Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 9.30.14

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

KanCare
Section 1115 Quarterly Report
Demonstration Year: 2 (1/1/2014-12/31/2014)
Federal Fiscal Quarter: 4/2014 (6/14-9/14)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

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

Demonstration Population	Enrollees at Close of Qtr. (09/30/14)	Total Unduplicated Enrollees in Quarter	Disenrolled in Qtr.
Population 1: ABD/SD Dual	17,709	18,937	1,228
Population 2: ABD/SD Non Dual	28,943	29,946	1,003
Population 3: Adults	39,471	43,500	4,029
Population 4: Children	224,505	239,048	14,543
Population 5: DD Waiver	8,697	8,766	69
Population 6: LTC	20,883	21,965	1,082
Population 7: MN Dual	1,191	1,353	162
Population 8: MN Non Dual	1,038	1,197	159
Population 9: Waiver	3,974	4,095	121
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**346,411**	**368,807**	**22,396**

III. Outreach/Innovation

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

During the 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 8 (7 attendees), July 14 (5 attendees) – special meeting to discuss Uncompensated Care Waiver only, September 16 (7 attendees).

Also during this quarter, the state's KanCare Advisory Council met on September 25, 2014. The Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists.

The agenda for the council's September meeting:

I. Welcome
II. Review and Approval of Minutes from Council meeting, June 11, 2014
III. Updates on KanCare with Q & A
    a. UnitedHealthcare Community Plan
    b. Amerigroup Kansas
    c. Sunflower State Health Plan
IV. KDADS Update – Gina Meier-Hummel, Commissioner of Community Service and Programs, Kansas Department for Aging and Disability Services
V. KDHE Update - Susan Mosier, Division Director, and Mike Randol, Director of Program Finance and Informatics, Division of Health Care Finance, Kansas Department of Health and Environment
VI. Next Meeting of KanCare Advisory Council – December 15, 2014, Curtis State Office Building, Room 530, 2:00 to 3:30 p.m.
VII. Adjourn

The KanCare Consumer and Specialized Issues Workgroup met on September 30, 2014. The agenda items included a report from the KanCare Ombudsman, HCBS waiver renewal updates, and a presentation from the Kansas Association for the Medically Underserved (KAMU) about dental resources and dental providers in Kansas. The meeting also included an in-depth look at KDHE's KanCare Executive Summary Report dated 09-18-14. The KanCare Consumer and Specialized Issues Workgroup meets quarterly.

The KanCare Provider Operations Issues workgroup met September 25, 2014. The KDHE senior pharmacy program manager provided an overview of the KanCare pharmacy program and discussed in detail Maximum Allowable Cost (MAC) pricing utilized by KanCare. All three MCOs had pharmacy

representatives attending as well. This pharmacy overview and subsequent question-and-answer session comprised the majority of the workgroup meeting. In addition, all three MCOs provided general claims and operational updates to the group in the time remaining. The KanCare Provider Operations Issues workgroup meets quarterly.

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

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

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

Health Homes

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

work on this initiative. The State Plan Amendment (SPA) to implement Health Homes for people with serious mental illness (SMI) was approved by CMS on July 28, 2014 with an effective date of July1, 2014.

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented at different times; Health Homes for people with chronic conditions has been delayed to allow for ensuring an adequate network of Health Home Partners
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, like CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012
- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services
    - Identifying the first target group, approximately 36,000 adults and children with SMI
    - Determining the goals for health homes and selecting quality measures, including eight required by CMS
    - Defining the provider qualifications and standards
    - Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
    - Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
    - Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
    - Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
    - Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
    - Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
    - Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures

and other components of the project

- Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm)
- Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
- Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
- Making presentations at various provider association conferences and meetings about the project
- Holding an educational webinar for interested providers
- Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
- Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
- Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
- Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduling, through CCSR, twice monthly webinars for providers interested in becoming HHPs to be held from February through June 2014
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes, beginning April 15, 2014
- Holding 32 meetings in 16 cities for consumers to introduce the Health Homes program
- Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Creating an informational brochure to help inform consumers about Health Homes
- Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Developing the PMPM rate for SMI Health Homes
- Publishing a draft Program Manual for SMI Health Homes
- Issuing tribal notification to the four recognized American Indian tribes
- Holding six day-long provider training sessions across the state
- Publishing a draft Program Manual for Chronic Conditions (CC) Health Homes
- Developing PMPM rates for CC Health Homes
- Developing the components the State wants the health plans to include in their contracts with HHPs
- Consulting with SAMHSA for the second, chronic conditions, SPA
- Issuing public notice about the SPAs and their fiscal impact

- Submitting both SPAs to CMS officially on May 7, 2014
- Withdrawing the Chronic Conditions SPA on June 30, 2014 to allow us more time to ensure an adequate network of Health Home Partners is available
- Performing an operational readiness review of the MCOs May 20-22, 2014
- Reviewing network reports submitted by the MCOs
- Completing operational work to receive files from and pay the MCOs for Health Home services
- Scheduling SMI Health Homes Implementation calls weekly to hear from providers and address systemic issues and questions
- Scheduling weekly calls with stakeholders to provide updates on the progress toward implementation of the Chronic Conditions Health Home

- Tasks completed since the last report:
  - Developing reporting requirements
  - Beginning Learning Collaborative activities, including establishing a schedule of monthly webinars and holding the first quarterly statewide in-person meeting
  - Continual outreach and engagement with providers to help them understand Health Homes, encourage them to consider becoming a Health Home Partner and foster cooperation and collaboration with HHPs
- Updates from implementation:
  - 25,630 people are enrolled in SMI Health Homes. A total of 4,592 people have opted out of Health Homes, for an opt out rate of almost 18% - less than our projected opt out rate of 25%. Members with intellectual or developmental disabilities (IDD) comprise 6.3% of current Health Home members.
  - There are 80 contracted Health Home Partners (HHPs), although not all 80 contract with all three Lead Entities (managed care organizations - MCOs). Each MCO has at least 56 contracted HHPs.
  - The Learning Collaborative kicked off in August, with a monthly webinar. There will be monthly webinars and quarterly in-person meetings for HHPs, Lead Entities and state staff to support provider implementation of Health Homes and provide peer-to-peer learning and exchange of ideas.
  - Currently, the two most frequently provided core services are comprehensive care management and care coordination, followed by health promotion.
- Success Stories:

  Below are some examples that illustrate how Health Homes are already making a difference:
  - A Health Home member who also has severe substance abuse issues had been in residential Substance Use Disorder treatment services at Mirror in Topeka for several months yet was still facing the possibility of leaving the program homeless. Mirror was able to work with her case manager through Valeo and Cornerstone to get her housing; she is currently successfully staying sober and not homeless. With help from Mirror and others she has been attending all her appointments and taking her medications on a

regular basis. Additionally Mirror helped set up an alarm system to remind her that she needed to take her medication in the evening - one area she had been struggling with.

- A Health Home member who has severe asthma was living in a cockroach infested home. Due to her limited resources, she is not able to pay the high cost of extermination services. Mirror was able to find a resource to help her pay for this through NET Reach, Neighborhood Empowerment Transformation - a local Topeka community resource that uses a systematic plan to address homelessness, poverty, safety and community through neighborhood empowerment and transformation. They helped arrange a pest control service that will reduce the rate substantially to make it more affordable to treat the infestation. An initial consultation has been completed. The Health Home expects elimination of this pest problem to have a positive impact on her health both physically and mentally.
- A 77 year old Hispanic female lives alone in Wyandotte County. She fell last year and broke her pelvis. She struggles to get to medical appointments and the store due to inconsistencies with relying on family for transportation and her inability to drive her car since her fall. When the Health Home care coordinator met with her, she began to cry as she talked about her family. She worries about her son who struggles with alcohol and depression and her daughter who struggles with drug abuse. She may have blamed herself for their struggles. She also expressed a desire to get out more, possibly volunteer and perhaps even work part-time at some point. She is also living with diabetes and often forgets to take her insulin after she eats breakfast.
    - The Health Home care coordinator made a referral to Wyandotte Aging and Disability Resource Center for assessment for in home services. The assessment was completed and they found her eligible for services. We worked together to identify a routine that she completes every morning; after breakfast she takes her dishes to sink and likes to look out the window into her backyard. We put a sign up in the window to remind her to take her insulin. We also made a referral for in home therapy services to provide support to her as she continues to struggle with her relationship with her children. She was not aware of the KanCare transportation benefit; we informed her of this service and worked with her to set up transportation to the remainder of her medical appointments.
- Valeo community mental health center is helping a woman who had not had an eye appointment in several years. When the Care Coordinator met her, she had previously broken her eye glass frames and had since bought an over-the-counter pair from a drug store. She took out the lenses and attempted to put her prescription lenses in. When she discovered they would not fit the correct way, she turned them upside down to get them in. Her guardian was unsure of how long exactly she had been wearing them this way. One of the goals was to get her into an eye doctor. She had an eye appointment a few weeks ago. Her guardian informed the Care Coordinator the examination found a

suspicious spot on her eye so she was referred to an eye specialist. She was seen there last week. The symptom could indicate a Pseudo tumor cerebri (a "false brain tumor") - likely due to high pressure within the skull caused by the buildup or poor absorption of cerebrospinal fluid (CSF). The suspicious spot could also indicate an actual tumor. An MRI has been scheduled to look more closely at this "spot."

- A young member's grandmother had contacted Valeo seeking help for him. She mentioned that he gets his days and nights mixed up, that he has both auditory and visual hallucinations, and uses drugs occasionally. A few years ago he was taken to a hospital and evaluated by a mental health provider, who stated that he was "criminally insane" and needed to be admitted. The grandmother was very worried about his well-being when she passes away, since she is his main caregiver. She provided us with his cell phone number, but stated that he rarely answers, and does not have an e-mail box set up.
    - When this information was given to the Health Home, the Care Coordinator immediately tried contacting him and tried several times for several days. This went on for a few weeks. One day, the Care Coordinator called him, and he picked up. The Coordinator talked with him for a few minutes, explaining Health Homes. He replied, "Yeah, I do think that would be a good program for me." He set up an appointment to meet with the Care Coordinator that same day. The Coordinator felt like he really opened up and a bond was created between them. The Care Coordinator explained to him that it would be a great benefit to him to go through Valeo Intake so he could utilize the services provided, such as seeing a medication support provider and a therapist. He agreed.
    - Later that day, his grandmother called, saying how excited her grandson was about the program. She was going to help him get to intake the next day. He was able to go through intake, and now has a case manager, and a medication provider through Valeo. The Care Coordinator is in contact with his grandmother quite frequently. The Health Home program helped him out, but it also helped relieve the stress his grandmother was experiencing.

- Tasks still to complete:
    - Assessing the feasibility of a regional, rather than statewide, implementation of the Chronic Conditions Health Home
    - Determine when to implement the Chronic Conditions Health Home, whether regionally or statewide

MCO Outreach Activities

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

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

Marketing Activities: Amerigroup participated in over 134 events for the third quarter which included partner development, sponsorships, outreach and advocacy. The primary focus for their Community Relation Representatives continued to be member education of services and benefits of the KanCare program. They continue to look to develop strong partnerships across the state by enhancing existing relationships and building new ones. Below is a sampling of Marketing activities Amerigroup supported in the third quarter:

- Hispanic Chamber of Commerce
- Sedgwick County Health Department - WIC Program
- Scott Dual Language School Summer School Presentation
- Shawnee Health Department
- Kansas Department of Children & Families Pratt Office

Outreach Activities: Amerigroup continued their outreach efforts where they reach out by phone and mail to new members to welcome them and to ensure they have completed their initial risk assessment. They also continued with their targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. The Community Relation Representatives participated in a variety of community events reaching over 32,000 Kansans this quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain invaluable feedback and to cover current topics that are relevant to their members such as: diabetes, well child visits, employment, high blood pressure, your PCP and you, and others. Below is a sampling of some of their outreach efforts this past quarter:

- March of Dimes – Bikers for Babies
- Olathe Head Start
- Bethel Life –Convoy of Hope
- Juntos, Center for Advancing Latino Health
- Bread of Life Exhibit
- 22nd Annual Parents University Exhibit

Advocacy Activities: Amerigroup's advocacy efforts for third quarter continue to be broad based to support the needs of their general population, pregnant women, children, people with disabilities and the elderly. Their staff is proactive and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help them learn what the needs of the community are and how they can better serve them and improve their quality of life. The third quarter advocacy efforts remain similar to those of the second quarter. Amerigroup continued to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process. Here are a few examples of their Advocacy Activities this last quarter:

• Mind Matters
• Association of Community Mental Health Centers for Kansas
• F.L. Schlagle High School Staff Presentation
• KAMU Conference
• Cafe Con Leche Committee
• March of Dimes

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:
Marketing Activities: In addition to sponsoring provider conferences and member health fairs, Sunflower sponsored the following fundraisers and community events during the third quarter, resulting in television, radio and online information being distributed regarding KanCare:

- Family Service and Guidance Center (FSGS) annual fundraiser series
- Wichita's 'School Rulez' Backpack Giveaway facilitated by Walmart and supported by the Urban League
- Truman Medical Center fundraiser event

Outreach Activities: Sunflower Health Plan participated in more than 50 outreach events throughout Kansas during the third quarter, and the activities facilitated directly by the health plan are these:

- A Start Smart for Your Baby community baby shower was held in Pittsburg, Kansas, on July 31. Topics covered included labor and delivery, finding a pediatrician, care after delivery for mom and dad, post-partum depression, WIC and breastfeeding. A Sunflower Health Plan RN was in attendance to address member questions related to pregnancy and childbirth.
- On September 18, Sunflower held an Adopt-a-School event in Junction City, Kansas, at Spring Valley Elementary School. The program focused on Anti-Bullying. Michelle Bain, children's author of Centene books promoting physical and behavioral health, traveled to Junction City to headline the event with 2nd and 3rd graders. The students signed the traveling "anti-bullying wall" that originated in Washington DC and came to Kansas from Washington State, and each student received a book and a healthy snack. Local news outlets covered the event.

Sunflower Health Plan conducted HEDIS-related outreach to members by mailing the summer edition of the Member Newsletter (Healthy Moves) to all members/heads of household, in addition to making the publication available online. The quarterly provider newsletter (Provider Report) was published online and emailed to providers subscribed to the health plan's email alert system.

Sunflower Health Plan partnered with community organizations to purchase and deliver back-to-school supplies and backpacks for two communities in August 2014:

- Wyandotte County Back to School Health Fair, held in two locations: Boys & Girls Club and Kansas City Kansas Community College, August 9
- Wichita's 'School Rulez' Backpack Giveaway , August 2

Advocacy Activities: Sunflower held its quarterly Member Advisory Committee (MAC) on September 30 in Topeka. Advocacy groups and KanCare families were represented at the meeting where Sunflower staff received feedback on improvements being made to the New Member Packet and other member activities. Sunflower participated in metro-area advocacy events during the third quarter, and an example is the Kansas Conference on Poverty. In addition, Sunflower provided medical management experts to speak at events advocating for the following public health issues:

- Reducing Infant Mortality – July 25, 2014, 11th Annual Heartbreak and Hope Conference, hosted by Wesley Medical Research & Education Foundation (WNREF) and Wesley's Perinatal Bereavement Team in conjunction with the local Community Action Team (CAT). Sunflower's Senior Vice President of Medical Management served as a panelist to share information about the role of managed care in improving health outcomes for women and children.
- Breastfeeding – Sept. 25, 2014, a Sunflower case manager and the plan's MemberConnections manager served as panelists for a session during the Kansas Breastfeeding Summit sponsored by the Kansas Health Foundation and United Methodist Health Ministry Fund.
- Whole-Person Care for Persons with I/DD – Sunflower's in-house consultants LifeShare/Pathways delivered 'Visions for An Integrated Life' training sessions for providers, caregivers, parents and other advocates.

