Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 9.30.15

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 3 (1/1/2015-12/31/2015)
Federal Fiscal Quarter: 4/2015 (7/15-9/15)

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I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the first quarter known as of September 30, 2015.

Demonstration Population	Enrollees at Close of Qtr. (09/30/2015)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	16,606	17,495	889
Population 2: ABD/SD Non Dual	28,418	28,898	480
Population 3: Adults	42,764	46,048	3,284
Population 4: Children	217,866	229,867	12,001
Population 5: DD Waiver	8,770	8,821	51
Population 6: LTC	20,669	21,744	1,075
Population 7: MN Dual	1,227	1,326	99
Population 8: MN Non Dual	1,047	1,093	46
Population 9: Waiver	3,926	4,024	98
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**341,293**	**359,316**	**18,023**

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 7, 2015 (4 attendees) and August 4,2015 (6 attendees).

The state's KanCare Advisory Council is next scheduled to meet on November 20, 2015. The KanCare Consumer and Specialized Issues Workgroup did not meet during the third quarter, because the State is undertaking a process to choose new members for this workgroup. The State plans to resume meetings of this workgroup during the fourth quarter.

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)
- PACE Program (quarterly)
- HCBS/MCO Provider Lunch and Learn teleconferences (1 hour, bi-weekly)
- HCBS Provider Forum teleconferences (monthly)
- HCBS-IDD Consumer Lunch and Learn teleconferences (1 hour, bi-weekly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO Association) board meetings (as requested)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association KanCare implementation technical assistance group
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration

- State Mental Health Hospital mental health reform meetings (quarterly)
- Multi-Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- I/DD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- MCO Technical Advisory Group (biweekly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Monthly meetings with the Association of Community Mental Health Centers, including Managed Care Organizations
- PRTF Stakeholder meeting (quarterly)
- DSM 5 Workgroups to discuss DSM 5 implementation
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- Kansas Hospital Association to discuss new Medicaid screening policies for KanCare members
- Six (6) regional meetings across the state to discuss new Medicaid screening policies and billing crisis services
- Crisis Response & Triage meetings with stakeholders including MCOs to improve timely, effective crisis services for members and improved care coordination post crises (bi-weekly)
- Lunch and Learn biweekly series on a variety of behavioral health topics including prevention and the prevention framework initiative; crisis response and triage; SUD 101; trauma informed systems of care; recovery and peer support
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the 9 subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Annual Recovery Rally and related activities
- 3-day Behavioral Health Services conference in Wichita
- Mental Health Excellence and grant project meetings

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

Health Homes

Kansas implemented Health Homes (HH) for people with serious mental illness (SMI) July 1, 2014. As of September 1, 2015, there were 37,593 KanCare members identified as eligible for the SMI HH. The opt-out rate for September 2015 was 22%, leaving 29,333 enrolled in SMI HHs. The opt-out rate has increased slightly, and the groups accounting for that are people with intellectual or developmental disabilities (IDD) and children in state custody. The engagement rate, calculated through June 2015 (due to encounter data lag), was 40.2%. Engagement is calculated by dividing the number of enrolled HH members by the number for whom a payment was made. For those served in the SMI HH, total payments through September 2015 were $27,544,911.34. Payments are made on a per-member per-month basis, but can only be triggered if a service is actually provided.

A Health Homes Conference was held in Wichita August 11 and 12, 2015. Approximately 250 staff from Health Home Partners, state agencies and managed care organizations attended. Overall feedback from participants was very positive and many have requested to make this an annual event. Funding for the conference was made possible by the Kansas Department of Health & Environment, Kansas Health Foundation, Amerigroup, Sunflower Health Plan, and United Healthcare Community Plan of Kansas.

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

HCBS Settings Final Rule

In the third quarter, KDADS and its university contractor Wichita State University (WSU) facilitated meetings in July and August regarding the HCBS settings final rule. The workgroup's charter was to determine what changes are required for HCBS settings to meet the final rule requirements, the design elements for the assessment tool, the process for conducting the assessment, and the process for submitting evidence of compliance. The workgroup, consisting of various stakeholders, collaborated and reviewed the HCB Settings federal rule and develop an onsite assessment instrument for the purpose of assessing settings for State's compliance with the final rule. The workgroup met for four weeks in large groups and individual subgroups to develop a draft onsite assessment instrument. The onsite assessment instrument was posted 30 days on the KDADS website for public comments. KDADS received minimal public comment on the draft onsite assessment instrument, and as a result minimal revisions were made to the original draft presented by stakeholders. The final onsite assessment tool will be utilized to assess HCBS funded settings for compliance with CMS guidelines. In the assessment process, HCBS settings that have not completed the self-assessment survey will be assessed in the first round along with settings meeting the definition under "higher scrutiny".

Waiver Integration Stakeholder Engagement (WISE) Workgroup

In September, KDHE and KDADS hosted a Waiver Integration Stakeholder Engagement (WISE) workgroup. The workgroup was chartered with evaluating the waiver integration concept and proposing recommendations to the State regarding system changes or service improvements needed in order integrate all seven HCBS programs under the 1115 authority. The group met for one session in September and three sessions in October 2015.

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup had its inaugural meeting on August 19, 2015. The workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society. The agenda for this group will be to analyze current credentialing practices in order to ease credentialing burdens for the

providers, while still enable the MCOs to follow their corporate credentialing needs. This workgroup will meet quarterly.

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 160 events for the third quarter of 2015. This included partner development, sponsorships, outreach and advocacy. The Community Relations Representatives' primary focus continues to be member education of services and benefits of the KanCare program. They work 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:

- Wichita Public Schools
- Grace Med Corporate Office
- Chanute Mobile Food Pantry
- Salina Family Health Care Center

Outreach Activities: Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They continue with ongoing targeted outreach to improve member knowledge about the services available to them. For example, Amerigroup will call members to help them understand the benefits of calling their nurse line instead of using the emergency room for non-emergent services. Amerigroup's Community Relations team expanded their Captain Amerigroup campaign in the third quarter to educate Kansans about the importance of children's medical, vision, hearing and dental screenings. The Community Relations Representatives participated in a variety of community events reaching almost 32,000 Kansans in the third quarter. Amerigroup highly values the benefits of these activities which provide opportunities to obtain valuable feedback and to cover current topics that are relevant to members, such as: diabetes, well child visits, employment, high blood pressure, how to prepare for your doctor visit, and more. Below is a sampling of some of Amerigroup's outreach efforts this past quarter:

- KCKCC Back to School Exhibit
- Bethel Life Church Convoy of Hope
- Saline County Back to School Fair
- Disability Caucus exhibit
- NCLR Family Expo Exhibit

Advocacy Activities: Amerigroup's advocacy efforts for third quarter continued to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the

elderly. Staff engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help staff learn the needs of the communities they serve and how they can better serve these communities. Amerigroup continues to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan. Here are a few examples of Amerigroup's advocacy activities this past quarter:

- Coalition for Independence ADA
- Health Department Wyandotte
- Conference on Poverty
- Child Start
- WIC Wyandotte
- HealthCore Clinic
- KDHE Special Health Care Regional Meeting

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

Marketing Activities: Sunflower Health Plan marketing activities for 3rd Quarter 2015 included unique opportunities to display the health plan's brand of services in front of national and local audiences. These included a major sponsorship and health screenings at a national Latino/Hispanic event and a book-signing event with the news media.

Examples of Sunflower's third quarter marketing activities:

- Sunflower Health Plan and its parent company Centene Corporation were major sponsors at the National Council of La Raza convention and family expo held in Kansas City, Missouri, from July 11-15, 2015. Sunflower contributed to the 40'x40' display with the support of 20+ health plan employees who volunteered their time to distribute Sunflower promotional items and work with the public at the Vision and Dental screening areas, which were also sponsored by Centene. This activity also falls into the "outreach" category, as many people were helped with vision and dental services they would not have received otherwise. Sunflower's CEO was also a speaker during the "Helen Rodriquez-Trias Health Award Reception" recognizing an affiliate organization of NCLR.
- On August 20, 2015, Sunflower held a media event and community gathering at the Topeka-Shawnee County Public Library to promote the book titled: "Darby Boingg Meets a Person with Disabilities," which features Ian, who uses a wheelchair and shares with the other characters how he's able to accomplish daily activities, even sports, much like they do. The book-reading and book-signing event reached viewers of WIBW TV and readers of KHI News Service. This event was also an "advocacy" activity for supporters of independent living. Important background information: In 2014, Sunflower employee Ian Kuenzi was interviewed by children's author Michelle Bain, whose company is contracted with Centene Corporation to develop health-related books and deliver presentations to children during school assemblies. Ian has cerebral palsy and serves Sunflower members by educating them about self-directed care.
- Notable third quarter sponsorships of stakeholder events and programs:

o National Council of La Raza (NCLR) Family Expo
o Family Service & Guidance Center (behavioral health provider) “Hearts Full of Hope” annual fundraiser
o Kansas Disability Caucus
o Kansas Pharmacists Association, Mid-America Pharmacy Conference, Awards Sponsor
o American Stroke Foundation Stroke Walk
o Community Mental Health Center Annual Conference on Behavioral Health
o Kansas Association for the Medically Underserved (KAMU) Annual Conference
o KDADS Behavioral Health Services Recovery Rally
o Iroquois Center for Human Development (ICHD) 5K Walk/Run

Outreach Activities: Third quarter outreach activities involved a Sunflower Member Health Fair (screenings, education and food) targeting members with diabetes, specifically those with care gaps. Sunflower also partnered with a local Farmers Market to provide (free) fresh produce to Sunflower members in an effort to encourage healthful eating. Also notable is a behavioral health & I/DD collaboration session piloted by Sunflower. Some additional details include:

• The health plan held a health fair on Saturday, August 1, 2015, at Swope Health Services in Kansas City, Kansas, inviting members with care gaps in diabetes care and members who were due for their dental exam. More than 25 members attended the health fair and received services, education and breakfast/lunch. This was a pilot/learning event for the health plan, with additional health fairs planned for 2016 at other locations around the State. This health fair was an opportunity to learn more about the barriers to health care and various strategies needed to help members see their PCP.

• Sunflower also piloted an initiative with a Farmers Market in an effort to connect health plan members with their local markets. On Wednesday, July 22, 7:30 a.m. – Noon, on the South Lawn of the Statehouse in Topeka, Sunflower partnered with the Midweek Farmers Market to provide fresh fruits and vegetables for its members. Sunflower mailed postcards inviting members to take advantage of a special offer: $10 worth of vouchers to be redeemed with the farmers at that market. Each voucher was worth $1, with each member receiving 10 vouchers slips. The health plan saw 122 of its members who came for the vouchers (it was anticipated only 20-40 would come, so the response was greater than expected). More than $1,000 was spent reimbursing the farmers for the vouchers they collected from health plan members.

• During 3Q15, Sunflower focused on making phone calls and home visits for the ‘PCP in 90 Days’ initiative. This involves helping new members find a primary care physician within 90 days of joining Sunflower Health Plan. During the third quarter, Sunflower’s Member Connections Representatives made over 500 successful phone calls and home visits for this initiative.

• The Member Connections Team also concentrated efforts around the Well Child Immunizations initiative. They continue to reach parents of new babies with education on the importance of getting their babies vaccinated. This involved telephonic outreach and home visits to these members.

• Sunflower Health Plan, LifeShare (Sunflower’s in-house I/DD experts) and Cenpatico Behavioral Health (Sunflower’s BH company) hosted a provider meeting July 10 in Topeka to begin to address care gaps in mental health (MH) services for members on the I/DD waiver. The goal is to foster improved

collaboration and sharing of expertise between MH and I/DD entities to ensure a more holistic and integrated approach for members who are dually diagnosed. Nine mental health providers, six I/DD providers, one pharmacy provider, and five Sunflower employees attended the first of several meetings.

• Summary of notable third quarter outreach events:

o National Council of La Raza (NCLR) Family Expo, July 11-15

o "Sunflower Member Day" at MidWeek Farmers Market, July 22

o Sunflower Member Health Fair, Aug. 1

o Wyandotte County Annual Back-to-School Fair, Aug. 1

o Kansas Disability Caucus

o Eight (8) Head Start RoundUp meetings with Parents of 3-5 year olds

o 6th Annual KC Ability Expo, Aug. 29

o Kansas Hospital Association conference, Sept. 10-11

o Community Health Fair, New Beginnings 7th-Day Adventist Church, Sept. 8

o Salina "Medicaid Leadership Health Fair" by Cerner, Sept. 25

o 8th Annual Community Health Fair in Dodge City, Sept. 19

o Mental Health Association Health Fair, Sept. 25

o Sunflower Member Baby Shower, Sept. 29

Advocacy Activities: During third quarter 2015, Sunflower employees participated in the following advocacy events:

• Recovery Rally for citizens struggling with mental illness, hosted by KDADS, Sept. 25

• Sunflower sponsored lunch for the third quarter meeting of "Health Literacy Kansas" which advocates for health literacy by bringing more awareness, education and training to groups responsible for providing health information to the Medicaid population.

• Sunflower-LifeShare spoke to providers and members at various events focused on disability services, such as the Disability Caucus.

• Sunflower facilitated WORK program "brainstorming meetings" on Sept. 11 in Hutchinson and on Sept. 4 in Wichita with Independent Living Counselors to advocate for members who may qualify for the WORK program.

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

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

Outreach Activities: United's Bilingual Community Outreach Specialists continue to focus on activities targeted within their respective geographical areas of Kansas for both English and Spanish language speaking members. Their key responsibilities involve conducting educational outreach to members, community based organizations and targeted provider offices about UnitedHealthcare, United's work with KanCare, the features and benefits of the plan and how to access those benefits. United's Provider Marketing Manager interacts with key provider offices and the provider community to assist with issue resolution and to ensure that providers are educated on the features and benefits of the UnitedHealthcare Community Plan of Kansas for United's members who visit their offices. Several key outreach initiatives this period included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, attendance at health fairs held throughout the state, and participation at a number of community stakeholder committee meetings. United's outreach team supported numerous FQHC and back to school events during the National Health Center Week. And in the third quarter United hosted its first Community Baby Shower in Dodge City. More of these events are planned for future quarters.

