# Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 9.30.13

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

*KanCare*
*Section 1115 Quarterly Report*
*Demonstration Year: 1 (1/1/2013-12/31/2013)*
*Federal Fiscal Quarter: 4/2013 (7/13-9/13)*

## Table of Contents

# I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

## II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the third quarter known as of October 31, 2013.

| Demonstration Population | Enrollees at Close of Qtr. (9/30/2013) | Total Unduplicated Enrollees in Quarter | Disenrolled in Qtr. |
|---|---|---|---|
| Population 1: ABD/SD Dual | 17,470 | 18,463 | 993 |
| Population 2: ABD/SD Non Dual | 28,988 | 29,954 | 966 |
| Population 3: Adults | 32,500 | 36,489 | 3,989 |
| Population 4: Children | 209,782 | 220,853 | 11,071 |
| Population 5: DD Waiver | 8,652 | 8,705 | 53 |
| Population 6: LTC | 21,457 | 22,471 | 1,014 |
| Population 7: MN Dual | 1,130 | 1,270 | 140 |
| Population 8: MN Non Dual | 1,045 | 1,243 | 198 |
| Population 9: Waiver | 4,365 | 4,472 | 107 |
| Population 10: UC Pool | N/A | N/A | N/A |
| Population 11: DSRIP Pool | N/A | N/A | N/A |
| **Total** | **325,389** | **343,920** | **18,531** |

## III. Outreach/Innovation

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

During the third 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: July 9 (8 attendees), September 3 (8 attendees). In addition, the state conducted consultation meetings with these stakeholders, on July 23 (at PBP Health Center – 12 attendees) and on July 27 (at White Cloud – 8 attendees).

Also during this quarter the state worked to implement the guidance received during a series of phone conferences with CMS, regarding the use of "in lieu of services." Consistent with the guidance received, Kansas intends for MCOs utilize this innovative and flexible service option whenever it is an effective, efficient and responsible option to best meet member needs. In order to monitor the use of this service, and to continue providing guidance to MCOs, the use of these services is being reported by each MCO in a monthly report, which will allow ongoing access to both programmatic and financial experience information associated with this innovative option. The guidance received from CMS and governing the using of this service option is summarized in the following scenarios:

1. *Alice is a member of KanCare who has been determined eligible for and is on the waiting list to receive PD waiver services. In the meantime, her MCO determines that it would most effectively meet her needs to provide a PD waiver-like service to Alice.*
    a. *Resolution: MCO provides the service and reports on their "in lieu of" services report, programmatic information.*
    b. *MCO also reports the value of the avoided service, and includes value of provided service as part of their financial experience.*
2. *Bob is a member of KanCare who is currently receiving PD waiver services, and the MCO determines that it would most effectively meet his short-term needs to provide a TBI waiver-like service to Bob to prevent Bob from needing to enter a nursing facility.*
    a. *Resolution: MCO provides the service and reports on their "in lieu of" services report, programmatic information.*
    b. *MCO also reports the value of the avoided service, and includes value of provided service as part of their financial experience. State includes this as part of D prime costs for the waiver member.*
3. *Carol is a member of KanCare who is not eligible for any HCBS waiver, and the MCO determines that it would most effectively meet her needs to provide a PD waiver-like service to Carol.*
    a. *Resolution: MCO provides the service and reports on their "in lieu of" services report, programmatic information.*
    b. *MCO also reports the value of the avoided service, and includes value of provided service as part of their financial experience.*

4. *Dan is a member of KanCare who is receiving PD waiver services, and the MCO determines that it would most effectively meet his needs by providing a non-Medicaid allowable service to Dan, in the form of a lift-fitted, used van that would increase Dan's independence and productivity and allow him to more independently live in his community, and his need for personal services would decrease significantly. Dan is not able to afford the cost of any vehicle that could be used to modify by adding a lift.*
    a. *Resolution: MCO provides the service and reports on their "in lieu of" services report, programmatic information.*
    b. *MCO also reports the value of the avoided service, and includes value of provided service as part of their financial experience.*
5. *Elaine is a member of KanCare who is not receiving any waiver service, but is at risk of intensive physical health deterioration that can be mitigated by a service not currently provided in the FFS program.*
    a. *Resolution: MCO provides the service and reports on their "in lieu of" services report, programmatic information.*
    b. *MCO also reports the value of the avoided service, and includes value of provided service as part of their financial experience.*

Another innovative program option Kansas has been developing as part of the KanCare program relates to the use of Health Homes. A summary of that developing option follows:

Kansas intends to implement the Medicaid Health Homes State Plan option that will include two target populations that are covered within the KanCare program. The following briefly describes the state's work on this initiative.

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented July 2014
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, including but not limited to CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012
- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services
    - Identifying the first target group, approximately 36,000 adults and children with SMI
    - Determining the goals for health homes and selecting quality measures, including eight required by CMS
    - Defining the provider qualifications and standards
    - Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
    - Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and

Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
    - Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
    - Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
    - Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
    - Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
    - Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures and other components of the project
    - Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm )
    - Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
    - Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
    - Making presentations at various provider association conferences and meetings about the project
    - Holding an educational webinar for interested providers
- Tasks still to complete include:
    - Completing definition of the second target population, people with other chronic conditions
    - Refining the PMPM rate – draft rate is being reviewed internally
    - Developing a HHP readiness tool
    - Contracting with Kansas Foundation for Medical Care to assist certain providers in planning to implement electronic health records (EHRs)
    - Contracting with WSU's Center for Community Support & Research to design and facilitate a Learning Collaborative for Health Home Partners, beginning January 2014
    - Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of health homes
    - Implementing a consumer education tour in early Spring 2014
    - Developing the components the State wants the health plans to include in their contracts with HHPs
    - Consulting with SAMHSA for the second, chronic conditions, SPA
    - Developing reporting requirements
    - Final submission of both SPAs

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

- Regular meetings with KDADS stakeholders such as the Association of Community Mental Health Centers (at minimum monthly) to include in Q3 KanCare presentation/legislative panel

discussion at the Association's Annual Behavioral Health Conference
- Provider and Operations External workgroup
- Annual School Nurses conference – KanCare overview with focus on coordination with school based services
- Regular meetings with ID/DD Friends and Family Committee
- Sunflower held an LTSS Summit for their care coordination staff – KDADS staff participated doing extensive training
- Held meeting with MCO's and CDDO stakeholders to help them understand managed care contracting
- Bi-weekly conference call/web-x meetings with United and Amerigroup and CMHC billers to continue to work through billing processes
- Held community meeting with ID/DD CSPs (Community Service Providers) in Johnson County and surrounding area and MCO's for Q & A around ID/DD roll into KanCare
- I/DD KanCare Educational Tour
- KanCare Advisory Committee – subcommittee Provider and Operational Issues
- KDHE participation in Kansas Hospital Association technical advisory group on KanCare implementation, focused on obstacles to timely and accurate reinbursement
- Biweekly DME stakeholder conference calls were instituted in August

Finally, state staff also continued educational tours for consumers during the third quarter of the Demonstration Year.

In the second quarter, Wichita State University's CSSR facilitators prepared a report and made five recommendations, which the State addressed and applied during third quarter activities.

