Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 6.30.14

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2014-3/31/2014)
Federal Fiscal Quarter: 3/2014 (03/14-06/14)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the second quarter known as of June 30, 2014.

Demonstration Population	Enrollees at Close of Qtr. (06/30/14)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	18,125	18,849	724
Population 2: ABD/SD Non Dual	29,281	30,007	726
Population 3: Adults	39,384	42,324	2,940
Population 4: Children	225,582	234,192	8,610
Population 5: DD Waiver	8,712	8,750	38
Population 6: LTC	21,097	22,156	1,059
Population 7: MN Dual	1,222	1,356	134
Population 8: MN Non Dual	1,126	1,264	138
Population 9: Waiver	4,126	4,216	90
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**348,655**	**363,114**	**14,459**

III. Outreach/Innovation

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

During the second quarter, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: April 8 (10 attendees), May 13 (11 attendees), June 3 (8 attendees).

KanCare open enrollment continues for the people how were approved for KanCare after January 2013. The agency mailed out 9,365 enrollment packet for the quarter, with 213 people choosing to change to a new MCO.

Month	No. of Packets Mailed	KC19 Changes	KC21 Changes	Total Changes
April 2014	2,790	82	7	89
May 2014	3,172	52	0	52
June 2014	3,403	68	4	72
Total	9,365	202	11	213

Also during this quarter, the state's KanCare Advisory Council held the third meeting of the newly appointed council on June 11, 2014. The 2013 Advisory Council consists of 13 members: 3 legislative members representing the House and Senate, 1 member representing mental health providers, 1 member representing CDDOs, 2 members representing physicians and hospitals, 3 members representing KanCare members, 1 member representing the developmental disabilities community, 1 member former Kansas Senator, 1 member representing pharmacists.

The agenda for the council's June meeting:

I. Welcome
II. Review and Approval of Minutes from Council Meeting, March 26, 2014
III. Updates on KanCare with Q & A
   a. Amerigroup Kansas
   b. Sunflower State Health Plan

c. UnitedHealthcare Community Plan

IV. Health Homes Update – Samantha Ferencik

V. Update on Employment First Initiative and Employment Pilots – Mary Ellen Wright

VI. Update from KanCare Ombudsman – Kerrie Bacon

VII. Review of KanCare Executive Summary - Acting Director Susan Mosier, Division of Health Care Finance, Kansas Department of Health and Environment

VIII. Update on I/DD Implementation and Elimination of the Underserved List – Acting Secretary Kari Bruffett, Kansas Department for Aging and Disability Services

IX. Next Meeting of KanCare Advisory Council - September 25, 2014, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.

X. Adjourn

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

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

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

Provider Experience Improvement Project

Following a survey of KanCare providers in December 2013 and January 2014, Kansas launched the Provider Experience Improvement (PEI) Project in March 2014. The PEI Project is designed to resolve provider-specific issues and strengthen the overall experience of providers who serve KanCare members. The PEI Project has three components:

- Outreach to each provider who indicated a concern in response to the provider experience survey completed in January 2014. This included issues related to prior authorization processes, claim payment accuracy or timeliness, and customer service experiences.
- Detailed analysis of both timeliness and accuracy of claims paid.
- Claims reprocessing – monitoring and reporting on the timeliness and accuracy of major claims reprocessing projects for the MCO's.

All portions of this project have been completed, and appropriate follow up has occurred with each MCO on relevant issues.

Health Homes

Kansas intends to implement the Medicaid Health Homes State Plan option that will include two target populations that are covered within the KanCare program. The following briefly describes the state's work on this initiative. The State Plan Amendment (SPA) for to implement Health Homes for people with serious mental illness (SMI) was approved by CMS on July 28, 2014 with an effective date of July1, 2014.

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented at different times; Health Homes for people with chronic conditions has been delayed to allow for ensuring an adequate network of Health Home Partners
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, like CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012
- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services

- Identifying the first target group, approximately 36,000 adults and children with SMI
- Determining the goals for health homes and selecting quality measures, including eight required by CMS
- Defining the provider qualifications and standards
- Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
- Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
- Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
- Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
- Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
- Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
- Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures and other components of the project
- Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm)
- Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
- Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
- Making presentations at various provider association conferences and meetings about the project
- Holding an educational webinar for interested providers
- Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
- Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
- Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)

- Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduling, through CCSR, twice monthly webinars for providers interested in becoming HHPs to be held from February through June 2014
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Holding 32 meetings in 16 cities for consumers to introduce the Health Homes program
- Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Creating an informational brochure to help inform consumers about Health Homes
- Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Developing the PMPM rate for SMI Health Homes
- Publishing a draft Program Manual for SMI Health Homes
- Issuing tribal notification to the four recognized American Indian tribes
- Holding six day-long provider training sessions across the state
- Publishing a draft Program Manual for Chronic Conditions (CC) Health Homes
- Developing PMPM rates for CC Health Homes
- Developing the components the State wants the health plans to include in their contracts with HHPs
- Consulting with SAMHSA for the second, chronic conditions, SPA
- Issuing public notice about the SPAs and their fiscal impact
- Submitting both SPAs to CMS officially on May 7, 2014

- Tasks completed since the last report:
  - Withdrawing the Chronic Conditions SPA on June 30, 2014 to allow us more time to ensure an adequate network of Health Home Partners is available
  - Performing an operational readiness review of the MCOs May 20-22, 2014
  - Reviewing network reports submitted by the MCOs
  - Completing operational work to receive files from and pay the MCOs for Health Home services
  - Scheduling SMI Health Homes Implementation calls weekly to hear from providers and address systemic issues and questions
  - Scheduling weekly calls with stakeholders to provide updates on the progress toward implementation of the Chronic Conditions Health Home
- Task still to complete
  - Developing reporting requirements
  - Assessing the feasibility of a regional, rather than statewide, implementation of the Chronic Conditions Health Home

HCBS Final Settings Rule – Public Comment Sessions and Transition Plans

In compliance with the CMS Final Rule, the draft HCBS Setting Transition Plans were open for Public Comment from June 14, 2014 to July 15, 2014. The Public Comment period was open for 30 days to allow all HCBS consumers and providers an opportunity to provide input to the Transition Plan. The Statewide HCBS Compliance Transition Plan will include results of the provider self-assessment and plans to address residential settings based on the guidance provided by CMS on March 20, 2014. Pending CMS guidance for day settings, the State will revise the Transition Plan to include additional guidance from CMS regarding application of the Final Rule to those settings.

The new HCBS Settings Rule from CMS applies to all programs that provide home and community based services. In Kansas, this rule will apply to all settings where home and community based services are provided for these programs:

- Frail Elderly (65+)
- Autism (starts services before age 6)
- Intellectual/Developmental Disability (5+)
- Physical Disability (16-64)
- Serious Emotional Disturbance (0-18)
- Technology Assisted (0 through 21)
- Traumatic Brain Injury (16-64)

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

- An Overall Summary of
  - public comments received
  - inventory and description of all HCBS Settings
  - how setting types meet or does not meet the federal HCBS Settings requirements
- An Assessment Plan
  - To complete assessments for HCBS Settings
  - To identify areas of non-compliance that need to be addressed
  - To identify the number of individuals affected by the HCBS Settings Rule
- A Compliance Plan
  - To ensure the health and safety of participants who reside in locations that need to meet corrective
  - action requirements for the setting to come into compliance during the State's specified transition
  - timeline
  - To move individuals to compliant settings, if necessary
- A Public Engagement Plan

- To Develop/Revise Transition Plan
- To provide forums for public comment periods and summarize responses
- To notify affected individuals about the impact of the HCBS Settings Rule and related changes
- To assist in developing transition plans elements

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

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

Additionally, providers were reminded to complete the provider Self-Assessment survey by June 30, and will have providers complete a separate assessment for 2015 for compliance purposes.

Provider Information Sessions

Quality Assurance Provider Informational Sessions were held April 21st through April 29th in Colby, Garden City, Salina, Wichita, Pittsburg, Topeka and Kansas City. The all day sessions were divided into three presentations that detailed the IDD license applications, checklists and tools used by the Quality Management Staff when making visits to licensed residential, day and targeted case managers.

The agenda included a detailed review of the new license applications, available on July 1, 2014, and other forms used for licensure visits and reviews. The IDD licensing applications were added to the State's online application tool. The information session included a presentation of the new quality assurance and program integrity structure, which included a description of the division of the quality management specialists into three teams, the rationale for making the change, and how the state will complete the restructuring. The three teams include licensing, quality assurance and program integrity. The State accepted input from the information sessions on changes to the forms and how they will be utilized in the future.

Providers also gave input into updates on the protocols for quality review, the elimination of the Kansas Lifestyle Opportunities tool in favor of the National Core Indicators, and updates to the Adverse Incident

Reporting (AIR) System. The discussion also included comments on webinars, the crisis review process, and the definition of need versus want. Additionally, the need for the program integrity control unit (PICU) to ensure appropriate referrals to the Medicaid Fraud Control Unit and KDHE's Office of Inspector General was discussed. A recent case of identified fraud was the result of the State's electronic visit verification system, Authenticare, which is required for all identified services. Additionally, this case revealed a potential weakness in the shared living residential arrangement, which resulted in a portion of the fraudulent activity, which resulted in the creation of the Shared Living Workgroup.

KDADS informed providers where to send questions and concerns, how to be added to the listserv for notification about provider policy updates, and how to use the KDADS Provider Issue Tracking Log. At every location, people indicated they were told there concerns were not appropriate for the issue tracking log; but we encouraged them to use the log so that we really know where the issues are and can address them.

The afternoon session included an overview of PACE, Money Follows the Person, waiver programs, program access, waitlist management, the requirement of Authenticare, an update to Financial Management Services, and the new multi-functional eligibility instrument (MFEI)

Additionally, a public information session was held about the CMS Final Rule related to provider owned and controlled settings. The CMS power point presentation on this subject was used for the presentation, and KDADS accepted public comments on the new rule and how it would apply to Kansas providers and settings. The audience included providers from Intellectual and Developmental Disability providers, Assisted Living Facilities, Residential Health Care Facilities, Home Pluses, PACE staff and care coordinators from the MCOs.

MCO Outreach Activities

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

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

Marketing Activities: Amerigroup participated in over 280 events for the second quarter which included partner development, sponsorships, outreach and advocacy. The primary focus for their Community Relation Representatives continued to be member education of services and benefits of the KanCare program. They look to develop strong partnerships across the state by enhancing existing relationships and building new ones. In the 2nd quarter, Amerigroup's Community Relations team also focused on actively pursuing intellectual and developmental disabilities member and provider feedback to ensure the program was progressing as planned. In addition, they supported the Health Homes launch activities. Below is a sampling of Marketing activities Amerigroup supported in the second quarter:

• National Alliance on Mental Illness Conference
• Hispanic Development Scholarship Fund
• Self-Advocacy Coalition of Kansas Conference
• Amerigroup Community Care Health Home Tours.

Outreach Activities: Amerigroup continued their outreach efforts where they reach out by phone and mail to new members to welcome them and to ensure they have completed their initial risk assessment. They also continued with their targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. The Community Relation Representatives participated in a variety of community events reaching over 20,000 Kansans this quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain invaluable feedback and to cover current topics that are relevant to their members such as: diabetes, well child visits, employment, high blood pressure, your PCP and you, and others. Below is a sampling of some of their outreach efforts this past quarter:
• 15th Annual Haskell Safety Health Wellness Fair Exhibit
• Wyandotte County WIC presentations
• Welcome Baby Jubilee Exhibit
• Special Olympics Kansas

Advocacy Activities: Amerigroup' s advocacy efforts for second quarter continue to be broad based to support the needs of their general population, pregnant women, children, people with disabilities and the elderly. Their staff is proactive and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help them learn what the needs of the community are and how they can better serve them and improve their quality of life. The second quarter advocacy efforts remain similar to those of the first quarter. Amerigroup continued to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process. Here are a few examples of their Advocacy Activities this last quarter:
• Governors Public Health Conference
• Connect the Dots – Better KCK
• Hispanic Task Force
• Mother & Child Health Coalition Meeting
• F.L. Schlagle High School Site Council Meeting

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:
Marketing Activities: The Sunflower MemberConnections representatives ramped up home visits to meet with moms and babies about the importance of getting infants in for their well-child visits. This is a key focus area for Sunflower member outreach to ensure the health of our members. Additionally,

Sunflower has targeted the Wichita (Sedgwick County) area for more work around emergency room diversion. The marketing team has worked with MemberConnections and Medical Management to create flyers and provider contact lists to help members learn more about the resources available to them when they need to see a doctor in a non-emergency situation.

In addition to over 60 member and/or provider events participated in during this quarter, the following outreach activities were carried out by Sunflower during this reporting period:

- The Spring edition of the quarterly newsletters for Members (Health Moves) and Providers (Provider Report) was published. The quarterly newsletter contains articles, photos and checklists that are seasonal and actionable for the audience, esp. those items related to HEDIS measures and other quality standards.
- During this reporting period, Sunflower's Health Homes implementation team developed and maintained strong working relationships with provider groups that would later become Health Homes Partners in the Sunflower network. Provider outreach included participation in webinars and other meetings hosted by the State or by the MCO. Sunflower's Chief Medical Director filmed a video message that is currently in the process of receiving closed captioning before being posted online. This video message is targeted at anyone interested in hearing about the importance of Health Homes from a medical and coordinated care perspective.
- During a ribbon-cutting event, the Sunflower satellite office in Wichita hosted many providers from the community who were recognized by the health plan president & CEO. This gave the health plan an opportunity to bring providers and community leaders in to the workspace and meet the people behind the scenes who are responsible for coordinating care in that region of the state.
- Sunflower worked alongside the other two KanCare companies, the American Cancer Society, the state health department (KDHE) and other organizations to develop a plan for sending reminder mailings to members due for their colorectal screening. The mailings are scheduled to be sent to members during 3rd quarter.
- During this 2nd quarter reporting, Sunflower marketing launched a blog section on its website to feature Member Success Stories and other articles of interest to members and providers. That new blog is available at: http://www.sunflowerhealthplan.com/category/news-category/blog-category/

Outreach Activities: The Member Connections team was involved in many outreach events throughout the state of Kansas in the second quarter of 2014 as follows:

Sunflower continued its Adopt-a-School partnership with Gertrude Walker Elementary in Garden City. Healthy foods and planting a garden were discussed in April and Sunflower partnered with the Mexican American Ministries in May to talk with the children about dental health. The children enjoyed planting a seed to take home and there was a book for each child at both events.

Under Sunflower's Adopt-a-School umbrella, they also had an event at the Boys and Girls Club in Wichita. Each child received an anti-bullying book and Sunflower partnered with the Girl Scouts to

speak about the topic of anti-bullying.

The Member Connections team continues outreach to new mothers in their areas to help them understand the importance of their post-partum and well child visits. The team helps members with any barriers to these visits such as transportation or access to a phone.

The Member Connections team was involved in these specific outreach events throughout the state of Kansas in the second quarter of 2014:

April Events:

- NAMI Housing and Homelessness Conference in Salina.
- Douglas and Jefferson County Resource Expo 2014 in Lawrence.
- CLO Midnight Farm Spring Family Fun Day in Baldwin City.
- Community Action Team Meeting in Wichita.
- West Village Head Start Meeting in Wichita.

May Events:

- Employment First Conference in Topeka.
- Health Literacy Advisory Council in Wichita and Topeka.
- 10th Annual Women's Health Fair in Kansas City.
- Impacting Population Health meetings in: Garden City and Beloit.
- Wyandotte County Early Childhood Interagency Council in Kansas City.
- Health and Wellness Fair in Topeka on the Capitol grounds.
- Allen County Multi-Agency Team in Iola.

June Events

- Impacting Population Health meeting in Topeka.
- Parent Health Literacy Training in Chanute.
- Riley County Public Health System Meeting.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: UHC's main activities continue to be focused on education of members concerning their health and their benefits of being a member of UnitedHealthcare Community Plan of Kansas. This is done this through attendance at community events that attract UHC's membership base, member welcome calls, mailings to those that could not be reached by phone, and sending out quarterly Member Newsletter to UHC membership. UHC also continues meeting individually with key Medicaid medical provider offices to provide them with education on the benefits that members can achieve by completing their health screenings and by effectively managing their health with wellness activities.

Outreach Activities: UHC has three outreach specialists focused on activities targeted within their specific geographic areas of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, its work with KanCare and the benefits of UHC's plan. They especially inform individuals about value added benefits. UHC also has a

Provider Marketing Manager whose role is to work with key provider offices throughout the State to assist them with issues regarding the transition to KanCare and to make sure they are educated on the benefits for UHC members who visit their offices.
- During the second quarter of 2014, UnitedHealthcare staff personally met with 3,975 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 second quarter of 2014, UnitedHealthcare staff personally met with 1,300 individuals from community based organizations located throughout Kansas. These organizations work directly with our members in various capacities.
- During the second quarter of 2014, UnitedHealthcare staff personally met with 904 individuals from provider offices located throughout the State.