- During the third quarter 2015, UnitedHealthcare staff personally met with approximately 4,892 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 2015, UnitedHealthcare staff personally met with approximately 590 individuals from community based organizations located throughout Kansas. These organizations work directly with United's members in various capacities.
- During the third quarter 2015, UnitedHealthcare staff personally met more than 905 individuals from provider offices located throughout the State.

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

- A key event during this quarter was United's participation in the Kansas Disability Caucus which allowed United's staff to interact with over 125 persons with disabilities and to promote health plan literacy and self-advocacy with attendees. Many members and disability advocates learned more about the benefits available to them through United Healthcare and how care coordination is provided to those on Home and Community Based Waiver programs. An important message United shared with members with disabilities is United's desire to support their personal goals and to encourage members to make informed decisions about which health plan is the best fit for them. A portion of United's outreach experiences include talking with people who have a newly acquired disability and are in need of good referrals and basic information about programs and services available in Kansas.

- During this quarter, United's outreach specialist worked to coordinate, with the Kansas Council on

Developmental Disabilities, a meeting focused on the current employment support system in Kansas. The meeting occurred on July 28th and was a gathering of over 50 key stakeholders from state agencies (KDHE-WORK program, Kansas Department of Commerce, Kansas Department for Children and Families-Vocational Rehabilitation), managed care organizations and many provider/advocacy network representatives who are invested in and working on employment of Kansans with disabilities. As a complement to United's system change grant funded by Empower Kansans, and in partnership with the DD Council, United continues to see a need to bring key stakeholders together to discuss how to improve employment outcomes for members with disabilities. United continues to actively engage community partners around improved employment outcomes for KanCare members, particularly those with disabilities.

IV. Operational Developments/Issues

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

   CMS approved Amendment 18 to the KanCare MCO contract on August 4, 2015. Amendment 18 addresses retro capitation adjustments related to health insurance provider fee, effective January 1, 2014, and WORK program background check.

   On June 29, 2015, the State of Kansas' new eligibility determination system, KEES (Kansas Eligibility and Enforcement System) went live. Since go live, all coverage requests for medical assistance programs are processed through KEES.

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

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

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

c. Enrollment issues: For the third quarter of calendar year 2015 there were 12 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

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

Enrollment Reason Categories	Total
Newborn Assignment	4
KDHE - Administrative Change	11
WEB - Change Assignment	19
KanCare Default - Case Continuity	109
KanCare Default – Morbidity	320
KanCare Default - 90 Day Retro-reattach	417
KanCare Default - Previous Assignment	563
KanCare Default - Continuity of Plan	1,774
AOE – Choice	284
Choice - Enrollment in KanCare MCO via Medicaid Application	532
Change - Enrollment Form	228
Change - Choice	335
Change - Access to Care – Good Cause Reason	13
Change - Case Continuity – Good Cause Reason	7
Change – Quality of Care - Good Cause Reason	3
Assignment Adjustment Due to Eligibility	7
Total	**4,626**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
Members - CY15 3rd quarter report

MCO	Access of ofc	Avail-ability	QOC	Attitude/ Service of Staff	Lack of Info from Prov	Billing/ Fin Issues	Transp-Timely & Qual Of Svc	Prior Auth	Level of Care	Pharm	VAS	Med Proc/ Inpt Trtmt	Waiver HCBS/ Home Health	Other
AMG	0	59	28	20	0	22	13	1	0	3	5	0	4	3
SUN	1	2	21	32	1	14	28	0	3	7	4	2	3	13
UHC	0	0	63	87	0	29	11	0	0	0	0	0	0	0
Total	1	61	112	139	1	65	52	1	3	10	9	2	7	16

MCOs' Appeals Database
Members - CY15 3rd quarter report

MCO	Dental	DME	Phar-macy	OP/IP Surg/Proc	Radio-logy/Gen Tests	Specialist Physician Ofc Visit	LTSS/HCBS PCA/LTC/RTC/ TCM/CBS/MH PBS Svcs	HH/ Hospice Hrs	OT/ PT/ ST	Inpt/ Outpt Covg	Other
AMG	0	1	0	5	9	0	5	0	0	7	0
SUN	5	7	35	5	13	0	32	18	7	4	0
UHC	6	15	65	7	0	0	20	0	0	56	1
Total	11	23	100	17	22	0	57	18	7	67	1

MCOs' Appeals Database
Providers - CY15 3rd quarter report (appeals resolved)

MCO	MCO Auth	MCO Prov. Rela-tions	MCO Claim/ Billing	MCO Clin/ UM	MCO Plan Admin/ Other	MCO Quality of Care/ Service	MCO Other	Vision Claim/ Billing	Dent Auth	Dent Claim/ Billing	Transp Quality of Care/ Service
AMG	3	0	9,193	96	0	0	0	2	3	16	0
SUN	45	2	101	11	1	14	5	39	3	2	0
UHC	0	0	851	0	0	0	0	44	0	14	0
Total	48	2	10,145	107	1	14	5	85	6	32	0

State of Kansas Office of Administrative Fair Hearings

Members - CY15 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Dental Denied/ Not Covered	CT/ MRI/ X-ray Denied	Pharm Denied	DME Denied	Home Health Hours Denied	Comm Psych Support/ BH Svcs Denied	Inpt/ PT/OT Rehab Denied	LTSS/ HCBS/ WORK PCA Hrs Denied	Med Proc/ Genetic Testing Denied	Specialist Ofc Visit/ Ambulance Denied
Withdrawn								1		1
Dismissed-Moot MCO reversed decision				1				1 2	1	
Dismissed-No Adverse Action							1			
Default Dismissal-Appellant did not appear					1			3		
Dismissed-Untimely			1					2		
OAH upheld MCO decision			2		1			1 4	1	
OAH reversed MCO decision							1			

Providers - CY15 3rd quarter report

AMG-Red SUN-Green UHC-Purple	Claim Denied (Contained Errors)	Claim Denied By MCO In Error	Recoup-ment	DME Denied	Radio-logy Denied	Home Health/ Hospice/LTC Denied	PT/ST/ Rehab Denied	Inpt/Outpt/ Observation Med Proc Denied	Mental Health HCBS/ TCM Hrs Denied	Pharm/ Lab/ Genetic Testing Denied
Withdrawn		210			1			3 2		2
Dismissed-Moot MCO reversed decision		113	1 1	1 1	1	9		5 5	1 1	1
Dismissed-No internal appeal	3		1 1	1		2 1		3 2 2	3 8	1 2 1
Dismissed-No adverse action								1	1	1
Default Dismissal-Appellant did not appear						3		1		
Dismissed-Untimely						2		2 4		
OAH upheld MCO decision				1		1		2 3		
OAH reversed MCO decision	91									

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q3 of 2015, there were a total of 98 requests, which is a decrease from 123 requests in second quarter of 2015. As in previous quarters, GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers with that MCO are available within access standards. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

The good cause requests during the third quarter of 2015 were continuing due to one hospital and associated clinic withdrawing from one network during the previous quarter. The remaining requests show varied reasons and causes for changing plans. The GCR requests showed an overall downward trend from the requests at the beginning of the year through September.

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

Status	July	August	September
Total GCRs filed	32	38	28
Approved	9	5	4
Denied	13	20	11
Withdrawn (resolved, no need to change)	7	8	3
Dismissed (due to inability to contact the member)	3	5	9
Pending	0	0	1

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

KanCare MCO	# of Unique Providers as of 12/31/14	# of Unique Providers as of 3/31/15	# of Unique Providers as of 6/30/15	# of Unique Providers as of 9/30/15
Amerigroup	13,997	14,863	15,201	15,954
Sunflower	18,056	19,131	20,376	20,226
UHC	19,476	20,482	20,823	20,840

h. Proposed changes to payment rates: KanCare MCO contract Amendment 19 and Amendment 20 are pending CMS approval. Amendment 19 updates risk corridor tables effective January 1, 2015. Amendment 20 updates the capitations rates effective January 1, 2015.

i. MLTSS implementation and operation: In the third quarter, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list. As part of the effort to eliminate the PD waiting list, KDADS requested assistance from the KanCare MCOs to reach out to their members who appear to be waiting for services but have not responded to the State's access to services letter.

j. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY3. They submitted their semi-annual reports on July 31, 2015. KFMC completed a review of the hospitals' semi-annual reports and submitted it to the State. The State submitted the estimated payment portion of the semi-annual reports to CMS on September 30, 2015.

k. Information on any issues regarding the concurrent 1915(c) waivers and on any upcoming 1915(c) waiver changes (amendments, expirations, renewals):
   - 1915(c) Renewals: CMS approved Kansas' 5 years renewal requests for the FE, PD, TBI and I/DD waiver programs.
   - KDADS submitted a renewal application for the Serious Emotional Disturbance (SED) waiver program to CMS on June 30, 2015. The SED waiver was scheduled to expire on September 30, 2015, but CMS granted a 90-day temporary extension which allows the SED waiver to continue operating through December 29, 2015.

l. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met once during the third quarter, on August 21, 2015, to review the current state of KanCare and HCBS services. The committee received reports from KDHE, KDADS, the KanCare Ombudsman, each of the three KanCare MCOs, and took comments from stakeholders. The committee also received information from the Kansas Insurance Commissioner.

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by HP, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 09.30.15 is attached. Utilizing the HP-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the DY are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	Member Month			Totals
MEG	*2015-07*	*2015-08*	*2015-09*	*Grand Total*
Population 1: ABD/SD Dual	16,995	16,609	16,635	50,239
Population 2: ABD/SD Non Dual	28,619	28,525	28,437	85,581
Population 3: Adults	43,704	44,247	42,764	130,715
Population 4: Children	223,800	224,365	217,755	665,920
Population 5: DD Waiver	8,752	8,764	8,783	26,299
Population 6: LTC	21,017	21,005	20,972	62,994
Population 7: MN Dual	1,238	1,244	1,239	3,721
Population 8: MN Non Dual	1,029	1,036	1,049	3,114
Population 9: Waiver	3,903	3,941	3,930	11,774
Grand Total	**349,057**	**349,736**	**341,564**	**1,040,357**

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

VIII. Consumer Issues

Summary of consumer issues during the third quarter of 2015:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor.
Member authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to confusing communication between the providers and the MCO, leading to incorrect or incomplete authorization requests, which were subsequently denied.	. Internal procedures were adjusted for clarity and a few requirements were relaxed.
Claims denied for TPL, when no applicable policy exists.	TPL files not loaded correctly by contractor vendor. TPL calculation errors also occurred.	System correction to make sure records are loaded correctly and TPL coordination of benefits correctly calculated.
Retroactively eligible members are denied authorizations.	Members are denied authorization due to retroactive eligibility. The determination date of eligibility is not loaded by the MCOs into their systems, and they cannot determine if this determination date is before or after the authorization request date.	There are plans to utilize a field in the new eligibility system KEES when it becomes available.

Continued consumer support was conducted by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 378 consumers. OEW also assisted 2144 consumers with urgent medical needs, provided information on applications and pending/reviews due to the KanCare Clearinghouse.

During this time period, OEW staff participated in 77 community events providing KanCare program outreach, education and information. The various events included: KanCare booth at the State Fair, Back to School events, WIC clinics and Tribal Health Fairs. OEW staff also completed KEES training in preparation for and implementation at go live.

IX. Quality Assurance/Monitoring Activity

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

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

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

The State values a collaborative approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program

direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; that the necessary data to evaluate the measures are identified and accessible; and that every concern or consideration from the MCOs is heard. When that process is complete (and as it recurs over time), as determined by the State, final details are communicated and binding upon each MCO.

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

- Quarterly business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2015, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Work continued during the third quarter on the planning for the comprehensive annual compliance reviews of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. The 2015 review will address both MCO regulatory requirements and many key state contract requirements, as well as monitoring resolution of identified compliance issues found in previous audits.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs under KDADS. During the second quarter, the HCBS portion of the TA meetings focused on compliance with the HCBS Final Rule and quality assurance measures.
- MFCU monthly meetings to address fraud, waste, and abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and troubleshoot operational problems. Monitor progress through issue logs.

- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted out on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Bi-weekly Technical Assistance meetings with MCOs related to nursing facilities, transitions from institutions, HCBS programs, and behavioral health issues. These meetings allow the State and the MCOs to discuss specific topics as they arise and ensure consistency and comprehensive review of policies that impact programs administered by KDADS.
- Complex Case staffing of HCBS and Behavioral Health issues. Each MCO brings complex cases for State consideration, and the State provides technical assistance about program policies and alternatives to address identified needs. These are held biweekly and integrated the State's behavioral health and long-term supports and services teams.
- The KDADS quality improvement team met to review quality review findings and determine remediation activities. Any findings as a result of the review were addressed at the time of the review or communicated to the MCOs directly and through the Bi-weekly Technical Assistance meetings for remediation.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider types. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing:
   1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/download/KanCare_MCO_Network_Access.pdf. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
   2. HCBS Service Providers by County: http://www.kancare.ks.gov/download/HCBS_Report_Update.pdf, includes a network status table of waiver services for each MCO.

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

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:20	2.80%	145,881
Sunflower	0:20	2.08%	137,888
United	0:21	1.68%	122,469
HP – Fiscal Agent	0.00	0.20%	18,442

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:16	1.10%	73,199
Sunflower	0:12	0.90%	82,914
United	0:05	0.40%	54,426
HP – Fiscal Agent	0.00	0.01%	5,274

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 2015 is attached.

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

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

Critical Incidents	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	**283**	**148**	**176**		**629**
Pending Resolution*	**34**	**167**	**182**		**361**
Total Received	**317**	**315**	**358**		**990**

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

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The HCAIP third quarter payments were made on July 10, 2015. The LPTH/BCCH Pool third quarter payments were processed on July 9, 2015. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to the second quarter.

