Quarterly Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Quarter Ending 6.30.17

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

KanCare
Section 1115 Quarterly Report
Demonstration Year: 5 (1/1/2017-12/31/2017)
Federal Fiscal Quarter: 3/2017 (4/17-6/17)

Table of Contents

I. Introduction

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

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

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

This five year demonstration will:

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

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

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

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

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

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned for the second quarter known as of June 30, 2017.

Demonstration Population	Enrollees at Close of Qtr. (6/30/2017)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	14,687	15,669	982
Population 2: ABD/SD Non Dual	28,693	29,175	482
Population 3: Adults	50,833	54,469	3,636
Population 4: Children	226,330	238,270	11,940
Population 5: DD Waiver	8,920	8,975	55
Population 6: LTC	20,046	21,012	966
Population 7: MN Dual	1,208	1,359	151
Population 8: MN Non Dual	1,220	1,309	89
Population 9: Waiver	4,618	4,726	108
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	**356,555**	**374,964**	**18,409**

III. Outreach/Innovation

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

During the 2nd quarter, a Tribal Technical Advisory Group (TTAG) meeting with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations was held on May 7, 2017. There were nine attendees present for the meeting – four attendees in person and five attendees by phone. The next scheduled meeting for TTAG is August 1, 2017.

Also during this quarter, the KanCare Advisory Council met. The Council consists of 13 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 representing the developmental disabilities community, 1 former Kansas Senator, 1 representing pharmacists. The meeting took place on June 13, 2017 at the CSOB room 530. The agenda was as follows:

I. Welcome
II. Review and Approval of Minutes from Council Meeting, March 27, 2017
III. KDHE Update – Mike Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment
IV. KDADS Update – Tim Keck, Secretary, Kansas Department for Aging and Disability Services
V. Updates on KanCare with Q&A
    a. Amerigroup Kansas
    b. Sunflower State Health Plan
    c. UnitedHealthcare Community Plan
VI. Update from KanCare Ombudsman – Kerrie Bacon
VII. Miscellaneous Agenda Items
    a. Review of Advisory Council membership and statutory requirements
    b. Update on the ADRC RFP
VIII. Next Meeting of KanCare Advisory Council – October 17, 2017, Curtis State Office Building, Room 530, 2:30 to 4:00 p.m.
IX. Adjourn

KDHE and KDADS also held nine meetings May 30 and 31 with provider associations and advocacy groups to collect input about KanCare and what improvements they would like to see in the 1115 demonstration renewal and the next round of MCO contracts. Information from these meetings is being used to inform both the 1115 renewal application and the request for proposals (RFP) for new MCO contracts – both beginning January 1, 2019. In June, twelve public meetings and a conference call were held to solicit input for KanCare renewal (KanCare 2.0). Six provider sessions and six consumer sessions were held in six different cities across Kansans, along with a consumer conference call. A total of 482 people attended these meetings. Information from these sessions is also being used to shape KanCare 2.0.

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

- Autism Advisory Council (quarterly)
- Money Follows the Person (quarterly) – ending this quarter
- PACE Program (quarterly)
- HCBS Provider Forum teleconferences (monthly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)

- Big Tent Coalition meetings to discuss KanCare and stakeholder issues (monthly)
- Interhab (CDDO and I/DD Provider Association) board meetings (monthly)
- KACIL (centers for independent living) board meetings (monthly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly 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
- I/DD 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 9 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)
- WSU-Community Engagement Institute Special Projects (weekly meeting) including HCBS Access Guide, Policy Gap Analysis, and Capacity Building survey
- KDADS-CDDO Eligibility workgroup tasked to update IDD Eligibility policy and Handbook-first meeting was 6/22/17

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

KanCare Credentialing Uniformity Workgroup

The KanCare Credentialing Uniformity Workgroup membership consists of the State, the three MCOs, the Fiscal Agent, and healthcare providers from the Kansas Hospital Association and Kansas Medical Society.

The agenda for this group is to analyze current enrollment and credentialing practices in order to ease burdens for the providers, while still enabling the MCOs to meet their corporate credentialing needs. The workgroup finalized an interim electronic PDF version of the credentialing forms and it is now posted for provider use on all KanCare credentialing websites. This workgroup is continuing its work with the Fiscal Agent to expand and upgrade the Provider Enrollment Portal, which will eventually incorporate many elements from the credentialing form. This Provider Enrollment Portal will be a centralized portal where providers can submit required documents one time rather than having to complete the same forms up to four different times. Version one of the portal is complete and assessment is underway. The design has been demonstrated to providers and MCO partners. Once this assessment of the design is complete, the first version of the portal will be revised and then operationalized by the end of 2017. The workgroup will be working with the Fiscal Agent to integrate the desired changes into the later version of this Provider Enrollment Portal, while also including any necessary items from the new Managed Care Rules.

KanCare Consumer and Specialized Issues (CSI) Workgroup

The CSI Workgroup met on June 20, 2017, at Sunflower Health Plan in Lenexa, Kansas. The meeting consisted of a report from the KanCare Ombudsperson, Kerrie Bacon, and a continuation of the discussion of the redesign of the Elderly and Persons with Disabilities KanCare application. KDHE is in the process of updating this application soon and will be running by our first draft by the Consumer and specialized Issues workgroup. A conversation about the Client Obligations on the HCBS programs was also on the agenda. The Client Obligation amount is determined by the State of Kansas and then assigned to a provider by the MCO, a CSI member expressed concern that client obligations discouraged people from getting HCBS services due to the cost share. There was also a request to place a list of the type of expenses that can be used to lower the client obligation on the KanCare web site.

MCO Outreach Activities

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

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

Marketing Activities: Amerigroup participated in over 300 events for the second quarter of 2017. This included partner development, sponsorships, member outreach and advocacy.

The Community Relations Representatives primary focus continues to be member education of services and how to get the most out of the KanCare program. They constantly look to develop strong partnerships across the state by enhancing existing relationships and building new ones.

Below is a sampling of Marketing activities Amerigroup supported in the second quarter:

- CHW Symposium
- Episcopal Social Service Kindness In Action Luncheon
- Wichita Health Alliance Coalition

- Job Olympics
- Governors Public Health Conference

Outreach Activities: Amerigroup's Outreach Care Specialists continued their telephonic outreach efforts and mailings to new members to welcome them and to ensure they have completed their initial health risk assessment. They continue with ongoing targeted outreach to improve member knowledge about the services available to them. They also reached out to members who appeared to be due for an annual checkup or needing other medical services to help schedule their appointment with their provider to help improve their overall health.

The Community Relations Representatives participated in a variety of community events reaching approximately 15,000 Kansans in the second quarter. Amerigroup highly values the benefits of these activities which give them the opportunity to obtain valuable feedback and to cover current topics that are relevant to their members, such as: KAN Be Healthy, access to care, diabetes, well child visits, employment, high blood pressure, your PCP and you, and more.

Amerigroup also met with members who participate in their adult, teen and foster care advisory groups to help assess their effectiveness and to improve various health related strategies, programs and systems of care

Below is a sampling of some of their outreach efforts this past quarter:

- March For Babies
- Special Olympics Opening Ceremonies
- Kansas Food Pantry Mobile Food Pantry
- Positive Aging Day
- Workability Wichita exhibit
- Community Health Fair and Block Party Exhibit
- City-Cowley County Health Department-Winfield

Advocacy Activities: Amerigroup' s advocacy efforts for second quarter continue to be broad based to support the needs of the general population, pregnant women, children, people with disabilities and the elderly. The staff is proactive and engaged at the local level by participating in coalitions, committees, and boards across the state. These commitments help the staff learn the needs of the communities they serve and how they can better serve these communities.

The second quarter advocacy efforts remain similar to those of the previous quarters. Amerigroup continues to educate families, members, potential members, caregivers, providers, and all those who work with the KanCare community. Amerigroup continues to help support their members in resolving issues through the KanCare Ombudsman and grievance and appeal process with the assistance of the Grievance Specialists on site at the Health Plan.

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

Marketing Activities: During 2nd Quarter 2017, Sunflower Health Plan sponsored local and statewide member and provider events as well as fundraisers for charitable organizations such as the American Heart Association (AHA) and American Diabetes Association (ADA). Sunflower's direct mail marketing material for the second quarter included member postcards and customized letters addressing preventive health care gaps for important screenings and immunizations. Notable stakeholder programs and events for marketing during Q2, 2017:

- American Academy of Pediatrics Spring Meeting
- 4th Annual Safe Kids Day at the Zoo, Topeka
- KMGMA (KS Medical Group Management Association) Spring Conference
- 2017 Symposium on Teen Suicide Prevention and Depression Awareness
- KS Healthcare Collaborative Annual Summit on Quality
- National Alliance on Mental Illness (NAMI) Walk
- Colby Care Mission
- Kansas Community Health Work Symposium
- 20th Annual Crime Victims' Rights Conference, hosted by the Governor and Attorney General
- Safe Sleep Community Baby Shower, by Derby Health Collaborative
- American Diabetes Association, Tour de Cure

Outreach Activities: Sunflower Health Plan's outreach activities for the 2nd Quarter, 2017, centered on home visits, farmers markets and vaccination clinics. The health plan also ramped up member outreach for tobacco cessation. Sunflower continued its work with individuals and community agencies to address the social determinants of health in Kansas communities. Sunflower's 20 MemberConnections Representatives completed their Community Health Worker (CHW) certification course this quarter. Examples of member outreach activities this quarter:

- Held two Farmers Market member programs during June
- Held four Sunflower member baby showers and participated in other community baby showers to promote prenatal care
- Participated in 15 community health events serving all populations, including the Kickapoo Nation Health Center's 16th annual health fair and a dental clinic with Great Plains Dental
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on May 25, 2016, in Wichita. The two main topics on the agenda were Pharmacy Updates and 2016 Clinical Focus Areas. Input was also received on the state's closure of the health homes program.
- Farmers Market member voucher events (4 from May-June)
- Community sponsored baby showers: Emporia in April, Cherokee County in May, Neosho County in May, Derby in June
- Participated in 8 community health events serving all populations, including the Kickapoo Nation Health Center's 17th annual health fair and the Pleasant Valley Middle School health fair
- Invited members to Clinic Day with Health Partnership Clinic in Olathe to help close care gaps
- Held Sunflower Health Plan's quarterly Member and Community Advisory Committee meeting on June 28 in Topeka.

- Sunflower volunteered at the Arc of Sedgwick County as well as the Special Olympics Summer Games

Advocacy Activities: Sunflower Health Plan's advocacy efforts for Q2 2017 centered on supports for people with disabilities, oral health for the maternal & child health population and work to help all populations improve individual health literacy. The health plan's farmer's market voucher program also kicked off this quarter. Sunflower participated in the following advocacy activities during Q2, 2017:

- Job Olympics, Overland Park
- 2nd Annual Transition Pathways Employment Fair, El Dorado
- Autism Awareness Rally, Overland Park
- Provider Parent University, Kansas City
- Workability Job Fair, Wichita
- Community Action Head Start Parent Dinner, Topeka
- Sedgwick County Developmental Disability Organization "Mental Health Approaches to IDD: A Resource for Trainers"
- Oral Health for Prenatal, Infant and Toddler: Statewide Workgroup, May and June
- Johnson County Suicide Prevention Coalition's "13 Reasons Why" Town Hall
- Family Employment Awareness Training (FEAT) Panel
- "People First" Language Webinar presented by Sunflower/LifeShare
- Self Advocates Coalition of Kansas (SACK) Conference, Topeka

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 KanCare benefits and general health education. UnitedHealthcare began using the newly designed and easier to understand welcome materials for new members and re-certifications. Plan staff completed new member welcome calls, and Health Risk Assessments. UnitedHealthcare also engaged in other outreach calls to invite members to Community Baby Showers and Clinic Days. New members were sent ID Cards and new member welcome kits in a timely manner. UnitedHealthcare mailed members the HealthTalk Spring newsletter (a quarterly newsletter) with tips on living a healthier life. UnitedHealthcare delivers the quarterly Practice Matters Newsletter to Providers with information that is important for their support of UnitedHealthcare Members. Throughout the quarter, UnitedHealtcare hosted a number of meetings and presentation with key providers, hospitals, Federally Qualified Health Centers (FQHC's) and Community Based Organizations throughout the state that involved discussions around exploring innovative and collaborative opportunities. UnitedHealthcare also supported the Kancare 2.0 Town Halls run by State Partners. UHC had representation at every Consumer and Provider meeting.

Outreach Activities: UnitedHealthcare Community Plan participated in and/or supported 111 Member facing activities which included 54 lobby sits at provider offices as well as 41 Events or Educational Opportunities to educate both consumers and providers. In Q2, UHC hosted one Community Baby Showers with Community Partners and an FQHC in Wichita where 120 Consumers were in attendance. In addition, UHC hosted one consumer event for the Frail Elderly, Intellectually Developmentally Disabled and Physically Disabled population in Olathe. And, UHC hosted one consumer event targeting

behavioral health consumers in Wichita. These Community Events were well received and attendees with information and resources to support their health and wellness. In addition, UHC helped organize a Wyandotte County Community Baby Shower in May in partnership with the Health Department and the other two MCO's. UnitedHealthcare also participated in four 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. 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 for members, community based organizations and targeted provider offices about Medicaid benefits, KanCare and UnitedHealthcare. Of key importance is to meet members where they are and help understand their personal goals and how we can help them reach those goals. UnitedHealthcare educates Members and Providers on Value Added benefits and the features and benefits of KanCare. UnitedHealthcare also interacts 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 and clinic days throughout the state. UnitedHealthcare also participated in a number of community stakeholder committee meetings in the second quarter of 2017. In particular, a lot of focus and support was provided to the IRC (International Rescue Committee) that offers support to refugees in Kansas through the Wilson-Fish program. This population of refugees in Kansas is medically underserved and in need of help and support to get preventative medical care. UHC Advocates were key speakers and participants in IRC meetings in Wichita. One final key activity was the UHC Member Advisory Meeting. The Q2 meeting was held in Olathe and focused on member education and specifically new materials for Logisticare Non-Emergency Transportation. The material was printed and attendees were asked to review and offer feedback and ideas. These materials had already been state approved, but not printed and mailed. UHC was able to make the changes suggested by members and the revised materials with the change incorporated will be printed. The rest of the Member Advisory Meeting focused ideas for Community events that UHC could sponsor, and thoughts on how to get additional attendance. The final topic of the Member Advisory Meeting was around HPV vaccinations and learning what consumers knew about this vaccination.

- During the second quarter 2017, UnitedHealthcare staff personally met with approximately 6,965 individuals who were members or potential members at community events, at member orientation sessions, and at lobby sits held at key provider offices throughout Kansas.
- During the second quarter 2017, UnitedHealthcare staff personally met with approximately 1,169 individuals from community based organizations located throughout Kansas. These organizations work directly with UHC members in various capacities.
- During the second quarter 2017, UnitedHealthcare staff personally met more than 970 individuals from provider offices located throughout the State.

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

Throughout this quarter, UHC supported Franklin County Resource Fair for Wellsville High School Special Education, Health and Safety Fair at Haskell Indian Nations University, Aging Expos/Senior Fairs, Early Childhood Conferences and Head Start, CDDO Events and Family Days. These events offer support for children, Native Americans and the waiver population and helped members and advocates learned more about how to access and navigate their benefits with United Healthcare, including how care coordination is provided to those on Home and Community Based Waiver programs and where to go when they have questions. 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. At events, it is not uncommon to meet individuals with a newly acquired disability who are in need of good referrals and basic information about programs and services available to them. Or, to 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.

Health Plan members also supported multiple committees and coalitions surrounding the challenges faced by consumers navigating the health care world. Examples of some of these committees include:

- International Rescue Committee (IRC)
- Self-Advocate Coalition of Kansas
- Hays Community Service Council,
- Pratt County Community Health & Resource Council,
- Thomas County Health Coalition,
- Great Bend Interagency Committee,
- Migrants Program Committee,
- Cultural Relations Board,
- Ford County Health Coalition,
- Lifestyle Diabetes Coaches Training,
- Tobacco Cessation Work Group,
- Crawford County Health Department WIC,
- Shawnee County Oral Health Coalition,
- Douglas/Jefferson County Transition Council,
- Transformers Committee,
- Family Advocacy Day,
- Head Start Program and
- Meetings with youth in school
- FIMR (Fetal and Infant Mortality Rate) Advocacy Group

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: No new plans have been contracted with for the KanCare program. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and 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.

CMS approved KanCare contract Amendment 23 on May 30, 2017 with an effective date of July 1, 2016. CMS approved KanCare contract Amendment 24 on May 30, 2017 with an effective date of January 1, 2017. CMS approved KanCare contract Amendment 25 on June 22, 2017 with an effective date of May 1, 2017.

Seven State Plan Amendments (SPA) addressing the 4% rate reduction with an effective date of July 1, 2016 were approved as noted below:

SPA Number	Subject	Approval Date
16-007	Frontis page	May 26, 2017
16-008	HCAIP rates	May 23, 2017
16-009	DRG outlier payment rates	May 23, 2017
16-011	ICF/IDD rates	May 23, 2017
16-012	Inpatient hospital rates	May 23, 2017
16-013	PRTF rates	May 23, 2017
16-014	NF rates	May 24, 2017

The state plan amendment 17-003 approved on May 22, 2017 with an effective date of January 1, 2017 is administrative in nature for the basic purpose to account for all services offered in the base benchmark alternative benefits plan.

The state plan amendment 17-004, NADAC, submitted on June 16, 2017 with an effective date of April 1, 2017 is pending CMS approval.

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-June, 2017 , follows:

MCO	Value Added Service *Jan.-June 2017*	Units YTD	Value YTD

Amerigroup	Adult Dental Care	1,935	$248,106
	Member Incentive Program	10,423	$198,495
	Mail Order OTC	3,955	$71,576
	Total of all Amerigroup VAS Jan- March 2017	***8,516***	***$598,297***
Sunflower	CentAccount Debit Card	36,204	$390,339
	Dental Visits for Adults	4,260	$202,679
	Pharmacy Consultation	4,905	$133,887
	Total of all Sunflower VAS Jan- March 2017	***71,916***	***$952,906***
United	Rewards for Preventive Visits & Health Actions	20,814	$74,365
	Adult Briefs	661	$56,174
	Baby Blocks Program and Rewards	1,008	$55,660
	Total of all United VAS Jan- March 2017	***40,044***	***$399,207***

c. Enrollment issues: For the second quarter of calendar year 2017 there were 10 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

The table below represents the enrollment reason categories for the second quarter of calendar year 2017. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	1
KDHE - Administrative Change	42
WEB - Change Assignment	45
KanCare Default - Case Continuity	96
KanCare Default – Morbidity	210
KanCare Default - 90 Day Retro-reattach	128
KanCare Default - Previous Assignment	486
KanCare Default - Continuity of Plan	748
AOE – Choice	485
Choice - Enrollment in KanCare MCO via Medicaid Application	1135
Change - Enrollment Form	318
Change - Choice	438
Change - Access to Care – Good Cause Reason	1
Change - Case Continuity – Good Cause Reason	1
Change – Due to Treatment not Available in Network – Good Cause	
Assignment Adjustment Due to Eligibility	12
Total	**4146**

d. Grievances, appeals and state hearing information

MCOs' Grievance Database
CY17 2nd quarter report

MCO	QOC (non HCBS, non Trans)	Customer Svcs	Member Rights Dignity	Access to Svc or Care	Pharm	QOC (HCBS)	Trans (incl Riem.)	Trans (No Show)	Trans (Late)	Trans (Safety)	VAS	Billing/Fin Issues (non Trans)	Other
AMG	6	8	2	6	4	6	21	29	5	3	1	32	7
SUN	9	17	2	1	7	12	24	21	24	12	4	11	7
UHC	24	6	0	5	6	8	12	11	30	7	5	55	1
Total	39	31	4	9	17	26	57	61	59	22	10	97	15

MCOs' Appeals Database
Members – CY17 2nd quarter report

Member Appeal Reasons **AMG – Red** **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**
MEDICAL NECESSITY DENIAL				
Criteria Not Met - DME	1 17 13	 2 	1 7 7	 8 6
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	29	28		1
Criteria Not Met - Medical Procedure (NOS)	4 15	 1	1 9	3 5
Criteria Not Met - Radiology	3 20	2 	 4	1 16
Criteria Not Met - Pharmacy	7 61 50	 6 1	5 42 30	2 13 19
Criteria Not Met - PT/OT/ST	6		6	
Criteria Not Met - Dental	1 5		 2	1 3
Criteria Not Met or Level of Care - Home Health				
Criteria Not Met - Hospice				
Criteria Not Met - Out of network provider, specialist or specific provider request				

