Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 6.30.13

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 1 (1/1/2013-12/31/2013)
Federal Fiscal Quarter: 3/2013 (4/13-6/13)

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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 first quarter known as of July 9, 2013.

Demonstration Population	Enrollees at Close of Qtr. (6/30/2013)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	17,326	18,449	1,123
Population 2: ABD/SD Non Dual	28,608	29,561	953
Population 3: Adults	31,404	35,284	3,880
Population 4: Children	206,895	219,994	12,009
Population 5: DD Waiver	8,751	8,811	60
Population 6: LTC	21,362	22,387	1,025
Population 7: MN Dual	1,148	1,296	148
Population 8: MN Non Dual	1,179	1,319	140
Population 9: Waiver	4,495	4,624	129
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**321,258**	**340,725**	**19,467**

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.

KanCare Advisor, the State's electronic implementation newsletter, is distributed to about 300 individual subscribers and various provider and consumer associations. Newsletters were distributed in the second quarter of the Demonstration Year on May 10 and June 17, 2013. In addition to distribution to subscribers, the Advisor is also available on the KanCare website.

During this second quarter, 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 2 (8 attendees), May 7 (7 attendees) and June 4 (10 attendees).

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

- Association of Community Mental Health Centers (at minimum monthly) to include the Executive directors, billers and children's services directors
- Area Agency on Aging KanCare overview
- Adult Protective Services KanCare overview
- Kansas Hospital Association KanCare implementation technical advisory group
- KanCare Consumer and Specialized Issues external workgroup
- KanCare Provider and Operations external workgroup
- Assisted Living annual conference KanCare overview
- Local health department routine and futures planning meetings
- KanCare Advisory Council

Finally, state staff also continued educational tours for consumers during the second quarter of the Demonstration Year. Consistent with STC #57, the focus for this quarter related to LTSS population members and providers. The state requested assistance from Wichita State University's Center for Community Support and Research to conduct these sessions.

The purpose of the meetings was to gather input from people receiving LTSS through KanCare; connect beneficiaries with information about KanCare and opportunities to troubleshoot problems; and provide the State with regional input to develop the delivery of the KanCare program to people receiving LTSS.

Meetings were held in six locations across Kansas: Coffeyville, Garden City, Wichita, Hays, Lawrence, and Salina. Two sessions were held in each location on the same day, from 1:00 to 3:00 p.m. and from 6:00 to 8:00 p.m._The majority of participants were family members of people receiving KanCare services or were providers of services. Most participants were concerned about or connected to people on the intellectual and developmental disabilities (I/DD) waiver.

At each listening session, there were usually two CCSR facilitators, two staff from the state (representing KDADS and KDHE), a representative from the regional Aging and Disability Resource Center, one or two other state staff serving regionally, a representative from the

enrollment broker, the KanCare ombudsman, and three to seven representatives from each of the three managed care organizations. For most meetings there were 12-16 staff present. Public participation in the twelve individuals sessions totaled 91 participants, with the greatest participation in Wichita (23).

As a result of the sessions, CCSR recommended the following next steps:

- **Share the report with the MCOs.**
- **Clarify care coordination and case management.** One area highlighted in particular among those receiving intellectual and developmental disabilities (I/DD) services was the role of care coordinators and targeted case managers.
- **Increase understanding of "ombudsman."** Participants responded positively to the KanCare ombudsman once they understood the role this position plays.
- **Consider additional options for member input.** Holding listening meetings across the state, as in this process, produced a relatively low response rate.
- **Emphasize customer service and communication.**

A summary of marketing, outreach 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 nearly 200 events for the second quarter allowing us to spread our message regarding education of services and benefits of the KanCare program. Amerigroup continued to keep its focus on building relationships and learning more about the value it can bring to the community. Examples of marketing activities include exhibits at conferences, events, and key community partners such as:

- Special Olympics Summer Games
- Kansas Self Advocate Coalition of Kansas
- Episcopal Social Services

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

- Shared information regarding nurse on-call line to members who have utilized the emergency room for non-emergent services.
- For members with hypertension, whose most recent blood pressure reading was controlled, Amerigroup provided support tips such as knowing blood pressure readings, taking medications as prescribed and following up with their doctor were provided to members.

Advocacy Activities: Advocacy efforts for second quarter continue to be broad based to support the needs of the general population, pregnant women, children, people with disabilities, and the elderly. Amerigroup staff is engaged at the local level with committees, coalitions, and boards of various nonprofit organizations that have a similar focus and mission. This quarter Amerigroup participated in educating members, families, caregivers, targeted case managers, and providers on the pilot program for members with intellectual and developmental disabilities. Amerigroup continued to help support members in resolving issues through the KanCare Ombudsman and grievance and appeal process.

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

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

- Email marketing system has been initiated to better inform providers and members of updates and happenings at the State and the plan.

- External newsletters have been designed and will be implemented in October for Members and Providers.

- Presentations and informational sheets continually updated for population-specific presentations and events (i.e. new moms, IDD)

- Sponsorships and partnerships with local organizations continues to be a top priority, garnering relationship building and positive exposure (i.e. Center for Independent Living - Wichita, $5,000 sponsorship for April event with maximum media coverage)

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

Advocacy Activities: Sunflower is heavily involved with advocacy groups and works with them to educate community members on changes in KanCare and services offered by Sunflower. Sunflower continues to think of creative and inexpensive ways to share resources and maximize services to members.

1. Sunflower State has the greatest number of members enrolled in the I/DD Pilot Project. Sunflower has a dedicated staff member who attends all rallies and meetings regarding this population and communicates with the organization.

2. Partnership initiated with Kansas Head Start Association to join forces in raising awareness on their program at locations across the state.

3. An outreach plan was developed for ADRCs and MemberConnections staff continue to meet with them and report back any issues.

4. All CDDOs were paid a visit between December and March to provide a presentation of how Sunflower will continue to work with them and assist them in helping members.

5. Ongoing discussions with Johnson County school districts and other school districts to partner in helping to get students healthy for the school year and make sure they have received all vaccinations.

6. New Mom/Baby shower events scheduled for August. More extensive plan to visit high-population areas with pregnant mothers to hold educational events.

7. Playing a lead role in promoting the WORK Program. Coordinating symposium to feature the benefits of employment to those with developmental disabilities.

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

Marketing Activities:

UHC's main activities have been focused on education with regard to the changes in KanCare and the benefits of UnitedHealthcare, done through member welcome calls, mailings to those who could not be reached by phone, and sending out its second Member Newsletter to those enrolled with UnitedHealthcare.

Outreach Activities:

UHC has three outreach specialists focused on activities targeted within a geographic area of Kansas. Their jobs are to be out in the communities, educating members, community based organizations and provider offices about UnitedHealthcare, UHC's work with KanCare and the benefits of the 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 of UnitedHealthcare.

- During the second quarter of 2013, UnitedHealthcare staff personally met with over 10,821 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 2013, UnitedHealthcare staff personally met with over 528 individuals from community based organizations located throughout Kansas. These organizations work directly with members in various capacities.

- During the second quarter of 2013, UnitedHealthcare staff personally met with over 835 individuals from provider offices located throughout the State.

Advocacy Activities:

Activities in advocacy remain focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with developmental disabilities. UHC has one Outreach Specialist focused specifically on working with Kansans with disabilities.

- The outreach specialist to the disabled community personally visited with over 320 advocates for the Kansans with disabilities, providing them with education on KanCare and UnitedHealthcare benefits.

- That same outreach specialist also began work on receiving requests for proposals from organizations throughout Kansas who would like to work with our Empower Kansans initiative which will be focused on providing grant dollars to those organizations who are working to employ the disabled throughout Kansas.

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: As the State reported to CMS during monthly conference call updates, there have been a variety of concerns regarding systems and reporting issues, in line with expectations of a transition of this magnitude. Through a variety of accessible forums and input avenues, Kansas has been advised of these types of issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. One issue that required more extensive solution building was the timeliness and accuracy of information used via the electronic visit verification, authorization and claims submission process for members who self-direct their HCBS waiver services. During the second quarter, that issue was substantially resolved, although still being monitored closely.