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

XII. Demonstration Evaluation

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

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

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

a. Claims Adjudication Statistics

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

b. Waiting List Management

PD Waiting List Management

In the quarter ending September 30, 2015, 490 individuals waiting for HCBS-PD services were offered services. Of those offers:

- 143 have accepted services
- 123 had other results (declined services, unable to contact, deceased)
- 224 have not responded

In the quarter ending September 30, 2015, 266 individuals started HCBS-PD services. Of those that started services:

- 103 individuals started services in July
- 82 individuals started services in August
- 81 individuals started services in September

The current point-in-time limit for HCBS-PD is 6,100. KDADS is currently serving approximately 5,400 individuals and offering services monthly. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 6,100 participants.

I/DD Waiting List Management

In the quarter ending September 30, 2015, no individuals waiting for HCBS-I/DD services were offered services.

In the quarter ending September 30, 2015, 163 individuals started HCBS-I/DD services. Of those that started services:

- 51 individuals started services in July
- 70 individuals started services in August
- 42 individuals started services in September

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,700 individuals. Based upon appropriations, KDADS will continue to offer services until waiver membership has reached 8,900 participants.

c. Money Follows the Person:

During the quarter ending June 30, 2015, there were 104 initial requests.

2015 Initial Request	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	YTD
Amerigroup	47	52	28		127
Sunflower	43	59	33		135
United	92	88	43		223
Total	**182**	**199**	**104**		**485**

Individuals continue to be found eligible and transition from qualifying institutions into the community on the Money Follows the Person Program. KDADS, with the help of the three Managed Care Organizations, will continue to improve the efforts to identify and follow up with the individuals who may be eligible to transition. The Sustainability Plan received approval from CMS on September 29, 2015. Prior to this date of approval, there were also a number of calls with CMS regarding the Sustainability Plan as well as ongoing National Grantee calls, MFP Peer to Peer Group Meetings, and a number of webinar series.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 09.30.15
X(e)	Summary of KanCare Ombudsman Activities for QE 09.30.15
XI	KanCare Safety Net Care Pool Reports for QE 09.30.15
XII	KFMC KanCare Evaluation Report for QE 09.30.15
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 09.30.15

XV. State Contacts

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XVI. Date Submitted to CMS

November 30, 2015

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

Quarter 3
Start Date: 7/1/2015
End Date: 9/30/2015

	Total Expenditures	Total Member-Months
Jul-15	217,412,595.61	353,101
Aug-15	226,776,745.11	351,509
Sep-15	221,759,391.22	340,982
Q3 Total	665,948,731.94	1,045,592

ADMIN SUMMARY	
	Expenditures
DY3Q3	

	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-15									
Expenditures	4,912,320.13	26,988,606.32	22,435,244.13	46,958,255.41	37,653,764.17	65,348,009.01	807,884.32	916,320.82	11,392,191.30
Member-Months	17,908	31,078	44,386	222,160	9,481	21,549	1,200	952	4,387
Aug-15									
Expenditures	3,798,473.10	30,890,790.74	25,147,455.43	48,165,959.65	38,307,743.85	66,802,997.09	650,268.96	1,381,835.19	11,631,221.10
Member-Months	16,977	28,345	45,577	224,443	8,839	21,122	1,247	1,027	3,932
Sep-15									
Expenditures	3,759,338.03	30,191,581.14	23,143,870.02	46,426,802.38	38,164,800.85	66,342,756.17	814,949.68	1,247,489.21	11,667,803.74
Member-Months	16,944	28,107	43,645	215,974	8,809	21,152	1,408	961	3,982
Q3 Total									
Expenditures	12,470,131.26	88,070,978.20	70,726,569.58	141,551,017.44	114,126,308.87	198,493,762.27	2,273,102.96	3,545,645.22	34,691,216.14
Member-Months	51,829	87,530	133,608	662,577	27,129	63,823	3,855	2,940	12,301
DY 2 - Q3 PMPM	240.60	1,006.18	529.36	213.64	4,206.80	3,110.07	589.65	1,206.00	2,820.19

Note:

1. For DY3 Member-Months are CAP + RETRO combined.
2. PCP expired at the end of DY2.
3. HEPC19 retro amounts allocated based on the quarterly HP MAR-8001-Q report [amount = meg/all megs].
4. Aug/Sep: Megs show slight decreases in Members due to recent KEES implementation. There are slight increases in some of the expenditures due to the accurately distributed HEP C Case rate.

KanCare Ombudsman Quarterly Report

For KDHE

Kerrie J. Bacon, KanCare Ombudsman
3rd Quarter, 2015

Accessibility

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) through the phone, email, letters and in person during the third quarter of 2015. There were 579 contacts through these various means, 187 of which were related to an MCO issue (32.3%). Third quarter had a small increase in contacts compared to the third quarter last year and a significant increase compared to second quarter.

3rd Qtr. Contacts	
July	175
August	199
September	205
Total	**579**

MCO related	
Amerigroup	63
Sunflower	72
United Health	52
Total	**187**

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579		

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

Outreach

- Attended the National Council on Disability Forum – July 7, 2015
- Attended the Conference on Poverty and provided information to consumers and vendors regarding the KanCare Ombudsman – July 15-17, 2015
- Provided outreach to the Kansas Statewide Homeless Coalition at their August 5, 2015 meeting.
- Attended the Disability Caucus and provided information to consumers and vendors regarding the KanCare Ombudsman – August 13-14, 2015
- Provided information and outreach to the Robert G. Bethell Joint Committee on HCBS and KanCare Oversight Committee – August 21, 2015
- Provided outreach to public through attendance at two listening sessions on the changes to the HCBS waiver (Universal waiver) – Wichita and Garden City – August 26-27, 2015
- Provided outreach to public through attendance at the Kansas Rehabilitation public listening session – September 28, 2015
- The Ombudsman's office sponsors the KanCare (I/DD) Friends and Family Advisory Council which met two times during third quarter.
- Hosted the KanCare Member Lunch-and-Learn bi-weekly conference calls for all KanCare members, parents, guardians and other consumers. Calls address topics of interest, resources in the community, emerging issues and includes a question and answer time. Managed care organizations continue to participate on the calls and answer questions as needed.

KanCare Ombudsman Volunteer Program Update

- Wichita volunteer training in progress. The training included 3 days of on-line training with pre and post testing, 2 days of in person training that included case studies and practice. Once the program begins, there will be three weeks of in-person mentoring by the Ombudsman and the Program Coordinator to ensure all volunteers are comfortable, prepared and ready to receive and answer calls from the public.
- "Go live" in Wichita – November 11th
- Kansas City and Johnson County locations confirmed and continuing to recruiting volunteers
    - Will begin training after the holidays

Volunteer Applications available on the KanCare Ombudsman webpage.
www.KanCare.ks.gov/ombudsman.htm

Data

Contact Method	
phone	462
email	112
letter	0
in person	5
online	0
Total	**579**

Caller Type	
Provider	102
Consumer	426
MCO employee	5
Other	46
Total	**579**

Consumer Sub-Caller Type	
HCBS Related	74
Long Term Care	29
Other	476
Total	**579**

Contact Information for 3rd Qtr. The average number of days to resolve an issue was 11 days. There is usually a correlation between the average number of days to resolve

	Qtr. 3 2014	Qtr. 4 2014	Qtr. 1 2015	Qtr. 2 2015	Qtr. 3 2015
Avg. Days to Resolve Issue	9	7	6	7	11
% files resolved in one day or less	47%	56%	54%	38%	36%
% files closed	86%	82%	85%	88%	92.6%

There are 20 issue categories. The top five concerns for 3rd quarter are Medicaid Eligibility, Other, HCBS General Issues, Appeals/Grievances and Billing.

Issue Category	**total**
Medicaid Eligibility Issues	206
Other	141
HCBS General Issues	54
Appeals / Grievances	47
Billing	41
Nursing Facility Issues	34
Medical Services	27
HCBS Eligibility issues	24
Unspecified	24
Pharmacy	14
HCBS Reduction in hours of service	13
(not identified)	12
Thank you.	11
Change MCO	10
Care Coordinator Issues	9
HCBS Waiting List	9
Transportation	8
Durable Medical Equipment	7
Housing Issues	4
Guardianship	2
Access to Providers (usually Medical)	1
Dental	1
Questions for Conference Calls/Sessions	0
Total	**699**

The Issue Categories below are listed for the last seven quarters in alphabetical order. The only numbers of note are the medicaid eligibility number jumped significantly in third quarter and the total number of issues also increased significantly. During third quarter the Medicaid eligibility information system (KEES) was implemented and the medicaid application process slowed down, then got behind and caused an increase in phone calls. I forwarded more serious issues to the Clearinghouse Manager and provided medical assistance resources for people while they were waiting for results/answers on medicaid applications. I also received overflow calls from Department of Children and Families (DCF). During this time the Ombudsman's office worked closely with both DCF Supervisors and the Clearinghouse Eligibility Manager to review prioritized cases.

Issues	**Q1/14**	**Q2/14**	**Q3/14**	**Q4/14**	**Q1/15**	**Q2/15**	**Q3/15**
Access to Providers	16	16	6	15	3	11	1
Appeals, Grievances	22	22	46	46	42	33	47
Billing	51	33	40	42	36	40	41
Care Coordinators	10	9	18	14	10	8	9
Change MCO	6	11	10	9	8	4	10
Dental	16	15	8	9	7	5	1
Durable Medical Equipment	25	35	25	8	25	12	7
Guardianship Issues	16	3	1	2	5	1	2
HCBS Eligibility issues	55	14	10	11	11	15	24
HCBS General Issues	11	25	45	49	60	36	54
HCBS Reduction in hours of service	22	11	15	8	10	8	13
HCBS Waiting List issues	3	8	19	7	11	8	9
Housing issues	3	8	12	10	1	6	4
Medicaid Eligibility Issues	81	73	90	194	139	108	206
Medicaid Service Issues	14	31	41	70	20	24	27
Nursing Facility Issues	8	12	16	24	15	34	34
Pharmacy	38	15	20	19	25	33	14
Questions for Conf. Calls/sessions	13	5	15	2	5	2	0
Transportation	11	8	18	13	12	17	8
Other	49	75	103	112	130	150	141
Unspecified	73	44	33	27	31	12	36
Thank you	2	1	10	13	14	15	11
Total	**545**	**474**	**600**	**704**	**620**	**582**	**699**

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

Resource Category	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15
QUESTION/ISSUE RESOLVED	118	81	84	61	65
USED RESOURCES/ISSUE RESOLVED	177	260	262	234	321
KDHE RESOURCES	107	87	95	77	124
DCF RESOURCES	22	15	20	13	25
MCO RESOURCES	98	55	79	73	48
HCBS TEAM	57	33	32	43	36
CSP MH TEAM	2	0	0	1	0
OTHER KDADS RESOURCES	38	17	31	31	38
PROVIDED RESOURCES TO MEMBER	23	20	85	108	177
REFERRED TO STATE/COMMUNITY AGENCY	20	18	22	54	75
REFERRED TO DRC AND/OR KLS	27	9	26	16	19
CLOSED	55	18	14	29	60
Total	**744**	**613**	**750**	**740**	**988**

Waiver	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15
PD	43	29	57	48	33
I/DD	42	36	35	25	29
FE	16	11	15	12	16
AUTISM	4	1	4	3	4
SED	5	4	1	7	5
TBI	19	10	10	9	7
TA	8	15	11	13	11
MFP	6	4	2	2	3
PACE	0	1	0	0	1
MENTAL HEALTH	4	10	5	9	7
BEHAVIOR HEALTH	0	0	0	0	0
NURSING FACILITY	10	25	12	28	33
Total	**157**	**146**	**152**	**156**	**149**

Issues Category by MCO by Quarter

Although the Ombudsman total issues increased for third quarter, the MCO total issues remained relatively the same or decreased for third quarter.

