Fourth Quarter & Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 12.31.2019 – Year Ending 12.31.19

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

KanCare
Section 1115 Fourth Quarter and Annual Report Demonstration Year: 7
(1/1/2019-12/31/2019)

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2019 Fourth Quarter Report

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 and Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017. On December 20, 2017, the State submitted an extension request for its Medicaid 1115 demonstration. On December 18, 2018 the Centers for Medicare and Medicaid Services approved a renewal of the Medicaid Section 1115 demonstration proposal entitled KanCare. The demonstration is effective from January 1, 2019 through December 31, 2023.

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;
- Continue to 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;
- Extend the Delivery System Reform Incentive Payment program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.
- Provide work opportunities and supports for individuals with specific behavioral health conditions and other disabilities.

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

- Continue to provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Further improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Maintain Medicaid cost control by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care;
- Continue to 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;
- Help Kansas Medicaid beneficiaries achieve healthier, more independent lives by coordinating services to strengthen social determinants of health and independence and person-centered planning;
- Promote higher levels of member independence through employment programs;
- Drive performance and improve quality of care for Kansas Medicaid beneficiaries by integrating value-based models, purchasing strategies and quality improvement programs; and
- Improve effectiveness and efficiency of the state Medicaid program with increased alignment of MCO operations, data analytic capabilities and expanded beneficiary access to SUD services.

This quarterly report is submitted pursuant to item #64 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued regarding 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 as of December 31, 2019.

Demonstration Population	Enrollees at Close of Quarter (12/31/2019)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,806	15,976	1,170
Population 2: ABD/SD Non-Dual	29,569	30,944	1,375
Population 3: Adults	44,391	48,320	3,929
Population 4: Children	200,228	210,822	10,594
Population 5: DD Waiver	9,095	9,159	64
Population 6: LTC	21,007	21,967	960
Population 7: MN Dual	1,429	2,082	653
Population 8: MN Non-Dual	947	1,142	195
Population 9: Waiver	4,175	4,506	331
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	325,647	344,918	19,271

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.

The KanCare Advisory Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 1 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists, and 1 representing hospitals. The fourth quarter KanCare Advisory Council meeting took place on December 11, 2019 at Memorial Hall Auditorium, 120 SW 10th Ave., Topeka, KS. The agenda was as follows:

- Welcome
- Review and Approval of Minutes from Council Meeting, August 5, 2019
- Old Business
    - Update on expected time for credentialing by each MCO for individual providers – Walt Hill
    - Update on staffing issues for those in need of Long-Term Care – Ed Nicholas
- New Business
    - Current and projected shortage of direct care workers (Direct Support Professionals) in Kansas – Allen Schmidt
    - Remedial actions against Aetna Better Health and how this has improved – Lora Key
    - Update on State's assessment of Aetna Better Health performance – Larry Martin
    - Update on progress of the steps being done on the different agencies that can help waiver consumers obtain the hours of care that have been allotted via their personal centered care plans for Nursing and or Personal Care Attendants (Self-directed or agency directed) – Ed Nicholas
    - Define the capable person policy in regard to the care of our disabled kids and adults in need of care per their personal care plans – Ed Nicholas

- KDHE Update – Adam Proffitt, Medicaid Director, Kansas Department of Health and Environment and Chris Swartz, Director of Operations/COO, Deputy Medicaid Director, Kansas Department of Health and Environment
- KDADS Update – Janis DeBoer, Deputy Secretary, Kansas Department for Aging and Disability Services
- KanCare Ombudsman Report – Kerrie Bacon, Ombudsman, KanCare Ombudsman Office (Written only)
- Updates on KanCare with Q&A
    - Aetna Better Health of Kansas
    - Sunflower State Health Plan
    - UnitedHealthcare Community Plan
- Adjourn

The Tribal Technical Assistance Group met November 5, 2019. The tribal members were consulted on the following items:

- Protected Income Level (PIL) increase effective September 1, 2019
- State Plan Amendment (SPA) for the elimination of the 90 day wait period for CHIP
- SPAs for dental rates, ER facility blended rate, Autism rates, Nursing facility rates and Nursing Facility rates for ventilator dependent citizens
- KanCare Open Enrollment – Reminder that tribal members may opt out of managed care
- The next meeting is scheduled for February 4, 2020.

During the fourth quarter of 2019, OEW staff participated in 37 community events providing KanCare program outreach, education and information for the following agencies/events: Local Health Departments/WIC clinics, Latino and Asian Wellness groups, Integrated Service Team rescue Mission, Kickapoo, Parents as Teachers (PAT), St. Francis OBGYN; DCF Resource fair; Adventure Dental; Baby Jubilee; Community Baby Showers; GraceMed; Lincoln Center; Raising Riley meetings, Riley County Perinatal Coalition Mtg; Early Childhood ; Early Education ; Geary County Maternal Health Committee; Flinthills Wellness Coalition; Flinthills Health Equity; Genesis Family Health; Catholic Charities; Bright Beginnings.

During the fourth quarter of 2019, support and assistance for consumers in the state for KanCare was provided by KDHE's 28 out-stationed eligibility workers (OEW). OEW staff determined eligibility for 3,720 consumers. OEW also assisted in resolving 1,503 issues involving urgent medical needs, obtaining correct information on applications, addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse. These OEW staff also assisted with 1,488 consumer phone calls and 963 Walk-Ins.

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:

- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- 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 and quarterly)

- 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)
- Medicaid Functional Eligibility Instrument (FE, PD & TBI) Advisory Workgroup
- IDD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-weekly)
- Kansas Association of Addiction Professionals (monthly)
- 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; SUD 101; trauma informed systems of care; recovery and peer support; housing and homeless initiatives; community crisis center development
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the nine subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Mental Health Excellence and grant project meetings
- Monthly Nursing Facility Stakeholder Meetings
- KDADS-CDDO-Stakeholder Meetings (quarterly)
- KDADS-CDDO Eligibility workgroup
- KDADS-Series of meetings with a coalition of advocacy groups including KanCare Advocates Network and Disability Rights Commission to discuss ways KDADS can provide more effective stakeholder engagement opportunities

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

OneCare Kansas Program

A legislative proviso directed KDHE to implement a health homes program. To avoid the confusion caused by the term health homes, a new name was selected for the program – OneCare Kansas. The program is scheduled to launch on April 1st, 2020. The program will have the same model as the state's previous health homes program. The target population is defined differently. The OneCare Kansas program will have two distinct populations.

Individuals who have a serious and persistent mental illness, defined as having at least one of the following diagnoses:

- Paranoid Schizophrenia
- Severe Bipolar Disorder

Individuals with one chronic condition defined as people who have Asthma that also are at risk for developing:

- Diabetes
- Hypertension
- Kidney Disease (not including Chronic Kidney Disease Stage 4 and ESRD)
- Cardiovascular Disease

- COPD
- Metabolic Syndrome
- Mental Illness (not including Paranoid Schizophrenia and Severe Bipolar Disorder)
- Substance Use Disorder
- Morbid Obesity (body weight 100lbs over normal body weight, BMI greater than 40, or BMI over 30 with obesity-related health problems)
- Tobacco Use or exposure to secondhand smoke

The state will use the MCOs as lead entities, who will contract with select providers to offer the required six core services. Monthly learning collaboratives will be held to assist the providers as they deliver services to these two OneCare Kansas populations.

MCO Outreach Activities

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

Information related to Aetna Better Health of Kansas marketing, outreach and advocacy activities:

Marketing Activities

In the fourth quarter of 2019, Aetna Better Health of Kansas (ABHKS) participated in various activities to market KanCare and the health plan to medical providers, current members and potential members. ABHKS Provider Experience and Community Outreach staff attended state conferences targeted at provider organizations throughout Kansas during the quarter. We also provided outreach directly to many provider offices as well. Through these efforts we touched over 890 individuals from provider offices around the State. ABHKS also attended several health fair events within the communities of Kansas where members and potential members were invited to attend. During the fourth quarter, ABHKS representatives visited with over 5,290 individuals at these events to educate them on ABHKS and KanCare. Examples of the events included the Olathe Head Start Health Fair; Cafe Con Leche in Wichita; KVC Adoption Day events in Hays, Salina and Wichita; the Salvation Army Christmas Distribution event; as well as several lobby sits at health clinics and food pantries around the State.

Outreach Activities

In the fourth quarter of 2019, ABHKS Community Development and System of Care team staff provided outreach activities to community-based organizations, advocacy groups and provider offices throughout Kansas. The Community Development team conducted six educational sessions providing ABHKS benefit information to community based organizations and provider offices in the State. Direct outreach visits to provider offices and community based organizations were conducted as well. ABHKS Community Development staff visited with individuals from over 890 provider offices and visited with over 2,500 individuals associated with community-based organizations in Kansas. Examples of the community-based organizations included the Marshall County Agency on Aging; One Million Cups in Wichita; LiveWell Northwest Kansas in Bird City; SKIL Resource Center in Pittsburg; Family Service and Guidance Center in Topeka; as well as many others. The ABHKS System of Care team also attended meetings with organizations working on issues affecting KanCare members such as foster care, homelessness, behavioral health, individuals with Intellectual and Development Disabilities, work programs and other issues. The System of Care team met with over 190 individuals in the fourth quarter of 2019. Examples include the Mission Project Parent Group in Mission; the Family Finding Event in Topeka; and the KanCare Policy Team Meeting in Topeka.

Advocacy Activities
ABHKS Member Advocates have established a relationship with the KanCare Ombudsman and receive direct referrals about member issues that require intervention efforts. During the fourth quarter of 2019, ABHKS Member Advocates assisted 19 members referred from the Ombudsman.

Information related to Sunflower State Health Plan marketing, outreach and advocacy activities:
Marketing Activities
During fourth quarter 2019, Sunflower Health Plan sponsored 76 local and statewide member and provider events as well as fundraisers for charitable organizations such as the American Diabetes Association Sunflower's direct mail marketing material for the fourth quarter included member postcards and customized letters addressing preventive health care gaps for important screenings and immunizations.

Notable stakeholder programs and events for marketing:

- Annual Step Out & Walk for the American Diabetes Association
- Early Head Start Regional Meetings
- Oral Health Kansas Dental Conference
- Interhab PowerUp Disability Summit
- Jingle Bell Run with the Arthritis Foundation
- One Vibrant Night Fundraiser

Outreach Activities
During the fourth Quarter, Sunflower Health Plan's outreach centered on community focused health/care insurance education forums for sharing value added benefits throughout the state. Sunflower co-coordinated immunization clinics to help close care gaps for childhood and adolescent vaccinations. Additionally, Sunflower launched a Speaker's Bureau program that enables our employee subject matter experts to further develop their communication skillsets in an effort to support our local community organizations directly. This enables community partners to have an expert level team within Sunflower Health Plan that can speak directly to various agencies in providing education, training or care for their members and advocates.

- Bi-National Health Fair focused on health for the Latino community.
- Participated in 16 community health events, including the Hispanic Heritage health events in Kansas City, KS, and the Poverty Conference in Wichita, KS.
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on December 4, 2019 in Lenexa, KS. The main agenda topics for member feedback were Member feedback on the Open Forum Survey meetings held during 3rd Quarter along with two guest speakers from SHP, Dr. Latimer (Chief Medical Officer) shared about various health indicators in the winter season and Depression along with Christina Speak, from Quality discussed the Grievance/Appeal process.
- Sunflower participated in 3 other community showers covering Montgomery, Wilson and Sedgwick counties to promote prenatal care.
- Giving Hope & Help Feminine Product Drive
- Holiday Sip n' Shop Event in Wichita, KS
- New Life Community Health Fair in Kansas City, KS
- Helping Hands Thanksgiving Giveaway in Kansas City, KS
- Turkey Trot 5K Walk/ Run Event in Wichita, KS

Advocacy Activities

Sunflower Health Plan's monthly Social Determinants of Health team to bring the health plan's SDoH initiatives and teams together in addressing programs and outreach to support employment, housing and food disparities across the state. This internal team made of our Community Relations, Community Health Service Representatives and the SDoH specialists collaboratively bring together all resources and supports for the benefit of health plan members.

During fourth quarter 2019, Sunflower staff contributed to community workgroups and coalitions advocating for health literacy, persons with disabilities and other topics addressing population health in Kansas.

The fourth Quarter community meetings and workgroups included:

- Health Alliance ICT
- Immunize Kansas Coalition meetings
- Jobs for America's Graduates – KS
- Health & Wellness Coalition of Wichita
- Fetal and Infant Mortality Review (FIMR) Community Action Teams
- Social Determinants for Health monthly meeting

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

Marketing Activities

UnitedHealthcare Community Plan of Kansas continued to focus on member, provider, and community education regarding 2019 KanCare benefits and general health education. Plan staff completed new member welcome calls and Health Risk Assessments. In Q4, UHC continues new incentive program to offer $10 debit cards to new UHC Members to complete Health Risk Assessment. New members were sent ID Cards and new member welcome kits in a timely manner. Throughout the quarter, UnitedHealthcare hosted a number of meetings and presentations with key providers, hospitals, Federally Qualified Health Centers (FQHC's) and Community Based Organizations like Catholic Charities, Consulate of Mexico, El Centro, Public Schools, Housing Authorities, Youth Rec Centers, YMCA, and Salvation Army as well as medical and behavioral health providers, health departments and faith based organizations throughout the state with a focus on innovation and collaboration. UnitedHealthcare also focused on grass-roots efforts by hosting small fun and educational events in low income housing and assisted living facilities where a lot of UHC members reside. The idea was to bring the information to the member without them having to travel.

Outreach Activities

UnitedHealthcare Community Plan participated in and/or supported 147 member facing activities, which included 58 lobby sits at provider offices, 1 Dental Clinic Day with Adventure, and 1 health and wellness clinic day with Mercy and Truth as well supported 79 events/health fairs or other educational opportunities for both consumers and providers. UnitedHealthcare organized and hosted 2 baby showers with community partners and supported an additional 6 community baby showers that were sponsored by other organizations. UnitedHealthcare leveraged bilingual Community Outreach Specialists that focused on activities targeted within assigned geographical areas across Kansas. These specialists are fluent in both English and Spanish languages and effectively communicate with members with diverse cultural backgrounds. Additional Outreach Specialists supported activities in their respective territories. UHC presented a Spanish Mental Health First Aid Class for youth and their families who speak only Spanish. The Outreach Specialists regularly support one another working collaboratively to serve UHC

Members. The key responsibility of the Outreach Specialist is to conduct educational outreach to members, community-based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. Of primary importance is to meet members where they are and help understand their personal goals and how UHC can help them reach those goals. A key area of focus in the fourth quarter was to outreach community based organizations to establish new relationships. UnitedHealthcare also interacted with key provider offices and the provider community to assist with issue resolution. Several key outreach initiatives this quarter included lobby sits, "Food for Thought Programs" hosted on-site at provider offices, and several health fairs. UnitedHealthcare also participated in a number of community stakeholder committee meetings during the fourth quarter of 2019.

Finally, UHC hosted the Q4 Member Advisory Meeting in Olathe. The Health Plan finds it critical to host meetings in different parts of the state in order to hear from those in both urban and rural areas, but this strategy makes it a challenge to have the same committee at each meeting. This advisory meeting focused on just listening and learning from members experiences with KanCare and UHC and answering questions about services.

During the fourth quarter 2019, UnitedHealthcare outreach staff personally met with approximately:

- 12,775 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.
- 1,316 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities.
- 1,207 individuals from provider offices located throughout the State.

Advocacy Activities

The UnitedHealthcare continued to support advocacy opportunities to support children and members with disabilities, and the individuals and agencies that support them.

Throughout this quarter, the team also worked closely with Health Plan Care Coordinators who support the waiver population. The Health Plan staff continued to stress to all members, including those with disabilities the desire to help support the members' personal goals and encouraged them to make informed decisions about enrollment in a KanCare plan. Staff will also meet consumers new to KanCare who are trying to understand their benefits. UnitedHealthcare remains committed to providing ongoing support and education to members and offering support to the consumers of Kansas. The Health Plan staff focused heavily on meeting with and supporting community based organizations in the first quarter. These organizations provide a direct line of support to our members and are a trusted source for information. In the fourth quarter Health Plan staff met with 85 Community Organizations, 21 different schools across the state and participated in 25 monthly coalition/task force meetings

Below is a list of the organizations the Health Plan staff interacted with during fourth quarter:

- 16th Judicial District Community Correction
- 25th Judicial Youth Services
- ARC of Central Plains
- Area Agency on Aging
- BCDS Thrift Shop
- Be Well Barton County
- Big Brothers Big Sisters
- Carbondale Attendance Center
- CASA
- Catholic Charities
- Catholic Social Services
- Center for Life Experiences
- Center of Grace
- Central Park Community Center
- Circles of Hope
- City of Dodge City
- City of Pratt
- Compass Behavioral Center
- Consulate of Mexico Kansas City
- Counseling Inc.
- Cultural Relations Agency

- Dodge City Chamber of Commerce
- Dodge City Hall
- Dodge City Police Department
- Dodge City Public Library
- Dominican Sisters Ministry
- Dream Center
- DSNWK
- Early Detections work program
- Effingham Community Library
- El Centro
- Family Crisis
- Family Crisis Center
- FCHC - Family Literacy
- Filipino Association
- Finney County Extension Office
- First Call for Help
- Fisher Community Center
- Garden City Police Board
- Garden City Police Department
- Garden City Recreation Center
- GCCC- Talent Search
- Goodwill
- Great Bend Public Library
- Harvest America
- Hays Area Children's Center
- Healthy Babies
- Healthy Families
- Horton Public Library
- Interfaith Health Conference
- Kansas Children Service League
- Kansas City Healthy Start
- Kansas Guardianship Program
- KCSL Head Start
- La Mega Radio Interview
- Latina leadership foundation
- Liberal Police Department
- Little Angels daycare
- McKinney Vento
- Midland Group
- Morrill Public Library
- Multi-services of Johnson County
- Olathe Parents as Teachers
- Options
- Osage City Public Library
- Overbrook Attendance Center
- Parents as Teachers
- Parsons Emergency Assistance
- Prairie Godmothers
- Preparémonos Topeka
- Radio Show la Ke buena
- Regional Prevention Center
- RSVP
- Russell Child Development
- Salvation Army
- Sedgwick County CRT
- Seward County Recreation Center
- St. Francis Ministries
- United Way Ellis County
- United Way of Ford
- United Way of Seward County
- Univision Kansas City
- WIC
- Women's Insight Center
- YMCA

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: 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 such issues are managed 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.

KanCare MCO Amendments approved by CMS in the fourth quarter.

Amendment Number	Subject	Submitted Date	Effective Date	Approval Date
0	Contract – Aetna Better Health, Sunflower State Health Plan and United HealthCare of the Midwest	6/22/2018	1/01/2019	11/6/2019
1	Contract term change from 5 years to 3 years with 2, 1-year extensions	7/06/2018	1/01/2019	11/6/2019

2	Capitation Rates 1/1/2019 – 12/31/2019	11/30/2018	1/01/2019	11/6/2019
3	Contract Corrections - Managed Care Rules	1/08/2019	1/01/2019	11/6/2019
4	Capitation Rates 4/1/2019 – 6/30/2019	7/09/2019	4/1/2019	11/6/2019
5	Capitation Rates 7/1/2019 – 12/31/2019	7/09/2019	7/1/2019	11/6/2019
6	Capitation Rates 7/1/2019 – 12/31/2019	9/20/2019	7/1/2019	11/6/2019
7	Reimbursement of Zolgensma	11/22/2019	7/1/2019	12/13/2019

42 CFR 438.6(c) Preprint approved by CMS:

Subject	Submitted Date	Effective Date	Approval Date
Direct the MCOs to pay the minimum fee schedule for services provided to KanCare enrollees for 1/1/10 – 12/31/20.	9/23/2019	1/01/2020	10/16/2019

State Plan Amendments (SPAs) approved:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
19-0008	Large Public Teaching Hospitals Reimbursement Rates (RAI)	6/18/2019	5/17/2019	12/04/2019
19-0009	PRTF Allowable Costs	6/27/2019	7/01/2018	10/28/2019
19-0011	DSH Methodology	8/21/2019	7/01/2019	12/02/2019
19-0012	DSH Methodology	9/10/2019	8/16/2019	11/19/2019
19-0013	Autism EPSDT Rate Change	9/20/2019	8/16/2019	11/27/2019
19-0015	Dental Rate Services	9/25/2019	8/16/2019	11/27/2019
19-0016	ER Facility Rate	9/25/2019	8/16/2019	11/27/2019
19-0017	NF/NFMH Rates SFY 2020	9/26/2019	7/01/2019	12/18/2019
19-0018	Basic Eligibility SPA for MacPro	10/15/2019	10/01/2019	11/05/2019

State Plan Amendments (SPA) pending approval:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
19-0019	DUR/SUPPORT ACT	12/02/2019	10/01/2019	
19-0023	Application – Paper and SSP	12/30/2019	10/01/2020	

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 services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2019, follows:

MCO	Value Added Service Jan- Dec 2019	Units YTD	Value YTD
Aetna	Adult Dental	1,953	$347,918
	Transportation Services	427	$44,019
	Weight Management	98	$12,898
	Total of All Aetna VAS	2,248	$315,411
Sunflower	Healthy Rewards	92,324	$966,609
	Comprehensive Medication Review	11,121	$299,539
	Dental visits for adults	2,981	$173,844

	Total of all Sunflower VAS	143,678	$2,060,966
United	Home Helper Catalog Supplies	12,091	$212,859
	Debit Card for Completing First Pre-Natal Visit	814	$167,543
	Baby Blocks Program and Rewards	1,363	$163,560
	Total of all United VAS	28,884	$1,015,994

c. Enrollment issues: For the fourth quarter of calendar year 2019 there were 4 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 fourth quarter of calendar year 2019. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	1,834
KDHE - Administrative Change	540
WEB - Change Assignment	10
KanCare Default - Case Continuity	853
KanCare Default – Morbidity	1,029
KanCare Default - 90 Day Retro-reattach	5,535
KanCare Default - Previous Assignment	1,016
KanCare Default - Continuity of Plan	838
Retro Assignment	6
AOE – Choice	122
Choice - Enrollment in KanCare MCO via Medicaid Application	7,660
Change - Enrollment Form	263
Change - Choice	428
Change - Access to Care – Good Cause Reason	12
Change - Case Continuity – Good Cause Reason	2
Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	428
Total	20,576

d. Grievances, appeals, and state hearing information:

MCOs' Member Adverse Initial Notice Timeliness Compliance
CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Notices of Adverse Service Authorization Decisions Sent Within Compliance Standards	100%	99%	100%
% of Notices of Adverse Expedited Service Authorization Decisions Sent Within Compliance Standards	100%	90%	100%
% of Notices of Adverse Termination, Suspension or Reduction Decisions Sent Within Compliance Standards (10 calendar days only)	100%	100%	100%

MCOs' Provider Adverse Initial Notice Compliance
CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Notices of Adverse Decision Sent to Providers Within Compliance Standards	100%	100%	99%

MCOs' Grievance Database
CY19 fourth quarter report

MCO	ABH		SUN		UHC		Total
	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	
QOC (non HCBS Providers)	1	10	8	28	14	19	80
QOC – Pain Medication			1	2			3
Customer Service	2	6	1	7	5	3	24
Member Rights Dignity		1	2	4		1	8
Access to Service or Care	2	2	2	15	1	8	30
Non-Covered Services	1	1		1			3
Pharmacy Issues	1	5	1	4	3	4	18
QOC HCBS Provider	2		9		2		13
Billing/Financial Issues (non-Transportation)		6	3	7	8	65	89
Transportation – Billing and Reimbursement	1	2	6	1		5	15
Transportation - No Show		6	11	12	9	11	49
Transportation - Late	2	10	23	19	10	22	86
Transportation - Safety	1	6	3	4		5	19
Transportation - No Driver Available				1	3		4
Transportation - Other	1	12	13	20	27	38	111
MCO Determined Not Applicable			2	3	2	13	20
Other			1			3	4
TOTAL	14	67	86	128	84	197	576

MCOs' Member Grievance Timeliness Compliance
CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Member Grievance Resolved and Resolution Notice Issued Within 30 Calendar Days	99%	100%	100%

MCOs' Provider Grievance Database
CY19 fourth quarter report

MCO	ABH	SUN	UHC	Total
Billing/Payment	1	3		4
Wrong Information				
Credentialing – MCO				
Network – MCO				
UM		1		1
CM				
Benefits/Eligibility		3		3
Pharmacy		2		2
Transportation		8	10	18

Services		1		1
Health Plan – Technology				
MCO Determined Not Applicable				
Other – Dissatisfaction with MCO Associate		1		1
Other (Must provide description in narrative column of Summary Reports)				
TOTAL	1	19	10	30

MCOs' Provider Grievance Timeliness Compliance
CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Provider Grievance Resolved Within 30 Calendar Days	100%	100%	100%
% of Provider Grievance Resolution Notices Sent Within Compliance Standards	100%	100%	100%

MCOs' Appeals Database
Members – CY19 fourth quarter report

Member Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined not Applicable
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met					
MA – CNM - Durable Medical Equipment	4 40 30		3 27 12	1 12 17	 1 1
MA – CNM - Inpatient Admissions (Non-Behavioral Health)	11 4 32	 19	3 2 3	5 1 10	3 1
MA – CNM - Medical Procedure (NOS)	12 11 13	 1	6 7 4	2 3 8	4 1
MA – CNM - Radiology	15 13		8 1	1 12	6
MA – CNM - Pharmacy	63 101 106	1 6 1	29 64 74	11 29 28	22 2 3
MA – CNM - PT/OT/ST	8 1		1 	7 1	
MA – CNM - Dental	7 3 12	 	2 2	3 3 7	2 3
MA – CNM - Home Health	6 1		4 	2 1	
MA – CNM - Out of network provider, specialist or specific provider request	2 9			2 9	
MA – CNM - Inpatient Behavioral Health	4 16 3	 2 	3 10 1	 4 2	1
MA – CNM - Behavioral Health Outpatient Services and Testing	1 3 4	 2 	1 1 1	 3	

MA – CNM - LTSS/HCBS	2 4		1	1 4	
MA – LOC – LTC NF	1			1	
MA – CNM - Mental Health	1			1	
MA – CNM - HCBS (change in attendant hours)	3		1	2	
MA – CNM – Ambulance (include Air and Ground)	2		1		1
MA – CNM - Other	19 2		15 1	4	 1
NONCOVERED SERVICE					
MA – NCS - Pharmacy	1 2		1 2		
MA – NCS - OT/PT/Speech	1			1	
MA – NCS - Durable Medical Equipment	1 1		1		 1
MA – NCS – Other	6		2	4	
MA – LCK - Lock In	2 1			2 1	
ADMINISTRATIVE DENIALS					
MA – ADMIN – Denials of Authorization (Unauthorized by Members)	17			10	7
TOTAL ABH - Red SUN – Green UHC - Purple	 121 257 223	 1 10 21	 56 138 100	 25 97 93	 39 12 9

* We removed categories from the above table that did not have any information to report for the month.

MCOs' Appeals Database
Member Appeal Summary – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Total Number of Appeals Resolved	121 257 223	1 10 21	56 138 100	25 97 93	39 12 9
Percentage Per Category		>1% 4% 9%	47% 54% 45%	21% 38% 42%	32% 4% 4%

MCOs' Member Appeal Timeliness Compliance
CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Member Appeals Resolved and Appeal Resolution Notice Issued in 30 Calendar Days	100%	100%	99%
% of Expedited Appeals Resolved and Appeal Resolution Notice Issued in 72 hours	100%	100%	97%

MCOs' Reconsideration Database
Providers - CY19 fourth quarter report (reconsiderations resolved)

PROVIDER Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
CLAIM DENIALS					
PR – CPD - Hospital Inpatient (Non-Behavioral Health)	156 1273 770		113 621 304	40 645 466	3 7
PR – CPD - Hospital Outpatient (Non-Behavioral Health)	169 1120 3867		123 718 1469	41 398 2398	5 4
PR – CPD - Pharmacy	7		3	3	1
PR – CPD - Dental	6 8		4 5	1 3	1
PR – CPD - Vision	2 58		1 8	1 50	
PR – CPD - Ambulance (Include Air and Ground)	30 56 89		20 31 40	2 17 49	8 8
PR – CPD - Medical (Physical Health not Otherwise Specified)	310 1332 12703		163 855 7143	128 406 5560	19 71
PR – CPD - Nursing Facilities - Total	3 75 359		3 54 209	 17 150	 4
PR – CPD - HCBS	343		259	46	38
PR – CPD - Hospice	14 25 310		12 24 166	 1 144	2
PR – CPD - Home Health	3 2		1	2 2	
PR – CPD - Behavioral Health Outpatient and Physician	28 102 1825		23 20 1083	5 35 742	 47
PR – CPD - Behavioral Health Inpatient	12 121		7 44	5 77	
PR – CPD - Out of network provider, specialist or specific provider	746 7565		25 4669	679 2896	42
PR – CPD - Radiology	24 302 1077		18 195 438	4 81 639	2 26
PR – CPD - Laboratory	66 671 7150		37 473 3006	27 198 4144	2

PR – CPD - PT/OT/ST	7 420 17		3 47 1	4 373 16	
PR – CPD - Durable Medical Equipment	72 398		31 220	37 163	4 15
PR – CPD - Other	4 13 750		1 1 358	1 9 392	2 3
Total Claim Payment Disputes	913 6942 36605		563 3556 18930	301 3121 17675	49 265
BILLING AND FINANCIAL ISSUES					
PR – BFI - Recoupment	10		6		4
ADMINISTRATIVE DENIAL					
PR – ADMIN - Denials of Authorization (Unauthorized by Members)	61		54	5	2
TOTAL ABH - Red SUN – Green UHC - Purple	 984 6942 36605		 623 3556 18930	 306 3121 17675	 55 265

MCOs' Provider Reconsiderations Database

Provider Reconsideration – Denied Claim Analysis – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Claim Denied-MCO in Error	Claim Denied-Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Reconsiderations					
MCO Reversed Decision on Reconsideration	54 2984 9745	569 538 9185	5	29	623 3556 18930
MCO Upheld Decision on Reconsideration			295 2933 11755	11 188 5920	306 3121 17675
Total Claim Payment Disputes	54 2984 9745	569 538 9185	295 2938 11755	11 217 5920	929 6677 36605

MCOs' Provider Reconsiderations Timeliness Compliance

CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Provider Reconsideration Resolution Notices Sent Within Compliance Standards	98%	100%	100%

MCOs' Appeals Database
Providers - CY19 fourth quarter report (appeals resolved)

PROVIDER Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
MEDICAL NECESSITY/LEVEL OF CARE - Criteria Not Met					
PA - CNM - Inpatient Admissions (Non-Behavioral Health)	9		3	5	1
PA - CNM - PT/OT/ST	3				3
PA - CNM - Inpatient Behavioral Health	3		2		1
CLAIM DENIAL					
PA – CPD - Hospital Inpatient (Non-Behavioral Health)	44 105 253	 1	23 62 42	10 39 165	11 4 45
PA – CPD - Hospital Outpatient (Non-Behavioral Health)	22 151 54	 1 	14 75 14	7 68 24	1 7 16
PA – CPD - Pharmacy	3		1	2	
PA – CPD - Dental	7 9 22		5 1 11	2 8 11	
PA – CPD - Vision	1 9 4		 3 2	1 6 2	
PA – CPD - Ambulance (Include Air and Ground)	2 9		1 4	1 1	 4
PA – CPD - Medical (Physical Health not Otherwise Specified)	73 272 142		40 135 19	23 114 83	10 23 40
PA – CPD - Nursing Facilities - Total	1 5 25		1 3 2	 2 16	 7
PA – CPD - Hospice	3 10 1		3 5	 4	 1 1
PA – CPD - Home Health	4 10 92	 2 	3 5 21	1 3 41	 30
PA – CPD - Behavioral Health Outpatient and Physician	14 47 30		12 29 13	2 18 12	 5
PA – CPD - Behavioral Health Inpatient	5 7		5 1	 6	

PA – CPD - Out of network provider, specialist or specific provider	215 1	4	53	135 1	23
PA – CPD - Radiology	8 29		7 22	1 7	
PA – CPD - Laboratory	12 50 86	1	4 2 4	6 39 59	2 8 23
PA – CPD - PT/OT/ST	12		7	2	3
PA – CPD - Durable Medical Equipment	26 56 1		18 24	4 30 1	4 2
PA – CPD - Other	1 2		1	 1	 1
BILLING AND FINANCIAL ISSUES					
PA – BFI - Recoupment	131 1		85	36 1	10
ADMINISTRATIVE DENIAL					
PA – ADMIN - Denials of Authorization (Unauthorized by Members)	14 36 2	 1 2	14 10	 15	 10
TOTAL ABH - Red SUN – Green UHC - Purple	 241 1163 730	 9 3	 151 527 133	 59 533 423	 31 94 171

* We removed categories from the above table that did not have any information to report for the month.

MCOs' Appeals Database

Provider Appeal Summary – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Reconsideration	984 6942 36605		623 3556 18930	306 3121 17675	55 265
Resolved at Appeal Level	241 1163 730	 9 3	151 527 133	59 533 423	31 94 171
TOTAL	1225 8105 37335	 9 3	774 4083 19063	365 3654 18098	86 359 171
Percentage Per Category		 >1% >1%	63% 50% 51%	30% 45% 48%	7% 5% 1%

MCOs' Appeals Database

Provider Appeal – Denied Claim Analysis – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Claim Denied-MCO in Error	Claim Denied-Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Appeals					
MCO Reversed Decision on Appeal	9 32 3	142 281 130	154	21	151 488 133
MCO Upheld Decision on Appeal			53 457 421	5 57 1	58 514 422
Total Claim Denials	9 32 3	142 281 130	53 611 421	5 78 1	209 1002 555

MCO's Provider Appeal Timeliness Compliance

CY19 fourth quarter report

MCO	ABH	SUN	UHC
% of Provider Appeals Resolved in 30 Calendar Days	98%	90%	100%
% of Provider Appeal Resolution Notices Sent Within Compliance Standard	98%	100%	99%

State of Kansas Office of Administrative Fair Hearings
Members – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met															
MH – CNM - Durable Medical Equipment	1 2	1			1			1							
MH – CNM - Inpatient Admissions (Non-Behavioral Health)	1	1													
MH – CNM - Medical Procedure (NOS)	1												1		
MH – CNM – Pharmacy	1 1 8		1					8					1		
MH – CNM – PT/OT/ST	2			1					1						
MH – CNM - Dental	1							1							
MH – CNM – Home Health	2				1			1							
MH – CNM - Out of network provider, specialist or specific provider request	1	1													
MH – LOC – LTSS/HCBS	1								1						

MH – CNM - HCBS (change in attendant Hours)	2	1												1	
MH – CNM - Other	3				1			2							
NONCOVERED SERVICE															
MH-NCS - Dental	1		1												
MH – LCK – LOCK IN	2							2							
MH – BFI – BILLING AND FINANCIAL ISSUES	1							1							
ADMINISTRATIVE DENIALS															
MH – ADMIN – Denials of Authorization (Unauthorized by Members)	1				1										
TOTAL ABH - Red SUN – Green UHC - Purple	 2 10 20	 2 2	 1 1 	 1 	 1 3			 2 14	 1 1				 1 1 	 1 	

* We removed categories from the above table that did not have any information to report for the month.

State of Kansas Office of Administrative Fair Hearings
Providers – CY19 fourth quarter report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY / LEVEL OF CARE - Criteria Not Met															

PH - CNM - Medical Procedure (NOS)	1							1							
PH – LOC – LTSS/HCBS	6	6													
CLAIM DENIAL															
PH - CPD - Hospital Inpatient (Non-Behavioral Health)	9 13	1 12			3 1			5							
PH - CPD - Hospital Outpatient (Non-Behavioral Health)	2	1						1							
PH - CPD - Pharmacy	3	2						1							
PH – CPD - Dental	1				1										
PH – CPD – Ambulance (include Air and Ground)	1						1								
PH - CPD - Medical (Physical Health not Otherwise Specified)	1				1										
PH – CPD - HCBS	1				1										
PH – CPD - Hospice	1 1					1		1							
PH - CPD - Home Health	1 2	1 1			1										
PH – CPD - Radiology	1							1							
PH - CPD – Laboratory	4							3			1				
PH - CPD - PT/OT/ST	1				1										

PH – CPD – Durable Medical Equipment	1				1										
BILLING AND FINANCIAL ISSUES															
PH - BFI - Recoupment	2				2										
RESOLVED WITHOUT SUBSTANTIVE CHANGES TO ORIGINAL CLAIM					3										
TOTAL ABH - Red SUN – Green UHC - Purple	 27 25	 9 15			 6 6	 1	 1	 10 3			 1				

* We removed categories from the above table that did not have any information to report for the month.

e. Quality of care: Please see Section IX "Quality Assurance/Monitoring Activity" below. HCBS Quality Reports for April-June 2019 are attached to this report.

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 (GCR) pursuant to 42 CFR 438.56 or the KanCare STCs. During the fourth quarter of 2019, most GCR requests were about provider choice, which is not an acceptable reason to switch plans outside of open enrollment. Members who chose to change managed care plans during the fourth quarter were informed changes in plans would be honored January 1, 2020. Therefore, the fourth quarter reflects a reduction in GCR requests.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2019, there was one state fair hearing filed for a denied GCR, and that case was dismissed. A summary of GCR actions this quarter is as follows:

Status	Oct	Nov	DEC
Total GCRs filed	13	6	5
Approved	3	0	1
Denied	7	5	4
Withdrawn (resolved, no need to change)	3	1	0
Dismissed (due to inability to contact the member)	0	0	0
Pending	0	0	0

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. The counts below represent the unique number of NPIs—or, where NPI is not available—provider name and service locations (based on the KanCare county designation identified in the KanCare Code Guide). This results in counts for the following:

- Providers with a service location in a Kansas county are counted once for each county.
- Providers with a service location in a border area are counted once for each state in which they have a service location that is within 50 miles of the KS border.
- Providers for services provided in the home are counted once for each county in which they are contracted to provide services.

KanCare MCO	# of Unique Providers as of 3/31/2019	# of Unique Providers as of 6/30/2019	# of Unique Providers as of 9/30/2019	# of Unique Providers as of 12/31/2019
Aetna	17,724	21,603	32,598	34,229
Sunflower	35,139	35,188	30,258	31,888
UHC	47,701	46,285	48,809	46,946

h. Payment rates: There were no payment rate changes for the quarter ending 12/31/19.

i. Health plan financial performance that is relevant to the demonstration: All KanCare MCOs remain solvent.

j. MLTSS implementation and operation: In October of 2019, Kansas offered services to 150 people on the HCBS IDD waiting list. In November and December of 2019, Kansas offered services to 615 people on the HCBS PD waiting list.

k. 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.

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

- The State continues to work with CMS regarding the Serious Emotional Disturbance Waiver (SED), particularly focusing on third-party assessments. Third-party assessments continued with the contractor (KU) during this quarter.
- The BI waiver was renewed by CMS in August 2019. In December, Kansas received CMS approval of an amendment to brain injury waiver services to youth ages birth through 15 years of age.
- The PD and FE waivers were set to expire on 12/31/19. Kansas submitted both the PD and the FE waiver drafts to CMS on October 1, 2019. Both were placed on temporary extension through 3/31/2020. Both are currently under review by CMS.

m. Legislative activity: The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight met November 18 & 19, 2019. The Committee heard presentations from individuals, providers, and organizations related to KanCare. KDHE presented testimony on the KanCare program in general, the 1115 demonstration, Medicaid eligibility (including the Clearinghouse contract), and the plan to move the eligibility work for elderly and disabled populations back to state staff. KDADS presented information on the state hospitals, the HCBS waiting lists, the status of HCBS waiver renewals, and nursing facility receivership legislation. The Committee also heard from the KanCare Ombudsman and the Medicaid Inspector General. Each MCO also provided information about their operations.

KDHE is participating in a number of legislative activities/workgroups focused on Medicaid Expansion in Kansas.

In the fourth quarter, KDHE continued collaborative efforts on the following activities as directed by the 2019 Kansas Legislature:

- The providers of Medicaid Home and Community Based Services (HCBS) waiver services received a 1.5% increase in reimbursement rates. This includes $10 million all funds and $4.2 million State General Funds (SGF)
- The Protected Income Level (PIL) for Medicaid Home and Community Based Services (HCBS) waiver recipients and individuals in the Program for All Inclusive Care (PACE) was increased to $1,177 (approximately 150% of SSI). The new PIL was in effect in September 2019.

- The Home and Community Based Services waitlist for Medicaid HCBS IDD and Medicaid PD received additional funding: IDD - $5.0 million all funds and $2.08 million SGF; PD - $1.0 million all funds and $416,600 SGF

n. Other Operational Issues: Transition of the eligibility work for elderly, disabled and long-term care started in September of 2019. The transition of all facilities was completed on 12/31/2019. KDHE held rapid response calls with stakeholders during the transition to ensure concerns were timely addressed. Twelve calls occurred since 10/01/2019. The final call was on 12/18/2019. Calls were recorded and posted on the KanCare website.

The agency kept the stakeholders updated on the status of the project. Meetings were scheduled throughout the fourth quarter with the following associations/stakeholders:

- Nursing Facility Association - Kansas Adult Care Executives (KACE)
- Nursing Facility Association - Kansas Health Care Association (KHCA)
- Nursing Facility Association - Leading Age
- National Association of Elder Law Attorneys – KS Chapter

V. Policy Developments/Issues

General Policy Issues**:** Kansas addressed policy concerns related to managed care organizations and state requirements through weekly KanCare Policy Committee, monthly 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: The State has updated the Budget Neutrality template provided by CMS and has submitted this through the PDMA system. The expenditures contained in the document reconcile to Schedule C from the CMS 64 report for QE 12 31 2019.

General reporting issues: KDHE continues to work with DXC, the fiscal agent, to modify reports as needed 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

This section reflects member month counts for each Medicaid Eligibility Group (MEG) by DY.

DY MEG	Member Months			
	Oct-19	Nov-19	Dec-19	TOTAL QE 12 31 2019
DY1 CY2013	0	0	0	0
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON-DUAL	0	0	0	0

MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	0	0
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON-DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY2 CY2014	0	0	0	0
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON-DUAL	0	0	0	0
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	0	0
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON-DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY3 CY2015	(6)	0	0	(6)
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON-DUAL	(2)	0	0	(2)
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	(4)	0	0	(4)
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON-DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY4 CY2016	(154)	0	(7)	(161)
MEG 1 - ABD/SD DUAL	(1)	0	(1)	(2)
MEG 2 - ABD/SD NON-DUAL	(126)	0	(4)	(130)
MEG 3 - ADULTS	(2)	0	0	(2)
MEG 4 - CHILDREN	(11)	0	0	(11)
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	(14)	0	(1)	(15)
MEG 7 - MN DUAL	0	0	(1)	(1)
MEG 8 - MN NON-DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY5 CY2017	(447)	(7)	(35)	(489)
MEG 1 - ABD/SD DUAL	(3)	8	0	5
MEG 2 - ABD/SD NON-DUAL	(354)	(4)	(24)	(382)
MEG 3 - ADULTS	(6)	0	0	(6)
MEG 4 - CHILDREN	(26)	(10)	(4)	(40)
MEG 5 - DD WAIVER	(18)	0	(4)	(22)
MEG 6 - LTC	(43)	0	(2)	(45)
MEG 7 - MN DUAL	1	(2)	(1)	(2)
MEG 8 - MN NON-DUAL	3	(2)	0	1
MEG 9 - WAIVER	(1)	3	0	2
DY6 CY2018	(905)	125	91	(689)
MEG 1 - ABD/SD DUAL	110	152	70	332

MEG 2 - ABD/SD NON-DUAL	(858)	(73)	(51)	(982)
MEG 3 - ADULTS	(38)	(1)	(3)	(42)
MEG 4 - CHILDREN	(38)	53	107	122
MEG 5 - DD WAIVER	(45)	0	(4)	(49)
MEG 6 - LTC	(42)	(28)	(13)	(83)
MEG 7 - MN DUAL	(6)	21	15	30
MEG 8 - MN NON-DUAL	18	(35)	(17)	(34)
MEG 9 - WAIVER	(6)	36	(13)	17
DY7 CY2019	327,407	326,599	329,761	983,767
MEG 1 - ABD/SD DUAL	15,023	14,936	14,944	44,903
MEG 2 - ABD/SD NON-DUAL	29,793	29,689	29,690	89,172
MEG 3 - ADULTS	45,589	45,250	45,498	136,337
MEG 4 - CHILDREN	201,023	200,568	202,999	604,590
MEG 5 - DD WAIVER	9,048	9,114	9,115	27,277
MEG 6 - LTC	20,458	20,566	20,889	61,913
MEG 7 - MN DUAL	1,324	1,431	1,504	4,259
MEG 8 - MN NON-DUAL	959	862	936	2,757
MEG 9 - WAIVER	4,190	4,183	4,186	12,559
Grand Total	325,895	326,717	329,810	982,422

Note: Totals do not include CHIP or MCHIP.

VIII. Consumer Issues

The consumer issues remain the same from previous quarters. A summary of the fourth quarter 2019 consumer issues is below:

Issue	Resolution	Action Taken to Prevent Further Occurrences
One MCO failed to deduct member client obligation – this caused overpayments and a significant number of recoupments. Could potentially cause large one-time payments by consumers.	MCOs should have systematic ways of deducting client obligation from claims when processing. One MCO counted upon their authorization system to trigger that deduction in the claims system. The authorization system did not function as expected.	Due to the breakdown with the authorization system, manual overrides were put in place and system configuration changes are needed. Providers are still being asked to refund the overpayments. Members will be asked to pay providers as necessary.
Delays in contracting and credentialing with one MCO, causing confusion about network providers.	There are many reasons this can occur. Sometimes providers fail to complete paperwork correctly/completely. Sometimes the MCO had backlogs in completing all the necessary checks to credential providers.	The MCO is deeming all enrolled providers as 'in-network' until credentialing timelines can be met.
Members sometimes find it difficult to find providers with open panels.	MCOs are working to correct provider network directory database issues. Also educating providers to reach out to MCOs when their directory information changes or if they add/subtract providers to the practice.	MCOs are instructed to report Open/Closed panels for all provider types and report this data in the quarterly reporting template. As part of KanCare 2.0, guidelines for the provider directory mandated inclusion of the open panel status information in the MCO directories. MCOs will be

		reporting in the new format beginning November 2019.
Retroactively eligible members are denied authorizations or claims denied for timely filing.	Members are denied authorization, services and care coordination due to retroactive eligibility.	Some of the MCO processes require manual intervention, which may lead to errors. Also, some MCOs require a claim to be submitted and denied before they can implement the retroactive eligibility protocol. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations.

IX. Quality Assurance/Monitoring Activity

The State Quality Management Strategy – The QMS is designed to provide an overarching framework for the State to allocate resources in an efficient manner with the objective of driving meaningful quality improvement (QI). Underneath the QMS lies the State's monitoring and oversight activities, across KDHE and KDADS, that act as an early alert system to more rapidly address MCO compliance issues and reported variances from expected results. Those monitoring and oversight activities represent the State's ongoing actions to ensure compliance with Federal and State contract standards. The framework of the QMS has been redesigned to look at the KanCare program and the population it serves in a holistic fashion to address all physical, behavioral, functional and social determinants of health and independence needs of the enrolled population. The QMS serves as the launch pad from which the State will continue to build and implement continuous QI principals in key areas of the KanCare program. The State will continue to scale the requirements of the QMS to address and support ongoing system transformation.

A requirement for approval of the 1115 waiver was development of a State QMS to define waiver goals and corresponding statewide strategies, as well as all standards and technical specifications for contract performance measurement, analysis, and reporting. CMS finalized new expectations for managed care service delivery in the 2017 Medicaid and CHIP Managed Care Final Rule. The intent of this QMS revision is to comply with the Final Rule, to establish regular review and revision of the State quality oversight process and maintain key State values of quality care to Medicaid recipients through continuous program improvement. Review and revision will feature processes for stakeholder input, tribal input, public notification, and publication to the Kansas Register.

The current QMS defines technical specifications for data collection, maintenance, and reporting to demonstrate recipients are receiving medically necessary services and providers are paid timely for service delivery. The original strategy includes most pre-existing program measures for specific services and financial incentives called pay for performance (P4P) measures to withhold a percentage of the capitation payment the managed care organizations (MCOs) can earn by satisfying certain quality benchmarks. Many of the program-specific, pre-existing measures were developed for the 1915(c) disability waivers designed and managed by the operating agency, KDADS, and administered by the single State Medicaid agency, KDHE. Regular and consistent cross-agency review of the QMS will highlight progress toward State goals and measures and related contractor progress. The outcome findings will demonstrate areas of compliance and non-compliance with Federal standards and State contract requirements. This systematic review will advance trending year over year for the State to engage contractors in continuous monitoring and improvement activities that ultimately impact the quality of services and reinforce positive change.

During the fourth quarter, the State participated in the following activities:

- Ongoing automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates. New report added in this quarter to monitor compliance with contract requirement 5.17.2.F. Contractor Key Personnel and Disabilities Hiring Plan.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate 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.
- Monitoring of the External Quality Review Organization (EQRO) work plan.
- Continued system design with the EQRO to collect reports specific to performance improvement projects (PIPs) and the Health Action Planning for the OneCare Kansas health homes program.
- Meetings with the EQRO along with the MCOs, KDADS, and KDHE to discuss EQRO activities and concerns.
- Performed onsite Joint BBA and State KanCare Contract Audits in this quarter with two of the three MCOs, with the third onsite scheduled for the first quarter of 2020. Coordinated material, agendas, and activities with KDADS and the EQRO to determine each MCO's level of compliance with the new KanCare contracts and federal requirements.
- Medicaid Fraud Control Unit 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 to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Additionally, top management staff from KDADS, KDHE and the three MCOs meet monthly face-to-face to discuss issues and improvements to KanCare.
- Monitor large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted on the KanCare website for providers and other interested parties to view. Continue monthly meetings to discuss trends and progress.
- Monitor member or provider specific issues through a tracking database that is shared with MCOs and KDADS for weekly review.
- Attend various provider training and workshops presented by the MCOs. Monitor for accuracy, answer questions as needed.
- With the implementation of KanCare 2.0 each MCO is required to participate in six PIPs. During the fourth quarter of 2019, PIP activities focused on MCOs continuing to submit proposed interventions for several of their PIP topics. MCOs are required to implement a minimum of five interventions per topic. KDHE met with state subject matter experts (SMEs) to confer on some PIP interventions (i.e., KDADS, clinical and employment staff). Revisions have been required of many of the proposed interventions. For the PIPs with approved interventions, the MCOs have begun submitting their draft methodologies. They are co-reviewed by the State and the EQRO, and the methodology is either approved or revisions are required. As of end of the quarter, all EPSDT PIP methodologies are approved, as well as the methodologies for Cervical Cancer Screening, Flu Vaccine, Advance Directives, and Prenatal Care and Timing PIPs. The technical specifications for the HPV and EPSDT PIPs were completed. Data reporting for these PIPs, as well as all others with approved methodologies, are expected in second quarter of 2020. The annual SMD PIP report from SHP was submitted this quarter. Review and validation should be completed in the second quarter of 2020.

- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE, and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Aging & Disability Community Services and Programs Commission (A&D CSP) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the MCO contracts. A tool developed by KDHE and KDADS was delivered to the MCOs to monitor compliance with HCBS Provider Qualifications. The MCOs contracted with a single vendor to complete the audits effective 1/1/2020. Future LTSS Quality Review reports will now be able to report data on Qualified Provider performance measure compliance.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Aging and Disability Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. During this quarter, HCBS performance measures were reported to CMS via the 372 reporting process. A quality assurance protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews.
- Below is the timeline that the KDADS Quality Review Team follows regarding the quality review process.

