Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.15

State of Kansas
Kansas Department of Health and Environment
Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2015-12/31/2015)
Federal Fiscal Quarter: 1/2016 (10/15-12/15)

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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, 2015.

Demonstration Population	Enrollees at Close of Qtr. (12/31/2015)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	16,330	17,339	1,009
Population 2: ABD/SD Non Dual	28,321	28,850	520
Population 3: Adults	44,763	46,814	2,051
Population 4: Children	223,785	228,960	5,175
Population 5: DD Waiver	8,766	8,824	58
Population 6: LTC	20,747	21,712	965
Population 7: MN Dual	1,239	1,329	90
Population 8: MN Non Dual	1,109	1,189	80
Population 9: Waiver	3,945	4,111	166
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**349,005**	**359,128**	**10,123**

III. Outreach/Innovation

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

During the fourth quarter, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following date with attendees in person and by phone: December 1, 2015 (10 attendees).

Also during this quarter, the state's KanCare Advisory Council met on November 20, 2015. 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 November meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, June 25, 2015
III. KDHE Update – Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
IV. KDADS Update – Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services
V. Updates on KanCare with Q & A
    a. Amerigroup Kansas
    b. Sunflower State Health Plan
    c. UnitedHealthcare Community Plan
VI. Miscellaneous Agenda Items
    a. Update on the integrated waiver
    b. Budget concerns and impact on services
    c. Parameters for value based/shared risk arrangements between MCOs and providers
    d. Plans for SMI and Chronic Conditions Health Homes
    e. Discussion of agency home health care workers and the new DOL rule
VII. Next Meeting of KanCare Advisory Council – February 22, 2016, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
VIII. Adjourn

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly)

- PACE Program (quarterly)
- HCBS/MCO Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS Provider Forum teleconferences (monthly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, bi-weekly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO Association) board meetings (as requested)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- Multi-Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- MCO Technical Advisory Group (biweekly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Monthly meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)
- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the 9 subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings

In addition, Kansas is pursuing some targeted outreach and innovation projects, including:

Health Homes

Kansas implemented Health Homes (HH) for people with serious mental illness (SMI) July 1, 2014. As of December 1, 2015, there were 39,833 KanCare members identified as eligible for the SMI HH. The opt-out rate for December 2015 was 28%, leaving 28,739 enrolled in SMI HHs. The opt-out rate has increased slightly, and the groups accounting for that are people with intellectual or developmental disabilities (IDD) and children in state custody. The engagement rate, calculated through July 2015 (due to encounter data lag), was 36.5%%. Engagement is calculated by dividing the number of enrolled HH members by the number for whom a payment was made.

For those served in the SMI HH, total payments through September 2015 were $31,412,127.88. Payments are made on a per-member per-month basis, but can only be triggered if a service is actually provided.

Waiver Integration Stakeholder Engagement (WISE) Workgroup

In January, KDHE and KDADS hosted a Waiver Integration Stakeholder Engagement (WISE) 2.0 Workgroup meeting. The workgroup was chartered with reviewing key topics for waiver integration, including waitlist management, supported employment, education and communication, and support broker/navigator service. The WISE 2.0 workgroup meetings with be lead and facilitated by focus group leads and the workgroup will be tasked with submitting recommendations to the State about their topic in February.

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup had its inaugural meeting on August 19, 2015. The workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society. The agenda for this group will be to analyze current credentialing practices in order to ease credentialing burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. During the fourth quarter, members of this group conducted research and product development, such as flowcharts of each MCO's credentialing process, and review of current standards of the Council for Affordable Quality Healthcare participating organizations. This workgroup is scheduled to meet again in January 2016.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on December 18, 2015. This meeting was attended by 7 new members, who replaced several who had been members for the past two years and did not renew their membership when group updates occurred. Topics for this workgroup meeting included the purpose of the CSI Workgroup, HCBS waiver updates, information on the Medicaid ERO, and a report from the KanCare Ombudsman.

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 150 events for the fourth quarter of 2015. The Community Relations Representatives' primary focus continues to be member education of services and benefits of the KanCare program. They constantly look to develop strong partnerships across the state by enhancing existing relationships and building new ones. Below is a sampling of Marketing activities Amerigroup supported in the fourth quarter:

- Catholic Charities Topeka Maintenance
- Health Core Clinic Lobby Exhibit
- KS Early Head Start Home Visitor Networking Presentation
- Salina Family Health Care Presentation
- Wichita Public Schools McKinney-Vento Christmas Distribution Exhibit

Outreach Activities: Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They continue with ongoing targeted outreach to improve member knowledge about the services available to them. 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. The Community Relations Representatives participated in a variety of community events reaching almost 10,000 Kansans in the fourth quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: diabetes, well child visits, employment, high blood pressure, your PCP and you, and more. Below is a sampling of some of their outreach efforts this past quarter:

- Disability Mentoring Days
- Cafe Con Leche Event Exhibit
- Binational Health Week Exhibit
- Health Care Association / KCAL Annual Convention and Trade Show
- Wyandotte Health Fair Exhibit
- Mexican Consulate Mobile Health Exhibit

Advocacy Activities: Amerigroup' s advocacy efforts for fourth quarter continued to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the elderly. The staff is proactive and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help the staff learn the needs of the communities they serve and how they can better serve these communities. The fourth quarter advocacy efforts remain similar to those of the previous quarters. Amerigroup continues to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community.

Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process with the assistance of the Grievance Specialists on site at the health plan. Here are a few examples of their Advocacy Activities this past quarter:

- Latino Coalition of Kansas City Meeting
- Connect the Dottes Meeting
- NAMI Conference Meeting
- United Way of the Plains Emergency Action Network Meeting
- KS Mosaic Meeting
- Autism Avenue Open House

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

Marketing Activities: Sunflower Health Plan marketing activities for 4th Quarter 2015 included sponsorships of member and provider events, as well as fundraisers. Sunflower's Marketing Department updated collateral for the New Member Packet, which is sent to new members during open enrollment.

- Examples of 4th quarter 2015 marketing that generated support and attendance at sponsored events as well as health plan visibility in the community include:

- Community Health Fair hosted by Southwest Medical Center, Liberal KS, Oct. 3, 2015
- Tonantzin Society's Day of the Dead event, Oct. 10, 2015
- InterHab's annual PowerUp conference, Oct. 14-15, 2015
- Kansas Oral Health Conference, Nov. 13-14, 2015
- GraceMed Clinic's 'Say Grace' 5K event to raise funds for clinic operations, Nov. 26, 2015

- Adjusted CentAccount program to include member incentives for HPV vaccinations and Child Well Care Visits
- Sunflower updated New Member Packets to include:

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

Outreach Activities: In addition to regularly scheduled Adopt-a-School events and Baby Showers facilitated by Sunflower's MemberConnections department, the health plan's 4th quarter 2015 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 13 communities from October through December.
- Medical Management staff contacted thousands of members in 4thQ 2015 to encourage them to receive the flu vaccine, and the outreach has seen positive results. Vaccination claims have increased

2.5% over last year and continue to climb.
- The Medical Management MemberConnections department organized the following outreach events throughout the state of Kansas in 4thQ 2015:
• Current initiatives: Well Child 7, PCP in 90 Days, and HPV vaccinations. Well Child 7 is geared to the parents of newborns to encourage them to get their immunizations and check-ups. The PCP in 90 Days initiative is outreach to our new members to help them find a primary care physician within 90 days of becoming a Sunflower Health Plan member. We are also outreaching to the parents of adolescents to encourage them to get the HPV series of vaccinations.
• Adopt-a-School events were held at Head Start locations in Wichita in the month of December. Each child received a health related children's book and a healthy snack. Topics covered included healthy eating and the benefits of exercise.
• A Start Smart for Your Baby Shower was held in Pittsburg, KS in December. Topics covered included: labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC, and breastfeeding. One Sunflower Health Plan RN was in attendance to address any member questions related to pregnancy and childbirth.

Advocacy Activities: Sunflower and its partner, LifeShare, advocated for people with I/DD through a variety of stakeholder engagement opportunities.
- In addition to sponsoring and attending various workshops, Sunflower employees hosted three presentations during the InterHab conference covering I/DD specific topics such as Healthcare, Shared Living 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' primary focus during this reporting period included continued emphasis around member, provider, and community education along with health and benefit literacy. United has accomplished this through participation and support for a variety of community events, as well as through activities such as new member welcome calls, various targeted member call campaigns, mailing new member welcome kits and communicating via UnitedHealthcare's quarterly Member and Provider Newsletters. United hosted a number of meetings and presentation with key providers, hospitals and FQHC's throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional strategic endeavors continued to focus on working with providers to ensure accurate panel assignments and attribution, where appropriate.

Outreach Activities: United's Bilingual Community Outreach Specialists continue to focus on activities targeted within their respective geographical areas of Kansas for both English and Spanish language speaking members. Their key responsibilities involve conducting educational outreach to members, community based organizations and targeted provider offices about UnitedHealthcare, the KanCare

program, the features and benefits of United's plan and how to access those benefits. United's Provider Marketing Manager interacts with key provider offices and the provider community to assist with issue resolution and to ensure that providers are educated on the features and benefits of the UnitedHealthcare Community Plan of Kansas for members who visit their offices. Several key outreach initiatives this period included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, attendance at health fairs and disability mentoring days held throughout the state, participation at a number of community stakeholder committee meetings. The Outreach team supported numerous FQHC events. And in fourth quarter United hosted two more Community Baby Showers, one in Garden City and one in Wichita. More of these events are planned throughout 2016.

- During the fourth quarter 2015, UnitedHealthcare staff personally met with approximately 6,049 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.
- During the fourth quarter 2015, UnitedHealthcare staff personally met with approximately 162 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.
- During the fourth quarter 2015, UnitedHealthcare staff personally met more than 399 individuals from provider offices located throughout the State.

Advocacy Activities: The UnitedHealthcare outreach specialist who is focused on supporting persons with disabilities, provided information and education on KanCare and UnitedHealthcare benefits to persons with disabilities and providers across the state. The specialist has also continued to be a direct resource to members with disabilities and the individuals and agencies that support them, to see that any concerns or issues reach the appropriate UnitedHealthcare staff for an appropriate response or resolution.

- One area of focus during this quarter was supporting and attending the many Disability Mentoring Day (DMD) events held around the state. At the DMD events, United Healthcare outreach specialists provided information to high school students with disabilities about UHC benefits and encouraged the students in their employment pursuits. At 2 locations United had a presentation to all the students about the importance of taking care of their health and the relationship between successful employment and well managed health for individuals. In addition to educating students with disabilities United was also able to network with local service agencies, transition counselors and other school district officials who are interacting regularly with young KanCare members, to assure they have accurate information about United Healthcare and KanCare benefits.

-Throughout this quarter, many members and disability advocates learned more about how to access their benefits with United Healthcare and how care coordination is provided to those on Home and Community Based Waiver programs. An important message United continues to share with members with disabilities is the desire to support their personal goals and to encourage members to make informed decisions about which health plan is the best fit for them. United also continues to feel there

is a need to help members with disabilities to understand their KanCare benefits and who they can contact within the state to determine eligibility, and ongoing communications about any changes in their circumstances. A portion of our outreach experiences include talking with people who have a newly acquired disability and are in need of good referrals and basic information about programs and services available in Kansas.

- During this quarter, this same outreach specialist attended the Interhab conference, a gathering of the largest I/DD provider association members in the state. Interhab members had the opportunity to receive updated information on benefits with United Healthcare. United Healthcare provided a workshop on Empower Kansans grants, with one of the grantees also presenting. The participating grantee is part of the Employment Systems Change Coalition, which is a group looking into best practices in other states around employment supports. This group has worked to gain stakeholder feedback, including from state agencies and will develop a set of recommendations to help improve employment outcomes in Kansas. In addition to the Empower Kansans grants, United continues to work with community partners and other stakeholders to further efforts to support members to become employed, particularly members with disabilities. United continues to explore ways to partner and expand its ability to be a leader in the employment of KanCare members with disabilities, and acknowledge this requires ongoing efforts to engage a diverse group of stakeholders.

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.

   CMS approved the KanCare MCO contract Amendment 19, for Sunflower and United Health Care on December 11, 2015. Amendment 19 implements capitation adjustments as well as defines the risk corridor tables, Pay for Performance program, and the Long Term Care rate-mix adjustment effective January 1, 2015 through December 31, 2015.

   Amerigroup Amendment 19 is pending approval with CMS. The State submitted a revised actuarial certification for Amerigroup through Amendment 20. Amendment 20 is currently under review for Amerigroup, Sunflower and United Health Care.

   On June 29, 2015, the State of Kansas' new eligibility determination system, KEES (Kansas Eligibility and Enforcement System) went live. Since go live, all coverage requests for medical assistance programs are processed through KEES. As with any change of this magnitude, there have been some delays in processing information for some Medicaid members, and the state

has been proactive about identifying those issues, determining the cause, and achieving resolution.

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

b. Benefits: All pre-KanCare benefits continue, and the state is working with MCOs and other stakeholders to ensure readiness to implement changes regarding Sleep Cycle Support services, and the related addition of Enhanced Care Services, effective January 1, 2016. In addition, the KanCare program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added service utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December, 2015, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	4,058	$477,683
	Member Incentive Program	12,480	$272,706
	Mail Order OTC	9,919	$166,450
	Total of all Amerigroup VAS Jan-Dec 2015	***26,457***	***$916,839***
Sunflower	CentAccount debit card	87,052	$1,741,040
	Dental visits for adults	17,295	$579,918
	Smoking cessation program	597	$143,280
	Total of all Sunflower VAS Jan-Dec 2015	***157,858***	***$4,297,916***
United	Adult Dental Services	1,767	$76,243
	Membership to Youth Organizations	1,385	$69,250
	Additional Vision Services	1,388	$60,151
	Total of all United VAS Jan-Dec 2015	***320,256***	***$8,801,476***

c. Enrollment issues: For the fourth quarter of calendar year 2015 there were 11 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the fourth quarter of calendar year 2015. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	1
KDHE - Administrative Change	41
WEB - Change Assignment	17
KanCare Default - Case Continuity	222
KanCare Default – Morbidity	517
KanCare Default - 90 Day Retro-reattach	223
KanCare Default - Previous Assignment	865

KanCare Default - Continuity of Plan	1717
AOE – Choice	586
Choice - Enrollment in KanCare MCO via Medicaid Application	970
Change - Enrollment Form	219
Change - Choice	310
Change - Access to Care – Good Cause Reason	8
Change - Case Continuity – Good Cause Reason	0
Change – Quality of Care - Good Cause Reason	0
Assignment Adjustment Due to Eligibility	14
Total	**5710**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY15 4th quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Lack of Info from Prov	Billing/ Fin Issues	Transp-Timely & Qual Of Svc	Prior Auth	Level of Care	Pharm	VAS	Med Proc/ Inpt Trtmt	Waiver HCBS/ Home Health	Other
AMG	0	5	9	13	0	25	60	0	3	4	4	2	2	13
SUN	0	4	6	21	1	12	62	3	4	8	3	4	2	17
UHC	1	0	13	20	3	42	73	1	1	2	0	0	0	14
Total	1	9	28	54	4	79	225	4	8	14	7	6	4	44

MCOs' Appeals Database
Members - CY15 4th quarter report

MCO	Dental	DME	Phar-macy	OP/IP Surg/Proc	Radio-logy/Gen Tests	Specialist Physician Ofc Visit	LTSS/HCBS PCA/LTC/RTC/ TCM/CBS/MH PBS Svcs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt/ Outpt Covg	Other
AMG	1	3	1	4	0	0	16	0	0	3	2
SUN	3	25	39	11	10	0	40	7	5	1	7
UHC	16	14	89	5	0	6	19	1	0	67	1
Total	20	42	129	20	10	6	75	8	5	71	10

MCOs' Appeals Database
Providers - CY15 4th quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Plan Admin/ Other	MCO Quality of Care/ Service	MCO Other	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Transp Quality of Care/ Service
AMG	4	0	10,433	74	0	0	0	9	1	18	0
SUN	27	2	109	12	0	13	10	68	5	1	0
UHC	0	0	596	0	0	0	0	11	0	13	0
Total	31	2	11,138	86	0	13	10	88	6	32	0

State of Kansas Office of Administrative Fair Hearings
Members - CY15 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Dental Denied/ Not Covered	CT/ MRI/ X-ray Denied	Pharm Denied	DME Denied	Home Health Hours Denied	Comm Psych Support/ BH Svcs Denied	Inpt/ PT/OT Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs Denied	Med Proc/ Genetic Testing Denied	Specialist Ofc Visit/ Ambulance Denied
Withdrawn				1	1		1		1	
Dismissed-Moot MCO reversed decision		1	1		1				1	
Dismissed-No Adverse Action								1		
Default Dismissal-Appellant did not appear								1		
Dismissed-Untimely								1		
OAH upheld MCO decision			1		1		1	3		
OAH reversed MCO decision										

Providers - CY15 4th quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied (Contained Errors)	Claim Denied By MCO In Error	Recoup-ment	DME Denied	Radio-logy Denied	Home Health/ Hospice/LTC Denied	Air Amb Charges	Inpt/Outpt/ Observation Med Proc Denied	Mental Health HCBS/ TCM Hrs Denied	Pharm/ Lab/ Genetic Testing Denied
Withdrawn		208			1	2	1	1 4		2 1
Dismissed-Moot MCO reversed decision	10	44 17	8 1	1 2		1		6 2 5	1 2	1
Dismissed-No internal appeal	1		3	1 1	2	6		3 1 6		20
Dismissed-No adverse action			1					2	3	
Default Dismissal-Appellant did not appear			1 3	2		3		2		
Dismissed-Untimely	1	1		2		1		4 1		
OAH upheld MCO decision						2 1		1 1	1	
OAH reversed MCO decision		4				1		1 1		

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q4 of 2015, there were a total of 35 requests, which is a dramatic decrease from 98 requests in third quarter of 2015. 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 Q4 of 2015 showed no particular trend. The remaining requests show varied reasons and causes for changing plans. The GCR requests showed an overall downward trend from the requests at the beginning of the year through December.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2015, 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	11	13	11
Approved	1	1	2
Denied	4	7	2
Withdrawn (resolved, no need to change)	3	4	4
Dismissed (due to inability to contact the member)	3	1	2
Pending	0	0	1

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. All three MCOs have made a concerted effort to review, revise and update their network adequacy reports based upon State feedback. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/31/15	# of Unique Providers as of 6/30/15	# of Unique Providers as of 9/30/15	# of Unique Providers as of 12/31/15
Amerigroup	14,863	15,201	15,954	13,652
Sunflower	19,131	20,376	20,226	19,914
UHC	20,482	20,823	20,840	14,833

h. Proposed changes to payment rates: Included in Section IV(a) above.

i. MLTSS implementation and operation: In the fourth quarter, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list, as well as individuals on the HCBS-I/DD Program waiting list. Additional details are included in section XIII below.