Advocacy Activities: UHC activities in advocacy are again focused on educational efforts surrounding KanCare and the benefits of UHC to members across the state. That includes special outreach to individuals with intellectual and developmental disabilities. UHC is also working to educate those individuals enrolled in the physical disability and frail elderly waiver programs. UHC has one Outreach Specialist focused specifically on working with individuals who touch Kansans with disabilities.
- UHC's outreach specialist to the disabled community personally visited with 359 advocates for the disabled in Kansas, providing them with education on KanCare and UnitedHealthcare benefits. She has also consistently been meeting with individual members and advocates across the State regarding implementation of I/DD services into managed care. She has also been working internally to make sure that all operations of plan activities are focused on making sure that our members are well represented in all processes.
- That same outreach specialist also worked in conjunction with the Empower Kansas steering committee on collecting more RFP's to award grantees which were presented to organizations during the second quarter of 2014.
- Every quarter UHC holds a Member Advisory Council meeting to educate members on what the plan is working on and receiving feedback on ways that we can improve our processes for members. During the second quarter, the meeting focused on the implementation of Health Homes in Kansas and how that will affect KanCare members going forward.

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services used, per KanCare MCO's top three value-added services by reported value and total, January-May, 2014, as reported 6.30.14, follows:

MCO	Value Added Service	Units	Value
Amerigroup	Adult Dental Care	1,400	$166,474.14
	Member Incentive Program	3,997	$105,180.00
	Mail Order OTC	3,591.00	$58,935.38
	Total of all Amerigroup VAS Jan-June 2014	*11,229.00*	*$401,227.72*
Sunflower	Dental visits for adults	11062	$205,965.90
	CentAccount debit card	18482	$369,640.00
	Smoking cessation program	222	$53,280.00
	Total of all Sunflower VAS Jan-June 2014	*45,950*	*$ 753,313.56*
United	Additional Vision Services	4,813	$233,127.15
	Join for Me - Pediatric Obesity Classes	25	$62,500.00
	Adult Dental Services	689	$36,785.71
	Total of all United VAS Jan-June 2014	*57,789*	*$471,584*
Combined Totals	**All MCOs - Jan-June 2014**	**114,968**	**$1,626,125**

c. Enrollment issues: For the second quarter of calendar year 2014 there were 14 Native Americans who chose to not enroll in KanCare.

The table below represents the enrollment reason categories for the 2nd quarter of calendar year 2014 (April, May, and June). All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories:

Start Reasons	Total
Newborn Assignment	9
KDHE - Administrative Change	15
WEB - Change Assignment	16
KanCare Default - Case Continuity	157
KanCare Default - Morbidity	192
KanCare Default - 90 Day Retro-reattach	43
KanCare Default - Previous Assignment	216
KanCare Default - Continuity of Plan	2,385
AOE – Choice	328
Choice - Enrollment in KanCare MCO via Medicaid Application	158
Change - Enrollment Form	397
Change - Choice	740
Change - Access to Care – Good Cause Reason	28
Change - Case Continuity – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	11
Total	**4,695**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY14 2nd quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Bene-fits	Billing/ Fin Issues	Transp-Timely	Transp-Access	Phar	DME	Med Proc/ Trtmt	Waiver HCBS Service	Mail/ Other
AMG	6	49	41	33	3	30	10	0	7	4	0	2	13
SUN	4	47	4	25	0	4	26	0	1	3	2	1	13
UHC	0	1	13	23	0	100	38	29	5	1	2	0	0

MCOs' Appeals Database
Members - CY14 2nd quarter report

MCO	PA Dental	PA DME	PA MRI, CT	PA Phar-macy	PA OP/IP Surg/ Proc	PA Comm Based Svcs	WORK Hours	LTSS/ HCBS PCA Hours	HH Hrs	OT/ PT/ ST	Inpt Covg	Ster/ Epid Inj/ Sleep	PCP/ Spec-ialist	LTACH/ RTC/ Air Amb	Claim Denial
AMG	1	5	3	4	1	0	0	15	0	0	1	0	0	0	2
SUN	0	18	19	20	6	16	0	0	7	9	36	4	0	3	0
UHC	2	10	0	8	2	0	0	28	0	0	0	1	1	1	0

MCOs' Appeals Database

Providers - CY14 2nd quarter report (appeals resolved)

MCO	MCO Auth	MCO Claim/ Billing	MCO Clin/ UM	MCO Phar	MCO Plan Admin/ Other	MCO QOC	MCO Cred/ Cont	Vision Auth	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Dent Plan Admin	Dent Clin/ UM	Cen-patico STRS Auth
AMG	16	6,537	79	0	0	0	0	0	9	0	48	0	0	0
SUN	21	232	34	1	8	0	0	26	55	17	8	0	21	0
UHC	0	765	0	0	0	1	0	1	13	0	22	0	0	0

State of Kansas Office of Administrative Fair Hearings

Members - CY14 2nd quarter report

AMG-Red SUN-Green UHC-Purple	PA Dental Denied	PA CT/ MRI/ X-ray Denied	PA Skilled Nursing Denied	PA Pharm Denied	PA DME Denied	PA Home Health Hours Denied	Assistive Svc Funds Denied	PA PT/ Inpt Rehab Denied	LTSS/ HCBS/ WORK PCA Hours Denied	PA Med Proc Denied
Withdrawn	1		1						9	
Dismissed-Moot MCO reversed denial		1	1	1 1	2	1	1	1	3	1
Default Dismissal Plaintiff no-show		1			1			1		
Dismissed-Untimely			1							
FH in process									1	
OAH upheld MCO decision			1	1						
OAH reversed MCO decision										
FH dec pending	1	1		1					1 20	1 1

Providers - CY14 2nd quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied	Dental Denied	DME Denied	Radiology Denied	Hearing Screen Denied	Home Health Denied	PT Denied	Inpt/ Hospice/ Rehab Coverage Denied	Waiver Eligibility Denied	Med Proc Denied
Withdrawn	4			1				4 2		1
Dismissed-Moot MCO reversed denial	72	2		1	1		1	1 6	1	
Dismissed-No internal appeal	5	5 11	1 1	4				3		
FH in process								3		
Dismissed-Untimely										
OAH upheld MCO decision										
FH dec pending	28			3		1	2	4		

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

f. Changes in provider qualifications/standards: There have been no changes in provider qualifications. A review of FMS providers resulted in working with the MCOs to identify FMS providers who no longer met the provider qualifications and ensure consumers were notified and provided choice of properly contracted and credentialed providers.

g. Access: During the first quarter of 2014, there was a late upswing in requests for changes in plan affiliation outside of the open enrollment period, a trend that continued into the second quarter of the year. As discussed in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In the first quarter of 2014, KDHE received 118 member requests to change health plans in total, with 90 requests in March. Only nine of the 90 requests were ultimately approved. In the second quarter of 2014, this trend continued with 313 requests submitted, with only 18 requests approved. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period based solely on the member's preference, when other participating providers with that MCO are available within access standards, are denied as not having good cause. The MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the second quarter of 2014, there were no state fair hearings filed for a denied GCR.

Status	April	May	June
Total GCRs filed	138	84	91
Approved	11	5	2
Denied	74	50	49
Withdrawn (resolved, no need to change)	38	8	17
Dismissed (due to inability to contact the member)	14	14	18
Pending	1	7	5

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

KanCare MCO	# of Unique Providers as of 6/30/13	# of Unique Providers as of 9/12/13	# of Unique Providers as of 12/31/13	# of Unique Providers as of 3/31/14	# of Unique Providers as of 6/30/14
Amerigroup	16,706	16,891	17,352	18,897	19,436
Sunflower	13,016	14,478	15,404	15,931	16,314
UHC	14,738	15,893	18,010	19,872	19,911

In March, two issues caused the majority of good cause requests and the largest amount of concern. Both of these issues continued into the second quarter of 2014. The first issue involved a number of dental practices either closing their panels or refusing entirely to accept patients from one of the plans. The affected plan has implemented remediation measures by switching to another dental sub-contractor.

A second source of concern was a large pediatric clinic which began in late March to give letters to their patients asking them to file good cause requests if the patient was enrolled with a certain plan. The issues from that clinic continued into the second quarter of 2014. This clinic is still contracted with all plans, but KDHE continues to see GCRs filed based upon the letters.

h. Proposed changes to payment rates: There were no proposed payment rate changes during this quarter.

i. MLTSS implementation and operation:

Community Transitions from Institutions

During the second quarter, Kansas and the MCOs began exploring options for improving the nursing home transitions. Nursing facility census has remained relatively stable, and the MCOs are seeing greater success at the time of discharge from a hospital or rehabilitation facility in diverting individual before they go into a nursing facility. The most significant barrier is related to Medicare only or private pay individuals who enter a nursing home and later become Medicaid eligible. Since it is more difficult to reintegrate individuals who have chosen a nursing facility prior to being Medicaid eligible, the MCOs are looking nursing facility data, working with nursing facility discharge planners, and increasing utilization of Money Follows the Person.

Over the third and fourth quarters, Kansas will review ways to improve use of Money Follows the Person and improve screening and discharge planning from the hospital for Medicare and other primary insurance individuals. The State is also looking at MDS data that may be useful for identifying who is likely to be able to live in a home and community based setting. Over the next six months, Kansas will focus on moving hundreds of individuals from institutional settings.

Quality Assurance and Program Integrity

Quality Management Staff reorganized in July of 2014. Staff duties are now divided into three groups. One group completes all licensing for the IDD and TCM programs. One group does all quality assurance for all waiver programs and Money Follows the Person.

Licensing

Licensing of Intellectual Developmental Disability (IDD) and Targeted Case Managers (TCM) Providers. KDADS Quality Management Staff make visits to all IDD service providers to assure they are in compliance with regulations. They issue an initial license and renew licenses on a yearly or biennially. Staff visits the residential and day settings where services are provided. They provide a statement of findings if they find issues out of compliance. The provider may request mediation if they disagree with the findings. Otherwise they are asked to submit a corrective action plan. The staff make follow up visits to assure the provider is back in compliance with the regulations.

Quality Review

Quality Assurance staff receives a list of individuals to review their records and complete a face to face interview with the individual receiving HCBS services. Staff use a protocol to review records and complete the interviews with the person in their own home. Questions are related to the services the individual is receiving and their satisfaction with the services that are being provided. The information is entered into a database and the information is used for reporting to providers, Centers for Medicare Medicaid and program improvement.

Program Integrity

In fiscal year 2014, the Program Integrity Control Unit (PICU) was created to ensure compliance with the Medicaid requirements to have appropriate policies and procedures to detect and refer possible allegations of fraud, waste, abuse, neglect or exploitation to the appropriate source. PICU staff investigates issues of concern from all sources when it involves individuals and waiver services. They follow up on any complaints from individuals who are receiving HCBS services, referrals from the Medicaid Fraud Control Unit at the Attorney General's Office, referrals from the Office of Inspector General at the Kansas Department for Health and Environment, and concerns or issues from the Program Integrity teams at the three MCOs. Additionally, they monitor the abuse, neglect and exploitation reports from Adult Protective Services (APS) at the Department for Children and Families (DCF). PICU staff are responsible for making appropriate referrals to MFCU, OIG, APS, and the MCOs when they become aware of credible information that could constitute fraud, waste, abuse, neglect or exploitation.

j. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). Children's Mercy Hospital has chosen to do the following projects: Complex Care for Children and Patient Centered Medical Homes (PCMH). Kansas University Medical Center will be completing Sepsis and Self-Management and Care (SMAC) Resiliency for their projects.

Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The State, KFMC and hospitals will be collaborating to determine what measures will be used to evaluate the projects for the DSRIP activities. The State, CMH, KU and KFMC have met several times to develop a DSRIP project timeline, Attachments F and G: DSRIP Protocols, Appendix B – DSRIP Planning Protocol Measures Catalog, and a Hospital DSRIP Plan application template. The Attachments F and G have been approved by CMS. CMS and the State have had several teleconferences to discuss Attachments F and G and Appendix B.

The State is researching the best mechanism to communicate with the DSRIP Learning Collaborative.

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

Quality Assurance Protocols

In fiscal year 2014, CMS approved the amendments to the HCBS programs to incorporate the new quality performance measures. The Autism, FE, TBI, Technology Assisted, and PD waivers were amended to include new quality measures for performance outcomes for the HCBS Programs. The Quality Assurance program tools were updated in fiscal year 2014 to reflect these changes. Licensed IDD providers can access the new applications for targeted case management, IDD residential and IDD day services on the KDADS website (www.kdasd.ks.gov).

The new protocols will look at quality assurance outcomes that are outlines in each HCBS program's waiver application with CMS. They have been updated to include expected outcomes in Medicaid programs for home and community based services. Provider trainings about the quality assurance measure and quality review process were held in late April.

New Program Integrity Protocols

In fiscal year 2014, PICU began receiving referrals from MFCU and OIG for monitoring and follow up. The Program Integrity Coordinator will track and refer complaints, concerns and allegations to the appropriate quality management specialist or PICU reviewer to make face-to-face visits, review collateral information and documents, contact staff or other personnel, and provide assistance to other teams to coordinate investigations, review and responses to issues. The quality and program integrity staff will work with Managed Care Organizations to investigate possible Medicaid fraud and will request corrective action and remediate as appropriate to the process, policy and federal and State regulations.

PD & FE 1915(c) Renewal

In the third quarter, KDADS will submit renewal applications for the Physical Disability and Frail Elderly 1915(c) waivers. The renewals will include a summary of public comment sessions,

transition plan language, and possible changes to the sleep cycle support and personal attendant care services in accordance with the Department of Labor Final Rule. Public Comment sessions related to the renewal will be held in mid-August.

CMS Final Rule on HCBS Settings

In the second quarter, KDADS completed a thirty day public comment period for the HCBS Final Rule related to provider owned and controlled settings. These sessions, were held in person and by conference call, and public comments could be submitted in person, by phone, or by email.

The purpose of the public comment sessions was to meet requirements for public comment period on the HCBS transition plan and to listen to comments from the public, record the comments, and prepare a summary to submit with the transition plans to CMS. Once approved by CMS, the Transition Plan will be added to the appropriate waivers through the amendment or renewal process. Kansas anticipates that the final rule related to settings will only affect settings for the IDD, PD, FE, and TBI programs. All other aspects of the Final Rule will be considered for amendments to the HCBS programs in the third and fourth quarters of 2014.

Department of Labor – Companionship Rule

At the end of the second quarter, the Department of Labor released two administrative interpretations, 2014-1 and 2014-2, related to 29 CFR 522.109, effective January 1, 2015. The US Department of Labor (DOL) modified a regulation, which may have a significant impact on whether direct service workers serving HCBS clients will be subject to the wage an hour regulation found at 29 CFR 522.109 beginning January 1, 2015. Despite the argument that states were notified last October of this final rule, the impact of the administrative interpretations of the new regulation on Medicaid-funded programs authorized under the Social Security Act could result in the elimination of services, in increased institutionalization, and inability of states to meet the labor mandates and maintain supports and services as current funding levels.

Under the recent interpretation, it appears that the DOL will combine hours worked for more than one client and treat them as if they were part of the same employment enterprise. In other words, if KDADS, an FMS provider, or an MCO was determined to be a sole or joint-employer, hours worked for all clients would be combined. If a DSW worked 20 hours for client A, 10 hours for client B, and 15 hours for client C every week, the DSW would be eligible for 5 hours of overtime compensation every week. Unlike the cash and counseling programs in a limited number of states for a small portion of the Medicaid-eligible populations, the Kansas model provides individuals with services designed to support an individual who needs assistance self-directing their care.

As such, Kansas is seeking clarification from the Department of Labor on the administrative interpretation as it relates to the State's system under its Medicaid program. More specifically, Kansas is seeking to clarify that the consumer is the employer of the direct service worker and the Medicaid program, established policies, pay structure, and support model are tools to assist the aging or disabled consumer who may not be able to afford or maintain a personal care worker or attendant without them.

