Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.14

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2014-12/31/2014)
Federal Fiscal Quarter: 1/2015 (10/14-12/14)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

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

Demonstration Population	Enrollees at Close of Qtr. (12/31/14)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	17,288	18,735	1,447
Population 2: ABD/SD Non Dual	28,910	29,746	836
Population 3: Adults	40,972	44,083	3,111
Population 4: Children	226,067	236,351	10,284
Population 5: DD Waiver	8,705	8,778	73
Population 6: LTC	20,617	21,922	1,305
Population 7: MN Dual	1,176	1,343	167
Population 8: MN Non Dual	1,015	1,182	167
Population 9: Waiver	3,910	4,034	124
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**348,660**	**366,174**	**17,514**

III. Outreach/Innovation

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

During the fourth quarter, a Tribal Technical Advisory Group (TTAG) meeting with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations was held, on the following date with attendees in person and by phone: December 2 (8 attendees).

Also during this quarter, the state's KanCare Advisory Council met on December 15, 2014. The Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists.

The agenda for the council's December meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, September 25, 2014
III. Updates on KanCare with Q & A
    a. Sunflower State Health Plan
    b. UnitedHealthcare Community Plan
    c. Amerigroup Kansas
IV. KDADS Update – Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services
V. KDHE Update – Susan Mosier, Acting Secretary/Director of KDHE Division of Health Care Finance/Medicaid Director Division, and Mike Randol, Director of Program Finance and Informatics, Division of Health Care Finance, Kansas Department of Health and Environment.
VI. Next Meeting of KanCare Advisory Council – March 16, 2015, Curtis State Office Building, Room 530, 2:00 to 3:30 pm
VII. Adjourn

The KanCare Consumer and Specialized Issues Workgroup met on December 18, 2014, in Lawrence, Kansas. The agenda items included a report from the KanCare Ombudsman, and HCBS waiver renewal updates. The meeting also included an in-depth look at KDHE's KanCare Executive Summary Report dated 12-15-14 and a discussion with the KanCare MCOs about case managers' continuity. We will be starting with and/or renewal membership for this workgroup as the two year expectation ended in 2014.

The KanCare Provider and Operational Issues workgroup met December 11, 2014. The KDHE Health Homes program manager related success stories about the new program, enabling some members to receive care that they might not otherwise have received. The KDADS program manager for behavioral health issues gave a presentation on some of the current challenges in KanCare with behavioral

health. All three MCOs had mental health program representatives attending to answer questions. These two overviews and subsequent question-and-answer sessions comprised the majority of the workgroup meeting. In addition, all three MCOs provided general claims and operational updates to the group. The KanCare Provider and Operational Issues workgroup meets quarterly.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly)
- HCBS-IDD Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, bi-weekly)
- CDDO meetings with KDADS and MCOs (bi-weekly)
- TCM meetings with KDADS and MCOs (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings (monthly) to discuss KanCare and stakeholder issues
- Interhab (CDDO Association) board meetings (as requested) and Interhab Annual Conference
- Traumatic Brain Injury Association of Kansas meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- KanCare's Provider and Operational Issues Workgroup (quarterly)
- KanCare's Consumer and Specialized Issues Workgroup (quarterly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings (monthly) to address billing and other concerns
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Quarterly Meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Series of meetings with KDADS to discuss the state hospital census
- Series of meetings and workgroups with KDADS discussing DSM 5 implementation
- Series of meetings and workgroups on HCBS Waiver Services renewal

In addition, Kansas has pursued some targeted outreach and innovation projects, including:

Health Homes

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. The State Plan Amendment (SPA) to implement Health Homes for people with serious mental illness (SMI) was approved by CMS on July 28, 2014 with an effective date of July1, 2014.

- 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 at different times; Health Homes for people with chronic conditions has been delayed to allow for ensuring an adequate network of Health Home Partners
- 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
- 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 to be held from February through June 2014
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Holding 32 meetings in 16 cities for consumers to introduce the Health Homes program
- 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
- Developing the PMPM rate for SMI Health Homes
- Publishing a draft Program Manual for SMI Health Homes
- Issuing tribal notification to the four recognized American Indian tribes
- Holding six day-long provider training sessions across the state
- Publishing a draft Program Manual for Chronic Conditions (CC) Health Homes
- Developing PMPM rates for 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
- Issuing public notice about the SPAs and their fiscal impact
- Submitting both SPAs to CMS officially on May 7, 2014

- Withdrawing the Chronic Conditions SPA on June 30, 2014 to allow us more time to ensure an adequate network of Health Home Partners is available
- Performing an operational readiness review of the MCOs May 20-22, 2014
- Reviewing network reports submitted by the MCOs
- Completing operational work to receive files from and pay the MCOs for Health Home services
- Scheduling SMI Health Homes Implementation calls weekly to hear from providers and address systemic issues and questions
- Scheduling weekly calls with stakeholders to provide updates on the progress toward implementation of the Chronic Conditions Health Home
- Developing reporting requirements
- Beginning Learning Collaborative activities, including establishing a schedule of monthly webinars and holding the first quarterly statewide in-person meeting
- Continual outreach and engagement with providers to help them understand Health Homes, encourage them to consider becoming a Health Home Partner and foster cooperation and collaboration with HHPs

- Updates from implementation:
  - 27,766 people are enrolled in SMI Health Homes. A total of 4,894 people have opted out of Health Homes, for an opt out rate of almost 15% - less than our projected opt out percentage of 25%. The opt out percentage has dropped by 3% since the last report. Members with intellectual or developmental disabilities (IDD) comprise 4.9% of current Health Home members.
  - There are 80 contracted Health Home Partners (HHPs), although not all 80 contract with all three Lead Entities (managed care organizations - MCOs). Each MCO has at least 56 contracted HHPs.
  - The Learning Collaborative kicked off in August, with a monthly webinar. There will be monthly webinars and quarterly in-person meetings for HHPs, Lead Entities and state staff to support provider implementation of Health Homes and provide peer-to-peer learning and exchange of ideas.
  - Currently, the two most frequently provided core services are Health Promotion and Care Coordination, followed by Comprehensive Care Management.
- Success Stories: There have been many early implementation successes. To share them, and inspire others, a booklet of successes has been developed and printed. A copy of that booklet is attached.

MCO Outreach Activities

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

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

Marketing Activities: Amerigroup participated in over 140 events for the fourth quarter, 2014, which included partner development, sponsorships, outreach and advocacy. The primary focus for their Community Relation Representatives continued to be member education of services and benefits of the KanCare program. They continue to develop strong partnerships across the state by enhancing existing relationships and building new ones. In the 4th quarter, Amerigroup's Community Relations team was involved in several annual conferences. They also actively pursued opportunities to strengthen relationships with organizations supporting their Diabetes and Well child initiatives. Below is a sampling of Marketing activities Amerigroup supported in the fourth quarter:

- Kansas InterHab 2014 Power UP Conference
- Kansas 2014 Disability Mentoring Days across the state.
- Kansas NAMI Conference
- Kansas HCBS State wide meetings
- FQHC partner development

Outreach Activities: Amerigroup continued their outreach efforts where they reach out by phone and mail to new members to welcome them and to ensure they have completed their initial risk assessment. They also continued with their targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services.

Amerigroup mailed new self-advocacy and wellness guides for men and women to all households in the fourth quarter. Amerigroup also updated their member handbook which is available through member services and through our member website. The Community Relation Representatives participated in a variety of community events reaching over 12,000 Kansans this quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain invaluable feedback and to cover current topics that are relevant to their members such as: diabetes, well child visits, employment, high blood pressure, your PCP and you, and others. Below is a sampling of some of their outreach efforts this past quarter:

- Kansas 2014 Disability Mentoring Days across the state.
- Kansas Cafe Con Leche Exhibit
- Kansas KIDS Network of Kansas Baby Shower

Advocacy Activities: Amerigroup's advocacy efforts for fourth quarter 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 proactive and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help them learn what the needs of the community are and how they can better serve them and improve their quality of life. The fourth quarter advocacy efforts remain similar to those of the previous quarters. Amerigroup continued to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process. Here are a few examples of their Advocacy Activities this last quarter:

- 2014 Minds Matter Community Works
- Kansas Central Exchange Network
- Kansas Mexican Consulate Exhibit
- Kansas Health Days USD 500 Exhibit
- Kansas Immediate Medical Care West Location Maintenance
- Kansas Resource for Independent Living Center

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

Marketing Activities: Sunflower Health Plan marketing activities for 4th Quarter 2014 included sponsorships of member and provider events, as well as fundraisers. Sunflower's Marketing Department developed new collateral for the New Member Packet, which is sent to new members during open enrollment.

Examples of fourth quarter 2014 marketing that generated support and attendance at sponsored events as well as health plan visibility in the community include:

- InterHab's annual PowerUp conference, Oct. 15-17, 2014
- Family & Service Guidance Center's annual Hearts of Hope fundraiser, series of fall 2014 events
- Brain Injury Association (BIA) of Kansas & Greater KC Family and Survivor Seminar, Oct. 25, Nov. 1, 2014
- GraceMed Clinic's 'Say Grace' 5K event to raise funds for clinic operations, Nov. 28, 2014
- Donated water bottles for attendees at Local Health Department 'Becoming a Mom' classes

Following market research and advisement from the plan's Member Advisory Committee, Sunflower's re-developed/re-branded New Member Packets include:

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

Outreach Activities: In addition to regularly scheduled Adopt-a-School events and Baby Showers facilitated by Sunflower's MemberConnections department, the health plan's 4Q14 outreach activities involved efforts to get members vaccinated against influenza and to collaborate on Disability Mentoring Day (DMD) events across Kansas.

Sunflower partnered with Independent Living Resource Centers, other provider types and community organizations to provide Disability Mentoring Day activities in more than 15 communities throughout October and November.

Medical Management staff contacted thousands of members in 4thQ 2014 to encourage them to receive the flu vaccine, and the outreach has seen positive results. Vaccination claims have more than doubled compared to last flu season.

The LifeShare Pathways team at Sunflower facilitated four flu vaccine clinics at service locations (e.g., CDDOs) for people with I/DD.

The Medical Management MemberConnections department organized the following outreach events throughout the state of Kansas in the 4th quarter of 2014:

- Adopt-a-School event - Lincoln Elementary in Lincoln, KS, in October for approximately 40 children. Each child received a healthy activities book, Fitropolis and a healthy snack.
- Start Smart baby shower - Wichita on October 30. Topics covered included labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC, and breastfeeding. Two Sunflower Health Plan RNs were in attendance to address any member questions related to pregnancy and childbirth. There were 17 members and guests with an attendance of more than 50 people.
- Adopt-a-School event - Head Start in Wichita on November 12. There were approximately 50 children in attendance. The Gunky Bacteria Brothers book and a healthy snack were given to each child.
- Adopt-a-School event - Lincoln Elementary, in Lincoln, KS, in November. There were approximately 60 children in attendance. The Gunky Bacteria Brothers book and a healthy snack were given to each child.
- Start Smart baby shower - Garden City on December 1. Topics covered included labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC, and breastfeeding. A Sunflower Health Plan RN was in attendance to address any member questions related to pregnancy and childbirth. There were 20 members and guests with an attendance of over 30 people.
- Adopt-a-School event - Ulysses, KS, on December 2 at Ulysses High School. The group of 7 teenagers included boys and girls that have had babies. They were given the following books: Baby Fuel; Body Well, Baby Well!; and, Dad: Little Word, Big Deal.

Advocacy Activities: Sunflower and its partner, LifeShare, advocated for people with I/DD through a variety of stakeholder engagement opportunities.

- One Sunflower employee attended the series of webinars called 'Advocacy Bootcamp' facilitated

throughout October and November by InterHab, the organization advocating for persons with I/DD and other disabilities.

• University partnerships – Engaged in conversations with university personnel from schools like University of Kansas, Washburn University, Emporia State University and Wichita State University to ensure ongoing awareness and best practices for people with I/DD, post-secondary education and employment.

• Self-Advocacy Coalition of Kansas (SACK) – Worked to expand self-advocacy groups and member participation in local and statewide events.

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

Marketing Activities: UnitedHealthcare Community Plan of Kansas' main activities are focused on education of members concerning health services and benefits while being a member of United. United has done this through attendance at community events that attract membership base, member welcome calls, mailings to those that could not reached by phone, and sending out quarterly Member Newsletters to membership. United continues meeting individually with key Medicaid medical provider offices to provide them with education on the benefits that members can achieve by completing their health screenings and by effectively managing their health with wellness activities.

Outreach Activities: United has three outreach specialists focused on activities targeted within their specific geographic areas of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, the features of KanCare and the benefits of the plan. They especially inform individuals about the value added benefits. United also has a Provider Marketing Manager whose role is to work with key provider offices throughout the State to assist them with any issues and to make sure the providers are educated on the benefits of UnitedHealthcare for members who visit their offices. More specifically:

- During the fourth quarter of 2014, UnitedHealthcare staff personally met with 4,329 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sites held at key provider offices throughout Kansas.
- During the fourth quarter of 2014, UnitedHealthcare staff personally met with 1,222 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.
- During the fourth quarter of 2014, UnitedHealthcare staff personally met with 796 individuals from provider offices located throughout the State.

Advocacy Activities: United's activities in advocacy continue to be focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with intellectual and developmental disabilities. United is also working to educate those individuals who participate in the physical disability and frail elderly waiver programs. United has one Outreach Specialist focused specifically and exclusively on members with disabilities and the providers/stakeholders who support them. More specifically:

- The United outreach specialist to the disabled community personally visited with 275 advocates for the disabled in Kansas, providing them with education on KanCare and UnitedHealthcare benefits. The specialist has also been meeting with individual members and advocates across the State regarding implementation of I/DD services into managed care. In addition, that specialist has been working internally to make sure that all operations of plan activities are focused on making sure that United members are well represented in all processes.
- That same outreach specialist also worked in conjunction with the Empower Kansas steering committee on collecting more RFPs to award grantees which were presented to organizations during the fourth quarter of 2014.
- Every quarter the plan holds a Member Advisory Council meeting to educate members on what the plan is working on and receive feedback on ways that United can improve the processes for members. During the fourth quarter, the meeting focused on Empower Kansans, the United project to update provider network information, and new value added benefits being offered to our members in 2015.

IV. Operational Developments/Issues

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

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December, 2014, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	3,662	$421,759
	Member Incentive Program	12,865	$279,055
	Mail Order OTC	8,990	$148,449
	Total of all Amerigroup VAS Jan-Dec 2014	***31,269***	***$1,010,273***
Sunflower	CentAccount debit card	49,468	989,360
	Dental visits for adults	19,324	406,952
	Smoking cessation program	579	138,960
	Total of all Sunflower VAS Jan-Dec 2014	***114,656***	***1,828,782***
United	Additional Vision Services	10,662	$517,351
	Adult Dental Services	2,039	$109,345
	Join for Me - Pediatric Obesity Classes	35	$87,500
	Total of all United VAS Jan-Dec 2014	***134,341***	***$1,094,729***

c. Enrollment issues: For the fourth quarter of calendar year 2014 there were 14 Native Americans who chose to not enroll in KanCare. Of those 14, only 9 remain eligible.

The table below represents the enrollment reason categories for the 4th quarter of calendar year 2014 (October, November & December). All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	4
KDHE - Administrative Change	152
WEB - Change Assignment	15
KanCare Default - Case Continuity	173
KanCare Default – Morbidity	447
KanCare Default - 90 Day Retro-reattach	216
KanCare Default - Previous Assignment	350
KanCare Default - Continuity of Plan	3,966
AOE – Choice	213
Choice - Enrollment in KanCare MCO via Medicaid Application	1,275
Change - Enrollment Form	372
Change - Choice	613
Change - Access to Care – Good Cause Reason	15
Change - Case Continuity – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	11
Total	**7,822**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY14 4th quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Bene-fits	Billing/ Fin Issues	Transp-Timely	Transp-Access	Phar	DME	Med Proc/ Trtmt	Waiver HCBS Service	Mail/ Other
AMG	4	55	20	27	1	25	0	2	5	0	0	12	3
SUN	3	32	5	27	9	24	31	0	2	0	0	0	13
UHC	0	0	24	59	1	183	65	0	2	0	0	0	0

Members - CY14 4th quarter report
MCOs' Appeals Database

MCO	PA Dental	PA DME	PA MRI, CT	PA Phar-Macy	PA OP/IP Surg/ Proc	PA Comm Based Svcs	LTSS/ HCBS PCA/ LTC/ RTC/ TCM/ MH Hrs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt Covg	Ster/ Epid Inj/ Sleep	PCP/ Spec-ialist	Bal Bill	Claim Denial	Lock-In
AMG	5	0	5	2	1	0	3	0	0	3	2	0	0	0	0
SUN	1	20	9	13	16	24	27	9	23	7	0	0	0	0	1
UHC	3	5	0	12	4	0	3	1	0	1	0	3	2	1	0

Providers - CY14 4th quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Phar	MCO Plan Admin/ Other	MCO QOC	MCO Cred/ Cont	Vision Auth	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Dent Plan Admin	Dent Clin/ UM	Cen-patico STRS Auth
AMG	8	2	2,776	43	0	0	0	0	0	2	0	0	0	0	0
SUN	0	0	649	0	0	0	0	0	1	19	6	2	0	0	0
UHC	0	0	2,335	0	0	0	0	0	0	6	0	14	0	0	0

State of Kansas Office of Administrative Fair Hearings

Members - CY14 4th quarter report

AMG-Red SUN-Green UHC-Purple	PA Dental Denied	PA CT/ MRI/ X-ray Denied	PA Skilled Nursing Denied	PA Pharm Denied	PA DME Denied	PA Home Health Hours Denied	Assistive Svc Funds Denied	PA PT/ Inpt Rehab Denied	LTSS/ HCBS/ WORK PCA Hours Denied	PA Med Proc Denied
Withdrawn	1						3	2 1		
Dismissed-Moot MCO reversed denial		1	2	1		3	3	1 2	1	
Dismissed-No Adverse Action			1							
Default Dismissal Plaintiff no-show	1	1		1	1	1	1	3	1	
Dismissed-Untimely				2			2	2		
FH in process										
OAH upheld MCO decision	1		1 1			5	2	2 1	1	1
OAH reversed MCO decision										
FH dec pending										

Providers - CY14 4th quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied	Dental Denied	DME Denied	Radiology Denied	Hearing Screen Denied	Home Health Denied	PT Denied	Inpt/ Hospice/ Rehab Coverage Denied	Waiver Eligibility Denied	Med Proc Denied
Withdrawn	10					1	1			10
Dismissed-Moot MCO reversed denial	59		2	1	9	5	1	6	2	59
Dismissed-No internal appeal	12 4			1	3			1	1	12 4
FH in process										
Dismissed-Untimely	2		1		1	11		1		2
OAH upheld MCO decision	3									3
FH dec pending										

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

f. Changes in provider qualifications/standards: In the fourth quarter of 2014, Kansas submitted renewals on December 31, 2014, that included proposed changes to provider qualifications related to FMS, guardianship, and conflict of interest mitigation. The proposed changes impact the Frail Elderly (FE), Intellectual/Developmental Disability (IDD), Physical Disability (PD), and Traumatic Brain Injury (TBI) programs.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. During the first half of 2014, there was an upswing in requests for changes in plan affiliation outside of the open enrollment period. This trend reversed course in the third quarter of 2014, and continued downwards through the final 2014 quarter, down to total of 98 from the 182 requests submitted for the third quarter. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers with that MCO are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

The good cause requests during the fourth quarter show no discernable trend for requests.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2014, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	October	November	December
Total GCRs filed	47	24	27
Approved	4	1	2
Denied	20	11	12
Withdrawn (resolved, no need to change)	14	6	5
Dismissed (due to inability to contact the member)	9	4	1
Pending	0	2	7

There are still providers being added to the MCOs' networks with much of the effort still focused upon I/DD service providers. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/31/14	# of Unique Providers as of 6/30/14	# of Unique Providers as of 9/30/14	# of Unique Providers as of 12/31/14
Amerigroup	15,667	13,455	13,682	13,997
Sunflower	15,931	16,314	17,728	18,056
UHC	19,872	19,911	19,747	19,476

h. Proposed changes to payment rates: Capitated payment rates were unchanged during this quarter.

i. MLTSS implementation and operation: In the fourth quarter, Kansas offered services to several hundred individuals on the HCBS-PD and HCBS-IDD Program waiting lists. Additional information is available in section XIII. Additionally, concentrated efforts to work with MCOs to move individuals out of institutional settings into their homes and communities using the Money Follows the Person federal grant resulted in a significant increase in referrals and transitions from institutions. The State will submit a comprehensive sustainability plan for Money Follows the Person by April 1, 2015. The State submitted four 1915(c) waiver renewals on December 31, 2014, with proposed changes and the CMS Final Rule required transition plans. Additional information is provided in subsection K below.

   Also In the fourth quarter, Kansas submitted updated changes to the financial management services (FMS) model in the HCBS renewals (FE, PD, TBI, and IDD), consistent with the FMS workgroup's recommendations and supporting consumers as employers of their direct service workers. Kansas operates a model that does not neatly fit in the two prescribed categories of FMS. However, CMS recognizes the value of the hybrid model in Kansas and provided guidance that the Kansas model is closest to the vendor fiscal employer agent model. Amendments for HCBS-Autism and HCBS-Technology Assisted will be submitted to CMS the first quarter of 2015.

j. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). Children's Mercy Hospital has chosen to do the following projects: Complex Care for Children and Patient Centered Medical Homes (PCMH). Kansas University Medical Center will be completing Sepsis and Self-Management and Care (SMAC) Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The State, KFMC and hospitals collaborated to determine the measures being used to evaluate the projects for the DSRIP activities. On

September 30, 2014, the State submitted the Children's Mercy Hospital and Kansas University Hospital Project Plans and Budgets to CMS per the timeline. CMS reviewed the DSRIP proposals submitted by the State and responded with further questions on November 21st. The State, KFMC and hospitals answered the questions and made appropriate changes to the DSRIP proposals. The final DSRIP proposals were submitted to CMS on December 19, 2014.