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

Outreach Activities: United has three outreach specialists focused on activities targeted within their specific geographic areas of Kansas. Their jobs are to conduct educational outreach to members, community based organizations and provider offices about UnitedHealthcare, the features of KanCare and the benefits of the plan. They especially inform individuals about the value added benefits. United also has a Provider Marketing Manager whose role is to work with key provider offices throughout the State to assist them with any issues and to make sure the providers are educated on the benefits of UnitedHealthcare for members who visit their offices. More specifically:

- During the third quarter of 2014, UnitedHealthcare staff personally met with 10,971 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 2014, UnitedHealthcare staff personally met with 831 individuals from community based organizations located throughout Kansas. These organizations work directly with our members in various capacities.
- During the third quarter of 2014, UnitedHealthcare staff personally met with 1,248 individuals from provider offices located throughout the State.

Advocacy Activities: United's activities in advocacy continue to be focused on educational efforts surrounding KanCare and the benefits of UnitedHealthcare to members across the state. That includes special outreach to individuals with intellectual and developmental disabilities. United is also working to educate those individuals who participate in the physical disability and frail elderly waiver programs. United has one Outreach Specialist focused specifically on working with individuals who touch Kansans with disabilities. More specifically:

- The United outreach specialist to the disabled community personally visited with 144 advocates for the disabled in Kansas providing them with education on KanCare and UnitedHealthcare benefits. The specialist has also been meeting with individual members and advocates across the State regarding implementation of I/DD services into managed care. She has also been working internally to make sure that all operations of plan activities are focused on making sure that Unitedmembers are well represented in all processes.
- That same outreach specialist also worked in conjunction with the Empower Kansas steering committee on collecting more RFP's to award grantees which were presented to organizations during the second quarter of 2014.
- Every quarter the plan holds a Member Advisory Council meeting to educate members on what the plan is working on and receive feedback on ways that United can improve the processes for members. During the third quarter, the meeting focused on member value added benefits, the United member website and member survey satisfaction questions.

IV. Operational Developments/Issues

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

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value added

services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-September, 2014, follows:

MCO	Value Added Service	Units YTD	Value YTD
Amerigroup	Adult Dental Care	2,715	$311,499
	Member Incentive Program	8,222	$197,035
	Mail Order OTC	6,660	$109,951
	Total of all Amerigroup VAS Jan-Sep 2014	***21,700***	***$739,688***
Sunflower	CentAccount debit card	38,174	$763,480
	Dental visits for adults	16,254	$308,991
	Smoking cessation program	406	$97,440
	Total of all Sunflower VAS Jan-Sep 2014	***86,350***	***$1,394,161***
United	Additional Vision Services	8,261	402,546
	Join for Me - Pediatric Obesity Classes	35	87,500
	Adult Dental Services	1,354	72,772
	Total of all United VAS Jan-Sep 2014	***105,699***	***$854,915***

c. Enrollment issues: For the second quarter of calendar year 2014 there was 1 Native American who chose to not enroll in KanCare. The table below represents the enrollment reason categories for the 3rd quarter of calendar year 2014 (July, August and September). All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories:

Start Reasons	Total
Newborn Assignment	9
KDHE - Administrative Change	146
WEB - Change Assignment	15
KanCare Default - Case Continuity	259
KanCare Default - Morbidity	417
KanCare Default - 90 Day Retro-reattach	205
KanCare Default - Previous Assignment	480
KanCare Default - Continuity of Plan	7024
AOE – Choice	119
Choice - Enrollment in KanCare MCO via Medicaid Application	883
Change - Enrollment Form	335
Change - Choice	405
Change - Access to Care – Good Cause Reason	11
Change - Case Continuity – Good Cause Reason	0
Assignment Adjustment Due to Eligibility	6
Total	**10,314**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY14 3rd quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Bene-fits	Billing/ Fin Issues	Transp-Timely	Transp-Access	Phar	DME	Med Proc/ Trtmt	Waiver HCBS Service	Mail/ Other
AMG	13	5	37	9	13	33	13	39	4	9	5	9	10
SUN	9	8	12	46	14	16	38	43	2	3	7	0	0
UHC	4	0	33	14	2	104	85	29	2	10	0	1	0

MCOs' Appeals Database
Members - CY14 3rd quarter report

MCO	PA Dental	PA DME	PA MRI, CT	PA Phar-macy	PA OP/IP Surg/ Proc	PA Comm Based Svcs	WORK Hours	LTSS/ HCBS PCA Hours	HH Hrs	OT/ PT/ ST	Inpt Covg	Ster/ Epid Inj/ Sleep	PCP/ Spec-ialist	LTACH/ RTC/ Air Amb	Claim Denial
AMG	13	5	37	9	13	33	13	39	4	9	5	9	10	13	5
SUN	9	8	12	46	14	16	38	43	2	3	7	0	0	9	8
UHC	4	0	33	14	2	104	85	29	2	10	0	1	0	4	0

MCOs' Appeals Database
Providers - CY14 2nd quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Phar	MCO Plan Admin/ Other	MCO QOC	MCO Cred/ Cont	Vision Auth	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Dent Plan Admin	Dent Clin/ UM	Cen-patico STRS Auth
AMG	11	3	7,653	99	0	0	0	0	5	4	2	28	0	0	0
SUN	62	0	99	44	0	2	0	0	5	23	18	0	2	33	0
UHC	0	0	472	0	0	0	0	0	0	17	0	2	0	0	0

State of Kansas Office of Administrative Fair Hearings

Members - CY14 3rd quarter report

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

Providers - CY14 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied	Dental Denied	DME Denied	Radiology Denied	Hearing Screen Denied	Home Health Denied	PT Denied	Inpt/ Hospice/ Rehab Coverage Denied	Waiver Eligibility Denied	Med Proc Denied
Withdrawn	2									
Dismissed-Moot MCO reversed denial	80	1	1 3			19		4	3	1 5 5
Dismissed-No internal appeal										4
FH in process										
Dismissed-Untimely										3
OAH upheld MCO decision	5									1
FH dec pending										

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

f. Changes in provider qualifications/standards: There have been no changes in provider qualifications. A review of Autism providers resulted in working with the MCOs to review contracting and credentialing procedures and provide clarification related to credentialing qualified Autism providers.

g. Access: During the first and second quarters of 2014, there was an upswing in requests for changes in plan affiliation outside of the open enrollment period. As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In the first quarter of 2014, KDHE started to receive an increasing number of requests, peaking in the second quarter of 2014. This trend reversed course in the third quarter of 2014, and KDHE experienced fewer requests than in the second quarter, down to total of 182 from the 313 requests submitted for the second quarter. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period based solely on the member's preference, when other participating providers with that MCO are available within access standards, are denied as not reflective of good cause. The MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

The good cause requests during the third quarter show only one significant trend, unlike the previous two quarters of 2014. One MCO plan terminated a provider from their network in late June. Some patients affiliated with this plan wished to continue to see this particular physician. Those patients were required to file good cause requests in order to remain with this physician.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the third quarter of 2014, there were no state fair hearings filed for a denied GCR. A summary of GCR actions this quarter is as follows:

Status	July	August	September
Total GCRs filed	60	57	65
Approved	2	1	7
Denied	24	22	30
Withdrawn (resolved, no need to change)	12	19	15
Dismissed (due to inability to contact the member)	22	15	11
Pending	0	0	2

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

KanCare MCO	# of Unique Providers as of 12/31/13	# of Unique Providers as of 3/31/14	# of Unique Providers as of 6/30/14	# of Unique Providers as of 9/30/14
Amerigroup	14,722	15,667	13,455	13,682
Sunflower	15,404	15,931	16,314	17,728
UHC	18,010	19,872	19,911	19,747

h. Proposed changes to payment rates: Capitated payment rates were changed to reflect various policy changes occurring subsequent to the previous rate setting period. Rates were also adjusted to account for elimination of the I/DD underserved listing, coverage of new drug therapies, and adjustment to the DRG rate.

i. MLTSS implementation and operation: In the third quarter, Kansas began working with the MCOs to review ways to improve use of Money Follows the Person program options and improve screening and discharge planning from the hospital for Medicare and other primary insurance individuals. The State is developing a sustainability plan for Money Follows the Person since the federal program sunsets in 2017. The State is working with contractors to obtain useful MDS data to identify individuals who are likely eligible and able to live in a home and community based setting either with Money Follows the Person or with assistance from the MCO if they are not eligible for an HCBS services. Over the next six months, Kansas will focus on moving hundreds of individuals from institutional settings.

j. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). Children's Mercy Hospital has chosen to do the following projects: Complex Care for Children and Patient Centered Medical Homes (PCMH). Kansas University Medical Center will be completing Sepsis and Self-Management and Care (SMAC) Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The State, KFMC and hospitals collaborated to determine the measures being used to evaluate the projects for the DSRIP activities. On September 30, 2014, the State submitted the Children's Mercy Hospital and Kansas University Hospital Project Plans and Budgets to CMS per the timeline.

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

Renewals and Amendments

In the third quarter, KDADS and CMS agreed that the State would not submit the renewal applications for the Intellectual and Developmental Disability, Traumatic Brain Injury, Physical Disability and Frail Elderly 1915(c) waivers until additional guidance from CMS was provided about the HCBS Transition Plan and new requirements of the CMS Final Rule. The renewals will include a summary of public comment sessions, transition plan language, and possible changes to the sleep cycle support and personal attendant care services in accordance with the Department of Labor Final Rule. Public Comment sessions related to the renewal were held in mid-August. CMS granted a second temporary extension for the IDD and TBI programs. In the third quarter, Kansas sought extension to submit the PD and FE renewals less than 90 days

before the expiration of those waivers on December 31, 2014. Following additional guidance from CMS, the State will conduct an additional public comment process during the temporary extension period to ensure full compliance with the notification requirements in the new regulation.

CMS Final Rule on HCBS Settings

In the third quarter, KDADS completed an additional round of public information sessions related to the HCBS Final Rule, Department of Labor Rule, and proposed changes to the HCBS Programs. These sessions, conducted in August, were held in person and by conference call, and public comments could be submitted in person, by phone, or by email. Additional information sessions will be held in mid-November to provide updates and additional information.

Department of Labor – Companionship Rule

At the end of the second quarter, the Department of Labor released two administrative interpretations, 2014-1 and 2014-2, related to 29 CFR 522.109, effective January 1, 2015. The US Department of Labor (DOL) modified a regulation, which may have a significant impact on the support of direct service workers serving HCBS clients. The administrative interpretations of the new regulation on Medicaid-funded programs authorized under the Social Security Act could result in the elimination of services, increased institutionalization, and inability of states to meet the labor mandates and maintain supports and services at current funding levels.

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

As such, Kansas continues to work with the Department of Labor to clarify that the consumer is the employer of the direct service worker and the Medicaid program, established policies, pay structure, and support model are tools to assist the aging or disabled consumer who may not be able to afford or maintain a personal care worker or attendant without them. Pending a determination by the Department of Labor regarding the joint employment status of the state, MCO and FMS providers, Kansas will continue meeting with stakeholders to make necessary changes to the HCBS programs and the long-term supports and services to comply with the Final Rule.

Financial Management Services

In the third quarter, Kansas submitted a description of its Financial Management Services (FMS) to CMS for review and approval. Kansas operates a model that does not neatly fit in the two prescribed categories of FMS. However, CMS recognizes the value of the hybrid model in Kansas and continues to review the described model to provide technical assistance to the state in submitting the FMS model in the renewals and amendments for services.

Ongoing MLTSS Activities

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

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

l. *Legislative activity:* The Robert G. Bethell Home & Community Based Services and KanCare Oversight Committee, a statutory joint committee, met once during the third quarter, on August 12, 2014, to review the current state of KanCare and the implementation of IDD long-term supports and services into KanCare. The committee received reports from KDHE, KDADS, and the Ombudsman's office and took comments from stakeholders, including providers and beneficiaries. The committee also heard reports from each KanCare managed care organization and testimony from the Kansas Insurance Department.

V. Policy Developments/Issues

a. **General Policy Changes**

Kansas addressed policy concerns related to managed care organizations and state requirements through the weekly KanCare Policy Committee, the biweekly KanCare Steering

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

b. **Traumatic Brain Injury Rehabilitation Facilities**

Policy and process clarification was provided regarding the admission to traumatic brain injury rehabilitative facilities (TBI-RFs) and discharges to the community. In Kansas, a TBI-RF is the institutional alternative for traumatic brain injury waiver services. During the third quarter, the State and MCOs began looking at the TBI-RF process to improve the system.

Additionally, stakeholders and MCOs participate in the traumatic brain injury workgroup to add better goal development and progress tracking for individuals who are served by the traumatic brain injury program. This will improve the person-centered planning process and provide a standardized review tool for demonstrating progress and continued need for rehabilitative services to meeting goals. Work will continue on TBI-RF and TBI progress policies in the fourth quarter.

c. **Positive Behavior Supports**

Positive Behavior Supports (PBS) services are currently available to members and can being billed through the Managed Care Organizations. KDADS continues to provide MCO and PBS facilitator training, support and clarification on service provision and billing processes. Training is underway statewide to incorporate information technology and other PBS resources to assist in the provision of PBS services.

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

Under managed care, Kansas now has many IDD consumers requesting host homes. Although Kansas does not oppose this model and views it as an alternative setting, Kansas currently does not have regulation or policy guiding these settings. KDADS is reviewing shared living, so the State can establish clear guidelines and quality monitoring. Policies have been drafted and will be prepared for public comment and review in the fourth quarter. Public presentations and information on shared living will be presented in the fourth quarter. The licensing regulation will also be reviewed with a request for comment and changes related to shared living sought from consumers and stakeholders.

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 2014 (DY2-Q3), the State removed the July payment amount/enrollment for June and input the August payment amount/enrollment for July. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. That budget neutrality monitoring spreadsheet for QE 9.30.14 is attached.

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

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	**Member Month**			**Totals**
MEG	*2014-07*	*2014-08*	*2014-09*	*Grand Total*
Population 1: ABD/SD Dual	18,307	18,096	17,720	54,123
Population 2: ABD/SD Non Dual	29,508	29,331	28,951	87,790
Population 3: Adults	40,261	40,016	39,476	119,753
Population 4: Children	227,352	226,773	224,509	678,634
Population 5: DD Waiver	8,725	8,714	8,703	26,142
Population 6: LTC	21,350	21,290	21,085	63,725
Population 7: MN Dual	1,322	1,273	1,200	3,795
Population 8: MN Non Dual	1,155	1,098	1,038	3,291
Population 9: Waiver	4,064	4,032	3,974	12,070
Grand Total	**352,044**	**350,623**	**346,656**	**1,049,323**

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

VIII. Consumer Issues

Summary of consumer issues during the second quarter of 2014:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member claims denied incorrectly due to Third Party Liability (TPL). Claims are denied for EOB's when none are required.	MCO's continue to have difficulties bypassing TPL editing for procedures known to never be covered by common TPL carriers (like Medicare). Issue is monitored by TPL manager with the State and issues are discussed during state/MCO conference calls.	All plans have system correction projects under way and reprocessing projects will follow. This information is posted on the KanCare Claims Resolution Log for providers and the State to review and monitor.
Prior authorization approvals not performed timely	MCOs have worked on streamlining processes for authorization requests, to speed the review time.	Timeliness will be monitored through prior authorization "turnaround time" reports.
Member client obligation incorrect.	Weekly spreadsheets were sent to the state, showing MCO remediation efforts until the main issue was corrected in April and May. Continuing system configuration issues remain, and programming projects are still underway.	Some system correction projects and reprocessing projects occurred during the third quarter. Further projects will continue into the fourth quarter of 2014.
Continued eligibility confirmation gaps causing denial of services for members, particularly at pharmacies.	When referred to the State, eligibility was confirmed and the medication dispensed. Eligibility issues can either be a system file load problem or an issue with an individual record, so it is time-consuming to perform root cause analysis on each situation.	Simultaneous to the State referral, the member information is sent to the MCO. They will correct their file information so the situation should not occur again for this member. Systematically, eligibility load times are still an issue, but still showing improvement. The plans are continually monitored by the State for progress.

