Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 6.30.15

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2015-12/31/2015)
Federal Fiscal Quarter: 3/2015 (4/15-6/15)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

- Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Control Medicaid costs by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care; and

- Establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well.

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

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the first quarter known as of June30, 2015.

Demonstration Population	Enrollees at Close of Qtr. (06/30/2015)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	17,813	18,145	962
Population 2: ABD/SD Non Dual	28,672	29,348	676
Population 3: Adults	43,900	47,291	3,391
Population 4: Children	225,578	238,079	12,501
Population 5: DD Waiver	8,743	8,797	54
Population 6: LTC	20,669	21,741	1,072
Population 7: MN Dual	1,230	1,369	139
Population 8: MN Non Dual	1,014	1,149	135
Population 9: Waiver	3,820	3,950	130
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**350,809**	**369,869**	**19,060**

III. Outreach/Innovation

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

During the second quarter, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued, on the following dates with attendees in person and by phone: April 7, 2015 in Mayetta, KS (12 attendees), May 5, 2015 (12 attendees) and June 2, 2015 (15 attendees).).

Also during this quarter, the state's KanCare Advisory Council met on April 2, 2015 and June 25, 2015. The Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists.

The agenda for the Council's April meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, December 15, 2014
III. KDHE Update - Susan Mosier, Secretary, Kansas Department of Health and Environment and Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
IV. KDADS Update – Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services
V. Updates on KanCare with Q & A
    a. Amerigroup Kansas
    b. Sunflower State Health Plan
    c. UnitedHealthcare Community Plan
VI. Update from KanCare Ombudsman – Kerrie Bacon
VII. Update on Employment First Initiative and Employment Pilots – Mary Ellen Wright
VIII. Next Meeting of KanCare Advisory Council – June 25, 2015, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
IX. Adjourn

The agenda for the Council's June meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, April 2, 2015
III. KDHE Update - Susan Mosier, Secretary, Kansas Department of Health and Environment and Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
IV. KDADS Update – Kari Bruffett, Secretary, Kansas Department for Aging and Disability Services

V. Updates on KanCare with Q & A
   a. Amerigroup Kansas
   b. Sunflower State Health Plan
   c. UnitedHealthcare Community Plan
VI. Update from KanCare Ombudsman – Kerrie Bacon
VII. Miscellaneous Agenda Items
   a. Discussion of $50 million proposed cuts
   b. New Assessment Instrument launch – InterRaI
   c. HB 2281 Impact on KanCare Stakeholders
   d. HCBS Home Modifications
VIII. Next Meeting of KanCare Advisory Council – September 10, 2015, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
IX. Adjourn

The KanCare Consumer and Specialized Issues Workgroup met on June 30, 2015, in Ottawa, Kansas, at the Kansas Aging & Disability Resource Center. The agenda items included a report from the KanCare Ombudsman, and updates from the KanCare MCOs' Member Advisory Committees. The meeting also included the announcement of the Elderly and Disabled populations' financial eligibility being moved from the Department for Children and Families to KDHE as of January 2016. The meeting included an in-depth look at KDHE's KanCare Executive Summary Report dated 06-25-2015. Since it has been over 2 years for the members on this workgroup, we will be looking for new members for the next quarterly meeting of the KanCare Consumer and Specialized Issues Workgroup and applications for this membership were handed out.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly)
- HCBS-IDD Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, bi-weekly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO Association) board meetings (as requested)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Quarterly Meetings with the Association of Community Mental Health Centers, including Managed Care Organizations

- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration
- State Mental Health Hospital mental health reform meetings (quarterly)
- DSM V Workgroups to discuss DSM 5 implementation in quarter 3

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

Health Homes

Kansas implemented Health Homes (HH) for people with serious mental illness (SMI) July 1, 2014. As of June 1, 2015, there were 36,967 KanCare members identified as eligible for the SMI HH. The opt-out rate for June 2015 was 17%, leaving 30,775 enrolled in SMI HHs. The opt-out rate has remained very stable for the program, with a monthly average rate of 16%. The engagement rate, calculated through February 2015 (due to encounter data lag), was 50.5%. Engagement is calculated by dividing the number of enrolled HH members by the number for whom a payment was made. Both the Lead Entities (MCOs) and the Health Home Partners (HHPs) are noting great difficulty in locating HH members and, when located, convincing them to participate in HHs. This population is often transient and addresses are not current; many are SSI recipients, who don't have Medicaid eligibility reviews, so their addresses are not updated annually as other KanCare members' are. In addition, because of the nature of many of the SMI diagnoses, this population tends to be distrustful of service systems and government, in general.

For those served in the SMI HH, total payments through May 2015 were $17,602,678. Payments are made on a per-member per-month basis, but can only be triggered if a service is actually provided.

In late April and early May, KDHE and KDADS staff held listening meetings with HHPs in 22 cities. Each meeting was hosted by a HHP, and all HHPs contracted to provide HH services to the SMI population were invited to attend the two-hour meetings. The majority of the meetings were small, although a few meetings involved 15 or more HHP staff; 219 HHP staff attended the meetings. The invitation included an agenda with a specific set of questions so the HHP staff could come prepared to answer the questions. The meetings were conducted in a quasi-focus group manner, ensuring that all attending HHPs were afforded an opportunity to respond to each question. Notes from each meeting were compiled and then categorized into major themes which were then shared with the three MCOs - Amerigroup, Sunflower State Health Plan and United Healthcare. The themes related to problems or barriers were also prioritized in order to determine where the most attention should be focused.

KDHE continues to work with the MCOs on the issues raised during the HHP listening tour. Some of the steps already taken as a result of the input provided by HHPs include:

- Launching an online survey of HHPs concerning their experience in serving foster care children in SMI HHs and plans to train the state's foster care contractors about KanCare and HHs
- Plans to hold a HH conference August 11 and 12, 2015
- Adding a "tips and tricks" feature to the monthly HH newsletter, the *Health Homes Herald*
- Providing small training segments during the bi-weekly SMI HH implementation call – early topics include explaining the Medicaid medically needy program and ways to best use the consulting physician in the HH

KDHE will also launch an SMI HH dashboard in early September, which will be posted on the HH website (http://www.kancare.ks.gov/health_home.htm). Thirteen different graphs and tables will provide stakeholders with information concerning enrollment and eligibility numbers, opt-out rates, engagement rate, payments, service mix, number of Health Action Plans completed and number of unduplicated monthly in-person and phone contacts made with HH members.

HCBS Educational Summit

In the second quarter, KDADS presented the 2015 HCBS "Systems at Work" Educational Summit. The summit took place on April 13 and 14, to provide educational information to consumers, families, caregivers, providers, and professionals that attended. The HCBS Summit included 117 breakout sessions focusing on HCBS related topics. The breakout session topics included the Nurse Delegation and Nurse Practice Act, Durable Power of Attorney/Guardianship, Conflict of Interest, Public Health Concerns, Trauma-Informed Systems of Care, HCBS Transition Plan, HCBS Programs, Housing and Homelessness, and more. Attendees were also provided the opportunity to attend KanCare MCO sessions focusing on the basics of the organizations, member benefits, and an overview for providers. Over 700 individuals attended the day and a half event, and they had the opportunity to interact with individuals from all across Kansas.

MCO Outreach Activities

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

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

Marketing Activities: Amerigroup participated in over 180 events for the second quarter of 2015. This included partner development, sponsorships, outreach and advocacy. The Community Relations Representatives' primary focus continues to be member education of services and benefits of the KanCare program. Below is a sampling of Marketing activities Amerigroup supported in the second quarter:

• Wichita Public Schools
• Lawrence Douglas County Health Department
• Kansas City Kansas Community College
• Kansas Special Olympics

Outreach Activities: Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They continue with ongoing targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. Amerigroup's Community Relations team introduced a Captain Amerigroup campaign in June to help educate Kansans about the importance of children's medical, vision, hearing and dental screenings. They also introduced their new 'Talking to your employer about your disability' brochure which complements their 'Pocket Resume' and 'Ace That Interview' documents to help with employment objectives for 2015. The Community Relations Representatives participated in a variety of community events reaching over 14,000 Kansans in the second quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: diabetes, well child visits, employment, high blood pressure, your PCP and you, and more.

Below is a sampling of some of Amerigroup's outreach efforts this past quarter:
- Teddy Bear Clinic Emporia
- 16th Annual Kansas Summit on Homelessness and Housing
- Eisenhower Middle School Health Day
- NAMI Walks Exhibit
- Junction City Family Fun Day Exhibit

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

Here are a few examples of Amerigroup's advocacy activities this past quarter:
- Visioneering Wichita Health Alliance Coalition
- HCBS Education Summit exhibit
- Mexican Consulate Exhibits
- Health Days USD 500
- LeadingAge Kansas Spring Conference

• Special Olympics
• Wichita Public Schools McKinney-Vento Program Parent Meeting

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:
Marketing Activities: Sunflower Health Plan marketing activities for 2nd Quarter 2015 included a provider contest to enhance communication across the network; filming and publicizing of a member success story; and sponsorships of events reaching large audiences in the provider and member communities
- Examples of 2nd Quarter 2015 marketing activities:
• Sunflower held a promotional campaign to encourage more providers to sign up for the plan's Email News Alerts. All providers who signed up for Sunflower email alerts between April 13 and May 15 were entered into a drawing, along with all previous subscribers. A drawing was held to award the winner a mini iPad. The month-long contest resulted in 95 new provider subscribers.
• Notable Sponsorships of Stakeholder Events and Programs:
- Kansas Special Olympics – Major sponsor of the Summer Games
- Topeka Department of Police, Crisis Intervention Team training - purchased manuals for the department to conduct this training, which supports law enforcement officers in their interaction with citizens suffering a mental health crisis.
- Independent Living Resource Center – Annual fundraiser supporting people with disabilities in Sedgwick County and South Central Kansas.
- NAMI Walk
• A Sunflower Health Plan member success story was filmed and published online. The story features a member and his family in South Central Kansas. The story was posted to Sunflower's YouTube account and publicized externally through social media.
• Sunflower's quarterly member and provider newsletters were redesigned during 2nd Quarter 2015 with the most current branding criteria used by the health plan. Each quarter, the member newsletter is mailed to each head of household. Both the member and provider newsletters educate stakeholders on the health initiatives and contain information that helps achieve quality outcome requirements.

Outreach Activities: In addition to reoccurring Adopt-a-School events and Baby Showers facilitated by Sunflower's MemberConnections department, the health plan's 2nd Quarter 2015 outreach activities involved efforts to educate adults and their caregivers about pre-diabetes.
- In April, Sunflower began distributing its KanBeWell pre-diabetes workbook to members enrolled in the plan's Pre-Diabetes Performance Improvement Project. By the end of 2Q15, 20 members were enrolled in the program, and the plan continues to recruit members who qualify.
- Sunflower's Claims, Medical Management, Behavioral Health, Customer Service, Quality, Communications and Compliance departments were represented at the Statewide Home and Community Based Services Educational Summit on April 13 & 14 in Topeka. The summit saw participation from most HCBS providers and many members receiving HCBS waiver services.
- In May, Sunflower participated in the 16th Annual Free Family 101 5K Walk/Run Community Block Party Health Fair

- In 2nd Quarter 2015, the health plan joined the Sedgwick County Business Leadership Network
- Sunflower held its 2nd Quarter Member Advisory Committee meeting on June 17
- Adopt-a-School Events were held in Liberal, KS, on two consecutive days; in Garden City, KS, once at Gertrude Walker Elementary, a second time with Head Start and a third time at The City on the Hill in the Garden City area.
- Start Smart for Your Baby Showers were held in Lawrence, Kansas City, and Pittsburg.

Advocacy Activities: During 2nd Quarter 2015, Sunflower employees participated in advocacy events focused on the following public health issues: maternal and child health, health literacy, and persons with disabilities.
- Sunflower attended the 2nd Quarter 2015 meetings of the Kansas Blue Ribbon Panel on Infant Mortality and the Mother & Child Health Coalition's Pregnancy, Infant, and Child Health Committee meeting. Both organizations have membership made up of maternal and child health clinicians, state officials and advocates. A Sunflower case management manager (nurse) served as a panelist at the MCHC meeting on May 12. These meetings allowed Sunflower to enhance its work with partner organizations to collectively advocate for and coordinate improved services in prenatal and perinatal care for health plan members and families.
- A Sunflower employee joined the board of directors of the Kansas Public Health Association, and from April 6-10, the health plan joined KPHA in promoting National Public Health Week.
- Sunflower participated in the 2nd Quarter 2015 Health Literacy Kansas meeting with advocates for health literacy whose purpose is to bring more awareness, education and training to groups responsible for providing health information to the Medicaid population.
- Employees from Sunflower Health Plan and its partner LifeShare participated in a march to the State Capitol facilitated by Topeka Independent Living Resource Center in celebration of the anniversary of the passing of the Americans with Disabilities Act.

Information related to UnitedHealthcare Community Plan marketing, outreach and advocacy activities:
Marketing Activities: United's primary focus during this reporting period included continued emphasis around member, provider, and community education along with health and benefit literacy. United has accomplished this through participation and support for a variety of community events, as well as through activities such as new member welcome calls, various targeted member call campaigns, mailing new member welcome kits and communicating via United's quarterly Member and Provider Newsletters. United hosted a number of meetings and presentation with key providers, hospitals and FQHCs throughout the state that involved discussions around exploring innovative and collaborative opportunities. Additional strategic endeavors continued to focus on working with providers to ensure accurate panel assignments and attribution, where appropriate.

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

community based organizations and targeted provider offices about United, the Kancare program, the features and benefits of United's plan and how to access those benefits. United's Provider Marketing Manager interacts with key provider offices and the provider community to assist with issue resolution and to ensure that providers are educated on the features and benefits of the UnitedHealthcare Community Plan of Kansas for our members who visit their offices. Several key outreach initiatives this period included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, attendance at health fairs held throughout the state, participation at a number of community stakeholder committee meetings and National Health Center Week planning.