The Kansas Department for Aging and Disability Services has reached out and requested input from consumers and providers of services to consumers impacted by the interpretations. Some of their shared concerns are as follows:

- Fewer clients will be able to self-direct their care because of these unintended consequences. The DOL ruling, if it remains, will work strongly against the principal of maintaining individuals in the least restrictive environment necessary to meet their needs. I'm afraid that the new DOL regulations will force members back into institutional settings.
- Several concerns dealt with limiting service worker hours due to budgetary constraints and the inability to find qualified staff, especially in rural communities. These concerns included loss of current staff that leave for better paying jobs and the inability for family members to maintain outside employment in order to fill gaps due to restricting service worker hours. Other related concerns identified the use of multiple workers and the increased human dynamics placed on consumers and their families in learning to deal with multiple care workers. All of the gaps in service that occur place increased risk to those in need of care.
- Sleep cycle support is the most cost effective service in all the waivers. If this service is changed to an hourly rate, the current state budgets will not cover this cost, which will lead to its discontinuation. Without this key service, persons will definitely be placed in institutions.
- The primary concern is for the individual receiving services and how this impacts their ability to remain in the community with qualified care providers who are adequately compensated.

Pending a determination by the Department of Labor regarding the joint employment status of the state, MCO and FMS providers, Kansas will continue meeting with stakeholders to make necessary changes to the HCBS programs and the long-term supports and services to comply with the Final Rule by January 1, 2015. To meet the timeline requirements for potential HCBS waiver amendments related to supports and services impacted by the Department of Labor Rule, KDADS will be hosting Public Comment Sessions in mid-August.

Financial Management Services

In light of the recent administrative interpretation of the Department of Labor Rule as it relate to the Companionship Rule and Live in Domestic Worker rule, the State has decided not to

continue to pursue change to the FMS model at this time. The FMS Workgroup and other stakeholders will be reviewing the potential impact of the DOL on the HCBS programs and find alternative solutions for sleep time support and managing overtime and travel requirements expected under the new interpretation of the DOL Final Rule. The state will exploring possible solutions for the rural and frontier areas of Kansas that will be impacted by the proposed rule and potential change to the Medicaid waivers.

Ongoing MLTSS Activities

As part of ongoing program integrity and development the KDADS HCBS staff continues to listen to consumer and provider input and participates in the following workgroups and steering committees to ensure consistency, quality assurance, program integrity, and program improvements including but not limited to:

- Autism Steering Committee
- FMS Workgroup
- CDDO Business Meeting
- Statewide Funding Committee
- Statewide Oversight Committee
- MCO Technical Assistance Teams
- Technology Assisted Workgroup
- MFP Steering Committee
- MCO Technical Assistance
- HCBS Provider Forum (monthly)
- Friends and Family Advisory Council
- Employment First Committee
- Shared Living Workgroup
- MFP Advisory Council

CMS 372 Submission Activities

CMS 372 reports have been submitted for the Autism, Technology Assisted (TA), Frail Elderly (FE) programs and Serious Emotional Disturbance (SED) were submitted to CMS on June 13, 2014. KDADS is corresponding with CMS regional office staff to clarify answers to the submitted questions. In the third quarter, KDADS will respond to follow-up questions from CMS on these reports and submit responses according to established timelines.

l. *Legislative activity:* The Robert G. Bethell Home & Community Based Services and KanCare Oversight Committee, a statutory joint committee, met once during the second quarter to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The committee received reports from KDHE, KDADS, and the Ombudsman's office and took comments from stakeholders, including providers and beneficiaries. The committee also heard reports from each KanCare managed care organization

and testimony from the Kansas Insurance Department.

The Legislature wrapped up their 2014 session on Saturday, May 3, 2014. The information below outlines the key pieces of legislation that impacted the Medicaid program and were signed into law by Governor Brownback.

Adult Home Care Licensure Act and Operator Registration bills—HB 2418, the Adult Care Home Licensure Act, was a clean-up bill that removed outdated rules and regulation references. HB 2717 created a registry for operators of assisted living, residential health care, home plus or adult day care facilities. The contents of HB 2717 were added to HB 2418 and both policy pieces passed unanimously in both the House and Senate.

ERO Trailer Bill—This amended legislation, which made name and substantive changes regarding the Kansas Department for Children and Families, the Kansas Department for Health and Environment, and the Kansas Department for Aging and Disabilities Services consistent with E.R.O. 41, was put into HB 2515, a conference report which passed both the House and Senate unanimously. The conference report contains updated language reflecting needed changes since the legislation was originally drafted.

Autism Insurance Coverage legislation—HB 2744 required insurance companies to provide coverage for autism spectrum disorder and would require additional licensure of persons providing applied behavior analysis.

Managed Care Organization (MCO) Prompt Pay Legislation—HB 2552 required the KanCare MCO's pay providers within a certain time period or the MCOs have to pay interest on the outstanding payments. An amendment was also added to this legislation that requires legislative approval of Medicaid expansion.

In the second quarter, the Governor announced that he would offer an amendment to the budget to utilize $5 million from the money derived from KanCare savings to be spent as follows:

Intellectual/Developmental Disability (I/DD) Waiver--$2.66 million will go toward reducing the IDD waiting lists. $1.33 million will go towards eliminating the "underserved" list, and $1.33 million will go towards reducing the "unserved" waiting list and allow Kansas to add 77 individuals to the IDD program.

Physically Disabled (PD) Waiver--$1.33 million will go towards reducing the PD waiting list and allow Kansas to add an additional 132 individuals to the PD program.

Behavioral Health Programs--$1.0 million will go towards behavioral health programs.

$500,000 will go towards Substance Use Disorder treatment beds and $500,000 will go towards programs that help reduce state hospital and jail usage.

V. Policy Developments/Issues

a. **General Policy Changes**

Kansas addressed policy concerns related to managed care organizations and state requirements through the weekly KanCare Policy Committee, the biweekly KanCare Steering Committee and the monthly joint and one-on-one meetings between KDHE, KDADS and MCO leadership. Policy changes are also communicated to MCOs through other scheduled and ad hoc meetings as necessary to ensure leadership and program staff are aware of the changes. All policies affecting the operation of the Kansas Medicaid program and MMIS are addressed through a defined and well-developed process that is inclusive (obtaining input from and receiving review by use 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. Limited policy changes were made during the second quarter.

b. **HCBS Quality Assurance Protocols**

CMS approved amendments to the 1915(c) waivers to incorporate new quality assurance performance measures consistent with recent CMS guidance. The HCBS Quality Measures protocols were revised and the data systems were updated to ensure the collection and availability of meaningful and reliable quality assurance data for all HCBS Quality Measures. Data collection under the new quality assurance measures will begin in the third quarter. Changes to the quality assurance performance measures will be incorporated in Attachment J.

c. **Targeted Case Management**

Policy changes were implemented for targeted case management during the implementation of IDD long-term supports and services into KanCare. In response, Kansas created a subcommittee of targeted case managers to review the impact of the new billing policy and submit recommendations to the KDADs Secretary for consideration. The subcommittee began meeting in the second quarter and submitted proposed changes that will be reviewed in the third quarter. Additionally, a subcommittee was created to develop an updated Needs Assessment and Person Centered Support Plan. This subcommittee will continue its work into the third quarter.

d. **Positive Behavior Supports**

Kansas included positive behavior supports services in KanCare on January 1, 2014, and worked during the first quarter of 2014 to develop policy changes to improve billing practices. KDADS and KDHE are reviewing the program definitions and policies to determine if additional changes are needed to improve access to, use of, and appropriate billing for positive behavior supports under the State Plan. Ongoing work continues on the Positive Behavior Supports policy.

Although independently contracted and credentialed providers were able to begin billing for PBS on April 1, 2014, billing for the service has not yet occurred. It is anticipated the PBS policy will contain clarification that will encourage providers to begin providing and billing for this service

e. **Home Based Family Therapy**

Policy changes are being developed to clarify identified client and per session billing requirements for Home Based Family Therapy. The draft policy also includes an expectation for practitioners who bill for Home Based Family Therapy to begin working with Kansas State University to maintain fidelity requirements for this service.

f. **Shared Living and IDD Residential Licensing**

The limitations of shared living are being reviewed and addressed by the newly created the Shared Living Workgroup and the Quality Assurance (QA) and Program Integrity Control Unit (PICU) teams. The subcontracting of residential licenses was presented in the April provider information sessions and most of the attendees were surprised about the fact that Shared Living (often referred to as "Host Homes" in Kansas) are not independently defined or recognized in Kansas. Under managed care, Kansas now has many IDD consumers requesting host homes with Sunflower at the forefront of encouraging this model. Although Kansas does not oppose this model and see it as an alternative setting, Kansas currently does not have regulation or policy guiding these settings. KDADS is reviewing shared living, so the State can establish clear guidelines and improving quality assurance and monitoring.

Some providers encouraged oversight but recommended not licensing them as an individual licensee, but keep these homes under the licensee, so the licensee is responsible with quality in place and the licensee must notify the state prior to anyone moving into this type of residential setting. The Shared Living Workgroup will meet biweekly through the summer to review the Shared Living Models in Kansas and propose recommendations for creating a permanent model that can be implemented by January 1st as a permanent community option.

g. **Personal Attendant Services and Department of Labor Rule**

Under current law (29 CFR 522.109), DSWs serving self-directing Medicaid Waiver clients are exempt from minimum wages and overtime compensation. This is because one of two exemptions usually apply to Medicaid Waivers:

1. Companionship rule
2. Live-in domestic services rule

As of January 1, 2015, the companionship rule and live-in domestic services rule will only apply to a DSW who is the sole employee of a person or family member of a person. If a DSW is employed by an governmental agency, non-profit organization, or a for profit organization the old exemptions and rules will not apply. Moreover, if a DSW has more than one employer (joint-

employment arrangement as determined by the DOL), the exemptions will not apply and the DSW will be eligible for the minimum wage and overtime benefits.

Primary Issue

Since the primary issue is determining a DSW's employment status under the self-directing model adopted by KanCare, Kansas will seek clarification from the DOL to determine if the DSW is the employee of KDADS or an MCO through a contracted FMS provider. It also appears that the DOL will combine hours worked for more than one client and treat them as if they were part of the same employment enterprise. In other words, if KDADS, an FMS provider, or an MCO was determined to be a sole or joint-employer, hours worked for all clients would be combined. If a DSW worked 20 hours for client A, 10 hours for client B, and 15 hours for client C every week, the DSW would be eligible for 5 hours of overtime compensation every week.

Secondary Issue

Additionally, due to the potential for a state to be a joint-employer with more than one self-directed participant, Kansas may now be required to track travel time between beneficiaries and reimburse workers for that time. Similarly, a worker that provides services across more than beneficiary may require overtime pay, even if none of the individuals used enough hours to require overtime payment on their own. As CMS notes, these additional expenses would not be linked to any one individual, so it would be challenging, and potentially inappropriate, to allocate those expenses in an individual's budget. Kansas will review the CMS guidance to identify some options for ensuring that FLSA requirements are met in situations where expenses are not linked to a single beneficiary.

To address the wage an hour rules related to personal attendant services and sleep cycle support, KDADS will be working closely with stakeholders, national organizations, consumers, and others as well as developing a working plan with the MCOs and KDHE to address the unintended consequences of the administrative interpretations from the DOL. Changes to these supports and services will be included in appropriate renewals and amendments by September 30, 2014.

h. **Client Obligation Exclusion Policy**

During the second quarter, questions related to client obligation were reviewed and addressed. As a result, KDADS drafted policy language to exclude certain services from client obligation being applied and ensure it is first applied to the highest costs services. Additionally a policy was draft related to non-payment of client obligation by a consumer and the appropriate procedural steps for notifying a consumer of the termination of services for failing to pay client obligation. These policies will be reviewed and finalized in the third quarter.

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. For the quarter ending June 2014 (DY2-Q2), the State removed the April payment amount/enrollment for March and input the July payment amount/enrollment for June. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. That budget neutrality monitoring spreadsheet for QE 6.30.14 is attached.

Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included. KDHE collected payment data for long-term services and supports and targeted case management for members on the I/DD HCBS waiver, services which were carved out from managed care through January 31, 2014, but required to be included in Budget Neutrality reporting.

General reporting issues: The second demonstration year has brought additional challenges to reporting. (Reports for both DY1 and DY2 are now needed and the fiscal agent needs to identify which DY the expenditure is charged to.) KDHE continues to work with HP, the fiscal agent, to modify reports as needed in order to have all data required in an appropriate format for efficient Section 1115 demonstration reporting. KDHE communicates with the other Medicaid agencies regarding any needed changes.

VII. Member Month Reporting

Sum of Member Unduplicated Count	**Member Month**			**Totals**
MEG	*2014-04*	*2014-05*	*2014-06*	*Grand Total*
Population 1: ABD/SD Dual	18,204	18,181	18,148	54,533
Population 2: ABD/SD Non Dual	29,538	29,470	29,308	88,316
Population 3: Adults	39,354	39,369	39,390	118,113
Population 4: Children	226,133	226,639	225,586	678,358
Population 5: DD Waiver	8,755	8,730	8,720	26,205
Population 6: LTC	21,517	21,439	21,331	64,287
Population 7: MN Dual	1,283	1,288	1,232	3,803

Population 8: MN Non Dual	1,153	1,172	1,130	3,455
Population 9: Waiver	4,189	4,167	4,128	12,484
Grand Total	**350,126**	**350,455**	**348,973**	**1,049,554**

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

VIII. Consumer Issues

Summary of consumer issues during the second quarter of 2014:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCO's work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member claims denied incorrectly due to Third Party Liability (TPL). Claims are denied for EOB's when none are required.	MCO's continue to have difficulties bypassing TPL editing for procedures known to never be covered by common TPL carriers (like Medicare).	All plans have system correction projects under way and reprocessing projects will follow. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor.
Retroactive member eligibility and prior authorizations.	Members granted retroactive eligibility due to eligibility assignment errors, have authorizations and claims denied for timely filing.	MCOs should waive timely filing limits for retroactively assigned beneficiaries, noting the late eligibility assignment date. Two system change orders have been written to assist the plans in identifying the retro assigned members and thus reduce the denial errors.
Member client obligation or patient liability incorrect.	Global system project completed in late February, which fixed a large portion of the issues. Weekly spreadsheets were sent to the state, showing MCO remediation efforts until the main issue was corrected in April and May.	All plans completed system correction projects and reprocessing projects during the second quarter.

Continued eligibility confirmation gaps causing denial of services for members, particularly at pharmacies.	When referred to the State, eligibility was confirmed and the medication dispensed. Eligibility issues can either be a system file load problem or an issue with an individual record, so it is time-consuming to perform root cause analysis on each situation.	Simultaneous to the State referral, the member information is sent to the MCO. They will correct their file information so the situation should not occur again for this member. Systematically, eligibility load times are still an issue, but still showing improvement. The plans are continually monitored by the State for progress.

In addition, related to consumer issues and supports: Continued additional outreach was completed by KDHE's out-stationed workers (OSWs) during the second quarter of 2014. OSWs completed 117 community outreach events, which include community partner meetings, Health Fairs, pregnant women parenting meetings, WIC clinics, etc. During these events, OSWs shared information on new MAGI eligibility requirements, on line application processes, gathered new applications, and assisted consumers with questions or problems with their KanCare services. OSWs completed training and implemented new eligibility policies and for KEES computer implementation. OSW's processed 527 applications for KanCare during this 3 month time period.

IX. Quality Assurance/Monitoring Activity

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

These sources of information guide the ongoing review of and updates to the KanCare QIS: Results of KanCare managed care organization (MCO) and state reporting, quality monitoring and other KanCare contract requirements; external quality review findings and reports; the state's onsite review results; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and the IMT's review of and feedback regarding the overall KanCare quality plan. This combined information assists the IMT and the MCOs to identify and

recommend quality initiatives and metrics of importance to the Kansas Medicaid population.

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, it will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use. This comprehensive strategy was updated with additional operational details, and the MCO QAPIs for 2013 were finalized and approved in June 2013.

The State values a collaborative, race-to-the-top approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalize; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process has been completed (and as it recurs over time), as determined by the State of Kansas, the final details as to each measure will be communicated and will be binding upon each MCO. These operational adjustments and updates will not require contract amendments, but will be documented as part of the quality strategy or in related operational guidelines and will be binding upon and put into place by each MCO.

During the second quarter of 2014, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to continue to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program, with extensive work on finalizing the operational details of measures for the year two P4P measures which will be validated by the state's EQRO, including integration of care, healthy life expectancy and nursing facility-related measures. Additional focus areas this quarter included work sessions to operationalize the new HCBS measures and related reporting, as well as initiation of a cross-agency work plan to complete the STC-required amendments to the KanCare Comprehensive Quality Strategy. Within the mandated 90 day timeline following CMS approval of udpates to the 1915(c) waivers, which made required technical changes to performance measures and also standardized measures across all of the Kansas HCBS waivers, and also reviewing other measures for updates and additional details, the state will obtain stakeholder input, provide public notice, and submit the amendment quality strategy to CMS.