KanCare open enrollment continues for the people who were approved for KanCare after January 2013. A summary of related activity for this quarter is as follows:

Month	No. of Packets Mailed	KC19 Changes	KC21 Changes	Total Changes
July 2014	3,143	63	9	72
August 2014	3,670	54	7	61
September 2014	3,924	53	4	57
Total	**10,737**	**170**	**20**	**190**

In addition, related to consumer issues and supports: Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEWs) during the third quarter of 2014, including the following: completed 98 Community Outreach Events, most notably Back to School fairs, State School Nurse Conference in Wichita, CMS Regional Conference in Kansas City, Tribal Health Summit, Kansas Immunization Conference, Café Con Leche, Latino Health Fair, Head Start collaboration meetings, WIC clinics, meeting with KAMU to coordinate with navigators and OEW for FFM open enrollment, and staffed the KanCare booth at the Kansas State Fair. At these events, KanCare applications and information on eligibility are shared with community partners and potentially eligible families; OEW may receive concerns regarding KanCare eligibility or services which OEW research and provide information to families.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established the KanCare Interagency Monitoring Team (IMT) as an important component of comprehensive oversight and monitoring. The IMT is a review and feedback body that will meets in frequent work sessions, focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS), consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. The IMT includes representatives from KDHE and KDADS, and operates under the policy direction of the KanCare Steering Committee which includes leadership from both KDHE and KDADS. Within KDHE, the KanCare Interagency Coordination and Contract Monitoring (KICCM) team, which facilitates the IMT, has the oversight responsibility for the monitoring efforts and development and implementation of the QIS. During this quarter, KDHE started a transition process that will result in some adjustments to the quality monitoring structure for the KanCare program, in an effort to better integrate KanCare support structures post-implementation. Those changes will be more fully developed during the fourth quarter.

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/onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from governmental agencies, the KanCare MCOs, Medicaid providers, Medicaid members/consumers, and public health advocates; and 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, they will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use.

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 operationalizing; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

During the third quarter of 2014, some of the key quality assurance/monitoring activities have included:

- Ongoing twice monthly business meetings between KDHE's KICCM team, other state staff as relevant to the subject matter, and cross-function/leadership MCO staff to continue to develop extensive operational details and clarity regarding the KanCare State Quality Strategy. Specific attention was paid to developing additional specificity for each of the performance measures and pay-for-performance measures in the KanCare program, with extensive work on finalizing the operational details of measures for the year two P4P measures which will be validated by the state's EQRO, including integration of care, healthy life expectancy and nursing facility-related measures. Additional focus areas this quarter included work sessions to complete the STC-required amendments to the KanCare Comprehensive Quality Strategy. Within the mandated 90 day timeline following CMS approval of udpates to the 1915(c) waivers, which made required technical changes to performance measures and also standardized measures across all of the Kansas HCBS waivers, and also reviewing other measures for updates and additional details, the state obtained stakeholder input, provided public notice, and submit the amended quality strategy to CMS on September 12, 2014.

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

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a monthly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits monthly

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

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

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

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

KanCare Customer Service Report - Member

MCO/Fiscal Agent January-September 2014	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:17	1.69%	132,616
Sunflower	0:19	2.45%	149,379
United	0:14	1.46%	124,272
HP – Fiscal Agent	0:00	.06%	5,103

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:19	1.19%	63,609
Sunflower	0:18	1.20%	88,329
United	0:11	.41%	56,037
HP – Fiscal Agent	0:00	.02%	6,599

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

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

e. Summary of ombudsman activities for the third quarter of 2014:

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the third quarter of 2014. There were 526 contacts through these various means, 256 of which were related to an MCO issue.

3rd Qtr. Contacts			MCO related	
July	182		Amerigroup	77
August	174		Sunflower	134
September	170		United Health	45
Total	**526**		**Total**	**256**

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

The KanCare Ombudsman website (http://www.kancare.ks.gov/ombudsman.htm) has information regarding the Ombudsman contact information, resources for and information for applying for KanCare, contact information for the three managed care organizations, grievance process, appeal process and state fair hearing process, the three managed care company handbook links, and quarterly and annual reports by the Ombudsman. A new resource added to the website during third quarter is a 4 page resource with medical, prescription, vision and dental assistance for those without insurance or with high spend downs (http://www.kancare.ks.gov/download/Medical_Assistance.pdf).

Outreach

- Provided a vendor booth for the Conference on Poverty in Topeka, July 16-18, 2014
- Provided testimony to the Bob Bethell KanCare Oversight Committee regarding Ombudsman second quarter activities, August 12, 2014.
- Had a dozen trainings with disability and community partnering organizations as part of orientation for the ombudsman volunteer coordinator training; used this also an opportunity for outreach for the Ombudsman office.
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during second quarter.
- Hosted the HCBS Lunch-and-Learn bi-weekly conference calls for all HCBS members, parents, guardians and other consumers. Calls addressed topics of interest from the HCBS team from Kansas Department on Aging and Disability Services (KDADS) and a question and answer time with a panel from the three Managed Care organizations.

Data

Contact Method	AmeriGroup	Sunflower	United	None	Total
Email	11	19	5	55	90
Face-to-Face Meeting	1	0	0	1	2
Letter	1	1	0	0	2
ONLINE	0	0	0	0	0
Other	0	0	0	0	0
Telephone	64	114	40	214	432
Total	**77**	**134**	**45**	**270**	**526**

Caller Type	AmeriGroup	Sunflower	United	None	Total
Consumer	68	112	33	199	412
MCO Employee	0	0	0	1	1
Other type	1	1	0	19	21
Provider	8	21	12	51	92
Total	77	134	45	270	526

Sub Caller Type	AmeriGroup	Sunflower	United	None	Total
HCBS Related	24	45	18	20	107
LTC Related	20	12	4	12	48
Other	33	77	23	238	371
Total	77	134	45	270	526

There are 20 issue categories. The top four concerns for 3rd quarter are:

- Appeals/Grievances
- HCBS General Issues
- Medicaid eligibility issues
- Billing issues

Issue Category	AmeriGroup	Sunflower	United	None	Total
Appeals / Grievances	3	31	5	7	46
HCBS General Issues	13	13	8	11	45
Medical Services	5	20	7	9	41
Billing	11	10	8	11	40

Durable Medical Equipment	9	13	2	1	25
Pharmacy	3	11	3	3	20
HCBS Waiting List	4	2	1	12	19
Care Coordinator Issues	4	13	0	1	18
Transportation	6	5	1	6	18
Nursing Facility Issues	2	1	0	13	16
HCBS Reduction in hours of service	2	7	3	3	15
Questions for Conference Calls/Sessions	0	0	0	15	15
Housing Issues	0	3	3	6	12
Change MCO	0	6	3	1	10
HCBS Eligibility issues	2	3	0	5	10
Dental	2	0	2	4	8
Access to Providers (usually Medical)	3	1	0	2	6
Guardianship	0	0	0	1	1
Medicaid Eligibility Issues	9	9	4	68	90
Other	7	11	5	80	103
Thank you	1	3	0	6	10
Unspecified	2	10	0	21	33
Total	87	172	55	286	600

In comparing issue categories over the last three quarters, three have stayed consistently in the top six as issues: durable medical equipment, billing, and appeals/grievances.

HCBS Waiver Or Program Area	AmeriGroup	Sunflower	United	None	Total
PD	10	17	5	11	43
I/DD	8	15	3	16	42
FE	1	7	5	3	16
Autism	0	3	0	1	4
SED	2	1	1	1	5
TBI	6	8	2	3	19
TA	0	4	0	4	8
MFP	0	3	2	1	6
PACE	0	0	0	0	0
Mental Health	0	2	0	2	4
Behavioral Health	0	0	0	0	0
Nursing Facility	2	1	1	6	10
Total	**29**	**61**	**19**	**48**	**157**

Resource Category shows what resources were used in resolving an issue:

Resource Category	AmeriGroup	Sunflower	United	none	total
Question/Issue Resolved	11	25	11	71	118
Used Resources/Issues Resolved	24	40	13	100	177
KDHE Resources	12	23	10	62	107
DCF Resources	2	5	1	14	22
MCO Resources	30	44	15	9	98
HCBS Team	11	14	5	27	57
CSP MH Team	0	1	0	1	2
Other KDADS Resources	5	8	8	17	38
Provided Resources To Member	1	7	2	13	23
Referred To State/Community Agency	3	1	2	14	20
Referred To DRC And/Or KLS	3	13	3	8	27
Closed	10	12	4	29	55
Total	**112**	**193**	**74**	**365**	**744**

Contact Information for 3rd Quarter

Open	Contact date entered, but no response or closed	**2**
Responded	Contact date entered and first response, but not closed.	71
Closed	Closed date is entered.	453
Total		**526**
% closed		85.9%

Average number of days to resolve an issue

Total # of days to resolution	/	Total # of Closed Files	=	Average Days To Resolution
3985		453		9

Statistics on number of days to resolve an issue during 3rd quarter:

- 246 files resolved in one day or less
- Mean (average) = 9
- Median (middle value when sorted in order) = 1
- Mode (most frequent) = 0 (less than a day)

Data Enhancements

The new tracker was put in place June 30, 2014. Starting third quarter, the additional reporting data includes the following:

- Waiver Related Type (if applicable)
  - Physical Disability
  - Intellectual/Developmental Disability
  - Frail Elderly
  - Autism
  - Severe Emotional Disability
  - Traumatic Brain Injury
  - Technical Assistance
  - Money Follows the Person
  - PACE
  - Mental Health
  - Behavior Health
  - Nursing Facility
- Consumer type (if applicable)
  - HCBS related
  - LTC related
  - Other
- Resource Category
  - Question/issue resolved
  - Used Resources/issue resolved
  - KDHE resources
  - DCF resources
  - MCO resources
  - HCBS team
  - CSP MH team
  - Other KDADS resources
  - Provided resources to member
  - Referred to state/community agency
  - Referred to DRC and/or KLS

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

f. Summary of MCO critical incident report: The Adverse Incident Reporting (AIR) System is the system used for behavioral health and HCBS critical incidents. All behavioral health and HCBS providers submit critical incidents for individuals receiving services. The critical incidents are reviewed by quality management specialists (field staff) who may make unannounced visits and research critical incidents to determine if additional corrective action and monitoring are required to protect the health, safety and welfare of those served by the programs involved. AIR is not intended

to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations, therefore, are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the PICU. This team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare and other community resources. A summary of year to date 2014 AIRS reports follows:

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	**AIR Totals**	**AIR Totals**	**AIR Totals**	**TOTALS**
Total # Received	389	333	315		1037
Total # Reviewed	208	174	167		549
Total # Pending Resolution	127	131	133		391
APS Substantiations*	95	94	93		282

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

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

Charter:

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

Expected Outcomes:

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The HCAIP Pool and LPTH/BCCH Pool third quarter payments were processed on September 30, 2014. The attached Safety Net Care Pool Reports identify 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

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

For the 3rd quarter of 2014, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish real-time enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

XIII. Other (IDD MLTSS Integration; IDD Billing and Claims; Waiting List Management; Money Follows the Person; Request for Additional Services List; Plan of Care Reductions; and Claims Adjudication Statistics)

a. **IDD Long-Term Supports and Services Integration into KanCare – February 1, 2014**
Beginning on February 1, 2014, HCBS services and targeted case management for individuals in the Kansas IDD waiver program were integrated into KanCare following a one month delay in implementation. There are approximately 8,700 individuals on Kansas' IDD waiver who were

affected by this change. The continuity of care period ran until July 31, 2014,. With the exception of a few individuals who have moved or requested removal from services, the MCOs have assessed every individual on the waiver and underserved waiting lists and developed Integrated Service Plans (ISP) for all individuals on the IDD program.

Kansas has successfully eliminated the IDD "underserved" list, which was created more than a decade ago, as of August 1, 2014. More than 1,700 assessments were completed, and under 10 appeals have been filed. More than 800 consumers requested and received additional services. The cost of the additional services is estimated at $11.6 million. Individuals who need additional services in the future may be assessed at any time by contacting the MCO.

Lunch and Learn Teleconferences

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

Summary of Stakeholder Engagement and Communication

- Public Information Sessions (August)
- TCM Bi-weekly Conference Calls with State MCOs
- CDDO Bi-weekly Conference Calls with State and MCOs (as requested)
- IDD Provider Bulletins (bi-weekly)
- HCBS Transition Plan information sessions
- Interhab Annual Conference
- Families Together education and training events
- Lunch and Learn Calls
    - Consumer calls are held bi-weekly at noon on Wednesdays
    - Provider calls are held bi-weekly at 11:00 on Mondays

IDD Billing and Claims Issues

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

HCBS/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	253,766	357,649	296,070	907,485
HCBS/IDD Claims Lines in Process/Pending	4954	211	8315	13,480
HCBS/IDD Claims Lines Paid	239,455	349,765	280,437	869,657
HCBS/IDD Claims Lines Denied	7420	7607	7318	22345
HCBS/IDD Billed Amount	$73,149,387	$109,834,354	$50,141,759	$233,125,500
HCBS/IDD Amount in Process/Pending	$1,555,459	$136,437	$2,575,266	$4,267,162

HCBS/IDD Amount Paid	$67,192,529	$104,409,172	$44,835,479	$216,437,180
HCBS/IDD Amount Denied	$3,148,126	$3,486,870	$2,731,015	$9,366,011

TCM/IDD	Amerigroup	Sunflower	United	Total
HCBS/IDD Claims Lines in Received	32,094	35,103	15,943	83,140
HCBS/IDD Claims Lines in Process/Pending	257	12	185	454
HCBS/IDD Claims Lines Paid	29,982	34,361	14,978	79,321
HCBS/IDD Claims Lines Denied	1795	675	780	3250
HCBS/IDD Billed Amount	$2,796,984	$3,924,234	$1,906,206	$8,627,423
HCBS/IDD Amount in Process/Pending	$34,637	$1,332	$28,316	$64,285
HCBS/IDD Amount Paid	$2,537,111	$3,675,903	$1,765,575	$7,978,589
HCBS/IDD Amount Denied	$115,271	$111,559	$107,454	$334,284

Denial of Claims – Top Reasons

Top HCBS/TCM Denial Reasons	Amerigroup	Sunflower	United	Total
1. Non-covered service/item	111	6	221	338
2. Service not authorized	879	0	49	928
3. Service limit exceeded without PA	0	2901	196	3097
4. Member not eligible	31	1	167	199
5. Provider not contracted for service	17	0	15	32
6. Duplicate Claim	4,620	5,066	4,217	13,903
7. Error in billing (procedure code, NPI, etc.)	237	59	2056	2352
8. Date of service not covered	0	0	0	0
9. Exceeds filing time limit	342	0	0	342
10. Claim and PA not matching	0	2	139	141
11. Denial required from primary insurance	199	0	141	340
12. Other	2779	247	897	3923

Turnaround Times

HCBS/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	6.6	5	8	6.4
HCBS/IDD Average Days Age All Claims	6.5	5	8	6.4

TCM/IDD	Amerigroup	Sunflower	United	State Average*
HCBS/IDD Average Days Age Clean	5.9	5	8	5.9
HCBS/IDD Average Days Age All Claims	5.9	5	8	5.9

*This is a weighted average based on the portion of MCO claims.

Summary of Improvements Related to Third Party Liability

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

Additionally the State has been working with First Data, the contractor for the electronic visit verification system known as AuthentiCare, to develop enhancements to the system to improve third party liability by allowing providers to attach it to the system. The enhancement is designed to allow providers to enter TPL information on the claim prior to submission through Authenticare/First Data and the MCOs conducted testing late in the third quarter for the enhancements to AuthentiCare to ensure claims would process appropriately. The TPL enhancement was implemented on October 1, 2014.

Temporarily, the TPL exception notification will be an *Informational Exception* only. This status will remain in effect until further notice. Providers must continue to enter TPL information for clients with TPL. The MCOs and KMAP will continue to edit for TPL on all claims except for I/DD. Although I/DD claims will not currently deny for TPL, the provider should enter all applicable TPL information for I/DD clients. In the fourth quarter, the State will issue further guidance on how to enter information for clients with Medicare Supplemental and BC/BS insurance.

Entering TPL information through this process will automatically establish TPL information for future claims for the period of one year from the TPL insurer's established denial date. Entering TPL information through this process allows AuthentiCare to transmit the insurance information with the claim so that providers do not receive a claim denial for TPL at the MCO level.

Further TPL enhancements are listed for the next First Data Release targeted for late November:

- The default in the TPL payment field will be changed to 0.00 on claims
- The TPL data fields will be open for provider edit purposes after the claim is saved and until the time of submission
- Claims entered on the Express Screen will not automatically receive the TPL exception.