- During the second quarter 2015, United staff personally met with approximately 3,599 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 2015, United staff personally met with approximately 568 individuals from community based organizations located throughout Kansas. These organizations work directly with United members in various capacities.
- During the second quarter 2015, United staff personally met more than 430 individuals from provider offices located throughout the State.

Advocacy Activities: United's efforts continue to be focused on education surrounding KanCare and the benefits of United to members across the state. This includes ongoing outreach to persons with intellectual and developmental disabilities and those that support them. United is also working to educate those individuals receiving services on the Physically Disabled and Frail Elderly waiver programs, as well as the other waiver programs. United has one Outreach Specialist who has a specialty in helping Kansans with disabilities.

The United outreach specialist focused on supporting persons with disabilities by providing information and education on KanCare and United benefits to advocates for persons with disabilities in Kansas across the state. The specialist has also continued to be a direct resource to members with disabilities and those that support them, to see that any concerns or issues reach the appropriate United staff for an appropriate response or resolution.

During this quarter, that specialist coordinated a public event to announce our 3rd round of Empower Kansans awardees in Parsons, Kansas. Over 45 people attended the event to celebrate the work of past grantees and the start of exciting projects with new grantees. One grant is specifically focused on system change and supports a grassroots coalition of providers and persons with disabilities to study what innovative things are being done in other states regarding disability employment and to hold focus groups to engage additional stakeholders about how to transform the employment system in Kansas. Correlating events included an open house at the local KU Assistive Technology access site and a networking luncheon to connect various stakeholders working on employment of persons with disabilities.

A key event during this quarter was United's participation in the Self Advocate Coalition of Kansas annual conference, which allowed us to interact with over 200 persons with developmental disabilities and to promote health plan literacy and self advocacy with attendees. Many advocates learned more about the benefits available to them through United Healthcare and were encouraged to learn what Managed Care Organizations are and to participate in discussions with their support team about their healthcare and making informed decisions.

IV. Operational Developments/Issues

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

   CMS approved Amendment 16 and Amendment 17 to the KanCare MCO contract on June 12, 2015. Amendment 16 updated capitation rates for mid-year adjustments that were effective on July 1, 2014. Amendment 17 updated the Business Associate Agreement per the HIPAA Omnibus rule with each health plan.

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added service utilization, per each of the KanCare MCOs, by top three value-added services and total for January-June, 2015, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	1,912	$225,395
	Member Incentive Program	5,717	$128,796
	Mail Order OTC	4,967	$83,085
	Total of all Amerigroup VAS Jan- June 2015	***15,215***	***$511,630***
Sunflower	CentAccount debit card	39,286	$785,720
	Dental visits for adults	13,022	$432,091
	Smoking cessation program	326	$78,240
	Total of all Sunflower VAS Jan-June 2015	***82,893***	***$1,445,744***
United	Adult Dental Services	988	$45,960
	Additional Vision Services	938	$40,264
	Membership to Youth Organizations	791	$39,550
	Total of all United VAS Jan-June 2015	***9,630***	***$317,061***

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

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

Enrollment Reason Categories	Total
Newborn Assignment	3
KDHE - Administrative Change	88
WEB - Change Assignment	16
KanCare Default - Case Continuity	190
KanCare Default – Morbidity	460
KanCare Default - 90 Day Retro-reattach	220
KanCare Default - Previous Assignment	289
KanCare Default - Continuity of Plan	2,765
AOE – Choice	446
Choice - Enrollment in KanCare MCO via Medicaid Application	1,129
Change - Enrollment Form	413
Change - Choice	478
Change - Access to Care – Good Cause Reason	8
Change - Case Continuity – Good Cause Reason	6
Change – Quality of Care - Good Cause Reason	2
Assignment Adjustment Due to Eligibility	14
Total	**6,527**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY15 2nd quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Lack of Info from Prov	Billing/ Fin Issues	Transp-Timely & Qual Of Svc	Prior Auth	Level of Care	Pharm	DME	Med Proc/ Inpt Trtmt	Waiver HCBS/ Home Health	Other
AMG	0	0	34	85	0	48	40	0	0	1	1	1	0	3
SUN	1	45	6	38	2	12	41	2	4	2	2	1	0	14
UHC	0	0	43	85	0	47	38	0	0	1	1	0	0	3
Total	1	45	83	208	2	107	119	2	4	4	4	2	0	20

MCOs' Appeals Database
Members - CY15 2nd quarter report

MCO	Dental	DME	Phar-macy	OP/IP Surg/Proc	Radio-logy	Specialist Physician Ofc Visit	LTSS/HCBS PCA/LTC/ RTC/TCM/ CBS/MH Svcs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt Covg	Other
AMG	0	3	1	3	0	0	2	0	1	4	1
SUN	3	31	39	12	6	3	12	23	8	11	1
UHC	9	18	47	4	0	1	17	0	0	48	1
Total	12	52	87	19	6	4	31	23	9	63	3

MCOs' Appeals Database
Providers - CY15 2nd quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Plan Admin/ Other	MCO Quality of Care/ Service	MCO Other	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Transp Quality of Care/ Service
AMG	8	23	7,581	83	0	0	0	17	2	19	0
SUN	0	0	487	0	0	0	0	21	0	16	0
UHC	27	2	150	13	2	29	39	55	5	3	0
Total	35	25	8,218	96	2	29	39	93	7	38	0

State of Kansas Office of Administrative Fair Hearings

Members - CY15 2nd quarter report

AMG-Red SUN-Green UHC-Purple	Dental Denied/ Not Covered	CT/ MRI/ X-ray Denied	Pharm Denied	DME Denied	Home Health Hours Denied	Comm Psych Support/ BH Svcs Denied	Inpt/ PT/OT Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs Denied	Med Proc/ Genetic Testing Denied	Specialist Ofc Visit Denied
Withdrawn								1 3		
Dismissed-Moot MCO reversed denial				1					1	
Dismissed-No Adverse Action										
Default Dismissal-Appellant did not appear								1		
Dismissed-Untimely							2			
OAH upheld MCO decision			1	1				1 1		1
OAH reversed MCO decision					1			1		
TOTAL										

Providers - CY15 1st quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied (Contained Errors)	Claim Denied By MCO In Error	Recoup -ment	DME Denied	Radio-logy Denied	Home Health/ Hospice/LTC Denied	PT/ST/ Rehab Denied	Inpt/Outpt/ Observation Services Denied	Mental Health Svcs Denied	Pharm Denied
Withdrawn	1					2		1		
Dismissed-Moot MCO reversed denial		37 5		1	1	2		1 4		
Dismissed-No internal appeal	2		1	1	1	1		2		
Dismissed-No adverse action	4			1		2				
Default Dismissal-Appellant did not appear				1		1				
Dismissed-Untimely				1				1		1
OAH upheld MCO decision				1				2		
OAH reversed MCO decision										
TOTAL										

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q2 of 2015, there were a total of 123 requests, which is a slight increase up from 107 requests in first quarter of 2015. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers with that MCO are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

The good cause requests during the second quarter of 2015 were mainly due to one hospital and associated clinic withdrawing from one network. Also one network has no pediatricians in a particular county, but there are pediatricians in a neighboring county within network standards that are available. These GCR requests have been denied due to network adequacy in the area. The remaining requests show varied reasons and causes for changing plans. The GCR requests showed an overall downward trend from the requests at the beginning of the year through June.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the second quarter of 2015, there were four state fair hearings filed for a denied GCR. One case is still pending, and the other three were dismissed. A summary of GCR actions this quarter is as follows:

Status	April	May	June
Total GCRs filed	58	33	32
Approved	6	1	3
Denied	27	25	13
Withdrawn (resolved, no need to change)	13	3	8
Dismissed (due to inability to contact the member)	12	4	5
Pending	0	0	3

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. Numbers of contracting providers are as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 9/30/14	# of Unique Providers as of 12/31/14	# of Unique Providers as of 3/31/15	# of Unique Providers as of 6/30/15
Amerigroup	13,682	13,997	14,863	15,201
Sunflower	17,728	18,056	19,131	20,376
UHC	19,747	19,476	20,482	20,823

h. Proposed changes to payment rates: There are two contract amendments, Amendment 18 and Amendment 19, pending approval with CMS. Amendment 18 addresses retro capitation adjustments and the WORK program background check. Amendment 19 addresses capitation adjustments.

i. MLTSS implementation and operation: In the second quarter, Kansas continued to offer services to individuals on the HCBS-PD and HCBS-I/DD Program waiting lists. Additionally, KDADS has concentrated efforts to work with MCOs to move individuals out of institutional settings and into their homes and communities using the Money Follows the Person federal grant.

j. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. Participants from the two hospitals, KFMC, and the State met on June 26, 2015, to discuss the DSRIP measures for each project. The hospitals have been identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY3. They are also reviewing the data regarding patients in order to complete the DY3 semi-annual report by July 31st.

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

- FE, PD, TBI & I/DD 1915(c) Renewals: CMS sent KDADS requests for additional information regarding renewal applications for the Intellectual and Developmental Disability (I/DD), Traumatic Brain Injury (TBI), Physical Disability (PD), and Frail Elderly (FE) 1915(c) waivers. Temporary extensions were granted until September 30, 2015.

- KDADS conducted the first meeting of the HCBS Final Rule Onsite Assessment Workgroup on June 29, 2015. The workgroup consists of consumers, family members, caregivers, and providers from all HCBS waiver populations. The workgroup is tasked with submitting a recommendation to the State on the assessment process and

assessment tool. Throughout the duration of the workgroup, members will be asked to consider what changes are required for HCBS settings to meet HCBS Final Rule requirements, the design elements for the assessment tool, the process for conducting the assessment, and the process for submitting evidence of compliance. The HCBS Final Rule Onsite Workgroup will have additional meetings in July and August.

l. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met once during the second quarter, on April 28, 2015, to review the current state of KanCare and HCBS services. The committee received reports from KDHE, KDADS, the KanCare Ombudsman, each of the three KanCare MCOs, and took comments from stakeholders. The committee also received information from the Kansas Insurance Commissioner. Also during the second quarter, KDHE and KDADS made KanCare-related informational presentations to legislative committees.

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 06.30.15 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2015-04*	*2015-05*	*2015-06*	*Grand Total*
Population 1: ABD/SD Dual	17,502	17,340	17,201	52,043
Population 2: ABD/SD Non Dual	28,962	28,920	28,696	86,578
Population 3: Adults	44,866	44,570	43,908	133,344
Population 4: Children	230,265	228,807	225,582	684,654
Population 5: DD Waiver	8,768	8,768	8,752	26,288
Population 6: LTC	20,983	20,998	20,914	62,895
Population 7: MN Dual	1,341	1,321	1,239	3,901
Population 8: MN Non Dual	1,135	1,107	1,015	3,257
Population 9: Waiver	3,864	3,859	3,820	11,543
Grand Total	**357,686**	**355,690**	**351,127**	**1,064,503**

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

VIII. Consumer Issues

Summary of consumer issues during the second quarter of 2015:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member authorization denials for variety of reasons. This caused some consumers to have a delay in service. Customer Service unable to consistently explain authorization requirements.	Most of the denials were due to confusing communication between the providers and the MCO, leading to incorrect or incomplete authorization requests, which were subsequently denied.	The MCOs created informational provider bulletins and reminders regarding authorizations. Some internal procedures were adjusted for clarity and a few requirements were relaxed. The plans also created informational talking points for the MCO customer representatives, and provided in-house training.
Claims denied for TPL, when no applicable policy exists.	TPL files not loaded correctly by contractor vendor. Also TPL programming at one MCO needed correction to have claims recognize when a provider type is excluded by the TPL policy.	System correction to make sure records are loaded correctly Also system correction to recognize provider type vs. TPL type.

Retroactively eligible members are denied authorizations.	Members are denied authorization due to retroactive eligibility. The determination date of eligibility is not loaded by the MCOs into their systems, and they cannot determine if this determination date is before or after the authorization request date.	There are plans to utilize a field in the new eligibility system KEES when it becomes available.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 433 consumers. OEW also assisted 321 consumers with urgent medical needs, provided information on applications and pending/reviews due to the KanCare Clearinghouse.

During this time period, OEW staff participated in 83 community events providing KanCare program outreach, education and information. The various events included: Health Fairs, Back to School Fairs, Hispanic Health Community Meetings, FQHC clinic staff, WIC/Immunization Clinics, Community Resource Fairs, Tribal Coordination Council, Early Head Start and Head Start Collaboration. OEW also completed KEES training in anticipation of upcoming system go live.

Also during this time period, OEW assisted in processing/reviewing 1498 FFM applications for Medicaid eligibility.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established iACT (the Interagency Collaboration Team) for comprehensive oversight and monitoring. This group replaces the KanCare Interagency Monitoring Team (IMT) as the oversight management team. iACT is a review and feedback body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). iACT makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. iACT includes leadership from both KDHE and KDADS and directs the policy initiatives of the KanCare Steering Committee.

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

The State Quality Strategy – as part of the comprehensive quality improvement strategy for the KanCare program – as well as the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare

MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, they will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

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

During the second quarter of 2015, some of the key quality assurance/monitoring activities have included:

- Quarterly business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2015, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the second quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. The 2015 review will address both MCO regulatory requirements and many key state contract requirements, as well as monitoring resolution of identified compliance issues found in previous audits.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and

the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS. During the second quarter, the HCBS portion of the TA meetings focused on compliance with the HCBS Final Rule and quality assurance measures.

- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings complex cases for State review and consideration, and the State provides technical assistance and insight into program policies, integration, and other alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss on-going provider and member issues, and troubleshoot operational problems. Monitor progress through issue logs.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue scheduled monthly meetings to discuss trends and progress.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS. During the second quarter, the HCBS portion of the TA meetings focused on compliance with the HCBS Final Rule and quality assurance measures.
- Complex Case staffing of HCBS and Behavioral Health staff from the State with the MCOs. Each MCO brings complex cases for State review and consideration, and the State provides technical assistance and insight into program policies, integration, and other alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- HCBS Quality Assurance Audits: MCO HCBS audits for 2013 were held onsite for 2 ½ days for each MCO during the second quarter. The reviews supplemented previous reporting/survey tools to ensure all HCBS benchmarking measures were complete. The MCOs provided a brief overview of the data and identified any challenges or changes in 2013 that would be reflected in the data. Additionally, the MCOs provided a brief overview of the documents being reviewed, where to find certain data points, and the changes made in 2013 that will be identified in 2014 files. Each MCO made care coordinators and other staff available to answer questions, gather additional documentation, address the person-centered planning and assessment process, review policies and procedures, and demonstrate systems or tools as needed.

X. Managed Care Reporting Requirements

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

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

b. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers, January-June 2015:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:16	2.0%	97,249
Sunflower	0:24	2.3%	91,826
United	0:21	2.4%	82,179
HP – Fiscal Agent	0.00	0.3%	12,396

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:17	1.0%	50,427
Sunflower	0:11	.8%	56,074
United	0:06	0.4%	36,966
HP – Fiscal Agent	0.00	0.02%	3,518

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

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

e. Summary of ombudsman activities for the second quarter of 2015 is attached.

f. Summary of MCO critical incident report: The Adverse Incident Reporting (AIR) System is the system used for behavioral health and HCBS critical incidents. All behavioral health and HCBS providers submit critical incidents for individuals receiving services. The critical incidents are reviewed by quality management specialists (field staff) who may make unannounced visits and research critical incidents to determine if additional corrective action and monitoring are required to protect the health, safety and welfare of those served by the programs involved.

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2015 AIRS reports through the quarter ending June 30, 2015, follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	**196**	**148**			**344**
Pending Resolution*	**121**	**167**			**288**
Total Received	**317**	**315**			**632**
APS Substantiations**	**66**	**NDA*****			

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

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

**** No Data Available (NDA) from DCF due to eligibility system (KEES) implementation.*

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. CMS approved the technical correction to Attachment J. The HCAIP first and second quarter payments were made on May 7, 2015. The LPTH/BCCH Pool second quarter payments were processed on April 9, 2015. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to the second quarter.

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

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). The draft KanCare evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas addressed that feedback, and the final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes. Since then, KFMC has developed and submitted quarterly evaluation reports, annual evaluation reports for 2013 and 2014, and a revised evaluation design in March 2015.

For the 2nd quarter of 2015, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (Claims Adjudication Statistics; Plan of Care Reduction Requests; Waiting List Management; and Money Follows the Person)

a. Claims Adjudication Statistics

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

b. Plan of Care Reduction Requests

Plan of care reduction requests for the I/DD waiver covering April – June 2015:

REQUEST STATUS	AMERIGROUP	SUNFLOWER	UNITED	Totals
Under Review	6	8	24	**38**
Approved	9	20	44	**73**
Denied	0	1	0	**1**
Returned for More Information	2	3	0	**5**
TOTAL	**17**	**32**	**68**	**117**

c. Waiting List Management:

PD Waiting List Management

In the quarter ending June 30, 2015, 501 individuals waiting for HCBS-PD services were offered services. Of those offers:

- 129 have accepted services
- 62 had other results (declined services, unable to contact, deceased)
- 310 have not responded

In the quarter ending June 30, 2015, 318 individuals started HCBS-PD services.
Of those that started services:

- 113 individuals started services in April
- 117 individuals started services in May
- 55 individuals started services in June
- 33 individuals moved from institutions into services on MFP

The current point-in-time limit for HCBS-PD is 5,900. KDADS is currently serving approximately 5,400 individuals and offering services monthly. On December 31, 2014, KDADS submitted a renewal for the PD waiver, which includes a proposed increase in the point-in-time limit to 6,100. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 6,100 participants, once the increased point-in-time number for the HCBS-PD Program is approved by CMS.

I/DD Waiting List Management

In the quarter ending June 30, 2015, 175 individuals waiting for HCBS-I/DD services were offered services. Of those offers:

- 106 accepted services
- 9 declined
- 60 have not responded

In the quarter ending June 30, 2015, 123 individuals started HCBS-I/DD services.
Of those that started services:

- 56 individuals started services in April
- 44 individuals started services in May
- 16 individuals started services in June
- 7 individuals moved from institutions into services on MFP

The current point-in-time limit for HCBS-I/DD is 8,700. KDADS is currently serving 8,667 individuals. KDADS submitted a renewal for the I/DD waiver, which includes a proposed increase in the point-in-time limit to 8,900. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants, once the increased point-in-time number for the HCBS-I/DD Program is approved by CMS.

d. Money Follows the Person:

During the quarter ending June 30, 2015, there were 199 initial requests.

2015 Initial Request	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Amerigroup	47	52			99
Sunflower	43	59			102
United	92	88			180
Total	182	199			381

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 06.30.15
X(e)	Summary of KanCare Ombudsman Activities for QE 06.30.15
XI	KanCare Safety Net Care Pool Reports for QE 06.30.15
XII	KFMC KanCare Evaluation Report for QE 06.30.15
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 06.30.15

XV. State Contacts

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XVI. Date Submitted to CMS

August 28, 2015

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

Quarter 2
Start Date: 4/1/2015
End Date: 6/30/2015

	Total Expenditures	Total Member-Months
Apr-15	228,679,142.54	413,540
May-15	229,703,592.59	413,346
Jun-15	225,694,036.51	394,451
PCP	0.00	
Q2 Total	684,076,771.64	1,221,337

ADMIN SUMMARY	
	Expenditures
DY3Q2	

	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-15									
Expenditures	3,903,519.65	31,573,765.05	24,132,685.50	49,622,946.29	38,214,916.83	65,875,026.57	881,102.02	3,181,777.35	11,293,403.28
Member-Months	22,808	43,024	55,254	243,329	11,749	26,495	2,057	1,668	7,156
May-15									
Expenditures	4,009,274.80	31,550,989.34	25,682,106.66	49,884,507.93	37,683,603.99	66,476,078.15	1,085,042.34	2,366,032.52	10,965,956.86
Member-Months	22,879	42,051	55,457	242,927	12,678	26,258	2,194	1,747	7,155
Jun-15									
Expenditures	3,884,553.29	31,209,462.03	23,332,428.67	49,241,876.59	38,274,157.10	66,328,053.31	741,033.90	1,481,702.07	11,200,769.55
Member-Months	21,427	38,183	52,478	237,678	11,311	24,497	1,758	1,399	5,720
PCP									
Expenditures	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Q2 Total									
Expenditures	11,797,347.74	94,334,216.42	73,147,220.83	148,749,330.81	114,172,677.92	198,679,158.03	2,707,178.26	7,029,511.94	33,460,129.69
Member-Months	67,114	123,258	163,189	723,934	35,738	77,250	6,009	4,814	20,031
DY 2 - Q2 PMPM	175.7807	765.3395	448.2362	205.4736	3,194.7137	2,571.8985	450.5206	1,460.2227	1,670.4173

Note:

1. For DY3 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. For now, all HEPC19 is reported under Meg 8-MN Non Dual. Those expenditures will be distributed across accurate MEGs and reflected in next quarter's BN report, with prior quarters restated.
4. Meg 8-MN Non Dual, began HEP C payments in April. Payment in April much higher because payments were retro-active to January 2014.
5. Meg 6-LTC, slight increase from previous quarter expenditures for this Meg due to LTC eligibility cleanup of the Mental Health Nursing Facilities
6. Meg 7-MN Dual, increase in retro-assignments for May; high level of spend down dollars therefore determined higher retro dollar amount. This would account for the reduction in June expenditures.

KanCare Ombudsman Quarterly Report

for KDHE

Kerrie J. Bacon, KanCare Ombudsman

2nd Quarter, 2015

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the second quarter of 2015. There were 462 contacts through these various means, 208 of which were related to an MCO issue. Second quarter had a decrease in contacts compared to the first quarter and to fourth quarter last year.

2nd Qtr. Contacts	
April	127
May	148
June	187
Total	**462**

MCO related	
Amerigroup	69
Sunflower	92
United Health	47
Total	**208**

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

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

Outreach

- Provided outreach information at the Home and Community Based Summit – 4/13-4/14/15
- Provided quarterly report to KanCare Oversight Committee – 4/28/15
- Provided overview of Ombudsman's office to St. Francis Hospital case managers (Topeka) – 5/26/15
- Provided outreach information at the Self Advocate Coalition of Kansas Conference in Topeka – Saturday, June 13, 2015
- Provided quarterly report for the Consumer and Specialized Issues (CSI) Workgroup meeting – June 30, 2015.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during second quarter.
- Hosted the KanCare Member Bi-Weekly Lunch-and-Learn conference calls for all HCBS members, parents, guardians and other consumers. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed.

KanCare Ombudsman Volunteer Program

Start-up Information

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

Training and Education

- Online and in-person regional training
- Pre and Post testing for competency

Volunteer Applications – available and posted mid-June.

Most volunteer applications came from Wichita area, so training is starting in Wichita. Additional marketing is being done in the Kansas City Metro area to recruit more volunteers.

For those interested in applying as a volunteer, applications are available on the KanCare Ombudsman webpage at www.kancare.ks.gov/ombudsman.htm.

Data

Contact Method	AmeriGroup	Sunflower	United	none	total
Email	12	10	5	55	82
Face-to-Face Meeting	0	0	0	1	1
Letter	0	1	0	0	1
ONLINE	0	0	0	0	0
Telephone	57	81	42	198	378
Total	**69**	**92**	**47**	**254**	**462**

Caller Type	AmeriGroup	Sunflower	United	none	total
Consumer	48	82	39	174	343
MCO Employee	0	1	2	0	3
Other type	5	0	0	17	22
Provider	16	9	6	63	94
Total	**69**	**92**	**47**	**254**	**462**

Sub Caller Type	AmeriGroup	Sunflower	United	none	total
HCBS RELATED	22	30	11	21	84
LTC RELATED	0	4	3	21	28
OTHER	47	58	33	212	350
Total	**69**	**92**	**47**	**254**	**462**

Contact Information for 2nd Qtr. The average number of days to resolve an issue was 7 days; 177 files were resolved in one day or less (38 percent)

Open	Contact date entered, but no response or closed	0
Responded	Contact date entered and first response, but not closed.	54
Closed	Closed dated is entered.	408
Total		**462**
% closed		88%

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

There are 20 issue categories. The top five concerns for 2nd quarter are Billing, HCBS General Issues, Nursing Facility Issues, Appeals/Grievances and Pharmacy.

Issue Category	AmeriGroup	Sunflower	United	none	total
Billing	12	11	5	12	40
HCBS General Issues	12	9	6	9	36
Nursing Facility Issues	1	3	4	26	34
Appeals / Grievances	9	15	3	6	33
Pharmacy	4	16	6	7	33
Medical Services	4	7	4	9	24
Transportation	7	4	3	3	17
HCBS Eligibility issues	2	6	1	6	15
Durable Medical Equipment	2	7	1	2	12
Access to Providers (usually Medical)	1	3	4	3	11
Care Coordinator Issues	3	3	2	0	8
HCBS Reduction in hours of service	0	4	2	2	8
HCBS Waiting List	2	0	0	6	8
Housing Issues	1	2	2	1	6
Dental	0	3	1	1	5
Change MCO	1	1	1	1	4
Questions for Conference Calls/Sessions	0	0	0	2	2
Guardianship	0	0	0	1	1
Medicaid Eligibility Issues	4	16	8	80	108
X-Other	20	19	11	100	150
Z Thank you.	0	3	1	8	12
Z Unspecified	0	0	0	15	15
Total	**85**	**132**	**65**	**300**	**582**

The Issue Categories below are listed for the last six quarters in alphabetical order. You will note that although Durable Medical Equipment dipped down in 4th quarter it is back up to the consistent range in 2nd quarter of 2015.

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

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

Resource Category	Q3/14	Q4/14	Q1/15	Q2/15
QUESTION/ISSUE RESOLVED	118	81	84	61
USED RESOURCES/ISSUE RESOLVED	177	260	262	234
KDHE RESOURCES	107	87	95	77
DCF RESOURCES	22	15	20	13
MCO RESOURCES	98	55	79	73
HCBS TEAM	57	33	32	43
CSP MH TEAM	2	0	0	1
OTHER KDADS RESOURCES	38	17	31	31
PROVIDED RESOURCES TO MEMBER	23	20	85	108
REFERRED TO STATE/COMMUNITY AGENCY	20	18	22	54
REFERRED TO DRC AND/OR KLS	27	9	26	16
CLOSED	55	18	14	29
Total	**744**	**613**	**750**	**740**

Waiver	Q3/14	Q4/14	Q1/15	Q2/15
PD	43	29	57	48
I/DD	42	36	35	25
FE	16	11	15	12
AUTISM	4	1	4	3
SED	5	4	1	7
TBI	19	10	10	9
TA	8	15	11	13
MFP	6	4	2	2
PACE	0	1	0	0
MENTAL HEALTH	4	10	5	9
BEHAVIOR HEALTH	0	0	0	0
NURSING FACILITY	10	25	12	28
Total	**157**	**146**	**152**	**156**

Issues for each MCO

Amerigroup – Although the call numbers (total) decreased slightly from 1st quarter to second quarter, the contacts related to Amerigroup increased, but compared to other quarters remained relatively consistent.

