286 inquiries; in Q4, the MCOs received 146,374 inquiries, a 44% decrease over time.

In Q4, 99.95% of the customer service inquiries received were resolved within 2 business days. During each quarter of CY2013, the 2-day resolution rate exceeded 99.7%. In Q4, 50 of the 75 inquiries not resolved within 2 business days were resolved within 5 business days, and all were resolved within 15 business days.

As indicated in Table 1, the data for Q1 is slightly inaccurate, as February and March data from United are under-reported by 129 inquiries. (Resolved within 2 business days plus not resolved within 2 business days does not equal the total number of inquiries reported for those months.) The percentage of inquiries resolved within 2 business days, however, would be unchanged even if all of the additional 129 inquiries were unresolved.

CONCLUSIONS

The customer service inquiry reports show that the MCOs have consistently met contractual and P4P standards for resolving inquiries within 2 to 5 business days in each quarter throughout CY2013. The number of inquiries received has also decreased significantly over time.

RECOMMENDATIONS

1. The KKMAR report includes monthly percentages of inquiries resolved within 2, 5, 8, and 15 days, but the report does not include the number of inquiries that the percentages are based on. Including this denominator in the report would better facilitate validation and comparison with data in other reports.
2. The current tracking system could be improved by including the number of individual members that have contacted the MCOs with customer service inquiries to better identify the scope of the customer service inquiries. Of the 746,634 inquiries received by the MCOs, it may be helpful to identify whether this represents calls from most members or represents a much smaller fraction of members who are in need of additional assistance.
3. Additional clarification should be provided as to the definition of “resolved.” Does “resolved” indicate that the member’s question has been answered, or does “resolved” mean that the member was referred to another source within the MCO or a subcontractor of the MCO? Tracking and reporting of multiple calls by individual members could also help identify whether calls have been “resolved.”

TIMELINESS OF CLAIMS PROCESSING

DATA SOURCE

Quarterly tracking and reporting of timely resolution of claims processing for CY2013 in the KanCare Evaluation was to be based on the MCOs’ contractual requirements 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. The only MCO reports on timeliness of claims processing available to KFMC for the Q4 CY2013 evaluation were the P4P reports, which report the percentage of clean claims processed within 20 days (instead of 30), the percentage of non-clean claims processed within 45 days (instead of 60), and the percentage of all claims processed within 60 days (instead of 90 days).

"Clean claim" is defined on the P4P reporting template as "one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. For purposes of the P4P measure, a clean claim is a claim that can be paid or denied with no additional intervention required and does not include adjusted or corrected claim; 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 (these claims may be pended until rates are loaded so the appropriate amounts can be paid)."

Claims that are excluded from the measures include "claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues" and "any claim which cannot be processed due to outstanding questions submitted to KDHE."

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

Each of the MCOs has interpreted the P4P timely claims processing report differently. As a result, data for the three MCOs cannot be combined, and each MCO's claims report is presented separately in Table 2, Table 3, and Table 4 below for Q1 to Q3. Because of a two-month claims lag built into the reporting structure, data are not available for Q4 as of this report date.

Data reported by Amerigroup (Table 2 below) are the most easily understood and analyzable without additional clarification required. For each month, "# Received" refers to the number of claims received during that particular month. "# Not Excluded from Measure" is determined by subtracting the "# Excluded from Measure" from the "# Received." The "# Processed Within x Days" (20 days for "clean claims," 45 days for "non-clean claims," and 60 days for "all claims") plus the "# Not Processed Within x Days" equals the "# Not Excluded from Measure." The "Percentage of Claims Processed within x Days" and the "# of days" measures are based on the number of claims received that month, whether or not they were processed in that month or a later month. For the time period from Q1 to Q3, 99.8% of Amerigroup's clean claims were processed within 20 days; 99.7% of non-clean claims were processed within 45 days; and 99.9% of all claims were processed within 60 days.

In United's reports (Table 3 below), "# received" minus the "# excluded from measure" also does not equal the "# not excluded from measure." The "# not excluded from measure" is actually a higher number of claims than the "# received" in 6 of the 9

months of Q1-Q3, including January (2013), the month that the KanCare program was implemented. Specific reasons for a higher number of claims processed than received are unclear.