- 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 receipt, distribution, review and feedback regarding submitted reports.
- Implementation and monitoring of the EQRO work plan for 2014, with the associated deliverables detail. One of the business meetings with the MCOs each month is dedicated to discussing EQRO activities, MCO requirements related to those activities, and timeline/action items to move all EQRO deliverables and related MCO deliverables along apace with good mutual understanding and clarity.
- Work continued during the second quarter of 2014 on the comprehensive annual compliance reviews of the MCOs – which were done in partnership between Kansas' External Quality Review Organization and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. Those annual reviews, which address both MCO regulatory requirements and many key state contract requirements, began in the fourth quarter of 2013, onsite components were completed in first quarter of 2014, and reporting has started and is slated to be completed in the third quarter.
- Bi-weekly Technical Assistance calls with the MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These calls allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS.
- Facilitation of provider and MCO training to address implementation and programmatic questions for the integration of IDD long-term supports and services into KanCare.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings a few complex cases for State review and consideration, and the State provides critical technical assistance and insight into program policies, integration, and other alternatives to meet an individuals' needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- OIG/Program Integrity monthly meetings to build a system of identifying, investigating, and preventing fraud, waste, abuse through interagency and managed care cooperation.
- Continued participation in the long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.

X. Managed Care Reporting Requirements

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

Each MCO submits a monthly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and

extract data to respond to requests received from various stakeholders. In addition, each MCO submits monthly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:

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

Beginning in September 2013, an additional report was submitted to KanCare administration by each MCO that demonstrates participation of providers who perform I/DD waiver services.

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

KanCare Customer Service Report - Member

MCO January-June 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:16	1.46%	80,255
Sunflower	0:19	2.53%	92,970
United	0:17	1.48%	82,768

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:41	0.87%	38,510
Sunflower	0:26	1.53%	59,788
United	0:10	0.33%	36,479

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 second quarter of 2014:

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the second quarter of 2014. There were 474 contacts through these various means, 210 of which were related to an MCO issue.

2nd Qtr Contacts	
April	148
May	169
June	157
Total	**474**

MCO related	
Amerigroup	73
Sunflower	91
United Health	46
Total	**210**

The KanCare Ombudsman website (http://www.kancare.ks.gov/ombudsman.htm) has information regarding the Ombudsman contact information, resources for and information for applying for KanCare, contact information for the three managed care organizations, grievance process, appeal process and state fair hearing process, the three managed care company handbook links, and quarterly and annual reports by the Ombudsman.

Outreach

- Provided a vendor booth for the ARC Transition Expo at Free State High School in Lawrence, KS, April 9, 2014.
- Provided testimony to the Bob Bethell KanCare Oversight Committee regarding Ombudsman first quarter activities, April 29, 2014
- Attended the Employment First Summit and provided a vendor booth; April 30-May 1, 2014. Approximately 300 people in attendance from the Disability Community.
- Attended the Health Home Listening Session; Pittsburg, KS, June 5; 2014. Provided information about the Ombudsman's office.
- Attended Training on the Prevention of Elder Abuse, Neglect and Exploitation, Augusta, KS. June 4, 2014. Provided information about the Ombudsman's office.
- Gave presentation on KanCare Ombudsman to Money Follows the Person Steering Committee, Topeka, KS. June 10, 2014.
- Gave Quarterly Report to KanCare Advisory Committee, Topeka, KS. June 11, 2014.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during second quarter.
- Hosted the HCBS Lunch-and-Learn bi-weekly conference calls for all HCBS members, parents, guardians and other consumers. Calls addressed topics of interest from the HCBS team from Kansas Department on Aging and Disability Services (KDADS) and a question and answer time with a panel from the three Managed Care organizations.

Data

Current Data Info

Contact Method	AmeriGroup	Sunflower	United	none	Total
Email (901)	11	17	11	44	83
Face-to-Face Meeting	0	2	0	0	2
Letter	0	1	0	4	5
ONLINE	0	0	0	0	0
Other	0	0	0	0	0
Telephone	62	71	35	216	384
Total	**73**	**91**	**46**	**264**	**474**

Caller Type	AmeriGroup	Sunflower	United	none	Total
Consumer	56	72	31	188	347
MCO Employee	3	0	0	2	5
Other type	0	0	0	7	7
Provider	14	19	15	67	115
Total	**73**	**91**	**46**	**264**	**474**

There are 20 issue categories. The top six concerns for 2nd quarter are: Medicaid eligibility issues, durable medical equipment, billing issues, medical services, HCBS General Issues and Appeals/Grievances.

Issue Category	AmeriGroup	Sunflower	United	none	Total
Medicaid Eligibility Issues	3	1	1	68	73
Durable Medical Equipment	11	10	7	7	35
Billing	7	7	6	13	33
Medical Services	3	16	3	9	31
HCBS General Issues	4	5	3	13	25
Appeals / Grievances	3	12	4	4	22
Access to Providers (usually Medical)	6	0	4	6	16
Dental	5	5	0	5	15
Pharmacy	5	4	3	3	15
HCBS Eligibility issues	3	4	0	7	14
Nursing Facility Issues	0	0	0	12	12
Change MCO	3	5	2	1	11
HCBS Reduction in hours of service	2	3	3	3	11
Care Coordinator Issues	0	6	2	1	9
HCBS Waiting List	1	3	1	3	8

Housing Issues	2	0	1	5	8
Transportation	3	2	2	1	8
Questions for Conference Calls/Sessions	0	0	0	5	5
Guardianship	0	2	0	1	3
Other	10	6	4	55	75
Thank you.	0	0	0	1	1
Unspecified	2	2	0	40	44
Total	**73**	**93**	**46**	**263**	**474**

In comparing issue categories, last quarter to this quarter, four of the top five remain the same (in order by second-quarter priority): durable medical equipment, billing, HCBS general issues, appeal/grievances.

Issue Category	Q1	Q2
Durable Medical Equipment	25	35
Billing	51	33
Medical Services		31
HCBS General Issues	55	25
Appeals / Grievances	22	22
Pharmacy	38	

Data Enhancements

The new tracker was put in place June 30th. Starting third quarter, the additional reporting data will include the following:

- Waiver Related Type (if applicable)
  - Physical Disability
  - Intellectual/Developmental Disability
  - Frail Elderly
  - Autism
  - Severe Emotional Disability
  - Traumatic Brain Injury
  - Technical Assistance
  - Money Follows the Person
  - PACE
  - Mental Health
  - Behavior Health
  - Nursing Facility
- Consumer type (if applicable)
  - HCBS related

    - LTC related
    - Other
- Resource Category
    - Question/issue resolved
    - Used Resources/issue resolved
    - KDHE resources
    - DCF resources
    - MCO resources
    - HCBS team
    - CSP MH team
    - Other KDADS resources
    - Provided resources to member
    - Referred to state/community agency
    - Referred to DRC and/or KLS

These enhancements will facilitate a more meaningful analysis of the issues going forward.

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

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Total # Received	**389**	**333**			
Total # Reviewed	**208**	**174**			
Total # Pending Resolution	**127**	**131**			
APS Substantiations*	**95**	**94**			

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

In addition, during the first quarter of 2014, KDHE established the Cross-Agency Adverse Incident Management Team, including representatives from KDHE (the single state Medicaid agency), KDADS (the state operating agency for disability and behavioral health services) and DCF (Department for Children and Families, where adult and child protective services are managed), and from all three KanCare MCOs. Work by that team continued thorough the second quarter. The charter and expected outcomes of the team are as follows:

Charter:

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

Expected Outcomes:

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The HCAIP Pool first quarter payments were processed in conjunction with the second quarter payments on May 9, 2014. The second quarter LPTH/BCCH Pool payments were processed on May 9, 2014. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to the second quarter.

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

XII. Demonstration Evaluation

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

For the 2nd quarter of 2014, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (IDD MLTSS Integration; IDD Billing and Claims; Money Follows the Person; Request for Additional Services List; and Claims Adjudication Statistics)

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

Beginning on February 1, 2014, HCBS services and targeted case management for individuals in the Kansas IDD waiver program were integrated into KanCare following a one month delay in implementation. There are approximately 8,700 individuals on Kansas' IDD waiver who were affected by this change. The continuity of care period runs until July 31, 2014, however, the majority of the individuals served on the IDD program has been assessed and have an Integrated Service Plan (ISP) developed to meet their needs. All individuals on the IDD program are expected to have a completed ISP and visit with their Care Coordinator.

Lunch and Learn Teleconferences

KDADs continued to host the IDD Provider Lunch and Learn sessions during the second quarter to provide consumers, self-advocates, providers, and stakeholders with an open forum for information, discussions, questions, and answers with the managed care organizations and the State. This format continued, however, the calls were decreased to bi-weekly calls and opened up to all HCBS consumers and providers. This created increased access to the MCOs and the State and developed a forum to provide information and educate the public.

Summary of Stakeholder Engagement and Communication

- Public Information Sessions (April)
- TCM Bi-weekly Conference Calls with State MCOs

- CDDO Bi-weekly Conference Calls with State and MCOs (as requested)
- IDD Provider Bulletins (bi-weekly)
- HCBS Transition Plan information sessions
- Lunch and Learn Calls
  - Consumer calls are held bi-weekly at noon on Wednesdays
  - Provider calls are held bi-weekly at 11:00 on Mondays

b. IDD Billing and Claims Issues

IDD Claim/Payment Status (data from February 1 – June 30, 2014)

HCBS/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	132,324	213,892	148,071	494,287
HCBS/IDD Claims Lines in Process/Pending	9,074	967	6,116	16,157
HCBS/IDD Claims Lines Paid	128,718	208,775	138,948	476,441
HCBS/IDD Claims Lines Denied	3,917	4,150	3,007	11,074
HCBS/IDD Billed Amount	$37,687,039	$63,950,540	$28,755,347	$130,392,926
HCBS/IDD Amount in Process/Pending	$2,068,817	$550,998	$1,719,724	$4,339,539
HCBS/IDD Amount Paid	$36,107,644	$60,899,030	$25,831,483	$122,838,157
HCBS/IDD Amount Denied	$1,254,586	$1,381,987	$1,204,140	$3,840,713

TCM/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	15,662	20,144	9,126	44,932
HCBS/IDD Claims Lines in Process/Pending	596	342	477	1,415
HCBS/IDD Claims Lines Paid	14,599	19,592	8,386	42,577
HCBS/IDD Claims Lines Denied	830	210	263	1303
HCBS/IDD Billed Amount	$1,430,059	$2,171,726	$1,091,686	$4,693,471
HCBS/IDD Amount in Process/Pending	$68,754	$33,612	$48,344	$150,711
HCBS/IDD Amount Paid	$1,314,795	$2,104,366	$1,014,571	$4,433,733
HCBS/IDD Amount Denied	$48,138	$32,240	$28,770	$109,148

Denial of Claims – Top Reasons

Top HCBS/TCM Denial Reasons	Amerigroup	Sunflower	United	Total
1. Non-covered service/item	36	5	43	84
2. Service not authorized	211	0	9	220
3. Service limit exceeded without PA	0	1739	151	1890
4. Member not eligible	18	1	124	143
5. Provider not contracted for service	17	0	12	29

6. Duplicate Claim	3,077	2,445	1,727	7,249
7. Error in billing (procedure code, NPI, etc.)	123	53	763	939
8. Date of service not covered	0	0	0	0
9. Exceeds filing time limit	51	0	0	51
10. Claim and PA not matching	0	0	46	46
11. Denial required from primary insurance	36	0	116	152
12. Other	1136	117	279	1532

Turnaround Times

HCBS/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	4.7	5.0	7.0	5.3
HCBS/IDD Average Days Age All Claims	4.7	5.0	7.0	5.3

TCM/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	5.2	5.0	7.0	5.5
HCBS/IDD Average Days Age All Claims	5.2	5.0	7.0	5.5
*This is a weighted average based on the portion of MCO claims.				

Early Billing and Claims Issues

Issues resolved during the second quarter include:

- Missing/Duplicate Authorizations:
- Third Party Liability (TPL)
- Client Obligation:

Missing/Duplicate Authorizations

In the second quarter, First Data, the Electronic Visit Verification (EVV) contractor, worked with FMS providers who identified duplicate authorizations in the system. The issue arose when AuthentiCare®, the EVV system, authorizations completed by MMIS Plan of Care approvals without the March 31, 2014 end date overlapped with authorizations submitted by MCOs. This created duplicate authorizations in AuthentiCare® for a number of providers. Claims confirmed by providers in AuthentiCare® "pend" against the first authorization received. Duplicate authorizations do not generally create a payment issue for providers unless the second and all subsequent authorizations for the same dates of service have a different number of units than is captured on the first authorization received. I

First Data staff worked closely with the MCOs on behalf of the provider to verify and correct authorizations because providers do not have access to delete duplicate authorizations. First

Data staff found a solution to delete future duplicate authorizations, but they could not delete authorizations that have had a claim "pended" against them.

The natural workflow for provider-confirmed claims is that they export from AuthentiCare® Kansas to HP, who then forwards claims to the applicable MCO. Though the authorizations created by MMIS Plans of Care do have KMAP as payer, the provider-confirmed claims still follow the natural workflow of export to HP who then forwards those claims to the applicable MCO for adjudication. KDADS and First Data deployed a permanent solution and in June the minimized duplicate authorizations and continued to work with providers individually to clean up any future authorizations that could cause a concern.

The follow-up of First Data, the State, the State's fiscal agency, and the three MCOs, in implementation of KanCare for I/DD consumers on February 1, 2014, required efficient project administration and effective communication among the partners. That partnership continues to provide support of one another as well as support for providers of HCBS waiver services to KanCare members. Of primary importance are accurate claims, backed by timely and correct service authorizations, which can be monitored on many levels to assure the integrity of service delivery. The EVV contractor has moved forward this quarter with enhancements to the solution proposed by MCOs and providers, approved by the State last quarter, to be implemented in the third quarter of 2014.

Summary of Improvements Related to Third Party Liability

KDHE is currently reaching out to insurance carriers in an attempt to secure blanket denials for service codes in order to assist providers in submitting claims with TPL involved. Efforts have been successful in obtaining some blanket denials, but the State has not obtained blanket denials from all carriers. Another avenue for obtaining blanket denials is through providers themselves. KDHE asked providers with a blanket denial from a carrier for service(s), to share the information with the State so could be shared with other providers. In order for the state to publish the denials for all providers to use, they must be blanket denials and not client-specific. That is, the letter from the carrier must state that it does cover the code(s) under any circumstances. A denial from the carrier that references a specific beneficiary or an EOB denial does not meet the criteria for a blanket denial. Blanket denials are submitted to KDHE via fax at (785) 296-4813 or via email.

Additionally the State has been working with First Data, the contractor for the electronic visit verification system known as AuthentiCare®, to develop enhancements to the system to improve third party liability by allowing providers to attach it to the system. Additionally, the MCOs worked to improve the third party liability issues for all of the HCBS programs. Enhancements to Amerigroup's system should be available early in the third quarter..

Summary of Improvements Related to Client Obligation Issues

During the first quarter, providers identified concerns that client obligation had not been taken

out consistently or applied to appropriate providers. During the second quarter, the state continued to work with and monitor MCO performance, and each MCO developed strategies to address these related issues:

- Accurate and timely member/provider notification of client obligation or any change in obligation amount.
- Accurate system processes to ensure neither too much nor too little deductions occur.
- Completion of provider training related to client obligation processes, and identification of contact persons to specifically resolve client obligation concerns.
- Ongoing MCO staff training related to accurate treatment of client obligation issues and resolution of related concerns.
- Reconciliation of overpayments and processes for providers to submit refunds/returns of overpayments.

c. Money Follows the Person

Kansas's Money Follows the Person (MFP), five year demonstration grant, serves four HCBS populations: the Frail Elderly (FE), the Physically Disabled (PD), the Traumatic Brain Injured (TBI), and the Intellectually/Developmentally Disabled (I/DD). During the first quarter of calendar year 2014, 33 individuals were transferred from institutions by the MCOs and during the second quarter 48 individuals transitioned. A new quality management specialist for SE Kansas was hired in January 2014. To increase the number of transitions from qualifying institutions to home and community based settings for individuals who would qualify for an HCBS program, the MCOs have identified single contacts for all MFP transitions and contracted with local independent living centers to provide transition coordination. Kansas is taking additional steps to improve the transition of individuals from qualifying institutions to ensure the program meets its goals and objectives. MFP is expected to meet its objectives to move individuals from qualifying institutions and shift them from Medicaid's traditional emphasis on institutional care to a system offering greater choices that include HCBS waiver services offered in a community setting.