Issue Category - Amerigroup	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15
Access to Providers (usually Medical)	6	3	6	0	1
Appeals / Grievances	3	3	4	3	9
Billing	7	11	7	10	12
Care Coordinator Issues	0	4	3	1	3
Change MCO	3	0	2	2	1
Dental	5	2	4	2	0
Durable Medical Equipment	11	9	4	2	2
Guardianship	0	0	0	1	0
HCBS Eligibility issues	3	2	3	0	2
HCBS General Issues	4	13	9	14	12
HCBS Reduction in hours of service	2	2	2	0	0
HCBS Waiting List	1	4	1	2	2
Housing Issues	2	0	2	0	1
Medicaid Eligibility Issues	3	9	13	9	4
Medical Services	3	5	15	1	4
Nursing Facility Issues	0	2	5	2	1
Pharmacy	5	3	2	1	4
Questions for Conference Calls/Sessions	0	0	0	0	0
Transportation	3	6	2	1	7
X-Other	10	6	11	10	20
Z Thank you.	0	1	1	0	0
Z Unspecified	2	2	0	2	0
Total	**73**	**87**	**96**	**63**	**85**

Sunflower – the second quarter call numbers (total) are relatively consistent with the last two quarters.

Issue Category - Sunflower	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15
Access to Providers (usually Medical)	0	1	5	0	3
Appeals / Grievances	12	31	30	22	15
Billing	7	10	13	13	11
Care Coordinator Issues	6	13	8	2	3
Change MCO	5	6	5	3	1
Dental	5	0	2	1	3
Durable Medical Equipment	10	13	4	10	7
Guardianship	2	0	0	0	0
HCBS Eligibility issues	4	3	4	2	6
HCBS General Issues	5	13	10	22	9
HCBS Reduction in hours of service	3	7	3	4	4
HCBS Waiting List	3	2	0	0	0
Housing Issues	0	3	4	0	2
Medicaid Eligibility Issues	1	9	16	17	16
Medical Services	16	20	15	5	7
Nursing Facility Issues	0	1	1	3	3
Pharmacy	4	11	5	7	16
Questions for Conference Calls/Sessions	0	0	1	1	0
Transportation	2	5	4	3	4
X-Other	6	11	13	14	19
Z Thank you.	0	3	1	4	3
Z Unspecified	2	10	3	3	0
Total	**93**	**172**	**147**	**136**	**132**

United - the second quarter call numbers (total) are significantly down from first quarter this year and relatively consistent with quarters prior to first quarter 2015.

Issue Category - United	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15
Access to Providers (usually Medical)	4	0	2	2	4
Appeals / Grievances	4	5	7	11	3
Billing	6	8	6	5	5
Care Coordinator Issues	2	0	3	5	2
Change MCO	2	3	1	2	1
Dental	0	2	0	2	1
Durable Medical Equipment	7	2	0	6	1
Guardianship	0	0	1	1	0
HCBS Eligibility issues	0	0	3	3	1
HCBS General Issues	3	8	13	11	6
HCBS Reduction in hours of service	3	3	1	4	2
HCBS Waiting List	1	1	1	3	0
Housing Issues	1	3	2	0	2
Medicaid Eligibility Issues	1	4	10	11	8
Medical Services	3	7	9	6	4
Nursing Facility Issues	0	0	2	4	4
Pharmacy	3	3	4	8	6
Questions for Conference Calls/Sessions	0	0	0	1	0
Transportation	2	1	3	5	3
X-Other	4	5	9	16	11
Z Thank you.	0	0	1	2	1
Z Unspecified	0	0	0	0	0
Total	**46**	**55**	**78**	**108**	**65**

Safety Net Care Pool Report

Demonstration Year 3 - QE June 2015

Large Public Teaching Hospital\Border City Children's Hospital Pool
Paid 04/09/2015

Provider Name	2nd Qtr Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	1,868,275.50	810,271.08	1,058,004.42
University of Kansas Hospital	5,604,827.25	2,430,813.58	3,174,013.67
Total	**7,473,102.75**	**4,293,546.63**	**4,232,018.09**

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

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 3 - QE June 2015

Health Care Access Improvement Pool
Paid 5/7/2015

Hospital Name	HCAIP DY/QTR: 2015/1 and 2015/2	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	74,564.00	32,338.41	42,225.59
Children's Mercy Hospital South	343,754.00	149,086.11	194,667.89
Coffeyville Regional Medical Center, Inc.	109,438.00	47,463.26	61,974.74
Cushing Memorial Hospital	251,590.00	109,114.58	142,475.42
Geary Community Hospital	204,100.00	88,518.17	115,581.83
Hays Medical Center, Inc.	607,060.00	263,281.92	343,778.08
Hutchinson Hospital Corporation	288,674.00	125,197.91	163,476.09
Kansas Medical Center LLC	19,958.00	8,655.78	11,302.22
Kansas Rehabilitation Hospital	12,058.00	5,229.55	6,828.45
Labette County Medical Center	135,878.00	58,930.29	76,947.71
Lawrence Memorial Hospital	522,392.00	226,561.41	295,830.59
Marillac Center INC	1,968.00	853.52	1,114.48
Memorial Hospital, Inc.	64,358.00	27,912.06	36,445.94
Menorah Medical Center	366,256.00	158,845.23	207,410.77
Mercy - Independence	108,820.00	47,195.23	61,624.77
Mercy Health Center - Ft. Scott	167,088.00	72,466.07	94,621.93
Mercy Hospital, Inc.	11,428.00	4,956.32	6,471.68
Mercy Reg Health Ctr	344,102.00	149,237.04	194,864.96
Miami County Medical Center	103,886.00	45,055.36	58,830.64
Morton County Health System	42,096.00	18,257.04	23,838.96
Mt. Carmel Medical Center	474,654.00	205,857.44	268,796.56
Newton Medical Center	225,144.00	97,644.95	127,499.05
Olathe Medical Center	422,866.00	183,396.98	239,469.02
Overland Park Regional Medical Ctr.	1,224,386.00	531,016.21	693,369.79
Prairie View Inc.	43,642.00	18,927.54	24,714.46
Pratt Regional Medical Center	95,056.00	41,225.79	53,830.21
Providence Medical Center	1,041,292.00	451,608.34	589,683.66
Ransom Memorial Hospital	139,958.00	60,699.78	79,258.22
Saint Luke's South Hospital, Inc.	193,776.00	84,040.65	109,735.35
Salina Regional Health Center	661,116.00	286,726.01	374,389.99
Salina Surgical Hospital	6,108.00	2,649.04	3,458.96
Shawnee Mission Medical Center, Inc.	1,290,780.00	559,811.29	730,968.71
South Central KS Reg Medical Ctr	109,414.00	47,452.85	61,961.15
Southwest Medical Center	242,646.00	105,235.57	137,410.43
SSH - Kansas City	2,540.00	1,101.60	1,438.40
St. Catherine Hospital	365,674.00	158,592.81	207,081.19
St. Francis Health Center	639,906.00	277,527.23	362,378.77
St. John Hospital	198,336.00	86,018.32	112,317.68
Stormont Vail Regional Health Center	1,925,532.00	835,103.23	1,090,428.77
Sumner Regional Medical Center	73,080.00	31,694.80	41,385.20
Surgical & Diag. Ctr. of Great Bend	351,826.00	152,586.94	199,239.06
Susan B. Allen Memorial Hospital	201,582.00	87,426.11	114,155.89
Via Christi Hospital St Teresa	185,602.00	80,495.59	105,106.41
Via Christi Regional Medical Center	3,208,042.00	1,391,327.82	1,816,714.18
Via Christi Rehabilitation Center	65,148.00	28,254.69	36,893.31
Wesley Medical Center	2,939,514.00	1,274,867.22	1,664,646.78
Western Plains Medical Complex	231,370.00	100,345.17	131,024.83
		8,820,789.23	**11,517,668.77**

2015 KanCare Evaluation Quarterly Report
Year 3, CY2015, Quarter 2, April - June
August 18, 2015

Background/Objectives

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

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the second quarter (Q2) CY2015 report include the following:

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

KanCare health care services are coordinated by three managed care organizations (MCOs): Amerigroup of Kansas, Inc. (Amerigroup), Sunflower State Health Plan (Sunflower), and UnitedHealthcare Community Plan of Kansas (UnitedHealthcare). For the KanCare Quarterly and Annual Evaluations, data from the three MCOs are combined wherever possible to better assess the overall impact of the KanCare program.

Timely Resolution of Customer Service Inquiries

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

Data Sources

The data sources for the Q2 CY2015 KanCare Quarterly Evaluation Report are monthly call center customer service reports that replace quarterly KanCare Key Management Activities Report (KKMAR) discontinued in Q4 CY2014.

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

Beginning in Q2 CY2014, monthly call center reports became the primary data source for reporting customer service inquiries. In CY2013, counts of customer service inquiries were based on Pay for Performance (P4P) report data. In Q1 CY2014, counts were based on monthly data reported to KFMC by MCO program managers.

Table 1 - Timeliness of Resolution of Customer Service Inquiries

	CY2015		YTD		
	Q1	Q2	CY2015	CY2014	CY2013
Number of Inquiries Received	152,412	144,336	296,748	275,534	442,713
Number of Inquiries Resolved Within 2 Business Days	152,407	144,329	296,736	275,446	441,762
Number of Inquiries Not Resolved Within 2 Business Days	5	7	12	84	822
Percent of Inquiries Resolved Within 2 Business Days	99.997%	99.995%	99.996%	99.968%	99.785%
Number of Inquiries Resolved Within 5 Business Days	152,412	144,336	296,748	275,521	442,713
Number of Inquiries Not Resolved Within 5 Business Days	0	0	0	13	0
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	100%	99.995%	100%
Number of Inquiries Resolved Within 15 Business Days	152,412	144,336	296,748	275,534	442,713
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%

Current Quarter and Trend over Time

In Q2 CY2015, 99.995% of the customer service inquiries received by the MCOs were resolved within two business days. The seven inquiries not resolved within two business days were resolved within five business days. The inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within two business days.

During each quarter to date the two-day resolution rate exceeded 99.7%; and, for the past three quarters the two-day resolution rate has exceeded 99.99%.

The MCOs categorize customer service inquiries in their monthly call center reports by 18 member service inquiry categories (see Table 2) and by 17 provider service inquiry categories (see Table 3).

Table 2 - Customer Service Inquiries by Member, Quarter 2 CY2014 to Quarter 2 CY2015

	CY2014						CY2015			
	Q2		Q3		Q4		Q1		Q2	
Member Inquiries	#	%	#	%	#	%	#	%	#	%
1. Benefit Inquiry – regular or VAS	17,373	21.8%	18,025	20.1%	15,799	21.3%	20,775	20.1%	**19,702**	**20.2%**
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2,242	2.5%	1,617	2.2%	2,059	2.0%	**1,754**	**1.8%**
3. Care management or health plan program	2,248	2.8%	2,363	2.6%	2,797	3.8%	2,309	2.2%	**2,976**	**3.0%**
4. Claim or billing question	6,626	8.3%	6,193	6.9%	5,490	7.4%	7,107	6.9%	**6,983**	**7.2%**
5. Coordination of benefits	1,494	1.9%	2,278	2.5%	2,252	3.0%	3,437	3.3%	**3,079**	**3.2%**
6. Disenrollment request	448	0.6%	507	0.6%	484	0.7%	632	0.6%	**561**	**0.6%**
7. Eligibility inquiry	8,336	10.5%	11,066	12.3%	9,462	12.8%	13,330	12.9%	**12,750**	**13.1%**
8. Enrollment information	1,830	2.3%	2,417	2.7%	2,220	3.0%	2,141	2.1%	**2,210**	**2.3%**
9. Find/change PCP	11,619	14.6%	12,509	13.9%	9,818	13.2%	15,586	15.1%	**13,407**	**13.7%**
10. Find a specialist	3,037	3.8%	3,905	4.4%	2,634	3.6%	4,070	3.9%	**3,875**	**4.0%**
11. Assistance with scheduling an appointment	89	0.1%	61	0.1%	43	0.1%	46	0.04%	**36**	**0.04%**
12. Need transportation	1,798	2.3%	1,621	1.8%	1,571	2.1%	1,812	1.8%	**1,789**	**1.8%**
13. Order ID card	6,406	8.0%	7,087	7.9%	5,372	7.2%	7,653	7.4%	**6,348**	**6.5%**
14. Question about letter or outbound call	1,003	1.3%	675	0.8%	701	0.9%	1,013	1.0%	**898**	**0.9%**
15. Request member materials	1,197	1.5%	1,059	1.2%	1,188	1.6%	1,080	1.0%	**1,112**	**1.1%**
16. Update demographic information	9,526	12.0%	11,494	12.8%	7,481	10.1%	13,404	13.0%	**12,639**	**13.0%**
17. Member emergent or crisis call	900	1.1%	1,293	1.4%	628	0.8%	938	0.9%	**834**	**0.9%**
18. Other	3,923	4.9%	4,887	5.4%	4,562	6.2%	5,768	5.6%	**6,641**	**6.8%**
Total	**79,582**		**89,682**		**74,119**		**103,160**		**97,594**	

Member customer service inquiries

- Of the 97,594 member calls, 45.7% were received by Sunflower, 32.1% by UnitedHealthcare, and 22.1% by Amerigroup.
- In Q2 CY2015, customer service inquiries were again higher than the number received in CY2014 quarters. There were 5,566 fewer customer service inquiries from members in Q2 CY2015 than in the previous quarter, with most of the decrease due to higher numbers of contacts in Q1 seemingly related to open enrollment (i.e., reduced number of calls for "Find/change PCP," "Order ID card," etc.).
- Sunflower again this quarter reported much higher numbers of inquiries related to "Update demographic information"; 23.3% of Sunflower's member inquiries (10,397 of 44,632), compared to 3.5% of those reported by Amerigroup (762 of 21,598) and 4.7% of those reported by UnitedHealthcare (1,480 of 31,364).