HCBS Quality Review Rolling Timeline							
	FISC/IT	A&D CSP	MCO/Assess	A&D CSP	FISC	A&D CSP	CSP
Review Period (look back period)	Samples Pulled *Posted to QRT	Notification to MCO/Assessor Samples posted	MCO/Assessor Upload Period *(60 days)	Review of MCO data *(90 days)	Data pulled & Compiled (30days)	Data & Findings Reviewed at LTC Meeting ***	Remediation Reviewed at LTC Meeting
01/01 – 03/31	4/1 – 4/15	4/16	4/16 – 6/15	5/16 – 8/15	9/15	October	November
04/01 – 06/30	7/1 – 7/15	7/16	7/16 – 9/15	8/16 – 11/15	12/15	January	February
07/01 – 09/30	10/1 – 10/15	10/16	10/16 – 12/15	11/16 – 2/15	3/15	April	May
10/01 – 12/31	1/1 – 1/15	1/16	1/16 – 3/15	2/16 – 5/15	6/15	July	August

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. The State's network data and analysis tools were moved from Excel into a dedicated database on a secure server during the second quarter of 2019. This database allows the State to give more robust and timely feedback to the MCOs. This method is less prone to breakdowns and improves business continuity. KDHE has continued to give MCOs feedback on the accuracy and completeness of their quarterly report. As

MCOs improve their reporting, feedback is becoming less about basic errors (duplicates) and more detailed (at provider level). The State had an opportunity to meet with two of the three MCO network teams during the onsite Joint BBA and state KanCare contract audit. The third is scheduled for the first quarter of 2020. In 2020, the State plans to complete another round of onsite visits with all three MCOs to collaborate and problem solve provider network reporting processes. Matching the report against additional data sources also gives a clearer picture of the report's accuracy and completeness. For example, the national NPI database is being referenced for matching of NPI types/specialties and taxonomies. The State also began collecting the data files for MCO provider directories this quarter. The State's plan is to give feedback to the MCOs when differences between the directory and network report are found. This process will also give the State insight into information such as office hours, cultural competency, and ADA capabilities. In addition, the State has asked the EQRO to perform a provider directory, KMAP, Provider Network Report comparison audit. This will give the State insight into opportunities for improvement.

Initial submission of the revised GeoAccess Report occurred in this quarter. The team has been meeting to develop tools and process to analyze and present these reports to our partners (KDADS, KFMC & MCOs). Initial feedback has focused on correct submission and formatting of these reports. The plan is to begin quarterly meetings in 2020 to discuss and evaluate any gaps in network coverage. KDHE and KDADS designed definitive GeoAccess standards and posted these standards on our KanCare website at:
https://www.kancare.ks.gov/policies-and-reports/network-adequacy

- MCO Network Access:
  - 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.
- HCBS Providers by Waiver Service:
  - 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, July - September 2019:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	15.12	3.3	168,868
Sunflower	10.02	2.3	203,156
United	19.5	.99	207,446
DXC – Fiscal Agent	0.04	0.38%	30,361

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	14.99	0	73,056
Sunflower	28.89	1.6	102,934
United	1.15	.29	88,043
DXC – Fiscal Agent	0.15	0.76%	37,881

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

MCOs' Grievance Trends
Members – CY19 Fourth Quarter

Aetna Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	81	
Top 5 Trends		
Trend 1: Transportation – Other	13	16%
Trend 2: Transportation – Late	12	15%
Trend 3: Quality of Care (non HCBS, non-Transportation)	11	14%
Trend 4: Customer Service	8	10%
Trend 5: Transportation – Safety	7	9%

Sunflower Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	214	
Top 5 Trends		
Trend 1: Transportation – Late	42	20%
Trend 2: Quality of Care (non HCBS, non-Transportation)	36	17%
Trend 3: Transportation – Other	33	15%
Trend 4: Transportation – No Show	23	11%
Trend 5: Access to Service or Care	17	8%

United Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	281	
Top 5 Trends		
Trend 1: Billing and Financial Issues	73	26%
Trend 2: Transportation – Other	65	23%
Trend 3: Quality of Care (non HCBS, non-Transportation)	33	12%
Trend 4: Transportation – Late	32	11%
Trend 5: Transportation – No Show	20	7%

United Member Grievances

- There were 73 member grievances categorized as Billing and Financial Issues which is a significant increase of 15 from quarter three.
- There were 65 member grievances categorized as Transportation – Other which is a significant increase of 28 from quarter three.

MCOs' Grievance Trends
Provider – CY19 Fourth Quarter

Aetna Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	1	
Top 5 Trends		
Trend 1: Billing/Payment	1	100%

Sunflower Fourth Quarter Grievance Trends	
Total # of Resolved Grievances	19

Top 5 Trends		
Trend 1:	8	42%
Trend 2:	3	16%
Trend 3:	3	16%
Trend 4:	2	11%

United Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	10	
Top 5 Trends		
Trend 1: Transportation	10	100%

MCO's Reconsideration Trends
Provider – CY19 Fourth Quarter

Aetna Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	984	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	310	32%
Trend 2: PR – CPD – Hospital Outpatient (non-Behavioral Health)	169	17%
Trend 3: PR – CPD – Hospital Inpatient (non-Behavioral Health)	156	16%
Trend 4: PR – CPD – Durable Medical Equipment	72	7%
Trend 5: PR – CPD – Laboratory	66	7%

Aetna Provider Reconsiderations

- There were 310 provider reconsiderations categorized as PR – CPD – Medical (Physical Health not Otherwise Specified) which is a significant increase of 259 from quarter three.
- There were 169 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (non-Behavioral Health) which is a significant increase of 129 from quarter three.
- There were 156 provider reconsiderations categorized as PR – CPD – Hospital Inpatient (non-Behavioral Health) which is a significant increase of 123 from quarter three.
- There were 72 provider reconsiderations categorized as PR – CPD – Durable Medical Equipment which is a significant increase of 62 from quarter three.
- There were 66 provider reconsiderations categorized as PR – CPD – Laboratory which is a significant increase of 59 from quarter three.

Sunflower Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	6942	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	1332	19%
Trend 2: PR – CPD – Hospital Inpatient (non-Behavioral Health)	1273	18%
Trend 3: PR – CPD – Hospital Outpatient (non-Behavioral Health)	1120	16%
Trend 4: PR – CPD – Out of network provider, specialist or specific provider request	746	11%
Trend 5: PR – CPD – Laboratory	671	10%

United Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	36605	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	12703	35%
Trend 2: PR -CPD Out of network provider, specialist or specific provider request	7565	21%

Trend 3: PR – CPD – Laboratory	7150	20%
Trend 4: PR – CPD – Hospital Outpatient (non-Behavioral Health)	3867	11%
Trend 5: PR – CPD – Behavioral Health Outpatient and Physician	1825	5%

United Provider Reconsiderations

- There were 1,825 provider reconsiderations categorized as PR – CPD – Behavioral Health Outpatient and Physician which is a significant increase of 165 from quarter three.

MCOs' Appeals Trends
Member/Provider – CY19 Fourth Quarter

Aetna Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	121		Total # of Resolved Provider Appeals	241	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	63	52%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	73	30%
Trend 2: MA – CNM – Radiology	15	12%	Trend 2: PA – CPD – Hospital Inpatient (non-Behavioral Health)	44	18%
Trend 3: MA – CNM – Medical Procedure (NOS)	12	10%	Trend 3: PA – CPD – Durable Medical Equipment	26	11%
Trend 4: MA – CNM – Inpatient Admissions (non-Behavioral Health)	11	9%	Trend 4: PA – CPD – Hospital Outpatient (non-Behavioral Health)	22	9%
Trend 5: MA – CNM – Dental	7	6%	Trend 5: PA – CPD – Behavioral Health Outpatient and Physician / PA – ADMIN – Denials of Authorization (Unauthorized by Members)	14	6%

- There were 73 provider appeals categorized as PA – CPD – Medical (Physical Health not Otherwise Specified) which is a significant increase of 66 from quarter three.
- There were 44 provider appeals categorized as PA – CPD – Hospital Inpatient (non-Behavioral Health) which is a significant increase of 40 from quarter three.
- There were 26 provider appeals categorized as PA – CPD – Durable Medical Equipment which is a significant increase of 25 from quarter three.
- There were 22 provider appeals categorized as PA – CPD – Hospital Outpatient (non-Behavioral Health) which is a significant increase of 20 from quarter three.
- There were 14 provider appeals categorized as PA – CPD – Behavioral Health Outpatient and Physician which is a significant increase of 14 from quarter three.

Sunflower Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	257		Total # of Resolved Provider Appeals	1163	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	101	39%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	272	23%
Trend 2: MA – CNM – Durable Medical Equipment	40	16%	Trend 2: PA – CPD – Out of network provider, specialist or specific provider request	215	18%
Trend 3: MA – CNM – Other	19	7%	Trend 3: PA – CPD – Hospital Outpatient (non-Behavioral Health)	151	13%

Trend 4: MA – ADMIN – Denials of Authorization (Unauthorized by Members)	17	7%	Trend 4: PA -BFI – Recoupment	131	11%
Trend 5: MA – CNM – Inpatient Behavioral Health	16	6%	Trend 5: PA – CPD – Hospital Inpatient (non-Behavioral Health)	105	9%

Sunflower Member Appeals

- There were 101 member appeals categorized as MA – CNM – Pharmacy which is a significant increase of 17 from quarter three.

Sunflower Provider Appeals

- There were 131 provider appeals categorized as PA – BFI – Recoupment which is a significant increase of 16 from quarter three.

United Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	223		Total # of Resolved Provider Appeals	730	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	106	48%	Trend 1: PA – CPD – Hospital Inpatient (non-Behavioral Health)	253	35%
Trend 2: MA – CNM – Inpatient Admissions (non-Behavioral Health)	32	14%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	142	19%
Trend 3: MA – CNM – Durable Medical Equipment	30	13%	Trend 3: PA – CPD – Home Health	92	13%
Trend 4: MA – CNM – Medical Procedure (NOS)	13	6%	Trend 4: PA – CPD – Laboratory	86	12%
Trend 5: MA – CNM – Dental	12	5%	Trend 5: PA – CPD – Hospital Outpatient (non-Behavioral Health)	54	7%

United Provider Appeals

- There were 92 provider appeals categorized as PA – CPD – Home Health which is a significant increase of 39 from quarter three.
- There were 86 provider appeals categorized as PA – CPD- Laboratory which is a significant increase of 34 from quarter three.

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY19 Fourth Quarter

- There was a total of 32 Member State Fair Hearings for all three MCOs. One decision was reversed by OAH.
- There was a total of 52 Provider State Fair Hearings for all three MCOs. No decisions were reversed by OAH.

Aetna Fourth Quarter					
Total # of Member SFH	2		Total # of Provider SFH	0	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

Sunflower Fourth Quarter					
Total # of Member SFH	10		Total # of Provider SFH	27	
OAH reversed MCO decision	1	10%	OAH reversed MCO decision	0	0%

United Fourth Quarter					
Total # of Member SFH	20		Total # of Provider SFH	25	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

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

e. Summary of ombudsman activities: The report for the second quarter of calendar year 2019 is attached.

f. Summary of MCO critical incident report:
The Adverse Incident Reporting (AIR) system is a critical incident management reporting and monitoring system for the detection, prevention, reporting, investigation and remediation of critical incidents with design components to ensure proper follow-up and resolution occurs for all defined adverse incidents. Additional requirements have been implemented to confirm review and resolutions regarding instances of seclusion, restraint, restrictive intervention, and death followed appropriate policies and procedures. The Kansas Department for Aging and Disability Services (KDADS) implemented enhancements to the AIR system on 9/17/18. These enhancements allow KDADS, KDHE, and MCOs to manage specific critical incidents in accordance with KDADS' AIR Policy.

All the Managed Care Organizations (MCOs) have access to the system. MCOs and KDADS staff may now both read and write information directly into the AIR system. Creating an Adverse Incident Report is forward facing, so anyone from a concerned citizen to an MCO Care Coordinator can report into the AIR system by visiting the KDADS website at www.kdads.ks.gov and selecting Adverse Incident Reporting (AIR) under the quick links. All reports are input into the system electronically. While a system with DCF is being developed to automatically enter determinations into AIR, KDADS requires duplicate reporting for instances of Abuse, Neglect and Exploitation to both DCF and the AIR system. Determinations received from the Kansas Department for Children and Families (DCF) are received by KDADS staff who review the AIR system and attach to an existing report, or manually enter reports that are not already in the AIR system. After reports are received and reviewed and waiver information is verified by KDADS staff in MMIS, MCOs receive notification of assigned reports. MCOs have the ability to provide follow-up information within the AIR system and address corrective action plans issued by KDADS as appropriate. To protect member protected health information, MCO access is limited to only their enrolled members. Please note that Kansas is in the process of establishing a memorandum of understanding (MOU) between KDADS and DCF to improve communication, data sharing and leverage resources between the agencies.

KDADS Program Integrity continues providing AIR training to Community Service Providers and any interested parties statewide upon request. Access to training materials and contact information to request a training is located on the KDADS website. Along with provider and individual training, KDADS provides updated trainings to the MCOs as requested for new staff and as a refresher to ensure efficient and consistent processes.

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 2019 AIR reports through the quarter ending December 31, 2019 follows:

Critical Incidents	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Reviewed	2,187	2,359	2,369	2,435	9,350
Pending Resolution	88	184	187	6	465
Total Received	2,275	2,543	2,556	2,441	9,815
APS Substantiations*	109	134	162	167	572

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

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 DY7 fourth quarter HCAIP UCC Pool payments were issued October 25, 2019. The DY7 quarter four LPTH/BCCH UC Pool payments will be issued February 7, 2020.

SNCP and HCAIP reports for the fourth quarter of DY 7 are attached to this report.

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). KFMC worked with KDHE to develop a draft evaluation design that was submitted to CMS June 27, 2019. The state is working to respond to CMS comments for the draft evaluation design.

XIII. Other (Claims Adjudication Statistics; Waiting List Management)

a. Post-award forums

No post-award forum was held during the October-December 2019 quarter.

b. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December 2019, is attached.

c. Waiting List Management

PD Waiting List Management

For the quarter ending December 31, 2019:

- Current number of individuals on the PD Waiting List: 1,504
- Number of individuals added to the waiting list: 408
- Number of individuals removed from the waiting list: 1,145
    - 868 started receiving HCBS-PD waiver services

- 54 were deceased
- 223 were removed for other reasons (refused services, voluntary removal, etc.)

d. I/DD Waiting List Management

For the quarter ending December 31, 2019:

- Current number of individuals on the I/DD Waiting List: 4,086
- Number of individuals added to the waiting list: 156
- Number of individuals removed from the waiting list: 177
  - 92 started receiving HCBS-I/DD waiver services
  - 3 were deceased
  - 82 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-IDD is 9,111. KDADS is currently serving 9,112 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
IV(e)	HCBS Quality Report for April-June 2019
X(e)	Summary of KanCare Ombudsman Activities for QE 9.30.19
XI	Safety Net Care Pool Reports DY 7 Q4 and HCAIP Reports DY7 Q4
XIII(b)	KDHE Summary of Claims Adjudication Statistics for January-September 2019

XV. State Contacts

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VI. Date Submitted to CMS

May 29, 2019

Home and Community Based Services Quality Review Report April - June 2019

KDADS HCBS Quality Review Report

Administrative Authority
PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Denominator: Number of Quality Review reports
Review Period: 04/01/2019 - 06/30/2019
Data Source: Quality Review Reports to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	1
Denominator	1
FE	**100%**
Numerator	1
Denominator	1
IDD	**100%**
Numerator	1
Denominator	1
TBI	**100%**
Numerator	1
Denominator	1
TA	**100%**
Numerator	1
Denominator	1
Autism	**100%**
Numerator	1
Denominator	1
SED	**100%**
Numerator	1
Denominator	1

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
FE								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
IDD								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
TBI								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
TA								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
Autism								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%
SED								
Statewide	25%	25%	25%	75%	100%	100%	100%	100%

Explanation of Findings:

Performance measure achieved.

Remediation:

No remediation necessary.

KDADS HCBS Quality Review Report

Administrative Authority
PM 2: Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency
Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS
Denominator: Total number of waiver amendments and renewals
Review Period: 04/01/2019 - 06/30/2019
Data Source: Number of waiver amendments and renewals sent to KDHE

Compliance By Waiver	Statewide
PD	**N/A**
Numerator	0
Denominator	0
FE	**N/A**
Numerator	0
Denominator	0
IDD	**N/A**
Numerator	0
Denominator	0
TBI	**N/A**
Numerator	0
Denominator	0
TA	**N/A**
Numerator	0
Denominator	0
Autism	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	N/A	100%	100%	100%	N/A	N/A	N/A	N/A
FE								
Statewide	not a measure	100%	100%	100%	N/A	N/A	N/A	N/A
IDD								
Statewide	100%	100%	100%	100%	N/A	100%	N/A	N/A
TBI								
Statewide	100%	100%	100%	100%	N/A	100%	N/A	N/A
TA								
Statewide	100%	100%	N/A	100%	N/A	100%	100%	N/A
Autism								
Statewide	100%	100%	N/A	N/A	100%	N/A	N/A	N/A
SED								
Statewide	100%	100%	N/A	N/A	100%	N/A	N/A	N/A

Explanation of Findings:

Not applicable.

Remediation:

No remediation necessary.

KDADS HCBS Quality Review Report

Administrative Authority
PM 3: Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Denominator: Number of waiver policy changes implemented by the Operating Agency
Review Period: 04/01/2019 - 06/30/2019
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**N/A**
Numerator	0
Denominator	0
FE	**N/A**
Numerator	0
Denominator	0
IDD	**N/A**
Numerator	0
Denominator	0
TBI	**N/A**
Numerator	0
Denominator	0
TA	**N/A**
Numerator	0
Denominator	0
Autism	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	N/A	N/A	100%	N/A	100%	100%	N/A	N/A
FE								
Statewide	N/A	N/A	100%	N/A	100%	100%	N/A	N/A
IDD								
Statewide	100%	N/A	100%	100%	100%	100%	N/A	N/A
TBI								
Statewide	100%	N/A	100%	100%	100%	100%	N/A	N/A
TA								
Statewide	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A
Autism								
Statewide	N/A	N/A	N/A	N/A	100%	100%	N/A	N/A
SED								
Statewide	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A

Explanation of Findings:

Not applicable.

Remediation:

No remediation necessary.

KDADS HCBS Quality Review Report

Administrative Authority
PM 4: Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Numerator: Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Denominator: Number of Long-Term Care meetings
Review Period: 04/01/2019 - 06/30/2019
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	3
Denominator	3
IDD	**100%**
Numerator	3
Denominator	3
TBI	**100%**
Numerator	3
Denominator	3
TA	**100%**
Numerator	3
Denominator	3
Autism	**100%**
Numerator	3
Denominator	3
SED	**100%**
Numerator	3
Denominator	3

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	Not a measure	45%	67%	70%	100%	100%	100%	100%
FE								
Statewide	100%	82%	50%	70%	100%	100%	100%	100%
IDD								
Statewide	Not a measure	91%	Not Available	70%	100%	100%	100%	100%
TBI								
Statewide	Not a measure	73%	Not Available	70%	100%	100%	100%	100%
TA								
Statewide	Not a measure	64%	Not Available	70%	100%	100%	100%	100%
Autism								
Statewide	Not a measure	91%	100%	70%	100%	100%	100%	100%
SED								
Statewide	Not a measure	100%	Not Available	70%	100%	100%	100%	100%

Explanation of Findings:

Performance measure achieved.

Remediation:

No remediation necessary.

KDADS HCBS Quality Review Report

Level of Care
PM 1: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Numerator: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Denominator: Total number of initial enrolled waiver participants
Review Period: 04/01/2019 - 06/30/2019
Data Source: Functional Assessor Record Review/State Data Systems

Compliance By Waiver	Statewide
PD	**89%**
Numerator	234
Denominator	263
FE	**94%**
Numerator	455
Denominator	482
IDD	**97%**
Numerator	142
Denominator	146
TBI	**94%**
Numerator	46
Denominator	49
TA	**100%**
Numerator	26
Denominator	26
Autism	**100%**
Numerator	4
Denominator	4
SED	**91%**
Numerator	365
Denominator	401

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	64%	83%	96%	86%	89%	92%	91%	89%
FE								
Statewide	81%	91%	93%	98%	100%	96%	95%	94%
IDD								
Statewide	99%	94%	90%	100%	100%	99%	98%	97%
TBI								
Statewide	62%	89%	81%	85%	96%	88%	88%	94%
TA								
Statewide	97%	89%	100%	98%	100%	100%	100%	100%
Autism								
Statewide	82%	No Data	100%	N/A	77%	96%	100%	100%
SED								
Statewide	99%	89%	88%	91%	92%	90%	93%	91%

Explanation of Findings:

For this Performance Measure, KDADS is utilizing KAMIS assessment data and MMIS eligibility data to determine compliance for six of the waivers, and the Autism waiver remains a record review.

Data pulled from KAMIS effective December 1, 2019.

Remediation:

Performance measure achieved, no remediation necessary.

KDADS HCBS Quality Review Report

Level of Care
PM 2: Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Denominator: Number of waiver participants who received Level of Care redeterminations
Review Period: 04/01/2019 - 06/30/2019
Data Source: Functional Assessor Record Review/State Data Systems

Compliance By Waiver	Statewide
PD	**74%**
Numerator	1044
Denominator	1404
FE	**79%**
Numerator	745
Denominator	942
IDD	**98%**
Numerator	2104
Denominator	2146
TBI	**74%**
Numerator	60
Denominator	81
TA	**100%**
Numerator	129
Denominator	129
Autism	**86%**
Numerator	6
Denominator	7
SED	Not a Waiver
Numerator	Performance
Denominator	Measure

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	47%	52%	64%	69%	68%	79%	71%	74%
FE								
Statewide	68%	70%	76%	79%	68%	84%	83%	79%
IDD								
Statewide	97%	74%	75%	77%	78%	97%	98%	98%
TBI								
Statewide	39%	50%	62%	65%	62%	70%	63%	74%
TA								
Statewide	94%	90%	86%	96%	93%	99%	99%	100%
Autism								
Statewide	68%	No Data	75%	78%	63%	65%	75%	86%
SED								
Statewide	93%	88%	94%	88%	89%	Not a Measure	Not a Measure	Not a Measure

Explanation of Findings:

For this Performance Measure, KDADS is utilizing KAMIS assessment data and MMIS eligibility data to determine compliance for six of the waivers, and the Autism waiver remains a record review.

Data pulled from KAMIS effective December 1, 2019.

Explanation of findings for Administrative data pull: The individual does not have a functional assessment within 365 days or the individual does not have a completed functional assessment within 365 days of the previous assessment.

Remediation:

KDADS HCBS Quality Review Report

Level of Care
PM 3: Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
Numerator: Number of waiver participants whose Level of Care determinations used the approved screening tool
Denominator: Number of waiver participants who had a Level of Care determination
Review Period: 04/01/2019 - 06/30/2019
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**81%**
Numerator	76
Denominator	94
FE	**89%**
Numerator	80
Denominator	90
IDD	**99%**
Numerator	91
Denominator	92
TBI	**91%**
Numerator	49
Denominator	54
TA	**100%**
Numerator	57
Denominator	57
Autism	**100%**
Numerator	11
Denominator	11
SED	**98%**
Numerator	86
Denominator	88

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	93%	84%	79%	80%	85%	81%	78%	81%
FE								
Statewide	88%	91%	91%	92%	88%	93%	96%	89%
IDD								
Statewide	97%	95%	99%	99%	99%	99%	100%	99%
TBI								
Statewide	64%	81%	79%	77%	82%	85%	84%	91%
TA								
Statewide	93%	98%	100%	100%	98%	100%	100%	100%
Autism								
Statewide	88%	No Data	90%	88%	91%	89%	100%	100%
SED								
Statewide	77%	79%	83%	88%	91%	95%	100%	98%

Explanation of Findings:

PD: current FAI assessment missing for the review period

Additional findings: missing current assessment

Remediation:

KDADS HCBS Quality Review Report

Level of Care
PM 4: Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor
Numerator: Number of initial Level of Care (LOC) determinations made by a qualified assessor
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2019 - 06/30/2019
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**81%**
Numerator	76
Denominator	94
FE	**89%**
Numerator	80
Denominator	90
IDD	**98%**
Numerator	90
Denominator	92
TBI	**91%**
Numerator	49
Denominator	54
TA	**100%**
Numerator	57
Denominator	57
Autism	**100%**
Numerator	11
Denominator	11
SED	**98%**
Numerator	86
Denominator	88

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	19%	68%	81%	80%	84%	81%	77%	81%
FE								
Statewide	24%	86%	91%	92%	88%	92%	96%	89%
IDD								
Statewide	92%	85%	96%	97%	96%	98%	99%	98%
TBI								
Statewide	57%	73%	83%	77%	82%	85%	84%	91%
TA								
Statewide	93%	100%	99%	100%	94%	100%	100%	100%
Autism								
Statewide	0%	No Data	57%	68%	85%	89%	100%	100%
SED								
Statewide	99%	71%	88%	86%	90%	94%	100%	98%

Explanation of Findings:

For this Performance Measure, the entire sample population is reviewed, regardless of whether the file contains an initial or an annual Level of Care determination.

PD: current FAI assessment missing for the review period

Remediation:

KDADS HCBS Quality Review Report

Level of Care
PM 5: Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2019 - 06/30/2019
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**81%**
Numerator	76
Denominator	94
FE	**89%**
Numerator	80
Denominator	90
IDD	**99%**
Numerator	91
Denominator	92
TBI	**91%**
Numerator	49
Denominator	54
TA	**100%**
Numerator	57
Denominator	57
Autism	**100%**
Numerator	11
Denominator	11
SED	**98%**
Numerator	86
Denominator	88

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	73%	83%	96%	80%	84%	81%	78%	81%
FE								
Statewide	91%	90%	96%	91%	100%	93%	96%	89%
IDD								
Statewide	98%	95%	91%	98%	100%	98%	100%	99%
TBI								
Statewide	58%	81%	83%	76%	96%	85%	84%	91%
TA								
Statewide	93%	98%	100%	100%	100%	100%	100%	100%
Autism								
Statewide	89%	No Data	100%	88%	88%	89%	100%	100%
SED								
Statewide	99%	88%	87%	89%	92%	95%	100%	98%

Explanation of Findings:

For this Performance Measure, the entire sample population is reviewed, regardless of whether the file contains an initial or an annual Level of Care determination.

PD: current FAI assessment missing for the review period

Remediation:

KDADS HCBS Quality Review Report

Qualified Providers
PM 1: Number and percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Numerator: Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Denominator: Number of all new licensed/certified waiver providers
Review Period: 04/01/2019 - 06/30/2019
Data Source:

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs and KDADS are creating a tool to utilize for these reviews.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	100%			N/A				
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	5%	No Data	No Data	N/A	N/A
Sunflower				30%				
United				N/A				
Statewide	100%			9%				
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	98%			N/A				
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	91%			N/A				
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	93%			N/A				
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	100%			N/A				
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	100%			N/A				

KDADS HCBS Quality Review Report

Qualified Providers
PM 2: Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Numerator: Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Denominator: Number of enrolled licensed/certified waiver providers
Review Period: 04/01/2019 - 06/30/2019
Data Source:

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs and KDADS are creating a tool to utilize for these reviews.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	100%			0%				
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	12%	No Data	No Data	N/A	N/A
Sunflower				23%				
United				0%				
Statewide	Not a measure			11%				
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	98%			0%				
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	89%			0%				
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	93%			0%				
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	14%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	100%			4%				
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	100%			0%				

KDADS HCBS Quality Review Report

Qualified Providers
PM 3: Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Numerator: Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Denominator: Number of all new non-licensed/non-certified providers
Review Period: 04/01/2019 - 06/30/2019
Data Source:

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs and KDADS are creating a tool to utilize for these reviews.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	75%			N/A				
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	100%			N/A				
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	Not a measure			N/A				
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	88%			N/A				
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	No Data			N/A				
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	82%			N/A				
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	Not a measure			N/A				

KDADS HCBS Quality Review Report

Qualified Providers
PM 4: Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Numerator: Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Denominator: Number of enrolled non-licensed/non-certified providers
Review Period: 04/01/2019 - 06/30/2019
Data Source:

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs and KDADS are creating a tool to utilize for these reviews.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	3%	No Data	No Data	N/A	N/A
Sunflower				1%				
United				0%				
Statewide	75%			1%				
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	Not a measure			0%				
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				8%				
United				0%				
Statewide	Not a measure			2%				
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	8%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	88%			3%				
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	13%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	No Data			4%				
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	8%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	91%			2%				
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	N/A	No Data	No Data	N/A	N/A
Sunflower				N/A				
United				N/A				
Statewide	89%			N/A				

KDADS HCBS Quality Review Report

Qualified Providers
PM 5: Number and percent of active providers that meet training requirements
Numerator: Number of providers that meet training requirements
Denominator: Number of active providers
Review Period: 04/01/2019 - 06/30/2019
Data Source:

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD				
Numerator				
Denominator				
FE				
Numerator				
Denominator				
IDD				
Numerator				
Denominator				
TBI				
Numerator				
Denominator				
TA				
Numerator				
Denominator				
Autism				
Numerator				
Denominator				
SED				
Numerator				
Denominator				

Explanation of Findings:

MCOs and KDADS are creating a tool to utilize for these reviews.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	No Data			0%				
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	No Data			0%				
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	99%			0%				
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	No Data			0%				
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	No Data			0%				
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	20%	No Data	No Data	N/A	N/A
Sunflower				36%				
United				0%				
Statewide	No Data			11%				
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup		No Data	No Data	0%	No Data	No Data	N/A	N/A
Sunflower				0%				
United				0%				
Statewide	88%			0%				

KDADS HCBS Quality Review Report

Service Plan
PM 1: Number and percent of waiver participants whose service plans address participants' goals
Numerator: Number of waiver participants whose service plans address participants' goals
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**91%**	**74%**	**72%**
Numerator	10	31	25	66
Denominator	24	34	34	92
FE	**47%**	**88%**	**67%**	**71%**
Numerator	8	29	26	63
Denominator	17	33	39	89
IDD	**53%**	**70%**	**39%**	**58%**
Numerator	8	35	11	54
Denominator	15	50	28	93
TBI	**29%**	**95%**	**88%**	**74%**
Numerator	4	19	14	37
Denominator	14	20	16	50
TA	**62%**	**90%**	**80%**	**79%**
Numerator	8	18	20	46
Denominator	13	20	25	58
Autism	**0%**	**0%**	**67%**	**36%**
Numerator	0	0	4	4
Denominator	2	3	6	11
SED	**95%**	**97%**	**97%**	**97%**
Numerator	19	28	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan incomplete

FE: Service plan not provided or did not cover entire review period, goals were not listed on service plan, no valid signature and/or date, person not authorized to sign as DPOA did so and documentation to determine "activation" was not provided, only the last page of the service plan was provided for review

IDD: Service plan not provided or did not cover entire review period, goals were not listed on the service plan, no valid signature and/or date

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan incomplete

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan incomplete, individual did not have authorization to sign for waiver participant

AU: Service plan not provided for the review period, documentation showed signed service plan date during the review period, goals are not listed

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		42%
Amerigroup		55%	33%	63%	79%	86%	N/A	N/A
Sunflower		57%	64%	59%	81%	78%	79%	91%
United		33%	49%	86%	85%	85%	88%	74%
Statewide	55%	50%	48%	69%	81%	83%	84%	72%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		47%
Amerigroup		50%	42%	54%	70%	75%	N/A	N/A
Sunflower		56%	51%	75%	79%	73%	94%	88%
United		45%	56%	81%	90%	87%	77%	67%
Statewide	Not a measure	50%	49%	70%	80%	79%	85%	71%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		53%
Amerigroup		36%	32%	53%	76%	83%	N/A	N/A
Sunflower		56%	56%	61%	70%	71%	74%	70%
United		52%	41%	73%	85%	85%	78%	39%
Statewide	99%	49%	45%	62%	75%	78%	75%	58%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		37%	41%	58%	78%	72%	N/A	N/A
Sunflower		37%	38%	80%	74%	73%	83%	95%
United		22%	55%	78%	79%	87%	77%	88%
Statewide	44%	34%	43%	68%	77%	75%	81%	74%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		62%
Amerigroup		50%	44%	69%	90%	99%	N/A	N/A
Sunflower		73%	85%	82%	65%	89%	86%	90%
United		64%	32%	70%	95%	70%	83%	80%
Statewide	93%	61%	54%	73%	83%	90%	84%	79%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		84%	56%	35%	88%	100%	N/A	N/A
Sunflower		47%	50%	50%	30%	33%	0%	0%
United		63%	36%	17%	13%	41%	50%	67%
Statewide	58%	69%	49%	37%	42%	52%	40%	36%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		95%
Amerigroup		91%	99%	98%	99%	96%	N/A	N/A
Sunflower		92%	95%	87%	98%	96%	100%	97%
United		89%	100%	98%	88%	97%	100%	97%
Statewide	98%	90%	98%	95%	95%	97%	100%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 2: Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**91%**	**85%**	**76%**
Numerator	10	31	29	70
Denominator	24	34	34	92
FE	**47%**	**85%**	**87%**	**79%**
Numerator	8	28	34	70
Denominator	17	33	39	89
IDD	**40%**	**80%**	**79%**	**73%**
Numerator	6	40	22	68
Denominator	15	50	28	93
TBI	**21%**	**90%**	**88%**	**70%**
Numerator	3	18	14	35
Denominator	14	20	16	50
TA	**69%**	**90%**	**84%**	**83%**
Numerator	9	18	21	48
Denominator	13	20	25	58
Autism	**0%**	**0%**	**67%**	**36%**
Numerator	0	0	4	4
Denominator	2	3	6	11
SED	**85%**	**83%**	**72%**	**78%**
Numerator	17	24	28	69
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, assessment not provided for review, service plan not completed timely

FE: Service plan not provided or did not cover entire review period, no valid signature and/or date, only the last page of the service plan was provided for review, person not authorized to sign as DPOA did so, service plan not completed timely and documentation to determine "activation" was not provided, assessment not provided for review

IDD: Service plan and/or needs assessment not provided or did not cover entire review period, no valid signature and/or date, service plan not signed by legal guardian, service plan not completed timely

TBI: Service plan not uploaded or did not cover entire review period, no valid signature and/or date, assessment not provided for review, service plan not completed timely

TA: Service plan not provided or did not cover entire review period, service plan uploaded for wrong individual, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period, services not listed on the service plan

SED: Service plan not provided for review period, assessment not provided for review - therefore unable to determine, assessment not provided for review

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		42%
Amerigroup		83%	55%	74%	83%	93%	N/A	N/A
Sunflower		90%	56%	63%	83%	77%	76%	91%
United		89%	68%	92%	87%	94%	91%	85%
Statewide	86%	87%	59%	76%	84%	88%	84%	76%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		47%
Amerigroup		79%	66%	74%	80%	88%	N/A	N/A
Sunflower		90%	53%	73%	75%	76%	86%	85%
United		88%	68%	84%	88%	90%	79%	87%
Statewide	87%	86%	61%	77%	81%	84%	82%	79%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		85%	67%	64%	77%	83%	N/A	N/A
Sunflower		77%	36%	65%	70%	77%	74%	80%
United		72%	47%	78%	91%	90%	85%	79%
Statewide	99%	78%	48%	68%	77%	82%	78%	73%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		21%
Amerigroup		67%	48%	65%	78%	75%	N/A	N/A
Sunflower		82%	28%	82%	74%	73%	83%	90%
United		70%	62%	80%	79%	84%	77%	88%
Statewide	72%	73%	45%	72%	77%	76%	81%	70%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		69%
Amerigroup		93%	58%	70%	88%	98%	N/A	N/A
Sunflower		98%	62%	74%	69%	85%	86%	90%
United		97%	58%	79%	92%	84%	91%	84%
Statewide	96%	96%	59%	73%	83%	91%	89%	83%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		81%	59%	33%	88%	82%	N/A	N/A
Sunflower		50%	45%	47%	15%	28%	0%	0%
United		63%	21%	22%	13%	24%	25%	67%
Statewide	59%	68%	46%	36%	37%	39%	20%	36%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		85%
Amerigroup		91%	99%	98%	99%	96%	N/A	N/A
Sunflower		91%	92%	87%	93%	88%	81%	83%
United		89%	98%	96%	84%	76%	56%	72%
Statewide	92%	90%	97%	94%	92%	87%	67%	78%

KDADS HCBS Quality Review Report

Service Plan
PM 3: Number and percent of waiver participants whose service plans address health and safety risk factors
Numerator: Number of waiver participants whose service plans address health and safety risk factors
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**91%**	**85%**	**76%**
Numerator	10	31	29	70
Denominator	24	34	34	92
FE	**53%**	**85%**	**87%**	**80%**
Numerator	9	28	34	71
Denominator	17	33	39	89
IDD	**40%**	**78%**	**79%**	**72%**
Numerator	6	39	22	67
Denominator	15	50	28	93
TBI	**29%**	**90%**	**88%**	**72%**
Numerator	4	18	14	36
Denominator	14	20	16	50
TA	**69%**	**90%**	**84%**	**83%**
Numerator	9	18	21	48
Denominator	13	20	25	58
Autism	**0%**	**0%**	**67%**	**36%**
Numerator	0	0	4	4
Denominator	2	3	6	11
SED	**95%**	**97%**	**97%**	**97%**
Numerator	19	28	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, assessment not provided for review

FE: Service plan not provided or did not cover entire review period, assesment not provided for review, no valid signature and/or date, person not authorized to sign as DPOA did so and documentation to determine "activation" was not provided, only the last page of the service plan was provided for review

IDD: Servce plan not provided or did not cover entire review period, no valid signature and/or date, service plan incomplete, assessment not provided for review

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, assessment not provided for review

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period, services are not listed on service plan

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		42%
Amerigroup		90%	44%	73%	81%	94%	N/A	N/A
Sunflower		89%	49%	67%	85%	75%	76%	91%
United		96%	67%	90%	88%	95%	88%	85%
Statewide	90%	91%	51%	76%	84%	88%	82%	76%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		53%
Amerigroup		92%	55%	75%	82%	89%	N/A	N/A
Sunflower		92%	50%	73%	77%	74%	86%	85%
United		95%	70%	82%	88%	91%	79%	87%
Statewide	Not a measure	93%	57%	76%	82%	84%	82%	80%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		90%	61%	67%	75%	83%	N/A	N/A
Sunflower		97%	36%	65%	73%	78%	74%	78%
United		89%	45%	78%	92%	90%	85%	79%
Statewide	99%	93%	46%	69%	78%	83%	78%	72%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		79%	45%	64%	80%	79%	N/A	N/A
Sunflower		91%	26%	84%	70%	74%	83%	90%
United		83%	64%	80%	79%	89%	77%	88%
Statewide	84%	84%	43%	72%	78%	79%	81%	72%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		69%
Amerigroup		96%	49%	73%	89%	98%	N/A	N/A
Sunflower		95%	61%	76%	66%	85%	86%	90%
United		94%	58%	79%	92%	84%	91%	84%
Statewide	96%	96%	54%	75%	83%	91%	89%	83%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		79%	59%	30%	88%	91%	N/A	N/A
Sunflower		61%	45%	47%	15%	28%	0%	0%
United		86%	21%	17%	13%	24%	25%	67%
Statewide	64%	74%	46%	34%	37%	41%	20%	36%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		95%
Amerigroup		90%	99%	97%	99%	96%	N/A	N/A
Sunflower		89%	95%	87%	98%	97%	100%	97%
United		86%	100%	97%	88%	97%	100%	97%
Statewide	99%	88%	98%	94%	95%	97%	100%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 4: Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**46%**	**91%**	**79%**	**75%**
Numerator	11	31	27	69
Denominator	24	34	34	92
FE	**53%**	**82%**	**85%**	**78%**
Numerator	9	27	33	69
Denominator	17	33	39	89
IDD	**40%**	**78%**	**71%**	**70%**
Numerator	6	39	20	65
Denominator	15	50	28	93
TBI	**36%**	**90%**	**94%**	**76%**
Numerator	5	18	15	38
Denominator	14	20	16	50
TA	**69%**	**90%**	**84%**	**83%**
Numerator	9	18	21	48
Denominator	13	20	25	58
Autism	**0%**	**0%**	**67%**	**36%**
Numerator	0	0	4	4
Denominator	2	3	6	11
SED	**95%**	**97%**	**97%**	**97%**
Numerator	19	28	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, assessment not provided for review, service plan not completed timely

FE: Service plan not provided or did not cover entire review period, assesment not provided for review, no valid signature and/or date, person not authorized to sign as DPOA did so and documentation to determine "activation" was not provided, only the last page of the service plan was provided for review, service plan not completed timely

IDD: Servce plan not provided or did not cover entire review period, no valid signature and/or date, service plan incomplete - goals were not written in plan, service plan not completed timely

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, assessment not provided for review, service plan not completed timely

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		46%
Amerigroup		88%	68%	76%	85%	91%	N/A	N/A
Sunflower		87%	69%	73%	87%	77%	76%	91%
United		85%	77%	92%	88%	94%	85%	79%
Statewide	80%	87%	70%	80%	86%	87%	81%	75%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		53%
Amerigroup		84%	76%	78%	82%	91%	N/A	N/A
Sunflower		88%	61%	84%	86%	76%	94%	82%
United		86%	79%	87%	90%	90%	82%	85%
Statewide	Not a measure	86%	71%	83%	86%	85%	88%	78%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		80%	80%	73%	77%	94%	N/A	N/A
Sunflower		80%	59%	74%	80%	79%	75%	78%
United		82%	55%	79%	92%	90%	89%	71%
Statewide	98%	81%	64%	75%	82%	83%	80%	70%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		36%
Amerigroup		76%	53%	64%	79%	79%	N/A	N/A
Sunflower		86%	43%	86%	80%	73%	78%	90%
United		77%	69%	85%	79%	84%	77%	94%
Statewide	64%	80%	53%	74%	80%	78%	78%	76%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		69%
Amerigroup		84%	68%	71%	90%	96%	N/A	N/A
Sunflower		97%	86%	85%	68%	89%	86%	90%
United		96%	58%	79%	95%	84%	91%	84%
Statewide	No Data	91%	72%	77%	84%	92%	89%	83%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		74%	59%	35%	88%	91%	N/A	N/A
Sunflower		51%	50%	47%	20%	39%	0%	0%
United		65%	29%	17%	13%	35%	50%	67%
Statewide	55%	65%	49%	36%	38%	50%	40%	36%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		95%
Amerigroup		92%	99%	98%	99%	96%	N/A	N/A
Sunflower		90%	94%	86%	98%	97%	100%	97%
United		87%	98%	97%	88%	95%	100%	97%
Statewide	Not a measure	90%	97%	94%	95%	96%	100%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 5: Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan
Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**46%**	**91%**	**85%**	**77%**
Numerator	11	31	29	71
Denominator	24	34	34	92
FE	**47%**	**85%**	**90%**	**80%**
Numerator	8	28	35	71
Denominator	17	33	39	89
IDD	**40%**	**80%**	**79%**	**73%**
Numerator	6	40	22	68
Denominator	15	50	28	93
TBI	**29%**	**90%**	**94%**	**74%**
Numerator	4	18	15	37
Denominator	14	20	16	50
TA	**69%**	**90%**	**84%**	**83%**
Numerator	9	18	21	48
Denominator	13	20	25	58
Autism	**0%**	**33%**	**67%**	**45%**
Numerator	0	1	4	5
Denominator	2	3	6	11
SED	**90%**	**97%**	**97%**	**95%**
Numerator	18	28	38	84
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan not completed timely

FE: Service plan not provided or did not cover entire review period, no valid signature and/or date, person not authorized to sign as DPOA did so, service plan not completed timely and documentation to determine "activation" was not provided

IDD: Servce plan not provided or did not cover entire review period, no valid signature and/or date, guardian signed service plan after services implemented, service plan not completed timely

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan not completed timely

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		46%
Amerigroup		88%	70%	79%	87%	97%	N/A	N/A
Sunflower		87%	70%	74%	88%	80%	76%	91%
United		84%	79%	89%	88%	95%	88%	85%
Statewide	Not a measure	87%	72%	81%	88%	91%	82%	77%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		47%
Amerigroup		83%	78%	76%	84%	92%	N/A	N/A
Sunflower		86%	60%	83%	87%	78%	94%	85%
United		87%	83%	88%	91%	92%	85%	90%
Statewide	90%	85%	72%	83%	88%	87%	89%	80%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		84%	76%	73%	76%	85%	N/A	N/A
Sunflower		82%	60%	74%	78%	83%	79%	80%
United		88%	51%	79%	93%	90%	89%	79%
Statewide	Not a measure	84%	63%	75%	81%	85%	83%	73%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		73%	51%	65%	80%	82%	N/A	N/A
Sunflower		84%	45%	86%	80%	79%	78%	90%
United		80%	69%	59%	79%	92%	85%	94%
Statewide	Not a measure	78%	52%	74%	80%	83%	81%	74%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		69%
Amerigroup		83%	75%	71%	90%	99%	N/A	N/A
Sunflower		97%	86%	84%	68%	89%	86%	90%
United		97%	58%	79%	95%	86%	91%	84%
Statewide	Not a measure	91%	76%	76%	84%	93%	89%	83%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		77%	59%	35%	88%	100%	N/A	N/A
Sunflower		53%	55%	50%	15%	44%	100%	33%
United		71%	36%	17%	6%	47%	50%	67%
Statewide	Not a measure	69%	52%	37%	35%	59%	60%	45%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		90%
Amerigroup		92%	98%	97%	97%	97%	N/A	N/A
Sunflower		90%	95%	86%	98%	96%	100%	97%
United		87%	99%	96%	86%	96%	100%	97%
Statewide	93%	90%	98%	94%	93%	97%	100%	95%

KDADS HCBS Quality Review Report

Service Plan
PM 6: Number and percent of service plans reviewed before the waiver participant's annual redetermination date
Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**83%**	**88%**	**85%**	**86%**
Numerator	20	30	29	79
Denominator	24	34	34	92
FE	**76%**	**88%**	**85%**	**84%**
Numerator	13	29	33	75
Denominator	17	33	39	89
IDD	**80%**	**80%**	**79%**	**80%**
Numerator	12	40	22	74
Denominator	15	50	28	93
TBI	**71%**	**80%**	**81%**	**78%**
Numerator	10	16	13	39
Denominator	14	20	16	50
TA	**92%**	**95%**	**96%**	**95%**
Numerator	12	19	24	55
Denominator	13	20	25	58
Autism	**100%**	**67%**	**67%**	**73%**
Numerator	2	2	4	8
Denominator	2	3	6	11
SED	**80%**	**86%**	**95%**	**89%**
Numerator	16	25	37	78
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely

AU: Service plan not provided or did not cover entire review period

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		83%
Amerigroup		73%	67%	71%	72%	91%	N/A	N/A
Sunflower		82%	72%	72%	70%	81%	73%	88%
United		92%	73%	83%	76%	89%	91%	85%
Statewide	82%	82%	70%	75%	72%	87%	82%	86%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		76%
Amerigroup		81%	67%	63%	70%	84%	N/A	N/A
Sunflower		85%	57%	78%	78%	83%	94%	88%
United		90%	69%	84%	91%	91%	90%	85%
Statewide	81%	85%	64%	76%	81%	86%	92%	84%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		80%
Amerigroup		75%	77%	68%	64%	80%	N/A	N/A
Sunflower		81%	66%	65%	63%	81%	74%	80%
United		91%	48%	54%	86%	84%	89%	79%
Statewide	97%	82%	66%	63%	70%	81%	79%	80%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		71%
Amerigroup		65%	44%	56%	63%	73%	N/A	N/A
Sunflower		84%	40%	88%	61%	88%	87%	80%
United		77%	65%	70%	65%	84%	85%	81%
Statewide	60%	76%	47%	68%	63%	80%	86%	78%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		92%
Amerigroup		81%	78%	72%	88%	92%	N/A	N/A
Sunflower		94%	89%	85%	68%	85%	90%	95%
United		96%	59%	70%	91%	93%	96%	96%
Statewide	92%	89%	79%	76%	83%	90%	93%	95%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		67%	52%	40%	82%	100%	N/A	N/A
Sunflower		43%	47%	38%	18%	83%	0%	67%
United		33%	38%	7%	20%	59%	50%	67%
Statewide	64%	57%	48%	31%	41%	78%	40%	73%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		80%
Amerigroup		89%	97%	94%	96%	95%	N/A	N/A
Sunflower		89%	91%	79%	92%	92%	100%	86%
United		83%	99%	85%	77%	97%	97%	95%
Statewide	80%	87%	96%	86%	88%	95%	99%	89%

KDADS HCBS Quality Review Report

Service Plan
PM 7: Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**96%**	**97%**	**94%**	**96%**
Numerator	23	33	32	88
Denominator	24	34	34	92
FE	**100%**	**94%**	**97%**	**97%**
Numerator	17	31	38	86
Denominator	17	33	39	89
IDD	**93%**	**94%**	**86%**	**91%**
Numerator	14	47	24	85
Denominator	15	50	28	93
TBI	**93%**	**90%**	**88%**	**90%**
Numerator	13	18	14	45
Denominator	14	20	16	50
TA	**100%**	**95%**	**96%**	**97%**
Numerator	13	19	24	56
Denominator	13	20	25	58
Autism	**100%**	**100%**	**100%**	**100%**
Numerator	2	3	6	11
Denominator	2	3	6	11
SED	**80%**	**86%**	**95%**	**89%**
Numerator	16	25	37	78
Denominator	20	29	39	88

Explanation of Findings:

Performance measure met across all waivers

Service plan not provided, no valid signature and/or date

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		96%
Amerigroup		20%	36%	67%	68%	98%	N/A	N/A
Sunflower		53%	58%	50%	54%	94%	91%	97%
United		50%	63%	80%	67%	99%	100%	94%
Statewide	75%	39%	53%	65%	62%	97%	96%	96%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		24%	71%	42%	70%	96%	N/A	N/A
Sunflower		39%	51%	63%	59%	92%	100%	94%
United		50%	47%	87%	86%	98%	95%	97%
Statewide	78%	38%	54%	65%	67%	96%	97%	97%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		93%
Amerigroup		7%	60%	27%	67%	95%	N/A	N/A
Sunflower		38%	16%	25%	47%	97%	96%	94%
United		16%	30%	30%	83%	97%	100%	86%
Statewide	97%	23%	28%	28%	60%	96%	98%	91%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		93%
Amerigroup		24%	42%	61%	67%	88%	N/A	N/A
Sunflower		54%	27%	75%	44%	86%	100%	90%
United		46%	50%	75%	33%	97%	92%	88%
Statewide	53%	38%	38%	67%	57%	89%	97%	90%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		32%	73%	56%	94%	96%	N/A	N/A
Sunflower		54%	89%	63%	57%	92%	100%	95%
United		38%	43%	60%	100%	98%	100%	96%
Statewide	92%	42%	75%	60%	83%	95%	100%	97%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		10%	0%	17%	75%	100%	N/A	N/A
Sunflower		17%	25%	50%	14%	94%	0%	100%
United		0%	0%	9%	0%	82%	100%	100%
Statewide	45%	11%	11%	16%	22%	91%	80%	100%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		80%
Amerigroup		90%	90%	97%	97%	96%	N/A	N/A
Sunflower		83%	79%	68%	88%	91%	100%	86%
United		84%	93%	83%	67%	96%	97%	95%
Statewide	85%	86%	88%	83%	83%	93%	99%	89%