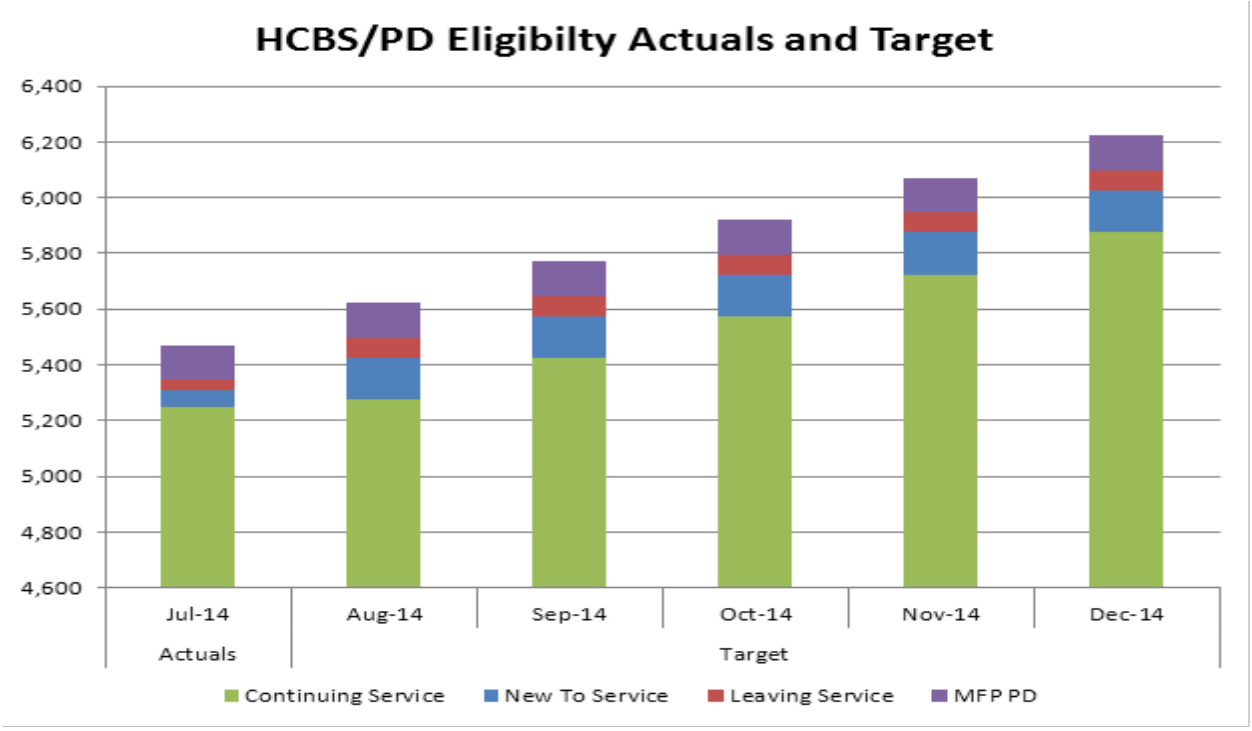
b. Waiting List Management

PD Waiting List Management

In the third quarter, KDADS had offered more than 400 individuals services from the PD Waiting list, including crisis requests that were approved. 240 individuals were offered services in July

and the first week of August. Also in July, approximately 300 Notices of Action (NOAs) were sent to those individuals who had not responded to the original letters sent in November 2013 and March 2014. Those individuals were provided an additional opportunity to verify continued need for services; if not, they will be removed from the waiting list.

Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 6,092. KDADS projects the process will be competed in December. Current approved point-in-time limit for the PD waiver is 5,900. Limit will be increased as part of the PD renewal. It is important to note that the validity of contact information continues to be a challenge in contacting individuals on the PD waiting list.



I/DD Unserved Waiting List Management

In the first two quarters of 2014, 104 individuals, waiting for HCBS-IDD services, were offered services. In the third quarter, the State offered services to an additional 107 individuals.

c. Money Follows the Person

Kansas's Money Follows the Person (MFP), five year demonstration grant, serves four HCBS populations: the Frail Elderly (FE), the Physically Disabled (PD), the Traumatic Brain Injured (TBI), and the Intellectually/Developmentally Disabled (I/DD). During the first quarter of calendar year 2014, 33 individuals were transferred from institutions by the MCOs and during the second quarter 48 individuals transitioned. During the third quarter of calendar year 2014,

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

1. Conducted a comprehensive review of the two primary data systems (MMIS and monthly reports) to reconcile discrepancies and identify areas for improvement;
2. Created a monthly meeting with the Managed Care Organizations (MCOs) to identify barriers, opportunities, risks, and sustainability and encouraged MCOs to utilize the MFP program for transitioning frail elderly nursing facility residents to community settings;
3. Established regular meetings with the MCO to focus on transitions from institutions and met with the MCO/MFP representatives to review MFP policies/procedures and discuss strategies for increasing MFP transitions; and
4. Solicited assistance from KDADS's quality field staff to reach and educate nursing facilities on the advantages of the MFP program and solicit referrals.
5. Scheduled training and education opportunities throughout Kansas related to Money Follows the Person, transitioning from intuitional settings, and long-term sustainability plans.
6. Started an internal workgroup on a sustainability plan for ensuring individuals will continue to move out of institutional settings and into the community either on a home and community based program or with other Medicaid services.

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

d. Request for Additional Services List

On January 31, 2014, KDADS sent a letter to all HCBS-IDD program participants who were currently receiving HCBS services and had asked for additional services in the past. Out of the 1740 individuals involved, KDADS received 1132 forms. Less than 25% of the individuals on the RASL responded that they needed services in 30 days. The MCOs are working with IDD Targeted Case Managers to assess all 1740 individuals and ensure all needs are identified and appropriate supports and services are provided. .

e. Plan of Care Reduction

The State reviews any requests for additional services, reduction in services, and terminations in services. The MCOs notify the State of voluntary and involuntary terminations, including voluntary removal from services, transitions between two services, moving out of state, and death. These are being reviewed at the time and as part of quality assurance and program integrity reviews to ensure changes in services are consistent with the expectation of the special

terms and conditions of the KanCare program. During the third quarter, there were no requests for reduction in services submitted to the State, so there is no submission or disposition data to report regarding plan of care reductions for this quarter.

f. **Claims Adjudication Statistics**
KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-September 2014, is attached.

XIV. Enclosures/Attachments

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

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

Section XII refers to the KFMC's 3rd Quarter 2014 KanCare Evaluation Quarterly Report related to the interim evaluation of KanCare performance measures reported quarterly. That report is attached.

Section XIII(f) refers to KDHE's Summary of KanCare MCO Claims Adjudication Statistics – QE 9.30.14, and that summary is attached.

XV. State Contact

Dr. Susan Mosier, Medicaid Director and Division 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 25, 2014

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

Quarter 3
Start Date: 7/1/2014
End Date: 9/30/2014

	Total Expenditures	Total Member-Months
Jul-14	210,757,140.41	353,346
Aug-14	216,669,554.35	361,230
Sep-14	213,744,562.14	357,386
PCP	(3,973,034.80)	
Q3 Total	637,198,222.10	1,071,962

ADMIN SUMMARY	
	Expenditures
DY2Q3	

	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-14									
Expenditures	3,378,546.70	31,754,053.67	21,700,740.14	46,328,575.63	34,119,564.90	59,408,838.33	1,414,369.26	2,246,644.48	10,405,807.30
Member-Months	18,837	30,359	40,388	225,564	9,163	21,900	1,440	1,405	4,290
Aug-14									
Expenditures	3,385,342.68	32,045,474.36	25,372,000.01	47,357,778.92	34,463,455.47	59,773,273.91	1,510,818.39	2,379,958.10	10,381,452.51
Member-Months	19,074	30,741	43,023	229,922	8,997	22,190	1,569	1,477	4,237
Sep-14									
Expenditures	3,371,265.24	31,398,498.97	24,169,009.07	46,877,290.41	34,965,968.29	59,163,823.37	1,392,977.67	2,169,127.29	10,236,601.83
Member-Months	18,691	30,141	42,149	228,622	8,961	22,030	1,407	1,225	4,160
PCP									
Expenditures	(11,685.27)	(614,748.93)	(214,169.09)	(2,814,045.17)	(58,895.88)	(130,864.94)	(1,161.90)	(37,447.34)	(90,016.28)
Q3 Total									
Expenditures	10,123,469.35	94,583,278.07	71,027,580.13	137,749,599.79	103,490,092.78	178,215,070.67	4,317,003.42	6,758,282.53	30,933,845.36
Member-Months	56,602	91,241	125,560	684,108	27,121	66,120	4,416	4,107	12,687
DY 2 - Q3 PMPM	178.8536	1,036.6313	565.6864	201.3565	3,815.8657	2,695.3277	977.5823	1,645.5521	2,438.2317

Note:
1. For DY2 Member-Months are CAP + RETRO combined.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 2 - QE September 2014

Health Care Access Improvement Pool
Paid 07-11-2014

Medicaid	Participating Hospitals	HCAIP 2nd Qtr Pmyt	Provider Access Fund 2443	Federal Medicaid Fund 3414
100007320C	Marillac Center INC	1,907.00	821.73	1,085.27
100099300A	Mt. Carmel Medical Center	218,236.00	94,037.89	124,198.11
201074770A	St. John Hospital	102,201.00	44,038.41	58,162.59
100089300A	Mercy - Independence	60,200.00	25,940.18	34,259.82
100105940A	Salina Regional Health Center	128,672.00	55,444.76	73,227.24
100098970A	Hays Medical Center, Inc.	313,378.00	135,034.58	178,343.42
100099270A	Ransom Memorial Hospital	86,279.00	37,177.62	49,101.38
100080610A	St. Francis Health Center	315,942.00	136,139.41	179,802.59
100088620A	Susan B. Allen Memorial Hospital	132,727.00	57,192.06	75,534.94
100088340A	Hutchinson Hospital Corporation	204,892.00	88,287.96	116,604.04
100088310A	St. Catherine Hospital	183,279.00	78,974.92	104,304.08
100099320A	Pratt Regional Medical Center	51,979.00	22,397.75	29,581.25
100088990A	Sumner Regional Medical Center	34,084.00	14,686.80	19,397.20
100099250A	Olathe Medical Center	300,858.00	129,639.71	171,218.29
100089300B	Mercy Health Center - Ft. Scott	95,683.00	41,229.80	54,453.20
100099490A	Southwest Medical Center	112,968.00	48,677.91	64,290.09
100089280A	Geary Community Hospital	132,386.00	57,045.13	75,340.87
100099200A	Mercy Hospital, Inc.	5,341.00	2,301.44	3,039.56
100099400A	Stormont Vail Regional Health Center	873,799.00	376,519.99	497,279.01
100098820A	Coffey County Hospital	11,460.00	4,938.11	6,521.89
100102820A	Newton Medical Center	192,431.00	82,918.52	109,512.48
100093850A	Shawnee Mission Medical Center, Inc.	616,117.00	265,484.82	350,632.18
100002710A	Memorial Hospital, Inc.	44,817.00	19,311.65	25,505.35
100099280A	Miami County Medical Center	67,245.00	28,975.87	38,269.13
100099420A	Bob Wilson Memorial Hospital	46,146.00	19,884.31	26,261.69
100088190A	Labette County Medical Center	72,833.00	31,383.74	41,449.26
100080640B	Via Christi Regional Medical Center	1,727,054.00	744,187.57	982,866.43
100327110A	Wesley Medical Center	1,178,379.00	507,763.51	670,615.49
100088000A	Cushing Memorial Hospital	106,293.00	45,801.65	60,491.35
100099120A	Lawrence Memorial Hospital	285,420.00	122,987.48	162,432.52
100265560A	Mercy Reg Health Ctr	133,915.00	57,703.97	76,211.03
100107200A	Coffeyville Regional Medical Center, Inc.	68,275.00	29,419.70	38,855.30
201074830A	Providence Medical Center	446,753.00	192,505.87	254,247.13
100080590A	South Central KS Reg Medical Ctr	46,073.00	19,852.86	26,220.14
100087540A	Morton County Health System	23,195.00	9,994.73	13,200.27
100098790A	Western Plains Medical Complex	141,655.00	61,039.14	80,615.86
100453760A	Overland Park Regional Medical Ctr.	611,996.00	263,709.08	348,286.92

100642360A	Menorah Medical Center	156,072.00	67,251.42	88,820.58
100332210A	Saint Luke's South Hospital, Inc.	92,753.00	39,967.27	52,785.73
100358410A	Salina Surgical Hospital	2,929.00	1,262.11	1,666.89
100396140A	Surgical & Diag. Ctr. of Great Bend	150,738.00	64,953.00	85,785.00
100421720A	Galichia Heart Hospital LLC	79,677.00	34,332.82	45,344.18
200677860A	Via Christi Hospital St Teresa	103,783.00	44,720.09	59,062.91
100259020A	SSH - Kansas City	21,642.00	9,325.54	12,316.46
100106820A	Kansas Rehabilitation Hospital	1,589.00	684.70	904.30
100105420A	Via Christi Rehabilitation Center	54,123.00	23,321.60	30,801.40
100080290B	Children's Mercy Hospital South	183,833.00	79,213.64	104,619.36
100005670A	Prairie View Inc.	9,903.00	4,267.20	5,635.80

Demonstration Year 2 - QE September 2014

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

Paid 07-11-2014

COS 011	PCA: 35008	Reason Code: LPBC			
Medicare #	**Medicaid #**	**Provider Name**	**4th Qtr Amt Paid**	**State General Fund 1000**	**Federal Medicaid Fund 3414**
263302	100080290A	Children's Mercy Hospital	2,491,034.00	1,073,386.55	1,417,647.45
170040	100099470A	University of Kansas Hospital	7,473,103.00	3,220,160.08*	4,252,942.92
		Total	**9,964,137.00**	**4,293,546.63**	**5,670,590.37**

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

2014 KanCare Evaluation Quarterly Report

Year 2, CY2014, Quarter 3, July - September

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**November 18, 2014**
Review Team:	**Janice Panichello, Ph.D., MPA, Director of Quality Review and Epidemiologist** **Lynne Valdivia, BSN, RN, MSW, Vice President of Quality Improvement and Review** **Donna Garwood, RN, BSN, Review, Quality Review Project Manager**

Prepared for:

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Year 2, CY2014, Quarter 3, July - September

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2014 KANCARE EVALUATION QUARTERLY REPORT
Year 2, CY2014, Quarter 3, July-September
NOVEMBER 18, 2014

BACKGROUND/OBJECTIVES

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

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the third quarter (Q3) CY2014 report include the following:

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

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

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

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

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

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

DATA SOURCES

Data sources for the Q3 CY2014 KanCare Quarterly Evaluation Report are quarterly KanCare Key Management Activities Reports (KKMAR) and call center reports newly implemented in CY2014. The call center reports were initially required weekly, but beginning in August 2014, they became due monthly.

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

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

CURRENT QUARTER AND TREND OVER TIME

In Q3 CY2014, 99.77% of the customer service inquiries received by the MCOs were resolved within two business days; 99.98% were resolved within 5 business days, and 100% were resolved within 15 business days. (See Table 1.)

During each quarter to date, the two-day resolution rate exceeded 99.7%. In Q3 CY2014, 296 of the 323 inquiries not resolved within two business days were resolved

within five business days, and the remaining 27 inquiries were resolved within 15 business days. The inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within 2 business days.