As a result of the sessions, CCSR recommended the following next steps (with follow up action items noted in italicized text):

- **Share the report with the MCOs.** *This report has been shared with the MCOs.*

- **Clarify care coordination and case management.** One area highlighted in particular among those receiving intellectual and developmental disabilities (I/DD) services was the role of care coordinators and targeted case managers.
    - *Tandem Team: The Care Coordinator will provide primary care case management and the Targeted Case Manager will provide targeted case management for individuals with IDD who are receiving TCM services. They will work together to develop the plan of care, ensure individuals have their needs met and services provided, and identify any changes as they are needed.*

- **Increase understanding of "ombudsman."** Participants responded positively to the KanCare ombudsman once they understood the role this position plays.
    - *Communication about the Ombudsman and how individuals can contact the Ombudsman's office is being included in all State communication to consumers.*
    - *The Ombudsman also participates in all statewide education and listening tours to speak to consumers, guardians, family members and friends*

- *Referrals to the Ombudsman office is encouraged by contracted entities when the member seems concerned or the contractor is unsure of who the member should call*

- **Consider additional options for member input.** Holding listening meetings across the state, as in this process, produced a relatively low response rate.
  - *Utilization of existing opportunities for member input*
    - *State participation in community organizations and meeting with boards for advocacy organizations (self-advocates and members are present) allowed a forum for informal feedback, suggestions and interaction with the State*
    - *MCOs are encouraged to utilize their community outreach opportunities to developed opportunities for member's to provide input and insight*
  - *Utilization of a consumer-focused advisory council*
    - *Friends and Family Advisory Council Steering Committee (F&F) and Education & Policy Subcommittees consisting of 25 individuals including self-advocates, friends, and family members (for I/DD KanCare Implementation)*
    - *Monthly meetings and bi-weekly meetings are held to review polices and communication plans and provide recommendations to leadership on a regular basis*
    - *The Friends and Family Advisory Council for the I/DD Pilot and Implementation into KanCare is intended to inform leadership of additional opportunities and resources to allow self-advocates and their family members or friends to provide a consumer voice to the State and share recommendations for improvements.*

- **Emphasize customer service and communication.**
  - *The State is exploring several formats for communicating with consumers and others about KanCare including improvements to the KanCare website and other State websites that provide information. Exploring member-friendly communication options will continue through the next quarter*
  - *Additional KanCare information is being provided to the contracted assessor entities to emphasize the "No Wrong Door" philosophy. Opportunities for improved communication and customer service are being explored and developed to ensure providers and members are aware of the services.*

A summary of 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 200 events for the third quarter allowing it to spread its message regarding education of services and benefits of the KanCare program to thousands of Kansans. Amerigroup continues to keep its focus on building relationships and learning more about the value the plan can bring to the community especially with the I/DD population. Examples of marketing activities include exhibits at conferences, community held events, and meeting with key community

partners. The largest attended events for the third quarter were:
- Community Back to School Fairs
- Kansas State Fair
- E.C. Tyree Community Day

Outreach Activities: Third quarter activity has a continued focus on welcoming newly enrolled members, gathering information about members through the health risk assessment and reminding members about the importance of key services such as EPSDT. Amerigroup continues to provide education to members. Outreach activity is provided through a variety of means such as phone calls and mailings. Similar to last quarter, Amerigroup provided a variety of outreach educational topics. For example:
- Amerigroup shared information regarding nurse on call line to members who have utilized the emergency room for non-emergent services.
- For members with hypertension, whose most recent blood pressure reading was controlled, Amerigroup provided support tips such as knowing blood pressure readings, taking medications as prescribed and following up with their doctor were provided to members.

Advocacy Activities: Advocacy efforts for third quarter continue to be broad based to support the needs of the plan's general population, pregnant women, children, people with disabilities, and the elderly. Amerigroup staff is engaged at the local level with committees, coalitions, and boards of various nonprofit organizations that have a similar focus and mission. This quarter the plan participated in educating members, families, caregivers, targeted case managers, and providers on the implementation of HCBS services for members with intellectual and developmental disabilities.

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

Marketing Activities: Marketing staff visits with and maintains relationships with media representatives throughout the state. A media log is maintained and media inquiries are reported to the state. Social media sites have been developed and ready to launch on November 1. Maintaining the website is vital in educating members and providers on the plan and services.
- Email marketing system has been initiated to better inform providers and members of updates and happenings at the State and the plan.
- External newsletters have been designed and will be implemented in December for Members and Providers.
- Presentations and informational sheets continually updated for population-specific presentations and events (i.e., new moms, IDD)
- Sponsorships and partnerships with local organizations continues to be a top priority, garnering relationship building and positive exposure (i.e. InterHab Conference, KAMU Conference, KACE conference and local health fairs)

Outreach Activities: Sunflower averages about 10 outreach events and presentations each week throughout the state. The calendar of events is submitted on a monthly basis to the state.

MemberConnections staff make regular visits to local ADRCs, CDDOs, Nursing Facilities, Independent Living Resource Centers, etc. to make sure Sunflower is meeting the needs of the organization and its members.

Advocacy Activities: Sunflower is heavily involved with advocacy groups and works with them to educate community members on changes in KanCare and services offered by Sunflower. The plan continues to think of creative and inexpensive ways to share resources and maximize services to members.
- Sunflower State has made it a priority to engage in the I/DD Pilot Project and the implementation process of the DD inclusion plan. The plan has a dedicated staff member who attends all meetings regarding this population and communicates with the organization.
- Partnership initiated with Kansas Head Start Association to join forces in raising awareness on their program at locations across the state.
- Monthly meetings held with health departments and CDDOs to find out best ways to partner and disseminate information.
- Project and communications plans developed for DD and Health Home inclusions.
- Ongoing discussions with Johnson County School districts and other school districts to partner in helping to get students healthy for the school year and make sure they have received all vaccinations.
- New Mom/Baby shower events scheduled for August. More extensive plan to visit high-population areas with pregnant mothers to hold educational events.
- Playing an active role in promoting the Work Program. Coordinating symposium to feature the benefits of employment to those with developmental disabilities.

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

Marketing Activities: UHC's main activities have been focused on education with regard to the continued emphasis of health and benefit literacy regarding the UnitedHealthcare Community Plan of Kansas members. UHC has done this through attendance at community events that attract its membership base, member welcome calls, mailings to those who could not be reached by phone, and sending out a third Member Newsletter to UHC membership.

Outreach Activities: UHC has three outreach specialists focused on activities targeted within a geographic area of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, its work with KanCare and the benefits of its plan. They especially inform individuals about value added benefits. UHC also has a Provider Marketing Manager whose role is to work with key provider offices throughout the State to assist them with issues regarding the transition to KanCare and to make sure they are educated on the benefits of UnitedHealthcare for members who visit their offices.
- During the third quarter of 2013, UnitedHealthcare staff personally met with 25,705 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 third quarter of 2013, UnitedHealthcare staff personally met with 1,011 individuals from

community based organizations located throughout Kansas. These organizations work directly with members in various capacities.
- During the third quarter of 2013, UnitedHealthcare staff personally met with 1,052 individuals from provider offices located throughout the State.

Advocacy Activities: UHC activities in advocacy are again focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with developmental disabilities. UHC has one Outreach Specialist focused specifically on working with individuals who touch Kansans with disabilities.
- The outreach specialist to the disabled community personally visited with 246 advocates for Kansans with disabilities, providing them with education on KanCare and UnitedHealthcare benefits.
- That same outreach specialist also worked in conjunction with the Empower Kansas steering committee on awarding over $260,000 to five organizations in Kansas focused on working to employ Kansans with disabilities throughout Kansas.

## IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: As the State reported to CMS during monthly conference call updates, there have been a variety of concerns regarding systems and reporting issues, in line with expectations of a transition of this magnitude. Through a variety of accessible forums and input avenues, the State has been advised of these types of issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include technical work groups with key provider associations to resolve outstanding issues impacting timely and accurate reimbursement, and claims projects to assess and correct systemic issues.

   Kansas completed the periodic (first daily, then several times weekly, and then weekly) KanCare Rapid Response calls with providers, members and advocates. Since that time, additional attention has been paid to evaluating the ongoing support activities and customer support performance of the MCOs. As that process came to a conclusion, Kansas prepared to do focused reviews of key infrastructure issues at each of the MCOs, to validate performance and help ensure strong performance as we shift to the longer term operation of the program. Based on experience in the first two quarters, the areas selected for more intensive desk review and onsite review included: customer service, provider credentialing, grievance/appeal management, prior authorization timeliness and accuracy, and TPL/client obligation/spend down processes. That focused review was conducted during the third quarter, and results of the review were developed and provided to the KanCare MCOs. Overall performance in the focused review was strong, but also led to action items to enhance performance and compliance. Those focused review items will be addressed as part of the annual compliance

reviews, for which preparation is underway. Those annual reviews, which will be comprehensive for the first annual cycle, will begin in the fourth quarter of 2013 and be completed in the first quarter of 2014.