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

FE, PD, TBI & IDD 1915(c) Renewal: In the third quarter, KDADS and CMS requested that the State would not submit the renewal applications for the Intellectual and Developmental Disability (IDD), Traumatic Brain Injury (TBI), Physical Disability (PD) and Frail Elderly (FE) 1915(c) waivers until additional guidance from CMS was provided about the HCBS Transition Plan and new requirements of the CMS Final Rule. Temporary extensions were granted to ensure Kansas complied with the Final Rule requirements for the renewals.

In the fourth quarter, to comply with the HCBS Final Rule on settings, person-centered planning and conflict of interest, KDADS hosted an additional 30 day public comment periods from November 10, 2014 to December 20, 2014. These sessions, conducted in November and December, were held in person and by conference call, and public comments were submitted in person, by phone, or by email. The renewals were submitted on December 31, 2014 and included proposed changes to the waivers related to guardianship, service definitions and the HCBS Transition plan. A summary of proposed changes and public comments are available online at www.kdads.ks.gov.

CMS Final Rule on HCBS Settings: In the fourth quarter, KDADS completed an additional round of public information sessions related to the HCBS Final Rule, Department of Labor Rule, and proposed changes to all of the HCBS Programs, including those being submitted for renewals. Additionally, education and information sessions were conducted via conference call related to the CMS Final Rule concerning conflict free requirements and the person-centered planning process. KDADS staff presented at stakeholder conferences and consumer meetings to address concerns related to these requirements. Kansas has requested technical assistance to ensure compliance and included proposed changes in the renewals.

k. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight Committee, a statutory joint legislative committee, met once during the fourth quarter, on November 18, 2014, to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The committee received reports from KDHE, KDADS, the KanCare Ombudsman, each of the three KanCare MCOs, and took comments from stakeholders, including providers, advocacy groups,

associations and other interested stakeholders. The committee received also information from Kansas Insurance Department and Legislative Post Audit staff.

V. Policy Developments/Issues

a. **General Policy Changes**

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

b. **HCBS Program Policy Changes**

During the fourth quarter, Kansas continued negotiations with contracted assessors for the HCBS-IDD Program. As a result of negotiations, it was agreed that the policy related to extraordinary funding for individuals with IDD who needed additional or extraordinary support and who would otherwise be institutionalized because of the medical or behavioral health needs was transferred to the MCOs, effective January 1, 2015. Previously, the community developmental disability organizations were responsible for reviewing and approving extraordinary funding for community service providers of day and residential supports. A temporary, transition policy was developed and presented for public comment in December 2014. This policy includes procedural steps for providers to submit requests and renewal packets directly to the MCOs for review and approval.

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 2014 (DY2-Q4), the State removed the October payment amount/enrollment for September and input the November payment amount/enrollment for October. 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. That budget neutrality monitoring spreadsheet for QE 12.31.14 is attached.

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.

General reporting issues: The second demonstration year has brought additional challenges to reporting. (Reports for both DY1 and DY2 are now needed and the fiscal agent needs to identify which DY the expenditure is charged to.) 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	*2014-10*	*2014-11*	*2014-12*	*Grand Total*
Population 1: ABD/SD Dual	18,047	17,836	17,313	53,196
Population 2: ABD/SD Non Dual	29,394	29,183	28,938	87,515
Population 3: Adults	41,016	40,994	40,979	122,989
Population 4: Children	227,116	226,807	226,073	679,996
Population 5: DD Waiver	8,725	8,732	8,716	26,173
Population 6: LTC	21,265	21,093	20,922	63,280
Population 7: MN Dual	1,321	1,289	1,186	3,796
Population 8: MN Non Dual	1,159	1,106	1,016	3,281
Population 9: Waiver	3,963	3,922	3,914	11,799
Grand Total	**352,006**	**350,962**	**349,057**	**1,052,025**

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

VIII. Consumer Issues

Summary of consumer issues during the fourth quarter of 2014:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member claims denied incorrectly due to Third Party Liability (TPL). Claims are denied for EOB's when none are required.	MCO's continue to have difficulties bypassing TPL editing for procedures known to never be covered by common TPL carriers (like Medicare). Issue is monitored by TPL manager with the State and issues are discussed during state/MCO conference calls.	All plans have system correction projects under way and reprocessing projects will follow. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor. KDHE is also constantly adding new procedures to bypass TPL requirements.
Member client obligation incorrect.	Weekly spreadsheets were sent to the state, showing MCO remediation efforts until the main issue was corrected in April and May. Continuing system configuration issues remain, and programming projects are still underway.	Some system correction projects and reprocessing projects continued during the fourth quarter. Further projects will continue into 2015.
Member claims denied incorrectly due to Third Party Liability (TPL). Claims are denied for EOB's when the member has no other insurance.	Members are having claims denied due to incorrect member lead TPL files. This is a sporadic problem with all MCO's, and there is an upswing of issues in Q4. Either old TPL information resurfaces on their file or a new file is built for TPL that does not apply to the member.	KDHE, the fiscal agent and the three MCOs are adopting a new TPL lead file layout/format to make the information more uniform and easier for everyone to update.
Retroactively eligible members are denied authorizations.	Members are denied authorization due to retroactive eligibility. The determination date of eligibility is not loaded by the MCOs into their systems, and they cannot determine if this determination date is before or after the authorization request date.	There is plans to utilize a field in the new eligibility system KEES when it becomes available.

KanCare open enrollment continues for the people who were approved for KanCare after January 2013. A summary of related activity for this quarter is as follows:

Month	No. of Packets Mailed	KC19 Changes	KC21 Changes	Total Changes
October 2014	10,121	369	36	405
November 2014	170,791	481	43	524
December 2014	11,827	602	31	633
Totals	**192,739**	**1,452**	**110**	**1,562**

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEWs). OEW staff assisted 260 consumers with urgent medical needs or provided information for applications/cases pending at the KanCare Clearinghouse.

During this time period, OEW staff attended 129 community events providing KanCare program outreach, education and information, most notably: Enrollments events in collaboration with ACA navigators; Health Fairs, Refugee meetings, Mexican Consulate meetings, Hispanic Health Fairs, Community Resource Fairs, Tribal Coordination Council, Early Head Start and Head Start Collaboration, Parent as Teacher meetings; OEW have been involved with Bureau of Family Health Communities for Kids assessment events, as part of the Title V Maternal and Child Health Block Grant 2020 Needs Assessment. OEW have also participated in Public Health Regional Partnership meetings, and as a result are involved with community health enhancement programs, such as Perinatal Coalition and Community Screening for young children.

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 iACT (the Interagency Collaboration Team) for comprehensive oversight and monitoring. This group replaces the KanCare Interagency Monitoring Team (IMT) as the oversight management team. iACT is a review and feedback body that will meet in frequent work sessions, 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. iACT 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.

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

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

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

During the fourth quarter of 2014, some of the key quality assurance/monitoring activities have included:

- Monthly business meetings between KDHE's MCO Management team and cross-

function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program.

- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is being automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2014 and 2015, with the associated deliverables detail. The ongoing monthly business meetings mentioned in first bullet also is used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the fourth quarter on the comprehensive annual compliance reviews of the MCOs – which were done in partnership between Kansas' EQRO 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, onsite components were completed in first quarter of 2014, and reporting has been finalized, with next steps to be monitoring resolution of identified compliance issues.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings complex cases for State review and consideration, and the State provides technical assistance and insight into program policies, integration, and other alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.

- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- OIG/Program Integrity monthly meetings to build a system of identifying, investigating, and preventing fraud, waste, abuse through interagency and managed care cooperation.
- Continued participation in state staff long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss on-going provider and member issues, and troubleshoot operational problems. Monitor progress through issue logs.

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. Each MCO also submits a separate report on I/DD service provider participation. 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.

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

KanCare Customer Service Report - Member

MCO/Fiscal Agent January-September 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:12	0.6%	163,183
Sunflower	0:20	2.2%	197,406
United	0:15	0.5%	166,849
HP – Fiscal Agent	0.00	0.1%	27,377

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:16	0.6%	83,123
Sunflower	0:18	1.3%	114,188
United	5.67	0.4%	72,649
HP – Fiscal Agent	0.00	0.02%	8,514

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 for the fourth quarter of 2014 is attached.

f. Summary of MCO critical incident report: The Adverse Incident Reporting (AIR) System is the system used for behavioral health and HCBS critical incidents. All behavioral health and HCBS providers submit critical incidents for individuals receiving services. The critical incidents are reviewed by quality management specialists (field staff) who may make unannounced visits and research critical incidents to determine if additional corrective action and monitoring are required to protect the health, safety and welfare of those served by the programs involved. AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations, therefore, are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the PICU. This team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare and other community resources. A summary of 2014 AIRS reports follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	**AIR Totals**	**AIR Totals**	**AIR Totals**	**TOTALS**
Total # Received	389	333	315	285	**1322**
Total # Reviewed	208	174	167	118	**667**
Total # Pending Resolution	127	131	133	143	**534**
APS Substantiations*	95	94	93	74	**356**

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

In addition, during the first quarter of 2014, KDHE established the Cross-Agency Adverse Incident Management Team, including representatives from KDHE (the single state Medicaid agency), KDADS (the state operating agency for disability and behavioral health services) and DCF (Department for Children and Families, where adult and child protective services are managed), and from all three KanCare MCOs. Work by that team continued through the fourth quarter, and next steps include publishing of an incident reporting guide developed from the team's work, as well as shaping the team for a long-term evaluation and collaboration focus. The charter and expected outcomes of the team are as follows:

Charter:

The purpose of the Adverse Incident Management Team is to establish a statewide strategy to delineate and structure multi-agency efforts related to critical/adverse incident reporting.

Several State agencies including DCF (Department of Children and Family Services), KDADS (Kansas Department of Aging and Disability Services) and KDHE (Kansas Department of Health and Environment) operate systems to receive, respond to manage and resolve incidents with the potential to impact members' health, welfare and safety. Some adverse incidents may be instances of abuse, neglect or exploitation by another person or the member themselves and some are the result of avoidable and unavoidable accidents such as medication errors and falls. Further, each agency utilizes a different data system to collect and warehouse adverse incident documentation, investigations, remediation and findings and distinct policies and procedures for numerous State and Federal reporting purposes. With the addition of the three KanCare Managed Care Organizations to these long-standing systems of care, the potential for competing and conflicting strategies to safeguards, monitoring, investigation and resolution is compounded. While there are some identifiable linkages between different state agencies, and between state agencies and stakeholders, each of these systems works fairly independent of the others.

Expected Outcomes:

- Agreed upon mutual understanding of the current adverse incident systems and natural linkages to develop a statewide strategy.
- Policy and Procedure development to delineate and structure multi-agency efforts.
- Monitoring process to evaluate the effectiveness of the statewide strategy.

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 HCAIP Pool and LPTH/BCCH Pool fourth quarter payments were processed on October 9, 2014. The attached Safety Net Care Pool Reports identify 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

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

For the 4th quarter of 2014, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish 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 (Annual Public Forum; IDD MLTSS Integration; TPL Enhancements; Waiting List Management; Money Follows the Person; Request for Additional Services List; Plan of Care Reductions; HCBS Waiver Transition Plans; and Claims Adjudication Statistics)

a. Annual Public Forum

The KanCare annual public forum, pursuant to STC 15, was conducted on December 19, 2014. A summary of the forum, including comments and issues raised at the forum, is attached.

b. IDD Long-Term Supports and Services Integration into KanCare – February 1, 2014

Beginning on February 1, 2014, HCBS services and targeted case management for individuals in the Kansas IDD waiver program were integrated into KanCare following a one month delay in implementation. There are approximately 8,700 individuals on Kansas' IDD waiver who were affected by this change. The continuity of care period ran until July 31, 2014. Kansas continued to monitor billing, claims and person-centered planning process through December 31, 2014.

Lunch and Learn Teleconferences

KDADs continued to host the IDD Provider Lunch and Learn sessions during the fourth quarter to provide consumers, self-advocates, providers, and stakeholders with an open forum for information, discussions, questions, and answers with the managed care organizations and the State. Additionally, the consumer lunch and learn calls were transferred to the KanCare Ombudsman office to better coordinate the responses and provide a forum for consumers to talk about broader issues related to KanCare and long-term supports and services.

Summary of Stakeholder Engagement and Communication

- Public Speaking Engagements for consumers, providers, and stakeholders (as requested)
- TCM Monthly Conference Calls with State MCOs
- CDDO Conference Calls with State and MCOs (as requested)
- IDD Provider Bulletins (bi-weekly) and HCBS Provider Bulletins (monthly)
- HCBS Transition Plan information sessions (July, August, November, December)
- Interhab Annual Conference
- Families Together education and training events
- Bi-weekly Provider and Consumer Lunch and Learn Calls

Provider Issue Tracking Log

This log provides valuable information about ongoing concerns and was expanded in the fourth quarter to be available for all providers to utilize if communication efforts with the Managed Care Organizations did not result in a resolution to the issue. This tool also provides data for the State to aggregate and identify areas for improvement and quality assurance review.

c. Enhancements Related to Third Party Liability

The State worked with First Data, the contractor for the electronic visit verification system

known as AuthentiCare®KS, to develop enhancements to the system to improve third party liability by allowing providers to attach it to the system. The enhancement is designed to allow providers to enter TPL information on the claim prior to submission through Authenticare/First Data. The TPL enhancement was implemented on October 1, 2014.

d. Waiting List Management

PD Waiting List Management

In the fourth quarter, more than 1,500 individuals were offered services. More than 2,500 individuals were offered services from the HCBS-PD waiting list in 2014. Multiple attempts were made to reach individuals on the HCBS-PD waiting list including offer letters, phone calls, and Notices of Action. Over 200 individuals on the HCBS-PD waiting list did not have an address or telephone number and had never applied for Medicaid (so they could not be located in MMIS). By December 31, 2014, 969 individuals were placed on HCBS-PD services, and more the 600 individuals from the HCBS-PD waiting list were in the process of being assessed for functional and financial eligibility. It is important to note that the validity of contact information continues to be a challenge in contacting individuals on the PD waiting list and the response rate has stayed consistent throughout the year around 25-35%.

The current approved point-in-time limit for the PD waiver is 5,900. KDADS submitted a renewal for the PD waiver, which includes a proposed increase in the point-in-time limit to 6, 092. Once approved, KDADS will continue to offer services until waiver membership has reached 6,092 participants. CMS approval is expected to be effective April 1, 2015.

I/DD Unserved Waiting List Management

In the first two quarters of 2014, 104 individuals, waiting for HCBS-IDD services, were offered services. In the third quarter, the State offered services to an additional 107 individuals. In the fourth quarter an additional 60 individuals were offered services. The current point-in-time limit for HCBS-IDD is 8,700. KDADS submitted a renewal for the IDD waiver, which includes a proposed increase in the point-in-time limit to 8,900. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants, once the increased point-in-time number for the HCBS-IDD Program is approved by CMS. CMS approval is expected to be effective April 1, 2015.

e. Money Follows the Person

Kansas's Money Follows the Person (MFP), five year demonstration grant, serves four HCBS waiver populations: Frail Elderly, Physical Disability, Traumatic Brain Injury, and Intellectual/Developmental Disability. During the fourth quarter of calendar year 2014, 56 individuals were able to return to their homes and communities with assistance of the MFP Program and MCOs.

By December 31, 2014, 204 individuals had transitioned from qualifying institutions into their homes and communities. This is a significant increase from the 110 transitions during the first year of KanCare. Kansas will continue to focus on increasing MFP transitions in compliance with the Action Plan with CMS.

KDADS will continue efforts to maximize MFP utilization during the next quarter and monitor increases in transitions. Collaboration with the three MCOs will continue to be strengthened, as well as efforts to market the MFP program through public education and stakeholder engagement.

f. Request for Additional Services List

On January 31, 2014, KDADS sent a letter to all HCBS-IDD program participants who were currently receiving HCBS services and had asked for additional services in the past. Kansas comprehensively addressed this issue during 2014, and by the fourth quarter KDADS was reviewing a sample of HCBS-IDD members to ensure the assessed needs are met, and providing a comprehensive report about this process and the results to CMS.

g. Plan of Care Reduction

The State reviews any requests for additional services, reduction in services, and terminations for HCBS-IDD services. MCOs could not request reductions in service prior to August 1, 2014. The MCOs notify the State of voluntary and involuntary terminations, including voluntary removal from services, transitions between two services, moving out of state, and death, using the State's information system (KAMIS). These are being reviewed at the time of request and as part of quality assurance and program integrity reviews to ensure changes in services are consistent with the expectation of the special terms and conditions of the KanCare program. During the fourth quarter, there were 52 requests for termination, reduction or suspension, but final review and approval had not been granted. During 2015, the state will continue to review reductions and ensure consistency among the MCOs when determining changes in services.

h. HCBS Waiver Transition Plans

The Transition Plans, posted online at www.kdads.ks.gov, ensure the TBI and IDD waiver renewals are in compliance with the new settings requirements and meet the expectations of CMS prior to submission of the Statewide HCBS Settings Compliance Transition Plan. The Final Transition Plan will include:

- An Overall Summary of
  - public comments received
  - inventory and description of all HCBS Settings
  - how setting types meet or does not meet the federal HCBS Settings requirements

- An Assessment Plan
  - To complete assessments for HCBS Settings
  - To identify areas of non-compliance that need to be addressed
  - To identify the number of individuals affected by the HCBS Settings Rule
- A Compliance Plan
  - To ensure the health and safety of participants who reside in locations that need to meet corrective
  - action requirements for the setting to come into compliance during the State's specified transition
  - Timeline
  - to move individuals to compliant settings, if necessary
- A Public Engagement Plan
  - To Develop/Revise Transition Plan
  - To provide forums for public comment periods and summarize responses
  - To notify affected individuals about the impact of the HCBS Settings Rule and related changes
  - To assist in developing transition plans elements

Wichita State University's Center for Community support and Research (CCSR) staff facilitated the public comment sessions that were held across Kansas with a morning and afternoon session available. KDADS staff presented background information and the draft transition plans for all seven HCBS programs. The room was divided into round tables for discussion, and the CCSR staff supported the public comment sessions and encouraged dialogue by asking the following questions:

1. What questions or understanding or clarification do you have?
2. Related to the rule you just heard about, what is already working in Kansas? Where are we already complying? What do you like about home and community based settings?
3. Based on what you heard today, what concerns do you have? What might need to be changed or improved to come into compliance with the rule? What do you think our biggest compliance issues will be?
4. What other types of settings should the state consider?
5. What other questions should the State think about?

Additionally, providers were reminded to complete the provider Self-Assessment survey. KDADS will have providers complete a separate assessment for 2015 for compliance purposes.

i. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December 2014, is attached.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
III	KanCare Health Home Success Stories Booklet
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 12.31.14
X(e)	Summary of KanCare Ombudsman Activities for QE 12.31.14
XI	KanCare Safety Net Care Pool Reports
XII	KFMC's KanCare Evaluation Report for QE 12.31.14
XIII(a)	Summary of 2014 KanCare Public Forum
XIII(i)	KDHE Summary of Claims Adjudication Statistics for QE 12.31.14

XV. State Contacts

Dr. Susan Mosier, Acting Secretary and Medicaid Director
Michael Randol, Division Director
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Division of Health Care Finance
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(785) 296-3512 (phone)
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XVI. Date Submitted to CMS

February 27, 2015

Health Homes

Early Implementation Successes

"We've discovered it's not about
what's billable;
it's what's needed."
~IDD HHP Nurse

AD ASTRA PER ASPERA
KanCare

Health Homes for individuals with Serious Mental Illness (SMI) went live in July of 2014 and members began receiving services in August of 2014. There are approximately 34,000 members currently being served by the SMI Health Homes. Though an individual's SMI diagnosis leads to their eligibility for the program, Health Home services address far more than their qualifying diagnosis.

The aim of Health Homes is to address the "whole person" through the use of 6 Core Services:

* Comprehensive Care Management
* Care Coordination
* Comprehensive Transitional Care
* Health Promotions
* Referral to Community Supports and Services
* Member and Family Support

These services are in addition to the services that members currently receive through KanCare.

This booklet contains some early implementation success stories. Where appropriate, we have changed members' names to protect their identity.

Connections for Life, High Plains Mental Health Center in Hays, Kansas

Connections for Life: Rethinking How SMI Impacts Daily Life

The most rewarding experiences we have encountered here at Connections for Life come from making a difference in the lives of our members. People who do not have a severe mental illness often take the personal ease of daily tasks for granted. Not thinking about how anxiety provoking it can be to call a doctor's office, make a dental appointment, pursue learning opportunities within the community, seek support for mental illness, or manage chronic illnesses. For most people these things are part of "normal" life and we make sure they are accomplished. As we have begun working in the Health Home, it forced us take a closer look at these routine tasks such as: calling a dentist and being told that there is a two-month waiting list for the next opening; a nurse asking you to describe your symptoms when trying to make a doctor's appointment; walking into the first day of class or group, not knowing anyone; and the stress of having a minor illness and not knowing the most efficient way to treat it. All of the above actually are a little stressful when we think about it. We attempt to walk in the shoes of our members, realizing that if it is stressful for us, it is daunting for an individual with severe mental illness.

"...if it is stressful for us, it is daunting for an individual with severe mental illness"

We have encountered people who had not seen a dentist in almost a decade and made appointments for them to have multiple abscessed teeth pulled. We have accompanied members to Vocational Rehabilitation interviews, providing a sense of hope and accomplishment. We are scheduling primary care appointments and following up to make sure these members understand how to manage their chronic conditions. We are often attending these primary care appointments with our members and reinforcing the physician's directions. We are referring to grief support groups, food banks, and parenting classes. We have attended health literacy workshops, and are using the curriculum to teach our adult members what to do when their child is ill. Our nurse care coordinator has a weekly support group, which provides health education to our members with various chronic conditions, and also includes a walking/exercise group. We enjoy seeing the hope in our members' faces as we teach them that taking preventative steps to become healthier is not only feasible, but rewarding as well. We have realized that anxiety contributes so much to the lack of preventative health care in these people, and we are helping them to overcome this barrier.