Table 1 - Timeliness of Resolution of Customer Service Inquiries

	CY2013				CY2014		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Number of Inquiries Received	261,286	181,427	157,547	146,374	141,964	133,570	**143,028**
Number of Inquiries Resolved Within 2 Business Days	260,859	180,903	157,185	146,299	141,907	133,539	**142,705**
Number of Inquiries Not Resolved Within 2 Business Days	298	524	362	75	57	27	**323**
Percent of Inquiries Resolved Within 2 Business Days	99.84%	99.71%	99.77%	99.95%	99.96%	99.98%	**99.77%**
Number of Inquiries Resolved Within 5 Business Days	261,286	181,427	157,458	146,349	141,951	133,570	**143,001**
Number of Inquiries Not Resolved Within 5 Business Days	0	0	89	25	13	0	**27**
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	99.94%	99.98%	99.99%	100%	**99.98%**
Number of Inquiries Resolved Within 15 Business Days	261,286	181,427	157,547	146,374	141,964	133,570	**143,028**
Number of Inquiries Not Resolved Within 15 Business Days	0	0	0	0	0	0	**0**
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	100%	100%	100%	100%	**100%**

Of the 143,028 customer service inquiries in Q3 CY2014, 89,682 (62.7%) were from members and 53,346 were from providers. (See Table 2.) In Q3 CY2014, there were 10,100 more customer service inquiries from members than the previous quarter, and there were 642 fewer customer service inquiries from providers. Of the 89,682 member calls, 47.7% were received by Sunflower, 26.6% by United, and 25.7% by Amerigroup. Of the 53,346 provider inquiries, 37% were received by Amerigroup, 33.7% by United, and 29.3% by Sunflower.

Although the number of inquiries increased this quarter compared to the previous quarter, as shown in Table 1 the aggregate number of customer service inquiries received by the MCOs has generally been decreasing over time. In Q1 CY2013, the MCOs received 261,286 inquiries; in Q1 CY2014, the MCOs received 141,964 inquiries, a 46% decrease. Compared to Q3 CY2013, there were 14,519 fewer inquiries in Q3 CY2014.

The monthly call center report categorizes customer service inquiries by 18 member categories and by 17 provider categories. For members, benefit inquiries were again the highest percentage (20.1%) of the 89,682 calls received in Q3, an increase of 832 compared with the previous quarter. The lowest percentage of calls (0.1%) was from members requesting assistance with scheduling an appointment. For providers, claim status inquiries were again the highest percentage (35.3%) of the 53,346 provider calls, and the lowest were from providers requesting provider materials (0.1%).

While the distribution by category has been fairly consistent by quarter, the categorization of the inquiries differs greatly by MCO. “Update Demographic Information,” for example comprised 12% of member inquiries in Q2 and 12.8% in Q3, and comprised 11.4% of provider inquiries in Q2 and 12.7% in Q3. Of the 6,794 provider inquiries in this category, 99.4% were reported by Sunflower; Amerigroup

categorized 40 of their provider calls in this category, and United categorized only 2 in this category. Of the 11,494 member inquiries categorized as "update demographic information," 78.5% were Sunflower inquiries, 21.1% of Sunflower's total member inquiries.

Table 2 - Customer Service Inquiries by Member and Provider, Quarter 3, CY2014

	Q2		Q3			Q2		Q3	
Member Inquiries	#	%	#	%	Provider Inquiries	#	%	#	%
1. Benefit Inquiry – regular or VAS	17,373	21.8%	18,025	20.1%	1. Authorization – New	2,149	4.0%	1,968	3.7%
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2,242	2.5%	2. Authorization – Status	3,649	6.8%	2,961	5.6%
3. Care management or health plan program	2,248	2.8%	2,363	2.6%	3. Benefits inquiry	5,071	9.4%	4,261	8.0%
4. Claim or billing question	6,626	8.3%	6,193	6.9%	4. Claim Denial Inquiry	4,843	9.0%	5,256	9.9%
5. Coordination of benefits	1,494	1.9%	2,278	2.5%	5. Claim Status Inquiry	18,401	34.1%	18,822	35.3%
6. Disenrollment request	448	0.6%	507	0.6%	6. Claim Payment Question/Dispute	6,829	12.6%	7,093	13.3%
7. Eligibility inquiry	8,336	10.5%	11,066	12.3%	7. Billing Inquiry	365	0.7%	326	0.6%
8. Enrollment information	1,830	2.3%	2,417	2.7%	8. Coordination of Benefit	1,012	1.9%	1,099	2.1%
9. Find/change PCP	11,619	14.6%	12,509	13.9%	9. Member Eligibility Inquiry	2,085	3.9%	1,986	3.7%
10. Find a specialist	3,037	3.8%	3,905	4.4%	10. Recoupment or Negative Balance	140	0.3%	150	0.3%
11. Assistance with scheduling an appointment	89	0.1%	61	0.1%	11. Pharmacy/Prescription Inquiry	505	0.9%	542	1.0%
12. Need transportation	1,798	2.3%	1,621	1.8%	12. Request Provider Materials	41	0.1%	40	0.1%
13. Order ID card	6,406	8.0%	7,087	7.9%	13. Update Demographic Information	6,181	11.4%	6,764	12.7%
14. Question about letter or outbound call	1,003	1.3%	675	0.8%	14. Verify/Change Participation Status	416	0.8%	284	0.5%
15. Request member materials	1,197	1.5%	1,059	1.2%	15. Web Support	508	0.9%	284	0.5%
16. Update demographic information	9,526	12.0%	11,494	12.8%	16. Credentialing Issues	285	0.5%	177	0.3%
17. Member emergent or crisis call	900	1.1%	1,293	1.4%	17. Other (including to provider services or provider representatives)	1,508	2.8%	1,333	2.5%
18. Other	3,923	4.9%	4,887	5.4%					
Total	79,582		89,682		Total	53,988		53,346	

Other examples of category counts reported for member inquiries that differed greatly by MCO included:

- United reported no calls for "Care management or health plan program" compared to 1,162 reported by Sunflower and 1,201 reported by Amerigroup.
- Amerigroup reported 969 inquiries for "Eligibility inquiry" compared to 5,078 reported by United and 5,019 reported by Sunflower.
- United reported no calls for "Need Transportation" (compared to 1,198 reported by Amerigroup and 423 reported by Sunflower), and reported no calls for "Member emergent or crisis call" (compared to 1,129 reported by Sunflower and 164 reported by Amerigroup).

Examples of category counts reported for provider inquiries that differed greatly by MCO included:

- Amerigroup reported 1,916 provider inquiries for "Authorization – New," while United reported 34 and Sunflower reported 18. Amerigroup reported 2,180 provider inquiries for "Authorization – Status," while United reported 291 and Sunflower reported 490.
- Sunflower reported no calls for "Claim Denial Inquiry" compared to 3,084 reported by United and 2,172 reported by Amerigroup.

- United reported 991 provider inquiries for "Coordination of Benefits" compared to 94 reported by Amerigroup and 14 reported by Sunflower.

There was also some inconsistency found in United's reporting of the percentage of member customer service inquiries resolved within 2, 5, and 8 days when comparing Customer Service reports and the quarterly KKMAR report. The Customer Service reports indicated that in July through September 100% of the member inquiries were resolved within 2 business days; the quarterly KKMAR report indicated that 98.7% were resolved within 2 business days, 99.9% were resolved within 5 business days, and 100% were resolved within 8 business days. In aggregating the data for the three MCOs this quarter, KFMC based United's resolution on the KKMAR report rates.

Conclusions

- The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within 2, 5, and 15 business days in each quarter of CY2013 and CY2014 to date. In Q3 CY2014, 99.77% of the customer service inquiries received by the MCOs were resolved within 2 business days; 99.98% were resolved within 5 business days, and 100% were resolved within 15 business days.
- The number of inquiries received has generally decreased greatly since tracking began in 2013, but increased by over 10,000 calls in Q3 CY2014. The increased number of calls in Q3 were from members; provider inquiries decreased in Q3 CY2014 by 642.
- The number of provider inquiries was comparable for the three MCOs. Sunflower received a higher number of member inquiries, 47.7% of the 89,682 calls, compared to 26.6% for United and 25.7% for Amerigroup.
- For members, benefit inquiries were again the highest percentage (20.1%) of the calls received in Q3, an increase of 832 compared with the previous quarter. For providers, claim status inquiries were again the highest percentage (35.3%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

Recommendations

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.
- Reports from MCOs should be compared to ensure that data in MCO quarterly reports are consistent with weekly or monthly reports for the same time period.

Timeliness of Claims Processing

Data Sources

Beginning this quarter, Timeliness of Claims Processing is based on MCO data reported in a monthly Claims Overview Report implemented in October 2014, and reporting claims data beginning in January 2014. To more clearly track timeliness of claims processing in CY2014, and as recommended in previous quarterly evaluation reports,

the State developed, with interagency input, the Claims Overview Report template to provide clearer and more detailed tracking of the timeliness of claims processing. In this revised report, MCOs now show the number of claims received each month and whether or not these claims were processed in a timely manner, as defined by the type of claim and State-specified timelines. Previous claims reports focused on the claims processed in a particular month, and reported the number and percentage of the claims that had been processed within the contractually required timeline. The new template reports the number of claims received during each month, and reports the number and percent of claims received that month that were processed within the contractually required timeline.

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

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

Due to the 30 to 90 day processing timelines, depending on type of claim, MCOs have submitted monthly reports for clean claims received in January through August, for non-clean claims received in January through July, and for all claims received in January through June. To best assess trends, timeliness of claims processing is reported and compared by quarter in this report. In the Q3 report, data is reported for Q1 and Q2 of CY2014, the quarters where data is available for each month of the quarter for all claim types.

In the Q2 CY2014 report, prior to implementation of the Claims Overview Report, KFMC reviewed the monthly Adjusted Claims Reports and the monthly Claims Processing Turnaround Time Reports to report the average turnaround time for processing clean claims. In the Q3 CY2014 report, average turnaround time for processing clean claims is again reported based on these reports for July through September.

TIMELINESS OF PROCESSING CLEAN CLAIMS, NON-CLEAN CLAIMS, AND ALL CLAIMS

As indicated in Table 3 below, for claims received by MCOs in January through June of 2014 (Q1 and Q2):

- 99.95% of 7,497,542 clean claims were processed within 30 days;

- 99.91% of 315,732 non-clean claims were processed within 60 days; and
- 99.99% of all claims (7,813,274) were processed within 90 days.

The MCOs received and processed a higher number of claims in all categories in Q2 compared to Q1; in Q2 there were over 275,700 more claims received and processed than in Q1.

Of the 3,914 clean claims not processed within 30 days, 93.2% (3,648) were Sunflower claims. United had only 64 clean claims not processed within 30 days. Amerigroup had 202 clean claims not processed within 30 days; 187 of the 202 were in March, while in Q2 Amerigroup had only 2 clean claims not processed within 30 days.

Only 14.7% of the claims that MCOs categorized as non-clean claims received were Sunflower claims. Sunflower reported receiving only 42,386 non-clean claims, compared to 188,530 received by Amerigroup and 85,528 from Sunflower.

Table 3 - Timeliness of Claims Processing, Quarters 1 and 2, CY2014

Clean Claims	**Q1**	**Q2**	**Q1/Q2**
Number of Claims Received	**3,632,827**	**3,864,791**	**7,497,618**
Number of Claims Excluded	**29**	**47**	**76**
Number of Claims Not Excluded	**3,632,798**	**3,864,744**	**7,497,542**
Number of Claims received within month processed within **30 days**	**3,630,990**	**3,862,638**	**7,493,628**
Number of Claims **not** processed within **30 days**	**1,808**	**2,106**	**3,914**
Percent of claims processed within **30 days**	**99.95%**	**99.95%**	**99.95%**
Non-Clean Claims	**Q1**	**Q2**	**Q1/Q2**
Number of Claims Received	**136,283**	**180,161**	**316,444**
Number of Claims Excluded	**375**	**337**	**712**
Number of Claims Not Excluded	**135,908**	**179,824**	**315,732**
Number of Claims received within month processed within **60 days**	**135,779**	**179,665**	**315,444**
Number of Claims **not** processed within **60 days**	**129**	**159**	**288**
Percent of claims processed within **60 days**	**99.91%**	**99.91%**	**99.91%**
All Claims	**Q1**	**Q2**	**Q1/Q2**
Number of Claims Received	**3,769,110**	**4,044,952**	**7,814,062**
Number of Claims Excluded	**404**	**384**	**788**
Number of Claims Not Excluded	**3,768,706**	**4,044,568**	**7,813,274**
Number of Claims received within month processed within **90 days**	**3,768,357**	**4,044,151**	**7,812,508**
Number of Claims **not** processed within **90 days**	**349**	**417**	**766**
Percent of claims processed within **90 days**	**99.99%**	**99.99%**	**99.99%**

CURRENT QUARTER AND TREND OVER TIME FOR AVERAGE TURNAROUND TIME FOR PROCESSING CLEAN CLAIMS

As indicated in Table 4 below, the MCOs processed 4,121,624 claims in Q3 CY2014 (includes claims received prior to Q3), an increase of over 210,000 more claims than in

Q2 CY 2014. In Q1 MCOs processed 3,630,971 claims; and in Q2 CY 2014 the MCOs processed 3,908,095 claims.

Although the MCOs processed over 210,000 more claims in Q3, the average monthly TAT for processing clean claims for total monthly services was again less than 1 to 2 weeks (6 to 10.9 days in Q3, compared to 6 to 11.5 days in Q1 and 6 to 10.8 days in Q2). In the last few months, United has decreased their average total number of days to process claims from 10.9 days to 7.3 days. Sunflower's and Amerigroup's rates have been fairly stable; Sunflower's total average number of days ranges from 6 to 8 days, and Amerigroup's from 6.9 to 8.5 days.

Table 4 - Number of All Claims Processed by Quarter by Service Category and Average Monthly Turnaround Time (TAT) Ranges for Clean Claims Processed, CY 2014

	Quarter 1		Quarter 2		Quarter 3	
	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims	Claims Processed	Average TAT Monthly Ranges for Processing Clean Claims
Hospital Inpatient	28,634	**6 to 18.6**	27,015	**5 to 19.2**	29,220	**7 to 17.4**
Hospital Outpatient	228,450	**3.6 to 12.8**	250,956	**3.6 to 11.8**	259,829	**4.1 to 11.2**
Pharmacy	1,156,361	**same day**	1,088,805	**same day**	1,316,690	**same day**
Dental	103,419	**2 to 21**	106,758	**3 to 13**	99,316	**3 to 13**
Vision	62,966	**7 to 12.5**	61,605	**8 to 12.1**	76,528	**8 to 12**
Non-Emergency Transportation	104,724	**10.9 to 18**	112,633	**11.3 to 17**	126,908	**11 to 14**
Medical (Physical health not otherwise specified)	1,314,470	**3.6 to 10.6**	1,451,647	**3.3 to 9.8**	1,462,780	**3.6 to 10.1**
Nursing Facilities	126,227	**4.3 to 11.2**	89,753	**4.6 to 11.5**	86,965	**5.7 to 9.6**
HCBS	300,085	**3.7 to 15.6**	342,996	**3.2 to 14.2**	334,036	**3.3 to 14.2**
Behavioral Health	355,493	**3.4 to 8.6**	375,927	**3.5 to 8.2**	329,352	**3.8 to 8.5**
Total	**3,630,971**	**6 to 11.5**	**3,908,095**	**6 to 10.8**	**4,121,624**	**6 to 10.9**

The average turnaround time for processing clean claims for individual service types again varied by service type and by MCO. Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs. Clean claims for non-emergency transportation had longer turnaround times, with monthly TATs ranging from 10.9 to 18 days in Q1, 11.3 to 17 days in Q2, and 11 to 14 days in Q3.

It should be noted that the average TAT monthly ranges reported in Table 4 only include clean claims processed by the MCOs in Q1 through Q3, and do not include clean claims that were not yet processed.

CONCLUSIONS

- With the input of agency staff, the EQRO, MCOs, and interagency work groups, the State developed and implemented in October 2014 a revised claims report to better track timeliness of claims processing. In this revised report, MCOs now show the number of claims received each month and whether or not these claims were

processed in a timely manner, as defined by the type of claim and State-specified timelines.

- In Q1 and Q2, MCOs processed 99.95% of clean claims within 30 days; 99.91% of non-clean claims within 60 days; and 99.99% of all claims within 90 days.
- Over 93% of the clean claims not processed within 30 days were Sunflower claims. Conversely, only 14.7% of the claims categorized as non-clean were Sunflower claims.
- The MCOs processed over 210,000 more clean claims in Q3 than in the previous quarter while maintaining a comparable average turnaround time of less than two weeks.