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added services used, per KanCare MCO's top three value-added services by reported value and total, January-September, 2013:

| MCO | Value Added Service | Units | Value |
|---|---|---|---|
| **Amerigroup** | Adult Dental Care | 1,926 | $239,443.84 |
| | Member Incentive Program | 6,462 | $204,250.00 |
| | Mail Order OTC | 5,238 | $84,416.12 |
| | *Total of all Amerigroup VAS Jan-Sept 2013* | *31,266* | *$751,917.22* |
| **Sunflower** | Dental visits for adults | 49,772 | $1,010,013.62 |
| | CentAccount debit card | 59,491 | $1,191,860.00 |
| | SafeLink®/Connenctions Plus cell phones | 8,727 | $417,412.41 |
| | *Total of all Sunflower VAS Jan-Sept 2013* | *796,888* | *$3,133,538.24* |
| **United** | Adult dental services | 3,719 | $483,470.00 |
| | KAN Be Healthy Screening | 42,334 | $423,340.00 |
| | Annual A1C Exam | 5,148 | $102,960.00 |
| | *Total of all United VAS Jan-Sept 2013* | *80,782* | *$2,111,598.28* |
| **Combined Totals** | **All MCOs - Jan-Sept 2013** | *908,936* | $5,997,053.74 |

c. Enrollment issues: For the third quarter of 2013 there are 14 American Indians/Alaska Natives who chose to not be enrolled in KanCare per the opt-out provision available to AI/AN members. The table below represents the enrollment reason categories for the 3rd quarter of calendar year 2013 (months July, August, September). All KanCare eligible members may choose a managed care plan at application or are defaulted to a managed care plan.

| Start Reasons | Total |
|---|---|
| Newborn assignment | 7 |
| Administrative change | 10 |
| WEB - Change Assignment | 24 |
| KanCare Default - Case Continuity | 279 |
| KanCare Default - Morbidity | 531 |
| KanCare Default - 90 Day Retro-reattach | 182 |
| KanCare Default - Previous Assignment | 303 |
| KanCare Default - Continuity of Plan | 2549 |

| | |
|---|---|
| Choice - Enrollment into KanCare MCO via Medicaid Application | 528 |
| Change - Enrollment Form | 407 |
| Change - Choice | 754 |
| Change - Access to Care - Good Cause Reason | 5 |
| Change - Case Continuity - Good Cause Reason | 12 |
| Assignment Adjustment Due to Eligibility | 11 |
| **Total** | **5,602** |

d. Grievances, appeals and state hearing information

***KDHE Grievance Data Base***

**Members- CY13 3rd quarter report**

| MCO | Access | Dental Access | Pharmacy | Benefits and Billing | Quality of Care | Rights and Dignity |
|---|---|---|---|---|---|---|
| Amerigroup | 14 | 3 | 23 | 41 | 0 | 1 |
| Sunflower | 4 | 0 | 25 | 71 | 0 | 2 |
| United | 1 | 0 | 14 | 5 | 1 | 0 |

**Providers – CY13 3rd quarter report**

| MCO | Access | Enrollment | Dental Access | Pharmacy | Benefits and Billing |
|---|---|---|---|---|---|
| Amerigroup | 2 | 11 | 6 | 42 | 45 |
| Sunflower | 2 | 1 | 9 | 70 | 34 |
| United | 2 | 1 | 4 | 51 | 13 |

***Grievances MCOs Database***

**Members- CY13 3rd quarter report:**

| MCO | Access | Quality | Benefits | Billing | Transportation | Pharmacy | Waiver Service |
|---|---|---|---|---|---|---|---|
| Amerigroup | 39 | 32 | 39 | 37 | 88 | 11 | 7 |
| Sunflower | 13 | 17 | 8 | 2 | 67 | 10 | 7 |
| United | 1 | 14 | 0 | 15 | 50 | 3 | 0 |

***Appeals MCOs' Database***

**Members:**

| MCO | Access | Quality | Benefits | Billing | Transportation | Pharmacy | Waiver Service |
|---|---|---|---|---|---|---|---|
| Amerigroup | 1 | 0 | 22 | 1 | 1 | 1 | 13 |
| Sunflower | 0 | 0 | 16 | 1 | 1 | 6 | 9 |
| United | 1 | 0 | 20 | 2 | 0 | 5 | 17 |

**Providers:**

| MCO | Access | Quality | Benefits | Billing | Transportation | Pharmacy | Waiver Service |
|---|---|---|---|---|---|---|---|
| Amerigroup | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sunflower | 0 | 0 | 73 | 1 | 2 | 54 | 7 |
| United | 0 | 0 | 7 | 0 | 0 | 3 | 0 |

***State of Kansas Office of Administrative Fair Hearings:***

**Members:**

| State Fair Hearings | Services were rendered | No adverse action | Member did not appear | MCO reversed decision before the Hearing occurred |
|---|---|---|---|---|
| **30** | 5 | 2 | 1 | 22 |

**Providers:**

| State Fair Hearings | Dismissed | Withdrawn | MCO Affirmed | MCO reversed decision before the Hearing occurred |
|---|---|---|---|---|
| **91** | 38 | 1 | 15 | 37 |

**Specifically Related to HCBS Services:**

| TOTAL Filed | Dismissed | Affirmed | Withdrawn | Reversed | Pending | Default | Modified |
|---|---|---|---|---|---|---|---|
| **27** | 7 | 4 | 3 | 0 | 10 | 2 | 1 |

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

f. Access: During the third quarter, there was a significant decrease in members' requests to change MCO plans. As discussed in the 2nd quarter report, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In the third quarter, KDHE received 225 member requests to change health plans, down from 543 requests in the second quarter.

All three plans continue to add providers to their networks, alleviating the reason for many of the change requests. Anecdotally we are finding KanCare members and their advocates are becoming more familiar with KanCare processes and their health plans and are more comfortable calling their plans directly with questions about their networks and coverage.

As in the second quarter, GCRs after the choice period based solely on the member's preference, when other participating providers with that MCO are available, are denied as not

having good cause. The MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. At the end of Q3, one fair hearing had been filed, and this was dismissed by the fair hearings officer. This is a decrease from eight fair hearings filed during the second quarter.

| Status | July | August | September |
|---|---|---|---|
| Total GCRs filed | 94 | 75 | 56 |
| Approved | 6 | 1 | 6 |
| Denied | 44 | 24 | 20 |
| Withdrawn (resolved, no need to change) | 31 | 40 | 18 |
| Dismissed (due to inability to contact the member) | 13 | 10 | 11 |
| Pending | 0 | 0 | 1 |

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

| KanCare MCO | # of Unique Providers as of 3/26/13 | # of Unique Providers as of 6/30/13 | # of Unique Providers as of 9/12/13 |
|---|---|---|---|
| Amerigroup | 11,746 | 16,706 | 16,891 |
| Sunflower | 10,006 | 13,016 | 14,478 |
| UHC | 11,105 | 14,738 | 15,893 |

Non-emergent medical transportation-related (NEMT) complaints (no-shows, late pick-ups, etc) remain a large percent of the grievances received by MCOs. In the upcoming annual audits the State is reviewing NEMT oversight functions and program improvement interventions.