Table 2 - Timeliness of Claims Processing - Amerigroup				
	Amerigroup			
Clean Claims	**Q1**	**Q2**	**Q3**	**Total**
Number Received	913,408	1,131,783	1,164,331	3,209,522
Number Excluded from Measure	558	43	23	624
Number Not Excluded from Measure (Amerigroup & United)	912,850	1,131,740	1,164,308	3,208,898
Number Processed (Sunflower only)				
Number Processed Within 20 Days	909,984	1,129,792	1,163,880	3,203,656
Percent Processed Within 20 Days (P4P =100%)	99.7%	99.8%	100%	99.8%
Number Not Processed Within 20 Days	2,866	1,948	428	5,242
Non-Clean Claims	**Q1**	**Q2**	**Q3**	**Total**
Number Received	34,023	10,676	8,291	52,990
Number Excluded from Measure	5	0	0	5
Number Not Excluded from Measure (Amerigroup & United)	34,018	10,676	8,291	52,985
Number Processed (Sunflower only)				
Number Processed Within 45 Days	33,884	10,676	8,291	52,851
Percent Processed Within 45 Days (P4P =100%)	99.6%	100%	100%	99.7%
Number Not Processed Within 45 Days	134	0	0	134
All Claims	**Q1**	**Q2**	**Q3**	**Total**
Number Received	947,431	1,142,459	1,172,622	3,262,512
Number Excluded from Measure	563	43	23	629
Number Not Excluded from Measure (Amerigroup & United)	946,868	1,142,416	1,172,599	3,261,883
Number Processed (Sunflower only)				
Number Processed Within 60 Days	946,757	1,140,713	1,172,344	3,259,814
Percent Processed Within 60 Days (P4P =100%)	100%	99.9%	100%	99.9%
Number Not Processed Within 60 Days	111	1,746	278	2,135

United reported that 96.7% of clean claims were processed within 20 days; 99.3% of non-clean claims were processed within 45 days; and 99.9% of all claims were processed within 60 days. Processing rates reported over the three quarters increased for clean claims from 93.2% in Q1 to 99.9% by Q3. For non-clean claims, rates increased from 99.4% in Q1 to 100% by Q3.

Sunflower also reports a higher number of claims processed than the "# received" minus the "# excluded from measure" for 7 of the 9 months in Q1 through Q3. No explanation is provided in these reports to explain why the number of claims processed is greater than the number received. Sunflower's Timely Claims Processing reports (summarized in Table 3 below) do not have the "# Not Excluded from Measure," but instead report the "# processed." As the "# received" minus the "# excluded from the measure" does not equal the "# processed," KFMC was not able to confirm that, although likely, these terms are equivalent.

Table 3 - Timeliness of Claims Processing - United				
	United			
Clean Claims	Q1	Q2	Q3	Total
Number Received	963,050	983,713	967,104	2,913,867
Number Excluded from Measure	1	0	4	5
Number Not Excluded from Measure (Amerigroup & United)	955,074	1,029,434	960,993	2,945,501
Number Processed (Sunflower)				
Number Processed Within 20 Days	890,256	998,516	959,854	2,848,626
Percent Processed Within 20 Days (P4P =100%)	93.2%	97.0%	99.9%	96.7%
Number Not Processed Within 20 Days	64,818	30,918	1,139	96,875
Non-Clean Claims	Q1	Q2	Q3	Total
Number Received	55,245	47,660	33,922	136,827
Number Excluded from Measure	167	157	81	405
Number Not Excluded from Measure (Amerigroup & United)	52,294	48,986	33,774	135,054
Number Processed (Sunflower)				
Number Processed Within 45 Days	51,973	48,313	33,774	134,060
Percent Processed Within 45 Days (P4P =99%)	99.4%	98.6%	100%	99.3%
Number Not Processed Within 45 Days	321	673	0	994
All Claims	Q1	Q2	Q3	Total
Number Received	995,826	1,031,373	1,001,026	3,028,225
Number Excluded from Measure	168	157	85	410
Number Not Excluded from Measure (Amerigroup & United)	1,012,150	1,078,420	994,767	3,085,337
Number Processed (Sunflower)				
Number Processed Within 60 Days	1,011,860	1,076,622	994,765	3,083,247
Percent Processed Within 60 Days (P4P =100%)	100%	99.8%	100%	99.9%
Number Not Processed Within 60 Days	290	1,798	2	2,090

Sunflower reported that 98% of clean claims were processed within 20 days; 93% of non-clean claims were processed within 45 days; and 99.8% of all claims were processed within 60 days. Processing rates reported over the three quarters decreased slightly over time for clean claims from 98.5% in Q1 to 98.1% in Q3. For non-clean claims, rates decreased from 96.1% in Q1 to 89.4% in Q3.

While the reporting and calculation method used by Amerigroup results in more clearly understood results and methodology, the method used by Sunflower and United is actually more in line with the template instructions that “claims are reported in the month they are processed/adjudicated.” The reason for the two month lag time, as indicated in the template instructions is “to allow time for claims processing.” The example given is that “the report submitted on April 30 will include claims received in January.” KFMC agrees with the two month lag time for claims processing, but recommends that claims received in January, but processed in a later month, be reported in January, the month the claim was received. Basing the processing time on the number of claims processed that month instead of the month the claims are received can potentially make it more difficult to verify that difficult or high cost claims are not being carried forward for extended periods of time. In the current report format, there is no requirement to explain the reason for a higher number of claims processed than were received that month, as is reported by Sunflower and United in Q2 and Q3 reports.