   Kansas completed the periodic (first daily, then several times weekly, and then weekly) KanCare Rapid Response calls with providers, members and advocates. Since that time, additional attention has been paid to evaluating the ongoing support activities and customer support performance of the MCOs. As that process came to a conclusion, Kansas prepared to do focused reviews of key infrastructure issues at each of the MCOs, to validate performance and help ensure strong performance as we shift to the longer term operation of the program. The areas selected for more intensive desk review and onsite review included: customer service, provider credentialing, grievance/appeal management, prior authorization timeliness and accuracy, and TPL/client obligation/spend down processes.

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-June, 2013:

MCO	Value Added Service	Units	Value
Amerigroup	Adult Dental Care	1,227	$156,933.81
	Healthy Rewards member incentive program	3,323	$117,700.00
	Mail Order OTC member monthly allowance	3,348	$53,737.88
	Totals for Amerigroup – all VAS – Jan-June	*21,591*	*$500,330.50*
Sunflower	CentAccount debit card	41,756	$836,175.00
	Dental visits for adults	22,007	$562,757.22
	SafeLink/Cenaccount cell phones	7,538	$360,542.54
	Totals for Sunflower – all VAS – Jan-Mar	*186,923*	*$2,036,002.00*
United	Additional vision services	12,856	$500,451.85
	KAN Be Healthy Screening	24,197	$241,970.00
	Annual A1C Exam	4,029	$80,580.00
	Totals for United – all VAS – Jan-Mar	*50,457*	*$1,041,641.85*
Combined Totals – all MCOs – Jan-June 2013		**258,971**	**$3,577,974.35**

c. Enrollment issues: For the second quarter of 2013 there are 16 American Indians/Alaska Natives who chose to not be enrolled in KanCare per the opt-out provision available to AI/AN members. The table below represents the enrollment reason categories for the 2nd quarter of calendar year 2013 (months April, May and June). All KanCare eligible members are defaulted to a managed care plan.

Start Reasons	Total
Newborn assignment	331
Administrative change	11
WEB - Change Assignment	31
KanCare Default - Case Continuity	1285
KanCare Default - Morbidity	1670
KanCare Default - 90 Day Retro-reattach	1858
KanCare Default - Previous Assignment	7027
KanCare Default - Continuity of Plan	3024
Choice - Enrollment into KanCare MCO via Medicaid Application	2613
Change - Enrollment Form	847
Change - Choice	7932
Change - Access to Care - Good Cause Reason	135
Change - Case Continuity - Good Cause Reason	6
Assignment Adjustment Due to Eligibility	35
Total	**26,805**

d. Grievances, appeals and state hearing information

KDHE Grievance Data Base

Members- CY13 2nd quarter report

MCO	Access	Dental Access	Pharmacy	Benefits and Billing	Quality of Care	Rights and Dignity
Amerigroup	23	5	26	69	4	0
Sunflower	20	6	41	73	3	1
United	23	0	17	44	2	0

Providers – CY13 2nd quarter report

MCO	Access	Enrollment	Dental Access	Pharmacy	Benefits and Billing
Amerigroup	3	11	9	13	161
Sunflower	1	1	16	18	51
United	2	3	0	14	95

Grievances MCOs Database

Members- CY13 2nd quarter report:

MCO	Access	Quality	Benefits	Billing	Transportation	Pharmacy	Waiver Service
Amerigroup	1	123	0	65	41	7	5
Sunflower	2	90	0	12	112	10	2
United	5	22	1	14	70	0	0

Providers- CY13 2nd quarter report:

MCO	Access	Quality	Benefits	Billing	Transportation	Pharmacy	Waiver Service
Amerigroup	0	0	0	3	0	0	0
Sunflower	0	0	0	0	0	0	0
United	0	9	0	7	8	4	0

Appeals MCOs' Database

Members:

MCO	Access	Quality	Benefits	Billing	Transportation	Pharmacy	Waiver Service
Amerigroup	0	5	3	4	0	6	0
Sunflower	0	0	0	0	0	0	0
United	0	1	13	0	1	11	0

Providers:

MCO	Access	Quality	Benefits	Billing	Transportation	Pharmacy	Waiver Service
Amerigroup	0	0	0	0	0	0	0
Sunflower	0	0	0	0	0	0	0
United	0	0	5	0	0	8	0

State of Kansas Office of Administrative Fair Hearings:

Members:

State Fair Hearings	Services were rendered	No adverse action	Member did not appear	Hearing scheduled in July
35	1	29	0	5

Providers:

State Fair Hearings	Dismissed	Withdrawn	MCO Affirmed	Hearing scheduled in July
45	33	5	2	5

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

f. Changes in provider qualification standards: None occurred during the quarter.

g. Access: The second quarter marked the end of the 90-day continuity of care period. After 4/4/13, members were unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs (which include a good cause reason [GCR] related to satisfaction with the service planning process). In the enrollment packets that were sent the fall of 2012, members were informed of the 90-day open enrollment period that would be ending on 4/4/13. This information was also posted and explained in detail on the KanCare website in the Consumer FAQs section. In the second quarter KDHE received 543 member requests to change health plans.

Most of these requests were because a member's preferred or needed provider was not in the particular MCO's network. The MCO is required to offer the member an appointment that meets the member's needs. If the MCO is able to do this with other contracting providers of like type/specialty, within the geographical access standards set forth in the contract for the member's county, the GCR is denied. If the MCO does not have an enrolled provider of like type/specialty that the member needs, within the geographical access standards, the MCO is tasked with offering a single case agreement to the requested provider. If the provider refuses this offer, this meets one of the definitions of good cause, and the request to change plans is approved. The MCO is then notified by KDHE that they have an inadequacy in their network and are expected to work diligently to fill this gap.

GCRs after the choice period based solely on the member's preference, when other participating providers with that MCO are available, 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. At the end of Q2, eight fair hearings had been filed. Two of these were dismissed by the fair hearings officer; five went to hearing and all were upheld by the hearing officer; and one was dismissed because the requested change was allowed after receiving more information from the member.

	April	**May**	**June**
Total GCRs filed	304	139	100
Approved	96	11	12
Denied	65	63	34
Withdrawn (resolved, no need to change)	111	45	30
Dismissed (due to inability to contact the member)	31	18	15
Pending	1	2	9

As in Q1, the second quarter showed continued growth in each Plan's network. Numbers of contracting providers as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	**# of Unique Providers as of 3/26/13**	**# of Unique Providers as of 6/30/13**
Amerigroup	11,746	16,706
Sunflower	10,006	13,016
UHC	11,105	14,738

Non-emergent medical transportation-related (NEMT) issues (no-shows, late pick-ups, etc) have decreased during Q2. KDHE believes the reason is twofold. As noted in the Q1 report, one of the MCO's transportation vendors was replaced effective 4/1/13, which has led to a drop in reported issues; and all three MCOs have worked closely with their NEMT vendors to educate the drivers on working with this particular population. For example, drivers have been educated to wait at least 10 minutes when picking someone up, before assuming a member is not home or is not coming out. This is also expected when a driver picks a member up at a provider's office. The NEMT vendors also are confirming the member's home address, and if the address on file is different, the vendor instructs them to contact Department for Children and Families (DCF) or the eligibility clearinghouse to make sure their address of record is updated. When scheduling NEMT, the vendors are also asking the members more questions to ensure that they have all pertinent information (Is anyone accompanying you to the appointment? Do you have any special equipment such as a walker or wheelchair that you need to bring with you? Do you

have any other special needs that we need to know about?). This ensures that the driver scheduled is aware of the member's needs, has room for those accompanying the member, and has room for any equipment the member may need.