Connections FOR LIFE

Katrece: From the Hospital Back to Her Home

In Katrece's words:

Angela has helped throughout my whole journey. She came to visit me in the hospital when nobody else did. Meeting with Angela felt sincere and that she wasn't just doing a job, but doing it because she actually cared. Angela helped me get in to mental health counseling and even attended my first session with me because I had anxiety about going to the appointment. When I feel down, I feel secure in calling Angela. She is an uplifting person. I truly feel Health Homes is a good program. When I was really sad and depressed Angela provided comfort and gave me hope. Angela has shown sympathy which shows me there are truly good people in the world. Every time we have met, Angela has been honest and genuine and I respect that. Angela helped me build my confidence up when I was feeling like giving up. Angela has helped me start to gain acceptance over my month long hospital stay by being supportive and helping me get in to therapy and mental health medication appointments. Angela has never turned her back on me ever at my worst. I hope Angela remains a support. I truly feel blessed to have these services in my life when I needed them the most.

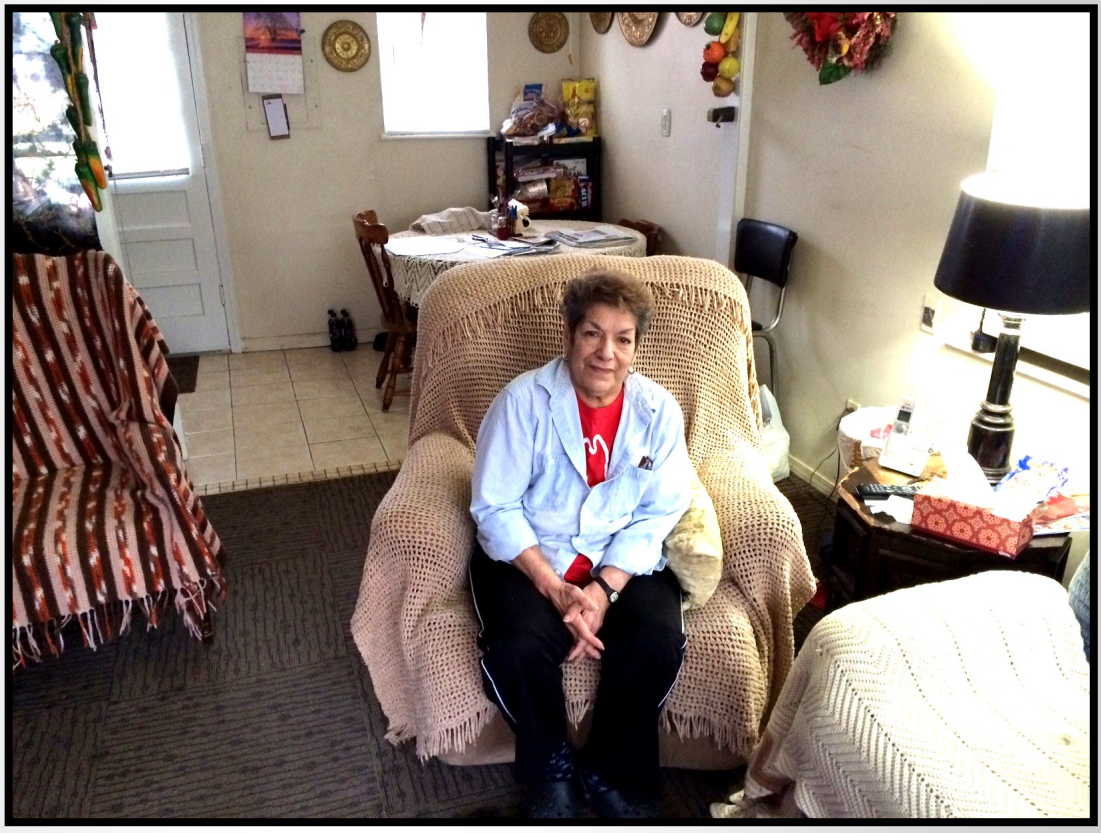
In Angela's words:

"...she wasn't just doing a job, but doing it because she actually cared"

I met Katrece in August at KU Medical center where she had been inpatient for a month due to Crohn's disease. She weighed 88 pounds when she left KU Medical Center and came home to Topeka to stay with her mother because she was unable to care for herself or her children at that time. I met with Katrece on a weekly basis at first because she appeared to have experienced trauma from being hospitalized and alone in the hospital for so long. Our sessions were often met with Katrece being tearful and hopeless over the weight she had lost and the constant pain she endured at that time. She was unwilling at first to see the need for therapy and mental health medication. Over time and after several meetings, she agreed to go to therapy and see a psychiatrist for medication. I made the appointments for her, made sure she had transportation and met her at her initial appointments with her therapist and psychiatrist as she was expressing severe anxiety over seeing any more doctors. I provided coping mechanisms for Katrece to help her reduce her frustration with those trying to help her. I coordinated her medical care with her nurse navigator through Cotton O'Neil to ensure she maintained her appointments. I worked with her mom and caretaker at the time to discuss coping mechanisms to use when Katrece and her mom would get in arguments.

This December, Katrece is living back in her own home, taking care of her two children and making amends with her estranged husband. She has her pain under control at this time. She has also been able to maintain her therapy appointments and reschedule them if she is unable to make them. In the past she would just stop going and not reschedule. She told me she is now up to 118 pounds. When I saw her this month, she met me at her front door with an amazing smile on her face. Katrece has come a long way from the person I met in August. She appears more optimistic about her future and has a stronger outlook on life.

Ramona: How Health Homes Treats the "Whole Person"



Ramona is 77 years old and lives alone in a single family home in Kansas City, Kansas. Through the assessment, staff at Mirror, Inc. were able to identify areas of need in Ramona's life that could affect her overall health and well-being. Ramona said she did not always have reliable transportation to medical appointments. She also reported that she had fallen in the past due to blackouts related to poor diabetes management.

We worked together to identify a routine she completes every morning; after breakfast she takes her dishes to the sink and likes to look out the window into her backyard. We put a sign up in the window to remind her to take her insulin.

She was not aware of the KanCare transportation benefit; we informed her of this service and worked with her to set up transportation to the remainder of her medical appointments. We also worked to get Ramona on the Frail Elderly Home and Community Based Services (HCBS/FE) waiver so she could acquire an in-home care giver. Due to Ramona's limited mobility from a fall that resulted in a broken pelvis, the caregiver would assist with cleaning in her home and cooking meals.

"It's more hands on, one-on-one."

Ramona also expressed ongoing stress and worry related to her two children. She reported that her son had a relationship with alcohol and it had taken over his life. She expressed strain in her relationship with her son and daughter. We gave Ramona contact information for In Home Family Therapy Associates. They are able to meet with KanCare members in their home and provide counseling services. We also worked with Ramona to get her KanCare benefits reinstated.

When asked how the Health Home program has benefited her Ramona stated, "It's more hands on, one-on-one. Maybe you don't even know what's out there to help and they can help find it. There are a lot of options that I know are there for me if I need to use them. Without this program I would have lost my Medicaid. I am very thankful about that."

Sunflower Diversified Services, Great Bend, Kansas

Sunflower Diversified Services is a non-profit organization located in Great Bend, Kansas providing services for both children and adults with developmental disabilities. Sunflower had its beginning in 1966 when family members and other community citizens established a program for children, and in 1969, a program for adults with disabilities was started.

Sunflower remains the only full service provider in this area that offers programs for all ages, from birth through retirement.

Sunflower's mission is to assist individuals in becoming as independent as possible, and to maintain that independence as long as possible. Sunflower believes that a disability should never prevent a person from living the most fulfilling life possible; nor should that individual ever shy away from participating in everything the community has to offer.

"One of the benefits of providing Health Home services has been that case managers have been able to focus on what the person needs instead of what is billable as Targeted Case Managers."

Sunflower is proud to include Health Homes as part of the services offered, not only to persons with disabilities, but also to the community. Our mission for assisting independence and assisting people to live fulfilling lives carries over to the Health Home program. We pride ourselves on our collaborative and creative team of case managers, nurses and support personnel who assist clients in identifying needs, setting goals and then working side by side with the client to achieve those goals.

One of the benefits of providing Health Home services has been that case managers have been able to focus on what the person needs instead of what is billable as Targeted Case Managers.

SERVING CHILDREN & ADULTS WITH DISABILITIES
Sunflower
DIVERSIFIED SERVICES, INC.
THE CHOICE FOR GROWTH
www.sunflowerdiv.com

Sunflower Diversified Services Health Homes has demonstrated tremendous success in helping people achieve healthier lives and the team is looking forward to continued success in making a difference!

Kenny: Health Homes Help Protect Members From Exploitation

Kenny began receiving Targeted Case Management services in September 2012. He is diagnosed with Mild Intellectual Disability, Intermittent Explosive Disorder and Adjustment Disorder with Disturbance of Conduct. He was found naked in his front yard, unresponsive due to inability to manage his diabetes in November 2012. He was unable to stop family members from exploiting him, unable to manage his finances and unable to maintain employment because he couldn't follow instructions or keep up with the pace. There was a risk of homelessness. There were continued concerns about lack of diabetic monitoring, not keeping appointments and continued exploitation by family and others.

Kenny was admitted into Health Home services with Sunflower Diversified Services, Inc. in September 2014. We discovered during development of his Health Action Plan that he was unable to read and write, but he is able to read and write numbers. Staff are now taking him grocery shopping to help him choose healthy foods in appropriate amounts. We are doing routine house checks to make sure that he is not overstocking on certain items or buying foods he doesn't need that will spoil. We are creating a "shopping notebook" with pictures to help him identify what brands and items he needs from the store. We are slowly moving him towards independence. Staff began by taking him to the grocery store, but now he is meeting them at the store. Eventually he will be going alone.

"While Health Home doesn't provide all the services Kenny needs, they have reduced the risks in his life significantly."

Kenny turns in his glucose readings weekly, so they can be monitored. We are working on nutritional training, making healthier selections, portion sizes and weight management. Health Home staff remind and transport him to all psychiatric and physician appointments. We also attend appointments with him. Recently we discovered that he was allergic to grapefruit and broke out with a rash. In the process we were able to identify a possible citrus allergy that was resolved by avoiding citrus foods. This prevented two visits to the ER in a two week period.

After the initial admission into Health Home, staff was able to identify more exploitation that required law enforcement involvement. While Health Home services don't provide all the services Kenny needs, they have reduced the risks in his life significantly.

Desiree: Health Homes are Making a Difference!

Neoma Felps of Valeo writes: In the short time I have been a Health Home Comprehensive Care Coordinator, I have had the opportunity to make an impact in many people's lives. One big success involves Desiree, a woman who had not had an eye appointment in several years. Desiree had broken her eye glass frames and had tried to replace the lenses of an over the counter pair with her own prescription lenses. When she discovered they would not fit the correct way, she turned them upside down to get them in.

Desiree's guardian, Linda, was unsure of how long she had been wearing them this way. Additionally, Linda reported that Desiree had been having "visual blackouts" in which her vision would turn completely black for a period of time. I worked with Linda, who has been by Desiree's side from the very beginning to assess what could be done to help Desiree. Given the situation, one of our first goals was to get Desiree into an eye doctor. After this appointment, I learned that the doctor found a suspicious "spot" on Desiree's eye and had referred her to an eye specialist.

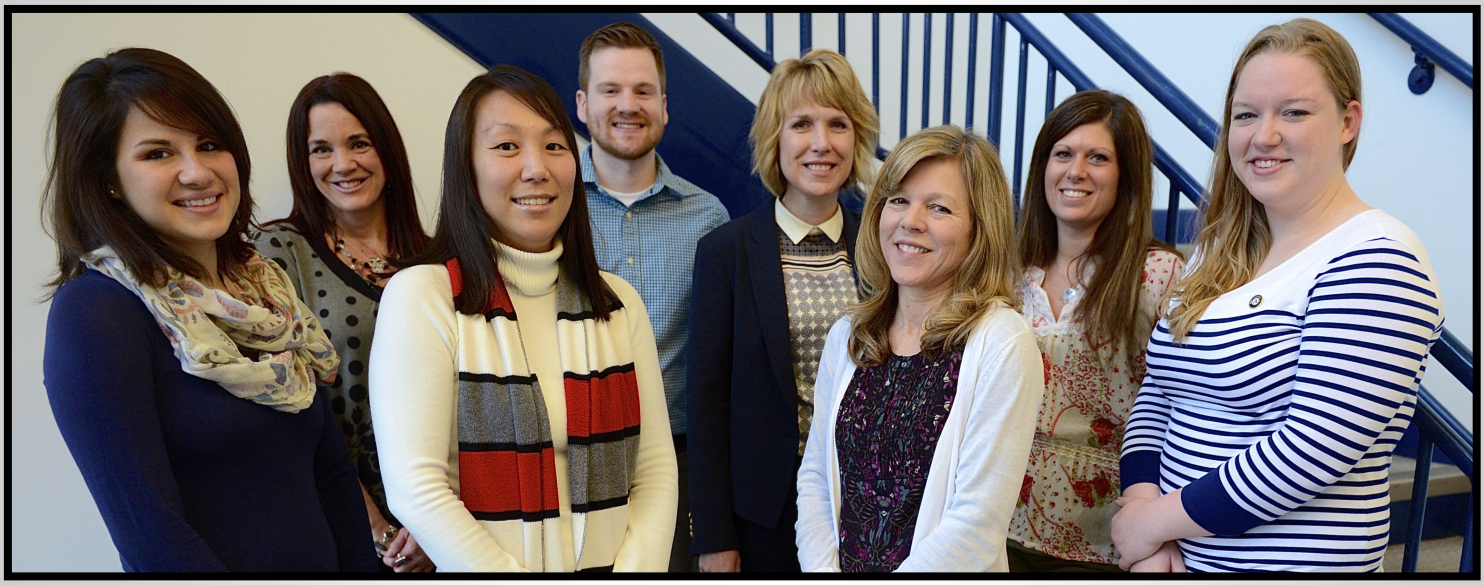
The eye doctor was concerned because the "spot" could be a an indication of a tumor. I helped get follow-up appointments and an MRI scheduled for Desiree. The MRI results showed that the "spot" was not cancerous, but was caused by swelling of the optic nerve (pseudotumor cerebri). The most common cause of this is increased spinal fluid pressure which can lead to visual changes if successful treatment is not given.

We were able to get Desiree new eye glasses and I helped schedule an appointment for Desiree with a neurologist. The neurologist prescribed medication to decrease the production of spinal fluid and ordered a lumbar puncture to relieve some of the excess fluid. Desiree noticed an immediate improvement in her vision after this procedure.

Desiree says of Health Homes: "If what I went through will help others, then I'm happy to share."

Desiree and Linda were so very appreciative for my help in setting up the eye appointments. Desiree has stayed strong throughout the entire process and wanted to share her story saying: "If what I went through will help others, then I'm happy to share".

This story reminds me of why I am here: to continue to help consumers strive as individuals and to make differences in their lives. One step at a time!



Health Connections Health Homes, Bert Nash Community Mental Health Center, Lawrence, Kansas

Marc: Getting Another Chance through Health Homes

Marc is a member in his late 50's who has been drinking for 30+ years. Marc has been banned from the homeless shelter and has been disowned by family. Marc has had numerous medical issues surrounding his drinking, such as broken fingers and head injuries due to frequent falls. Marc went to inpatient treatment around 10 years ago and has struggled with relapse. Marc has been homeless for the last month and has been sleeping in the park. Marc was originally scheduled for inpatient treatment at New Chance on November 26th but missed his ride. The Health Home care coordinator contacted New Chance and was able to reserve Marc's bed for December 4th. The care coordinator then spoke to the housing team leader at Bert Nash. The housing team leader agreed to assist with paying for Marc to stay at a hotel until he went to New Chance on December 4th. The care coordinator then contacted Marc's MCO for transportation services and scheduled Marc to be picked up on December 4th. The care coordinator spoke with Marc's Bert Nash case manager who graciously agreed to ensure that he did not miss his ride on December 4th to New Chance. Marc left for treatment at 7:30AM on December 4th and the care coordinator spoke to New Chance that afternoon to ensure Marc checked in. The care coordinator also spoke to Marc that night and provided him with encouragement and support. Marc will be in treatment for 28 days. The care coordinator, along with Marc's Bert Nash case manager continue to be in contact with New Chance and will follow up throughout his stay in treatment.

"The goal of the health home is to decrease inpatient stays, decrease ER visit and decrease symptoms related to chronic conditions," team leader Amy Warren said.

Bert Nash
COMMUNITY MENTAL HEALTH CENTER
Health Connections
A HEALTH HOME PROGRAM

COMCARE Health Home, Sedgwick County, Kansas

Health Links of Sedgwick County is a COMCARE Health Home with over 3,000 assigned members. We are located in Wichita, Kansas and have a dedicated team of health home nurse care managers, QMHP care managers and care coordinators who aim to help our members access physical health care, establish wellness and prevention goals and manage their care in a more coordinated fashion. Health Links developed and provides our members with Health Links membership cards so they can share this information during behavioral and physical health visits and emergency room contacts to provide increased opportunity for point-of-service care coordination between treatment team members and Health Links staff. Health risk screening activities have identified that this population is more specialty versus preventive care focused so a primary aim of our team is to connect members with a primary care physician. Following are a couple of success stories.

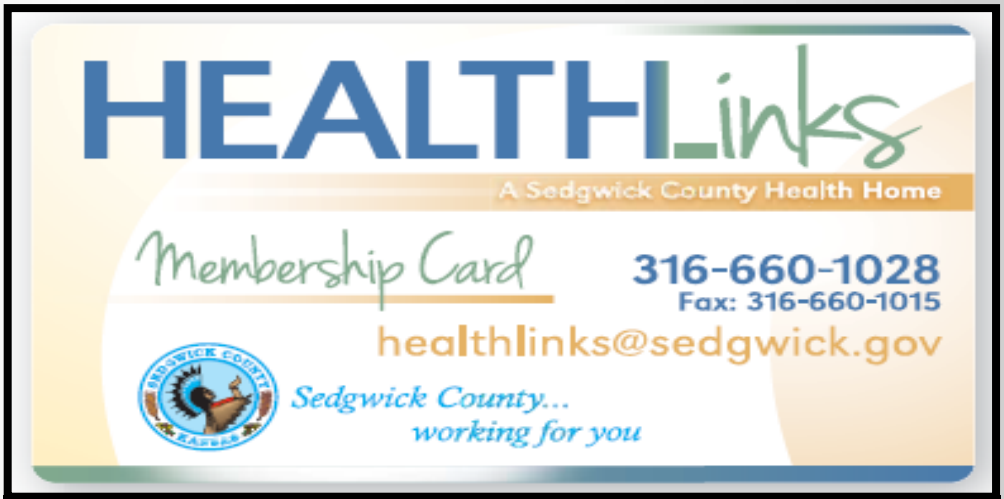
Joe: Health Homes and Beyond

Joe is a 52 year old male with multiple chronic conditions who has had recent back surgery. While working to transition Joe from the hospital to his home following surgery, it became apparent that home health services were not adequate for his recovery. Our Health Link Care Manager spent considerable time gathering relevant information and working with the medical team and MCO to admit Joe to inpatient rehabilitation services which were able to better meet his recovery needs. Without care management services through Health Links, Joe would not have achieved optimal health outcomes, as he was not adequately able to take care of his personal needs in his home. These quick actions also minimized Joe's length of stay in the rehabilitation center, as he was actively involved in discharge planning with his care team and Health Home care manager from point-of-admission to planned discharge from the rehabilitation center.

"Without care management services through Health Homes, Joe would not have achieved optimal health outcomes,..."

Roger: Cutting His Smoking in Half

Roger is 27 years old and participated early on in the completion of an initial health risk screening. However, Roger was reluctant to engage in the development of a Health Action Plan (HAP). The Health Links staff continued to reach out to Roger over the phone and eventually gained Roger's trust.



The staff at Health Links have distributed membership cards to every member on their Health Homes roster. These cards identify them as a Health Home member and have important information for the member's caregivers and other providers.

After a couple of months Roger began to participate in developing health goals for his HAP, including the selection of a Primary Care Physician to oversee his care, getting an eye exam and reducing smoking over time. Establishing a relationship with a medical provider was new to Roger so he asked for assistance from his Care Manager in making the initial calls and indicated he would be more comfortable going to the appointment if his Health Links Care Coordinator attended his initial appointment with him. The Care Coordinator was able to do this, which decreased Roger's anxiety.

Health Links' waiting room contains health literacy tools such as the portion plate and artery visuals displayed above. These hands-on tools are a big hit with the members and offer an opportunity for Health Links staff to engage the member in their own health.

With this assistance, Roger has not only followed through with his first medical appointment, he has also obtained prescription glasses from the optometrist. Even more, with the help of his Health Links Care Coordinator, Roger has reduced his smoking by a half of a pack a day with the goal of reducing this even more!

From the initial goal of just getting engaged in his own healthcare to his reduction in smoking, Roger has benefitted from making goals and working towards them. Roger says without the support of Health Links he would not have scheduled or attended any of these appointments.