Table 4 - Timeliness of Claims Processing - Sunflower				
	Sunflower			
Clean Claims	Q1	Q2	Q3	Total
Number Received	899,806	1,193,952	1,246,877	3,340,635
Number Excluded from Measure	1	20	5	26
Number Not Excluded from Measure (Amerigroup & United)				
Number Processed (Sunflower)	898,534	1,230,035	1,237,637	3,366,206
Number Processed Within 20 Days	884,805	1,199,749	1,214,377	3,298,931
Percent Processed Within 20 Days (P4P =100%)	98.5%	97.5%	98.1%	98.0%
Number Not Processed Within 20 Days	13,729	30,286	23,260	67,275
Non-Clean Claims	Q1	Q2	Q3	Total
Number Received	74,563	45,751	41,567	161,881
Number Excluded from Measure	1	1	1	3
Number Not Excluded from Measure (Amerigroup & United)				
Number Processed (Sunflower)	54,399	46,343	43,711	144,453
Number Processed Within 45 Days	52,266	43,041	39,090	134,397
Percent Processed Within 45 Days (P4P =99%)	96.1%	92.9%	89.4%	93.0%
Number Not Processed Within 45 Days	2,133	3,302	4,621	10,056
All Claims	Q1	Q2	Q3	Total
Number Received	974,369	1,239,703	1,288,444	3,502,516
Number Excluded from Measure	2	1	6	9
Number Not Excluded from Measure (Amerigroup & United)				
Number Processed (Sunflower)	952,933	1,276,378	1,281,348	3,510,659
Number Processed Within 60 Days	952,521	1,272,346	1,275,943	3,500,810
Percent Processed Within 60 Days (P4P =100%)	100%	99.8%	99.7%	99.8%
Number Not Processed Within 60 Days	412	4,032	5,405	9,849

CONCLUSIONS

Due to differences in reporting data, data for the three MCOs cannot be combined. No explanations were provided as to why the number of claims processed by United and Sunflower exceeds the number of claims received in some months and quarters. The State is aware of these issues and will be working with the MCOs to address this issue in future MCO reporting.

RECOMMENDATIONS

1. KFMC recommends that the three MCOs report timeliness of claims processing in a consistent way.
2. KFMC recommends that the reporting process be revised to more closely resemble the process currently being used by Amerigroup. If this reporting process is implemented, KFMC recommends that the template instructions be revised to instruct the MCOs to report the number and percentage of claims processed within the required 20, 45, or 60 days in the month that the claims were initially received.
3. If the reporting process used by United and Sunflower is preferred by the State, KFMC recommends that additional explanations be required in the MCO reports to better describe and define the types of claims processed, where the number processed that month exceeds the number received.

4. KFMC recommends that Sunflower modify their report to change "# processed" to "# not Excluded from Measure" so that all three MCOs have consistent reporting terminology.

GRIEVANCES

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

Grievances are reported and tracked on a quarterly basis by MCOs in at least three separate reports:

- The P4P reports track the number of grievances received during the quarter; the number of grievances resolved and not resolved within 20 days; and the number of grievances resolved and not resolved within 40 days.
- The Special Terms and Conditions (STC) Quarterly Reports track the number of grievances received in the quarter; the total number of the grievances received in the quarter that were resolved; and counts of grievances by category type. The report includes spaces for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.
- The Grievance and Appeal (GAR) reports track the number of grievances received in the quarter; the number of grievances for which an acknowledgement letter was sent within 10 days; 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 the grievances, including Reason for the Grievance, narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. "Reasons for the Grievance" are further summarized by count in a Reason Summary Chart in the report.

In reviewing the counts reported on the number of grievances received during each quarter, KFMC found that counts often varied slightly by report. Annual differences ranged from 5 to 25, with a combined possible difference of 47 grievances. As each of these reports has a different purpose and focus, it is possible that different staff may review the reports (and possibly not review all three reports). The grievance reports may also be submitted to KDHE on different dates, and counts of grievances may have been revised since submission of the various reports.

KFMC also found inconsistent categorization of grievances in different reports.

- In one of the MCO's Q3 STC report, the 84 grievances were categorized as follows: Quality of Care (16); Benefit Denial or Limitation (4); Claims/Billing Issues (15); Member Rights/Dignity (1); and Customer Service (2).

    - Additional grievance categories in the STC report include: Access to Service or Care; Transportation; Service or Care Disruption; Health Plan Administration; Clinical/Utilization Management; and Other.
- In the MCO's Q3 GAR report, 84 grievances were categorized as follows: Quality of Care (18); Billing and Financial Issues (15); Attitude/Service of Staff (9); Timeliness (40); Prior or Post Authorization (1); and Pharmacy (1).
    - Additional grievance categories in the GAR report include: Accessibility of Office; Quality of office, building; Criteria Not Met – Durable Medical Equipment; Criteria Not Met – Inpatient Admissions; Criteria Not Met – Medical Procedure; Lack of Information from Provider; Level of Care Dispute; HCBS; Sterilization; Sleep Studies; Availability; and Overpayments.

RECOMMENDATIONS

1. KFMC recommends that MCOs and KDHE complete quality checks on grievance reports to ensure consistent reporting of the quarterly number of grievances received.
2. KFMC recommends that grievances categories within reports be clearly defined, and that, wherever possible, grievances categories in different reports be consistently named and defined.

TIMELY RESOLUTION OF GRIEVANCES

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation is based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days.

DATA SOURCE

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report described above.