NEMT Complaints:

KanCare MCO	Q1	Q2
Amerigroup	106	50
Sunflower	119	68
UHC	85	80

Some issues related to eligibility confirmation remain, during the short time between when beneficiaries are deemed eligible for KanCare and when the MCOs and their subcontractors receive and load the eligibility files (within 24 hours for the MCOs and two days for subcontractors). KDHE and the MCOs continue to educate providers on preferred alternatives to confirm eligibility (calling the fiscal agent, or checking the KMAP website).

h. Proposed changes to payment rates: There were no proposed payment rate changes during Q2.

i. Health plan financial performance that is relevant to the demonstration: There are no significant issues with health plan financial performance to report during this period.

j. MLTSS implementation and operation:

- The State meets weekly with the MCOs to provide technical assistance on various waiver topics, frequently asked questions, and areas of concerns such as HCBS waiver-specific issues, grievances and appeals, plan of care approval workflows, FMS provider concerns, and upcoming education and training opportunities for the State and MCOs. During this quarter, the State held an MCO training forum. Similar meetings and training have been developed for providers. This quarter, the State continues to meet with MCO's and other providers around topics such as the mental health screening processes, PRTF processes, I/DD system processes, and Nursing Facility processes.
- The State, Electronic Visit Verification (EVV) contractor and the MCOs continue to work to identify issues as they are presented by providers. The EVV contractor continues to update EVV to ensure appropriate authorizations and minimize disruptions for service delivery and billing. The state has identified necessary EVV system changes, and the EVV contractor has begun working on system changes that will make the process more efficient and expand its use for other programs.
- There were 181 Plan of Care (POC) Reductions in the second quarter of KanCare. The State continues to review and approve POC Reductions within ten business days of the POC Reduction request. The POC Reduction request is reviewed by a minimum of three HCBS program managers. 21 POC Reductions were denied due, in part, to lack of information to

make a determination, the others were approved and none are under review. To maximize efficiency, the State hosted an MCO Forum that included specific training on how to submit a POC Reduction and what information in necessary to determine the status of a Plan of Care Reduction. MCO's completed all of their initial Plans of Care as they were required to within the first 180 days of KanCare.

k. Updates on the safety net care pool including DSRIP activities: The project team continued to work toward the planning and funding and mechanics protocols for the DSRIP project. The protocols were presented for public comment on the State's website via a webinar on April 26, 2013. The webinar also discussed the list of focus areas that were created by the DSRIP team and the Healthy Kansas 2020 steering committee. Participating hospitals must choose at least two projects from the focus areas list. The DSRIP project team submitted the focus area list to CMS on May 8, 2013.

Kansas has proposed delaying the implementation of the DSRIP pool for one year to allow the State and CMS to focus on other critical activities related to Kansas' Section 1115 Demonstration waiver.

Specifically, Kansas proposed the following:

- Delay implementation of DSRIP payments for one year, to begin January 1, 2015, in DY 3
- Continue Uncompensated Care (UC) pool payments into DY 2 to participating DSRIP hospitals with a total UC payment limit for the BCCH/LPTH pool of $39,856,550 in DY 2.
- Begin DSRIP pool payments in DY 3, with increasing funds allocated through DSRIP and decreasing funds allocated through UC in DYs 4 and 5. Proposed pool limits are listed below.

	DY 1 (CY 2013)	**DY 2 (CY 2014)**	**DY 3 (CY 2015)**	**DY 4 (CY 2016)**	**DY 5 (CY 2017)**	**Total**
UC Pool: HCAIP	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$41,000,000	$205,000,000
UC Pool: BCCH/LPH	$39,856,550	$39,856,550	$29,856,550	$19,856,550	$9,856,550	$139,282,750
DSRIP	N/A	N/A	$10,000,000	$20,000,000	$30,000,000	$60,000,000
% UC Pool	100%	100%	87.6%	75.3%	62.9%	---
% DSRIP	N/A	N/A	12.4%	24.7%	37.1%	---
Total	$80,856,550	$80,856,550	$80,856,550	$80,856,550	$80,856,550	$404,282,750

- Allow the previously submitted required documentation (including proposed focus areas and draft Planning and Funding and Mechanics protocols) to fulfill the requirements of STC 69 (b, e and f).
- Shift reporting and outcome measure requirements back one DY. For example, the previous DSRIP requirements for DY 2 will now be fulfilled in DY3; DY 3 requirements will now be fulfilled in DY 4.

- Eliminate the previously stipulated DY 5 DSRIP requirements. DY5 will now be devoted to achieving the previous requirements stipulated for DY 4.

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

- The State submitted the TA Waiver renewal to CMS by April 30, 2013. Responses to CMS questions were submitted timely.
- All 1915(c) waivers will be amended during the third and fourth quarters of KanCare to reflect amendments for the quality assurance measures in each waiver. The State is receiving Technical Assistance from the CMS NQE contractor. For the I/DD Waiver, the State will be requesting Technical Assistance for NCI implementation from NASDDDS.
- The 1915(c) waiver staff continues to provide MCO and provider training on waiver services and waiver policies and procedures for each specific waiver. Waiver staff also participates in several workgroups and steering committees to address any 1915(c) issues or areas of concern and ensure quality measures are being consistently applied.
- The State submitted a request in the second quarter to amend the HCBS-I/DD waiver to include changes specifically related to the KanCare 1115 I/DD Pilot Project. Pending response from CMS, further amendments to the waiver will be submitted related to KanCare and quality strategies after approval of the recent amendment.
- The State intends to amend the 1915(c) waiver for members with intellectual or developmental disabilities to align with the Section 1115 demonstration amendment to include LTSS for those members in KanCare.

m. Legislative activity: During the quarter ending June 30, the Kansas Legislature adopted budgets for State Fiscal Years 2014 and 2015 that include funding for KanCare. During the quarter, the Governor proposed, and the Legislature adopted, designating a combined $37 million in those fiscal years to reduce the waiting lists for the PD and I/DD waivers. A separate budget proviso also said a portion of that funding is linked to I/DD LTSS being included in KanCare on Jan. 1, 2014 (if not, the state funds designated for the I/DD waiting list, $4 million, will be lapsed).

The Legislature also adopted a a budget proviso to require certain transition protections for I/DD members when their long-term services and supports are included in KanCare:

- Enrollees may keep current LTSS providers on their approved service plans, even if those providers are not in the network, for 180 days from January 1, 2014, or until a service plan is completed and either agreed upon by the enrollee or resolved through the appeals or a fair hearing process and implemented.
- Enrollees may keep their targeted case managers, provided those case managers are employed with community developmental disability organizations (CDDOs) or CDDO subcontractors.
- Enrollees using ID/DD residential providers may access those providers up to one year from January 1, 2014, regardless of contracting status.
- The MCOs must comply with the specific powers and duties of the CDDOs provided in Kansas

law. They also must contract with at least two providers serving each county for each covered LTSS in the benefit package for the enrollees with intellectual or developmental disabilities (unless the county has an insufficient number of providers), and must make at least three contract offers to all LTSS providers serving such enrollees at or above the state-set fee for service rate.

- In 2014, the State will conduct an educational tour to provide information to enrollees with intellectual or developmental disabilities and LTSS providers. The State also will review, in the first 180 days of 2014, each MCO's ID/DD service planning process, and will conduct, in 2014 and 2015, training for each MCO to ensure that they understand the DD services system.
- The Kansas Department for Aging and Disabilities Services (KDADS) will, in fiscal years 2014 and 2015, review and approve all plans of care for ID/DD waiver members for which a reduction, suspension or termination of services is proposed.

V. Policy Developments/Issues

In June, KDHE initiated the public notice process for an amendment to the Section 1115 demonstration. The State indicated it would request CMS approval to implement three changes to KanCare, effective January 1, 2014: (1) provide long term supports and services (LTSS) for individuals with intellectual or developmental disabilities through KanCare managed care plans; (2) establish three pilot programs to support employment and alternatives to Medicaid; and (3) change the timeline for the Delivery System Reform Incentive Payment (DSRIP) Pool.