In April of 2014, Kansas submitted an Action Plan (for increasing the number of transitions) because we did not meet our transition goals for CY 2013. Our goal was 182 transitions. Actual transitions for CY 2013 were 110. The Action Plan identifies the following barriers to increasing transitions: 1) Tracking Methodology; 2) MFP Enrollment for the Frail Elderly population; 3) MCO Education and Investment; 4) Outreach; and 5) Staff Capacity. Since the Action Plan was submitted, KDADS has:

1. Conducted a comprehensive review of the two primary data systems (MMIS and monthly reports) to reconcile discrepancies and identify areas for improvement;
2. Encouraged MCOs to utilize the MFP program for transitioning frail elderly nursing facility residents to community settings;
3. Established regular meetings with the MCO to focus on transitions from institutions and met with the MCO/MFP representatives to review MFP policies/procedures and discuss strategies for increasing MFP transitions; and
4. Solicited assistance from KDADS's quality field staff to reach and educate nursing

facilities on the advantages of the MFP program and solicit referrals.

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

d. Request for Additional Services List (RASL)

On January 31, 2014, KDADS sent a letter to all HCBS-IDD program participants who are currently receiving HCBS services and have asked for additional services in the past. The MCOs are working with the Targeted Case Managers to assess all individuals on the "underserved" list (1740) and ensure all needs are identified and appropriate supports and services are provided. . Out of the 1740 individuals on the RASL, KDADS has received 1132 forms received; however, by the end of the second quarter more than 1,500 individuals had been assessed. Less than 25% of the individuals on the RASL responded that they needed services in 30 days. Additional services were identified and added to the Integrated Service Plan. MCOs worked with CDDOs to address capacity concerns and ensure services

e. Claims Adjudication Statistics

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

XIV. Enclosures/Attachments

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

Section XI refers to the Safety Net Care Pool Reports, which detail sources of funding for pool payments applicable to this quarter, per STC 67(b). Those reports are attached.

Section XII refers to the KFMC's 2nd Quarter 2014 KanCare Evaluation Quarterly Report related to the assessment of KanCare performance measures reported quarterly. That report is attached.

Section XIII(e) refers to KDHE's Summary of KanCare MCO Claims Adjudication Statistics – QE 6.30.14, and that summary is attached.

XV. State Contact

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Division of Health Care Finance
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XVI. Date Submitted to CMS

August 29, 2014

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

Quarter 2
Start Date: 4/1/2014
End Date: 6/30/2014

	Total Expenditures	Total Member-Months
Apr-14	211,697,022.77	357,343
May-14	214,846,073.69	357,700
Jun-14	218,590,630.36	358,408
PCP	(3,994,116.70)	
Q2 Total	641,139,610.12	1,073,451

	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
Apr-14									
Expenditures	3,349,622.72	32,664,944.47	20,373,320.53	46,811,601.28	33,908,450.11	60,116,529.60	1,345,342.95	2,225,138.10	10,902,073.01
Member-Months	18,626	30,766	40,881	228,310	9,359	22,098	1,452	1,412	4,439
May-14									
Expenditures	3,380,448.17	32,407,174.33	22,672,568.82	46,945,898.84	34,638,969.80	60,015,348.49	1,490,932.10	2,393,119.36	10,901,613.78
Member-Months	18,977	30,823	41,214	227,969	9,058	22,359	1,488	1,476	4,336
Jun-14									
Expenditures	3,515,069.29	31,534,560.12	28,853,706.64	46,791,416.67	34,050,501.45	59,752,463.99	1,405,775.29	2,142,767.53	10,544,369.38
Member-Months	19,318	30,954	42,315	227,568	8,991	22,050	1,456	1,350	4,406
PCP									
Expenditures	(11,818.39)	(624,217.80)	(211,317.15)	(2,825,125.69)	(59,039.08)	(131,094.47)	(1,138.40)	(36,850.09)	(93,515.63)
Q2 Total									
Expenditures	10,233,321.79	95,982,461.12	71,688,278.84	137,723,791.10	102,538,882.28	179,753,247.61	4,240,911.94	6,724,174.90	32,254,540.54
Member-Months	56,921	92,543	124,410	683,847	27,408	66,507	4,396	4,238	13,181
DY 2 - Q2 PMPM	179.7811	1,037.1661	576.2260	201.3956	3,741.2027	2,702.7719	964.7206	1,586.6387	2,447.0481

Note:

1. For DY2 Member-Months include both current months members as well as retro assignments.
2. Q2 Pop 3, Adults - Expenditures higher due to an additional $2.4M in delivery payments. These payments are sporadic as they are dependent upon the submission of encounter data.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - QE June 2014

Health Care Access Improvement Pool

Paid 05-09-2014

Participating Hospitals	HCAIP DY/QTR: 2014/2	Provider Access Fund 2443	Federal Medicaid Fund 3414
Marillac Center INC	$ 1,907.00	$ 821.73	$ 1,085.27
Mt. Carmel Medical Center	$ 218,236.00	$ 94,037.89	$ 124,198.11
St. John Hospital	$ 102,201.00	$ 44,038.41	$ 58,162.59
Mercy - Independence	$ 60,200.00	$ 25,940.18	$ 34,259.82
Salina Regional Health Center	$ 128,672.00	$ 55,444.76	$ 73,227.24
Hays Medical Center, Inc.	$ 313,378.00	$ 135,034.58	$ 178,343.42
Ransom Memorial Hospital	$ 86,279.00	$ 37,177.62	$ 49,101.38
St. Francis Health Center	$ 315,942.00	$ 136,139.41	$ 179,802.59
Susan B. Allen Memorial Hospital	$ 132,727.00	$ 57,192.06	$ 75,534.94
Hutchinson Hospital Corporation	$ 204,892.00	$ 88,287.96	$ 116,604.04
St. Catherine Hospital	$ 183,279.00	$ 78,974.92	$ 104,304.08
Pratt Regional Medical Center	$ 51,979.00	$ 22,397.75	$ 29,581.25
Sumner Regional Medical Center	$ 34,084.00	$ 14,686.80	$ 19,397.20
Olathe Medical Center	$ 300,858.00	$ 129,639.71	$ 171,218.29
Mercy Health Center - Ft. Scott	$ 95,683.00	$ 41,229.80	$ 54,453.20
Southwest Medical Center	$ 112,968.00	$ 48,677.91	$ 64,290.09
Geary Community Hospital	$ 132,386.00	$ 57,045.13	$ 75,340.87
Mercy Hospital, Inc.	$ 5,341.00	$ 2,301.44	$ 3,039.56
Stormont Vail Regional Health Center	$ 873,799.00	$ 376,519.99	$ 497,279.01
Coffey County Hospital	$ 11,460.00	$ 4,938.11	$ 6,521.89
Newton Medical Center	$ 192,431.00	$ 82,918.52	$ 109,512.48
Shawnee Mission Medical Center, Inc.	$ 616,117.00	$ 265,484.82	$ 350,632.18
Memorial Hospital, Inc.	$ 44,817.00	$ 19,311.65	$ 25,505.35
Miami County Medical Center	$ 67,245.00	$ 28,975.87	$ 38,269.13
Bob Wilson Memorial Hospital	$ 46,146.00	$ 19,884.31	$ 26,261.69
Labette County Medical Center	$ 72,833.00	$ 31,383.74	$ 41,449.26
Via Christi Regional Medical Center	$ 1,727,054.00	$ 744,187.57	$ 982,866.43
Wesley Medical Center	$ 1,178,379.00	$ 507,763.51	$ 670,615.49
Cushing Memorial Hospital	$ 106,293.00	$ 45,801.65	$ 60,491.35
Lawrence Memorial Hospital	$ 285,420.00	$ 122,987.48	$ 162,432.52
Mercy Reg Health Ctr	$ 133,915.00	$ 57,703.97	$ 76,211.03
Coffeyville Regional Medical Center, Inc.	$ 68,275.00	$ 29,419.70	$ 38,855.30
Providence Medical Center	$ 446,753.00	$ 192,505.87	$ 254,247.13
South Central KS Reg Medical Ctr	$ 46,073.00	$ 19,852.86	$ 26,220.14
Morton County Health System	$ 23,195.00	$ 9,994.73	$ 13,200.27
Western Plains Medical Complex	$ 141,655.00	$ 61,039.14	$ 80,615.86
Overland Park Regional Medical Ctr.	$ 611,996.00	$ 263,709.08	$ 348,286.92
Menorah Medical Center	$ 156,072.00	$ 67,251.42	$ 88,820.58
Saint Luke's South Hospital, Inc.	$ 92,753.00	$ 39,967.27	$ 52,785.73

Participating Hospitals	HCAIP DY/QTR: 2014/2	Provider Access Fund 2443	Federal Medicaid Fund 3414
Salina Surgical Hospital	$ 2,929.00	$ 1,262.11	$ 1,666.89
Surgical & Diag. Ctr. of Great Bend	$ 150,738.00	$ 64,953.00	$ 85,785.00
Galichia Heart Hospital LLC	$ 79,677.00	$ 34,332.82	$ 45,344.18
Kansas Medical Center LLC	$ 75,092.00	$ 32,357.14	$ 42,734.86
Via Christi Hospital St Teresa	$ 103,783.00	$ 44,720.09	$ 59,062.91
SSH - Kansas City	$ 21,642.00	$ 9,325.54	$ 12,316.46
Kansas Rehabilitation Hospital	$ 1,589.00	$ 684.70	$ 904.30
Via Christi Rehabilitation Center	$ 54,123.00	$ 23,321.60	$ 30,801.40
Children's Mercy Hospital South	$ 183,833.00	$ 79,213.64	$ 104,619.36
Prairie View Inc.	$ 9,903.00	$ 4,267.20	$ 5,635.80
Total	$ 10,107,002.00	$ 4,355,107.16	$ 5,751,894.84

Demonstration Year 2 - QE June 2014

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

Paid 05-09-2014

Provider Name	LPTH/BCCH DY/QTR: 2014/2	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.00	1,073,386.55	1,417,647.45
University of Kansas Hospital	7,473,103.00	3,220,160.08*	4,252,942.92
Total	**9,964,137.00**	**4,293,546.63**	**5,670,590.37**

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

2014 KanCare Evaluation Quarterly Report

Year 2, CY2014, Quarter 2, April - June

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**August 20, 2014**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist** **Lynne Valdivia, RN, BSN, MSW, Vice President of Quality Improvement and Review** **Donna Garwood, RN, BSN, Review, Quality Review Project Manager** **Cissy McKinzie, CPM, Quality Review Coordinator**

Prepared for:

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2014 KanCare Evaluation Quarterly Report

Year 2, CY2014, Quarter 2, April - June

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2014 KanCare Evaluation Quarterly Report
Year 2, CY2014, Quarter 2, April - June
August 20, 2014

Background/Objectives

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

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the second quarter (Q2) CY2014 report include the following:

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

KanCare health care services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc., (Amerigroup), Sunflower State Health Plan

(Sunflower), and UnitedHealthcare Community Plan of Kansas (United). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

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

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

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

DATA SOURCES

Data sources for the Q2 CY2014 KanCare Quarterly Evaluation Report are monthly KanCare Key Management Activities Reports (KKMAR) and weekly call center reports newly implemented in CY2014. (Amerigroup titles the call center report as "Call Center Response Statistics Report"; United titles the report "Daily Call Center Report"; and Sunflower titles their weekly call center report as "Key Management Activities Report.")

In the quarterly KKMAR and weekly call center reports, MCOs report the quarterly or weekly and cumulative counts and percentages of member and provider inquiries resolved within 2, 5, 8, 15, and greater than 15 days, as well as the percentage of inquiries pending. The new weekly call center reports provide counts of customer service inquiries by members and providers by inquiry type.

In Table 1 below, the quarterly counts of member and provider customer service inquiries for Q1-Q4 of CY2013 were based on Pay for Performance (P4P) report data, and the quarterly counts for Q1 CY2014 were based on monthly data reported to KFMC by MCO program managers. Percentages reported in the KKMAR were then used to calculate the number of inquiries resolved and not resolved within 2, 5, and 15 business days. As indicated above, beginning in Q2 CY2014, the weekly call center reports are now the primary data source for reporting customer service inquiries.

CURRENT QUARTER AND TREND OVER TIME

As shown in Table 1, the number of customer service inquiries received by the MCOs has decreased significantly over time. In Q1 CY2013, the MCOs received a total of 261,286 inquiries; in Q1 CY2014, the MCOs received 141,964 inquiries, a 46% decrease over time. In Q2 CY2014, the MCOs received 133,570 customer service inquiries, a decrease of 5.9% since the previous quarter.

Table 1 - Timeliness of Resolution of Customer Service Inquiries						
	CY2013				CY2014	
	Q1	Q2	Q3	Q4	Q1	Q2
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964	**133,570**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907	**133,539**
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57	**27**
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%	**99.98%**
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951	**133,570**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13	**0**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%	**100%**
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964	**133,570**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%	**100%**

In Q2 CY2014, 99.98% of the customer service inquiries received by the MCOs were resolved within two business days. During each quarter to date, the two-day resolution rate exceeded 99.7%. In Q2 CY2014, the 27 inquiries not resolved within two business days were resolved within 5 business days. The 27 inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within two business days.

The weekly call center report categorizes customer service inquiries by 18 member types and by 17 provider types. (See Table 2.) For members, benefit inquiries were the highest percentage (21.8%) of the 79,582 calls received in Q2. The lowest percentage of calls (0.1%) was from members requesting assistance with scheduling an appointment. For providers, claim status inquiries were the highest percentage (34.1%) of the 53,988 provider calls, and the lowest were from providers requesting provider materials (0.1%).

Overall, the distribution of customer service inquiries was generally consistent among the three MCOs. One exception was the “update demographic information category” that comprised 12% of member inquiries and 11.4% of provider inquiries, principally due to inquiries of Sunflower members and providers. Sunflower reported 7,440 of the 9,526 member inquiries on “update demographic information” (19.8% of Sunflower’s member inquiries), and 6,156 of the 6,181 provider inquiries for update of demographic information (38.2% of Sunflower’s total number of provider inquiries).

CONCLUSIONS

The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within 2 to 5 business days in each quarter of CY2013 and CY2014 to date. The number of inquiries received has also decreased greatly over time. The newly implemented customer service reports provide detailed documentation of the numbers and types of member and provider customer service inquiries and calls received and responded to by each MCO call center. These reports are an improvement over the previous KKMAR reports that provided percentages of

inquiries resolved, but did not include the number and types of inquiries from members and providers.

Table 2 - Customer Service Inquiries by Member and Provider, Quarter 2, CY2014					
Member Inquiries	**#**	**%**	**Provider Inquiries**	**All**	**All %**
1. Benefit Inquiry – regular or VAS	17,373	21.8%	1. Authorization – New	2,149	4.0%
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2. Authorization – Status	3,649	6.8%
3. Care management or health plan program	2,248	2.8%	3. Benefits inquiry	5,071	9.4%
4. Claim or billing question	6,626	8.3%	4. Claim Denial Inquiry	4,843	9.0%
5. Coordination of benefits	1,494	1.9%	5. Claim Status Inquiry	18,401	34.1%
6. Disenrollment request	448	0.6%	6. Claim Payment Question/Dispute	6,829	12.6%
7. Eligibility inquiry	8,336	10.5%	7. Billing Inquiry	365	0.7%
8. Enrollment information	1,830	2.3%	8. Coordination of Benefit	1,012	1.9%
9. Find/change PCP	11,619	14.6%	9. Member Eligibility Inquiry	2,085	3.9%
10. Find a specialist	3,037	3.8%	10. Recoupment or Negative Balance	140	0.3%
11. Assistance with scheduling an appointment	89	0.1%	11. Pharmacy/Prescription Inquiry	505	0.9%
12. Need transportation	1,798	2.3%	12. Request Provider Materials	41	0.1%
13. Order ID card	6,406	8.0%	13. Update Demographic Information	6,181	11.4%
14. Question about letter or outbound call	1,003	1.3%	14. Verify/Change Participation Status	416	0.8%
15. Request member materials	1,197	1.5%	15. Web Support	508	0.9%
16. Update demographic information	9,526	12.0%	16. Credentialing Issues	285	0.5%
17. Member emergent or crisis call	900	1.1%	17. Other (including to provider services or provider representatives)	1,508	2.8%
18. Other	3,923	4.9%			
Total	**79,582**		**Total**	**53,988**	

RECOMMENDATIONS

- The current tracking system could be improved by including the number of unduplicated individual members and providers that have contacted the MCOs with customer service inquiries to better identify the scope of the customer service inquiries. It may be helpful to identify whether the customer service inquiries to date represent calls from most members or represent a much smaller fraction of members contacting the MCOs.
- Reports from MCOs should be compared to ensure MCOs are reporting data consistently. (One of the MCOs, for example, included abandoned calls in the reported count of "# of Calls Documented," while the other two MCOs reported only completed calls in this field.)