- The number of member inquiries categorized by each of the MCOs as "Other" continues to increase, now accounting for 6.8% of the inquiries, a higher percentage than 12 of the 18 categories.
- In Q2, benefit inquiries were again the highest percentage (20.2%) of member inquiries. The lowest percentage of calls (0.04%) was from members requesting assistance with scheduling an appointment.
- Categories where 66% or more of the inquiries in Q2 were reported by one MCO included:
  - "Member emergent or crisis call" – 99.8% of 834 inquiries - Sunflower;
  - "Update demographic information" – 82.3% of 12,639 inquiries - Sunflower;
  - "Enrollment information" – 76.4% of 2,210 inquiries - Amerigroup;
  - "Request member materials" – 71.9% of 1,112 inquiries – Sunflower; and
  - "Need transportation" – 67.2% of 1,789 inquiries – Amerigroup.

Table 3 - Customer Service Inquiries by Provider, Quarter 2 CY2014 to Quarter 2 CY2015

	CY2014						CY2015			
	Q2		Q3		Q4		Q1		Q2	
Provider Inquiries	#	%	#	%	#	%	#	%	#	%
1. Authorization – New	2,149	4.0%	1,968	3.7%	1,841	3.9%	2,351	4.8%	**2,369**	**5.1%**
2. Authorization – Status	3,649	6.8%	2,961	5.6%	2,306	4.8%	2,456	5.0%	**2,417**	**5.2%**
3. Benefits inquiry	5,071	9.4%	4,261	8.0%	4,256	8.9%	4,594	9.3%	**4,144**	**8.9%**
4. Claim Denial Inquiry	4,843	9.0%	5,256	9.9%	4,760	10.0%	5,182	10.5%	**3,990**	**8.5%**
5. Claim Status Inquiry	18,401	34.1%	18,822	35.3%	18,284	38.3%	19,457	39.5%	**21,314**	**45.6%**
6. Claim Payment Question/Dispute	6,829	12.6%	7,093	13.3%	6,355	13.3%	6,822	13.9%	**6,005**	**12.8%**
7. Billing Inquiry	365	0.7%	326	0.6%	552	1.2%	851	1.7%	**436**	**0.9%**
8. Coordination of Benefit	1,012	1.9%	1,099	2.1%	1,095	2.3%	1,167	2.4%	**939**	**2.0%**
9. Member Eligibility Inquiry	2,085	3.9%	1,986	3.7%	1,652	3.5%	1,866	3.8%	**1,804**	**3.9%**
10. Recoupment or Negative Balance	140	0.3%	150	0.3%	162	0.3%	353	0.7%	**243**	**0.5%**
11. Pharmacy/Prescription Inquiry	505	0.9%	542	1.0%	568	1.2%	599	1.2%	**599**	**1.3%**
12. Request Provider Materials	41	0.1%	40	0.1%	28	0.1%	31	0.1%	**62**	**0.1%**
13. Update Demographic Information	6,181	11.4%	6,764	12.7%	4,093	8.6%	538	1.1%	**418**	**0.9%**
14. Verify/Change Participation Status	416	0.8%	284	0.5%	226	0.5%	272	0.6%	**282**	**0.6%**
15. Web Support	508	0.9%	284	0.5%	183	0.4%	197	0.4%	**209**	**0.4%**
16. Credentialing Issues	285	0.5%	177	0.3%	90	0.2%	163	0.3%	**239**	**0.5%**
17. Other	1,508	2.8%	1,333	2.5%	1,287	2.7%	2,353	4.8%	**1,270**	**2.7%**
Total	**53,988**		**53,346**		**47,738**		**49,252**		**46,742**	

Provider customer service inquiries

- Of the 46,742 provider inquiries received by MCOs in Q2 CY2015, Amerigroup received 39.8%, Sunflower 31.1%, and UnitedHealthcare 29.1%.
- Provider inquiries decreased in Q2 CY2015 by 2,510 compared to the previous quarter and by 7,246 compared to Q2 CY2014.

- For providers, claim status inquiries were again the highest percentage (45.6%) of the 46,742 provider calls, and the lowest was from providers requesting provider materials (0.1%).
- Categories where 66% or more of the inquiries in Q2 were reported by one MCO included:
  - "Authorization – New" – 99.1% of 2,369 inquiries – Amerigroup;
  - "Update demographic information" – 91.4% of 418 inquiries – Sunflower;
  - "Coordination of benefits" – 91.1% of 939 inquiries – UnitedHealthcare;
  - "Recoupment or negative balance" – 88.5% of 243 inquiries – UnitedHealthcare;
  - "Authorization – Status" – 71.0% of 2,419 inquiries – Amerigroup;
  - "Verify/Change participation status" – 68.1% of 282 inquiries – Sunflower; and
  - "Request provider materials" – 66.1% of 62 inquiries – Amerigroup.

Recommendations

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Examples include:
  - Member customer service inquiries
    - "Other" - The number of inquiries categorized as "Other" continues to increase, now accounting for 6.8% of the inquiries, a higher percentage than 12 of the 18 categories.
    - "Update demographic information" – Each quarter Sunflower has reported much higher numbers of inquiries – over 82% of the combined MCO total for this category and 23.3% of Sunflower's overall member inquiries (10,397 of 44,632).
    - Other Categories where two thirds or more of the inquiries in Q2 CY2015 were reported by one MCO included:
      - "Member emergent or crisis call" – 99.8% of 834 inquiries - Sunflower;
      - "Enrollment information" – 76.4% of 2,210 inquiries - Amerigroup;
      - "Request member materials" – 71.9% of 1,112 inquiries – Sunflower; and
      - "Need transportation" – 67.2% of 1,789 inquiries – Amerigroup.
  - Provider customer service inquiries
    - Categories where 66% or more of the inquiries in Q2 CY2015 were reported by one MCO included:
      - "Authorization – New" – 99.1% of 2,369 inquiries – Amerigroup;
      - "Update demographic information" – 91.4% of 418 inquiries – Sunflower;
      - "Coordination of benefits" – 91.1% of 939 inquiries – UnitedHealthcare;
      - "Recoupment or negative balance" – 88.5% of 243 inquiries – UnitedHealthcare;
      - "Authorization – Status" – 71.0% of 2,419 inquiries – Amerigroup;
      - "Verify/Change participation status" – 68.1% of 282 inquiries – Sunflower; and
      - "Request provider materials" – 66.1% of 62 inquiries – Amerigroup.

Timeliness of Claims Processing

A "clean claim" is a claim that can be paid or denied with no additional intervention required and does not include: adjusted or corrected claims; claims that require documentation (i.e., consent forms, medical records) for processing; claims from out-of-network providers that require research and setup of that provider in the system; and claims from providers where the updated rates, benefits, or policy changes were not provided by the State 30 days or more before the effective date. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity. Claims that are excluded from the measures include "claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues" and "any claim which cannot be processed due to outstanding questions submitted to KDHE."

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

Data Sources

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

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

Timeliness of Claims Processing based on Claim Type and Date Received

The MCOs are contractually required to process 100% of clean claims within 30 days; 99% of non-clean claims within 60 days; and 100% of all claims within 90 days.

For claims received in Q1 CY2015 (see Table 4):

- 99.982% of 4,288,714 "clean claims" received in Q1 CY2015 were processed within 30 days.
  - In Q1 CY2015, the numbers and percentages of "clean claims" not processed within 30 days were lower than in each of the four preceding quarters.
  - Of the 751 "clean claims" not processed within 30 days – 691 (92.0%) were claims received by Sunflower; 48 were claims received by UnitedHealthcare; and 12 were claims received by Amerigroup.
- 99.978% of 128,218 "non-clean claims" received in Q1 were processed within 60 days.
  - In Q1 CY2015, the numbers and percentages of "non-clean claims" not processed within 60 days were lower than in each of the four preceding quarters.

  - Of the 28 "non-clean claims" not processed within 60 days –16 were claims received by Amerigroup; 11 were claims received by Sunflower; and 1 was received by UnitedHealthcare.
- 99.998% of 4,416,931 "all claims" received in Q1 were processed within 90 days.
  - In Q1 CY2015, the numbers and percentages of "all claims" not processed within 90 days were lower than in each of the four preceding quarters.
  - Of the 71 claims not processed within 90 days – 37 were claims received by UnitedHealthcare; 32 were claims received by Sunflower; and 2 were claims received by Amerigroup.

Table 4 - Timeliness of Claims Processing, Quarter 1 CY2014 to Quarter 1 CY2015

	CY2014				CY2015
Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Number of clean claims received in quarter	3,916,708	4,172,590	4,118,292	4,293,014	**4,288,714**
Number of claims excluded	29	47	18	2	**0**
Number of clean claims not excluded	3,916,679	4,172,543	4,118,274	4,293,012	**4,288,714**
Number of clean claims received within quarter processed within 30 days	3,914,870	4,170,436	4,116,668	4,288,088	**4,287,963**
Number of clean claims received within quarter not processed within 30 days	1,809	2,107	1,606	4,924	**751**
Percent of clean claims processed within 30 days	**99.950%**	**99.950%**	**99.961%**	**99.885%**	**99.982%**
Non-Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1-Q4**
Number of non-clean claims received in quarter	137,570	178,534	140,895	174,130	**128,581**
Number of claims excluded	375	337	317	376	**363**
Number of non-claims not excluded	137,195	178,197	140,578	173,754	**128,218**
Number of non-clean claims received within quarter processed within 60 days	137,089	178,062	140,502	173,678	**128,190**
Number of non-clean claims not processed within 60 days	106	135	76	76	**28**
Percent of non-clean claims processed within 60 days	**99.920%**	**99.924%**	**99.946%**	**99.956%**	**99.978%**
All Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1-Q4**
Number of claims received in quarter	4,054,278	4,351,124	4,259,187	4,467,144	**4,417,294**
Number of claims excluded	404	384	335	378	**363**
Number of claims not excluded	4,053,874	4,350,740	4,258,852	4,466,766	**4,416,931**
Number of claims received within quarter processed within 90 days	4,053,746	4,350,651	4,258,729	4,466,651	**4,416,860**
Number of claims not processed within 90 days	128	89	123	115	**71**
Percent of claims processed within 90 days	**99.997%**	**99.998%**	**99.997%**	**99.997%**	**99.998%**

Average Turnaround Time for Processing Clean Claims

As indicated in Table 5, the MCOs processed 4,426,522 clean claims in Q2 CY2015 (includes claims received prior to Q1), a decrease of 99,929 compared to Q1 CY2015. Excluding pharmacy

claims (which are processed same day) there were 39,720 fewer claims processed in Q2 compared to Q1. Comparing year-to-date (YTD), however, there were 1,078,782 more claims processed in Q1/Q2 CY2015 compared to Q1/Q2 CY2014; an increase of 831,127 when excluding pharmacy claims.

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

Table 5 - Average Turnaround Time (TAT) Ranges for Processing Clean Claims, by Service Category

	CY2015				YTD (Quarter 1 and Quarter 2)			
	Quarter 1		Quarter 2		CY2015		CY2014	
	Claims Processed	Average TAT Monthly Ranges	Claims Processed	Average TAT Monthly Ranges	Claims Processed	Average TAT Monthly Ranges	Claims Processed	Average TAT Monthly Ranges
Hospital Inpatient	27,110	**6.4 to 15.9**	25,479	**8.1 to 13.7**	52,589	**6.4 to 15.9**	47,102	**5 to 19.2**
Hospital Outpatient	240,486	**3.5 to 10.8**	248,217	**4.8 to 10.5**	488,703	**3.5 to 11.8**	438,405	**3.6 to 12.8**
Pharmacy	1,740,255	**same day**	1,680,046	**same day**	3,420,301	**same day**	3,172,646	**same day**
Dental	105,373	**4 to 13.1**	103,787	**4 to 13**	209,160	**3 to 13.1**	209,983	**2 to 21**
Vision	57,234	**10 to 12.1**	57,520	**9 to 11.9**	114,754	**8 to 12.1**	116,756	**7 to 12.3**
Non-Emergency Transportation	107,432	**10.7 to 15**	116,200	**10.4 to 14**	223,632	**10.7 to 17**	209,391	**10.9 to 18**
Medical (Physical health not otherwise specified)	1,475,673	**3.4 to 10.5**	1,455,678	**4.4 to 10.0**	2,931,351	**3.3 to 10.5**	2,350,696	**3.3 to 10.6**
Nursing Facilities	90,576	**4.2 to 9.7**	78,635	**5.6 to 8.1**	169,211	**4.2 to 11.5**	155,528	**4.3 to 11.5**
HCBS	263,182	**4.1 to 8.7**	253,141	**5.4 to 10.2**	516,323	**3.2 to 14.2**	384,004	**3.2 to 15.6**
Behavioral Health	419,130	**2.7 to 9.4**	407,819	**4.2 to 10.5**	826,949	**2.7 to 9.4**	789,680	**3.4 to 9.4**
Total All Claims	**4,526,451**		**4,426,522**		**8,952,973**		**7,874,191**	
Total Claims/Average TAT (Excluding Pharmacy)	**2,786,196**	**4.3 to 10.3**	**2,746,476**	**5.3 to 10.2**	**5,532,672**	**4.3 to 10.8**	**4,701,545**	**4.5 to 11.5**

While the average time to process clean claims averaged less than two weeks for all services, the average monthly TAT for processing clean claims has not changed greatly over this past year for most of the services. As shown in Table 5, the average TAT for Total Services (excluding pharmacy claims processed same day) was 5.3 to 10.2 days in Q2 CY2015.

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

- Pharmacy - Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
- Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 10.4 to 14 days in Q2 CY2015.
- Vision – The average TATs were consistently a week or longer in Q2 and the previous five quarters for all of the MCOs. In Q2 CY2015, the average monthly TATs ranged from 9 to 11.9 days.