KDADS HCBS Quality Review Report

Service Plan
PM 8: Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Numerator: Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**46%**	**91%**	**88%**	**78%**
Numerator	11	31	30	72
Denominator	24	34	34	92
FE	**53%**	**85%**	**87%**	**80%**
Numerator	9	28	34	71
Denominator	17	33	39	89
IDD	**40%**	**76%**	**79%**	**71%**
Numerator	6	38	22	66
Denominator	15	50	28	93
TBI	**29%**	**85%**	**88%**	**70%**
Numerator	4	17	14	35
Denominator	14	20	16	50
TA	**69%**	**90%**	**80%**	**81%**
Numerator	9	18	20	47
Denominator	13	20	25	58
Autism	**0%**	**0%**	**67%**	**36%**
Numerator	0	0	4	4
Denominator	2	3	6	11
SED	**95%**	**97%**	**97%**	**97%**
Numerator	19	28	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan not completed timely

FE: Service plan not provided or did not cover entire review period, no valid signature and/or date, person not authorized to sign as DPOA did so, service plan not completed timely, documentation to determine "activation" was not provided, provider not able to provide services due to consumer apprehension - citing trouble with previous staff, only the last page of the service plan was uploaded

IDD: Servce plan not provided or did not cover entire review period, no valid signature and/or date, guardian signed service plan after services implemented, service plan not completed timely

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, service plan not completed timely

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant, care coordinator noted that consumer(s) was not recieving all hours due to staff shortage with provider

AU: Service plan not provided or did not cover entire review period, plan noted services

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		46%
Amerigroup		94%	69%	79%	83%	93%	N/A	N/A
Sunflower		96%	72%	76%	88%	80%	76%	91%
United		96%	78%	91%	87%	93%	91%	88%
Statewide	85%	95%	72%	81%	86%	88%	84%	78%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		53%
Amerigroup		83%	76%	75%	81%	86%	N/A	N/A
Sunflower		96%	64%	86%	87%	77%	94%	85%
United		96%	79%	89%	88%	92%	85%	87%
Statewide	87%	92%	72%	83%	86%	85%	89%	80%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		78%	84%	73%	75%	82%	N/A	N/A
Sunflower		97%	62%	77%	80%	82%	81%	76%
United		100%	59%	81%	90%	89%	89%	79%
Statewide	98%	92%	68%	77%	81%	84%	84%	71%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		81%	55%	63%	77%	73%	N/A	N/A
Sunflower		95%	46%	84%	76%	76%	74%	85%
United		85%	71%	83%	76%	82%	77%	88%
Statewide	70%	87%	56%	72%	77%	75%	75%	70%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		69%
Amerigroup		98%	73%	79%	88%	98%	N/A	N/A
Sunflower		100%	86%	82%	68%	87%	86%	90%
United		96%	58%	82%	92%	86%	96%	80%
Statewide	100%	98%	74%	80%	83%	93%	91%	81%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		89%	59%	37%	88%	91%	N/A	N/A
Sunflower		100%	55%	50%	15%	28%	0%	0%
United		50%	21%	17%	13%	41%	25%	67%
Statewide	50%	86%	49%	38%	37%	48%	20%	36%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		95%
Amerigroup		91%	99%	95%	99%	96%	N/A	N/A
Sunflower		96%	94%	84%	98%	98%	100%	97%
United		92%	99%	91%	86%	96%	100%	97%
Statewide	13%	93%	98%	90%	94%	97%	100%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 9: Number and percent of survey respondents who reported receiving all services as specified in their service plan
Numerator: Number of survey respondents who reported receiving all services as specified in their service plan
Denominator: Number of waiver participants interviewed by QMS staff
Review Period: 04/01/2019 - 06/30/2019
Data Source: Customer Interview

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**91%**	**92%**	**93%**	**92%**
Numerator	10	12	14	36
Denominator	11	13	15	39
FE	**100%**	**86%**	**100%**	**95%**
Numerator	6	12	18	36
Denominator	6	14	18	38
IDD	**100%**	**93%**	**100%**	**96%**
Numerator	7	26	18	51
Denominator	7	28	18	53
TBI	**100%**	**100%**	**100%**	**100%**
Numerator	3	4	3	10
Denominator	3	4	3	10
TA	**50%**	**100%**	**91%**	**90%**
Numerator	1	7	10	18
Denominator	2	7	11	20
Autism	**N/A**	**100%**	**67%**	**75%**
Numerator	0	1	2	3
Denominator	0	1	3	4
SED	**Not a waiver performance measure**			
Numerator				
Denominator				

Explanation of Findings:

AU: consumer/representative responded with service provider shortage concerns, long waitlists for services with providers

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		91%
Amerigroup		97%			94%	94%	N/A	N/A
Sunflower		92%			97%	98%	88%	92%
United		93%			91%	98%	83%	93%
Statewide	Not a measure	94%	No Data	No Data	94%	97%	86%	92%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		85%			97%	96%	N/A	N/A
Sunflower		86%			93%	95%	100%	86%
United		82%			91%	94%	87%	100%
Statewide	87%	84%	No Data	No Data	94%	95%	94%	95%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		92%			93%	100%	N/A	N/A
Sunflower		96%			99%	97%	100%	93%
United		93%			92%	100%	93%	100%
Statewide	Not a measure	94%	No Data	No Data	96%	98%	98%	96%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		81%			81%	87%	N/A	N/A
Sunflower		88%			79%	78%	91%	100%
United		83%			76%	92%	100%	100%
Statewide	Not a measure	83%	No Data	No Data	80%	85%	92%	100%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		50%
Amerigroup		89%			96%	98%	N/A	N/A
Sunflower		84%			94%	95%	100%	100%
United		85%			94%	100%	100%	91%
Statewide	Not a measure	87%	No Data	No Data	95%	98%	100%	90%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup		74%			89%	67%	N/A	N/A
Sunflower		70%			50%	88%	0%	100%
United		60%			75%	50%	50%	67%
Statewide	Not a measure	71%	No Data	No Data	68%	68%	33%	75%
SED	**Not a waiver performance measure**							
Aetna								
Amerigroup								
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Service Plan
PM 10: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**38%**	**91%**	**85%**	**75%**
Numerator	9	31	29	69
Denominator	24	34	34	92
FE	**47%**	**85%**	**85%**	**78%**
Numerator	8	28	33	69
Denominator	17	33	39	89
IDD	**40%**	**78%**	**79%**	**72%**
Numerator	6	39	22	67
Denominator	15	50	28	93
TBI	**21%**	**95%**	**88%**	**72%**
Numerator	3	19	14	36
Denominator	14	20	16	50
TA	**62%**	**90%**	**84%**	**81%**
Numerator	8	18	21	47
Denominator	13	20	25	58
Autism	**0%**	**33%**	**67%**	**45%**
Numerator	0	1	4	5
Denominator	2	3	6	11
SED	**100%**	**93%**	**97%**	**97%**
Numerator	20	27	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, choice section on service plan was left blank, only the last page of the service plan was uploaded

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely, choice section on service plan was left blank

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		38%
Amerigroup		68%	56%	68%	80%	97%	N/A	N/A
Sunflower		58%	69%	73%	85%	80%	76%	91%
United		69%	73%	89%	87%	94%	91%	85%
Statewide	52%	65%	65%	76%	84%	90%	84%	75%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		47%
Amerigroup		68%	59%	64%	82%	92%	N/A	N/A
Sunflower		76%	59%	82%	86%	77%	94%	85%
United		77%	75%	85%	91%	93%	87%	85%
Statewide	56%	74%	63%	77%	86%	87%	91%	78%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		51%	45%	68%	74%	84%	N/A	N/A
Sunflower		68%	42%	69%	71%	79%	77%	78%
United		75%	55%	76%	91%	89%	89%	79%
Statewide	99%	64%	46%	70%	77%	83%	81%	72%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		21%
Amerigroup		54%	50%	53%	76%	82%	N/A	N/A
Sunflower		75%	40%	86%	80%	80%	83%	95%
United		70%	74%	83%	79%	92%	85%	88%
Statewide	44%	65%	52%	67%	78%	83%	83%	72%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		62%
Amerigroup		87%	65%	68%	85%	96%	N/A	N/A
Sunflower		84%	80%	77%	66%	89%	86%	90%
United		92%	58%	79%	95%	86%	91%	84%
Statewide	96%	86%	68%	72%	81%	92%	89%	81%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		67%	67%	47%	88%	100%	N/A	N/A
Sunflower		44%	45%	50%	40%	50%	100%	33%
United		88%	21%	17%	19%	29%	50%	67%
Statewide	40%	63%	49%	42%	48%	54%	60%	45%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		94%	91%	98%	99%	97%	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	100%	93%
United		84%	97%	88%	88%	97%	97%	97%
Statewide	98%	89%	88%	90%	94%	94%	99%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 11: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver services
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**33%**	**91%**	**85%**	**74%**
Numerator	8	31	29	68
Denominator	24	34	34	92
FE	**47%**	**85%**	**85%**	**78%**
Numerator	8	28	33	69
Denominator	17	33	39	89
IDD	**40%**	**80%**	**79%**	**73%**
Numerator	6	40	22	68
Denominator	15	50	28	93
TBI	**21%**	**95%**	**94%**	**74%**
Numerator	3	19	15	37
Denominator	14	20	16	50
TA	**54%**	**90%**	**84%**	**79%**
Numerator	7	18	21	46
Denominator	13	20	25	58
Autism	**0%**	**33%**	**67%**	**45%**
Numerator	0	1	4	5
Denominator	2	3	6	11
SED	**100%**	**93%**	**97%**	**97%**
Numerator	20	27	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, only the last page of the service plan was uploaded

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely, choice section on service plan was left blank

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely, missing documentation of choice

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		33%
Amerigroup		68%	53%	62%	79%	96%	N/A	N/A
Sunflower		72%	50%	71%	36%	74%	76%	91%
United		77%	73%	84%	78%	94%	91%	85%
Statewide	64%	72%	57%	72%	64%	88%	84%	74%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		47%
Amerigroup		67%	57%	67%	80%	92%	N/A	N/A
Sunflower		86%	47%	82%	35%	74%	94%	85%
United		85%	74%	84%	80%	92%	87%	85%
Statewide	59%	80%	57%	78%	63%	86%	91%	78%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		40%
Amerigroup		55%	46%	70%	71%	85%	N/A	N/A
Sunflower		68%	35%	69%	34%	79%	77%	80%
United		77%	50%	74%	89%	88%	89%	79%
Statewide	No Data	66%	42%	71%	58%	83%	81%	73%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		21%
Amerigroup		56%	50%	52%	74%	82%	N/A	N/A
Sunflower		80%	23%	86%	28%	79%	83%	95%
United		74%	67%	80%	76%	92%	85%	94%
Statewide	53%	68%	45%	66%	63%	83%	83%	74%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		54%
Amerigroup		86%	65%	71%	86%	99%	N/A	N/A
Sunflower		97%	53%	79%	29%	86%	86%	90%
United		94%	55%	64%	82%	86%	91%	84%
Statewide	96%	91%	60%	72%	68%	93%	89%	79%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		79%	52%	47%	88%	100%	N/A	N/A
Sunflower		50%	27%	61%	20%	56%	100%	33%
United		88%	14%	17%	13%	41%	50%	67%
Statewide	55%	72%	35%	46%	38%	61%	60%	45%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		94%	92%	98%	99%	97%	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	100%	93%
United		84%	97%	88%	87%	97%	97%	97%
Statewide	98%	89%	88%	90%	93%	94%	99%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 12: Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
Numerator: Number of waiver participants whose record contains documentation indicating a choice of community-based services
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**4%**	**91%**	**85%**	**66%**
Numerator	1	31	29	61
Denominator	24	34	34	92
FE	**6%**	**85%**	**85%**	**70%**
Numerator	1	28	33	62
Denominator	17	33	39	89
IDD	**13%**	**80%**	**79%**	**69%**
Numerator	2	40	22	64
Denominator	15	50	28	93
TBI	**0%**	**95%**	**88%**	**66%**
Numerator	0	19	14	33
Denominator	14	20	16	50
TA	**8%**	**90%**	**84%**	**69%**
Numerator	1	18	21	40
Denominator	13	20	25	58
Autism	**0%**	**33%**	**67%**	**45%**
Numerator	0	1	4	5
Denominator	2	3	6	11
SED	**100%**	**93%**	**97%**	**97%**
Numerator	20	27	38	85
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, missing documenation of choice

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, only the last page of the service plan was uploaded, choice section on service plan was left blank, missing documentation of choice

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely, missing documentation of choice

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely, missing documentation of choice

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant, missing documenation of choice

AU: Service plan not provided or did not cover entire review period, missing

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		4%
Amerigroup		76%	57%	67%	81%	98%	N/A	N/A
Sunflower		74%	67%	73%	87%	80%	76%	91%
United		80%	78%	88%	87%	95%	91%	85%
Statewide	Not a measure	76%	66%	75%	85%	91%	84%	66%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		6%
Amerigroup		67%	58%	72%	81%	92%	N/A	N/A
Sunflower		87%	56%	82%	86%	77%	94%	85%
United		85%	79%	84%	91%	93%	87%	85%
Statewide	65%	80%	63%	79%	86%	87%	91%	70%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		13%
Amerigroup		47%	47%	66%	73%	87%	N/A	N/A
Sunflower		69%	41%	68%	74%	80%	77%	80%
United		78%	57%	79%	92%	88%	89%	79%
Statewide	No Data	64%	46%	70%	78%	84%	81%	69%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		55%	51%	54%	78%	84%	N/A	N/A
Sunflower		79%	40%	86%	78%	79%	83%	95%
United		73%	74%	83%	79%	92%	85%	88%
Statewide	No Data	67%	52%	68%	78%	84%	83%	66%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		8%
Amerigroup		87%	65%	69%	85%	99%	N/A	N/A
Sunflower		98%	80%	81%	68%	89%	86%	90%
United		94%	55%	79%	95%	86%	91%	84%
Statewide	No Data	92%	68%	74%	81%	93%	89%	69%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		86%	67%	65%	94%	100%	N/A	N/A
Sunflower		47%	59%	67%	70%	61%	100%	33%
United		75%	43%	33%	38%	35%	75%	67%
Statewide	No Data	72%	59%	60%	67%	61%	80%	45%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup		94%	92%	98%	99%	97%	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	100%	93%
United		85%	98%	88%	87%	97%	97%	97%
Statewide	99%	90%	89%	91%	93%	94%	99%	97%

KDADS HCBS Quality Review Report

Service Plan
PM 13: Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**8%**	**88%**	**85%**	**66%**
Numerator	2	30	29	61
Denominator	24	34	34	92
FE	**6%**	**82%**	**85%**	**69%**
Numerator	1	27	33	61
Denominator	17	33	39	89
IDD	**7%**	**74%**	**79%**	**65%**
Numerator	1	37	22	60
Denominator	15	50	28	93
TBI	**0%**	**95%**	**88%**	**66%**
Numerator	0	19	14	33
Denominator	14	20	16	50
TA	**8%**	**90%**	**84%**	**69%**
Numerator	1	18	21	40
Denominator	13	20	25	58
Autism	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				
SED	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		8%
Amerigroup		64%	58%	72%	81%	92%	N/A	N/A
Sunflower		73%	68%	72%	87%	79%	76%	88%
United		77%	78%	88%	86%	95%	91%	85%
Statewide	Not a measure	71%	66%	77%	84%	89%	84%	66%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		6%
Amerigroup		64%	59%	73%	79%	88%	N/A	N/A
Sunflower		84%	59%	81%	87%	74%	94%	82%
United		77%	79%	85%	88%	93%	87%	85%
Statewide	65%	75%	64%	79%	85%	85%	91%	69%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		7%
Amerigroup		34%	47%	64%	68%	84%	N/A	N/A
Sunflower		61%	39%	60%	65%	77%	75%	74%
United		77%	57%	73%	93%	89%	89%	79%
Statewide	No Data	53%	46%	64%	73%	82%	80%	65%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		50%	50%	56%	73%	80%	N/A	N/A
Sunflower		85%	43%	82%	78%	79%	83%	95%
United		70%	74%	83%	79%	89%	85%	88%
Statewide	No Data	66%	52%	68%	75%	81%	83%	66%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		8%
Amerigroup		82%	56%	66%	84%	99%	N/A	N/A
Sunflower		98%	82%	79%	68%	89%	86%	90%
United		100%	58%	79%	95%	84%	91%	84%
Statewide	No Data	90%	64%	72%	81%	93%	89%	69%
Autism	**Self-direction is not offered for this waiver**							
Aetna								
Amerigroup								
Sunflower								
United								
Statewide								
SED	**Self-direction is not offered for this waiver**							
Aetna								
Amerigroup								
Sunflower								
United								
Statewide								

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, missing documentation of choice

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, only the last page of the service plan was uploaded, missing documentation of choice

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely, missing documentation of choice

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely, missing documentation of choice

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant, missing documentation of choice

Remediation:

KDADS HCBS Quality Review Report

Health and Welfare
PM 1: Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes
Numerator: Number of unexpected deaths for which review/investigation resulted in the identification of preventable causes
Denominator: Number of unexpected deaths
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**75%**	**100%**	**83%**
Numerator	0	3	2	5
Denominator	0	4	2	6
FE	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	3	0	3
Denominator	0	3	0	3
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	4	10	4	18
Denominator	4	10	4	18
TBI	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	1	0	1
Denominator	0	1	0	1
TA	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	2	0	2
Denominator	0	2	0	2
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

MCO review/investigation is compliant regarding follow-up and resolution for unexpected deaths reported in the Adverse Incident Reporting system. Sunflower had one report included in the fallout data for this performance measure which the MCO identified preventable causes on the PD waiver during this timeframe. Sunflower provided detailed follow-up explaining how their review/investigation identified preventable causes; in summary, the individual left hospital AMA, condition deteriorated and did not improve once readmitted resulting in death. Review/Investigation followed appropriate policies and procedures, sufficient MCO follow-up/documentation included, no remediation necessary for Sunflower.

SED reports are not currently routed to the HCBS worklist in the AIR system. Behavioral Health receives SED AIR reports and provide follow-up and remediation, as applicable.

Remediation:

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							88%	75%
United							100%	100%
Statewide							89%	83%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							0%	N/A
Statewide							75%	100%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							80%	100%
Statewide							94%	100%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	100%
United							N/A	N/A
Statewide							N/A	100%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							N/A	N/A
Statewide							100%	100%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 2: Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures
Numerator: Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**100%**	**100%**	**100%**
Numerator	0	4	2	6
Denominator	0	4	2	6
FE	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	3	0	3
Denominator	0	3	0	3
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	4	10	4	18
Denominator	4	10	4	18
TBI	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	1	0	1
Denominator	0	1	0	1
TA	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	2	0	2
Denominator	0	2	0	2
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

All unexpected deaths identified for the timeframe were reviewed, KDADS confirms that 100% of review/investigation followed appropriate policies and procedures. Sufficient follow-up and documentation was provided by the MCOs to complete the reports and for KDADS Program Integrity staff to confirm findings.

SED reports are not currently routed to the HCBS worklist in the AIR system. Behavioral Health receives SED AIR reports and provide follow-up and remediation, as applicable.

Remediation:

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							63%	50%
United							100%	100%
Statewide							67%	67%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							33%	67%
United							0%	N/A
Statewide							25%	67%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		25%
Amerigroup	No Data						N/A	N/A
Sunflower							75%	70%
United							60%	50%
Statewide							71%	56%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	0%
United							N/A	N/A
Statewide							N/A	0%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	0%
United							N/A	N/A
Statewide							100%	0%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken
Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**100%**	**100%**	**100%**
Numerator	0	4	2	6
Denominator	0	4	2	6
FE	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	3	0	3
Denominator	0	3	0	3
IDD	**75%**	**100%**	**100%**	**94%**
Numerator	3	10	4	17
Denominator	4	10	4	18
TBI	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	1	0	1
Denominator	0	1	0	1
TA	**N/A**	**100%**	**N/A**	**100%**
Numerator	0	2	0	2
Denominator	0	2	0	2
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

Aetna had one report included in fallout data due to having insufficient information to complete the report, which resulted in a KDADS Corrective Action Plan (CAP) being issued. Aetna provided additional information/documentation, answered all follow-up questions from KDADS, and confirmed that appropriate follow-up measures were taken. MCO investigation did not identify any preventable causes or quality of care concerns; no further action necessary on the report referenced.

SED reports are not currently routed to the HCBS worklist in the AIR system. Behavioral Health receives SED AIR reports and provide follow-up and remediation, as applicable.

Remediation:

All 3 MCOs have received additional and ongoing trainings to ensure sufficient information is provided to properly resolve adverse incidents, particularly reports involving deaths. Ongoing trainings include examples, outlines necessary information for KDADS to confirm MCO findings and sufficiently resolve incidents. Since receiving a Corrective Action Plan issued by KDADS Program Integrity, Aetna has improved follow-up to ensure resolution and that KDADS Program Integrity can confirm findings.

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	N/A
Statewide							100%	100%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		75%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	94%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	100%
United							N/A	N/A
Statewide							N/A	100%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							N/A	N/A
Statewide							100%	100%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 4: Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**50%**	**91%**	**85%**	**78%**
Numerator	12	31	29	72
Denominator	24	34	34	92
FE	**29%**	**91%**	**90%**	**79%**
Numerator	5	30	35	70
Denominator	17	33	39	89
IDD	**33%**	**80%**	**82%**	**73%**
Numerator	5	40	23	68
Denominator	15	50	28	93
TBI	**29%**	**95%**	**94%**	**76%**
Numerator	4	19	15	38
Denominator	14	20	16	50
TA	**31%**	**90%**	**88%**	**76%**
Numerator	4	18	22	44
Denominator	13	20	25	58
Autism	**0%**	**33%**	**83%**	**55%**
Numerator	0	1	5	6
Denominator	2	3	6	11
SED	**25%**	**59%**	**95%**	**67%**
Numerator	5	17	37	59
Denominator	20	29	39	88

Explanation of Findings:

PD: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, information regarding A/N/E not provided for review

FE: Service plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, only the last page of the service plan was uploaded, information regarding A/N/E not provided for review

IDD: Service plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely, information regarding A/N/E not provided for review

TBI: Service plan not provided or did not cover entire review period, no valid signature and/or date, serve plan not completed timely, information regarding A/N/E not provided for review

TA: Service plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant, information regarding A/N/E not provided for review

AU: Service plan not provided or did not cover entire review period

SED: Information regarding A/N/E not provided for review

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		50%
Amerigroup		51%	19%	67%	87%	97%	N/A	N/A
Sunflower		88%	72%	74%	90%	85%	82%	91%
United		90%	80%	88%	88%	95%	94%	85%
Statewide	65%	72%	53%	76%	88%	93%	88%	78%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		59%	16%	61%	85%	92%	N/A	N/A
Sunflower		86%	62%	84%	89%	80%	94%	91%
United		92%	80%	88%	93%	92%	90%	90%
Statewide	80%	78%	50%	78%	89%	88%	92%	79%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		33%
Amerigroup		23%	6%	59%	78%	86%	N/A	N/A
Sunflower		87%	59%	75%	82%	85%	81%	80%
United		100%	56%	79%	93%	90%	89%	82%
Statewide	99%	68%	42%	71%	83%	86%	84%	73%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		29%
Amerigroup		30%	12%	56%	81%	82%	N/A	N/A
Sunflower		94%	45%	84%	78%	86%	91%	95%
United		80%	76%	85%	79%	92%	85%	94%
Statewide	57%	63%	34%	69%	80%	85%	89%	76%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		31%
Amerigroup		61%	38%	75%	91%	99%	N/A	N/A
Sunflower		99%	86%	84%	72%	90%	86%	90%
United		97%	61%	79%	95%	84%	91%	88%
Statewide	86%	82%	57%	78%	86%	93%	89%	76%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		62%	8%	23%	88%	100%	N/A	N/A
Sunflower		33%	29%	39%	50%	56%	100%	33%
United		43%	14%	6%	13%	47%	75%	83%
Statewide	90%	50%	16%	26%	50%	63%	80%	55%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		25%
Amerigroup		88%	64%	27%	25%	75%	N/A	N/A
Sunflower		80%	53%	22%	16%	39%	61%	59%
United		78%	63%	19%	5%	21%	10%	95%
Statewide	89%	82%	60%	23%	15%	45%	33%	67%

KDADS HCBS Quality Review Report

Health and Welfare
PM 5: Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames
Numerator: Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver
Denominator: Number of participants' reported critical incidents
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**70%**	**100%**	**99%**	**92%**
Numerator	32	65	69	166
Denominator	46	65	70	181
FE	**82%**	**100%**	**98%**	**96%**
Numerator	18	60	39	117
Denominator	22	60	40	122
IDD	**92%**	**100%**	**98%**	**98%**
Numerator	298	1008	466	1772
Denominator	323	1009	474	1806
TBI	**100%**	**100%**	**100%**	**100%**
Numerator	5	38	28	71
Denominator	5	38	28	71
TA	**100%**	**100%**	**100%**	**100%**
Numerator	4	6	3	13
Denominator	4	6	3	13
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

Statewide compliance of completing assigned reports within 30 days is met, however fallout data indicates Aetna was below the threshold for the PD and FE waivers. The majority of reports included with fallout data were completed within 39 days, with the longest follow-up taking 56 days to complete. 3 reports were identified as duplicates, which were awaiting additional information to complete and account for 6 of the reports in fallout data.

Follow-up and documentation included with all MCO completed reports was sufficient to resolve incidents and in most cases explain delays; no requests for additional information from KDADS was necessary and no CAPs were issued due to insufficient follow-up/evidence. MCO ensured members safety and quality of care was assessed and maintained.

SED reports are not currently routed to the HCBS worklist in the AIR system. Behavioral Health receives SED AIR reports and provide follow-up and remediation, as applicable.

Remediation:

Since the time period reviewed, Aetna has become fully staffed and trained on the Adverse Incident Reporting System. All MCO staff have received formal AIR training and additional instructions to reach out to Program Integrity when resolution may take longer than 30 days. Documentation is included on the report to indicate the notification date and reason for potential delays.

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		70%
Amerigroup	No Data						N/A	N/A
Sunflower							96%	100%
United							100%	99%
Statewide							98%	92%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		82%
Amerigroup	No Data						N/A	N/A
Sunflower							87%	100%
United							98%	98%
Statewide							92%	96%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		92%
Amerigroup	No Data						N/A	N/A
Sunflower							89%	100%
United							100%	98%
Statewide							93%	98%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							96%	100%
United							100%	100%
Statewide							98%	100%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							100%	N/A
Statewide							100%	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 6: Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures
Numerator: Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver
Denominator: Number of reported critical incidents
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**100%**	**100%**	**100%**	**100%**
Numerator	46	61	68	175
Denominator	46	61	68	175
FE	**100%**	**100%**	**100%**	**100%**
Numerator	21	56	40	117
Denominator	21	56	40	117
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	323	1009	470	1802
Denominator	323	1009	470	1802
TBI	**100%**	**100%**	**100%**	**100%**
Numerator	5	38	28	71
Denominator	5	38	28	71
TA	**100%**	**100%**	**100%**	**100%**
Numerator	4	4	3	11
Denominator	4	4	3	11
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

DCF forwards determinations for all Adult Protective Services (APS) reports (Screened-Out, Unsubstantiated and Substantiated). All reports received from DCF are entered into the AIR system and assigned to corresponding MCOs. Remediation reports provided by DCF are compared to reports entered into AIR for the time period reviewed and indicates the state adhered to follow-up measures for all reports received.

Autism and SED determination information is not provided as the state awaits an MOU between KDADS and DCF/CPS to share additional information. The State has also been working with CMS to remedy this gap in reporting.

DCF sends screened-in and screened-out reports for children, which are manually entered into AIR, as applicable. SED waiver reports are routed to the Behavioral Health Commission for necessary follow-up and/or remediation by staff who oversee and license CMHCs. HCBS and Behavioral Health currently have different processes for Adverse Incident follow-up and remediation and are working on collaborating to make necessary updates to address overall reporting issues.

Remediation:

KDADS is working with DCF to receive determination information as it pertains to CPS reports. Intakes for child reports are received in the AIR system and Behavioral Health provides any necessary follow-up/remediation until processes are updated to allow for accurate reporting.

KDADS HCBS continues to work with DCF and the Behavioral Health Commission to include accurate information as it pertains to child/SED member reports. HCBS is assisting with updated Behavioral Health policies, procedures and practices to address the issue.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							100%	100%
United							100%	100%
Statewide							100%	100%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							100%	N/A
Statewide							100%	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 7: Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Numerator: Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Denominator: Number of restraint applications, seclusion or other restrictive interventions
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
FE	**N/A**	**N/A**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	0	0	1	1
IDD	**100%**	**100%**	**40%**	**82%**
Numerator	4	8	2	14
Denominator	4	8	5	17
TBI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	0	0	1	1
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

Fallout data was reviewed and indicates the MCOs compliance with policy/procedure and this performance measure. The reports included in fallout data for United Healthcare show that MCO investigation identified 5 reports where unauthorized use of restraint/seclusion/restrictive interventions were utilized (1 FE, 3 on I/DD waiver and 1 on TA waiver). Information form the reporter and follow-up by the MCO for the 1 report on the FE waiver indicates that Seclusion was marked incorrectly (the reporter felt the individual's self-neglect was keeping them away from other people); sufficient follow-up was provided by the MCO and all necessary parties were involved to assist in resolving. For those reported as not following appropriate policy and procedure, United Healthcare initiated additional follow-up to ensure proper education was provided to staff, necessary adjustments made to Behavior Support Plans, and/or identified potential quality of care concerns for further investigation/remediation. Processes outlined in policy and procedure, as well as, standard operating procedures has ensured consistent and efficient follow-up for all reported restraints/seclusions/restrictive interventions. No remediation necessary for the MCOs.

Reports involving restraint/seclusion/restrictive interventions for SED participants are routed to Behavioral Health for necessary follow-up and/or remediation.

Remediation:

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	0%
Statewide							N/A	0%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		100%
Amerigroup	No Data						N/A	N/A
Sunflower							62%	100%
United							29%	40%
Statewide							50%	82%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	0%
Statewide							N/A	0%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 8: Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator: Number of unauthorized uses of restrictive interventions
Review Period: 04/01/2019 - 06/30/2019
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
FE	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
IDD	**N/A**	**N/A**	**100%**	**100%**
Numerator	0	0	2	2
Denominator	0	0	2	2
TBI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**100%**	**100%**
Numerator	0	0	1	1
Denominator	0	0	1	1
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED				
Numerator				
Denominator				

Explanation of Findings:

There were 3 total unauthorized uses of restraint/seclusion/restrictive interventions reported during the timeframe. All unauthorized restraint/seclusion/restrictive interventions were reported appropriately and received all necessary follow-up to resolve.

Reports involving restraint/seclusion/restrictive interventions for SED participants are routed to Behavioral Health for necessary follow-up and/or remediation.

Remediation:

KDADS HCBS continues to work with the Behavioral Health Commission to include accurate information as it pertains to SED member reports.

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							100%	N/A
United							100%	100%
Statewide							100%	100%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	100%
Statewide							N/A	100%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		N/A
Amerigroup	No Data						N/A	N/A
Sunflower							N/A	N/A
United							N/A	N/A
Statewide							N/A	N/A
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		
Amerigroup	No Data						N/A	N/A
Sunflower								
United								
Statewide								

KDADS HCBS Quality Review Report

Health and Welfare
PM 9: Number and percent of waiver participants who received physical exams in accordance with State policies
Numerator: Number of HCBS participants who received physical exams in accordance with State policies
Denominator: Number of HCBS participants whose service plans were reviewed
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**63%**	**47%**	**78%**	**63%**
Numerator	12	14	25	51
Denominator	19	30	32	81
FE	**60%**	**69%**	**61%**	**64%**
Numerator	9	20	22	51
Denominator	15	29	36	80
IDD	**83%**	**88%**	**71%**	**83%**
Numerator	10	44	17	71
Denominator	12	50	24	86
TBI	**44%**	**56%**	**62%**	**55%**
Numerator	4	10	8	22
Denominator	9	18	13	40
TA	**83%**	**90%**	**86%**	**87%**
Numerator	10	18	19	47
Denominator	12	20	22	54
Autism	**0%**	**67%**	**60%**	**56%**
Numerator	0	2	3	5
Denominator	1	3	5	9
SED	**65%**	**76%**	**46%**	**60%**
Numerator	13	22	18	53
Denominator	20	29	39	88

Explanation of Findings:

PD: Physical exam documentation not provided for review, documentation provided does not cover all or part of the review period, missing documentation of last physical exam

FE: Physical exam documentation not provided for review, documentation provided does not cover all or part of the review period, missing documentation of last physical exam

IDD: Physical exam documentation not provided for review, documentation provided does not cover all or part of the review period, missing documentation of last physical exam

TBI: Physical exam documentation not provided for review, missing documentation of last physical exam

AU: Physical exam documentation not provided for review

SED: Physical exam documentation not provided for review

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		63%
Amerigroup		78%			20%	46%	N/A	N/A
Sunflower		81%			34%	40%	45%	47%
United		88%			34%	23%	50%	78%
Statewide	Not a measure	82%	No Data	No Data	29%	37%	48%	63%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		60%
Amerigroup		89%			23%	34%	N/A	N/A
Sunflower		97%			31%	28%	47%	69%
United		97%			31%	18%	71%	61%
Statewide	Not a measure	95%	No Data	No Data	29%	27%	59%	64%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		83%
Amerigroup		91%			28%	56%	N/A	N/A
Sunflower		99%			52%	70%	79%	88%
United		99%			26%	29%	60%	71%
Statewide	Not a measure	97%	No Data	No Data	39%	56%	73%	83%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		44%
Amerigroup		84%			21%	29%	N/A	N/A
Sunflower		94%			32%	30%	43%	56%
United		93%			19%	35%	54%	62%
Statewide	Not a measure	90%	No Data	No Data	23%	30%	47%	55%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		83%
Amerigroup		100%			39%	54%	N/A	N/A
Sunflower		100%			56%	79%	89%	90%
United		97%			68%	62%	69%	86%
Statewide	Not a measure	100%	No Data	No Data	49%	63%	80%	87%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		100%			56%	90%	N/A	N/A
Sunflower		92%			65%	73%	100%	67%
United		100%			19%	42%	25%	60%
Statewide	Not a measure	98%	No Data	No Data	48%	59%	40%	56%
SED								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		65%
Amerigroup		54%			76%	87%	N/A	N/A
Sunflower		55%			27%	71%	71%	76%
United		46%			47%	61%	42%	46%
Statewide	Not a measure	52%	No Data	No Data	52%	67%	55%	60%

KDADS HCBS Quality Review Report

Health and Welfare
PM 10: Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan
Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
Denominator: Number of waiver participants with a red flag designation
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**58%**	**88%**	**85%**	**79%**
Numerator	14	30	29	73
Denominator	24	34	34	92
FE	**53%**	**88%**	**87%**	**81%**
Numerator	9	29	34	72
Denominator	17	33	39	89
IDD	**60%**	**78%**	**79%**	**75%**
Numerator	9	39	22	70
Denominator	15	50	28	93
TBI	**43%**	**90%**	**94%**	**78%**
Numerator	6	18	15	39
Denominator	14	20	16	50
TA	**38%**	**90%**	**84%**	**76%**
Numerator	5	18	21	44
Denominator	13	20	25	58
Autism	**0%**	**100%**	**67%**	**64%**
Numerator	0	3	4	7
Denominator	2	3	6	11
SED	**Not a waiver performance measure**			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		58%
Amerigroup		59%	53%	73%	86%	96%	N/A	N/A
Sunflower		77%	49%	66%	79%	85%	85%	88%
United		64%	80%	88%	87%	94%	91%	85%
Statewide	Not a measure	67%	58%	75%	84%	92%	88%	79%
FE								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		53%
Amerigroup		61%	62%	72%	84%	90%	N/A	N/A
Sunflower		72%	56%	72%	77%	81%	83%	88%
United		76%	81%	85%	91%	91%	87%	87%
Statewide	59%	70%	65%	76%	84%	87%	85%	81%
IDD								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		60%
Amerigroup		67%	61%	65%	74%	86%	N/A	N/A
Sunflower		58%	32%	59%	70%	72%	77%	78%
United		70%	58%	73%	90%	86%	93%	79%
Statewide	Not a measure	64%	47%	64%	76%	79%	83%	75%
TBI								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		43%
Amerigroup		46%	49%	62%	80%	82%	N/A	N/A
Sunflower		68%	42%	80%	84%	88%	91%	90%
United		56%	74%	80%	79%	89%	85%	94%
Statewide	Not a measure	56%	52%	70%	81%	85%	89%	78%
TA								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		38%
Amerigroup		75%	54%	79%	90%	99%	N/A	N/A
Sunflower		91%	58%	77%	78%	85%	81%	90%
United		86%	63%	79%	95%	86%	91%	84%
Statewide	Not a measure	83%	57%	78%	87%	92%	86%	76%
Autism								
Aetna	N/A	N/A	N/A	N/A	N/A	N/A		0%
Amerigroup		77%	44%	32%	88%	100%	N/A	N/A
Sunflower		53%	27%	67%	80%	72%	100%	100%
United		38%	7%	6%	13%	41%	50%	67%
Statewide	Not a measure	64%	30%	40%	62%	67%	60%	64%
SED	**Not a waiver performance measure**							
Aetna								
Amerigroup								
Sunflower								
United								
Statewide								

Explanation of Findings:

PD: Service/backup plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date

FE: Service/backup plan not provided or did not cover entire review period, service plan not completed timely, no valid signature and/or date, only the last page of the service plan was uploaded

IDD: Service/backup plan not provided or did not cover entire review period, guardian signed service plan after services implemented, no valid signature and/or date, service plan not completed timely

TBI: Service/backup plan not provided or did not cover entire review period, no valid signature and/or date, servce plan not completed timely

TA: Service/backup plan not provided or did not cover entire review period, no valid signature and/or date, individual did not have authorization to sign for waiver participant

AU: Service plan not provided or did not cover entire review period

Remediation:

KDADS HCBS Quality Review Report

Financial Accountability
PM 1: Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Numerator: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Denominator: Total number of provider claims
Review Period: 04/01/2019 - 06/30/2019
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
PD	**96%**
Numerator	96,071
Denominator	100,488
FE	**95%**
Numerator	53,837
Denominator	56,816
IDD	**95%**
Numerator	154,898
Denominator	162,308
TBI	**91%**
Numerator	9,416
Denominator	10,347
TA	**96%**
Numerator	7,567
Denominator	7,907
Autism	**82%**
Numerator	14
Denominator	17
SED	**75%**
Numerator	18,914
Denominator	25,276
All HCBS Waivers	**94%**
Numerator	340,717
Denominator	363,159

Compliance Trends	2013	2014	2015	2016	2017	2018	Jan-Mar 2019	Apr-Jun 2019
PD								
Statewide	not a measure	N/A	N/A	N/A	N/A	96%	95%	96%
FE								
Statewide	not a measure	N/A	N/A	N/A	N/A	95%	94%	95%
IDD								
Statewide	not a measure	N/A	N/A	N/A	N/A	97%	96%	95%
TBI								
Statewide	not a measure	N/A	N/A	N/A	N/A	90%	92%	91%
TA								
Statewide	not a measure	N/A	N/A	N/A	N/A	91%	96%	96%
Autism								
Statewide	not a measure	N/A	N/A	N/A	N/A	82%	95%	82%
SED								
Statewide	not a measure	N/A	N/A	N/A	N/A	82%	74%	75%
All HCBS Waivers								
Statewide	not a measure	90%	88%	95%	95%	95%	94%	94%

Explanation of Findings:

MCO self-reported data.

Remediation:

Financial Accountability
PM 2: Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Numerator: Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Denominator: Total number of capitation (payment) rates
Review Period: 04/01/2019 - 06/30/2019
Data Source: KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	24
Denominator	24
FE	**100%**
Numerator	24
Denominator	24
IDD	**100%**
Numerator	48
Denominator	48
TBI	**100%**
Numerator	12
Denominator	12
TA	**100%**
Numerator	12
Denominator	12
Autism	**100%**
Numerator	12
Denominator	12
SED	**100%**
Numerator	12
Denominator	12

Compliance Trends	2013	2014	2015	2016	2017	2018	2019
PD							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
FE							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
IDD							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
TBI							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
TA							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
Autism							
Statewide	not a measure	100%	100%	100%	100%	100%	100%
SED							
Statewide	not a measure	100%	100%	100%	100%	100%	100%

Explanation of Findings:

Performance Measure achieved.

Remediation:

No remediation necessary.

KanCare Ombudsman Report

Quarter 4, 2019 (based on calendar year)

October 1 – December 31, 2019

Data downloaded 1/14/2020

KanCare Ombudsman Office

Kerrie Bacon, KanCare Ombudsman
Email: KanCare.Ombudsman@ks.gov or Kerrie.Bacon@ks.gov
Phone: (785) 296-6270
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Address: 503 S. Kansas Ave., Topeka, KS 66603
Website: www.kancareombudsman.ks.gov

Find us on: facebook

I. Table of Contents

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A. Increased calls for Topeka office
B. Divided Issues Category into three sections (pages 13-15)
C. New data being tracked
D. New Data Category - Tracking cases with priority codes - as needed (page 13)

III. KanCare Ombudsman Purpose

The KanCare Ombudsman Office helps Kansas Medicaid beneficiaries and applicants, with a priority on individuals participating long-term care services through KanCare.

The KanCare Ombudsman Office assists KanCare beneficiaries and applicants with access, service and benefit problems. The office:

- assists KanCare members with seeking resolution to complaints or concerns regarding their interaction with their KanCare plan or eligibility
- helps applicants with information, resources and in-person assistance with the KanCare application and renewal process
- provides information about the KanCare grievance and appeal process that is available through the KanCare plans and the State Fair Hearing process

The Centers for Medicare and Medicaid Services Special Terms and Conditions (2019), Section 42 for KanCare, provides the KanCare Ombudsman program description and objectives.

This quarterly report provides updates about the KanCare Ombudsman Office activities; see the Outreach section – page 6, and information collected (data) starting on page 7.

IV. Accessibility by Ombudsman's Office

A. Initial Contacts

The KanCare Ombudsman Office was available to members and potential members of KanCare (Medicaid) by phone, email, written communication, social media, and in person during 2019.

The KanCare Ombudsman Office has helped an increasing number of KanCare members and applicants over the last several years, starting in 2016 with the beginning of trained volunteer help in the two satellite offices (Olathe and Wichita). For the last two years, total quarterly contacts have averaged around 1,000. Fourth quarter took a dip in contacts, however January 2020 had over 360 contacts which is a normal monthly contact number.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2014	545	474	526	547
2015	510	462	579	524
2016	1,130	846	687	523
2017	825	835	970	1,040
2018	1,214	1,059	1,088	1,124
2019	1,060	1,097	1,071	915

B. Accessibility through the KanCare Ombudsman Volunteer Program

The Kancare Ombudsman Office has two satellite offices; one in Olathe and one in Wichita. Both satellite offices answer KanCare questions, help with issues and assist with filling out KanCare applications on the phone and in person at the offices.

The main means of contact with the two satellite offices is through the KanCare Ombudsman Toll Free number, which directs calls based on the area code of the caller. The satellite offices are each covering over 20 hours per week in serving KanCare beneficiaries.

The Olathe and Wichita offices each have one volunteer in training (not listed below). The Satellite offices current coverage is listed below. Information on the Satellite office hours and contact information can be found on the Ombudsman web pages on the About/Contact Us page.

	Volunteer Hours	# of Volunteers	# of hours covered/wk.	Area Codes covered
Olathe Satellite Office	M: 9am-4pm T:9am-4pm W:10am-2pm Th: 9am-12:30pm F: 9am-12:30pm	5	25	913, 785, 816
Wichita Satellite Office	M: 9am-1pm T: 10am-2pm W: 1:30-3:30pm Th: 10am-2pm F: 9am-4:30pm	5	21.5	316, 620

Information as of 2/6/2020

V. Outreach by Ombudsman's office

The KanCare Ombudsman Office is responsible to help beneficiaries and applicants to understand the KanCare application process, benefits and services, and provide training and outreach to community organizations. The office does this through education, publications and training.

The outreach for 4th quarter, 2019 continues down significantly from past quarters from 49 in first quarter to 8 in 4th quarter (see chart below). In June of 2019 the part-time staff member on loan from the Governor's office was recalled to full-time in her area. That part-time person helped the Topeka office with complex calls and call volume in general. Our office has been short-staffed since that time and had to reprioritize all staff duties to ensure KanCare members and applicants received timely responses. Outreach and community/organizational meetings have stopped except in very limited instances. There have been no Liaison trainings in 4th quarter. Requests for speaking engagements are being pushed back to fall 2020.

	Q1/19	Q2/19	Q3/19	Q4/19
Outreach	49	23	14	8

For the full listing of outreach events, see Appendix A

VI. Data by Ombudsman Office

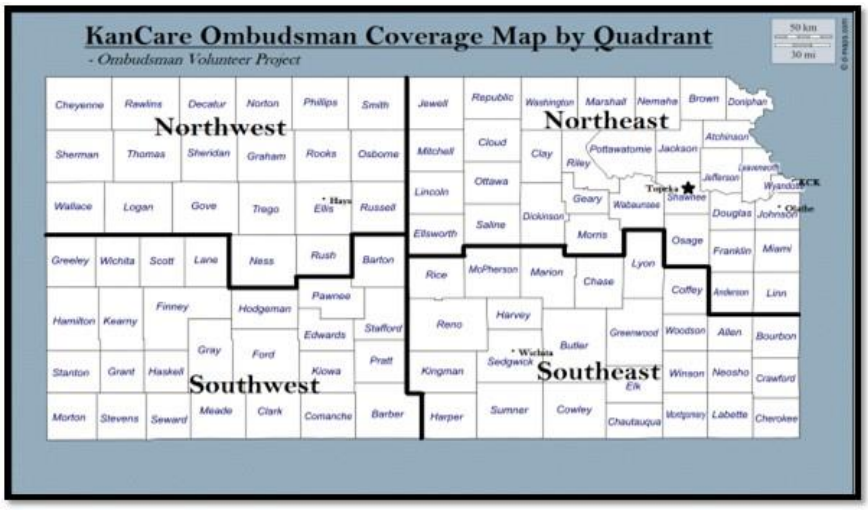
The data for the KanCare Ombudsman Office includes data by region, office location, contact method, caller type, program type, issue category, action taken and priority.

A. Data by Region

1. Initial Contacts to KanCare Ombudsman Office by Region

The KanCare Ombudsman coverage is divided into four regions. The map directly below shows the counties included in each region. The north/south dividing line is based on the state area codes coverage (785 and 620).

- 785, 913 and 816 area code calls go to the Olathe Satellite office.
- 316 and 620 area code calls go to the Wichita Satellite office.
- The remaining calls, direct calls and complex calls go to the Topeka (main) office.



Most contacts for the KanCare Ombudsman Office are coming from the east side of the state which also ties to where Medicaid members are located within the state (see chart on page 9) and the population density of Kansas (see map on page 9).

Ombudsman Office Calls by Region

Region	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Northeast	157	220	238	187	183	210	174	183
Southeast	59	135	163	244	205	129	126	172
Northwest	14	16	10	14	7	20	11	8
Southwest	14	18	14	29	19	24	17	17
Out of State	14	17	21	17	16	8	4	3
Not Identified	955	653	639	633	630	706	739	532
Total	**1,213**	**1,059**	**1,085**	**1,124**	**1,060**	**1,097**	**1,071**	**915**

2. KanCare/Medicaid Members by Region

This chart shows the KanCare/Medicaid population by the KanCare Ombudsman regions. The majority of the Medicaid population is located in the eastern two regions.

Medicaid

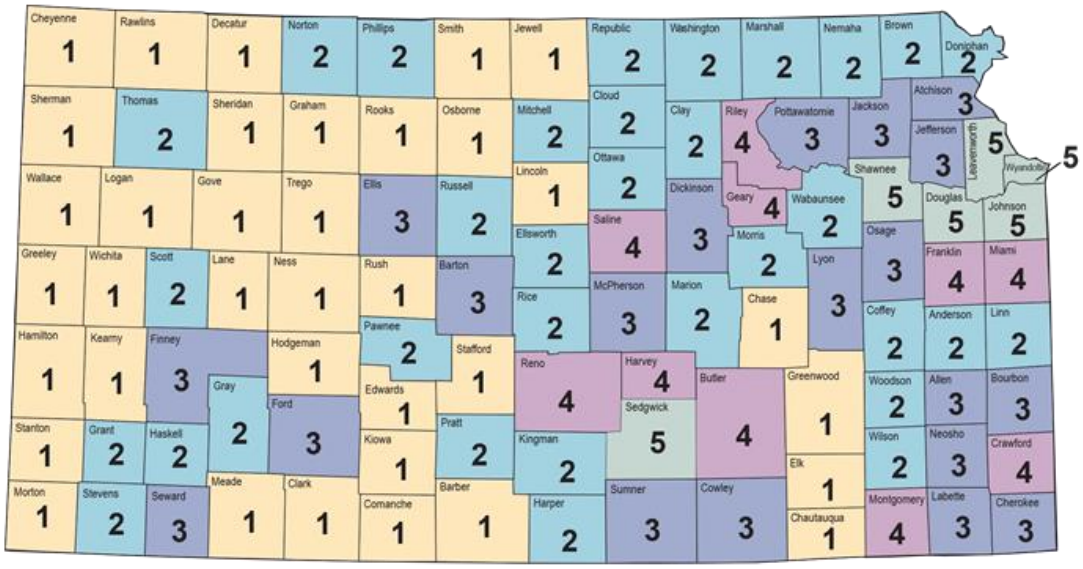
Region	Q4/18	Q1/19	Q2/19	Q3/19
Northeast	194,798	205,267	179,011	188,184
Southeast	175,370	185,683	160,821	169,598
Northwest	12,488	13,240	11,575	12,163
Southwest	38,023	40,073	34,613	36,291
Total	**420,679**	**444,263**	**386,020**	**406,236**

Data as of end of September 2019

3. Kansas Population Density

This chart shows the population density of Kansas and helps in understanding why most of the Medicaid population and KanCare Ombudsman calls are from the eastern part of Kansas.

Based on 2015 Census data – www.KCDCinfo.ks.gov Kansas Population Density map using number of people per square mile (ppsm)



5 Urban - 150+ ppsm
4 Semi-Urban - 40-149.9 ppsm
3 Densely-Settled Rural - 20 to 39.9 ppsm
2 Rural - 6 to 19.9 ppsm
1 Frontier - less than 6 ppsm

B. Data by Office Location

Initial phone calls to the KanCare Ombudsman toll-free number (1-855-643-8180) are sent directly to one of three KanCare Ombudsman offices based on the area code the call is coming from. Olathe receives 913, 785 and 816 area code calls. Wichita receives 620 and 316 area code calls. All other toll-free calls go to the Main office (Topeka). People also may call all three offices directly; the direct phone numbers for the satellite offices are listed on the KanCare Ombudsman webpage, Contact Us.

Contacts by Office	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Main - Topeka	772	619	491	546	561	620	733	537
Olathe	68	81	223	177	166	213	212	182
Wichita	374	359	371	401	333	264	126	196
Total	**1,214**	**1,059**	**1,085**	**1,124**	**1,060**	**1,097**	**1,071**	**915**

C. Data by Contact Method

There is a new listing below called Social Media. Since the KanCare Ombudsman office is on Facebook, we anticipate there may be instances when people will contact us for help through Facebook.

Face-to-face contacts are usually through:

- Assistance by appointment at the satellite offices in Olathe and Wichita to help complete applications.
- Assistance to Kansas Department of Aging and Disability Services (KDADS) walk-ins in Topeka who need help with Medicaid related questions.
- people with personal concerns who attend KanCare public meetings. The KanCare Ombudsman office tries to attend most of these and be available to answer individual questions/issues that may come up.