TIMELINESS OF CLAIMS PROCESSING

Timeliness of claims processing for claims processed in CY2013 was based on data in quarterly Pay for Performance (P4P) reports submitted by MCOs. P4P reports for

claims processing were discontinued in CY2014, as claims processing incentives were in place only in the first year of KanCare to assist in the initial implementation of the program. At least two MCO claims reports were added in Q1 CY2014 that track in great detail claim denials and adjusted claims. These reports, however, do not report timeliness of processing clean and non-clean claims within the contractual timelines of 30 days for clean claims, 60 days for non-clean claims, and 90 days for all claims.

Claims data in the CY2013 P4P reports had been reported differently by the MCOs and, as a result, could not be aggregated. The focus of the claims data was on the timeliness of claims *processed* each quarter rather than on the timeliness of processing claims *received* each quarter. KFMC recommended that timeliness of claims processing be reported instead based on the claims received each quarter. For example, of the number of claims the MCO received in June 2014, how many of these were processed within the contractual requirements of 30 days (if clean claims), within 60 days (if non-clean claims), and within 90 days for all claims?

To more clearly track timeliness of claims processing in CY2014, and as recommended in previous quarterly evaluation reports, the State has drafted, with interagency input, a report template currently being finalized that will provide much clearer and more detailed tracking of the timeliness of claims processing. This report will be implemented in October 2014, at which time the MCOs will report claims data beginning with claims received in January 2014.

As the revised report has not yet been implemented, timeliness of claims processing is limited in focus for this quarterly report and is based on claims data from the monthly Adjusted Claims Reports and the monthly Claims Processing Turnaround Time (TAT) Denied Claims by Category and Month Reports for January through June 2014. The focus in this quarterly report is on the turnaround time of processing clean claims. Processing timeliness of claims received by the MCOs beginning in January 2014 will be analyzed in the next KanCare Evaluation Quarterly Report.

DATA SOURCES

As indicated above, MCOs began reporting detailed claims data on two additional templates.

- In the monthly Adjusted Claims Reports, MCOs report the number of claims processed by service type, the total value of claims, the number of claims adjusted up and down, and the dollar amounts of the adjustments. Data is reported by hospital inpatient, hospital outpatient, pharmacy, dental, vision, transportation, medical, nursing facilities, HCBS, and behavioral health.
- In the monthly Claims Processing TAT Denied Claims by Category and Month Reporting, MCOs are reporting the number of claims submitted and the value of denied clean claims and all claims by the same categories as listed above in the Adjusted Claims Reports. The top ten denial reasons are also reported for these same categories, along with details on the number and dollar amounts.

CURRENT QUARTER AND TREND OVER TIME

As indicated in Table 3 below, the MCOs processed 3,630,971 claims in Q1 CY2014. In Q2 CY 2014, the MCOs processed 3,908,095 claims, over a 7% increase from Q1.

Table 3 also provides the average TAT for clean claims. 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."

It should be noted that the average TAT monthly ranges reported in Table 3 below only include clean claims processed by the MCOs in Q1 and Q2, and does not include clean claims that were not yet processed. The revised reporting template will provide counts of claims processed (or not processed) within the State's timeliness standards.

Table 3 - Number of All Claims Processed by Quarter by Service Category and Average Monthly Turnaround Time (TAT) Ranges for Clean Claims Processed

	Quarter 1		Quarter 2	
	Claims Processed	Average TAT Monthly Ranges for Clean Claims Processed	Claims Processed	Average TAT Monthly Ranges for Clean Claims Processed
Hospital Inpatient	28,634	6 to 18.6	27,015	5 to 19.2
Hospital Outpatient	228,450	3.6 to 12.8	250,956	3.6 to 11.8
Pharmacy	1,156,361	1	1,088,805	1
Dental	103,419	2 to 21	106,758	3 to 13
Vision	62,966	7 to 12.5	61,605	8 to 12.1
Non-Emergency Transportation	104,724	10.9 to 18	112,633	11.3 to 17
Medical (Physical health not otherwise specified)	1,314,470	3.6 to 10.6	1,451,647	3.3 to 9.8
Nursing Facilities	126,227	4.3 to 11.2	89,753	4.6 to 11.5
HCBS	300,085	3.7 to 15.6	342,996	3.2 to 14.2
Behavioral Health	355,493	3.4 to 8.6	375,927	3.5 to 8.2
Total	3,630,971	6 to 11.5	3,908,095	6 to 10.8

The average monthly TATs for processing clean claims for total monthly services were less than 1 to 2 weeks (6 to 11.5 days in Q1; 6 to 10.8 days in Q2). The average

turnaround time for processing clean claims for individual service types varied by service type and by MCO. Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs in Q1 and Q2. Clean claims for non-emergency transportation had longer turnaround times, with monthly TATs ranging from 10.9 to 18 days in Q1 and from 11.3 to 17 days in Q2.

CONCLUSIONS

With the input of agency staff, the EQRO, and interagency work groups, the State has drafted a revised claims report to better track timeliness of claims processing within the contractually required timelines. The revised claims template is anticipated to be finalized by September 2014 and implemented in October (for claims received by MCOs beginning in January 2014); it will provide clearer, more understandable reporting of timeliness of claims processing. In the revised report (as currently drafted), MCOs will report the number of clean claims received in the month and the number of those claims that were processed (and not processed) within 30 days; the number of non-clean claims received in the month, and the number of those claims that were processed (and not processed) within 60 days; and, the number of all claims received in the month, and the number of those claims that were processed (and not processed) within 90 days.

Monthly turnaround times for processing clean claims vary by service type, particularly when comparing the lowest and highest monthly average TATs by MCO. The monthly average TATs for processing clean claims for most services were generally less than 2 weeks. The average monthly TATs for processing clean claims for total monthly services were less than 1 to 2 weeks (6 to 11.5 days in Q1; 6 to 10.8 days in Q2).

RECOMMENDATIONS

- When the new reports tracking timeliness of claims processing are first implemented in October, quality review is recommended to ensure that all MCOs have clear understanding of data to be reported in each field and that data is reported in consistent ways by the three MCOs.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for services 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) reports track the number of grievances received in the quarter; the number of grievances closed in the quarter; the number of grievances resolved within 30 business days; and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of the grievances, including narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. Categories of the grievances received during the quarter are further summarized by count in a Reason Summary Chart in the report.

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11 grievance categories, and the GAR Reason Summary Table has 20 categories. (See Table 4.) Only three of the categories overlap clearly.

Table 4 - Comparison of Grievance Report Categories, Quarter 1 and Quarter 2, CY2014

	Reports		STC Report				GAR Report			
			Q1		Q2		Q1		Q2	
	STC	GAR	#	% of Total Received	#	% of Total Received	#	% of Total Received	#	% of Total Received
Transportation	√		226	45.4%	206	40.9%				
Claims/Billing Issues	√	√	106	21.3%	123	24.4%	125	25.1%	128	25.6%
Quality of Care or Service	√	√	44	8.8%	64	12.7%	48	9.6%	48	9.6%
Customer Service	√		38	7.6%	29	5.8%				
Access to Service or Care	√		24	4.8%	21	4.2%				
Health Plan Administration	√		20	4.0%	15	3.0%				
Benefit Denial or LImitation	√		13	2.6%	15	3.0%				
Service or Care Disruption	√		6	1.2%	16	3.2%				
Member Rights/Dignity	√		1	0.2%	8	1.6%				
Clinical/Utilization Management	√		0	0.0%	4	0.8%				
Other	√	√	20	4.0%	3	0.6%	26	5.2%	21	4.2%
Attitude/Service of Staff		√					106	21.3%	70	14.0%
Timeliness		√					85	17.1%	95	19.0%
Availability		√					80	16.1%	91	18.2%
Pharmacy		√					6	1.2%	13	2.6%
Lack of Information from Provider		√					4	0.8%	2	0.4%
Criteria Not Met - Medical Procedure		√					4	0.8%	4	0.8%
Criteria Not Met - Durable Medical Equipment		√					3	0.6%	4	0.8%
Prior or Post Authorization		√					3	0.6%	6	1.2%
Accessibility of Office		√					3	0.6%	9	1.8%
HCBS		√					2	0.4%	3	0.6%
Level of Care Dispute		√					2	0.4%	2	0.4%
Quality of Office, Building		√					1	0.2%	3	0.6%
Sleep Studies		√					0		1	0.2%
Criteria Not Met - Inpatient Admissions		√					0		0	
Sterilization		√					0		0	
Overpayments		√					0		0	
Total			498		504		498		500	

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

categories would assist the MCOs in categorizing grievances and improving consistency throughout the KanCare program. In Q3 KDHE will be providing training to MCOs that will include a focus on grievance resolution.

Transportation-related grievances are a good example of differences in categorization by each of the MCOs. Of the 204 total transportation-related grievances, 45% were categorized as "Timeliness" and 29% were categorized as "Availability." (See Table 5 below.) By MCO, however, Amerigroup categorized less than 9% of transportation-related grievances as "Timeliness" and 58% as "Availability"; United categorized 83.6% as "Timeliness" and 0% as "Availability"; and Sunflower categorized 40% as "Timeliness" and 32% as "Availability."

Table 5 - Transporation-Related Grievances by Category, Quarter 2, CY2014

	Amerigroup	Sunflower	United	Total
Timeliness	6	**25**	**61**	**92**
Availability	**40**	**20**	0	**60**
Attitude/Service of Staff	10	16	9	35
Quality of Care	6	0	2	8
Billing and Financial Issues	3	1	1	5
Accessibility of Office	1	0	0	1
Prior or Post Authorization	1	0	0	1
Quality of Office, Building	1	0	0	1
Other	1	0	0	1
Transportation-Related Total	**69**	**62**	**73**	**204**

KFMC found a few differences in data reported by the MCOs in the GAR and STC reports; these differences, however, were fewer and more minor than in previous quarters. Amerigroup, for example, reported in the GAR that they reviewed 168 grievances this quarter and resolved 178 grievances; they reported in one section of the GAR receiving 165 grievances this quarter, but in another section 164 grievances received. Sunflower reported in the GAR that 125 grievances were resolved, but in another section reported 123 closed in the quarter. United itemized 209 grievances in the STC report of 206 received; in reviewing the grievances detailed in the GAR, KFMC found the 206 grievances reported to have been reviewed and resolved in Q2 were actually 204 due to two exact duplicate grievances (member numbers entered as a text field in one grievance and as a numeric field in another).

It should also be noted that some grievance "resolutions," particularly those related to billing issues and transportation, involve repeated contacts to providers and vendors. Grievance resolution details in the GAR report indicated, for example, that several providers were contacted by the MCO multiple times regarding balance billing of members. United had 99 grievances in Q2 CY2014 related to balance billing, including 10 grievances related to balance billing by one medical center. As this is the second year of the KanCare program, it would seem that the number of providers who are balance billing members would be decreasing.

RECOMMENDATIONS

- Grievance categories within these reports should be more clearly defined. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of data within reports and between reports where applicable.
- Grievances related to balance billing of members should be reviewed to identify providers that have been contacted multiple times to identify patterns that may warrant additional communication to the providers to reduce future balance billing of members.

TRACK TIMELY RESOLUTION OF GRIEVANCES

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

DATA SOURCE

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

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

As shown in Table 5 below, 96.6% (490) of the 507 grievances closed in Q2 CY2014 were resolved within 30 business days; 98.6% (500) were resolved within 60 business days; and 1.4% (7) were not resolved within 60 business days. (Six of the seven grievances not resolved within 60 business days were reported by Amerigroup and one reported by United.)

The numbers of grievances received in the first two quarters of CY2014 were higher than the previous two quarters, but comparable to the number received in Q2 CY2013. The number of grievances closed by the MCOs each quarter has also increased. This is the first quarter since Q1 CY2013, however, where 100% of grievances were not resolved within 60 days. (Q1 CY2014 was the first quarter for 100% of grievances to not be resolved within 30 days.) In CY2013, resolution of grievances was a P4P measure; to receive incentive payments related to grievance resolution, MCOs needed to resolve 98% of grievances within 20 days and 100% of grievances within 40 days. (The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not equal the number of grievances "resolved" during the quarter.)

Table 6 - Timeliness of Resolution of Grievances						
	CY2013				CY2014	
	Q1	Q2	Q3	Q4	Q1	Q2
Number of Grievances Received in Quarter	445	496	422	423	498	**501***
Number of Grievances Closed in Quarter*	422	462	412	427	501	**507**
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	**490**
Percent of Grievances closed in Quarter Resolved Within 30 Business Days*	100%	100%	100%	100%	99.6%	**96.6%**
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	**500**
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days*	100%	100%	100%	100%	100%	**98.6%**
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	**7**

*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.

CONCLUSIONS

This is the first quarter since Q1 CY2013 where 100% of grievances were not resolved within 60 days. (Q1 CY2014 was the first quarter for 100% of grievances to not be resolved within 30 days.) The numbers of grievances received in the first two quarters of CY2014 were higher than the previous two quarters, but comparable to the number received in Q2 CY2013. The number of grievances closed by the MCOs each quarter has also increased.

RECOMMENDATIONS

- The State should continue to work with the MCOs to review grievances not resolved within 60 days to identify any preventable reasons for delay.
- Additional clarification and guidance should be provided as to how “resolved” is defined. Does “resolved” indicate that a final response has been provided for the member’s concern, or does “resolved” include situations where follow-up contacts to providers or vendors will still need to be made by the MCO?
- Reporting the number of individual members who have filed grievances in the quarter, as well as the number of individual providers and vendors related to the grievances, could also be of help in defining the scope of grievances received in the quarter.

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

DATA SOURCES

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

ALL GRIEVANCES

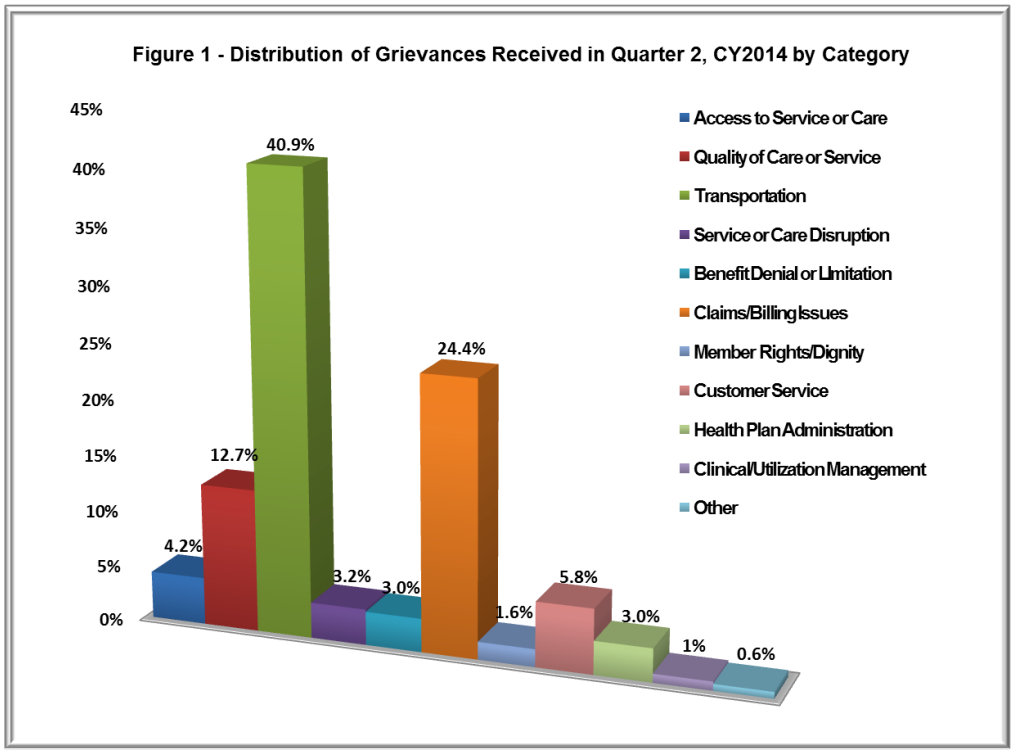
Table 7 summarizes the quarterly numbers and types of grievances to date for the aggregated MCO data. The number of grievances has increased slightly each quarter since Q2 CY2013. The grievance types that increased the most in Q2 were Claims/Billing Issues and Quality of Care or Service. The number of transportation-related grievances continues to be the most frequently reported, but there were twenty fewer transportation-related grievances than the previous quarter. As displayed in Figure 1, 40.9% of the grievances in Q2 were related to transportation.