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). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY3. CMS approved the semi-annual payment for the hospitals on October 22, 2015 and the payments were made on October 30, 2015 (a report of

those payments is attached). A DSRIP Learning Collaborative was held on November 16, 2015, at Kansas University with Children's Mercy Hospital, KFMC and the State in attendance.

k. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
   - 1915(c) Amendments: Kansas submitted waiver amendment requests for the FE, PD, TBI and I/DD waiver programs to comply with the Department of Labor Final Rule.
   - Kansas submitted a renewal application for the Serious Emotional Disturbance (SED) waiver program to CMS on June 30, 2015. The SED waiver was scheduled to expire on September 30, 2015, but CMS granted extensions which allow the SED waiver to continue operating through March 28, 2016. Likewise, the Autism waiver has been granted extension through March 30, 2016.

l. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met once during the fourth quarter, on December 29, 2015, to review the current state of KanCare and HCBS services. The committee received reports from KDHE, KDADS, the KanCare Ombudsman, and each of the three KanCare MCOs, and took comments from stakeholders.

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 12.31.15 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2015-10*	*2015-11*	*2015-12*	*Grand Total*
Population 1: ABD/SD Dual	16,674	16,494	16,340	49,508
Population 2: ABD/SD Non Dual	28,475	28,387	28,329	85,191
Population 3: Adults	44,205	44,863	44,763	133,831
Population 4: Children	221,184	223,415	223,785	668,384
Population 5: DD Waiver	8,792	8,791	8,770	26,353
Population 6: LTC	21,031	20,998	20,884	62,913
Population 7: MN Dual	1,297	1,252	1,243	3,792
Population 8: MN Non Dual	1,127	1,146	1,109	3,382
Population 9: Waiver	3,990	3,997	3,947	11,934
Grand Total	**346,775**	**349,343**	**349,170**	**1,045,288**

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

VIII. Consumer Issues

Summary of consumer issues during the fourth quarter of 2015:

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 authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to confusing communication between the providers and the MCO, leading to incorrect or incomplete authorization requests, which were subsequently denied.	A few requirements were relaxed, but there are lingering issues due to the process being largely a manual review process.
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims.	This happens sporadically, and there are multiple causes. MCOs are researching the issue.

Retroactively eligible members are denied authorizations or claims denied for timely filing.	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 are plans to utilize a field in the new eligibility system KEES when it becomes available. Most of the processes require manual intervention, which still may lead to errors. A programmatic solution from all three MCOs is being considered.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 576 consumers. OEW also assisted in resolving 697 issues involving such matters as urgent medical needs, providing information on applications and pending applications/reviews to the KanCare Clearinghouse.

During this time period, OEW staff participated in 79 community events providing KanCare program outreach, education and information. OEW staff also completed KEES training in preparation for and implementation at go live.

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 partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). iACT makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. iACT includes leadership from both KDHE and KDADS and directs the policy initiatives of the KanCare Steering Committee.

The following sources of information guide the ongoing review of and updates to the KanCare QIS: Results of KanCare managed care organization (MCO) and state reporting, quality monitoring/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and 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 2015, some of the key quality assurance/monitoring activities have included:

- Quarterly business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2015, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the fourth quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. The 2016 review will be the full Balanced Budget Act review, and planning started in Q4 for this audit. It will assess identified compliance issues as well as findings from previous audits. We will also have monitor for compliance with the state contract.
- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and troubleshoot operational problems. Monitor progress through issue logs.

- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Complex Case staffing of HCBS and Behavioral Health issues. Each MCO brings complex cases for State consideration, and the State provides technical assistance about program policies and alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:
   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, January-December 2015:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:20	2.66%	189,795
Sunflower	0:18	1.84%	179,670
United	0:18	1.41%	159,007
HP – Fiscal Agent	0.00	0.20%	25,131

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:14	.78%	93,563
Sunflower	0:11	0.81%	108,922
United	0:06	0.35%	71,055
HP – Fiscal Agent	0.00	0.13%	6,947

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 2015 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 are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2015 AIRS reports through the quarter ending December 31, 2015, follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	**283**	**170**	**176**	**220**	**849**
Pending Resolution*	**34**	**145**	**182**	**97**	**458**
Total Received	**317**	**315**	**358**	**317**	**1307**
APS Substantiations**	**66**	**77**	**75**	**104**	**322**

**Some critical incidents pending resolution were inadvertently omitted from the 1st Quarter report.*

***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 fourth quarter of 2015, the Cross-Agency Adverse Incident Management Team met to review and make recommendations to the draft Incident Report Guide. The team finished all substantive revisions, discussed next steps following distribution of the Incident Reporting Guide and came to consensus on a meeting schedule for the next year. After distribution of the guide, the team will shift focus to opportunities for process and system improvement related to adverse incidents.

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 fourth quarter payments were made on October 9, 2015. The LPTH/BCCH Pool fourth quarter payments were processed on October 7, 2015. 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, annual evaluation reports for 2013 and 2014, and a revised evaluation design in March 2015.

For the fourth quarter of 2015, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (Claims Adjudication Statistics; Waiting List Management; Money Follows the Person; and Annual Public Forum)

a. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December, 2015, is attached.

b. Waiting List Management

PD Waiting List Management

In the quarter ending December 31, 2015, 889 individuals waiting for HCBS-PD services were offered services. Of those offers:

- 462 have accepted services
- 12 had other results (declined services, unable to contact, deceased)
- 415 have not responded

I/DD Waiting List Management

In the quarter ending December 31, 2015, 100 individuals waiting for HCBS-I/DD services were offered services. Also in that quarter, KDADS started clean-up of the HCBS-I/DD Waiting List. There were 150 individuals identified who were already coded for HCBS-IDD services. CDDOs were notified and began working to ensure those consumers were on services. There were 14 individuals identified as having moved out of state that were removed from the Waiting List. KDADS will continue clean-up of the list into the next quarter.

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,700 individuals. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants.

c. Money Follows the Person:

During the quarter ending December 31, 2015, there were 104 initial requests.

2015 Initial Request	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Amerigroup	47	52	28	31	158
Sunflower	43	59	33	28	163
United	92	88	43	45	268
Total	**182**	**199**	**104**	**104**	**589**

Individuals continue to be found eligible and transition from qualifying institutions into the community on the Money Follows the Person Program. KDADS, with the help of the three Managed Care Organizations, will continue to improve the efforts to identify and follow up with the individuals who may be eligible to transition. The Sustainability Plan received approval from CMS on September 29, 2015. Prior to this date of approval, there were also a number of calls with CMS regarding the Sustainability Plan as well as ongoing National Grantee calls, MFP Peer to Peer Group Meetings, and a number of webinar series.

d. Annual Public Forum

The KanCare annual public forum, pursuant to STC 15, was conducted on November 20, 2015. A summary of the forum, including comments and issues raised at the forum, is attached.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
IV(j)	KanCare DSRIP DY3 Semi Annual Payment Report for QE 12.31.15
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 12.31.15
X(e)	Summary of KanCare Ombudsman Activities for QE 12.31.15
XI	KanCare Safety Net Care Pool Reports for QE 12.31.15
XII	KFMC KanCare Evaluation Report for QE 12.31.15
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 12.31.15
XIII(d)	Summary of KanCare Annual Forum for QE 12.31.15

XV. State Contacts

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XVI. Date Submitted to CMS

February 25, 2016

Delivery System Reform Incentive Payment (DSRIP) Program Report

Demonstration Year 3 - QE December 2015

DY 3 DSRIP Semi Annual Payment
Paid 10/30/2015

Provider Name	4th Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	$ 843,281.25	$ 371,381.06	$ 471,900.19
University of Kansas Hospital	$ 2,177,578.13	959,005.41*	$ 1,218,572.72
Total	**$ 3,020,859.38**	**$ 1,330,386.47**	**$ 1,690,472.91**

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

DY 3
Start Date: 1/1/2015
End Date: 12/31/2015

Quarter 4
Start Date: 10/1/2015
End Date: 12/31/2015

	Total Expenditures	Total Member-Months
Oct-15	293,179,254.79	364,387
Nov-15	226,663,158.75	359,844
Dec-15	231,215,481.26	352,407
Q4 Total	751,057,894.80	1,076,638

	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-15									
Expenditures	4,842,564.48	38,840,773.05	30,688,683.64	60,922,022.27	48,889,460.72	91,060,305.24	968,852.87	2,151,421.71	14,815,170.81
Member-Months	18,596	31,340	48,270	226,529	9,714	22,504	1,502	1,351	4,581
Nov-15									
Expenditures	3,815,998.88	31,094,361.18	24,609,363.63	49,187,694.99	38,390,063.25	65,218,395.04	779,723.42	1,643,293.74	11,924,264.62
Member-Months	17,746	30,109	47,149	226,259	9,553	21,881	1,398	1,251	4,498
Dec-15									
Expenditures	3,833,194.42	31,209,185.64	24,355,629.94	49,243,453.16	39,239,361.15	68,673,981.61	797,094.24	1,794,989.37	12,068,591.73
Member-Months	16,736	28,456	46,461	224,275	8,787	21,034	1,367	1,281	4,010
Q4 Total									
Expenditures	12,491,757.78	101,144,319.87	79,653,677.21	159,353,170.42	126,518,885.12	224,952,681.89	2,545,670.53	5,589,704.82	38,808,027.16
Member-Months	53,078	89,905	141,880	677,063	28,054	65,419	4,267	3,883	13,089
DY 3 - Q4 PMPM	235.3472	1,125.0133	561.4158	235.3594	4,509.8341	3,438.6445	596.5949	1,439.5325	2,964.9345

Note:

1. For DY3 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. Expenditures show slight increase from DY3Q3 due to mid-year rate adjustments that went into place October 2015; retro-active to January 1, 2015.

KanCare Ombudsman Quarterly Report

Robert G. Bethell Joint Committee on HCBS and KanCare Oversight

Kerrie J. Bacon, KanCare Ombudsman
4th Quarter, 2015

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the fourth quarter of 2015. There were 524 contacts through these various means, 139 of which were related to an MCO issue (26.5%). Fourth quarter had a small decrease in contacts compared to the fourth quarter last year compared to third quarter.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	

MCO related	Q1/14	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15	Q4/15
Amerigroup	67	73	77	56	53	69	63	45
Sunflower	96	91	134	102	96	92	72	62
United Health	51	46	45	52	75	47	52	32
Total	**214**	**210**	**256**	**210**	**221**	**208**	**187**	**139**

The KanCare Ombudsman webpage (http://www.kancare.ks.gov/ombudsman.htm) continues to provide information and resources to members of KanCare and consumers.

Outreach by Ombudsman's office

- Presentation to Silver-haired Legislators, October 6, 2015
- Attended Wichita State University Athlete's Fair (manned a booth and discussed with students the Ombudsman program and volunteer opportunities) November 11, 2015
- Participated in Listening Sessions for Waiver Integration at Wichita , November 12, 2015
- Attended Alzheimer Conference (Manned a booth discussing the Ombudsman as a resource and presenting the volunteer opportunity) November 17, 2015
- Attended Delano District Meeting (Presented the Ombudsman as a resource, and presented the volunteer opportunity) November 17, 2015
- Provided KanCare Ombudsman report to KanCare Advisory Council, November 20, 2015
- Attended Optimist Club meeting (presented the Ombudsman as a resource and presented the volunteer opportunity) December 7, 2015
- Provided KanCare Ombudsman report at KanCare Consumer Specialized Interest Workgroup meeting, December 18, 2015
- Provided quarterly KanCare Ombudsman report to Robert G. Bethell Joint Committee on HCBS and KanCare Oversight Committee, December 29, 2015
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during fourth quarter.
- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians, consumers and other interested parties. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed.

KanCare Ombudsman Volunteer Program Update

- Wichita volunteer office started answering phones and assisting KanCare members on November 11th. In addition to training during this time, they have assisted approximately 67 consumers. There are six volunteers and two more that are in training.
    - Kansas City and Johnson County locations confirmed.
    - Working with various organizations to recruit volunteers
    - Plan to begin training of Volunteers in February.
- Volunteer Applications available on the KanCare Ombudsman webpage. www.KanCare.ks.gov/ombudsman.htm

Data by Ombudsman's Office

Contact Method	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15	Q4/15
phone	432	455	415	378	462	438
email	90	90	94	82	112	83
letter	2	1	1	1	0	2
in person	2	0	0	1	5	1
online	0	1	0	0	0	0
Total	**526**	**547**	**510**	**462**	**579**	**524**

Caller Type	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15	Q4/15
Provider	92	77	111	94	102	93
Consumer	412	437	366	343	426	385
MCO employee	1	3	3	3	5	3
Other	21	30	30	22	46	43
Total	**526**	**547**	**510**	**462**	**579**	**524**

Contact Information. The average number of days to resolve an issue during fourth quarter was 6 days.

	Qtr. 3 2014	Qtr. 4 2014	Qtr. 1 2015	Qtr. 2 2015	Qtr. 3 2015	Qtr. 4 2015
Avg. Days to Resolve Issue	9	7	6	7	11	6
% files resolved in one day or less	47%	56%	54%	38%	36%	45%
% files closed	86%	82%	85%	88%	92.6%	83.2%

When reviewing fourth quarter and the last year and a half, the most frequent calls regarding home and community based waivers were the physical disability waiver and the intellectual/developmental disability waiver. There were an average number of calls received during that timeframe, comparatively, regarding the frail elderly and technology assistance waivers.

Waiver	**Q3/14**	**Q4/14**	**Q1/15**	**Q2/15**	**Q3/15**	**Q4/15**
PD	43	29	57	48	33	28
I/DD	42	36	35	25	29	28
FE	16	11	15	12	16	18
AUTISM	4	1	4	3	4	5
SED	5	4	1	7	5	4
TBI	19	10	10	9	7	9
TA	8	15	11	13	11	13
MFP	6	4	2	2	3	1
PACE	0	1	0	0	1	1
MENTAL HEALTH	4	10	5	9	7	11
SUB USE DIS	0	0	0	0	0	2
NURSING FACILITY	10	25	12	28	33	29
Other	377	421	512	320	443	391
Total	**534**	**567**	**664**	**476**	**592**	**540**

The top five issues for fourth quarter are Medicaid Eligibility Issues, Other, Billing, HCBS General Issues, and HCBS Eligibility Issues. HCBS Eligibility Issues was new for this quarter; the other four have remained relatively consistent.

Issues	Q1/14	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15	Q4/15
Access to Providers	16	16	6	15	3	11	1	12
Appeals, Grievances	22	22	46	46	42	33	47	26
Billing	51	33	40	42	36	40	41	30
Care Coordinators	10	9	18	14	10	8	9	8
Change MCO	6	11	10	9	8	4	10	9
Dental	16	15	8	9	7	5	1	4
Durable Medical Equipment	25	35	25	8	25	12	7	8
Guardianship Issues	16	3	1	2	5	1	2	1
HCBS Eligibility issues	55	14	10	11	11	15	24	30
HCBS General Issues	11	25	45	49	60	36	54	34
HCBS Reduction in hours of service	22	11	15	8	10	8	13	16
HCBS Waiting List issues	3	8	19	7	11	8	9	11
Housing issues	3	8	12	10	1	6	4	3
Medicaid Eligibility Issues	81	73	90	194	139	108	206	182
Medicaid Service Issues	14	31	41	70	20	24	27	21
Nursing Facility Issues	8	12	16	24	15	34	34	29
Other	49	75	103	112	130	150	141	149
Pharmacy	38	15	20	19	25	33	14	20
Questions for Conf Calls/sessions	13	5	15	2	5	2	0	1
Thank you	2	1	10	13	14	15	11	12
Transportation	11	8	18	13	12	17	8	7
Unspecified	73	44	33	27	31	12	36	21
Total	**545**	**474**	**600**	**704**	**620**	**582**	**699**	**634**

Resource Category shows what resources were used in resolving an issue. If a Question/Issue is resolved, then it is answered without having to call, refer to another resource, or provide another resource for assistance. If an issue is resolved using a resource, then one of the other categories below is also usually noted to indicate which resource was called to find the help needed, or referred the member to, or possibly a document was provided. There are many times when multiple resources are provided to a member/contact.