The State published an abbreviated public notice of this proposed amendment in the June 27, 2013, *Kansas Register*. The same day, a full public notice and the draft amendment letter were posted on the KanCare website for public comment, and an email notification was sent to stakeholder distribution lists. The State also distributed an initial notice of its intent to amend the KanCare 1115 demonstration to tribal governments and Indian Health Service, Tribal Organization, and Urban Indian Organization providers (I/T/U providers) on June 7, 2013.

The public comment period ran through July 29. Public meetings and tribal consultations occurred during the month of July and will be detailed in the next quarterly report (details are also available in the amendment submitted August 19).

In addition to the KanCare-specific legislative activity noted in the previous section, the final budget legislation also included language that would require express consent of the Legislature before an ACA-related eligibility expansion could be implemented.

Also in the quarter, KDHE and the Department for Children and Families continued to meet milestones in the development of the Kansas Eligibility Enforcement System, on pace for October 2013 Phase II go-live.

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 2013 (DY1-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.

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

General reporting issues: KDHE continues to work with HP, the fiscal agent, to create and revise reports in order to have all data needed in an appropriate format for efficient Section 1115 demonstration reporting.

VII. Member Month Reporting

Sum of Member Undup Count	**Member Month**			**Totals**
MEG	*2013-04*	*2013-05*	*2013-06*	*Grand Total*
Population 1: ABD/SD Dual	17,716	17,544	17,342	52,602
Population 2: ABD/SD Non Dual	29,009	28,916	28,618	86,543
Population 3: Adults	32,227	32,041	31,405	95,673
Population 4: Children	211,186	209,745	206,989	627,920
Population 5: DD Waiver	8,749	8,752	8,756	26,257
Population 6: LTC	21,769	21,682	21,552	65,003
Population 7: MN Dual	1,297	1,222	1,152	3,671
Population 8: MN Non Dual	1,147	1,166	1,180	3,493
Population 9: Waiver	4,526	4,517	4,495	13,538
Grand Total	**327,626**	**325,585**	**321,489**	**974,700**

VIII. Consumer Issues

Summary of most common consumer issues that during second quarter:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established).	When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled.	Providers can confirm eligibility by directly accessing KMAP or calling customer service. A load time schedule has been provided by all MCOs to guide expectations.
At the end of the 90 day choice period (4-4-13), some members found their preferred providers were not contracted with their assigned MCO, or needed/desired services were not available through the MCO.	MCOs provided needed services within the State's geographic access standards, either with in-network providers or single case agreements with out-of-network providers. If access standards could not be met, members were granted their request for re-assignment to a different health plan.	MCOs' continue contracting efforts to close gaps in their provider networks.
Prescriptions and other services were delayed or denied for lack of a prior authorization.	• Some PA requirements were relaxed, upon guidance from State Program Managers and Pharmacist. • Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit. • MCO's PA processes were improved to provide more rapid decisions.	For Rx, the State Pharmacy unit is monitoring MCOs' PA lists for compliance
Incorrect information was given to members and providers by customer service representatives.	• Instruction/correction of individual staff when issues were called to MCO's attention. • On occasion, MCO has covered services which were provided on the basis of incorrect information.	Ongoing education of CSRs to understand the eligibility information available to them and KanCare benefits.
Transportation issues: drivers late for appointments, or fail to show up; rudeness; difficulty in scheduling	MCO's transportation vendors address issues for which grievances are filed, provide ongoing education, and dismiss drivers, if necessary. Transportation vendors also educate members on importance of giving 3 days' notice for non-emergent trips.	• MCOs monitor grievance data for trends to identify problem areas and drivers. • One MCO changed to a different NEMT vendor on 4-1-13 resulting in a decline in grievances.
Incorrect application of spenddown, client obligation, and patient liability	MCO education to providers on how to properly apply claims to patient responsibility (spenddown).	Ongoing discussion and process adjustment with MCO staff to assure system set-up is correct

IX. Quality Assurance/Monitoring Activity

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

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

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

The State values a collaborative, race-to-the-top approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalize; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process has been completed (and as it recurs over time), as determined by 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 KanCare operation, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program.
- Extensive interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate to the MCOs both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the receipt, distribution, review and feedback regarding submitted reports.
- Development of the EQRO work plan for calendar year 2013, and beginning of 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.
- Both the initial orientation meeting of the KanCare Interagency Monitoring Team, for state staff who will be standing members, part of a rotating group of members, or resource persons for the IMT. During the first business meeting of the IMT, the areas of shared work included:
    - Dialogue regarding increased clarification of cross-agency roles in the KanCare model.
    - Work sessions regarding access to HCBS services and utilization management issues, and quality/monitoring updates and futures planning.
- Continued management of the KanCare Key Management Activities Reporting (KKMAR) tool and related process, to capture multi-weekly then weekly snapshots of MCO performance in five key early-operation categories:
    - Customer Servcie Management
    - Call Center Management
    - Member & Provider Appeal/Member Grievance Management
    - Claims Processing & Claims Denial Management
    - Provider Network, LTSS Transition & Hot Spot Management
- Planning for monitoring of key mangement activities of the MOCs as the implmentation period came to a close, and we shifted focus together to the more long-term operation of the KanCare program. The planning included development of a mid-year focused review of each MCO related to core operational issues, and ongoing reporting of the KKMAR activities/results.
- Facilitation of multi-weekly then weekly KanCare Rapid Response Stakeholder Calls, to hear from providers, members, advocates and other stakeholders as to any issue of concern or question related to the launch and operation of the KanCare program. Those calls resulted in quick turnaround responsive action to either address the question or build a solution to the

concern. The calls also resulted in the developing/regular updating/posting of the KanCare Rapid Response Stakeholder Issues Log that is posted at the www.KanCare.ks.gov website for ready access.

- Participation in Program Implementation Beneficiary Protection Calls and Bi-Monthly Monitoring calls with CMS, pursuant to STCs 77 and 78.
- Identification of timetable to accomplish during the first year of KanCare operation, the completed merger of HCBS waiver-based performance measures and practices within the comprehensive Kansas state quality strategy. That timetable includes these core features:
    - Quarter 1: Clarify the details of current HCBS waiver performance measures and specify measurement features as well as monitoring roles/responsibilities for each; and initiate ride alongs between state quality staff and MCO care management staff.
    - Quarter 2: Complete performance measure updates; complete ride alongs; and begin focused discussions about lessons learned and effective ways to complete the merger of the programs/measures/monitoring responsibilities into the KanCare structure.
    - Quarter 3: Complete evaluation of merger options and decide on strategies to complete the merger and specify monitoring roles/responsibilities in the new structure; start process of amending each relevant HCBS waiver.
    - Quarter 4: Finalize and submit HCBS wavier amendments.
    - Quarter 5: Develop related State Quality Strategy revisions.

  Progress continues on this set of activities. The State is working to develop appropriate quality strategies for the 1915(c) waivers that align with the 1115 demonstration quality measures per STCs 37 and 45. Technical assistance has been requested to ensure adequate quality measures are included in the 1915(c) waiver amendments to provide outcome-based and evidence-based measures. The State will consider the upcoming changes to HCBS quality reporting and health and safety measurements in the third and fourth quarters to ensure the updates to HCBS quality strategies align with current CMS guidance and State quality strategies

- Development and implementation of process to ensure LTSS-related ride alongs occurred between MCO staff and state quality monitoring staff; and process to receive and either approve or disapprove any MCO-initiated reduction in LTSS services Plans of Care.

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

program and financial management staff, and are incorporated into updated QIS and other documents.

X. Managed Care Reporting Requirements

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

Each MCO submitted a weekly network adequacy report through the end of June 2013. Beginning in July, MCOs will submit their network report monthly. The State uses this report to monitor quality of network data and additions 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 review.

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 provider type.
2. HCBS Service Providers by County, http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

b. Customer service reporting, including average speed of answer at the plans and call abandonment rates: MCO performance reporting in all core customer service/call center functions is reflected for January-June 2013 in the Attachment "KanCare Key Management Activities Report."