Contact Method	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Telephone	1,090	930	909	939	898	948	956	794
Email	112	119	153	161	152	138	107	109
Letter	2	1	2	3	1	5	2	1
Face-to-Face Meeting	7	9	22	20	12	6	5	8
Other	2	0	2	1	5	0	0	1
Social Media	0	0	0	0	0	0	1	2
CONTACT METHOD TOTAL	**1,213**	**1,059**	**1,088**	**1,124**	**1,068**	**1,097**	**1,071**	**915**

D. Data by Caller Type

Most contacts are consumers which includes beneficiaries, family member, friend, etc. The "Other type" callers are usually state employees, lawyers, schools, and students/researchers looking for data.

Provider issues are a combination of providers calling to assist a member or applicant having issues, or provider billing issues which we forward to KDHE.

CALLER TYPE	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Provider	96	81	99	93	93	69	112	65
Consumer	1,065	943	899	977	920	939	901	794
MCO Employee	6	4	5	4	8	11	1	7
Other Type	46	31	85	50	47	78	57	49
CALLER TYPE TOTAL	**1,213**	**1,059**	**1,088**	**1,124**	**1,068**	**1,097**	**1,071**	**915**

E. Data by Program Type

The top program types that we received calls for in fourth quarter were Physical Disability waiver Frail Elderly waiver and nursing facility concerns.

Five program types were added at the end of August:

- Foster Care
- MediKan
- Institutional Transition from
    - Long Term Care/Nursing Facility (LTC/NF)
    - Mental Health/Behavioral Health (MH/BH)
    - Prison/Jail

PROGRAM TYPE	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
PD	51	27	28	37	40	32	21	29
I/DD	29	27	36	32	30	36	37	20
FE	27	22	30	31	25	20	43	36
AUTISM	1	1	2	4	3	4	1	2
SED	9	2	8	7	5	7	13	10
TBI	7	10	9	6	13	11	7	12
TA	5	3	7	3	5	7	7	10
WH	5	4	6	5	2	5	1	2
MFP	1	0	0	0	0	0	0	1
PACE	0	0	0	0	2	1	2	4
MENTAL HEALTH	2	1	3	2	2	5	2	5
SUB USE DIS	0	0	0	0	1	0	2	1
NURSING FACILITY	47	39	28	41	33	27	27	48
FOSTER CARE	0	0	0	0	0	0	0	0
MEDIKAN	0	0	0	0	0	0	9	3
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	0	0	1	5
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	0	0	0	3
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**184**	**136**	**157**	**168**	**161**	**155**	**173**	**191**

There may be multiple selections for a member/contact.

F. *NEW!* Data by Priorities

This is new data that is now available. The Ombudsman Office is tracking priorities for two purposes:

1. This allows our staff and volunteers to pull up pending cases, review their status and possibly request an update from the partnering organization that we have requested assistance from.
2. This helps provide information on the more complex cases that are worked by the Ombudsman Office.

The priorities are defined as follows:

- HCBS – Home and Community Based Services
- Long Term Care/NF – Long Term Care/Nursing Facility
- Urgent Medical Need – 1) there is a medical need, 2) if the need is not resolved in 5-10 days, the person could end up in the hospital.
- Urgent – non-medical need that needs to be resolved in the next 7-10 days; could be eviction from home or nursing facility or urgent financial.
- Life Threatening – If not resolved in 1-4 days person's life could be endangered. (should not be used very often.)

PRIORITY	Q3/2019	Q4/2019
HCBS	39	60
Long Term Care / MF	12	24
Urgent Medical Need	13	33
Urgent	23	29
Life Threatening	6	8
PRIORITIES TOTAL	**93**	**154**

There may be multiple selections for a member/contact.

G. Data by Issue Categories

The Issue Categories have been divided into three groups for easier tracking and reporting purposes. The three groups are:

- **Medicaid Issues**
- **Home and Community Based Services/Long Term Services (HCBS/LTSS)**,
- **Other Issues**.

Other Issues may be Medicaid related but are tied to a non-Medicaid program or issue that is worthy of tracking.

1. Medicaid Issues

Seven issues were added to this section and are highlighted in gray. The top issues are still Medicaid eligibility and renewal issues.

MEDICAID ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Access to Providers (usually Medical)	4	2	8	10	11	14	26	15
Appeals/Fair Hearing questions/issues	46	26	38	16	17	12	10	12
Background Checks	4	0	1	0	2	1	0	1
Billing	40	26	33	19	30	29	54	35
Care Coordinator Issues	10	11	7	14	18	5	15	16
Change MCO	12	7	5	37	12	10	4	6
Choice Info on MCO	3	3	3	20	7	8	3	3
Coding Issues	32	9	11	21	15	11	9	4
Consumer said Notice not received	16	6	15	13	6	7	3	6
Cultural Competency	0	0	0	0	0	0	1	0
Data Requests	3	2	4	0	2	4	0	1
Dental	10	9	6	7	11	6	6	6
Division of Assets	10	3	5	11	8	11	13	12
Durable Medical Equipment	1	4	9	13	4	5	3	2
Grievances Questions/Issues	28	35	23	12	12	19	26	36
Help understanding mail (NOA)	0	0	0	0	0	0	3	6
MCO transition	0	0	0	0	0	0	1	3
Medicaid Application Assistance	185	135	144	174	171	137	130	171
Medicaid Eligibility Issues	209	219	183	187	152	145	147	187
Medicaid Fraud	3	2	2	5	1	4	3	2
Medicaid General Issues/questions	63	186	200	256	273	254	183	197
Medicaid info (status) update	210	217	196	187	124	175	149	188
Medicaid Renewal	103	58	39	24	56	119	84	51
Medical Card issues	0	0	0	0	0	0	1	9
Medicare Savings Plan Issues	19	17	20	25	22	29	62	77
MediKan issues	0	0	0	0	0	0	4	3
Moving to / from Kansas	16	14	21	19	20	17	18	17
Medical Services	23	27	11	13	18	10	13	17
Pain management issues	0	0	0	1	5	1	0	2
Pharmacy	16	1	2	11	18	16	10	11
Pregnancy issues	0	0	0	0	0	0	5	5
Prior authorization issues	0	0	0	0	0	0	1	1
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	3	10
Respite	0	1	0	1	1	0	0	1
Spend Down Issues	28	32	24	28	29	21	34	33
Transportation	16	10	9	12	11	9	14	9
Working Healthy	3	6	8	9	3	5	5	6
MEDICAID ISSUES TOTAL	**1,113**	**1,068**	**1,027**	**1,145**	**1,059**	**1,084**	**1,043**	**1,161**

There may be multiple selections for a member/contact.

2. HCBS/LTSS Issues

The top two issues for this group are HCBS Eligibility Issues and HCBS General Issues. (HCBS stands for Home and Community Based Services)

HCBS/LTSS ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Client Obligation	53	35	24	27	22	19	27	14
Estate Recovery	10	4	10	8	4	9	10	9
HCBS Eligibility issues	46	28	37	34	35	33	46	60
HCBS General Issues	36	35	60	49	62	47	65	67
HCBS Reduction in hours of service	7	2	3	2	6	3	3	0
HCBS Waiting List	4	4	4	10	6	7	8	6
Nursing Facility Issues	20	19	23	24	36	39	54	49
HCBS/LTSS ISSUES TOTAL	**176**	**127**	**161**	**154**	**171**	**157**	**213**	**205**

There may be multiple selections for a member/contact.

3. Other Issues

There were six new issues created at the end of August (highlighted in gray) to help better understand concerns that may be *related* to Medicaid.

OTHER ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Abuse / neglect complaints	10	10	7	2	8	6	4	3
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	0	1	2
Affordable Care Act Calls	15	12	9	8	5	5	3	4
Community Resources needed	0	0	0	0	0	0	3	6
Domestic Violence concerns	0	0	0	0	0	0	1	0
Foster Care issues	0	0	0	0	0	0	1	2
Guardianship	3	6	5	5	1	1	2	6
Homelessness	0	0	0	0	0	0	1	3
Housing Issues	7	8	7	4	5	5	7	4
Medicare related Issues	17	23	26	31	18	15	18	23
Social Security Issues	9	13	12	24	16	15	19	7
Used Interpreter	0	0	0	0	0	0	0	6
X-Other	213	114	132	135	134	119	114	85
Z Thank you	558	510	482	498	408	399	350	398
Z Unspecified	78	68	72	80	97	110	137	99
OTHER ISSUES TOTAL	**910**	**764**	**752**	**787**	**692**	**675**	**661**	**648**

There may be multiple selections for a member/contact.

H. Data by Managed Care Organization – See Appendix B

(pages 23-29)

VII. Action Taken

This section reflects the action taken by the KanCare Ombudsman Office and the related organizations assisting the KanCare Ombudsman Office. This data shows information on:

- response rates for the KanCare Ombudsman office
- response rates to resolve the question/concern for related organizations that are asked to assist by the Ombudsman office
- how contacts are resolved

A. Responding to Issues

1. Ombudsman Office response to members/applicants

The Ombudsman Office goal is to respond to a contact within two business days.

Quarter yr.	Nbr Contacts	% Responded 0-2 Days	% Responded in 3-7 Days	% Response 8 or More Days
Q1/2018	1,213	82%	17%	1%
Q2/2018	1,059	90%	10%	1%
Q3/2018	1,088	87%	12%	1%
Q4/2018	1,124	86%	14%	0%
Q1/2019	1,068	88%	11%	1%
Q2/2019	1,096	91%	8%	1%
Q3/2019	1,071	95%	4%	1%
Q4/2019	915	93%	6%	0%

Chart reflects calendar day response time.

2. Organizational response to Ombudsman requests

The KanCare Ombudsman office sends requests for review and assistance to various KanCare/related organizations. The following information provides data on the resolution rate for issues that have been referred.

Q4/2019

Nbr Referrals	Referred to	% Resolved 0-2 Days	% Resolved 3-7 Days	% Resolved 7-30 Days	% Resolved 31 or More Days
147	Clearinghouse	65%	17%	14%	4%
2	DCF	50%	0%	0%	50%
2	KDADS-Behavior Health	100%	0%	0%	0%
4	KDADS-HCBS	25%	75%	0%	0%
-	KDADS-Health Occ. Cred.	0%	0%	0%	0%
18	KDHE-Eligibility	44%	50%	6%	0%
6	KDHE-Program Staff	83%	17%	0%	0%
3	KDHE-Provider Contact	100%	0%	0%	0%
-	KMAP	0%	0%	0%	0%
10	Aetna	60%	30%	0%	10%
-	Amerigroup	0%	0%	0%	0%
8	Sunflower	25%	38%	13%	25%
5	UnitedHealthcare	60%	20%	20%	0%

B. Resolving requests

1. Action Taken by KanCare Ombudsman Office to resolve requests

84% (or 4 out of 5) of initial calls were resolved by providing some type of resource, for example the KanCare Ombudsman office contacted another organization to resolve the issue, shared resources through mailings, provided referrals to other organizations, etc.

Note: The totals will not match "Initial Contacts chart" because not all cases are closed at the end of the quarter. This must be filled in before closing a case.

Action Taken Resolution Type	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Questions/Issue Resolved (No Resources)	105	69	76	106	94	85	69	58
Used Contact or Resources/Issue Resolved	766	675	776	874	837	871	909	768
Closed (No Contact)	101	133	115	134	126	123	79	62
ACTION TAKEN RESOLUTION TYPE TOTAL	**972**	**877**	**967**	**1,114**	**1,057**	**1,079**	**1,057**	**888**

There may be multiple selections for a member/contact

2. Referred Beneficiary to an Organization for Assistance

This chart provides information on when our office tells a member, "This is who you need to call and here is the phone number." It may also be used if we contact an organization that is not listed in the section to track dates. This is usually "State or Community Agency."

Action Taken Additional Help	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Provided Resources	772	758	808	666	567	537	682	662
Mailed/Email Resources	221	182	136	140	151	123	152	167
TOTAL	**993**	**940**	**944**	**806**	**718**	**660**	**834**	**829**

There may be multiple selections for a member/contact.

3. Ombudsman Office Resolution of Issues

The average days to close/resolve an issue remained relatively the same over the last four quarters. The improvement in 3rd quarter, 2018 was due to clarification for staff and volunteers to close a case based on resolution date or if no response, on the date last contacted. Prior to this, cases were closed by many at the end of the quarter when I sent out the reminder to close cases.

The percentage for closing cases in 8 or more days increased by three percentage points. Our office believes this is due, in part, by more complex calls coming to the Ombudsman Office.

Quarter/Year	Number Contacts	Avg Days To Completion	% Completed 0-2 Days	% Completed in 3-7 Days	% Completed 8 or More Days
Q1/2018	1,069	12	56%	17%	28%
Q2/2018	1,036	10	60%	13%	27%
Q3/2018	1,043	4	72%	17%	11%
Q4/2018	1,107	4	71%	18%	11%
Q1/2019	1,051	5	71%	17%	13%
Q2/2019	1,021	4	75%	13%	13%
Q3/2019	1,002	5	75%	10%	15%
Q4/2019	837	5	72%	11%	17%

VIII. Appendix A - Outreach by Ombudsman's office

This is a listing of the KanCare Ombudsman Outreach to members and community by way of participation in conferences where members and/or providers attend, newsletters, social media, training events, public comments sessions by the state for KanCare related issues, etc.

A. Outreach through Collaboration and Education

This outreach includes Community Events/Presentations such as education, networking and referrals.

- Ascensions HOPE Via Christi PACE facility tour- networking and PACE presentation (Wichita, KS) (10/24/19)
- United Way Emergency Assistance Providers mtg (Wichita, KS) (11/19/19)
- Center for Child Health & Development – Gave them brochures to pass out to families (English and Spanish)
- Via Christi HOPE (Wichita PACE Center) – Presentation of KanCare Ombudsman Office and our role (10/24/2019) (we also toured their facility and learned their role as well.)

B. Outreach through Print Media and Social Media

- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (10-12/19)
- Facebook site redesign and posting; Post engagement increased by 3,367%.

C. Outreach through Collaboration and Training

- Manhattan (Riley Co.) (In-person training): Via Christi Manhattan Group of Social Workers and other community organization staff members from surrounding counties. (10/16/19)
- Participating in United Way of the Plains Monthly meeting of Community Emergency Assistance Providers- (Wichita, KS- 10/15/19)

IX. Appendix B – Information by Managed Care Organization

A. Aetna-Issue Categories

MEDICAID ISSUES	Q1/19	Q2/19	Q3/19	Q4/19
Access to Providers (usually Medical)	2	2	4	5
Appeals/Fair Hearing questions/issues	0	1	1	0
Background Checks	0	0	0	0
Billing	3	0	5	4
Care Coordinator Issues	10	1	4	4
Change MCO	4	3	2	2
Choice Info on MCO	2	0	2	2
Coding Issues	1	0	1	1
Consumer said Notice not received	0	1	0	0
Cultural Competency	0	0	0	0
Data Requests	0	0	0	0
Dental	3	0	2	2
Division of Assets	0	0	0	1
Durable Medical Equipment	1	2	2	0
Grievances Questions/Issues	2	2	4	3
Help understanding mail (NOA)	0	0	0	0
MCO transition	0	0	1	2
Medicaid Application Assistance	2	1	1	2
Medicaid Eligibility Issues	5	7	2	5
Medicaid Fraud	0	0	0	0
Medicaid General Issues/questions	16	18	5	7
Medicaid info (status) update	4	1	4	5
Medicaid Renewal	1	12	3	2
Medical Card issues	0	0	0	0
Medicare Savings Plan Issues	2	1	1	2
MediKan issues	0	0	0	0
Moving to / from Kansas	0	0	1	1
Medical Services	3	4	4	3
Pain management issues	0	1	0	0
Pharmacy	4	3	1	2
Pregnancy issues	0	0	0	0
Prior authorization issues	0	0	0	0
Refugee/Immigration/SOBRA issues	0	0	0	0
Respite	0	0	0	0
Spend Down Issues	1	3	2	3
Transportation	4	0	4	5
Working Healthy	0	0	0	0
MEDICAID ISSUES TOTAL	**70**	**63**	**56**	**63**

There may be multiple selections for a member/contact.

HCBS/LTSS ISSUES	Q1/19	Q2/19	Q3/19	Q4/19
Client Obligation	2	3	2	2
Estate Recovery	0	0	0	0
HCBS Eligibility issues	5	3	3	7
HCBS General Issues	7	5	7	6
HCBS Reduction in hours of service	0	0	1	0
HCBS Waiting List	2	0	0	1
Nursing Facility Issues	0	1	3	2
HCBS/LTSS ISSUES TOTAL	**16**	**12**	**16**	**18**

There may be multiple selections for a member/contact.

OTHER ISSUES	Q1/19	Q2/19	Q3/19	Q4/19
Abuse / neglect complaints	0	0	0	0
ADA Concerns	0	0	0	0
Adoption issues	0	0	0	0
Affordable Care Act Calls	0	0	0	0
Community Resources needed	0	0	0	0
Domestic Violence concerns	0	0	0	0
Foster Care issues	0	0	0	0
Guardianship	0	0	0	0
Homelessness	0	0	0	0
Housing Issues	0	0	1	0
Medicare related Issues	0	1	4	2
Social Security Issues	1	1	1	0
Used Interpreter	0	0	0	0
X-Other	14	6	6	2
Z Thank you	26	32	28	22
Z Unspecified	1	1	3	3
Health Homes	0	0	0	0
OTHER ISSUES TOTAL	**42**	**41**	**43**	**29**

There may be multiple selections for a member/contact.

B. Aetna–Program Type

PROGRAM TYPE	Q1/19	Q2/19	Q3/19	Q4/19
PD	3	2	1	2
I/DD	1	4	2	1
FE	2	1	3	2
AUTISM	0	0	0	0
SED	0	1	0	2
TBI	2	3	2	2
TA	2	1	2	1
WH	0	0	0	0
MFP	0	0	0	0
PACE	0	0	0	0
MENTAL HEALTH	0	0	2	0
SUB USE DIS	0	0	0	0
NURSING FACILITY	0	2	1	2
FOSTER CARE	0	0	0	0
MEDIKAN	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0
PROGRAM TYPE TOTAL	**10**	**14**	**13**	**12**

There may be multiple selections for a member/contact.

C. Sunflower–Issue Category

MEDICAID ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Access to Providers (usually Medical)	3	1	4	5	4	3	5	2
Appeals/Fair Hearing questions/issues	0	4	5	0	1	3	0	0
Background Checks	1	0	0	0	0	0	0	0
Billing	8	6	6	2	4	7	6	2
Care Coordinator Issues	2	2	0	2	2	4	5	4
Change MCO	3	2	1	3	2	1	1	0
Choice Info on MCO	0	0	0	1	1	1	0	1
Coding Issues	7	2	1	5	4	3	0	0
Consumer said Notice not received	1	2	3	4	0	0	0	0
Cultural Competency	0	0	0	0	0	0	1	0
Data Requests	0	0	0	0	0	0	0	0
Dental	3	1	0	4	0	2	0	0
Division of Assets	1	0	0	0	0	0	0	0
Durable Medical Equipment	1	1	0	2	0	0	0	0
Grievances Questions/Issues	2	5	5	4	0	6	6	4
Help understanding mail (NOA)	0	0	0	0	0	0	0	0
MCO transition	0	0	0	0	0	0	0	0
Medicaid Application Assistance	2	2	0	1	1	0	1	2
Medicaid Eligibility Issues	8	13	10	11	14	5	3	10
Medicaid Fraud	0	0	0	2	0	0	0	0
Medicaid General Issues/questions	7	9	13	17	18	6	7	9
Medicaid info (status) update	7	5	9	5	4	8	4	9
Medicaid Renewal	3	6	4	4	4	10	6	6
Medical Card issues	0	0	0	0	0	0	1	0
Medicare Savings Plan Issues	2	2	3	0	0	0	2	2
MediKan issues	0	0	0	0	0	0	0	0
Moving to / from Kansas	1	0	0	0	1	0	0	0
Medical Services	4	4	0	3	5	3	2	5
Pain management issues	0	0	0	0	1	0	0	0
Pharmacy	2	0	0	5	6	2	0	2
Pregnancy issues	0	0	0	0	0	0	0	2
Prior authorization issues	0	0	0	0	0	0	0	0
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Spend Down Issues	0	3	1	3	2	0	3	3
Transportation	2	1	1	2	2	1	2	2
Working Healthy	0	1	1	1	1	0	1	0
MEDICAID ISSUES TOTAL	**70**	**72**	**67**	**86**	**77**	**65**	**56**	**65**

There may be multiple selections for a member/contact.

HCBS/LTSS ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Client Obligation	5	3	4	1	1	0	4	1
Estate Recovery	0	0	0	0	0	0	0	0
HCBS Eligibility issues	8	5	8	3	5	5	6	4
HCBS General Issues	12	3	9	8	7	9	6	8
HCBS Reduction in hours of service	1	0	0	1	2	1	0	0
HCBS Waiting List	0	0	0	1	1	1	1	1
Nursing Facility Issues	1	0	3	0	0	1	1	0
HCBS/LTSS ISSUES TOTAL	**27**	**11**	**24**	**14**	**16**	**17**	**18**	**14**

There may be multiple selections for a member/contact.

OTHER ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Abuse / neglect complaints	2	0	0	1	0	0	1	0
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	1	0	0	1	0	0
Community Resources needed	0	0	0	0	0	0	0	0
Domestic Violence concerns	0	0	0	0	0	0	0	0
Foster Care issues	0	0	0	0	0	0	0	0
Guardianship	0	1	1	1	0	0	0	0
Homelessness	0	0	0	0	0	0	0	0
Housing Issues	1	0	0	2	0	0	0	0
Medicare related Issues	0	3	3	2	1	0	0	1
Social Security Issues	1	0	0	1	0	0	0	0
Used Interpreter	0	0	0	0	0	0	0	0
X-Other	8	9	8	15	10	8	5	5
Z Thank you	49	27	49	41	34	29	23	29
Z Unspecified	0	2	0	5	3	4	2	1
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**61**	**42**	**62**	**68**	**48**	**42**	**31**	**36**

There may be multiple selections for a member/contact.

D. Sunflower-Program Type

PROGRAM TYPE	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
PD	13	5	7	6	2	5	5	4
I/DD	5	3	4	3	5	4	4	2
FE	5	2	0	2	3	2	6	2
AUTISM	0	0	1	0	0	0	1	0
SED	0	0	1	1	0	0	0	1
TBI	1	0	3	3	4	2	0	2
TA	2	0	0	0	1	0	2	1
WH	1	1	1	0	1	1	0	0
MFP	1	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	0	0	0	0	0	0	0	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	4	1	3	0	0	1	0	2
FOSTER CARE	0	0	0	0	0	0	0	0
MEDIKAN	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	0	0	0	1
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**32**	**12**	**20**	**15**	**16**	**15**	**18**	**15**

There may be multiple selections for a member/contact.

E. UnitedHealthcare-Issue Category

MEDICAID ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Access to Providers (usually Medical)	0	0	0	0	2	2	4	2
Appeals/Fair Hearing questions/issues	4	2	5	2	1	1	1	0
Background Checks	0	0	0	0	0	1	0	0
Billing	6	3	9	2	1	2	4	3
Care Coordinator Issues	4	4	3	4	5	0	1	4
Change MCO	2	1	0	3	2	3	0	3
Choice Info on MCO	0	1	0	1	0	1	0	0
Coding Issues	2	0	1	3	3	1	1	0
Consumer said Notice not received	0	0	1	2	0	0	1	1
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	1	0	0	0	0	0
Dental	0	1	0	2	3	1	1	0
Division of Assets	1	0	0	0	0	0	0	0
Durable Medical Equipment	0	0	0	1	2	1	1	1
Grievances Questions/Issues	3	3	4	0	4	0	2	4
Help understanding mail (NOA)	0	0	0	0	0	0	0	0
MCO transition	0	0	0	0	0	0	0	0
Medicaid Application Assistance	4	4	1	6	2	0	0	0
Medicaid Eligibility Issues	11	14	10	9	11	9	4	0
Medicaid Fraud	0	0	0	1	0	0	0	0
Medicaid General Issues/questions	4	7	10	18	20	10	10	4
Medicaid info (status) update	4	9	4	2	9	10	3	3
Medicaid Renewal	7	6	3	3	2	6	3	3
Medical Card issues	0	0	0	0	0	0	0	2
Medicare Savings Plan Issues	4	1	1	1	0	0	1	0
MediKan issues	0	0	0	0	0	0	1	0
Moving to / from Kansas	1	0	0	1	0	0	0	0
Medical Services	2	7	6	3	2	0	1	0
Pain management issues	0	0	0	1	2	0	0	0
Pharmacy	4	1	0	3	2	4	3	0
Pregnancy issues	0	0	0	0	0	0	0	0
Prior authorization issues	0	0	0	0	0	0	1	0
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	0	0
Respite	0	1	0	0	0	0	0	0
Spend Down Issues	3	7	6	4	4	2	1	2
Transportation	6	2	2	0	1	2	1	1
Working Healthy	0	0	1	1	0	1	0	0
MEDICAID ISSUES TOTAL	**72**	**74**	**68**	**73**	**78**	**57**	**45**	**33**

There may be multiple selections for a member/contact.

HCBS/LTSS ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Client Obligation	8	2	6	7	2	1	2	0
Estate Recovery	0	0	0	0	0	0	0	1
HCBS Eligibility issues	5	3	6	3	4	2	1	3
HCBS General Issues	4	5	15	10	12	8	4	4
HCBS Reduction in hours of service	0	0	1	0	3	0	0	0
HCBS Waiting List	0	1	1	1	2	0	2	1
Nursing Facility Issues	0	3	3	3	2	0	3	3
HCBS/LTSS ISSUES TOTAL	**17**	**14**	**32**	**24**	**25**	**11**	**12**	**12**

There may be multiple selections for a member/contact.

OTHER ISSUES	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
Abuse / neglect complaints	0	3	0	0	0	0	0	0
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0	0	0	0
Community Resources needed	0	0	0	0	0	0	0	0
Domestic Violence concerns	0	0	0	0	0	0	0	0
Foster Care issues	0	0	0	0	0	0	0	0
Guardianship	0	0	1	0	0	0	0	0
Homelessness	0	0	0	0	0	0	0	0
Housing Issues	1	0	0	0	0	1	0	0
Medicare related Issues	0	0	1	1	2	0	0	1
Social Security Issues	0	1	0	1	0	0	1	0
Used Interpreter	0	0	0	0	0	0	0	0
X-Other	9	3	4	9	11	7	2	2
Z Thank you	46	40	42	47	49	29	22	14
Z Unspecified	1	0	1	1	2	1	2	5
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**57**	**47**	**49**	**59**	**64**	**38**	**27**	**22**

There may be multiple selections for a member/contact.

F. UnitedHealthcare-Program Type

PROGRAM TYPE	Q1/18	Q2/18	Q3/18	Q4/18	Q1/19	Q2/19	Q3/19	Q4/19
PD	7	5	3	9	10	5	2	5
I/DD	2	3	7	1	6	10	1	0
FE	4	2	4	3	4	3	3	1
AUTISM	0	0	0	0	1	0	0	0
SED	1	0	4	1	2	1	0	0
TBI	1	1	3	0	2	0	1	0
TA	0	1	0	2	0	1	0	0
WH	2	1	1	0	0	0	0	0
MFP	0	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	0	0	0	2	0	1	0	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	3	3	2	4	2	1	2	5
FOSTER CARE	0	0	0	0	0	0	0	0
MEDIKAN	0	0	0	0	0	0	1	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	0	0	0	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**20**	**16**	**24**	**22**	**27**	**22**	**10**	**12**

There may be multiple selections for a member/contact.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7- QTR 4

DSRIP Payment

Paid dates 10/11/2019

Provider Names	DY7 QTR 4 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	1,781,250	736,725	1,044,525
University of Kansas Hospital	8,240,625	3,408,322*	4,832,303
Total	10,021,875	4,145,047	5,876,828

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7 - Quarter 4

Health Care Access Improvement Pool

Paid date 10/24/2019

Provider Names	Program Name	Program ID	Amount	Payment Date	Liability Date	Warrant number	Provider Access Fund 2443	Federal Medicaid Fund 3414
ADVENTHEALTH OTTAWA	Health Care Access Improvement Program Pool	03264	47,430	10/24/2019	12/31/2019	008220119	19,370	28,060
ASCENSION VIA CHRISTI HOSPITAL ST. TERESA INC	Health Care Access Improvement Program Pool	03264	69,720	10/24/2019	12/31/2019	005004504	28,474	41,246
ASCENSION VIA CHRISTI REHABILIATATION HOSPITAL	Health Care Access Improvement Program Pool	03264	20,457	10/24/2019	12/31/2019	008219921	8,355	12,102
BOB WILSON MEMORIAL GRANT COUNTY HOSPITAL	Health Care Access Improvement Program Pool	03264	24,277	10/24/2019	12/31/2019	008219772	9,915	14,362
CHILDRENS MERCY SOUTH	Health Care Access Improvement Program Pool	03264	193,774	10/24/2019	12/31/2019	008219744	79,137	114,637
COFFEYVILLE REGIONAL MEDICAL CENTER INC	Health Care Access Improvement Program Pool	03264	61,439	10/24/2019	12/31/2019	008219943	25,092	36,347
DOCTORS HOSPITAL LLC	Health Care Access Improvement Program Pool	03264	2,678	10/24/2019	12/31/2019	005004339	1,094	1,584
GEARY COUNTY HOSPITAL	Health Care Access Improvement Program Pool	03264	52,802	10/24/2019	12/31/2019	005004355	21,564	31,238
HAYS MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	196,217	10/24/2019	12/31/2019	008219785	80,135	116,082
HUTCHINSON REGIONAL MEDICAL CENTER INC	Health Care Access Improvement Program Pool	03264	179,889	10/24/2019	12/31/2019	008219845	73,467	106,422
KANSAS HEART HOSPITAL LLC	Health Care Access Improvement Program Pool	03264	9,881	10/24/2019	12/31/2019	008220059	4,035	5,846
KANSAS REHABILITATION HOSPITAL	Health Care Access Improvement Program Pool	03264	1,870	10/24/2019	12/31/2019	008220009	764	1,106
KVC PRAIRIE RIDGE PSYCHIATRIC HOSPITAL	Health Care Access Improvement Program Pool	03264	236	10/24/2019	12/31/2019	8225006	96	140
LABETTE CO MED	Health Care Access Improvement Program Pool	03264	52,209	10/24/2019	12/31/2019	005004509	21,322	30,887
LAWRENCE MEMORIAL HOSPITAL	Health Care Access Improvement Program Pool	03264	331,266	10/24/2019	12/31/2019	008219983	135,289	195,977
MCPHERSON HOSPITAL INC	Health Care Access Improvement Program Pool	03264	34,121	10/24/2019	12/31/2019	008219855	13,935	20,186
MENORAH MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	156,071	10/24/2019	12/31/2019	008219972	63,739	92,332
MIAMI COUNTY MEDICAL CENTER INC	Health Care Access Improvement Program Pool	03264	43,664	10/24/2019	12/31/2019	005004263	17,832	25,832
MORTON COUNTY HOSPITAL *	Health Care Access Improvement Program Pool	03264	23,104	10/24/2019	3/31/2019	005004575	9,912	13,192
MORTON COUNTY HOSPITAL *	Health Care Access Improvement Program Pool	03264	23,104	10/24/2019	6/30/2019	005004575	9,912	13,192
MORTON COUNTY HOSPITAL *	Health Care Access Improvement Program Pool	03264	23,104	10/24/2019	9/30/2019	005004575	9,912	13,192
MORTON COUNTY HOSPITAL	Health Care Access Improvement Program Pool	03264	23,105	10/24/2019	12/31/2019	005004575	9,436	13,669
NEWTON MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	137,334	10/24/2019	12/31/2019	008219904	56,087	81,247
OLATHE MEDICAL CENTER INC	Health Care Access Improvement Program Pool	03264	227,144	10/24/2019	12/31/2019	005004264	92,766	134,378
OVERLAND PARK REG MED CTR	Health Care Access Improvement Program Pool	03264	964,533	10/24/2019	12/31/2019	008219745	393,915	570,618
PRAIRIE VIEW HOSPITAL	Health Care Access Improvement Program Pool	03264	869	10/24/2019	12/31/2019	005004456	355	514
PRATT REGIONAL MEDICAL CENTER CORPORTATION	Health Care Access Improvement Program Pool	03264	34,625	10/24/2019	12/31/2019	008219909	14,141	20,484
PROVIDENCE MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	340,454	10/24/2019	12/31/2019	005004286	139,041	201,413
SAINT JOHN HOSPITAL	Health Care Access Improvement Program Pool	03264	70,887	10/24/2019	12/31/2019	005004284	28,950	41,937
SAINT LUKES CUSHING HOSPITAL	Health Care Access Improvement Program Pool	03264	61,239	10/24/2019	12/31/2019	008219781	25,010	36,229
SAINT LUKES SOUTH HOSPITAL INC	Health Care Access Improvement Program Pool	03264	51,543	10/24/2019	12/31/2019	008219957	21,050	30,493
SALINA REGIONAL HEALTH CENTER	Health Care Access Improvement Program Pool	03264	182,468	10/24/2019	12/31/2019	008219938	74,520	107,948
SALINA SURGICAL HOSPITAL	Health Care Access Improvement Program Pool	03264	1,908	10/24/2019	12/31/2019	005004514	779	1,129
SHAWNEE MISSION MEDICAL CENTER INC	Health Care Access Improvement Program Pool	03264	591,517	10/24/2019	12/31/2019	008219804	241,576	349,941
SOUTH CENTRAL KANSAS REGIONAL MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	36,443	10/24/2019	12/31/2019	008219890	14,883	21,560
SOUTHWEST MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	70,771	10/24/2019	12/31/2019	008219809	28,903	41,868
ST CATHERINE HOSPITAL	Health Care Access Improvement Program Pool	03264	245,768	10/24/2019	12/31/2019	008219770	100,372	145,396
STORMONT VAIL HEALTH CARE INC	Health Care Access Improvement Program Pool	03264	1,251,736	10/24/2019	12/31/2019	008219780	511,209	740,527
SUSAN B ALLEN MEMORIAL HOSPITAL	Health Care Access Improvement Program Pool	03264	81,832	10/24/2019	12/31/2019	008219796	33,420	48,412

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7 - Quarter 4

Health Care Access Improvement Pool

Paid date 10/24/2019

Provider Names	Program Name	Program ID	Amount	Payment Date	Liability Date	Warrant number	Provider Access Fund 2443	Federal Medicaid Fund 3414
THE UNIVERSITY OF KANSAS HEALTH SYSTEM GREAT BEND	Health Care Access Improvement Program Pool	03264	84,536	10/24/2019	12/31/2019	005004544	34,525	50,011
TOPEKA HOSPITAL LLC D/B/A THE UNIVERSITY OF KANSAS	Health Care Access Improvement Program Pool	03264	448,058	10/24/2019	12/31/2019	008220118	182,987	265,071
VIA CHRISTI HOSPITAL MANHATTAN	Health Care Access Improvement Program Pool	03264	229,504	10/24/2019	12/31/2019	008219947	93,729	135,775
VIA CHRISTI HOSPITAL PITTSBURG	Health Care Access Improvement Program Pool	03264	229,319	10/24/2019	12/31/2019	008219777	93,654	135,665
VIA CHRISTI HOSPITALS WICHITA INC	Health Care Access Improvement Program Pool	03264	1,582,439	10/24/2019	12/31/2019	008219942	646,268	936,171
WESLEY MEDICAL CENTER	Health Care Access Improvement Program Pool	03264	1,659,883	10/24/2019	12/31/2019	008220019	677,896	981,987
WESLEY REHABILITATION HOSPITAL, AN AFFILIATE OF EN	Health Care Access Improvement Program Pool	03264	9,985	10/24/2019	12/31/2019	008219685	4,078	5,907
WESTERN PLAINS MEDICAL COMPLEX	Health Care Access Improvement Program Pool	03264	103,955	10/24/2019	12/31/2019	008219683	42,455	61,500
Total			**10,269,168**				**4,195,356**	**6,073,812**

*** DY 7 Payments not Q4**

1115 Waiver- Safety Net Care Pool Report

Demonstration Year 7 - Quarter 4

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

No Payments

Hospital Name	LPTH\BCCH DY/QTR 2019/4	State General Fund 1000	Federal Medicaid Fund 3414
CHILDRENS MERCY HOSPITAL	0	0	0
UNIVERSITY OF KANSAS HOSPITAL AUTHORITY	0	0	0
Total	**0**	**0**	**0**

KDHE Summary of Claims Adjudication Statistics –

January through December 2019 – KanCare MCOs

Aetna Service Type	Total claim count - YTD cumulative	Total claim count $ value YTD cumulative	# Claims denied – YTD cumulative	$ Value of claims denied YTD cumulative	% Claims denied – YTD cumulative
Hospital Inpatient	18,634	$818,745,504	3,109	$151,726,940	16.7%
Hospital Outpatient	211,765	$716,456,776	32,607	$114,631,183	15.4%
Pharmacy	1,909,237	$138,060,546	533,855	$0	28.0%
Dental	117,233	$39,694,357	11,252	$4,096,218	9.6%
Vision	9,025	$2,139,845	668	$151,386	7.4%
NEMT	68,453	$2,995,947	566	$32,567	0.8%
Medical (physical health not otherwise specified)	1,686,169	$689,104,589	189,391	$117,221,645	11.2%
Nursing Facilities-Total	54,151	$162,430,510	5,064	$19,453,072	9.4%
HCBS	277,541	$125,312,232	9,846	$4,107,399	3.5%
Behavioral Health	212,539	$83,410,163	13,622	$8,713,351	6.4%
Total All Services	4,352,208	$2,694,940,305	786,358	$411,420,410	18.1%

SUNFLOWER Service Type	Total claim count - YTD cumulative	Total claim count $ value YTD cumulative	# Claims denied – YTD cumulative	$ Value of claims denied YTD cumulative	% Claims denied – YTD cumulative
Hospital Inpatient	39,854	$2,083,229,362	10,031	$689,506,497	25.17%
Hospital Outpatient	361,975	$1,058,369,907	46,113	$164,726,145	12.74%
Pharmacy	1,925,113	$198,153,743	445,261	$90,013,896	23.13%
Dental	171,888	$54,845,115	17,768	$3,900,600	10.34%
Vision	112,641	$28,382,727	17,683	$4,961,015	15.70%
NEMT	173,852	$4,988,429	2,265	$65,841	1.30%
Medical (physical health not otherwise specified)	1,792,871	$1,119,845,536	235,963	$226,852,439	13.16%
Nursing Facilities-Total	138,213	$381,246,998	11,029	$48,639,624	7.98%
HCBS	670,298	$376,219,897	50,009	$25,004,709	7.46%
Behavioral Health	794,747	$141,884,426	82,418	$18,133,068	10.37%
Total All Services	6,181,452	$5,447,166,143	918,540	$1,271,803,832	14.86%

UNITED Service Type	Total claim count - YTD cumulative	Total claim count $ value YTD cumulative	# Claims denied – YTD cumulative	$ Value of claims denied YTD cumulative	% Claims denied – YTD cumulative
Hospital Inpatient	30,155	$1,447,884,363	6,437	$381,203,572	21.35%
Hospital Outpatient	346,745	$1,069,794,202	63,792	$209,216,430	18.40%
Pharmacy	1,898,330	$249,107,521	475,378	$114,362,560	25.04%
Dental	169,705	$58,099,966	22,579	$8,607,231	13.30%
Vision	82,906	$19,458,114	10,115	$2,237,851	12.20%
NEMT	189,015	$5,582,108	2,249	$68,364	1.19%
Medical (physical health not otherwise specified)	1,717,586	$1,107,539,287	306,481	$343,697,652	17.84%
Nursing Facilities-Total	109,105	$323,013,068	13,779	$44,047,288	12.63%
HCBS	485,251	$231,219,895	21,508	$9,965,755	4.43%
Behavioral Health	741,353	$186,403,215	60,212	$29,430,553	8.12%
Total All Services	5,770,151	$4,698,101,738	982,530	$1,142,837,257	17.03%

2019 Annual Report

I. Introduction

Pursuant to the KanCare Special Terms and Conditions issued by the Centers for Medicare and Medicaid Services, Number 11-W-00283/7, the State of Kansas, Department of Health and Environment, Division of Health Care Finance, submits this seventh annual report related to Demonstration Year 2019. 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 and Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017. On December 20, 2017, the State submitted an extension request for its Medicaid 1115 demonstration. On December 18, 2018 the Centers for Medicare and Medicaid Services approved a renewal of the Medicaid Section 1115 demonstration proposal entitled KanCare. The demonstration is effective from January 1, 2019 through December 31, 2023.

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;
- Continue to 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;
- Extend the Delivery System Reform Incentive Payment program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.

- Provide work opportunities and supports for individuals with specific behavioral health conditions and other disabilities.

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

- Continue to provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, and LTSS/HCBS;
- Further improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Maintain Medicaid cost control by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care;
- Continue to 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;
- Help Kansas Medicaid beneficiaries achieve healthier, more independent lives by coordinating services to strengthen social determinants of health and independence and person-centered planning;
- Promote higher levels of member independence through employment programs;
- Drive performance and improve quality of care for Kansas Medicaid beneficiaries by integrating value-based models, purchasing strategies and quality improvement programs; and
- Improve effectiveness and efficiency of the state Medicaid program with increased alignment of MCO operations, data analytic capabilities and expanded beneficiary access to SUD services.

II. STC 64(a) – Operational Updates

Items from the 2019 quarterly reports which are not included in other areas of this annual report, have not already been provided in cumulative annual form, and/or are subject to annualizing are summarized here:

A. Operational Developments/Issues:

i. Systems and reporting issues, approval and contracting with new plans: 2019 implemented a new phase for the KanCare program. Two of the previous MCOs remained in the KanCare program (Sunflower and UnitedHealthcare), while we transitioned from Amerigroup to Aetna. The State implemented a Transition of Care policy in force for the first 90 days of 2019, to ensure care continuity of members transitioning from one MCO to another – all authorizations and Person-Centered Support Plans created by the previous MCO would remain in effect during that period. Aetna also continued this period beyond 90 days to ensure that all the PCSPs were updated and accurate. In addition, Aetna also considered any KMAP enrolled providers 'in-network' for all of 2019. 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. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues; and provider surveys or focused projects to assess and address systemic issues. Annual reviews of the MCOs are discussed elsewhere in this report. Each quarter, the State reports then-current consumer issues, their resolution, and actions taken to prevent further occurrences. Summaries of those issues are included in the state's quarterly STC reports submitted to CMS and posted at www.kancare.ks.gov.

B. KanCare Ombudsman Annual Report:
   i. A summary of the KanCare Ombudsman program activities for demonstration year 2019 is attached.

C. Legislative Activity:
   i. KDHE and KDADS conducted robust legislative activity and engagement throughout the 2019 demonstration year. Updates legislative activity are provided in each quarterly 1115 Waiver Report. For the most recent update please see section IV(m.) of the 2019 fourth quarter report.

D. Annual Public Forum Update:
   i. The KanCare annual public forum, pursuant to STC 71, was conducted on December 11, 2019. A summary of the forum, including comments and issues raised at the forum, is attached.

III. STC 64(b) – Benefit Performance Metrics and Data

A. Benefits:

All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value-added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2019, follows:

MCO	Value Added Service Jan- Dec 2019	Units YTD	Value YTD
Aetna	Adult Dental	1,953	$347,918
	Transportation Services	427	$44,019
	Weight Management	98	$12,898
	Total of All Aetna VAS	2,248	$315,411
Sunflower	Healthy Rewards	92,324	$966,609
	Comprehensive Medication Review	11,121	$299,539
	Dental visits for adults	2,981	$173,844
	Total of all Sunflower VAS	143,678	$2,060,966
United	Home Helper Catalog Supplies	12,091	$212,859
	Debit Card for Completing First Pre-Natal Visit	814	$167,543
	Baby Blocks Program and Rewards	1,363	$163,560
	Total of all United VAS	28,884	$1,015,994

B. Enrollment issues:

For the calendar year 2019 there were 23 Native Americans who chose to not enroll in KanCare.

The table below represents the enrollment reason categories for calendar year 2019. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	1980
KDHE - Administrative Change	788
WEB - Change Assignment	108
KanCare Default - Case Continuity	1491
KanCare Default – Morbidity	1862
KanCare Default - 90 Day Retro-reattach	6216

KanCare Default - Previous Assignment	2409
KanCare Default - Continuity of Plan	2705
Retro Assignment	6
AOE – Choice	14290
Choice - Enrollment in KanCare MCO via Medicaid Application	12052
Change - Enrollment Form	1291
Change - Choice	1528
Change - Access to Care – Good Cause Reason	55
Change - Case Continuity – Good Cause Reason	2
Change – Due to Treatment not Available in Network – Good Cause	0
Assignment Adjustment Due to Eligibility	503
Mass Transfer	91834
Total	139120

C. Grievances and appeals:

The following grievance, appeal and state fair hearing data reports activity for all of 2019.