Amerigroup

Issue Category - Amerigroup	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15
Access to Providers (usually Medical)	6	3	6	0	1	0
Appeals / Grievances	3	3	4	3	9	5
Billing	7	11	7	10	12	7
Care Coordinator Issues	0	4	3	1	3	3
Change MCO	3	0	2	2	1	4
Dental	5	2	4	2	0	0
Durable Medical Equipment	11	9	4	2	2	0
Guardianship	0	0	0	1	0	0
HCBS Eligibility issues	3	2	3	0	2	9
HCBS General Issues	4	13	9	14	12	12
HCBS Reduction in hours of service	2	2	2	0	0	5
HCBS Waiting List	1	4	1	2	2	3
Housing Issues	2	0	2	0	1	1
Medicaid Eligibility Issues	3	9	13	9	4	10
Medical Services	3	5	15	1	4	2
Nursing Facility Issues	0	2	5	2	1	5
Pharmacy	5	3	2	1	4	2
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Transportation	3	6	2	1	7	4
Other	10	6	11	10	20	11
Thank you.	0	1	1	0	0	1
Unspecified	2	2	0	2	0	5
Total	**73**	**87**	**96**	**63**	**85**	**89**

Sunflower

Issue Category - Sunflower	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15
Access to Providers (usually Medical)	0	1	5	0	3	0
Appeals / Grievances	12	31	30	22	15	18
Billing	7	10	13	13	11	9
Care Coordinator Issues	6	13	8	2	3	3
Change MCO	5	6	5	3	1	3
Dental	5	0	2	1	3	0
Durable Medical Equipment	10	13	4	10	7	1
Guardianship	2	0	0	0	0	1
HCBS Eligibility issues	4	3	4	2	6	1
HCBS General Issues	5	13	10	22	9	10
HCBS Reduction in hours of service	3	7	3	4	4	4
HCBS Waiting List	3	2	0	0	0	2
Housing Issues	0	3	4	0	2	0
Medicaid Eligibility Issues	1	9	16	17	16	13
Medical Services	16	20	15	5	7	7
Nursing Facility Issues	0	1	1	3	3	3
Pharmacy	4	11	5	7	16	5
Questions for Conference Calls/Sessions	0	0	1	1	0	0
Transportation	2	5	4	3	4	1
Other	6	11	13	14	19	14
Thank you.	0	3	1	4	3	5
Unspecified	2	10	3	3	0	1
Total	**93**	**172**	**147**	**136**	**132**	**101**

United

Issue Category - United	Q2/14	Q3/14	Q4/14	Q1/15	Q2/15	Q3/15
Access to Providers (usually Medical)	4	0	2	2	4	1
Appeals / Grievances	4	5	7	11	3	6
Billing	6	8	6	5	5	7
Care Coordinator Issues	2	0	3	5	2	2
Change MCO	2	3	1	2	1	1
Dental	0	2	0	2	1	0
Durable Medical Equipment	7	2	0	6	1	2
Guardianship	0	0	1	1	0	0
HCBS Eligibility issues	0	0	3	3	1	4
HCBS General Issues	3	8	13	11	6	7
HCBS Reduction in hours of service	3	3	1	4	2	2
HCBS Waiting List	1	1	1	3	0	1
Housing Issues	1	3	2	0	2	1
Medicaid Eligibility Issues	1	4	10	11	8	10
Medical Services	3	7	9	6	4	6
Nursing Facility Issues	0	0	2	4	4	4
Pharmacy	3	3	4	8	6	2
Questions for Conference Calls/Sessions	0	0	0	1	0	0
Transportation	2	1	3	5	3	2
Other	4	5	9	16	11	10
Thank you.	0	0	1	2	1	0
Unspecified	0	0	0	0	0	2
Total	**46**	**55**	**78**	**108**	**65**	**70**

Next Steps for Ombudsman's office

The Ombudsman's office will be setting up the Kansas City and Johnson County volunteer program during 4th quarter. The locations are confirmed. Getting the number of volunteers needed for both sites is the next goal. We are currently marketing in several places to encourage potential volunteers to consider sharing their time with this exciting venture.

The KanCare Ombudsman Volunteer Program is designed to help serve KanCare members in resolving problems regarding their services, coverage, access and rights. All volunteers are asked to complete an application, background check and interview. Accepted volunteers complete online and in-person training modules. They are tested before their training and after for their competency on the following subjects:

- Processes – applications, benefits, and claims
- Resources for beneficiaries
- Handling of calls and levels of inquiries
- Appeals, state fair hearings, and grievances
- Practice cases and case studies

For an application, go to www.KanCare.ks.gov/ombudsman.htm

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 3 - QE September 2015

Health Care Access Improvement Pool

Paid 07/09/2015

Hospital Name	HCAIP DY/QTR: 2015/3	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	37,282.00	16,169.20	21,112.80
Children's Mercy Hospital South	171,877.00	74,543.05	97,333.95
Coffeyville Regional Medical Center, Inc.	54,719.00	23,731.63	30,987.37
Cushing Memorial Hospital	125,795.00	54,557.29	71,237.71
Geary Community Hospital	102,050.00	44,259.09	57,790.92
Hays Medical Center, Inc.	303,530.00	131,640.96	171,889.04
Hutchinson Hospital Corporation	144,337.00	62,598.96	81,738.04
Kansas Medical Center LLC	9,979.00	4,327.89	5,651.11
Kansas Rehabilitation Hospital	6,029.00	2,614.78	3,414.22
Labette County Medical Center	67,939.00	29,465.14	38,473.86
Lawrence Memorial Hospital	261,196.00	113,280.71	147,915.29
Marillac Center INC	984.00	426.76	557.24
Memorial Hospital, Inc.	32,179.00	13,956.03	18,222.97
Menorah Medical Center	183,128.00	79,422.61	103,705.39
Mercy - Independence	54,410.00	23,597.62	30,812.38
Mercy Health Center - Ft. Scott	83,544.00	36,233.03	47,310.97
Mercy Hospital, Inc.	5,714.00	2,478.16	3,235.84
Mercy Reg Health Ctr	172,051.00	74,618.52	97,432.48
Miami County Medical Center	51,943.00	22,527.68	29,415.32
Morton County Health System	21,048.00	9,128.52	11,919.48
Mt. Carmel Medical Center	237,327.00	102,928.72	134,398.28
Newton Medical Center	112,572.00	48,822.48	63,749.52
Olathe Medical Center	211,433.00	91,698.49	119,734.51
Overland Park Regional Medical Ctr.	612,193.00	265,508.10	346,684.90
Prairie View Inc.	21,821.00	9,463.77	12,357.23
Pratt Regional Medical Center	47,528.00	20,612.89	26,915.11
Providence Medical Center	520,646.00	225,804.17	294,841.83
Ransom Memorial Hospital	69,979.00	30,349.89	39,629.11
Saint Luke's South Hospital, Inc.	96,888.00	42,020.33	54,867.67
Salina Regional Health Center	330,558.00	143,363.00	187,195.00
Salina Surgical Hospital	3,054.00	1,324.52	1,729.48
Shawnee Mission Medical Center, Inc.	645,390.00	279,905.64	365,484.36
South Central KS Reg Medical Ctr	54,707.00	23,726.43	30,980.57
Southwest Medical Center	121,323.00	52,617.79	68,705.21
SSH - Kansas City	1,270.00	550.80	719.20
St. Catherine Hospital	182,837.00	79,296.41	103,540.59
St. Francis Health Center	319,953.00	138,763.62	181,189.38
St. John Hospital	99,168.00	43,009.16	56,158.84
Stormont Vail Regional Health Center	962,766.00	417,551.61	545,214.39
Sumner Regional Medical Center	36,540.00	15,847.40	20,692.60
Surgical & Diag. Ctr. of Great Bend	175,913.00	76,293.47	99,619.53
Susan B. Allen Memorial Hospital	100,791.00	43,713.06	57,077.94
Via Christi Hospital St Teresa	92,801.00	40,247.79	52,553.21
Via Christi Regional Medical Center	1,604,021.00	695,663.91	908,357.09
Via Christi Rehabilitation Center	32,574.00	14,127.34	18,446.66
Wesley Medical Center	1,469,757.00	637,433.61	832,323.39
Western Plains Medical Complex	115,685.00	50,172.58	65,512.42
	10,169,229.00	**4,410,394.62**	**5,758,834.38**

Safety Net Care Pool Report

Demonstration Year 3 - QE September 2015

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

Paid 07/09/2015

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

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

2015 KanCare Evaluation Quarterly Report
Year 3, Quarter 3, July – September 2015
November 17, 2015

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) on 8/24/2013, and it was approved on 9/11/2013. The Kansas Foundation for Medical Care, Inc. (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

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

A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the third quarter (Q3) CY2015 report include the following:

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

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

In CY2015, the KanCare Reporting System Automation Project was launched. This system provides central access for MCOs to upload KanCare reports. Reports are categorized as being approved or under review. State staff, MCOs, and the EQRO are able to provide comments and receive email confirmation when new reports or revised versions of reports are uploaded. For the KanCare Evaluation process, this has allowed timely access to reports and has greatly streamlined the reporting and review process.

Recommendations from the quarterly and annual KanCare Evaluation reports are also discussion items at quarterly 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 two business days of inquiry receipt, 98% of all inquiries within five business days, and 100% of all inquiries within 15 business days.

Data Sources

The data sources for the Q3 CY2015 KanCare Quarterly Evaluation Report are monthly call center customer service reports MCOs submit to KDHE. In these reports, MCOs report the monthly counts, cumulative counts, and percentages of member and provider inquiries resolved within two, five, eight, 15, and greater than 15 days, as well as the percentage of inquiries pending at month's end. The call center reports also provide counts of customer service inquiries by inquiry type from members and providers each month.

Current Quarter and Trend over Time

In Q3 CY2015, 99.997% of the customer service inquiries received by the MCOs were resolved within two business days (see Table 1).

Table 1. Timeliness of Resolution of Customer Service Inquiries

	CY2015			Year-to-Date (Q1 to Q3)		
	Q1	Q2	Q3	CY2013	CY2014	CY2015
Number of Inquiries Received	152,412	144,336	**144,372**	418,562	600,260	441,120
Number of Inquiries Resolved Within 2 Business Days	152,407	144,329	**144,367**	418,151	598,947	441,103
Number of Inquiries Not Resolved Within 2 Business Days	5	7	**5**	407	1,184	17
Percent of Inquiries Resolved Within 2 Business Days	99.997%	99.995%	**99.997%**	99.902%	99.781%	99.996%
Number of Inquiries Resolved Within 5 Business Days	152,412	144,336	**144,372**	418,522	600,171	441,120
Number of Inquiries Not Resolved Within 5 Business Days	0	0	**0**	40	89	0
Percent of Inquiries Resolved Within 5 Business Days	100%	100%	**100%**	99.990%	99.985%	100%
Number of Inquiries Resolved Within 15 Business Days	152,412	144,336	**144,372**	418,562	600,260	441,120
Number of Inquiries Not Resolved Within 15 Business Days	0	0	**0**	0	0	0
Percent of Inquiries Resolved Within 15 Business Days	100%	100%	**100%**	100%	100%	100%

The five inquiries not resolved within two business days were resolved within five business days. The inquiries not resolved within two business days were from members; all provider inquiries were identified as resolved within two business days. During each quarter to date the two-day resolution rate exceeded 99.7%; and, for the past three quarters the two-day resolution rate has exceeded 99.99%.

Member customer service inquiries

The MCOs categorize member customer service inquiries in their monthly call center reports by 18 service inquiry categories (see Table 2). Sunflower added a category for Health Homes; the 177 grievances reported in Q3 CY2015 as "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

Table 2. Customer Service Inquiries by Member, Quarter 2 CY2014 to Quarter 3 CY2015

	CY2014						CY2015					
	Q2		Q3		Q4		Q1		Q2		Q3	
Member Inquiries	#	%	#	%	#	%	#	%	#	%	#	%
1. Benefit Inquiry – regular or VAS	17,373	21.8%	18,025	20.1%	15,799	21.3%	20,775	20.1%	19,702	20.2%	18,611	18.8%
2. Concern with access to service or care; or concern with service or care disruption	1,729	2.2%	2,242	2.5%	1,617	2.2%	2,059	2.0%	1,754	1.8%	1,691	1.7%
3. Care management or health plan program	2,248	2.8%	2,363	2.6%	2,797	3.8%	2,309	2.2%	2,976	3.0%	3,008	3.0%
4. Claim or billing question	6,626	8.3%	6,193	6.9%	5,490	7.4%	7,107	6.9%	6,983	7.2%	7,383	7.5%
5. Coordination of benefits	1,494	1.9%	2,278	2.5%	2,252	3.0%	3,437	3.3%	3,079	3.2%	3,030	3.1%
6. Disenrollment request	448	0.6%	507	0.6%	484	0.7%	632	0.6%	561	0.6%	634	0.6%
7. Eligibility inquiry	8,336	10.5%	11,066	12.3%	9,462	12.8%	13,330	12.9%	12,750	13.1%	15,214	15.4%
8. Enrollment information	1,830	2.3%	2,417	2.7%	2,220	3.0%	2,141	2.1%	2,210	2.3%	2,838	2.9%
9. Find/change PCP	11,619	14.6%	12,509	13.9%	9,818	13.2%	15,586	15.1%	13,407	13.7%	12,823	13.0%
10. Find a specialist	3,037	3.8%	3,905	4.4%	2,634	3.6%	4,070	3.9%	3,875	4.0%	3,835	3.9%
11. Assistance with scheduling an appointment	89	0.1%	61	0.1%	43	0.1%	46	0.04%	36	0.0%	26	0.0%
12. Need transportation	1,798	2.3%	1,621	1.8%	1,571	2.1%	1,812	1.8%	1,789	1.8%	1,402	1.4%
13. Order ID card	6,406	8.0%	7,087	7.9%	5,372	7.2%	7,653	7.4%	6,348	6.5%	6,240	6.3%
14. Question about letter or outbound call	1,003	1.3%	675	0.8%	701	0.9%	1,013	1.0%	898	0.9%	1,175	1.2%
15. Request member materials	1,197	1.5%	1,059	1.2%	1,188	1.6%	1,080	1.0%	1,112	1.1%	1,511	1.5%
16. Update demographic information	9,526	12.0%	11,494	12.8%	7,481	10.1%	13,404	13.0%	12,639	13.0%	13,481	13.6%
17. Member emergent or crisis call	900	1.1%	1,293	1.4%	628	0.8%	938	0.9%	834	0.9%	717	0.7%
18. Other	3,923	4.9%	4,887	5.4%	4,562	6.2%	5,768	5.6%	6,641	6.8%	5,388	5.4%
Total	79,582		89,682		74,119		103,160		97,594		99,007	

- Of the 99,007 member calls in Q3 CY2015, 46.5% were received by Sunflower, 34.1% by UnitedHealthcare, and 19.4% by Amerigroup.
- In Q3 CY2015 and the two previous quarters, member customer service inquiries were higher than in each quarter of CY2014.
- Benefit inquiries continue in Q3 to be the highest percentage (18.8%) of member inquiries.
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO in the last four quarterly reports include:
  - "Member emergent or crisis call" – 99.4% of 717 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 99.8%; Q1 CY2015 – 99.7%; Q4 CY2014 – 99.7%)

- "Update demographic information" – 82.1% of 13,481 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 82.3%; Q1 CY2015 – 82.1%; Q4 CY2014 - 71.0%)
- "Enrollment information" – 76.8% of 2,838 inquiries were reported in Q3 CY2015 by Amerigroup. (Q2 CY2015 - 76.4%; Q1 CY2015 - 76.6%; Q4 CY2014 - 80.5%)
- "Need transportation" – 73.7% of 1,402 inquiries were reported in Q3 CY2015 by Amerigroup. (Q2 CY2015 - 67.2%; Q1 CY2015 - 75.8%; Q4 CY2014 - 80.8%)

Provider customer service inquiries

The MCOs categorize provider customer service inquiries in their monthly call center reports by 17 provider service inquiry categories (see Table 3). Sunflower added a category for provider inquiries related to Health Homes; the 19 grievances reported in Q3 CY2015 as "Health Homes" were added to the "Other" category for consistency in reporting aggregated counts and percentages for the three MCOs.