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

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

e. Summary of ombudsman activities :

The Office of Ombudsman continues to serve an important role as a resource to Kansas Medicaid consumers. The Ombudsman's role has evolved as consumer's concerns have been less frequent, but increasingly complex. During this transition, the focus has remained on providing improved customer service. More calls are answered "live" and additional administrative resources have been devoted to developing the Ombudsman Contact Log. With over 1,700 contacts to date, the Ombudsman has developed resources to efficiently communicate and collaborate to help resolve concerns. Average response time averages eight hours from initial contact. Current resolution rate is approximately 80%, with an increase in concerns that require follow up after the initial efforts to facilitate a resolution.

With several months experience, the Ombudsman has benefited from an expanded network of contacts and resources. Through experience, he has become more efficient in interacting with the various stakeholders and he has developed key relationships. Through trial and error, he has developed clarity and purpose in his interactions with consumers. Simply, he has learned to concentrate on the important issues and communicate the limits of his resources and refer matters that are outside the scope of his office.

During the second quarter, the subject matter of the concerns has evolved to (in order of prevalence):

1) Eligibility for KanCare (remains the top inquiry)
2) Establishing a relationship and reliable communication with the plans and State staff
3) Billing/Claims and the grievance/appeal process
4) Pharmacy and Durable Medical Equipment prior authorizations
5) Transportation scheduling and concerns
6) Status of plan provider networks and access to care

Emerging issues continue to include changes in plans of care (services) and "good cause" request to change plans. The Ombudsman has narrowed his focus to be responsive to consumer demand with an increased reliance on appropriate delegation to routine or administrative inquiries. He continues to advocate for the resources necessary to deliver a responsive and effective resource for consumers.

The Ombudsman has presented to stakeholder groups upon request and attended KanCare public forums. Additionally, the Ombudsman has responded to inquiries about his experience and perspective about the function of the office. Above all, he has advocated for constructive dialog and engaged in open discussion and thoughtful consideration based on the consumer perspective.

The ombudsman remains involved in various workgroups:

1) I/DD Waiver Pilot
2) HCBS Technical Workgroup
3) KDADS Internal I/DD Workgroup
4) KDADS KanCare Weekly Workgroup
5) KDADS Friends and Family Workgroup
6) CMS Implementation Monitoring Meetings

In summary, the Ombudsman devotes a majority of his time engaging with KanCare consumers. The central themes have remained consistent and are representative of the system change. Consumers have a reliable resource that is responsive to their individual needs. Although every interaction does not result in the desired outcome, each consumer receives the respect and compassion they deserve. The Ombudsman takes pride in serving Kansas Medicaid consumers and continues to work tirelessly to respond to their needs.

f. Summary of MCO critical incident report:

In the second quarter, KDADS continued transition to the centralized Adverse Incident Reporting (AIR) web-based system for all of the providers except the I/DD waiver. During the transition period, entries into the previous system continued for a part of April and May with full integration into AIR achieved by June. Therefore, for the second quarter, the report differentiates for April and May.

Critical Incidents reported into AIR for second quarter (including HCBS):

Total # of Critical Incidents Received	122
Total # of Critical Incidents Reviewed	101
Total # of Critical Incidents Pending	21

Critical Incidents reported to KDADS manual database for second quarter (April & May):

Total # of Critical Incidents Received	66
Total # of Critical Incidents Reviewed	66
Total # of Critical Incidents Pending	0
Total # of Critical Incidents Substantiated	51

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, 2013. The second quarter LPTH/BCCH Pool payments were processed on May 9, 2013. The Attachment Safety Net Care Pool Report identifies 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

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

The draft evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas has reviewed that feedback and is working internally and with the external evaluator, MCOs and others to address that feedback. The final design

was completed and submitted by Kansas to CMS on August 23, 2013.

The timeline from there will include:

- Adjustments to the evaluation plan will be completed and submitted for approval whenever relevant amendments to the 1115 waiver are submitted, and otherwise as applicable.
- Quarterly and Annual evaluation progress reports will be submitted.
- Draft evaluation report to be submitted 120 days after expiration of the demonstration.

XIII. Other (Post Award Forums; I/DD Pilot Project)

a. Post Award Forum: The Post-Award Forum was conducted June 25 during a meeting of the KanCare Advisory Council. More than 60 stakeholders, in addition to members of the Advisory Council, attended. After listening to a presentation on KanCare implementation, three stakeholders – a consumer, a provider, and a representative of an advocacy organization – offered comments during the forum; additional questions and discussion followed from Advisory Council members on other agenda items related to implementation. Cards were also distributed to attendees indicating that email comments would be accepted for the forum through June 28.

   The consumer concern related to a service that was initially authorized but then disallowed by a KanCare MCO because it is not a covered service for adults. By the end of the meeting, the MCO had identified an alternative resource to address the member's need. The provider, a pharmacist, spoke favorably of interaction with State staff but also expressed concerns about delays in receiving confirmation of eligibility for members needing prescriptions filled. (See Section IV(g) and Section VIII). The advocate asked for clarification about what the Ombudsman's resolution rate represented. (The rate represents issues that have been resolved; unresolved issues include those that have been pended for more information or final resolution.)

   Among written comments, the focus was on operational issues. One individual, a provider, expressed concern about initial primary care provider assignments, which were affected by the state of each MCO's network development at the time of initial assignment. The provider believed it would be preferable to have one MCO option rather than three, because of contracting complications. A second individual asked for consistency from the MCOs in how to apply the fee-for-service payment floor to services that were manually priced in FFS Medicaid. A provider association reiterated concerns raised during the Advisory Council meeting about each plan's compliance with contractual requirements for maximum allowable cost (MAC) generic drug pricing and administration, including the requirement that each plan have transparent MAC pricing lists. Each plan was in the process of developing real-time MAC pricing lookups for pharmacists.

b. In preparation for the inclusion of long-term supports and services in KanCare on January 1, 2013, KDADS began enrolling participants in a voluntary KanCare I/DD Pilot Program on March 1, 2013. Enrollment ended on June 30, 2013. The pilot consists of 25 providers and 550 individuals with intellectual and/or developmental disabilities who are currently receiving services under the KDADS HCBS Waiver. Updates are prominently posted on the KDADS and KanCare websites with information for consumers and providers.

The three main objectives of the KanCare I/DD Pilot Project, as developed by the blue-ribbon panel of I/DD stakeholders, are as follows:

1. Relationship building/shared understanding between MCOs and I/DD system
2. Define how services/service delivery will look under KanCare
3. Develop/Test billing processes for January 1, 2014 inclusion

Several activities have occurred during the past few months to demonstrate that the KanCare I/DD Pilot Project is meeting its objectives.

- **Relationship building/shared understanding between MCOs and I/DD system**
  - With the assistance of Wichita State University, the state and members of the KanCare I/DD Pilot Advisory Committee developed a survey to measure all participant and guardian levels of knowledge of KanCare at different stages of the pilot process.
  - The three MCOs have been participating regularly in the I/DD Pilot Committee biweekly meetings.
  - As a part of the effort to increase the knowledge level of Managed Care Organizations (MCOs) regarding the I/DD system, members of the Advisory Committee invited Care Coordinators from the MCOs to meet with several current I/DD system Targeted Case Managers and discuss the roles of both the Care Coordinators and the TCMs.
  - Also, members of the Employment First Work Group met with MCOs and the Pilot Advisory Committee to discuss the challenges of assisting people with disabilities to obtain employment in integrated/competitive work settings.
  - The MCOs and Pilot Advisory Committee also met with members of the Challenging Behaviors Work Group to discuss issues related to supporting persons who demonstrate difficult-to-manage behaviors.
  - During the month of June state staff, along with staff from the MCOs and representatives from the Advisory Committee, held meetings in Garden City,

Arkansas City/Winfield, Parsons, and Lawrence and met with more than 100 participants, providers and TCMs to provide information regarding KanCare and the Pilot. Another meeting is scheduled in early July in Great Bend.