For additional information
please visit our website:
http://www.kancare.ks.gov/health_home.htm

Or contact:
Rick Hoffmeister
Health Homes Program Manager
785.368.6260
RHoffmeister@kdheks.gov

KanCare

01-2015

DY 2
Start Date: 1/1/2014
End Date: 12/31/2014

Quarter 4
Start Date: 10/1/2014
End Date: 12/31/2014

	Total Expenditures	Total Member-Months
Oct-14	246,403,664.75	367,913
Nov-14	223,321,981.42	357,923
Dec-14	220,420,409.38	357,041
PCP	(3,370,532.41)	
Q4 Total	686,775,523.14	1,082,877

ADMIN SUMMARY	
	Expenditures
DY2Q4	28,126,403

	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-14									
Expenditures	6,077,966.05	30,750,361.82	23,933,754.94	52,713,858.18	40,664,629.81	79,003,525.48	416,748.76	1,090,113.33	11,752,706.38
Member-Months	19,172	31,205	44,471	233,086	9,105	23,231	1,640	1,521	4,482
Nov-14									
Expenditures	4,233,549.71	31,310,774.10	24,524,469.83	48,567,926.67	36,022,088.96	65,688,037.86	553,744.33	1,730,997.89	10,690,392.07
Member-Months	18,572	30,300	42,710	228,343	8,982	22,051	1,541	1,363	4,061
Dec-14									
Expenditures	4,026,861.16	30,519,712.91	22,430,339.37	48,452,124.13	38,249,597.61	63,266,652.29	991,754.38	1,783,217.75	10,700,149.78
Member-Months	18,334	30,198	42,535	227,516	8,949	22,281	1,728	1,410	4,090
PCP									
Expenditures	(14,668.66)	(457,771.96)	(196,248.83)	(2,443,019.30)	(51,190.46)	(115,182.84)	(463.08)	(17,775.19)	(74,212.09)
Q4 Total									
Expenditures	14,323,708.26	92,123,076.87	70,692,315.31	147,290,889.68	114,885,125.92	207,843,032.79	1,961,784.39	4,586,553.78	33,069,036.14
Member-Months	56,078	91,703	129,716	688,945	27,036	67,563	4,909	4,294	12,633
DY 2 - Q4 PMPM	255.4247	1,004.5808	544.9776	213.7919	4,249.3389	3,076.2848	399.6301	1,068.1308	2,617.6709

Note:
1) Administration costs are allocated to the waiver based on the percentage of Waiver assistance expenditures to the total Medicaid assistance expenditures.
2) Reported expenditures are net of Risk Corridor payments.
3) The increase in expenditures for the 4th quarter is due to mid-year capitation payment adjustments that occurred in November 2014, as well as contractual obligations to the Managed Care Organizations.
4) Administrative expenses lower in Q4 due to several large invoices not paid in December. Additionally, school based administration payments were delayed.

KanCare Ombudsman Quarterly Report to KDHE

Kerrie J. Bacon, KanCare Ombudsman
4th Quarter, 2014

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the third quarter of 2014. There were 547 contacts through these various means, 210 of which were related to an MCO issue. Fourth quarter had an increase in contacts compared third quarter and to last year.

4th Qtr. Contacts	
October	238
November	175
December	134
Total	**547**

MCO related	
Amerigroup	56
Sunflower	102
United Health	52
Total	**210**

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	

The KanCare Ombudsman website (http://www.kancare.ks.gov/ombudsman.htm) has information regarding the Ombudsman contact information, resources for and information about applying for KanCare, contact information for the three Managed Care Organizations, the grievance process, the appeal process and state fair hearing process, the three managed care organization (MCO) handbook links, quarterly and annual reports by the Ombudsman and a resource providing a four-page document with medical, prescription, vision and dental assistance for those without insurance or with high spend downs (http://www.kancare.ks.gov/download/Medical_Assistance.pdf).

The KanCare website was updated with a revision of the ***Contact Us page*** to guide people to correct contact information based on calls received over the past year by the Ombudsman's office. (http://www.kancare.ks.gov/contact_us.htm)

Outreach

- Attended PRTF (Psychiatric Residential Treatment Facility) Stakeholder Meeting; 10/8/14
- Provided a Vendor Booth at Interhab Conference; 10/16/14
- Attended State Aging and Advisory Council Meeting; 10/17/14
- Spoke briefly about Ombudsman's office at Brain Injury Conference; 10/25/14
- Attended HCBS Public Listening Sessions 11/14/14
- Presented to the Bob Bethel KanCare Oversight Committee; 11/18/14
- Mailed all Targeted Case Managers in Kansas (101 TCMs) a letter of introduction from the Ombudsman and a package of Ombudsman brochures.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met once during fourth quarter.
- Hosted the HCBS Lunch-and-Learn bi-weekly conference calls for all HCBS members, parents, guardians and other consumers. Calls addressed topics of interest and emerging issues and included a guided question and answer time with a panel from the three Managed Care Organizations. ***The format is changing for 2015.*** We are calling it the KanCare Member Lunch and Learn Bi-Weekly Calls. The topics will be about KanCare and resources that may be of interest to people who are on Medicaid. We are hoping to appeal to the broader range of members including the long-term care members.

KanCare Ombudsman Volunteer Program

Start-up Information

- Planned start date August 1, 2015
- Soft start-up in most populous areas of Kansas
    - Kansas City Metro Area, then Wichita

Training and Education

- Online and in-person regional training
- Pre and Post testing for competency
- Subjects
    - Medicaid history and agencies, federal to state
    - Processes – applications, benefits, processes and claims
    - Resources
    - Handling of calls and levels of inquiries
    - Practice and case studies

Data

Contact Method	AmeriGroup	Sunflower	United	none	total
Email	5	18	6	61	90
Face-to-Face Meeting	0	0	0	1	1
Letter	0	0	1	0	1
ONLINE	0	0	0	0	0
Other	0	0	0	0	0
Telephone	51	84	45	275	455
Total	**56**	**102**	**52**	**337**	**547**

Caller Type	AmeriGroup	Sunflower	United	none	total
Consumer	51	82	46	258	437
MCO Employee	0	3	0	0	3
Other type	0	3	2	25	30
Provider	5	14	4	54	77
Total	**56**	**102**	**52**	**337**	**547**

Sub Caller Type	AmeriGroup	Sunflower	United	none	total
HCBS RELATED	14	30	18	8	70
LTC RELATED	3	3	3	12	21
Other	39	69	31	317	456
Total	**56**	**102**	**52**	**337**	**547**

Contact Information for 4th Qtr:

- The average number of days to resolve an issue was 7 days.
- Statistics on number of days to resolve an issue during 4th quarter:
  - As of 1/14/15, 450 files closed out of 547; 82%.
  - 308 files resolved in one day or less
  - Mean (average) = 7
  - Median (middle) = 0 (less than a day)
  - Mode (most frequent) = 0 (less than a day)

Open	Contact date entered, but no response or closed	0
Responded	Contact date entered and first response, but not closed.	97
Closed	Closed dated is entered.	450
Total		**547**
% closed		82%

There are 20 issue categories. The top four concerns for 4th quarter are Medical Services, HCBS General Issues, Appeals/Grievances, and Billing issues.

Issue Category	AmeriGroup	Sunflower	United	none	total
Medical Services	15	15	9	31	70
HCBS General Issues	9	10	13	17	49
Appeals / Grievances	4	30	7	5	46
Billing	7	13	6	16	42
Nursing Facility Issues	5	1	2	16	24
Pharmacy	2	5	4	8	19
Access to Providers (usually Medical)	6	5	2	2	15
Care Coordinator Issues	3	8	3	0	14
Transportation	2	4	3	4	13
HCBS Eligibility issues	3	4	3	1	11
Housing Issues	2	4	2	2	10
Change MCO	2	5	1	1	9
Dental	4	2	0	3	9
Durable Medical Equipment	4	4	0	0	8
HCBS Reduction in hours of service	2	3	1	2	8
HCBS Waiting List	1	0	1	5	7
Guardianship	0	0	1	1	2
Questions for Conference Calls/Sessions	0	1	0	1	2
Medicaid Eligibility Issues	13	16	10	155	194
X-Other	11	13	9	79	112
Z Thank you.	1	1	1	10	13
Z Unspecified	0	3	0	24	27
Total	**96**	**147**	**78**	**383**	**704**

In comparing issue categories over the last four quarters, two categories have stayed consistently in the top six: billing, and appeals/grievances. Note: The Issue Category number equals more than the total number of callers because we are able to choose more than one issue category. Members often have more than one issue when they call.

Resource Category shows what resources were used in resolving an issue.

Resource Category	AmeriGroup	Sunflower	United	none	total
QUESTION/ISSUE RESOLVED	8	6	9	58	81
USED RESOURCES/ISSUE RESOLVED	23	50	25	162	260
KDHE RESOURCES	7	18	12	50	87
DCF RESOURCES	2	0	2	11	15
MCO RESOURCES	10	28	16	1	55
HCBS TEAM	6	8	6	13	33
CSP MH TEAM	0	0	0	0	0
OTHER KDADS RESOURCES	2	9	1	5	17
PROVIDED RESOURCES TO MEMBER	0	4	0	16	20
REFERRED TO STATE/COMMUNITY AGENCY	3	5	1	9	18
REFERRED TO DRC AND/OR KLS	0	5	0	4	9
CLOSED	0	3	0	15	18
(not identified)	17	18	7	73	115
Total	78	154	79	417	728

Waiver	AmeriGroup	Sunflower	United	none	total
PD	5	8	8	8	29
I/DD	5	15	6	10	36
FE	2	3	4	2	11
AUTISM	0	1	0	0	1
SED	1	2	1	0	4
TBI	3	2	2	3	10
TA	6	4	3	2	15
MFP	1	0	1	2	4
PACE	0	0	0	1	1
MENTAL HEALTH	4	1	3	2	10
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	2	3	1	19	25
(not identified)	34	66	28	293	421
Total	63	105	57	342	567

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - QE December 2014

Health Care Access Improvement Pool
Paid 10/09/14

Hospital Name	HCAIP DY/QTR: 2014/4	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	46,145.26	20,013.20	26,261.27
Children's Mercy Hospital South	183,831.09	79,727.54	104,618.27
Coffey County Hospital	11,459.13	4,969.83	6,521.39
Coffeyville Regional Medical Center, Inc.	68,276.98	29,611.73	38,856.43
Cushing Memorial Hospital	106,294.33	46,099.85	60,492.10
Galichia Heart Hospital LLC	79,676.21	34,555.57	45,343.73
Geary Community Hospital	132,386.42	57,415.99	75,341.11
Hays Medical Center, Inc.	313,378.23	135,912.14	178,343.55
Hutchinson Hospital Corporation	204,890.87	88,861.17	116,603.40
Kansas Medical Center LLC	75,091.36	32,567.12	42,734.50
Kansas Rehabilitation Hospital	1,590.45	689.78	905.12
Labette County Medical Center	72,831.63	31,587.08	41,448.48
Lawrence Memorial Hospital	285,421.50	123,787.30	162,433.37
Marillac Center INC	1,906.19	826.71	1,084.81
Memorial Hospital, Inc.	44,815.50	19,436.48	25,504.50
Menorah Medical Center	156,070.19	67,687.64	88,819.55
Mercy - Independence	60,201.35	26,109.32	34,260.59
Mercy Health Center - Ft. Scott	95,681.52	41,497.07	54,452.35
Mercy Hospital, Inc.	5,342.33	2,316.97	3,040.32
Mercy Reg Health Ctr	133,914.70	58,078.80	76,210.85
Miami County Medical Center	67,246.01	29,164.59	38,269.70
Morton County Health System	23,194.08	10,059.27	13,199.75
Mt. Carmel Medical Center	218,234.56	94,648.33	124,197.29
Newton Medical Center	192,432.14	83,457.82	109,513.13
Olathe Medical Center	300,858.69	130,482.42	171,218.68
Overland Park Regional Medical Ctr.	611,997.69	265,423.40	348,287.88
Prairie View Inc.	9,904.86	4,295.74	5,636.85
Pratt Regional Medical Center	51,980.18	22,543.80	29,581.92
Providence Medical Center	446,754.38	193,757.37	254,247.92
Ransom Memorial Hospital	86,278.18	37,418.85	49,100.91
Saint Luke's South Hospital, Inc.	92,751.19	40,226.19	52,784.70
Salina Regional Health Center	128,673.98	55,805.91	73,228.36
Salina Surgical Hospital	2,928.88	1,270.26	1,666.83
Shawnee Mission Medical Center, Inc.	616,117.07	267,209.97	350,632.23
South Central KS Reg Medical Ctr	46,073.21	19,981.95	26,220.27
Southwest Medical Center	112,968.12	48,994.28	64,290.16
SSH - Kansas City	21,642.20	9,386.22	12,316.57
St. Catherine Hospital	183,280.69	79,488.83	104,305.04
St. Francis Health Center	315,943.74	137,024.80	179,803.58
St. John Hospital	102,201.97	44,324.99	58,163.14
Stormont Vail Regional Health Center	873,800.20	378,967.15	497,279.69
Sumner Regional Medical Center	34,082.68	14,781.66	19,396.45
Surgical & Diag. Ctr. of Great Bend	150,737.88	65,375.02	85,784.93
Susan B. Allen Memorial Hospital	132,727.79	57,564.04	75,535.39
Via Christi Hospital St Teresa	103,781.18	45,009.90	59,061.87
Via Christi Regional Medical Center	1,727,055.33	749,023.90	982,867.19
Via Christi Rehabilitation Center	54,121.53	23,472.51	30,800.56
Wesley Medical Center	1,178,380.02	511,063.42	670,616.07
Western Plains Medical Complex	141,654.38	61,435.50	80,615.51
	10,107,008.04	**4,383,409.39**	**5,751,898.27**

Safety Net Care Pool Report

Demonstration Year 2 - QE December 2014

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

Paid 10/15/14

Provider Name	4th Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.00	1,080,361.45	1,417,647.45
University of Kansas Hospital	7,473,103.00	3,241,084.77*	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.

Kansas Foundation for Medical Care, Inc.

2014 KanCare Evaluation Quarterly Report

Year 2, CY2014, Quarter 4, October - December

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**February 18, 2015**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist** **Lynne Valdivia, BSN, RN, MSW, Vice President of Quality Improvement and Review**

Prepared for:

KanCare

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2014 KANCARE EVALUATION QUARTERLY REPORT
Year 2, CY2014, Quarter 4, October-December
FEBRUARY 18, 2015

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 for most metrics. Data sources for assessing annual performance measures include administrative data, medical and case records, and consumer and provider feedback.

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the fourth quarter (Q4) CY2014 report include the following:

- Timely resolution of customer service inquiries.
- Timeliness of claims processing.
- Grievances
  - Track timely resolution of grievances.
  - Compare/track the number of access-related grievances over time, by population categories.
  - Compare/track the number of grievances related to quality over time, by population.
- Ombudsman's Office
  - Track the number and type of assistance provided by the Ombudsman's office.
  - Evaluate for trends regarding types of questions and grievances submitted to the Ombudsman's office.
- Systems - Quantify system design innovations implemented in Kansas 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 (UnitedHealthcare). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

In response to recommendations made in the previous KanCare Evaluation Quarterly Reports and in the KanCare Annual Evaluation Report, State staff have drafted or revised reporting templates, held interagency and interagency/MCO work group meetings, and have met with the Ombudsman (Kerrie Bacon) and staff from KDHE and KDADS. Follow-up on these recommendations has been a priority agenda item on monthly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

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

DATA SOURCES

The data sources for the Q4 CY2014 KanCare Quarterly Evaluation Report are monthly call center customer service reports that replace quarterly KanCare Key Management Activities Report (KKMAR) discontinued this quarter.

In the monthly call center reports, MCOs report the monthly counts, cumulative counts, and percentages of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end. The call center reports also provide counts of customer service inquiries by inquiry type from members and providers each month.

In Table 1, the quarterly counts of member and provider customer service inquiries for Q1-Q4 of CY2013 were based on Pay for Performance (P4P) report data, and the quarterly counts for Q1 CY2014 were based on monthly data reported to KFMC by MCO program managers. Percentages reported in the KKMAR were then used to calculate the number of inquiries resolved and not resolved within two, five, and 15 business days. Beginning in Q2 CY2014, the monthly call center reports are now the primary data source for reporting customer service inquiries.

CURRENT QUARTER AND TREND OVER TIME

In Q4 CY2014, 99.99% of the customer service inquiries received by the MCOs were resolved within two business days. The inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within two business days. During each quarter to date, the two-day resolution rate exceeded 99.7%.

In Q4 CY2014, five of the 18 inquiries not resolved within two business days were resolved within five business days, and six inquiries were resolved within 15 business days. While 99.99% of customer service inquiries were resolved within five business days, this was the first quarter with less than 100% resolution within 15 business days.

Table 1 - Timeliness of Resolution of Customer Service Inquiries

	CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964	133,570	143,028	**121,857**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907	133,539	142,705	**121,839**
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57	27	323	**18**
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%	99.98%	99.77%	**99.99%**
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951	133,570	143,001	**121,844**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13	0	27	**13**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%	100%	100%	**99.99%**
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964	133,570	143,028	**121,850**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0	0	0	**7**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%	100%	100%	**99.99%**

The quarterly number of customer service inquiries to the three MCOs in Q4 CY2014 is the lowest to date. As shown in Table 1 the aggregate number of customer service inquiries received by the MCOs has generally been decreasing over time. In Q1 CY2013, the MCOs received 261,286 inquiries; in Q1 CY2014, the MCOs received 141,964 inquiries, a 46% decrease. Compared to Q4 CY2013, there were 24,517 fewer inquiries in Q4 CY2014.

Of the 121,857 customer service inquiries in Q4 CY2014, 74,119 (60.8%) were from members (Table 2) and 47,738 were from providers (Table 3). In Q4 CY2014, there were 15,563 fewer customer service inquiries from members than the previous quarter and 5,608 fewer customer service inquiries from providers. Of the 74,119 member calls, 37.7% were received by Sunflower, 31.5% by UnitedHealthcare, and 30.8% by Amerigroup. Of the 47,738 provider inquiries, 37.3% were received by Amerigroup, 34.3% by UnitedHealthcare, and 28.5% by Sunflower.

The monthly call center report categorizes customer service inquiries by 18 member categories and by 17 provider categories. For members, benefit inquiries were again the highest percentage (21.3%) of the 74,119 calls received in Q4, a decrease of 2,226 compared with the previous quarter. The lowest percentage of calls (0.1%) was from members requesting assistance with scheduling an appointment. For providers, claim status inquiries were again the highest percentage (38.3%) of the 47,738 provider calls, and the lowest was from providers requesting provider materials (0.1%).

Table 2 - Customer Service Inquiries by Member, Quarters 2 to 4, CY2014						
	Q2		Q3		Q4	
Member Inquiries	#	%	#	%	#	%
1. Benefit Inquiry – regular or VAS	17,373	21.8%	18,025	20.1%	**15,799**	**21.3%**
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2,242	2.5%	**1,617**	**2.2%**
3. Care management or health plan program	2,248	2.8%	2,363	2.6%	**2,797**	**3.8%**
4. Claim or billing question	6,626	8.3%	6,193	6.9%	**5,490**	**7.4%**
5. Coordination of benefits	1,494	1.9%	2,278	2.5%	**2,252**	**3.0%**
6. Disenrollment request	448	0.6%	507	0.6%	**484**	**0.7%**
7. Eligibility inquiry	8,336	10.5%	11,066	12.3%	**9,462**	**12.8%**
8. Enrollment information	1,830	2.3%	2,417	2.7%	**2,220**	**3.0%**
9. Find/change PCP	11,619	14.6%	12,509	13.9%	**9,818**	**13.2%**
10. Find a specialist	3,037	3.8%	3,905	4.4%	**2,634**	**3.6%**
11. Assistance with scheduling an appointment	89	0.1%	61	0.1%	**43**	**0.1%**
12. Need transportation	1,798	2.3%	1,621	1.8%	**1,571**	**2.1%**
13. Order ID card	6,406	8.0%	7,087	7.9%	**5,372**	**7.2%**
14. Question about letter or outbound call	1,003	1.3%	675	0.8%	**701**	**0.9%**
15. Request member materials	1,197	1.5%	1,059	1.2%	**1,188**	**1.6%**
16. Update demographic information	9,526	12.0%	11,494	12.8%	**7,481**	**10.1%**
17. Member emergent or crisis call	900	1.1%	1,293	1.4%	**628**	**0.8%**
18. Other	3,923	4.9%	4,887	5.4%	**4,562**	**6.2%**
Total	**79,582**		**89,682**		**74,119**	

Table 3 - Customer Service Inquiries by Provider, Quarters 2 to 4, CY2014						
	Q2		Q3		Q4	
Provider Inquiries	#	%	#	%	#	%
1. Authorization – New	2,149	4.0%	1,968	3.7%	**1,841**	**3.9%**
2. Authorization – Status	3,649	6.8%	2,961	5.6%	**2,306**	**4.8%**
3. Benefits inquiry	5,071	9.4%	4,261	8.0%	**4,256**	**8.9%**
4. Claim Denial Inquiry	4,843	9.0%	5,256	9.9%	**4,760**	**10.0%**
5. Claim Status Inquiry	18,401	34.1%	18,822	35.3%	**18,284**	**38.3%**
6. Claim Payment Question/Dispute	6,829	12.6%	7,093	13.3%	**6,355**	**13.3%**
7. Billing Inquiry	365	0.7%	326	0.6%	**552**	**1.2%**
8. Coordination of Benefit	1,012	1.9%	1,099	2.1%	**1,095**	**2.3%**
9. Member Eligibility Inquiry	2,085	3.9%	1,986	3.7%	**1,652**	**3.5%**
10. Recoupment or Negative Balance	140	0.3%	150	0.3%	**162**	**0.3%**
11. Pharmacy/Prescription Inquiry	505	0.9%	542	1.0%	**568**	**1.2%**
12. Request Provider Materials	41	0.1%	40	0.1%	**28**	**0.1%**
13. Update Demographic Information	6,181	11.4%	6,764	12.7%	**4,093**	**8.6%**
14. Verify/Change Participation Status	416	0.8%	284	0.5%	**226**	**0.5%**
15. Web Support	508	0.9%	284	0.5%	**183**	**0.4%**
16. Credentialing Issues	285	0.5%	177	0.3%	**90**	**0.2%**
17. Other	1,508	2.8%	1,333	2.5%	**1,287**	**2.7%**
Total	**53,988**		**53,346**		**47,738**	

While the distribution by category has been fairly consistent by quarter, the categorization of the inquiries differs greatly by MCO. “Update Demographic Information,” for example, comprised 18.7% of member inquiries and 8.6% of provider inquiries in Q4. Of the 4,093 provider inquiries in this category, 99.3% were reported by Sunflower; Amerigroup categorized 25 of their provider calls in this category, and UnitedHealthcare categorized only 3 in this category. Of the 7,481 member inquiries categorized as “update demographic information,” 69.7% were Sunflower inquiries, 18.7% of Sunflower’s total member inquiries, compared to 6.0% of Amerigroup member inquiries and 3.8% of UnitedHealthcare member inquiries. .