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

As shown in Table 5 below, 100% of the grievances closed in each quarter of CY2013 were resolved within 30 business days.

The number of grievances closed each quarter remained consistent throughout CY2013. In the second half of the year, the MCOs received 96 fewer grievances than were received in the first half of CY2013.

CONCLUSIONS

In each quarter of CY2013, 100% of the grievances closed each quarter were resolved within 30 business days.

Table 5 - Timeliness of Resolution of Grievances					
	Q1	Q2	Q3	Q4	Total
Number of Grievances Received in Quarter	445	496	422	423	1786
Number of Grievances Closed in Quarter*	422	462	412	427	1723
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	1723
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	100%
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	1723
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%

*The "number of grievances closed" in Q2, Q3, and Q4 includes grievances received in previous quarters that were processed in subsequent quarters.

COMPARE / TRACK THE NUMBER OF ACCESS-RELATED AND QUALITY-RELATED GRIEVANCES OVER TIME, BY POPULATION CATEGORIES.

DATA SOURCE

The data sources used for comparing and tracking over time the access-related and quality-related grievances, by population, are the quarterly STC reports described above.

When KanCare was launched, grievances were monitored in significant detail, and the type of service/member issue involved was clear. The State monitored for any trends, and there were none that indicated any specific member type needed to be addressed separately. Now that the Intellectually/Developmentally Disabled (I/DD) members are being included, they are being monitored separately. Going forward, all HCBS waivers, by type, will be monitored separately to detect any programmatic trends.

ALL GRIEVANCES

Table 6 summarizes the annual and quarterly numbers and types of grievances for the combined MCO populations. As displayed in Figure 1, over 50% of the grievances throughout the year were related to transportation.

Table 7, which delineates the percentages of grievances within each quarter, shows that over 60% of the grievances in Q1 were transportation related. In Q4, only 43.3% of the grievances were transportation-related. Customer Service Grievances also showed a decreasing trend over time, decreasing each quarter from 11.6% of the Q1 grievances to 6% of the Q4 grievances.

Table 6 - Number of Grievances by Category					
	Q1	Q2	Q3	Q4	Total
Access to Service or Care	16	13	13	27	69
Quality of Care or Service	19	34	30	56	139
Transportation	271	261	183	182	897
Service or Care Disruption	3	11	16	7	37
Benefit Denial or LImitation	16	4	7	10	37
Claims/Billing Issues	35	87	48	72	242
Member Rights/Dignity	4	5	10	6	25
Customer Service	52	52	34	25	163
Health Plan Administration	17	31	26	27	101
Clinical/Utilization Management	4	10	14	5	33
Other	13	3	18	3	37
Total No. of Grievances Received	450	511	399	420	1780
Total No of Grievances Resolved	407	453	344	385	1589