- **Define how services/service delivery will look under KanCare**

  - At the most fundamental level, the Pilot Committee, the state, and all three MCOs agree that service delivery and the assessment/tiering for those services should remain in the hands of the CDDOs, CSPs and TCMs.

  - Since January 2012, the administration has maintained its policy decision to allow individuals with I/DD the ability to retain their Targeted Case Manager (TCM). As such, the I/DD Pilot will begin working on reviewing the role and responsibilities of TCM and align the definitions and work of the TCM with CMS regulations.

  - CDDOs will continue to perform BASIS Assessments to determine eligibility for I/DD Waiver services. TCMs develop the plan of care and work with the MCOs

  - I/DD Waiver recipients in the KanCare I/DD Pilot Project have begun to take advantage of the Value-Added Services available through the MCO Health Plans. Limited Care Coordinator interaction indicates that pilot members have not experienced major service delivery interruptions while in the pilot project.

  - Following the close of the 2013 regular legislative session, the I/DD Pilot Committee has focused on clearly defining the services and service delivery for the I/DD population that will meet the needs of the consumer while aligning with the managed care delivery system under KanCare.

  - Over the next few weeks the I/DD Pilot Committee will be shifting its focus from developing the claims/billing system to developing the practical aspects of the workflow process including the development and transmission of the plans of care to the MCOs

- **Develop/Test billing processes for January 1, 2014 inclusion**

  - The I/DD Pilot Committee has been monitoring the progress of the technical development of the claims billing system for the I/DD Pilot Project to test claims prior to the January 1, 2014 implementation.

  - Establishing and testing billing processes for I/DD services under KanCare has been a primary focus the Pilot Committee. However, until the close of session, many were hesitant to begin detailed discussions about the IT requirements and synchronization between the MCOs, state and provider billing mechanisms. As a result, explicit discussions about how to bill were did not begin until the first part of

June.

- The I/DD Pilot Project has reached the final stages of the technical design of the claims billing system. Currently, IT staff from the state, the MCOs and from the state fiscal agent are developing testing systems, which will allow pilot service providers to bill and receive payment for services provided to pilot participants in a manner similar as to how they will beginning January 1, 2014.

- Providers will receive training regarding the process prior to initial claims billing. Provider billing through the system is expected to begin in the fall of 2013.

Ongoing and Future activities include:

- Carefully defining the roles of community services providers, MCO care coordinators and targeted case managers to ensure continuity of care, collaborative communication, and comprehensive education;

- Statewide educational forums with consumers, providers, and MCO staff in the fall of 2013;

- MCO Technical Assistance to resolve any questions related to policies, procedures and complaints, and to improve consumer relations with each MCO;

- Friends and Family Advisory Council Steering Committee on Education and Policy for the I/DD populations will be meeting regularly in the fall of 2013 to ensure smooth transition of the HCBS I/DD communities into the KanCare managed care delivery system;

- Training for providers on using the AIR System for reporting critical incidents involving I/DD Pilot participants; this training will be used to improve training for other service providers in the latter months of 2013 in preparation for January 1, 2014;

- Beta testing of the billing claims system and full-scale testing of the process including plan-of-care development and coordination between the TCM and Care Coordinators for pilot participants;

- Developing pilot goals, action plans, and implementation of activities related to employment and collaborating with mental health providers; and

- Preparing and ensuring consumers, providers, and community organizations understand the credentialing and contracting process with MCOs, including timelines and procedures to be completed prior to January 1, 2014.

XIV. Enclosures/Attachments

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

Section X(b) refers to report reflecting the MCOs' second quarter customer service and call center performance, entitled KanCare Key Management Activities Report, which is attached.

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

XV. State Contacts(s)

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XVI. Date Submitted to CMS

August 30, 2013

KanCare BN Monitoring DY1-Q2

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

Quarter 2
Start Date: 4/1/2013
End Date: 6/30/2013

	Total Expenditures	Total Member-Months
Apr-13	164,039,266.49	329,812
May-13	194,059,607.16	327,705
Jun-13	214,464,600.56	321,489
PCP:	(11,009,942.54)	
Q2 Total	561,553,531.67	979,006

(Actual/Estimate)

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Apr-13									
Expenditures	4,008,575.03	28,501,037.08	12,915,689.07	39,770,395.91	10,655,689.53	53,295,392.65	1,471,438.87	1,631,987.87	11,789,060.48
Member-Months	18,060	29,516	32,128	211,213	8,797	22,411	1,317	1,712	4,658
May-13									
Expenditures	4,041,479.22	28,939,809.07	13,402,478.61	40,316,587.21	38,046,973.31	53,718,923.79	1,605,110.18	1,801,991.59	12,186,254.18
Member-Months	17,653	29,204	33,232	209,442	8,796	21,767	1,354	1,668	4,589
Jun-13									
Expenditures	3,971,041.49	30,415,579.52	13,272,754.63	45,064,375.88	54,161,202.92	52,808,126.32	1,012,811.98	1,534,333.96	12,224,373.86
Member-Months	17,342	28,618	31,405	206,989	8,756	21,552	1,152	1,180	4,495
PCP									
Expenditures	(65,051.75)	(2,400,217.79)	(698,151.79)	(6,620,191.78)	(232,611.03)	(606,434.10)	(4,575.82)	(120,604.86)	(262,103.62)
Q2 Total									
Expenditures	11,956,043.99	85,456,207.88	38,892,770.52	118,531,167.22	102,631,254.73	159,216,008.66	4,084,785.21	4,847,708.56	35,937,584.90
Member-Months	53,055	87,338	96,765	627,644	26,349	65,730	3,823	4,560	13,742
DY 1 - Q2 PMPM	225.3519	978.4539	401.9301	188.8510	3,895.0721	2,422.2731	1,068.4764	1,063.0940	2,615.1641

KanCare Key Management Activities Report

Excerpt

Dates/Times Covered by Report	Date of Report
6/25/2013 (12:00 a.m.) to 6/30/2013 (11:59 p.m.)	Tuesday, July 02, 2013

Cumulatively Covers
1/1/2013 to date noted above

KanCare

Amerigroup Kansas, Inc.

KanCare Key Management Activities Report

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	1,981
# of Calls Documented - Cumulative	78,208

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	393	12,706
2. Concern with access to service or care; or concern with service or care disruption	100	3,886
3. Care management or health plan program	94	3,946
4. Claim or billing question	116	3,053
5. Coordination of benefits	16	945
6. Disenrollment request	11	556
7. Eligibility inquiry	49	2,453
8. Enrollment information	95	3,214
9. Find/change PCP	374	30,339
10. Find a specialist	29	1,584
11. Assistance with scheduling an appointment	3	65
12. Need transportation	86	3,360
13. Order ID card	117	5,184
14. Question about letter or outbound call	334	1,475
15. Request member materials	13	570
16. Update demographic information	70	2,077
17. Member emergent or crisis call	1	37
18. Other	80	2,758

Standard	Reporting Period	Cumulative
% resolved within 2 business days	99.7%	99.96%
% resolved within 5 business days	0.0%	0.01%
% resolved within 8 business days	0.0%	0.00%
% resolved within 15 business days	0.0%	0.00%
% resolved > 15 business days	0.0%	0.00%
% pending	0.3%	0.03%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	1,377
# of Calls Documented - Cumulative	38,598

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – New	140	8,314
2. Authorization – Status	207	5,990
3. Benefits inquiry	116	4,214
4. Claim Denial Inquiry	209	3,007
5. Claim Status Inquiry	466	9,107
6. Claim Payment Question/Dispute	102	1,655
7. Billing Inquiry	7	336
8. Coordination of Benefit	6	169
9. Member Eligibility Inquiry	30	1,089
10. Recoupment or Negative Balance	0	0
11. Pharmacy/Prescription Inquiry	9	349
12. Request Provider Materials	9	137
13. Update Demographic Information	3	90
14. Verify/Change Participation Status	7	451
15. Web Support	42	2,554
16. Credentialing Issues	8	507
17. Other (including to provider services or provider representatives)	16	629

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100.0%	100.0%
% resolved within 5 business days	0.0%	0.0%
% resolved within 8 business days	0.0%	0.0%
% resolved within 15 business days	0.0%	0.0%
% resolved > 15 business days	0.0%	0.0%
% pending	0.0%	0.0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	40	1,460
2. Community Service Organization	0	10
3. Other Public or Private Entities	1	32

KanCare

Amerigroup Kansas, Inc.