Other examples of category counts reported for member inquiries that differed greatly by MCO included:

- UnitedHealthcare reported no calls for “Need Transportation” compared to 1,311 reported by Amerigroup and 260 reported by Sunflower.
- Sunflower reported 626 “Member emergent or crisis calls, compared to two reported by Amerigroup and zero calls reported by UnitedHealthcare.

Examples of category counts reported for provider inquiries that differed greatly by MCO included:

- Amerigroup reported 1,809 provider inquiries for “Authorization – New,” while UnitedHealthcare reported nine and Sunflower reported 23. Amerigroup reported 1,695 provider inquiries for “Authorization – Status,” while UnitedHealthcare reported 236 and Sunflower reported 375.
- Sunflower reported no calls for “Claim Denial Inquiry,” compared to 2,560 reported by UnitedHealthcare and 2,200 reported by Amerigroup.
- UnitedHealthcare reported 1,000 provider inquiries for “Coordination of Benefits” compared to 83 reported by Amerigroup and 12 reported by Sunflower.

CONCLUSIONS

- In Q4 CY2014, 99.99% of the customer service inquiries received by the MCOs were resolved within two business days. The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within two, five, and 15 business days in each quarter of CY2013 and CY2014 to date.
- Of the 18 inquiries not resolved within two business days, five were resolved within five business days and six within 15 business days. Seven inquiries were reported as not being resolved within 15 business days.
- The number of inquiries in Q4 CY2014 is the lowest number received by the three MCOs to date.
- Of the 74,119 customer inquiries by members, Sunflower received 37.7% of the calls, UnitedHealthcare 31.5%, and Amerigroup 30.8%. Of the 47,738 provider inquiries, Amerigroup received 37.3%, UnitedHealthcare 34.3%, and Sunflower 28.5%.
- For members, benefit inquiries were again the highest percentage (21.3%) of the calls received in Q4, a decrease, however, of 2,226 compared with the previous

quarter. For providers, claim status inquiries were again the highest percentage (38.3%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

RECOMMENDATION
- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.

TIMELINESS OF CLAIMS PROCESSING

DATA SOURCES
Beginning last quarter, Timeliness of Claims Processing is based on MCO data reported in a monthly Claims Overview Report implemented in October 2014, and reporting claims data beginning in January 2014. To more clearly track timeliness of claims processing in CY2014, and as recommended in previous quarterly evaluation reports, the State developed, with interagency input, the Claims Overview Report template to provide clearer and more detailed tracking of the timeliness of claims processing.
In this revised report, MCOs now show the number of claims received each month and whether or not these claims were processed in a timely manner, as defined by the type of claim and State-specified timelines. Prior to October 2014, claims reports focused on the claims processed in a particular month, and reported the number and percentage of the claims that had been processed within the contractually required timeline. The current template reports the number of claims received by each MCO during each month, and reports the number and percent of claims received that month that were processed within the contractually required timelines.

Clean claims are to be processed within 30 days, non-clean claims within 60 days, and all claims within 90 days. Clean claims received in the middle or end of a month may be processed in that month or the following month. Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements.

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

Due to the 30 to 90 day processing timelines, depending on type of claim, MCOs have submitted monthly reports for clean claims received in January through November, for non-clean claims received in January through October, and for all claims received in January through September. To best assess trends, timeliness of claims processing is reported and compared by quarter in this report. In the Q4 report, data are reported for Q1 through Q3, CY2014, quarters where data are available for each month of the quarter for all claim types.

Turnaround time (TAT) data for the two previous quarters were reported in monthly Adjusted Claims and Claims Processing Turnaround Time (TAT) reports. In Q4, the State consolidated claims reports into one monthly Claims Overview report. In the Q4 CY2014 report, average TATs for processing clean claims are based on data reported in October through December Claims Overview reports for claims processed during these months. (Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.) The average TATs are compared to those from the two previous quarters.

TIMELINESS OF PROCESSING CLEAN CLAIMS, NON-CLEAN CLAIMS, AND ALL CLAIMS

As indicated in Table 4:

- 99.96% of 3,801,628 “clean claims” received in Q3 were processed within 30 days;
- 99.95% of 127,719 “non-clean claims” received in Q3 were processed within 60 days; and
- 99.99% of 3,929,347 “all claims” received in Q3 were processed within 90 days.

For claims received by MCOs in January through September of 2014 (Q1 through Q3):

- 99.95% of 11,295,537 clean claims were processed within 30 days;
- 99.94% of 441,924 non-clean claims were processed within 60 days; and
- 99.99% of all claims (11,738,584) were processed within 90 days.

The MCOs received and processed fewer claims in all categories in Q3 compared to Q2, but a higher number of claims in all categories compared to Q1.

The number and percentage of clean claims and non-clean claims not processed within 30 days and 60 days, respectively, decreased in Q3 compared to both Q1 and Q2. The number of “all claims” not processed within 90 days increased slightly in Q3.

- Of the 1,606 clean claims not processed within 30 days in Q3, 97.6% (1,567) were Sunflower claims. In Q3, UnitedHealthcare had 33 clean claims not processed within 30 days, and Amerigroup had only six clean claims not processed within 30 days. In Q1 and Q2 of CY2014, Sunflower had similarly higher numbers and percentages of clean claims that were not processed within 30 days. In Q1, 87.9% of the 1,809 clean claims not processed within 30 days were Sunflower claims; in Q2, 97.8% of the 2,109 clean claims not processed within 30 days were Sunflower claims.
- Only 63 non-clean claims were not processed within 60 days.
- Of the 444 “all claims” not processed within 90 days, 354 (79.7%) were UnitedHealthcare claims. Sunflower had 87 “all claims” not processed within 90 days, and Amerigroup had only three “all claims” not processed within 90 days. In

Q1 and Q2 of CY2014, UnitedHealthcare had similarly higher numbers and percentages of "all claims" not processed within 90 days. In Q1, 76.5% of the 323 "all claims" not processed within 90 days were UnitedHealthcare claims; in Q2, 86.3% of the 400 "all claims" not processed within 90 days were UnitedHealthcare claims.

Table 4 - Timeliness of Claims Processing, Quarters 1 to 3, CY2014

Clean Claims	Q1	Q2	Q3	Q1-Q3
Number of Claims Received	3,631,133	3,862,852	3,801,646	11,295,631
Number of Claims Excluded	29	47	18	94
Number of Claims Not Excluded	3,631,104	3,862,805	3,801,628	11,295,537
Number of Claims received within month processed within **30 days**	3,629,295	3,860,696	3,800,022	11,290,013
Number of Claims **not** processed within **30 days**	1,809	2,109	1,606	5,524
Percent of claims processed within **30 days**	99.95%	99.95%	99.96%	99.95%
Non-Clean Claims	**Q1**	**Q2**	**Q3**	**Q1-Q3**
Number of Claims Received	136,782	178,135	128,036	442,953
Number of Claims Excluded	375	337	317	1,029
Number of Claims Not Excluded	136,407	177,798	127,719	441,924
Number of Claims received within month processed within **60 days**	136,312	177,670	127,656	441,638
Number of Claims **not** processed within **60 days**	95	128	63	286
Percent of claims processed within **60 days**	99.93%	99.93%	99.95%	99.94%
All Claims	**Q1**	**Q2**	**Q3**	**Q1-Q3**
Number of Claims Received	3,767,915	4,040,987	3,929,682	11,738,584
Number of Claims Excluded	404	384	335	1,123
Number of Claims Not Excluded	3,767,511	4,040,603	3,929,347	11,737,461
Number of Claims received within month processed within **90 days**	3,767,188	4,040,203	3,928,903	11,736,294
Number of Claims **not** processed within **90 days**	323	400	444	1,167
Percent of claims processed within **90 days**	99.99%	99.99%	99.99%	99.99%

CURRENT QUARTER AND TREND OVER TIME FOR AVERAGE TURNAROUND TIME FOR PROCESSING CLEAN CLAIMS

As indicated in Table 5, the MCOs processed 4,466,932 clean claims in Q4 CY2014 (includes claims received prior to Q4), an increase of 345,308 more claims than in Q3 CY 2014. The number of clean claims processed has increased during each quarter of CY2014. In Q1CY2014, 3,630,971 clean claims were processed, a difference of 835,971 compared to Q4.

Although the MCOs processed over 345,000 more claims in Q4, the average monthly TAT for processing clean claims for total monthly services was again less than 1 to 2 weeks, decreasing from 6 to10.9 days in Q3 to 4.3 to 10.2 days in Q4.

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

- Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs. The high volume of pharmacy claims also contributes to reduce the overall average TAT.
- Clean claims for non-emergency transportation had longer TATs, with monthly TATs ranging from 10.9 to 18 days in Q1, 11.3 to 17 days in Q2, 11 to 14 days in Q3, and 11 to 13.6 days in Q4.
- Dental claims also have longer TATs; in Q4 Dental TATs averaged 12 to 13.3 days for the three MCOs. In earlier quarters of CY2014, Dental TATs had wider ranges, in Q1 ranging from 2 to 21 days and in Q2 and Q3 ranging from 3 to 13 days.
- In Q4, UnitedHealthcare had the highest average monthly TAT for all services except Dental (tied with Amerigroup for lowest average monthly TAT). Amerigroup had the lowest average monthly TAT for all services. (The TAT for Pharmacy was "same day" for all three MCOs.)
- TATs for Nursing Facilities, HCBS, and Medical claims continue to have wide ranges. The TAT in Q4 for Nursing Facilities, for example, ranged from 4.0 to 10.8 days. While the TAT for HCBS in Q4 ranged from 4.0 to 10.1 days, the high end of the range in Q4 is lower than the three previous quarters (14.2 at the high end in Q2 and Q3 and 15.6 in Q1).

Table 5 - Number of All Claims Processed by Quarter by Service Category and Average Monthly Turnaround Time (TAT) Ranges for Clean Claims Processed, CY 2014

	Quarter 1		Quarter 2		Quarter 3		Quarter 4	
	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims
Hospital Inpatient	28,634	**6 to 18.6**	27,015	**5 to 19.2**	29,220	**7 to 17.4**	27,375	**6.6 to 12.8**
Hospital Outpatient	228,450	**3.6 to 12.8**	250,956	**3.6 to 11.8**	259,829	**4.1 to 11.2**	252,041	**4.2 to 9.6**
Pharmacy	1,156,361	**same day**	1,088,805	**same day**	1,316,690	**same day**	1,604,130	**same day**
Dental	103,419	**2 to 21**	106,758	**3 to 13**	99,316	**3 to 13**	105,340	**12 to 13.3**
Vision	62,966	**7 to 12.5**	61,605	**8 to 12.1**	76,528	**8 to 12**	58,246	**8 to 12**
Non-Emergency Transportation	104,724	**10.9 to 18**	112,633	**11.3 to 17**	126,908	**11 to 14**	133,337	**11 to 13.6**
Medical (Physical health not otherwise specified)	1,314,470	**3.6 to 10.6**	1,451,647	**3.3 to 9.8**	1,462,780	**3.6 to 10.1**	1,514,103	**3.2 to 10**
Nursing Facilities	126,227	**4.3 to 11.2**	89,753	**4.6 to 11.5**	86,965	**5.7 to 9.6**	108,011	**4.0 to 10.8**
HCBS	300,085	**3.7 to 15.6**	342,996	**3.2 to 14.2**	334,036	**3.3 to 14.2**	299,835	**4.0 to 10.1**
Behavioral Health	355,493	**3.4 to 8.6**	375,927	**3.5 to 8.2**	329,352	**3.8 to 8.5**	364,514	**2.8 to 8.3**
Total	**3,630,971**	**6 to 11.5**	**3,908,095**	**6 to 10.8**	**4,121,624**	**6 to 10.9**	**4,466,932**	**4.3 to 10.2**

It should be noted that the average TAT monthly ranges reported in Table 5 only include clean claims processed by the MCOs in Q1 through Q4, and do not include clean claims received but not yet processed.

CONCLUSIONS

- In Q3, MCOs processed 99.96% of clean claims within 30 days; 99.95% of non-clean claims within 60 days; and 99.99% of all claims within 90 days.
- The number and percentage of clean claims and non-clean claims not processed within 30 days and 60 days, respectively, decreased in Q3 compared to both Q1 and Q2.
- Over 97% of the 1,606 clean claims not processed within 30 days in Q3 were Sunflower claims. Compared to the other MCOs, Sunflower had similarly higher numbers and percentages of the clean claims not processed in Q1 and Q2.
- Of the 444 "all claims" not processed within 90 days in Q3, 354 (79.7%) were UnitedHealthcare claims. Compared to the other MCOs, UnitedHealthcare had similarly higher numbers and percentages in Q1 and Q2.
- The MCOs processed 4,466,932 clean claims in Q4 CY2014 (includes claims received prior to Q4), an increase of 345,308 more claims than in Q3 CY 2014. The number of clean claims processed has increased during each quarter of CY2014.
- The average monthly TAT for processing clean claims for total monthly services was again this quarter less than 1 to 2 weeks.
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO. Pharmacy claims had the shortest TAT (same day). Non-emergency transportation and dental claims have the longest TATs. TATs for Nursing Facilities, HCBS, and Medical claims continue to have wide ranges. The TAT in Q4 for Nursing Facilities, for example, ranged from 4.0 to 10.8 days.

RECOMMENDATIONS

- Sunflower should make a concerted effort to improve processes to increase the percentage of clean claims processed within 30 days.
- UnitedHealthcare should identify potential reasons for higher percentages of "all claims" not processed within 90 days.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims such as those for Nursing Facilities where other MCOs have much lower average monthly turnaround times or where the average number of days varies by five to seven days month to month.

GRIEVANCES

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

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

- The Special Terms and Conditions (STC) Quarterly Report tracks the number of grievances received in the quarter; the total number of the grievances received in

the quarter that were resolved; and counts of grievances by category type. The report includes space for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.

- The Grievance and Appeal (GAR) reports track the number of grievances received in the quarter; the number of grievances closed in the quarter; the number of grievances resolved within 30 business days; and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of the grievances, including narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. Categories of the grievances received during the quarter are further summarized by count in a Reason Summary Chart in the report.

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the GAR Reason Summary Table has 20 categories. (See Table 6.) Only three of the categories overlap clearly (Claims/Billing Issues, Quality of Care or Service, and Other).

Table 6 - Comparison of Grievance Report Categories, Quarters 1 to 4, CY2014

	Reports		STC Report								GAR Report							
			Q1		Q2		Q3		Q4		Q1		Q2		Q3		Q4	
	STC	GAR	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Transportation	√		226	45.4%	206	40.9%	291	43.3%	213	35.0%								
Claims/Billing Issues	√	√	106	21.3%	123	24.4%	151	22.5%	213	35.0%	125	25.1%	128	25.6%	144	23.4%	229	36.3%
Quality of Care or Service	√	√	44	8.8%	64	12.7%	88	13.1%	70	11.5%	48	9.6%	48	9.6%	58	9.4%	40	6.3%
Customer Service	√		38	7.6%	29	5.8%	42	6.3%	21	3.4%								
Benefit Denial or LImitation	√		13	2.6%	15	3.0%	30	4.5%	8	1.3%								
Access to Service or Care	√		24	4.8%	21	4.2%	26	3.9%	34	5.6%								
Health Plan Administration	√		20	4.0%	15	3.0%	20	3.0%	23	3.8%								
Member Rights/Dignity	√		1	0.2%	8	1.6%	14	2.1%	17	2.8%								
Service or Care Disruption	√		6	1.2%	16	3.2%	5	0.7%	2	0.3%								
Clinical/Utilization Management	√		0	0.0%	4	0.8%	5	0.7%	1	0.2%								
Other	√	√	20	4.0%	3	0.6%	0	0.0%	7	1.1%	26	5.2%	21	4.2%	34	5.5%	33	5.2%
Availability		√									80	16.1%	91	18.2%	124	20.2%	86	13.6%
Timeliness		√									85	17.1%	95	19.0%	103	16.7%	97	15.4%
Attitude/Service of Staff		√									106	21.3%	70	14.0%	101	16.4%	113	17.9%
Lack of Information from Provider		√									4	0.8%	2	0.4%	9	1.5%	4	0.6%
Level of Care Dispute		√									2	0.4%	2	0.4%	9	1.5%	5	0.8%
Prior or Post Authorization		√									3	0.6%	6	1.2%	8	1.3%	4	0.6%
Accessibility of Office		√									3	0.6%	9	1.8%	8	1.3%	5	0.8%
Pharmacy		√									6	1.2%	13	2.6%	5	0.8%	8	1.3%
Criteria Not Met - Medical Procedure		√									4	0.8%	4	0.8%	2	0.3%	1	0.2%
Criteria Not Met - Durable Medical Equipment		√									3	0.6%	4	0.8%	5	0.8%		
Sleep Studies		√											1	0.2%	2	0.3%		
HCBS		√									2	0.4%	3	0.6%	1	0.2%	5	0.8%
Quality of Office, Building		√									1	0.2%	3	0.6%	1	0.2%		
Sterilization		√													1	0.2%		
Criteria Not Met - Inpatient Admissions		√																
Overpayments		√															1	0.2%
Total			498		504		672		609		498		500		615		631	

The GAR report includes detailed descriptions of the grievances that were resolved within the quarter. In reviewing these detailed grievances, KFMC found many of the grievances did not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified. Clearer definitions of grievance categories would assist the MCOs in categorizing grievances and improving consistency throughout the KanCare program.

Transportation-related grievances are a good example of differences in categorization by each of the MCOs. Of the 218 transportation-related grievances resolved in Q4, 43.6% were categorized as "Timeliness"; 27.1% were categorized as "Availability"; 22.0% were categorized as "Attitude/Service of Staff"; 6.0% were "Billing and Financial Issues"; 0.5% "Level of Care Dispute"; and 0.9% "Other." (See Table 7.) MCOs varied in their categorization rates:

- Amerigroup categorized 0% of 48 transportation-related grievances as "Timeliness," 79.2% as "Availability," 8.3% as "Billing and Financial Issues," 8.3% as "Attitude/Service of Staff," and 4.2% as "Other."
- UnitedHealthcare categorized 63.7% of 102 transportation-related grievances as "Timeliness"; 0% as "Availability"; 33.3% as "Attitude/Service of Staff"; and 2.9% as "Billing and Financial Issues."
- Sunflower categorized 44.1% of 68 transportation-related grievances as "Timeliness"; 30.9% as "Availability," 14.7% as "Attitude/Service of Staff"; 8.8% as "Billing and Financial Issues"; and 1.5% as "Level of Care Dispute."

Table 7 - Transportation-Related Grievances by Category, Quarter 4, CY2014

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Timeliness			30	44.1%	65	63.7%	95	43.6%
Availability	38	79.2%	21	30.9%			59	27.1%
Attitude/Service of Staff	4	8.3%	10	14.7%	34	33.3%	48	22.0%
Billing and Financial Issues	4	8.3%	6	8.8%	3	2.9%	13	6.0%
Level of Care Dispute			1	1.5%			1	0.5%
Other	2	4.2%					2	0.9%
Transportation-Related Total	48		68		102		218	

In reviewing the descriptions of the grievances, an additional concern is the number of transportation-related grievances in Q4 (also reported in Q3) related to concerns by members about their safety, including reckless and careless driving, driver texting, accidents, and speeding. Also of concern is the number of transportation-related grievances described as "no show." At least 32 UnitedHealthcare grievances and 17 Sunflower grievances were described as "no show."

It should also be noted that some grievance "resolutions," particularly those related to billing issues and transportation, involve repeated contacts to providers and vendors. As this is the end of the second year of the KanCare program, it would seem that the number of providers who are balance billing members should be decreasing. In Q2 CY2014, UnitedHealthcare had 99 grievances related to "Billing and Financial Issues";

in Q3 114 of 287 grievances were categorized as "Billing and Financial Issues"; and in Q4 183 (54.8%) of 334 grievances were categorized as "Billing and Financial Issues." (Amerigroup had 24 billing-related grievances in Q4, and Sunflower had 22.) The Q4 UnitedHealthcare GAR report lists 140 different providers for these 183 grievances. One of the medical centers was listed in 11 of these grievances (and was also linked to multiple balance billing related grievances in previous quarters). In the STC report, UnitedHealthcare indicated they send a letter to "each provider who erroneously billed members advising him or her to cease billing," and that the "Provider Relations Team is informed of repeat offenders in order to educate those providers about the claims submission process and the regulations that prohibit billing a Medicaid member." Since 118 of the 183 providers were listed only once in the Q4 UnitedHealthcare GAR report, it would seem beneficial to educate providers proactively rather than reactively about balance billing regulations.

CONCLUSIONS

- Grievance categories in the GAR and STC reports continue to be interpreted differently by each MCO. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations.
- The grievance categories with the highest number of grievances were those related to transportation and billing. Most of the billing-related grievances (79.9%) were UnitedHealthcare grievances for billing of members by 140 different providers.
- The GAR reports have some inconsistencies by MCOs in their reporting of grievances.