- Dental - Dental claims had the widest variation in TATs for MCO processing of claims. Sunflower reported average monthly TATs in Q2 CY2015 ranging from 4 to 6 days, compared to average TATs of 13 days for Amerigroup and UnitedHealthcare.
- Other services with wide variations in TATs by MCO in Q2 (and for the previous five quarters) include Behavioral Health (4.2 to 10.5 days in Q2); Hospital Outpatient (4.8 to 10.5 days in Q2); Hospital Inpatient (8.1 to 13.7 days in Q2); and Medical (4.4 to 10.0 days in Q2).

In Q1 and Q2 CY2015, UnitedHealthcare had higher average monthly TATs than Amerigroup and Sunflower for all services except Non-Emergency Transportation. In Q2, Amerigroup had lower average monthly TATs for Hospital Inpatient, Hospital Outpatient, Medical, Vision, Medical, Behavioral Health, and for the average TAT total for all services. In Q2, Sunflower had lower average monthly TATs for Dental and HCBS services.

Beginning in CY2015, the TAT for Nursing Facility claims and HCBS claims are pay-for-performance measures, added as an incentive for the MCOs to reduce the TATs for processing claims for these services.

Recommendations

- Sunflower should make concerted efforts to improve processes to increase the number and percentage of clean claims processed within 30 days.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times and where the average number of days varies by five to nine days month to month (including claims for Dental, Behavioral Health, Medical, Hospital Outpatient, and Hospital Inpatient).

Grievances

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

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

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

narratives of grievance description and resolution, date received, Medicaid ID, number of business days to resolve, etc. Categories of the grievances received during the quarter are further summarized by count in a Reason Summary Chart in the report.

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

Table 6 - Comparison of Grievance Report Categories, STC and GAR Reports, Quarter 2 CY2015

	Reports		STC Report		GAR Report			
			Received Q2		Reasons Table		Grievance Details	
	STC	GAR	#	%	#	%	#	%
Transportation	√		245	51.0%				
Claims/Billing Issues	√	√	56	11.7%	86	15.9%	83	15.8%
Quality of Care or Service	√	√	40	8.3%	56	10.3%	42	8.0%
Customer Service	√		29	6.0%				
Benefit Denial or LImitation	√		10	2.1%				
Access to Service or Care	√		33	6.9%				
Health Plan Administration	√		19	4.0%				
Member Rights/Dignity	√		15	3.1%				
Service or Care Disruption	√		4	0.8%				
Clinical/Utilization Management	√		2	0.4%				
Attitude/Service of Staff		√			144	26.6%	141	26.9%
Availability		√			99	18.3%	101	19.2%
Timeliness		√			83	15.3%	80	15.2%
Pharmacy		√			10	1.8%	9	1.7%
Lack of Information from Provider		√			5	0.9%	6	1.1%
Level of Care Dispute		√			4	0.7%	4	0.8%
Prior or Post Authorization		√			3	0.6%	3	0.6%
Accessibility of Office		√			1	0.2%	1	0.2%
Criteria Not Met - Medical Procedure		√			6	1.1%	8	1.5%
Criteria Not Met - Durable Medical Equipment		√			2	0.4%	2	0.4%
HCBS		√					1	0.2%
Sterilization		√			1	0.2%	1	0.2%
Other	√	√	27	5.6%	42	7.7%	34	6.5%
"AOR" (Appointment of Representation)							9	1.7%
Total			480		542		525	

The GAR report also includes grievance details, including categorization of each grievance using the categories listed in the GAR report Reasons Summary Table. In reviewing the detailed grievances in the GAR report, KFMC found many of the grievances did not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified. Clearer definitions of grievance categories would assist the MCOs in categorizing grievances and improving consistency throughout the KanCare program.

Transportation-related grievances are a good example of differences in categorization by each of the MCOs (see Table 7). Of the 271 transportation-related grievances resolved in Q2, 31.7% were categorized as "Availability"; 29.5% were categorized as "Timeliness"; 27.7% were categorized as "Attitude/Service of Staff"; 5.5% were "Billing and Financial Issues"; 1.5% "Quality of Care or Service"; 0.4% "Level of Care Dispute"; 0.4% "Prior or Post Authorization"; 0.7% "Other"; and 2.2% "AOR."

- Amerigroup categorized 70.1% of 77 transportation-related grievances as "Availability"; 16.9% as "Attitude/Service of Staff"; and 13.0% as "Billing and Financial Issues."
- Sunflower categorized 31.1% of 103 transportation-related grievances as "Availability"; 39.8% as "Timeliness"; 17.5% as "Attitude/Service of Staff"; 4.9% as "Billing and Financial Issues"; 1.9% as "Quality of Care or Service"; 1.0% as "Accessibility of Office"; 1.0% as "Level of Care Dispute"; 1.0% as "Prior or Post Authorization"; and 1.9% as "Other."
- UnitedHealthcare categorized 42.9% of 91 transportation-related grievances as "Timeliness"; 48.4% as "Attitude/Service of Staff"; 2.0% as "Quality of Care or Service"; and 6.6% as "AOR."

Table 7 - Transportation-Related Grievances by Category, Quarter 2 CY2015

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Availability	54	70.1%	32	31.1%			86	31.7%
Timeliness			41	39.8%	39	42.9%	80	29.5%
Attitude/Service of Staff	13	16.9%	18	17.5%	44	48.4%	75	27.7%
Billing and Financial Issues	10	13.0%	5	4.9%			15	5.5%
Quality of Care or Service			2	1.9%	2	2%	4	1.5%
Accessibility of Office			1	1.0%			1	0.4%
Level of Care Dispute			1	1.0%			1	0.4%
Prior or Post Authorization			1	1.0%			1	0.4%
Other			2	1.9%			2	0.7%
AOR "Appointment of Representation"					6	6.6%	6	2.2%
Transportation-Related Total	77		103		91		271	

Other examples include:

- In Q2 CY2015, UnitedHealthcare categorized nine grievances as "AOR," not one of the categories the State has identified for categorizing grievances. In Q1 CY2015, UnitedHealthcare categorized 13 grievances as "AOR." At that time, KFMC contacted UnitedHealthcare and was told that "AOR" refers to "Appointment of Representation." The

descriptions UnitedHealthcare provides for their grievances are generally very limited, and text is cut off for most grievance descriptions, making it difficult to determine whether the grievances are categorized appropriately or to determine appropriate categories for grievances, particularly where grievances are labeled as "AOR." Based on the limited descriptions, six of the grievances categorized as "AOR" appear to be transportation-related, one references balance billing, one is related to pre-service denial, and one is described as a "provider services issue."

- Grievances related to follow-up credit monitoring due to the data breach of Anthem, the parent company of Amerigroup were categorized as "Attitude/Service of Staff," "Availability," and "Other."
- Grievances categorized as "Attitude/Service of Staff" could also be categorized as quality of care (grievances noted as having been referred to quality management staff for investigation), sleep study, billing, HCBS, level of care dispute, or pharmacy.
- The number of grievances categorized as "Other" continues to be increasing. This quarter, 42 grievances were listed as "Other" in the Reasons Summary Table in the GAR report, sixth highest of the 14 grievance categories in the table.

Track Timely Resolution of Grievances

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

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

Data Source

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

Current Quarter Compared to Previous Quarters

As shown in Table 8, 96.8% (508) of the 525 grievances closed in Q2 CY2015 were resolved within 30 business days; and 99.6% (523) were resolved within 60 business days.

The 96.8% of grievances resolved within 30 business days in Q2 CY2015 was below the 98% contractual requirement. In all previous quarters, with the exception of Q2 CY2014 (96.6%), over 98% of grievances were reported as resolved within 30 business days.

- Amerigroup reported that 92.7% (152) of 164 grievances closed in Q2 were resolved within 30 business days; the remaining 12 were resolved within 31 to 60 business days.
- The two grievances not resolved within the State-required 60 business days were grievances received by Sunflower. Sunflower reported 165 (97.1%) of 170 grievances closed in Q2 were resolved within 30 business days; three grievances were resolved within 31 to 60 business days.

- UnitedHealthcare reported that 100% of 191 grievances closed in Q2 were resolved within 30 business days.

Table 8 - Timeliness of Resolution of Grievances

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

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

In Q2 CY2015, the number of grievances received decreased by over 28% to 491 compared to 684 in the previous quarter. In the first ten quarters of KanCare to date, the number of grievances received ranged from 422 (Q3 CY2013) to 684 (Q1 CY2015). The number of grievances closed by quarter ranged from 412 (Q3 CY2013) to 684 (Q3 CY2014).

The numbers of grievances reported as received again was inconsistent in the STC and in one or more sections of the GAR reports.

- Sunflower reported in both the STC and GAR reports receiving 170 grievances in Q2 CY2015. However, based on the detailed descriptions of grievances provided in the GAR report, the 170 reported by Sunflower as received in Q2 include 22 grievances received in Q1 2015 (and resolved in Q2). (In Q1 CY2015, Sunflower reported in both the STC and GAR reports receiving and resolving 203 grievances. Based on dates reported in the GAR report grievance details, 13 of the 203 grievances reported as received in Q1 were received in Q4 CY2014.)
- UnitedHealthcare reported in the STC report that 160 grievances were received this quarter. In the GAR report, however, UnitedHealthcare reported that 171 grievances were received.

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

Data Sources

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

All Grievances

Table 9 summarizes the quarterly numbers and types of grievances to date for the aggregated MCO data. In Q2 CY2015, 480 grievances received were reported, 187 fewer than in Q1 CY2015.

Table 9 - Number of Grievances Received each Quarter by Category*

	CY2013				CY2014				CY2015	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Transportation	271	261	183	182	226	206	291	213	251	245
Claims/Billing Issues	35	87	48	72	106	123	151	213	217	56
Quality of Care or Service	19	34	30	56	44	64	88	70	53	40
Access to Service or Care	16	13	13	27	24	21	26	34	34	33
Health Plan Administration	17	31	26	27	20	15	20	23	13	19
Customer Service	52	52	34	25	38	29	42	21	49	29
Member Rights/Dignity	4	5	10	6	1	4	14	17	14	15
Benefit Denial or LImitation	16	4	7	10	13	15	30	8	24	10
Service or Care Disruption	3	11	16	7	6	16	5	2	6	4
Clinical/Utilization Management	4	10	14	5	0	8	5	1	4	2
Other	13	3	18	3	20	3	0	7	2	27
Total Grievances Received	450	511	399	420	498	504	672	609	667	480

* As reported by MCOs in STC reports.

Transportation-related grievances continued to be the most frequently reported, with 245 in Q2. As displayed in Table 10, 51.0% of the grievances in Q2 were related to Transportation. In the past ten quarters, 44.7% of 5,210 grievances were related to Transportation.

Table 10 - Percentage of Grievances Received, by Category

	CY2015		YTD (Q1 and Q2)		
	Q1	Q2	CY2015	CY2014	CY2013
Total Grievances Received	667	480	1,147	1,002	961
	% of 667	% of 480	% of 1,147	% of 1,002	% of 961
Transportation	37.6%	51.0%	43.2%	43.1%	55.4%
Claims/Billing Issues	32.5%	11.7%	23.8%	22.9%	12.7%
Quality of Care or Service	7.9%	8.3%	8.1%	10.8%	5.5%
Access to Service or Care	5.1%	6.9%	5.8%	4.5%	3.0%
Health Plan Administration	1.9%	4.0%	2.8%	3.5%	5.0%
Customer Service	7.3%	6.0%	6.8%	6.7%	10.8%
Member Rights/Dignity	2.1%	3.1%	2.5%	0.5%	0.9%
Benefit Denial or LImitation	3.6%	2.1%	3.0%	2.8%	2.1%
Service or Care Disruption	0.9%	0.8%	0.9%	2.2%	1.5%
Clinical/Utilization Management	0.6%	0.4%	0.5%	0.8%	1.5%
Other	0.3%	5.6%	2.5%	2.3%	1.7%

The grievance category (as reported in the STC report) that decreased the most in Q2 in count and percentage was "Claims/Billing Issues." In Q2, 11.7% (56) of 480 grievances were related to claims/billing, compared to 32.5% (217) in Q1.

On a positive note, in Q2 CY2015, UnitedHealthcare reported only 46 grievances related to "Billing and Financial Issues." In previous quarterly reports concerns were raised about the increasingly high number of grievances related to balance billing. In Q1 CY2015, UnitedHealthcare reported 174 grievances, and in Q4 CY2014 reported 183 grievances, categorized as "Billing and Financial Issues."

Table 11 reports the types of grievances resolved in Q2 CY2015 in total and by waiver.

Table 11 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 2 CY2015*

	Number of Grievances		Grievances by Waiver Type						
	All Members	Waiver Members Subtotal	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	83	11	5		3	2	1		
Quality of Care or Service	42	14	4		10				
Attitude/Service of Staff	141	36	5	7	18	1	1		4
Timeliness	80	12	3	1	7		1		
Availability	101	30	6	2	17	2	1		2
Pharmacy	9	3	1	1					1
Lack of Information from Provider	6	1		1					
Level of Care Dispute	4	1			1				
Prior or Post Authorization	3	1		1					
HCBS	1	1		1					
Accessibility of Office	1	0							
Criteria not met - Durable Medical Equipment	2	0							
Criteria not met - Medical Procedure	8	0							
Sterilization	1	0							
"AOR" (Appointment of Representation)	9	0							
Other	34	8		2	2	1		1	2
Total Grievances Resolved Q2	525	118	24	16	58	6	4	1	9
Transportation-Related	271	59	10	4	39	1	2	0	3
# of Members with Grievances Resolved Q2	479	113	23	16	54	6	4	1	9

*Includes grievances received in Quarter 1 CY2015 that were resolved in Quarter 2 CY2015

Of 525 grievances resolved in Q2 CY2015 reported by 479 members, 118 (22.5%) were reported by 113 members receiving waiver services. Compared to the previous quarter, the number and percentage of grievances reported by members receiving waiver services dropped; in Q1, 170 (27%) of 630 grievances were reported by 160 members receiving waiver services.