NEMT-related complaints (all categories included – customer service of driver, customer service of vendor, timeliness, mileage reimbursement, no-shows):

NEMT Complaints:

| KanCare MCO | 2013 - Q1 | 2013 - Q2 | 2013 - Q3 |
|---|---|---|---|
| Amerigroup | 106 | 50 | 86 |

| | | | |
|---|---|---|---|
| Sunflower | 119 | 68 | 69 |
| UHC | 85 | 80 | 49 |

There are still provider confirmation issues around eligibility during the short time between when beneficiaries are deemed eligible for KanCare and when the MCOs and their subcontractors receive and load the eligibility files (within 24 hours for the MCOs and two days for subcontractors). KDHE and the MCOs continue to educate providers on preferred alternatives to confirm eligibility (calling the fiscal agent, or checking the KMAP website) and the fiscal agent call center processes escalated eligibility inquiries through the MCOs to the requesting provider.

g. Proposed changes to payment rates: Effective July 1, 2013, the KanCare capitation rates were adjusted to reflect the following changes:
   - Updating the cost based rates paid to the Rural Health Clinics and the Federally Qualified Health Clinics;
   - Updating the Long Term Care mix and for the inclusion of the nursing facility supplemental payments.

h. MLTSS implementation and operation:
   - During the third quarter, the State met weekly with the MCOs to develop, discuss, and provide technical assistance. Updates were made to the workflows for HCBS program-specific issues such as client obligation, third party liability, and the plan of care process. The State and MCOs worked with multiple stakeholder groups to address provider-related concerns. Frequent concerns were related to FMS provider issues. In response, the State utilized the FMS Workgroup to develop recommendations to the State surrounding the application of the Affordable Care Act, Department of Labor's final rule on companionship, and other FMS-related matters that were not specific to KanCare implementation. As part of the continued implementation and operation process, the State provided education to the MCOs related to care coordination, program policies and procedures, and stakeholder engagement. Weekly complex case staffing has moved to bi-weekly meetings and more often as needed to address any concerns that may arise.
   - The State, the Electronic Visit Verification (EVV) contractor and MCOs have partnered to identify and resolve any lingering billing issues presented by providers. The EVV contractor works as a liaison with providers to ensure appropriate MCO authorizations that assure the integrity of service delivery and timely billing. Updates were made to the EVV system in July to accommodate MCO reporting requests. The EVV contractor has met with MCOs and providers to gather suggestions for future enhancements that will leverage additional savings to the State and its partners in their delivery of HCBS in Kansas. That proposal has been presented to the State. Additional updates to the system are expected over the next few months.

- There were 949 Plan of Care (POC) Reduction requests in the third quarter of KanCare. The significant increased volume (up from 181 requests in the second quarter), is largely due to one MCO choosing to wait until the third quarter to submit all its requests. To improve efficiency, the State developed technical improvements to allow the State to continue to address service plan reductions. The POC Reduction request continues to be reviewed by three HCBS Staff members and approved by the Program Manager, Assistant Director or Director. Plans may be approved, approved with recommendations, aborted, or denied.

| **Total Requested** | Total Approved | Total Denied | Under Review |
|---|---|---|---|
| **949** | 875 | 72 | 2 |

72 POC Reductions were denied due to the request exceeding the threshold score on a 0 to 5 scale (for example a threshold score of 2.5 or higher based on risk factors). During the third quarter, the option to abort a POC Request for additional information was utilized to minimize denials for administrative reasons. Additional technical changes will be added to allow State staff to return a POC Reduction Request for additional information without the need to abort. These technical corrections will be applied for the IDD MLTSS POC Reduction requests and continue after the State stops reviewing other HCBS POC Reduction requests on January 1, 2014.

i. Updates on the safety net care pool including DSRIP activities: Kansas proposed and CMS approved delaying the implementation of the DSRIP pool for one year to allow the State and CMS to focus on other critical activities related to Kansas' Section 1115 Demonstration waiver.

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

- The Technology Assisted (TA) waiver was renewed and effective for the third quarter of KanCare.
- All 1915(c) waivers were prepared for amendment during the third quarter of KanCare to reflect amendments for the quality assurance measures in each waiver. The State is receiving Technical Assistance from the CMS NQE contractor. The State will incorporate consistent quality assurance measures in each waiver after feedback from CMS on the quality assurance measures submitted for the I/DD 1915(c) waiver (see below).
- The 1915(c) waiver staff continues to provide MCO and provider training on waiver services and waiver policies and procedures for each specific waiver.
- HCBS staff participate in the following workgroups and steering committees to ensure consistency and listen to provider and consumer concerns, including but not limited to:
    - Autism Workgroup
    - FMS Workgroup

- IDD KanCare Implementation Workgroup
- TA Workgroup
- MFP Workgroup
- MCO Technical Assistance
- HCBS Provider Forum (monthly)
- Friends and Family Advisory Council

- The State submitted a request in the third quarter to amend the HCBS-I/DD waiver to include quality measures in the waiver consistent with the QIS and CMS guidance and the integration of IDD LTSS into the KanCare 1115 Demonstration Project.
- The I/DD Waiver requested technical assistance from NASDDDS for NCI Implementation. Training was held in September, and the KDADS quality management field staff will begin conducting surveys for individuals on the IDD Program in the fourth quarter.
- During the third quarter, the State utilized technical assistance through Truven to work on quality measures that included the Quality Improvement Strategy (QIS) and the recent CMS guidance on health, safety and welfare assurances and subassurances.

k. Legislative activity: The 2013 legislative session ended during the second quarter. During the third quarter, the Legislative Coordinating Council approved interim committee days for the newly created Robert G. Bethell Home & Community Based Services and KanCare Oversight committee, a statutory joint committee. A report from two meetings of the Oversight Committee will be included in the next quarterly report.

## V. Policy Developments/Issues

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

Also in the quarter, KDHE and the Department for Children and Families continued development of the Kansas Eligibility Enforcement System and transitioned to a phased functional implementation of Phase II.

## VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. For the quarter ending

September 2013 (DY1-Q3), the State removed the July payment amount/enrollment for June and input the October payment amount/enrollment for September. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent.

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

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

## VII. Member Month Reporting

| **Sum of Member Unduplicated Count** | **Member Month** | | | **Totals** |
|---|---|---|---|---|
| *MEG* | *2013-07* | *2013-08* | *2013-09* | *Grand Total* |
| Population 1: ABD/SD Dual | 17,720 | 17,621 | 17,485 | 52,826 |
| Population 2: ABD/SD Non Dual | 29,329 | 29,201 | 29,007 | 87,537 |
| Population 3: Adults | 32,793 | 32,729 | 32,503 | 98,025 |
| Population 4: Children | 210,625 | 210,652 | 209,787 | 631,064 |
| Population 5: DD Waiver | 8,676 | 8,685 | 8,657 | 26,018 |
| Population 6: LTC | 21,815 | 21,806 | 21,703 | 65,324 |
| Population 7: MN Dual | 1,265 | 1,202 | 1,139 | 3,606 |
| Population 8: MN Non Dual | 1,112 | 1,101 | 1,051 | 3,264 |
| Population 9: Waiver | 4,460 | 4,407 | 4,365 | 13,232 |
| **Grand Total** | **327,795** | **327,404** | **325,697** | **980,896** |