RECOMMENDATIONS

- MCOs, particularly UnitedHealthcare, should make efforts to educate all providers (and not just those reported by members) about balance billing regulations and policies to reduce the number of billing-related grievances.
- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of data within reports and between reports where applicable.
- MCOs should continue to work with transportation vendors to reduce the number of "no shows" and late arrival times.

TRACK TIMELY RESOLUTION OF GRIEVANCES

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

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 8, 99.8% (614) of the 615 grievances closed in Q4 CY2014 were resolved within 30 business days; 100% (615) were resolved within 60 business days. (The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not equal the number of grievances "resolved" during the quarter.)

Table 8 - Timeliness of Resolution of Grievances

	CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Grievances Received in Quarter	445	496	422	423	498	501	679	**609**
Number of Grievances Closed in Quarter*	422	462	412	427	501	507	684	**615**
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	490	680	**614**
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	99.6%	96.6%	99.4%	**99.8%**
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	500	683	**615**
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%	98.6%	99.9%	**100.0%**
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	7	1	**0**

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

In the first six quarters of KanCare to date, the number of grievances received and the number of grievances closed increased slightly each quarter. In Q3 CY2014, the number of grievances received (679) and the number of grievances closed (684) were a sharper increase than the previous quarters. In Q4, the number of grievances received decreased by 70 (609), still over 100 to150 higher than CY2013 and the first half of CY2014.

- Of the three MCOs, in Q4 UnitedHealthcare had the highest number of grievances received (312), Sunflower received the fewest grievances (146). Amerigroup received 151 grievances in Q4.
- In the Q4 STC report, UnitedHealthcare reported 298 of 312 grievances received in Q4 were resolved in Q4; Amerigroup reported 116 of 151 grievances received in Q4 were resolved in Q4; and Sunflower reported that 146 of the 146 grievances received were resolved in Q4.
- In the quarterly GAR reports, MCOs report the number and type of grievances resolved during the quarter, including those received during a previous quarter.
  - UnitedHealthcare reported that 334 grievances were resolved in Q4, including 36 received in Q3.

- While Sunflower reported in the STC and GAR reports that 146 of the 146 grievances received in Q4 were resolved in Q4, descriptions of 146 grievances in the GAR report included 21 grievances received in Q3 and only 125 received in Q4.
- Amerigroup reported in the GAR report that 135 grievances were resolved in Q4, including 116 of the 151 grievances received in Q4 (reported in the STC report). Amerigroup provided descriptions of 154 grievances, including 116 received in Q4, 19 received in Q3, and 19 that were not resolved until Q1 CY2015.

Conclusions

- In Q4, 99.8% of grievances closed were resolved within 30 business days; 100% were resolved within 60 business days.
- In reporting the numbers of grievances resolved in Q4 in the GAR report, MCOs appeared to differ in the criteria they used to categorize and report these grievances.
- In the first six quarters of KanCare to date, the number of grievances received and the number of grievances closed increased slightly each quarter. In Q3 CY2014, there was a sharper increase than the previous quarters. In Q4, the number of grievances received decreased by 70 (609), still over 100 to150 higher than each quarter in CY2013 and the first half of CY2014.

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

Data Sources

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

All Grievances

Table 9 summarizes the quarterly numbers and types of grievances to date for the aggregated MCO data. In Q4 there were 609 grievances, 82 fewer than in Q3, but higher than the six previous quarters.

The grievance category that increased the most in Q4 was Claims/Billing Issues. The numbers of grievances in this category have steadily increased each quarter of CY2013 and CY2014. The 213 Claims/Billing Issue grievances in Q4 tie with Transportation-related grievances for the highest number of grievances received. As displayed in Table 10 and Figure 1, 35% of the grievances in Q4 were related to transportation and 35% were related to Claims/Billing Issues. Figure 2 shows the distribution of grievances in Q3 for comparison.

Table 9 - Number of Grievances Received by Category								
	CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Transportation	271	261	183	182	226	206	291	213
Claims/Billing Issues	35	87	48	72	106	123	151	213
Quality of Care or Service	19	34	30	56	44	64	88	70
Access to Service or Care	16	13	13	27	24	21	26	34
Health Plan Administration	17	31	26	27	20	15	20	23
Customer Service	52	52	34	25	38	29	42	21
Member Rights/Dignity	4	5	10	6	1	4	14	17
Benefit Denial or LImitation	16	4	7	10	13	15	30	8
Service or Care Disruption	3	11	16	7	6	16	5	2
Clinical/Utilization Management	4	10	14	5	0	8	5	1
Other	13	3	18	3	20	3	0	7
Total Grievances Received in Quarter	450	511	399	420	498	504	691	609
Total Grievances Resolved by the end of the quarter of those received in the quarter*†	407	453	344	385	474	474	672	560

*MCOs are contractually required to resolve 98% of member grievances within 30 day, and 100% of member grievances within 60 business days (via an extension request). Grievances received late in the quarter may not be resolved until the following quarter.
†Does not include Grievances resolved in the quarter that were received in the previous quarter

Table 10 - Percentage of Grievances by Category Within Each Quarter To Date								
	CY2013				CY2014			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Grievances Received	450	511	399	420	498	504	691	609
	% of 450	% of 511	% of 399	% of 420	% of 498	% of 504	% of 691	% of 609
Transportation	60.2%	51.1%	45.9%	43.3%	45.4%	40.9%	43.3%	35.0%
Claims/Billing Issues	7.8%	17.0%	12.0%	17.1%	21.3%	24.4%	22.5%	35.0%
Quality of Care or Service	4.2%	6.7%	7.5%	13.3%	8.8%	12.7%	13.1%	11.5%
Access to Service or Care	3.6%	2.5%	3.3%	6.4%	4.8%	4.2%	3.9%	5.6%
Health Plan Administration	3.8%	6.1%	6.5%	6.4%	4.0%	3.0%	3.0%	3.8%
Customer Service	11.6%	10.2%	8.5%	6.0%	7.6%	5.8%	6.3%	3.4%
Member Rights/Dignity	0.9%	1.0%	2.5%	1.4%	0.2%	1.6%	2.1%	2.8%
Benefit Denial or LImitation	3.6%	0.8%	1.8%	2.4%	2.6%	3.0%	4.5%	1.3%
Service or Care Disruption	0.7%	2.2%	4.0%	1.7%	1.2%	3.2%	0.7%	0.3%
Clinical/Utilization Management	0.9%	2.0%	3.5%	1.2%	0.0%	0.8%	0.7%	0.2%
Other	2.9%	0.6%	4.5%	0.7%	4.0%	0.6%	0.0%	1.1%

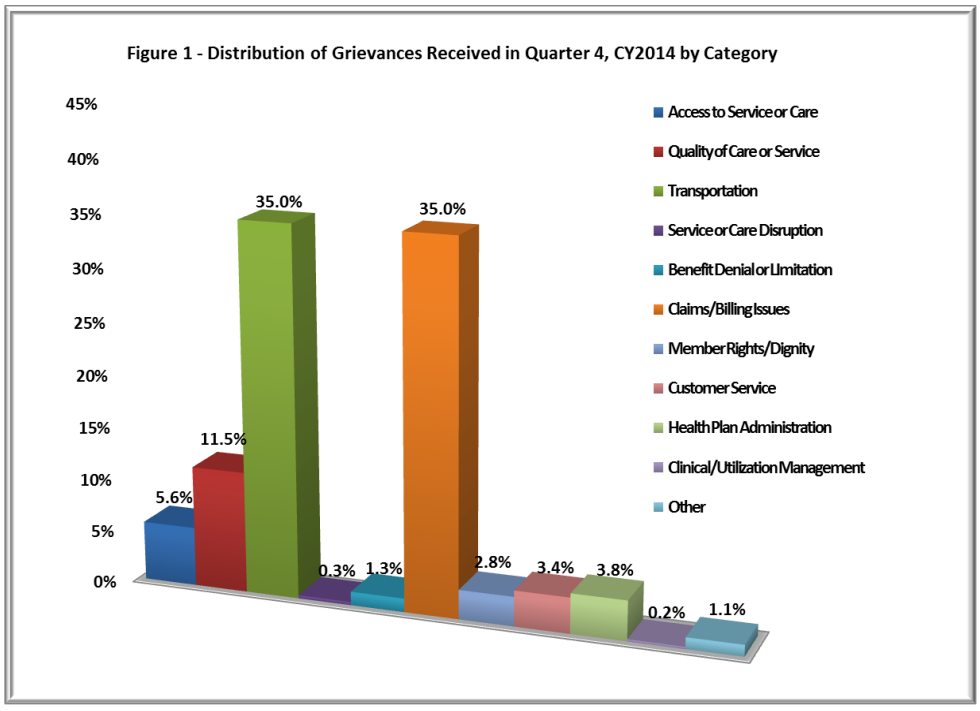


Figure 1 - Distribution of Grievances Received in Quarter 4, CY2014 by Category
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
5.6%
11.5%
35.0%
0.3%
1.3%
35.0%
2.8%
3.4%
3.8%
0.2%
1.1%
Access to Service or Care
Quality of Care or Service
Transportation
Service or Care Disruption
Benefit Denial or Limitation
Claims/Billing Issues
Member Rights/Dignity
Customer Service
Health Plan Administration
Clinical/Utilization Management
Other

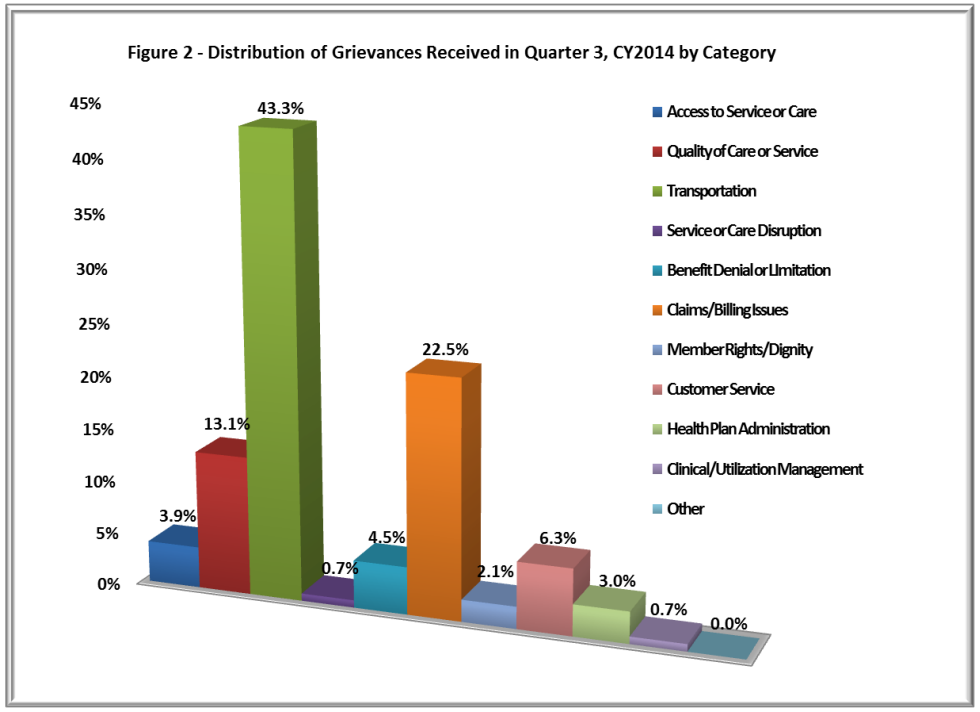


Figure 2 - Distribution of Grievances Received in Quarter 3, CY2014 by Category
45%
40%
35%
30%
25%
20%
15%
10%
5%
0%
3.9%
13.1%
43.3%
0.7%
4.5%
22.5%
2.1%
6.3%
3.0%
0.7%
0.0%
Access to Service or Care
Quality of Care or Service
Transportation
Service or Care Disruption
Benefit Denial or Limitation
Claims/Billing Issues
Member Rights/Dignity
Customer Service
Health Plan Administration
Clinical/Utilization Management
Other

Table 11 reports the types of grievances resolved in Q4 CY2014 in total and by waiver.

Of 615 grievances resolved in Q4 CY2014, 175 (28.5%) were reported by members receiving waiver services. Of the 175 grievances received from waiver members, 79 (45.3%) were transportation-related. Physical Disability (PD) waiver members had the most grievances, with 68 members reporting 81 grievances in Q4.

Table 11 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 4, CY2014*

			Grievances by Waiver Type						
	All Members	Waiver Members Subtotal	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	228	55	15	8	21	4	2	1	4
Quality of Care or Service	40	9	1		5	1	1		1
Attitude/Service of Staff	107	30	7	3	11	5	2		2
Timeliness	97	25	4	1	18				2
Availability	81	41	9	2	18	3	4		5
Pharmacy	8	1			1				
Accessibility of Office	7	1			1				
Lack of Information from Provider	4	1				1			
Level of Care Dispute	4	1			1				
Prior or Post Authorization	4	0							
HCBS	3	2	1						1
Overpayments	1	0							
Other	31	9	1		5		1		2
Total Grievances Resolved Q4	615	175	38	14	81	14	10	1	17
Transportation-Related	218	79	15	4	40	3	7	1	9
# of Members with Grievances Resolved Q4	567	147	31	10	68	13	8	1	16

*Includes grievances received in Quarter 3, CY2014, that were resolved in Quarter 4, CY2014

Access-Related Grievances

Of the 609 grievances received in Q4 CY2014, 34 (5.6%) were categorized in the STC report as "Access to Service or Care." (See Tables 9 and 10.) Access-related grievances have consistently been one of the least frequent categories of reported grievances. The number of "Access to Service or Care" grievances has increased each quarter of CY2014, ranging from 24 in Q1 to 34 in Q4.

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

- Amerigroup described 10 access-related grievances received this quarter as situations where members had difficulty or were unable to obtain services or supplies. They indicated they plan to continue to monitor grievances for repeat providers, and that "provider relations staff continue to monitor the network to identify service gaps and work with provider to contract with Amerigroup to perform key services."
- UnitedHealthcare reported 12 access-related grievances received in Q4. They indicated that grievances related to availability of network providers are considered

during their geo access studies to identify potential network gaps. For grievances related to appointment availability, provider offices are contacted to review appointment availability standards.
- Sunflower reported 12 access-related grievances and that there were "no trends identified at this time."

No grievances were specifically categorized in the GAR as "Access to Care or Service." Other categories in the GAR that could be related to "Access to Service or Care" include "Accessibility of Office" and "Availability." Based on the grievance detail provided in the GAR reports, other categories that could involve "Access to Service or Care" issues in Q4 included "Attitude/Service of Staff," "Other," and "Quality of Care" (members told that providers were not accepting new patients).

The GAR report provides additional details on grievances resolved during Q4 CY2014. "Accessibility of Office" grievances included concerns about access to a physical therapist, access to a pediatrician in their area, access to adult dental care, a provider who moved his location more than once, being dropped as a patient by a provider, difficulty getting through to MCO customer service staff by phone, and being told by a crisis hotline to call back the next day.

KFMC again recommends that KDHE work with the MCOs to develop more consistent categorization of grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of access-related grievances, as well as other grievance categories.

QUALITY-RELATED GRIEVANCES

Of the 609 grievances received in Q4 CY2014, 70 (11.5%) were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 40 of the grievances resolved in Q4 (6.3%) were categorized as "Quality of Care" (QOC).

In CY2014, there were 266 grievances categorized in the STC report as being related to QOC. The number of QOC grievances increased during each quarter of CY2014 ranging from 44 in Q1 CY2014 to 70 in Q4.

In the STC report, MCOs are asked to "insert a brief summary of trends and any actions taken to prevent recurrence."
- Amerigroup described the 31 QOC grievances received in Q4 as situations where "members felt they received inappropriate treatment from their treating provider." Thirteen of the 31 grievances were referred to the Quality Management for a Quality of Care investigation.
- UnitedHealthcare indicated the 28 QOC grievances included a variety of issues ranging from unprofessional behavior to allegations of misdiagnosis.
- Sunflower reported 11 QOC grievances received in Q4, and that there were "no trends identified at this time."

Of the 40 QOC grievances reported in the GAR as resolved, 9 were from members receiving waiver services including: one member receiving TBI (Traumatic Brain Injury)

waiver services; five members receiving PD (Physical Disability) waiver services; one member receiving FE (Frail Elderly) waiver services; one member receiving TA (Technology Assistance) waiver services; and one member receiving SED (Serious Emotional Disturbance) waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q4, KFMC found additional grievances that could potentially be considered to be related to QOC, particularly where resolution was through the MCO Quality Management staff, that were categorized as "Attitude/Service of Staff," "Level of Care Dispute," "Accessibility of Office," "Timeliness," and "Availability." Alternatively, several grievances categorized as QOC could just as easily have been categorized as "Attitude/Service," "Level of Care Dispute," "Availability," or "HCBS."

KFMC recommends that criteria be better defined for "quality of care" and the other grievance categories in the STC and GAR reports. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.

CONCLUSIONS (ACCESS AND QUALITY OF CARE GRIEVANCES)

- The number of grievances categorized as access-related and QOC have increased each quarter of CY2014; access-related grievances ranged from 24 in Q1 to 34 in Q4, and QOC grievances ranged from 44 in Q1 to 70 in Q4. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude that access-related and QOC grievances are actually increasing. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.
- Grievances referred for Quality of Care review and processing are often not categorized as "Quality of Care."

RECOMMENDATIONS

- Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

OMBUDSMAN'S OFFICE

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

DATA SOURCES

The primary data source in Q4 CY2014 is the KanCare Ombudsman Update report presented by Kerrie Bacon, the KanCare Ombudsman, on 1/23/2015, to the Robert G. (Bob) Bethell Joint Legislative Committee on Home and Community Based Services and KanCare Oversight.

CURRENT QUARTER AND TREND OVER TIME

The Ombudsman's Office has a current staffing of three individuals – the Ombudsman, a part-time assistant, and a third full-time volunteer coordinator who began work in September 2014. The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral, as needed, to the Ombudsman or other State agency staff. Ombudsman's Office staff are working with the Center for Community Support and Research at Wichita State University to develop a training program for volunteers. Training of volunteers is planned to begin by August 2015, first in Kansas City, followed by Wichita, and then expand statewide in 2016.

Contact with the Ombudsman's Office is primarily by phone and email, but also includes face-to-face contacts. 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.

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

Table 12 summarizes the number and type of contacts received and caller types in Q4 CY2014. There were 210 MCO-related contacts this quarter, 38.4% of the 547contacts reported. There were 46 fewer MCO-related contacts in Q4 than Q3, but the same number as in Q2 CY2014. Most of the contacts to the Ombudsman's Office in Q4 CY2014 were from consumers, 79.9% of 526 contacts and 85.2% of the 210 MCO-related contacts. Phone contacts comprised 83.2% of the contacts this quarter. The 90 email contacts reported this quarter did not include the many emails made in response to initial emails.

Table 12 - Ombudsman Contacts by Contact Method and Caller Type, Quarter 4, CY 2014

Contact Method			Caller Type		
	All contacts	MCO-related		All contacts	MCO-related
Phone	455	179	Consumer	437	179
Email	90*	29*	Provider	77	23
Letter	1	1	MCO employee	3	3
In person	1	1	Other	30	5
Total	547	210	Total	547	210

*Does not include additional emails responding to the initial emails.

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 13, 110 contacts were waiver-related in Q4, compared to 143 in Q3 CY2014. The most frequent waiver-related issues were for/from KanCare members receiving waiver services for Intellectual/Developmental Disability (I/DD) (36 contacts in Q4; 42 contacts in Q3) and for Physical Disability (PD) (29 contacts in Q4; 43 in Q3).

Since some contacts include more than one issue, the Ombudsman's Office began tracking the number of issues in addition to the number of contacts. As reported in Table 14, there were 704 issues and inquiries tracked out of the 547 contacts in Q4 CY2014. The highest number of issues and inquiries were related to Medicaid Eligibility (194 issues) and HCBS (75 issues). Of the 704 issues and inquiries, 321 (45.6%) were MCO-related.

Table 13 - Waiver-Related Inquiries to Ombudsman Office, Quarters 3 and 4, CY2014

	Q3 CY2014		Q4 CY2014	
Waiver	#	%	#	%
Intellectual/Developmental Disability (I/DD)	42	29.4%	36	32.7%
Physical Disability (PD)	43	30.1%	29	26.4%
Technology Assisted (TA)	8	5.6%	15	13.6%
Frail Elderly (FE)	16	11.2%	11	10.0%
Traumatic Brain Injury (TBI)	19	13.3%	10	9.1%
Serious Emotional Disturbance (SED)	5	3.5%	4	3.6%
Money Follows the Person (MFP)	6	4.2%	4	3.6%
Autism	4	2.8%	1	0.9%
Total	143		110	

Of 450 files closed in Q4, 308 (68.4%) were resolved in one day or less. The average number of days (mean value) was seven days, the median number of days (middle number of days of the 308 files) was one day or less, and the mode (most frequent value) was also one day or less.

In Q4, the Ombudsman's Office began reporting the number of issues that involved responding to questions and the number of issues that involved use of other resources from various State agencies, MCOs, and other community resources. Call volume by month was also reported for CY2014. October had the highest call volume (238 calls), followed by March (197 calls) and February (195 calls). Lowest call volumes were in December (134 calls), followed by April (148 calls) and January (153 calls).