- Of the 118 grievances received from waiver members, 59 (50%) were transportation-related.

- Physical Disability (PD) waiver members had the most grievances in Q2, with 54 members reporting 58 grievances, 39 (67.2%) transportation-related. This was a decrease compared to Q1 when 94 PD waiver members reported 98 grievances, 59.2% transportation-related.
- Frail Elderly (FE) waiver members had the second highest number of reported grievances in Q2, with 23 members reporting 24 grievances, 10 (40%) transportation related. In Q1 CY2015, 26 members reported 31 grievances, 45.2% transportation-related. In Q4 CY2014, 31 members receiving FE waiver services reported 38 grievances, 39.5% transportation-related.
- Intellectual/Developmental Disability (I/DD) waiver members reported 16 grievances (from 16 members), with four that were transportation-related. In Q1 CY2015, 17 members receiving I/DD waiver services reported 17 grievances, four that were transportation-related.
- The number of Traumatic Brain Injury (TBI) grievances dropped from 17 in Q4 CY2014 to 11 in Q1 CY2015 to 9 (from 9 members) in Q2 CY2015. Three of the grievances reported by members receiving TBI waiver services were transportation-related.
- Other waiver members reporting grievances were Serious Emotional Disturbance (SED) waiver (six grievances from six members), two transportation-related; Technology Assisted (TA) (four grievances from four members), two transportation-related; and one grievance from a member receiving Autism services (not transportation-related).

Access-Related Grievances

Of the 480 grievances received in Q2 CY2015, 33 (5.4%) were categorized in the STC report as "Access to Service or Care." (See Tables 9 and 10.) Access-related grievances have consistently been one of the least frequent categories of reported grievances. The number of "Access to Service or Care" grievances has ranged from 13 reported in Q2 and Q3 of CY2013 to 34 reported in Q4 CY2014 and Q1 CY2015.

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

- Amerigroup did not provide details for the six access-related grievances received in Q2 CY2015. As in previous STC reports, these were described as follows: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continue to monitor our network to identify service gaps and work with providers to contract with Amerigroup to perform key services*."
- UnitedHealthcare did not provide descriptions for the five access-related grievances received in Q2. As in previous STC reports, they included the following language: "*Grievances related to availability of network providers are considered during their geo access studies to identify potential network gaps. For grievances related to appointment availability, provider offices are contacted to review appointment availability standards*."
- Sunflower did not provide descriptions for the 22 access-related grievances received in Q2. They indicated, "*No trends were identified in this area in this quarter.*"

The STC report indicates that 33 of the grievances were related to "Access to Service or Care." As there is no "Access to Service or Care" grievance category in the GAR report, it is not possible to cross-reference these grievances. The 33 grievances identified in the STC report as "Access to Service or Care" could potentially be included in "Accessibility of Office" (1 grievance in Q2); "Availability" (101 grievances in Q2); "Level of Care Dispute" (4 grievances in Q2); "Prior or Post Authorization" (3 grievances in Q2); "Timeliness" (80 grievances in Q2); and/or "HCBS" (1 grievance in Q2).

Quality-Related Grievances

Of 480 grievances received in Q2 CY2015, 40 (8.3%) were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 56 of 542 (10.3%) grievances in the Q2 Reasons Summary Table, and 42 of 525 (8.0%) of grievances resolved in Q2 were categorized as QOC.

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

- Amerigroup indicated that 1 of the 16 QOC grievances received in Q2 was referred to Quality Management for a Quality of Care Investigation. As in previous STC reports, they included the following language: "*Members felt they received inappropriate treatment from their treating provider. These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action.*
- UnitedHealthcare did not provide descriptions of the 16 QOC grievances received in Q2. As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"
- Sunflower reported eight QOC grievances received in Q2, and that, "*There are no trends in this area in this quarter*."

Of the 42 QOC grievances reported in the GAR report as resolved, 14 were from members receiving waiver services including: 10 members receiving PD waiver services and 4 members receiving FE waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q2, KFMC found several grievances that could potentially be considered to be related to QOC, particularly where resolution was through the MCO Quality Management staff, that were categorized as "Attitude/Service of Staff"; "Criteria Not Met – Durable Medical Equipment"; and "Other." UnitedHealthcare also described 14 grievances as "Quality of Service" (QOS) issues or "QOC/QOS" issues, but categorized these as "Attitude/Service of Staff," "Timeliness," and "AOR." Due to the limited information and cut-off text descriptions of grievances, it is difficult to assess if any or all of these 14 grievances are categorized correctly.

Alternatively, several grievances categorized as QOC could just as easily have been categorized as "Billing/Financial Issues," "Availability," "Timeliness," "Level of Care Dispute," or "Prior or Post Authorization."

Recommendations

- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined. The State should work with the MCOs to identify specific criteria for categorizing grievances to provide better consistency in reporting. Additional definitions should be provided by the State to the MCOs as to what counts of grievances should be reported in the Reasons Summary Chart, STC report, and other sections of the GAR report.
    - Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
    - Separate categories for "Quality of Care" and "Quality of Services," with clearer definitions and criteria, could allow clearer distinction between grievances related to perceived inappropriate health care and service quality (such as late pick-up for an appointment).
- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
- MCOs should minimize categorization of grievances as "Other" wherever possible.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should categorize grievances using State identified categories and criteria. Grievance categories such as "AOR" should not be added by MCOs.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).

Ombudsman's Office

- ***Track the Number and Type of Assistance Provided by the Ombudsman's Office.***
- ***Evaluate Trends Regarding Types of Questions and Grievances Submitted to the Ombudsman's Office.***

Data Sources

The primary data source in Q2 CY2015 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend Over Time

The Ombudsman's Office has a current staffing of three individuals – the Ombudsman, a part-time assistant, and a full-time volunteer coordinator who began work in September 2014.

The volunteer coordinator's responsibilities include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral as needed, to the Ombudsman or other State agency staff through the KanCare Ombudsman Volunteer Program. Recruitment of volunteers began in June 2015. As most volunteer applications were from the Wichita area, training is beginning in Wichita. The Ombudsman Office is conducting additional marketing to recruit additional volunteers in the Kansas City metropolitan area, with plans to expand statewide in 2016.

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

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

Table 12 summarizes the number and type of contacts received and caller types in Q2 CY2015. There were 208 MCO-related contacts this quarter, 45.0% of the 462 contacts reported. Most of the contacts to the Ombudsman's Office in Q2 CY2015 were from consumers, 74.2% of 462 contacts and 81.3% of the 208 MCO-related contacts. Phone contacts comprised 81.8% of the contacts this quarter. The 82 email contacts reported this quarter did not include the many emails made in response to initial emails.

Table 12 - Ombudsman Contacts by Method and Caller Type, Quarter 2 CY2015					
Contact Method			Caller Type		
	All contacts	MCO-related		All contacts	MCO-related
Phone	378	180	Consumer	343	169
Email	82*	27*	Provider	94	31
Letter	1	1	MCO employee	3	3
Face-to-face	1	0	Other	22	5
Total	462	208	Total	462	208
*Does not include additional emails responding to the initial emails.					

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 13, 119 contacts were waiver-related in Q2 CY2015, compared to 135 in Q1 CY2015, 110 in Q4 CY2014, and 143 in Q3 CY2014. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Physical Disability (PD) (48 contacts Q2 CY2015, 57 contacts in Q1 CY2015, 29 in Q4 CY2014, and 43 in Q3 CY2014) and Intellectual/Developmental Disability (I/DD) (25 contacts in Q2 CY2015, 35 contacts in Q1 CY2015, 36 in Q4 CY2014, and 42 in Q3 CY2014).

Table 13 - Waiver-Related Inquiries to Ombudsman Office, Quarter 3 CY2014 to Quarter 2 CY2015								
	CY2014				CY 2015			
	Q3 CY2014		Q4 CY2014		Q1 CY2015		Q2 CY2015	
Waiver	#	%	#	%	#	%	#	%
Intellectual/Developmental Disability (I/DD)	42	29.4%	36	32.7%	35	25.9%	25	21.0%
Physical Disability (PD)	43	30.1%	29	26.4%	57	42.2%	48	40.3%
Technology Assisted (TA)	8	5.6%	15	13.6%	11	8.1%	13	10.9%
Frail Elderly (FE)	16	11.2%	11	10.0%	15	11.1%	12	10.1%
Traumatic Brain Injury (TBI)	19	13.3%	10	9.1%	10	7.4%	9	7.6%
Serious Emotional Disturbance (SED)	5	3.5%	4	3.6%	1	0.7%	7	5.9%
Money Follows the Person (MFP)	6	4.2%	4	3.6%	2	1.5%	2	1.7%
Autism	4	2.8%	1	0.9%	4	3.0%	3	2.5%
Total	143		110		135		119	

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of issues in addition to the number of contacts. As reported in Table 14, there were 582 issues and inquiries tracked out of the 462 contacts in Q2 CY2015. The highest number of issues and inquiries were related to Medicaid Eligibility (108 in Q2, compared to 139 Medicaid eligibility issues in the previous quarter and 194 in Q4 CY2014) and HCBS (44 issues in Q2, compared to 92 HCBS issues in the previous quarter and 75 in Q4 CY2014). Of the 582 issues and inquiries, 282 (48.5%) were MCO-related.

Of 408 files closed in Q2, 177 (38%) were resolved in one day or less. The average number of days to resolve issues was seven days.

Table 14 - Issue and Inquiry Types Submitted to Ombudsman, Quarter 4 CY2014 to Quarter 2 CY2015

	CY2014					CY2015									
	Quarter 4					Quarter 1					Quarter 2				
	All Issues		MCO-related Issues			All Issues		MCO-related Issues			All Issues		MCO-related Issues		
Issues	#	% of 704	#	% of 321	% of 704	#	%	#	% of 307	% of 620	#	%	#	% of 282	% of 582
Medicaid Eligibility Issues	194	27.6%	39	12.1%	5.5%	139	22.4%	37	12.1%	6.0%	108	18.6%	28	9.9%	4.8%
Appeals, Grievances	46	6.5%	41	12.8%	5.8%	42	6.8%	36	11.7%	5.8%	33	5.7%	27	9.6%	4.6%
Medical Service Issues	70	9.9%	39	12.1%	5.5%	20	3.2%	12	3.9%	1.9%	24	4.1%	15	5.3%	2.6%
Billing	42	6.0%	26	8.1%	3.7%	36	5.8%	28	9.1%	4.5%	40	6.9%	28	9.9%	4.8%
Durable Medical Equipment	8	1.1%	8	2.5%	1.1%	25	4.0%	18	5.9%	2.9%	12	2.1%	10	3.5%	1.7%
Pharmacy	19	2.7%	11	3.4%	1.6%	25	4.0%	16	5.2%	2.6%	33	5.7%	26	9.2%	4.5%
HCBS															
HCBS General Issues	49	7.0%	32	10.0%	4.5%	60	9.7%	47	15.3%	7.6%	36	6.2%	27	9.6%	4.6%
HCBS Eligibility Issues	11	1.6%	10	3.1%	1.4%	11	1.8%	5	1.6%	0.8%	15	2.6%	9	3.2%	1.5%
HCBS Reduction in Hours of Service	8	1.1%	6	1.9%	0.9%	10	1.6%	8	2.6%	1.3%	8	1.4%	6	2.1%	1.0%
HCBS Waiting List	7	1.0%	2	0.6%	0.3%	11	1.8%	5	1.6%	0.8%	8	1.4%	2	0.7%	0.3%
Care Coordinator Issues	14	2.0%	14	4.4%	2.0%	10	1.6%	8	2.6%	1.3%	8	1.4%	8	2.8%	1.4%
Transportation	13	1.8%	9	2.8%	1.3%	12	1.9%	9	2.9%	1.5%	17	2.9%	14	5.0%	2.4%
Nursing Facility Issues	24	3.4%	8	2.5%	1.1%	15	2.4%	9	2.9%	1.5%	34	5.8%	8	2.8%	1.4%
Housing Issues	10	1.4%	8	2.5%	1.1%	1	0.2%	0	0.0%	0.0%	6	1.0%	5	1.8%	0.9%
Change MCO	9	1.3%	8	2.5%	1.1%	8	1.3%	7	2.3%	1.1%	4	0.7%	3	1.1%	0.5%
Dental	9	1.3%	6	1.9%	0.9%	7	1.1%	5	1.6%	0.8%	5	0.9%	4	1.4%	0.7%
Access to Providers	15	2.1%	13	4.0%	1.8%	3	0.5%	2	0.7%	0.3%	11	1.9%	8	2.8%	1.4%
Guardianship Issues	2	0.3%	1	0.3%	0.1%	5	0.8%	2	0.7%	0.3%	1	0.2%	0	0.0%	0.0%
Other	114	16.2%	34	10.6%	4.8%	135	21.8%	42	13.7%	6.8%	152	26.1%	50	17.7%	8.6%
Unspecified or Thank you	40	5.7%	6	1.9%	0.9%	45	7.3%	11	3.6%	1.8%	27	4.6%	4	1.4%	0.7%
Total	704		321		45.6%	620		307		49.5%	582		282		48.5%

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q2 CY2015, 99.995% of the customer service inquiries received by the MCOs were resolved within two business days. The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within two, five, and 15 business days in each quarter of CY2013, CY2014, and CY2015 to date.
- Of the 7 inquiries not resolved within two business days, all were resolved within five business days.
- Member customer service inquiries
  - Of the 97,594 member calls, 45.7% were received by Sunflower, 32.1% by UnitedHealthcare, and 22.1% by Amerigroup.