MCOs' Member Adverse Initial Notice Timeliness Compliance
CY19 Annual report

MCO	ABH	SUN	UHC
% of Notices of Adverse Service Authorization Decisions Sent Within Compliance Standards	98%	98%	100%
% of Notices of Adverse Expedited Service Authorization Decisions Sent Within Compliance Standards	100%	53%	94%
% of Notices of Adverse Termination, Suspension or Reduction Decisions Sent Within Compliance Standards (10 calendar days only)	100%	100%	100%

MCOs' Provider Adverse Initial Notice Compliance
CY19 Annual report

MCO	ABH	SUN	UHC
% of Notices of Adverse Decision Sent to Providers Within Compliance Standards	100%	100%	99%

MCOs' Member Grievance Database
CY19 Annual Report

MCO	ABH		SUN		UHC		Total
	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	
QOC (non HCBS Providers)	13	33	43	100	37	95	321
QOC – Pain Medication	4	4	5	16	2	5	36
Customer Service	18	20	26	37	18	21	140
Member Rights Dignity	2	3	6	6	1	2	20
Access to Service or Care	12	20	23	46	12	24	137
Non-Covered Services	3	4	2	5	1	5	20
Pharmacy Issues	17	18	7	10	8	34	94
QOC HCBS Provider	5		38		14		57
Billing/Financial Issues (non-Transportation)	1	15	25	23	27	204	295

Transportation – Billing and Reimbursement	6	12	17	7	5	13	60
Transportation - No Show	6	24	39	47	20	40	176
Transportation - Late	5	31	82	72	40	65	295
Transportation - Safety	3	9	17	24	10	23	86
Transportation - No Driver Available	1	1	3	5	3	1	14
Transportation - Other	12	48	75	81	71	103	390
MCO Determined Not Applicable	2	2	7	15	5	39	70
Other	3	5	8	4	2	9	31
Total	113	249	423	498	276	683	2242

MCO's Member Grievance Timeliness Compliance
CY19 Annual report

MCO	ABH	SUN	UHC
% of Member Grievance Resolved and Resolution Notice Issued Within 30 Calendar Days	98%	100%	99%

MCOs' Provider Grievance Database
CY19 Annual report

MCO	ABH	SUN	UHC	Total
Billing/Payment	2	30	3	35
Wrong Information				
Credentialing – MCO	1	2		3
Network – MCO	1			1
UM		8		8
CM		2		2
Benefits/Eligibility	1	4		5
Pharmacy		8		8
Transportation		51	22	73
Services		4		4
Health Plan – Technology		1		1
MCO Determined Not Applicable				
Other – Dissatisfaction with MCO Associate	2	4	1	7
Other (Must provide description in narrative column of Summary Reports)		4	17	21
Total	7	118	43	168

MCO's Provider Grievance Timeliness Compliance
CY19 Annual report

MCO	ABH	SUN	UHC
% of Provider Grievance Resolved Within 30 Calendar Days	96%	100%	100%
% of Provider Grievance Resolution Notices Sent Within Compliance Standards	100%	100%	100%

MCOs' Appeals Database
CY19 Annual report

Member Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined not Applicable
Medical necessity/level of care – criteria not met					
MA – CNM - Durable Medical Equipment	33 145 115	2 3 1	16 89 31	8 52 73	7 1 10
MA – CNM - Inpatient Admissions (Non-Behavioral Health)	41 9 150	1 105	10 4 12	20 4 31	10 1 2
MA – CNM - Medical Procedure (NOS)	74 57 35	2 1 5	34 32 11	25 23 17	13 1 2
MA – CNM - Radiology	63 93 2		35 30 2	15 63	13
MA – CNM - Pharmacy	225 358 554	12 35 12	89 228 397	62 93 118	62 2 27
MA – CNM - PT/OT/ST	11 3		2	9 3	
MA – CNM - Dental	25 16 42	 1 4	6 6 4	15 9 28	4 6
MA – CNM - Home Health	7 12 7	1	5 7 3	1 5 2	 2
MA – CNM - Out of network provider, specialist or specific provider request	4 2 26	 1	2 6	2 2 18	 1
MA – CNM - Inpatient Behavioral Health	15 42 13	 5	10 20 2	2 17 8	3 3
MA – CNM - Behavioral Health Outpatient Services and Testing	4 6 18	1 3 1	2 3 3	 13	1 1
MA – CNM - LTSS/HCBS	18 22	1 1	2 5	15 13	 3
MA – LOC – LTC NF	1			1	
MA – CNM - Mental Health	2 6		1 2	1 3	 1
MA – CNM - HCBS (change in attendant hours)	7		1	6	
MA – CNM – Ambulance (include Air and Ground)	2		1		1
MA – CNM - Other	87 6	1	44 2	42 3	 1
Noncovered Service					
MA – NCS - Dental	4 3		1	3 3	
MA – NCS - Pharmacy	6	1	2	2	1

	4 4		4 3	1	
MA – NCS – Out of Network providers	1			1	
MA – NCS - OT/PT/Speech	4			4	
MA – NCS - Durable Medical Equipment	19 1		13	6	 1
MA – NCS – Other	1 50 3		 34 1	1 16	 2
MA – LCK - Lock In	2 9			2 8	 1
Authorization Denials					
MA – AUTH – Late submission by member/provider rep.	3 2		 1	 1	3
MA – AUTH – No authorization submitted	2 18		2 1	 17	
Administrative Denials					
MA – ADMIN – Denials of Authorization (Unauthorized by Members)	54			47	7
Total ABH - Red SUN – Green UHC - Purple	 507 1003 1038	 20 50 130	 215 521 485	 154 420 360	 118 12 63

** We removed categories from the above table that did not have any information to report for the year.*

MCO's Appeals Database
Member Appeal Summary – CY19 Annual report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Total Number of Appeals Resolved	507 1003 1038	20 50 130	215 521 485	154 420 360	118 12 63
Percentage Per Category		4% 5% 12%	43% 52% 47%	30% 42% 35%	23% 1% 6%

MCO's Member Appeal Timeliness Compliance
CY19 Annual report

MCO	ABH	SUN	UHC
% of Member Appeals Resolved and Appeal Resolution Notice Issued in 30 Calendar Days	98%	99%	99%
% of Expedited Appeals Resolved and Appeal Resolution Notice Issued in 72 hours	100%	97%	94%

MCOs' Reconsideration Database
Providers - Annual report (reconsiderations resolved)

PROVIDER Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Claim Denials					

PR – CPD - Hospital Inpatient (Non-Behavioral Health)	200 5697 3401		151 2805 1219	46 2812 2182	3 80
PR – CPD - Hospital Outpatient (Non-Behavioral Health)	223 4548 15497		168 2082 6420	50 2375 9077	5 91
PR – CPD - Pharmacy	7		3	3	1
PR – CPD - Dental	16 99		12 65	3 34	1
PR – CPD - Vision	2 272		1 111	1 161	
PR – CPD - Ambulance (Include Air and Ground)	36 152 548		24 88 305	4 51 243	8 13
PR – CPD - Medical (Physical Health not Otherwise Specified)	372 4735 50607		212 2648 27728	139 1855 22879	21 232
PR – CPD - Nursing Facilities - Total	3 231 2591		3 105 1396	 121 1195	 5
PR – CPD - HCBS	1107		742	262	103
PR – CPD - Hospice	15 213 1122		13 130 597	 79 525	2 4
PR – CPD - Home Health	4 1 4		2	2 1 4	
PR – CPD - Behavioral Health Outpatient and Physician	30 220 6811		25 34 4672	5 47 2139	 139
PR – CPD - Behavioral Health Inpatient	12 21 311		7 108	5 203	 21
PR – CPD - Out of network provider, specialist or specific provider	2879 35286		66 23840	2680 11446	133
PR – CPD - Radiology	31 1189 4694		22 691 2043	7 417 2651	2 81
PR – CPD - Laboratory	73 2916 24344		41 1402 9866	30 1409 14478	2 105
PR – CPD - PT/OT/ST	8 2863 87		4 2090 18	4 773 69	
PR – CPD - Durable Medical Equipment	82 1676		40 932	38 693	4 51
PR – CPD - Other	14 49 3021		10 3 1358	2 10 1663	2 36
Billing and Financial Issues					
PR – BFI - Recoupment	44		32	7	5

	10		10		
Administrative Denial					
PR – ADMIN - Denials of Authorization (Unauthorized by Members)	98 4639		88 3123	8 1516	2
Total ABH - Red SUN – Green UHC - Purple	1270 28868 15297 3		858 13994 82703	354 13780 70270	58 1094

** We removed categories from the above table that did not have any information to report for the year.*

MCO's Provider Reconsiderations Database
Provider Reconsiderations – Denied Claim Analysis – CY19 Annual report

ABH - Red SUN – Green UHC - Purple	Claim Denied-MCO in Error	Claim Denied-Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Reconsiderations					
MCO Reversed Decision on Reconsideration	119 10178 36234	617 1681 21512	29 62 7378	74 2073 13074	839 13994 78198
MCO Upheld Decision on Reconsideration	5 19580	18 4 14646	319 10752 16154	14 3024 17731	356 13780 68111
Total Claim Payment Disputes	124 10178 55814	635 1685 36158	348 10814 23532	88 5097 30805	1195 27774 146309

MCO's Provider Reconsiderations Timeliness Compliance
CY19 Annual Report

MCO	ABH	SUN	UHC
% of Provider Reconsideration Resolution Notices Sent Within Compliance Standards	96%	100%	100%

MCOs' Appeals Database
Providers - CY19 Annual Report (appeals resolved)

Provider appeal reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Medical Necessity/Level of Care - Criteria Not Met					
PA - CNM - Inpatient Admissions (Non-Behavioral Health)	9		3	5	1
PA - CNM - PT/OT/ST	3				3
PA - CNM - Inpatient Behavioral Health	3		2		1
CLAIM DENIAL					
PA – CPD - Hospital Inpatient (Non-Behavioral Health)	52 570	8	26 295	14 249	12 18

	885	1	119	537	228
PA – CPD - Hospital Outpatient (Non-Behavioral Health)	29 1009 287	22	19 488 42	9 447 112	1 52 133
PA – CPD - Pharmacy	4 5 1		2 1	2 4 1	
PA – CPD - Dental	13 75 56	1	7 19 26	5 56 30	
PA – CPD - Vision	2 82 16		51 7	2 28 8	3 1
PA – CPD - Ambulance (Include Air and Ground)	2 13 21		2 8 7	4 5	1 9
PA – CPD - Medical (Physical Health not Otherwise Specified)	82 854 527	9	47 412 71	24 386 241	11 47 215
PA – CPD - Nursing Facilities - Total	1 32 63	1	1 13 15	4 19	14 29
PA – CPD - Hospice	3 40 1	1	3 24	14	1 1
PA – CPD - Home Health	5 103 206	7 1	4 52 43	1 43 97	1 65
PA – CPD - Behavioral Health Outpatient and Physician	16 140 136	1 1	13 60 40	3 77 52	2 43
PA – CPD - Behavioral Health Inpatient	6 23 19	1	6 12 5	10 12	2
PA – CPD - Out of network provider, specialist or specific provider	722 1	13	117	527 1	65
PA – CPD - Radiology	13 144 6	3	10 87 3	2 51 3	1 3
PA – CPD - Laboratory	12 201 183	3	4 45 6	6 142 105	2 11 72
PA – CPD - PT/OT/ST	57 4		29 2	25 1	3 1
PA – CPD - Durable Medical Equipment	29 149 3	2	20 78 2	5 64 1	4 5
PA – CPD - Other	2 6 282		2 3 39	2 79	1 164
Billing and Financial Issues					
PA – BFI - Recoupment	5		5		

	398 53	5	319 18	56 33	18 2
Administrative Denial					
PA – ADMIN - Denials of Authorization (Unauthorized by Members)	17 156 2	 1 2	17 53	92	10
Total ABH - Red SUN – Green UHC - Purple	 296 4791 2752	 1 77 5	 188 2171 445	 73 2286 1337	 34 257 965

** We removed categories from the above table that did not have any information to report for the year.*

MCO's Appeals Database
Provider Appeal Summary – CY19 Annual report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal	MCO Determined Not Applicable
Reconsideration	1270 28868 152973		858 13994 82703	354 13780 70270	58 1094
Resolved at Appeal Level	296 4791 2752	1 77 5	188 2171 445	73 2286 1337	34 257 965
Total	1566 33659 155725	1 77 5	1046 16165 83148	427 16066 71607	92 1351 965
Percentage Per Category		>1% >1% >1%	67% 48% 53%	27% 48% 46%	6% 4% 1%

MCO's Appeals Database
Provider Appeal – Denied Claim Analysis – CY19 Annual report

ABH - Red SUN – Green UHC - Purple	Claim Denied- MCO in Error	Claim Denied- Provider Error	Claim Denied – Correctly Billed and Correctly Denied/Paid	Claim Paid – Correctly Billed and Correctly Paid	Total
Provider Appeals					
MCO Reversed Decision on Appeal	17 33 15	148 332 400	8 1289	10 201	183 1855 415
MCO Upheld Decision on Appeal	2	1 27	62 1859 1314	10 284 1	75 2170 1315
Total Claim Denials	19 33 15	149 359 400	70 3148 1314	20 485 1	258 4025 1730

MCO's Provider Appeal Timeliness Compliance
CY19 Annual Report

MCO	ABH	SUN	UHC
% of Provider Appeals Resolved in 30 Calendar Days	98%	91%	99%
% of Provider Appeal Resolution Notices Sent Within Compliance Standard	97%	99%	99%

State of Kansas Office of Administrative Fair Hearings

Members – CY19 Annual Report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
Medical necessity/level of care – criteria not met															
MH – CNM - Durable Medical Equipment	8 5	1 3			5	1		1 2							
MH – CNM - Inpatient Admissions (Non-Behavioral Health)	2 1	1		1	1										
MH – CNM - Medical Procedure (NOS)	4 1				1			3					1		
Radiology	2														
MH – CNM – Pharmacy	4 11 34	2 1 1	2 1	1	3			6 27			1		1 1 2		
MH – CNM – PT/OT/ST	3			1				1	1						
MH – CNM - Dental	3 1	1				1		1 1							
MH – CNM – Home Health	2				1			1							
MH – CNM - Out of network provider, specialist or specific provider request	1 2	1			1			1							
MH – CNM - Inpatient Behavioral Health	1 1							1					1		
MH – LOC – LTSS/HCBS	4 2	1			1			2	1				1		
MH – CNM - HCBS (change in attendant Hours)	4	1	2											1	
MH – CNM - Other	2 5				3			2 2							
Noncovered service															
MH-NCS - Dental	1 1 1		1 1					1							

MH-NCS-Pharmacy	5						5								
MH-NCS - Durable Medical Equipment	1 1				1			1							
MH – LCK – LOCK IN	2							2							
MH – BFI – BILLING AND FINANCIAL ISSUES	1							1							
Administrative Denials															
MH-ADMIN-Denials of Authorization(Unauthorized by Members)	3						3								
Total ABH - Red SUN – Green UHC - Purple	 5 47 65	 2 5 6	 1 5 1	 1 1 1	 8 9	 2 	 	 20 44	 1 1	 	 1 	 	 1 3 3	 1 	

** We removed categories from the above table that did not have any information to report for the year.*

State of Kansas Office of Administrative Fair Hearings
Providers – CY19 Annual Report

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY / LEVEL OF CARE - Criteria Not Met															
PH - CNM - Medical Procedure (NOS)	1						1								
PH - LOC - LTSS/HCBS	6	6													
CLAIM DENIAL															
PH - CPD - Hospital Inpatient (Non-	29 64	8 48	2		12 6	2		7 6	1	1					

Behavioral Health)															
PH - CPD - Hospital Outpatient (Non-Behavioral Health)	4 2	2			1			1 2							
PH - CPD - Pharmacy	1 11	1 5						6							
PH – CPD - Dental	1				1										
PH - CPD - Vision	2				2										
PH – CPD – Ambulance (include Air and Ground)	1 1	1					1								
PH - CPD - Medical (Physical Health not Otherwise Specified)	5 2	1			2	1		1 1	1						
PH – CPD – Nursing Facilities - Total	1				1										
PH – CPD - HCBS	1 1	1			1										
PH – CPD - Hospice	1 1					1		1							
PH - CPD - Home Health	9 3	1 1			8 1			1							
PH - CPD - Behavioral Health	4	1			3										

Outpatient and Physician															
PH - CPD - Behavioral Health Inpatient	3	2			1										
PH – CPD - Radiology	2							2							
PH - CPD – Laboratory	15 2				1		1	12 1	1		1				
PH - CPD - PT/OT/ST	4 1				3 1			1							
PH – CPD – Durable Medical Equipment	4 1	2			1 1				1						
PH – CPD - Other	1 3							2	1 1						
BILLING AND FINANCIAL ISSUES															
PH - BFI - Recoupment	5 3	2			2 3		1								
TOTAL ABH - Red SUN – Green UHC - Purple	 0 94 101	 26 56	 2		 35 16	 2 2	 1 2	 23 22	 4 2	 1	 1				
Resolved without substantive changes to original claim	34 6	3	2		24 6			1							

** We removed categories from the above table that did not have any information to report for the year.*

MCOs' Grievance Trends
Members – CY19 Annual

Aetna Member Grievances:

- There were 158 transportation grievances in CY2019 which accounts for 56% of Aetna's member grievances in CY2019.

Aetna Annual Grievance Trends		
Total # of Resolved Grievances	362	
Top 5 Trends		
Trend 1: Transportation – Other	60	17%
Trend 2: Quality of Care (non HCBS, non-Transportation)	46	13%
Trend 3: Customer Service	38	10%
Trend 4: Transportation – Late	36	10%
Trend 5: Pharmacy Issues	35	10%

Sunflower Member Grievances:

- There were 469 transportation grievances in CY2019 which accounts for 51% of Sunflower's member grievances in CY2019. This is a significant increase of 157 (50%) from 312 transportation grievances reported in CY2018.
- There were 156 member grievances categorized as Transportation – Other which is a significant increase of 57 from CY2018.
- There were 154 member grievances categorized as Transportation – Late which is a significant increase of 65 from CY2018.
- There were 143 member grievances categorized as Quality of Care (non HCBS, non-Transportation) which is a significant increase of 51 from CY2018.
- Sunflower's total member grievances for CY2019 is 921 which is a significant increase of 242 (36%) from 679 in CY2018.

Sunflower Annual Grievance Trends		
Total # of Resolved Grievances	921	
Top 5 Trends		
Trend 1: Transportation – Other	156	17%
Trend 2: Transportation – Late	154	17%
Trend 3: Quality of Care (non HCBS, non-Transportation)	143	16%
Trend 4: Transportation – No Show	86	9%
Trend 5: Access to Service or Care	69	7%

United Member Grievances:

- There were 394 transportation grievances in CY2019 which accounts for 41% of United's member grievances in CY2019. This is a significant increase of 48 (14%) from 346 transportation grievances in CY2018.
- There were 174 member grievances categorized as Transportation – Other which is a significant increase of 55 from CY2018.
- United's total member grievances for CY2019 is 959 which is a significant increase of 52 (6%) from 907 in CY2018.

United Annual Grievance Trends		
Total # of Resolved Grievances	959	
Top 5 Trends		
Trend 1: Billing and Financial Issues (non-Transportation)	231	24%

Trend 2: Transportation – Other	174	18%
Trend 3: Quality of Care (non HCBS, non-Transportation)	132	14%
Trend 4: Transportation – Late	105	11%
Trend 5: Transportation – No Show	60	6%

MCOs' Grievance Trends
Provider – CY19 Annual

Aetna Annual Grievance Trends		
Total # of Resolved Grievances	7	
Top 5 Trends		
Trend 1: Billing/Payment	2	29%
Trend 2: Other – Dissatisfaction with MCO Associate	2	29%

Sunflower Provider Grievances:

- There were 51 transportation grievances in CY2019 which accounts for 43% of Sunflower's provider grievances in CY2019.
- Tracking of provider grievances by categories started in CY2019 Quarter 1.

Sunflower Annual Grievance Trends		
Total # of Resolved Grievances	118	
Top 5 Trends		
Trend 1: Transportation	51	43%
Trend 2: Billing/Payment	30	25%
Trend 3: UM	8	7%
Trend 4: Pharmacy	8	7%

United Provider Grievances:

- There were 22 transportation grievances in CY2019 which accounts for 51% of United's provider grievances in CY2019.
- Tracking of provider grievances by categories started in CY2019 Quarter 1.

United Annual Grievance Trends		
Total # of Resolved Grievances	43	
Top 5 Trends		
Trend 1: Transportation	22	51%
Trend 2: Other (Must provide description in narrative column of summary reports)	17	40%
Trend 3: Billing/Payment	3	7%

MCO's Reconsideration Trends
Provider – CY19 Annual Quarter

Aetna Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	1270	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	372	29%
Trend 2: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	223	18%
Trend 3: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	200	16%
Trend 4: PR – ADMIN – Denials of Authorization (Unauthorized by Members)	98	8%
Trend 5: PR – CPD – Durable Medical Equipment	82	6%

Sunflower Provider Reconsiderations

- There were 5,697 provider reconsiderations categorized as PR – CPD - Hospital Inpatient (Non-Behavioral Health) which is a significant increase of 1,900 from CY2018.
- There were 4,735 provider reconsiderations categorized as PR – CPD - Medical (Physical Health not Otherwise Specified) which is a significant increase of 576 from CY2018.
- There were 2,916 provider reconsiderations categorized as PR - CPD – Laboratory which is a significant increase of 647 from CY2018.
- There were 2,879 provider reconsiderations categorized as PR – CPD – Out of network provider, specialist or specific provider request which is a significant increase of 2,765 from CY2018.
- Sunflower's total provider reconsiderations for CY2019 is 28,868 which is a significant increase of 6,185 (27%) from 22,683 in CY2018.

Sunflower Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	28868	
Top 5 Trends		
Trend 1: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	5697	20%
Trend 2: PR – CPD – Medical (Physical Health not Otherwise Specified)	4735	16%
Trend 3: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	4548	16%
Trend 4: PR – CPD – Laboratory	2916	10%
Trend 5: PR – CPD – Out of network provider, specialist or specific provider request	2879	10%

United Provider Reconsiderations

- There were 50,607 provider reconsiderations categorized as PR – CPD – Medical (Physical Health not Otherwise Specified) which is a significant increase of 19,844 from CY2018.
- There were 35,286 provider reconsiderations categorized as PR – CPD – Out of network provider, specialist or specific provider request which is a significant increase of 27,820 from CY2018.
- There were 24,344 provider reconsiderations categorized as PR – CPD – Laboratory which is a significant increase of 18,687 from CY2018.
- There were 15,497 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health) which is a significant increase of 11,093 from CY2018.
- There were 6,811 provider reconsiderations categorized as PR – CPD – Behavioral Health Outpatient and Physician which is a significant increase of 132 from CY2018.
- United's total provider reconsiderations for CY2019 is 152,973 which is a significant increase of 87,165 (132%) from 65,808 in CY2018.

United Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	152973	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	50607	33%
Trend 2: PR – CPD – Out of network provider, specialist or specific provider request	35286	23%
Trend 3: PR – CPD – Laboratory	24344	16%
Trend 4: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	15497	10%
Trend 5: PR – CPD – Behavioral Health Outpatient and Physician	6811	4%

MCOs' Appeals Trends
Member/Provider – CY19 Annual

Aetna Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	507		Total # of Resolved Provider Appeals	296	
Top 5 Trends			Top 5 Trends		

Trend 1: MA – CNM – Pharmacy	225	44%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	82	28%
Trend 2: MA – CNM – Medical Procedure (NOS)	74	15%	Trend 2: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	52	18%
Trend 3: MA – CNM – Radiology	63	12%	Trend 3: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	29	10%
Trend 4: MA – CNM – Inpatient Admissions (Non-Behavioral Health)	41	8%	Trend 4: PA – CPD – Durable Medical Equipment	29	10%
Trend 5: MA – CNM – Durable Medical Equipment	33	7%	Trend 5: PA – ADMIN – Denials of Authorization (Unauthorized by Members)	17	6%

Sunflower Member Appeals:

- There were 358 member appeals categorized as MA – CNM – Pharmacy which is a significant increase of 82 from CY2018.
- There were 93 member appeals categorized as MA – CNM – Other which is a significant increase of 62 from CY2018.
- There were 1,003 member appeals in CY2019 which is a significant increase of 188 (23%) from 815 member appeals in CY2018.

Sunflower Provider Appeals:

- There were 1,009 provider appeals categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health) which is a significant increase of 302 from CY2018.
- There were 854 provider appeals categorized as PA – CPD – Medical (Physical Health not Otherwise Specified) which is a significant increase of 718 from CY2018.
- There were 722 provider appeals categorized as PA – CPD – Out of network provider, specialist or specific provider request which is a significant increase of 631 from CY2018.
- There are 570 provider appeals categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health) which is a significant increase of 170 from CY2018.
- There were 398 provider appeals categorized as PA – BFI – Recoupment which is a significant increase of 376 from CY2019.
- There were 4,791 provider appeals in CY2019 which is a significant increase of 2,413 (101%) from 2,378 provider appeals in CY2018

Sunflower Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	1003		Total # of Resolved Provider Appeals	4791	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	358	36%	Trend 1: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	1009	21%
Trend 2: MA – CNM – Durable Medical Equipment	145	14%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	854	18%
Trend 3: MA – CNM – Radiology	93	9%	Trend 3: PA – CPD – Out of network provider, specialist or specific provider request	722	15%
Trend 4: MA – CNM – Other	87	9%	Trend 4: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	570	12%
Trend 5: MA – CNM – Medical Procedure (NOS)	57	6%	Trend 5: PA – BFI - Recoupment	398	8%

United Member Appeals:

- There were 554 member appeals categorized as MA – CNM – Pharmacy which is a significant increase of 258 from CY2018.
- There were 115 member appeals categorized as MA – CNM – Durable Medical Equipment which is a significant increase of 52 from CY2018.
- There were 1,038 member appeals in CY2019 which is a significant increase of 387 (59%) from 651 provider appeals in CY2018.

United Provider Appeals:

- There were 282 provider appeals categorized as PA – CPD – Other which is a significant increase of 264 from CY2018.
- There were 206 provider appeals categorized as PA – CPD – Home Health which is a significant increase of 69 from CY2018.
- There were 2,752 provider appeals in CY2019 which is an increase of 6 from 2,746 provider appeals in CY2018.

United Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	1038		Total # of Resolved Provider Appeals	2752	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	554	53%	Trend 1: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	885	32%
Trend 2: MA – CNM – Inpatient Admissions (Non-Behavioral Health)	150	14%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	527	19%
Trend 3: MA – CNM – Durable Medical Equipment	115	11%	Trend 3: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	287	10%
Trend 4: MA – CNM – Dental	42	4%	Trend 4: PA – CPD – Other	282	10%
Trend 5: MA – CNM – Medical Procedure (NOS)	35	3%	Trend 5: PA – CPD – Home Health	206	7%

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY19 Annual

- No default orders were issued against Aetna, Sunflower and United Healthcare in CY2019.

Aetna Annual					
Total # of Member SFH	5		Total # of Provider SFH	0	
OAH reversed MCO decision	1	20%	OAH reversed MCO decision	0	0%

Sunflower Annual					
Total # of Member SFH	47		Total # of Provider SFH	94	
OAH reversed MCO decision	1	2%	OAH reversed MCO decision	0	0%

United Annual					
Total # of Member SFH	65		Total # of Provider SFH	101	
OAH reversed MCO decision	1	2%	OAH reversed MCO decision	0	0%

D. Customer Service: Reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers January- December 2019:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	15.12	3.3	168,868
Sunflower	10.02	2.3	203,156
United	19.5	.99	207,446
DXC – Fiscal Agent	0.04	0.38%	30,361

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	14.99	0	73,056
Sunflower	28.89	1.6	102,934
United	1.15	.29	88,043
DXC – Fiscal Agent	0.15	0.76%	37,881

E. Critical Incident Summary of Reporting:

Critical Incidents January-December 2019	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	2019
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Reviewed	2,187	2,359	2,369	2,435	9,350
Pending Resolution	88	184	187	6	465
Total Received	2,275	2,543	2,556	2,441	9,815
APS Substantiations*	109	134	162	167	572

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

KDADS Program Integrity continues providing AIR training to Community Service Providers and any interested parties statewide upon request. Access to training materials and contact information to request a training is located on the KDADS website. Along with provider and individual training, KDADS provides updated trainings to the MCOs as requested for new staff and as a refresher to ensure efficient and consistent processes.

All determinations received from the Department for Children and Families (DCF) involving allegations of abuse, neglect and exploitation (ANE) are manually entered into the AIR system and assigned for follow-up by the individuals corresponding MCO. Evidence verifies the updated process provides assurances for individual health, safety and welfare and that quality of care concerns are consistently identified and resolved. KDADS and DCF regularly collaborate and meet when trends are identified, as well as on a case-by-case basis to utilize all available resources and ensure necessary action is taken to resolve.

Performance Measure data regarding abuse, neglect, exploitation, restraint, seclusion and unexpected deaths, along with all other defined adverse incidents, are tracked in real-time as Adverse Incident Reports are completed. KDADS Program Integrity staff reviews and provides confirmation of resolution or Corrective Action if there is insufficient follow-up to resolve. Though some Corrective Action Plans (CAPs) were necessary following implementation of the updated process, MCOs provided follow-up action and documentation ahead of agreed upon timeframes to address any insufficiencies. CAPs issued were beneficial to establish guidelines and ensure consistent follow-up to complete reports. Following state issued CAPs, the MCOs have made necessary adjustments to maintain processes that follow policy and procedure.

The MCOs contact KDADS Program Integrity Manager to ensure proper follow-up occurs and to address any questions on a case-by-case basis. The MCOs also provide outreach via email to indicate if additional time, beyond follow-up requirements, is necessary and/or if there are any additional updates to include on a completed report. Collaboration between KDADS Program Integrity and the MCOs helps ensure individual health, safety, welfare and quality of care is maintained and necessary action is taken to avoid reoccurrence.

F. Access to Care:

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. 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.

In 2019, most approved requests were due to a single hospital refusing to contract with one MCO. The Secretary of the Kansas Department of Health and Environment and the State Medicaid Director opted to approve any good cause request filed for members who expressed a desire for continuity of care with this particular provider and the associated professional providers. The remaining requests were due largely to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. GCRs filed 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 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.

During 2019, there were two state fair hearings filed for a denied GCR. One defaulted, and one was dismissed. A summary of GCR actions for 2019 is as follows:

Status	2019 Totals
Total GCRs filed	195
Approved	47
Denied	103
Withdrawn (resolved, no need to change)	35
Dismissed (due to inability to contact the member)	10
Pending	0

Access to Dental Care: KanCare and partner agencies continue to emphasize the importance of regular dental care for our members and are committed to maintaining an increased utilization of these important services. Results indicate dental services have been consistently provided.

	SFY2017	SF2018
Total Eligible receiving dental treatment	129,564	127,260
Total Eligible receiving preventative services	121,855	120,084

G. HCBS Waiver Updates:

i. FE: The Frail Elderly waiver was in the Request for Additional Information stage at the conclusion of calendar year 2019 and was placed on Temporary Extension through March of 2020.

ii. IDD: CMS approved the Intellectual and Developmental Disability (IDD) waiver renewal effective July 1, 2019.

iii. PD: The Physical Disability waiver was in the Request for Additional Information stage with CMS at the conclusion of calendar year 2019 and was placed on Temporary Extension through March of 2020.

iv. TBI: CMS approved the Traumatic Brain Injury (TBI) renewal effective July 1, 2019. An amendment to expand eligibility to individuals with acquired brain injuries was approved by CMS on August 5, 2019. The name of the waiver was changed to Brain Injury (BI) waiver at this time. Further, CMS approved an amendment effective December 1, 2019 to expand eligibility to youth.

H. Beneficiary CAHPS Survey:

The Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys are conducted annually by the KanCare Managed Care organizations and validated by the state's External Quality Review organization (EQRO) the Kansas Foundation for Medical Care (KFMC).

CAHPS is a survey tool developed to assess consumer satisfaction and member experiences with their health plan. It is a nationally standardized survey tool sponsored by the Agency for Health Care Research and Quality (AHRQ) and co-developed with National Committee for Quality Assurance (NCQA). The survey measures how well health plans are meeting their member's expectations and goals; to determine which areas of service have the greatest effect on member's overall satisfaction; and to identify areas of opportunity for improvement which could aid plans in increasing the quality of care provided to members.

Detailed specifications are provided by NCQA to be used by health plans in conducting the survey. In order for a health plan's CAHPS survey to be a dependable source of information, it must be administered according to the published CAHPS technical specifications. When administered properly, CAHPS surveys provide information regarding the access, timeliness and quality of health care services provided to health care consumers.

The following members were identified for participation in the survey:

- Currently enrolled when the survey was conducted
- Enrolled in the health plan for at least the last six months
- Child population that was 17 years of age or younger as of 12/2018 from both the TXIX and Title XXI plans
- Adult population that was 18 years of age as of 12/2018
- The sample did not include more than one person per household

CAHPS surveys were conducted in 2019 by Sunflower and UnitedHealthcare (UHC), with continuing positive results. No direct comparison of aggregated results in 2019 with prior years can be made, however, as results in 2013-2018 included Amerigroup survey results. Aetna, which began providing managed care in Kansas in 2019 in place of Amerigroup, will, along with Sunflower and UHC, conduct CAHPS surveys in 2020.

I. Annual Summary of Network Adequacy:

The MCOs continue to recruit and add providers to their networks. The table below shows the provider growth rate from the 1st Quarter of 2019 to fourth Quarter of 2019. The data in this table is based on the Provider Network Report submitted by each MCO quarterly. The counts represent the unique number of NPIs—or, where NPI is not available—provider name and service locations. This results in counts for the following:

- Providers with a service location in a Kansas county are counted once for each county.
- Providers with a service location in a border area are counted once for each state in which they have a service location that is within 50 miles of the KS border.
- Out of state providers (>50 miles from KS border) are counted once.
- Providers for services provided in the home are counted once for each county in which they are contracted to provide services. *This measure was implemented Q3-2018.

KanCare MCO	# of Unique Providers as of 3/31/2019	# of Unique Providers as of 6/30/2019	# of Unique Providers as of 9/30/2019	# of Unique Providers as of 12/31/2019
Aetna	17,724	21,603	32,598	34,229
Sunflower	35,139	35,188	30,258	31,888
UHC	47,701	46,285	48,809	46,946

KDHE continues to provide feedback and analysis of data trends in the Network Adequacy Report through the KDHE-built monitoring tool. KDHE performed MCO training sessions with the MCO credentialing and data staff in 2018 to show how the report should be completed and how to understand the scorecards issued each quarter through the monitoring tool. The network adequacy reporting from the MCOs remains problematic to analyze due to repetitive and extensive errors with duplication, incorrect types and specialties, incorrect addresses, and inconsistency in reporting between MCOs. Each MCO has struggled with correcting their data. While the reports are much improved since previous years, errors remain. Another follow-up with more in-depth training is planned for 2Q 2020.

In April of 2019, revised KanCare Network Adequacy Standards were published. Major changes include adding travel time requirements, separating many pediatric and adult providers, clarifying provider type and specialty codes included in each provider type count, more consistency in rural vs urban requirements, and most HCBS services are now measured in number of days to begin providing the services (as opposed to 2 per county).

New GeoAccess reports were created and implemented in 2019. This includes 6 data sets:

- Maps by Specialties Report: This report contains GeoAccess maps that show statewide coverage for specified provider types & specialties.
- Mapped Provider Count Report: This is a companion Excel report to the Maps by Specialties Report that shows—for each Specialty—the number of providers and locations, percent of members residing within the required radius of the provider, and average distance in miles to provider by county type.
- Specialty-Care Standards Report: This report contains an Excel table that shows provider specialties with routine and/or urgent access standards; displays the number of providers contracted by county and identifies the percent of appointments not meeting the access standard.
- NEMT Report: This report contains an Excel table showing number of trips requested and scheduled per county, as well as percent of trips not meeting standards, for the

claims processed during the quarter, by county.

- Unmapped Specialties Report: This report contains an Excel table that lists the number of unique contracted and credentialed KanCare providers by specialty. This report only contains specialties for which no map is required.
- Access and Availability Analysis Report: This report compares data over the last two quarters demonstrating the strength of network for each mapped provider type and includes basic network summary information in a Word document. The report will also include an analysis of any gaps in coverage along with actions the MCO is taking to address network weaknesses. The reporter is required to address the status of initiatives and areas of focus, such as foster care, as needed.

The first submission of the revised GeoAccess reports was October 30, 2019. Major changes include mapping of many more provider types, ADA compliant mapping format, adding NEMT report, Specialty Care Report, and the Access and Availability Analysis Report.

As the new Managed Care rules have removed enrollment responsibility from MCOs, the State of Kansas added complete provider enrollment duties into the contract with their Fiscal Agent to build a new MMIS system. In that new system, we are building a provider enrollment portal that all Kansas Medicaid providers must use to enroll. The Fiscal Agent will assign specialties and provider types per the enrollment and taxonomy information provided by the provider. Phase one of this system was operational in 2017. This new system will be a solution to one long-standing problem with network adequacy analysis – inaccurate provider data from the MCO reports. With the new system, this will provide standardized provider types, specialties, and address information, thus eliminating some of the current errors with the network adequacy reports. Issues remain with a system, which puts the responsibility for accurateness on the provider and a one-way (State to MCO) communication channel.

Regarding MCO compliance with provider 24/7 availability, here are the processes, protocols and results from each of the MCOs:

Aetna Annual Assessment of Network Appointment Accessibility

Methodology

An interdepartmental workgroup comprised of representatives from Network Management and Quality Management departments was formed to assess the adequacy of member access to appointments and after-hours services for network providers. Data was collected and results analyzed against standards for access to services delivered by contracted medical and behavioral health practitioners both during and after business hours for the data collection period of February 20, 2020 through March 9, 2020. Opportunities were prioritized and action plans were developed as appropriate; urgent matters were addressed with management immediately. Results are presented to the Grievance and Appeals Committee, Service Improvement Committee, Quality Management/Utilization Management Committee and the Quality Management Oversight Committee.

Aetna Better Health of Kansas defines practitioner types as follows:

Practitioner Types for Appointment Access Analysis

Category	Practitioner Type
Primary Care	General Pediatrician, Family Practitioner, General Internist, General Practitioner
Specialty Care: High-Volume/High-Impact	Oncology: Oncologist

	OB/Gyn: Certified Nurse Midwife, Maternal Fetal Medicine, Obstetrician/Gynecologist
Behavioral Health	Prescribers: Psychiatrist, Psychiatric Nurse Practitioner Non-Prescribers: Psychologist, Licensed Clinical Mental Health Professional, Licensed Clinical Psychotherapist, Licensed Mental Health Professional, Positive Behavioral Support

Practitioner Appointment Accessibility Study

The accessibility study was conducted at the provider group level and utilized the Practitioner Appointment Accessibility Survey tool to collect data regarding timely access to care. As performance issues were identified, Aetna Better Health of Kansas evaluated the data to identify the root cause and developed an action plan as appropriate. The provider is re-surveyed according to Aetna Better Health of Kansas protocol described below. The survey is conducted and reported annually.

Network and Quality representatives conducted calls to primary care, specialty care and behavioral health providers and ask a series of questions outlined in the Practitioner Appointment Accessibility Survey tool. The questions assessed availability of the various appointment types (e.g., routine, urgent, emergent and after hours). The representatives entered responses into the survey tool and results were analyzed to determine if appointment criteria were met. Should the criteria not be met, Network Managers determine actions at both the individual provider level as well as at the network level.

Audit Population Determination
Random sample of 260 network providers from a universe of 6466 providers. The entire universe was sampled with at a 90% confidence level (5% margin of error).

Universe of Providers by Specialty (n=6466)

- Primary Care: 3137 providers (48.5% of total providers)
- OB-Gyn: 410 providers (6.3% of total providers)
- Oncology: 201 providers (3.1% of total providers)
- BH Prescriber: Psychiatry: 367 providers (5.7% of total providers)
- BH Non-Prescribers: 2351 providers (36.3% of total providers)

This sample of 260 providers was then used to conduct random sampling by provider specialties using the proportion of that specialty type within the universe. Oversampling was conducted to assure an adequate number of providers for this study.

Representative Sample of Provider Specialty (n=260)

- Primary Care: 126 providers
- OB-Gyn: 17 providers
- Oncology: 8 providers
- BH Prescriber: Psychiatry: 15 providers
- BH Non-Prescribers: 94 providers

There was and oversample of an additional 227 providers throughout the course of this study. They were representative of all provider types.

Study Period
February 20, 2020 through March 9, 2020

Indicators

The following table provides the measures for the different types of practitioners surveyed.

Scoring: Compliance with the standards is scored for each measure as:

- Pass - Appointment access met standards on or before the required timeframe.
- Fail - Appointment access did not meet standards on or before the required timeframe.

Provider Accessibility Survey Indicators/Goals

Primary Care Physician / Family Practice / Pediatrics
Routine: 80% of Providers will have appointments available within 30 days of request
Non-urgent: 80% of providers will have appointments available within 72 hours of request
Urgent: 80% of providers will have appointments available within 48 hours of request
After Hours: 80% of providers will provide after-hours coverage 24 hours/7 days per week
Specialists/ High-Volume Specialists/ High-Impact Specialists (Oncology and Obstetrics/Gynecology)
Routine: 80% of Providers will have appointments available within 30 days of request
Non-urgent: 80% of providers will have appointments available within 72 hours of request
Urgent: 80% of providers will have appointments available within 48 hours of request
After Hours: 80% of providers will provide after-hours coverage 24 hours/7 days per week
OB/Gyn – 1st Trimester: 80% of providers will have appointments available within 14 calendar days of request
OB/Gyn – 2nd Trimester: 80% of providers will have appointments available within 7 calendar days of request
OB/Gyn – 3rd Trimester: 80% of providers will have appointments available within 3 business days of request
Behavioral Health – Prescribers and Non-Prescribers
Routine/Initial Visit: 80% of providers will have appointments available within 10 business days of initial request
Non-Life-Threatening Emergency: 80% of providers will have appointments available within 6 hours of request
Urgent: 80% of providers will have appointments available within 48 hours of request
After Hours: 80% of providers will provide after-hours coverage 24 hours/7 days per week

Results are displayed by provider type as well as the appointment type. Note: For the Quantitative Analysis, all non-prescribing BH providers are grouped into a single survey.

Quantitative Analysis

Network Management and Quality Management staff conducted the annual provider survey to evaluate appointment and after-hours accessibility for services delivered by randomly selected medical and behavioral health providers. This was done to assess and ensure that members have access to routine, non-urgent, urgent and after-hours care. A total of 260 providers were selected for this survey with another 227 providers included as an oversample.

2020 Provider Appointment Accessibility Results

Appointment Type	Numerator/Denominator*	Goal	Rate*	Goal Met/Not Met
Primary Care Physician/Family Practice/Pediatrics General Pediatrician, Family Practitioner, General Internist, General Practitioner				
Routine	107/115	80%	93.0%	Met

Non-Urgent	41/115	80%	35.7%	Not Met
Urgent	86/115	80%	74.8%	Not Met
After Hours	101/115	80%	87.8%	Met
Specialists - Oncology and Obstetrics/Gynecology				
Oncologist				
Routine	8/9	80%	88.9%	Met
Non-Urgent	3/9	80%	33.3%	Not Met
Urgent	6/9	80%	66.7%	Not Met
After Hours	7/9	80%	77.8%	Not Met
OB-Gyn: Certified Nurse Midwife, Maternal Fetal Medicine, Obstetrician/Gynecologist				
Routine	11/17	80%	64.7%	Not Met
Non-Urgent	7/17	80%	41.2%	Not Met
Urgent	15/17	80%	88.2%	Met
After Hours	11/17	80%	64.7%	Not Met
Initial 1st trimester	11/15	80%	73.3%	Not Met
Initial 2nd trimester	7/12	80%	58.3%	Not Met
Initial 3rd trimester	5/12	80%	41.7%	Not Met
Behavioral Health (Prescriber) - Psychiatrist, Psychiatric Nurse Practitioner				
Routine	5/15	80%	33.3%	Not Met
Urgent	5/15	80%	33.3%	Not Met
Non-life-threatening emergency	15/15	80%	100.0%	Met
After Hours	9/15	80%	60.0%	Not Met
Behavioral Health (Non-Prescriber) Psychologist, Licensed Clinical Mental Health Professional, Licensed Clinical Psychotherapist, Licensed Mental Health Professional, Positive Behavioral Support				
Routine	51/64	80%	79.7%	Not Met
Urgent	47/67	80%	70.1%	Not Met
Non-life-threatening emergency	51/67	80%	76.1%	Not Met
After Hours	43/65	80%	66.2%	Not Met

*Caution should be taken in drawing conclusions for any measure with a denominator less than 30 providers.

There were 293 providers contacted which (met) the overall goal of 260 respondents. These contacts met the volume of provider contacts required in the sampling methodology for all provider types. Overall, there were 5 appointment type goals met out of 23 appointment types surveyed. This study revealed that in each provider type, at least 2 goals for appointment availability were not met. It does not appear that the provider type is a key determinant as to whether the appointment type goal was met. Additionally, there was no consistency across the study in the type of appointment that did not meet the goal. As this is the initial survey for Aetna Better Health of Kansas, there is no historical data available for comparison or goal setting.

PCP

The routine appointment type goal of 80 percent was exceeded by 13 percentage points with a rate of 93 percent. Additionally, the rate of after-hours contact (access to a provider or call services 24 hours per day and 7 days per week) was 87.8 percent. The appointment type "non-urgent" had the lowest rate of 35.7 percent with 41 of 115 offices responding that there were non-urgent appointments within 72 hours. Overall, the PCP had a response rate of 115 provider offices out of 131 office contacted for a response rate of 87.8 percent.

Oncology

There were 9 provider office responding to the study. The overall response rate was 47.4 percent with nine of 19 offices responding. The established goal (80 percent) was met for the routine appointment (88.9 percent) indicating that an appointment was available within 30 days of the contact. There non-urgent and urgent appointment availability fell below the goal (80 percent) with rates of 33.3 percent and 66.7 percent respectively. The after-hour goal was not met indicating that the member would not be able to reach his/her provider or a call service who would contact the member with a provider. Given the number of oncologist responses is less than 30, caution should be taken in interpretation of results.

Obstetrics and Gynecology

There were 17 provider office staff that responded to the survey. The established goal of 80 percent was met for the "urgent" appointment type at 88.2 percent meaning that the appointment was available within 48 hours of the request. Routine and non-urgent appointment types did not meet the goal (64.7 percent and 41.2 percent respectively). Assessment was made as to appointment availability by trimester of pregnancy. Regardless of the trimester, the goal of 80 percent meeting the timeliness of available appointments was not met. It is noted that there were 12 providers responding to the survey regarding appointment availability within the second and third trimester. This is a decrease of 3 providers between the first and second trimesters as well as a decrease from 17 providers responding to the survey overall. Given the number of Ob-Gyn responses is less than 30, caution should be taken in interpreting the results. The after-hours goal of having coverage 24 hours for 7 days per week so that the member could contact their provider was not met (64.7 percent).

Behavioral Health (Prescriber)

There was one appointment type, "non-life-threatening emergency", that exceeded the established goal of 80 percent. The non-life-threatening emergency rate was 100 percent indicating that all providers had an appointment available within 6 hours of the request. The goal was not met for routine and urgent appointments (33.3 percent and 33.3 percent respectively). The rate of respondents indicating that a member could contact the provider, or a call center was 60 percent which did not meet the established goal. The response rate to this survey was 60 percent (15 responses out of 25 contacts). Given the number of BH prescribers responses is less than 30, caution should be taken in interpreting the results.

Behavioral Health (Non-Prescriber)

For purposes of this analysis, all behavioral health non-prescribers (e.g. psychologists, licensed BH professionals) were considered in this specialty type. The overall response rate was 66.3 percent with 67 provider offices responding and 101 contacted. This provider type did not meet any of the 3 appointment types with rates ranging between 70.1 percent (urgent) to 79.7 percent (routine). The rate of after-hours availability (66.2 percent) did not meet the established goal (80 percent).

For purposes of this analysis, all behavioral health non-prescribers (e.g. psychologists, licensed BH professionals) were considered in this specialty type. The overall response rate was 66.3 percent with 67 provider offices responding and 101 contacted. This provider type did not meet any of the 3 appointment types with rates ranging between 70.1 percent (urgent) to 79.7 percent (routine).

Qualitative Analysis

Overall, this survey identified multiple opportunities to increase awareness and adherence to appointment availability standards and after-hours access to providers on a 24/7 basis. However, within the scope of the survey there were findings that does impact interpretation of results and required next actions.

Sampling Methodology

Goals were not consistently met by provider type nor appointment type. The sampling methodology used was appropriate for identifying the providers from the universe and selecting the sample based on the proportion of providers within the universe. However, given the number of failures for each provider type, this survey should be expanded to include a valid sample (confidence interval 90 percent =/- 5 percent) for each provider type. This expanded survey would allow for a more comprehensive understanding of the goals that are not met.

Obstetrics and Gynecology

It was noted during calls with providers to complete the survey that members who are calling with an urgent issue or calling for an initial appointment within the second or third trimester as referred to a nurse or midwife for further evaluation prior to scheduling a same day appointment or appointment within the trimester standards. These responses were included in the survey as positive responses, meeting the Aetna Better Health standard. It was also noted that members in the first trimester are seen by the office nurse practitioner for the initial appointment. One provider had an age restriction, not providing appointments for members younger than 16 years of age.

Behavioral Health

Behavioral health appointment standards are the same for prescribers and non-prescribers. As expected, non-prescribers were more difficult to contact as many were not affiliated with a group thus, no centralized appointment coordinator to assist. For these providers, a message must be left by the member and a call back from provider to complete appointment scheduling. These non-prescribing clinicians were also less likely to have after-hours service available. Some, especially in outlying areas, had calls referred to a nurse line, with urgent and emergency calls referred to the hospital for triage and care. Most prescribers (psychiatrists and psychiatric nurse practitioners were affiliated with a group or community mental health. Access to routine appointments within ten days for prescribers was difficult to obtain: most availability falling within 10 to 30 days.

After Hours

When Aetna Better Health of Kansas staff contacted the provider offices regarding after hours availability, the responses varied from “members will leave messages on the answering machine” or “transfer calls to the Nurse Line” to “have after hours call service” and “our doctor is on call”. On a recurrent basis, the provider office front-line staff could not articulate the after-hours procedures. This may present an opportunity for Aetna Better Health of Kansas to clarify the expectations that members have 24/7 availability to a medical provider.

Additional Reports

Aetna Better Health of Kansas identifies and analyzes multiple sources of data to understand the member experience with appointment availability. One key analysis is member grievances. In 2019 there were 11 member grievances related to access to appointments or providers. There were no trends identified. Network Management continues evaluates the network for adequacy of providers. On a quarterly basis, assessment is completed on providers locations and specialties.

Barriers

The following barriers were noted:

- Low denominators do not allow for adequate assessment of key drivers to the failure
- Inconsistent awareness of providers as to appointment availability standards

- Large provider groups have complex processes to manage appointment, e.g. urgent requests are forwarded to office nurse for triage and scheduling
- Front office staff/appointment coordinators are unaware of appointment standards
- Provider capacity to meet the appointment standards may be limited

Sunflower Health Plan Appointment and After-Hours Access to Care Report
Sunflower Health Plan monitors primary care appointment and after-hours access, specialty care and behavioral health practitioner appointment accessibility annually against its standards, and initiates actions as needed to improve. SHP monitors primary care practitioner (PCP) and specialist appointment accessibility, primary care after-hours access, and behavioral health practitioners to ensure members have access to medical care 24 hours a day, 7 days a week. This report describes the monitoring methodology, results, and analysis.

In accordance with the state contract, Sunflower Health Plan defines urgent care appointment accessibility as within 48 hours from the time of the request for both PCPs and high-impact/high-volume specialists; routine appointment accessibility for PCPs and specialists as not to exceed three weeks and 30 days, respectively, from the date of member requests. After-hours access is defined as having an appropriate after-hours mechanism (i.e. answering machine or answering service with appropriate messaging regarding seeking emergency and urgent care). Sunflower Health Plan also monitors office wait times and defines an acceptable wait time as within 45 minutes from the time the member enters a practitioner office, for both PCP and specialists.

Sunflower Health Plan utilized SPH Analytics to conduct a survey of participating practitioners, including PCPs and high-impact (oncology) and high-volume (OB/GYN) specialists. Sunflower Health Plan's appointment availability surveys request confirmation that the practitioner can accommodate members' appointment needs based on current practitioner availability for routine and urgent appointments. Data was collected by standardized survey; offices were contacted by telephone during normal business hours to determine if practitioners are adhering to the appointment access standards for new patients. Offices were queried about urgent appointments and routine care accessibility for the 1st available, 2nd available, and 3rd available appointments, as well as office wait time. Sunflower Health Plan considers the third appointment availability to be the best overall indicator of appointment availability, as the first and second available appointments may actually reflect available urgent appointments or appointments available due to cancellations for a given day, which may not represent average accessibility. Successful survey completions were completed with 543 practitioner offices for PCPs and specialists displayed below.

Table 1 below displays the urgent and routine care appointment accessibility standards and results for primary care office surveys conducted. Table 2 displays the results from the survey of after-hours accessibility.

Office Surveys – Primary Care Routine and Urgent Care Appointment Access

Medicaid	Access Standard	Appointment Results
Urgent Care	Primary care urgent appointments within 48 hours	New Patients - 67%
		Established Patients – 80%
Routine Care - New Patients	Primary care routine appointments not to exceed 3 weeks	1st Available - 74%
		2nd Available - 71%
		3rd Available - 67%

Routine Care - Established Patients	Primary care routine appointments not to exceed 3 weeks	1st Available - 89%
		2nd Available - 85%
		3rd Available - 82%
Wait Time	Primary care wait time not to exceed 45 minutes	91%

Survey of After-Hours Care

Number of Medicaid Providers	Number Fully Compliant	Number of Noncompliant	% of Providers Fully Compliant
205	116	89	57%

The results from the survey of specialist offices regarding routine and urgent care access are displayed in Table 3.

Office Surveys – Specialists Routine and Urgent Care Appointment Access

Medicaid	Access Standard	Appointment Results
Urgent Care (Oncology)	Oncology care for urgent appointments within 48 hours	New Patients - 77%
		Established Patients - 77%
Routine Care - New Patients (Oncology)	Oncology care for routine appointments within 30 days	1st Available - 87%
		2nd Available - 87%
		3rd Available - 87%
Routine Care - Established Patients (Oncology)	Oncology care for routine appointments within 30 days	1st Available - 95%
		2nd Available - 88%
		3rd Available - 88%
Wait Time (Oncology)	Oncology care wait time not to exceed 45 minutes	81%
Urgent Prenatal Care (OB/GYN)	OB/GYN care for urgent appointments within 48 hours	New Patients - 61%
		Established Patients - 74%
Prenatal Care (OB/GYN) – Initial Pregnant Woman Visit	OB/GYN care for initial appointments not to exceed 14 calendar days	New Patients - 78%
		Established Patients - 77%
Prenatal Care - New Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	1st Available - 93%
		2nd Available - 88%
		3rd Available - 88%
Prenatal Care - New Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	1st Available - 87%
		2nd Available - 84%
		3rd Available - 84%
Prenatal Care - New Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	1st Available - 90%
		2nd Available - 89%
		3rd Available - 89%
Prenatal Care - Established Patients (OB/GYN) – 1st Trimester	OB/GYN routine care within 30 days of the First Trimester	1st Available - 95%
		2nd Available - 94%
		3rd Available - 91%
Prenatal Care - Established Patients (OB/GYN) – 2nd Trimester	OB/GYN routine care within 30 days of the Second Trimester	1st Available - 91%
		2nd Available - 90%
		3rd Available - 90%
Prenatal Care - Established Patients (OB/GYN) – 3rd Trimester	OB/GYN routine care within 30 days of the Third Trimester	1st Available - 91%
		2nd Available - 88%
		3rd Available - 88%
Wait Time (OB/GYN)	OB/GYN care wait time not to exceed 45 minutes	90%

The results from the survey of behavioral health offices regarding routine and urgent care access are displayed in Table 4.

Behavioral Health Routine and Urgent Care Appointment Access

Medicaid	Access Standard	Appointment Results
Urgent Care (Behavioral Health Prescribers)	Behavioral Health care for urgent appointments within 48 hours	New Patients – 49%
		Established Patients – 72%
Routine Care - New Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	1st Available - 40%
		2nd Available - 31%
		3rd Available - 26%
Routine Care - Established Patients (Behavioral Health Prescribers)	Behavioral health care for routine appointments within 10 Days	1st Available - 56%
		2nd Available - 40%
		3rd Available - 33%
Non-Life-Threatening Emergent Care (Behavioral Health Prescribers)	Behavioral Health Non-Life-Threatening Emergent Care within 6 hours	100%
Urgent Care (Behavioral Health Non-Prescribers)	Behavioral health care for urgent appointments within 48 hours	New Patients – 65%
		Established Patients – 79%
Routine Care – New Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	1st Available - 79%
		2nd Available - 72%
		3rd Available - 62%
Routine Care – Established Patients (Behavioral Health Non-Prescribers)	Behavioral health care for routine appointments within 10 Days	1st Available - 83%
		2nd Available - 76%
		3rd Available - 66%
Non-Life-Threatening Emergent Care (Behavioral Health Non-Prescribers)	Behavioral Health Non-Life-Threatening Emergent Care within 6 hours	99%

UnitedHealthcare Appointment Waiting Times/After Hours Access

	PCP		Specialist		OB		BH		Total	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Sample size	169	160	162	151	133	127	186	183	650	621
Percent (number) contacted	89.3 % (151)	70.6 % (113)	71.6 % (116)	86.8 % (131)	86.5 % (115)	77.2 % (98)	38.7 % (72)	43.7 % (80)	69.8 % (454)	68.0 % (422)
Percent (number) completed*	74.8 % (113)	91.2 % (103)	59.9 % (97)	70.2 % (106)	72.2 % (96)	63.0 % (80)	26.3 % (49)	36.6 % (67)	78.2 % (355)	84.4 % (356)
After hours calls **	151	76	146	106	96	80	NA	NA	393	262

Table 1: Description of Sample

* Survey completion rates are computed as a percentage of those contacted. **BH providers are not included in after-hours calls; after-hours calls are placed to all other providers who participate in survey.