Figure 1

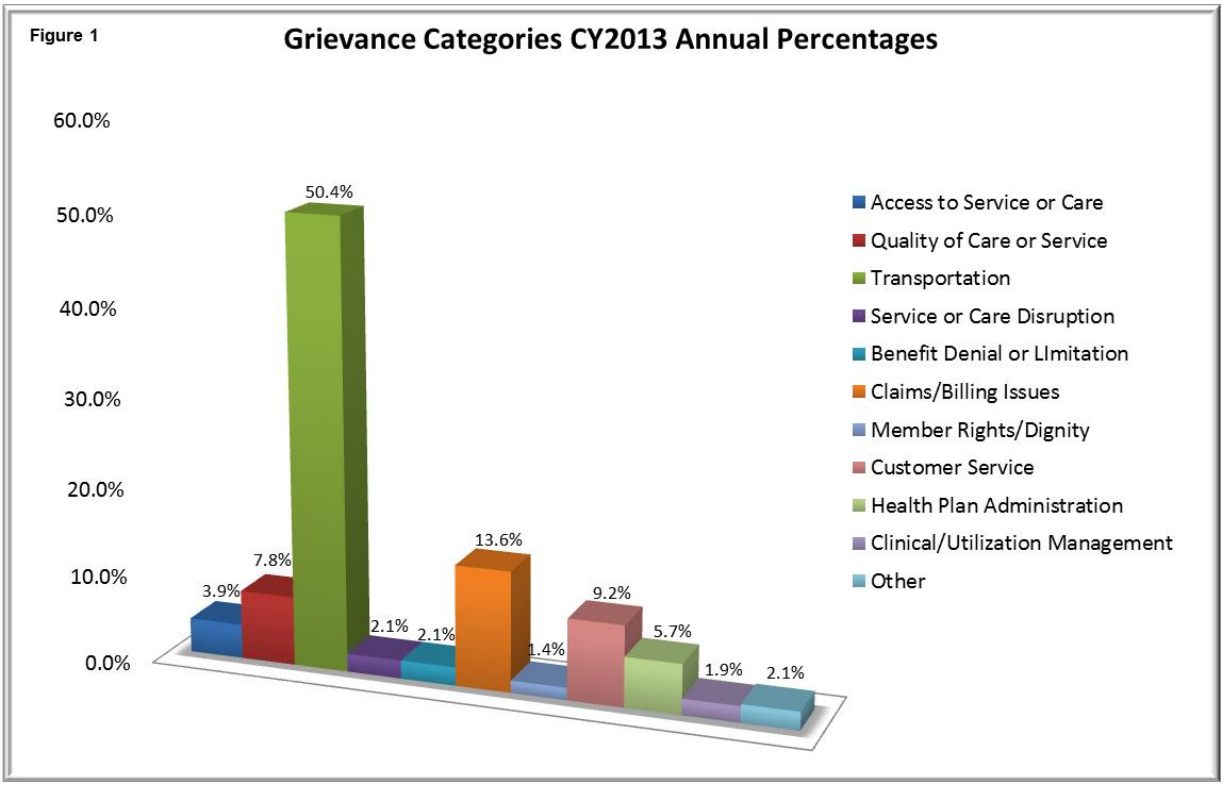

Table 7 - Percentage of Grievance by Category					
	Q1	Q2	Q3	Q4	Annual Total
Denominator	450	511	399	420	1780
Access to Service or Care	3.6% (n=16)	2.5% (n=13)	3.3% (n=13)	6.4% (n=27)	3.9% (n=69)
Quality of Care or Service	4.2% (n=19)	6.7% (n=34)	7.5% (n=30)	13.3% (n=56)	7.8% (n=139)
Transportation	60.2% (n=271)	51.1% (n=261)	45.9% (n=183)	43.3% (n=182)	50.4% (n=897)
Service or Care Disruption	0.7% (n=3)	2.2% (n=11)	4.0% (n=16)	1.7% (n=7)	2.1% (n=37)
Benefit Denial or LImitation	3.6% (n=16)	0.8% (n=4)	1.8% (n=7)	2.4% (n=10)	2.1% (n=37)
Claims/Billing Issues	7.8% (n=35)	17.0% (n=87)	12.0% (n=48)	17.1% (n=72)	13.6% (n=242)
Member Rights/Dignity	0.9% (n=4)	1.0% (n=5)	2.5% (n=10)	1.4% (n=6)	1.4% (n=25)
Customer Service	11.6% (n=52)	10.2% (n=52)	8.5% (n=34)	6.0% (n=25)	9.2% (n=163)
Health Plan Administration	3.8% (n=17)	6.1% (n=31)	6.5% (n=26)	6.4% (n=27)	5.7% (n=101)
Clinical/Utilization Management	0.9% (n=4)	2.0% (n=10)	3.5% (n=14)	1.2% (n=5)	1.9% (n=33)
Other	2.9% (n=13)	0.6% (n=3)	4.5% (n=18)	0.7% (n=3)	2.1% (n=37)

Table 8 below shows the percentage and distribution of the annual number of grievances by category of grievance.

Table 8 - Quarterly Changes in Grievances by Category					
	Q1	Q2	Q3	Q4	Annual Total #
Total Percentage of Annual Grievances Per Quarter.	25.3%	28.7%	22.4%	23.6%	1780
Access to Service or Care	23.2% (n=16)	18.8% (n=13)	18.8% (n=13)	39.1% (n=27)	**69**
Quality of Care or Service	13.7% (n=19)	24.5% (n=34)	21.6% (n=30)	40.3% (n=56)	**139**
Transportation	30.2% (n=271)	29.1% (n=261)	20.4% (n=183)	20.3% (n=182)	**897**
Service or Care Disruption	8.1% (n=3)	29.7% (n=11)	43.2% (n=16)	18.9% (n=7)	**37**
Benefit Denial or LImitation	43.2% (n=16)	10.8% (n=4)	18.9% (n=7)	27.0% (n=10)	**37**
Claims/Billing Issues	14.5% (n=35)	36.0% (n=87)	19.8% (n=48)	29.8% (n=72)	**242**
Member Rights/Dignity	16.0% (n=4)	20.0% (n=5)	40.0% (n=10)	24.0% (n=6)	**25**
Customer Service	31.9% (n=52)	31.9% (n=52)	20.9% (n=34)	15.3% (n=25)	**163**
Health Plan Administration	16.8% (n=17)	30.7% (n=31)	25.7% (n=26)	26.7% (n=27)	**101**
Clinical/Utilization Management	12.1% (n=4)	30.3% (n=10)	42.4% (n=14)	15.2% (n=5)	**33**
Other	35.1% (n=13)	8.1% (n=3)	48.6% (n=18)	8.1% (n=3)	**37**

ACCESS-RELATED GRIEVANCES

Of the 69 access-related grievances reported in CY2013, 27 were reported in Q4, 39.1% of the annual access-related grievances (Table 8). Access-related grievances comprised 6.4% of the Q4 reported grievances (Table 7), a higher percentage than previous quarters. As indicated in Table 9 below, 3 of the 69 access-related grievances were grievances reported for SED waiver members.