RECOMMENDATIONS

- With assistance from the State, Sunflower should review the criteria for defining claims as clean and non-clean and assess whether clean claims not processed within 30 days may actually be non-clean claims. If the clean claims not processed within 30 days do meet the criteria for clean claims, Sunflower should make a concerted effort to improve timeliness of processing clean claims.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for services where other MCOs have much lower average monthly turnaround times.

GRIEVANCES

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

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

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

The STC and GAR reports each have lists of specific grievance categories that have only a few categories with similar category names. The STC report includes 11

grievance categories, and the GAR Reason Summary Table has 20 categories. (See Table 5.) Only three of the categories overlap clearly (Claims/Billing Issues, Quality of Care or Service, and Other).

Table 5 - Comparison of Grievance Report Categories, Quarters 1 to 3, CY2014

	Reports		STC Report						GAR Report					
			Q1		Q2		Q3		Q1		Q2		Q3	
	STC	GAR	#	%	#	%	#	%	#	%	#	%	#	%
Transportation	√		226	45.4%	206	40.9%	291	43.3%						
Claims/Billing Issues	√	√	106	21.3%	123	24.4%	151	22.5%	125	25.1%	128	25.6%	144	23.4%
Quality of Care or Service	√	√	44	8.8%	64	12.7%	88	13.1%	48	9.6%	48	9.6%	58	9.4%
Customer Service	√		38	7.6%	29	5.8%	42	6.3%						
Benefit Denial or LImitation	√		13	2.6%	15	3.0%	30	4.5%						
Access to Service or Care	√		24	4.8%	21	4.2%	26	3.9%						
Health Plan Administration	√		20	4.0%	15	3.0%	20	3.0%						
Member Rights/Dignity	√		1	0.2%	8	1.6%	14	2.1%						
Service or Care Disruption	√		6	1.2%	16	3.2%	5	0.7%						
Clinical/Utilization Management	√		0	0.0%	4	0.8%	5	0.7%						
Other	√	√	20	4.0%	3	0.6%	0	0.0%	26	5.2%	21	4.2%	34	5.5%
Availability		√							80	16.1%	91	18.2%	124	20.2%
Timeliness		√							85	17.1%	95	19.0%	103	16.7%
Attitude/Service of Staff		√							106	21.3%	70	14.0%	101	16.4%
Lack of Information from Provider		√							4	0.8%	2	0.4%	9	1.5%
Level of Care Dispute		√							2	0.4%	2	0.4%	9	1.5%
Prior or Post Authorization		√							3	0.6%	6	1.2%	8	1.3%
Accessibility of Office		√							3	0.6%	9	1.8%	8	1.3%
Pharmacy		√							6	1.2%	13	2.6%	5	0.8%
Criteria Not Met - Medical Procedure		√							4	0.8%	4	0.8%	2	0.3%
Criteria Not Met - Durable Medical Equipment		√							3	0.6%	4	0.8%	5	0.8%
Sleep Studies		√							0		1	0.2%	2	0.3%
HCBS		√							2	0.4%	3	0.6%	1	0.2%
Quality of Office, Building		√							1	0.2%	3	0.6%	1	0.2%
Sterilization		√							0		0		1	0.2%
Criteria Not Met - Inpatient Admissions		√							0		0		0	
Overpayments		√							0		0		0	
Total			498		504		672		498		500		615	

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

Transportation-related grievances are a good example of differences in categorization by each of the MCOs. Of the 310 total transportation-related grievances, 38.7% were categorized as “Timeliness,” 31.3% were categorized as “Availability,” and 22.3% were

categorized as "Attitude/Service of Staff." (See Table 6 below.) MCOs varied in their categorization rates:

- Amerigroup categorized only 1.5% of transportation-related grievances as "Timeliness," 77.3% as "Availability," and 12.1% as "Attitude/Service of Staff."
- United categorized 66.9% as "Timeliness," 0% as "Availability," and 31.5% as "Attitude/Service of Staff."
- Sunflower categorized 30% as "Timeliness," 38.3% as "Availability," and 18.3% as "Attitude/Service of Staff."

Table 6 - Transportation-Related Grievances by Category, Quarter 3, CY2014

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Timeliness	1	1.5%	36	30.0%	83	66.9%	120	38.7%
Availability	51	77.3%	46	38.3%	0	0	97	31.3%
Attitude/Service of Staff	8	12.1%	22	18.3%	39	31.5%	69	22.3%
Quality of Care	1	1.5%	0	0.0%	0	0	1	0.3%
Billing and Financial Issues	3	4.5%	7	5.8%	2	1.6%	12	3.9%
Lack of Information from Provider	0	0	2	1.7%	0	0	2	0.6%
Quality of Office, Building	1	1.5%	0	0	0	0	1	0.3%
Other	1	1.5%	7	5.8%	0	0	8	2.6%
Transportation-Related Total	66		120		124		310	

In reviewing the descriptions of the grievances, an additional concern is the number of transportation-related grievances in Q3 related to concerns by members about their safety, including reckless and careless driving, driver texting, accidents, and speeding.

Also of concern is the number of transportation-related grievances described as "no show" but categorized as Timeliness and Attitude/Service of Staff. United, for example, described 30 "Timeliness" grievances as "no show issues."

KFMC again found a few differences in data reported by two of the MCOs in the GAR and STC reports. Amerigroup, for example, reported in the GAR that they reviewed 193 grievances this quarter and resolved 198 grievances; they reported in the GAR receiving 179 grievances this quarter, but in the STC report reported receiving 193 grievances. In the GAR report, United itemized and reported resolution of 287 grievances; the total reported in the Reasons Summary of the GAR, however, was 209.

It should also be noted that some grievance "resolutions," particularly those related to billing issues and transportation, involve repeated contacts to providers and vendors. As this is the second year of the KanCare program, it would also seem that the number of providers who are balance billing members would be decreasing. In Q2 CY2014, United had 99 grievances related to balance billing; in Q3, 114 of United's 287 reviewed grievances were categorized as Billing and Financial Issues. KFMC identified 8 additional grievances categorized as "Attitude/Service of Staff" that were related to billing issues and concerns.

RECOMMENDATIONS

- Grievance categories within the GAR and STC reports should be more clearly defined. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Data in the GAR and STC grievance reports should be reviewed and compared to ensure consistent reporting of data within reports and between reports where applicable.
- MCOs should make efforts to educate providers about balance billing to reduce the number of billing-related grievances.
- United should provide additional details for grievances they now describe as "no show issues" to clarify whether these are truly "no show."

TRACK TIMELY RESOLUTION OF GRIEVANCES

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

DATA SOURCE

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

CURRENT QUARTER COMPARED TO PREVIOUS QUARTERS

As shown in Table 7 below, 99.4% (680) of the 684 grievances closed in Q3 CY2014 were resolved within 30 business days; 99.9% (683) were resolved within 60 business days; and 0.1% (1) was not resolved within 60 business days.

In the first six quarters of KanCare to date, the number of grievances received and the number of grievances closed increased slightly each quarter. In Q3 CY2014, the number of grievances received (679) and the number of grievances closed (684) were a sharper increase than the previous quarters. There were 178 more grievances received in Q3 CY2014 than in Q2 CY2014, and 177 more grievances closed in Q3 CY2014 than in Q2 CY2014. Of the three MCOs, Amerigroup had the fewest grievances received (179) and closed (184), and United had the highest number of grievances received (287) and closed (287) in Q3 CY2014. Sunflower had 213 grievances received and closed in Q3 CY2014.

This is the second quarter since Q1 CY2013 where 100% of grievances were not resolved within 60 days; however, only 1 grievance was not resolved within 60 business days, compared to 7 in the previous quarter. (Q1 CY2014 was the first quarter for 100% of grievances to not be resolved within 30 days.) In CY2013, resolution of grievances was a P4P measure; to receive incentive payments related to grievance resolution, MCOs needed to resolve 98% of grievances within 20 days and 100% of grievances within 40 days. (The number of grievances reported as resolved in a quarter includes

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

Table 7 - Timeliness of Resolution of Grievances

	CY2013				CY2014		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Number of Grievances Received in Quarter	445	496	422	423	498	501	**679**
Number of Grievances Closed in Quarter*	422	462	412	427	501	507	**684**
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	490	**680**
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	99.6%	96.6%	**99.4%**
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	500	**683**
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%	98.6%	**99.9%**
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	7	**1**

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

Conclusions

- In Q3 CY2014, the number of grievances received (679) and the number of grievances closed (684) were a sharper increase than the previous quarters. There were 178 more grievances received in Q3 CY2014 than in Q2 CY2014, and 177 more grievances closed in Q3 CY2014 than in Q2 CY2014.
- 99.4% of grievances closed in Q3 were resolved within 30 business days; 99.9% were resolved within 60 business days; and 0.1% (1 grievance) was not resolved within 60 business days.

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

Data Sources

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

All Grievances

Table 8 summarizes the quarterly numbers and types of grievances to date for the aggregated MCO data. The grievance types that increased the most in Q3 were Transportation, Claims/Billing Issues, and Quality of Care or Service. The number of transportation-related grievances continues to be the most frequently reported. As

displayed in Table 9 and Figure 1, 43.3% of the grievances in Q3 were related to transportation.

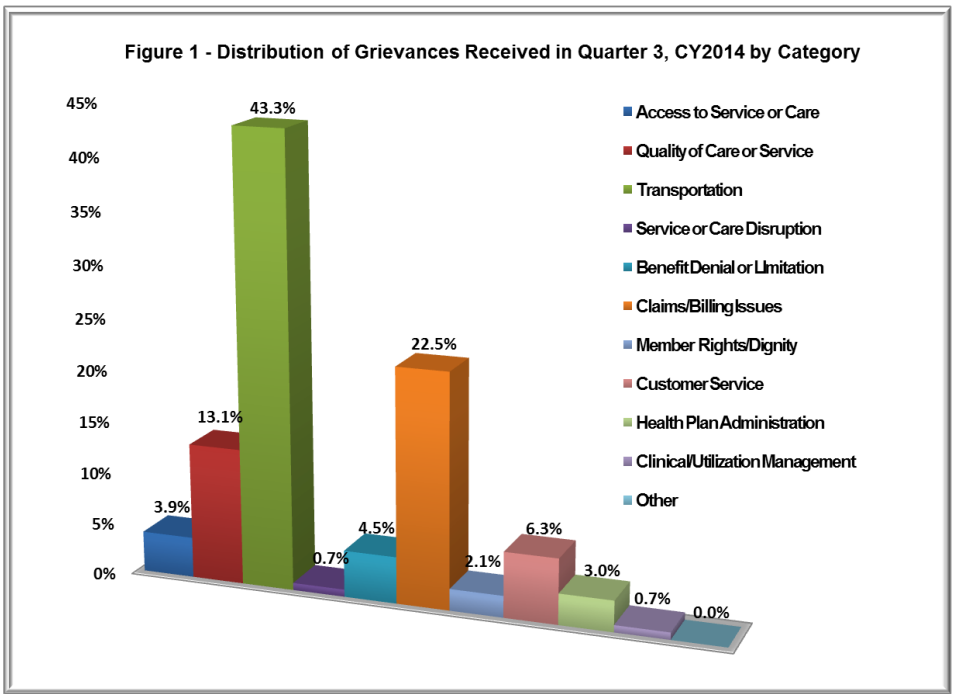
Table 8 - Number of Grievances by Category

	CY2013				CY2014		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Transportation	271	261	183	182	226	206	291
Claims/Billing Issues	35	87	48	72	106	123	151
Quality of Care or Service	19	34	30	56	44	64	88
Customer Service	52	52	34	25	38	29	42
Access to Service or Care	16	13	13	27	24	21	26
Health Plan Administration	17	31	26	27	20	15	20
Benefit Denial or LImitation	16	4	7	10	13	15	30
Service or Care Disruption	3	11	16	7	6	16	5
Clinical/Utilization Management	4	10	14	5	0	8	5
Member Rights/Dignity	4	5	10	6	1	4	14
Other	13	3	18	3	20	3	0
Total Grievances Received in Quarter	450	511	399	420	498	504	691
Total Grievances Resolved by the end of the quarter of those received in the quarter*†	407	453	344	385	474	474	672

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

Table 9 - Percentage of Grievances by Category Within Each Quarter To Date

	CY2013				CY2014		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Total Grievances Received	450	511	399	420	498	504	672
	% of 450	% of 511	% of 399	% of 420	% of 498	% of 504	% of 672
Transportation	60.2%	51.1%	45.9%	43.3%	45.4%	40.9%	43.3%
Access to Service or Care	3.6%	2.5%	3.3%	6.4%	4.8%	4.2%	3.9%
Quality of Care or Service	4.2%	6.7%	7.5%	13.3%	8.8%	12.7%	13.1%
Claims/Billing Issues	7.8%	17.0%	12.0%	17.1%	21.3%	24.4%	22.5%
Customer Service	11.6%	10.2%	8.5%	6.0%	7.6%	5.8%	6.3%
Health Plan Administration	3.8%	6.1%	6.5%	6.4%	4.0%	3.0%	3.0%
Benefit Denial or LImitation	3.6%	0.8%	1.8%	2.4%	2.6%	3.0%	4.5%
Service or Care Disruption	0.7%	2.2%	4.0%	1.7%	1.2%	3.2%	0.7%
Member Rights/Dignity	0.9%	1.0%	2.5%	1.4%	0.2%	1.6%	2.1%
Clinical/Utilization Management	0.9%	2.0%	3.5%	1.2%	0.0%	0.8%	0.7%
Other	2.9%	0.6%	4.5%	0.7%	4.0%	0.6%	0.0%



Beginning in Q1 CY2014, KDHE added a field to the detailed grievances template in the GAR report for tracking the "type of waiver member" reporting the grievance. Table 10 below reports the types of grievances resolved in Q3 CY2014 and available information on waiver types. Of 616 grievances resolved in Q3 CY2014, 185 (30%) were reported by members receiving waiver services. (Although 684 grievances were reported as "resolved" in Q3, the itemized list of grievance types in the GAR report includes only 616 due to 78 that were omitted from United's Reasons Summary totals.) Of the 185 grievances received from waiver members, 93 (50.3%) were transportation-related. Physical Disability (PD) waiver members had the most grievances, reporting 87 of the 185 grievances (primarily transportation-related).

ACCESS-RELATED GRIEVANCES

Of the 672 grievances received in Q3 CY2014, 26 (3.9%) were categorized in the STC report as "Access to Service or Care." (See Tables 8 and 9.) Access-related grievances have consistently been one of the least frequent categories of reported grievances.

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

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

Table 10 - Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 3, CY2014*									
	All Members	Waiver Members		Grievances by Waiver Type					
	Total	Waiver Members Subtotal	Waiver Transportation-Related	FE	I/DD	PD	SED	TA	TBI
Billing and Financial Issues	144	31	6	10	4	9	2	5	1
Quality of Care or Service	58	12	1	3		6	1		2
Attitude/Service of Staff	101	38	17	7	3	19	1	3	5
Timeliness	103	38	35	10	3	20	1	1	3
Availability	124	35	29	6	5	19	1	1	3
Pharmacy	5	3	0	2		1			
Lack of Information from Provider	9	3	1			2		1	
Criteria Not Met - Medical Procedure	2	1	0	1					
Criteria Not Met - Durable Medical Equipment	5	2	0			1			1
Prior or Post Authorization	8	3	0		1	2			
Accessibility of Office	8	1	0		1				
HCBS	2	2	0			1			1
Level of Care Dispute	9	3	0		1	2			
Quality of Office, Building	1	1	0	1					
Sterilizations	1	0							
Sleep Studies	2	0							
Other	34	12	4	3	2	5		1	1
Total	616	185	93	43	20	87	6	12	17

*Includes grievances received in Quarter 2, CY2014, that were resolved in Quarter 3, CY2014

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

- Amerigroup described the 14 access-related grievances as situations where members had difficulty or were unable to obtain services or supplies.
- United indicated their 3 access-related grievances were situations where providers refused to render services to members.
- Sunflower reported that 6 of the 9 access-related grievances this quarter were related to not being able to access or locate a PCP.

No grievances were specifically categorized in the GAR as “Access to Care or Service.” Other categories in the GAR that could be related to “Access to Service or Care” include “Accessibility of Office” and “Availability” Based on the grievance detail provided in the reports, other categories that could involve “Access to Service or Care” issues include “Pharmacy,” “Prior or Post Authorization,” “Sleep Studies,” “Criteria Not Met – Durable Medical Equipment,” or “HCBS.”