Criteria Not Met – Inpatient Behavioral Health	3 34		1 11	2 23
Criteria Not Met – Behavioral Health Outpatient Services and Testing	1 3 10	 1	 2 2	1 1 7
Level of Care - LTSS/HCBS	16 12	3	8 7	5 5
Level of Care - WORK				
Level of Care - LTC NF				
Level of Care - Mental Health				
Ambulance (include Air and Ground)				
Other- Medical Necessity	2 6	 2	 1	2 3
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	1 2 1	 	 1 	1 1 1
Service not covered - Home Health	6		3	3
Service not covered - Pharmacy	1 2	 1		1 1
Service not covered - Out of Network providers				
Service not covered - OT/PT/Speech				
Service not covered - DME	1 6		 3	1 3
Service not covered - Behavioral Health	1			1
Other - Noncovered service	8 8	 5	2 2	6 1
Lock In				
Billing and Financial Issues				
AUTHORIZATION DENIAL				
Late Submission by Member/Member Rep.				
No authorization submitted	1	1		
MCO TIMELINES				
Noncompliance with PA Authorization Timeframes				
Non Compliance with Resolution of Appeals and Issuance of Notice				
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **39** **192** **126**	 **5** **9** **39**	 **16** **96** **45**	 **18** **87** **42**

MCOs' Appeals Database
Providers - CY17 2nd quarter report (appeals resolved)

Member Appeal Reasons AMG – Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal	MCO upheld Decision on Appeal
MEDICAL NECESSITY DENIAL				
Criteria Not Met - DME	1 17 13	 2 	1 7 7	 8 6
Criteria Not Met - Inpatient Admissions (Non-Behavioral Health)	29	28		1
Criteria Not Met - Medical Procedure (NOS)	4 15	 1	1 9	3 5
Criteria Not Met - Radiology	3 20	2 	 4	1 16
Criteria Not Met - Pharmacy	7 61 50	 6 1	5 42 30	2 13 19
Criteria Not Met - PT/OT/ST	6		6	
Criteria Not Met - Dental	1 5		 2	1 3
Criteria Not Met or Level of Care - Home Health				
Criteria Not Met - Hospice				
Criteria Not Met - Out of network provider, specialist or specific provider request				
Criteria Not Met – Inpatient Behavioral Health	3 34		1 11	2 23
Criteria Not Met – Behavioral Health Outpatient Services and Testing	1 3 10	 1	 2 2	1 1 7
Level of Care - LTSS/HCBS	16 12	3 	8 7	5 5
Level of Care - WORK				
Level of Care - LTC NF				
Level of Care - Mental Health				
Ambulance (include Air and Ground)				

Other- Medical Necessity	2 6	2	1	2 3
NONCOVERED SERVICE DENIAL				
Service not covered - Dental	1 2 1		1	1 1 1
Service not covered - Home Health	6		3	3
Service not covered - Pharmacy	1 2	1		1 1
Service not covered - Out of Network providers				
Service not covered - OT/PT/Speech				
Service not covered - DME	1 6		3	1 3
Service not covered - Behavioral Health	1			1
Other - Noncovered service	8 8	5	2 2	6 1
Lock In				
Billing and Financial Issues				
AUTHORIZATION DENIAL				
Late Submission by Member/Member Rep.				
No authorization submitted	1	1		
MCO TIMELINES				
Noncompliance with PA Authorization Timeframes				
Non Compliance with Resolution of Appeals and Issuance of Notice				
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	 **39** **192** **126**	 **5** **9** **39**	 **16** **96** **45**	 **18** **87** **42**

MCOs' Appeals Database

Provider Appeal Summary – CY17 2nd quarter report

AMG – Red **SUN – Green** **UHC - Purple**	**Number Resolved**	**Withdrawn**	**MCO Reversed Decision on Appeal**	**MCO upheld Decision on Appeal**
Total Number of Appeals Resolved	39 192 126	5 9 39	16 96 45	18 87 42

Percentage Per Category		13% 5% 31%	41% 50% 36%	46% 45% 33%

State of Kansas Office of Administrative Fair Hearings
Members – CY17 2nd quarter report

AMG-Red SUN-Green UHC-Purple	**Withdrawn**	**Dismissed-Moot MCO Reversed decision**	Dismissed – No Internal Appeal	**Dismissed-No Adverse Action**	**Default Dismissal-Appellant did not respond/ appear**	**Dismissed-Untimely**	**OAH upheld MCO decision**	**OAH reversed MCO decision**
Dental Denied/ Not Covered		1						
CT/MRI/X-Ray Denied			1				1	
DME Denied							1	
Home Health hours Denied								
Comm Psych Supt/ BH Svcs Denied								
LTSS/HCBS/Work PCA Hrs Denied	3	1 1 2					1	
Pharm/Lab/Genetic Testing Denied		1						
Inpt/Outpt/Observation Med Procedure Denied								
Specialist Ofc Visit/ Ambulance Denied								
TOTAL AMG – Red SUN – Green UHC – Purple	3	1 3 2	1				1 2	

State of Kansas Office of Administrative Fair Hearings
Providers – CY17 2nd quarter report

AMG-Red SUN-Green UHC-Purple	**Withdrawn**	**Dismissed-Moot MCO Reversed decision**	**Dismissed – No Internal Appeal**	**Dismissed-No Adverse Action**	**Default Dismissal-Appellant did not respond/ appear**	**Dismissed-Untimely**	**OAH upheld MCO decision**	**OAH reversed MCO decision**
Claim Denied (Contained Errors)	7 65	15 12 1	3 6 6	4 2	2 1	1	1	

Claim Denied by MCO in Error	3	2						
Recoupment	1 9	1	1					
DME Denied		1						
Dental Denied								
Radiology Denied			1					
Home Health/Hospice/ LTC Denied								
Air/Ambulance Charges								
Inpt/Outpt/Observation Med Procedure Denied – Facility Charges	15 8	1						
Inpt/Outpt/Observation Med Procedure Denied – Physician charges								
Mental Health HCBS/TCM Hrs Denied		1						
Pharm/Lab/Genetic Testing Denied		2						
TOTAL **AMG – Red** **SUN – Green** **UHC - Purple**	8 92 8	16 17 3	4 7 6	4 2	2 1	1	1	

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

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. In Q1 of 2017, there were a total of 37 requests, which is a very large reduction in comparison to the 171 requests in third quarter of 2016. But Q2 of 2017 showed an increase again, up from 37 requests in Q1 to 101 requests for Q2.

The majority of good cause requests (GCRs) during the Q1 of 2017 continue to be due to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. KDHE and the MCOs issued educational materials or information late in 2016, including what could be added to member enrollment packets, to further explain what would be considered "good cause." Unfortunately, GCRs still occur due to providers advising patients to file GCRs to switch plans. One fairly large pediatric practice dropped their contract with one MCO and sent letters to all their patients, advising them to send good cause requests to switch to a different MCO. And as in previous quarters, 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. The remaining requests show varied reasons and causes for changing plans.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the second quarter of 2017, there were 4 state fair hearings filed for a denied GCR. Two had the decision affirmed, one defaulted against the appellant for failure to appear, and the fourth is scheduled for a hearing in August. A summary of GCR actions this quarter is as follows:

Status	April	May	June
Total GCRs filed	31	45	25
Approved	0	0	0
Denied	22	33	20
Withdrawn (resolved, no need to change)	7	5	5
Dismissed (due to inability to contact the member)	2	7	0
Pending	0	0	0

Providers are constantly added to the MCOs' networks, with much of the effort focused upon HCBS service providers. All three MCOs have made a concerted effort to review, revise and update their network adequacy reports based upon State feedback. The networks are not changing significantly, but the network reports generated still require updates.

Quarter one of 2017, the way data was pulled was changed to reflect the number of unique providers per name, NPI and city. Previously, we indicated unique providers by name and NPI, eliminating multiple records for providers who served in more than one city. Since Kansas is a highly rural state with many providers serving in multiple clinic locales, we felt a revision of this report would be a more accurate reflection of network capacity. The MCOs continue to review and correct their data, which explains the changes in numbers:

KanCare MCO	# of Unique Providers as of 9/30/16	# of Unique Providers as of 12/31/16	# of Unique Providers as of 3/31/17	# of Unique Providers as of 6/30/17
Amerigroup	16,623	16,886	16,498/23,758	25,904
Sunflower	20,734	21,391	22,313/30,992	31,780
UHC	24,321	23,778	23,777/39,881	32,216

MLTSS implementation and operation: In the first quarter of 2017, Kansas continued to offer services to individuals on the HCBS-PD Program waiting list, as well as individuals on the HCBS-I/DD Program

waiting list. Kansas offered services to 217 people on the HCBS-PD waiver wait list in the month of April with a 64% acceptance rate. Kansas offered services to 409 people on June 21st. The acceptance rate cannot be calculated at this time because acceptance letters are still outstanding. Kansas offered services to 60 people on the HCBS-IDD waiver wait list in May, 2017 with a 73% acceptance rate.

During this quarter the Money follows the Person (MFP) program transitioned to sustainability services. KDADS sought input from stakeholders and MCO on a proposed policy to continue to encourage supports designed to move members to community based services. Current members of the MFP program will continue to receive supports during the 365 days post-transition.

i. Updates on the safety net care pool including DSRIP activities: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continued identifying community partners, creating training for community partners, and working toward reaching the project milestones for the DY4. The State made the DY4 annual payment to the hospitals on May 12, 2017.

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

- The Serious Emotional Disturbance (SED) waiver has been approved as of April 28th, 2017. The effective date of the waiver is April 1, 2017. The State is continuing to work on processes to ensure a smooth transition with the conflict of interest practice outline in the approved SED waiver. The State is currently working with stakeholders to formulate the most effective way to achieve these approved changes.
- The Autism waiver has been approved as of June 14, 2017. The effective date of the waiver is April 1, 2017. The three services removed from the waiver are now accessible through the Medicaid State Plan. The State is currently working with MCOs to build capacity needed for the remaining three services.

k. *Legislative activity:* The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight, a statutory joint legislative committee, met on April 19, 2017, to review the current state of KanCare and HCBS services.
- The committee received KanCare program updates from KDHE, including eligibility determinations, KanCare contracts re-procurement schedule, and MCO financial status.
- The committee received information from KDADS about state hospital issues, HCBS waiver and waiting list updates, and activities related to the HCBS Settings Rule.
- The committee also received presentations from Kansas Foundation for Medical Care (KFMC) about various reporting measures in KanCare, presentations from each of the KanCare MCOs, received information from the KanCare Ombudsman, and took comments from stakeholders (with related responses from agency and MCO staff).

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: KDHE issues retroactive monthly capitated payments; therefore, the budget neutrality document cannot be reconciled on a quarterly basis to the CMS 64 expenditure report because the CMS 64 reflects only those payments made during the quarter. Based on this, the State is not using the CMS-64 as the source document, but rather is using a monthly financial summary report provided by DXC, the State's fiscal agent. The budget neutrality monitoring spreadsheet for QE 6.30.17 is attached. Utilizing the DXC-provided monthly financial summary, the data is filtered by MEG excluding CHIP and Refugee, and retro payments in the demonstration year are included.

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

VII. Member Month Reporting

Sum of Member Unduplicated Count	**Member Month**			**Totals**
MEG	*2017-04*	*2017-05*	*2017-06*	*Grand Total*
Population 1: ABD/SD Dual	15,046	14,853	14,699	44,598
Population 2: ABD/SD Non Dual	28,773	28,712	28,702	86,187
Population 3: Adults	51,459	51,249	50,834	153,542
Population 4: Children	228,804	229,120	226,330	684,254
Population 5: DD Waiver	8,951	8,941	8,924	26,816
Population 6: LTC	20,406	20,406	20,250	61,062
Population 7: MN Dual	1,282	1,280	1,213	3,775
Population 8: MN Non Dual	1,230	1,210	1,223	3,663
Population 9: Waiver	4,560	4,569	4,619	13,748
Grand Total	**360,511**	**360,340**	**356,794**	**1,077,645**

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

VIII. Consumer Issues

Consumer issues remain static. A summary of second quarter of 2017 consumer issues remains:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Member spenddown issues – spenddown incorrectly applied by plans, causing unpaid claims and inflated patient out of pocket amounts.	MCOs work with the State to monitor and adjust incorrect spenddown amounts. Weekly spreadsheets are sent to the State, showing the MCO remediation efforts.	All affected plans have system correction projects and reprocessing projects continuing in progress. This information is posted on each plan's Issue logs, and the KanCare Claims Resolution Log for providers and the State to review and monitor. MCOs must report spenddown files to the State that track the spenddown files. Unfortunately, this has been a difficult system issue to resolve.
Member authorization denials for variety of reasons. This caused some consumers to have a delay in service.	Most of the denials were due to incomplete authorization requests, which were subsequently denied.	A few authorization and documentation requirements were relaxed, but there are lingering issues due to the process being largely a manual review process. And there are provider errors in billing which cause denials (incorrect dates, units, procedure codes, etc.).
Client obligation assessed on incorrect claims/patients.	MCOs occasionally assess (or fail to assess) client obligation on the correct member and/or claims.	This happens sporadically, and there are multiple causes.
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.	The State discussed this issue with all MCOs during the State on site reviews in 2016. All MCOs were instructed to report this information accurately as there is an existing field for Open/Closed panels. Also, the network adequacy report was revised to include a column for member count, and member capacity. We have instructed the MCOs to submit this information for panel monitoring purposes. MCOS have begun to report using a new template in 2017, and have begun to actively collect and report this data in the quarterly reporting template. The State is also developing guidelines for the provider directory as mandated by CMS.

Issue	Resolution	Action Taken to Prevent Further Occurrences
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. All authorization and customer service employees receive frequent updates on how to deal with retro authorizations. Also instructions for providers on how to submit requests for authorizations on retro eligible members.

Support and assistance for consumers around the state for KanCare was provided by KDHE's out-stationed eligibility workers (OEW). OEW staff assisted in determining eligibility for 4,277 consumers. OEW also assisted in resolving 2,392 issues involving such matters as urgent medical needs, obtaining correct information on applications and addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse. These OEW staff assisted with 1,516 consumer phone calls.

During this quarter, OEW staff also participated in 34 community events providing KanCare program outreach, education and information.

IX. Quality Assurance/Monitoring Activity

Kansas has created a broad-based structure to ensure comprehensive, collaborative and integrated oversight and monitoring of the KanCare Medicaid managed care program. KDHE and KDADS have established the Medicaid Enterprise Leadership (MEL) team for comprehensive oversight and monitoring. The MEL team is a review, feedback and policy direction body partly focusing on the monitoring and implementation of the State's KanCare Quality Improvement Strategy (QIS). The MEL team makes sure that KanCare activity is consistent with the managed care contract and approved terms and conditions of the KanCare 1115(a) Medicaid demonstration waiver. The MEL team directs the policy initiatives of the KanCare Steering Committee, which includes both executive and operational leadership from both KDHE and KDADS.

The following sources of information guide the ongoing review of and updates to the KanCare QIS:

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

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

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

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

During the second quarter of 2017, some of the key quality assurance/monitoring activities have included:

- Quarterly business meetings between KDHE's MCO Management team and cross-function/leadership MCO staff to continue to further develop operational details regarding the KanCare State Quality Strategy. Specific attention was paid to development of the performance measures, pay-for-performance measures and performance improvement projects in the KanCare program.
- Ongoing 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.
- Ongoing interagency and cross-agency collaboration, and coordination with MCOs, to develop and communicate both specific templates to be used for reporting key components of performance for the KanCare program, as well as the protocols, processes and timelines to be used for the ongoing receipt, distribution, review and feedback regarding submitted reports. The process of report management, review and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data.
- Implementation and monitoring of the External Quality Review Organization (EQRO) work plan for 2017, with the associated deliverables detail. The ongoing quarterly business meetings mentioned in first bullet also are used to discuss and plan EQRO activities, the MCO requirements related to those activities, and the associated EQRO timeline/action items.
- Compilation of the comprehensive 2016 annual compliance review of the MCOs – which are done in partnership between Kansas' EQRO and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency.
- Ongoing analysis and workgroups reviewing the new Managed Care rules with the associated changes for quality.

- 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 out 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.
- 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 Survey, Certification and Credentialing Commission (SCCC) 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 Special Terms and Conditions.
- Also for the programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the 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. *HCBS Quality Review reports for CY 2013, 2014, 2015 and through September 2016 are attached to this report.*
- During this quarter, the Quality Assurance team within KDADS began their review of the 1/1/2017 through 3/31/207 period. January – June 2016 and July – September 2016 Quality Review reports were submitted and reviewed during this quarter's LTC Committee meetings.

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping: Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. In addition, each MCO submits quarterly network reports that serve as a tool for KanCare managers to monitor accessibility to certain provider

types. Each MCO also submits a separate report on HCBS service provider participation. Based on these network reports, two reports are published to the KanCare website monthly for public viewing: http://www.kancare.ks.gov/policies-and-reports/network-adequacy

1. Summary and Comparison of Physical and Behavioral Health Network is posted at http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/mco-network-access.pdf?sfvrsn=2. This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
2. HCBS Service Providers by County: http://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/hcbs-providers-by-waiver-service.pdf?sfvrsn=4, includes a network status table of waiver services for each MCO.

b. Customer service reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers, January-June 2017:

KanCare Customer Service Report - Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:23	1.97%	93,531
Sunflower	0:19	1.59%	89,419
United	0:14	0.69%	90.340
DXC – Fiscal Agent	0.00	0.0%	10,261

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Amerigroup	0:24	1.93%	46,906
Sunflower	0:13	1.16%	51,589
United	3:31	0.74%	43,664
DXC – Fiscal Agent	0.00	0.0%	8,754

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 – CY17 2nd Quarter

Amerigroup 2nd Qtr. Grievance Trends		
Total # of Resolved Grievances	130	
Top 5 Trends		
Trend 1: Billing/Fin. Issues (Non Transportation)	32	25%
Trend 2: Transportation No Show	29	22%

Trend 3: Transportation (Including Reimbursement)	21	16%
Trend 4: Customer Service	8	6%
Trend 5: Other	7	5%

Amerigroup Member Grievances:

- The top five Amerigroup member grievances account for 97 (75%) of the total 130 member grievances for CY2017 Qtr. 2
- The largest number of grievances submitted is Billing/Financial Issues (Non Transportation) of which 17 (53%) of the 32 grievances are for providers balance billing
- The second largest number of grievances submitted is Transportation No Show of which 11 (38%) of the 29 grievances are for no driver available. This is a decrease of 25% over CY2017 Qtr. 1 in which 21 (63%) of the 33 grievances were for no driver available
- The third largest number of grievances submitted is Transportation (Including Reimbursement).
- Transportation No Show and Transportation (Including Reimbursement) account for 50 (86%) of the 58 total transportation grievances this quarter
- Transportation grievances for all four categories account for 45% of Amerigroup's member grievances this quarter

Sunflower 2nd Qtr. Grievance Trends		
Total # of Resolved Grievances	151	
Top 5 Trends		
Trend 1: Transportation (Including Reimbursement)	24	16%
Trend 2: Transportation Late	24	16%
Trend 3: Transportation No Show	21	14%
Trend 4: Customer Service	17	11%
Trend 5: Quality of Care (HCBS) and Transportation Safety (both categories had the same number of grievances)	12	8%

Sunflower Member Grievances:

- The top five Sunflower member grievances account for 98 (65%) of the total 151 member grievances for CY2017 Qtr. 2
- The largest number of grievances submitted is Transportation (Including Reimbursement) and Transportation Late. Transportation (Including Reimbursement) had a significant drop from 38 in qtr. 1 to 24 this quarter which is a 37% drop
- Transportation Late had a significant increase from 9 in Qtr. 1 to 24 in Qtr. 2 which is a 62% increase. The State will follow-up with Sunflower's Logisticare Member Experience Team (MET) which was recently formed to address transportation grievances
- The third largest number of grievances submitted is Transportation No Show which had an increase of 8 from the previous quarter
- The fourth largest number of grievances submitted is Customer Service which had a significant decrease of 13 (57%) from the previous quarter

- Transportation grievances for all four categories account for 54% of Sunflower's member grievances this quarter

United 2nd Qtr. Grievance Trends		
Total # of Resolved Grievances	170	
Top 5 Trends		
Trend 1: Billing/Financial Issues (Non Transportation)	55	32%
Trend 2: Transportation Late	30	18%
Trend 3: Quality of Care (Non HCBS, Non Transportation)	24	14%
Trend 4: Transportation (Including Reimbursement)	12	7%
Trend 5: Transportation No Show	11	6%

United Member Grievances:

- The top five United member grievances account for 132 (78%) of the total 170 member grievances for CY2017 Qtr. 2
- The largest number of grievances submitted is for Billing/Financial Issues (Non Transportation) of which 40 (72%) of the 55 grievances are for providers balance billing
- The second largest number of grievances submitted is Transportation Late which has steadily increased each of the last four quarters
- The third largest number of grievances submitted is Quality of Care (Non HCBS, Non Transportation) which with 24 grievances dropped by 14 (37%) from the previous quarter total of 38
- Transportation grievances all four categories account for 35% of United's member grievances this quarter

MCOs' Appeals Trends
Member/Provider – CY17 2nd Quarter

Amerigroup 2nd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	39		**Total # of Resolved Provider Appeals**	709	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Level of Care - LTSS/HCBS	16	41%	**Trend 1: Claim Denied - by MCO Error**	372	52%
Trend 2: Criteria Not Met - Pharmacy	7	18%	**Trend 2: Claim Denied - contained errors**	223	31%
Trend 3: Criteria Not Met - Medical Procedure (NOS)	4	10%	**Trend 3: Criteria Not Met - Pharmacy**	35	5%

Trend 4: Criteria Not Met - Radiology	3	8%	**Trend 4: Criteria Not Met - Inpatient Admissions (Non Behavioral Health)**	19	3%
Trend 5: Criteria Not Met - Inpatient Behavioral Health	3	8%	**Trend 5: Late Notification**	18	3%

Amerigroup Member Appeals:

- The top five Amerigroup member appeals account for 33 (85%) of the total 39 member appeals for CY2017 Qtr. 2. The State is following up with Amerigroup on their number of member appeals due to the significant lower number when comparing them to the other two MCOs
- The first largest number of member appeals submitted is Level of Care – LTSS/HCBS of which 13 (81%) of the 16 appeals are for reduction/elimination of waiver services
- The second largest number of grievances submitted is Criteria Not Met – Pharmacy of which 5 (71%) of the 7 appeals Amerigroup overturned their original decision

Amerigroup Provider Appeals:

- The top five Amerigroup provider appeals account for 667 (94%) of the total 709 provider appeals for CY2017 Qtr. 2
- The first largest number of provider appeals submitted is Claim Denied – by MCO in Error of which 154 (41%) of the 372 appeals Amerigroup overturned their original decision
- The second largest number of provider appeals submitted is Claim Denied – Contained Errors of which 129 (58%) of the 223 appeals Amerigroup overturned their original decision
- The third largest number of provider appeals submitted is Criteria Not Met – Pharmacy of which 30 (86%) of the 35 appeals Amerigroup overturned their original decision. There was a significant drop of 13 from the previous quarter

Sunflower 2nd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	192		**Total # of Resolved Provider Appeals**	384	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	61	32%	**Trend 1: Claim Denied - contained errors**	128	33%
Trend 2: Criteria Not Met - Inpatient Behavioral Health	34	18%	**Trend 2: Criteria Not Met - Vision**	43	11%
Trend 3: Criteria Not Met - Radiology	20	10%	**Trend 3: Claim Denied - by MCO in Error**	38	10%
Trend 4: Criteria Not Met - DME	17	9%	**Trend 4: Late Submission by Member/Member Representative**	37	10%
Trend 5: Criteria Not Met - Medical Procedure (NOS)	15	8%	**Trend 5: No authorization submitted**	33	9%

Sunflower Member Appeals:

- The top five Sunflower member appeals account for 147 (77%) of the total 192 member appeals for CY2017 Qtr. 2
- The first largest number of member appeals submitted is Criteria Not Met – Pharmacy of which 42 (67) of the 61 appeals Sunflower overturned their original decision

- The second largest number of member appeals submitted is Criteria Not Met – Inpatient Behavioral Health which has significantly increased in the last two quarters from 20 member appeals in CY2016 Qtr. 4
- The third largest number of appeals submitted is for Criteria Not Met – Radiology which has a significant increase from 4 (80) last quarter to 20 this quarter
- The fourth largest number of member appeals submitted is Criteria Not Met – DME which 17 is a slight increase from the previous quarter
- The fifth largest number of member appeals submitted is Criteria Not Met – Medical Procedure (NOS) which 9 (60%) of the 15 appeals are medical procedures denied for pain management

Sunflower Provider Appeals:

- The top five Sunflower provider appeals account for 239 (62%) of the total 384 provider appeals for CY2017 Qtr. 2
- The first largest number of provider appeals submitted is Claim Denied – Contained Errors of which 49 (38%) of the 128 appeals Sunflower overturned their original decision
- The second largest number of provider appeals submitted is Criteria Not Met – Vision. The State is following up with Sunflower on their number of these appeals due to the high number in comparing them with the other two MCOs who do not have any for this category over the last four quarters
- The third largest number of provider appeals submitted is Claim Denied – By MCO in Error of which 26 (68%) of the 38 appeals Sunflower overturned their original decision
- The fourth largest number of provider appeals submitted is Late Submission by Member/Member Representative which has a significant increase of 24 from the previous quarter
- The fifth largest number of provider appeals submitted is No Authorization Submitted which has a significant increase of 25 from the previous quarter. The State is following up with Sunflower on their almost 50% increase of provider appeals this quarter from the previous three quarters

United 2nd Qtr. Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	126		**Total # of Resolved Provider Appeals**	580	
Top 5 Trends			**Top 5 Trends**		
Trend 1: Criteria Not Met - Pharmacy	50	40%	**Trend 1: Claim Denied - contained errors**	378	65%
Trend 2: Criteria Not Met - Inpatient Admissions (Non Behavioral Health)	29	23%	**Trend 2: No authorization submitted**	74	13%
Trend 3: Criteria Not Met - DME	13	10%	**Trend 3: Criteria Not Met - Inpatient Admissions (Non Behavioral health)**	58	10%
Trend 4: Criteria Not Met - Behavioral Health Outpatient Services and Testing	10	8%	**Trend 4: Claim Denied - by MCO in error.**	42	7%
Trend 5: Other - Noncovered Services	8	6%	**Trend 5: Other - Not Covered Service**	14	2%

United Member Appeals:

- The top five United member appeals account for 110 (87%) of the total 126 member appeals for CY2017 Qtr. 2
- The first largest number of member appeals submitted is Criteria Not Met – Pharmacy of which 30 (60%) of the 50 appeals United overturned their original decision
- The second largest number of member appeals submitted is Criteria Not Met – Inpatient Admissions (Non Behavioral Health) of which 28 (97%) of the 29 appeals were Withdrawn by the member

United Provider Appeals:

- The top five provider appeals for United account from 566 (98%) of the total 580 provider appeals for CY2017 Qtr. 2
- The first largest number of provider appeals submitted is Claim Denied – Contained Errors which is an increase of 348 from the previous quarter
- The second largest number of provider appeals submitted is No Authorization Submitted which is an increase of 59 from the previous quarter
- The third largest number of provider appeals submitted is Criteria Not Met – Inpatient Admissions (Non Behavioral Health) which had a significant decrease of 41 from the previous quarter
- The fourth largest number of provider appeals submitted is Claim Denied – by MCO in Error; United overturned their original decision for all of these appeals
- The fifth largest number of provider appeals submitted is Other – Not Covered Service which had a significant decrease of 130 from the previous quarter. The State is following up with United on their almost 50% to 65% increase of provider appeals this quarter from the previous three quarters

MCOs' State Fair Hearing Reversed Decisions
Member/Provider – CY17 2nd Quarter

- There were a total of 13 Member State Fair Hearings for all three MCOs. No decisions were reversed by OAH
- There were a total of 172 Provider State Fair Hearings for all three MCOs. No decisions were reversed by OAH

Amerigroup 2nd Qtr.					
Total # of Member SFH	1		**Total # of Provider SFH**	**36**	
OAH reversed MCO decision	0	0%	**OAH reversed MCO decision**	**0**	**0%**

Sunflower 2nd Qtr.					
Total # of Member SFH	5		**Total # of Provider SFH**	118	
OAH reversed MCO decision	0	0%	**OAH reversed MCO decision**	0	0%

United 2nd Qtr.					
Total # of Member SFH	7		**Total # of Provider SFH**	18	
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 for the second quarter of 2017 is attached.

f. Summary of MCO critical incident report: Shifting focus to opportunities for process and system improvement, the Cross-Agency Adverse Incident Management Team drafted a Critical Incident Form for MCOs to track MCO-specific critical incidents and document provider and MCO correspondence,

collaboration and responses to each incident. The team made several suggestions to revise the types of critical incidents and current definitions of critical incidents collected in the Adverse Incident Reporting (AIR) database. An AIR timeline was developed and presented to the MCOs at the December Cross-Agency Adverse Incident Management Team meeting. Also, a review of the performance measures as they correspond to critical incidents was provided to the group to serve as a foundation for the work that needs to be completed. As a result, the Cross-Agency Adverse Incident Management Team agreed to devote more time to this project starting January 1, 2017 and meet bi-weekly until the appropriate processes and systems are in place.

Role and responsibility clarification for all parties will be prioritized and suggestions were made for reducing report duplication across the critical incident management system. The team began reassessing progress related to the applicable KanCare Special Terms and Conditions and documenting advancements by subject area and by agency.

KDADS has made significant progress on this project. Areas that are still being finalized include:

- Developing an automatic feed to pull APS and CPS reports into the AIR system
- Creating reports for each performance measure – specifically unexpected death, restraint, seclusion and restrictive interventions.
- Making final revisions to AIR, if needed, by KDADS IT
- Training MCO representatives once all system changes are in place
- Scheduling monthly meetings with each MCO to provide the appropriate amount of oversight of the AIR system, analyze trends and drill down in to any specific cases as necessary.

KDADS IT staff presented a demonstration of the AIR system for data element identification for future reporting requirements and preferences for canned reports and functionality. The system was revised to reflect the AIR policy revisions and assessed for performance measure reporting accuracy. Coordination meetings to leverage resources continue between KDADS' commissions and state agencies for full implementation.

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 2017 AIRS reports through the quarter ending March 31, 2017 follows:

Critical Incidents	**1st Qtr**	**2nd Qtr**	**3rd Qtr**	**4th Qtr**	**YTD**
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	**TOTALS**
Reviewed	1,610	1,903			3,513
Pending Resolution	0	0			0
Total Received	1,610	1,903			3,513
APS Substantiations*	58	93			151

**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 first and second quarter HCAIP UCC Pool payments were made June 29, 2017. The LPTH/BCCH Pool first and second quarter payments were made May 19, 2017.

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

XII. Demonstration Evaluation

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

For the first quarter of 2017, KFMC's quarterly report is attached. As with the previous evaluation design reports, the State will review the Quarterly Report, with specific attention to the related recommendations, and will continue to take responsive action designed to accomplish enhancements to the state's oversight and monitoring of the KanCare program, and to improve outcomes for members utilizing KanCare services.

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

a. Claims Adjudication Statistics

KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December, 2016, is attached.

b. Waiting List Management

PD Waiting List Management

For the quarter ending June 30, 2017:

- Current number of individuals on the PD Waiting List: 807
- Number of individuals added to the waiting list: 407
- Number of individuals removed from the waiting list: 376
    - 221 started receiving HCBS-PD waiver services
    - 8 were deceased
    - 147 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management

For the quarter ending June 30, 2017:

- Current number of individuals on the I/DD Waiting List: 3,677
- Number of individuals added to the waiting list: 136
- Number of individuals removed from the waiting list: 208
    - 123 started receiving HCBS-I/DD waiver services
    - 85 were removed for other reasons (refused services, voluntary removal, etc.)

The current point-in-time limit for HCBS-I/DD is 8,900. KDADS is currently serving 8,881 individuals.

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
VI	KanCare Budget Neutrality Monitoring Spreadsheet for QE 6.30.17
IX	HCBS Quality Data Reports for 2013 through September 2016
X(e)	Summary of KanCare Ombudsman Activities for QE 6.30.17
XI	KanCare Safety Net Care Pool Report for QE 6.30.17
XII	KFMC KanCare Evaluation Report for QE 6.30.17
XIII(a)	KDHE Summary of Claims Adjudication Statistics for QE 6.30.17

XV. State Contacts

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

XVI. Date Submitted to CMS

August 31, 2017

DY 5
Start Date: 1/1/2017
End Date: 12/31/2017

Quarter 2
Start Date: 4/1/2017
End Date: 6/30/2017

	Total Expenditures	Total Member-Months
Apr-17	$244,979,481	352,446
May-17	$239,928,874	352,893
Jun-17	$237,583,925	354,325
Q2 Total	$722,492,280	1,059,664

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
Apr-17									
Expenditures	$1,354,058	$35,775,082	$26,648,984	$49,079,961	$42,364,270	$74,030,465	$648,327	$2,257,967	$12,820,367
Member-Months	7,313	37,462	52,534	216,479	9,126	21,854	1,496	1,351	4,831
May-17					0				
Expenditures	$1,335,562	$35,091,683	$25,407,451	$49,206,583	$41,574,848	$71,688,873	$756,709	$2,067,291	$12,799,874
Member-Months	7,338	37,709	52,380	217,204	9,131	21,560	1,494	1,283	4,794
Jun-17									
Expenditures	$1,282,608	$35,722,951	$25,957,535	$49,190,719	$41,529,323	$68,478,780	$747,401	$2,308,325	$12,366,283
Member-Months	7,066	37,900	53,459	218,090	9,054	21,109	1,436	1,371	4,840
Q2 Total									
Expenditures	$3,972,228	$106,589,716	$78,013,970	$147,477,263	$125,468,441	$214,198,118	$2,152,437	$6,633,583	$37,986,524
Member-Months	21,717	113,071	158,373	651,773	27,311	64,523	4,426	4,005	14,465
DY 5 - Q2 PMPM	$183	$943	$493	$226	$4,594	$3,320	$486	$1,656	$2,626

Appendix 2: 2013 Performance Measures **Mental Health/Serious Emotional Disturbance**		Compliance Percentage	Explanation/Remediation
1	Percentage of Members reporting their physical health as good within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
2	The Percentage of Members reporting they are connected to the people who support them the most within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
3	The Percentage of Members reporting they are doing what they want for their work within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
4	Percentage of adults with an SPMI who report having a place to live that is comfortable for them.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
5	The CONTRACTOR will ensure CMHC providers offer timely initial appointments. All new Members will be offered an initial appointment within 10 calendar days.	78%	
6	The CONTRACTOR will maintain the following access standards for screening by a CMHC for institutional care: **Post-Stabilization** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Emergent** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Urgent** - 24 hours from initial contact to arrival of CMHC staff to the emergency room setting.		
7	100% of clinical eligibility exception requests will receive a response from the Operating Agency within the three business days required timeframe.	FFY2013: 87%	
8	100% of participants reviewed will have a POC that were adequate and appropriate to their needs (including health care needs) as indicated in their assessments.	92%	
9	100% percent of participants reviewed POC's have adequate and appropriate strategies to address their safety risks as in indicated in their assessments.	99%	
10	100% of POCs address goals as indicated in the participants' assessments.	98%	

Appendix 2: 2013 Performance Measures **Mental Health/Serious Emotional Disturbance**		Compliance Percentage	Explanation/Remediation
11	100% of participants' POC include the participant's and or parent or caregiver's signature as specified in the approved SED Waiver.	93%	
12	100% of participants' POC are developed by a wraparound team.	98%	
13	100% of participants POC will be reviewed within 90 days of the last review.	80%	
14	100% of participants POCs will be updated when warranted by changes in participant needs.	85%	
15	100% of participants will receive services as specified in the POC.	13%	
16	100% of participant records will contain an appropriately completed and signed FCAD (freedom of choice form) that specifies choice was offered between institutional and SED Waiver services.	99%	
17	100% of participant records will contain an appropriate completed and signed FCAD (freedom of choice form) that specifies choices were offered among SED Waiver services and providers.	98%	
18	100% of provider agencies, who deliver SED Waiver services, initially meeting licensure requirements prior to furnishing SED Waiver services.	100%	
19	100% of provider agencies, who deliver SED Waiver services, will continuously meet licensure requirements while furnishing SED Waiver services.	100%	
20	100% of provider agencies, who deliver SED Waiver services, will have an active agreement with the State Medicaid Fiscal Agent.	100%	
21	100% of non-licensed/non-certified providers of SED Waiver services will meet training requirements.	89%	
22	100% newly developed or revised provider training will be approved by the Operating Agency.		

Appendix 2: 2013 Performance Measures **Mental Health/Serious Emotional Disturbance**		Compliance Percentage	Explanation/Remediation
23	100% of active providers (by provider type) will meet training requirements.	88%	
24	100% of reports related to the abuse, neglect, or exploitation of participants where an investigation was initiated within the established time frames.	100%	
25	100% of participants will receive information on how to report suspected abuse, neglect, or exploitation of children.	FFY2013: 89%	
26	100% of participants will receive information regarding their rights to a State Fair Hearing via the Notice of Action (NOA) form.	99%	
27	100% of allegations of abuse neglect or exploitation screened in, investigated, and will have a determination made within the required timeframe as indicated by SRS Children and Family Services Policies and Procedures.	100%	
28	100% of aggregated performance measure reports, generated by the Operating Agency and reviewed by the State Medicaid Agency, will contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	N/A during the reporting period	
29	100% of SED Waiver amendments, renewals and financial reports will be approved by the State Medicaid Agency prior to implementation by the Operating Agency.	100%	
30	100% of SED Waiver concepts and policies requiring new or additional MMIS programming will be approved by the State Medicaid Agency prior to implementation by the Operating Agency.	N/A during the reporting period	
31	The number and percent of paid claims for SED Waiver services reviewed that did not result in recoupment.	98%	
32	The number and percent of claims verified through the CONTRACTOR(S) CONTRACTOR's compliance audit to have paid in accordance with the participant's SED Waiver service plan.	98%	

Appendix 2: 2013 Performance Measures **Mental Health/Serious Emotional Disturbance**		Compliance Percentage	Explanation/Remediation
33	The number and percent of participants' annual level of care determinations where the level of care criteria was applied correctly on the annual evaluation form.	77%	
34	The number and percent of initial Level of Care determinations made by a qualified evaluator	99%	
35	The number and percent of participants' initial Level of Care assessment instruments that demonstrated participants met criteria, as specified in the approved waiver.	FFY2013: 99%	
36	The number and percent of participants who receive their annual Level of Care evaluation within twelve months of the previous Level of Care evaluation.	93%	
37	The number and percent of participants who were determined to meet Level of Care/clinical eligibility requirements prior to receiving waiver services.	99%	
38	The percentage of adult Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	10%	
39	The percentage of youth Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	7%	
40	The percentage of youth Members readmitted to an inpatient psychiatric facility within 90 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	11%	
41	The average number of inpatient days per youth for all youth Members discharged from a PRTF during the reporting period.	ALOS 73	

Appendix 4: 2013 Performance Measures **DD Wavier**		Compliance Percentage	Explanation/Remediation
1	100% of new enrollees in sample who had a LOC indicating need for institutional LOC prior to receipt of services.	99%	
2	100% of participants receiving annual reassessment within 12 months of initial or 12 months of last reassessment.	97%	
3	100% of participants receiving LOC determination assessment are appropriately eligible receiving waiver services.	98%	
4	100% of participants receiving LOC determination reassessment with approved assessment tool during current service year.	97%	
5	100% of participants receiving LOC reassessment by an approved assessor during current service year.	92%	
6	100% of aggregated performance measure reports generated by the Operating agency and reviewed by the Medicaid agency contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	25%	Due to timing associated with quality review and data collection, annual numbers were provided to the Medicaid agency as opposed to quarterly. Moving forward processes changes have been made that will allow for quarterly reporting of results to be provided regularly.
7	100% of waiver amendments, renewals, and financial reports were approved by the Medicaid agency prior to implementation by the Operating agency.	100%	
8	100% of waiver concepts and policies requiring MMIS programming provided by the Operating agency are approved by the Medicaid agency prior to development of a formal implementation plan by the Operating agency.	100%	
9	100% of sample new providers have obtained appropriate licensure/certification	98%	
10	100% of sample enrolled providers meet applicable license / certification requirements	98%	
11	100% of sample new providers meet provider qualifications, including training requirements.		KDADS staff is working to develop an audit of the MCOs to evaluate compliance with provider qualification requirements in the first year of KanCare. The review will focus on a random and statistically significant sample of providers for CY 2013 by MCO.
12	100% of sample enrolled providers meet provider qualifications, including training requirements.		KDADS staff is working to develop an audit of the MCOs to evaluate compliance with provider qualification requirements in the first year of KanCare. The review will focus on a random and statistically significant sample of providers for CY 2013 by MCO.
13	100% of sample enrolled providers meet established training requirements.	99%	
14	100% of sample participants have service plans that address functional needs during service year.	99%	
15	100% of sample participants have service plans that address health and safety risk factors during service year.	99%	