Table 7 - Number of Grievances by Category

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

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

Table 8 - Percentage of Grievances by Category Within Each Quarter To Date						
	CY2013				CY2014	
	Q1	Q2	Q3	Q4	Q1	Q2
Total Grievances Received	450	511	399	420	498	504
	% of 450	% of 511	% of 399	% of 420	% of 498	% of 504
Transportation	60.2%	51.1%	45.9%	43.3%	45.4%	40.9%
Access to Service or Care	3.6%	2.5%	3.3%	6.4%	4.8%	4.2%
Quality of Care or Service	4.2%	6.7%	7.5%	13.3%	8.8%	12.7%
Claims/Billing Issues	7.8%	17.0%	12.0%	17.1%	21.3%	24.4%
Customer Service	11.6%	10.2%	8.5%	6.0%	7.6%	5.8%
Health Plan Administration	3.8%	6.1%	6.5%	6.4%	4.0%	3.0%
Benefit Denial or LImitation	3.6%	0.8%	1.8%	2.4%	2.6%	3.0%
Service or Care Disruption	0.7%	2.2%	4.0%	1.7%	1.2%	3.2%
Member Rights/Dignity	0.9%	1.0%	2.5%	1.4%	0.2%	1.6%
Clinical/Utilization Management	0.9%	2.0%	3.5%	1.2%	0.0%	0.8%
Other	2.9%	0.6%	4.5%	0.7%	4.0%	0.6%



Beginning in Q1 CY2014, KDHE added a field to the detailed grievances template in the GAR report for tracking the “type of waiver member (if applicable).” Table 9 below reports the types of grievances resolved in Q2 CY2014 and available information on waiver types. Of the 507 grievances resolved in Q2 CY2014, 143 (28.2%) were reported by members receiving waiver services. While over 40% (204) of the 507 grievances were transportation-related, over 53% (76) of the 143 grievances reported by members

receiving waiver services were transportation-related (41 PD, 18 FE, 9 TBI, 6 I/DD, and 2 SED).

Table 9 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 2, CY2014*

			Grievances by Waiver Type						
	Total - All Members	Waiver Members Subtotal	FE	I/DD	PD	SED	Autism	TA	TBI
Billing and Financial Issues	128	13	2	3	5	2		1	
Quality of Care or Service	56	9	3	2	3				1
Attitude/Service of Staff	74	28	6	1	15	1		1	4
Timeliness	95	26	6	2	16				2
Availability	93	41	8	3	21	3		1	5
Pharmacy	11	4		3	1				
Lack of Information from Provider	2	1		1					
Criteria Not Met - Medical Procedure	4	3		1					
Criteria Not Met - Durable Medical Equipment	3	1	1	2					
Prior or Post Authorization	5	1		1					
Accessibility of Office	9	3	1					1	1
HCBS	3	2	1	1					
Level of Care Dispute	2	1		1					
Quality of Office, Building	1	1			1				
Sleep Studies	1	0							
Other	20	9	2	1	1	3	1		1
Total	507	143	30	22	63	9	1	4	14

*Includes grievances received in Quarter 1, CY2014 that were resolved in Quarter 2, CY2014

ACCESS-RELATED GRIEVANCES

Of the 504 grievances received in Q2 CY2014, 21 (4.2%) were categorized in the STC report as "Access to Service or Care." (See Tables 7 and 8.) Access-related grievances increased during each quarter of CY2013 (ranging from 16 in Q1 to 27 in Q4) and decreased slightly in Q1 and Q2 CY2014.

As described in the STC report, "Access to Service or Care" grievances include:

- Difficulty obtaining services or supplies,
- Inability to see their preferred provider due to a closed panel,
- Denial of an appointment due to confusion surrounding ID cards, and
- Inability to seek therapy services from an out-of-network provider.

In the STC report, two of the MCOs provided additional descriptions of the grievances received that were related to "Access to Service or Care."

- Amerigroup described the 14 access-related grievances as situations where members had difficulty or were unable to obtain services or supplies.
- United indicated their 2 access-related grievances were cases where members were unable to seek services from providers that were out-of-network.
- Sunflower reported that there was no trend identified for their 5 access-related grievances.

No grievances were specifically categorized in the GAR as "Access to Care or Service." Other categories in the GAR that could be related to "Access to Service or Care" include "Accessibility of Office" (9 grievances received in Q2; 9 grievances resolved in Q2) and "Availability" (91 grievances received in Q2; 93 grievances resolved in Q2, 60 that were transportation-related). Based on the grievance detail provided in the reports, other categories that could involve "Access to Service or Care" issues include "Pharmacy," "Prior or Post Authorization," "Sleep Studies," "Criteria Not Met – Durable Medical Equipment," or "HCBS."

The GAR report provides additional details on the 507 total grievances resolved during Q2 CY2014. "Accessibility of Office" grievances included concerns about wait time for appointments, timely transportation, difficulties rescheduling cancelled appointments, access to durable medical equipment, and difficulty with phone access to the audio library.

Several grievances classified this quarter as "Attitude/Service of Staff" could also be considered access-related as they included a month-long wait time for a dental appointment, no return transportation from a doctor visit, cancelled transportation, and difficulty rescheduling an appointment.

KDHE staff indicated they will be scheduling interagency/MCO work group meetings this quarter to review the criteria being used by the MCOs in categorizing grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of access-related grievances, as well as other grievance categories.

QUALITY-RELATED GRIEVANCES

Of the 504 grievances received in Q2 CY2014, 64 (12.7%) were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 48 of the grievances received (9.6%) and 56 of the grievances resolved (11.0%) were categorized as "Quality of Care" (QOC).

To date, there have been 247 grievances categorized in the STC report as being related to QOC. The number of QOC grievances increased during each quarter of CY2013 (ranging from 19 in Q1 CY2013 to 56 in Q4 CY2013), dropped to 44 in Q1 CY2014, and then increased to 64 in Q2 CY2014.

As described in the STC report, the QOC grievances include:

- Members reporting that they received inappropriate treatment from their treating providers,
- Unprofessional behavior by a provider's office staff,
- Potential fraudulent behavior of a home health aide, and
- Care managers not being attentive to member needs.

In the STC report, two of the MCOs provided additional descriptions of the grievances received that were related to QOC:

- Amerigroup described the 24 QOC grievances as situations where members felt they received inappropriate treatment from their treating provider, and reported that 14 of the 24 grievances were referred to their quality management staff for a QOC investigation.
- United indicated their 28 QOC grievances included a variety of issues ranging from unprofessional behavior by the provider office staff, providers exhibiting behavior that could be a breach of HIPAA guidelines, and grievances related to providers not spending enough time with their patients.
- Sunflower reported that there was no trend identified for their 12 QOC grievances.

Of the 56 QOC grievances reported in the GAR as resolved, 9 were from members receiving waiver services: one was a member receiving TBI (traumatic brain injury) waiver services; three were members receiving PD (Physical Disability) services; three were members receiving FE (Frail Elderly) services; and two were members receiving I/DD (Intellectual/Developmental Disability) waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q2, KFMC found a number of additional grievances that could potentially be considered to be related to QOC that were categorized as "Attitude/Service of Staff," "Billing and Financial Issues," "Availability," and "Timeliness." Alternatively, some of the grievances categorized as QOC could just as easily have been categorized as "Availability," "Pharmacy," "Timeliness," and "Billing and Financial Issues."

As indicated above, KDHE is scheduling interagency/MCO work group meetings this quarter to review the criteria being used by the MCOs in categorizing grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of grievances related to quality of care, as well as other grievance categories.

CONCLUSIONS

In Q2 CY2014, there was an increase in grievances categorized as QOC and a decrease in access-related grievances. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude that QOC grievances are actually increasing or that access-related grievances have decreased. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

RECOMMENDATIONS

- Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are recommended.

- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).
- For access-related grievances, tracking and reporting of the residential region of the members could potentially better identify areas of Kansas where additional focus should be placed on increasing the number of PCPs and/or specialists available to members.
- Reports should be reviewed for quality and completeness to ensure information such as "type of waiver" are accurately and consistently reported by all three MCOs.

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 Q2 CY2014 is the KanCare Ombudsman Update report presented by Kerrie Bacon, the KanCare Ombudsman, on 8/12/2014, to the Robert G. (Bob) Bethell Joint Legislative Committee on Home and Community Based Services and KanCare Oversight.

CURRENT QUARTER AND TREND OVER TIME

The Ombudsman's Office has a current staffing of two individuals – the Ombudsman and a part-time assistant, with a third full-time volunteer coordinator scheduled to begin work in September. The volunteer coordinator's responsibilities will 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.

Contact with the Ombudsman's Office is primarily by phone and email, but also includes face-to-face contacts. A primary task for the Ombudsman's Office has been to provide information to KanCare members and assist them in reaching MCO staff that can provide additional information and assistance in resolving questions and concerns.

As delineated in the CMS Kansas Special Terms and Conditions (STC), revised in January 2014, data the Ombudsman's Office tracks 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.

A new Oracle-based tracking system implemented in Q1 CY2014 allows real time electronic tracking of each caller's contact information, the reason for the call (tracked by category), follow-up contact needs, and the ability to add notes specific to the call. As a result of the changes in the tracking system in Q1 and Q2 CY2014, including a major update in Q2, the Ombudsman has been able to give a more accurate and more complete accounting of the number and types of contacts and issues addressed.

Table 10 summarizes the number and type of contacts received and caller types in Q2CY2014. This quarter the Ombudsman's Office was able to begin reporting the number of contacts that were MCO-related compared to other types of contacts. There were 210 MCO-related contacts this quarter, 44.3% of the contacts reported. Beginning in Q3 CY2014, due to improvements in the new tracking system, the Ombudsman's Office will begin reporting contacts by waiver-related type (where applicable), by consumer type (HCBS, LTC, etc.) where applicable, and by resource category (whether the question/issue was resolved, State agency resources, etc.).

Table 10 - Ombudsman Contacts by Contact Method and Caller Type, Quarter 2, CY2014

Contact Method			Caller Type		
	All contacts	MCO related		All contacts	MCO related
Phone	384	168	Consumer	347	159
Email	83*	39*	Provider	115	48
Letter	5	1	MCO employee	5	3
In person	2	2	Other	7	0
Total	**474**	**210**	**Total**	**474**	**210**

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

Most of the contacts to the Ombudsman's Office were from consumers, 73% of 474 contacts in Q2 CY2014 and 71% of 546 contacts in Q1 CY2014. Phone contacts comprised 81% of the 474 contacts this quarter, compared to 63% of 546 phone contacts last quarter. The 83 email contacts reported this quarter did not include the many emails made in response to initial emails.

As shown in Table 11 below, the Ombudsman's Office received a wide variety of questions and requests for assistance in Q2 CY2014. In Q1 CY2014, contacts from 50 or more individuals were related to Medicaid Eligibility (61 contacts, 13.1% of 467 contacts), Access to Providers (59 contacts, 12.6%), HCBS Eligibility (55 contacts, 11.8%), and Billing (50 contacts, 10.7%). In Q2 CY2014, issues were more diverse, with only one issue category with 50 or more contacts – Medicaid Eligibility Issues (73 contacts, 15.4% of 474 contacts). Of the MCO-related issues in Q2, the highest number of contacts were related to Durable Medical Equipment (28 contacts, 13.2% of 212 MCO-related contacts), Medical Service Issues (22 contacts, 10.4%), Billing (20 contacts, 9.4%), and Appeals/Grievances (19 contacts, 9.0%).

Table 11 - Types of Issues and Inquiries Submitted to Ombudsman, Quarters 1 and 2, CY2014							
Issues	Quarter 1 CY2014		Quarter 2 CY2014				
	All Issues		All Issues		MCO-related Issues		
	#	% of 467	#	% of 474	#	% of 212	% of 474
Medicaid Eligibility Issues	61	13.1%	73	15.4%	5	2.4%	0.0%
Durable Medical Equipment	24	5.1%	35	7.4%	28	13.2%	5.9%
Billing	50	10.7%	33	7.0%	20	9.4%	4.2%
Medical Service Issues	4	0.9%	31	6.5%	22	10.4%	4.6%
Appeals, Grievances	23	4.9%	22	4.6%	19	9.0%	4.0%
Access to Providers	59	12.6%	16	3.4%	10	4.7%	2.1%
Pharmacy	39	8.4%	15	3.2%	12	5.7%	2.5%
Dental	16	3.4%	15	3.2%	10	4.7%	2.1%
HCBS							
HCBS General Issues	7	1.5%	25	5.3%	12	5.7%	2.5%
HCBS Eligibility Issues	55	11.8%	14	3.0%	7	3.3%	1.5%
HCBS Reduction in Hours of Service	23	4.9%	11	2.3%	8	3.8%	1.7%
HCBS Waiting List	2	0.4%	8	1.7%	5	2.4%	1.1%
Nursing Facility Issues	6	1.3%	12	2.5%	0	0.0%	0.0%
Change MCO	6	1.3%	11	2.3%	10	4.7%	2.1%
Care Coordinator Issues	7	1.5%	9	1.9%	8	3.8%	1.7%
Transportation	11	2.4%	8	1.7%	7	3.3%	1.5%
Housing Issues	3	0.6%	8	1.7%	3	1.4%	0.6%
Guardianship Issues	15	3.2%	3	0.6%	2	0.9%	0.4%
I/DD Conference Call Questions	12	2.6%	5	1.1%	0	0.0%	0.0%
Other	49	10.5%	120	25.3%	24	11.3%	5.1%
Total	467		474		212		

While some of the categories of issues are similar to grievance categories tracked by the State, the Ombudsman's Office issues include a wide range of requests for assistance that are not necessarily issues that would be categorized as "grievances." As the interagency/MCO work group works to more clearly define "grievances," including Ombudsman Office staff in the work group will better facilitate expanded consistency and clarity in reporting by various agencies.

CONCLUSIONS

A major update to the KanCare Ombudsman's tracking system has greatly improved and expanded the scope and tracking capacity of issues and contacts. This quarter, the Ombudsman's Office was able to report contacts that were and were not MCO-related. Next quarter reporting will include contacts that were waiver-related, contacts by type of service received (HCBS, LTC, etc.), and other resource referrals and recommendations. The Ombudsman met with KDHE staff to discuss tracking of contacts to her office, and she will continue to be involved in interagency efforts to better define grievances.

Addition of a volunteer coordinator to the staff in Q3 will further expand contacts and assistance to consumers throughout Kansas.

RECOMMENDATIONS

- Continued involvement of the Ombudsman in the interagency work group defining grievance criteria will also be beneficial in continuing to track and resolve member and provider concerns throughout the system.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.
- When tracking issues and inquiries (as identified in Table 11 above), it would be helpful to track and provide counts of how many of each of these contacts were to obtain initial or general information and how many were grievance-like issues or concerns.

QUANTIFY SYSTEM DESIGN INNOVATIONS IMPLEMENTED IN KANSAS

The KanCare quarterly evaluations include updates on system design innovations implemented in Kansas such as person centered medical homes, electronic health record use, use of telehealth, and electronic referral systems. Some of these systems may be created by KanCare such as Health Homes, and some are dependent upon the providers in the program to initiate, such as electronic health records. Related initiatives are also led by other entities in Kansas. To isolate the effects of the KanCare demonstration from other initiatives occurring in Kansas, KFMC will first complete a cataloguing of the various related initiatives occurring in Kansas. KFMC will reach out to the various provider associations and state agencies to identify, at a minimum, initiatives with potential to affect a broad KanCare population. KFMC will collect the following information about the other initiatives to help determine overlap with KanCare initiatives:

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

KDHE staff spent much of Q2 CY2014 in conference calls and webinars assisting the new Health Home Partners (HHPs) and Lead Entities (MCOs) in preparing to initiate Health Home services for Medicaid enrollees with Serious Mental Illness (SMI). The program had a July 1, 2014, implementation date with services beginning August 1, 2014. It is projected that approximately 36,000 people who are Medicaid eligible and meet criteria will be assigned to a Health Home with a choice to opt out if they choose not to participate. The second population, KanCare enrollees with chronic conditions such as asthma or diabetes and are at risk for another condition, were also targeted for Health Home services to be implemented July 1 but have been indefinitely delayed as there was not an adequate number of providers to offer client choice of at least two providers.

KDHE has a Preparedness and Planning tool for potential HHPs to complete (http://www.kancare.ks.gov/health_home/providers_materials.htm). The purpose of the tool is for self-assessment as well as an introduction to the MCOs. There is a question regarding use of an interoperable EHR. If the response is no, there are follow-up questions as indicated below:

1. Do you currently have the capacity to submit a plan, within 90 days of contracting as a HPP, to implement the EHR?
2. The State expects HHPs to achieve full implementation of the EHR within a timeline approved by the Lead Entity. Provide an estimate of how long it may take you to meet this expectation.
3. The State expects HHPs to have the capacity to connect to one of the certified state HIEs, KHIN or LACIE. Provide an estimate of how long it may take you to meet this expectation.