The GAR report provides additional details on grievances resolved during Q3 CY2014. “Accessibility of Office” grievances included concerns about access to dental care, difficulties getting through to MCO customer service staff by phone, wait time for appointments, requests to see specific providers, and unhappiness with the way the member was treated at a hospital.

KFMC again recommends that KDHE work with the MCOs to develop more consistent categorization of grievances in the STC and GAR reports. Clarification of these criteria, and inclusion of comparable category types in both reports, would improve the ability to assess trends over time in reporting of access-related grievances, as well as other grievance categories.

QUALITY-RELATED GRIEVANCES

Of the 691 grievances received in Q3 CY2014, 88 (12.7%) were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 58 of the grievances resolved (9.4%) were categorized as "Quality of Care" (QOC).

To date, there have been 335 grievances categorized in the STC report as being related to QOC. The number of QOC grievances increased during each quarter of CY2013 (ranging from 19 in Q1 CY2013 to 56 in Q4 CY2013), dropped to 44 in Q1 CY2014, and then increased to 64 in Q2 CY2014. In Q3 CY2014, the number of quality-related grievances increased again to 88.

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

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

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

- Amerigroup described the 28 QOC grievances this quarter as situations where members felt they received inappropriate treatment from their treating provider, and reported that 18 of the 28 grievances were referred to their quality management staff for a QOC investigation.
- United indicated their 35 QOC grievances included a variety of issues ranging from unprofessional behavior to members upset with care coordinators.
- Sunflower reported that all but 3 of the 25 QOC grievances this quarter were related to provider care of members.

Of the 58 QOC grievances reported in the GAR as resolved, 12 were from members receiving waiver services: two were members receiving TBI (traumatic brain injury) waiver services; six were members receiving PD (Physical Disability) services; three were members receiving FE (Frail Elderly) services; and one was a member receiving SED (Serious Emotional Disturbance) waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q3, KFMC found many additional grievances that could potentially be considered to be related to QOC that were categorized most frequently as "Attitude/Service of Staff," with several additional grievances categorized as "Level of Care Dispute," "Quality of Office, Building," and "Availability." Alternatively, several grievances categorized as QOC could

just as easily have been categorized as "Billing and Financial Issues," "Availability," or "HCBS."

KFMC recommends that criteria be better defined for "quality of care" and the other grievance categories in the STC and GAR reports. Use of comparable category types and clear criteria in both reports would improve the ability to assess trends over time in reporting of grievances related to quality of care and other grievance categories.

Conclusions

- In Q3 CY2014, there was an increase in grievances categorized as QOC and in access-related grievances. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude that QOC grievances are actually increasing or that access-related grievances have decreased. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

Recommendations

- Clearer definitions and criteria for categorizing "Access to Service or Care," "Quality of Care," and other grievance categories in the GAR and STC reports are needed.
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).
- Reports should be reviewed for quality and completeness to ensure information such as "type of waiver" are accurately and consistently reported by all three MCOs.

Ombudsman's Office

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

Data Sources

The primary data source in Q3 CY2014 is the KanCare Ombudsman Update report presented by Kerrie Bacon, the KanCare Ombudsman, on 11/18/2014, to the Robert G. (Bob) Bethell Joint Legislative Committee on Home and Community Based Services and KanCare Oversight, and on KFMC interviews with Kerrie Bacon in November 2014.

Current Quarter and Trend Over Time

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

September 2014. The volunteer coordinator's responsibilities will include recruitment of volunteers statewide to provide information and assistance to KanCare members, and referral, as needed, to the Ombudsman or other State agency staff. Ombudsman's Office staff are working with the Center for Community Support and Research at Wichita State University to develop a training program for volunteers. Training of volunteers is planned to begin first in Kansas City and Wichita by July 2015 and expand statewide in 2016.

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

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

Table 11 summarizes the number and type of contacts received and caller types in Q3 CY2014. There were 256 MCO-related contacts this quarter, 48.7% of the 526 contacts reported, compared with 210 MCO-related contacts in the previous quarter. Most of the contacts to the Ombudsman's Office were from consumers, 78% of 526 contacts in Q3 CY2014, 73% of 474 contacts in Q2 CY2014, and 71% of 546 contacts in Q1 CY2014. Phone contacts comprised 82% of the contacts this quarter. The 90 email contacts reported this quarter did not include the many emails made in response to initial emails.

Table 11 - Ombudsman Contacts by Contact Method and Caller Type, Quarter 3, CY 2014

Contact Method			Caller Type		
	All contacts	MCO-related		All contacts	MCO-related
Phone	432	218	Consumer	412	213
Email	90*	35*	Provider	92	41
Letter	2	2	MCO employee	1	0
In person	2	1	Other	21	2
Total	526	256	Total	526	256

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

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 12 below, 157 contacts were waiver-related, and 109 of these were also MCO-related. The most frequent waiver-related and special services issues were for/from KanCare members receiving waiver services for Physical Disability (PD), 43 contacts, and for Intellectual/Developmental Disability (I/DD), 42 contacts.

Table 12 - Waiver-Related and Special Service Issues and Inquiries in Contacts to Ombudsman's Office, Quarter 3, CY2014

	All Issues		MCO-related Issues	
Waiver and Special Services	#	% of 157 waiver-related contacts	#	% of 109 MCO waiver-related contacts
Physical Disability (PD)	43	27.4%	32	29.4%
Intellectual/Developmental Disability (I/DD)	42	26.8%	26	23.9%
Frail Elderly (FE)	16	10.2%	13	11.9%
Traumatic Brain Injury (TBI)	19	12.1%	16	14.7%
Technology Assisted (TA)	8	5.1%	4	3.7%
Money Follows the Person (MFP)	6	3.8%	5	4.6%
Serious Emotional Disturbance (SED)	5	3.2%	4	3.7%
Autism	4	2.5%	3	2.8%
Mental Health	4	2.5%	2	1.8%
Nursing Facility	10	6.4%	4	3.7%
Total	157		109	

Since some contacts include more than one issue, the Ombudsman's Office began tracking the number of issues in addition to the number of contacts. As reported in Table 13, there were 600 issues and inquiries tracked out of the 526 contacts in Q3 CY2014. The highest number of issues and inquiries were related to Medicaid Eligibility (90 issues) and HCBS (89 issues) Of the 600 issues and inquiries, 314 (52.3%) were MCO-related.

This quarter, the Ombudsman's Office also began tracking the number of days to resolve an issue. Of 453 files closed in Q3, 246 (54.3%) were resolved in one day or less. The average number of days (mean value) was 9 days, the median number of days (middle number of days of the 453 files) was 1 day, and the mode (most frequent value) was zero (less than one day).

Table 13 - Types of Issues and Inquiries Submitted to Ombudsman, Quarter 3, CY2014					
	Quarter 3 CY2014				
	All Issues		MCO-related Issues		
Issues	#	% of 600	#	% of 314	% of 600
Medicaid Eligibility Issues	90	15.0%	22	7.0%	3.7%
Appeals, Grievances	45	7.5%	38	12.1%	6.3%
Medical Service Issues	41	6.8%	32	10.2%	5.3%
Billing	40	6.7%	29	9.2%	4.8%
Durable Medical Equipment	25	4.2%	24	7.6%	4.0%
Pharmacy	20	3.3%	17	5.4%	2.8%
HCBS					
HCBS General Issues	45	7.5%	34	10.8%	5.7%
HCBS Eligibility Issues	10	1.7%	5	1.6%	0.8%
HCBS Reduction in Hours of Service	15	2.5%	12	3.8%	2.0%
HCBS Waiting List	19	3.2%	7	2.2%	1.2%
Care Coordinator Issues	18	3.0%	17	5.4%	2.8%
Transportation	18	3.0%	12	3.8%	2.0%
Nursing Facility Issues	16	2.7%	3	1.0%	0.5%
Housing Issues	12	2.0%	6	1.9%	1.0%
Change MCO	10	1.7%	9	2.9%	1.5%
Dental	8	1.3%	4	1.3%	0.7%
Access to Providers	6	1.0%	4	1.3%	0.7%
Guardianship Issues	1	0.2%	0	0.0%	0.0%
I/DD Conference Call Questions	15	2.5%	0	0.0%	0.0%
Other	146	24.3%	39	12.4%	6.5%
Total	600		314		52.3%

CONCLUSIONS

- In Q3 CY2014, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive. This quarter, the Ombudsman's Office began tracking issues and inquiries by waiver and special services and by number of days to resolution.
- Since some contacts include more than one issue, in Q3 the Ombudsman's Office began tracking the number of issues in addition to the number of contacts. In 526 contacts and calls, 600 issues and inquiries were tracked this quarter.
- A third staff member was hired this quarter as volunteer coordinator. Ombudsman's Office staff are working with the Center for Community Support and Research at Wichita State University to develop a training program for volunteers. Training of volunteers is planned to begin first in Kansas City and Wichita by July 2015 and expand statewide in 2016.

RECOMMENDATIONS

- When tracking issues and inquiries (as identified in Table 13 above), it would be helpful to track and provide counts of how many of each of these contacts were to obtain initial or general information and how many were more serious issues or concerns that are likely more time-intensive to resolve.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.

QUANTIFY SYSTEM DESIGN INNOVATIONS IMPLEMENTED IN KANSAS

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

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

HEALTH HOMES

The Health Homes program for KanCare members with Serious Mental Illness (SMI) was implemented on 7/1/2014, with services beginning 8/1/2014. There were 25,814 Home Health (HH) welcome letters mailed to qualified members in July. Only 8.7% (2,237) of those sent a letter opted out from the program. Letters will go out monthly to newly identified members that qualify to be enrolled in a HH. As of September 2014, there were 94 providers contracting with one or more Lead Entities (KanCare MCOs) to serve as Health Home Partners (HHPs).

KDHE's Preparedness and Planning tool is a self-assessment for potential HHPs. As of October 2014, there have been 98 respondents to the self-assessment tool; 65 of these providers were listed as HHPs with one or more of the Health Home Lead Entities in September. Not all providers answered all questions. Of the 78 providers that responded to the question whether they currently use an interoperable Electronic Health Record (EHR), 44 (56%) responded "no" and 34 (44%) responded "yes." Of the 34 providers with EHRs, 28 were HHPs as of September 2014. Of the 44 providers without an EHR, 23 were HHPs. The anticipated time until EHR implementation was 15 months

for all providers without an EHR. Monitoring the progress of these organizations, as well as additional HHPs, could be a good way to monitor the influence of KanCare on EHR adoption in Kansas.

PATIENT CENTERED MEDICAL HOMES

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

- Kansas Academy of Family Physicians (KAFP) - Kansas Primary Care Medical Home Initiative
  - *Consumer and provider populations impacted:* Primary Care practices and all of their patients regardless of payers.
  - *Coverage by location/region:* The eight primary care practices were located in Ellsworth, Lawrence, Pittsburg, Plainville, Sabetha, St. Francis, Winfield, and Wichita.
  - *Available post-KanCare performance measure data:* In a 2/19/2014 email, KAFP reported colorectal cancer screening and tobacco free data. Aggregate data for the 8 pilot practices, from July 2011 through December 2013, were as follows:
    - Colorectal cancer screenings increased from 33% to 49%
    - Tobacco free patients increased from 18% to 62%.
  - *Start date and current stage of the initiative*: Phase 1 was 1/1/2011– 12/31/2013. Two of the eight practices achieved Level 3 NCQA certification before the end of phase one. KAFP contracted with KFMC in May 2014 to continue this work through March 2015. The start date for Phase 2 of KAFP's initiative, with KFMC's Regional Extension Center (REC) providing technical assistance, began in May 2014. KFMC is working with four of the original KAFP pilot sites to pursue NCQA PCMH certification. The three remaining clinics plan to submit before March 2015.
- Kansas Foundation for Medical Care
  - REC PCMH work
    - *Consumer and provider populations impacted:* Primary Care practices and all of their patients regardless of payer.
    - *Coverage by location/region:* Practices are located in Fredonia, Manhattan, Topeka, Wichita (3), and Winfield.
    - *Start dates and current stage of the initiative*: Six clinics started working with KFMC on PCMH in March 2013. All plan to submit to NCQA for PCMH recognition before March 2015. A seventh clinic started in May 2014, with plans to submit to NCQA for PCMH recognition under the 2014 standards in late 2015 or early to mid-2016..
- Blue Cross/Blue Shield of Kansas (BCBSK)
  BCBSK has a Quality Based Reimbursement Program (QBRP) for their contracting providers, which provides an opportunity to earn additional revenue for performing defined activities.
  - *Consumer and provider populations impacted:* All specialty types contracted with BCBSK and their patients.

  - *Coverage by location/region:* Kansas, excluding metro Kansas City
  - *Start dates and current stage of the initiative*: Since 2011, BCBSK has incentivized a number of provider based quality improvement initiatives such as, EHR adoption, electronic prescribing, participating in a Health Information Exchange (HIE), and PCMH. These incentives change each year but will continue into 2015.
- Kansas Association for the Medically Underserved (KAMU) - Medicare Advanced Primary Care Practice (APCP) Demonstration
  - *Consumer and provider populations impacted:* Federally Qualified Health Centers (FQHCs) and their patients.
  - *Coverage by location/Region*: Junction City and Wichita.
  - *Start dates and current stage of the initiative:* November 2011 with a scheduled end date of 10/31/2014, with the goal of Level 3 recognition. The FQHC in Wichita achieved Level 3 PCMH accreditation on 1/12/2014. The FQHC in Junction City has submitted documentation to NCQA for review.
- Kansas Health Foundation (KHF) and KAMU- PCMH Initiative
  - *Consumer and provider populations impacted:* Safety Net Clinics and their patients.
  - *Coverage by location/region:* Nine safety net clinics.
  - *Start dates and current stage of the initiative*: January 2012 through December 2014 (originally June 2014). This initiative has been extended through the end of calendar year 2014. Four clinics have chosen to continue to receive concentrated supports.
- REACH Healthcare Foundation – Medical Home Initiative
  - *Consumer and provider populations impacted:* Safety Net Primary Care Clinics in the Kansas City metropolitan area and their patients.
  - *Available performance measure data:* A white paper was released on 3/13/2014, describing the project and some of the results. Below are the patient experience questions that were chosen for reporting and trending through PCMH Effectiveness Reporting Collaborative (PERC):
    - Access to care - includes questions to understand barriers to access, such as wait times for an appointment or wait times while in the clinic.
    - Communication with Provider – to understand the relationship between patient and provider and any communication barriers which may impede patient engagement.
    - Coordination of Care – Questions on this measure varied by participating clinic.
    - Whole person care – Most of the clinics chose questions centered on respect and inclusivity; one clinic opted for indicators of parental guidance around childhood development.
    - Medical Home – attempts to determine the patient's recognition of a site of care as their medical home.
  - *Coverage by location/region:* Johnson and Wyandotte counties (4 clinics), as well as four clinics in Missouri.
  - *Start dates and current stage of the initiative:* 2010 and ended early in 2013; however, the foundation re-launched their support of clinics within their 6-county coverage area with another initiative that began later in 2013.

Of the 17 designated FQHCs in Kansas, there are10 that have achieved PCMH recognition, as of Q3 CY2014. These clinics are located in Emporia, Great Bend, Hays, Hutchinson, Kansas City (2), Lawrence, Olathe, Salina, and Wichita.

HEALTH INFORMATION TECHNOLOGY (EHRS AND MU)

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

CMS has a role in HITECH as well. CMS operationalized MU by setting up core and menu set measures that must be met by EPs and EHs to receive incentive dollars or to avoid Medicare reduced payment adjustments. CMS administers the MU incentive program for Medicare Eligible Professional (EPs) and Eligible Hospitals (EHs). The State of Kansas is in charge of the program for Kansas Medicaid providers within CMS guidelines. Medicaid incentives are for providers that adopt/implement/upgrade to certified EHR technology and for MU. From January 2011 to September 2014, the following incentive provider payments to Kansas EPs and EHs have been made:

- Medicare Eligible Professionals: $68.70 million
- Medicaid Eligible Professionals: $19.93 million
- Eligible Hospitals: $201.83 million

KFMC, through funding by KDHE/DHCF, is providing technical assistance to Medicaid providers who have not yet reached Meaningful Use of an EHR. KFMC will assist 200 Medicaid healthcare providers with selection, implementation, and meaningful use of an EHR between now and 9/30/2015. KFMC is currently working with 65 Medicaid providers, and has received an expression of interest in the program from 103 more. As part of this KDHE program, KFMC also conducted an EHR readiness assessment and assisted with vendor selection for 22 Health Home Partners contracted with KanCare.