Table 9 - Grievances Related to Access to Service or Care					
	Q1	Q2	Q3	Q4	Total
Access Grievances - All Members	16	13	13	27	69
Access Grievances - SED Waiver Members Only	1	2	0	0	3

The STC report described access-related grievances within each quarter:

- Q1 access-related grievances included network gaps, eligibility, difficulty finding a provider in the geographic area, and preference for different primary care providers (PCPs) than those assigned.
- Q2 access-related grievances included providers refusing services to the member; preference for a PCP not in the network; and pharmacy-related grievances.
- Q3 access-related grievances again included providers refusing services to a member, and also included provider availability.
- Q4 access-related grievances included difficulties getting services/supplies, and specialist availability (oral surgery and dermatology).

QUALITY-RELATED GRIEVANCES

Of the 139 quality-related grievances reported in CY2013, 56 were reported in Q4, 40.3% of the annual access-related grievances (Table 8). Quality-related grievances comprised 13.3% of the Q4 reported grievances (Table 7), a higher percentage than previous quarters. The number and percentage of quality-related grievances increased with each quarter of CY2013, increasing from 19 to 56 grievances. As indicated in Table 9 below, 4 of the 139 quality-related grievances were grievances reported for SED waiver members.

Descriptions of quality of care related grievances were generally described in each quarter as perceptions by members of inappropriate treatment by providers, and also included rude and unprofessional behavior by the provider's office staff, difficulty obtaining correct prescriptions, inattentive treatment from care managers, and perception of not receiving adequate care due to being a Medicaid member.

Table 10 - Grievances Related to Quality of Care or Service					
	Q1	Q2	Q3	Q4	Total
Quality of Care Grievances - All Members	19	34	30	56	139
Quality of Care Grievances - SED Waiver Members Only	0	1	2	1	4

CONCLUSIONS

Grievances related to access and quality of care have been increasing over time, particularly for quality of care grievances, which, in Q4, were almost triple the number in Q1 and almost double that of Q2 and Q3.

RECOMMENDATIONS

- As quality of care grievances have increased, MCOs should continue to identify providers that have repeated grievances.
- As indicated above, clearer definitions of "access" are recommended.
- For access-related grievances, tracking and reporting of the residential region of the members could potentially better identify areas of Kansas where focus on the increasing the number of PCPs and/or specialists should be increased.

OMBUDSMAN'S OFFICE

- **EVALUATE TRENDS REGARDING TYPES OF QUESTIONS AND GRIEVANCES SUBMITTED TO THE OMBUDSMAN'S OFFICE.**
- **TRACK THE NUMBER AND TYPE OF ASSISTANCE PROVIDED BY THE OMBUDSMAN'S OFFICE.**

DATA SOURCES

KFMC staff met with James Bart, the Ombudsman during CY2013, and with Kerrie Bacon, the current Ombudsman, on January 31st to discuss the tracking systems used during CY2013 and those planned for CY2014. Another major source of data is the KanCare Ombudsman Update report presented by James Bart on January 17, 2014, to the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight.

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

As of the end of Q4, CY2013, the Ombudsman's Office has a current staffing of two individuals – the Ombudsman and a part-time assistant (as of August 2013). Contact with the Ombudsman's Office is primarily by phone and email. A primary task for the Ombudsman's Office has been to provide information to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns.

In CY2013, the primary tracking mechanism used by the Ombudsman's Office has been the Ombudsman Log. The Log record is based on reporting and categorizing voicemail messages received by the office. Details on other contacts, such as email, outgoing phone calls by the Ombudsman staff, and in-person meetings, are not included in the Ombudsman Log. In the first eight months, before the part-time assistant was hired, most calls received were first received through voicemail due to high volume. With the additional staffing, more calls have been taken directly. As a result, the earlier months of the Ombudsman Log provide a more complete record of the types and number of calls received by the Ombudsman's Office.

Table 11 below summarizes the number and types of voicemail calls received in CY2013. As indicated in Table 11, over half of the 1,848 voicemail calls were messages where the caller did not indicate the reason for the call. Of the remaining calls, the most frequent reason for the calls were related to Pharmacy, Transportation, Billing, and Membership questions and issues. Voicemail calls decreased from 615 in Q1 to 456 in Q2, 436 in Q3, and 341 in Q4. No record, however, has been kept by the Ombudsman's Office on the volume of calls that did not go to voicemail. Although the volume of voicemails decreased greatly throughout the year, some or most of the decrease could be due to the increased availability of staff in the later months of CY2013.

Table 11 - Categorization of Voice Mail Calls Received by Ombudsman's Office

Reason for Call	Q1	Q2	Q3	Q4	Annual Total
Unspecified/Reason Not Disclosed	344	248	207	171	**970**
Reduction in Hours/Service	11	16	12	35	**74**
Eligibility	42	25	70	31	**168**
Pharmacy/Transportation	59	68	28	29	**184**
Billing	72	40	34	24	**170**
Membership	65	2	36	14	**117**
Appeals/Grievance	3	14	10	7	**34**
Status of Network	11	10	8	7	**36**
Assessments	0	4	3	4	**11**
Dental	0	3	5	0	**8**
Thank you for assistance	2	0	2	3	**7**
Returning Ombudsman Call	6	26	21	16	**69**
Total	**615**	**456**	**436**	**341**	**1848**

As shown in Table 12 below, 69% of the voicemail calls related to Pharmacy and Transportation were in Q1 and Q2 of CY2013. Over half of the calls related to Membership, and 42% of calls related to Billing occurred during Q1. Messages related to Reduction of Hours/Service were increased in Q4; 35 messages were recorded in Q4, twice as many as recorded in Q1 and Q2.