Resource Category	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15	Q4/15
QUESTION/ISSUE RESOLVED	118	81	84	61	65	58
USED RESOURCES/ISSUE RESOLVED	177	260	262	234	321	296
KDHE RESOURCES	107	87	95	77	124	87
DCF RESOURCES	22	15	20	13	25	37
MCO RESOURCES	98	55	79	73	48	62
HCBS TEAM	57	33	32	43	36	29
CSP MH TEAM	2	0	0	1	0	2
OTHER KDADS RESOURCES	38	17	31	31	38	58
PROVIDED RESOURCES TO MEMBER	23	20	85	108	177	184
REFERRED TO STATE/COMMUNITY AGENCY	20	18	22	54	75	72
REFERRED TO DRC AND/OR KLS	27	9	26	16	19	5
CLOSED	55	18	14	29	60	72
Total	**744**	**613**	**750**	**806**	**988**	**962**

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

- Medicaid applications - Creating volunteer training in first quarter for assisting consumers with filling out Medicaid applications.
- Grievance, Appeal and State Fair Hearing assistance - Long term –Create training for volunteers so they can assist members one-on-one with the grievance, appeal, and/or state fair hearing process. Goal: 4th quarter, 2016.

Safety Net Care Pool Report

Demonstration Year 3 - QE December 2015

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

Paid 10/08/2015

Provider Name	4th Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	1,868,275.50	822,788.53	1,045,486.97
University of Kansas Hospital	5,604,827.25	2,468,365.92*	3,136,461.33
Total	**7,473,102.75**	**3,291,154.45**	**4,181,948.30**

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

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 3 - QE December 2015

Health Care Access Improvement Pool

Paid 10/08/2015

Hospital Name	HCAIP DY/QTR: 2015/4	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	37,281.00	16,418.55	20,862.45
Children's Mercy Hospital South	171,876.00	75,694.19	96,181.81
Coffeyville Regional Medical Center, Inc.	54,719.00	24,098.25	30,620.75
Cushing Memorial Hospital	125,795.00	55,400.12	70,394.88
Geary Community Hospital	102,050.00	44,942.82	57,107.18
Hays Medical Center, Inc.	303,529.00	133,674.17	169,854.83
Hutchinson Hospital Corporation	144,336.00	63,565.57	80,770.43
Kansas Heart Hospital LLC	73,463.00	32,353.11	41,109.89
Kansas Medical Center LLC	9,979.00	4,394.75	5,584.25
Kansas Rehabilitation Hospital	6,028.00	2,654.73	3,373.27
Kansas Surgery & Recovery Center	11,777.00	5,186.59	6,590.41
Labette County Medical Center	67,940.00	29,920.78	38,019.22
Lawrence Memorial Hospital	261,197.00	115,031.16	146,165.84
Manhattan Surgical Center	58.00	25.54	32.46
Memorial Hospital, Inc.	32,180.00	14,172.07	18,007.93
Menorah Medical Center	183,127.00	80,649.13	102,477.87
Mercy - Independence	4,919.00	2,166.33	2,752.67
Mercy Health Center - Ft. Scott	83,545.00	36,793.22	46,751.78
Mercy Hospital, Inc.	5,712.00	2,515.56	3,196.44
Mercy Reg Health Ctr	172,051.00	75,771.26	96,279.74
Miami County Medical Center	51,942.00	22,875.26	29,066.74
Mid-America Rehabilitation Hospital	137,062.00	60,362.10	76,699.90
Morton County Health System	21,047.00	9,269.10	11,777.90
Mt. Carmel Medical Center	237,327.00	104,518.81	132,808.19
Newton Medical Center	112,573.00	49,577.15	62,995.85
Olathe Medical Center	211,435.00	93,115.97	118,319.03
Overland Park Regional Medical Ctr.	612,195.00	269,610.68	342,584.32
Prairie View Inc.	21,820.00	9,609.53	12,210.47
Pratt Regional Medical Center	47,526.00	20,930.45	26,595.55
Providence Medical Center	520,647.00	229,292.94	291,354.06
Ransom Memorial Hospital	69,977.00	30,817.87	39,159.13
Saint Luke's South Hospital, Inc.	96,887.00	42,669.03	54,217.97
Salina Regional Health Center	330,558.00	145,577.74	184,980.26
Salina Surgical Hospital	3,053.00	1,344.54	1,708.46
Shawnee Mission Medical Center, Inc.	645,389.00	284,229.32	361,159.68
South Central KS Reg Medical Ctr	54,707.00	24,092.96	30,614.04
Southwest Medical Center	121,321.00	53,429.77	67,891.23
SSH - Kansas City	1,269.00	558.87	710.13
St. Catherine Hospital	182,839.00	80,522.30	102,316.70
St. Francis Health Center	319,952.00	140,906.86	179,045.14
St. John Hospital	99,169.00	43,674.03	55,494.97
Stormont Vail Regional Health Center	962,765.00	424,001.71	538,763.29
Sumner Regional Medical Center	36,541.00	16,092.66	20,448.34
Surgical & Diag. Ctr. of Great Bend	175,913.00	77,472.09	98,440.91
Susan B. Allen Memorial Hospital	100,790.00	44,387.92	56,402.08
Via Christi Hospital St Teresa	92,800.00	40,869.12	51,930.88
Via Christi Regional Medical Center	1,604,022.00	706,411.29	897,610.71
Via Christi Rehabilitation Center	32,576.00	14,346.47	18,229.53
Wesley Medical Center	1,469,758.00	647,281.42	822,476.58
Wesley Rehabilitation Hospital	72,759.00	32,043.06	40,715.94
Western Plains Medical Complex	115,686.00	50,948.11	64,737.89
Wichita Specialty Hospital	7,506.00	3,305.64	4,200.36
	10,421,373.00	**4,589,572.67**	**5,831,800.33**

Kansas Foundation for Medical Care, Inc
2947 SW Wanamaker Drive
Topeka, Kansas 66614-4193
Phone 785-273-2552
kfmc.org

February 16, 2016

Elizabeth Phelps, MPA, JD
Public Service Executive III
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: 2015 KanCare Evaluation Quarterly Report
Year 3, Quarter 4, October - December

Dear Ms. Phelps:

Enclosed is the 4th Quarter 2015 KanCare Evaluation quarterly report. If you have questions regarding this information, please contact me, jpanichello@kfmc.org.

Sincerely,

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

Enclosures

2015 KanCare Evaluation

Quarterly Report

Year 3, Quarter 4, October - December

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**February 16, 2016**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

KanCare

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February 16, 2016

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) on 8/24/2013; it was approved by CMS on 9/11/2013 and updated in March 2015. The Kansas Foundation for Medical Care, Inc. (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the fourth quarter (Q4) CY2015 report include the following:

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

KanCare 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 CY2015, the KanCare Reporting System Automation Project was launched. This system provides central access for MCOs to upload KanCare reports. Reports are categorized as being approved or under review. State staff, MCOs, and the EQRO are able to provide comments and receive email confirmation when new reports or revised versions of reports are uploaded. For the KanCare Evaluation process, this has allowed timely access to reports and has greatly streamlined the reporting and review process.

Recommendations from the quarterly and annual KanCare Evaluation reports are also discussion items at quarterly 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 two business days of inquiry receipt, 98% of all inquiries within five business days, and 100% of all inquiries within 15 business days.

Data Sources

The data sources for the Q4 CY2015 KanCare Quarterly Evaluation Report are monthly call center customer service reports MCOs submit to KDHE. In these reports, MCOs report the monthly counts, cumulative counts, and percentages of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end. The call center reports also provide counts of customer service inquiries by inquiry type from members and providers each month.

Current Quarter and Trend Over Time

In Q4 CY2015, 99.993% of the customer service inquiries received by the MCOs were resolved within two business days (see Table 1). In each quarter of CY2015, the MCOs' reported results have met or exceeded contractual requirements for timeliness of resolution of customer service inquiries.

The 24 inquiries not resolved within two business days were resolved within five 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%.

On an annual basis, there were 22.6% fewer inquiries in CY2015 than in CY2013 and 6.9% more inquiries than in CY2014. The percentage of inquiries resolved within two business days has improved each year, with only 41 inquiries not resolved within two business days in CY2015, compared to 425 in CY2014 and 1,259 in CY2013. In CY2015, all inquiries were resolved within

five business days, compared to 53 not resolved within five business days in CY2014 and 114 in CY2013.

Table 1. Timeliness of Resolution of Customer Service Inquiries

	CY2015				Annual Comparison 2013-2015		
	Q1	Q2	Q2	Q4	CY2013	CY2014	CY2015
Number of Inquiries Received	152,412	144,336	144,372	**136,515**	746,634	540,419	**577,635**
Number of Inquiries Resolved Within 2 Business Days	152,407	144,329	144,367	**136,491**	745,246	539,990	**577,594**
Number of Inquiries Not Resolved Within 2 Business Days	5	7	5	**24**	1,259	425	**41**
Percent of Inquiries Resolved Within 2 Business Days	99.997%	99.995%	99.997%	**99.982%**	99.814%	99.921%	**99.993%**
Number of Inquiries Resolved Within 5 Business Days	152,412	144,336	144,372	**136,515**	746,520	540,366	**577,635**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	0	**0**	114	53	**0**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	100%	**100%**	99.985%	99.990%	**100%**
Number of Inquiries Resolved Within 15 Business Days	152,412	144,336	144,372	**136,515**	746,634	540,412	**577,635**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	**0**	0	7	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	**100%**	100%	99.999%	**100%**

Member Customer Service Inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2). Sunflower added a category for Health Homes; the 188 grievances reported in Q4 CY2015 as related to "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Table 2. Customer Service Inquiries from Members, CY2015

	CY2015									
	Q1		Q2		Q3		Q4		CY2015 total	
Member Inquiries	#	%	#	%	#	%	#	%	#	%
1. Benefit Inquiry – regular or VAS	20,775	20.1%	19,702	20.2%	18,611	18.8%	**18,031**	**19.8%**	**77,119**	**19.7%**
2. Concern with access to service or care; or concern with service or care disruption	2,059	2.0%	1,754	1.8%	1,691	1.7%	**1,597**	**1.8%**	**7,101**	**1.8%**
3. Care management or health plan program	2,309	2.2%	2,976	3.0%	3,008	3.0%	**2,882**	**3.2%**	**11,175**	**2.9%**
4. Claim or billing question	7,107	6.9%	6,983	7.2%	7,383	7.5%	**6,396**	**7.0%**	**27,869**	**7.1%**
5. Coordination of benefits	3,437	3.3%	3,079	3.2%	3,030	3.1%	**2,898**	**3.2%**	**12,444**	**3.2%**
6. Disenrollment request	632	0.6%	561	0.6%	634	0.6%	**544**	**0.6%**	**2,371**	**0.6%**
7. Eligibility inquiry	13,330	12.9%	12,750	13.1%	15,214	15.4%	**14,423**	**15.8%**	**55,717**	**14.2%**
8. Enrollment information	2,141	2.1%	2,210	2.3%	2,838	2.9%	**2,371**	**2.6%**	**9,560**	**2.4%**
9. Find/change PCP	15,586	15.1%	13,407	13.7%	12,823	13.0%	**11,765**	**12.9%**	**53,581**	**13.7%**
10. Find a specialist	4,070	3.9%	3,875	4.0%	3,835	3.9%	**3,469**	**3.8%**	**15,249**	**3.9%**
11. Assistance with scheduling an appointment	46	0.04%	36	0.0%	26	0.0%	**40**	**0.0%**	**148**	**0.04%**
12. Need transportation	1,812	1.8%	1,789	1.8%	1,402	1.4%	**1,220**	**1.3%**	**6,223**	**1.6%**
13. Order ID card	7,653	7.4%	6,348	6.5%	6,240	6.3%	**5,797**	**6.4%**	**26,038**	**6.7%**
14. Question about letter or outbound call	1,013	1.0%	898	0.9%	1,175	1.2%	**1,319**	**1.4%**	**4,405**	**1.1%**
15. Request member materials	1,080	1.0%	1,112	1.1%	1,511	1.5%	**1,056**	**1.2%**	**4,759**	**1.2%**
16. Update demographic information	13,404	13.0%	12,639	13.0%	13,481	13.6%	**11,967**	**13.1%**	**51,491**	**13.2%**
17. Member emergent or crisis call	938	0.9%	834	0.9%	717	0.7%	**661**	**0.7%**	**3,150**	**0.8%**
18. Other	5,768	5.6%	6,641	6.8%	5,388	5.4%	**4,801**	**5.3%**	**22,598**	**5.8%**
Total	**103,160**		**97,594**		**99,007**		**91,237**		**390,998**	

- Of the 91,237 member calls in Q4 CY2015, 43.8% were received by Sunflower, 36.6% by UnitedHealthcare, and 19.5% by Amerigroup.

- In each quarter of CY2015, member customer service inquiries were higher than in each quarter of CY2014. The number of inquiries in Q4 CY2015, however, was lower than the three previous quarters of CY2015.
- Benefit inquiries continue in Q4 to be the highest percentage (19.8%) of member inquiries.
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO in the last five quarters include:
  - "Member emergent or crisis call" – 99.4% of 661 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 99.4%; Q2 CY2015 - 99.8%; Q1 CY2015 – 99.7%; Q4 CY2014 – 99.7%)
  - "Update demographic information" – 81.4% of 11,967 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 82.1%; Q2 CY2015 - 82.3%; Q1 CY2015 – 82.1%; Q4 CY2014 - 71.0%)
  - "Enrollment information" – 80.5% of 2,371 inquiries were reported in Q4 CY2015 by Amerigroup. (Q3 CY2015 – 76.8%; Q2 CY2015 - 76.4%; Q1 CY2015 - 76.6%; Q4 CY2014 – 80.5%)
  - "Need transportation" – 70.0% of 1,220 inquiries were reported in Q4 CY2015 by Amerigroup. (Q3 CY2015 – 73.7%; Q2 CY2015 - 67.2%; Q1 CY2015 - 75.8%; Q4 CY2014 - 80.8%)

Provider Customer Service Inquiries

The MCOs categorize provider customer service inquiries in their monthly call center reports by 17 provider service inquiry categories (see Table 3). Sunflower added a category for provider inquiries related to Health Homes; the 10 grievances reported in Q4 CY2015 as related "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

- Provider inquiries again decreased this quarter; 87 fewer provider inquiries were in received in Q4 CY2015 compared to Q3 CY2015, and 2,460 fewer compared to Q4 CY2014.
- Of the 45,278 provider inquiries received by MCOs in Q4 CY2015, Amerigroup received 36.2%, Sunflower 36.8%, and UnitedHealthcare 27.0%.
- For providers, claim status inquiries were again the highest percentage (49.5%) of the 45,278 provider inquiries. The three claims-related categories ("Claim denial inquiry," "Claim status inquiry," and "Claim payment question/dispute") together accounted for 69.9% of the provider inquiries in Q4 CY2015.
- Categories where two thirds or more of the provider inquiries in Q4 and four previous quarters were reported by one MCO included:
  - "Authorization – New" – 98.6% of 1,759 inquiries in Q4 CY2015 were reported by Amerigroup. (Q3 CY2015 – 98.0%; Q2 CY2015 – 99.1%; Q1 CY2015 – 99.1%; Q4 CY2014 – 98.1%)
  - "Update demographic information" – 93.7% of 495 inquiries were reported in Q4 CY2015 by Sunflower. (Q3 CY2015 – 96.2%; Q2 CY2015 - 91.4%; Q1 CY2015 - 95.5%; Q4 CY2014 - 99.5%)

- "Coordination of benefits" – 87.9% of 777 inquiries were reported in Q4 CY2015 by UnitedHealthcare. (Q3 CY2015 – 85.5%; Q2 CY2015 - 76.8%; Q1 CY2015 - 90.7%; Q4 CY2014 - 91.0%)
- "Verify/Change participation status" – 72.2% of 273 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 77.8%; Q2 CY2015 - 68.1%; Q1 CY2015 - 67.6%; Q4 CY2014 - 66.4%)
- "Authorization – Status" – 69.9% of 2,594 inquiries in Q4 CY2015 were reported by Amerigroup. (Q3 CY2015 – 67.4%; Q2 CY2015 - 71.0%; Q1 CY2015 - 70.8%; Q4 CY2014 - 72.0%)

Table 3. Customer Service Inquiries from Providers, CY2015

	CY2015									
	Q1		Q2		Q3		Q4		CY2015 total	
Provider Inquiries	#	%	#	%	#	%	#	%	#	%
1. Authorization – New	2,351	4.8%	2,369	5.1%	1,880	4.1%	1,759	3.9%	8,359	4.5%
2. Authorization – Status	2,456	5.0%	2,417	5.2%	2,323	5.1%	2,594	5.7%	9,790	5.2%
3. Benefits inquiry	4,594	9.3%	4,144	8.9%	4,043	8.9%	3,806	8.4%	16,587	8.9%
4. Claim denial inquiry	5,182	10.5%	3,990	8.5%	5,498	12.1%	4,411	9.7%	19,081	10.2%
5. Claim status inquiry	19,457	39.5%	21,314	45.6%	19,898	43.9%	22,399	49.5%	83,068	44.5%
6. Claim payment question/dispute	6,822	13.9%	6,005	12.8%	5,315	11.7%	4,833	10.7%	22,975	12.3%
7. Billing inquiry	851	1.7%	436	0.9%	363	0.8%	308	0.7%	1,958	1.0%
8. Coordination of benefits	1,167	2.4%	939	2.0%	792	1.7%	777	1.7%	3,675	2.0%
9. Member eligibility inquiry	1,866	3.8%	1,804	3.9%	1,935	4.3%	1,564	3.5%	7,169	3.8%
10. Recoupment or negative balance	353	0.7%	243	0.5%	165	0.4%	91	0.2%	852	0.5%
11. Pharmacy/prescription inquiry	599	1.2%	599	1.3%	438	1.0%	477	1.1%	2,113	1.1%
12. Request provider materials	31	0.1%	62	0.1%	62	0.1%	34	0.1%	189	0.1%
13. Update demographic information	538	1.1%	418	0.9%	764	1.7%	495	1.1%	2,215	1.2%
14. Verify/change participation status	272	0.6%	282	0.6%	441	1.0%	273	0.6%	1,268	0.7%
15. Web support	197	0.4%	209	0.4%	252	0.6%	194	0.4%	852	0.5%
16. Credentialing issues	163	0.3%	239	0.5%	208	0.5%	195	0.4%	805	0.4%
17. Other	2,353	4.8%	1,270	2.7%	988	2.2%	1,068	2.4%	5,679	3.0%
Total	49,252		46,742		45,365		45,278		186,637	

Recommendations

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Categories where over two-thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:

- Member customer service inquiries: "Update demographic information," "Member emergent or crisis call," "Enrollment information," and "Need transportation."
- Provider customer service inquiries: "Authorization – New," "Update demographic information," "Coordination of benefits," "Authorization – Status," and "Verify/Change participation status."