Table 14 - Types of Issues and Inquiries Submitted to Ombudsman, Quarter 4, CY2014

	Quarter 4 CY2014				
	All Issues		MCO-related Issues		
Issues	#	% of 704	#	% of 321	% of 704
Medicaid Eligibility Issues	194	15.0%	39	12.1%	5.5%
Appeals, Grievances	46	7.5%	41	12.8%	5.8%
Medical Service Issues	70	6.8%	39	12.1%	5.5%
Billing	42	6.7%	26	8.1%	3.7%
Durable Medical Equipment	8	4.2%	8	2.5%	1.1%
Pharmacy	19	3.3%	11	3.4%	1.6%
HCBS					
HCBS General Issues	49	7.5%	32	10.0%	4.5%
HCBS Eligibility Issues	11	1.7%	10	3.1%	1.4%
HCBS Reduction in Hours of Service	8	2.5%	6	1.9%	0.9%
HCBS Waiting List	7	3.2%	2	0.6%	0.3%
Care Coordinator Issues	14	3.0%	14	4.4%	2.0%
Transportation	13	3.0%	9	2.8%	1.3%
Nursing Facility Issues	24	2.7%	8	2.5%	1.1%
Housing Issues	10	2.0%	8	2.5%	1.1%
Change MCO	9	1.7%	8	2.5%	1.1%
Dental	9	1.3%	6	1.9%	0.9%
Access to Providers	15	1.0%	13	4.0%	1.8%
Guardianship Issues	2	0.2%	1	0.3%	0.1%
I/DD Conference Call Questions	2	2.5%	1	0.3%	0.1%
Other	152	24.3%	39	12.1%	5.5%
Total	704		321		45.6%

CONCLUSIONS

- In Q4 CY2014, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive. This quarter, the Ombudsman's Office began tracking trends in the number and types of issues and inquiries. Issues and inquiries were also tracked this quarter by the types of

resources accessed to respond to inquiries, as well the number of contacts that were responses to questions.

- In 547 contacts and calls, 704 issues and inquiries were tracked this quarter. Of these 704 issues, 321 (45.6%) were MCO-related. The highest number of issues and inquiries were related to Medicaid Eligibility (194 issues) and HCBS (75 issues).
- Of 450 files closed in Q4, 308 (68.4%) were resolved in one day or less. The average number of days (mean value) was seven days, the median number of days (middle number of days of the 308 files) was one day or less, and the mode (most frequent value) was also one day or less.
- Training of volunteers is planned to begin in August 2015, first in Kansas City and Wichita, and expand statewide in 2016.

RECOMMENDATION

- While the Ombudsman's Office is tracking MCO-related contacts and issues, tracking of issues referred to MCOs in the MCO GAR report is recommended to assist in identifying resolution of grievances referred to the MCOs by the Ombudsman's Office. Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman for resolution could assist in tracking resolution of grievances.

QUANTIFY SYSTEM DESIGN INNOVATIONS IMPLEMENTED IN KANSAS

The KanCare quarterly evaluations include updates on system design innovations implemented in Kansas such as patient centered medical homes, electronic health record use, use of telehealth, and electronic referral systems. Some of these systems may 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. Related initiatives are also led by other entities in Kansas. To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC is first completing a cataloguing of the various related initiatives occurring in Kansas. KFMC is reaching out to the various provider associations and state agencies to identify, at a minimum, initiatives with potential to affect a broad KanCare population. KFMC will collect the following information about the other initiatives to help determine, wherever possible, overlap with KanCare initiatives:

- Consumer and provider populations impacted,
- Coverage by location/region,
- Available post-KanCare performance measure data, and
- Start dates and current stage of the initiative.

HEALTH HOMES

The Health Homes program for KanCare members with Serious Mental Illness (SMI) was implemented on 7/1/2014, with services beginning 8/1/2014. Welcome letters go out monthly to newly identified members that qualify to be enrolled in a Health Home. As reported in the December 2014 newsletter, "Health Homes Herald," about 34,000 Kansans are served by the Health Homes program. The newsletter provides success

stories and program updates; it can be found at the following Internet address: (http://www.kancare.ks.gov/health_home/news_herald.htm). Currently, there are 82 Health Home Partners (HHPs) contracted with one or more Lead Entities (KanCare MCOs). Interested providers continue to submit the Preparedness and Planning Tool, a self-assessment for potential HHPs.

PATIENT CENTERED MEDICAL HOMES

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 (PCMHs) and be recognized by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Committee (URAC). Below is a summary of these organizations and the work they are doing:

- Kansas Academy of Family Physicians (KAFP) - Kansas Primary Care Medical Home Initiative
  - *Consumer and provider populations impacted:* Primary Care practices and all of their patients regardless of payers.
  - *Coverage by location/region:* The eight primary care practices were located in Ellsworth, Lawrence, Pittsburg, Plainville, Sabetha, St. Francis, Winfield, and Wichita.
  - *Start date and current stage of the initiative*: Phase 1 was 1/1/2011– 12/31/2013. Two of the eight practices achieved Level 3 NCQA certification before the end of Phase one. KAFP contracted with KFMC in May 2014 to continue this work through March 2015. The start date for Phase 2 of KAFP's initiative, with KFMC's Regional Extension Center (REC) providing technical assistance, began in May 2014. KFMC is working with four of the original KAFP pilot sites to pursue NCQA PCMH certification. The three remaining clinics plan to submit before March 2015.
- Kansas Foundation for Medical Care
  - REC PCMH work
    - *Consumer and provider populations impacted:* Primary Care practices and all of their patients regardless of payer.
    - *Coverage by location/region:* Practices are located in Fredonia, Manhattan, Topeka, Wichita (3), and Winfield.
    - *Start dates and current stage of the initiative*: Six clinics started working with KFMC on PCMH in March 2013. One has submitted to NCQA for PCMH recognition; four plan to submit before March 31, 2015; and the sixth clinic will submit later in 2015. A seventh clinic started in May 2014, with plans to submit to NCQA for PCMH recognition under the 2014 standards in late 2015 or early to mid-2016.
- Blue Cross/Blue Shield of Kansas (BCBSK)
  BCBSK has a Quality Based Reimbursement Program (QBRP) for their contracting providers, which provides an opportunity to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSK and their patients.
  - *Coverage by location/region:* Kansas, excluding metro Kansas City

  - *Start dates and current stage of the initiative*: Since 2011, BCBSK has incentivized a number of provider-based quality improvement initiatives such as, EHR adoption, electronic prescribing, participating in a Health Information Exchange (HIE), and PCMH. These incentives change each year but will continue into 2015.
- Kansas Association for the Medically Underserved (KAMU) - Medicare Advanced Primary Care Practice (APCP) Demonstration
  - *Consumer and provider populations impacted:* Federally Qualified Health Centers (FQHCs) and their patients.
  - *Coverage by location/Region*: Junction City and Wichita.
  - *Start dates and current stage of the initiative:* The project ended 10/31/2014. As noted in the previous quarterly report, the FQHC in Wichita achieved Level 3 PCMH accreditation on 1/12/2014. The FQHC in Junction City has submitted documentation to NCQA for review.
- Kansas Health Foundation (KHF) and KAMU- PCMH Initiative
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.
  - *Coverage by location/region:* Nine safety net clinics.
  - *Start dates and current stage of the initiative*: January 2012 through December 2014 (originally June 2014). This initiative had been extended through the end of calendar year 2014. Four clinics chose to continue to receive concentrated supports through the extension period.

HEALTH INFORMATION TECHNOLOGY (EHRS AND MU)

As mentioned in previous quarterly reports, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created provisions to promote the Meaningful Use (MU) of health information technology. The Office of the National Coordinator for Health Information Technology (ONC) has provided technical assistance to over 100,000 primary care physicians via its Regional Extension Center (REC) program since 2010. KFMC, the Kansas REC, has provided support to more than 1,600 Eligible Professionals (EPs) and Eligible Hospitals (EHs) across the state to achieve MU. KFMC will continue to provide these services through April 2016.

CMS has a role in HITECH as well. CMS operationalized MU by setting up core and menu set measures that must be met by EPs and EHs to receive incentive dollars or to avoid Medicare reduced payment adjustments. CMS administers the MU incentive program for Medicare Eligible Professional (EPs) and Eligible Hospitals (EHs). The State of Kansas is in charge of the program for Kansas Medicaid providers within CMS guidelines. Medicaid incentives are for providers that adopt/implement/upgrade to certified EHR technology and for MU. From January 2011 to December 2014, the following incentive provider payments to Kansas EPs and EHs have been made:

- Medicare Eligible Professionals: $71,350,300 (up from $68.70 million in September 2014)
- Medicaid Eligible Professionals: $20,285,258 (up from $19.93 million in September 2014)
- Eligible Hospitals: $235,194,143 (up from $201.83 million in September 2014)

KFMC, through funding by KDHE/DHCF, is providing technical assistance to Medicaid providers who have not yet reached Meaningful Use of an EHR. KFMC will assist 200 Medicaid healthcare providers with selection, implementation, and meaningful use of an EHR between now and 9/30/2015. KFMC is currently working with 140 Medicaid providers; this is up from the 65 reported in the third quarter KanCare Evaluation report. KFMC has also received an expression of interest in the program from 108 more eligible providers. As part of this KDHE program, KFMC also conducted an EHR readiness assessment and assisted with vendor selection for 24 Health Home Partners contracted with KanCare.

HEALTH INFORMATION EXCHANGE

Increasing Health Information Exchange (HIE) capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of health care providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE), have continued to expand their capabilities and to offer services to a wider audience. Below is a summary of the incorporation of HIE into the system for providing healthcare in Kansas.

- **KHIN**
  - **Health Homes:** The KanCare Health Home Partners are expected to have the capacity to connect to one of the certified state HIEs. One goal for the Health Home model is for all providers to have a complete record (physical and mental health) available to assist with care for this special needs population. It was noted in the previous quarterly report that KHIN found a challenge to be that many of the organizations do not yet have an EHR. Recently, KHIN noted they are seeing growing technical knowledge and capabilities with the Health Home Partners.
  - **KanCare MCOs**: KHIN has been working with KanCare MCOs to ensure they have accurate, up-to-date information on their members. While a record of health care service is available to the MCOs upon receipt of a claim, KHIN provides the service information in real time at the point of care being received. KHIN can provide daily updates to the MCOs regarding member activity in the last 24 hours. This allows MCOs the ability to implement effective care management. Two of the three MCOs, Amerigroup and UnitedHealthcare, are members of KHIN. There is the opportunity for the MCOs to develop various alerts and to use longitudinal information regarding their members to help reduce Medicaid costs and improve care for their Kansas patients.
  - **Personal Health Record (PHR):** Thirty-five KHIN members, mostly small hospitals and medical clinics, are participating in a pilot program with KHIN's MyKSHealth eRecord. This is an increase from the 26 participants reported in the last quarterly report. MyKSHealth eRecord is a PHR that is available for free to all patients who receive care from Kansas health care providers. KHIN has obtained a REACH Healthcare Foundation grant that will be used for a large media campaign, beginning in April 2015, to educate providers and consumers about the PHR.

  - **Quality Measure Reporting**: Now that KHIN has a significant amount of clinical data, KHIN is beginning to focus more on quality measure reporting. KHIN is able to perform data extracts for specified quality measures, e.g., hemoglobin A1c values, cholesterol levels, glucose monitoring, hypertension monitoring, etc., and report them back to the providers.
- **LACIE**
  - **Patients queried**: LACIE is receiving more than 100,000 queries per month.
  - **Transportable Physician Orders for Patient Preferences (TPOPP)**: LACIE continues to work towards implementing the ability to place End of Life Preferences/Protocols and Orders into the exchange so that healthcare providers can access this information. This initiative is designed to improve the quality of care people receive at the end of life by translating their treatment goals and preferences into their medical orders.
  - **Emergency Medical Service Agencies**: LACIE is able to provide information to field medics proactively.
  - **Images in LACIE**: LACIE continues to work toward providing URL hyperlinks to images directly from the radiology report allowing access to images. This includes EKG, EEG, wound care, etc.
  - **KS WebIZ:** LACIE is working to obtain a grant that would help offset costs for providers to push immunizations to KS WebIZ, as well as query the immunization registry from within LACIE.
- **KHIN and LACIE**
  - **Provider Directory**: Both HIEs have developed or are working on developing a provider directory that can be accessed when Direct Secure Messaging addresses are needed to exchange information.

TELEHEALTH AND TELEMEDICINE

Telehealth and telemedicine are important to states such as Kansas that have large rural areas with limited access to healthcare providers, particularly specialists. The work of the University of Kansas Center for Telemedicine and Telehealth (KUCTT) has been discussed in previous quarterly reports. It provides a very valuable service to many areas of the state.

The University of Kansas Hospital will be able to increase its services to rural providers in western Kansas due to a Centers for Medicare and Medicaid Services Innovation grant of $12 million. The goal is to reduce deaths from heart disease and stroke, working with Hays Medical Center, 10 critical access hospitals and rural primary care providers serving western Kansas. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information exchange, “big data” analysis, and population health management.

OVERALL CONCLUSIONS

A number of templates and reports were added or are being revised in CY2014 to improve efficiency, consolidate reporting where possible, and to provide more detailed information where indicated. The Claims Overview Report, for example, implemented in

October 2014 and reporting claims received and processed beginning in January 2014, provides a much clearer reporting of timely processing of claims for each claim type. Monthly customer service reports, once required of MCOs weekly, provide more efficient reporting while providing more detailed data. The Ombudsman's Office has greatly expanded their tracking system this year to provide much more complete reporting. A number of additional programs, including Health Homes, are also being launched and expanded.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

- In Q4 CY2014, 99.99% of the customer service inquiries received by the MCOs were resolved within 2 business days. The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within 2, 5, and 15 business days in each quarter of CY2013 and CY2014 to date.
- Of the 18 inquiries not resolved within 2 business days, 5 were resolved within 5 business days and six within 15 business days. Seven inquiries were reported as not being resolved within 15 business days.
- The number of inquiries in Q4 CY2014 is the lowest number received by the three MCOs to date.
- Of the 74,119 customer inquiries by members, Sunflower received 37.7% of the calls, UnitedHealthcare 31.5%, and Amerigroup 30.8%. Of the 47,738 provider inquiries, Amerigroup received 37.3%, UnitedHealthcare 34.3%, and Sunflower 28.5%.
- For members, benefit inquiries were again the highest percentage (21.3%) of the calls received in Q4, a decrease, however, of 2,226 compared with the previous quarter. For providers, claim status inquiries were again the highest percentage (38.3%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

TIMELINESS OF CLAIMS PROCESSING

- In Q3, MCOs processed 99.96% of clean claims within 30 days; 99.95% of non-clean claims within 60 days; and 99.99% of all claims within 90 days.
- The number and percentage of clean claims and non-clean claims not processed within 30 days and 60 days, respectively, decreased in Q3 compared to both Q1 and Q2.
- Over 97% of the 1,606 clean claims not processed within 30 days in Q3 were Sunflower claims. Compared to the other MCOs, Sunflower had similarly higher numbers and percentages of the clean claims not processed in Q1 and Q2.
- Of the 444 "all claims" not processed within 90 days in Q3, 354 (79.7%) were UnitedHealthcare claims. Compared to the other MCOs, UnitedHealthcare had similarly higher numbers and percentages in Q1 and Q2.
- The MCOs processed 4,466,932 clean claims in Q4 CY2014 (includes claims received prior to Q4), an increase of 345,308 more claims than in Q3 CY 2014. The number of clean claims processed has increased during each quarter of CY2014.
- The average monthly TAT for processing clean claims for total monthly services was again this quarter less than 1 to 2 weeks.

- The average TAT for processing clean claims for individual service types again varied by service type and by MCO. Pharmacy claims had the shortest TAT (same day). Non-emergency transportation and dental claims have the longest TATs. TATs for Nursing Facilities, HCBS, and Medical claims continue to have wide ranges. The TAT in Q4 for Nursing Facilities, for example, ranged from 4.0 to 10.8 days.

GRIEVANCES

- In Q4, 99.8% of grievances closed were resolved within 30 business days; 100% were resolved within 60 business days.
- In the first six quarters of KanCare to date, the number of grievances received and the number of grievances closed increased slightly each quarter. In Q3 CY2014, there was a sharper increase than the previous quarters. In Q4, the number of grievances received decreased by 70 (609), still over 100 to150 higher than each quarter in CY2013 and the first half of CY2014.
- Grievance categories in the GAR and STC reports continue to be interpreted and reported differently by each MCO. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations.
- The grievance categories with the highest number of grievances were those related to transportation and billing. Most of the billing-related grievances (79.9%) were UnitedHealthcare grievances for billing of members by 140 different providers.
- The GAR reports have some inconsistencies by MCOs in their reporting of grievances. MCOs appeared to differ in the criteria they used to categorize and report grievances.
- The number of grievances categorized as access-related and QOC have increased each quarter of CY2014; access-related grievances ranged from 24 in Q1 to 34 in Q4, and QOC grievances ranged from 44 in Q1 to 70 in Q4. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude that access-related and QOC grievances are actually increasing. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

OMBUDSMAN'S OFFICE

- In Q4 CY2014, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive. This quarter, the Ombudsman's Office began tracking trends in the number and types of issues and inquiries. Issues and inquiries were also tracked this quarter by the types of resources accessed to respond to inquiries, as well the number of contacts that were responses to questions.
- In 547 contacts and calls, 704 issues and inquiries were tracked this quarter. Of these 704 issues, 321 (45.6%) were MCO-related. The highest number of issues and inquiries were related to Medicaid Eligibility (194 issues) and HCBS (75 issues).

- Of 450 files closed in Q4, 308 (68.4%) were resolved in one day or less. The average number of days (mean value) was seven days, the median number of days (middle number of days of the 308 files) was one day or less, and the mode (most frequent value) was also one day or less.
- Training of volunteers is planned to begin in August 2015, first in Kansas City and Wichita, and expand statewide in 2016.

Systems Design Innovations

- There are increasing numbers of providers partnering with various organizations on system design innovations.
- The KDHE Health Homes program had around 34,000 enrolled members in December 2014. This is up from 23,000 as of August 2014. There are currently 82 Health Home Partners contracting with one or more KanCare MCOs. KHIN has noted they are seeing growing technical knowledge and capabilities with the Health Home Partners.
- Regarding Medicare and Medicaid Incentive Provider Payments related to health information technology, $326,829,702 has been distributed to Kansas professionals and hospitals, by December 31, 2014. This is an increase of over $36 million since September 30, 2014.
- Efforts continue in Kansas to increase the use of the Health Information Exchanges.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.

Timeliness of Claims Processing

- Sunflower should make a concerted effort to improve processes to increase the percentage of clean claims processed within 30 days. UnitedHealthcare should identify potential reasons for higher percentages of “all claims” not processed within 90 days.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims such as those for Nursing Facilities where other MCOs have much lower average monthly turnaround times or where the average number of days varies by five to seven days month to month.

Grievances

- MCOs, UnitedHealthcare in particular, should make efforts to educate providers about balance billing to reduce the number of billing-related grievances.
- MCOs should continue to work with transportation vendors to reduce the number of “no shows” and late arrival times.
- Data in the GAR and STC grievance reports should be reviewed and compared for quality and completeness to ensure consistent and accurate reporting of data within reports and between reports where applicable.

- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined.
  - Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
  - Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
  - The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

OMBUDSMAN'S OFFICE

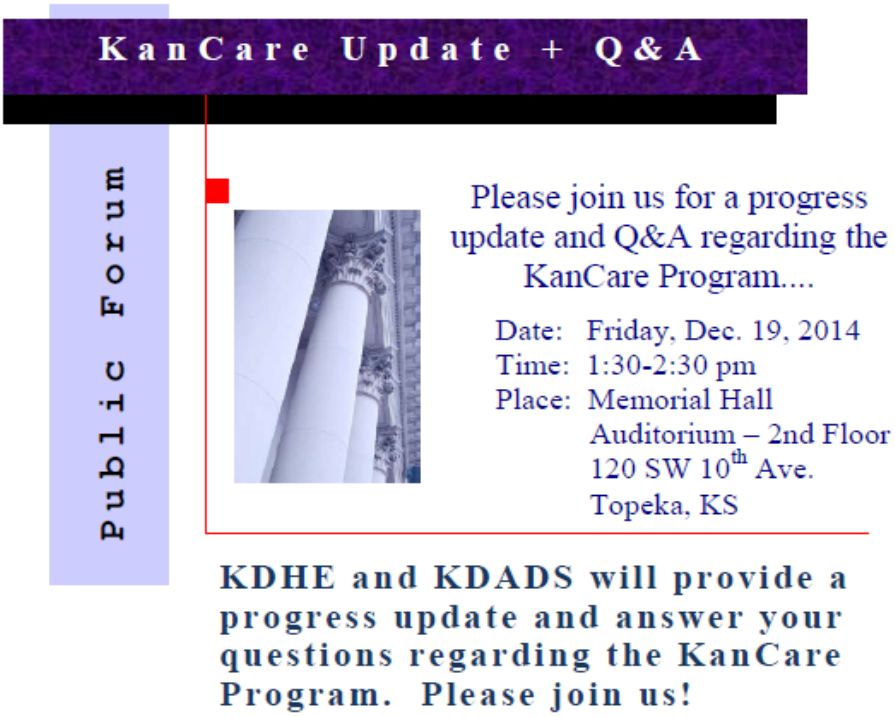
- While the Ombudsman's Office is tracking MCO-related contacts and issues, tracking of issues referred to MCOs in the MCO GAR report is recommended to assist in identifying resolution of grievances referred to the MCOs by the Ombudsman's Office. Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman for resolution could assist in tracking resolution of grievances.

End of report.