  - In Q2 CY2015, member customer service inquiries were again higher than in CY2014 quarters. There were 5,566 fewer customer service inquiries from members in Q2 CY2015 than in the previous quarter, with most of the decrease due to higher numbers of contacts in Q1 seemingly related to open enrollment (i.e., reduced number of calls for "Find/change PCP," "Order ID card," etc.).
  - In Q2, benefit inquiries were again the highest percentage (20.2%) of member inquiries. The lowest percentage of calls (0.04%) was from members requesting assistance with scheduling an appointment.
  - The number of member inquiries categorized by each of the MCOs as "Other" continues to increase, now accounting for 6.8% of the inquiries, a higher percentage than 12 of the 18 categories.
- Provider customer service inquiries
  - Of the 46,742 provider inquiries in Q2 CY2015, Amerigroup received 39.8%, Sunflower 31.1%, and UnitedHealthcare 29.1%.
  - Provider inquiries decreased in Q2 CY2015 by 2,510 compared to the previous quarter and by 7,246 compared to Q2 CY2014.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

Timeliness of Claims Processing

- The numbers and percentages of "clean claims" not processed within 30 days, of "non-clean claims" not processed within 60 days, and of all claims processed within 90 days were lower in Q1 CY2015 than in each of the four preceding quarters.
- Of 4,288,715 "clean claims" received in Q1 CY2015, 99.982% were processed within 30 days. Of 128,218 "non-clean claims" received in Q1 CY 2015, 99.964% were processed within 60 days; of 4,416,932 "all claims" received in Q1 99.998% were processed within 90 days.
- Of the 753 "clean claims" not processed within 30 days – 691 (91.8%) were claims received by Sunflower; 50 were claims received by UnitedHealthcare; and 12 were claims received by Amerigroup.
- The MCOs processed 4,426,522 clean claims in Q2 CY2015 (includes claims received prior to Q1), a decrease of 99,929 compared to Q1 CY2015. Excluding pharmacy claims (which are processed same day), there were 39,720 fewer claims processed in Q2 compared to Q1. Comparing year-to-date (YTD), however, there were 1,078,782 more claims processed in Q1/Q2 CY2015 compared to Q1/Q2 CY2014; an increase of 831,127 when excluding pharmacy claims.
- In Q2 CY2015, the average TAT for Total Services was 5.3 to 10.2 days.
- While the average time to process clean claims averaged less than two weeks for all services, the average monthly TAT for processing clean claims has not changed greatly in the past year for most services.
- The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
  - Pharmacy - Clean pharmacy claims had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.

  - Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 10.4 to 14 days in Q2 CY2015.
  - Vision – The average TATs were consistently a week or longer in Q2 and the previous five quarters for all of the MCOs. In Q2 CY2015, the average monthly TATs ranged from 9 to 11.9 days.
  - Dental - Dental claims had the widest variation in TATs for MCO processing of claims. Sunflower reported average monthly TATs in Q2 CY2015 ranging from 4 to 6 days, compared to average TATs of 13 days for Amerigroup and UnitedHealthcare.
  - Other services with wide variations in TATs by MCO in Q2 (and for the previous five quarters) include Behavioral Health (4.2 to 10.5 days in Q2); Hospital Outpatient (4.8 to 10.5 days in Q2); Hospital Inpatient (8.1 to 13.7 days in Q2); and Medical (4.4 to 10.0 days in Q2).
- In Q1 and Q2, UnitedHealthcare had higher average monthly TATs than Amerigroup and Sunflower for all services except Non-Emergency Transportation.
- Beginning in CY2015, TAT for clean claims for Nursing Facilities and HCBS claims are pay-for-performance measures, providing an incentive for MCOs to reduce the TATs for processing claims for these services.

Grievances

- When categorizing grievance in the GAR and STC reports, MCOS continue to use inconsistent criteria. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations.
- In Q2 CY2015, the number of grievances received decreased by over 28% to 491 compared to 684 in the previous quarter.
- Of 525 grievances closed in Q2 CY2015, 96.8% (508) were resolved within 30 business days, and 99.6% were resolved within 60 business days.
  - Both Amerigroup and Sunflower resolved fewer than 98% of grievances within the contractually required 30 day time period; Amerigroup reported that 92.7% (152) of 164 grievances were resolved within 30 days, and Sunflower reported that 97.1% (165) of 170 grievances were resolved within 30 days.
  - UnitedHealthcare reported that 100% of 191 grievances were resolved within 30 days.
  - The two grievances not resolved within 60 business days were received by Sunflower.
- The numbers of grievances reported as received again was inconsistent in the STC and in one or more sections of the GAR reports.
  - Sunflower reported in both the STC and GAR reports receiving 170 grievances in Q2 CY2015. However, based on the detailed descriptions of grievances provided in the GAR report, the 170 reported by Sunflower as received in Q2 include 22 grievances received in Q1 2015 (and resolved in Q2). (In Q1 CY2015, Sunflower reported in both the STC and GAR reports receiving and resolving 203 grievances. Based on dates reported in the GAR report grievance details, 13 of the 203 grievances reported as received in Q1 were received in Q4 CY2014.)

  - UnitedHealthcare reported in the STC report that 160 grievances were received this quarter. In the GAR report, however, UnitedHealthcare reported that 171 grievances were received.
- The grievance categories with the highest number of grievances were those related to transportation; 245 of 480 (51.0%) of grievances received in Q2.
- The grievance category that decreased the most in Q2 in count and percentage was "Claims/Billing Issues." In Q2, 11.7% (56) of 480 grievances were related to "Claims/Billing Issues," compared to 32.5% (217) in Q1.
- UnitedHealthcare categorized nine grievances as "AOR" (Appointment of Representation), not one of the categories identified by the State. UnitedHealthcare provides only limited descriptions of grievances, and most descriptions are cut off, making it difficult to determine how these nine grievances should be categorized, and to assess whether other grievances are categorized appropriately.
- The number of grievances categorized as "Other" continues to be increasing. This quarter, 42 grievances were listed as "Other" in the Reasons Summary Tables of the GAR report, sixth highest of the 14 grievance categories in the table.
- Of 525 grievances reported as resolved by MCOs in Q2 CY2015 (reported by 479 members), 118 (22.5%) were reported by 113 members receiving waiver services.
- The number of access-related grievances each quarter is a relatively small percentage of grievances reported; in Q2 CY2015, MCOs categorized 33 of 480 (6.9%) grievances received as "Access to Service or Care."
- The number of grievances MCOs categorized as QOC is also a relatively small percentage of grievances reported. In Q2 CY2015, only 40 (5.5%) of 480 grievances were categorized as QOC.
- Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but where descriptions include "Quality of Service," "QOC/QOS," or where the grievance has been referred to Quality Management as a possible QOC grievance), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude whether access-related and QOC grievances are increasing or decreasing. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.
- Descriptions in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 32 grievances in the category that quarter.

Ombudsman Office

- In Q2 CY2015, the Ombudsman Office tracked 582 issues identified in 462 contacts and calls received. Of the 582 issues, 282 (48.5%) were MCO-related. The highest number of issues and inquiries were related to Medicaid Eligibility (108 issues) and HCBS (44 issues).
- Of 408 files closed in Q2, 177 (38%) were resolved in one day or less. The average number of days to resolve issues was seven days.

- Recruitment of volunteers for the KanCare Ombudsman Volunteer Program began in June 2015. Due to the number of volunteer applications received in the Wichita area, training of volunteers is beginning in Wichita. The Ombudsman Office is conducting additional marketing to recruit additional volunteers in the Kansas City metropolitan area, with plans to expand statewide in 2016.
- There were 119 waiver-related inquiries in Q2 CY2015. The most frequent waiver-related inquiries in Q2, and in the last four quarters, have been from members receiving waiver services for PD and I/DD; of 507 waiver-related inquiries from July 2014 through June 2015, 177 (34.9%) were from members receiving PD waiver services and 138 (27.2%) were from members receiving I/DD waiver services.

Recommendations Summary

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

Timely Resolution of Customer Service Inquiries

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Examples include:
  - Member customer service inquiries
    - "Other" - The number of inquiries categorized as "Other" continues to increase, now accounting for 6.8% of the inquiries, a higher percentage than 12 of the 18 categories.
    - "Update demographic information" – Each quarter Sunflower has reported much higher numbers of inquiries – over 82% of the combined MCO total for this category and 23.3% of Sunflower's overall member inquiries (10,397 of 44,632).
    - Other Categories where two thirds or more of the inquiries in Q2 CY2015 were reported by one MCO included:
      - "Member emergent or crisis call" – 99.8% of 834 inquiries - Sunflower;
      - "Enrollment information" – 76.4% of 2,210 inquiries - Amerigroup;
      - "Request member materials" – 71.9% of 1,112 inquiries – Sunflower; and
      - "Need transportation" – 67.2% of 1,789 inquiries – Amerigroup.
  - Provider customer service inquiries
    - Categories where 66% or more of the inquiries in Q2 were reported by one MCO included:
      - "Authorization – New" – 99.1% of 2,369 inquiries – Amerigroup;
      - "Update demographic information" – 91.4% of 418 inquiries – Sunflower;
      - "Coordination of benefits" – 91.1% of 939 inquiries – UnitedHealthcare;
      - "Recoupment or negative balance" – 88.5% of 243 inquiries – UnitedHealthcare;

- "Authorization – Status" – 71.0% of 2,419 inquiries – Amerigroup;
- "Verify/Change participation status" – 68.1% of 282 inquiries – Sunflower; and
- "Request provider materials" – 66.1% of 62 inquiries – Amerigroup.

Timeliness of Claims Processing

- Sunflower should make concerted efforts to improve processes to increase the number and percentage of clean claims processed within 30 days.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times and where the average number of days varies by five to nine days month to month (including claims for Dental, Behavioral Health, Medical, Hospital Outpatient, and Hospital Inpatient).

Grievances

- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as "Quality of Care," particularly if resolution of the grievances is through the Quality Management staff.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).
- Grievance categories within the GAR and STC reports should be more clearly defined by the State. Wherever possible, grievance categories in different reports should be consistently named and defined. The State should work with the MCOs to identify specific criteria for categorizing grievances to provide better consistency in reporting. Additional definitions should be provided by the State to the MCOs as to what counts of grievances should be reported in the Reasons Summary Chart, STC report, and other sections of the GAR report.
  - Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.
  - Separate categories for "Quality of Care" and "Quality of Services," with clearer definitions and criteria, could allow clearer distinction between grievances related to perceived inappropriate health care and service quality (such as late pick-up for an appointment).
- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.

- Grievances referred to MCO Quality Management as Quality of Care grievances should be categorized as “Quality of Care,” particularly if resolution of the grievances is through the Quality Management staff.
- MCOs should minimize categorization of grievances as “Other” wherever possible.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should categorize grievances using State identified categories and criteria. Grievance categories such as “AOR” should not be added by MCOs.

End of report.

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

Amerigroup- YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	21,414	$760,516,860.15	3,687	$176,342,020.57	17.22%	7.8
Hospital Outpatient	173,753	$447,868,436.59	19,953	$50,047,130.21	11.48%	4.6
Pharmacy	983,930	$61,911,860.28	269,183	Not Applicable	27.36%	Same Day
Dental	66,176	$18,280,340.94	5,790	$1,522,766.61	8.75%	13.0
Vision	37,129	$10,576,164.31	4,925	$1,963,702.50	13.26%	9.0
NEMT	66,948	$2,599,643.22	705	$25,939.58	1.05%	18.0
Medical (physical health not otherwise specified)	1,022,468	$591,656,183.50	128,135	$102,513,646.63	12.53%	4.2
Nursing Facilities-Total	58,161	$132,227,315.46	6,523	$11,073,795.39	11.22%	5.5
HCBS	102,580	$53,952,878.33	9,414	$4,353,730.27	9.18%	5.5
Behavioral Health	327,934	$42,487,652.65	27,101	$3,571,752.23	8.26%	3.8
Total All Services	**2,860,493**	**$2,122,077,335.43**	**475,416**	**$351,414,483.99**	**16.62%**	**7.9**

Sunflower - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	17,207	560,903,733	3,457	123,647,076	20.09%	9.12
Hospital Outpatient	166,000	328,763,696	21,566	34,611,791	12.99%	6.86
Pharmacy	1,536,994	150,295,410	399,388	74,547,063	25.99%	1.00
Dental	76,511	19,812,114	5,944	1,364,190	7.77%	13.00
Vision	44,480	10,662,075	5,182	1,385,929	11.65%	11.90
NEMT	72,124	2,061,023	181	5,879	0.25%	8.25
Medical (physical health not otherwise specified)	952,281	431,057,534	123,570	90,380,783	12.98%	6.22
Nursing Facilities-Total	63,544	136,364,498	5,473	17,934,003	8.61%	6.00
HCBS	246,390	113,644,798	16,318	6,904,107	6.62%	5.45
Behavioral Health	369,286	51,908,626	27,992	4,957,607	7.58%	5.55
Total All Services	**3,544,817**	**1,805,473,506**	**609,071**	**355,738,428**	**17.18%**	**6.58**

United - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	14,508	$492,776,913.32	3,310	$123,431,254.61	22.81%	12.7
Hospital Outpatient	154,203	$382,632,085.47	24,274	$99,312,822.18	15.74%	9.3
Pharmacy	886,020	$108,979,386.28	226,948	$50,583,794.89	25.61%	0.0
Dental	65,831	$18,846,084.76	3,956	$1,140,046.89	6.01%	13.0
Vision	5,465	$1,121,737.96	571	$142,804.16	10.45%	11.9
NEMT	74,725	$2,005,677.12	283	$6,089.78	0.38%	10.9
Medical (physical health not otherwise specified)	989,884	$388,454,685.53	150,031	$89,254,187.50	15.15%	9.2
Nursing Facilities-Total	48,022	$112,235,376.05	5,252	$14,453,474.60	10.94%	7.9
HCBS	171,897	$39,947,331.90	12,080	$3,445,130.97	7.02%	8.6
Behavioral Health	134,096	$38,694,882.05	10,720	$6,595,628.68	7.99%	9.1
Total All Services	2,544,651	$1,585,694,160	437,425	$388,365,234	17.19%	**9.3**