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

	CY2014						CY2015					
	Q2		Q3		Q4		Q1		Q2		Q3	
Provider Inquiries	#	%	#	%	#	%	#	%	%	#	#	%
1. Authorization – New	2,149	4.0%	1,968	3.7%	1,841	3.9%	2,351	4.8%	2,369	5.1%	1,880	4.1%
2. Authorization – Status	3,649	6.8%	2,961	5.6%	2,306	4.8%	2,456	5.0%	2,417	5.2%	2,323	5.1%
3. Benefits inquiry	5,071	9.4%	4,261	8.0%	4,256	8.9%	4,594	9.3%	4,144	8.9%	4,043	8.9%
4. Claim denial inquiry	4,843	9.0%	5,256	9.9%	4,760	10.0%	5,182	10.5%	3,990	8.5%	5,498	12.1%
5. Claim status inquiry	18,401	34.1%	18,822	35.3%	18,284	38.3%	19,457	39.5%	21,314	45.6%	19,898	43.9%
6. Claim payment question/dispute	6,829	12.6%	7,093	13.3%	6,355	13.3%	6,822	13.9%	6,005	12.8%	5,315	11.7%
7. Billing inquiry	365	0.7%	326	0.6%	552	1.2%	851	1.7%	436	0.9%	363	0.8%
8. Coordination of benefits	1,012	1.9%	1,099	2.1%	1,095	2.3%	1,167	2.4%	939	2.0%	792	1.7%
9. Member eligibility inquiry	2,085	3.9%	1,986	3.7%	1,652	3.5%	1,866	3.8%	1,804	3.9%	1,935	4.3%
10. Recoupment or negative balance	140	0.3%	150	0.3%	162	0.3%	353	0.7%	243	0.5%	165	0.4%
11. Pharmacy/prescription inquiry	505	0.9%	542	1.0%	568	1.2%	599	1.2%	599	1.3%	438	1.0%
12. Request provider materials	41	0.1%	40	0.1%	28	0.1%	31	0.1%	62	0.1%	62	0.1%
13. Update demographic information	6,181	11.4%	6,764	12.7%	4,093	8.6%	538	1.1%	418	0.9%	764	1.7%
14. Verify/change participation status	416	0.8%	284	0.5%	226	0.5%	272	0.6%	282	0.6%	441	1.0%
15. Web support	508	0.9%	284	0.5%	183	0.4%	197	0.4%	209	0.4%	252	0.6%
16. Credentialing issues	285	0.5%	177	0.3%	90	0.2%	163	0.3%	239	0.5%	208	0.5%
17. Other	1,508	2.8%	1,333	2.5%	1,287	2.7%	2,353	4.8%	1,270	2.7%	988	2.2%
Total	53,988		53,346		47,738		49,252		46,742		45,365	

- Provider inquiries again decreased this quarter; 1,377 fewer provider inquiries were in received in Q3 CY2015 compared to Q2 CY2015, and 7,981 fewer compared to Q3 CY2014.
- Of the 45,365 provider inquiries received by MCOs in Q3 CY2015, Amerigroup received 37.4%, Sunflower 34.0%, and UnitedHealthcare 28.6%.
- For providers, claim status inquiries were again the highest percentage (43.9%) of the 45,365 provider calls. The three claims-related categories ("Claim denial inquiry," "Claim status inquiry," and "Claim payment question/dispute") together accounted for 67.7% of the provider inquiries in Q3 CY2015.

- Categories where two thirds or more of the provider inquiries in Q3 and previous quarters were reported by one MCO included:
  - "Authorization – New" – 98.0% of 1,898 inquiries in Q3 CY2015 were reported by Amerigroup. (Q2 CY2015 – 99.1%; Q1 CY2015 – 99.1%; Q4 CY2014 – 98.1%)
  - "Update demographic information" – 96.2% of 746 inquiries were reported in Q3 CY2015 by Sunflower. (Q2 CY2015 - 91.4%; Q1 CY2015 - 95.5%; Q4 CY2014 - 99.5%)
  - "Coordination of benefits" – 85.5% of 792 inquiries were reported in Q3 CY2015 by UnitedHealthcare. (Q2 CY2015 - 76.8%; Q1 CY2015 - 90.7%; Q4 CY2014 - 91.0%)
  - "Verify/Change participation status" – 77.8% of 441 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 68.1%; Q1 CY2015 - 67.6%; Q4 CY2014 - 66.4%)
  - "Recoupment or negative balance" – 75.2% of 165 inquiries in Q3 CY2015 were reported by UnitedHealthcare. (Q2 CY2015 - 76.8%; Q1 CY2015 - 94.3%; Q4 CY2014 - 78.5%)
  - Authorization – Status" – 67.4% of 2,323 inquiries in Q3 CY2015 were reported by Amerigroup. (Q2 CY2015 - 71.0%; Q1 CY2015 - 70.8%; Q4 CY2014 - 72.0%)

Recommendations

The State should work with the MCOs to develop consistent criteria for classifying the member and provider customer service inquiries. Categories where over two-thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:

- Member customer service inquiries: "Update demographic information," "Member emergent or crisis call," "Enrollment information," and "Need transportation."
- Provider customer service inquiries: "Authorization – New," "Update demographic information," "Coordination of benefits," "Recoupment or negative balance," "Authorization – Status," and "Verify/Change participation status."

Timeliness of Claims Processing

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." In Table 4, the numbers of excluded claims in CY 2014 and CY2015 Q1 and Q2 are listed for each of the claim categories – Clean Claims, Non-Clean Claims, and All Claims.

To allow for claims lag, the KanCare Evaluation Report for Q3 assesses timeliness of processing clean, non-clean, and all claims reports received through Q2 CY2015.

Table 4 . Timeliness of Claims Processing, Quarter 1 CY2014 to Quarter 2 CY2015

	CY2014				CY2015	
Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of clean claims received in quarter	3,916,708	4,172,590	4,118,292	4,293,014	4,289,335	4,289,875
Number of claims excluded	29	47	18	2	0	149
Number of clean claims not excluded	3,916,679	4,172,543	4,118,274	4,293,012	4,289,335	4,289,726
Number of clean claims received within quarter processed within 30 days	3,914,870	4,170,436	4,116,668	4,288,088	4,288,566	4,285,952
Number of clean claims received within quarter not processed within 30 days	1,809	2,107	1,606	4,924	769	3,774
Percent of clean claims processed within 30 days	99.950%	99.950%	99.961%	99.885%	99.982%	99.912%
Non-Clean Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of non-clean claims received in quarter	137,570	178,534	140,895	174,130	128,497	109,977
Number of claims excluded	375	337	317	376	363	295
Number of non-claims not excluded	137,195	178,197	140,578	173,754	128,134	109,682
Number of non-clean claims received within quarter processed within 60 days	137,089	178,062	140,502	173,678	128,104	109,632
Number of non-clean claims not processed within 60 days	106	135	76	76	30	50
Percent of non-clean claims processed within 60 days	99.920%	99.924%	99.946%	99.956%	99.977%	99.954%
All Claims	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Number of claims received in quarter	4,054,278	4,351,124	4,259,187	4,467,144	4,417,832	4,399,852
Number of claims excluded	404	384	335	378	363	444
Number of claims not excluded	4,053,874	4,350,740	4,258,852	4,466,766	4,417,469	4,399,408
Number of claims received within quarter processed within 90 days	4,053,746	4,350,651	4,258,729	4,466,651	4,417,389	4,399,090
Number of claims not processed within 90 days	128	89	123	115	80	317
Percent of claims processed within 90 days	99.997%	99.998%	99.997%	99.997%	99.998%	99.993%

Data Sources

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

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

Timeliness of Claims Processing by Claim Type and Date Received

The MCOs are contractually required to process 100% of clean claims within 30 days; 99% of non-clean claims within 60 days; and 100% of all claims within 90 days. In Table 4, the number and percentages of clean, non-clean, and all claims processed within these contractual time periods are summarized.

Numbers and percentages reported in previous quarterly reports are revised somewhat due at times to delays in MCOs receiving vendor claims for a particular month. Amerigroup and UnitedHealthcare have made only a few revisions and have provided explanations for each change. In each monthly report submitted by Sunflower in 2015, however, minor revisions are reported for data reported for each prior month. Additional explanations for these revisions should be provided to better determine reasons for revisions of data for claims received up to nine months earlier.

For claims received in Q2 CY2015:

- Clean claims: 99.912% of 4,289,726 clean claims received in Q2 CY2015 were reported by the MCOs as processed within 30 days.
  - In Q2 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - In Q2 CY2015, the percentage of clean claims not processed within 30 days was higher than in each of the five preceding quarters. In Q2 3,774 clean claims were not processed within 30 days; in Q1 CY2015, only 769 clean claims were not processed within 30 days.
  - Of the 3,774 clean claims not processed within 30 days – 3,367 (89.2%) were claims received by Sunflower; 383 (10.1%) were claims received by Amerigroup; and 24 (0.6%) were claims received by UnitedHealthcare.
- Non-clean claims: 99.954% of 109,682 non-clean claims received in Q2 CY2015 were reported by the MCOs as processed within 60 days.
  - In Q2 CY2015, all of the MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - In Q2 CY2015, the numbers and percentages of non-clean claims not processed within 60 days were lower than in each of the four preceding quarters.
  - Of the 50 “non-clean claims” not processed within 60 days – 25 (50%) were claims received by Sunflower; 23 (46%) were claims received by Amerigroup; and 2 (4%) were claims received by UnitedHealthcare.
- All claims: 99.993% of 4,399,407 “all claims” received in Q2 CY2015 were reported by the MCOs as processed within 90 days.
  - In Q2 CY2015, none of the MCOs met the requirement of processing 100% of claims within 90 days.
  - Of the 317 claims not processed within 90 days – 197 (62.1%) were claims received by Amerigroup; 118 (37.2%) were claims received by Sunflower; and 2 (0.6%) were claims received by UnitedHealthcare.
  - In Q2 CY2015, the numbers and percentages of “all claims” not processed within 90 days were higher than in each of the four preceding quarters. In the previous five

quarters, the number of claims not processed within 90 days ranged from 89 to 128, compared to 317 in Q2 CY2015.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 5, the MCOs reported 4,428,767 clean claims processed in Q3 CY2015 (includes claims received prior to Q3). Excluding pharmacy claims (which are processed same day) there were 2,245 more claims processed in Q3 compared to Q2. Comparing year-to-date (YTD), there were 1,571,192 more clean claims (excluding pharmacy claims) processed in Q1-Q3 CY2015 compared to Q1-Q3 CY2014.

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

	CY2015 Quarterly Average TAT Monthly Ranges and Number of Clean Claims			Year-to-Date (Quarter 1 to Quarter 3) CY2014 and CY2015			
	Q1	Q2	Q3	CY2014		CY2015	
	Average TAT Monthly Ranges	Average TAT Monthly Ranges	Average TAT Monthly Ranges	Claims Processed	Average TAT Monthly Ranges	Claims Processed	Average TAT Monthly Ranges
Hospital Inpatient	6.4 to 15.9	8.1 to 13.7	**8.7 to 14.1**	84,869	5 to 19.2	76,828	6.4 to 15.9
Hospital Outpatient	3.5 to 10.8	4.8 to 10.5	**4.8 to 9.7**	739,235	3.6 to 12.8	732,951	3.5 to 10.8
Pharmacy	same day	same day	**same day**	3,561,856	same day	5,093,807	same day
Dental	4 to 13.1	4 to 13	**9.0 to 13**	309,493	2 to 21	315,602	4 to 13.1
Vision	10 to 12.1	9 to 11.9	**9.0 to 12.5**	201,099	7 to 12.5	174,411	9 to 12.5
Non-Emergency Transportation	10.7 to 15	10.4 to 14	**10.4 to 16.0**	344,265	10.9 to 18	346,547	10.4 to 16
Medical (Physical health not otherwise specified)	3.4 to 10.5	4.4 to 10.0	**4.9 to 8.7**	4,228,897	3.3 to 10.6	4,357,760	3.4 to 10.5
Nursing Facilities	4.2 to 9.7	5.6 to 8.1	**4.1 to 7.7**	302,945	4.3 to 11.5	250,724	4.1 to 9.7
HCBS	4.1 to 8.7	5.4 to 10.2	**5.4 to 8.5**	977,117	3.2 to 15.6	812,146	4.1 to 10.2
Behavioral Health	2.7 to 9.4	4.2 to 10.5	**4.9 to 9.1**	1,060,772	3.4 to 8.6	1,220,964	2.7 to 10.5
Total Claims (Excluding Pharmacy)	2,786,196	2,746,476	**2,755,261**	8,248,692		8,287,933	
Average TAT (Excluding Pharmacy)	**4.3 to 10.3**	**5.3 to 10.2**	**5.8 to 9.1**		**6 to 11.5**		**4.3 to 10.3**

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

While the average time to process clean claims averaged less than two weeks for all services, the average monthly TAT for processing clean claims has changed only slightly over this past year for most of the services. The average TAT for Total Services (excluding pharmacy claims processed same day) was 5.8 to 9.1 days in Q3 CY2015 compared to 5.3 to 10.2 days in Q2 CY2015.

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

- Pharmacy - Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
- Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 10.4 to 16 days in Q3 CY2015.
- Vision – The average TATs were consistently a week or longer in Q3 and previous quarters for all of the MCOs. In Q3 CY2015, the average monthly TATs ranged from 9 to 12.5 days.
- Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 9 to 13 days in Q3 CY2015 for each of the MCOs.
- Hospital Inpatient – Hospital Inpatient claims had TATs in Q3 CY2015 ranging from 8.7 to 14.1 days.