Timeliness of Claims Processing

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." In Table 4, the numbers of excluded claims in CY 2014 and CY2015 Q1 and Q2 are listed for each of the claim categories – Clean Claims, Non-Clean Claims, and All Claims.

To allow for claims lag, the KanCare Evaluation Report for Q4 assesses timeliness of processing clean, non-clean, and all claims reports received through Q3 CY2015.

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether or not these claims were processed in a timely manner as defined by the type of claim and State-specified timelines.

The report also includes average turnaround time (TAT) for processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month. The average TATs are compared to those from the previous quarter and during the same time period year-to-date.

Timeliness of Claims Processing by Claim Type and Date Received

The MCOs are contractually required to process 100% of clean claims within 30 days; 99% of non-clean claims within 60 days; and 100% of all claims within 90 days. In Table 4, the number and percentages of clean, non-clean, and all claims processed within these contractual time periods are summarized.

Numbers and percentages reported in previous quarterly reports included minor revisions due to delays in MCOs receiving vendor claims for a particular month. While Amerigroup and

UnitedHealthcare had made a few revisions and provided explanations for each change, Sunflower's monthly reports in 2015 included data revisions for each prior month. In the Q3 CY2015 KanCare Evaluation Report, KFMC recommended that Sunflower provide explanations for revisions of claims data reported in previous monthly reports. With the assistance of the State, Sunflower revised their claims reporting to now allow more consistent monthly reporting of claims data. It should be noted, as well, however, that the differences in Sunflower's monthly reporting did not substantively alter the overall percentages of claims processed within the contractually-required time periods. The claims data for Q3 CY2015, and updated data from Q1 and Q2 CY2015 (Table 4), reflect the changes in reporting processes and present more accurate and comparable reporting of aggregated data from the three MCOs.

Table 4 . Timeliness of Claims Processing, Quarter 1 to Quarter 3 CY2015

	CY2015		
Clean Claims	**Q1**	**Q2**	**Q3**
Number of clean claims received in quarter	4,286,321	4,289,702	**4,293,079**
Number of claims excluded	0	149	**332**
Number of clean claims not excluded	4,286,321	4,289,554	**4,292,747**
Number of clean claims received within quarter processed within 30 days	4,285,471	4,286,621	**4,289,240**
Number of clean claims received within quarter not processed within 30 days	850	2,933	**3,506**
Percent of clean claims processed within 30 days	**99.980%**	**99.932%**	**99.918%**
Non-Clean Claims	**Q1**	**Q2**	**Q3**
Number of non-clean claims received in quarter	180,921	164,613	**150,256**
Number of claims excluded	352	306	**1,310**
Number of non-claims not excluded	180,569	164,307	**148,946**
Number of non-clean claims received within quarter processed within 60 days	180,540	164,247	**148,743**
Number of non-clean claims not processed within 60 days	29	60	**203**
Percent of non-clean claims processed within 60 days	**99.984%**	**99.963%**	**99.864%**
All Claims	**Q1**	**Q2**	**Q3**
Number of claims received in quarter	4,467,242	4,454,315	**4,443,335**
Number of claims excluded	352	455	**1,642**
Number of claims not excluded	4,466,890	4,453,860	**4,441,693**
Number of claims received within quarter processed within 90 days	4,466,811	4,453,606	**4,441,633**
Number of claims not processed within 90 days	79	**254**	**60**
Percent of claims processed within 90 days	**99.998%**	**99.994%**	**99.999%**

For claims received in Q3 CY2015:

- Clean claims: 99.918% of 4,292,747 clean claims received in Q3 CY2015 were reported by the MCOs as processed within 30 days.
  - In Q3 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q3 CY2015, the percentage of clean claims not processed within 30 days was higher than in preceding quarters. In Q3 3,506 clean claims were not processed within 30 days, compared to only 850 in Q1 CY2015 and 2,933 in Q2 CY2015.

  - Of the 3,506 clean claims not processed within 30 days – 3,268 (93.2%) were claims received by Sunflower; 204 (5.8%) were claims received by Amerigroup; and 34 (1.0%) were claims received by UnitedHealthcare.
- Non-clean claims: 99.864% of 150,256 non-clean claims received in Q3 CY2015 were reported by the MCOs as processed within 60 days.
  - In Q3 CY2015, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q3 CY2015, the numbers and percentages of non-clean claims not processed within 60 days were higher than in the two preceding quarters.
  - Of the 203 "non-clean claims" not processed within 60 days – 175 (86.2%) were claims received by Amerigroup; and 28 (13.8%) were claims received by Sunflower.
- All claims: 99.999% of 4,441,693 "all claims" received in Q3 CY2015 were reported by the MCOs as processed within 90 days.
  - In Q3 CY2015, none of the MCOs met the requirement of processing 100% of claims within 90 days.
  - Of the 60 claims not processed within 90 days – 33 (55.0%) were claims received by Amerigroup; 24 (40.0%) were claims received by Sunflower; and 3 (5.0%) were claims received by UnitedHealthcare.
  - In Q3 CY2015, the numbers and percentages of "all claims" not processed within 90 days were lower than the two preceding quarters. In Q2 CY2015, the MCOs reported 254 claims not processed within 90 days, and 79 claims in Q1 CY2015.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 5, the MCOs reported 4,438,662 clean claims processed in Q4 CY2015 (includes claims received prior to Q4). Excluding pharmacy claims (which are processed same day) there were 2,711,874 claims, 43,387 fewer claims processed in Q4 compared to Q3. Comparing year-to-date there were 628,809 more clean claims (excluding pharmacy claims) processed in CY2015 compared to CY2014.

It should be noted that the average TAT monthly ranges reported in Table 5 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed. Also, the average TATs reported for "Total Claims" are weighted averages calculated after excluding pharmacy claims, as pharmacy claims for each of the MCOs are processed "same day."

While the average time to process clean claims averaged less than two weeks for all services, the average monthly TAT for processing clean claims has changed only slightly over this past year for most of the services. The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.9 to 8.8 days in Q4 CY2015.

Table 5. Average Turnaround Time (TAT) Ranges for Processing Clean Claims, by Service Category						
	Average TAT Monthly Ranges and Total Number of Clean Claims Processed in CY2015				Average TAT Monthly Ranges by Year	
	Q1	Q2	Q3	Q4	CY2014	CY2015
Hospital Inpatient	6.4 to 15.9	8.1 to 13.7	8.7 to 14.1	7.7 to 11.7	5 to 19.2	6.4 to 15.9
Hospital Outpatient	3.5 to 10.8	4.8 to 10.5	4.8 to 9.7	4.6 to 8.6	3.6 to 12.8	3.5 to 10.8
Pharmacy	same day	same day	same day	same day	same day	same day
Dental	4 to 13.1	4 to 13	9.0 to 13	8.0 to 13	2 to 21	4 to 13.1
Vision	10 to 12.1	9 to 11.9	9.0 to 12.5	7.0 to 12.0	7 to 12.5	9 to 12.5
Non-Emergency Transportation	10.7 to 15	10.4 to 14	10.4 to 16.0	8.9 to 16.0	10.9 to 18	10.4 to 16
Medical (Physical health not otherwise specified)	3.4 to 10.5	4.4 to 10.0	4.9 to 8.7	4.9 to 8.5	3.3 to 10.6	3.4 to 10.5
Nursing Facilities	4.2 to 9.7	5.6 to 8.1	4.1 to 7.7	4.7 to 7.8	4.3 to 11.5	4.1 to 9.7
HCBS	4.1 to 8.7	5.4 to 10.2	5.4 to 8.5	5.4 to 7.9	3.2 to 15.6	4.1 to 10.2
Behavioral Health	2.7 to 9.4	4.2 to 10.5	4.9 to 9.1	4.9 to 9.9	3.4 to 8.6	2.7 to 10.5
Total Claims (Including Pharmacy)	4,526,451	4,426,522	4,428,767	4,438,662	16,763,501	17,820,402
Total Claims (Excluding Pharmacy)	2,786,196	2,746,476	2,755,261	2,711,874	10,370,998	10,999,807
Average TAT (Excluding Pharmacy)	4.3 to 10.3	5.3 to 10.2	5.8 to 9.1	5.9 to 8.8	4.3 to 11.5	4.3 to 10.3

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

- Pharmacy - Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
- Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 8.9 to 16 days in Q4 CY2015. In December, however, each of the MCOs had lower TATs than in the October and November.
- Vision – The average TATs were consistently a week or longer in Q4 and previous quarters for all of the MCOs. In Q4 CY2015, the average monthly TATs ranged from 7 to 12 days. Amerigroup had the shortest TATs each month of Q4 (7.0 to 8.0 days), compared to 11.9 to 12.0 days for Sunflower and 11.8 to 12.0 days for UnitedHealthcare.
- Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 8.0 to 13.0 days in Q4 CY2015. Sunflower had the shortest TATs each month, ranging from 8.0 to 9.0 days; Amerigroup and UnitedHealthcare had TATs of 13.0 days for each month in Q4.
- Hospital Inpatient – Hospital Inpatient claims had TATs in Q4 CY2015 ranging from 7.7 to 11.7 days.
- Nursing Facilities – Nursing Facility claims had TATs ranging from 4.7 to 7.8 days in Q4. Amerigroup had lower TATs in each month of Q4 (4.7 to 5.5 days), compared to 7.3 to 7.8 days for Sunflower and 6.6 to 7.4 days for UnitedHealthcare.
- HCBS – HCBS claims had TATs ranging from 5.4 to 7.9 days. Sunflower had the shortest TATs in Q4, ranging from 5.4 to 6.7 days, compared to 7.1 to 7.9 days for UnitedHealthcare and 7.7 to 7.9 days for Amerigroup.

Recommendations

- Related to monthly reporting of contractual requirements for processing claims, additional explanations should be provided in monthly reports when changes are made to data reported in earlier months.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

Grievances

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

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

- The Special Terms and Conditions (STC) Quarterly Report tracks the number of grievances received in the quarter, the total number of the grievances received in the quarter that were resolved, and counts of grievances by category type. The report includes space for MCOs to provide a brief summary for each of these types of grievances of trends and any actions taken to prevent recurrence.
- The Grievance and Appeal (GAR) report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 business days, and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of grievance resolved, including narratives of grievance description and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Track Timely Resolution of Grievances

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

The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not equal the number of grievances "resolved" during the quarter.

Data Sources

Timeliness of resolution of grievances is reported by each MCO in the quarterly GAR report described above. The number of grievances received and resolved each quarter is also reported in the STC quarterly report.

Current Quarter Compared to Previous Quarters

As shown in Table 6, 99.3% (440) of the 443 grievances reported by the MCOs as closed in Q4 CY2015 were reported as resolved within 30 business days; and 99.8% (442) were resolved within 60 business days.

- Amerigroup reported 140 (100%) of 140 grievances closed in Q4 were resolved within 30 business days.
- Sunflower reported 144 (97.96%) of 147 grievances closed in Q4 were resolved within 30 business days. Two of the remaining three grievances were resolved within 31 to 60 business days.
- UnitedHealthcare reported that 156 (100%) of 156 grievances closed in Q4 were resolved within 30 business days.

The one grievance not resolved within the State-required 60 business days was a grievance received by Sunflower.

Table 6. Timeliness of Resolution of Grievances CY2013 to Q4 CY2015

	CY2013				CY2014				CY2015			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of Grievances Received in Quarter	445	496	422	423	498	501	679	609	684	491	442	**404**
Number of Grievances Closed in Quarter*	422	462	412	427	501	507	684	615	636	525	442	**443**
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	490	680	614	625	508	433	**440**
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	99.6%	96.6%	99.4%	99.8%	98.3%	96.8%	98.0%	**99.3%**
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	500	683	615	630	523	440	**442**
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%	98.6%	99.9%	100.0%	99.1%	99.6%	99.5%	**99.8%**
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	7	1	0	6	2	2	**1**

*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 Q4 CY2015, the number of grievances received (404) was lower than the number received in the previous seven quarters. In the first 11 quarters of KanCare to date, the number of grievances received ranged from 404 (Q4 CY2013) to 684 (Q1 CY2015). The number of grievances closed by quarter ranged from 412 (Q3 CY2013) to 684 (Q3 CY2014).

Compare/Track the Number of Grievances, Including 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

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. Only three of the categories overlap clearly - Claims/Billing Issues, Quality of Care or Service, and Other. The GAR report also includes grievance details, including categorization of each grievance using the categories listed in the GAR report Reasons Summary Table.

Table 7 summarizes the number and types of grievances received (as reported to the State in the STC reports), and Table 8 summarizes the quarterly numbers and types of grievances resolved (as reported in the GAR reports) in CY2015 and annual totals for CY2013 to CY2015.

Table 7. Number of Grievances Received* by Quarter CY2015 and Annual Totals

	CY2015				Annual Totals		
	Q1	Q2	Q3	Q4	CY2013	CY2014	CY2015
Transportation	251	245	192	**182**	897	936	**870**
Claims/Billing Issues	217	56	44	**62**	242	593	**379**
Quality of Care or Service	53	40	57	**22**	139	266	**172**
Access to Service or Care	34	33	35	**42**	69	105	**144**
Health Plan Administration	13	19	11	**9**	101	78	**52**
Customer Service	49	67	36	**42**	163	130	**194**
Member Rights/Dignity	14	15	17	**13**	25	36	**59**
Benefit Denial or LImitation	24	10	12	**8**	37	66	**54**
Service or Care Disruption	6	4	3	**6**	37	29	**19**
Clinical/Utilization Management	4	2	0	**2**	33	14	**8**
Other	2	27	20	**16**	37	30	**65**
Total Grievances Received	**667**	**480**	**427**	**404**	**1,780**	**2,283**	**2,016**

*As reported by MCOs in STC reports.

In the Q4 CY2015 STC report, MCOs reported they received 404 grievances, 23 fewer than in Q3 CY2015 and 263 fewer than in Q1 CY2015. In CY2015, MCOs received 2,016 grievances compared to 2,283 in CY2014 and 1,780 in CY2013.

Transportation-related grievances continued to be the most frequently reported grievance received, with 182 in Q4, 45.1% of the 404 grievances. In CY2015, the number of transportation-related grievances received has dropped somewhat each quarter, ranging from a 251 in Q1 CY2015 to 182 in Q4 CY2014. In comparing annual percentages, transportation-related grievances compose 41% to 50% of total grievances received.

Grievances related to “Claims/Billing Issues” increased slightly from 44 in Q3 CY2015 to 62 in Q4 CY2015, down from 217 in Q1 CY2015.