Appendix 4: 2013 Performance Measures **DD Wavier**		Compliance Percentage	Explanation/Remediation
16	100% of sample participants have service plans that address personal goals during the service year.	99%	
17	100% of sample participants have a service plan developed in accordance with approved procedures.	98%	
18	100% of sample participants have service plan updated annually.	97%	
19	100% of sample participants have service plans updated/revised as warranted by participants' needs.	97%	
20	100% of sample participants receive services in the type, scope, and frequency identified in service plan.	98%	
21	100% of sample participants have signed choice form.		Due to the transition to KanCare, KDADS does not have data available for this measure.
22	100% of sample participant's records have documentation that specifies choice of HCBS provider.	99%	
23	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation.	99%	
24	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation.	99%	
25	100% of ANE reports are screened for appropriate investigation.	100%	
26	100% of ANE reports are appropriately substantiated.	100%	
27	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver	100%	
28	100% of claims not in accordance with the reimbursement methodology are denied/suspended.	100%	
29	100% of claims paid are supported with appropriate documentation.	100%	
30	100% of FMS Providers utilize Electronic Visit Verification		

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
1	100% of new enrollees in sample who had a LOC indicating need for institutional LOC prior to receipt of services.	64%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure timely completion of assessments. The measure reflects incomplete documentation of prior assessments that was not available or not provided timely by the previous assessing entity. In 2013, Kansas provided additional training and guidance regarding the policy and required documentation for LOC assessments. For consistency, management of the contract for the assessing entity has been transferred to the commission managing the waiver.
2	100% of participants receiving annual reassessment within 12 months of initial or 12 months of last reassessment.	47%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. Some of the original assessments were not readily available for the new assessing entities, during the transition phase and individuals were allowed to continue receiving services until a reassessment has been completed. This resulted in some assessments being completed outside of the 365 day window. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure timely completion of assessments.
3	100% of participants receiving LOC determination assessment are appropriately eligible receiving waiver services	73%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. During regular reviews of the data, the State identified this deficiency and began remediation efforts to ensure accurate initial assessments based on waiver eligibility was reviewed and approved by the State. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure accurate completion of assessments.
4	100% of participants receiving LOC determination reassessment with approved assessment tool during current service year.	93%	

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
5	100% of participants receiving LOC reassessment by an approved assessor during current service year.	19%	The contract for the 2013 assessments was changed in October of 2012. At the time, trainings were conducted by KDADS staff for the new assessors, specific to correct completion of the FAI and upload into KAMIS. This training was conducted in multiple venues and platforms but did not generate a certificate for completion. This measure failed due to lack of documentation of evidence the individual assessors had completed these two specific trainings. KDADS will begin to issue a certificate of completion to assure proper documentation can be maintained.
6	100% of aggregated performance measure reports generated by the Operating agency and reviewed by the Medicaid agency contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	Due to the transition to KanCare, KDADS does not have data available for this measure.	
7	100% of waiver amendments, renewals, and financial reports were approved by the Medicaid agency prior to implementation by the Operating agency.	N/A	
8	100% of waiver concepts and policies requiring MMIS programming provided by the Operating agency are approved by the Medicaid agency prior to development of a formal implementation plan by the Operating agency.	N/A	
9	100% of sample new providers have obtained appropriate licensure/certification.	100%	
10	100% of sample enrolled providers meet applicable license / certification requirements.	100%	
11	100% of sample new providers meet provider qualifications, including training requirements.	75%	For implementation of KanCare in 2013 and in compliance with the 1115 special terms and conditions, managed care organizations maintained services and supports to existing providers even if they had not completed all credentialing requirements to ensure continuity of care during transition. MCOs had limited ability to

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
			collect timely documentation from smaller existing HCBS providers, some of which may no longer be qualified providers. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Additional training was completed to ensure the MCOs ensure all current providers are qualified, collect appropriate documentation as part of credentialing, and maintain evidence of qualified providers.
12	100% of sample enrolled providers meet provider qualifications, including training requirements.	75%	For implementation of KanCare in 2013 and in compliance with the 1115 special terms and conditions, managed care organizations maintained services and supports to existing providers even if they had not completed all credentialing requirements to ensure continuity of care during transition. MCOs had limited ability to collect timely documentation from smaller existing HCBS providers, some of which may no longer be qualified providers. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Additional training was completed to ensure the MCOs ensure all current providers are qualified, collect appropriate documentation as part of credentialing, and maintain evidence of qualified providers.
13	100% of sample enrolled providers meet established training requirements.		
14	100% of sample participants have service plans that address functional needs during service year.	86%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Some of the plans identified in 2013 were plans based on the previous year (2012), and the new service plans in 2014 should reflect the remediation efforts.

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
15	100% of sample participants have service plans that address health and safety risk factors during service year.	90%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. This is expected to be a temporary decrease in plans addressing health and safety risks attributed to establishing new processes within the MCOs and an increased number of health and safety risk factors identified based on coordination of physical health and behavioral health under managed care.
16	100% of sample participants have service plans that address personal goals during the service year.	55%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Some of the plans identified in 2013 were plans based on the previous year (2012); however, most integrated service plans only included generic goals found on most plans and did not include personal goals. There appears to be a correlation with earlier measures that is being remediated with updated person-centered planning processes and integrated service plans.
17	100% of sample participants have a service plan developed in accordance with approved procedures.	80%	This measure is reported as a composite measure of earlier measures. Non-compliance in any performance measure was identified as non-compliant for this measure. This measure has a direct correlation to earlier measures and remediation efforts in those areas will impact the results of this measure. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Program Managers worked with MCOs to address concerns about the consistent application of policies and procedures. Ongoing remediation in 2013 and 2014 addressed timeline requirements and waiver procedures for ensuring timely accuracy.

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
18	100% of sample participants have service plan updated annually.	82%	For the first 3 months of 2013, Kansas extended all existing plans of care through March 31, 2013 to ensure continuity of care during the transition process for all HCBS programs. This extended some plans of care beyond the review period. This is expected to be a temporary decrease in annual review of plans, as MCOs maintained previous plans of care (from 2012) during the transition period unless there was a significant change in circumstances warranting an immediate review of services and needs and an update to the plan of care.
19	100% of sample participants have service plans updated/revised as warranted by participants' needs.	75%	In the past, this Performance Measure relied upon a Case File question that asked about the reason for the most recent UAI and whether it was due to a change in medical condition. However, since designing the question, the State has determined as a result of its own follow-up and remediation efforts that the data obtained through the question does not support the Performance Measure. The question only captured the reason for the most recent assessment, but it did not capture whether there was a change in the first place that warranted a new assessment and/or a new Plan of Care. In partnership with Truven Health Analytics, the State has developed a new performance measure to capture this data in the future.
20	100% of sample participants receive services in the type, scope, and frequency identified in service plan	85%	In 2014, Kansas amended the waiver after developing global quality assurance measures based on new CMS guidance and with technical assistance from Truven. This measure was determined to no longer be applicable under the Managed Care delivery model. Additionally, Kansas received limited response to the consumer interviews for this measure, which has been adjusted to include other data sources for validation. Additionally, this measure may have been impacted by the number of individuals who responded differently to this question because they had a change to their service plan in 2013, following the continuity of care period, which may have increased, decreased or changed the services they received in 2013. Some individuals have 2 or more service plans during the review period.
21	100% of sample participants have signed choice form.	64%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with

Appendix 5: 2013 Performance Measures **PD Waiver**		Compliance Percentage	Explanation/Remediation
			MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. In 2013, MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
22	100% of sample participant's records have documentation that specifies choice of HCBS provider.	52%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
23	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation.	65%	
24	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation.	N/A	
25	100% of ANE reports are screened for appropriate investigation.	100%	
26	100% of ANE reports are appropriately substantiated.	13%	
27	100% of reviewed claims paid are in accordance with the reimbursement methodology specified in the waiver		
28	100% of reviewed claims not in accordance with the reimbursement methodology are denied/suspended.	N/A	
29	100% of reviewed claims paid are supported with appropriate documentation.	N/A	

Appendix 5: 2013 Performance Measures **PD Waiver**	Compliance Percentage	Explanation/Remediation

30	100% of claims paid are supported with appropriate documentation.	N/A	
31	100% of FMS Providers utilize Electronic Visit Verification		

Appendix 6: 2013 Performance Measures **Traumatic Brain Injury**		Compliance Percentage	Explanation/Remediation
1	100% of new enrollees in sample who had a LOC indicating need for institutional LOC prior to receipt of services.	62%	
2	100% of participants receiving annual reassessment within 12 months of initial or 12 months of last reassessment.	39%	
3	100% of participants receiving LOC determination assessment are appropriately eligible receiving waiver services.	58%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
4	100% of participant's receiving LOC determination reassessment with approved assessment tool during current service year.	64%	
5	100% of participant's receiving LOC reassessment by an approved assessor during current service year.	57%	
6	100% of aggregated performance measure reports generated by the Operating agency and reviewed by the Medicaid agency contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	25%	Due to timing associated with quality review and data collection annual numbers were provided to the Medicaid agency as opposed to quarterly. Moving forward processes changes have been made that will allow for quarterly reporting of results to be provided regularly.
7	100% of waiver amendments, renewals, and financial reports were approved by the Medicaid agency prior to implementation by the Operating agency.	100%	
8	100% of waiver concepts and policies requiring MMIS programming provided by the Operating agency are approved by the Medicaid agency prior to development of a formal implementation plan by the Operating agency.	100%	
9	100% of sample enrolled providers meet applicable license / certification requirements.	89%	
10	100% of sample new providers meet provider qualifications, including training requirements.		

Appendix 6: 2013 Performance Measures **Traumatic Brain Injury**	Compliance Percentage	Explanation/Remediation

11	100% of sample new providers meet provider qualifications, including training requirements.	88%	
12	100% of sample enrolled providers meet provider qualifications, including training requirements.	88%	
13	100% of sample enrolled providers meet established training requirements.		
14	100% of sample participants have service plans that address functional needs during service year.	72%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
15	100% of sample participants have service plans that address health and safety risk factors during service year.	84%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
16	100% of sample participants have service plans that address personal goals during the service year.	44%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
17	100% of sample participants have a service plan developed in accordance with approved procedures.	64%	This measure is reported as a composite measure of earlier measures. Non-compliance in any performance measure was identified as non-compliant for this measure. This measure has a direct correlation to earlier measures and remediation efforts in those areas will impact the results of this measure. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Program Managers worked with MCOs

Appendix 6: 2013 Performance Measures **Traumatic Brain Injury**		Compliance Percentage	Explanation/Remediation
			to address concerns about the consistent application of policies and procedures. Kansas identified a gap in information and records for MCOs related to the Autism program, contracting and credentialing, and capacity. While Autism waiver participants had a service plan, they were not always conducted within the approved timeframes and appropriate timelines. Ongoing remediation in 2013 and 2014 addressed contracting and credentialing delays and capacity issues that contributed to the decline in this measure.
18	100% of sample participants have service plan updated annually.	60%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
19	100% of sample participants have service plans updated/revised as warranted by participants' needs.	53%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
20	100% of sample participants receive services in the type, scope, and frequency identified in service plan.	70%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
21	100% of sample participants have signed choice form.	53%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has

Appendix 6: 2013 Performance Measures **Traumatic Brain Injury**		Compliance Percentage	Explanation/Remediation
			occurred and the program performance measures are met in accordance with CMS requirements.
22	100% of sample participant's records have documentation that specifies choice of HCBS provider.	44%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
23	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation.	57%	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements
24	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect, and exploitation.	N/A	During the first year of post KanCare implementation, the State discovered areas of concern, relating to the performance measures, which required the provision of technical assistance, training, and policy clarification. The State provided guidance to contracted entities to remediate any discoveries identified less than 87%. In 2014, the State will conduct heightened scrutiny reviews targeting areas of concern to ensure that remediation has occurred and the program performance measures are met in accordance with CMS requirements.
25	100% of ANE reports are screened for appropriate investigation.	100%	
26	100% of ANE reports are appropriately substantiated.	16%	
27	100% of reviewed claims paid are in accordance with the reimbursement methodology specified in the waiver.		
28	100% of reviewed claims not in accordance with the reimbursement methodology are denied /suspended.		
29	100% of reviewed claims paid are supported with appropriate documentation.		

Appendix 6: 2013 Performance Measures **Traumatic Brain Injury**	Compliance Percentage	Explanation/Remediation
30	90% of persons receiving waiver services are making progress in rehabilitation and/or independent living skills training.		
31	100% of FMS Providers utilize Electronic Visit Verification		

Appendix 7: 2013 Performance Measures **TA Waiver**		Compliance Percentage	Explanation/Remediation
1	Percentage of children with re-hospitalization within the first 6 months of program admission.		
2	100% of new enrollees in sample who had a LOC indicating need for institutional LOC prior to receipt of services.	97%	
3	100% of participants receiving annual reassessment within 12 months of initial or 12 months of last reassessment.	94%	
4	100% of participants receiving LOC determination assessment are appropriately eligible receiving waiver services.	93%	
5	100% of participants receiving LOC determination reassessment with approved assessment tool during current service year.	93%	
6	100% of participants receiving LOC reassessment by an approved assessor during current service year.	93%	
7	100% of aggregated performance measure reports generated by the Operating agency and reviewed by the Medicaid agency contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.		
8	100% of waiver amendments, renewals, and financial reports were approved by the Medicaid agency prior to implementation by the Operating agency.	100%	
9	100% of waiver concepts and policies requiring MMIS programming provided by the Operating agency are approved by the Medicaid agency prior to development of a formal implementation plan by the Operating agency.	N/A during this reporting period	
10	100% of sample new providers have obtained appropriate licensure/certification.	93%	
11	100% of sample enrolled providers meet applicable license/certification requirements.	93%	
12	100% of sample new providers meet provider qualifications, including training requirements.		

Appendix 7: 2013 Performance Measures **TA Waiver**	Compliance Percentage	Explanation/Remediation

13	100% of sample enrolled providers meet provider qualifications, including training requirements.		
14	100% of sample enrolled providers meet established training requirements.		
15	100% of sample participants have service plans that address functional needs during service year.	96%	
16	100% of sample participants have service plans that address health and safety risk factors during service year.	96%	
17	100% of sample participants have service plans that address personal goals during the service year.	96%	
18	100% of sample participants have a service plan developed in accordance with approved procedures.		Explanation: This measure is reported as a composite measure of earlier measures. Non-compliance in any performance measure was identified as non-compliant for this measure. This measure has a direct correlation to earlier measures and remediation efforts in those areas will impact the results of this measure. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Program Managers worked with MCOs to address concerns about the consistent application of policies and procedures. Kansas identified a gap in information and records for MCOs related to the Autism program, contracting and credentialing, and capacity. While Autism waiver participants had a service plan, they were not always conducted within the approved timeframes and appropriate timelines. Ongoing remediation in 2013 and 2014 addressed contracting and credentialing delays and capacity issues that contributed to the decline in this measure.
19	100% of sample participants have service plan updated annually.	92%	
20	100% of sample participants have service plans updated/revised as warranted by participants' needs.	92%	

Appendix 7: 2013 Performance Measures **TA Waiver**		Compliance Percentage	Explanation/Remediation
21	100% of sample participants receive services in the type, scope, and frequency identified in service plan.	100%	
22	100% of sample participants have signed choice form.	96%	
23	100% of sample participants' records have documentation that specifies choice of HCBS provider.	96%	
24	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation.	86**%**	Explanation: This measure was remediated through technical assistance with MCO. The MCO remediation includes care/service coordinator providing information on how to report potential abuse, neglect and exploitation as part information and assistance to the participant and family. The MCO provides evidence to this assurance through documentation on the integrated service plan of care.
25	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation.		
26	100% of ANE reports are screened for appropriate investigation	100%	
27	100% of ANE reports are appropriately substantiated.	0%	
28	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver.	100%	
29	100% of claims not in accordance with the reimbursement methodology are denied or suspended.		
30	100% of claims paid are supported with appropriate documentation.		
31	100% of FMS Providers utilize Electronic Visit Verification.		

Appendix 8: 2013 Performance Measures **Autism Waiver and ICF/MRs**		Compliance Percentage	Explanation/Remediation
1	100% of new enrollees in sample who had a LOC indicating need for institutional LOC prior to receipt of services.	82%	Kansas reviewed the record review results with the assessing entity and provided guidance on the policy, appropriate scheduling of assessments, and documentation collection and retention.
2	100% of participants receiving annual reassessment within 12 months of initial or 12 months of last reassessment	68%	The definitional standard of annual redetermination was changed within Kansas from annual, to within 365 days. KDADS providing additional policy and compliance guidance to the single contractor the AU assessment responsibility.
3	100% of participants receiving LOC determination assessment are appropriately eligible receiving waiver services.	89%	
4	100% of participants receiving LOC determination reassessment with approved assessment tool during current service year.	88%	
5	100% of participants receiving LOC reassessment by an approved assessor during current service year.	0%	Review of the 3 autism assessors in 2013 revealed each of the assessors was missing at least 1 component of the required documentation to show full compliance. The non-compliance was specific to the inability to provide documentation as opposed to the actual qualifications of the assessors. Specifically, missing proof of auto insurance, or lack of documentation for "no match" results of child protective services abuse registry. The state has provided the contractor with guidance that is must maintain evidence that the assessors have been cleared all background checks, including documentation that no matches exist, and that auto insurance must be kept on file.
6	100% of aggregated performance measure reports generated by the Operating agency and reviewed by the Medicaid agency contain discovery, remediation and system improvement efforts for ongoing compliance of the assurances.	25%	Due to timing associated with quality review and data collection annual numbers were provided to the Medicaid agency as opposed to quarterly. Moving forward processes changes have been made that will allow for quarterly reporting of results to be provided regularly.
7	100% of waiver amendments, renewals, and financial reports were approved by the Medicaid agency prior to implementation by the Operating agency.	100%	
8	100% of waiver concepts and policies requiring MMIS programming provided by the Operating agency are approved by the Medicaid agency prior to development of a formal implementation plan by the Operating agency.	N/A – none during this reporting period	
9	100% of sample new providers have obtained appropriate licensure/certification.	100%	

Appendix 8: 2013 Performance Measures **Autism Waiver and ICF/MRs**	Compliance Percentage	Explanation/Remediation

10	100% of sample enrolled providers meet applicable license / certification requirements.	100%	
11	100% of sample new providers meet provider qualifications, including training requirements.	82%	For implementation of KanCare in 2013 and in compliance with the 1115 special terms and conditions, managed care organizations maintained services and supports to existing providers even if they had not completed all credentialing requirements to ensure continuity of care during transition. MCOs had limited ability to collect timely documentation from smaller existing HCBS providers, some of which may no longer be qualified providers. Kansas identified a gap in information and records for MCOs related to the Autism program, contracting and credentialing, and capacity. Kansas increased the number of children served on the program from 45 to 65 in November 2013. Ongoing remediation in 2013 and 2014 addressed contracting and credentialing delays and capacity issues that contributed to the decline in this measure and Kansas reported in its Quarterly KanCare report on the resulting new policies to ensure all Autism providers continue to meet all provider qualifications.
12	100% of sample enrolled providers meet provider qualifications, including training requirements.	91%	
13	100% of sample enrolled providers meet established training requirements.	N/A	The State recently collaborated with CMS' technical contractor and CMS to develop performance measures and tracking methods to capture this information.
14	100% of sample participants have service plans that address functional needs during service year.	59%	Kansas expanded the program from 45 to 65 in November of 2013. The MCOS and their provider networks required expansion to meet the needs of these participants. Children were eligible in November 2013 and services were started in 2014, and KDADS worked with KDHE to improve the credentialing criteria to avoid similar limits in the future.
15	100% of sample participants have service plans that address health and safety risk factors during service year.	64%	In 2013, a number of Autism waiver participants (59%) did not have service plans that addressed functional needs during the current service year. Remediation processes were instituted during the MCO Technical Assistance calls. The remaining five percent had service plans that addressed functional needs but the service plans did not address health and safety risk factors during the current service year. Service plan development guidance has been provided to the MCOs and the state implemented additional monitoring