In Q3 CY2015 (and in the two previous quarters), UnitedHealthcare had higher average monthly TATs than Amerigroup and Sunflower for Hospital Inpatient, Hospital Outpatient, Medical, Nursing Facilities, HCBS, and Behavioral Health claims. In Q3 CY2015 and (and in the two previous quarters), Amerigroup had lower average monthly TATs for Vision claims. In Q3 CY2015 (and the previous quarter) Sunflower had lower average monthly TATs for Dental and HCBS services.

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

Recommendations

- Sunflower should make concerted efforts to improve processes to increase the number and percentage of clean claims processed within 30 days.
- Related to monthly reporting of contractual requirements for processing claims, additional explanations should be provided in monthly reports when changes are made to data reported in earlier months.
- MCOs should continue to work to reduce the turnaround times for clean claims, particularly for processing claims where other MCOs have much lower average monthly turnaround times.

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) report tracks 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 grievance resolved, including narratives of grievance description and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Track Timely Resolution of Grievances

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

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

Data Sources

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

Current Quarter Compared to Previous Quarters

As shown in Table 6, 98.0% (433) of the 442 grievances reported by the MCOs as closed in Q3 CY2015 were reported as resolved within 30 business days; and 99.5% (440) were resolved within 60 business days.

While the aggregate percentage of grievances resolved within 30 business days in Q3 CY2015 met the 98% contractual requirement, only one of the three MCOs reported that 98% or more of the grievances closed in Q3 CY2015 were resolved within 30 days.

- UnitedHealthcare reported that 100% of 158 grievances closed in Q3 were resolved within 30 business days.
- Sunflower reported that 97.6% (123) of 126 grievances closed in Q3 were resolved within 30 business days; the remaining three grievances were resolved within 31 to 60 business days.
- Amerigroup reported 152 (96.2%) of 158 grievances closed in Q3 were resolved within 30 business days; 156 (98.7%) grievances were resolved within 31 to 60 business days.

- The two grievances not resolved within the State-required 60 business days were grievances received by Amerigroup.

Table 6. Timeliness of Resolution of Grievances CY2013 to Q3 CY2015

	CY2013				CY2014				CY2015		
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Number of Grievances Received in Quarter	445	496	422	423	498	501	679	609	684	491	442
Number of Grievances Closed in Quarter*	422	462	412	427	501	507	684	615	636	525	442
Number of Grievances Closed in Quarter Resolved Within 30 Business Days*	422	462	412	427	499	490	680	614	625	508	433
Percent of Grievances closed in Quarter Resolved Within 30 Business Days	100%	100%	100%	100%	99.6%	96.6%	99.4%	99.8%	98.3%	96.8%	98.0%
Number of Grievances Closed in Quarter Resolved Within 60 Business Days*	422	462	412	427	501	500	683	615	630	523	440
Percent of Grievances Closed in Quarter Resolved Within 60 Business Days	100%	100%	100%	100%	100%	98.6%	99.9%	100.0%	99.1%	99.6%	99.5%
Number of Grievances Closed in Quarter Not Resolved Within 60 Business Days*	0	0	0	0	0	7	1	0	6	2	2

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

In Q3 CY2015, the number of grievances received (442) was lower than the number received in the previous six quarters. In the first 11 quarters of KanCare to date, the number of grievances received ranged from 422 (Q3 CY2013) to 684 (Q1 CY2015). The number of grievances closed by quarter ranged from 412 (Q3 CY2013) to 684 (Q3 CY2014).

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

Data Sources

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

All Grievances

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. Only three of the categories overlap clearly - Claims/Billing Issues, Quality of Care or Service, and Other. The GAR report also includes grievance details, including categorization of each grievance using the categories listed in the GAR report Reasons Summary Table.

Table 7 summarizes the number and types of grievances received (as reported to the State in the STC reports), and Table 8 summarizes the quarterly numbers and types of grievances resolved (as reported in the GAR reports) in Q3 CY2015 and the first three quarters of CY2013 to CY2015.

Table 7. Number of Grievances Received* - Quarter 1 to Quarter 3 CY2015 and Year-to-Date CY2013 to CY2015

	CY2015			Year-to-Date (Q1 to Q3)		
	Q1	Q2	Q3	CY2013	CY2014	CY2015
Transportation	251	245	192	715	723	688
Claims/Billing Issues	217	56	44	170	380	317
Quality of Care or Service	53	40	57	83	196	150
Access to Service or Care	34	33	35	42	71	102
Health Plan Administration	13	19	11	74	55	43
Customer Service	49	67	36	138	109	152
Member Rights/Dignity	14	15	17	19	19	46
Benefit Denial or LImitation	24	10	12	27	58	46
Service or Care Disruption	6	4	3	30	27	13
Clinical/Utilization Management	4	2	0	28	13	6
Other	2	27	20	34	23	49
Total Grievances Received	667	480	427	1,360	1,674	1,612

*As reported by MCOs in STC reports.
†Does not include grievances resolved in the quarter that were received in the previous quarter

In the Q3 CY2015 STC report, MCOs reported they received 427 grievances, 53 fewer than in Q2 CY2015 and 240 fewer than in Q1 CY2015. In the first three quarters of CY2015, MCOs received 1,612 grievances compared to 1,674 in the first three quarters of CY2014 and 1,360 in the first three quarters of CY2013.

Transportation-related grievances continued to be the most frequently reported grievance received, with 192 in Q3, 45.0% of the 427 grievances. In comparing year-to-date (YTD) for the first three quarters of CY2013 to CY2015, the number of transportation-related grievances has been relatively the same, with only 27 to 35 fewer in the first three quarters of CY2015 compared to CY2013 and CY2014.

Grievances related to “Claims/Billing Issues” continued to decrease, with only 44 received in Q3 CY2015, down from 217 in Q1 CY2015.

The numbers reported in the STC and GAR reports this quarter had some conflicting reporting of data. UnitedHealthcare, for example, in GAR Resolution Timeframe reported that 158 grievances were received in Q3; in the STC report 143 grievances are listed as received in Q3. Data are also not always consistent within the same report. Although the total counts of

resolved grievances summarized in Amerigroup's Q3 CY2015 GAR "Reason Summary Chart" and grievance detail are the same, the counts for nine of ten categories of resolved grievances differ.

Table 8. Comparison of Grievances Resolved* - Quarters 1 to 3 CY2015 and Year-to-Date CY2013 to CY2015

	CY2015			Year-to-Date (Q1 to Q3)		
	Q1	Q2	Q3	CY2013	CY2014	CY2015
Claims/Billing Issues	227	86	63	172	397	376
Quality of Care or Service	40	56	96	84	154	192
Attitude/Service of Staff	116	144	138	268	277	398
Availability	83	99	82	455	295	264
Timeliness	86	83	24	202	283	193
Pharmacy	9	10	3	19	24	22
Lack of Information from Provider	3	5	5	4	15	13
Level of Care Dispute	5	4	2	5	13	11
Prior or Post Authorization	5	3	7	5	17	15
Accessibility of Office	3	1	1	17	20	5
Criteria Not Met - Medical Procedure	6	6	2	2	10	14
Criteria Not Met - Durable Medical Equipment	2	2	1	1	12	5
Criteria Not Met - Inpatient Hospitalization	2	-	1	1	-	3
HCBS	12	-	7	1	6	19
Sleep Studies	-	-	1	1	3	1
Sterilization	-	1	1	-	1	2
Overpayments	-	-	-	-	-	-
Quality of Office, Building	-	-	-	-	5	-
Other	36	42	39	36	81	117
Total	635	542	473	1,273	1,613	1,650

*As reported in quarterly grievance (GAR) reports.

In reviewing the detailed grievances in the GAR report, KFMC found, as in previous reviews, many of the grievances do not appear to be based on specific or consistent criteria by the MCOs, and some grievances appeared to be misclassified.

Transportation-related grievances are a good example of differences in categorization by each of the MCOs (see Table 9). While in the STC report transportation-related grievances are identified separately, in the GAR report the transportation-related grievances are listed in a number of categories, varying in interpretation by MCO. Of 213 transportation-related grievances resolved in Q3 CY2015, 23.9% were categorized as "Quality of Care or Service"; 31.0% as "Availability"; 26.3% as "Attitude/Service of Staff"; 9.4% as "Timeliness; 5.2% as "Billing and Financial Issues"; 1.4% as "Other"; 1.9% as "AOR" (not one of the State-identified

categories); 0.5% (1 grievance) as "Lack of Information from Provider"; and 0.5% (1 grievance) very misclassified as "Sterilization."

Table 9. Transportation-Related Grievances Resolved by Category, Quarter 3 CY2015

	Amerigroup		Sunflower		United		Total	
	#	%	#	%	#	%	#	%
Availability	52	61.2%	14	41.2%			66	31.0%
Timeliness	10	11.8%	7	20.6%	3	3.2%	20	9.4%
Attitude/Service of Staff	9	10.6%	7	20.6%	40	42.6%	56	26.3%
Billing and Financial Issues	7	8.2%	4	11.8%			11	5.2%
Quality of Care or Service	4	4.7%			47	50%	51	23.9%
Lack of Information from Provider	1	1.2%					1	0.5%
Sterilization			1	2.9%			1	0.5%
Other	2	2.4%	1	2.9%			3	1.4%
AOR "Appointment of Representation"					4	4.3%	4	1.9%
Transportation-Related Total	85		34		94		213	

An additional complication is the addition of an "AOR" category, not one of the categories the State has identified for categorizing grievances, in the GAR report by UnitedHealthcare. Inclusion of AOR by UnitedHealthcare first occurred in Q1 CY2015 when 13 grievances were categorized as "AOR." At that time, KFMC contacted UnitedHealthcare and was told that "AOR" refers to "Appointment of Representation." In Q3 CY2015, UnitedHealthcare categorized seven grievances as "AOR." The descriptions UnitedHealthcare provides for their grievances are generally very limited, and text is cut off for most grievance descriptions in the GAR report grievance details, making it difficult to determine whether the grievances are categorized appropriately or to determine appropriate categories for grievances, particularly where grievances are labeled as "AOR."

In response to recommendations made in the previous KanCare Evaluation Quarterly Reports, KDHE staff scheduled regular meetings with EQRO staff in Q4 CY2015 to review the grievance and appeals categories in the STC and GAR reports, revise the categories to better promote consistency in reporting, and define criteria for reporting for each category. KDHE is scheduling meetings with MCO staff to discuss these changes and provide additional training to promote more consistent and accurate categorization of grievances and appeals received by the MCOs. After meeting with the MCOs, specific changes, particularly those related to recommendations in previous KanCare Quarterly Reports, will be reviewed in the KanCare Q4 Quarterly report. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, should greatly improve the ability to assess the number and types of grievances received and resolved each quarter and to assess trends over time.

Table 10 reports the types of grievances resolved in Q3 CY2015 in total and by waiver, as well as the number of transportation-related grievances based on grievance narrative details.

Table 10. Comparison of Grievance Categories by Waiver for Grievances Resolved in Quarter 3 CY2015*

	Grievances		Grievances by Waiver Type						
	All Members	Waiver Members	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	64	12	2	4	3	2	1		
Quality of Care or Service	99	32	12	1	17		1		1
Attitude/Service of Staff	138	41	10	1	26				4
Timeliness	23	4	3			1			
Availability	85	27	6	1	12				8
Pharmacy	4	2			1				1
Lack of Information from Provider	5	0							
Level of Care Dispute	2	0							
Prior or Post Authorization	6	3		1	2				
HCBS	5	4			4				
Accessibility of Office	1	0							
Criteria not met - Durable Medical Equipment	1	0							
Criteria not met - Inpatient admissions	1	1		1					
Criteria not met - Medical Procedure	2	0							
Sleep Studies	1	0							
Sterilization	1	0							
"AOR" (Appointment of Representation)	7	0							
Other	29	9	1	2	4				2
Total Grievances Resolved Q3	474	135	34	11	69	3	2	0	16
Transportation-Related	213	61	24	3	29	1	1	0	3
# of Members with Grievances Resolved Q3	444	112	26	11	62	3	2	0	11

*Includes grievances received in Quarter 2 CY2015 resolved in Quarter 3 CY2015

Of 474 grievances resolved in Q3 CY2015 reported by 444 members, 135 (28.5%) were from 112 members receiving waiver services. Compared to the previous quarter, the number and percentage of grievances reported by members receiving waiver services increased; in Q2, 118 (22.5%) of 525 grievances were reported by 113 members receiving waiver services.

- Of the 135 grievances received from waiver members, 61 (45.2%) were transportation-related.
- Physical Disability (PD) waiver members had the most grievances in Q3, with 62 members reporting 69 grievances, 29 (42%) transportation-related. In Q2, 39 of 58 (67%) grievances reported by PD waiver members were transportation-related; in Q1, 58 of 98 (59.2%) grievances were transportation-related.
- Frail Elderly (FE) waiver members had the second highest number of reported grievances in Q3, with 26 members reporting 34 grievances, 24 (70.6%) transportation-related. Transportation-related grievances reported by FE waiver members were increased in Q3

compared to the three previous quarters. In Q3 CY2015, 24 of 34 grievances (70.6%) reported by FE waiver members were transportation-related, compared to in 10 of 24 grievances (40%) in Q2 CY2015, 14 of 31 (45.2%) in Q1 CY2015; and 15 of 38 (39.5%) in Q4 CY2014.