Table 1 Analysis

A sample of providers was drawn representing primary care, behavioral health care and high-volume high-impact specialists (Ob-gyn, orthopedics, cardiology, otolaryngology, and oncology/hematology). Providers selected for the sample were those with the highest number of visits as of the time the

sample was drawn in April 2019 (primary care >=100 visits YTD). Surveys were conducted from late May through June 2019.

Compared to 2018, a slightly smaller sample was drawn (621 compared to 650) and contact rates and survey rates were slightly lower. 68% of the sample was able to be contacted, and 84.4% of those completed the survey. It should be noted that the survey completion rate is calculated as a percentage of those contacted; therefore, when calculated as a percentage of the entire sample, 57% of the sample were interviewed. Reasons for not being interviewed are outlined in Table 2.

To obtain the estimated intervals to the next available appointment, UHC agents (via a contractor, DialAmerica) ask to speak to the individual who schedules appointments for the practice. They then ask for the date of the first available appointment for a United member (without specifying line of business, e.g., Medicaid) for each category of urgency or visit type (emergency, urgent, routine; and, for PCPs, adult physical and EPSDT). For OB, rather than urgency of care, they ask for the first available appointment based on trimester of pregnancy. To calculate compliance with appointment standards, the theoretical appointment date is subtracted from the date the call was made, and the waiting interval (in days) is computed and compared to the contractual standard (See Tables 3A-B). Average days to appointment are shown in Table 4. For after-hours calls, a second call is made after normal working hours to determine the accessibility of urgent care (Table 5). (Emergency and after-hours calls are not made to BH providers, as it is assumed these urgent situations would be handled by the ER.)

Table 2: Most Common Reasons for Not Being Able to Survey Offices*

	PCP		Specialist		OB-Gyn		BH		Total	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	169	160	162	151	133	127	186	183	650	621
Refused to participate	3.6% (6)	0.6% (1)	3.7% (6)	0.7% (1)	3% (4)	0.0% (0)	0% (0)	0.5% (1)	2.5% (16)	0.5% (3)
Unable to Contact in 3 Attempts	3.6% (6)	6.3% (10)	19.8% (32)	10.6% (16)	8.3% (11)	4.7% (6)	58.1% (108)	15.3% (28)	24.2% (157)	9.7% (60)
Technical Problems	1.2% (2)	2.5% (4)	3.7% (6)	0.7% (1)	0.8% (1)	0.0% (0)	2.2% (4)	0.5% (1)	2% (13)	1.0% (6)
Moved, did not update information	5.3% (9)	3.8% (6)	6.2% (10)	0.0% (0)	4.5% (6)	1.6% (2)	2.7% (5)	1.6% (3)	4.6% (30)	1.8% (11)
Total Not Surveyed	13.6% (23)	35.6% (57)	33.3% (54)	29.8% (45)	16.5% (22)	37.0% (47)	62.9% (117)	63.4% (116)	33.2% (216)	42.7% (265)

*Entire sample for each specialty type used as a denominator. The refusal rate is lower when computed as a percent of the entire sample rather than as a percent of those contacted (Table 1).

Table 2 Analysis

The percentage of providers unreachable for survey increased to 42% this year compared to nearly half in previous years. The biggest drops were in refusals to participate and technical problems, such as wrong numbers and cell phones, which cannot be called. BH providers had the largest number of cell phone no-contacts, probably representing their more mobile practice patterns (more locations, fewer office staff to schedule appointments). Inability to reach the scheduler remained a persistent problem, accounting for 10% of the sample this year (24% last year). Slight less providers moved to a different practice and did not update contact information, especially among BH providers. The sample includes only providers eligible to be interviewed. Those who had retired, gone out of business, dropped out as a UHC provider or were otherwise ineligible were eliminated before the sample was calculated.

Table 3A-3B. Appointment Wait Time Standards According to State and NCQA Specifications

Table 3A: Percent of Surveyed Offices Who are In Compliance with State Contractual Appointment Standards

Compliance Rates*	PCP		Specialist**#		OB**		BH		Total	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	113	103	97	106	96	80	49	67	355	356
Emergency care	99.1 % (112)	100.0 %	100% (97)	100.0 %	NA	NA	NA	NA	99.5 % (209)	100.0 % (209)
Urgent care	99.1 % (112)	100.0 %	100% (97)	100.0 %	NA	NA	83.7 % (41)	100.0 %	96.5 % (250)	100.0 % (276)
Routine care	100% (113)	100.0 %	100% (97%)	100.0 %	NA	NA	95.9 % (47)	100.0 %	99.2 % (257)	100.0 % (276)
Adult physical	90.3 % (102)	100.0 %	NA	NA	NA	NA	NA	NA	90.3 % (102)	100.0 % (103)
EPSDT/Well Child	54.9 % (62)	100.0 %	NA	NA	NA	NA	NA	NA	54.9 % (62)	100.0 % (103)
After hours coverage	100% (113)	73.8% (76)	100% (97)	84.9% (90)	100 % (96)	90.0% (72)	NA	NA	100% (306)	82.4% (289)
OB first trimester	NA	NA	NA	NA	99% (95)	100.0 %	NA	NA	99% (95)	100.0 % (80)
OB second trimester	NA	NA	NA	NA	100 % (96)	100.0 %	NA	NA	100% (96)	100.0 % (80)
OB third trimester	NA	NA	NA	NA	99% (95)	100.0 %	NA	NA	99% (95)	100.0 % (80)
OB High Risk	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Percentages are based on completed surveys.

**High volume specialists surveyed in were adult and pediatric cardiology, ophthalmology, otolaryngology, orthopedics and pulmonary medicine. Each type was included in each quarter.

Table 3B: Percent of Surveyed Offices Who are In Compliance with NCQA Appointment Standards

Compliance Rates*		PCP		Specialist**#		OB**		BH		Total
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
		% (n)		% (n)		% (n)		% (n)		% (n)
Sample Size	113	103	97	106	96	80	49	67	355	356
Emergency care	99.1% (112)	100.0 %	100 % (97)	100.0 %	NA	NA	NA	NA	99.5 % (209)	100.0 % (209)
Urgent care	99.1% (112)	100.0 %	100 % (97)	100.0 %	NA	NA	83.7 % (41)	100.0 %	96.5 % (250)	100.0 % (276)

Routine care	100% (113)	100.0 %	100 % (97)	100.0 %	NA	NA	95.9 % (47)	100.0 %	99.2 % (257)	100.0 % (276)
Adult physical	90.3% (102)	100.0 %	NA	NA	NA	NA	NA	NA	90.3 % (102)	100.0 % (103)
EPSDT/Well Child	54.9% (62)	100.0 %	NA	NA	NA	NA	NA	NA	54.9 % (62)	100.0 % (103)
After hours coverage	113 (100%)	73.8% (76)	NA	84.9% (90)	NA	90.0% (72)	NA	NA	100% (113)	82.4% (289)
OB first trimester	NA	NA	NA	NA	NA	100.0 %	NA	NA	NA	100.0 % (80)
OB second trimester	NA	NA	NA	NA	NA	100.0 %	NA	NA	NA	100.0 % (80)
OB third trimester	NA	NA	NA	NA	NA	100.0 %	NA	NA	NA	100.0 % (80)
OB High Risk	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Percentages are based on completed surveys.

**High volume specialists surveyed in were adult and pediatric cardiology, ophthalmology, otolaryngology, orthopedics and pulmonary medicine. Each type was included in each quarter.

#NCQA standard for emergency care is "immediate" and for urgent care "same day." Any same-day appointment was counted as satisfying both categories.

Table 3 Analysis

Tables 3A and 3B, shown above, reflect timeliness of appointment access using two sets of standards: those specified in the State contract and those required by the National Committee on Quality Assurance (QI5). As shown in the matrix above, NCQA standards are generally tighter for all except physical exams, where 4 weeks are allowed compared to 3. Appointment timeliness is calculated in whole days as the date of the appointment minus the date the practice was called. Therefore, immediate access can only be evaluated if a same-day appointment is offered, and calls made later in the day with next-day access will appear noncompliant even though they fall within 24 hours. OB access is determined according to trimester of pregnancy rather than emergent, urgent, or routine need, and NCQA standards do not exist for these categories of access. Emergency access for behavioral health is not included because it is assumed that BH emergencies are referred to emergency rooms rather than being treated in office settings.

The process for assessing access is as follows: operators at a third-party vendor, Dial America, call offices on a list provided by the MCO using a pre-arranged script. The script explains the purpose and asks whether this is a good time for the call; if not, a call-back time is arranged (three attempts are made). The scripts ask for the first available appointment date for a United member (Medicaid is not specified) for an emergency, urgent, or routine need. For PCPs, the scripts also ask for a date for an adult physical and EPSDT exam. The operator then asks whether these appointment dates apply to all providers on the list or only certain ones. Dates are adjusted as needed for providers with different availability, though in most cases the appointment times given apply to all providers on the list. It should be noted that not all providers in the practice are assessed in any given call because random sampling means that only certain providers may be in the sample.

Pregnancy access is asked according to trimester of pregnancy, with longer compliance times allowed for earlier stages (three weeks for first trimester, two for second trimester, and one for third trimester). High-risk pregnancy access is also assessed, although no specific standards exist for either the State or NCQA.

Access is generally much higher for PCPs than specialists and follows a similar pattern through the years. About three-quarters of PCPs can provider a same-day appointment for emergencies and urgent care and more than 90% can provide care within the standard (21 days for State, 14 for NCQA) for routine care.

Obstetric care improved this year over last, with only 100% of providers able to schedule an appointment within a week for a patient in the third trimester of pregnancy (in 2018, the number was 99%). 100% could schedule an appointment within two weeks for a member in the second trimester, and 100% within three weeks for a member in the first trimester. It should be noted that these data do not include Family Practitioners and Nurse Midwives who also provide a substantial amount of obstetrical care in the State of Kansas and whose obstetrical access was not assessed separately from other care.

Urgent (within 48 hours) behavioral health care was also more available, with 100% able to provide an appointment compared to 84% last year. It should be noted that the sample size of BH providers this year (n=67) is almost half the size last year (n=84). On the other hand, the large number of providers who were unable to be contacted due to having only cell phones may have created some bias in the sample.

Table 4: Average Number of Days Wait for Scheduled Appointment

	PCP (Days)		Specialist (Days)		OB (Days)		BH (Days)	
	2018	2019	2018	2019	2018	2019	2018	2019
Sample Size	113	103	97	106	96	80	49	67
Emergency care	0.58	5.6	1.5	11	NA	NA	NA	NA
Urgent care	0.62	4.8	1.8	10.8	NA	NA	2.9	7.6
Routine care	1.5	8.3	18		NA	NA	9.0	10.5
Adult physical	12.2	19	NA	NA	NA	NA	NA	NA
EPSDT/Well Child	12.2	39	NA	NA	NA	NA	NA	NA
OB first trimester	NA	NA	NA	NA	9.6	10.3	NA	NA
OB second trimester	NA	NA	NA	NA	8.4	11.9	NA	NA
OB third trimester	NA	NA	NA	NA	7	11.4	NA	NA
OB High Risk	NA	NA	NA	NA	2.4	23.8	NA	NA

Table 4 Analysis

Table 4 shows access in terms of average days to an appointment based on urgency and specialty type. The generally longer times than in previous years were the result of a small number of physicians with extremely long wait times (up to 3 months in several cases). They occurred across all specialty types. The reasons for these delays are unknown. These data should be interpreted cautiously, as the Table 3 access data are much more reflective of the typical experience.

Table 5: After Hours Compliance

	PCP % (n)		Specialist % (n)		OB % (n)		BH* % (n)		Total % (n)	
	2018	2019	2018	2019	2018	2019	2018	2019	2018	2019
Sample Size	169	160	162	151	133	127	186	183	464	438
Answering service, nurse, physician or message with number to contact	89.3 % (151)	47.5 % (76)	90.1 % (146)	59.6 % (90)	69.9 % (93)	56.7 %	NA	NA	84.1 % (390)	54.3 % (238)
Answering machine instructing member to go to nearest hospital	0% (0)	11.9 % (19)	0% (0)	10.6 % (16)	0.8% (1)	4.7%	NA	NA	0.2% (1)	9.4% (41)
Phone rings continuously with no answer	2.4% (4)	1.9% (3)	0% (1)	0.0%	0% (0)	0.8%	NA	NA	0.9% (4)	0.9% (4)
Other unacceptable (typically, message instructing member to dial 911)	5.3% (9)	2.5% (4)	8.6% (14)	0.0%	0% (2)	0.0%	NA	NA	5% (23)	1.1% (5)

*BH does not have after-hours compliance calls.

Table 5 Analysis

After hours calls were placed to all provider types except behavioral health. Across all provider types, 84.1% had an adequate process in place, such as an answering service, nurse, physician, or number to contact. This represents a decline from the previous years. The state contract requirements regarding after-hours access are as follows: "2.2.5.10 "The CONTRACTOR(S) shall have procedures in place to ensure medically necessary services are available to Members on a 24 hours-per-day, seven (7) days per week basis." Medically necessary services can be carried out by an Emergency Room or Hospital, if needed, after hours.

IV. STC 64(c) – Budget Neutrality and Financial Reporting Requirements

Total annual expenditures for the demonstration population for Demonstration Year 7 (CY2019), with administrative costs reported separately, are set out in the attached document entitled "KanCare Expenditure & Enrollment Data DY7 CY2019." Yearly enrollment reports for demonstration enrollees for Demonstration Year 7 (CY2019), including all individuals enrolled in the demonstration, that include the member months, as required to evaluate compliance with the budget neutrality agreement, and the total number of unique enrollees within Demonstration Year 7, are also set out in the attached document entitled "KanCare Expenditure & Enrollment Data DY7 CY2019."

The State has updated the quarterly Budget Neutrality template provided by CMS and has submitted this through the PDMA system. Please see Section VI of the fourth quarter report. The expenditures contained in the document reconcile to Schedule C from the CMS 64 report for QE 12 31 2019.

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 attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to 2019/DY7.

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

Delivery System Reform Incentive Payment (DSRIP) Pool: 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 continue identifying community partners, creating training for community partners, and working toward reaching the project milestones for DY6. The CMS approved DSRIP annual and semi-annual payments were made on July 19, 2019 and October 11, 2019 respectively. A summary of 2019/DY7 DSRIP payments is attached.

Summary of Plan Financial Performance: As of December 31, 2019, all three plans are in a sound and solvent financial standing.

Statutory filings for the KanCare health plans can be found on the NAIC's "Company Search for Compliant and Financial Information" website: https://eapps.naic.org/cis/.

V. STC 64(d) – Evaluation Activities and Interim Findings

A. 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. This approach is guided by information collected from 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 State and Federal agencies, the KanCare MCOs, Medicaid providers, Medicaid members, and public health advocates. This combined information assists KDHE, KDADS and the MCOs to identify and recommend quality initiatives to monitor and implement the State's KanCare Quality Management Strategy (QMS). The QMS is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration.

The State Quality Management 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.

An example of this process occurred recently when MCOs expressed concern regarding not receiving phone numbers for approximately 42% of their members from the State. (When the primary applicant is not eligible, no phone number is included in the file sent to the MCO.) Further, performance improvement project activities have been demonstrating improved health outcomes and increasing HEDIS rates when the MCO reaches out, by phone, to the member. The State, along with relevant partners, researched the issue, brainstormed, and collaborated to discuss options and has begun implementing a solution.

To support the quality strategy, KDHE staff conduct regular meetings with MCO staff, relevant cross-agency program management staff, and EQRO staff to work on KanCare operational details and ensure that quality activities are occurring consistent with Section 1115(a) standard terms and conditions, the KanCare quality management strategy and KanCare contract requirements. Included in this work have been reviews, revisions, and updates to the QMS, including operational specifications of the performance measures (and pay for performance measures); reporting specifications and templates; LTSS oversight and plan of care review/approval protocols; and KanCare Key Management Activity reporting and follow-up. All products are distributed to relevant cross-agency program and financial management staff and are incorporated into updated QMS and other documents.

Kansas has provided quarterly updates to CMS about the various activities related to HEDIS measurements; CAHPS surveys; Mental Health surveys; Pay for Performance measures; and about specific activities related to MLTSS services, quality measures, and related HCBS waiver amendment application development and submission. State planning for integration of the Managed Care Final Rules related to the Quality Strategy has begun. Performance measures continue to evolve and change based upon analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data and claim encounter data.
As part of its Stakeholder engagement strategy, KDADS and National Association of State Directors of Developmental Disabilities Services (NASDDDS) hosted a Stakeholder Planning/Engagement workday on September 6, 2017. Invitees included self-advocates, providers, CDDOs (Community Developmental Disability Organizations), Disability Rights Center, Kansas Council on Developmental Disabilities (KCDD), Families Together, university partners, MCOs, parents and consumers, as well as State staff. The topics discussed that day were: barriers, development and next steps for residential and day supports, community life engagement, supported employment and systems sustainability.

As part of a new MCO contract and new Special Terms and Conditions, the EQRO was required to create a new Evaluation Design. In January, KFMC, KDHE and KDADS worked together to address CMS recommendations regarding the KanCare 2.0 Evaluation Design. The revised design was submitted to CMS on January 17, 2020 and KDHE received notice of CMS approval on February 19, 2020. KFMC initiated discussions with the MCOs, during the January 23, 2020 State/MCO/EQRO contract meeting, regarding data needed for the evaluation. Data needed from the MCOs primarily includes member-level data for eleven HEDIS measures, CAHPS survey data, completed Health Screening Tools and completed Health Risk Assessments. Other data needed for evaluation will be obtained by KFMC from encounter data (from MCOs' claims); Medicaid enrollment and eligibility data; OneCare Kansas (OCK) Health Action Plan (HAP) documents and Learning Collaborative meetings; and by conducting surveys and key informant interviews. KFMC anticipates accessing encounter data for 2019 KanCare services during second and third quarters 2020, thus allowing sufficient claim lag time. HEDIS and CAHPS data will be available in the third and fourth quarters of 2020.

KFMC has been attending OneCare Kansas Planning Council meetings and is developing the web-based HAP portal in collaboration with KDHE for an April 1 effective date. KFMC will attend OCK Learning Collaborative meetings to begin after program implementation. KFMC is also participating in the

Behavioral Health and Disability Employment Support Pilot Advisory Group, to learn and to provide input regarding evaluation measures since employment services are a component in the KanCare 2.0 evaluation.

KanCare 2.0 evaluation activities and deliverables going forward include:

- Develop detailed methodologies and analytic plans for testing hypotheses.
- Continue participation in OCK and Employment Pilot Advisory Group meetings.
- Obtain needed data as it is available and begin evaluation analyses; initial data anticipated in summer 2020.
- Review/discuss data sources, reports and findings with KDHE, KDADS and the MCOs during quarterly contract meetings and as needed.
- Provide quarterly written updates to KDHE regarding KanCare 2.0 Evaluation progress.
- Provide annual reports of progress and any key findings by April each year.
- Submit interim evaluation report, addressing all KanCare 2.0 evaluation design elements, one year prior to the end of the demonstration (December 2022).
- Submit final summative evaluation report 18 months from the end of the demonstration (June 2025).

During 2019, KDADS engaged stakeholders in a number of workgroups focused on the needs specific to our youth populations to develop ideas and recommendations regarding the Serious Emotional Disturbance, Technology Assisted, and Autism waiver services populations. In addition, KDADS conducted multiple listening sessions across the state to discuss HCBS waiver renewals and potential amendments to the HCBS waivers.

B. Utilization Data:

One component of the state's analysis of our Medicaid program is a comparison of current service utilization with the Pre-KanCare baseline year (CY 2012). This comparison provides information on shifts and trends in general and specific service areas, including services for both physical and behavioral health care needs, nursing facility and HCBS services, as well as inpatient and outpatient service settings. Refinement of our processes for compiling utilization data has allowed the state to compare utilization for across a spectrum of 17 service types thus allowing us to monitor specific service areas as well as general service types across the entire array of Managed Care services. This process requires an appropriate length of time to pass prior to capturing utilization data for analysis, therefore an analysis of calendar year 2019 data has not been finalized in time for this report.

The table provided below contains the KanCare Utilization Report for our sixth demonstration year (CY2018). A comparison between pre-KanCare rates (CY 2012) and CY2018 data demonstrates the continuation of a positive trend in reducing the utilization and expense attributed to inpatient facility services during the sixth year of KanCare, thereby supporting the continued success of our KanCare program's primary goal of controlling Medicaid costs by emphasizing health, wellness, prevention and early detection.

During the first five years of our demonstration program, KanCare has also maintained an upward trend in utilization of community based, local, outpatient office visits and ancillary services by our Members. By providing the MCOs with financial incentives based on outcomes that are tied to meaningful and reliable performance measures, the state is improving health care quality for our Members and reducing the overall cost of Medicaid in Kansas.

KanCare Utilization		CY 2012	CY 2018	Comparison CY 2018 vs CY 2012	
Type of Service	Measure Reported	Utilization Per/1000	Utilization Per/1000	Utilization Per/1000	% Difference
Behavioral Health	Claims	4,829	4,433	-396	-8%
Dental	Claims	878	948	70	8%
DME	Claims	460	457	-3	-1%
FQHCs/RHCs	Claims	751	859	108	14%
HCBS	Units	4,187	4,301	114	3%
Hospice	Claims	20	27	7	36%
Independent Laboratory	Claims	807	655	-152	-19%
Inpatient	Days	818	636	-182	-22%
Long Term Care	Days	374	371	-3	-1%
Medical-Specialty	Claims	1,836	1,211	-625	-34%
Medical-General Practice	Claims	3,615	3,790	175	5%
Medical-Other	Claims	655	648	-7	-1%
Outpatient ER	Claims	763	712	-51	-7%
Outpatient ER ANCILLARY	Claims	1,498	1,522	24	2%
Outpatient Non-ER	Claims	1,072	994	-78	-7%
Pharmacy	Prescriptions	10,096	9,516	-580	-6%
Renal Dialysis Center	Claims	27	27	0	1%
Targeted Case Management	Claims	793	409	-384	-48%
Transportation - AMB	Claims	103	110	7	6%
Transportation - NEMT	Claims	515	827	312	61%
Vision	Claims	382	451	69	18%
*Utilization per 1000 formula is (Units Reported/Member Months) x 12,000 - this illustrates the services used per 1000 beneficiaries over a 12-month period.					
CY 2018 data extracted from the DSS includes claims with a date of service between 1/1/2018 and 12/31/2018 with a paid date greater than or equal to 1/1/2018; CY 2012 data extracted from the DSS includes claims with a date of service between 1/1/2012 and 12/31/2012 with a paid date greater than or equal to 1/1/2012.					
The Utilization Report consists of two Medicaid data sets, one for CY 2018 (1/1/2018 through 12/31/2018) and one for CY 2012 (1/1/2012 through 12/31/2012). The purpose of this report is to compare the 2018 KanCare data to the 2012 Pre-KanCare data to gauge the MCOs' expenditures and the corresponding utilization of services.					

C. Summary of Performance Improvement Projects (PIPs):

With the implementation of KanCare 2.0, each MCO is required to participate in 6 PIPs. MCOs are contractually required to perform at least three clinical and two non-clinical PIPs annually, with one of the non-clinical PIPs focused on LTSS. Additionally, because all 3 MCOs fell below the 85% mark on their EPSDT 416 report measures, they are all required to initiate an EPSDT Outreach and Engagement PIP. Summary of 2019 PIP activities include:

i. Monthly PIP team meetings
ii. Selection and approval of PIP topics
iii. Continuation of HPV collaborative PIP and bringing new MCO up to speed
iv. Redesign of tools and processes to focus on complying with protocols, ensuring interventions are measurable, ease of use, consistency and improve documentation of outcomes

v. Pre-approval of interventions
vi. Methodology reviews and approvals
vii. Clarifying technical specifications for each measure
viii. Transition from a stagnant data recounting mechanism to a web-based, robust reporting system

The EQRO reviews and validates the reports for each PIP annually. The finalized reports will be attached at the end of this report submission.

D. Outcomes of Performance Measure Monitoring:

A summary of statewide results (all three KanCare MCOs aggregated) for calendar years 2013-2018 (measurements conducted in 2019) validated by Kansas Foundation for Medical Care. These numbers show the Kansas performance compared to the national 50th percentile on each of the measures. This information is detailed in a chart "HEDIS Comparison Measures-Physical Health & 2018 Performance Measure Validation" attached to this report.

E. Pay for Performance Measures:

The final results of the KanCare MCOs' performance for the 2018 pay for performance measures (measured in 2019) are detailed in the "2018 Pay for Performance Summary" document attached to this report.

F. Outcomes of Onsite Reviews:

The State of Kansas collaborated with its contracted External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC) to conduct the 2019 Balanced Budget Act (BBA) and 2019 Annual State Contract Review in tandem. The audit included assessment of the level to which each MCO performs the duties of the contract through operationalization of MCO policies and procedures and the quality of services delivered to providers and members. The questions were developed to diligently examine provider and member outcomes stemming from each MCO's service delivery model.

Site visits to MCOs took place between November of 2019 and January of 2020. The Aetna Better Health of Kansas site visit was held November 18-20 and was the sole three-day event. The State and KFMC chose to schedule sufficient time with this first-year MCO to address outstanding readiness review deliverables and to acquire thorough insight and awareness of the plan's operating systems.

Of particular interest to the State was each MCO's ability to demonstrate KanCare contract compliance through the use of KanCare-specific technology and a highly functioning operations management systems. Interviews with MCO staff were conducted by State team leads and accompanying SMEs. Principal topics included:

- Member and provider grievances and appeals demonstrating adherence to KanCare 2.0 Attachment D contract requirements including systems for tracking notices, acknowledgement letters, routing, monitoring, reporting, and readiness for 2020 legislation involving provider appeal turnaround time and EQR independent reviews.
- Financial reporting to meet accounting program requirements through record retention, software maintenance and insolvency planning; MCO management of physician incentive plans.
- Network adequacy standards and network management; contract compliance with Standards, reporting, recruitment, and retention; HCBS network growth. Accurate accounting of unique providers, unique locations, adult and pediatric PCPs and specialists, HCBS providers, accurate Geo Access maps
- Customer Service policies, desk procedures, call-center tracking system, inquiry type disbursement, and real-time observation of live customer service call center inquiries.

- Validation of current sub-contractor contracts, vendor contract compliance, and performance monitoring tools.
- Utilization Management to include post-desk review discussion of members' physical health, behavior health, LTSS, SHCN, dental, vision, and pharmacy cases, UM policies, desk procedures, workflow, and PH/BH service integration. Considerable time was taken to hear MCO staff describe the service coordination process designed and utilized to ensure members receive timely and appropriate initial health screenings, Health Risk Assessments, needs assessments, and person-centered service planning, as needed.
- Cultural Competency in the delivery of services, provider office policies and practices, and MCO written materials requirements.

The findings for the audits are still under review and rebuttal.

Value Added Benefits (VAB) are another way in which adult members may access preventive dental services. In 2019, 5334 Adult members received Dental services as Value added services provided through the MCO's. The value of these services totaled $552,043.00.

VI. STC 64(e) – SUD Health IT

Kansas had two primary SUD Health IT systems functioning at a statewide level, the Kansas Client Placement Criteria (KCPC) and K-TRACS. KCPC was primarily used by SUD service providers to guide assessment and collect client level data to submit to the state. K-TRACS is the state's prescription drug monitoring program.

In late 2018, the KCPC was taken offline due to concerns about data-security. During 2019, the state worked to create a system to replace the KCPC and developed the Kansas Substance Use Reporting Solution (KSURS). KSURS serves a basic function of collecting & monitoring client level data but does not fully replace the more robust KCPC which included additional provider-oriented tools like assessments and treatment plans. KSURS has been operational for more than 9 months, and the state is currently working to develop an RFP for a state hospital EHR solution which will help modernize and combine numerous mental health and SUD health IT solutions in a single system. It is anticipated that this modernization effort will take between 18 and 24 months to be fully realized statewide.

Kansas submitted a SUD Health IT Plan as part of the SUD Implementation Protocol that was approved by CMS in 2019. The Kansas Board of Pharmacy is responsible for the oversight and implementation of K-TRACS. The Kansas SUD Health IT Plan focuses on improving the functionality and utilization of K-TRACS to monitor the prescription and usage of controlled substances and other drugs of concern in Kansas. At the beginning of 2019, K-TRACS was connected to 31 others states across the country. The Board of Pharmacy continues to work on integration within the region including the state of Nebraska and several county and municipalities in Missouri. Other efforts and progress in 2019 include the launch of NarxCare, a CDC grant funded project that enhanced the functionality of K-TRACS by providing a client dashboard with metrics, tools and risk scores for patients prescribed controlled substances. NarxCare also provides direct access to provider education tools for high-risk individuals. Finally, Kansas has continued efforts to improve provider use of K-TRACS through the INTEGR.x.8 solution, allowing providers to access K-TRACS information directly through their electronic health record. INTEGR.x8 allows for more seamless K-TRACS use in provider workflow, increasing the efficiency and likelihood of utilization. Kansas' progress on the submitted SUD Health IT Plan are evident in the outcomes below demonstrating increased provider use and growth of the PDMP program.

Measure	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Aggregate Registered Users	12,690	13,073	13,469	13,776
Prescribers	9,540	9,828	10,091	10,315
Pharmacists	2,946	3,030	3,151	3,229
Others (investigators, administrators, agencies)	204	215	227	232

Measure	Q1 2019	Q2 2019	Q3 2019	Q4 2019
New Users				
Prescribers	206	288	263	307
Pharmacists	96	84	121	78
Others (investigators, administrators, agencies)	18	12	13	5

2019	January	February	March	April	May	June
Total Patient Queries	184,857	167,404	180,619	187,519	188,254	171,003
	July	August	September	October	November	December
	184,047	183,689	186,140	218,533	189,326	199,433

Kansas has included SUD Health IT metrics in the Monitoring Plan that corresponds with the recently submitted and revised KanCare 2.0 Section 1115 Substance Use Disorder Demonstration Evaluation Design. When the requested revisions are approved by CMS, this should fulfill the STC requirements, along with ongoing reports and updates and become Attachment R.

VII. Enclosures/Attachments

The following items are attached to and incorporated in this annual report:

Section of Report Where Attachment Noted	Description of Attachment
STC 64(a)	KanCare Ombudsman Report – DY7 2019
STC 64(a)	KanCare 2019 Public Forum Summary
STC 64(c)	KanCare Safety Net Care Pool Reports (including DSRIP payments)
STC 64(c)	KanCare Expenditure & Budget Neutrality – DY7 2019
STC 64(d)	2018 Pay for Performance Summary
STC 64(d)	HEDIS Comparison Measures-Physical Health & 2018 Performance Measure Validation

VIII. State Contacts(s)

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IX. Date Submitted to CMS

May 29, 2019

KanCare Ombudsman Office

ANNUAL REPORT 2019

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I. Table of Contents

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II. Highlights/Dashboard

A. Annual Report - new information

The KanCare Ombudsman Office is providing information on activity and outcome as well as trends for this annual report.

1. Activity and Outcome:

- Accessibility by Ombudsman Office (page 5)
- Outreach by Ombudsman Office (page 7)
- Data by Issue Category (page 13)

2. Trends:

- Outreach by the Ombudsman Office (page 7)
- Data by Office Location (page 10)
- Data by Program Type (page 12)
- Data by Issues Categories (page 15 and 16)
- Recap of Trends in Data (page 20)

B. Enhancements or changes in 2019

1. Volunteer Agreement

The KanCare Ombudsman Office updated the Volunteer Agreement to be easier to read/understand and still be in line with state agreements.

2. Pilot survey:

The KanCare Ombudsman Office did a pilot in Wichita to track the benefits of the services provided by the KanCare Ombudsman Office (page 21 and 22)

3. Improvements to Data Reporting (page 22)

- More options for tracking member contacts.
- Added more options in program type
- Moved Issues Category to three sections for easier tracking and reporting
- Added a few reports so the data is pulled through the system rather than keeping the numbers on a spreadsheet.
- Added Priorities for data tracking purposes as well as tracking members that need to be prioritized. (HCBS, LTC, Urgent Medical Need, Urgent and Life Threatening.)

III. KanCare Ombudsman Office Purpose

The KanCare Ombudsman Office helps Kansas Medicaid beneficiaries and applicants, with a priority on individuals participating long-term care services through KanCare.

The KanCare Ombudsman Office assists KanCare beneficiaries and applicants with access, service and benefit problems. The office:

- assists KanCare members with seeking resolution to complaints or concerns regarding their interaction with their KanCare plan or eligibility
- helps applicants with information, resources and in-person assistance with the KanCare application and renewal process
- provides information about the KanCare grievance and appeal process that is available through the KanCare plans and the State Fair Hearing process

The Centers for Medicare and Medicaid Services Special Terms and Conditions (2019), Section 42 for KanCare, provides the KanCare Ombudsman program description and objectives.

This annual report provides updates about the KanCare Ombudsman Office activities; see the Outreach section – page 6, and information collected (data) starting on page 7.

IV. Accessibility by Ombudsman's Office

A. Initial Contacts

Activity: The KanCare Ombudsman Office was available to members and potential members of KanCare (Medicaid) by phone, email, written communication, social media, and in person during 2019.

Outcome:

The KanCare Ombudsman Office has helped an increasing number of KanCare members and applicants over the last several years, starting in 2016 with the beginning of trained volunteer help in the two satellite offices (Olathe and Wichita). For the last two years, total quarterly contacts have averaged around 1,000. Fourth quarter took a dip in contacts, however January 2020 had over 360 contacts which is a normal monthly contact number.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
2014	545	474	526	547	2,092
2015	510	462	579	524	2,075
2016	1,130	846	687	523	3,186
2017	825	835	**970**	**1,040**	3,670
2018	**1,214**	**1,059**	**1,088**	**1,124**	4,485
2019	**1,060**	**1,097**	**1,071**	**915**	4,143

B. Accessibility through the KanCare Ombudsman Volunteer Program

The Kancare Ombudsman Office has two satellite offices; one in Olathe and one in Wichita. Both satellite offices answer KanCare questions, help with issues and assist with filling out KanCare applications on the phone and in person at the offices.

The main means of contact with the two satellite offices is through the KanCare Ombudsman Toll Free number, which directs calls based on the area code of the caller. The satellite offices are each covering over 20 hours per week in serving KanCare beneficiaries.

The Olathe and Wichita offices each have one volunteer in training (not listed below). The Satellite offices current coverage is listed below. Information on the Satellite office hours and contact information can be found on the Ombudsman web pages on the About/Contact Us page.

	Volunteer Hours	# of Volunteers	# of hours covered/wk.	Area Codes covered
Olathe Satellite Office	M: 9am-4pm T:9am-4pm W:10am-2pm Th: 9am-12:30pm F: 9am-12:30pm	5	25	913, 785, 816
Wichita Satellite Office	M: 9am-1pm T: 10am-2pm W: 1:30-3:30pm Th: 10am-2pm F: 9am-4:30pm	5	21.5	316, 620

Information as of 2/6/2020

V. Outreach by Ombudsman's office

Activity: The KanCare Ombudsman Office is responsible to help beneficiaries and applicants to understand the KanCare application process, benefits and services, and provide training and outreach to community organizations. The office does this through education, publications and training.

Outcome: The outreach for 2019 is down significantly from past years. In June of 2019 the part-time staff member on loan from the Governor's office was recalled to full-time in her area. That part-time person helped the Topeka office with complex calls and call volume in general. Our office has been short-staffed since that time and had to reprioritize all staff duties to ensure KanCare members and applicants received timely responses. Outreach and community/organizational meetings have stopped except in very limited instances. There have been no Liaison trainings in 4th quarter. Requests for speaking engagements are being pushed back to fall 2020.

For complete Outreach listing for 2019, see Appendix A, starting on page 23.

Trend: Outreach and Education

The KanCare Ombudsman Office went from 136 in 2018 to 82 events or publications in 2019 (8 in 4th quarter). This decrease in outreach is because staff duties were reprioritized starting in June due to loss of part-time person on loan to our office and loss of staff (turnover) in the Wichita office and time needed to train.

VI. Data by Ombudsman's Office

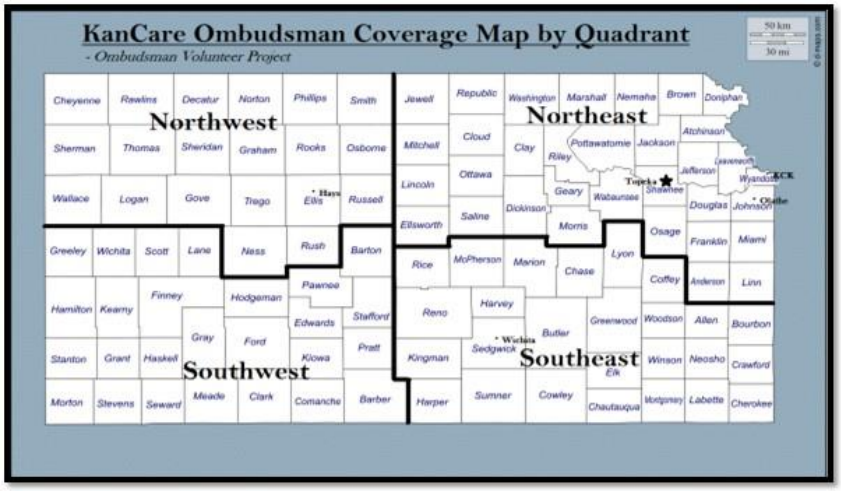
In addition to the contact information on page 4, the data for the KanCare Ombudsman Office includes data by: region, office location, contact method (phone, email, etc.), caller type, program type, issue categories, action taken and priority.

A. Data by Region

1. Initial Contacts to KanCare Ombudsman Office by Region

The KanCare Ombudsman coverage is divided into four regions. The map directly below shows the counties included in each region. The north/south dividing line is based on the state area codes coverage (785 and 620).

- 785, 913 and 816 area code calls go to the Olathe Satellite office.
- 316 and 620 area code calls go to the Wichita Satellite office.
- The remaining calls, direct calls and complex calls go to the Topeka (main) office.



Most calls are coming from the east side of the state which also ties to the Medicaid members within the state and the population density of Kansas (on the next page).

KanCare Ombudsman Calls by Region

Region	2018	2019
Northeast	805	751
Southeast	605	635
Northwest	54	46
Southwest	76	78
Out of State	69	31
Not Identified	2,875	2,610
Total	**4,484**	**4,151**

2. KanCare/Medicaid Members by Region

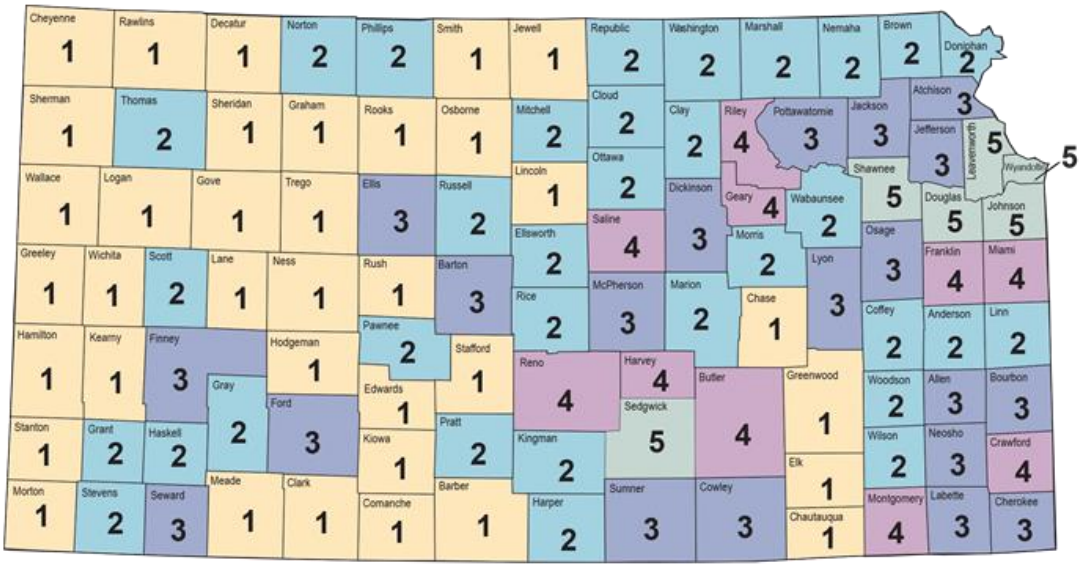
Medicaid

Region	
Northeast	189,133
Southeast	170,237
Northwest	12,223
Southwest	36,472
Total	**408,065**

Data as of 12/19/19

3. Population Density by KanCare Ombudsman Region

This map shows the population density of Kansas and helps in understanding why most of the Medicaid population and KanCare Ombudsman calls are from the eastern part of Kansas



Based on 2015 Census data –Kansas Population Density map using number of people per square mile (ppsm) (www.KCDCinfo.ks.gov):

1. Frontier - less than 6 ppsm
2. Rural - 6 to 19.9 ppsm
3. Densely Settled Rural - 20 to 39.9 ppsm
4. Semi-Urban - 40-149.9 ppsm
5. Urban - 150+ ppsm

B. Data by Office Location

Initial phone calls to the KanCare Ombudsman toll-free number (1-855-643-8180) are sent directly to one of three KanCare Ombudsman offices based on the area code the call is coming from. Olathe receives 913, 785 and 816 area code calls. Wichita receives 620 and 316 area code calls. All other toll-free calls go to the Main office (Topeka). People also may call all three offices directly; the direct phone numbers for the satellite offices are listed on the KanCare Ombudsman webpage, Contact/About Us.

The Topeka and Olathe offices are up in calls while Wichita is significantly down in calls. This is due to a hiring and training a new staff person in Wichita. During this time, extra calls were sent to the Topeka and Olathe offices.

Contacts by Office	2018	2019
Main - Topeka	2,428	2,452
Olathe	549	772
Wichita	1,507	927
Total	4,484	4,151

Trend:

Wichita is down significantly from 2018 in initial contacts. This is due mainly because there was staff turnover in the summer. We were without a staff supervisor for the VISTA and volunteers for three months. Once the new person was hired, there is a two-month training and mentoring process. This transition also resulted in less outreach in the southern part of Kansas, which we believe impacted these numbers as well.

C. Data by Contact Method

During 2019 we created a new listing below called Social Media. Since the KanCare Ombudsman Office is on Facebook, there are instances when people will contact us for help through Facebook.

Face-to-face contacts are usually through:

- walk-in assistance at the satellite offices in Olathe and Wichita.
- assistance to KDADS walk-ins in Topeka who need help with Medicaid related questions.
- people with personal concerns who attend KanCare public meetings. The KanCare Ombudsman Office tries to attend most of these and be available to answer individual questions/issues that may come up.

Contact Method	2017	2018	2019
Telephone	3,112	3,868	3,596
Email	517	545	506
Letter	2	8	9
Face-to-Face Meeting	30	58	31
Other	11	5	6
Social Media	0	0	3
CONTACT METHOD TOTAL	**3,672**	**4,484**	**4,151**

D. Data by Caller Type

Most contacts are consumers which includes beneficiaries, family member, friend, etc. The "Other type" callers are usually state employees, lawyers, schools, and students/researchers looking for data.

Provider issues are a combination of providers calling to assist a member or applicant having issues, or provider billing issues which we forward to Kansas Department of Health and Environment (KDHE).

CALLER TYPE	2017	2018	2019
Provider	492	369	339
Consumer	2,927	3,884	3,554
MCO Employee	44	19	27
Other Type	209	212	231
CALLER TYPE TOTAL	**3,672**	**4,484**	**4,151**

E. Data by Program Type

The top program types that we receive calls for are three of the Home and Community Based Services waivers (Physical Disability, Intellectual/Developmental Disability, and Frail Elderly) and nursing facility concerns.

Five program types have been added during 2019 (highlighted in gray):

- Foster Care
- MediKan
- Institutional Transition from
    - Long Term Care/Nursing Facility (LTC/NF)
    - Mental Health/Behavioral Health (MH/BH)
    - Prison/Jail

PROGRAM TYPE	2017	2018	2019
PD	154	143	122
I/DD	200	124	123
FE	128	110	124
AUTISM	7	8	10
SED	18	26	35
TBI	27	32	43
TA	27	18	29
WH	4	20	10
PACE	2	0	9
MENTAL HEALTH	17	8	14
SUB USE DIS	0	0	4
NURSING FACILITY	251	155	135
FOSTER CARE	0	0	3
MEDIKAN	0	0	12
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	6
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	3
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0
PROGRAM TYPE TOTAL	**838**	**645**	**683**

Trend:

There was an increase in renewal calls regarding the Technology Assistive HCBS wavier in 2019. The Ombudsman Office noted it in October of 2019. An email was sent to KDHE requesting a review of why there seemed to be an increase. The researched the cases and found a technical error in processing the renewals for that waiver. It was fixed immediately. They will be monitoring the TA waivers for some time to verify that the issue does not reappear.

F. Data by Priorities

Priority Data is new data that started in 3rd quarter, 2019. The Ombudsman Office is tracking priorities for two purposes:

1. This allows our staff and volunteers to pull up pending cases, review their status and request an update from the partnering organization that we have requested assistance from.
2. This helps provide information on the more complex cases that are worked by the Ombudsman Office.

The priorities are defined as follows:

- HCBS – Home and Community Based Services
- Long Term Care/NF – Long Term Care/Nursing Facility
- Urgent Medical Need – 1) there is a medical need, 2) if the need is not resolved in 5-10 days, the person could end up in the hospital.
- Urgent – non-medical need that needs to be resolved in the next 7-10 days; could be eviction from home or nursing facility or urgent financial.
- Life Threatening – If not resolved in 1-4 days person's life could be endangered. (should not be used very often.)

PRIORITY	Q3,4 2019
HCBS	99
Long Term Care / NF	36
Urgent Medical Need	46
Urgent	52
Life Threatening	14
PRIORITIES TOTAL	**247**

G. Data by Issue Category

Activity: There are now around 60 issue categories that we are tracking. We started with 20 categories in 2014.

The Issue Categories were divided into three groups during 3rd quarter, 2019 for easier tracking and reporting purposes.

Outcome: We are now better able to identify areas of concern for KanCare members and applicants and see when certain areas begin to be more of an issue or are becoming less of an issue.

An example of that is: Medicaid Eligibility seems to be a down-trending issue while Medicaid Renewals seem to be an up-trending issue. Medicare Saving Plan and Pharmacy seem to be on the rise, however anecdotally, it is probably connected to the uptrend in Medicaid Renewal issues.

1. Medicaid Issues

The top issues are Medicaid general issues, Medicaid information update and Medicaid Eligibility Issues.

MEDICAID ISSUES	2017	2018	2019
Access to Providers (usually Medical)	51	24	66
Appeals/Fair Hearing questions/issues	44	126	51
Background Checks	2	5	4
Billing	90	118	148
Care Coordinator Issues	34	42	54
Change MCO	12	61	32
Choice Info on MCO	0	29	21
Coding Issues	29	73	39
Consumer said Notice not received	2	50	22
Cultural Competency	0	0	1
Data Requests	8	9	7
Dental	29	32	29
Division of Assets	14	29	44
Durable Medical Equipment	18	27	14
Grievances Questions/Issues	107	98	93
Help understanding mail (NOA)	0	0	9
MCO transition	0	0	4
Medicaid Application Assistance	441	638	609
Medicaid Eligibility Issues	951	798	631
Medicaid Fraud	0	12	10
Medicaid General Issues/questions	0	705	907
Medicaid info (status) update	4	810	636
Medicaid Renewal	171	224	310
Medical Card issues	0	0	10
Medicare Savings Plan Issues	30	81	190
MediKan issues	0	0	7
Moving to / from Kansas	27	70	72
Medical Services	60	74	58
Pain management issues	0	1	8
Pharmacy	43	30	55
Pregnancy issues	0	0	10
Prior authorization issues	0	0	2
Refugee/Immigration/SOBRA issues	0	0	13
Respite	0	2	2
Spend Down Issues	108	112	117
Transportation	34	47	43
Working Healthy	5	26	19
MEDICAID ISSUES TOTAL	2,314	4,353	4,347

Trend: Category Issues that are down trending (in yellow)

- Medicaid Eligibility Issues is trending down
- Medicaid Status Updates is trending down.
- Appeal and Fair Hearing questions is trending down.
- The Ombudsman Office suggests, anecdotally, that these down trending issues are due to the downtrend in initial application issues during the 2019 year.

Trend: Category Issues that are up trending (in gray):

- Medicaid Renewal issues trended up for 2019. The Medicare Saving Plan and Pharmacy calls are also trending up and tend to be related to issues with renewals.
- KDHE implemented several strategies to improve the renewal concerns. Fourth quarter shows Medicaid renewal issues down significantly from the two prior quarters.

	Q1/19	Q2/19	Q3/19	Q4/19
Medicaid Renewal	56	119	84	51

2. HCBS/LTSS Issues

The top two issues for this group are Nursing Facility issues and HCBS General Issues. (HCBS stands for Home and Community Based Services)

HCBS/LTSS ISSUES	2017	2018	2019
Client Obligation	123	139	82
Estate Recovery	21	32	32
HCBS Eligibility issues	216	145	174
HCBS General Issues	137	180	241
HCBS Reduction in hours of service	19	14	12
HCBS Waiting List	27	22	27
Nursing Facility Issues	110	86	178
HCBS/LTSS ISSUES TOTAL	**653**	**618**	**746**

3. Other Issues

There are six new issues created during this quarter (highlighted in gray) to help better understand concerns that may be related to Medicaid.

OTHER ISSUES	2017	2018	2019
Abuse / neglect complaints	2	29	21
ADA Concerns	0	0	0
Adoption issues	0	0	3
Affordable Care Act Calls	19	44	17
Community Resources needed	0	0	9
Domestic Violence concerns	0	0	1
Foster Care issues	0	0	3
Guardianship	11	19	10
Homelessness	0	0	4
Housing Issues	17	26	21
Medicare related Issues	37	97	74
Social Security Issues	5	58	57
Used Interpreter	0	0	6
X-Other	1,018	594	452
Z Thank you	1,407	2,048	1,555
Z Unspecified	216	298	443
Health Homes	3	0	0
OTHER ISSUES TOTAL	**2,735**	**3,213**	**2,676**

H. Data by Managed Care Organization (MCO) – See Appendix B, pages 29-34

VII. Action Taken

This section reflects the action taken by the KanCare Ombudsman Office and the related organizations assisting the KanCare Ombudsman Office. This section shows data on:

- response rates for the KanCare Ombudsman Office
- response rates to resolve the question/concern for related organizations that are asked to assist by the Ombudsman Office
- how contacts are resolved

A. Responding to Issues

1. Ombudsman Office response to members/applicants

The Ombudsman Office goal is to respond to a contact within two business days. Even with significant increase in contacts, the KanCare Ombudsman Office has significantly improved the percent of caller contacted in 0-2 days over the last two years.

Quarter/ yr.	Nbr Contacts	% Responded 0-2 Days	% Responded in 3-7 Days	% Responded 8 or More Days
Q1/2018	1213	82%	17%	1%
Q2/2018	1059	90%	10%	0%
Q3/2018	1088	87%	12%	1%
Q4/2018	1124	86%	14%	0%
Q1/2019	1068	88%	11%	1%
Q2/2019	1096	91%	8%	1%
Q3/2019	1071	95%	4%	1%
Q4/2019	915	93%	7%	0%

2. Organizational response to Ombudsman requests

This chart shows the response time for completing the member/applicant request from our office. Contacts are made primarily in two ways:

- Sending an email requesting assistance for a resolution
- Doing a three-way call with the organization to help determining what the issue may be or what information may be needed to resolve an issue.