Kerrie Bacon, the current Ombudsman, reported that she is continuing to use the Ombudsman Log to track calls, including both voicemail messages and live calls. She is researching tracking systems that will meet the reporting criteria defined in the CMS STC revised in January 2014. As defined in the STC, data that will need to be tracked include the date of the incoming request (and date of any change in status); the volume and type 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.

Table 12 - Quarterly Changes in Types of Voicemail Calls Received by the Ombudsman's Office					
	Percent of Annual Total				
Reason for Call	Q1	Q2	Q3	Q4	Annual Total
Reduction in Hours/Service	15% (n=11)	22% (n=16)	16% (n=12)	**47%** (n=35)	**74**
Eligibility	25% (n=42)	15% (n=25)	**42%** (n=70)	18% (n=31)	**168**
Pharmacy/Transportation	32% (n=59)	**37%** (n=68)	15% (n=28)	16% (n=29)	**184**
Billing	**42%** (n=72)	24% (n=40)	20% (n=34)	14% (n=24)	**170**
Membership	**56%** (n=65)	2% (n=2)	31% (n=36)	12% (n=14)	**117**
Appeals/Grievance	9% (n=3)	**41%** (n=14)	29% (n=10)	21% (n=7)	**34**
Status of Network	**31%** (n=11)	28% (n=10)	22% (n=8)	19% (n=7)	**36**
Assessments	0 (n=0)	**36%** (n=4)	27% (n=3)	**36%** (n=4)	**11**
Dental	0 (n=0)	38% (n=3)	**63%** (n=5)	0% (n=0)	**8**

CONCLUSIONS

Tracking of member concerns and interactions has been limited over this past year to tracking of voicemail messages received. In CY2014, tracking systems will need to be implemented to meet criteria defined in the revised STC and should greatly improve tracking of member concerns from original contact through resolution.

RECOMMENDATIONS

1. Comprehensive tracking of member concerns related to the Ombudsman through phone calls, emails, and personal contact will greatly improve tracking of member concerns.
2. Tracking of non-issue related services provided by the Ombudsman's Office is recommended.

QUANTIFY SYSTEM DESIGN INNOVATIONS IMPLEMENTED BY KANCARE

One of the KanCare measures included in the KanCare quarterly evaluation is to "quantify system design innovations implemented by KanCare such as: person centered medical homes, electronic health record use, use of telehealth, and electronic referral systems." Some of these systems can be created by KanCare such as Health Homes, and some are dependent upon the providers in the program to initiate, such as electronic health records.

KDHE is on track to implement Health Homes for two target populations on 7/1/2014. The first population will be KanCare beneficiaries with "one serious and persistent mental health condition" and the second target population will be KanCare beneficiaries with "one chronic condition and at risk for a second." All beneficiaries who meet the definitions for these populations will be assigned to a Health Home and will have to "opt-out" if they choose not to participate. The Health Home model expands upon patient centered medical home models to include links to community and social supports. All of the caregivers in a health home will communicate with one another so that all of the beneficiary's needs are addressed in a comprehensive manner.

There are a number of organizations in Kansas who have or are currently involved in efforts to help healthcare providers become Patient Centered Medical Homes (PCMH) and be recognized by the National Committee for Quality Assurance (NCQA). Below is a summary of these organizations and the work they are doing:

- In February 2007 the national associations representing primary care physicians; American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA) released joint principles of PCMH. In September 2007, the Kansas organization representing primary care physicians convened and formed the Kansas Primary Care Physicians Coalition, focusing on initiatives surround PCMHs. On 1/1/2011, the Kansas PCMH Initiative began under the collaborative leadership of these four Kansas organizations. Kansas PCMH was a 24-month pilot project to demonstrate the impact of transitioning to patient-centered care for small (≤5 physicians) physician practices. The initiative was started with major funding from the United Methodist Health Ministry Fund, the Sunflower Foundation, and the Kansas Health Foundation. In April 2011, Blue Cross/Blue Shield of Kansas pledged payer support for the eight selected clinics. Carolyn Gaughan, KAFP Executive Director, reports that two of the eight practices achieved Level 3 NCQA PCMH certification and all eight practices evidenced improvement in the quality of care provided.
- KFMC's Regional Extension Center (REC) partnered with TransforMED to provide assistance to six physician practices in five communities statewide to implement the PCMH model of care. While the KFMC is no longer partnering with TransforMED, the KFMC Patient-Centered Medical Home Partnership (PCMHP) continues to assist the six physician practices in becoming PCMH certified through strategic use of an electronic health record system. According to Karlen Haury, Program Leader, five of the six practices plan to submit for NCQA certification this year.
- Blue Cross/Blue Shield of Kansas in addition to its participation in the Kansas PCMH Initiative implemented a Quality Based Reimbursement Program (QBRP) in 2012 and modified it for 2013 to ensure they achieve qualified health plan status as required by the Health Care Reform Act. The QBRP is also utilized to encourage high quality and cost constraints. The QBRP 2013 provides office-based primary care physicians a .75% incentive payment if the clinic receives PCMH recognition through NCQA. It should also be noted that BC/BS of Kansas also has a .50% incentive for clinics that have received Diabetes recognition through NCQA's program.