HEALTH INFORMATION EXCHANGE

Increasing Health Information Exchange (HIE) capabilities is also a component of the HITECH Act. The presence of HIE is becoming more central in the work of health care providers in Kansas. As reported previously, there are two HIE organizations in Kansas that have been provided Certificates of Authority by KDHE to provide the sharing of health information in Kansas. The organizations, Kansas Health Information Network (KHIN) and the Lewis and Clark Information Exchange (LACIE) have continued to expand their capabilities and to offer services to a wider audience. Below is a summary of the incorporation of HIE into the system for providing healthcare in Kansas.

- **KHIN**
  - **Health Homes:** HHPs, as discussed above, are expected to have the capacity to connect to one of the certified state HIEs. One goal for the Health Home model is for all providers to have a complete record (physical and mental health) available

to assist with care for this special needs population. KHIN has found a challenge to be that many of the organizations do not yet have an EHR.

- **KanCare MCOs**: KHIN has been working with KanCare MCOs to ensure they have accurate, up-to-date information on their members. While a record of health care service is available to the MCOs upon receipt of a claim, KHIN provides the service information in real time at the point of care being received. KHIN can provide daily updates to the MCOs regarding member activity in the last 24 hours. This allows MCOs the ability to implement effective care management. Two of the three MCOs, Amerigroup and United, are members of KHIN. There is the opportunity for the MCOs to develop various alerts and to use longitudinal information regarding their members to help reduce Medicaid costs and improve care for their Kansas patients.
- **Personal Health Record (PHR):** Twenty-six KHIN members, mostly small hospitals and medical clinics, are participating in a pilot program with KHIN's MyKSHealth eRecord. MyKSHealth eRecord is a PHR that is available for free to all patients who receive care from Kansas health care providers. KHIN has obtained a REACH Healthcare Foundation grant that will be used for a large media campaign early in January 2015 to educate providers and consumers about the PHR.
- **Veterans Administration (VA) pilot**: The Robert J. Dole VA Medical Center in Wichita and the Hutchinson Regional Medical Center cooperated on a pilot program with KHIN to move patient records between the two hospitals. The pilot involved training the veterans on how to download their health information from the VA's system and upload it to their MyKSHealth eRecord and send it to their non-VA health care providers.
- **Quality Measure Reporting**: Now that KHIN has a significant amount of clinical data, KHIN is beginning to focus more on quality measure reporting. KHIN is able to perform data extracts for specified quality measures, e.g., hemoglobin A1c values, cholesterol levels, glucose monitoring, hypertension monitoring, etc., and report them back to the providers.

- **LACIE**
  - **Patients queried**: As of August 2014, LACIE had almost 100,000 (cumulative) patients queried compared to 5,601 as of August 2013. Over half (51,315) of these queries occurred in July and August 2014.
  - **Transportable Physician Orders for Patient Preferences (TPOPP)**: LACIE provides the ability to place End of Life Preferences/Protocols and Orders into the exchange so that healthcare providers can access this information. This initiative is designed to improve the quality of care people receive at the end of life by translating their treatment goals and preferences into their medical orders.
  - **Emergency Medical Service Agencies**: LACIE is able to provide information to field medics proactively.
  - **Images in LACIE**: LACIE can provide URL hyperlinks to images directly from the radiology report allowing access to images. This includes EKG, EEG, wound care, etc.

- **KHIN and LACIE**
  - **BCBSK** has included (as previously noted) a component of HIE in their Quality-Based Reimbursement Program (QBRP) for 2015. Prescribing providers, defined by BCBSK, can earn an extra 2.5 percent payment on eligible CPT codes under two circumstances: 1) if they search for patient medical information at least 30 times per quarter, or 2) if a direct connection with HL7 data feeds that supply the Kansas Minimum Data Set to an approved health information network is established. Incentive payments will begin 1/1/2015; actions performed during the qualifying period that started 8/1/2014 will determine eligibility. Hospitals that meet these requirements can earn 0.05% on all hospital billable services.
  - **Provider Directory**: Both HIEs have developed or are working on developing a provider directory that can be accessed when Direct Secure Messaging addresses are needed to exchange information.

TELEHEALTH AND TELEMEDICINE

Telehealth and telemedicine are important to states such as Kansas that have large rural areas with limited access to healthcare providers, particularly specialists. The work of the University of Kansas Center for Telemedicine and Telehealth (KUCTT) has been discussed in previous quarterly reports. It provides a very valuable service to many areas of the state.

The University of Kansas Hospital will be able to increase its services to rural providers in western Kansas due to a Centers for Medicare and Medicaid Services Innovation grant of $12 million. The goal is to reduce deaths from heart disease and stroke, working with Hays Medical Center, 10 critical access hospitals and rural primary care providers serving western Kansas. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information exchange, “big data” analysis, and population health management.

OVERALL CONCLUSIONS

A number of templates and reports were added or are being revised in CY2014 to improve efficiency, consolidate reporting where possible, and to provide more detailed information where indicated. The Claims Overview Report, for example, implemented in October 2014 and reporting claims received and processed beginning in January 2014, provides a much clearer reporting of timely processing of claims for each claim type. Monthly customer service reports, once required of MCOs weekly, provide more efficient reporting while providing more detailed data. The Ombudsman’s Office has greatly expanded their tracking system this year to provide much more complete reporting. A number of additional programs, including Health Homes, are also being launched and expanded. Other Q3 activities described in this report are summarized below.

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

- The customer service inquiry reports show that the MCOs have consistently met contractual standards for resolving inquiries within 2, 5, and 15 business days in each quarter of CY2013 and CY2014 to date. In Q3 CY2014, 99.77% of the

customer service inquiries received by the MCOs were resolved within 2 business days; 99.98% were resolved within 5 business days, and 100% were resolved within 15 business days.

- The number of inquiries received has generally decreased greatly since tracking began in 2013, but increased by over 10,000 calls in Q3 CY2014. The increased number of calls in Q3 were from members; provider inquiries decreased in Q3 CY2014 by 642.
- The number of provider inquiries was comparable for the three MCOs. Sunflower received a higher number of member inquiries, 47.7% of the 89,682 calls, compared to 26.6% for United and 25.7% for Amerigroup.
- For members, benefit inquiries were again the highest percentage (20.1%) of the calls received in Q3, an increase of 832 compared with the previous quarter. For providers, claim status inquiries were again the highest percentage (35.3%) of calls.
- Based on the wide range of reported number of calls in some of the categories, criteria used by the MCOs to categorize member and provider inquiries appear to vary greatly by MCO.

Timeliness of Claims Processing

- With the input of agency staff, the EQRO, MCOs, and interagency work groups, the State developed and implemented in October 2014 a revised claims report to better track timeliness of claims processing. In this revised report, MCOs now show the number of claims received each month and whether or not these claims were processed in a timely manner, as defined by the type of claim and State-specified timelines.
- In Q1 and Q2, MCOs processed 99.95% of clean claims within 30 days; 99.91% of non-clean claims within 60 days; and 99.99% of all claims within 90 days.
- Over 93% of the clean claims not processed within 30 days were Sunflower claims. Conversely, only 14.7% of the claims categorized as non-clean were Sunflower claims.
- The MCOs processed over 210,000 more clean claims in Q3 than in the previous quarter while maintaining a comparable average turnaround time of less than two weeks.

Grievances

- In Q3 CY2014, the number of grievances received (679) and the number of grievances closed (684) were a sharper increase than the previous quarters. There were 178 more grievances received in Q3 CY2014 than in Q2 CY2014, and 177 more grievances closed in Q3 CY2014 than in Q2 CY2014.
- 99.4% of grievances closed in Q3 were resolved within 30 business days; 99.9% were resolved within 60 business days; and 0.1% (1 grievance) was not resolved within 60 business days.
- Categories of grievances continue to differ by report.
- The grievance category with the highest number of grievances continues to be those related to transportation.
- In Q3 CY2014, there was an increase in grievances categorized as QOC and in access-related grievances. Due to the wide range in types of grievances categorized as QOC, the number of grievances not categorized as QOC (but could just as easily

be classified as such), and due to the many categories in the GAR report that included grievances that could be considered access-related, it is difficult to conclude that QOC grievances are actually increasing or that access-related grievances have decreased. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, would improve the ability to assess the number of access-related and QOC-related grievances and to assess trends over time.

OMBUDSMAN'S OFFICE

- In Q3 CY2014, the Ombudsman's Office has continued to expand and improve their tracking and reporting of issues and inquiries they receive. This quarter, the Ombudsman's Office began tracking issues and inquiries by waiver and special services and by number of days to resolution.
- Since some contacts include more than one issue, in Q3 the Ombudsman's Office began tracking the number of issues in addition to the number of contacts. In 526 contacts and calls, 600 issues and inquiries were tracked this quarter.
- A third staff member was hired this quarter as volunteer coordinator. Ombudsman's Office staff are working with the Center for Community Support and Research at Wichita State University to develop a training program for volunteers. Training of volunteers is planned to begin first in Kansas City and Wichita by July 2015 and expand statewide in 2016.

SYSTEMS DESIGN INNOVATIONS

- The KDHE Health Homes program was implemented in Q3, with over 23,000 enrolled members as of August 2014. There were 94 providers contracting with one or more KanCare MCOs to serve as Health Home Partners, as of September 2014.
- During Q3, there were six identified PCMH initiatives in Kansas.
- Regarding Medicare and Medicaid Incentive Provider Payments related to health information technology, over $290 million has been distributed to Kansas professionals and hospitals, by September 30, 2014.
- Efforts continue in Kansas to increase the use of the Health Information Exchanges.
- Also, a $12 million Centers for Medicare and Medicaid Services Innovation grant was recently awarded to the University of Kansas Hospital, working with Hays Medical Center, 10 critical access hospitals and rural primary care providers serving western Kansas. This Rural Clinically Integrated Network (RCIN) will expand the use of telehealth, robust health information exchange, "big data" analysis, and population health management.

RECOMMENDATIONS SUMMARY

TIMELY RESOLUTION OF CUSTOMER SERVICE INQUIRIES

- The State should work with the MCOs to develop consistent criteria for classifying the member and provider inquiries.
- Reports from MCOs should be compared to ensure that data in MCO quarterly reports are consistent with weekly or monthly reports for the same time period.

TIMELINESS OF CLAIMS PROCESSING

- With assistance from the State, Sunflower should review the criteria for defining claims as clean and non-clean and assess whether clean claims not processed within 30 days may actually be non-clean claims. If the clean claims not processed within 30 days do meet the criteria for clean claims, Sunflower should make a concerted effort to improve timeliness of processing clean claims.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for services where other MCOs have much lower average monthly turnaround times.

GRIEVANCES

- Data in the GAR and STC grievance reports should be reviewed and compared for quality and completeness to ensure consistent and accurate reporting of the quarterly number of grievances received and resolved.
- Grievance categories within the GAR and STC reports should be more clearly defined. Wherever possible, grievance categories in different reports should be consistently named and defined.
- Clearer definitions and criteria for categorizing “Access to Service or Care,” “Quality of Care,” and other grievance categories in the GAR and STC reports are needed.
- MCOs should make efforts to educate providers about balance billing to reduce the number of billing-related grievances.
- United should provide additional details for grievances they now describe as “no show issues” to clarify whether these are truly “no show.”
- The type and scope of access-related grievances would be more clearly defined by reporting transportation-related access grievances separately from grievances related to non-transportation-related access issues, particularly in the GAR report (as the STC report already tracks transportation-related grievances separately).
- Reports should be reviewed for quality and completeness to ensure information such as “type of waiver” are accurately and consistently reported by all three MCOs.

OMBUDSMAN’S OFFICE

- When tracking issues and inquiries (as identified in Table 13 above), it would be helpful to track and provide counts of how many of each of these contacts were to obtain initial or general information and how many were more serious issues or concerns that are likely more time-intensive to resolve.
- Addition of a tracking field on the grievance detail report to identify grievances forwarded to the MCOs by the Ombudsman could assist in tracking resolution of grievances initially reported to and tracked by the Ombudsman.

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

Amerigroup- YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	36,012	$1,129,166,197.89	6,926	$233,405,840.06	19.20%	7.8
Hospital Outpatient	286,233	$779,984,475.35	44,218	$102,294,734.70	15.61%	4.4
Pharmacy	1,319,535	$81,901,949.14	282,672	Not Applicable	21.42%	Same Day
Dental	101,966	$28,936,632.59	10,434	$3,291,829.28	10.23%	13.0
Vision	72,367	$19,835,491.22	16,101	$5,549,494.25	22.25%	8.0
NEMT	139,012	$5,193,945.38	338	$12,801.19	0.24%	19.0
Medical (physical health not otherwise specified)	1,453,266	$610,358,554.18	183,081	$82,895,293.04	12.64%	4.2
Nursing Facilities-Total	85,935	$201,944,527.46	10,429	$17,551,009.87	12.10%	6.1
HCBS	126,085	$73,955,040.11	9,066	$5,780,925.15	7.25%	5.8
Behavioral Health	495,989	$63,432,399.25	49,951	$6,654,138.39	10.06%	4.1
Total All Services	**4,116,400**	**$2,994,709,212.57**	**613,216**	**$457,436,065.93**	**14.90%**	**8.0**

Sunflower - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	24,524	$808,063,647.78	5,548	$196,830,159.17	22.62%	9.61
Hospital Outpatient	235,169	$436,908,956.01	31,972	$41,751,762.94	13.60%	7.08
Pharmacy	2,165,781	$171,406,124.24	500,099	$63,369,728.24	23.09%	1.00
Dental	14,806	$3,856,551.06	751	$228,772.72	5.07%	13.00
Vision	70,659	$15,725,192.22	9,218	$2,409,275.02	13.05%	11.92
NEMT	100,958	$3,011,888.59	429	$11,965.77	0.42%	11.13
Medical (physical health not otherwise specified)	1,286,200	$541,325,031.58	183,911	$92,364,602.09	14.30%	6.27
Nursing Facilities-Total	91,639	$189,080,620.40	8,707	$23,333,763.34	9.50%	6.15
HCBS	309,135	$149,352,412.69	11,614	$7,744,036.69	3.76%	5.43
Behavioral Health	540,320	$76,804,676.73	33,039	$7,545,243.11	6.11%	5.66
Total All Services	**4,839,191**	**$2,395,535,101.31**	**785,288**	**$435,589,309.09**	**16.23%**	**7.7**

United - YTD Cumulative Claim Type	Total claim count	Total claim count $ value	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	22,632	$732,870,738.12	4,664	$186,128,556.45	20.60%	14.4
Hospital Outpatient	218,319	$526,241,457.35	34,301	$113,673,189.15	15.71%	10.1
Pharmacy	1,304,969	$61,298,695.36	304,398	$55,182,733.95	23.33%	0.0
Dental	101,395	$27,660,238.50	10,247	$1,798,484.81	10.11%	14.0
Vision	53,510	$10,314,982.26	7,192	$1,526,537.69	13.44%	12.0
NEMT	74,929	$2,660,088.35	11,468	$13,192.05	15.31%	11.4
Medical (physical health not otherwise specified)	1,321,925	$463,461,818.93	165,838	$77,268,447.12	12.55%	9.0
Nursing Facilities-Total	75,829	$165,534,534.94	6,319	$16,685,479.60	8.33%	9.9
HCBS	240,952	$59,250,697.04	14,591	$3,851,231.65	6.05%	11.6
Behavioral Health	221,589	$57,601,876.42	19,254	$10,889,607.29	8.68%	8.1
Total All Services	**3,636,049**	**$2,106,895,127.00**	**578,272**	**$467,017,460.00**	**15.90%**	**9.5**