Qtr. 4 2019

Nbr Referrals	Avg Days Referred	Referred to	% Responded 0-2 Days	% Responded 3-7 Days	% Responded 7-30 Days	% Responded 31 or More Days
147	5	Clearinghouse	65%	17%	14%	4%
2	27	DCF	50%	0%	0%	50%
2	1	KDADS-Behavior Health	100%	0%	0%	0%
4	4	KDADS-HCBS	25%	75%	0%	0%
-	-	KDADS-Health Occ. Cred.	0%	0%	0%	0%
18	3	KDHE-Eligibility	44%	50%	6%	0%
6	1	KDHE-Program Staff	83%	17%	0%	0%
3	0	KDHE-Provider Contact	100%	0%	0%	0%
-	-	KMAP	0%	0%	0%	0%
10	7	Aetna	60%	30%	0%	10%
8	12	Sunflower	25%	38%	13%	25%
5	3	UnitedHealthcare	60%	20%	20%	0%

B. Resolving requests

1. Action Taken by KanCare Ombudsman Office to resolve requests

Action Taken Resolution Type	2017	2018	2019
Questions/Issue Resolved (No Resources)	417	356	306
Used Contact or Resources/Issue Resolved	2,505	3,091	3,385
Closed (No Contact)	367	483	389
ACTION TAKEN RESOLUTION TYPE TOTAL	**3,289**	**3,930**	**4,080**

There may be multiple selections for a member/contact

2. Additional Help provided by KanCare Ombudsman Office

Action Taken Additional Help	2017	2018	2019
Provided Resources	1,340	3,004	2,448
Mailed/Email Resources	409	679	593
ACTION TAKEN ADDITIONAL HELP TOTAL	**1,749**	**3,683**	**3,041**

There may be multiple selections for a member/contact.

3. Ombudsman Office Resolution of Issues

This chart indicates how long it is taking to resolve cases, from the first day our office is contacted to the day the case is resolved/closed. Notice that in 2019, in the last three quarters, cases were completed in 0-2 days over 90% of the time.

Quarter/yr	Nbr Contacts	% Completed 0-2 Days	% Completed in 3-7 Days	% Completed 8 or More Days
Q1/2017	827	77%	21%	2%
Q2/2017	835	80%	19%	1%
Q3/2017	970	65%	31%	4%
Q4/2017	1040	69%	22%	9%
Q1/2018	1213	82%	17%	1%
Q2/2018	1059	90%	10%	0%
Q3/2018	1088	87%	12%	1%
Q4/2018	1124	86%	14%	0%
Q1/2019	1068	88%	11%	1%
Q2/2019	1096	91%	8%	1%
Q3/2019	1071	95%	4%	1%
Q4/2019	915	93%	6%	1%

VIII. Trends in Data

A. Outreach and Education

Outreach for the KanCare Ombudsman Office went from 136 in 2018 to 82 in 2019 (8 in 4th quarter). This decrease in outreach is because staff duties were reprioritized starting in June due to loss of part-time person on loan to our office and staff turnover in the Wichita office. See pages 23-28.

B. Initial Contacts by Region (page 7)

Wichita is down significantly from 2018 in initial contacts. This is due mainly because of staff turnover in the summer of 2019 and extra calls were sent to the Topeka office. Once the new person was hired, there was a two-month training and mentoring process. This transition also resulted in less outreach in the southern part of Kansas, which we believe impacted these numbers as well.

C. Program Type (page 11):

Calls increased regarding the Technology Assistive HCBS wavier in 2019. The Ombudsman Office noted it in October of 2019. An email was sent to KDHE requesting a review of why there seemed to be an increase. KDHE found an error in processing the renewals and were able to fix it immediately. They are monitoring the TA waivers to verify that the issue does not reappear.

D. Category Issues (page 12 - 15):

Down trending Category Issues

- Medicaid Eligibility Issues is trending down
- Medicaid Status Updates is trending down.
- Appeal and Fair Hearing questions is trending down.
- The Ombudsman Office suggests, anecdotally, that these down trending issues are due to the downtrend in initial application issues during the 2019 year.

Up trending Category Issues:

- Medicaid Renewal issues are trending up for 2019. The Medicare Savings Plan and Pharmacy calls are also trending up and tend to be related to issues with renewals.
- KDHE has implemented several strategies to improve the renewal concerns. Fourth quarter renewal issues were significantly down compared to second and third quarter.

IX. Changes from the past year (Enhancements)

A. FAQs for Applications and FAQs for General KanCare.

The KanCare Ombudsman Office has created 27 frequently asked questions (FAQ) and answers about application assistance and other general KanCare questions. These questions are now a fact sheet and also a new page of resources on the KanCare Ombudsman web pages.

B. Website Updates:

1. Updates:
   - Updated Home and Community Based Services (HCBS) Fact Sheets;
     - After changes in policy and/or protected income limit changed.
   - Updated Grievance, Appeal and Fair Hearing Fact sheets
   - Updated the D-SNP (Dual Special Needs Program) Fact Sheet for 2020
   - Volunteer Recognition:
     - Changed Volunteer Recognition on the website to be based on years rather than hours.
   - Application Assistance Guide:
     - Continue to add names (and counties) to the list of organizations that will provide application assistance across the state. This list is to help provide more capacity for applicants of KanCare who need help with their applications. Now up to 65 counties covered with application assistance.

2. Additions:
   - Directory of Mental Health Resource by KDADS

C. Updated the Volunteer Agreement

Updated the formatting and wording for easier reading and still in line with KDADS requirements.

D. Pilot Survey to Track and Report Benefit of Services Provided

Wichita State University/Community Engagement Institute (WSU CEI)/Ombudsman staff devised a brief survey in an effort to track and report the benefit of their services. Throughout December, KanCare Ombudsman volunteers and staff concluded their calls by asking, "Would you call the Ombudsman's Office again if you needed help?" The volunteer and staff each made tally marks and notes in their own copy of the table similar to the one below.

Callers' responses are collated below. Response was positive, which confirmed staff's general expectations. This valuable data indicates the satisfaction with and potential ongoing need for these services.

Would you call the Ombudsman's Office again if you needed help? *(Tally marks)*		*BRIEFLY list the area of caller's concern (1-3 words if possible)*
YES	36	(areas listed include: Application assistance, Status of application, Address update, Eligibility, Working Healthy issues, PACE, NF application, Disability, Pregnancy, Division of Assets, Grievance, Spend down, Intervention for child)
NO		
Declined to Answer	1	("Non-functioning phone")
Did Not Ask	9	("Left message," "forgot," or no note)

WSU CEI staff also monitored volunteer reaction at being tasked with posing this question at the end of every call. Reaction ranged from indifference to very negative.

The plan going forward is to have the Olathe and Topeka offices also do the survey once we are back up to full staffing.

E. Improvements in Data Reporting

- More options for tracking member contacts.
- Added more options in program type
- Moved Issues Category to three sections for easier tracking and reporting
- Added a few reports so the data is pulled through the system rather than keeping the numbers on a spreadsheet.
- Added Priorities for data tracking purposes as well as tracking members that need to be prioritized. (HCBS, LTC, Urgent Medical Need, Urgent and Life Threatening.)

X. Appendix A – Outreach by Ombudsman's Office

A. Outreach through Collaboration and Education

- Contacted the Peace and Social Justice Center on 1/3/19 to request they hang our outreach flier.
- Met with Aetna advocates to share about the KanCare Ombudsman program and communication process; 1/3/19
- Participated in the KanCare Long Term Care Team meetings (monthly)
- Participated in the Monthly Joint MCO meetings (monthly)
- Participated in the KanCare Steering Committee meetings (monthly)
- Shared information regarding where to find updated Liaison Training information, and a reminder of the Aetna change at the United Way Emergency Assistance Network Meeting on 1/15; Approximately 20 attendees
- Presented KanCare Ombudsman program overview to the House Health and Human Services Committee; 1/29/19
- Cheyenne County Health Dept. – Flyer posted (County: Cheyenne) (January 2019)
- Norton County Health Department – Flyer posted (County: Norton) (January 2019)
- Osborne County Health Department – Flyer posted (County: Osborne) (January 2019)
- Rawlins County Health Department – Flyer posted (County: Rawlins) (January 2019)
- Presented KanCare Ombudsman program overview to the Senate Public Health and Welfare Committee; 2/5/19
- Presented KanCare Ombudsman Annual Report to the Bob Bethell Joint Committee on HCBS and KanCare; 2/15/19
- Presented to the Sedgwick County Advisory Council on Aging on 2/27/19 over our office and our volunteer opportunities.
- Dropped off Spanish KanCare Ombudsman flyers at Treehouse as well as information about our volunteer program
- Tabled on 2/27/19 at the WSU Health Fair; Approximately 150 passers-by
- Presented to Chisholm Place Assisted Living Center about the Ombudsman's Office, gave information about the FE Waiver and the KanCare application process on 3/26/19 from 6 p.m. to 8 p.m.; 25 attendees
- Participated in the Kansas Meaningful Measures meeting; 3/1/19
- Deaf and Hard of Hearing Day at the Capital (resources only); 3/5/19 (Topeka, KS)

- 4/3/19 (Manhattan, KS): Governor's Public Health Conference – Outreach event for Public Health Departments and Nurses; vendor table with resources
- 4/13/19 (Wichita KS): presented to the Caregiver Support Group about services and volunteer program at Ascension Lutheran Church.
- 4/13/19 (Wichita KS): attended Medical Mission at Home to provide information about our services at Mueller Magnet Elementary School.
- 4/17/19 (Wichita KS): presented about services and gave information about program to the director of The Senior Information Series at Botanica at WSU CEI.
- 4/22/19 (Hays) All MCO provider Training; vendor table with resources
- 4/23/19 (Dodge City) Area Agency on Aging Health Fair; vendor table with resources
- 4/23/19 (Wichita) All MCO Provider Training; vendor table with resources
- 4/23/19 (Horton, KS): Kickapoo Health Fair; vendor table with resources
- 4/24/19 (Olathe, KS): PD and FE Waiver Public Comment Sessions; available to answer questions
- 4/24/19 (Wichita KS): tabled and provided information about our office at the MCO Provider Training in at the Wichita Eugene M. Hughes Metroplex.
- 4/25/19 (Wichita KS): tabled and provided information about office at the Waiver Renewal Stakeholder Engagement Sessions at the Eugene M. Hughes Metroplex.
- 4/29/19 (Topeka) Bob Bethell Joint Committee on HCBS and KanCare; provided testimony and first quarter report.
- 5/1/19 (Olathe, KS) All MCO Provider Training; vendor table with resources.
- 5/6/19 (Topeka) KanCare Advisory Council Meeting; provided overview of first quarter report
- 5/30/19 (Wichita, KS): Wichita Bridge Center, Parklane- Outreach Opportunity
- 6/11/19 (Greensburg) Post-Legislative Stakeholder Meeting; available to answer questions if needed.

This outreach includes Community Events/Presentations such as education, networking and referrals.

- Midwest Ability Summit - event booth (Overland Park, KS) 8/24/19)
- KU Volunteer Fair – event booth (Lawrence, KS) (8/26/19)
- Together We Can Learn event booth (Overland Park, KS) (9/28/19)
- Kansas Midwest Ability Summit - event booth (Overland Park, KS) (8/24/19)

- Community Block Party at The Center – event booth (9/7/19) (Wichita)
- Ascensions HOPE Via Christi PACE facility tour- networking and PACE presentation (Wichita, KS) (10/24/19)
- United Way Emergency Assistance Providers mtg (Wichita, KS) (11/19/19)
- Center for Child Health & Development – Gave them brochures to pass out to families (English and Spanish)
- Via Christi HOPE (Wichita PACE Center) – Presentation of KanCare Ombudsman Office and our role (10/24/2019) (we also toured their facility and learned their role as well.)

B. Outreach through Publications

- Sedgwick County League of Women's Voters (1/3/19)
- Sedgwick County Advisory Council on Aging (1/3/19)
- Paul University Parish of Wichita (1/10/19)
- The Seed Church of Wichita (1/10/19)
- Community Service Board Volunteer Fair on Wichita State University's campus (1/29/19)
- All Department for Children and Families (DCF) offices throughout Kansas display outreach information on their lobby televisions, for those consumers in the waiting rooms (1/31/19).
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (1-3/2019)
- Unitarian Universalist Social Justice Group (3/4/19)
- Aldersgate United Methodist Volunteer Group (3/4/19)
- St. Anne Peace and Social Justice Group (3/4/19)
- WSU Psychology Department Chair (3/6/19)
- WSU Sociology Department Chair (3/6/19)
- Newman University Psychology Department Chair (3/6/19)
- Newman University Sociology Department Chair (3/6/19)
- Newman University Allied Health Department Chair (3/6/19)
- Newman University Social Work Field Education Coordinators (3/6/19)
- WSU Marketing Department Chair (3/25/19)
- Butler County Community College Marketing Department Chair (3/25/19)
- Newman Marketing Department Chair (3/25/19)
- WSU Shocker Student Marketing (3/25/19)
- Butler County Community College Sociology and Social Work Department Chair (3/25/19)
- Outreach Flyer Posted in Libraries (1-3/19):

- Olathe Public Library (Johnson, Co.) (1-3/2019)
    - Rawlins Co.
    - Smith Center Co.
    - Norton Co.
    - Rush Co.
    - Thomas Co.
    - Cheyenne Co.
    - Decatur Co.
    - Sheridan Co.
    - Graham Co.
    - Wallace Co.
    - Logan Co.
    - Trego Co.
    - Phillips Co.
    - Rooks Co.
    - Ellis Co.
    - Russell Co.

- Mailed an introductory letter and KanCare Ombudsman brochures (English and Spanish) to 130 Community Based Organizations (Aging and Disability Resource Centers, Community Developmental Disability Organizations, Centers for Independent Living, Families Together, Long Term Care Ombudsmen, Community Mental Health Centers, Senior Health Insurance Counselors of Kansas, Veterans Association Counselors.)
- All DCF offices throughout Kansas continue to display our outreach post on their lobby televisions, for those consumers in the waiting rooms.
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (4-6/19)
- **<u>Outreach Flyer Continue to be Posted in Libraries:</u>**
    1. Olathe Public Library (Johnson, Co.)
    2. Rawlins Co.
    3. Smith Center Co.
    4. Norton Co.
    5. Rush Co.
    6. Thomas Co.
    7. Cheyenne Co.
    8. Decatur Co.
    9. Sheridan Co.
    10. Graham Co.
    11. Wallace Co.
    12. Logan Co.
    13. Trego Co.
    14. Phillips Co.
    15. Rooks Co.
    16. Ellis Co.
    17. Russell Co.
- Outreach through Social Media
    - KanCare Ombudsman Facebook page, (Counties: All), KanCare Advisory Council Meeting (6/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Volunteer flier (7/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Clearinghouse info. (7/22/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Get to Know Kerrie, (7/18/19)

    - KanCare Ombudsman Facebook page, (Counties: All), Summer Food Program info. (5/21/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Lyme Disease, (5/21/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Directory of Mental Health Resources info. (5/10/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Long Term Care Ombudsman info. (5/2/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Inclusive family center info. (5/2/19)
    - KanCare Ombudsman Facebook page, (Counties: All), KDADS Physical Disability Waiver Renewal Public Comment Presentation, (5/2/19)
    - KanCare Ombudsman Facebook page, (Counties: All), KDADS Frail Elderly Waiver Renewal Public Comment, (5/2/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Butler County Spring Fling, (4/1/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Sedgwick County Developmental Disability Organization (SCDDO): Community County Informational Meeting, (4/10/19)
    - KanCare Ombudsman Facebook page, (Counties: All), WSU Student Health Services, (4/10/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Critical Condition: Stories of Health in the Heartland Premiere, (4/12/19)
    - KanCare Ombudsman Facebook page, (Counties: All), SCDDO: Community County Informational meeting, (4/17/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Senior Expo-Dodge City, (4/24/19)
    - KanCare Ombudsman Facebook page, (Counties: All), Frail Elderly (FE) Waiver Meeting, (4/24/19)
    - KanCare Ombudsman Facebook page, (Counties: All), HCBS Physical Disability Waiver Renewal meeting, (4/24/19)
- Provided brochures and applications to two Wichita community organizations (August 2019)
- Facebook posts on the KanCare Ombudsman Facebook approximately 1-2 a week during quarter.
- Golden Years Newspaper (Counties: Franklin, Osage, Anderson, Linn, Coffey) (10-12/19)
- Facebook site redesign and posting; Post engagement increased by 3,367%.

C. Outreach through Collaboration and Training

- Trained providers in Butler County on general Medicaid information, and how the Ombudsman Office can serve them on 1/17/19; 37 attendees.
- Trained social workers at Harry-Hynes Memorial Hospice on general Medicaid information, and how the Ombudsman Office can assist on 1/23/19; 8 attendees
- Liaison Training; Great Bend, KS (Barton Co.): Kansas Guardianship Program (1/10/19)
- Liaison Training; Colby, KS (Thomas Co.): Citizens Medical Center (2/13/19)
- Indian Creek Volunteer Fair (Olathe, KS) (2/1/19)
- Atchison Senior Living (training was done in Olathe, KS due to weather – broke up the Atchison training into two classes) (2/27/19)
- Atchison Senior Living (Atchison, KS) (3/12/19)
- Kansas City, KS (Wyandotte Co.): "Are you Ready for the Golden Years?" presented by Bethel SDA Church, (Invited to be on panel answering questions to the public on Medical Assistance) (4/14/19)
- Topeka: Community Developmental Disability organization (CDDO) Quarterly Business Meeting; provided an overview of the KanCare Ombudsman Office (5/16/19)
- Wichita: Positive Aging Day WSU Event; presentation. (6/18/19)
- Participating in MCO Training- event booth (Olathe, KS 7/16/19) (Wichita, KS 7/10/19)
- KanCare Application Training - Victory Hills Assisted Living (Kansas City, KS) (8/22/19)
- Medicaid Liaison Training; Marion County Department on Aging and other community organization staff members from surrounding counties; 7/30/19 (Newton, KS) (Harvey Co.) (In-person training):
- Medicaid Liaison Training; Cloud Co. Health Dept. and other community organization staff members from surrounding counties; 8/1/19 (Concordia, KS) (Cloud Co.) (In-person training)
- Medicaid Liaison Training; Phillips County Retirement Center and other community organization staff members from surrounding counties; 9/6/19 (Phillipsburg, KS) (Phillips Co.) (In-person training)
- Kansas Conference on Poverty - event booth (Topeka, KS) (7/17/19 & 7/18/19)
- Manhattan (Riley Co.) (In-person training): Via Christi Manhattan Group of Social Workers and other community organization staff members from surrounding counties. (10/16/19)
- Participating in United Way of the Plains Monthly meeting of Community Emergency Assistance Providers- (Wichita, KS- 10/15/19)

XI. Appendix B – Data by MCO

A. Aetna

HCBS/LTSS ISSUES	2019
Client Obligation	9
Estate Recovery	0
HCBS Eligibility issues	18
HCBS General Issues	25
HCBS Reduction in hours of service	1
HCBS Waiting List	3
Nursing Facility Issues	6
HCBS/LTSS ISSUES TOTAL	**62**
MEDICAID ISSUES	**2019**
Access to Providers (usually Medical)	13
Appeals/Fair Hearing questions/issues	2
Background Checks	0
Billing	12
Care Coordinator Issues	19
Change MCO	11
Choice Info on MCO	6
Coding Issues	3
Consumer said Notice not received	1
Cultural Competency	0
Data Requests	0
Dental	7
Division of Assets	1
Durable Medical Equipment	5
Grievances Questions/Issues	11
Help understanding mail (NOA)	0
MCO transition	3
Medicaid Application Assistance	6
Medicaid Eligibility Issues	19
Medicaid Fraud	0
Medicaid General Issues/questions	46
Medicaid info (status) update	14
Medicaid Renewal	18
Medical Card issues	0
Medicare Savings Plan Issues	6
MediKan issues	0
Moving to / from Kansas	2
Medical Services	14
Pain management issues	1
Pharmacy	10
Pregnancy issues	0
Prior authorization issues	0
Refugee/Immigration/SOBRA issues	0
Respite	0
Spend Down Issues	9

Transportation	13
Working Healthy	0
MEDICAID ISSUES TOTAL	**252**
OTHER ISSUES	**2019**
Abuse / neglect complaints	0
ADA Concerns	0
Adoption issues	0
Affordable Care Act Calls	0
Community Resources needed	0
Domestic Violence concerns	0
Foster Care issues	0
Guardianship	0
Homelessness	0
Housing Issues	1
Medicare related Issues	7
Social Security Issues	3
Used Interpreter	0
X-Other	28
Z Thank you	108
Z Unspecified	8
Health Homes	0
OTHER ISSUES TOTAL	**155**
PROGRAM TYPE	**2019**
PD	8
I/DD	8
FE	8
AUTISM	0
SED	3
TBI	9
TA	6
WH	0
MFP	0
PACE	0
MENTAL HEALTH	2
SUB USE DIS	0
NURSING FACILITY	5
FOSTER CARE	0
MEDIKAN	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0
INSTITUTIONAL TRANSITION FROM MH/BH	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0
PROGRAM TYPE TOTAL	**49**

B. Sunflower

HCBS/LTSS ISSUES	2017	2018	2019
Client Obligation	17	13	6
Estate Recovery	1	0	0
HCBS Eligibility issues	29	24	20
HCBS General Issues	23	32	30
HCBS Reduction in hours of service	3	2	3
HCBS Waiting List	3	1	4
Nursing Facility Issues	4	4	2
HCBS/LTSS ISSUES TOTAL	**80**	**76**	**65**
MEDICAID ISSUES	**2017**	**2018**	**2019**
Access to Providers (usually Medical)	12	13	14
Appeals/Fair Hearing questions/issues	2	9	4
Background Checks	0	1	0
Billing	23	22	19
Care Coordinator Issues	10	6	15
Change MCO	3	9	4
Choice Info on MCO	0	1	3
Coding Issues	6	15	7
Consumer said Notice not received	0	10	0
Cultural Competency	0	0	1
Data Requests	0	0	0
Dental	3	8	2
Division of Assets	0	1	0
Durable Medical Equipment	5	4	0
Grievances Questions/Issues	17	16	16
Help understanding mail (NOA)	0	0	0
MCO transition	0	0	0
Medicaid Application Assistance	6	5	4
Medicaid Eligibility Issues	49	42	32
Medicaid Fraud	0	2	0
Medicaid General Issues/questions	0	46	40
Medicaid info (status) update	0	26	25
Medicaid Renewal	25	17	26
Medical Card issues	0	0	1
Medicare Savings Plan Issues	1	7	4
MediKan issues	0	0	0
Moving to / from Kansas	1	1	1
Medical Services	14	11	15
Pain management issues	0	0	1
Pharmacy	8	7	10
Pregnancy issues	0	0	2
Prior authorization issues	0	0	0
Refugee/Immigration/SOBRA issues	0	0	0
Spend Down Issues	13	7	8
Transportation	9	6	7
Working Healthy	0	3	2
MEDICAID ISSUES TOTAL	**207**	**295**	**263**

OTHER ISSUES	2017	2018	2019
Abuse / neglect complaints	0	3	1
ADA Concerns	0	0	0
Adoption issues	0	0	0
Affordable Care Act Calls	1	1	1
Community Resources needed	0	0	0
Domestic Violence concerns	0	0	0
Foster Care issues	0	0	0
Guardianship	1	3	0
Homelessness	0	0	0
Housing Issues	3	3	0
Medicare related Issues	2	8	2
Social Security Issues	1	2	0
Used Interpreter	0	0	0
X-Other	63	40	28
Z Thank you	109	166	115
Z Unspecified	4	7	10
Health Homes	0	0	0
OTHER ISSUES TOTAL	**184**	**233**	**157**
PROGRAM TYPE	**2017**	**2018**	**2019**
PD	31	31	16
I/DD	34	15	15
FE	18	9	13
AUTISM	2	1	1
SED	1	2	1
TBI	4	7	8
TA	5	2	4
WH	1	3	2
MFP	1	1	0
PACE	0	0	0
MENTAL HEALTH	2	0	0
SUB USE DIS	0	0	0
NURSING FACILITY	16	8	3
FOSTER CARE	0	0	0
MEDIKAN	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	1
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0
PROGRAM TYPE TOTAL	**115**	**79**	**64**

C. UnitedHealthcare

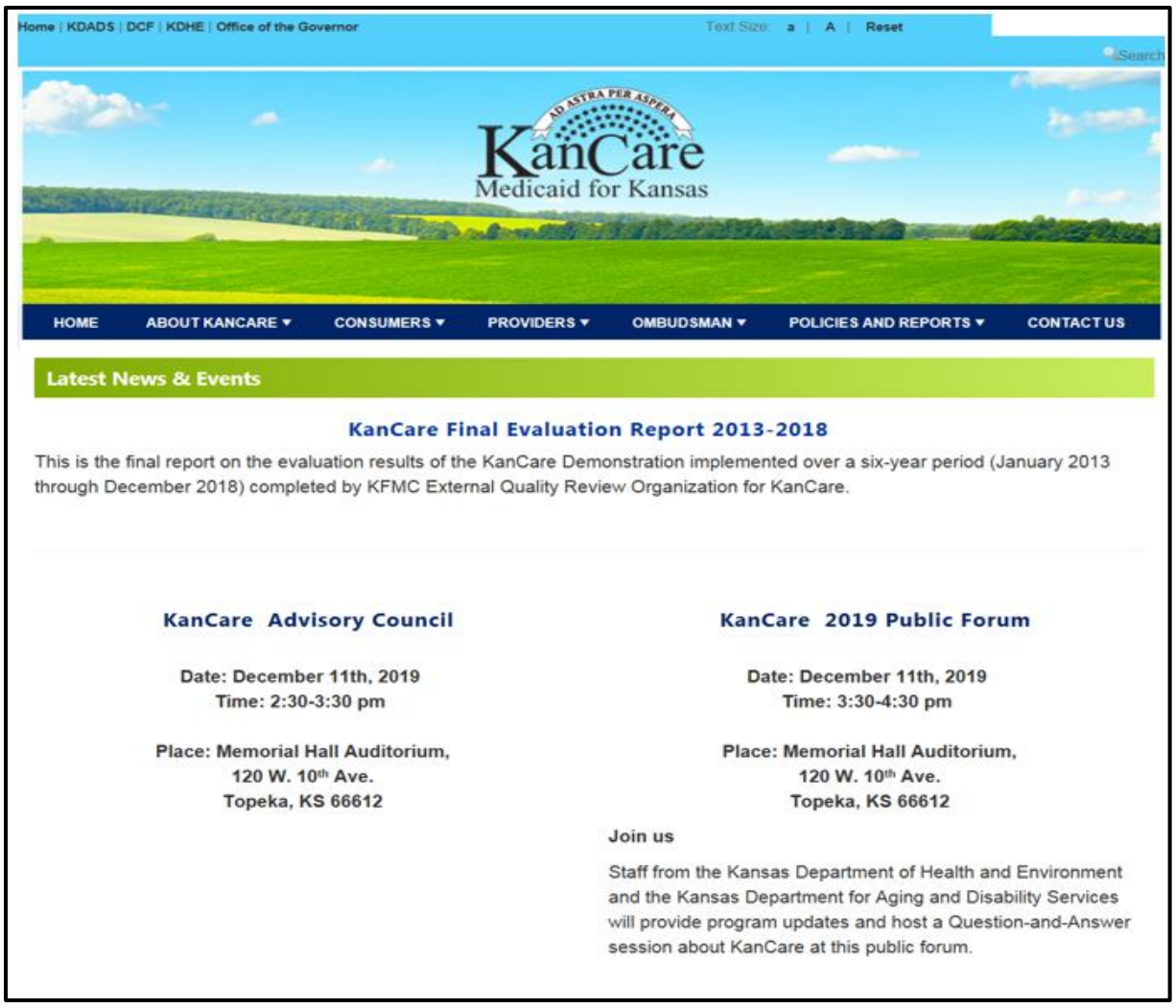
HCBS/LTSS ISSUES	2017	2018	2019
Client Obligation	12	23	5
Estate Recovery	1	0	1
HCBS Eligibility issues	25	17	10
HCBS General Issues	16	34	28
HCBS Reduction in hours of service	4	1	3
HCBS Waiting List	0	3	5
Nursing Facility Issues	7	9	8
HCBS/LTSS ISSUES TOTAL	**65**	**87**	**60**
MEDICAID ISSUES	**2017**	**2018**	**2019**
Access to Providers (usually Medical)	8	0	10
Appeals/Fair Hearing questions/issues	5	13	3
Background Checks	0	0	1
Billing	13	20	10
Care Coordinator Issues	9	15	10
Change MCO	6	6	8
Choice Info on MCO	0	2	1
Coding Issues	3	6	5
Consumer said Notice not received	0	3	2
Cultural Competency	0	0	0
Data Requests	0	1	0
Dental	6	3	5
Division of Assets	1	1	0
Durable Medical Equipment	5	1	5
Grievances Questions/Issues	10	10	10
Help understanding mail (NOA)	0	0	0
MCO transition	0	0	0
Medicaid Application Assistance	4	15	2
Medicaid Eligibility Issues	42	44	24
Medicaid Fraud	0	1	0
Medicaid General Issues/questions	0	39	44
Medicaid info (status) update	0	19	25
Medicaid Renewal	14	19	14
Medical Card issues	0	0	2
Medicare Savings Plan Issues	1	7	1
MediKan issues	0	0	1
Moving to / from Kansas	0	2	0
Medical Services	8	18	3
Pain management issues	0	1	2
Pharmacy	4	8	9
Pregnancy issues	0	0	0
Prior authorization issues	0	0	1
Refugee/Immigration/SOBRA issues	0	0	0

Respite	0	1	0
Spend Down Issues	9	20	9
Transportation	7	10	5
Working Healthy	0	2	1
MEDICAID ISSUES TOTAL	**155**	**287**	**213**
OTHER ISSUES	**2017**	**2018**	**2019**
Abuse / neglect complaints	1	3	0
ADA Concerns	0	0	0
Adoption issues	0	0	0
Affordable Care Act Calls	0	0	0
Community Resources needed	0	0	0
Domestic Violence concerns	0	0	0
Foster Care issues	0	0	0
Guardianship	1	1	0
Homelessness	0	0	0
Housing Issues	1	1	1
Medicare related Issues	3	2	3
Social Security Issues	0	2	1
Used Interpreter	0	0	0
X-Other	57	25	22
Z Thank you	96	175	114
Z Unspecified	10	3	10
Health Homes	0	0	0
OTHER ISSUES TOTAL	**169**	**212**	**151**
PROGRAM TYPE	**2017**	**2018**	**2019**
PD	20	24	22
I/DD	22	13	17
FE	21	13	11
AUTISM	1	0	1
SED	1	6	3
TBI	5	5	3
TA	3	3	1
WH	0	4	0
MFP	0	0	0
PACE	0	0	0
MENTAL HEALTH	3	2	1
SUB USE DIS	0	0	0
NURSING FACILITY	16	12	10
FOSTER CARE	0	0	0
MEDIKAN	0	0	1
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0
PROGRAM TYPE TOTAL	**92**	**82**	**71**

Summary of Annual KanCare Post Award Forum Held 12.11.19

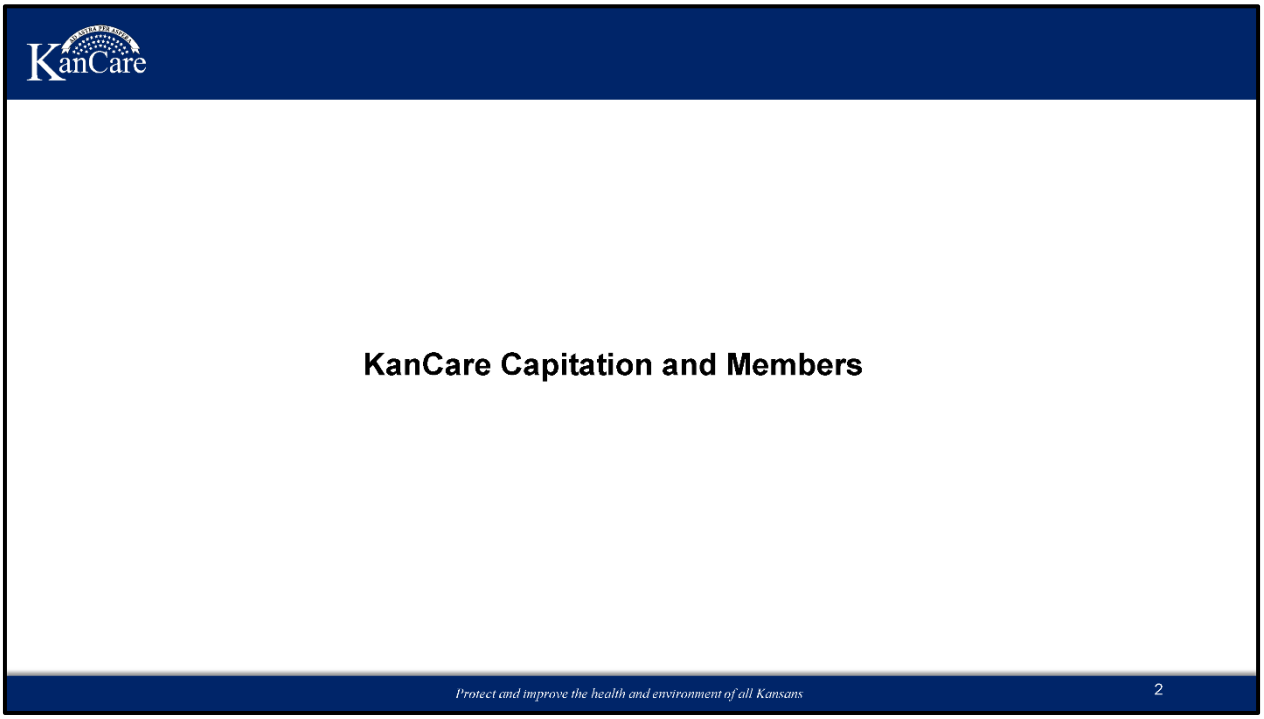
The KanCare Special Terms and Conditions, at item #71, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC64a, associated with the quarter in which the forum was held. The state must also include the summary of its annual report.

Consistent with this provision, Kansas held its 2019 KanCare Public Forum, providing updates and opportunity for input, on Wednesday, December 11, 2019, from 3:30-4:30 pm at Memorial Hall Auditorium, 120 SW 10th Ave., Topeka, Kansas. The forum was published on the face page of the www.KanCare.ks.gov website, starting in October 2019. A screen shot of the notice from the KanCare website face page is as follows:



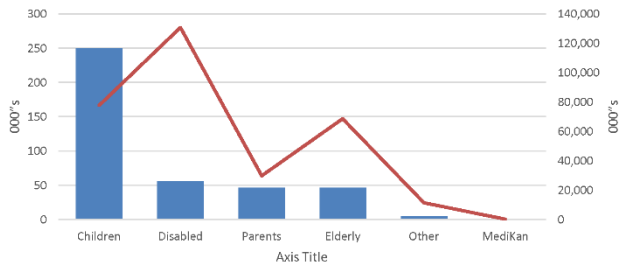
At the public forum, approximately 20 KanCare program stakeholders (providers, members, and families) attended, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; and staff from the KanCare managed care organizations. A summary of the information presented by state staff is included in the following PowerPoint documents:

KDHE:



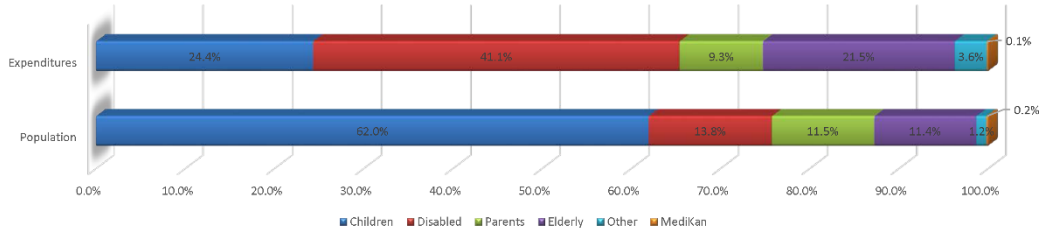
Medicaid/CHIP Member Eligibility and Expenditures

Calendar Year 2019 (Jan - Sep)



	% Total	
	Population	Expenditures
Children	62.0%	24.4%
Disabled	13.8%	41.1%
Parents	11.5%	9.3%
Elderly	11.4%	21.5%
Other	1.2%	3.6%
MediKan	0.2%	0.1%

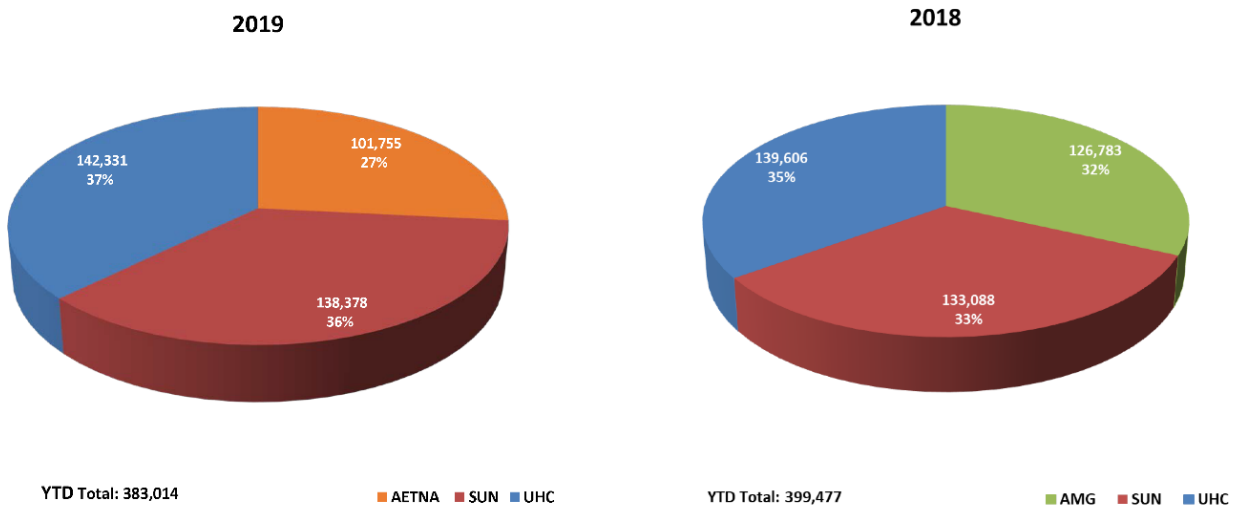
Eligibility and Expenditure Comparison



Capitation Comparison with Members YTD CY 2019 (Jan - Sep)

*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assisted, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities, Money Follows the Person Frail Elderly and Physically Disabled, and the Physically Disabled and Frail Elderly Waivers

Average Members by MCO YTD



KanCare Provider Network

Provider Network

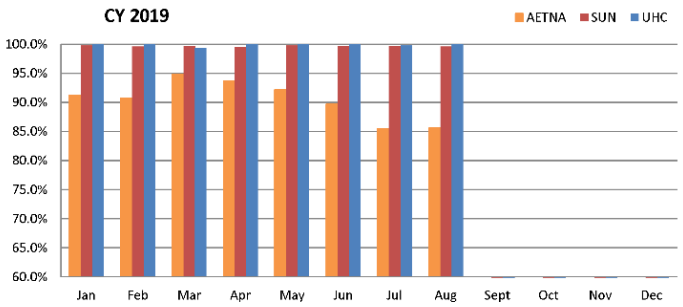
KanCare MCO	# of Unique Provider/ Locations as of 12/31/18*	# of Unique Provider/ Locations as of 03/31/19*	# of Unique Providers as of 6/30/19	# of Unique Provider/ Locations as of 9/30/19
Aetna	N/A	17,724	21,603	32,598
Sunflower	31,998	35,139	35,188	30,258**
UHC	39,799	41,701Δ	46,285	48,809

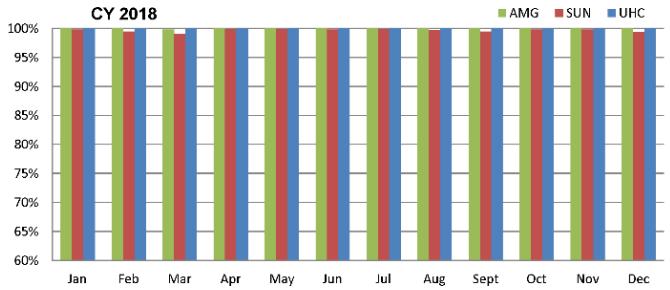
**3Q 2019 MCO terminated all network providers who do not have an active KMAP ID
*Changes to MCO reporting implemented in Q3-2018 now provide more complete HCBS provider counts. Specifically, for providers who travel to the member for services, the count now includes a count of each county in which a provider is contracted to provide services.
Δ May not include full county counts for 588 home-based service providers for whom incomplete data was received.

Note: The counts below represent the unique number of NPIs—or, where NPI is not available—provider name and service locations (based on the KanCare county designation identified in the KanCare Code Guide). This results in counts for the following:
Providers with a service location in a Kansas county are counted once for each county.
Providers with a service location in a border area are counted once for each state in which they have a service location that is within 50 miles of the KS border.
Out of state providers (>50 miles from KS border) are counted once.
Providers for services provided in the home are counted once for each county in which they are contracted to provide services.

KanCare Claims Overview

Claims Data-% Clean Claims Processed Within 30 days



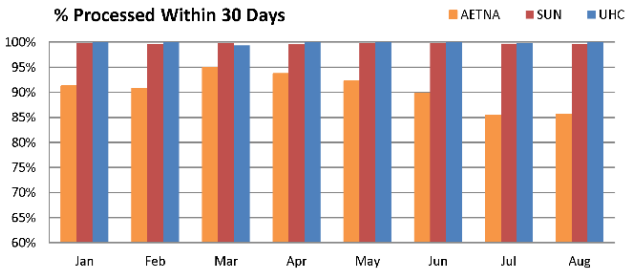


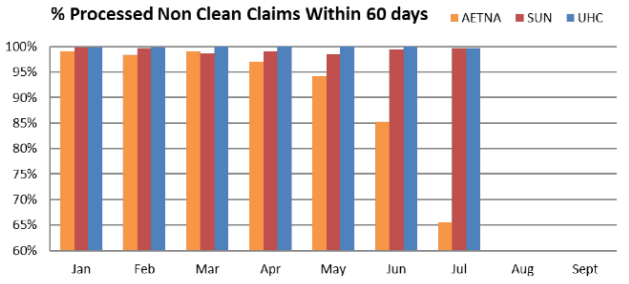
Claims Processed 2019 (Jan-Sept)	Total Claim Count			Total Claim %		
Service Type	**AETNA**	**SUN**	**UHC**	**AETNA**	**SUN**	**UHC**
Pharmacy	1,430,790	1,827,846	1,421,573	43.0%	36.8%	33.0%
Medical	1,192,123	1,316,197	1,275,110	35.9%	26.5%	29.6%
Behavioral Health	153,489	591,209	556,511	4.6%	11.9%	12.9%
HCBS	197,513	496,974	358,000	5.9%	10.0%	8.3%
Hospital Outpatient	149,726	264,262	257,657	4.5%	5.3%	6.0%
NEMT	58,463	129,531	142,297	1.8%	2.6%	3.3%
Dental	85,469	129,457	126,575	2.6%	2.6%	2.9%
Nursing Facilities-Total	38,031	101,029	79,972	1.1%	2.0%	1.9%
Vision	6,618	85,238	62,212	0.2%	1.7%	1.4%
Hospital Inpatient	11,943	29,951	22,774	0.4%	0.6%	0.5%
Total All Services	**3,324,165**	**4,971,694**	**4,302,681**	**100%**	**100%**	**100%**

Contact Standard: 100% of Clean Claims Processed within 30 days

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, 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 (these claims may be pended until rates are loaded so the appropriate amounts can be paid)
Percent = Number clean claims processed within 30 days divided by Number of claims received
Processed = adjudication decision making of a claim being approved to paid or denied.

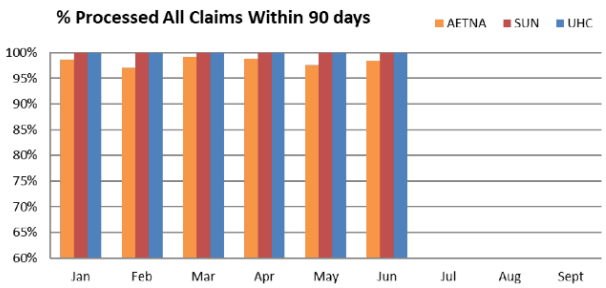
Claims Data-% Clean Claims Processed Within 30 days





Contact Standard: 100% of Clean Claims Processed within 30 days

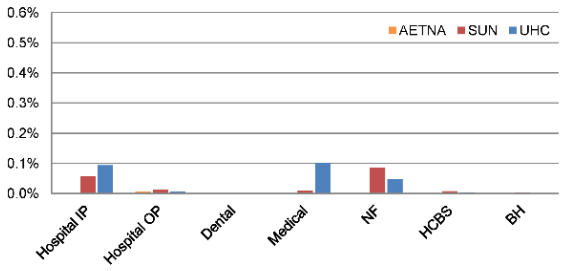
A clean claim is a claim that can be paid or denied with no additional intervention required and does **not** include: Adjusted or corrected claims, Claims that require documentation (i.e., consent forms, medical records) for processing, Claims from out-of-network providers that require research and setup of that provider in the system, 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 (these claims may be pended until rates are loaded so the appropriate amounts can be paid)
Percent = Number clean claims processed within 30 days divided by Number of claims received
Processed = adjudication decision making of a claim being approved to paid or denied.



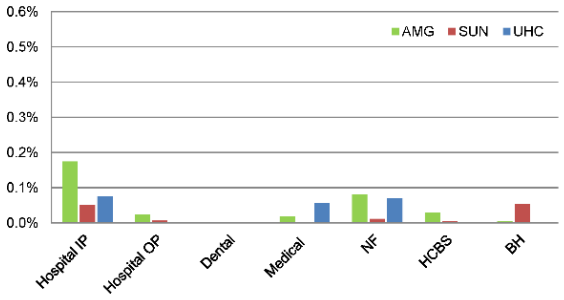
Timely Claims Processing Standard- 100% of clean claims are processed within 30 calendar days; 99% of all non clean claims are processed within 60 calendar days; 100% of all claims are processed within 90 calendar days

Claims Data-Percent of Claims Adjusted more than 3 times

CY 2019 (Jan-Sept)



CY 2018 (Jan-Dec)

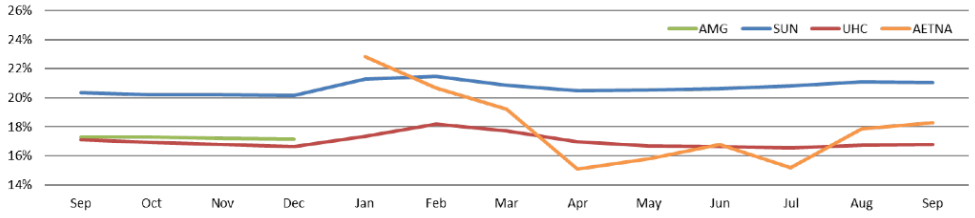


YTD claim requiring adjustments greater than 3 times represents Accuracy
Purpose: The purpose is to review payment accuracy
Methodology: Monitoring the frequency of the claims adjustments by MCO in each category utilizing the total claims adjusted/claims processed *(category provider type: Hospital Inpatient, Hospital Outpatient, Dental, Medical, Nursing Facilities, HCBS, BH). Pharmacy, Vision and NEMT Have had 0% adjustments over 3 times for over one year so have been dropped from this report.* Pharmacy is point of sale processing so will not have adjustments

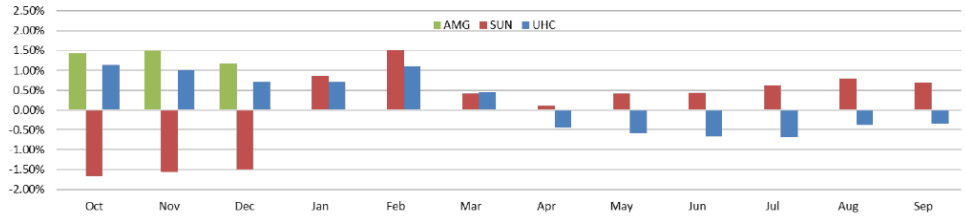
Total YTD claims adjusted 4 or more times divided by the YTD total number of claims processed by service type.