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

## VIII. Consumer Issues

Summary of most common consumer issues during third quarter:

| Issue | Resolution | Action Taken to Prevent Further Occurrences |
|---|---|---|
| Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established). | When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled. | • Assurance that eligibility file is loaded in timely fashion by MCOs and their vendors.<br>• Providers can confirm eligibility by directly accessing KMAP or calling customer service. |
| Some members found, after their 90 day "choice period" expired, that their preferred providers were not contracted with their assigned MCO, or that needed/desired services were not available through that MCO. Thus, members requested reassignment. | MCOs worked to assure needed services were available within the State's geographic access standards, either with in-network providers or single case agreements with out-of-network providers. If those conditions were not met, members were granted their request for re-assignment to a different health plan. | MCOs' contracting efforts are ongoing, to close gaps in their provider networks. Requests for reassignment are down almost 60% from the previous quarter. |
| Prescriptions and other services were delayed or denied for lack of a prior authorization. | • Some PA requirements were relaxed, upon guidance from State Program Managers and Pharmacist.<br>• Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit.<br>• MCO's PA processes were improved to provide more rapid decisions. | For Rx, the State's Pharmacist continues to monitor MCOs' PA lists to assure that they aren't incorrectly requiring PAs. This is a focus of the upcoming annual review. |
| Incorrect information was given to members and providers by customer service representatives. | • Instruction/correction of individual staff when issues were called to MCO's attention.<br>• On occasion, MCO has covered services which were provided on the basis of incorrect information. | Ongoing education of CSRs to understand the eligibility information available to them, the services which are covered by KanCare, and correct routing of calls. |
| Incorrect application of spenddown, client obligation, and patient liability | MCO education to providers on how to properly apply claims to patient responsibility (spenddown). | The State developed material and conducted a training session for MCO staff targeting these issues. |
| Members received bills for denied services which should be covered by Medicaid | Some system set-up errors have resulted in claims for services being denied as non-covered. As these are identified, State and MCOs work together to determine correction needed; claims are reprocessed. | MCOs continue to resolve system errors and processes to assure correct claims adjudication. Members are not required to pay for covered services. |

| | | |
|---|---|---|
| Members who have received Home Health services in the past have had service payments reduced or denied when the MCOs reviewed plans of care upon recertification. | Home Health providers have exercised appeal and State Fair Hearing rights on behalf of members. State program staff have reviewed documentation provided upon appeal, to assure that program requirements have been met. | State staff are reviewing MCOs' processes to assure compliance with State and Federal guidelines. The State maintains regular communication with Home Health providers and selectively reviews payment reductions. |
| Transportation issues: drivers late for appointments, or fail to show up; rudeness; difficulty in scheduling | MCO's transportation vendors address issues for which grievances are filed, provide ongoing education, and dismiss drivers, if necessary. Transportation vendors also educate members on importance of giving 3 days' notice for non-emergent trips. | MCOs monitor grievance data for trends to identify problem areas and drivers. |

## IX. Quality Assurance/Monitoring Activity

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

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

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

put into use. This comprehensive strategy was updated with additional operational details, and the MCO QAPIs for 2013 were finalized and approved in June 2013.

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

During the third quarter of KanCare operation, some of the key quality assurance/monitoring activities have been:

- Ongoing and at least twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program, with extensive work on customizing measures for the year two P4P measures which will be validated by the state's EQRO, and finalizing the Agreed Upon Procedure specifications for year one P4P measures to be validated by each MCO's external financial auditor.
- Extensive interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate to the MCOs both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the receipt, distribution, review and feedback regarding submitted reports.
- Operationalizing the EQRO work plan for 2013 and into 2014, with the associated deliverables detail. One of the business meetings with the MCOs each month is dedicated to discussing EQRO activities, MCO requirements related to those activities, and timeline/action items to move all EQRO deliverables and related MCO deliverables along apace with good mutual understanding and clarity.
- Ongoing meetings of the KanCare Interagency Monitoring Team, with primary focus this quarter being the update of HCBS waiver performance measures and merging them with the KanCare comprehensive quality strategy, and attention to the related state support infrastructure. This

included extensive shared attention on the HCBS waiver measure specification changes and the 1115 program/quality monitoring structure. In addition, on 8.29.13, IMT members participated in a KanCare Quality Overview information sessions that included review, training and information sharing regarding all key components of the KanCare comrehensive state quality strategy and related monitoring and evaluation activities, including consideration of EQRO functions and the KanCare evaluation design.

- Planning for monitoring of key mangement activities of the MCOs as the implmentation period came to a close, and we shifted focus together to the more long-term operation of the KanCare program. During the third quarter, KDHE and KDADS collaborated to conduct a mid-year focused review of each MCO related to core operational issues, and ongoing reporting of the KKMAR activities/results. The review focused on core operational areas of the KanCare MCOs, to validate performance reports and to help ensure strong performance as the program shifted from the launch/initial implementation phase to the long-term/operational phase. Program management, contract monitoring and fiscal oversight staff from KDHE and KDADS obtained and assessed extensive documentation samples reflecting MCO performance and conducted related onsite reviews of these KanCare operational areas:
    - Customer Service – for both members and providers
    - Provider Credentialing – including timing and accuracy of related processes
    - Grievances and Appeals – for both members and providers
    - Prior Authorizations – including timing and accuracy of MCO and subcontractor decisions
    - Third Party Liability, Spend Down and Client Obligation – evaluating program integrity

  The KanCare MCOs were promptly responsive to the documentation requests, and made available relevant staff and information during the onsite portion of the reviews. The focused reviews identified substantive areas of strong performance for each MCO, but also areas where processes needed to be strengthened or expanded to ensure long-term success. Operational considerations were also highlighted for both the state and the MCOs as to effective ways to obtain and present review information in ways that demonstrate compliance and communicate the actual performance of both the MCOs and the subcontractors for which they are responsible.
- Facilitation of technical assistance activities for MCOs to address implementation and programmatic questions related to the HCBS waiver services. This weekly meeting allowed the State and the MCOs to touch-base and address any concerns or clarification needed related to each program.
- Facilitation of complex case staffing for cases involving individuals with multiple disabilities or complex needs. This weekly meeting for behavioral health and HCBS services allowed the State to work with the MCO to find creative solutions, apply policies to specific situations, and address issues identified by consumers, providers, the MCO, or the State for a specific consumer.
- Identification of timetable to accomplish during the first year of KanCare operation, the completed merger of HCBS waiver-based performance measures and practices within the

comprehensive Kansas state quality strategy.

Progress continues on this set of activities.

- During the third quarter, the State completed technical assistance with Truven to help ensure the quality measures in each 1915(c) waiver was consistent with each other and aligned with the 1115 demonstration quality measures per STCs 37 and 45.
- The IDD amendment for inclusion of the IDD program into KanCare was submitted during the third quarter; the remaining waiver amendments will be submitted following feedback from CMS on the quality assurance measures in the submitted amendment..
- HCBS reports that align with the recommended quality measures will be developed in the fourth quarter following submission of the waiver amendments. These reports will include detailed quality metrices that will ensure health, safety and welfare of concerns.

- KDADS Quality Management Specialists (QMS) continued to provide quality oversight activities for the 1915(c) waiver programs. The activities include the following:
  - QMS completed MCO and ADRC case file reviews and conducted customer interviews to ensure members are receiving services as on their plans of care. Additional HCBS reports and data were collected to review for compliance with policies and procedures and develop additional reports that demonstrate trending to provide to the legislative KanCare Oversight Committee.
  - QMS reviewed and assessed POC Reduction Requests submitted to the State for review. They were assigned to follow up selected requests with in-home visits, if necessary, to assure reductions are appropriate and the individual's health, safety and welfare needs were being met. They recommended tapered reductions as needed to allow the individual and/or direct service worker adequate time to transition to the reduction.
  - QMS reviewed the ride-along process utilized during the first two quarters to determine areas of improvement for the IDD Implementation process. The QMS staff observed the process utilitized by the MCOs to develop a plan of care and worked closely with staff to address concerns related to service, service interruption, or provider concerns. Lessons learned will be applied to the ride-along process for integration of I/DD LTSS into KanCare.
  - QMS continued quality monitoring activities related to investigting critical incidents involving HCBS consumers and/or providers that are submitted into the Adverse Incident Reporting (AIR) system. Critical incidents must be entered within 24 hours of the incident, and have been reviewed within 48 hours of the report. The AIR system for reporting critical incidents tracks the status of the individual cases. All reports have now been added to AIR with ongoing training and monitoring to continue in the fourth quarter. Complaints and grievances (not rising to the level of a critical incident) are also

reviewed by a QMS as requested

- QMS met with staff from Adult Protective Services for the quarterly meeting to discuss the monthly reports that are submitted and emerging trends related to HCBS consumers. During the session it was identified that the Memorandum of Understanding should be modified to ensure access to confidential information by the MCOs is permissible. QMS staff work closely with the APS workers to investigate waiver-related concerns connected to APS reports regardless of substantiation.
- QMS continue to monitoring of service plans to determine that an individual's needs are being met are conducted through home visits of a random selection of individuals on a monthly basis.
- The State is on the national steering committee for the development of the National Core Indicators for the Aging and Disabled (NCI-AD). The NCI-AD is being developed using the current NCI (for IDD) model to develop additional quality measures for other disabled and aging populations. During the September HCBS National Conference, the steering committee met to develop the survey, which would address the specific concerns of the aging and disability populations.