Table 8 - Comparison of Grievances Resolved*- Quarters 1 to 4							
	CY2015				Annual Totals		
	Q1	Q2	Q3	Q4	CY2013	CY2014	CY2015
Claims/Billing Issues	227	86	63	77	266	626	453
Quality of Care or Service	40	56	96	71	113	194	263
Attitude/Service of Staff	116	144	138	120	385	390	512
Availability	83	99	82	83	568	381	320
Timeliness	86	83	24	26	243	380	219
Pharmacy	9	10	3	11	23	32	33
Lack of Information from Provider	3	5	5	2	5	19	15
Level of Care Dispute	5	4	2	8	8	18	19
Prior or Post Authorization	5	3	7	6	8	21	21
Accessibility of Office	3	1	1	2	18	25	7
Criteria Not Met - Medical Procedure	6	6	2	1	11	11	15
Criteria Not Met - Durable Medical Equipment	2	2	1	0	2	12	5
Criteria Not Met - Inpatient Hospitalization	2	-	1	0	1	-	3
HCBS	12	-	7	3	3	11	22
Sleep Studies	-	-	1	0	1	3	1
Sterilization	-	1	1	1	-	1	3
Overpayments	-	-	-	-	-	1	-
Quality of Office, Building	-	-	-	1	-	5	1
Other	36	42	42	45	42	114	123
Total	635	542	542	457	1,697	2,244	2,143

* As reported in quarterly grievance (GAR) reports.

The numbers reported in the STC and GAR reports this quarter had some conflicting reporting of data. UnitedHealthcare initially reported in the GAR report 139 grievances received in Q4 and in the STC report 127 grievances received in Q4. UHC submitted a corrected STC report, explaining that the difference was due to misunderstanding report specifications that resulted in excluding 12 grievances that had been withdrawn.

Data are also not always consistent within the same report. In the GAR report, Amerigroup categorized and provided detailed descriptions of 140 grievances resolved in Q4 CY2015, but reported only 107 grievances in the Q4 CY2015 GAR "Reason Summary Chart."
In reviewing the detailed grievances in the GAR report, KFMC found, as in previous reviews, many of the grievances do not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified. "Sterilization," for example, could be intended to track grievances related to informed consent prior to a tubal ligation or vasectomy, but has also been interpreted to categorize a grievance related to a moldy smell in diagnostic equipment and a grievance related to concern about possible flea bites during transportation.

Transportation-related grievances are a consistent example of differences in categorization by each of the MCOs (see Table 9). While in the STC report transportation-related grievances are identified separately, in the GAR report the transportation-related grievances are listed in a number of categories, varying in interpretation by MCO. Of 206 transportation-related grievances resolved in Q4 CY2015, 30.1% were categorized as "Availability"; 28.2% as "Attitude/Service of Staff"; 20.9% as "Quality of Care or Service"; 10.7% as "Timeliness; 3.4% as "Billing and Financial Issues"; 1.9% as "Other"; 3.9% as "AOR" (not one of the State-identified categories); 0.5% (1 grievance) as "Lack of Information from Provider"; and 0.5% (1 grievance) as "Level of Care."

Table 9. Transportation-Related Grievances Resolved by Category, Quarter 4 CY2015

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Availability	39	59.1%	23	41.8%			62	30.1%
Timeliness	12	18.2%	9	16.4%	1	1.2%	22	10.7%
Attitude/Service of Staff	6	9.1%	15	27.3%	37	43.5%	58	28.2%
Billing and Financial Issues	3	4.5%	3	5.5%	1	1.2%	7	3.4%
Quality of Care or Service	5	7.6%			38	45%	43	20.9%
Lack of Information from Provider			1	1.8%			1	0.5%
Level of Care			1	1.8%			1	0.5%
Other	1	1.5%	3	5.5%			4	1.9%
AOR "Appointment of Representation"					8	9.4%	8	3.9%
Transportation-Related Total	66		55		85		206	

An additional complication is the addition of an "AOR" category, not one of the categories the State has identified for categorizing grievances, in the GAR report by UnitedHealthcare. Inclusion of AOR by UnitedHealthcare first occurred in Q1 CY2015 when 13 grievances were categorized as "AOR." At that time, KFMC contacted UnitedHealthcare and was told that "AOR" refers to "Appointment of Representation." In Q4 CY2015, UnitedHealthcare categorized 12 grievances as "AOR." The descriptions UnitedHealthcare provides for most grievances were, as in previous quarterly reports, very limited and/or cut off mid-sentence (or mid-word), making it difficult to determine whether the grievances are categorized appropriately or to determine appropriate categories for grievances, particularly where grievances are labeled as "AOR." Of 170 grievances reported in Q4 by UnitedHealthcare in the GAR report, descriptions for 111 did not include descriptions of the grievance or grievance resolution adequate to assess whether grievances were appropriately categorized, and six grievances had no information at all provided on grievance resolution. (In Q4, Sunflower had four grievances with no information provided on grievance resolution.)

Table 10 reports the types of grievances resolved in Q4 CY2015 in total and by waiver, as well as the number of transportation-related grievances based on grievance narrative details. Table 11 reports the waiver-related grievances by quarter in CY2015.

Table 10. Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 4 CY2015*									
	Grievances		Grievances by Waiver Type						
	All Members	Waiver Members	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	77	13	3	4	4				2
Quality of Care or Service	71	24	3	2	16	1			2
Attitude/Service of Staff	120	29	6	3	12	1	1		6
Timeliness	26	4	1		3				
Availability	83	26	3	2	10	1	4		6
Pharmacy	11	2	1						1
Lack of Information from Provider	2	0							
Level of Care Dispute	8	1				1			
Prior or Post Authorization	6	2			2				
HCBS	3	3			1	1			1
Accessibility of Office	2	0							
Criteria not met - Medical Procedure	1	1					1		
Quality of Office, Building	1	0							
Sterilization	1	0							
"AOR" (Appointment of Representation)	12	1			1				
Other	33	9	3	3	2				1
Total Grievances Resolved Q4	**457**	**115**	**20**	**14**	**51**	**5**	**6**	**0**	**19**
Transportation-Related	**206**	**52**	**11**	**4**	**22**	**1**	**4**	**0**	**7**
# of Members with Grievances Resolved Q4	**412**	**99**	**18**	**13**	**44**	**5**	**5**	**0**	**14**

*Includes grievances received in Quarter 3 CY2015 resolved in Quarter 4 CY2015

Of 457 grievances resolved in Q4 CY2015 reported by 412 members, 115 (25.2%) were from 99 members receiving waiver services. Compared to the previous quarter, the number and percentage of grievances reported by members receiving waiver services decreased; in Q3, 135 (28.5%) of 474 grievances were reported by 112 members receiving waiver services.

- Of the 115 grievances received from waiver members, 52 (45.2%) were transportation-related. In CY2015, 47.6% of 538 waiver-related grievances were transportation related; 43.5% of 2,086 of the total resolved grievances in CY2015 were transportation-related.
- Physical Disability (PD) waiver members had the most grievances in Q4, with 44 members reporting 51 grievances, 22 (43.1%) transportation-related. The number and percentages of grievances received by the MCOs from PD waiver members, as well as the number and percentage that were transportation-related, were lower in Q4 than in the previous three quarters. In Q3, 29 of 69 (42.0%) grievances reported by 62 PD waiver members were transportation-related; in Q2 CY2015 39 of 58 (67%) grievances reported by PD waiver members were transportation-related; and in Q1, 58 of 98 (59.2%) grievances were transportation-related. In CY2015, PD waiver members reported 276 grievances, 51.3% of waiver-related grievances. Of these, 53.6% were transportation-related.

Table 11. Waiver-Related Grievances Resolved by Quarter, CY2015*					
Physically Disabled (PD) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	98	58	69	51	276
Number of Members Reporting Grievances	94	54	62	44	254
Number of Transportation-Related Grievances	58	39	29	22	148
% Transportation-Related Grievances	59.2%	67.2%	42.0%	43.1%	53.6%
Frail Elderly (FE) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	31	24	34	20	109
Number of Members Reporting Grievances	26	23	26	18	93
Number of Transportation-Related Grievances	14	10	24	11	59
% Transportation-Related Grievances	45.2%	41.7%	70.6%	55.0%	54.1%
Intellectually/Developmentally Disabled (I/DD) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	17	16	11	14	58
Number of Members Reporting Grievances	17	16	11	13	57
Number of Transportation-Related Grievances	4	4	3	4	15
% Transportation-Related Grievances	23.5%	25.0%	27.3%	28.6%	25.9%
Traumatic Brain Injury (TBI) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	11	9	16	19	55
Number of Members Reporting Grievances	11	9	11	14	45
Number of Transportation-Related Grievances	5	3	3	7	18
% Transportation-Related Grievances	45.5%	33.3%	18.8%	36.8%	32.7%
Technology Assisted (TA) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	6	4	2	6	18
Number of Members Reporting Grievances	5	4	2	5	16
Number of Transportation-Related Grievances	1	2	1	4	8
% Transportation-Related Grievances	16.7%	50.0%	50.0%	66.7%	44.4%
Serious Emotional Disturbance (SED) Waiver	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	6	6	3	5	20
Number of Members Reporting Grievances	6	6	3	5	20
Number of Transportation-Related Grievances	2	1	1	1	5
% Transportation-Related Grievances	33.3%	16.7%	33.3%	20.0%	25.0%
Total (Waiver-Related)	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	170	118	135	115	538
Number of Members Reporting Grievances	160	113	112	99	484
Number of Transportation-Related Grievances	84	59	61	52	256
% Transportation-Related Grievances	49.4%	50.0%	45.2%	45.2%	47.6%
All Grievances (Waiver and Non-Waiver)	**Q1**	**Q2**	**Q3**	**Q4**	**CY2015**
Number of Grievances	630	525	474	457	2,086
Number of Members Reporting Grievances	589	479	444	412	1,924
Number of Transportation-Related Grievances	218	271	213	206	908
% Transportation-Related Grievances	34.6%	51.6%	44.9%	45.1%	43.5%

*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.

- Frail Elderly (FE) waiver members had the second highest number of reported grievances in Q4, with 18 members reporting 20 grievances, 11 (55.0%) transportation-related. In CY2015, 93 FE waiver members reported 109 grievances, 54.1% transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members in Q4 reported 14 grievances (from 13 members), with four that were transportation-related. In CY2015, 57 members receiving I/DD waiver services reported 58 grievances, 15 (25.9%) that were transportation-related.
- Traumatic Brain Injury (TBI) waiver members reported 19 grievances from 14 members in Q4, seven (36.8%) transportation-related. In CY2015, 45 TBI members reported 55 grievances, 18 (32.7%) transportation-related.
- Serious Emotional Disturbance (SED) waiver members reported five grievances in Q4, one transportation-related, from five members. In CY2015, 20 SED waiver members reported 20 grievances, five transportation-related.
- Technology Assisted (TA) waiver members reported six grievances in Q4 from five members, four (66.7%) transportation-related. In CY2015, 16 TA members reported 18 grievances, eight (44.4%) transportation-related.

Access-Related Grievances

Of the 404 grievances received in Q4 CY2015, 42 (10.4%) were categorized in the STC report as "Access to Service or Care" (see Table 7). Access-related grievances have consistently been one of the least frequently categorized grievances. The number of "Access to Service or Care" grievances has ranged from 13 reported in Q2 and Q3 of CY2013 to 42 reported in Q4 CY2015.

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

- Amerigroup reported four access-related grievances received in Q4 CY2015. As in previous STC reports, these were described as follows: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continue to monitor our network to identify service gaps and work with providers to contract with Amerigroup to perform key services*."
- UnitedHealthcare reported nine access-related grievances received in Q4. These were described as, "*Service or care disruptions are tracked and trended monthly. Grievances related to service or care disruption this quarter occurred due to members having difficulty obtaining services from providers."*
- Sunflower reported 28 access-related grievances received in Q4. In the STC trend summary, Sunflower reported, *"This quarter Sunflower has identified the following trends: 25% of these grievances were regarding the access to RX including 3 regarding lock-in and 3 issues regarding access to medication and 1 regarding the incorrect diabetic test strips."*

As there is no "Access to Service or Care" grievance category in the GAR report, it is not possible to compare quarterly changes in the number of access-related grievances resolved. The 42 grievances identified in the STC report as "Access to Service or Care" could potentially be categorized in the GAR report (based on grievance descriptions) as "Accessibility of Office,"

"Availability," "Level of Care Dispute," "Prior or Post Authorization," "Timeliness," "Criteria not met – medical procedure" (related to replacement of a child's broken eyeglasses), "HCBS," and/or "Quality of Care." Grievances categorized as "Quality of Care" that could be considered "Access to Service or Care" included delay in getting glasses fixed, delay in getting a prescription refill due to a provider being out of the country, and delay by a nursing facility in providing a knee brace ordered by a member's physician.

Quality-Related Grievances

In Q4 CY2015, 22 (5.5%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 71 (15.5%) of 457 grievances reported as resolved in Q4 were categorized as QOC. As in the previous quarter, over half of the grievances reported as QOC were transportation-related; 43 (60.6%) of the 71 in Q4 CY2015 and 51 (53.1%) of 96 in Q3 CY2015. In Q4 CY2015, 56 of the 71 (78.9%) QOC grievances were reported by UnitedHealthcare; 38 of the 56 (67.9%) QOC grievances reported by UnitedHealthcare were transportation-related.

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

- UnitedHealthcare did not provide descriptions of the nine QOC grievances received in Q4. As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"
- Amerigroup reported **three** QOC grievances, but in the text said "*1 of the **2** grievances were referred to Quality Management for a Quality of Care Investigation*." The summary added, *"Members felt they received inappropriate treatment from their treating provider*." As in previous STC reports, Amerigroup included the following language: "*These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action."*
- Sunflower reported 10 QOC grievances received in Q4, and that, "*These items are regarding how the member felt they were not being cared for by the provider and/or provider staff. 40% were forwarded to QOC coordinator.*"

Of the 71 QOC grievances reported in the GAR report as resolved in Q4 CY2015, 24 were from members receiving waiver services including: 16 members receiving PD waiver services, three members receiving FE waiver services, two members receiving I/DD waiver services, two member receiving TBI waiver services, and one member receiving SED waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q4, KFMC found several 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," and/or "Other." Due to the limited information and cut-off text descriptions of grievances, it is difficult to assess whether grievances categorized by UnitedHealthcare are related to QOC.

In addition to the 43 transportation-related grievances categorized as QOC, descriptions of several grievances categorized as QOC could instead have potentially been categorized as "Availability," "Timeliness," or "Attitude/Service of Staff"

Follow-up on Previous Recommendations

In Q4 CY2015, KDHE staff scheduled regular meetings with EQRO staff to review the grievance and appeals categories in the STC and GAR reports, revise the categories to better promote consistency in reporting, and define criteria for reporting for each category. KDHE subsequently scheduled trainings with MCO staff to discuss these changes and promote more consistent and accurate categorization of grievances and appeals received by the MCOs. Definitions of grievance and appeals categories were developed, and examples are included in the revised template instructions and were reviewed in the trainings with MCO staff. A number of categories that had been included in the GAR report as "grievances" were re-assessed and determined to be more appropriately categorized as "appeals." The revisions include consistent categorization of grievances and appeals in the GAR and STC reports, which previously had differing categories for some grievance types. The GAR report, which previously did not include a "transportation" category, will in the revised template have a transportation category with subcategories to include tracking of "no shows," lateness, and safety issues.

The revised template will be implemented in Q2 CY2016 to allow MCOs adequate time to put the new reporting processes into place and provide additional clarification and/or training as needed. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, should greatly improve the ability to assess the number and types of grievances received and resolved each quarter and to assess trends over time.

Recommendations

- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.

- In the timeframe identified by the State for implementing the revised grievance templates, MCOs should categorize grievances using the revised categories and criteria.
- Grievance categories (such as "AOR") not defined by the State, should not be added by MCOs.
- MCOs should ensure their staff understand the revised grievances and appeals categories and should contact the State to request clarification for any grievance or appeals categories where criteria are not clearly understood by MCO staff.

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 CY2015 is the quarterly KanCare Ombudsman Update report, with follow-up discussions with Kerrie Bacon, KanCare Ombudsman.

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 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 through the KanCare Ombudsman Volunteer Program. Recruitment of volunteers began in June 2015. The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers then receive three weeks of in-person mentoring by the Ombudsman and program coordinator.

As most volunteer applications were from the Wichita area, training began in Wichita. Six volunteers have completed training, and two more are in training. The Wichita volunteer office began responding to calls and providing assistance to KanCare members as of 11/11/2015, providing assistance to approximately 67 individuals.

The Ombudsman's Office is conducting additional marketing to recruit additional volunteers in the Kansas City metropolitan area, including Johnson County, with plans to expand statewide in 2016. As of the end of Q4 CY2015, Kansas City and Johnson County locations have been confirmed, and training is planned to begin in February 2016.

Next steps include developing volunteer training (in Q1 CY2016) to provide assistance in filling out Medicaid applications and training (goal: Q4 CY2016) to assist KanCare members one-on-one with the grievance, appeal, and/or State Fair Hearing process.