Appendix 8: 2013 Performance Measures **Autism Waiver and ICF/MRs**	Compliance Percentage	Explanation/Remediation
		efforts to assess ongoing performance.
16	100% of sample participants have service plans that address personal goals during the service year.	58%	This measure correlates to the expansion of the individuals served on the waiver in 2013. The state initiated MCO technical assistance calls to provide guidance and monitor development of IBPs to assure compliance for 2014.
17	100% of sample participants have a service plan developed in accordance with approved procedures.	55%	This measure has a direct correlation to earlier measures and remediation efforts in those areas will impact the results of this measure. Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation.
18	100% of sample participants have service plan updated annually.	64%	For the first 3 months of 2013, Kansas extended all existing plans of care through March 31, 2013 to ensure continuity of care during the transition process for all HCBS programs. This extended some plans of care beyond the review period. This is expected to be a temporary decrease in annual review of plans, as MCOs maintained previous plans of care (from 2012) during the transition period unless there was a significant change in circumstances warranting an immediate review of services and needs and an update to the plan of care. 2014 record review is expected to reflect improvements in this measures based on the remediation efforts.
19	100% of sample participants have service plans updated/revised as warranted by participants' needs.	45%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas addressed the process and procedures related to updating plans of care based on the participant's needs. While services needed to address changing circumstances, integrated service plans of care were not consistently updated. 2014 record review is expected to demonstrate improvements in this measure related to 2013 and 2014 remediation efforts.
20	100% of sample participants receive services in the type, scope, and frequency identified in service plan.	**50%**	In 2014, Kansas amended the waiver after developing global quality assurance measures based on new CMS guidance and with technical assistance from Truven. This measure was determined to no longer be applicable under the Managed Care delivery model. Additionally, Kansas received limited response to the consumer interviews for this measure, which has been adjusted to include other data sources for

Appendix 8: 2013 Performance Measures **Autism Waiver and ICF/MRs**	Compliance Percentage	Explanation/Remediation
		validation.
21	100% of sample participants have signed choice form.	55%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. In 2013, MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
22	100% of sample participant's records have documentation that specifies choice of HCBS provider.	40%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
23	100% of sample participants / families know how to identify, prevent and protect from abuse, neglect and exploitation.	90%	
24	100% of sample providers have adequate training to prevent, protect from and report abuse, neglect and exploitation.	8%	As part of the 2013 remediation, KDADS through technical assistance with MCO health plans, facilitated remediation for this measure by ensuring that the MCOs document education/ training that the participants received for the purpose of protecting from, and reporting abuse, neglect, and exploitation. MCOs document education/ training was received on the participant's Integrated Service Plan (ISP).
25	100% of ANE reports are screened for appropriate investigation.	100%	
26	100% of ANE reports are appropriately substantiated.	0%	
27	100% of claims paid are in accordance with the reimbursement methodology specified in the waiver.	100%	
28	100% of claims not in accordance with the reimbursement methodology are denied or suspended.	19%	

Appendix 8: 2013 Performance Measures **Autism Waiver and ICF/MRs**		Compliance Percentage	Explanation/Remediation
29	100% of reviewed claims paid are supported with appropriate documentation.		
30	The Vineland scores show a 40% overall improvement for participants on the waiver.		
31	100% of sample support staff have adequate knowledge to prevent, protect from, and report abuse, neglect and exploitation.	100%	
32	100% of sample number of waiver participants/families report the participant is safe when receiving HCBS waiver services.		
33	100% of all admissions to the ICF/MR have gone through the LOC assessment process completed by the Local CDDO.		
34	100% of those participants who are "ward of the court" seeking admission to an ICF/MR have obtained courts' approval.		
35	100 % of all admissions to an ICF/MR meet the Condition of participation: Active treatment services.		
36	100% of all participants must receive a continuous active treatment program.		
37	100% of all ICF/MR facilities will submit accurate and timely cost reports.		
38	100% of participants in an ICF/MR will not be younger than 16 years of age.		
39	100% of ICF/MR facilities will be either classified as small or medium size facility.		

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**		Methodology	Compliance Percentage	Explanation/Remediation
1	90% of clean FE claims (claims that do not trigger an edit for denial or suspension) are processed within 14 days	N= Number of FE claims not denied or suspended during the review period but paid within 14 days. D= Total number of FE claims received that are not denied or suspended during the review period.		
2	99.5% of clean FE claims (claims that do not trigger an edit for denial or suspension) are processed within 21 days	N= Number of FE claims not denied or suspended but paid within 21 days during the review period. D= Total number of FE claims received that are not denied or suspended during the review period.		
3	100% of valid claims Plans of Care are processed within 60 days	N= Number of FE claims for Medicaid approved Plans of Care that are paid within 60 days during the review period. D= Total number of FE claims received that are for Medicaid approved Plans of Care during the review period.		
4	100%	N= Number of FE provider claims paid in accordance with the State's approved reimbursement methodology during the review period. D= Total number of FE provider claims paid during the review period.		
5	5% improvement in Member satisfaction rate	N= Number of customers who are surveyed and report satisfaction during the review period. D= Total number of customers who are surveyed during the review period.		
6	100%	N= Number & percent of reports submitted by KDADS. D= Total number of and percent of QRRs reviewed by KDHE.	25%	Due to timing associated with quality review and data collection, annual numbers were provided to the Medicaid agency as opposed to quarterly. Moving forward, process changes have been made that will allow for quarterly reporting of results to be provided regularly.
7	100%	N= Number of policies approved by KDADS. D= Total number of policies submitted to Medicaid Agency prior to implementation.	N/A – none during this reporting period	
8	100%	N= Number of Field Services Manual policy changes. D= Number of notifications state Medicaid agency received prior to implementation.	N/A – none during this reporting period	
9	100%	N= Number of LTC meeting attended by KDADs Program Manager. D= Total number of LTC meetings held by KDHE.	100%	
10	100%	N= Number of new participants seeking services who have a level of care indicating need for institutional level of care. D= Total number of new enrollees.	81%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. During 2013, the State implemented Technical Assistance calls and amended its

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**	Methodology	Compliance Percentage	Explanation/Remediation
			contract to ensure timely completion of assessments. Additional guidance was given to the contractor regarding the policy and required documentation for LOC assessments. For consistency, management of the contract for the assessing entity has been transferred to the commission managing the waiver.
11	N= Number of case file reviews reflect eligibility determination was made within 6 working days of intake. D= Total number of files reviewed.	58%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure timely completion of assessments. The State expects to see improvements for 2014 reports.
12	N= Number of participants who received an annual determination within 365 days. D= Total number of participants who received an annual redetermination.	68%	In October 2012, Kansas transitioned assessments from the Centers for Independent Living to the Aging and Disability Resource Center, which is currently contracted with the State's Area Agencies on Aging. Some of the original assessments were not readily available for the new assessing entities during the transition phase and individuals were allowed to continue receiving services until a reassessment was completed. This resulted in some assessments being completed outside of the 365 day window. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure timely completion of assessments. The State expects to see improvements for 2014 reports.
13	N= Number of participants receiving initial and annual Level of Care determinations made on state's approved form. D= Total number of participant initial and annual Level of Care determinations.	88%	In December 2012, Kansas transitioned assessments from the Uniform Assessment Instrument to the Functional Assessment Instrument. This resulted in some individuals not receiving the appropriate assessment during the reassessment period for the current year. During regular reviews of the data, the State identified this deficiency and began remediation efforts to ensure accurate reassessments were completed. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure accurate completion of assessments. The State expects to see improvements for 2014 reports.
14	N= Number of participants who received LOC determinations by qualified assessors. D= Total number of participants who received a LOC determination.	24%	The contract for the 2013 assessments was changed in October of 2012. At the time, trainings were conducted by KDADS staff for the new assessors, specific to correct completion of the (Functional Assessment Instrument) FAI and upload into State data system. This training was conducted in multiple venues and platforms but did not generate a certificate for completion. This measure failed due to lack of documentation of evidence that the individual assessors had completed these two specific trainings. KDADS will begin to issue a certificate of completion to assure proper documentation can be maintained.
15	N= Number of participants with initial or annual level	91%	

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**		Methodology	Compliance Percentage	Explanation/Remediation
		of care determinations made where the LOC criteria was accurately applied. D= Total number of participants with initial or annual level of care determinations.		
16	100%	N= Number of newly enrolled providers that initially met licensure requirements. D= Total number of newly enrolled providers.	100%	
17	100%	N= Number of newly-enrolled non-licensed FE providers that have met waiver requirements. D= Total number of newly-enrolled non-licensed FE providers.	100%	
18	100%	N= Number of direct service providers that received the required training. D= Total number of direct service providers.		This performance measure was not implemented in 2013. In partnership with Truven Health Analytics, the State revised its quality review processes and protocols to align with the managed care environment (KanCare). This performance measure was removed during the process.
19	100%	N= Number of FE participants who have service plans that address their needs. D= Total number of FE participants who have service plans.	87%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Some of the plans identified in 2013 were plans based on the previous year (2012), and the new service plans in 2014 should reflect the remediation efforts.
20	100%	N= Number of participant observed by Quality Review staff to have no unmet needs. D= Total number of participants reviewed.	99%	
21	100%	N= Number of FE waiver participants who have a disaster red flag designation with a back-up plan. D= Total number of FE waiver participants reviewed.	59%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas addressed the lack of disaster back-up plans identified for FE waiver participants with a disaster red flag designation during quarterly reviews and critical incident reviews. During the MCO Technical Assistance calls, the MCOs identified standard elements for back-up plans and amended their integrated service plans of care to include this information. MCOs also completed comprehensive training for LTSS care coordinators on waiver requirements and service plan development. In 2014, Kansas amended the waiver after developing global quality assurance measures based on new CMS guidance and with technical assistance from Truven. This measure was determined to no longer be applicable under the Managed Care delivery model.

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**		Methodology	Compliance Percentage	Explanation/Remediation
22	100%	N= Number of participants whose service plan was based on information documented in the assessment. D= Total number of services plans reviewed.	78%	In December 2012, Kansas transitioned assessments from the Uniform Assessment Instrument to the Functional Assessment Instrument. This resulted in some individuals not receiving the appropriate assessment during the reassessment period for the current year. During regular reviews of the data, the State identified this deficiency and began remediation efforts to ensure accurate reassessments were completed. During 2013, the State implemented Technical Assistance calls and amended its contract to ensure accurate completion of assessments. The State expects to see improvements for 2014 reports.
23	100%	N= Number of waiver participant files reviewed during the review period for whom the Customer Service Plans started within the number of specified days. D= Total number of files reviewed during the review period.	91%	
24	100%	N= Number of service plans files reviewed with appropriate participant and management entity involvement. D= Total number of service plans files reviewed.	90%	
25	100%	N= Number and percent of initial and updated Service Plans with management entity involvement. D= Total number of initial and updated service plans.	88%	
26	100%	N = Number of service plans during the review period that were reviewed prior to annual redetermination. D = total number of service plans during the review period with an annual redetermination.	81%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. This is expected to be a temporary decrease in annual review of plans, as MCOs maintained previous plans of care (from 2012) during the transition period unless there was a significant change in circumstances warranting an immediate review of services and needs. This extended some plans of care beyond the annual review period.
27	100%	N= Number of FE waiver participants with a documented change in needs whose service plans was revised as needed. D= Total number of service plans with documented changes.	78%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas addressed the process and procedures related to updating plans of care based on the participant's needs. While services needed to address changing circumstances were provided by the MCO, the integrated service plans of care were not consistently updated timely to reflect the changes. 2014 record review is expected to demonstrate improvements in this

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**	Methodology	Compliance Percentage	Explanation/Remediation

				measure related to 2013 and 2014 remediation efforts.
28	100%	N= Number of FE waiver participants reporting that attendants/workers worked the amount of time authorized on the Service Plan. D= Total number of FE waiver participants interviewed during review period.	94%	
29	100%	N= Number of participants reviewed reporting they received services identified on their service plan. D= Total number of participants interviewed during that review period.	87%	
30	100%	N= Number of participants who reported attendants/workers reported on time. D= Total number of participants interviewed during that review period.	98%	
31	100%	N= Number of participants whose files were reviewed during the review period and whose records contain a Customer Choice form indicating choice of community based services v. Nursing Facility care. D= Total number of participants whose files were reviewed during the review period.	65%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. In 2013, MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
32	100%	N= Number of participants whose files were reviewed during the review period and whose records contain a Customer Choice form indicating their choice for self-directed or agency-directed services. D= Total number of participants whose files were reviewed during the review period.	65%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. In 2013, MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
33	100%	N= Number of FE waiver participants whose files were reviewed during the review period and whose records contain Customer Choice form indicating choice of service providers. D= Total number of FE waiver participants whose files were reviewed during the review period.	56%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
34	100%	N= Number of FE waiver participants or participants' representatives that have signed the most recent	59%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During

Appendix 10: 2013 Performance Measures **Frail Elderly Waiver**		Methodology	Compliance Percentage	Explanation/Remediation
		plan of care indicating choice of waiver services. D= Total number of FE waiver participant files reviewed.		these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas identified a gap in documenting choice options for participants on the HCBS programs. MCOs updated and improved their tools to ensure choice was captured on the integrated service plan of care or on a choice form that indicated all forms of choice.
35	100%	N= Number of participants whom Quality Review staff observed as having no identifiable health or welfare concerns. D= Total participants observed by Quality Review staff during the review period.	99%	
36	100%	N= Number of critical incidents reported by the ADRC/MCO to the Department of Children and Families (DCF) or KDADS Complaint Hotline that are substantiated. D= Total number of critical incidents reported by the ADRC/MCO.	11%	
37	100%	N= Number currently employed ADRC assessors and MCO care managers(coordinators, service managers, etc.) that have received training to educate participants on how to identify, protect from, and report abuse, neglect and exploitation. D= Total number currently employed ADRC assessors and MCO care managers.	100%	As part of the 2013 remediation, KDADS through technical assistance with MCO health plans, facilitated remediation for this measure by ensuring that the MCOs document education/ training received for the purpose of protecting from, and reporting abuse, neglect, and exploitation.
38	100%	N= Number of participants who report knowing how to prevent, protect from, and report abuse neglect and exploitation. D= Total number of participants interviewed during the reporting period.	80%	Kansas started MCO Technical Assistance calls in May 2013 to address the processes, procedures, and policies related to the HCBS programs. During these weekly Technical Assistance meetings with MCO leadership and care coordination staff, the state addressed areas that needed remediation. Kansas specifically addressed updating the person-centered planning process related to the documentation of the standard, including provisions for annually and routinely documenting providing this information to participants and families as part of the person-centered planning process and care coordination. Additionally, Kansas received limited response to the consumer interviews for this measure, which has been adjusted to include other data sources for validation.
39	100%	N=Number of EVV claims paid per billing agency. D= Total number of FMS providers enrolled.		Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.

Appendix 2: 2014 Performance Measures **Mental Health/SED**		Compliance Percentage	Explanation/Remediation
1	Percentage of Members reporting their physical health as good within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
2	The Percentage of Members reporting they are connected to the people who support them the most within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
3	The Percentage of Members reporting they are doing what they want for their work within one standard deviation of the mean. The indicator is measured by regions as established by the CONTRACTOR as approved by SRS.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
4	Percentage of adults with an SPMI who report having a place to live that is comfortable for them		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
5	The CONTRACTOR will ensure CMHC providers offer timely initial appointments. All new Members will be offered an initial appointment within 10 calendar days.	76%	
6	The CONTRACTOR will maintain the following access standards for screening by a CMHC for institutional care: **Post-Stabilization** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Emergent** - 1 hour from initial contact to arrival of CMHC staff to the emergency room setting. **Urgent** - 24 hours from initial contact to arrival of CMHC staff to the emergency room setting.		Explanation: Data has not been collected on this item because a methodology has not been developed. This measurement will require data collection processes that don't currently exist within the MCOs systems.
7	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process.

Appendix 2: 2014 Performance Measures **Mental Health/SED**	Compliance Percentage	Explanation/Remediation

			Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
8	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	100%	
9	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
10	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	100%	
11	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	89%	
12	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	88%	
13	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	79%	Explanation: During the review process, the appropriate documentation was not available for verification of the approved screening tool. Remediation: The State of Kansas will ensure that a process is in place to ensure the use of the approved screen tool.
14	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	71%	Explanation: During the review process, the appropriate documentation was not available for verification of the qualified assessor. Remediation: The State of Kansas has developed an application for the submission of assessor qualification documentation and will keep records of all assessor trainings.
15	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	88%	
16	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility		
17	Number and percent of new licensed / certified waiver provider applicants that initially met licensure requirements, certification requirements,	N/A	Explanation: During CY2014, there were no new licensed/certificated waiver provider applicants.

Appendix 2: 2014 Performance Measures **Mental Health/SED**	Compliance Percentage	Explanation/Remediation

	and other waiver standards prior to furnishing waiver services		
18	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards	100%	
19	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services	N/A	Explanation: There are no non-licensed/certified SED waiver providers in the State of Kansas.
20	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements	N/A	Explanation: There are no non-licensed/certified SED wavier providers in the State of Kansas.
21	Number and percent of active providers that meet training requirements	91%	Explanation: Data collected during federal fiscal year 2014 instead of calendar year.
22	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	90%	
23	Number and percent of waiver participants whose service plans address health and safety risk factors	88%	
24	Number and percent of waiver participants whose service plans address participants' goals	90%	
25	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	90%	
26	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	90%	
27	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	87%	
28	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	86%	Explanation: During the review process, the appropriate documentation was not available for verification of addressing changes needed for service plan revisions. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.

Appendix 2: 2014 Performance Measures **Mental Health/SED**		Compliance Percentage	Explanation/Remediation
29	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	93%	
30	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	90%	
31	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	89%	
32	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	89%	
33	100% of participants' POC are developed by a wraparound team.	92%	
34	100% of participants POC will be reviewed within 90 days of the last review.	80%	
35	100% of participants will receive information regarding their rights to a State Fair Hearing via the Notice of Action (NOA) form.	92%	
36	Number and percent of participants whom the Customer Service Plans started within the number of specified days	87%	
37	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	92%	
38	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
40	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.

Appendix 2: 2014 Performance Measures **Mental Health/SED**		Compliance Percentage	Explanation/Remediation
41	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	89%	
42	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
43	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	100%	
44	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	N/A	Explanation: There were no restraint applications, seclusion, or other restrictive interventions during this reporting period.
45	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	N/A	Explanation: There were no unauthorized uses of restrictive interventions during this reporting period.
46	Number and percent of waiver participants who received physical exams in accordance with State policies	52%	Explanation: During the review process, the appropriate documentation was not available for verification of the occurrence of a physical exam. Remediation: The State of Kansas will ensure that a copy of the participants' physical exam is available for review through the review process.
47	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology		Explanation: Since the inception of KanCare, the state has moved from fee for service to capitation payments to the MCOs. The state does not pay claims for waiver services.
48	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract	90%	Explanation: This is an aggregate percentage for all HCBS waivers.
49	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	100%	
50	Number and percent of claims not in accordance with the reimbursement methodology are denied/suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
51	The percentage of adult Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility	11%	

Appendix 2: 2014 Performance Measures **Mental Health/SED**	Compliance Percentage	Explanation/Remediation
	includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.		
52	The percentage of youth Members readmitted to an inpatient psychiatric facility within 30 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	5%	
53	The percentage of youth Members readmitted to an inpatient psychiatric facility within 90 days of a previous discharge as a result of a mental health inpatient screen. An inpatient psychiatric facility includes any state mental health hospital, inpatient psychiatric facility or medical facility providing psychiatric services.	7%	
54	The average number of inpatient days per youth for all youth Members discharged from a PRTF during the reporting period.	56,945/801 = ALOS 71	

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency that was submitted to the State Medicaid Agency.	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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.	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.	N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports.	91%	
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services.	94%	
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination.	74%	Explanation: Assessments were not completed in a timely fashion for all participants. Remediation: The State of Kansas is drafting clear guidance and training that will detail the functional eligibility process including functional assessor and state roles and responsibilities.
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the states approved screening tool.	95%	
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor.	85%	Explanation: Assessor qualifications were not on file for verification at the time of this review. Remediation: The State of Kansas is drafting clear guidance and training that will detail the assessor qualifications documentation requirements.
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied.	95%	
10	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility.		
11	Number and percent of participants whose cases were eligibility determination was made within six (6) working		

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
	days of intake.		
12	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.	100%	
13	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards.	100%	
14	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
16	Number and percent of active providers that meet		Remediation: MCO credentialing standards, required in the KanCare

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
	training requirements.		contract, serve (d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet training requirements prior to being in full compliance with MCO credentialing and contract standards. Training requirements must continue to be met for active providers to remain in a MCOs network. New and active waiver providers must submit documentation from the training organization, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable training from the agencies providing the training to the service provider. Failure to comply with all MCO credentialing standards will result in the suspension of an active provider's contract with an MCO. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
17	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment.	78%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participants' assessed needs and capabilities as indicated in the assessment. Some of the service plans were found to be out of compliance due to failure to address the needs of the participant; however, a majority of the service plans were out of compliance due to lack of authorization of the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
18	Number and percent of waiver participants whose service plans address health and safety risk factors.	93%	
19	Number and percent of waiver participants whose service plans address participants' goals.	49%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participants' goals as indicated in the assessment. Some of the service plans were found to be out of compliance due to failure to address the goals of the participants. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
20	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver.	82%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans were developed according to the processes in the approved waiver. Many elements were reviewed to determine this

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
		measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
21	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan.	84%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant was present and involved in the development of the service plan. The service plans were out of compliance due to lack of participant authorization (as indicated by the participant's signature) required to verify that the participant was involved in the service plan development. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
22	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	82%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans were reviewed before the participant's annual redetermination date. The service plans were out of compliance due to failure to provide previous service plan, failure to complete within the specified timeline or lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
23	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change.	23%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.