- Intellectual/Developmental Disability (I/DD) waiver members reported 11 grievances (from 11 members), with three that were transportation-related. In Q2 CY2015, 16 members receiving I/DD waiver services reported 16 grievances, four that were transportation-related.
- The number of Traumatic Brain Injury (TBI) grievances dropped from 17 in Q4 CY2014 to 11 in Q1 CY2015, then to 9 in Q2 CY2015, increasing in Q3 CY2015 to 16 grievances reported by 8 TBI waiver members. Three of the grievances reported by TBI waiver members were transportation-related.
- Other waiver members reporting grievances were Serious Emotional Disturbance (SED) waiver (three grievances from three members), one transportation-related; and Technology Assisted (TA) (two grievances from two members), one transportation-related.

Access-Related Grievances

Of the 427 grievances received in Q3 CY2015, 35 (8.2%) were categorized in the STC report as "Access to Service or Care" (see Table 7). Access-related grievances have consistently been one of the least frequent categories of reported grievances. The number of "Access to Service or Care" grievances has ranged from 13 reported in Q2 and Q3 of CY2013 to 35 reported this quarter.

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

- Amerigroup and UnitedHealthcare, as in previous STC reports, did not provide details for the access-related grievances reported for Q3 CY2015.
  - Amerigroup reported five access-related grievances received in Q3 CY2015. As in previous STC reports, these were described as follows: "*Members had difficulty or were unable to obtain services or supplies. Plan continues to monitor grievances filed for Access to Service or Care for possible quality of care issues and repeat providers. Plan provider relations staff continue to monitor our network to identify service gaps and work with providers to contract with Amerigroup to perform key services*."
  - UnitedHealthcare reported four access-related grievances received in Q3. As in previous STC reports, they included the following language: "*Grievances related to availability of network providers are used as part of geo access studies to identify potential network gaps. For grievances related to appointment availability, provider offices are contacted to review appointment availability standards*."
- Sunflower reported 26 access-related grievances received in Q3. In the STC trend summary, Sunflower reported, *"24% of these grievances were regarding the access to RX including 2 regarding lock-in. There were also 2 complaints regarding possible fraud according [to] the member (1 – Someone else using id, 1 – Provider billing for services not provided) there were also 4 complaints regarding Sunflower Case Managers."*

As there is no "Access to Service or Care" grievance category in the GAR report, it is not possible to compare quarterly changes in the number of access-related grievances resolved. The 35 grievances identified in the STC report as "Access to Service or Care" could potentially be categorized in the GAR report as "Accessibility of Office" (1 grievance in Q3); "Availability" (82 grievances in Q3); "Level of Care Dispute" (2 grievances in Q3); "Prior or Post Authorization" (7 grievances in Q3); "Timeliness" (24 grievances in Q3); and/or "HCBS" (7 grievances in Q3).

Quality-Related Grievances

In Q3 CY2015, 57 (13.3%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 96 of 473 (20.3%) grievances reported as resolved in Q3 were categorized as QOC. The number reported in Q3 CY2015 is a 71% increase over the previous quarter (56) and a 140% increase over the 40 grievances categorized as QOC in Q1 CY2015. The major reason, however, for the significant increase is the categorization of 51 of the 96 (53.1%) as QOC that were transportation-related, a separate category in the STC report.

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

- Amerigroup indicated that 1 of the 23 QOC grievances received in Q3 was referred to Quality Management for a Quality of Care Investigation. As in previous STC reports, they included the following language: "*These issues were monitored by Quality Management Nurses as potential Quality of Care concerns. Plan continues to monitor providers and concerns for possible trends. Concerns that were investigated and substantiated were elevated to the medical director who followed up with providers on corrective action."*
- UnitedHealthcare did not provide descriptions of the 21 QOC grievances received in Q3. As in previous STC reports, they included the following language: "*Quality of Service or Care issues represented a wide variety of issues from unprofessional behavior to allegations of misdiagnosis. Provider relations advocates work together with facilities and physicians offices to ensure member satisfaction and quality care is being provided. Quality of care grievances go through the MCOs confidential peer review process.*"
- Sunflower reported 13 QOC grievances received in Q3, and that, "*These items are regarding how the member felt they were not being cared for by the provider and/or provider staff. 54% were forwarded to QOC coordinator.*"

Of the 96 QOC grievances reported in the GAR report as resolved in Q3 CY2015, 32 were from members receiving waiver services including: 17 members receiving PD waiver services, 12 members receiving FE waiver services, one member receiving I/DD waiver services, and one member receiving TA waiver services.

In reviewing the descriptions of resolved grievances in the three MCOs' GAR reports for Q3, KFMC found several grievances that could potentially be considered to be related to QOC, particularly where resolution was through the MCO Quality Management staff, that were categorized as "Attitude/Service of Staff," "Criteria Not Met – Medical Procedures," and/or "Level of Care Dispute." Due to the limited information and cut-off text descriptions of

grievances, it is difficult to assess if any the grievances categorized by UnitedHealthcare as "AOR" are related to QOC.

In addition to the 51 transportation-related grievances categorized as QOC, descriptions of several grievances categorized as QOC could just as easily have been categorized as "Availability," "Timeliness," "Level of Care Dispute," "Pharmacy," or "Prior or Post Authorization."

Recommendations

- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- Once criteria for grievances and appeals are finalized by the State, the MCOs should ensure their staff participate in training and consistently categorize grievances and appeals using the revised criteria.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should categorize grievances using State identified categories and criteria. Grievance categories such as "AOR" should not be added by MCOs.

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 CY2015 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

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

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

The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers will then receive three weeks of in-person mentoring by the Ombudsman and program coordinator.

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

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

Table 11 summarizes the number and caller types in Q3 CY2015. Of 579 contacts to the Ombudsman's Office in Q3, 426 (73.6%) were from consumers.

Table 11. Ombudsman's Office Contacts by Caller Type, Quarter 3 CY2015

Caller Type	Number	Percentage
Consumer	426	73.6%
Provider	102	17.6%
MCO employee	5	0.9%
Other	46	7.9%
Total	579	

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of issues in addition to the number of contacts. As reported in Table 12, there were 699 issues and inquiries tracked out of the 579 contacts in Q3 CY2015. As in the previous three quarters, the highest numbers of issues and inquiries were related to Medicaid Eligibility (206 in Q3 CY2015; 108 in Q2 CY2015; 139 in Q1 CY2015, and 194 in Q4 CY2014). Of the 579 inquiries in Q3 CY2015, 187 (32.2%) were MCO-related, down from 282 of 582 inquiries (48.5%) in Q2 CY2015. Of the 699 issues identified of the 579 inquiries, 260 (37.2%) were MCO-related.

Table 12. Issue and Inquiry Types Submitted to the Ombudsman's Office, Quarter 4 CY2014 to Quarter 3 CY2015

	CY2014			CY2015										
	Q4			Q1			Q2			Q3				
	All	MCO-related		All	MCO-related		All	MCO-related		All		MCO-related		
Issues	% of 704	% of 321	% of 704	%	% of 307	% of 620	%	% of 282	% of 582	#	%	#	% of 260	% of 699
Medicaid Eligibility Issues	28%	12%	6%	22%	12%	6%	19%	10%	5%	206	29%	33	13%	5%
Appeals, Grievances	7%	13%	6%	7%	12%	6%	6%	10%	5%	47	7%	29	11%	4%
Medical Service Issues	10%	12%	6%	3%	4%	2%	4%	5%	3%	27	4%	15	6%	2%
Billing	6%	8%	4%	6%	9%	5%	7%	10%	5%	41	6%	23	9%	3%
Durable Medical Equipment	1%	3%	1%	4%	6%	3%	2%	4%	2%	7	1%	3	1%	0%
Pharmacy	3%	3%	2%	4%	5%	3%	6%	9%	4%	14	2%	9	3%	1%
HCBS														
HCBS General Issues	7%	10%	5%	10%	15%	8%	6%	10%	5%	54	8%	29	11%	4%
HCBS Eligibility Issues	2%	3%	1%	2%	2%	1%	3%	3%	2%	24	3%	14	5%	2%
HCBS Reduction in Hours of Service	1%	2%	1%	2%	3%	1%	1%	2%	1%	13	2%	11	4%	2%
HCBS Waiting List	1%	1%	0.3%	2%	2%	1%	1%	1%	0.3%	9	1%	6	2%	1%
Care Coordinator Issues	2%	4%	2%	2%	3%	1%	1%	3%	1%	9	1%	8	3%	1%
Transportation	2%	3%	1%	2%	3%	1%	3%	5%	2%	8	1%	7	3%	1%
Nursing Facility Issues	3%	3%	1%	2%	3%	1%	6%	3%	1%	34	5%	12	5%	2%
Housing Issues	1%	3%	1%	0%	0%	0%	1%	2%	1%	4	1%	2	1%	0%
Change MCO	1%	3%	1%	1%	2%	1%	1%	1%	1%	10	1%	8	3%	1%
Dental	1%	2%	1%	1%	2%	1%	1%	1%	1%	1	0.1%	0	0%	0%
Access to Providers	2%	4%	2%	0.5%	1%	0.3%	2%	3%	1%	1	0.1%	1	0.4%	0.1%
Guardianship Issues	0.3%	0.3%	0.1%	1%	1%	0.3%	0%	0%	0%	2	0.3%	1	0.4%	0.1%
Other	16%	11%	5%	22%	14%	7%	26%	18%	9%	141	20%	35	13%	5%
Unspecified or Thank you	6%	2%	1%	7%	4%	2%	5%	1%	1%	47	7%	14	5%	2%
Percentage of Total MCO-related Issues			46%			50%			48%					37%
Total Issues	704	321	704	620	307	620	582	282	582	699		260		699

Beginning in Q3 CY2014, due to improvements in the tracking system, the Ombudsman's Office began reporting contact issues by waiver-related type as well. As shown in Table 13, 108 contacts were waiver-related in Q3 CY2015, compared to 119 in Q2 CY2015, 135 in Q1 CY2015, 110 in Q4 CY2014, and 143 in Q3 CY2014. The most frequent waiver-related issues were again for/from KanCare members receiving waiver services for Physical Disability (PD) and Intellectual/Developmental Disability (I/DD); of 615 waiver-related inquiries from July 2014 through September 2015, 210 (34.1%) were from members receiving PD waiver services and 167 (27.1%) were from members receiving I/DD waiver services.

Table 13. Waiver-Related Inquiries to the Ombudsman's Office, Quarter 3 CY2014 to Quarter 3 CY2015										
	CY2014				CY 2015					
	Q3		Q4		Q1		Q2		Q3	
Waiver	#	%	#	%	#	%	#	%	#	%
Intellectual/Developmental Disability (I/DD)	42	29.4%	36	32.7%	35	25.9%	25	21.0%	29	26.9%
Physical Disability (PD)	43	30.1%	29	26.4%	57	42.2%	48	40.3%	33	30.6%
Technology Assisted (TA)	8	5.6%	15	13.6%	11	8.1%	13	10.9%	11	10.2%
Frail Elderly (FE)	16	11.2%	11	10.0%	15	11.1%	12	10.1%	16	14.8%
Traumatic Brain Injury (TBI)	19	13.3%	10	9.1%	10	7.4%	9	7.6%	7	6.5%
Serious Emotional Disturbance (SED)	5	3.5%	4	3.6%	1	0.7%	7	5.9%	5	4.6%
Money Follows the Person (MFP)	6	4.2%	4	3.6%	2	1.5%	2	1.7%	3	2.8%
Autism	4	2.8%	1	0.9%	4	3.0%	3	2.5%	4	3.7%
Total	143		110		135		119		108	

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q3 CY2015, 99.997% of the customer service inquiries received by the MCOs were resolved within two business days. Of the five inquiries not resolved within two business days, all were resolved within five business days.
- During each quarter to date the two-day resolution rate exceeded 99.7%; and, for the past three quarters the two-day resolution rate has exceeded 99.99%.
- Member customer service inquiries
  - Benefit inquiries were the highest percentage (18.8%) of member inquiries
  - There are four categories where two thirds or more of the inquiries in the last four quarterly reports were reported by one MCO:
    - "Member emergent or crisis call" – 99.4% of 717 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 99.8%; Q1 CY2015 – 99.7%; Q4 CY2014 – 99.7%)
    - "Update demographic information" – 82.1% of 13,481 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 82.3%; Q1 CY2015 – 82.1%; Q4 CY2014 - 71.0%)
    - "Enrollment information" – 76.8% of 2,838 inquiries were reported in Q3 CY2015 by Amerigroup. (Q2 CY2015 - 76.4%; Q1 CY2015 - 76.6%; Q4 CY2014 - 80.5%)
    - "Need transportation" – 73.7% of 1,402 inquiries were reported in Q3 CY2015 by Amerigroup. (Q2 CY2015 - 67.2%; Q1 CY2015 - 75.8%; Q4 CY2014 - 80.8%)
- Provider customer service inquiries
  - Provider inquiries again decreased this quarter; 1,377 fewer provider inquiries were in received in Q3 CY2015 compared to Q2 CY2015, and 7,981 fewer compared to Q3 CY2014.
  - For providers, claim status inquiries were again the highest percentage (43.9%) of the 45,365 provider calls. The three claims-related categories ("Claim denial inquiry," "Claim

status inquiry," and "Claim payment question/dispute") together accounted for 67.7% of the provider inquiries in Q3 CY2015.