KanCare Key Management Activities Report

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period		Performance Result Cumulative from 1.1.13	
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100.0%		100.0%	
Hold time in seconds – initial connection	**Requirement:** 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	110587	97.9%	110587	97.9%
Hold time in seconds – subsequent to initial connection	**Monitoring Only:** Average hold time	2:10		2:10	
# and % of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	3519	100.0%	122080	100.0%
# and % of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	2716	100.0%	113645	99.9%
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day *[For Amerigroup: # of calls that utilized virtual hold; #/% returned within one day or less.]*	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day				
	Number & Percentage of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	558	100.0%	558	100.0%
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	15	100.0%	810	100.0%
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand				
	Total Number of Fax Calls Received	409		15,878	
	Number & Percentage of Fax Calls that DO NOT Receive a Busy Signal	402	98.3%	15,577	98.1%
# and % of member calls abandoned	--	285	0.4%	285	0.4%
# and % of provider calls abandoned	--	286	0.8%	286	0.8%
Average member call length	--	7:13		7:13	
Average provider call length	--	5:56		5:56	
Average seconds to answer member calls	--	0:08		0:08	
Average seconds to answer provider calls	--	0:16		0:16	

KanCare Key Management Activities Report

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	3,019
# of Calls Documented - Cumulative	172,371

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	511	24,861
2. Concern with access to service or care; or concern with service or care disruption	66	3,787
3. Care management or health plan program	161	6,286
4. Claim or billing question	166	2,450
5. Coordination of benefits	19	644
6. Disenrollment request	4	437
7. Eligibility inquiry	265	14,335
8. Enrollment information		97
9. Find/change PCP	537	59,550
10. Find a specialist	94	4,246
11. Assistance with scheduling an appointment	16	118
12. Need transportation	241	7,611
13. Order ID card	195	9,595
14. Question about letter or outbound call	50	20,058
15. Request member materials	118	6,777
16. Update demographic information	161	5,741
17. Member emergent or crisis call	75	2,029
18. Other	141	3,749

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100%	100%
% resolved within 5 business days		
% resolved within 8 business days		
% resolved within 15 business days		
% resolved > 15 business days		
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	969
# of Calls Documented - Cumulative	20,586

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – new	2	27
2. Authorization – status	64	1,758
3. Benefits inquiry	71	1,282
4. Claim denial inquiry		0
5. Claim status inquiry	550	9,962
6. Claim payment question/dispute	77	1,738
7. Billing inquiry		2
8. Coordination of benefit		12
9. Member eligibility inquiry	35	1,378
10. Recoupment or negative balance		10
11. Pharmacy/prescription inquiry	7	250
12. Request provider materials	4	54
13. Update demographic information	71	2,369
14. Verify/change participation status	17	452
15. Web support	2	73
16. Credentialing issues	20	421
17. Other (including to provider services or provider representatives)	49	798

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100%	100%
% resolved within 5 business days		
% resolved within 8 business days		
% resolved within 15 business days		
% resolved > 15 business days		
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	239	11,425
2. Community service organization		6
3. Other public or private entities	28	1,084

KanCare Key Management Activities Report

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period	Performance Result Cumulative from 1.1.13
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100	100
Hold time in seconds – initial connection	**Requirement:** 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	Mbr-4 Sec-98.83% (6/25) Mbr-3 Sec-98.93% (6/26) Mbr-4 Sec-98.23% (6/27) Mbr-2 Sec,99.41% (6/28) Prv-3 Sec-98.28 (6/25) Prv-3 Sec-99.53% (6/26) Prv-5 Sec-98.05% (6/27) Prv-2 Sec ,99.47% (6/28)	Member-11 Sec-93.76% Provider-7 Sec-95.01%
# and % of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	100	100
# and % of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	100	100
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day	0	0
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	17 vm calls, 100% returned	1580vm calls left, 98% returned
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand		
	Total Number of Fax Calls Received	0	0
	Number & Percentage of Fax Calls that DO NOT Receive a Busy Signal	0	0
# and % of member calls abandoned	--	2 Ab, 0.29% (6/25) 7 Ab, 1.07% (6/26) 5 Ab, 0.81% (6/27) 3 Ab,0.59% (6/28)	1173 Aban,0.97%
# and % of provider calls abandoned	--	2 Ab, 0.86% (6/25) 0 Ab, 0% (6/26) 0 Ab, 0% (6/27) 1 Abn,0.53% (6/28)	195 Aban,0.71%
Average member call length	--	5:12 (6/25) 5:08 (6/26) 5:18 (6/27) 5:15 (6/28)	5:35
Average provider call length	--	6:45 (6/25) 6:38 (6/26) 7:27 (6/27) 6:55 (6/28)	6:17
Average seconds to answer member calls	--	4 (6/25) 3 (6/26) 4 (6/27) 2 (6/28)	11
Average seconds to answer provider calls	--	3 (6/25) 3 (6/26) 5 (6/27) 2 (6/28)	7
Average Hold Time in Seconds - Members	--	39 (6/25) 41 (6/26) 47 (6/27) 48 (6/28)	39
Average Hold Time in Seconds - Providers	--	35 (6/25) 11 (6/26) 31 (6/27) 11 (6/28)	37

KanCare Key Management Activities Report

United Healthcare

SUBJECT AREA I: CUSTOMER SERVICE MANAGEMENT

Members

# of Calls Documented - Reporting Period	1,822
# of Calls Documented - Cumulative	85,618

Inquiry Type	# Reporting Period	# Cumulative
1. Benefit Inquiry – regular or VAS	477	27,391
2. Concern with access to service or care; or concern with service or care disruption	0	0
3. Care management or health plan program	75	4,083
4. Claim or billing question	65	2,446
5. Coordination of benefits	81	2,087
6. Disenrollment request	4	1,345
7. Eligibility inquiry	378	7,010
8. Enrollment information	6	3,258
9. Find/change PCP	351	25,271
10. Find a specialist	68	2,140
11. Assistance with scheduling an appointment	14	509
12. Need transportation	16	703
13. Order ID card	244	5,756
14. Question about letter or outbound call	4	646
15. Request member materials	6	345
16. Update demographic information	4	933
17. Member emergent or crisis call	0	18
18. Other	23	2,046

Standard	Reporting Period	Cumulative
% resolved within 2 business days	98.5%	98.5%
% resolved within 5 business days	100.0%	100.0%
% resolved within 8 business days	0%	0%
% resolved within 15 business days	0%	0%
% resolved > 15 business days	0%	0%
% pending	0%	0%

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Providers

# of Calls Documented - Reporting Period	1,114
# of Calls Documented - Cumulative	23,935

Inquiry Type	# Reporting Period	# Cumulative
1. Authorization – new	63	741
2. Authorization – status	46	1,051
3. Benefits inquiry	242	3,838
4. Claim denial inquiry	47	1,563
5. Claim status inquiry	201	3,262
6. Claim payment question/dispute	30	799
7. Billing inquiry	39	914
8. Coordination of benefit	73	986
9. Member eligibility inquiry	311	3,958
10. Recoupment or negative balance	4	303
11. Pharmacy/prescription inquiry	25	757
12. Request provider materials	4	257
13. Update demographic information	2	305
14. Verify/change participation status	2	205
15. Web support	1	125
16. Credentialing issues	5	289
17. Other (including to provider services or provider representatives)	19	690

Standard	Reporting Period	Cumulative
% resolved within 2 business days	100.0%	99.9%
% resolved within 5 business days	100%	100%
% resolved within 8 business days	0%	#REF!
% resolved within 15 business days	0%	#REF!
% resolved > 15 business days	0%	#REF!
% pending	0%	#REF!