Appendix 4: 2014 Performance Measures **I/DD**		Compliance Percentage	Explanation/ Remediation
24	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.	92%	
25	Number and percent of survey respondents who reported receiving all services as specified in their service plan.	94%	
26	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative.	64%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of community-based versus institutional care. For many cases, a choice form was not available or had not been authorized by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCOs are collaborating on a form to create a consistent method for documenting choice.
27	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care.	53%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice to agency-direct or self-direct their care. For many cases, a choice form was not available or had not been authorized by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCOs are collaborating on a form to create a consistent method for documenting choice.
28	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers.	64%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver service providers. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCOs are collaborating on a form to create a consistent method for documenting choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services.	66%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver services. For many cases, a choice form was not available or had not been authorized by the participant (as indicated by the participant's signature).

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
		Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCOs are collaborating on a form to create a consistent method for documenting choice.
30	Number and percent of participants whom the Customer Service Plans started within the Number of specified days.	97%	
31	Number and percent of participants who received timely Notices of Action for adverse actions.	75%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for adverse actions. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of adverse actions, including participant rights and responsibilities.
32	Number and percent of participants who received Notices of Action for Plan of Care updates.	61%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
33	Number and percent of participants who reported attendants/workers reported on time.		Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. KDADS is working to revise its quality review processes and protocols to incorporate this measure.
34	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.	78%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the MCO assessments included physical, behavioral, and functional components to determine the participant's needs. The assessments were out of compliance as they addressed some of the elements but did not incorporate all three components. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
35	Number and percent of customers who are satisfied.	98%	

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
36	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
37	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
38	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan.	64%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participants who have a disaster red flag designation also have a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or service plan or the backup plan did not address all the participant's needs (i.e., staff not showing up). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
40	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation.	75%	Explanation: Onsite quality reviews of MCOs and participant interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Many of the participants interviewed had difficulty remembering if information about ANE was provided during the previous year. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement.
41	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
42	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures.	100%	
43	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable

Appendix 4: 2014 Performance Measures **I/DD**	Compliance Percentage	Explanation/ Remediation
	as specified in the approved waiver.		format. The state is currently developing a work plan to accumulate the data and create the proper reports.
44	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
45	Number and percent of waiver participants who received physical exams in accordance with State policies.	97%	
46	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns.		Explanation: Face to face customer interviews were not conducted during this time period. However, MCO care coordinators report any health and welfare concerns to the appropriate state entity, Adult Protective Services, Adult Care Home hotline, or to the program manager for appropriate follow up. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
47	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
48	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract.	90%	This is an aggregate percentage for all HCBS waivers.
49	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS.	100%	
50	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
51	Number and percent of Providers utilize Electronic Visit Verification.		

Appendix 5: 2014 Performance Measures **PD**	Compliance Percentage	Explanation/Remediation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	0/0 = N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	45%	Remediation: KDADS will ensure that the PD program is represented in the LTC meetings through in-person or written reports by the PD program manager or HCBS Director.
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	83%	Explanation: Completion of the initial Level of Care (LOC) evaluation within the specific timeline was impacted by several factors including inability to contact participant/representative and participant relocation. Remediation: KDADS will be working with the Aging and Disability Resource Centers (ADRCs) to complete a clean-up of functional eligibility reassessments.
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	52%	Explanation: Completion of the annual Level of Care (LOC) evaluation within the specific timeline was impacted by several factors including inability to contact participant/representative and participant relocation. Remediation: KDADS will be working with the Aging and Disability Resource Centers (ADRCs) to complete a clean-up of functional eligibility reassessments.
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	84%	Explanation: For some participants, quality staff was unable to locate a copy of the approved screening tool in the participant's file. Remediation: The State of Kansas will require that a copy of the participant's assessment is available for review through the database system.
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	68%	Explanation: For some assessors, quality staff was unable to locate the assessor qualification documentation required to verify that the individual is a qualified assessor.

Appendix 5: 2014 Performance Measures **PD**	Compliance Percentage	Explanation/Remediation
		Remediation: The State of Kansas has developed an application for the submission of assessor qualification documentation and will keep records of all assessor trainings.
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	83%	Explanation: During the quality reviews, staff discovered that several functional assessment level of care (LOC) scores were incorrectly calculated by assessors. KDADS completes an initial FAI training, including LOC calculation, with all newly hired assessors. Remediation: Moving forward, KDADS will provide additional trainings for functional assessors to ensure correct LOC calculation.
10	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility		
11	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake		
12	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		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
13	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New

Appendix 5: 2014 Performance Measures **PD**		Compliance Percentage	Explanation/Remediation
			licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
14	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and

Appendix 5: 2014 Performance Measures **PD**	Compliance Percentage	Explanation/Remediation
		MCO reporting.
16 Number and percent of active providers that meet training requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
17 Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	87%	
18 Number and percent of waiver participants whose service plans address health and safety risk factors	91%	
19 Number and percent of waiver participants whose service plans address participants' goals	50%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participant's goals. Many of the service plans were found to be out of compliance due to the use of standardized goals rather than an individualized goal for the specific participant. In addition, several of the service plans were out of compliance due to lack of authorization from the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
20 Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	86%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans were developed according to the processes in the approved waiver. Many elements were reviewed to determine this measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the

Appendix 5: 2014 Performance Measures **PD**		Compliance Percentage	Explanation/Remediation
			requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
21	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	87%	
22	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	82%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the services plans were reviewed before the participant's annual redetermination date. The service plans were out of compliance due to failure to provide previous service plan, failure to complete within the specified timeline or lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
23	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	39%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
24	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	95%	
25	Number and percent of survey respondents who reported receiving all services as specified in their service plan	94%	
26	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	76%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of community-based versus institutional care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will

Appendix 5: 2014 Performance Measures **PD**		Compliance Percentage	Explanation/Remediation
			detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
27	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	71%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice to agency-direct or self-direct their care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
28	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	65%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver service providers. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	72%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver services. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
30	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	93%	
31	Number and percent of participants who received timely Notices of Action for adverse actions	86%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for adverse actions. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe.

Appendix 5: 2014 Performance Measures **PD**		Compliance Percentage	Explanation/Remediation
			Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of adverse actions, including participant rights and responsibilities.
32	Number and percent of participants who received Notices of Action for Plan of Care updates	39%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
33	Number and percent of participants who reported attendants/workers reported on time		Explanation: Due to the transition to KanCare and staffing challenges KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
34	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	87%	
35	Number and percent of customers who are satisfied	96%	
36	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
37	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
38	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	67%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participants who have a disaster red flag designation with a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or service plan or the backup plan did not address all the participant's needs (i.e., staff not showing up).

Appendix 5: 2014 Performance Measures **PD**	Compliance Percentage	Explanation/Remediation
		Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
40 Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	64%	Explanation: Onsite quality reviews of MCOs and participant interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Many of the participants interviewed had difficulty remembering if information about ANE was provided during the previous year. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement.
41 Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames		Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
42 Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures	100%	
43 Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver		Explanation: The state does not have a current process for appropriately tracking unexpected deaths and is developing a work plan and requests technical assistance.
44 Number and percent of unauthorized uses of restrictive interventions that were appropriately reported		Explanation: The state does not have a current process for appropriately tracking unexpected deaths and is developing a work plan and requests technical assistance.
45 Number and percent of waiver participants who received physical exams in accordance with State policies	73%	Explanation: During the review process, the appropriate documentation was not available for verification of the occurrence of a physical exam. Remediation: The State of Kansas will require that a copy of the participants' physical exam is available for review through the review process.
46 Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns		Explanation: Face to face Customer interviews were not conducted during this time period but program and quality staff followed up on health and welfare concerns. However, MCO care coordinators report any health and welfare concerns to the appropriate state entity, Adult Protective Services or the Adult Care Home hotline and to the program manager. Remediation: The State of Kansas is drafting clear guidance that will

Appendix 5: 2014 Performance Measures **PD**	Compliance Percentage	Explanation/Remediation
		detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
47	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology	Explanation: Since the inception of KanCare, the state has moved from fee for service to capitation payments to the MCOs. The state does not pay claims for waiver services.
48	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract	90% Explanation: This is an aggregate percentage for all HCBS waivers.
49	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS	100%
50	Number and percent of claims not in accordance with the reimbursement methodology are denied/suspended.	Explanation: Since the inception of KanCare, the state has moved from fee for service to capitation payments to the MCOs. The state does not pay claims for waiver services.
51	Number and percent of Providers utilize Electronic Visit Verification	

Appendix 6: 2014 Performance Measures **TBI**		Compliance Percentage	Remediation/Explanation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	0/0 = N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	73%	Explanation: Reporting for the TBI program was inconsistent in 2014 due to personnel changes. Remediation: KDADS will ensure that the TBI program is represented in the LTC meetings through in-person or written reports by the TBI program manager or HCBS Director.
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	89%	
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	50%	Explanation: Completion of the annual Level of Care (LOC) evaluation within the specific timeline was impacted by several factors including inability to contact participant/representative and participant relocation. Remediation: KDADS will be working with the Aging and Disability Resource Centers (ADRCs) to complete a clean-up of functional eligibility reassessments.
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	81%	Explanation: For some participants, quality staff was unable to locate a copy of the approved screening tool in the participant's file. Remediation: The State of Kansas will ensure that a copy of the participant's assessment is available for review through the database system.

Appendix 6: 2014 Performance Measures **TBI**		Compliance Percentage	Remediation/Explanation
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	73%	Explanation: For some assessors, quality staff was unable to locate the assessor qualification documentation required to verify that the individual is a qualified assessor. Remediation: The State of Kansas has developed an application for the submission of assessor qualification documentation and will keep records of all assessor trainings.
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	81%	Explanation: During the quality reviews, staff discovered that several functional assessment level of care (LOC) scores were incorrectly calculated by assessors. KDADS completes an initial FAI training, including LOC calculation, with all newly hired assessors. Remediation: Moving forward, KDADS will provide additional trainings for functional assessors to ensure correct LOC calculation.
10	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility		Attachment J performance measure
11	Number and percent of participants whose cases were eligibility determination was made within 6 working days of intake		Attachment J performance measure
12	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		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
13	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
		compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
14 Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15 Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
16 Number and percent of active providers that meet training		Remediation: MCO credentialing standards, required in the KanCare

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
	requirements		contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet training requirements prior to being in full compliance with MCO credentialing and contract standards. Training requirements must continue to be met for active providers to remain in an MCOs network. New and active waiver providers must submit documentation from the training organization, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable training from the agencies providing the training to the service provider. Failure to comply with all MCO credentialing standards will result in the suspension of an active provider's contract with an MCO. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
17	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	73%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participants' assessed needs and capabilities as indicated in the assessment. Some of the service plans were found to be out of compliance due to failure to address the needs of the participant; however, a majority of the service plans were out of compliance due to lack of authorization of the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
18	Number and percent of waiver participants whose service plans address health and safety risk factors	84%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participants' health and safety risk factors. Some of the service plans were found to be out of compliance due to failure to address the risk factors of the participant; however, a majority of the service plans were out of compliance due to lack of authorization from the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
19	Number and percent of waiver participants whose service plans address participants' goals	34%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participant's goals. Many of the service plans were found to be out of compliance due to the use of

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
		standardized goals rather than an individualized goal for the specific participant. In addition, several of the service plans were out of compliance due to lack of authorization from the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
20	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	79%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans were developed according to the processes in the approved waiver. Many elements were reviewed to determine this measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
21	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	78%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant was present and involved in the development of the service plan. The service plans were out of compliance due to lack of participant authorization (as indicated by the participant's signature) required to verify that the participant was involved in the service plan development. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
22	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	76%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the services plans were reviewed before the participant's annual redetermination date. The service plans were out of compliance due to failure to provide previous service plan, failure to complete within the specified timeline or lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.

Appendix 6: 2014 Performance Measures **TBI**		Compliance Percentage	Remediation/Explanation
23	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	38%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
24	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	87%	
25	Number and percent of survey respondents who reported receiving all services as specified in their service plan	83%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant was receiving all services as specified in their service plan. Many of the participants interviewed had difficulty remembering service provision of the previous year. In addition, some participants reported difficulty in obtaining providers in remote, rural areas. Remediation: The State of Kansas has worked with the MCOs to discuss provider capacity and methods for obtaining providers in rural areas.
26	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	67%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of community-based versus institutional care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
27	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	66%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice to agency-direct or self-direct their care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
		and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
28	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	65%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver service providers. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	68%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver services. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
30	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	78%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan started within the specified number of days. The service plans were out of compliance as a result of failure to complete the service plan within the specified timeline due to several reasons, including failure to connect with the participant's responsible person. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
31	Number and percent of participants who received timely Notices of Action for adverse actions	66%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for adverse actions. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of adverse actions, including participant rights and responsibilities.

Appendix 6: 2014 Performance Measures **TBI**		Compliance Percentage	Remediation/Explanation
32	Number and percent of participants who received Notices of Action for Plan of Care updates	42%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
33	Number and percent of participants who reported attendants/workers reported on time		Explanation: Due to the transition to KanCare and staffing challenges KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
34	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	71%	Remediation: Onsite quality reviews of MCOs were conducted to determine if the MCO assessments included physical, behavioral, and functional components to determine the participant's needs. The assessments were out of compliance as they addressed some of the elements but did not incorporate all three components. Explanation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
35	Number and percent of customers who are satisfied	83%	Remediation: In 2015, the MCOs developed customer satisfaction surveys to conduct throughout the year to gather data on ways to improve customer satisfaction.
36	Number and percent of customers who are making progress	19%	Remediation: In 2015, the Integrated Service Plan (ISP) was modified to include goal planning in the ISP development process. In addition, the State is currently developing a standardized progress reporting tool to better monitor rehabilitative progress. Until the standardized tool is available, the MCOs have been instructed to gather progress reports from rehabilitative service providers.
37	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
38	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of unexpected deaths for which the	No Data Available	While the state does maintain this data at various agencies, we

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
	appropriate follow-up measures were taken		currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
40	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	11%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participants who have a disaster red flag designation with a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or service plan or the backup plan did not address all the participant's needs (i.e., staff not showing up). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
41	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	63%	Explanation: Onsite quality reviews of MCOs and participant interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Many of the participants interviewed had difficulty remembering if information about ANE was provided during the previous year. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement.
42	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
43	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	100%	
44	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
45	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
46	Number and percent of waiver participants who received physical exams in accordance with State policies	90%	
47	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or		Explanation: Face to face Customer interviews were not conducted during this time period but program and quality staff followed up on

Appendix 6: 2014 Performance Measures **TBI**	Compliance Percentage	Remediation/Explanation
	welfare concerns		health and welfare concerns. However, MCO care coordinators report any health and welfare concerns to the appropriate state entity, Adult Protective Services or the Adult Care Home hotline and to the program manager. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
48	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
49	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract	90%	Explanation: This is an aggregate percentage for all HCBS waivers.
50	Number and percent of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS	100%	
51	Number and percent of claims not in accordance with the reimbursement methodology are denied / suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
52	Number and percent of Providers utilize Electronic Visit Verification		

Appendix 7: 2014 Performance Measures **TA**		Compliance Percentage	Explanation/Remediation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency	N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports	64%	Explanation: Reporting for the TA program was inconsistent in 2014 due to personnel changes. Remediation: KDADS will ensure that the TA program is represented in the LTC meetings through in-person or written reports by the TA program manager or HCBS Director.
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services	89%	
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination	90%	
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool	98%	
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor	100%	
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied	98%	
10	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility		
11	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake		
12	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		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New

Appendix 7: 2014 Performance Measures **TA**	Compliance Percentage	Explanation/Remediation
		providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
13 Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
14 Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process

Appendix 7: 2014 Performance Measures **TA**	Compliance Percentage	Explanation/Remediation
		includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15 Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
16 Number and percent of active providers that meet training requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.

Appendix 7: 2014 Performance Measures **TA**		Compliance Percentage	Explanation/Remediation
17	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	96%	
18	Number and percent of waiver participants whose service plans address health and safety risk factors	96%	
19	Number and percent of waiver participants whose service plans address participants' goals	61%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participant's goals. Many of the service plans were found to be out of compliance due to the use of standardized goals rather than an individualized goal for the specific participant. In addition, several of the service plans were out of compliance due to lack of authorization from the participant/representative (as indicated by the participant's/representative's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
20	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver	91%	
21	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan	91%	
22	Number and percent of service plans reviewed before the waiver participant's annual redetermination date	89%	
23	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change	42%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of authorization from the participant/representative (as indicated by the participant's/representative's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the service plan revision requirements, including the MCOs role and responsibilities.
24	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan	98%	

Appendix 7: 2014 Performance Measures **TA**		Compliance Percentage	Explanation/Remediation
25	Number and percent of survey respondents who reported receiving all services as specified in their service plan	87%	
26	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative	92%	
27	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care	90%	
28	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	86%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participant/representative was provided the choice of waiver service providers. For many cases, a choice form was not available or had not been authorized by the participant/representative (as indicated by the participant's/representative's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services	91%	
30	Number and percent of participants whom the Customer Service Plans started within the Number of specified days	98%	
31	Number and percent of participants who received timely Notices of Action for adverse actions	89%	
32	Number and percent of participants who received Notices of Action for Plan of Care updates	50%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants or their representative received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear policies that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
33	Number and percent of participants who reported attendants/workers reported on time		Explanation: Due to the transition to KanCare and staffing challenges KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.

Appendix 7: 2014 Performance Measures **TA**	Compliance Percentage	Explanation/Remediation
34	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs	95%	
35	Number and percent of customers who are satisfied	96%	
36	Percentage of children with re-hospitalization within the first six (6) months of program admission		
37	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
38	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
40	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan	83%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participants had a disaster red flag designation with a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or the service plan/backup plan did not address all the participant's needs (i.e., staff not showing up). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
41	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation	82%	Explanation: Onsite quality reviews of MCOs and consumer interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Remediation: The State of Kansas is drafting clear policies that will detail the ANE information and assistance requirement.
42	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.

Appendix 7: 2014 Performance Measures **TA**		Compliance Percentage	Explanation/Remediation
43	Number and percent of reported critical incidents requiring review / investigation where the State adhered to its follow-up measures	100%	
44	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
45	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
46	Number and percent of waiver participants who received physical exams in accordance with State policies	100%	
47	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns		Explanation: Face to face customer interviews were not conducted during this time period but program and quality staff followed up on health and welfare concerns. MCO care coordinators report any health and welfare concerns to the appropriate state entity, Child/Adult Protective Services or the Adult Care Home hotline and to the program manager. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
48	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
49	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract	90%	Explanation: This is an aggregate percentage for all HCBS waivers.
50	Number and percent of payment rates that were certified to be actuarially sound by the State’s actuary and approved by CMS	100%	
51	Number and percent of claims not in accordance with the reimbursement methodology are denied/suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
52	Number and percent of Providers utilize Electronic Visit Verification		

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency that was submitted to the State Medicaid Agency.	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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.	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.	0/0 = N/A	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports.	91%	
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services.		Explanation: Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination.		Explanation: Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the states approved screening tool.		Explanation: Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor.		Explanation: Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied.		Explanation: Due to the transition to KanCare and staffing challenges, KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
10	Number and percent of participants whose cases were closed appropriately and timely due to the loss of Medicaid financial eligibility.		
11	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake.		
12	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.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
13	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
14	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services,

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
			and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
16	Number and percent of active providers that meet training requirements.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
17	100% of ICF/MR facilities will be either classified as small or medium size facility.		
18	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment	68%	Explanation: Quality reviews of MCOs were conducted to determine if the service plans addressed participants' assessed needs and capabilities as indicated in the assessment. Some of the service plans were found to be out of compliance due to failure to address the needs of the participant; however, a majority of the service plans were out of compliance due to lack of authorization of the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
19	Number and percent of waiver participants whose service plans address health and safety risk factors.	74%	Explanation: Quality reviews of MCOs were conducted to determine if the service plans addressed participants' health and safety risk factors. Some of the service plans were found to be out of compliance due to failure to address the risk factors of the participant; however, a majority of the service plans were out of compliance due to lack of authorization from the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
20	Number and percent of waiver participants whose service plans address participants' goals.	69%	Explanation: Quality reviews of MCOs were conducted to determine if the service plans addressed participant's goals. Many of the service plans were found to be out of compliance due to the use of standardized goals rather than an individualized goal for the specific participant. In addition, several of the service plans were out of compliance due to lack of authorization from the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
21	Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver.	65%	Explanation: Quality reviews of MCOs were conducted to determine if the service plans were developed according to the processes in the approved waiver. Many elements were reviewed to determine this measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
22	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan.	69%	Explanation: Quality reviews of MCOs were conducted to determine if the service plans were developed according to the processes in the approved waiver. Many elements were reviewed to determine this measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
23	Number and percent of service plans reviewed before the waiver participant's annual redetermination date.	59%	Explanation: Quality reviews of MCOs were conducted to determine if the services plans were reviewed before the participant's annual redetermination date. The service plans were out of compliance due to failure to provide previous service plan, failure to complete within the specified timeline or lack of participant authorization (as indicated by the participant's signature).