During a June 3, 2014, stakeholder meeting, KDHE reported 118 Preparedness and Planning tools had been received. In a separate communication, KDHE provided KFMC an Excel file with details on the response to the Interoperable EHR question(s) provided by 93 potential HHPs. Thirty-four (37%) have an interoperable EHR. Thirty-six (39%) currently have the capacity to submit a plan for obtaining an EHR within 90 days of contracting as a HHP. Nineteen (20%) do not currently have the capacity to submit a plan for obtaining an EHR within 90 days of contracting as a HHP. Four organizations did not answer the question. The progress of these organizations, as well as additional HHPs, could be a good way to monitor the influence of KanCare on HIE in Kansas.

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

- Kansas Academy of Family Physicians (KAFP) - Kansas Primary Care Medical Home Initiative
  - Consumer and provider populations impacted: Primary Care practices and all of their patients regardless of payers.
  - Coverage by location/region: The eight primary care practices were located in Ellsworth, Lawrence, Pittsburg, Plainville, Sabetha, St. Francis, Winfield, and Wichita.
  - Start dates and current stage of the initiative: January 2011.
    Phase 1 was originally scheduled to end 12/31/13; however, KAFP, the lead organization contracted with KFMC to assist four of the remaining five pilot clinics to achieve PCMH recognition.
- KFMC's Regional Extension Center (REC) Patient-Centered Medical Home Partnership (PCMHP)
  - Consumer and provider populations impacted: Primary Care practices and all of their patients regardless of payer.
  - Coverage by location/region: The six practices were located in Fredonia, Manhattan, Topeka, Wichita (2), and Winfield.

  - Start dates and current stage of the initiative: March 2013. This is a 2-year project. All six clinics plan to submit to NCQA for PCMH recognition before March 2015.
- Blue Cross/Blue Shield of Kansas (BCBSK)
  - Consumer and provider populations impacted – All specialty types contracted with BCBSK and their patients.
  - Coverage by location/region: entire State.
  - Start dates and current stage of the initiative: BCBSK Quality Based Reimbursement Program (QBRP) program has been in place since 2011.
  - Contracting BCBSKS providers have an opportunity to earn additional revenue through increased allowances for meeting defined quality metrics that include PCMH recognition.
- Kansas Association for the Medically Underserved (KAMU) - Medicare Advanced Primary Care Practice (APCP) Demonstration
  - Consumer and provider populations impacted: Federally Qualified Health Centers (FQHCs) and their patients.
  - Coverage by location/Region: Junction City and Wichita.
  - Start dates and current stage of the initiative: November 2011 and with end by October 31, 2014, with the goal of Level 3 recognition.
- Kansas Health Foundation (KHF) and KAMU- PCMH Initiative
  - Consumer and provider populations impacted: Safety Net Clinics and their patients.
  - Coverage by location/region: Nine safety net clinics.
  - Start dates and current stage of the initiative: January 2012 through June 2014.
- REACH Healthcare Foundation – Medical Home Initiative
  - Consumer and provider populations impacted: Safety Net Primary Care Clinics and their patients.
  - Coverage by location/Region: Johnson and Wyandotte counties (4 clinics), as well as four clinics in Missouri.
  - Start dates and current stage of the initiative: 2010 and ended early in 2013; however, the foundation re-launched their support of clinics within their 6-county coverage area with another initiative that began later in 2013.

Of the 17 designated FQHCs in Kansas, there are, as of Q2 CY2014,10 that have achieved PCMH recognition. These clinics are located in Emporia, Great Bend, Hays, Hutchinson, Kansas City (2), Lawrence, Olathe, Salina, and Wichita.

As mentioned in previous quarterly reports, the Health Information Technology for Economic and Clinical Health Act (HITECH Act) created provisions to promote the Meaningful Use (MU) of health information technology. The Office of the National Coordinator for Health Information Technology (ONC) has provided technical assistance to over 100,000 primary care physicians via its Regional Extension Center (REC) program since 2010. KFMC, the Kansas REC, has provided support to more than 1,600 Eligible Professionals (EPs) and Eligible Hospitals (EHs) across the state to achieve MU. KFMC will continue to provide these services through February 2015.

CMS has a role in HITECH as well. CMS operationalized MU by setting up core and menu set measures that must be met by EPs and EHs to receive incentive dollars or to avoid Medicare reduced payment adjustments. CMS administers the MU incentive program for Medicare EPs and EHs. Each state is in charge of the program for Medicaid providers. At the writing of this report, more than $220 million has been paid to Medicare EPs and EHs in Kansas and more than $57 million to Medicaid EPS and EHs.

Increasing Health Information Exchange (HIE) capabilities is also a component of HITECH. As reported previously, two HIE organizations have become viable HIEs in Kansas; the Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE). KHIN has 75 different organizations "live" in production sending data to KHIN on a real time basis. LACIE has 30 participant organizations located in both Kansas and Missouri.

KFMC, through funding by KDHE/DHCF, is providing technical assistance to Medicaid providers who have not yet reached MU of an EHR. KFMC will assist 200 Medicaid healthcare providers with selection, implementation, and meaningful use of an EHR between now and Sept 30, 2015. As part of this KDHE program, KFMC also conducted an EHR readiness assessment and assisted with vendor selection for 22 Health Home Partners contracted with KanCare. The KDHE-funded program, combined with the continuation of the REC program through February 2015, should have a positive effect on the availability of health information exchange.

Telehealth and telemedicine are important to states such as Kansas that have large rural areas with limited access to healthcare providers, particularly specialists. The work of the University of Kansas Center for Telemedicine and Telehealth (KUCTT) has been discussed in previous quarterly reports. It provides a very valuable service to many areas of the state. Some telehealth services are hampered by the physical location of the equipment within the receiving facility. Robots, highly sophisticated telemedicine robots, are appearing in some small, rural Kansas hospitals, which have eased the shortage of specialists in many areas. In early June, the Kansas Health Institute (KHI) reported on the use of a telemedicine robot at Hamilton County Hospital in Syracuse, which borders Colorado in southwest Kansas.

OVERALL CONCLUSIONS

A number of templates and reports were added or are being revised in CY2014 to improve efficiency, consolidate reporting where possible, and to provide more detailed information where indicated. Phone contacts to MCOs and their vendors, for example, are now being tracked individually and in greater detail. Beginning in Q1 CY2014, much greater detail is being reported to the State on denied and adjusted claims. Work group meetings are being scheduled to further streamline reporting and to respond to recommendations made in the KanCare Quarterly and Annual Evaluation Reports.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

- The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within 2 to 5 business days in each

quarter of CY2013 and CY2014 to date. The number of inquiries received has also decreased greatly over time.

- The newly implemented customer service reports provide detailed documentation of the numbers and types of member and provider customer service inquiries and calls received and responded to by each MCO call center. These reports are an improvement over the previous KKMAR reports that provided percentages of inquiries resolved, but did not include the number and types of inquiries from members and providers.

TIMELINESS OF CLAIMS PROCESSING

- With the input of agency staff, the EQRO, and interagency work groups, the State has drafted a revised claims report to better track timeliness of claims processing within the contractually required timelines. The revised claims template is anticipated to be finalized by September 2014 and implemented in October (for claims received by MCOs beginning in January 2014); it will provide clearer, more understandable reporting of timeliness of claims processing. In the revised report (as currently drafted), MCOs will report the number of clean claims received in the month and the number of those claims that were processed (and not processed) within 30 days; the number of non-clean claims received in the month, and the number of those claims that were processed (and not processed) within 60 days; and, the number of all claims received in the month, and the number of those claims that were processed (and not processed) within 90 days.
- Monthly turnaround times for processing clean claims vary by service type, particularly when comparing the lowest and highest monthly average TATs by MCO. The monthly average TATs for processing clean claims for most services were generally less than 2 weeks. The average monthly TATs for processing clean claims for total monthly services were less than 1 to 2 weeks (6 to 11.5 days in Q1; 6 to 10.8 days in Q2).

GRIEVANCES

- Timeliness of Grievance Resolution: This is the first quarter since Q1 CY2013 where 100% of grievances were not resolved within 60 days. (Q1 CY2014 was the first quarter for 100% of grievances to not be resolved within 30 days.) The numbers of grievances received in the first two quarters of CY2014 were higher than the previous two quarters, but comparable to the number received in Q2 CY2013. The number of grievances closed by the MCOs each quarter has also increased.
- Categories of grievances continue to differ by report. A work group that includes representatives of MCOs, various State programs, and the EQRO will be meeting to establish more consistent grievance categories and criteria to provide greater consistency in reporting.
- The grievance category with the highest number of grievances continues to be those related to transportation.
- In Q2 CY2014, there was an increase in grievances categorized as QOC and a decrease in access-related grievances. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult

to conclude that QOC grievances are actually increasing or that access-related grievances have decreased. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

Ombudsman's Office

- The KanCare Ombudsman has been making considerable progress in improving the tracking system. This quarter, the Ombudsman's Office was able to report contacts that were and were not MCO-related. Next quarter reporting will include contacts that were waiver-related, contacts by type of service received (HCBS, LTC, etc.), and other resource referrals and recommendations.
- The Ombudsman met with KDHE staff to discuss tracking of contacts to her office, and she will continue to be involved in interagency efforts to better define grievances.
- Addition of a volunteer coordinator to the staff in Q3 will further expand contacts and assistance to consumers throughout Kansas.

Systems Design Innovations

- KDHE worked with providers and MCOs in Q2 in preparation for implementing Health Homes Services on August 1, 2014, for KanCare members who have serious mental illnesses (SMI). Through KanCare and other health care agency efforts, progress continues in implementing and increasing the use of EHR, increasing the number of PCMHs, and expanding the scope of telehealth in Kansas.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

- The current tracking system could be improved by including the number of unduplicated individual members and providers that have contacted the MCOs with customer service inquiries to better identify the scope of the customer service inquiries. It may be helpful to identify whether the customer service inquiries to date represent calls from most members or represent a much smaller fraction of members contacting the MCOs.
- Reports from MCOs should be compared to ensure MCOs are reporting data consistently. (One of the MCOs, for example, included abandoned calls in the reported count of "# of Calls Documented," while the other two MCOs reported only completed calls in this field.)

Timeliness of Claims Processing

- When the new reports tracking timeliness of claims processing are first implemented in October, quality review is recommended to ensure that all MCOs have clear understanding of data to be reported in each field and that data is reported in consistent ways by the three MCOs.

- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for services where other MCOs have much lower average monthly turnaround times.

GRIEVANCES

- Data in the GAR and STC grievance reports should be reviewed and compared for quality and completeness to ensure consistent and accurate reporting of the quarterly number of grievances received and resolved.
- Grievance categories within the GAR and STC reports should be more clearly defined. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Grievances related to balance billing of members should be reviewed to identify providers that have been contacted multiple times to identify patterns that may warrant additional communication to the providers to reduce future balance billing of members.
- The State should continue to work with the MCOs to review grievances not resolved within 60 days to identify any preventable reasons for delay.
- Additional clarification and guidance should be provided as to how "resolved" is defined. Does "resolved" indicate that a final response has been provided for the member's concern, or does "resolved" include situations where follow-up contacts to providers or vendors will still need to be made by the MCO?
- Reporting the number of individual members who have filed grievances in the quarter, as well as the number of individual providers and vendors related to the grievances, could also be of help in defining the scope of grievances received in the quarter.
- For access-related grievances, tracking and reporting of the residential region of the members could potentially better identify areas of Kansas where additional focus should be placed on increasing the number of PCPs and/or specialists available to members.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

OMBUDSMAN'S OFFICE

- Continued involvement of the Ombudsman in the interagency work group defining grievance criteria will also be beneficial in continuing to track and resolve member and provider concerns throughout the system.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.
- When tracking issues and inquiries (as identified in Table 11 above), it would be helpful to track and provide counts of how many of each of these contacts were to obtain initial or general information and how many were grievance-like issues or concerns.

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

AMG- YTD Claim Type	Claims Processed	Total $ Value of Claims Processed	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	Average TAT - YTD cumulative
Hospital Inpatient	19,352	$86,539,093.63	23,313	$732,430,561.30	4,631	$152,196,962.43	19.82%	7.1
Hospital Outpatient	159,332	$22,001,317.97	192,087	$525,237,963.96	32,868	$76,676,696.80	17.15%	4.3
Pharmacy	838,643	$53,680,767.23	877,417	$53,497,328.27	182,845	Not Applicable	20.84%	Same Day
Dental	67,365	$9,571,423.13	67,365	$18,206,380.01	7,088	$1,861,078.41	10.52%	13.0
Vision	38,358	$2,847,298.71	38,424	$9,087,736.32	9,682	$2,609,807.19	25.20%	8
NEMT	90,386	$3,414,826.74	90,386	$3,414,827.06	173	$6,829.17	0.19%	15.0
Medical (Physical health not otherwise specified)	942,738	$84,876,074.48	932,405	$399,293,766.96	120,601	$57,275,798.41	12.90%	4.0
Nursing Facilities	59,354	$87,483,079.52	59,304	$140,751,939.62	7,193	$12,319,299.87	12.12%	5.7
HCBS	273,528	$77,944,250.19	76,715	$45,929,611.24	5,410	$3,380,725.25	7.05%	4.5
BH	166,453	$31,598,083.47	333,722	$41,136,983.00	35,122	$4,577,382.79	10.49%	4.1
Total	**2,655,509**	**$459,956,215.07**	**2,691,138**	**$1,968,987,097.74**	**405,613**	**$310,904,580.32**	**15.07%**	**7.3**

SUN- YTD Claim Type	Claims Processed	Total $ Value of Claims Processed	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	Average TAT - YTD cumulative
Hospital Inpatient	20,782	$94,820,139.48	11,112	$75,728,118.19	2,352	$15,657,873.41	21.17%	8
Hospital Outpatient	178,164	$25,723,181.33	116,263	$43,867,678.47	15,661	$6,824,356.87	13.47%	6
Pharmacy	697,443	$71,539,604.00	1,441,160	$87,702,251.00	319,684	$15,921,067.00	22.18%	Same Day
Dental	73,664	$10,185,891.63	78,687	$19,389,990.87	6,798	$1,547,918.88	8.64%	3
Vision	51,245	$3,472,139.98	46,191	$10,058,562.77	5,891	$1,510,179.99	12.75%	12
NEMT	66,843	$1,980,305.87	66,843	$1,980,305.87	349	$9,668.94	0.52%	11
Medical (Physical health not otherwise specified)	1,000,310	$88,450,051.31	637,012	$156,711,020.58	71,674	$19,953,793.86	11.25%	5
Nursing Facilities	105,892	$128,401,516.36	45,691	$90,799,849.04	3,873	$10,127,563.30	8.48%	8
HCBS	232,128	$97,542,879.58	161,923	$50,391,896.41	4,428	$2,693,431.14	2.73%	4
BH	368,395	$35,537,264.69	296,862	$36,958,215.27	13,385	$3,748,219.99	4.51%	5
Total	**2,794,866**	**2,900,758**	**2,901,744**	**$573,587,888.47**	**444,095**	**$77,994,073.38**	**15.30%**	**6**

UHC- YTD Claim Type	Claims Processed	Total $ Value of Claims Processed	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	Average TAT - YTD cumulative
Hospital Inpatient	2,288	$9,489,960.05	15178	$481,391,270.67	3100	$121,688,047.11	20.42%	15.05
Hospital Outpatient	21,783	$2,971,852.43	143825	$361,553,203.39	22047	$78,056,023.55	15.32%	10.49
Pharmacy	473,995	$36,393,225.34	885371	$43,770.93	204641	$42,277.19	23.11%	Same Day
Dental	57,616	$8,371,002.47	69148	$18,532,820.98	8382	$1,309,644.32	12.12%	14
Vision	34,968	$5,789,626.98	34722	$6,667,072.37	5267	$1,136,263.23	15.17%	12.05
NEMT	60,128	$1,726,994.82	60128	$1,727,027.62	369	$11,197.29	0.61%	11.34
Medical (Physical health not otherwise specified)	142,012	$16,459,102.97	843781	$298,238,357.39	99361	$48,782,748.51	11.77%	9.03
Nursing Facilities	7,727	$10,731,996.36	50759	$108,404,671.71	4025	$10,081,171.08	7.93%	9.34
HCBS	26,547	$4,972,014.25	146072	$38,374,664.68	8062	$2,166,739.04	5.51%	12.1
BH	11,324	$1,004,881.47	191288	$44,872,500.31	16935	$8,614,783.24	8.85%	8.11
Total	**838,388**	**$97,910,657.14**	**2440272**	**$1,359,805,360.05**	**372189**	**$271,888,894.56**	**15.25%**	**9.79**