Summary of KanCare Annual Post Award Forum Held 12.19.14

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

Consistent with this provision, Kansas held its 2014 KanCare Public Forum, providing updates and opportunity for input, on Friday, December 19, 2014, from 1:30-2:30 pm at the Memorial Hall Auditorium, 120 SW 10th Ave., Topeka, Kansas. The forum was published as a "Latest News – Upcoming Events" on the face page banner of the www.KanCare.ks.gov website, starting on November 20, 2014. A screenshot of that face page banner is included in the PowerPoint document utilized at the forum (set out below). A screen shot of the notice linked from the KanCare website face page banner is as follows:



At the public forum, 22 KanCare program stakeholders attended and participated, as well as Acting Secretary Susan Mosier, MD, and additional staff from the Kansas Department of Health and

Environment; and Secretary Kari Bruffett, and additional staff from the Kansas Department of Aging and Disability Services. A summary of the information presented by state staff is included in the following PowerPoint document:

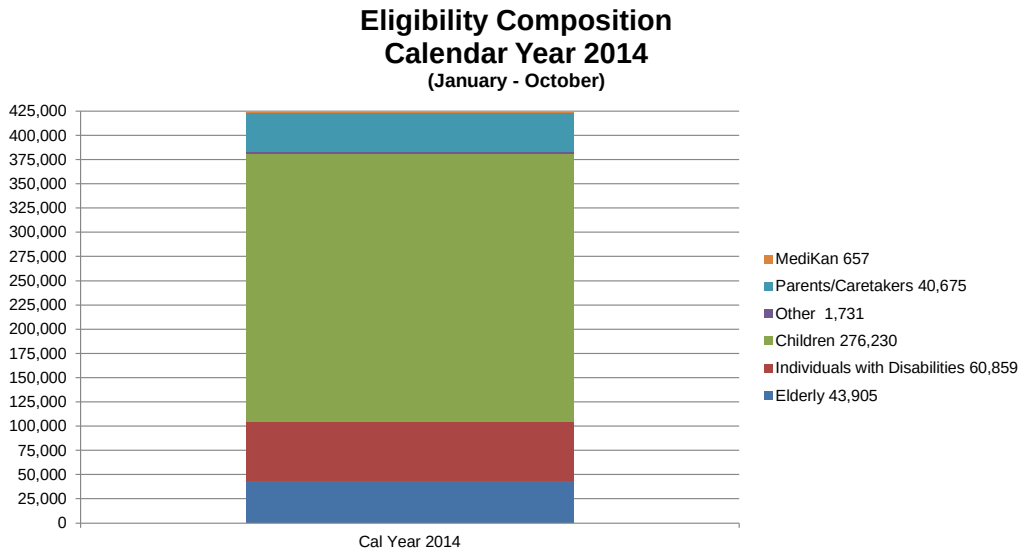
2014 KanCare Public Forum
Updates & Opportunity for Input

Friday, December 19, 2014

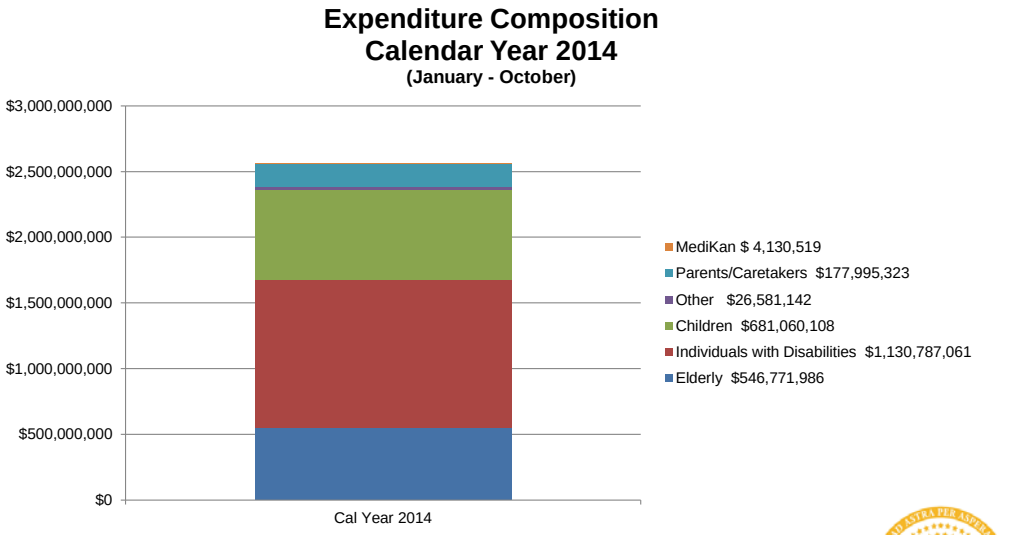
Agenda for Today

- Review Some KanCare Updates
  - Medicaid Members & Expenditures
  - KanCare Member Issues And Updates
  - KanCare Expenditures
  - Provider Network
  - Value Added Benefits
  - Customer Service
  - Health Homes
- Receive Questions, Suggestions And Other Feedback
  - Note Cards
  - Follow Up – Today And After

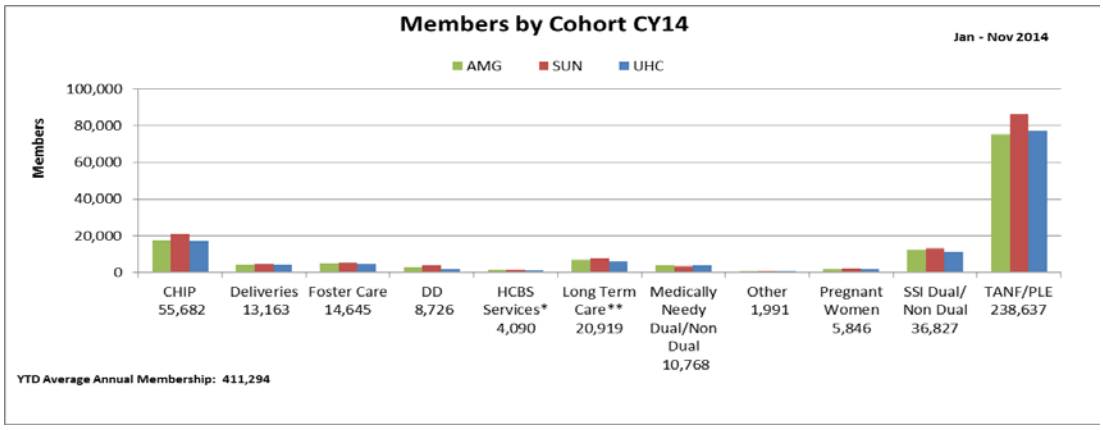
Medicaid Members - General



Medicaid Expenditures

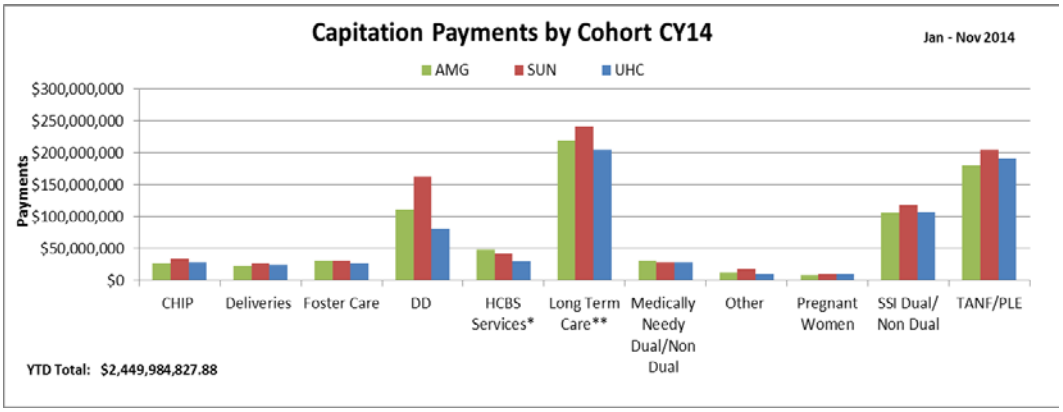


Members & Expenditures



*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assistance, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities; Money Follows the Person – Frail Elderly and Physical Disability Services; and the Physical Disability and Frail Elderly Waivers

Members & Expenditures



*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assistance, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities; Money Follows the Person – Frail Elderly and Physical Disability Services; and the Physical Disability and Frail Elderly Waivers

Member Issues - KDADS

- Physical Disability Waiver – Waiting List
- Intellectual/Developmental Disability Waiver – Transition
- Mental Health – Updates
- Utilization of Hospital Services by HCBS Waiver Members
  - Reduction in Emergency Department services for HCBS members
  - Decrease in use of inpatient services for HCBS members

Provider Networks

KanCare MCO	# of Unique Providers as of 9/30/14
Amerigroup	13,682
Sunflower	17,728
United	19,747

KanCare MCO	# of IDD Unique Providers HCBS / TCM	
	as of 5/20/14	as of 10/31/14
Amerigroup	74%/ 89%	76%/ 92%
Sunflower	81%/ 93%	82%/ 94%
United	73%/ 79%	73%/ 83%

Value Added Benefits

Amerigroup	Members YTD	Total Units YTD	Total Value YTD
Adult Dental Care	1,463	3,023	$347,842
Member Incentive Program	4,539	9,510	$222,580
Mail Order OTC	6,518	7,434	$122,694
Healthy Families Program	73	79	$62,500
Pest Control	205	232	$29,920
Smoking Cessation Program	122	223	$23,958
Hypoallergenic Bedding	104	111	$10,921
Weight Watcher Vouchers	117	169	$6,233
Member Transportation to Community Locations	100	1	$287
Entertainment Book Coupons	25	26	$14
2014 YTD GRAND TOTAL	18,359	24,333	$826,950

Value Added Benefits

Sunflower	Members YTD	Total Units YTD	Total Value YTD
CentAccount debit card	42,591	43,232	$864,640
Dental visits for adults	5,729	16,589	$319,723
Smoking cessation program	465	465	$111,600
Start Smart (mothers/children)	3,341	3,341	$94,049
Disease and Healthy Living Coaching	27,705	27,688	$72,268
Lodging for specialty and inpatient care	92	603	$48,843
SafeLink®/ Connections Plus cell phones	265	265	$12,675
In-home caregiver support/ additional respite	34	3,132	$10,181
Community Programs for Healthy Children:	410	410	$6,150
Meals for specialty and inpatient care	24	119	$2,975
Hospital companion	6	699	$2,272
2014 YTD GRAND TOTAL	74,419	96,544	$1,545,374

Value Added Benefits

United	Members YTD	Total Units YTD	Total Value YTD
Additional Vision Services	7,222	9,208	$449,600
Join for Me - Pediatric Obesity Classes*	35	35	$87,500
Adult Dental Services	1,475	1,528	$82,062
Annual Wellness Reminders	89,380	97,299	$61,298
Baby Blocks Program and Rewards	1,089	831	$49,361
Peer Bridgers Program	177	210	$47,628
Sesame Street - Food For Thought	982	988	$34,580
Weight Watchers - Free Classes	604	289	$34,391
Membership to Youth Organizations	566	681	$34,050
Infant Care Book for Pregnant Women	923	1,014	$13,182
Mental Health First Aid Program	114	133	$12,594
KAN Be Healthy Screening Age 3 to 19 - Debit Card Reward	957	957	$9,570
KAN Be Healthy Screening Age Birth to 30 months - Debit Card Reward	442	742	$7,420
Additional Podiatry Visits	69	47	$4,560
Asthma Bedding	104	81	$4,212
New Member Dental Exam - Debit Card Reward	277	354	$3,540
Coverage for Sports/School Physicals	128	45	$2,916
New Member Vision Exam - Debit Card Reward	207	255	$2,550
Join for Me - Reward for Completion of Program	209	35	$1,750
Weight Watchers Reward - Reward for Completing Classes	184	30	$1,500
Adult Biometric Screening - Debit Card Reward	86	94	$1,410
A is for Asthma	1,030	1,144	$572
Annual Vision Exam for Person with Diabetes - Debit Card Reward	89	15	$300
Annual A1C Exam - Debit Card Reward	17	15	$150
Follow-Up After Behavioral Health Hospitalization - Debit Card Reward	54	5	$125
Annual Monitoring for Persistent Medications - Debit Card Reward	11	12	$120
2014 YTD GRAND TOTAL	114,472	116,047	$946,942

Customer Service

MEMBER SERVICES MCO/Fiscal Agent Jan.-Sept. 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:17	1.69%	132,616
Sunflower	0:19	2.45%	149,379
United	0:14	1.46%	124,272
HP – Fiscal Agent	0:00	.06%	5,103

PROVIDER SERVICES MCO/Fiscal Agent Jan.-Sept. 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:19	1.19%	63,609
Sunflower	0:18	1.20%	88,329
United	0:11	.41%	56,037
HP – Fiscal Agent	0:00	.02%	6,599

Health Homes

- Health Homes for members with Serious Mental Illness – implemented July 1, 2014
- As of December, 2014
  - 34,151 members enrolled
  - Approximately 90 contracted Health Partners

KanCare

Health Homes

- Seeing many early implementation success stories from members using Health Home service
- Sharing information and updates in many ways, including monthly Health Homes Herald Newsletter
- Example of success story

KanCare

Q&A / Input / Suggestions / Next Steps

- Note Cards
  - Write out your question/suggestion
  - Include your name and phone # or email address for feedback
- Next Steps
  - Address what can here today
  - Follow up on individual questions/suggestions as needed
  - Summary of today's forum and your input/follow up will be included in the next KanCare quarterly report

More Information on: www.KanCare.ks.gov

A summary of the questions from participants, with responsive information provided, is as follows:

#	Public Forum Participant Question	Summary of Response
1	The waiver renewal calls for PD waiver consumers to move to the FE waiver when they turn 65. Is the FE waiver reimbursement going to be raised to the level of the PD wavier so Direct Support workers will not be taking a 40 cent an hour pay cut?	This proposal has generated a number of public comments, and we know a required transition at age 65 is a concern for some. The State will take those comments into account prior to submitting the waiver renewal Dec. 31. (Note: Subsequently, at the conclusion of the comment period, the State removed that provision.)
2	Will the final proposal of the TBI waiver be shared with providers/members prior to submission? Is the intent of the TBI waiver understood by the current administration, and are the values and cost savings noted? Per charts, HCBS is less costly – we need to keep members home rather than in facilities.	The waiver renewal application will be posted on the KDADS website when it is submitted, with a summary of changes based on public input. The State does value the TBI and other HCBS waivers, which help people remain in their homes and communities.
3	Have you made any progress on the FLSA home setting rule? Please share what you're going to do.	Kansas has proposed policy changes that will further clarify and assist self-directed consumers in their role as employer. The State is also closely following related litigation on this issue. No restrictions on services related to the Final Rule were proposed as part of the waiver renewals (for example, no new restrictions on work week).
4	When do you think case managers will stabilize? (i.e. decrease turnover) Is there a plan to improve notification when a case manager changes?	Clarified that the questions were indeed focused on the care coordinators who are employees of the MCO's. Provided these answers: Given the relative newness of the KanCare program, the state expected there would be some turnover of care coordination staff, and has monitored that issue consistently from the beginning of the program. Care coordination staffing has stabilized over time, and during 2014 the care coordinator positions vacated have ranged between 1 and 2.5 per month across the three MCOs. The state will continue to monitor this issue. The MCO's have notification plans in place when care coordinators change. If there are particular concerns with an MCO please let state staff know.
5	After adding the next group for chronic conditions into Health Homes, do you have plans to add other types of groups into the Health Home program, such as making I/DD a condition for enrollment into a Health Home?	Yes, following the implementation of the Chronic Conditions Health Home (Asthma and Diabetes), the plan would be to add additional groups to Health Homes. (The question came from an I/DD provider.) Specifically, if you have ideas relating to how the I/DD population could be included in Health Homes, we would welcome them.
6	KanCare contractors are still far behind on their payments to service providers. What can be done to facilitate these payments?	This is an issue that we continue to monitor closely, and review MCO performance regularly. Some additional improvement activities include: • Developing regulations to implement the inclusion of MCO payments to providers as part of Kansas' Prompt Pay Act (via HB2552 in the 2014 legislative session).

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- Returning an enhanced performance in timeliness of claim payment as one of the Pay for Performance measures for 2015.
- Reviewing regular reporting from and conducting monthly meetings with MCO leadership and staff which includes review of claim payment issues and any related provider concerns.

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<tr><td>7</td><td>Customer Service: Are there any statistics on call resolutions? Is there a breakdown between providers calling MCOs and how successful their questions were resolved? And is there a breakdown of consumers calling the MCOs and how successful their questions were answered?</td><td>

Yes – a snapshot of customer service inquiries resolution is included in the KanCare Evaluation report that is attached to each of the state's KanCare Special Terms and Conditions reports (available at the KanCare website). From the latest report, this summary:

<table>
<tr><th colspan="8">Table 1 - Timeliness of Resolution of Customer Service Inquiries</th></tr>
<tr><th></th><th colspan="4">CY2013</th><th colspan="3">CY2014</th></tr>
<tr><th></th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th><th>Q1</th><th>Q2</th><th>Q3</th></tr>
<tr><td>Number of Inquiries Received</td><td>261,286</td><td>181,427</td><td>157,547</td><td>146,374</td><td>141,964</td><td>133,570</td><td>143,028</td></tr>
<tr><td>Number of Inquiries Resolved Within 2 Business Days</td><td>260,859</td><td>180,903</td><td>157,185</td><td>146,299</td><td>141,907</td><td>133,539</td><td>142,705</td></tr>
<tr><td>Number of Inquiries Not Resolved Within 2 Business Days</td><td>298</td><td>524</td><td>362</td><td>75</td><td>57</td><td>27</td><td>323</td></tr>
<tr><td>Percent of Inquiries Resolved Within 2 Business Days</td><td>99.84%</td><td>99.71%</td><td>99.77%</td><td>99.95%</td><td>99.96%</td><td>99.98%</td><td>99.77%</td></tr>
<tr><td>Number of Inquiries Resolved Within 5 Business Days</td><td>261,286</td><td>181,427</td><td>157,458</td><td>146,349</td><td>141,951</td><td>133,570</td><td>143,001</td></tr>
<tr><td>Number of Inquiries Not Resolved Within 5 Business Days</td><td>0</td><td>0</td><td>89</td><td>25</td><td>13</td><td>0</td><td>27</td></tr>
<tr><td>Percent of Inquiries Resolved Within 5 Business Days</td><td>100%</td><td>100%</td><td>99.94%</td><td>99.98%</td><td>99.99%</td><td>100%</td><td>99.98%</td></tr>
<tr><td>Number of Inquiries Resolved Within 15 Business Days</td><td>261,286</td><td>181,427</td><td>157,547</td><td>146,374</td><td>141,964</td><td>133,570</td><td>143,028</td></tr>
<tr><td>Number of Inquiries Not Resolved Within 15 Business Days</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Percent of Inquiries Resolved Within 15 Business Days</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td><td>100%</td></tr>
</table>

Of the 143,028 customer service inquiries in the third quarter of calendar year 2014 (the most recent reporting period), 89,682 (62.7%) were from members, and 53,346 (37.3%) were from providers. For member inquiries, "resolved" means that the issue about which the member called was answered or addressed to conclusion. For provider inquiries, "resolved" can mean that the caller was referred to the correct MCO staff to get the inquiry answered or addressed to conclusion.

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KDHE Summary of Claims Adjudication Statistics – January through December 2014 – KanCare MCOs

Amerigroup- YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	47,732	$1,512,393,951	9,091	$322,239,475	18.98%	8.0
Hospital Outpatient	376,557	$1,029,184,522	58,835	$142,341,930	15.60%	4.6
Pharmacy	1,763,453	$111,288,306	380,926	Not Applicable	21.60%	Same Day
Dental	132,147	$36,323,625	11,852	$3,613,425	8.97%	13.0
Vision	73,037	$18,712,571	13,696	$4,480,093	18.75%	8.0
NEMT	195,861	$7,276,920	877	$33,378	0.45%	13.0
Medical (physical health not otherwise specified)	1,976,363	$833,436,376	236,178	$113,797,747	11.93%	4.0
Nursing Facilities-Total	135,322	$306,621,261	13,485	$22,524,744	9.92%	5.7
HCBS	181,660	$105,588,629	14,929	$11,115,200	8.27%	5.5
Behavioral Health	658,777	$83,985,725	67,277	$8,886,377	10.15%	3.9
Total All Services	**5,540,909**	**$4,044,811,890**	**807,146**	**$629,032,373**	**14.57%**	**7.3**

Sunflower - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	32,992	1,095,807,351	7,315	271,197,864	22.17%	9.7
Hospital Outpatient	320,736	604,026,796	42,979	57,493,287	13.40%	7.2
Pharmacy	2,906,531	240,537,484	690,790	93,667,033	23.77%	1.0
Dental	151,705	38,017,721	12,975	3,022,611	8.55%	13.0
Vision	91,754	20,577,586	12,014	3,018,039	13.09%	11.9
NEMT	139,694	4,239,636	610	13,649	0.44%	12.3
Medical (physical health not otherwise specified)	1,766,655	732,564,634	246,441	127,323,750	13.95%	6.4
Nursing Facilities-Total	125,358	256,996,724	11,916	32,172,683	9.51%	6.2
HCBS	431,450	205,798,002	16,733	9,802,808	3.88%	5.6
Behavioral Health	714,796	100,737,487	44,637	9,559,977	6.24%	5.9
Total All Services	**6,681,671**	**$3,299,303,423**	**1,086,410**	**$607,271,701**	**16.26%**	**4.3**

United - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	27,469	$889,835,647	5,716	$234,312,426	20.81%	13.8
Hospital Outpatient	269,217	$652,169,388	42,280	$143,015,251	15.70%	9.8
Pharmacy	1,581,524	$78,473,117	371,630	$66,292,504	23.50%	0.0
Dental	124,790	$34,245,122	11,665	$2,139,807	9.35%	14.0
Vision	64,571	$12,568,780	8,515	$1,790,628	13.19%	12.0
NEMT	63,682	$3,411,925	221	$15,147	0.35%	11.4
Medical (physical health not otherwise specified)	1,657,826	$572,879,223	214,818	$96,092,640	12.96%	8.9
Nursing Facilities-Total	92,304	$202,577,555	7,884	$20,835,413	8.54%	9.0
HCBS	328,674	$80,338,323	19,479	$5,024,1871	5.93%	8.1
Behavioral Health	242,742	$66,412,284	20,907	$12,608,557	8.61%	10.9
Total All Services	**4,452,799**	**2,592,911,369**	**703,115**	**582,126,563**	**15.79%**	**9.5**