Claims Denial Data CY 2018-19

Percent Denied Claims by Month YTD Cumulative



Percentage Point Increase/Decrease From Previous Year

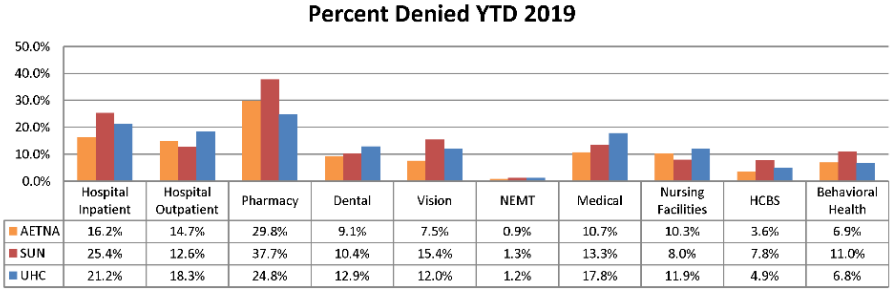


Claims Denial Data

Claims Processed 2019 (Jan-Sept)	Total Claim Count			Total Claim %		
Service Type	AETNA	SUN	UHC	AETNA	SUN	UHC
Pharmacy	1,430,790	1,827,846	1,421,573	43.0%	36.8%	33.0%
Medical	1,192,123	1,316,197	1,275,110	35.9%	26.5%	29.6%
Behavioral Health	153,489	591,209	556,511	4.6%	11.9%	12.9%
HCBS	197,513	496,974	358,000	5.9%	10.0%	8.3%
Hospital Outpatient	149,726	264,262	257,657	4.5%	5.3%	6.0%
NEMT	58,463	129,531	142,297	1.8%	2.6%	3.3%
Dental	85,469	129,457	126,575	2.6%	2.6%	2.9%
Nursing Facilities-Total	38,031	101,029	79,972	1.1%	2.0%	1.9%
Vision	6,618	85,238	62,212	0.2%	1.7%	1.4%
Hospital Inpatient	11,943	29,951	22,774	0.4%	0.6%	0.5%
Total All Services	**3,324,165**	**4,971,694**	**4,302,681**	**100%**	**100%**	**100%**

Claims Processed 2019 (Jan-Sept)	Total Claim Count			Total Denied Claim			Total Claim Denied %		
Service Type	AETNA	SUN	UHC	AETNA	SUN	UHC	AETNA	SUN	UHC
Pharmacy	1,430,790	1,827,846	1,421,573	425,850	689,326	352,659	29.8%	37.71%	24.81%
Medical	1,192,123	1,316,197	1,275,110	127,052	175,629	226,771	10.7%	13.34%	17.78%
Behavioral Health	153,489	591,209	556,511	10,557	64,931	37,984	6.9%	10.98%	6.83%
HCBS	197,513	496,974	358,000	7,020	38,654	17,364	3.6%	7.78%	4.85%
Hospital Outpatient	149,726	264,262	257,657	22,044	33,301	47,094	14.7%	12.60%	18.28%
NEMT	58,463	129,531	142,297	497	1,634	1,728	0.9%	1.26%	1.21%
Dental	85,469	129,457	126,575	7,739	13,427	16,267	9.1%	10.37%	12.85%
Nursing Facilities-Total	38,031	101,029	79,972	3,926	8,062	9,545	10.3%	7.98%	11.94%
Vision	6,618	85,238	62,212	498	13,100	7,482	7.5%	15.37%	12.03%
Hospital Inpatient	11,943	29,951	22,774	1,933	7,595	4,817	16.2%	25.36%	21.15%
Total All Services	**3,324,165**	**4,971,694**	**4,302,681**	**607,116**	**1,045,659**	**721,711**	**18.26%**	**21.03%**	**16.77%**

Claims Denial Data



KanCare

KanCare Member Benefits

KanCare

Value Added Services - January- September 2019

Aetna	Members YTD	Total Units YTD	Total Value YTD
Adult Dental	958	1,407	$247,729
Transportation Services	123	439	$44,498
Weight Management	90	98	$12,898
Podiatry Visits	156	228	$7,321
Healthy Teens Membership	46	46	$1,610
GED Support	9	9	$1,188
Asthma Hypoallergenic Sheets	10	10	$70
Home-delivered meals	9	9	$63
Memory Care Locks	1	1	$34
TOTAL	1,403	2,248.0	$315,411
KanCare Grand Total	121,005	135,249	$2,705,555

Sunflower	Members YTD	Total Units YTD	Total Value YTD
Healthy Rewards	70,104	70,596	$735,894
Comprehensive Medication Review	5,451	7,798	$222,116
Dental visits for adults	1,431	2,165	$129,583
In-home telemonitoring: Service	340	340	$85,000
Farmers Market Vouchers	7,768	7,768	$77,680
Community Health Services Home Visiting Program	2,337	2,337	$61,089
Start Smart for Your Baby	1,987	2,109	$59,368
Smoking cessation program	246	246	$59,040
	496	1,633	$38,721
Caregiving Collaborations - Assessment Assistance	453	675	$24,098
Healthy Solutions for Life - Disease Management	10,124	10,124	$20,248
Dentures	13	19	$14,863
Boys & Girls Clubs	284	284	$14,200
NF-Community Transition	21	80	$5,617
Sunny's Kid Club	1,611	1,611	$4,978
Healthy Solutions for Life - Weight Management Program	1,969	1,969	$3,938
Employment - GED Test Vouchers	6	6	$3,344
In-home telemonitoring: Install	13	13	$2,275
Adopt-A-School Program	1	1	$225
Employment - Transportation	12	15	$162
Employment - Referral	12	12	$140
Enhanced Transportation for F/E & PD waiver members	2	3	$48
TOTAL	104,711	109,804	$1,562,628

United	Members YTD	Total Units YTD	Total Value YTD
Home Helper Catalog Supplies	3,345	9,536	$171,425
Baby Blocks Program and Rewards	1,026	1,026	$123,120
Debit Card for Completing First Pre-Natal Visit	587	587	$118,274
Adult Dental Services	2,389	2,669	$111,993
Adult Dentures	84	187	$79,156
Frames and Lenses	858	2,544	$77,197
UHC Health Rewards Program	3,066	3,066	$48,174
Membership to Youth Organizations	608	608	$27,760
Pest Control	74	74	$18,967
Respite Care Services	11	27	$15,662
Medications Calendar	1,907	1,907	$4,251
Seeking Safety Training Events	5	5	$4,025
Mental Health First Aid Program	21	24	$2,875
Transportation to WIC Appointments	27	54	$1,563
Sesame Street - Food For Thought	40	40	$1,400
MedicAlert Bracelets	79	79	$790
Adults Parks and Rec Catalog	8	8	$400
A is for Asthma	741	741	$371
Help Getting GED	15	15	$275
TOTAL	14,891	23,197	$827,516

In Lieu of Services January- September 2019

Aetna	Unduplicated Members	Value of Service Provided	Value of Services Avoided	Sunflower	Unduplicated Members	Value of Service Provided	Value of Services Avoided	United	Unduplicated Members	Value of Service Provided	Value of Services Avoided
Additional **Medicaid covered** services, beyond existing limitations, including personal care services, sleep cycle support, home modifications, equipment and assisted services … in lieu of members needing to be admitted to an acute care hospital or nursing facility	10	$119,719	$326,430	Additional personal care services, beyond existing waiver limitations… in lieu of members needing to be admitted to a nursing facility	73	$403,288	$1,113,459	Additional personal care services, personal care services, beyond existing waiver limitation, sleep cycle support, and home delivered meals … in lieu of members needing to be admitted to a nursing facility	45	$665,954	$1,588,000
Non-Covered services including private nurse, PET scans, CPAP equipment and sleep cycle support in lieu of members needing to access ICU, acute hospital, or nursing facility services	0	$0	$0	Non-Covered services covering a wide range of equipment, orthotics, testing, physician services and outpatient surgery in lieu of members needing to access acute hospital, home health, or more intensive physical or behavioral health services	32	$17,521	$819,095	Non-Covered services Sleep studies, testing, and home health in lieu of members needing to access to acute hospital, or nursing facility services	316	$1,605,503	$5,464,001
Totals	**10**	**$119,719**	**$326,430**	**Totals**	**105**	**$420,809**	**$1,932,554**	**Totals**	**361**	**2,271,457**	**$7,052,001**

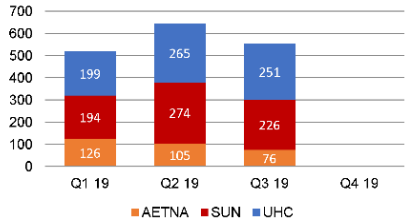
KanCare YTD Total

Unduplicated Members	Value of Service Provided	Value of Services Avoided
476	$7,592,529	$9,310,985

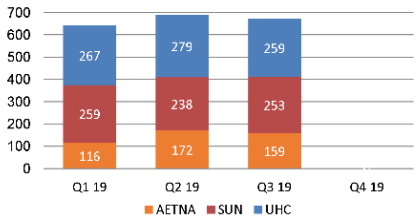
KanCare Grievance, Appeal and State Fair Hearing

Member Grievance and Appeals Comparison

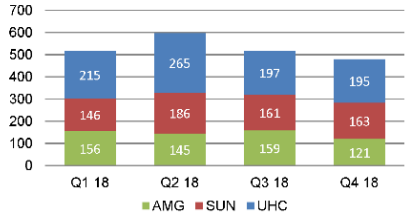
Member Grievances 2019



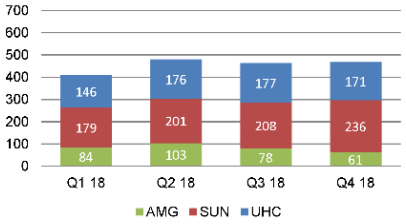
Member Appeals 2019



Member Grievances 2018

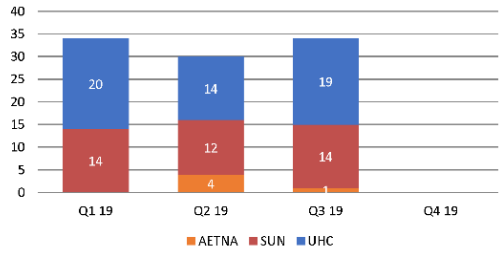


Member Appeals 2018

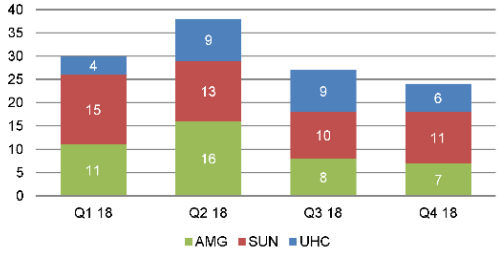


Member State Fair Hearing Comparison

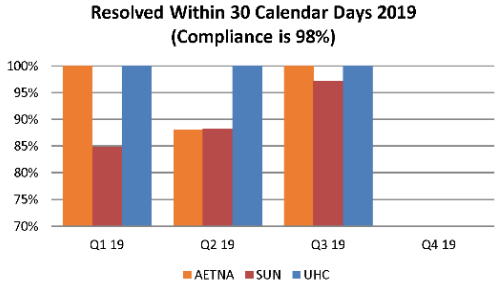
Member State Fair Hearings 2019

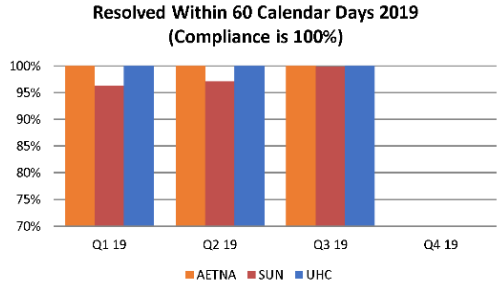


Member State Fair Hearings 2018



Provider Appeal Compliance





Protect and improve the health and environment of all Kansans

21

KDADS:


AD ASTRA PER ASPERA
KanCare
KanCare Public Forum
December 11, 2019


KanCare
HOME AND COMMUNITY BASED SERVICES (HCBS)
2
Protecting Kansans, Promoting Recovery, Supporting Self Sufficiency
Kansas

HCBS Waiver Enrollment – October

HCBS Program	Number of People Eligible to Receive HCBS Services	Number of People on Wait List	Number of Proposed Recipients
Autism	50		317 (as of 10/31/2019)
Serious Emotional Disturbance (SED)	3,240		
Technology Assisted (TA)	574		
Frail Elderly (FE)	4,775		
Brain Injury (BI)*	425		
Intellectual and Developmental Disabilities (I/DD)	9,019	4,021	
Physical Disability (PD)	5,882	1,576	

Notes:
- *Approved as BI waiver August 5, 2019
- Data as of November 7, 2019
- The HCBS Monthly Summary is posted under Monthly Waiver Program Participation Reports at http://kdads.ks.gov/commissions/home-community-based-services-(hcbs)

Current Efforts to Reduce the Waiting List

HCBS Program	Number of People Eligible to Receive HCBS Services	Number of People on Wait List	Offers
Intellectual and Developmental Disabilities (I/DD)	9,019	4,021	257 offers made YTD 2019
Physical Disability (PD)	5,882	1,576	1,394 offers made YTD 2019

2018 vs. 2019 Eligibility & Wait List

HCBS Program	Number of People Eligible to Receive HCBS Services		Number of People on Wait List	
	2018	2019	2018	2019
Intellectual and Developmental Disabilities (I/DD)	9,077	9,019	3,840	4,021
Physical Disability (PD)	5,823	5,882	1,645	1,576

*Compares October 2018 and October 2019 HCBS Monthly Summary Data

Efforts to Impact Kansas Waitlists

- KDHE and KDADS are working collaboratively on a Disability and Behavioral Health Employment Support Pilot Program.
- The pilot is designed to help 500 members obtain and maintain employment.
- The pilot will operate a voluntary pilot program for eligible KanCare members through the 1115 demonstration.
- The pilot will operate during the KanCare waiver period, with a possibility of renewal, if deemed effective.
- Members may be eligible for the pilot program depending on their eligibility group and financial eligibility:
  - Individuals eligible for SSI on a waiting list for HCBS may be eligible.
  - Individuals eligible for SSI who choose to leave HCBS may be eligible.
  - Individuals eligible for SSI or SSDI and determined disabled according to the Social Security Standards.

Waiver Renewal Listening Sessions

- As part of our commitment to increasing collaboration with stakeholders, KDADS has utilized the last three months to conduct listening sessions with participants, families, stakeholders and providers regarding the I/DD, PD, and FE Waivers.
- The sessions focused on the vision for the future of the 1915c waivers, as well as potential amendments to the current waivers to address stakeholder concerns.
- KDADS has also engaged a TA Waiver workgroup and an Autism services workgroup to evaluate the needs of participants receiving these services.

Waiver Renewal Listening Sessions (continued)

HCBS Waiver Listening Sessions

Date	Group Name	Location	No. of Attendees
July 31, 2019	Waiver Service Providers	Great Bend	10
July 31, 2019	Stakeholders/Participants	Great Bend	11
August 1, 2019	Waiver Service Providers	Garden City	15
August 1, 2019	Stakeholders/Participants	Garden City	17
August 2, 2019	Kansas Advocates Network	Topeka	22
August 29, 2019	Self-Advocates Coalition of Kansas	Topeka	15
September 11, 2019	Families for KanCare Reform	Lenexa	7
September 10, 2019	Community Developmental Disability Organizations (CDDOs)	Topeka	27
September 19, 2019	GRAIL	Topeka	2
September 25, 2019	Johnson County Developmental Services Stakeholders	Olathe	30
October 8, 2019	Self-Advocates of Lawrence	Lawrence	18
October 15, 2019	Stakeholders/Participants/Providers	Parsons	16
October 22, 2019	Cottonwood CDDO Affiliate Meeting	Lawrence	17

Waiver Renewal Listening Sessions (continued)

Throughout the listening sessions, stakeholders addressed many topics which could be grouped into several common themes:

- HCBS Waitlist Management and Transitions
- HCBS Waiver Services
- Employment and Workforce Issues
- Self-Direction and Self-Determination
- Transportation Issues
- Targeted Case Management
- Background Checks
- General KanCare or MCO-Related Issues

Brain Injury Waiver

- Kansas received formal approval on November 25, 2019 to expand the BI Waiver to include youth ages birth through 15 years. The amendment was effective December 1, 2019.
- Development of the functional assessment tool for youth ages 4 through 15 years is completed and is available for use.
- Children ages birth through 3 years will access the waiver via a physician order.

Protected Income Level Success Stories

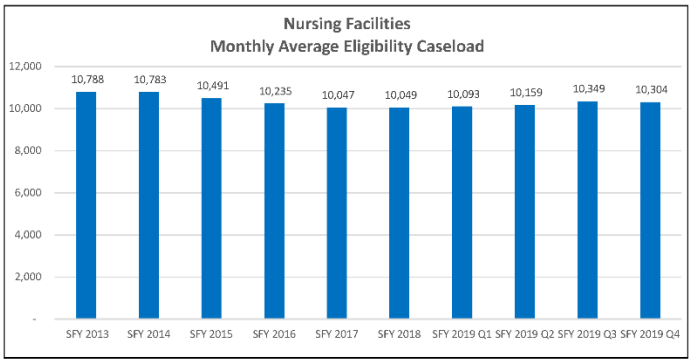
The change in the Protected Income Level has had a significant impact on HCBS waiver participants. A few examples of the letters we've received:

- "We could buy meat!"
- A participant reports that she'll now be able to eat more and pay off bills she hasn't been able to. She says this is going to lower her stress.
- "Because of the reduction, he can pay for some of the dental and medical that was not covered by insurance. He can afford to get shoes twice a year at $200 each time. They are special order…"

LONG-TERM CARE

Average Census for State Institutions and Long-Term Care Facilities

- The monthly Medicaid average eligibility caseload for nursing facilities has remained steady.



13 *Protecting Kansans, Promoting Recovery, Supporting Self Sufficiency*

After the presentations from both KDHE and KDADS, participants were offered the opportunity to present questions or comments for discussion. Most of the comments and questions were related to Aetna onboarding and Medicaid Expansion. Director Proffitt explained the work the agencies were completing on the new data warehouse. One stakeholder-advocate complained about the low attendance and that he had not received notice of the annual public forum. Director Proffitt explained the publication of the notice for the Public Forum on the KanCare website.

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7- YE 2019

DSRIP Payment

Paid dates 1/1/2019 through 12/31/2019

Provider Names	YE 2019 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	6,231,027	2,671,933	3,559,094
University of Kansas Hospital	16,073,437	6,814,813*	9,258,624
Total	22,304,464	9,486,746	12,817,718

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7- YE 2019

Health Care Access Improvement Pool

Paid dates 1/1/2019 through 12/31/2019

Provider Names	YE 2019 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
ADVENTHEALTH OTTAWA/RANSOM MEMORIAL	189,726	82,512	107,214
ASCENSION VIA CHRISTI HOSPITAL ST. TERESA INC	278,874	121,282	157,592
ASCENSION VIA CHRISTI REHABILITATION HOSPITAL	81,828	35,587	46,241
BOB WILSON MEMORIAL GRANT COUNTY HOSPITAL	97,111	42,234	54,877
CHILDRENS MERCY SOUTH	775,099	337,091	438,008
COFFEYVILLE REGIONAL MEDICAL CENTER INC	245,753	106,878	138,875
DOCTORS HOSPITAL LLC	10,712	4,659	6,053
GEARY COUNTY HOSPITAL	211,208	91,854	119,354
HAYS MEDICAL CENTER	784,868	341,339	443,529
HUTCHINSON REGIONAL MEDICAL CENTER INC	719,556	312,935	406,621
KANSAS HEART HOSPITAL LLC	39,527	17,190	22,337
KANSAS MEDICAL CENTER LLC *	28,789	12,679	16,110
KANSAS REHABILITATION HOSPITAL	7,474	3,250	4,224
KVC PRAIRIE RIDGE PSYCHIATRIC HOSPITAL	938	408	530
LABETTE CO MED	208,836	90,823	118,013
LAWRENCE MEMORIAL HOSPITAL	1,325,061	576,269	748,792
MCPHERSON HOSPITAL INC	136,478	59,354	77,124
MENORAH MEDICAL CENTER	624,290	271,504	352,786
MERCY HOSPITAL FORT SCOTT	29,877	12,994	16,883
MIAMI COUNTY MEDICAL CENTER INC	174,662	75,961	98,701
MORTON COUNTY HOSPITAL**	39,496	17,730	21,766
MORTON COUNTY HOSPITAL	92,417	40,192	52,225
NEWTON MEDICAL CENTER	549,339	238,908	310,431
OLATHE MEDICAL CENTER INC	908,570	395,137	513,433
OVERLAND PARK REG MED CTR	3,858,132	1,677,902	2,180,230
PRAIRIE VIEW HOSPITAL	3,476	1,512	1,964
PRATT REGIONAL MEDICAL CENTER CORPORTATION	138,503	60,235	78,268
PROVIDENCE MEDICAL CENTER	1,361,819	592,255	769,564
SAINT JOHN HOSPITAL	283,551	123,316	160,235
SAINT LUKES CUSHING HOSPITAL	244,962	106,534	138,428
SAINT LUKES SOUTH HOSPITAL INC	206,175	89,666	116,509
SALINA REGIONAL HEALTH CENTER	729,875	317,423	412,452
SALINA SURGICAL HOSPITAL**	2,849	1,279	1,570
SALINA SURGICAL HOSPITAL	7,632	3,319	4,313
SHAWNEE MISSION MEDICAL CENTER INC	2,366,062	1,029,000	1,337,062
SOUTH CENTRAL KANSAS REGIONAL MEDICAL CENTER	145,769	63,395	82,374
SOUTHWEST MEDICAL CENTER	283,090	123,116	159,974
ST CATHERINE HOSPITAL	983,069	427,537	555,532
STORMONT VAIL HEALTH CARE INC	5,006,938	2,177,517	2,829,421
SUMNER REGIONAL MEDICAL CENTER**	47,864	21,486	26,378
SUMNER REGIONAL MEDICAL CENTER	92,119	40,062	52,056
SUSAN B ALLEN MEMORIAL HOSPITAL	327,325	142,354	184,971
THE UNIVERSITY OF KANSAS HEALTH SYSTEM GREAT BEND	338,150	147,061	191,089
TOPEKA HOSPITAL LLC D/B/A THE UNIVERSITY OF KANSAS	1,792,232	779,442	1,012,790
VIA CHRISTI HOSPITAL MANHATTAN	918,016	399,245	518,771
VIA CHRISTI HOSPITAL PITTSBURG	917,279	398,925	518,354
VIA CHRISTI HOSPITALS WICHITA INC	6,329,759	2,752,812	3,576,947
WESLEY MEDICAL CENTER	6,639,529	2,887,531	3,751,998
WESLEY REHABILITATION HOSPITAL, AN AFFILIATE OF EN	39,940	17,370	22,570
WESTERN PLAINS MEDICAL COMPLEX	415,814	180,838	234,976
Grand Total	**41,040,418**	**18,423,043**	**22,617,374**

* DY 4 Payment

** DY 6 Payment

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 7- YE 2019

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

Paid dates 1/1/2019 through 12/31/2019

Hospital Name	YE 2019 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
CHILDRENS MERCY HOSPITAL	$ 1,848,102	$ 803,740	$ 1,044,362
UNIVERSITY OF KANSAS HOSPITAL AUTHORITY*	$ 5,544,309	$ 2,411,220	$ 3,133,089
Total	**$ 7,392,411**	**$ 3,214,960**	**$ 4,177,451**
*IGT funds are received from the University of Kansas Hospital			

State Of Kansas
Kansas Department of Health and Environment
Division of Health Care Finance
KanCare Annual Report
Demonstration Year 7
Calendar Year 2019

Population	Unduplicated Beneficiaries by Population	Member Months	Expenditures
Pop 1: ABD/SD Dual	21,756	179,791	$ 45,662,491
Pop 2: ABD/SD Non Dual	36,602	357,103	$ 445,989,832
Pop 3: Adults	66,344	551,553	$ 323,961,398
Pop 4: Children	259,425	2,427,978	$ 677,772,669
Pop 5: DD Waiver	9,488	108,594	$ 512,583,358
Pop 6: LTC	26,105	243,382	$ 1,044,677,885
Pop 7: MN Dual	4,394	16,125	$ 15,387,865
Pop 8: MN Non Dual	2,064	11,335	$ 22,480,930
Pop 9: Waiver	6,074	51,473	$ 163,368,995
Total	432,252	3,947,334	$ 3,251,885,422

Administration	$ 204,403,311

Overall Unduplicated Beneficiaries	415,433

Notes:
1. CHIP and MCHIP are excluded.
2. Enrollment data is updated through Mar 2020 capitation data.
3. Member months data is updated through Mar 2020 capitation data.
4. Expenditure data is updated through QE 12 31 2019.

2018 Pay-for-Performance Summary – Amerigroup 3/12/2020

MCO Data Sources						
HEDIS Measure		**2017**	**2018**	**Increase**	**≥50th QC?**	**Target Met?**
CDC – HbA1c Control (< 8.0%)	*	**54.89%**	**59.12%**	4.23	Yes, >75th	**Met 100%**
CIS – Childhood Immunization Status – Combination 10	*	**26.03%**	**35.77%**	9.74	Yes, ≥50th	**Met 100%**
IMA – Immunizations for Adolescent – Combination 2	*	**29.20%**	**25.79%**	-3.41	No, <25th	Not Met
PPC – Timeliness of Prenatal Care	*	**72.26%**	**74.45%**	2.19	No, <25th	Not Met
W34 – Well Child Visits Years in 3rd-6th Years of Life	*	**72.51%**	**69.85%**	-2.66	No, <50th	Not Met
CCS – Cervical Cancer Screening	*	**54.50%**	**59.61%**	5.11	<50th	**Met 100%**
ADV – Annual Dental Visits – Total	*	**64.02%**	**65.02%**	1.00	Yes, >75th	**Met 100%**
APC – Use of Multiple Antipsychotic in Children and Adol.	^	**4.78%**	**4.61%**	.17% (decr)	<10th	**Met 100%**

*Performance Targets: Increase ≥ 5 percentage points (100% payment), Increase ≥ 3 percentage points (50% payment), 50th QC Percentile or higher (100% payment)
^Performance Target: Rate ≤ 4.75% (100% payment)

State Data Sources						
Minimum Data Set (MDS) Measures		**Target**	**2017**	**2018**	**Change**	**Target Met?**
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication	*	≤14.21%	**15.62%**	**13.13%**	2.49 decrease	**Met 100%**
NF residents discharged to the community who are admitted to a hospital within 30 days of discharge	^	≤11% or ↓5 pps	**13.85%**	**11.87%**	1.98 decrease	Not Met
Residents of a NF or NFMH discharged to a community setting	†	≥50%	**60.42%**	**64.97%**	4.55 increase	**Met 100%**
AuthentiCare Measure						
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date	‡	≥75% or ↑15 pp	**85.04%**	**89.19**	4.15 increase	**Met 100%**

*Performance Target: Improvement (decrease) ≥ 1 percentage point (100% payment)
^Performance Target: Rate ≤ 11% (100% payment), or improvement (Decrease) ≥ 5 percentage points
†Performance Target: Rate ≥ 50% (100% payment)
‡Performance Target: Rate ≥ 75% (100% payment), or improvement (increase) ≥ 15 percentage points (50% payment)

MCO and State Data Sources						
Encounter Data Measures		**Target**	**Quarter**	**2017**	**2018**	**Target Met?**
% covered services accurately submitted via encounter within 30 days of claim paid date	*	≥97.50%	Q1	**94.74%**	**83.73%**	Not Met
			Q2	**35.84%**	**92.45%**	Not Met
			Q3	**76.62%**	**78.90%**	Not Met
			Q4	**68.85%**	**95.58%**	Not Met
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO	*	≥97.50%	Q1	**84.44%**	**86.88%**	Not Met
			Q2	**91.54%**	**89.74%**	Not Met
			Q3	**87.40%**	**89.32%**	Not Met
			Q4	**81.48%**	**92.38%**	Not Met

*Quarterly Performance Target: ≥97.50%

2018 Pay-for-Performance Summary – Sunflower 3/12/2020

MCO Data Sources						
HEDIS Measure		**2017**	**2018**	**Increase**	**≥50th QC?**	**Target Met?**
CDC – HbA1c Control (< 8.0%)	*	**54.99%**	**48.18%**	-6.81	No, <50th	Not Met
CIS – Childhood Immunization Status – Combination 10	*	**38.44%**	**34.79%**	-3.65	Yes, ≥50th	**Met 100%**
IMA – Immunizations for Adolescent – Combination 2	*	**29.93%**	**35.77%**	5.84	Yes, ≥50th	**Met 100%**
PPC – Timeliness of Prenatal Care	*	**67.64%**	**69.83%**	2.19	No, <25th	Not Met
W34 – Well Child Visits Years in 3rd-6th Years of Life	*	**66.18%**	**68.13%**	1.95	No, <33.33rd	Not Met
CCS – Cervical Cancer Screening	*	**56.20%**	**54.50%**	-1.70	No, <25th	Not Met
ADV – Annual Dental Visits – Total	*	**65.15%**	**66.13%**	0.98	Yes, >75th	**Met 100%**
APC – Use of Multiple Antipsychotic in Children and Adol.	^	**4.64%**	**3.97%**	.67 (decr)	No, <25th	**Met 100%**

*Performance Targets: Increase ≥ 5 percentage points (100% payment), Increase ≥ 3 percentage points (50% payment), 50th QC Percentile or higher (100% payment)
^Performance Target: Rate ≤ 4.75% (100% payment)

State Data Sources						
Minimum Data Set (MDS) Measures		**Target**	**2017**	2018	**Change**	**Target Met?**
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication	*	≤14.21%	**14.19%**	**12.50%**	1.69 decrease	**Met 100%**
NF residents discharged to the community who are admitted to a hospital within 30 days of discharge	^	≤11% or ↓5 pps	**12.93%**	**12.63%**	0.30 decrease	Not Met
Residents of a NF or NFMH discharged to a community setting	†	≥50%	**62.95%**	**57.02%**	-5.93%	**Met 100%**
AuthentiCare Measure						
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date	‡	≥75% or ↑15 pp	**96.59%**	**95.96%**	-0.63%	**Met 100%**

*Performance Target: Improvement (decrease) ≥ 1 percentage point (100% payment)
^Performance Target: Rate ≤ 11% (100% payment), or improvement (Decrease) ≥ 5 percentage points
†Performance Target: Rate ≥ 50% (100% payment)
‡Performance Target: Rate ≥ 75% (100% payment), or improvement (increase) ≥ 15 percentage points (50% payment)

MCO and State Data Sources						
Encounter Data Measures		**Target**	**Quarter**	**2017**	**2018**	**Target Met?**
% covered services accurately submitted via encounter within 30 days of claim paid date	*	≥97.50%	Q1	**91.96%**	**96.58%**	Not Met
			Q2	**93.27%**	**95.41%**	Not Met
			Q3	**84.31%**	**97.69%**	**Met 100%**
			Q4	**86.06%**	**98.56%**	**Met 100%**
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO	*	≥97.50%	Q1	**96.54%**	**99.50%**	**Met 100%**
			Q2	**99.06%**	**99.31%**	**Met 100%**
			Q3	**103.55%**	**99.54%**	**Met 100%**
			Q4	**101.36%**	**98.87%**	**Met 100%**

*Quarterly Performance Target: ≥97.50%

2018 Pay-for-Performance Summary – UnitedHealthCare 3/12/2020

MCO Data Sources						
HEDIS Measure		**2017**	**2018**	**Increase**	**≥50th QC?**	**Target Met?**
CDC – HbA1c Control (< 8.0%)	*	**55.01%**	**58.26%**	3.25	Yes, >75th	**Met 100%**
CIS – Childhood Immunization Status – Combination 10	*	**35.04%**	**33.09%**	-1.95	No, <50th	Not Met
IMA – Immunizations for Adolescent – Combination 2	*	**31.87%**	**33.58%**	1.71	No, <50th	Not Met
PPC – Timeliness of Prenatal Care	^		**82.45%**		No, <50th	Undecided
W34 – Well Child Visits Years in 3rd-6th Years of Life	*	**74.85%**	**72.59%**	-2.26	No, <50th	Not Met
CCS – Cervical Cancer Screening	*	**64.96%**	**63.26%**	-1.70	Yes, ≥50th	**Met 100%**
ADV – Annual Dental Visits – Total	*	**65.26%**	**65.00%**	-0.26	Yes, >75th	**Met 100%**
APC – Use of Multiple Antipsychotic in Children and Adol.	†	**2.99%**	**3.01%**	-0.02 (decr)	<33.33rd	**Met 100%**

*Performance Targets: Increase ≥ 5 percentage points (100% payment), Increase ≥ 3 percentage points (50% payment), 50th QC Percentile or higher (100% payment)
^Changes in methodology maded the 2018 rate uncomparable to the 2017 rate. Calculation of a new baseline is still in progress.
†Performance Target: Rate ≤ 4.75% (100% payment)

State Data Sources						
Minimum Data Set (MDS) Measures		**Target**	**2017**	**2018**	**Change**	**Target Met?**
Residents of a NF or nursing facility for mental health (NFMH) receiving antipsychotic medication	*	≤14.21%	**14.12%**	**12.76%**	1.36 decrease	**Met 100%**
NF residents discharged to the community who are admitted to a hospital within 30 days of discharge	^	≤11% or ↓5 pps	**11.70%**	**13.16%**	1.46 increase	Not Met
Residents of a NF or NFMH discharged to a community setting	†	≥50%	**55.90%**	**58.15%**	2.25 increase	**Met 100%**
AuthentiCare Measure						
Authorizations of plans of care loaded into AuthentiCare within 5 days of plan of care start date	‡	≥75% or ↑15 pp	**95.06%**	**93.43**	-1.63 increase	**Met 100%**

*Performance Target: Improvement (decrease) ≥ 1 percentage point (100% payment)
^Performance Target: Rate ≤ 11% (100% payment), or improvement (Decrease) ≥ 5 percentage points
†Performance Target: Rate ≥ 50% (100% payment)
‡Performance Target: Rate ≥ 75% (100% payment), or improvement (increase) ≥ 15 percentage points (50% payment)

MCO and State Data Sources						
Encounter Data Measures		**Target**	**Quarter**	**2017**	**2018**	**Target Met?**
% covered services accurately submitted via encounter within 30 days of claim paid date	*	≥97.50%	Q1	**96.53%**	**97.47%**	Not Met
			Q2	**95.84%**	**97.72%**	**Met 100%**
			Q3	**95.86%**	**94.39%**	Not Met
			Q4	**99.30%**	**99.71%**	**Met 100%**
% of reported financial reflecting service payments that are matched by an encounter record submitted by the MCO	*	≥97.50%	Q1	**98.74%**	**100.93%**	**Met 100%**
			Q2	**98.96%**	**100.57%**	**Met 100%**
			Q3	**98.74%**	**100.33%**	**Met 100%**
			Q4	**100.08%**	**98.45%**	**Met 100%**

*Quarterly Performance Target: ≥97.50%

Physical Health HEDIS Measures, CY2013 – CY2018												
Measure	HEDIS Aggregated Results						Quality Compass ≥50th Percentile					
	2013	2014	2015	2016	2017	2018	2013	2014	2015	2016	2017	2018
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
Ages 20–44	85.4%	84.3%	83.7%	82.6%	83.6%	**83.1%**	↑	↑	↑	↑	↑	^
Ages 45–64	92.2%	92.4%	92.3%	91.3%	90.7%	**90.4%**	↑	↑	↑	↑	↑	^
Ages 65 and older	89.5%	88.6%	89.7%	90.1%	90.9%	**91.3%**	↑	↑	↑	↑	↑	^
Total – Ages 20 and older	88.4%	87.5%	87.1%	86.2%	86.7%	**86.6%**	↑	↑	↑	↑	↑	^
Annual Dental Visit (ADV)												
Ages 2–3	40.8%	41.2%	42.8%	45.8%	46.6%	**45.8%**	↑	↑	↑	↑	↑	↑
Ages 4–6	66.3%	65.7%	66.2%	69.2%	70.7%	**71.2%**	↑	↑	↑	↑	↑	↑
Ages 7–10	70.7%	70.1%	70.4%	72.7%	73.7%	**74.9%**	↑	↑	↑	↑	↑	↑
Ages 11–14	62.8%	62.8%	63.2%	66.4%	67.7%	**68.6%**	↑	↑	↑	↑	↑	↑
Ages 15–18	53.9%	53.5%	54.1%	57.2%	58.7%	**59.5%**	↑	↑	↑	↑	↑	↑
Ages 19–20	31.5%	30.2%	34.7%	33.1%	33.9%	**35.5%**	↓	↓	↑	↓	↓	↓
Total – Ages 2–20	60.3%	60.0%	60.9%	63.7%	64.8%	**65.4%**	↑	↑	↑	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)* *(CMS Core Quality Measure)*												
Ages 13–17	49.0%	50.8%	46.4%	50.2%	43.6%	**43.4%**	↑	↑	↑	↑	*	↑
Ages 18 and older	40.9%	41.3%	37.7%	40.1%	34.7%	**35.3%**	↑	↑	↓	↓	*	↓
Total – Ages 13 and older	42.1%	42.6%	38.9%	41.4%	35.8%	**36.2%**	↑	↑	↑	↑	*	↓
Engagement in Treatment for Alcohol or other Drug Dependence (IET)* *(CMC Core Quality Measure)*												
Ages 13–17	32.5%	31.0%	26.8%	27.5%	23.6%	**21.6%**	↑	↑	↑	↑	*	↑
Ages 18 and older	12.2%	12.1%	10.7%	12.4%	10.4%	**10.3%**	↑	↑	↑	↑	*	↓
Total – Ages 13 and older	15.2%	14.8%	12.9%	14.3%	12.0%	**11.6%**	↑	↑	↑	↑	*	↓
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*												
Prenatal Care	71.4%	70.4%	67.4%	68.4%	69.3%	**75.5%**	↓	↓	↓	↓	↓	↓
Postpartum Care	58.5%	55.8%	57.5%	58.0%	61.1%	**58.2%**‡	↓	↓	↓	↓	↓	↓
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*												
Ages 16–20	42.4%	41.0%	41.3%	41.0%	39.6%	**37.5%**	↓	↓	↓	↓	↓	↓
Ages 21–24	55.6%	54.5%	53.5%	52.8%	54.5%	**54.9%**	↓	↓	↓	↓	↓	↓
Total – Ages 16–24	46.1%	45.4%	45.8%	45.3%	45.1%	**43.5%**	↓	↓	↓	↓	↓	↓
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*												
		72.2%	77.6%	80.9%	86.5%	**90.4%**‡		↓	↓	↓	↓	^
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents *(CMS Core Quality Measure)*												
Weight Assessment/BMI for Children and Adolescents (WCC)												
Ages 3–11	33.7%	44.3%	48.9%	55.5%	64.3%	**66.3%**‡	↓	↓	↓	↓	↓	^
Ages 12–17	36.6%	47.3%	48.1%	56.9%	65.6%	**59.3%**‡	↓	↓	↓	↓	↓	^
Total – Ages 3–17	34.7%	45.3%	48.6%	56.0%	64.7%	**63.8%**‡	↓	↓	↓	↓	↓	^
Counseling for Nutrition for Children and Adolescents (WCC)												
Ages 3–11	47.4%	50.8%	50.6%	55.4%	60.6%	**43.5%**	↓	↓	↓	↓	↓	↓
Ages 12–17	46.0%	47.0%	45.7%	53.1%	56.7%	**38.6%**	↓	↓	↓	↓	↓	↓
Total – Ages 3–17	46.9%	49.5%	49.1%	54.7%	59.2%	**41.8%**	↓	↓	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)												
Ages 3–11	39.6%	43.5%	43.3%	47.9%	51.9%	**37.3%**	↓	↓	↓	↓	↓	↓
Ages 12–17	53.1%	50.6%	48.3%	58.6%	57.8%	**42.6%**	↓	↓	↓	↓	↓	↓
Total – Ages 3–17	44.0%	45.8%	44.9%	51.5%	53.9%	**39.2%**	↓	↓	↓	↓	↓	↓
Follow-Up after Hospitalization for Mental Illness, within seven days of discharge (FUH)* *(CMS Core Quality Measure)*												
	61.0%	56.2%	62.8%	64.4%	59.0%	**55.3%**	↑	↑	↑	↑	*	^
Follow-Up Care for Children Prescribed ADHD Medication (ADD)^ *(CMS Core Quality Measure)*												
Initiation Phase		48.0%	50.7%	52.2%	49.5%	**48.7%**		↑	↑	↑	^	↑
Continuation & Maintenance Phase		54.8%	61.2%	61.4%	57.5%	**56.1%**		↑	↑	↑	^	↑

↑ Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

* Quality Compass identified "Break in Trending" due to specification changes from prior year

^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

† HEDIS rates greater than 50th percentile that indicate poor performance

‡ KanCare rates for measures are aggregation of only Sunflower Health Plan and United HealthCare (PPC-Postpartum, WCC-BMI, ABA, CBP)

Physical Health HEDIS Measures, CY2013 – CY2018 (Continued)

Measure	HEDIS Aggregated Results						Quality Compass ≥50th Percentile					
	2013	2014	2015	2016	2017	2018	2013	2014	2015	2016	2017	2018
Adolescent Well Care Visits (AWC) ***(CMS Core Quality Measure)***												
	43.6%	46.7%	46.8%	47.7%	53.3%	**50.7%**	↓	↓	↓	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) *(CMS Core Quality Measure)*												
	63.4%	65.9%	64.8%	67.3%	71.0%	**70.1%**	↓	↓	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*												
0 visits		4.2%	3.0%	3.4%	2.9%	**3.9%**		↑†	↑†	↑†	↑†	↑†
1 visit		4.4%	3.3%	3.5%	3.4%	**3.6%**		↑†	↑†	↑†	↑†	↑†
2 visits		6.0%	4.8%	4.8%	4.1%	**5.0%**		↑†	↑†	↑†	↑†	↑†
3 visits		7.1%	6.5%	5.5%	6.5%	**6.9%**		↑†	↑†	↑†	↑†	↑†
4 visits		12.3%	9.1%	8.6%	8.0%	**9.9%**		↑	↓	↓	↓	↑
5 visits		16.8%	14.5%	15.5%	14.4%	**15.9%**		↓	↓	↓	↓	↑
6 or more visits		49.3%	58.7%	58.6%	60.7%	**54.8%**		↓	↓	↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*												
	47.3%	51.5%	48.2%	52.1%	53.6%	**58.6%‡**	↓	↓	↓	↓	↓	*
Comprehensive Diabetes Care (CDC)												
HbA1c Testing *(CMS Core Quality Measure)*	83.1%	84.8%	84.9%	85.8%	86.2%	**87.7%**	↓	↓	↓	↓	↓	^
Eye Exam (Retinal)	50.1%	58.6%	62.5%	64.4%	62.4%	**64.8%**	↓	↑	↑	↑	↑	^
Medical Attention for Nephropathy	75.8%	76.8%	89.2%	87.2%	88.8%	**86.7%**	↓	↓	↓	↓	↓	^
HbA1c Control (<8.0%)	39.0%	39.3%	46.6%	51.0%	55.0%	**54.9%**	↓	↓	↓	↑	↑	^
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	54.4%	52.9%	45.4%	41.1%	35.3%	**36.8%**	↓	↓	↓	↓	↓	^
Blood Pressure Control (<140/90)	53.1%	52.6%	58.8%	57.9%	61.1%	**43.3%**	↓	↓	↓	↓	↓	^
Appropriate Testing for Children with Pharyngitis (CWP)												
	51.6%	52.2%	55.1%	61.2%	68.6%	**73.3%**	↓	↓	↓	↓	↓	↓
Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure in 2013-2017)*												
5–11 years of age		27.4%	29.1%	31.7%	38.0%	**38.5%**		↑	↑	↑	↑	^
12–18 years of age		24.1%	26.6%	31.9%	36.4%	**37.8%**		↑	↑	↑	↑	^
19–50 years of age		39.6%	38.3%	41.4%	46.6%	**47.3%**		↑	↑	↑	↑	^
51–64 years of age		53.0%	55.1%	60.1%	60.2%	**62.9%**		↑	↑	↑	↑	^
Total – Ages 5–64		28.1%	29.9%	33.7%	39.2%	**40.4%**		↓	↓	↑	↑	^
Annual Monitoring for Patients on Persistent Medications (MPM)* *(CMS Core Quality Measure)*												
	84.9%	89.7%	90.2%	89.5%	90.0%	**90.4%**	↓	↑	↑	↑	*	↑
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
	71.9%	73.5%	76.3%	79.2%	81.9%	**86.6%**	↓	↓	↓	↓	↓	↓

↑ Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

* Quality Compass identified "Break in Trending" due to specification changes from prior year

^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

† HEDIS rates greater than 50th percentile that indicate poor performance

‡ KanCare rates for measures are aggregation of only Sunflower Health Plan and United HealthCare (PPC, WCC-BMI, ABA, CBP)

Physical Health HEDIS Measures, CY2013 – CY2018												
Measure	**HEDIS Aggregated Results**						**Quality Compass ≥50th Percentile**					
	2013	**2014**	**2015**	**2016**	**2017**	**2018**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Adults' Access to Preventive/Ambulatory Health Services (AAP)												
Ages 20–44	85.4%	84.3%	83.7%	82.6%	83.6%	**83.1%**	↑	↑	↑	↑	↑	^
Ages 45–64	92.2%	92.4%	92.3%	91.3%	90.7%	**90.4%**	↑	↑	↑	↑	↑	^
Ages 65 and older	89.5%	88.6%	89.7%	90.1%	90.9%	**91.3%**	↑	↑	↑	↑	↑	^
Total – Ages 20 and older	88.4%	87.5%	87.1%	86.2%	86.7%	**86.6%**	↑	↑	↑	↑	↑	^
Annual Dental Visit (ADV)												
Ages 2–3	40.8%	41.2%	42.8%	45.8%	46.6%	**45.8%**	↑	↑	↑	↑	↑	↑
Ages 4–6	66.3%	65.7%	66.2%	69.2%	70.7%	**71.2%**	↑	↑	↑	↑	↑	↑
Ages 7–10	70.7%	70.1%	70.4%	72.7%	73.7%	**74.9%**	↑	↑	↑	↑	↑	↑
Ages 11–14	62.8%	62.8%	63.2%	66.4%	67.7%	**68.6%**	↑	↑	↑	↑	↑	↑
Ages 15–18	53.9%	53.5%	54.1%	57.2%	58.7%	**59.5%**	↑	↑	↑	↑	↑	↑
Ages 19–20	31.5%	30.2%	34.7%	33.1%	33.9%	**35.5%**	↓	↓	↑	↓	↓	↓
Total – Ages 2–20	60.3%	60.0%	60.9%	63.7%	64.8%	**65.4%**	↑	↑	↑	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)* *(CMS Core Quality Measure)*												
Ages 13–17	49.0%	50.8%	46.4%	50.2%	43.6%	**43.4%**	↑	↑	↑	↑	*	↑
Ages 18 and older	40.9%	41.3%	37.7%	40.1%	34.7%	**35.3%**	↑	↑	↓	↓	*	↓
Total – Ages 13 and older	42.1%	42.6%	38.9%	41.4%	35.8%	**36.2%**	↑	↑	↑	↑	*	↓
Engagement in Treatment for Alcohol or other Drug Dependence (IET)* *(CMC Core Quality Measure)*												
Ages 13–17	32.5%	31.0%	26.8%	27.5%	23.6%	**21.6%**	↑	↑	↑	↑	*	↑
Ages 18 and older	12.2%	12.1%	10.7%	12.4%	10.4%	**10.3%**	↑	↑	↑	↑	*	↓
Total – Ages 13 and older	15.2%	14.8%	12.9%	14.3%	12.0%	**11.6%**	↑	↑	↑	↑	*	↓
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*												
Prenatal Care	71.4%	70.4%	67.4%	68.4%	69.3%	**75.5%**	↓	↓	↓	↓	↓	↓
Postpartum Care	58.5%	55.8%	57.5%	58.0%	61.1%	**58.2%‡**	↓	↓	↓	↓	↓	↓
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*												
Ages 16–20	42.4%	41.0%	41.3%	41.0%	39.6%	**37.5%**	↓	↓	↓	↓	↓	↓
Ages 21–24	55.6%	54.5%	53.5%	52.8%	54.5%	**54.9%**	↓	↓	↓	↓	↓	↓
Total – Ages 16–24	46.1%	45.4%	45.8%	45.3%	45.1%	**43.5%**	↓	↓	↓	↓	↓	↓
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*												
		72.2%	77.6%	80.9%	86.5%	**90.4%‡**		↓	↓	↓	↓	^
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents *(CMS Core Quality Measure)*												
Weight Assessment/BMI for Children and Adolescents (WCC)												
Ages 3–11	33.7%	44.3%	48.9%	55.5%	64.3%	**66.3%‡**	↓	↓	↓	↓	↓	^
Ages 12–17	36.6%	47.3%	48.1%	56.9%	65.6%	**59.3%‡**	↓	↓	↓	↓	↓	^
Total – Ages 3–17	34.7%	45.3%	48.6%	56.0%	64.7%	**63.8%‡**	↓	↓	↓	↓	↓	^
Counseling for Nutrition for Children and Adolescents (WCC)												
Ages 3–11	47.4%	50.8%	50.6%	55.4%	60.6%	**43.5%**	↓	↓	↓	↓	↓	↓
Ages 12–17	46.0%	47.0%	45.7%	53.1%	56.7%	**38.6%**	↓	↓	↓	↓	↓	↓
Total – Ages 3–17	46.9%	49.5%	49.1%	54.7%	59.2%	**41.8%**	↓	↓	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)												
Ages 3–11	39.6%	43.5%	43.3%	47.9%	51.9%	**37.3%**	↓	↓	↓	↓	↓	↓
Ages 12–17	53.1%	50.6%	48.3%	58.6%	57.8%	**42.6%**	↓	↓	↓	↓	↓	↓
Total – Ages 3–17	44.0%	45.8%	44.9%	51.5%	53.9%	**39.2%**	↓	↓	↓	↓	↓	↓
Follow-Up after Hospitalization for Mental Illness, within seven days of discharge (FUH)* *(CMS Core Quality Measure)*												
	61.0%	56.2%	62.8%	64.4%	59.0%	**55.3%**	↑	↑	↑	↑	*	^
Follow-Up Care for Children Prescribed ADHD Medication (ADD)^ *(CMS Core Quality Measure)*												
Initiation Phase		48.0%	50.7%	52.2%	49.5%	**48.7%**		↑	↑	↑	^	↑
Continuation & Maintenance Phase		54.8%	61.2%	61.4%	57.5%	**56.1%**		↑	↑	↑	^	↑

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

***** Quality Compass identified "Break in Trending" due to specification changes from prior year

^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

† HEDIS rates greater than 50th percentile that indicate poor performance

‡ KanCare rates for measures are aggregation of only Sunflower Health Plan and United HealthCare (PPC-Postpartum, WCC-BMI, ABA, CBP)

Physical Health HEDIS Measures, CY2013 – CY2018 (Continued)												
Measure	HEDIS Aggregated Results						Quality Compass ≥50th Percentile					
	2013	2014	2015	2016	2017	2018	2013	2014	2015	2016	2017	2018
Adolescent Well Care Visits (AWC) *(CMS Core Quality Measure)*												
	43.6%	46.7%	46.8%	47.7%	53.3%	**50.7%**	↓	↓	↓	↓	↓	↓
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34) *(CMS Core Quality Measure)*												
	63.4%	65.9%	64.8%	67.3%	71.0%	**70.1%**	↓	↓	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*												
0 visits		4.2%	3.0%	3.4%	2.9%	**3.9%**		↑†	↑†	↑†	↑†	↑†
1 visit		4.4%	3.3%	3.5%	3.4%	**3.6%**		↑†	↑†	↑†	↑†	↑†
2 visits		6.0%	4.8%	4.8%	4.1%	**5.0%**		↑†	↑†	↑†	↑†	↑†
3 visits		7.1%	6.5%	5.5%	6.5%	**6.9%**		↑†	↑†	↑†	↑†	↑†
4 visits		12.3%	9.1%	8.6%	8.0%	**9.9%**		↑	↓	↓	↓	↑
5 visits		16.8%	14.5%	15.5%	14.4%	**15.9%**		↓	↓	↓	↓	↑
6 or more visits		49.3%	58.7%	58.6%	60.7%	**54.8%**		↓	↓	↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*												
	47.3%	51.5%	48.2%	52.1%	53.6%	**58.6%‡**	↓	↓	↓	↓	↓	*
Comprehensive Diabetes Care (CDC)												
HbA1c Testing *(CMS Core Quality Measure)*	83.1%	84.8%	84.9%	85.8%	86.2%	**87.7%**	↓	↓	↓	↓	↓	^
Eye Exam (Retinal)	50.1%	58.6%	62.5%	64.4%	62.4%	**64.8%**	↓	↑	↑	↑	↑	^
Medical Attention for Nephropathy	75.8%	76.8%	89.2%	87.2%	88.8%	**86.7%**	↓	↓	↓	↓	↓	^
HbA1c Control (<8.0%)	39.0%	39.3%	46.6%	51.0%	55.0%	**54.9%**	↓	↓	↓	↑	↑	^
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	54.4%	52.9%	45.4%	41.1%	35.3%	**36.8%**	↓	↓	↓	↓	↓	^
Blood Pressure Control (<140/90)	53.1%	52.6%	58.8%	57.9%	61.1%	**43.3%**	↓	↓	↓	↓	↓	^
Appropriate Testing for Children with Pharyngitis (CWP)												
	51.6%	52.2%	55.1%	61.2%	68.6%	**73.3%**	↓	↓	↓	↓	↓	↓
Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure in 2013-2017)*												
5–11 years of age		27.4%	29.1%	31.7%	38.0%	**38.5%**		↑	↑	↑	↑	^
12–18 years of age		24.1%	26.6%	31.9%	36.4%	**37.8%**		↑	↑	↑	↑	^
19–50 years of age		39.6%	38.3%	41.4%	46.6%	**47.3%**		↑	↑	↑	↑	^
51–64 years of age		53.0%	55.1%	60.1%	60.2%	**62.9%**		↑	↑	↑	↑	^
Total – Ages 5–64		28.1%	29.9%	33.7%	39.2%	**40.4%**		↓	↓	↑	↑	^
Annual Monitoring for Patients on Persistent Medications (MPM)* *(CMS Core Quality Measure)*												
	84.9%	89.7%	90.2%	89.5%	90.0%	**90.4%**	↓	↑	↑	↑	*	↑
Appropriate Treatment for Children with Upper Respiratory Infection (URI)												
	71.9%	73.5%	76.3%	79.2%	81.9%	**86.6%**	↓	↓	↓	↓	↓	↓

↑Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile

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