Note on Standards: Per the Contract, 95% of inquiries must be resolved within 2 business days of receipt and 98% must be resolved within 5 business days of receipt. To be eligible for pay-for-performance payments, 98% of inquiries must be resolved within 2 business days of receipt and 100% must be resolved within 8 business days of receipt.

Other

Inquiry Type	# Reporting Period	# Cumulative
1. Potential Member	6	664
2. Community service organization	0	10
3. Other public or private entities	0	22

KanCare Key Management Activities Report

United Healthcare

SUBJECT AREA II: CALL CENTER MANAGEMENT

Call Center and Other Responsiveness – Issue (Member and Provider unless otherwise stated)	Requirement	Performance Result this Reporting Period	Performance Result Cumulative from 1.1.13
No busy signal	**Requirement:** 99% of calls will be answered by an individual or an electronic device without receiving a busy signal	100%	100%
Hold time in seconds – initial connection	Requirement: 95% of all calls, whether incoming or outgoing, will be placed on hold for no more than one minute	97.9%	97.5%
Hold time in seconds – subsequent to initial connection	**Specific requirement not stated. For KDHE monitoring purposes only.**		
	Total number of calls placed on hold - Member	388	24,381
	Average Hold Time - Member	120	88
	Total number of calls placed on hold - Provider	105	5,021
	Average Hold Time - Provider	199	133
# of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	2910	111644
% of calls resolved during initial contact	**Requirement:** 90% of calls answered will be resolved by the MCO during the initial contact	99.11%	98.80%
# of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	2944	108239
% of calls recorded and recording maintained	**Requirement:** 100% of received phone calls are recorded and the recordings maintained	100%	100%
# of calls left on voice mail during working hours; #/% that are retrieved and returned within one business day *[For Amerigroup: # of calls that utilized virtual hold; #/% returned within one day or less.]*	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned during one business day		
	Number of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	**NA**	**NA**
	Percentage of Calls that Utilized Virtual Hold and Call Returned within One Day or Less	**NA**	**NA**
# of calls left on voice mail after working hours; #/% that are retrieved and returned within one business day	**Requirement:** 100% of calls left on voice mail during or after working hours will be retrieved and returned within one business day	**1 / 100%**	**295 / 100%**
# fax calls that receive a busy signal, and # of fax calls received	**Requirement:** 98% of the time, fax lines shall meet customer demand		
	Total Number of Fax Calls Received	0	0
	Number of Fax Calls that DO NOT Receive a Busy Signal	0	0
	Percentage of Fax Calls that DO NOT Receive a Busy Signal	100%	100%
# of member calls abandoned	--	5	466
% of member calls abandoned	--	0.30%	0.5%
# of provider calls abandoned	--	3	52
% of provider calls abandoned	--	0.30%	0.20%
Average member call length	--	291	357
Average provider call length	--	447	456
Average seconds to answer member calls	--	4.07	6.42
Average seconds to answer provider calls	--	0.82	1.76

Safety Net Care Pool Report

Demonstration Year 1 - QE June 2013

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

Paid 5/9/13

Provider Name	1st Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	2,491,034.00	1,083,350.69	1,407,683.31
University of Kansas Hospital	7,473,103.00	3,250,052.49*	4,223,050.51
Total	**9,964,137.00**	**4,333,403.35**	**5,630,733.82**

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

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 1 - QE June 2013

Health Care Access Improvement Pool
Paid 5-8-2013

Hospital Name	HCAIP DY/QTR: 2013/2	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	30,672.00	13,339.25	17,332.75
Children's Mercy Hospital South	132,776.00	57,744.28	75,031.72
Coffey County Hospital	22,628.00	9,840.92	12,787.08
Coffeyville Regional Medical Center, Inc.	85,288.00	37,091.75	48,196.25
Cushing Memorial Hospital	121,789.00	52,966.04	68,822.96
Galichia Heart Hospital LLC	36,289.00	15,782.09	20,506.91
Geary Community Hospital	108,556.00	47,211.00	61,345.00
Hays Medical Center, Inc.	372,362.00	161,940.23	210,421.77
Hutchinson Hospital Corporation	290,352.00	126,274.08	164,077.92
Kansas Heart Hospital LLC	30,369.00	13,207.48	17,161.52
Kansas Medical Center LLC	46,233.00	20,106.73	26,126.27
Kansas Rehabilitation Hospital	6,317.00	2,747.26	3,569.74
Kansas Surgery & Recovery Center	4,846.00	2,107.53	2,738.47
Labette County Medical Center	90,810.00	39,493.27	51,316.73
Lawrence Memorial Hospital	223,486.00	97,194.06	126,291.94
Memorial Hospital, Inc.	42,456.00	18,464.11	23,991.89
Menorah Medical Center	207,646.00	90,305.25	117,340.75
Mercy - Independence	47,986.00	20,869.11	27,116.89
Mercy Health Center - Ft. Scott	82,850.00	36,031.47	46,818.54
Mercy Hospital, Inc.	3,239.00	1,408.64	1,830.36
Mercy Reg Health Ctr	170,152.00	73,999.10	96,152.90
Miami County Medical Center	57,668.00	25,079.81	32,588.19
Mid-America Rehabilitation Hospital	17,575.00	7,643.37	9,931.63
Morton County Health System	35,477.00	15,428.95	20,048.05
Mt. Carmel Medical Center	207,216.00	90,118.24	117,097.76
Newman Memorial County Hospital	127,347.00	55,383.21	71,963.79
Newton Medical Center	123,879.00	53,874.98	70,004.02
Olathe Medical Center	366,181.00	159,252.12	206,928.88
Overland Park Regional Medical Ctr.	585,431.00	254,603.94	330,827.06
Pratt Regional Medical Center	57,255.00	24,900.20	32,354.80
Providence Medical Center	396,598.00	172,480.47	224,117.53
Ransom Memorial Hospital	73,654.00	32,032.12	41,621.88
Saint Catherine Hospital	172,435.00	74,991.98	97,443.02
Saint Francis Health Center	619,423.00	269,387.06	350,035.94
Saint John Hospital	99,673.00	43,347.79	56,325.21
Saint Luke's South Hospital, Inc.	121,261.00	52,736.41	68,524.59
Salina Regional Health Center	263,396.00	114,550.92	148,845.08
Salina Surgical Hospital	654.00	284.42	369.58
Select Specialty Hospital - Kansas City	5,211.00	2,266.26	2,944.74
Select Specialty Hospital - Wichita	5,736.00	2,494.59	3,241.41
Shawnee Mission Medical Center, Inc.	707,194.00	307,558.67	399,635.33
South Central KS Reg Medical Ctr	21,473.00	9,338.61	12,134.39
Southwest Medical Center	117,327.00	51,025.51	66,301.49
Specialty Hospital of Mid America	376.00	163.52	212.48
Stormont Vail Regional Health Center	943,679.00	410,406.00	533,273.00
Summit Surgical LLC	776.00	337.48	438.52
Sumner Regional Medical Center	27,744.00	12,065.87	15,678.13
Susan B. Allen Memorial Hospital	114,299.00	49,708.64	64,590.36
Via Christi Hospital St Teresa	161,584.00	70,272.88	91,311.12
Via Christi Regional Medical Center	1,465,595.00	637,387.27	828,207.73
Via Christi Rehabilitation Center	17,202.00	7,481.15	9,720.85
Wesley Medical Center	1,000,423.00	435,083.96	565,339.04
Western Plains Medical Complex	125,520.00	54,588.65	70,931.35
	10,196,364.00	**4,434,398.70**	**5,761,965.30**