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. Contacts with the Ombudsman's Office are primarily by phone and email, but also include face-to-face contacts. Ombudsman staff participate in a number of outreach activities, including in Q4 CY2015 a booth at the Alzheimer Conference, sponsor of the KanCare (I/DD) Friends and Family Advisory Council, hosting of the KanCare Member Lunch-and-Learn bi-weekly conference calls, and attendance at the Wichita State University Athlete's Fair (booth for recruiting volunteers), the Delano District Meting, the Optimist Club, and the KanCare Consumer Specialized Interest Workgroup meeting.

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.

Of 524 contacts to the Ombudsman's Office in Q4, 385 (73.5%) were from consumers, 93 (17.7%) from providers, three were from MCO employees, and 43 were categorized as "other." In Q4 CY2015, 139 (26.5%) of the 524 contacts were related to an MCO issue. As shown in Table 12, the number and percentage of MCO-related contacts in Q4 CY2015 was the lowest since the Ombudsman began tracking these in Q1 CY2014. While the number of "all contacts" decreased by only 0.8% in CY2015 (17 fewer contacts), the number of MCO-related contacts decreased by 14.8% (132 fewer MCO-related contacts).

Table 12. Contacts to the Ombudsman's Office, Total and MCO-Related

CY2014			
	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
Q1	545	214	39.3%
Q2	474	210	44.3%
Q3	526	256	48.7%
Q4	547	210	38.4%
Total CY2014	2,092	890	42.5%
CY2015			
	All Contacts	MCO-Related Contacts	% MCO-Related Contacts
Q1	510	224	43.9%
Q2	462	208	45.0%
Q3	579	187	32.3%
Q4	524	139	26.5%
Total CY2015	2,075	758	36.5%

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts. Table 13 includes the counts by quarter of issue types tracked during CY2014 and CY2015. Four of the five top issues in frequency were highest in both CY2014 and CY2015:

- Medicaid Eligibility (CY2014 – 438, 25% of 1,747 issues; CY2015 – 635, 35% of 1,805 issues);
- Billing (CY2014 – 166, 10% of 1,747 issues; CY2015 – 147, 8% of 1,805 issues);
- Appeals/Grievances (CY2014 - 136, 8% of 1,747 issues; CY2015 – 148, 8% of 1,805 issues); and
- HCBS General Issues (CY2014 – 130, 7% of 1,747 issues; CY2015 – 184, 10% of 1,805 issues). HCBS-related issues, including HCBS Eligibility, HCBS Reduction in Hours of Services, and HCBS Waiting List in addition to HCBS General Issues, totaled 313 in CY2014 (18% of 1,747 issues) and totaled 350 in CY2015 (19% of 1,805 issues).

The remaining top five issue in frequency in CY2014 was Medical Service Issues (156; 9% of 1,747 issues; CY2015 – 92; 5% of 1,805 issues. Nursing Facility Issues were the fifth most frequent issue in CY2015 (112; 6% of 1,805 issues; CY2014 – 60; 3% of 1,747 issues).

Table 13. Contact Types Submitted to the Ombudsman's Office, CY2014 to CY2015

	CY2014						CY2015					
	Q1	Q2	Q3	Q4	Total CY2014		Q1	Q2	Q3	Q4	Total CY2015	
	#	#	#	#	#	%	#	#	#	#	#	%
Medicaid Eligibility Issues	81	73	90	194	438	**25%**	139	108	206	182	635	**35%**
Appeals, Grievances	22	22	46	46	136	**8%**	42	33	47	26	148	**8%**
Medical Service Issues	14	31	41	70	156	**9%**	20	24	27	21	92	**5%**
Billing	51	33	40	42	166	**10%**	36	40	41	30	147	**8%**
Durable Medical Equipment	25	35	25	8	93	**5%**	25	12	7	8	52	**3%**
Pharmacy	38	15	20	19	92	**5%**	25	33	14	20	92	**5%**
HCBS												
HCBS General Issues	11	25	45	49	130	**7%**	60	36	54	34	184	**10%**
HCBS Eligibility Issues	55	14	10	11	90	**5%**	11	15	24	30	80	**4%**
HCBS Reduction in Hours of Service	22	11	15	8	56	**3%**	10	8	13	16	47	**3%**
HCBS Waiting List	3	8	19	7	37	**2%**	11	8	9	11	39	**2%**
Care Coordinator Issues	10	9	18	14	51	**3%**	10	8	9	8	35	**2%**
Transportation	11	8	18	13	50	**3%**	12	17	8	7	44	**2%**
Nursing Facility Issues	8	12	16	24	60	**3%**	15	34	34	29	112	**6%**
Housing Issues	3	8	12	10	33	**2%**	1	6	4	3	14	**1%**
Change MCO	6	11	10	9	36	**2%**	8	4	10	9	31	**2%**
Dental	16	15	8	9	48	**3%**	7	5	1	4	17	**1%**
Access to Providers	16	16	6	15	53	**3%**	3	11	1	12	27	**1%**
Guardianship Issues	16	3	1	2	22	**1.3%**	5	1	2	1	9	**0.5%**
Total Issues	**408**	**349**	**440**	**550**	**1,747**		**440**	**403**	**511**	**451**	**1,805**	

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 14, 106 contacts were reported as waiver-related in Q4 CY2015, comparable to the previous quarter (108). From Q3 CY2014 through Q4 CY2015, the number of waiver-related inquiries ranged from 106 to 143 (Q3 CY2014).The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Physical Disability (PD) and Intellectual/Developmental Disability (I/DD); of 721 waiver-related inquiries from July 2014 through December 2015, 238 (33.0%) were from members receiving PD waiver services, and 195 (27.0%) were from members receiving I/DD waiver services.

Table 14. Waiver-Related Inquiries to the Ombudsman's Office, Quarter 3 CY2014 to Quarter 4 CY2015

	CY2014				CY 2015							
	Q3		Q4		Q1		Q2		Q3		Q4	
Waiver	#	%	#	%	#	%	#	%	#	%	#	%
Intellectual/Developmental Disability (I/DD)	42	29.4%	36	32.7%	35	25.9%	25	21.0%	29	21.0%	**28**	**26.4%**
Physical Disability (PD)	43	30.1%	29	26.4%	57	42.2%	48	40.3%	33	40.3%	**28**	**26.4%**
Technology Assisted (TA)	8	5.6%	15	13.6%	11	8.1%	13	10.9%	11	10.9%	**13**	**12.3%**
Frail Elderly (FE)	16	11.2%	11	10.0%	15	11.1%	12	10.1%	16	10.1%	**18**	**17.0%**
Traumatic Brain Injury (TBI)	19	13.3%	10	9.1%	10	7.4%	9	7.6%	7	7.6%	**9**	**8.5%**
Serious Emotional Disturbance (SED)	5	3.5%	4	3.6%	1	0.7%	7	5.9%	5	5.9%	**4**	**3.8%**
Money Follows the Person (MFP)	6	4.2%	4	3.6%	2	1.5%	2	1.7%	3	1.7%	**1**	**0.9%**
Autism	4	2.8%	1	0.9%	4	3.0%	3	2.5%	4	2.5%	**5**	**4.7%**
Total	**143**		**110**		**135**		**119**		**108**		**106**	

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q3 CY2015, 99.993% of the customer service inquiries received by the MCOs were resolved within two business days. Of the 24 inquiries not resolved within two business days, all were resolved within five business days.
- During each quarter to date the two-day resolution rate exceeded 99.7%.
- Member customer service inquiries
  - MCOs received 91,237 member customer service inquiries, 7,770 fewer than the previous quarter.
  - Benefit inquiries were the highest percentage (19.8%) of member inquiries
  - There are four categories where two thirds or more of the inquiries in the last five quarters were reported by one MCO:
    - "Member emergent or crisis call" – 99.4% of 661 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 99.4%; Q2 CY2015 - 99.8%; Q1 CY2015 – 99.7%; Q4 CY2014 – 99.7%)
    - "Update demographic information" – 81.4% of 11,967 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 82.1%; Q2 CY2015 - 82.3%; Q1 CY2015 – 82.1%; Q4 CY2014 - 71.0%)

    - "Enrollment information" – 80.5% of 2,371 inquiries were reported in Q4 CY2015 by Amerigroup. (Q3 CY2015 – 76.8%; Q2 CY2015 - 76.4%; Q1 CY2015 - 76.6%; Q4 CY2014 - 80.5%)
    - "Need transportation" – 70.0% of 1,220 inquiries were reported in Q4 CY2015 by Amerigroup. (Q3 CY2015 – 73.7%; Q2 CY2015 - 67.2%; Q1 CY2015 - 75.8%; Q4 CY2014 - 80.8%)
- Provider customer service inquiries
    - Provider inquiries again decreased this quarter; 87 fewer provider inquiries were in received in Q4 CY2015 compared to Q3 CY2015, and 2,460 fewer compared to Q4 CY2014.
    - For providers, claim status inquiries were again the highest percentage (49.5%) of the 45,278 provider calls. The three claims-related categories ("Claim denial inquiry," "Claim status inquiry," and "Claim payment question/dispute") together accounted for 69.9% of the provider inquiries in Q4 CY2015.
    - Categories where two thirds or more of the provider inquiries in Q4 and four previous quarters were reported by one MCO included:
        - "Authorization – New" – 98.6% of 1,759 inquiries in Q4 CY2015 were reported by Amerigroup. (Q3 CY2015 – 98.0%; Q2 CY2015 – 99.1%; Q1 CY2015 – 99.1%; Q4 CY2014 – 98.1%)
        - "Update demographic information" – 93.7% of 495 inquiries were reported in Q4 CY2015 by Sunflower. (Q3 CY2015 – 96.2%; Q2 CY2015 - 91.4%; Q1 CY2015 - 95.5%; Q4 CY2014 - 99.5%)
        - "Coordination of benefits" – 87.9% of 777 inquiries were reported in Q4 CY2015 by UnitedHealthcare. (Q3 CY2015 – 85.5%; Q2 CY2015 - 76.8%; Q1 CY2015 - 90.7%; Q4 CY2014 - 91.0%)
        - "Verify/Change participation status" – 72.2% of 273 inquiries in Q4 CY2015 were reported by Sunflower. (Q3 CY2015 – 77.8%; Q2 CY2015 - 68.1%; Q1 CY2015 - 67.6%; Q4 CY2014 - 66.4%)
        - "Authorization – Status" – 69.9% of 2,594 inquiries in Q4 CY2015 were reported by Amerigroup. (Q3 CY2015 – 67.4%; Q2 CY2015 - 71.0%; Q1 CY2015 - 70.8%; Q4 CY2014 - 72.0%)
    - 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

- **Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days**
    - In Q3 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,292,747 clean claims received in Q3 CY2015, 99.918% were processed within 30 days. Of the 3,506 clean claims not processed within 30 days, 93.2% (3,268) were claims received by Sunflower; 5.8% (204) were claims received by Amerigroup; and 1.0% (34) were claims received by UnitedHealthcare.

- In Q3 CY2015, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 150,256 non-clean claims received in Q3 CY 2015, 99.864% were processed within 60 days. In Q3 CY2015, the numbers and percentages of non-clean claims not processed within 60 days were higher than in the two preceding quarters.
- Of 4,441,693 "all claims" received in Q3 CY2015, 99.999% were processed within 90 days. Of the 60 claims not processed within 90 days, 33 (55%) were claims received by Amerigroup; 24 (40%) were claims received by Sunflower; and 3 (5%) were claims received by UnitedHealthcare. In Q3 CY2015, the numbers and percentages of "all claims" not processed within 90 days were lower than in the two preceding quarters.
- As recommended in the previous KanCare Evaluation Quarterly Report, Sunflower reviewed and revised their monthly "timeliness of claims reporting" process, which now provides more consistent reporting of aggregated monthly claims processing data.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q4 CY2015, the average TAT for Total Services was 5.9 to 8.8 days.
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - Pharmacy - Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
    - Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 8.9 to 16 days in Q4 CY2015. In December, however, each of the MCOs had lower TATs than in the October and November.
    - Vision – The average TATs were consistently a week or longer in Q4 and previous quarters for all of the MCOs. In Q4 CY2015, the average monthly TATs ranged from 7 to 12 days. Amerigroup had the shortest TATs each month of Q4 (7.0 to 8.0 days), compared to 11.9 to 12.0 days for Sunflower and 11.8 to 12.0 days for UnitedHealthcare.
    - Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 8.0 to 13.0 days in Q4 CY2015. Sunflower had the shortest TATs each month, ranging from 8.0 to 9.0 days; Amerigroup and UnitedHealthcare had TATs of 13.0 days for each month in Q4.
    - Hospital Inpatient – Hospital Inpatient claims had TATs in Q4 CY2015 ranging from 7.7 to 11.7 days.
    - Nursing Facilities – Nursing Facility claims had TATs ranging from 4.7 to 7.8 days in Q4. Amerigroup had lower TATs in each month of Q4 (4.7 to 5.5 days), compared to 7.3 to 7.8 days for Sunflower and 6.6 to 7.4 days for UnitedHealthcare.
    - HCBS – HCBS claims had TATs ranging from 5.4 to 7.9 days. Sunflower had the shortest TATs in Q4, ranging from 5.4 to 6.7 days, compared to 7.1 to 7.9 days for UnitedHealthcare and 7.7 to 7.9 days for Amerigroup.

Grievances

- When categorizing grievance in the GAR and STC reports, MCOS continue to use inconsistent criteria. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations. In Q4, 43 of 71 grievances categorized as "Quality of Care" were related to quality of transportation services.
- In Q4 CY2015, KDHE staff scheduled regular meetings with EQRO staff to review the grievance and appeals categories in the STC and GAR reports, revise the categories to better promote consistency in reporting, and define criteria for reporting for each category. KDHE subsequently scheduled trainings with MCO staff to discuss these changes and promote more consistent and accurate categorization of grievances and appeals received by the MCOs. Definitions of grievance and appeals categories were developed, and examples are included in the revised template instructions and were reviewed in the trainings with MCO staff. A number of categories that had been included in the GAR report as "grievances" were re-assessed and determined to be more appropriately categorized as "appeals." The revisions include consistent categorization of grievances and appeals in the GAR and STC reports, which previously had differing categories for some grievance types. The GAR report, which previously did not include a "transportation" category, will in the revised template have a transportation category with subcategories to include tracking of "no shows," lateness, and safety issues. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, should greatly improve the ability to assess the number and types of grievances received and resolved each quarter and to assess trends over time.
- Templates with revised grievance and appeal categories are planned to be implemented by Q2 CY2016, which allows MCOs adequate time to put the new reporting processes into place and provides additional clarification and/or training as needed.
- In Q4 CY2015, the number of grievances received (404) was lower than the number received in the previous seven quarters.
- Of 443 grievances closed in Q4 CY2015, 99.3% (440) were resolved within 30 business days, and 99.8% (442) were resolved within 60 business days. The one grievance not resolved within the State-required 60 business days was a grievances received by Sunflower.
- The grievance categories with the highest number of grievances were those related to transportation; 182 of 404 (45.1%) of grievances received in Q4.
- UnitedHealthcare again this quarter categorized grievances (12) as "AOR" (Appointment of Representation), which is not one of the GAR categories. UnitedHealthcare provides only limited descriptions of grievances, and most descriptions are cut off, making it difficult to determine how these 12 grievances should be categorized and/or to assess whether other grievances are categorized appropriately.
- Of 457 grievances reported by 412 members as resolved by MCOs in Q4 CY2015, 115 (25.2%) were reported by 99 members receiving waiver services.
- The number of access-related grievances each quarter is a relatively small percentage of grievances reported; MCOs categorized 42 (10.4%) of 404 grievances received in Q4 CY2015 as "Access to Service or Care."

- In Q4 CY2015, 22 (5.5%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 71 of 457 (15.5%) grievances reported as resolved in Q4 were categorized as QOC; 43 (60.6%) of these were transportation-related.
- Descriptions in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 32 grievances in the category that quarter.
- The numbers reported in the STC and GAR reports this quarter had some conflicting reporting of data or were reported differently within the same report.

Ombudsman's Office

- In Q4 CY2015, the Ombudsman's Office tracked issues in 524 contacts and calls received. Of the 524 contacts, 139 (26.5%) were MCO-related, the lowest number and percentage since the Ombudsman's Office began tracking these contacts in CY2014. The highest number of issues and inquiries in CY2014 and CY2015 were related to Medicaid Eligibility, Billing, Appeals/Grievances, and HCBS-related issues.
- There were 106 waiver-related inquiries, comparable to the previous quarter (108). From Q3 CY2014 through Q4 CY2015, the number of waiver-related inquiries ranged from 106 to 143 (Q3 CY2014).The most frequent waiver-related inquiries in Q4, and in the previous five quarters, have been from members receiving waiver services for PD and I/DD; of 721 waiver-related inquiries from July 2014 through December 2015, 238 (33.0%) were from members receiving PD waiver services and 195 (27.0%) were from members receiving I/DD waiver services.
- Recruitment of volunteers for the KanCare Ombudsman Volunteer Program began in June 2015. Due to the number of volunteer applications received in the Wichita area, training of volunteers began in Wichita. Six volunteers in Wichita have completed training, and two more are in training. Additional volunteers are being recruited in the Kansas City and Johnson County areas; locations have been confirmed, and training in these areas is planned to begin in February 2016.
- Next steps include developing volunteer training in Q1 CY2016 to provide assistance in filling out Medicaid applications and training (goal: Q4 CY2016) to assist KanCare members one-on-one with the grievance, appeal, and/or State Fair Hearing process.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Categories where over two thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:
  - Member customer service inquiries: "Update demographic information," "Member emergent or crisis call," "Enrollment information," and "Need transportation."