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

## X. Managed Care Reporting Requirements

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

Each MCO submitted a weekly network adequacy report through the end of June 2013. Beginning in July, MCOs submitted their network report monthly. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders.

In addition, each MCO submits monthly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Based on these network reports, two reports are published to the KanCare website monthly for public viewing.

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the acces 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 average speed of answer at the plans and call abandonment rates:

| Member Call Top 5 Reasons | | | | | |
|---|---|---|---|---|---|
| **Amerigroup** | **Sept. 2013** | **Sunflower** | **Sept. 2013** | **United** | **Sept. 2013** |
| Find/change PCP | 30.6% | PCP Change | 12.8% | Benefits Inquiry | 30% |
| Benefit Inquiry – regular or VAS | 17.5% | Eligibility Inquiry | 9.6% | Find / Change PCP | 25% |
| Order ID card | 7.3% | ID Card Request | 7.8% | Order ID Card | 8% |
| Claim or billing question | 5.9% | Case Management | 4.4% | Eligibility Inquiry | 12% |
| Care management or health plan program | 5.6% | Claims Status Inquiry | 4.4% | Care Management or Health Plan Program | 3% |
| **Other Member Customer Service Performance Results** | | | | | |
| **Member (Voice Portal & Live Agent)** | **YTD 2013** | **Beneficiary Calls-** | **YTD 2013** | **Member Services** | **YTD 2013** |
| Total # Calls Offered | 3771.45 | Total Offered | 156,256 | Total Offered | 109,770 |
| Total # Handled | 3761.025 | Total Handled | 155,228 | Total Handled | 108,834 |
| Average seconds to answer | 0.003116 | Average seconds to answer | 9 | Average seconds to answer | 3.93 |
| Average length of call | 0:04:29 | Average length of call | 5:24:20 | Average length of call | 05:17 |
| Abandon Volume | 10.425 | Abandon Volume | 1548 | Abandon Volume | 582 |
| Abandon Rate | 0.26% | Abandon Rate | 1.0% | Abandon Rate | 0.3% |

| Provider Call Top 5 Reasons | | | | | |
|---|---|---|---|---|---|
| **Amerigroup** | **Sept. 2013** | **Sunflower** | **Sept. 2013** | **United** | **Sept. 2013** |
| Authorization – new | 25.8% | Claims Status | 58.90% | Benefits Inquiry | 16% |
| Claim status inquiry | 24.3% | Adjustment | 13.31% | Claim Status Inquiry | 34% |
| Authorization – status | 13.2% | Prior Authorization Status | 3.43% | Claim Denial Inquiry | 10% |
| Benefits inquiry | 9.8% | Eligibility Inquiry | 3.10% | Update Demographic Information | 2% |
| Claim denial inquiry | 8.6% | Claims Submission Status | 2.09% | Member Eligibility Inquiry | 14% |
| **Other Provider Customer Service Performance Results** | | | | | |
| **Provider (Voice Portal & Live Agent)** | **YTD 2013** | **Provider Calls** | **YTD 2013** | **Provider Services** | **YTD 2013** |
| Total # Calls Offered | 2057.75 | Total Offered | 44,899 | Total Offered | 40,543 |
| Total # Handled | 2047.9 | Total Handled | 44,557 | Total Handled | 40,456 |
| Average seconds to answer | 0.000118721 | Average seconds to answer | 8 | Average seconds to answer | 2.73 |
| Average length of call | 0:04:19 | Average length of call | 6:30:20 | Average length of call | 07:34 |
| Abandon Volume | 9.85 | Abandon Volume | 327 | Abandon Volume | 92 |
| Abandon Rate | 0.48% | Abandon Rate | 0.7% | Abandon Rate | 0.2% |

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

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

e. Summary of ombudsman activities :

The Office of Ombudsman continues to serve an important role as a resource to Kansas Medicaid consumers. During this period, the focus has shifted to investigating and advocating for additional resources to improve the reporting and customer service functions of the office. An ombudsman assistant has been hired and is actively developing the Ombudsman log and developing the tools to provide accurate reports. This addition also resulted in improved response time and concern resolution. The Ombudsman assistant is the liaison for the recently formed Friends and Family Steering Committee, creating the opportunity for parents and guardians to contribute their perspective about policies related to I/DD waiver services.

Thus far, the ombudsman log has documented 1,600+ messages to date. This number does not include calls that are responded to live or 7,800 incoming and 4,700 outgoing E-mails. Despite the volume the workload has continued to be manageable, with all messages and E-mails returned promptly, usually the same day. To document these results, a random, third party survey tool is being developed to report on consumer satisfaction. The ombudsman continues to be clear in communicating his function with consumers, with a primary focus on resolving critical issues and providing resources and collaboration in an informal and unbiased manner.

In order to retain objectivity, the ombudsman does not advocate for the consumer, but retains a balanced approach. By remaining neutral, it encourages effective communication between the various stakeholders. The utility of the ombudsman is dependent upon active listening, defining the relevant facts, and in encouraging mutual respect in resolutions. Consumer satisfaction and resolution rates are dramatically enhanced by providing an impartial and objective discussion of the concern. By understanding the context and history of concerns and resolutions, the ombudsman is a unique resource for consumers to become informed and play an active role in finding appropriate solutions.

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

1) Eligibility for KanCare (remains the top inquiry)
2) Billing/claims and prior authorizations
3) Grievance/appeal and state fair hearing process
4) Pharmacy and durable medical equipment prior authorizations
5) Reductions in plans of care
6) Status of plan provider networks and access to care

The Ombudsman continues to present to stakeholder groups and at KanCare public forums. Additionally, the Ombudsman actively participates in internal and external forums to enhance the visibility and understanding of the collective concerns and experiences of consumers. Due to the location and interaction with State program staff, there is direct feedback and exchange of information regarding concerns and effective approaches to resolution. Much of the utility of ombudsman is through the unique perspective gained through daily interactions between consumers, the State, the MCO's and many other stakeholder groups.

The ombudsman remains involved in various workgroups:

1) I/DD Waiver Pilot
2) KDADS Internal I/DD Workgroup
3) KDADS KanCare Weekly Workgroup
4) KDADS Friends and Family Steering Committee and Communication/Education Sub-committee
5) CMS Implementation Monitoring Meetings

In summary, the Ombudsman has been a responsive resource for KanCare consumers. As consumers'

have experienced concerns, they are being heard and acted upon. With the addition of an assistant, communication and statistical reporting of interactions and outcomes will be more objectively documented. Thus far the feedback by consumers has been very positive. The State also plans a consumer survey to measure their satisfaction related to their interaction with the ombudsman's office.

f. Summary of MCO critical incident report:

In the third quarter all critical incidents were submitted into the Adverse Incident Reporting (AIR) system. Some enhancements to the system were requested during the third quarter. QMS staff identified some incidents were reported by providers or other contracted entities that did not meet the definition of a critical incident. Although this information may be important to KDADS and/or the MCOs, it was filtered out of the report to ensure we were tracking and sharing information but not counting it as a critical incident.

| Critical Incidents | 1st Qtr | | | 2nd Qtr | | | 3rd Qtr | 4th Qtr | YTD |
|---|---|---|---|---|---|---|---|---|---|
| | (AIR) | (KDADS) | Totals | (AIR) | (KDADS) | Totals | AIR Totals | AIR Totals | **TOTALS** |
| **Total # Received** | 43 | 300 | **343** | 122 | 66 | **190** | **131** | | **664** |
| **Total # Reviewed** | 36 | 247 | **283** | 101 | 66 | **167** | **112** | | **562** |
| **Total # Pending** | 7 | 53 | **60** | 21 | 0 | **21** | **8** | | **N/A** |
| **Total # Substantiated** | NR | NR | NR | NR | 51 | **51** | **115** | | **166** |

## XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The Attachment Safety Net Care Pool Report identifies pool payments to participating hospitals, including funding sources, applicable to the third quarter.