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
			Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
24	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change.	11%	Explanation: Quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
25	Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.	86%	Explanation: Quality reviews of MCOs were conducted and determined the MCOs were out of compliance due to failure to provide documentation of the type, scope, amount, duration, and frequency as specified in the service plan. Remediation: The State of Kansas is drafting clear guidance that will detail the documentation required, including the MCOs role and responsibilities.
26	Number and percent of survey respondents who reported receiving all services as specified in their service plan.	71%	Explanation: Quality reviews of MCOs were conducted to determine if the participant was receiving all services as specified in their service plan. Many of the participants interviewed had difficulty remembering service provision of the previous year. In addition, some participants reported difficulty in obtaining providers in remote, rural areas. Remediation: The State of Kansas has worked with the MCOs to discuss provider capacity and methods for obtaining providers in rural areas.
27	Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative.	72%	Explanation: Quality reviews of MCOs were conducted to determine if participants were provided the choice of community-based versus institutional care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
			MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
28	Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care.	50%	Explanation: Quality reviews of MCOs were conducted to determine if participants were provided the choice to agency-direct or self-direct their care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers	63%	Explanation: Quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver service providers. For many cases, a choice form was not available or had not been authorized by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
30	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services.	72%	Explanation: Quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver services. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
31	The Vineland scores show a 40% overall improvement for participants on the waiver.		
32	100% of all admissions to the ICF/MR have gone through the LOC assessment process completed by the Local CDDO.		
33	100 % of all admissions to an ICF/MR meet the Condition of participation: Active treatment services.		
34	100% of all participants must receive a continuous active treatment program.		

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
35	100% of participants in an ICF/MR will not be younger than six (6) years of age.		
36	100% of those participants who are "ward of the court" seeking admission to an ICF/MR have obtained courts' approval.		
37	Number and percent of participants whom the Customer Service Plans started within the Number of specified days.	85%	Explanation: Quality reviews of MCOs were conducted to determine if the participant's service plan started within the specified number of days. The service plans were out of compliance as a result of failure to complete the service plan within the specified timeline due to several reasons, including failure to connect with the participant's responsible person. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
38	Number and percent of participants who received timely Notices of Action for adverse actions.	70%	Explanation: Quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for adverse actions. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of adverse actions, including participant rights and responsibilities.
39	Number and percent of participants who received Notice of Action for Plan of Care updates	27%	Explanation: Quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
40	Number and percent of participants who reported attendants/workers reported on time.		Explanation: Due to the transition to KanCare and staffing challenges KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
41	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.	68%	Explanation: Quality reviews of MCOs were conducted to determine if the MCO assessments included physical, behavioral, and functional components to determine the participant's needs. The assessments were out of compliance as they addressed some of the elements but did not incorporate all three components. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
42	Number and percent of customers who are satisfied.	82%	Remediation: In 2015, the MCOs developed customer satisfaction surveys to conduct throughout the year to gather data on ways to improve customer satisfaction.
43	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes.		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
44	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures.		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
45	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken.		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
46	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan.	64%	Explanation: Quality reviews of MCOs were conducted to determine if the participants who have a disaster red flag designation with a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or service plan or the backup plan did not address all the participant's needs (i.e., staff not showing up). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
47	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation.	50%	Explanation: Quality reviews of MCOs and participant interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Many of the participants interviewed had difficulty remembering if information about ANE was provided during the previous year. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement.
48	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames.	No Data Available	While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
49	Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures.	100%	
50	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver.		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
51	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.		While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
52	Number and percent of waiver participants who received physical exams in accordance with State policies.	98%	
53	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns.		Explanation: Face to face customer interviews were not conducted during this time period. However, MCO care coordinators report any health and welfare concerns to the appropriate state entity, Adult Protective Services, Adult Care Home hotline, or to the program manager for appropriate follow up. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
54	Number and percent of provider claims that are coded and paid in accordance with the states approved reimbursement methodology.		Explanation: Since the inception of KanCare, the state has moved from fee for service to capitation payments to the MCOs. The state does not pay claims for waiver services.

Appendix 7: 2014 Performance Measures **Autism and ICF/MFs**		Compliance Percentage	Explanation/Remediation
55	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract.	90%	Explanation: This is an aggregate percentage for all HCBS waivers.
56	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS.	100%	
57	Number and percent of claims not in accordance with the reimbursement methodology are denied/suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.
58	100% of all ICF/MR facilities will submit accurate and timely cost reports		
59	Number and percent of Providers utilize Electronic Visit Verification.		

Appendix 10: 2014 Performance Measures **FE**		Compliance Percentage	Explanation/Remediation
1	Number and percent of Quality Review reports generated by KDADS, the Operating Agency that was submitted to the State Medicaid Agency.	25%	Explanation: Quality Review reporting was not generated or submitted routinely due to inconsistencies in the quality review process. Remediation: KDADS will attend the LTC meetings to report on quality findings and provide updates on a quarterly basis.
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.	100%	
3	Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency.	N/A during this reporting period	Explanation: During calendar year 2014, there were no policy changes submitted to the State Medicaid Agency.
4	Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports.	82%	Remediation: KDADS will ensure that the FE program is represented in the LTC meetings through in-person or written reports by the PD program manager or HCBS Director.
5	Number and percent of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services.	91%	
6	Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination.	70%	Explanation: Completion of the annual Level of Care (LOC) evaluation within the specific timeline was impacted by several factors including inability to contact participant/representative and participant relocation. Remediation: KDADS will be working with the Aging and Disability Resource Centers (ADRCs) to complete a clean-up of functional eligibility reassessments.
7	Number and percent of waiver participants whose Level of Care (LOC) determinations used the states approved screening tool.	91%	
8	Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor.	86%	Explanation: For some assessors, quality staff was unable to locate the assessor qualification documentation required to verify that the individual is a qualified assessor. Remediation: The State of Kansas has developed an application for the submission of assessor qualification documentation and will keep records of all assessor trainings.
9	Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied.	90%	
10	Number and percent of participants whose cases were eligibility determination was made within six (6) working days of intake.		
11	Number and percent of participants whose cases were closed		

Appendix 10: 2014 Performance Measures **FE**	Compliance Percentage	Explanation/Remediation
	appropriately and timely due to the loss of Medicaid financial eligibility.		
12	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.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
13	Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
14	Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A

Appendix 10: 2014 Performance Measures **FE**	Compliance Percentage	Explanation/Remediation
	prior to furnishing waiver services.		waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
15	Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
16	Number and percent of active providers that meet training requirements.		Remediation: MCO credentialing standards, required in the KanCare contract, serve(d) as proxy for this quality measure. A waiver service provider is not permitted to deliver waiver services, and is not a contracted provider in an MCO's network, until a robust credentialing process has been completed. New providers must meet licensure requirements

Appendix 10: 2014 Performance Measures **FE**		Compliance Percentage	Explanation/Remediation
			and certification requirements prior to being in full compliance with MCO credentialing and contract standards. New licensed and certified waiver providers must submit documentation from the licensing and certifying entities to the KanCare MCO, detailing all requirements have been met. The MCO credentialing process includes verification of all applicable licenses and certifications from the licensing and certifying agencies. A provider contract is not extended to any entity failing to comply with all MCO credentialing standards. The credentialing process is monitored by the SSMA and the operating agency through onsite records reviews and MCO reporting.
17	Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment.	86%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participants' assessed needs and capabilities as indicated in the assessment. Some of the service plans were found to be out of compliance due to failure to address the needs of the participant; however, a majority of the service plans were out of compliance due to lack of authorization of the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
18	Number and percent of waiver participants whose service plans address health and safety risk factors.	93%	
19	Number and percent of waiver participants whose service plans address participants' goals.	50%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans addressed participant's goals. Many of the service plans were found to be out of compliance due to the use of standardized goals rather than an individualized goal for the specific participant. In addition, several of the service plans were out of compliance due to lack of authorization from the participant/representative (as indicated by the participant's/representative's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
20	Number and percent of waiver participants whose service plans were developed according to the processes in the approved	86%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the service plans were developed according to

Appendix 10: 2014 Performance Measures **FE**	Compliance Percentage	Explanation/Remediation
	waiver.		the processes in the approved waiver. Many elements were reviewed to determine this measure including participation at the POC development meeting, compliance with POC development timeframe, and participation authorization of POC. Many of the service plans were found out of compliance due to failure to meet the requirements of one or more of the elements listed above. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development and goal setting processes, including the MCOs role and responsibilities.
21	Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan.	85%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant was present and involved in the development of the service plan. The service plans were out of compliance due to lack of participant authorization (as indicated by the participant's signature) required to verify that the participant was involved in the service plan development. Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
22	Number and percent of service plans reviewed before the waiver participant's annual redetermination date.	85%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the services plans were reviewed before the participant's annual redetermination date. The service plans were out of compliance due to failure to provide previous service plan, failure to complete within the specified timeline or lack of participant authorization (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
23	Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change.	38%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant's service plan was revised to address a participant's change in needs. The service plans were out of compliance due to failure to update service plan in accordance with needs change request in case log and lack of authorization from the participant/representative (as indicated by the participant's/representative's signature).

Appendix 10: 2014 Performance Measures **FE**	Compliance Percentage	Explanation/Remediation
		Remediation: The State of Kansas is drafting clear guidance that will detail the service plan revision requirements, including the MCOs role and responsibilities.
24 Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.	92%	
25 Number and percent of survey respondents who reported receiving all services as specified in their service plan.	84%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participant was receiving all services as specified in their service plan. Many of the participants interviewed had difficulty remembering service provision of the previous year. In addition, some participants reported difficulty in obtaining providers in remote, rural areas. Remediation: The State of Kansas has worked with the MCOs to discuss provider capacity and methods for obtaining providers in rural areas.
26 Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative.	80%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of community-based versus institutional care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
27 Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care.	75%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice to agency-direct or self-direct their care. For many cases, a choice form was not available or had not been authorization by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
28 Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers.	74%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participant/representative was provided the

Appendix 10: 2014 Performance Measures **FE**		Compliance Percentage	Explanation/Remediation
			choice of waiver service providers. For many cases, a choice form was not available or had not been authorized by the participant/representative (as indicated by the participant's/representative's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
29	Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services.	80%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants were provided the choice of waiver services. For many cases, a choice form was not available or had not been authorizated by the participant (as indicated by the participant's signature). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities. MCO's are working together to create a consistent method for documenting a participants choice.
30	Number and percent of participants whom the Customer Service Plans started within the Number of specified days.	90%	
31	Number and percent of participants who reported attendants/workers reported on time.		Explanation: Due to the transition to KanCare and staffing challenges KDADS does not have data available for this measure. Remediation: KDADS is working to revise its quality review processes and protocols to incorporate this measure.
32	Number and percent of customers who are satisfied.	92%	
33	Number and percent of participants who received timely Notices of Action for adverse actions.	72%	Explanation: Onsite quality reviews of MCOs were conducted to determine if participants received a timely Notice of Action for adverse actions. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of adverse actions, including participant rights and responsibilities.
34	Number and percent of participants who received Notices of	38%	Explanation: Onsite quality reviews of MCOs were conducted

Appendix 10: 2014 Performance Measures **FE**		Compliance Percentage	Explanation/Remediation
	Action for Plan of Care updates.		to determine if participants received a timely Notice of Action for plan of care updates. For many cases, a NOA was not found in the participant's file or was not sent within the specific timeframe. Remediation: The State of Kansas is drafting clear guidance that will detail the appropriate MCO notification of plan of care updates, including participant rights and responsibilities.
35	Number and percent of waiver participants who had assessments completed by the MCO that included physical, behavioral, and functional components to determine the member's needs.	87%	
36	Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
37	Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
38	Number and percent of unexpected deaths for which the appropriate follow-up measures were taken.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
39	Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan.	70%	Explanation: Onsite quality reviews of MCOs were conducted to determine if the participants who have a disaster red flag designation with a related disaster back up plan. For many cases, a disaster backup plan was not found in the participant's file or service plan or the backup plan did not address all the participant's needs (i.e., staff not showing up). Remediation: The State of Kansas is drafting clear guidance that will detail the plan of care development process, including the MCOs role and responsibilities.
40	Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation.	78%	Explanation: Onsite quality reviews of MCOs and participant interviews were conducted to determine if participants received information on how to report suspected abuse, neglect, or exploitation. Many of the participants interviewed

Appendix 10: 2014 Performance Measures **FE**	Compliance Percentage	Explanation/Remediation
		had difficulty remembering if information about ANE was provided during the previous year. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement.
41	Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
42	Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures.	100%	
43	Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
44	Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.	No Data Available	Explanation: While the state does maintain this data at various agencies, we currently do not have an accurate method for compiling the data into a reportable format. The state is currently developing a work plan to accumulate the data and create the proper reports.
45	Number and percent of waiver participants who received physical exams in accordance with State policies.	95%	
46	Number and percent of waiver participants whom Quality Review staff observed as having no identifiable health or welfare concerns.		Explanation: Face to face customer interviews were not conducted during this time period but program and quality staff followed up on health and welfare concerns. MCO care coordinators report any health and welfare concerns to the appropriate state entity, Child/Adult Protective Services or the Adult Care Home hotline and to the program manager. Remediation: The State of Kansas is drafting clear guidance that will detail the ANE information and assistance requirement. Customer interviews will be conducted by the state Quality Management Specialists to monitor compliance**.**
47	Number and percent of provider claims that are coded and paid in accordance with the state's approved reimbursement methodology.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.

Appendix 10: 2014 Performance Measures **FE**		Compliance Percentage	Explanation/Remediation
48	Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract.	90%	
49	Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS.	100%	
50	Number and percent of Providers utilize Electronic Visit Verification.		
51	Number and percent of claims not in accordance with the reimbursement methodology are denied/suspended.		Explanation: Since the inception of KANCARE the state has moved from Fee For Service to Capitation payments to the MCO. The state does not pay claims for waiver services.

Kansas
Department for Aging
and Disability Services

Home and Community Based Services
Quality Review Report
2015
March 29, 2017

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 Qualtiy Review reports
Review Period: 01/01/2015 - 12/31/2015
Data Source: Quality Review Reports to KDHE

Compliance By Waiver	Statewide
PD	**25%**
Numerator	1
Denominator	4
FE	**25%**
Numerator	1
Denominator	4
IDD	**25%**
Numerator	1
Denominator	4
TBI	**25%**
Numerator	1
Denominator	4
TA	**25%**
Numerator	1
Denominator	4
Autism	**25%**
Numerator	1
Denominator	4
SED	**25%**
Numerator	1
Denominator	4

Compliance Trends	2013	2014	2015
PD			
Statewide	25%	25%	25%
FE			
Statewide	25%	25%	25%
IDD			
Statewide	25%	25%	25%
TBI			
Statewide	25%	25%	25%
TA			
Statewide	25%	25%	25%
Autism			
Statewide	25%	25%	25%
SED			
Statewide	25%	25%	25%

Explanation of Findings:

2015 Quality Reviews were completed in a one year timeframe. There was no quarterly data to report.

Remediation:

KDADS adopted a Quality Review Policy in 2016 and are expected to be back on a quarterly review process in December 2017.

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: 01/01/2015 - 12/31/2015
Data Source: Number of waiver amendments and renewals sent 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	**N/A**
Numerator	0
Denominator	0
Autism	**100%**
Numerator	1
Denominator	1
SED	**100%**
Numerator	1
Denominator	1

Compliance Trends	2013	2014	2015
PD			
Statewide	N/A	100%	100%
FE			
Statewide	not a measure	100%	100%
IDD			
Statewide	100%	100%	100%
TBI			
Statewide	100%	100%	100%
TA			
Statewide	100%	100%	N/A
Autism			
Statewide	100%	100%	100%
SED			
Statewide	100%	100%	100%

Explanation of Findings:

Remediation:

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: 01/01/2015 - 12/31/2015
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	7
Denominator	7
FE	**100%**
Numerator	7
Denominator	7
IDD	**100%**
Numerator	5
Denominator	5
TBI	**100%**
Numerator	2
Denominator	2
TA	**100%**
Numerator	2
Denominator	2
Autism	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

Compliance Trends	2013	2014	2015
PD			
Statewide	N/A	N/A	100%
FE			
Statewide	N/A	N/A	100%
IDD			
Statewide	100%	N/A	100%
TBI			
Statewide	100%	N/A	100%
TA			
Statewide	N/A	N/A	N/A
Autism			
Statewide	N/A	N/A	N/A
SED			
Statewide	N/A	N/A	N/A

Explanation of Findings:

Remediation:

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: 01/01/2015 - 12/31/2015
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**67%**
Numerator	8
Denominator	12
FE	**50%**
Numerator	6
Denominator	12
IDD	
Numerator	
Denominator	Not Available
TBI	
Numerator	
Denominator	Not Available
TA	
Numerator	
Denominator	Not Available
Autism	**100%**
Numerator	12
Denominator	12
SED	
Numerator	
Denominator	Not Available

Compliance Trends	2013	2014	2015
PD			
Statewide	Not a measure	45%	67%
FE			
Statewide	100%	82%	50%
IDD			
Statewide	Not a measure	91%	Not Available
TBI			
Statewide	Not a measure	73%	Not Available
TA			
Statewide	Not a measure	64%	Not Available
Autism			
Statewide	Not a measure	91%	100%
SED			
Statewide	Not a measure	100%	Not Available

Explanation of Findings:

For those programs labeled as "Not Available" sufficient meeting notes or documentation was not available to determine compliance with this measure.

Remediation:

Per the 372 CAP response, beginning January 2017 KDADS has internal procedures to ensure updates are provided for each program. In addition, KDADS will be keeping a file of formal meeting notes from KDHE for documentation purposes.

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 enrolled waiver participants
Review Period: 01/01/2015 - 12/31/2015
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**96%**
Numerator	23
Denominator	24
FE	**93%**
Numerator	54
Denominator	58
IDD	**90%**
Numerator	9
Denominator	10
TBI	**81%**
Numerator	25
Denominator	31
TA	**100%**
Numerator	50
Denominator	50
Autism	**100%**
Numerator	14
Denominator	14
SED	**88%**
Numerator	273
Denominator	310

Compliance Trends	2013	2014	2015
PD			
Statewide	64%	83%	96%
FE			
Statewide	81%	91%	93%
IDD			
Statewide	99%	94%	90%
TBI			
Statewide	62%	89%	81%
TA			
Statewide	97%	89%	100%
Autism			
Statewide	82%	No Data	100%
SED			
Statewide	99%	89%	88%

Explanation of Findings:

Completion of the annual Level of Care (LOC) evaluation within the specific timeline was impacted by several factors including inability to contact participant/representative and participant location for annual LOC assessments. For initial eligibility, the previous agency that determined financial eligibility was unable to do so prior to services being delivered.

Remediation:

KDADS began working with contracted assessors for all HCBS waivers to complete a clean-up of functional eligibility assessments. KDADS is also implementing ongoing reporting measures to ensure timeliness of assessments and closures. For initial eligibility, financial eligibility determination responsibility was moved to the Kansas Department of Health and Environment effective 1/1/2016. This was done to ensure consistency and ensure that all eligibility requirements are met prior to an individual receiving HCBS services.

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: 01/01/2015 - 12/31/2015
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**64%**
Numerator	150
Denominator	233
FE	**76%**
Numerator	164
Denominator	215
IDD	**75%**
Numerator	199
Denominator	264
TBI	**62%**
Numerator	114
Denominator	183
TA	**86%**
Numerator	127
Denominator	147
Autism	**82%**
Numerator	45
Denominator	55
SED	**94%**
Numerator	253
Denominator	270

Compliance Trends	2013	2014	2015
PD			
Statewide	47%	52%	64%
FE			
Statewide	68%	70%	76%
IDD			
Statewide	97%	74%	75%
TBI			
Statewide	39%	50%	62%
TA			
Statewide	94%	90%	86%
Autism			
Statewide	68%	No Data	75%
SED			
Statewide	93%	88%	94%

Explanation of Findings:

Completion of annual Level of Care (LOC) evaluations within the specific timeline was impacted by several factors including inability to contact participant/representative and participant relocation.