- Categories where two thirds or more of the provider inquiries in Q3 and three previous quarters were reported by one MCO included:
  - "Authorization – New" – 98.0% of 1,898 inquiries in Q3 CY2015 were reported by Amerigroup. (Q2 CY2015 – 99.1%; Q1 CY2015 – 99.1%; Q4 CY2014 – 98.1%)
  - "Update demographic information" – 96.2% of 746 inquiries were reported in Q3 CY2015 by Sunflower. (Q2 CY2015 - 91.4%; Q1 CY2015 - 95.5%; Q4 CY2014 - 99.5%)
  - "Coordination of benefits" – 85.5% of 792 inquiries were reported in Q3 CY2015 by UnitedHealthcare. (Q2 CY2015 - 76.8%; Q1 CY2015 - 90.7%; Q4 CY2014 - 91.0%)
  - "Verify/Change participation status" – 77.8% of 441 inquiries in Q3 CY2015 were reported by Sunflower. (Q2 CY2015 - 68.1%; Q1 CY2015 - 67.6%; Q4 CY2014 - 66.4%)
  - "Recoupment or negative balance" – 75.2% of 165 inquiries in Q3 CY2015 were reported by UnitedHealthcare. (Q2 CY2015 - 76.8%; Q1 CY2015 - 94.3%; Q4 CY2014 - 78.5%)
  - Authorization – Status" – 67.4% of 2,323 inquiries in Q3 CY2015 were reported by Amerigroup. (Q2 CY2015 - 71.0%; Q1 CY2015 - 70.8%; Q4 CY2014 - 72.0%)

- 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

- **Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days**
  - In Q2 CY2015, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,289,726 clean claims received in Q2 CY2015, 99.912% were processed within 30 days. Of the 3,774 clean claims not processed within 30 days, 89.2% (3,367) were claims received by Sunflower; 10.1% (383) were claims received by Amerigroup; and 0.6% (24) were claims received by UnitedHealthcare.
  - In Q2 CY2015, all of the MCOs reported that they met the contractual requirement of processing at least 99% of non-clean claims within 60 days. Of 109,682 non-clean claims received in Q2 CY 2015, 99.954% were processed within 60 days. In Q2 CY2015, the numbers and percentages of non-clean claims <u>not</u> processed within 60 days were lower than in each of the four preceding quarters.
  - In Q2 CY2015, none of the MCOs met the contractual requirement to process 100% of "all claims" within 90 days. Of 4,399,407 "all claims" received in Q2 CY2015, 99.993% were processed within 90 days. Of the 317 claims not processed within 90 days, 197 (62.1%) were claims received by Amerigroup; 118 (37.2%) were claims received by Sunflower; and 2 (0.6%) were claims received by UnitedHealthcare. In Q2 CY2015, the numbers and percentages of "all claims" <u>not</u> processed within 90 days were higher than in each of the four preceding quarters.
  - To allow for claims lag, the Q3 KanCare Quarterly Evaluation reports the number of clean and non-clean claims received in Q2 and whether these claims were processed within contractually required time periods of 30 to 90 days. In its monthly claims reports, Sunflower has regularly revised the number of claims reported for previous

months. Additional explanation should be provided by each MCO when counts of claims for up to nine months earlier are revised each month.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q3 CY2015, the average TAT for Total Services was 5.8 to 9.1 days.
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - Pharmacy - Clean pharmacy claims, had the shortest turnaround times and were consistently processed on a same day basis by each of the three MCOs.
    - Non-emergency transportation - Clean claims for non-emergency transportation had longer TATs for all MCOs, with monthly average TATs ranging from 10.4 to 16 days in Q3 CY2015.
    - Vision – The average TATs were consistently a week or longer in Q3 and previous quarters for all of the MCOs. In Q3 CY2015, the average monthly TATs ranged from 9 to 12.5 days.
    - Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 9 to 13 days in Q3 CY2015 for each of the MCOs.
    - Hospital Inpatient – Hospital Inpatient claims had TATs in Q3 CY2015 ranging from 8.7 to 14.1 days.
  - In Q3 CY2015 (and in the two previous quarters), UnitedHealthcare had higher average monthly TATs than Amerigroup and Sunflower for Hospital Inpatient, Hospital Outpatient, Medical, Nursing Facilities, HCBS, and Behavioral Health claims. In Q3 CY2015 and (and in the two previous quarters), Amerigroup had lower average monthly TATs for Vision claims. In Q3 CY2015 (and the previous quarter) Sunflower had lower average monthly TATs for Dental and HCBS services.
  - Beginning in CY2015, the TAT for Nursing Facility claims and HCBS claims are pay-for-performance measures, added as an incentive for the MCOs to reduce the TATs for processing claims for these services.

Grievances

- KDHE staff scheduled regular meetings with EQRO staff in Q4 CY2015 to review the grievance and appeals categories in the STC and GAR reports, revise the categories to better promote consistency in reporting, and define criteria for reporting for each category. KDHE is scheduling meetings with MCO staff to discuss these changes and provide additional training to promote more consistent and accurate categorization of grievances and appeals received by the MCOs. After meeting with the MCOs, specific changes, particularly those related to recommendations in previous KanCare Quarterly Reports, will be reviewed in the KanCare Q4 Quarterly report. Developing standardized category criteria, and ensuring consistent use of categories and criteria in the GAR and STC reports, should greatly improve the ability to assess the number and types of grievances received and resolved each quarter and to assess trends over time.
- When categorizing grievance in the GAR and STC reports, MCOS continue to use inconsistent criteria. Transportation-related grievances, in particular, continue to be categorized differently by each MCO for similarly described situations. In Q3, 51 of 96

grievances categorized as "Quality of Care" were related to quality of transportation services.

- In Q3 CY2015, the number of grievances received (427) was lower than the number received in the previous six quarters.
- Of 442 grievances closed in Q3 CY2015, 98.0% (433) were resolved within 30 business days, and 99.5% (440) were resolved within 60 business days. While the aggregate percentage of grievances resolved within 30 business days in Q3 CY2015 met the 98% contractual requirement, only one of the three MCOs reported that 98% or more of the grievances closed in Q3 CY2015 were resolved within 30 days.
  - UnitedHealthcare reported that 100% of 158 grievances were resolved within 30 days
  - Sunflower reported that 97.6% (123) of 126 grievances closed in Q3 were resolved within 30 business days; the remaining three grievances were resolved within 31 to 60 business days.
  - Amerigroup reported 152 (96.2%) of 158 grievances closed in Q3 were resolved within 30 business days; 156 (98.7%) grievances were resolved within 31 to 60 business days.
  - The two grievances not resolved within the State-required 60 business days were grievances received by Amerigroup.
- The grievance categories with the highest number of grievances were those related to transportation; 192 of 427 (45.0%) of grievances received in Q3.
- Grievances related to "Claims/Billing Issues" continued to decrease, with only 44 received in Q3 CY2015, down from 217 in Q1.
- UnitedHealthcare again this quarter categorized grievances (7) as "AOR" (Appointment of Representation), which is not one of the GAR categories. UnitedHealthcare provides only limited descriptions of grievances, and most descriptions are cut off, making it difficult to determine how these nine grievances should be categorized, and to assess whether other grievances are categorized appropriately.
- Of 474 grievances reported by 444 members as resolved by MCOs in Q3 CY2015, 135 (28.5%) were reported by 112 members receiving waiver services.
- The number of access-related grievances each quarter is a relatively small percentage of grievances reported; MCOs categorized 35 of 427 (8.2%) grievances received in Q3 CY2015 as "Access to Service or Care."
- In Q3 CY2015, 57 (13.3%) of grievances received were categorized in the STC report as being related to "Quality of Service or Care" (QOC). In the GAR report, 96 of 473 (20.3%) grievances reported as resolved in Q3 were categorized as QOC. The number reported in Q3 CY2015 is a 71% increase over the previous quarter (56) and a 140% increase over the 40 grievances categorized as QOC in Q1 CY2015. The major reason, however, for the significant increase is the categorization of 51 of the 96 (53.1%) as QOC that were transportation-related, a separate category in the STC report.
- Descriptions in the STC report of "trends and any actions taken to prevent recurrence" for most of the grievance categories include the same language each quarter whether there were three grievances or 32 grievances in the category that quarter.
- The numbers reported in the STC and GAR reports this quarter had some conflicting reporting of data. UnitedHealthcare, for example, in GAR Resolution Timeframe reported that 158 grievances were received in Q3; in the STC report 143 grievances are listed as

received in Q3. Data are also not always consistent within the same report. Although the total counts of resolved grievances summarized in Amerigroup's Q3 CY2015 GAR "Reason Summary Chart" and grievance detail are the same, the counts for nine of ten categories of resolved grievances differ.

Ombudsman's Office

- In Q3 CY2015, the Ombudsman's Office tracked 699 issues identified in 579 contacts and calls received. Of the 699 issues, 260 (37.2%) were MCO-related, down from 282 of 582 (48.5%) in Q2 CY2015. The highest number of issues and inquiries were, as in the previous three quarters, related to Medicaid Eligibility (108 issues).
- There were 108 waiver-related inquiries, down slightly from 119 in Q2 CY2015. The most frequent waiver-related inquiries in Q3, and in the previous four quarters, have been from members receiving waiver services for PD and I/DD; of 615 waiver-related inquiries from July 2014 through September 2015, 210 (34.1%) were from members receiving PD waiver services and 167 (27.1%) were from members receiving I/DD waiver services.
- Recruitment of volunteers for the KanCare Ombudsman Volunteer Program began in June 2015. Due to the number of volunteer applications received in the Wichita area, training of volunteers began in Wichita. The Ombudsman's Office is conducting additional marketing to recruit additional volunteers in the Kansas City metropolitan area, with plans to expand statewide in 2016.
- The volunteer training includes three days of on-line training and two days of in-person training that include case studies and practice. Volunteers will then receive three weeks of in-person mentoring by the Ombudsman and program coordinator.

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 customer service inquiries. Categories where over two thirds of the inquiries were reported by one MCO in each of the last four quarters include the following:

- Member customer service inquiries: "Update demographic information," "Member emergent or crisis call," "Enrollment information," and "Need transportation."
- Provider customer service inquiries: "Authorization – New," "Update demographic information," "Coordination of benefits," "Recoupment or negative balance," "Authorization – Status," and "Verify/Change participation status."

Timeliness of Claims Processing

- Sunflower should make concerted efforts to improve processes to increase the number and percentage of clean claims processed within 30 days.
- Related to monthly reporting of contractual requirements for processing claims, additional explanations should be provided in monthly reports when changes are made to data reported in earlier months.

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

Grievances

- MCOs should review and compare data in each quarterly GAR and STC reports to ensure that the number of grievances received and the number resolved within the quarter are consistently and accurately reported.
- Once criteria for grievances and appeals are finalized by the State, the MCOs should ensure their staff participate in training and consistently categorize grievances and appeals using the revised criteria. Consistent categorization using the revised criteria should greatly improve quarterly reporting and trend analysis of grievances and appeals.
- MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.
- UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter and should ensure that text descriptions are not cut off mid-sentence.
- MCOs should categorize grievances using State identified categories and criteria. Grievance categories such as "AOR" should not be added by MCOs.

End of report.

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

Amerigroup - YTD Cumulative Claim Type	Total claim count	Total claim count $ value*	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	31,698	$1,151,511,244	5,529	$259,969,091	17.44%	8.2
Hospital Outpatient	266,823	$690,223,610	30,246	$74,031,518	11.34%	4.7
Pharmacy	1,547,326	$94,020,860	479,105	Not Applicable	30.96%	Same Day
Dental	100,875	$28,045,655	9,157	$2,557,848	9.08%	13.0
Vision	56,128	$15,752,498	7,061	$2,613,494	12.58%	9.0
NEMT	106,381	$3,897,669	1,153	$44,921	1.08%	17.0
Medical (physical health not otherwise specified)	1,536,575	$885,021,962	203,012	$171,990,254	13.21%	4.6
Nursing Facilities-Total	84,177	$192,559,257	9,737	$16,668,607	11.57%	5.1
HCBS	180,483	$83,700,800	40,968	$7,994,526	22.70%	6.0
Behavioral Health	487,440	$65,290,778	41,068	$5,619,039	8.43%	4.2
Total All Services	**4,397,906**	**$3,210,024,338**	**827,036**	**$541,489,302**	**18.81%**	**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	24,646	$790,656,389	5,012	$185,037,128	20.34%	9.66
Hospital Outpatient	245,884	$495,857,553	32,416	$61,167,521	13.18%	6.72
Pharmacy	2,298,402	$219,086,629	597,196	$107,428,429	25.98%	1.00
Dental	113,439	$29,249,355	8,707	$1,977,829	7.68%	8.00
Vision	67,919	$16,243,545	8,268	$2,217,016	12.17%	11.90
NEMT	112,640	$3,208,728	277	$8,722	0.25%	10.72
Medical (physical health not otherwise specified)	1,405,545	$642,327,992	178,234	$138,888,433	12.68%	5.96
Nursing Facilities-Total	93,881	$199,738,195	8,189	$25,522,594	8.72%	5.94
HCBS	344,324	$162,368,437	20,105	$10,257,090	5.84%	5.60
Behavioral Health	544,957	$78,534,233	41,301	$7,068,371	7.58%	6.27
Total All Services	**5,251,637**	**$2,637,271,056**	**899,705**	**$539,573,135**	**17.13%**	**6.47**

United - YTD Cumulative Claim Type	Total claim count	Total claim count $ value*	# claims denied	$ value of claims denied	% claims denied	Average TAT
Hospital Inpatient	21,326	$732,253,344	4,984	$197,599,109	23.37%	12.5
Hospital Outpatient	230,004	$566,911,147	36,088	$138,148,883	15.69%	9.2
Pharmacy	1,324,669	$157,297,619	339,836	$72,609,849	25.65%	0.0
Dental	100,646	$28,535,672	7,291	$2,145,053	7.24%	13.0
Vision	52,518	$10,941,660	5,453	$1,376,900	10.38%	12.0
NEMT	117,691	$3,173,982	359	$8,371	0.31%	10.7
Medical (physical health not otherwise specified)	1,480,010	$584,609,531	225,160	$129,838,739	15.21%	8.9
Nursing Facilities-Total	74,184	$182,568,568	8,771	$24,842,384	11.82%	7.7
HCBS	296,113	$61,953,716	54,331	$6,039,347	18.34%	8.3
Behavioral Health	197,526	$58,068,360	15,252	$9,356,883	7.72%	8.9
Total All Services	**3,894,687**	**$2,386,313,603**	**697,525**	**$581,965,523**	**17.91%**	**9.2**

*Total claim count dollar value of claims, per service type submitted, includes all billed amounts. It is not reduced by any adjustments, or denial amounts.