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

## XII. Demonstration Evaluation

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

The draft evaluation design was submitted by Kansas to CMS on April 26, 2013. CMS conducted review and provided feedback to Kansas on June 25, 2013. Kansas reviewed that feedback worked internally and with the external evaluator, MCOs and others to address that feedback. The final design was completed and submitted by Kansas to CMS on August 23, 2013. On September 11, 2013, Kansas was informed that the Evaluation Design had been approved by CMS with no changes.

The timeline from here will include:

- Adjustments to the evaluation plan will be completed and submitted for approval whenever relevant amendments to the 1115 waiver are submitted, and otherwise when modifications become necessary during the course of evaluating KanCare.
- Quarterly and Annual evaluation progress reports will be submitted.
- Draft evaluation report to be submitted 120 days after expiration of the demonstration.

## XIII. Other (I/DD Pilot Project; Implementation of I/DD LTSS)

a. KanCare I/DD Pilot Program: There are over 500 providers in the KanCare I/DD Pilot Program who are being served by 25 providers. The Pilot is supported by the I/DD Pilot Committee, which met bi-weekly in the third quarter to ensure the three main objectives of the KanCare I/DD Pilot Project are met:

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

During the third quarter, the I/DD Pilot Committee shifted its focus from the technical development of the billing and claims process and began developing practical aspects of the workflow process including the development and transmission of the plans of care to the MCOs.

Provider Updates include:

- Providers were trained on the AIR Reporting system and will begin using it to report critical incidents for individuals with IDD in the fourth quarter. Currently, reports for critical incidents for individuals with IDD are submitted by the CDDO to the Statewide Oversight Committee for review, tracking and trending. On January 1, 2014, all critical incidents will be reported in AIR.
- Providers attended training and question and answer sessions hosted by the State to address contracting and credentialing concerns, present pilot updates, and prepare providers for changes coming on January 1, 2014.
- The I/DD Pilot Committee identified needed changes to the current billing and claims process that included a system change to a 15 minute billing unit for Day Supports to be

effective on January 1.

Pilot updates are being added to the website monthly. Recent third quarter updates are highlighted below and the full report can be found on the KDADS website at the following link: http://www.kdads.ks.gov/CSP/IDD/KanCare_Imp/DD_Pilot_Activities.html

- During the month of September, staff from the Lieutenant Governor's office, KDADS and the three MCOs conducted a statewide tour to Hays, Wichita, Parsons and Olathe. Separate sessions were held in each location for service providers and persons receiving services and their families. Sessions were well attended. More than 400 consumers, family, friends, targeted case managers and other providers attended statewide.
- Members of the Pilot Advisory Group, Pilot Providers, the KanCare Managed Care Organizations and KDADS staff had an opportunity to meet with Nancy Thaler and Barbara Brent from the National Association of State Directors of Developmental Disabilities and Ari Ne'eman, the President and co-founder of the Autistic Self-Advocacy Network. These national experts presented an overview of what is going on nationally related to managed care. They discussed what different states are doing and what national trends toward managed care they were observing. Additionally, they spent time with the groups talking about what outcomes stakeholders wanted to achieve with managed care for I/DD long-term care and supports.
- The Pilot Advisory Group and Friends and Family Advisory Council will work with KDADS to review the recommendations provided by a CDDO Workgroup related to how services and service delivery will function under KanCare. These recommendations cover different areas of the system including financial management, plan of care development, dispute resolution, network sufficiency, extraordinary funding and waiting list management. Over the next few weeks, KDADS, MCOs and CDDOs will meet to discuss the process to provide guidance to KDADS leadership about system design and improvements.
- MCO care coordinators and targeted case managers are working together to develop plans of care, prior to January 1, for individuals with I/DD. Each MCO has completed face-to-face contacts with all pilot members and their targeted case managers. They have utilized their needs assessment and health risk assessment tools to identify value added services, additional behavioral health and physical health services, and assistive technology for individuals in the pilot to experience the benefits of care coordination under the MCO.
- MCOs began training on how to bill through the MCO portals during the third quarter. Providers will be allowed to continue billing through the current KMAP process, but MCOs were able to provide hands-on training opportunities for providers to find the benefit of billing through the front-end portals offered by each MCO. Training will continue through the fourth quarter to ensure every provider has an opportunity to complete the training needed to minimize the potential for payment disruption.
- The State began testing billing claims with the MCOs during the third quarter. During the month of September test claims files were submitted daily to determine any potential

claims and billing errors that may arise. During the fourth quarter, providers will bill directly through KMAP or the MCO and will be paid by the MCO to finalize the billing and testing claims process and ensure timely payments to providers.

b. KanCare Implementation for I/DD LTSS: Day long weekly meetings with the MCOs and the State began during the third quarter to ensure policies and procedures were in place for the IDD LTSS. The discussions include technical staff from HP, KDADS, KDHE, and the MCOs to ensure system readiness on January 1, 2014. Readiness Reviews will be conducted in the fourth quarter.

Education and Engagement

- Additional Listening Tours for I/DD KanCare Implementation
  - September 22nd – Hays – consumer and provider sessions (40+)
  - September 23rd – Wichita – consumer and provider sessions (150+)
  - September 24th – Parson – consumer and provider sessions (50+)
  - September 25th – Olathe – consumer and provider sessions (200+)

  Greater turnout at these events as we took a different approach to outreach and information
- Consumer Engagement: Each MCO has been actively reaching out to each individual on the Pilot as well as beginning to reach out to other individuals with IDD who are receiving behavioral and physical health through an MCO.
- Provider Engagement: Several trainings across the State have been hosted and include the creation of Provider-focused Frequently Asked Questions, Policy Clarification memorandum. Additional trainings are planned for the fourth quarter to educate providers about roles, responsibilities and developments.
- State staff provided training on person-centered support planning by Ari Ne'eman, Nancy Thaler and Barbara Brent. The training, held September 19 and 20 included:
  - Speaker Backgrounds:
    - Arie Ne'eman, president and co-founder of the Autistic Self-Advocacy Network, explained that the I/DD system has different priorities and best practices making them different from managed care in other context. Traditional managed care cost savings related to case management and health care generally doesn't apply in this context. Long-term supports and services last over decades, and the goal is to move away from institutions, group homes, and sheltered workshops.
    - Nancy Thaler, Executive Director of the National Association of State Directors of Developmental Disability Services (NASDDDS), heads a federally approved association that connects member states with each other and their best practices, public policy and conferences to share what is going on in the I/DD field.
    - Barbara Brent, State Policy Director of NASDDDS, is the former State Director of

Arizona's Developmental Disability Department (as the single Managed Care Organization) and focused her discussion on managed care best practices including improving the person-centered planning model, school-to-work pipeline, and supports to families.