- The Kansas Association for the Medically Underserved (KAMU), which is the Kansas Primary Care Association, has been working on a PCMH initiative with its Federally Qualified Health Center (FQHC) members. In 2012, KAMU and the FQHCs began working with Qualis, a non-profit organization located in Seattle, Washington, to assist the FQHC's to meet NCQA PCMH certification standards. Susan Wood, KAMU Chief Quality Officer, reports that about 40% of the 17 FQHCs in Kansas have been recognized by NCQA as PCMHs.

The American Recovery and Reinvestment Act (ARRA) signed into law in February 2009 included the Health Information Technology for Economic and Clinical Health Act (HITECH Act). HITECH includes provisions to promote the meaningful use of health information technology to improve the quality and value of American health care. The Office of the National Coordinator for Health Information Technology (ONC) within the Department of Health and Human Services (HHS) was given the responsibility of coordinating the effort to implement a nationwide health information network (NwHIN) infrastructure that allows for the use and exchange of electronic health information in electronic format.

ONC, in addition to convening the health IT community to prioritize, develop and harmonize the standards and specifications needed to enable interoperable health information exchange across the country, recognized that small physician clinics would need technical assistance to adopt and implement electronic health records. This technical assistance was provided to over 100,000 priority primary care physicians by 62 RECs located across the country. KFMC is the REC for Kansas and will continue to provide these services through February 2015.

The Centers for Medicare & Medicaid (CMS) also have a role in HITECH. CMS operationalized MU by setting up core and menu set measures that must be met by eligible professionals (EPs) and eligible hospitals (EHs) to receive incentive dollars or to avoid Medicare reduced payment adjustments. CMS administers the MU incentive program for Medicare EPs and EHs. Each state is in charge of the program for Medicaid providers. However, there is very little variation allowed between what CMS requires in each state's program.

CMS also provided funds to each state to develop health information exchange (HIE) capabilities. Kansas has two certified HIE organizations, the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). Both of these HIEs are operational and are actively sharing electronic clinical information with each other and their participants.

The HITECH Act has fueled interoperability advancements which will enable IT infrastructure needed for true care coordination. KanCare's Health Home Partners (HHPs) will be required to provide truly collaborative coordination and management of care. KanCare is in a position to improve the exchange of information between all care providers for beneficiaries.

KDHE contracted with KFMC to provide technical assistance to Medicaid providers who have not yet reached MU of an EHR. KFMC will also conduct an EHR readiness

assessment, vendor selection, and implementation services for Health Home Partners contracted with KanCare. This contract and the continuation of the REC program through February 2015 should have a positive effect on the availability of health information exchange.

Telehealth and telemedicine are important to states such as Kansas which have large rural areas with limited access to healthcare providers, particularly specialists. The University of Kansas Medical School, Center for Telemedicine & Telehealth (KUCTT) stated in 1991 providing a service to a community in western Kansas. Today it provides services to more than 100 sites throughout the state. It also hosts education events for health professionals, teachers, students, and the public across the network. The Heartland Telehealth Resource Center (HTRC) is one of several, federally designated telehealth resource centers supported by the Telehealth Resource Center Grant Program administered through the Office for the Advancement of Telehealth (OAT) in the Office of Health Information Technology. KUCTT is the leading organization of HTRC.

The United States Department of Agriculture (USDA) Rural Development program has distance learning and telemedicine loan and grant programs specifically designed to meet the educational and health care needs of rural America. Various organizations in Kansas benefit from this resource. KVC Health Systems, Inc. provides a good example of how this program can assist KanCare providers in providing access to their members. According to an article in the online version of Kansas Farmer, published on 2/18/2014, KVC Health Systems, Inc. was one of two Kansas organizations to receive distance learning and telemedicine grants totaling more than $750,000.

KVC Health Systems is a nonprofit child welfare and behavioral healthcare organization whose headquarters is located in Olathe, KS. KVC will use its $330,695 grant to develop a video conferencing platform and purchase 400 iPads. The development of the video conferencing platform will enable KVC to extend continuing education and required supervision for staff in rural, high-need areas. The iPads will be placed in the homes of children in foster care in West Virginia and Kentucky. The iPads will enable these children to have immediate assistance of KVC staff when they need it the most. KVC will expand this program to subsidiaries in Kansas and Nebraska after a successful initial implementation. The success of solutions such as this, will be important to monitor as options for increasing access to KanCare beneficiaries.

KFMC did not find any evidence of a comprehensive electronic referral system being utilized by primary care and specialty practitioners.

KFMC will update the activities of the organizations contained within this section each quarter as appropriate. Additionally, this section will be updated with new KanCare initiatives and/or resources provided by other entities.

End of report.