- Provider customer service inquiries: "Authorization – New," "Update demographic information," "Coordination of benefits," "Authorization – Status," and "Verify/Change participation status."

Timeliness of Claims Processing

- Related to monthly reporting of contractual requirements for processing claims, additional explanations should be provided in monthly reports when changes are made to data reported in earlier months.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

Grievances

- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.
- In the timeframe identified by the State for implementing the revised grievance templates, MCOs should categorize grievances using the revised categories and criteria.
- Grievance categories (such as "AOR") not defined by the State, should not be added by MCOs.
- MCOs should ensure their staff understand the revised grievances and appeals categories and should contact the State to request clarification for any grievance or appeals categories where criteria are not clearly understood by MCO staff.

End of report.

KDHE Summary of Claims Adjudication Statistics – January through December 2015 – KanCare MCOs

AMERIGROUP Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	53,580	$1,817,900,724.09	7,319	$327,031,214.26	13.66%
Hospital Outpatient	350,109	$907,764,320.17	39,915	$96,247,662.18	11.40%
Pharmacy	2,046,533	$126,311,323.92	619,161	Not Applicable	30.25%
Dental	138,228	$38,032,363.18	12,424	$3,600,035.50	8.99%
Vision	75,241	$22,020,535.58	9,807	$4,454,119.91	13.03%
NEMT	142,392	$5,074,585.39	1,442	$57,986.70	1.01%
Medical (physical health not otherwise specified)	2,037,633	$1,124,628,611.86	269,849	$214,006,005.93	13.24%
Nursing Facilities-Total	109,227	$252,111,154.77	12,634	$22,203,712.07	11.57%
HCBS	231,655	$111,991,572.62	44,705	$9,928,811.40	19.30%
Behavioral Health	652,727	$86,502,128.68	55,335	$7,733,498.22	8.48%
Total All Services	5,837,325	$4,492,337,320.26	1,072,591	$685,263,046.17	18.37%

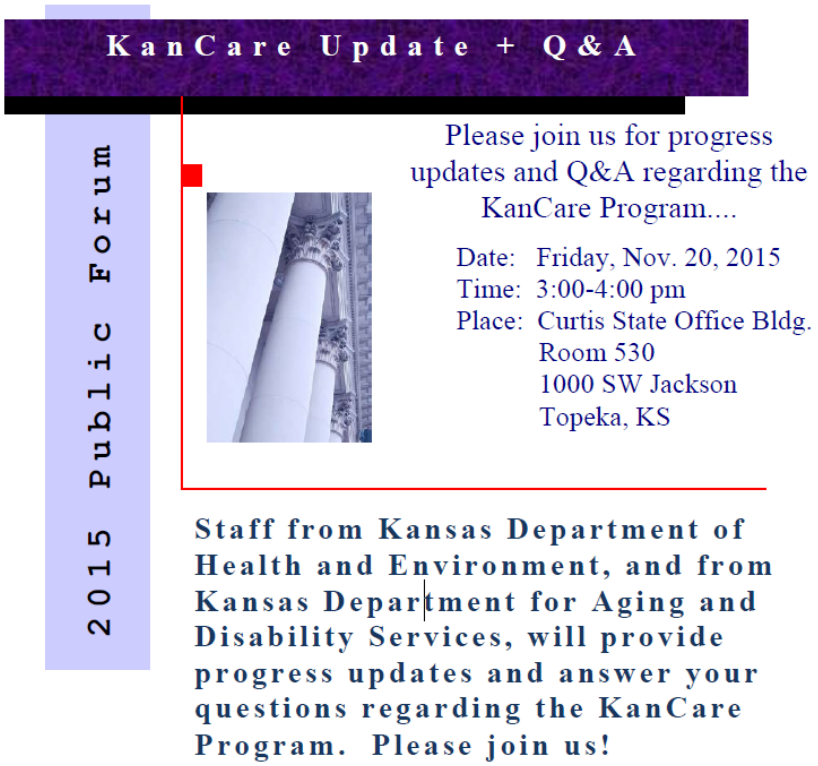
SUNFLOWER Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	31,953	1,019,465,875	6,767	243,179,456	21.18%
Hospital Outpatient	324,933	657,509,542	44,203	80,336,481	13.60%
Pharmacy	3,069,580	291,524,108	790,431	142,531,640	25.75%
Dental	155,989	36,065,976	13,649	2,790,027	8.75%
Vision	90,452	21,374,064	12,289	3,145,666	13.59%
NEMT	151,613	4,294,772	428	11,162	0.28%
Medical (physical health not otherwise specified)	1,862,692	822,903,103	234,011	166,652,100	12.56%
Nursing Facilities-Total	130,676	277,349,566	15,103	38,143,811	11.56%
HCBS	444,655	210,876,868	24,955	13,134,159	5.61%
Behavioral Health	726,648	104,170,362	58,358	9,493,490	8.03%
Total All Services	6,989,191	3,445,534,234	1,200,194	699,417,994	17.17%

UNITED Service Type	Total claim count - YTD cumulative	total claim count $ value YTD cumulative	# claims denied – YTD cumulative	$ value of claims denied YTD cumulative	% claims denied – YTD cumulative
Hospital Inpatient	28,446	$982,853,847.33	6,542	$264,939,639.42	22.99%
Hospital Outpatient	303,106	$736,830,327.28	49,174	$166,528,279.53	16.22%
Pharmacy	1,784,886	$203,501,374.83	459,300	$92,409,772.03	25.73%
Dental	138,242	$39,016,715.82	10,565	$3,051,640.23	7.64%
Vision	69,361	$14,232,857.78	7,677	$1,882,092.22	11.07%
NEMT	160,851	$4,303,741.58	505	$10,378.12	0.31%
Medical (physical health not otherwise specified)	1,979,813	$808,024,788.17	301,025	$191,392,880.93	15.20%
Nursing Facilities-Total	99,718	$245,061,863.79	12,628	$36,515,537.82	12.66%
HCBS	383,307	$81,768,381.25	59,921	$7,170,255.42	15.63%
Behavioral Health	259,795	$78,858,166.56	20,292	$12,385,151.72	7.81%
Total All Services	5,207,525	$3,194,452,064	927,629	$776,285,627	17.81%

Summary of KanCare Annual Post Award Forum Held 11.20.15

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 2015 KanCare Public Forum, providing updates and opportunity for input, on Friday, November 20, 2015, from 3:00-4:00 pm at the Curtis State Office Building, Room 530, 1000 SW Jackson, Topeka, Kansas. The forum was published as a "Latest News – Upcoming Events" on the face page banner of the www.KanCare.ks.gov website, starting on October 21, 2015. 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, 13 KanCare program stakeholders (providers, members, and families) attended and participated, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; and staff from the KanCare managed care organizations. A summary of the information presented by state staff is included in the following PowerPoint document:

2015 KanCare Public Forum
Updates & Opportunity for Input

Friday, November 20, 2015

Agenda for Today

- Review Some KanCare Information And Updates
  - Medicaid Members & Expenditures
  - KanCare Expenditures
  - Provider Network
  - Value Added Benefits
  - Grievances, Appeals and State Fair Hearings
  - Waiver Integration
  - Other KanCare Member Issues And Updates
- Receive Questions, Suggestions And Other Feedback
  - Note Cards
  - Follow Up – Today And After

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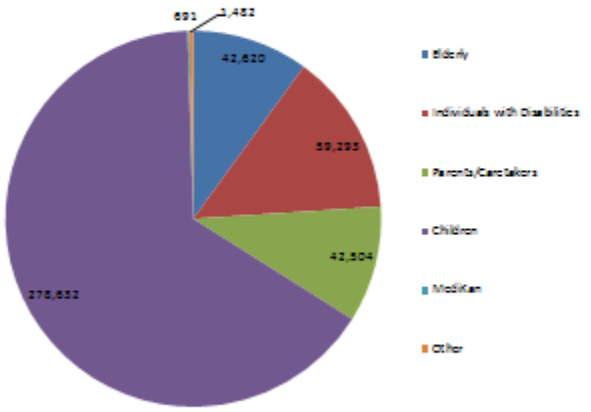
Medicaid Members - General

Eligibility Composition **Calendar Year 2015 (January – September)**



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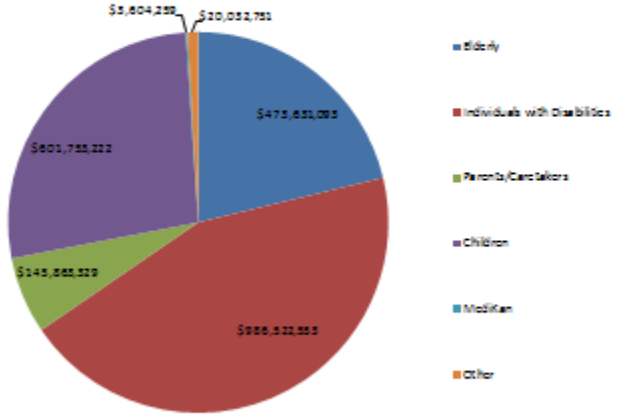
Medicaid Expenditures

Expenditure Composition **Calendar Year 2015(January - September)**



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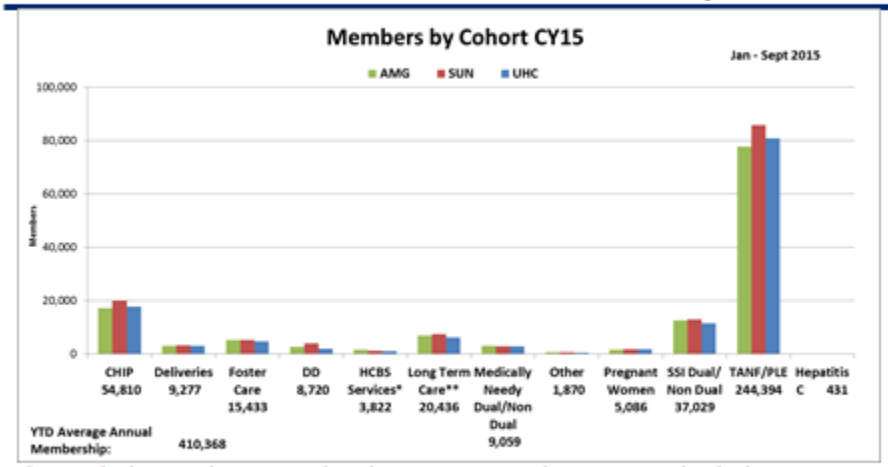
KanCare Member Groups



*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

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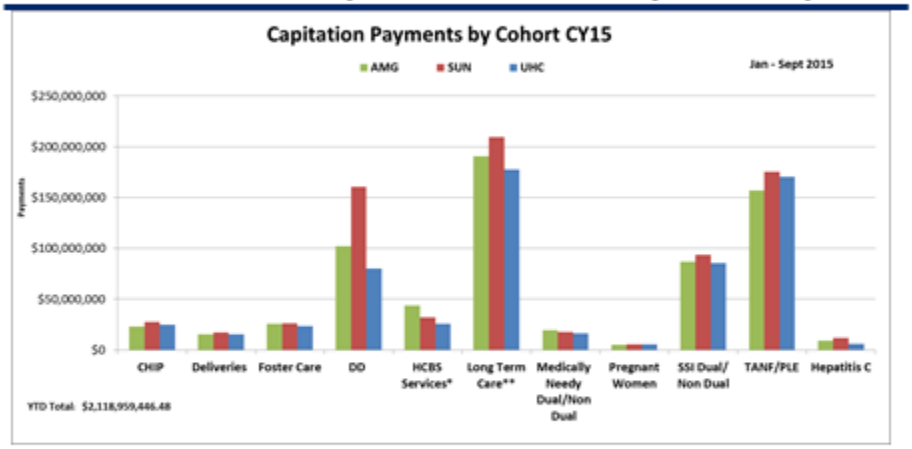
KanCare Expenditures by Group



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**Long Term Care includes Nursing Facilities; Money Follows the Person – Frail Elderly and Physical Disability Services; and the Physical Disability and Frail Elderly Waivers

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Provider Networks & VAB Totals

KanCare Provider Networks	
KanCare MCO	**Number of Unique Providers as of 9/30/15**
Amerigroup	15,954
Sunflower	20,226
United	20,840

Value Added Benefits – January-September 2015 Summary			
KanCare MCO	**Total Members YTD**	**Total Units YTD**	**Total Value YTD**
Amerigroup	17,494	26,013	$792,589
Sunflower	102,703	126,440	$2,162,143
United	12,815	13,003	$450,851
Statewide Totals	**133,012**	**165,456**	**$3,405,583**

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Value Added Benefits

Amerigroup	Members YTD	Total Units YTD	Total Value YTD
Adult Dental Care	202	3,031	$351,685
Member Incentive Program	507	8,915	$199,311
Mail Order OTC	805	7,520	$125,996
Healthy Families Program	31	70	$56,250
Pest Control	42	177	$22,187
Smoking Cessation Program	114	169	$18,681
Additional Respite Care for DD Waiver Population	6,433	496	$6,100
Additional Respite Care for Autism Waiver Population	3,037	2,005	$5,964
Weight Watcher Vouchers	4,448	93	$3,430
Hypoallergenic Bedding	3	30	$2,975
2015 YTD (Jan-Sept) GRAND TOTAL	17,494	26,013	$792,589

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Value Added Benefits

Sunflower	Members YTD	Total Units YTD	Total Value YTD
CentAccount debit card	57,864	65,580	$1,311,600
Dental visits for adults	5,489	15,607	$522,667
Smoking cessation program	477	477	$114,480
Disease and Healthy Living Coaching	35,636	35,636	$93,012
Start Smart	2,322	2,359	$66,406
SafeLink®/Connections Plus cell phones	399	399	$19,084
In-home caregiver support/ additional respite	59	5,153	$16,747
Lodging for specialty and inpatient care	48	106	$8,586
Community Programs for Healthy Children: Boys & Girls Clubs	379	379	$5,685
Hospital companion	4	677	$2,200
Meals for specialty and inpatient care	26	67	$1,675
2015 YTD (Jan-Sept) GRAND TOTAL	**102,703**	**126,440**	**$2,162,143**

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Value Added Benefits

United (Displaying VABs with $600 or more utilization YTD)	Members YTD	Total Units YTD	Total Value YTD
Adult Dental Services	1,484	1,484	$68,493
Additional Vision Services	973	973	$120,039
Membership to Youth Organizations	1,105	1,105	$55,250
Baby Blocks Program and Rewards	808	808	$47,995
Peer Bridgers Program	151	151	$37,044
Join for Me - Pediatric Obesity Classes	14	14	$35,000
Adult Briefs	341	366	$34,952
Weight Watchers - Free Classes	256	256	$30,464
KAN Be Healthy Screening Age 3 to 19 - Debit Card Reward	2,054	2,054	$20,540
Home Helper Catalog Supplies	473	473	$16,633
Additional Podiatry Visits	68	68	$14,079
Infant Care Book for Pregnant Women	902	902	$11,726
KAN Be Healthy Screening (Birth to 30 months - Debit Card)	605	661	$6,610
Sesame Street - Food For Thought	152	152	$5,320
Medications Calendar	2,085	2,085	$5,296
Adult Biometric Screening - Debit Card Reward	199	199	$2,985
Mental Health First Aid Program	13	13	$1,799
Join for Me - Reward for Completion of Program	35	35	$1,750
Asthma Bedding	18	18	$936
Weight Watchers Reward - Reward for Completing Classes	12	12	$600
2015 YTD (Jan-Sept) GRAND TOTAL	**12,815**	**13,003**	**$450,851**

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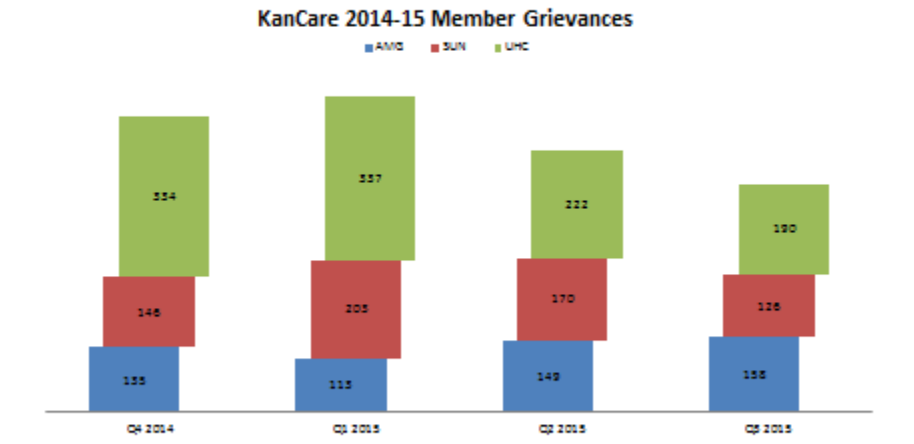
Member Grievances