- Education and Engagement were the focus of the two day training. The information provided during these sessions will be made available on the website.
- The Thursday morning session consisted of State employees from KDADS and KDHE, and included a dynamic discussion related to creating the best possible system and meeting the needs of the consumers and their families, noting that it is helpful to look at the goal not outcomes; cost efficiency and better care coordination are outcomes, not goals; and having a good life as designed and developed by the individual with developmental disabilities while minimizing the dependency on providers should be the goal.
- The Thursday afternoon session consisted of employees from all three MCO's who learned more about the person-centered planning theory, independent living philosophy, and better quality communication and connection with their members. The question and answer session engaged attendees to discuss opportunities to be an example of a managed care system that meets the long-term supports and services needs of the I/DD population. Topics include the role of support coordination, examples of needs assessments and service plans, person-centered practices, suggestions for supporting families across the lifespan, employment initiatives and self-direction, and the need of individuals with co-occurring mental illness, people with challenging behavior, and sexual/criminal offenders
- Friday morning's session was reserved for consumers, families, friends, and their support team members. It was an excellent opportunity for the State to listen o stakeholders concerns, experiences, goals, and ideas for improving the system. The discussion was facilitated by Arie, Nancy, and Barbara and resulted in an engaged conversation that will inform future discussion related to communication and outreach to providers, consumers, and the IDD community.

## XIV. Enclosures/Attachments

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

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

## XV. State Contacts(s)

Kari Bruffett, Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3512 (phone)
(785) 296-4813 (fax)
KariBruffett@kdheks.gov

Dr. Susan Mosier, Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3512 (phone)
(785) 296-4813 (fax)
SMosier@kdheks.gov

## XVI. Date Submitted to CMS

November 27, 2013

**KanCare BN Monitoring**
**YTD DY1, Q1-Q3**

**DY 1**

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

| | Total Expenditures | Total Member-Months |
|---|---|---|
| **DY1Q1** | 551,219,424.24 | 979,907 |
| **DY1Q2** | 561,553,531.67 | 977,939 |
| **DY1Q3** | 615,970,528.35 | 980,896 |
| **DY1Q4** | 0.00 | 0 |
| **DY1 Total** | 1,728,743,484.26 | 2,938,742 |

(Actual/Estimate)

| | Population 1: ABD/SD Dual | Population 2: ABD/SD Non Dual | Population 3: Adults | Population 4: Children | Population 5: DD Waiver | Population 6: LTC | Population 7: MN Dual | Population 8: MN Non Dual | Population 9: Waiver |
|---|---|---|---|---|---|---|---|---|---|
| **DY1Q1** | | | | | | | | | |
| *Expenditures* | 11,820,828.17 | 83,365,882.52 | 37,508,648.01 | 117,749,154.42 | 94,909,142.82 | 160,873,260.89 | 4,005,540.87 | 5,098,329.12 | 35,888,637.42 |
| *Member-Months* | 52,847 | 85,951 | 94,778 | 633,754 | 26,136 | 65,712 | 3,636 | 3,534 | 13,559 |
| **DY1Q2** | | | | | | | | | |
| *Expenditures* | 11,956,043.99 | 85,456,207.88 | 38,892,770.52 | 118,531,167.22 | 102,631,254.73 | 159,216,008.66 | 4,084,785.21 | 4,847,708.56 | 35,937,584.90 |
| *Member-Months* | 53,055 | 87,338 | 96,765 | 627,644 | 26,349 | 65,730 | 3,823 | 3,493 | 13,742 |
| **DY1Q3** | | | | | | | | | |
| *Expenditures* | 13,157,058.10 | 94,297,820.17 | 43,344,523.01 | 129,454,334.92 | 102,884,701.63 | 182,939,896.67 | 4,773,881.85 | 5,934,134.99 | 39,184,177.01 |
| *Member-Months* | 52,826 | 87,537 | 98,025 | 631,064 | 26,018 | 65,324 | 3,606 | 3,264 | 13,232 |
| **DY1Q4** | | | | | | | | | |
| *Expenditures* | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| *Member-Months* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **DY1 Total** | | | | | | | | | |
| *Expenditures* | 36,933,930.26 | 263,119,910.57 | 119,745,941.54 | 365,734,656.56 | 300,425,099.18 | 503,029,166.22 | 12,864,207.93 | 15,880,172.67 | 111,010,399.33 |
| *Member-Months* | 158,728 | 260,826 | 289,568 | 1,892,462 | 78,503 | 196,766 | 11,065 | 10,291 | 40,533 |
| **DY 1 - Cumulative PMPM** | 232.69 | 1,008.79 | 413.53 | 193.26 | 3,826.93 | 2,556.48 | 1,162.60 | 1,543.11 | 2,738.77 |

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

**Quarter 3**
Start Date: 7/1/2013
End Date: 9/30/2013

| | Total Expenditures | Total Member-Months |
|---|---|---|
| **Jul-13** | 170,059,543.19 | 327,795 |
| **Aug-13** | 226,576,714.22 | 327,404 |
| **Sep-13** | 224,936,627.28 | 325,697 |
| **PCP:** | (5,602,356.34) | |
| **Q3 Total:** | 615,970,528.35 | 980,896 |

(Actual/Estimate)

| | Population 1: ABD/SD Dual | Population 2: ABD/SD Non Dual | Population 3: Adults | Population 4: Children | Population 5: DD Waiver | Population 6: LTC | Population 7: MN Dual | Population 8: MN Non Dual | Population 9: Waiver |
|---|---|---|---|---|---|---|---|---|---|
| **Jul-13** | | | | | | | | | |
| *Expenditures* | 4,087,657.17 | 29,696,617.33 | 13,680,572.77 | 41,748,625.59 | 11,453,820.41 | 53,528,856.42 | 1,711,390.20 | 2,025,223.07 | 12,126,780.23 |
| *Member-Months* | 17,720 | 29,329 | 32,793 | 210,625 | 8,676 | 21,815 | 1,265 | 1,112 | 4,460 |
| **Aug-13** | | | | | | | | | |
| *Expenditures* | 4,755,654.15 | 34,553,756.18 | 15,611,511.85 | 47,474,475.11 | 37,465,207.00 | 68,892,543.62 | 1,632,139.39 | 2,065,963.60 | 14,125,463.32 |
| *Member-Months* | 17,621 | 29,201 | 32,729 | 210,652 | 8,685 | 21,806 | 1,202 | 1,101 | 4,407 |
| **Sep-13** | | | | | | | | | |
| *Expenditures* | 4,347,056.44 | 31,288,804.48 | 14,417,884.01 | 43,582,781.88 | 54,077,239.75 | 60,821,740.11 | 1,432,817.37 | 1,904,913.99 | 13,063,389.25 |
| *Member-Months* | 17,485 | 29,007 | 32,503 | 209,787 | 8,657 | 21,703 | 1,139 | 1,051 | 4,365 |
| **PCP** | | | | | | | | | |
| *Expenditures* | (33,309.66) | (1,241,357.82) | (365,445.62) | (3,351,547.66) | (111,565.53) | (303,243.48) | (2,465.11) | (61,965.67) | (131,455.79) |
| **Q3 Total:** | | | | | | | | | |
| *Expenditures* | 13,157,058.10 | 94,297,820.17 | 43,344,523.01 | 129,454,334.92 | 102,884,701.63 | 182,939,896.67 | 4,773,881.85 | 5,934,134.99 | 39,184,177.01 |
| *Member-Months* | 52,826 | 87,537 | 98,025 | 631,064 | 26,018 | 65,324 | 3,606 | 3,264 | 13,232 |
| **DY 1 - Q3 PMPM** | 249.0641 | 1,077.2339 | 442.1783 | 205.1366 | 3,954.3663 | 2,800.5005 | 1,323.8718 | 1,818.0561 | 2,961.3193 |

# Safety Net Care Pool Report

## Demonstration Year 1 - QE September 2013

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

**Paid 7/12/13**

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

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

# 1115 Waiver - Safety Net Care Pool Report

## Demonstration Year 1 - QE September 2013

Health Care Access Improvement Pool

Paid 7-12-2013

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