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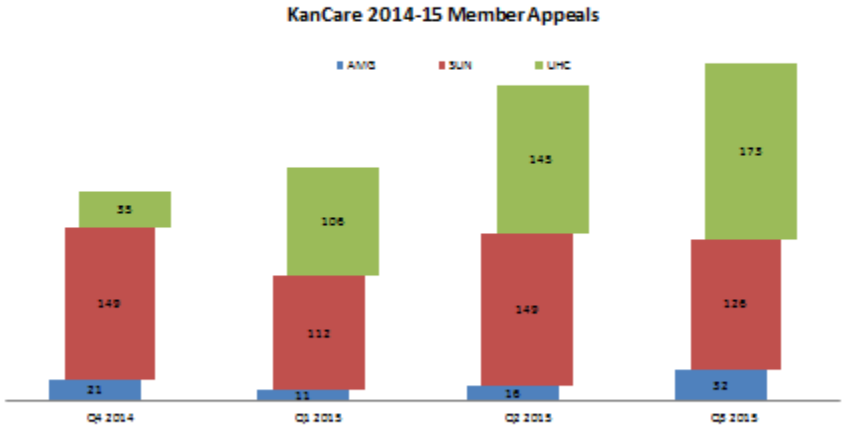
Member Appeals



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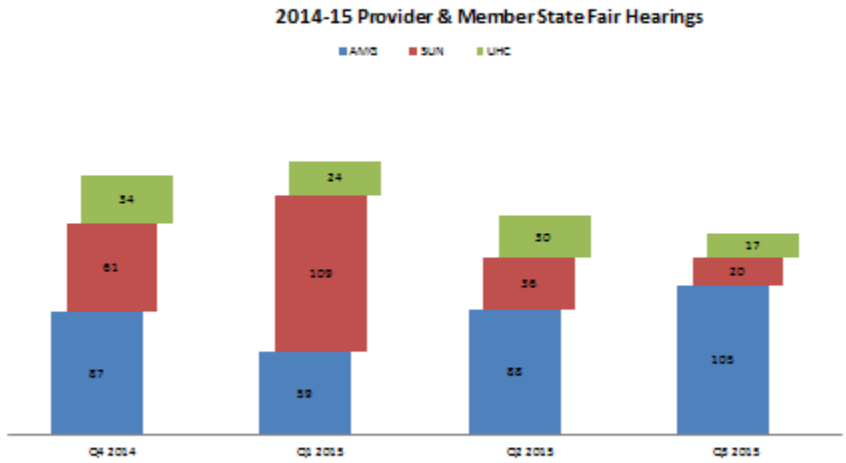
State Fair Hearings



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Waiver Integration – What Is It?

Full integration of seven 1915(c) waivers into the 1115 waiver

- Entrance to HCBS will remain the same; services fall into two broader categories: adults and children
- Eligibility requirements/process remain the same
- Children will continue to be entitled to all medically necessary services identified through Early Periodic Screening Diagnosis and Treatment (EPSDT)
- All members continue to be entitled to medically necessary state plan services in KanCare
- Services will be authorized through personalized plans of care

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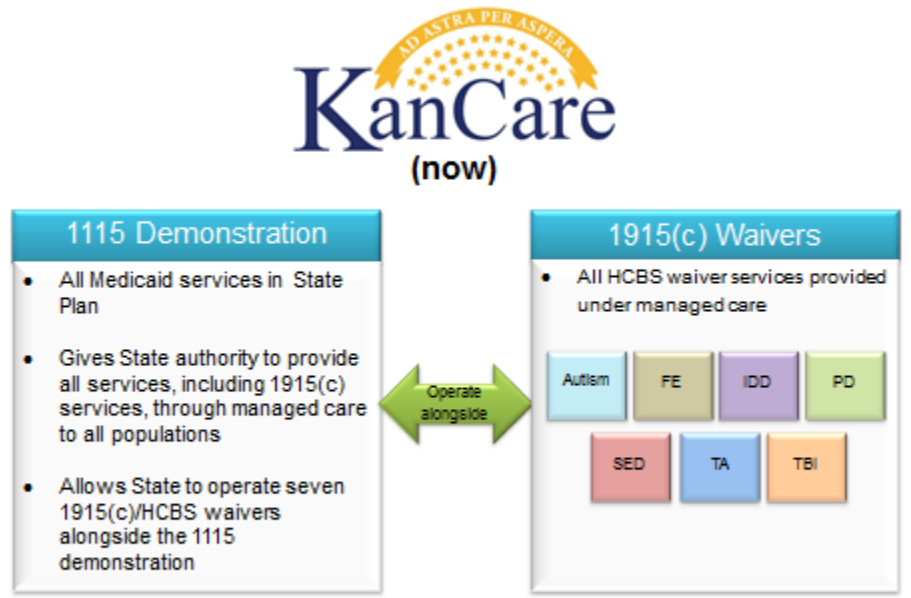
KanCare
(now)
1115 Demonstration
All Medicaid services in State Plan
Gives State authority to provide all services, including 1915(c) services, through managed care to all populations
Allows State to operate seven 1915(c)/HCBS waivers alongside the 1115 demonstration
Operate alongside
1915(c) Waivers
All HCBS waiver services provided under managed care
Autism
FE
IDD
PD
SED
TA
TBI

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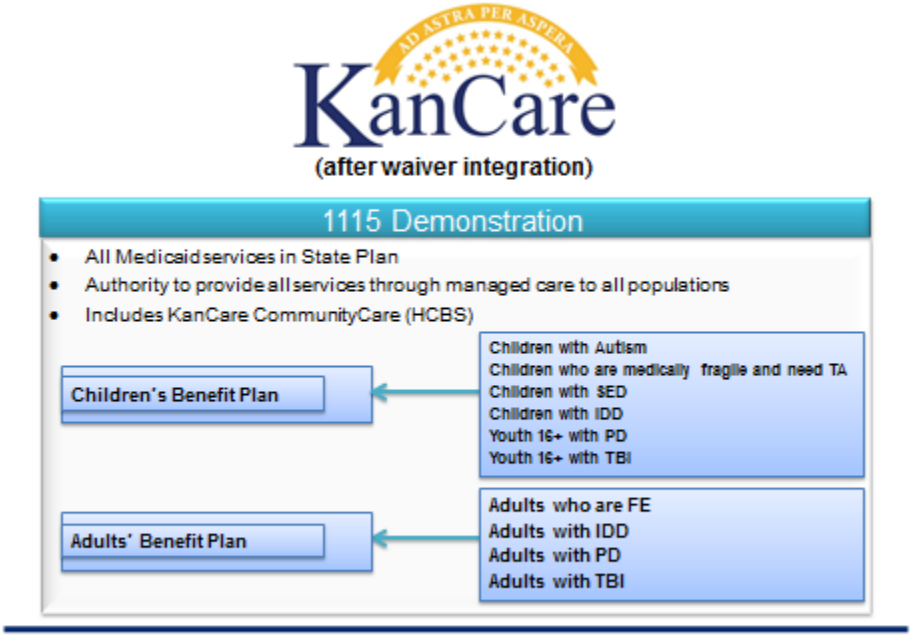
KanCare
(after waiver integration)
1115 Demonstration
All Medicaid services in State Plan
Authority to provide all services through managed care to all populations
Includes KanCare CommunityCare (HCBS)
Children's Benefit Plan
Children with Autism
Children who are medically fragile and need TA
Children with SED
Children with IDD
Youth 16+ with PD
Youth 16+ with TBI
Adults' Benefit Plan
Adults who are FE
Adults with IDD
Adults with PD
Adults with TBI

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Waiver Integration – Why?

- To create parity for populations served through Home and Community Based Services (HCBS) – services should be based on a personalized plan of care and centered on an individual's needs rather than their disability
- To offer a broader array of services – some individuals have disabilities that qualify them for more than one HCBS program, but they are limited to a single set of services

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Waiver Integration – Why? cont

- To improve moves between HCBS Programs and in transitioning from child to adult services
- To support development and expansion of community-based services
- To make things simpler for KanCare members, their families, and providers

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Waiver Integration - Stakeholder Input

- Two rounds of statewide information sharing sessions and listening tours (including evening sessions and conference call options).
- Focused work of Waiver Integration Stakeholder Engagement (WISE) workgroup
  - 100 stakeholders across all disability groups, providers, consumers and families
  - Five focus groups worked over four, 4-hour sessions, making numerous recommendations

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WISE Workgroup Recommendations

Access, Eligibility and Navigation:

1. Waitlists
   - Eliminate if possible
   - Cost savings should be applied to waitlist reduction
2. No change to pathway to eligibility
3. Eliminate the child and adult population service packages and combine into one
4. Develop basic 1115 waiver training and deliver to interested stakeholders

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WISE Workgroup Recommendations

Service Provision and Limitations:

1. Expand employment supports
2. Combine certain services
3. Establish new services

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WISE Workgroup Recommendations

Provider Qualifications and Licensing:

1. Reduce administrative burdens and streamline processes for providers
2. Ensure qualified providers
3. Maintain choice for providers and participants

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WISE Workgroup Recommendations

Policy and Regulation Review:

1. Develop an Operational Council to assist with policy review and development specific to waiver integration.
2. Develop a Policy Advisory Council to assist State staff in the development and revision of policy.
3. Develop a specific plan for communication regarding regulation and policy.
4. Collaborate with stakeholders to write an integrated waiver program manual and develop policies to further operationalize aspects of the program manual.

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WISE Workgroup Recommendations

Education, Training and Communication:

1. Make sure all documents use both person-first language and plain language at the sixth grade level.
2. Continue to bring state staff and all stakeholders together to communicate, collaborate, and work together.
3. Utilize a variety of mediums to provide training and education.
4. Require provider training on integrated waiver before providers are allowed to provide waiver services.

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Other Member Issues - KDADS

- IMD Exclusion
- Progress on Physical Disability Waiver – Waiting List
- HCBS Settings – Transition Plan

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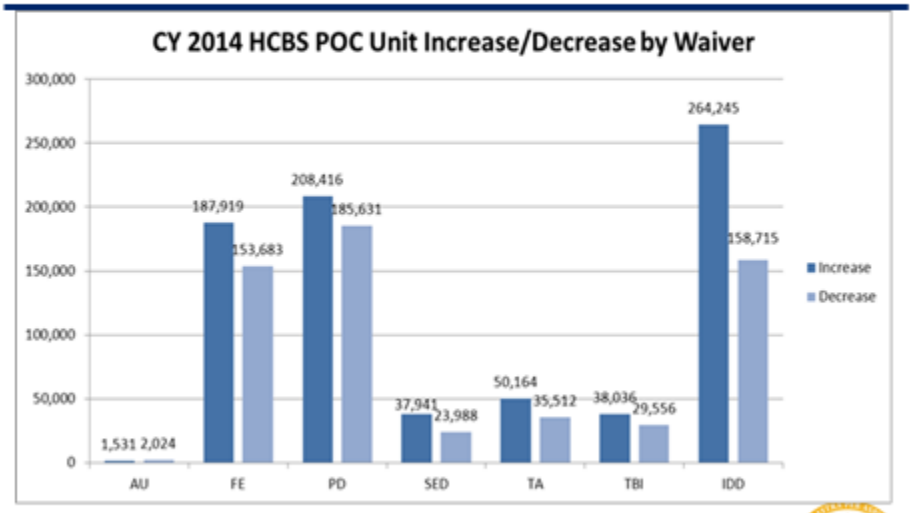
Other Member Issues–KDADS, cont



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Q&A / Input / Suggestions / Next Steps

- Note Cards
  - Write out your question/suggestion / input
  - Include your name and phone # or email address for feedback
- Next Steps
  - Address what we 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

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More Information/Updates: www.KanCare.ks.gov

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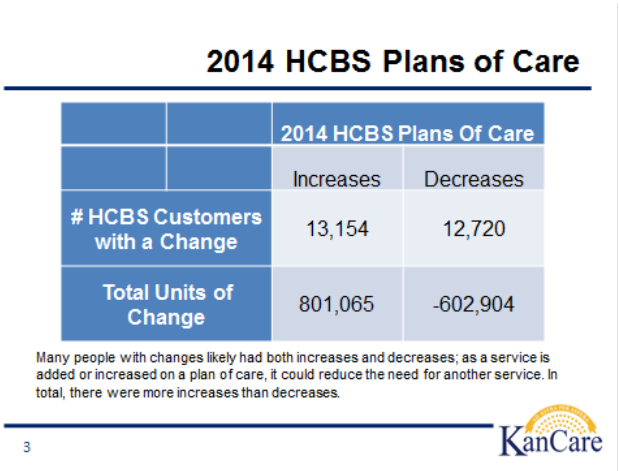
A summary of the questions from participants, with responsive information provided, is as follows:

#	Public Forum Participant Question	Summary of Response
1	Please explain change in staffing for Medicaid eligibility. When will that occur?	Effective January 1, 2016, the Kansas Department of Health and Environment (KDHE) will be responsible for processing and maintaining the Elderly and Disabled medical assistance cases, instead of the Kansas Department for Children and Families (DCF). Additional details about this change will be posted to KDHE's website, and also will be distributed to providers, members and other stakeholders in mid-December. Training sessions will be held in advance of the change for providers who are involved in the related eligibility process.
2	What is the hypothesis for the integrated waiver?	The values that will continue to govern include: right service, right person, right time. In addition, we anticipate it will result in a broader array of service options for people.
3	Will procedures for entry into the integrated waiver be the same across MCOs?	Eligibility paths will stay the same. However, MCOs are not responsible for this process and the related procedures; eligibility policies and decisions remain the state's responsibility, which is implemented via other contractors and separate from MCO responsibilities.
4	Please give a status update on the DD waiting list.	There are currently 3,584 people waiting. There are 8,753 people receiving I/DD waiver services, plus 38 people receiving I/DD services via the Money Follows the Person program.
5	Will the KanCare Consumer Workgroup continue to function during the integrated waiver discussions?	The KanCare Consumer and Specialized Issues Workgroup, has been in operation since before the KanCare program launched, and the current plan is that it will continue. New members were selected for that workgroup earlier in 2015; it is set to meet in December, 2015; and it will continue in operation indefinitely.
6	Regarding slide #26 *[plan of care increases/decreases in units, by waiver]* –# of persons experiencing increases/decreases would be helpful.	Yes – we have that information and have previously published it; it will be included also as part of the summary of this meeting:  2014 HCBS Plans of Care 2014 HCBS Plans Of Care Increases / Decreases # HCBS Customers with a Change: 13,154 / 12,720 Total Units of Change: 801,065 / -602,904 Many people with changes likely had both increases and decreases; as a service is added or increased on a plan of care, it could reduce the need for another service. In total, there were more increases than decreases. 3 KanCare
7	Out of the 100 stakeholders how many are representative of each group? I.e. consumer, family and so on. How do they pick them? When you do more focus groups will it be new group?	Concerning the process of selection, KDADS asked for volunteers to participate in the waiver integration working groups. The volunteers submitted applications and were selected with an attempt to ensure a balanced representation from each waiver population and allow for first time volunteer access. I/DD representation was approximately 37%; PD/FE 24%; and the remaining populations were represented at a lower rate. This is attributed to the fact the IDD and PD

		representatives turned in a disproportionally higher number of applications. We will be holding a second round of stakeholder working group meetings after the first of the year.
8	When will KEES be fixed?	The multiple system changes that are reflected in the KEES system were launched effective 7.1.15. We knew there would be, and there have been, some transition challenges and we have been very actively managing and resolving them timely. This system is significantly more complex than the previous system for staff working with it (in our effort to make it more end user friendly and accessible for members and providers), so there has been – as anticipated – a learning curve. This did contribute to a short-term delay in processing applications, which has been the focus of our improvement efforts. That delay has been decreasing and is moving toward resolution and toward what we plan as the fully operational/stabilized state.
9	What is the current timeframe for eligibility?	Our goal is a 45 day decision timeframe. That is not always happening yet, but is where we are headed, and in the meantime we have a quick turnaround process in place for time-sensitive and critical need applications.
10	Is there any way KDHE can enforce the one-year timely filing limit with the MCOs?	This is an issue based on a contractual relationship between providers and MCOs. The default standard is a 180 day timely filing, but if there is an exception to that either by contract with the MCO or on a situation-specific basis, providers should request that of the MCOs. If there are questions or concerns about this issue, providers should contact their provider representative at the applicable MCO to address them.
11	Is KDHE aware that the MCO's transition to ICD10 has caused several denials on claims incorrectly? I.e., claims being denied stating "incorrect CLIA #" when that is false?	We had not heard of that being an issue, but certainly as part of the healthcare system-wide shift to ICD 10 effective 10.1.15, there is the potential for things needing to be tweaked. KDHE will have our provider relations staff reach out to the questioner to review and assist with resolution of this concern.
12	Could you provide examples of new services you are considering?	Support broker
13	We have some questions/concerns about personal care services currently being received. These issues would assist with staff retention: • There is no allowance for paid training for these workers, who understandably do not want to come in for training without pay. • We would like to have the option of family (in this case, parents of person receiving the service) supplementing the rate of pay for personal care workers.	These are important issues and KDADS will follow up with the questioner to get additional details and provide responses/guidance as to options.