Remediation:

KDADS began working with contracted assessors for all HCBS waivers to complete a clean-up of functional eligibility assessments beginning 7/1/2016. KDADS has implemented ongoing reporting methods to ensure timeliness of assessments. Timeliness of closures will be addressed through financial eligibility responsibilities that were moved to the Kansas Department of Health and Environment effective 1/1/2016. As of March 2014, reporting on this performance measure was no longer required by CMS. On next waiver renewal, this performance measure will be removed.

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: 01/01/2015 - 12/31/2015
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**79%**
Numerator	203
Denominator	257
FE	**91%**
Numerator	246
Denominator	270
IDD	**99%**
Numerator	273
Denominator	277
TBI	**79%**
Numerator	167
Denominator	212
TA	**99%**
Numerator	205
Denominator	207
Autism	**94%**
Numerator	66
Denominator	70
SED	**83%**
Numerator	255
Denominator	309

Compliance Trends	2013	2014	2015
PD			
Statewide	93%	84%	79%
FE			
Statewide	88%	91%	91%
IDD			
Statewide	97%	95%	99%
TBI			
Statewide	64%	81%	79%
TA			
Statewide	93%	98%	100%
Autism			
Statewide	88%	No Data	90%
SED			
Statewide	77%	79%	83%

Explanation of Findings:

Some assessors were using outdated screening tools. For FE/PD they were using the UAI instead of the FAI. Previously they had directive from the state to use UAI so we did not pay for another FAI. However, the waivers indicate FAI as the approved screening tool in 2015. Directive was given to all ADRCs in 2015 to discontinue use of the UAI for HCBS purposes and move only to using the FAI.

Remediation:

KDADS began working with contracted assessors for all HCBS waivers to complete a clean-up of functional eligibility assessments beginning 7/1/2016. KDADS has implemented ongoing reporting methods to ensure timeliness of assessments and training on the required screening tool and case closure if indicated. KDADS hired an ADRC Manager to provider better coordination and oversight. KDADS is currently in the process of renewing the SED waiver to add additional clarity surrounding the assessment process.

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: 01/01/2015 - 12/31/2015
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**81%**
Numerator	208
Denominator	257
FE	**91%**
Numerator	247
Denominator	270
IDD	**96%**
Numerator	267
Denominator	277
TBI	**83%**
Numerator	176
Denominator	212
TA	**99%**
Numerator	205
Denominator	207
Autism	**61%**
Numerator	43
Denominator	70
SED	**88%**
Numerator	273
Denominator	309

Compliance Trends	2013	2014	2015
PD			
Statewide	19%	68%	81%
FE			
Statewide	24%	86%	91%
IDD			
Statewide	92%	85%	96%
TBI			
Statewide	57%	73%	83%
TA			
Statewide	93%	100%	99%
Autism			
Statewide	0%	No Data	57%
SED			
Statewide	99%	71%	88%

Explanation of Findings:

Documentation of assessor qualifications was not consistently provided to KDADS from the assessing entity as needed to verify that individual assessors were qualified.

Remediation:

In 2015, the State of Kansas implemented an application for the submission of assessor qualification documentation and will keep records of all assessor requirements. The State will work with all Level of Care (LOC) assessing entities and give clear guidelines to ensure that required documentation of assessor qualifications are available for review. A quarterly reporting process has been implemented to update assessor qualifications for quality review.

KDADS HCBS Quality Review Report

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: 01/01/2015 - 12/31/2015
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**96%**
Numerator	23
Denominator	24
FE	**96%**
Numerator	55
Denominator	57
IDD	**91%**
Numerator	10
Denominator	11
TBI	**83%**
Numerator	25
Denominator	30
TA	**100%**
Numerator	54
Denominator	54
Autism	**100%**
Numerator	14
Denominator	14
SED	**87%**
Numerator	270
Denominator	309

Compliance Trends	2013	2014	2015
PD			
Statewide	73%	83%	96%
FE			
Statewide	91%	90%	96%
IDD			
Statewide	98%	95%	91%
TBI			
Statewide	58%	81%	83%
TA			
Statewide	93%	98%	100%
Autism			
Statewide	89%	No Data	100%
SED			
Statewide	99%	88%	87%

Explanation of Findings:

Non-compliant findings include the following reasons: the case file had missing documentation, inaccurate calculations, and/or missing assessments.

Remediation:

The State of Kansas will draft clear guidelines to the assessing entities to ensure that all required documentation is available for review upon request. The State will continue to provide trainings for functional assessors to ensure timely and accurate LOC.

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: 01/01/2015 - 12/31/2015
Data Source:

Compliance By Waiver	Amerigroup	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:

2015 Provider Qualifications were not reviewed per CMS guidance.

Remediation:

KDADS, per CMS guidance, focused on 2016 reviews. We are now finalizing those findings to help inform remediation activities.

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide	100%		
FE			
Amerigroup			
Sunflower			
United			
Statewide	100%		
IDD			
Amerigroup			
Sunflower			
United			
Statewide	98%		
TBI			
Amerigroup			
Sunflower			
United			
Statewide	91%		
TA			
Amerigroup			
Sunflower			
United			
Statewide	93%		
Autism			
Amerigroup			
Sunflower			
United			
Statewide	100%		
SED			
Amerigroup			
Sunflower			
United			
Statewide	100%		

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide	100%		
FE			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure		
IDD			
Amerigroup			
Sunflower			
United			
Statewide	98%		
TBI			
Amerigroup			
Sunflower			
United			
Statewide	89%		
TA			
Amerigroup			
Sunflower			
United			
Statewide	93%		
Autism			
Amerigroup			
Sunflower			
United			
Statewide	100%		
SED			
Amerigroup			
Sunflower			
United			
Statewide	100%		

Explanation of Findings:

2015 Provider Qualifications were not reviewed per CMS guidance.

Remediation:

KDADS, per CMS guidance, focused on 2016 reviews. We are now finalizing those findings to help inform remediation activities.

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide	75%		
FE			
Amerigroup			
Sunflower			
United			
Statewide	100%		
IDD			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure		
TBI			
Amerigroup			
Sunflower			
United			
Statewide	88%		
TA			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
Autism			
Amerigroup			
Sunflower			
United			
Statewide	82%		
SED			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure		

Explanation of Findings:

2015 Provider Qualifications were not reviewed per CMS guidance.

Remediation:

KDADS, per CMS guidance, focused on 2016 reviews. We are now finalizing those findings to help inform remediation activities.

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide	75%		
FE			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure		
IDD			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure		
TBI			
Amerigroup			
Sunflower			
United			
Statewide	88%		
TA			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
Autism			
Amerigroup			
Sunflower			
United			
Statewide	91%		
SED			
Amerigroup			
Sunflower			
United			
Statewide	89%		

Explanation of Findings:

2015 Provider Qualifications were not reviewed per CMS guidance.

Remediation:

KDADS, per CMS guidance, focused on 2016 reviews. We are now finalizing those findings to help inform remediation activities.

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: 01/01/2015 - 12/31/2015
Data Source:

Compliance By Waiver	Amerigroup	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:

2015 Provider Qualifications were not reviewed per CMS guidance.

Remediation:

KDADS, per CMS guidance, focused on 2016 reviews. We are now finalizing those findings to help inform remediation activities.

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
FE			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
IDD			
Amerigroup			
Sunflower			
United			
Statewide	99%		
TBI			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
TA			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
Autism			
Amerigroup			
Sunflower			
United			
Statewide	No Data		
SED			
Amerigroup			
Sunflower			
United			
Statewide	88%		

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**33%**	**64%**	**49%**	**48%**
Numerator	43	77	40	160
Denominator	129	121	81	331
FE	**42%**	**51%**	**56%**	**49%**
Numerator	49	67	45	161
Denominator	117	131	80	328
IDD	**32%**	**56%**	**41%**	**45%**
Numerator	35	92	36	163
Denominator	109	165	88	362
TBI	**41%**	**38%**	**55%**	**43%**
Numerator	48	25	23	96
Denominator	116	65	42	223
TA	**44%**	**85%**	**32%**	**54%**
Numerator	48	56	12	116
Denominator	110	66	38	214
Autism	**56%**	**50%**	**36%**	**49%**
Numerator	15	11	5	31
Denominator	27	22	14	63
SED	**99%**	**95%**	**100%**	**98%**
Numerator	111	88	131	330
Denominator	112	93	131	336

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		55%	33%
Sunflower		57%	64%
United		33%	49%
Statewide	55%	50%	48%
FE			
Amerigroup		50%	42%
Sunflower		56%	51%
United		45%	56%
Statewide	Not a measure	50%	49%
IDD			
Amerigroup		36%	32%
Sunflower		56%	56%
United		52%	41%
Statewide	99%	49%	45%
TBI			
Amerigroup		37%	41%
Sunflower		37%	38%
United		22%	55%
Statewide	44%	34%	43%
TA			
Amerigroup		50%	44%
Sunflower		73%	85%
United		64%	32%
Statewide	93%	61%	54%
Autism			
Amerigroup		84%	56%
Sunflower		47%	50%
United		63%	36%
Statewide	58%	69%	49%
SED			
Amerigroup		91%	99%
Sunflower		92%	95%
United		89%	100%
Statewide	98%	90%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**55%**	**56%**	**68%**	**59%**
Numerator	71	68	55	194
Denominator	129	121	81	331
FE	**66%**	**53%**	**68%**	**61%**
Numerator	77	69	54	200
Denominator	117	131	80	328
IDD	**67%**	**36%**	**47%**	**48%**
Numerator	73	59	41	173
Denominator	109	165	88	362
TBI	**48%**	**28%**	**62%**	**45%**
Numerator	56	18	26	100
Denominator	116	65	42	223
TA	**58%**	**62%**	**58%**	**59%**
Numerator	64	41	22	127
Denominator	110	66	38	214
Autism	**59%**	**45%**	**21%**	**46%**
Numerator	16	10	3	29
Denominator	27	22	14	63
SED	**99%**	**92%**	**98%**	**97%**
Numerator	112	86	129	327
Denominator	113	93	131	337

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		83%	55%
Sunflower		90%	56%
United		89%	68%
Statewide	86%	87%	59%
FE			
Amerigroup		79%	66%
Sunflower		90%	53%
United		88%	68%
Statewide	87%	86%	61%
IDD			
Amerigroup		85%	67%
Sunflower		77%	36%
United		72%	47%
Statewide	99%	78%	48%
TBI			
Amerigroup		67%	48%
Sunflower		82%	28%
United		70%	62%
Statewide	72%	73%	45%
TA			
Amerigroup		93%	58%
Sunflower		98%	62%
United		97%	58%
Statewide	96%	96%	59%
Autism			
Amerigroup		81%	59%
Sunflower		50%	45%
United		63%	21%
Statewide	59%	68%	46%
SED			
Amerigroup		91%	99%
Sunflower		91%	92%
United		89%	98%
Statewide	92%	90%	97%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**44%**	**49%**	**67%**	**51%**
Numerator	57	59	54	170
Denominator	129	121	81	331
FE	**55%**	**50%**	**70%**	**57%**
Numerator	64	66	56	186
Denominator	117	131	80	328
IDD	**61%**	**36%**	**45%**	**46%**
Numerator	67	59	40	166
Denominator	109	165	88	362
TBI	**45%**	**26%**	**64%**	**43%**
Numerator	52	17	27	96
Denominator	116	65	42	223
TA	**49%**	**61%**	**58%**	**54%**
Numerator	54	40	22	116
Denominator	110	66	38	214
Autism	**59%**	**45%**	**21%**	**46%**
Numerator	16	10	3	29
Denominator	27	22	14	63
SED	**99%**	**95%**	**100%**	**98%**
Numerator	112	88	131	331
Denominator	113	93	131	337

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		90%	44%
Sunflower		89%	49%
United		96%	67%
Statewide	90%	91%	51%
FE			
Amerigroup		92%	55%
Sunflower		92%	50%
United		95%	70%
Statewide	Not a measure	93%	57%
IDD			
Amerigroup		90%	61%
Sunflower		97%	36%
United		89%	45%
Statewide	99%	93%	46%
TBI			
Amerigroup		79%	45%
Sunflower		91%	26%
United		83%	64%
Statewide	84%	84%	43%
TA			
Amerigroup		96%	49%
Sunflower		95%	61%
United		94%	58%
Statewide	96%	96%	54%
Autism			
Amerigroup		79%	59%
Sunflower		61%	45%
United		86%	21%
Statewide	64%	74%	46%
SED			
Amerigroup		90%	99%
Sunflower		89%	95%
United		86%	100%
Statewide	99%	88%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**68%**	**69%**	**77%**	**70%**
Numerator	88	83	62	233
Denominator	129	121	81	331
FE	**76%**	**61%**	**79%**	**71%**
Numerator	89	80	63	232
Denominator	117	131	80	328
IDD	**80%**	**59%**	**55%**	**64%**
Numerator	87	98	48	233
Denominator	109	165	88	362
TBI	**53%**	**43%**	**69%**	**53%**
Numerator	62	28	29	119
Denominator	116	65	42	223
TA	**68%**	**86%**	**58%**	**72%**
Numerator	75	57	22	154
Denominator	110	66	38	214
Autism	**59%**	**50%**	**29%**	**49%**
Numerator	16	11	4	31
Denominator	27	22	14	63
SED	**99%**	**94%**	**98%**	**97%**
Numerator	112	87	129	328
Denominator	113	93	131	337

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		88%	68%
Sunflower		87%	69%
United		85%	77%
Statewide	80%	87%	70%
FE			
Amerigroup		84%	76%
Sunflower		88%	61%
United		86%	79%
Statewide	Not a measure	86%	71%
IDD			
Amerigroup		80%	80%
Sunflower		80%	59%
United		82%	55%
Statewide	98%	81%	64%
TBI			
Amerigroup		76%	53%
Sunflower		86%	43%
United		77%	69%
Statewide	64%	80%	53%
TA			
Amerigroup		84%	68%
Sunflower		97%	86%
United		96%	58%
Statewide	No Data	91%	72%
Autism			
Amerigroup		74%	59%
Sunflower		51%	50%
United		65%	29%
Statewide	55%	65%	49%
SED			
Amerigroup		92%	99%
Sunflower		90%	94%
United		87%	98%
Statewide	Not a measure	90%	97%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**70%**	**70%**	**79%**	**72%**
Numerator	90	85	64	239
Denominator	129	121	81	331
FE	**78%**	**60%**	**83%**	**72%**
Numerator	91	79	66	236
Denominator	117	131	80	328
IDD	**76%**	**60%**	**51%**	**63%**
Numerator	83	99	45	227
Denominator	109	165	88	362
TBI	**51%**	**45%**	**69%**	**52%**
Numerator	59	29	29	117
Denominator	116	65	42	223
TA	**75%**	**86%**	**58%**	**76%**
Numerator	83	57	22	162
Denominator	110	66	38	214
Autism	**59%**	**55%**	**36%**	**52%**
Numerator	16	12	5	33
Denominator	27	22	14	63
SED	**98%**	**95%**	**99%**	**98%**
Numerator	112	88	130	330
Denominator	114	93	131	338

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		88%	70%
Sunflower		87%	70%
United		84%	79%
Statewide	Not a measure	87%	72%
FE			
Amerigroup		83%	78%
Sunflower		86%	60%
United		87%	83%
Statewide	90%	85%	72%
IDD			
Amerigroup		84%	76%
Sunflower		82%	60%
United		88%	51%
Statewide	Not a measure	84%	63%
TBI			
Amerigroup		73%	51%
Sunflower		84%	45%
United		80%	69%
Statewide	Not a measure	78%	52%
TA			
Amerigroup		83%	75%
Sunflower		97%	86%
United		97%	58%
Statewide	Not a measure	91%	76%
Autism			
Amerigroup		77%	59%
Sunflower		53%	55%
United		71%	36%
Statewide	Not a measure	69%	52%
SED			
Amerigroup		92%	98%
Sunflower		90%	95%
United		87%	99%
Statewide	93%	90%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**67%**	**72%**	**73%**	**70%**
Numerator	73	73	36	182
Denominator	109	101	49	259
FE	**67%**	**57%**	**69%**	**64%**
Numerator	66	53	29	148
Denominator	98	93	42	233
IDD	**77%**	**66%**	**48%**	**66%**
Numerator	79	82	31	192
Denominator	103	125	65	293
TBI	**44%**	**40%**	**65%**	**47%**
Numerator	42	18	22	82
Denominator	96	45	34	175
TA	**78%**	**89%**	**59%**	**79%**
Numerator	62	47	13	122
Denominator	79	53	22	154
Autism	**52%**	**47%**	**38%**	**48%**
Numerator	12	7	3	22
Denominator	23	15	8	46
SED	**97%**	**91%**	**99%**	**96%**
Numerator	96	79	116	291
Denominator	99	87	117	303

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		73%	67%
Sunflower		82%	72%
United		92%	73%
Statewide	82%	82%	70%
FE			
Amerigroup		81%	67%
Sunflower		85%	57%
United		90%	69%
Statewide	81%	85%	64%
IDD			
Amerigroup		75%	77%
Sunflower		81%	66%
United		91%	48%
Statewide	97%	82%	66%
TBI			
Amerigroup		65%	44%
Sunflower		84%	40%
United		77%	65%
Statewide	60%	76%	47%
TA			
Amerigroup		81%	78%
Sunflower		94%	89%
United		96%	59%
Statewide	92%	89%	79%
Autism			
Amerigroup		67%	52%
Sunflower		43%	47%
United		33%	38%
Statewide	64%	57%	48%
SED			
Amerigroup		89%	97%
Sunflower		89%	91%
United		83%	99%
Statewide	80%	87%	96%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**36%**	**58%**	**63%**	**53%**
Numerator	8	18	12	38
Denominator	22	31	19	72
FE	**71%**	**51%**	**47%**	**54%**
Numerator	10	19	8	37
Denominator	14	37	17	68
IDD	**60%**	**16%**	**30%**	**28%**
Numerator	6	5	7	18
Denominator	10	31	23	64
TBI	**42%**	**27%**	**50%**	**38%**
Numerator	14	8	8	30
Denominator	33	30	16	79
TA	**73%**	**89%**	**43%**	**75%**
Numerator	19	17	3	39
Denominator	26	19	7	52
Autism	**0%**	**25%**	**0%**	**11%**
Numerator	0	1	0	1
Denominator	2	4	3	9
SED	**90%**	**79%**	**93%**	**88%**
Numerator	43	34	62	139
Denominator	48	43	67	158

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		20%	36%
Sunflower		53%	58%
United		50%	63%
Statewide	75%	39%	53%
FE			
Amerigroup		24%	71%
Sunflower		39%	51%
United		50%	47%
Statewide	78%	38%	54%
IDD			
Amerigroup		7%	60%
Sunflower		38%	16%
United		16%	30%
Statewide	97%	23%	28%
TBI			
Amerigroup		24%	42%
Sunflower		54%	27%
United		46%	50%
Statewide	53%	38%	38%
TA			
Amerigroup		32%	73%
Sunflower		54%	89%
United		38%	43%
Statewide	92%	42%	75%
Autism			
Amerigroup		10%	0%
Sunflower		17%	25%
United		0%	0%
Statewide	45%	11%	11%
SED			
Amerigroup		90%	90%
Sunflower		83%	79%
United		84%	93%
Statewide	85%	86%	88%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**69%**	**72%**	**78%**	**72%**
Numerator	89	87	63	239
Denominator	129	121	81	331
FE	**76%**	**64%**	**79%**	**72%**
Numerator	89	84	63	236
Denominator	117	131	80	328
IDD	**84%**	**62%**	**59%**	**68%**
Numerator	92	102	52	246
Denominator	109	165	88	362
TBI	**55%**	**46%**	**71%**	**56%**
Numerator	64	30	30	124
Denominator	116	65	42	223
TA	**73%**	**86%**	**58%**	**74%**
Numerator	80	57	22	159
Denominator	110	66	38	214
Autism	**59%**	**55%**	**21%**	**49%**
Numerator	16	12	3	31
Denominator	27	22	14	63
SED	**99%**	**94%**	**99%**	**98%**
Numerator	110	87	130	327
Denominator	111	93	131	335

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS has drafted clear guidance to all three MCOs to ensure that all required service plan information and signatures/dates are clearly documented on the participant's POC to render it valid for quality review in terms of type, scope, amount, duration, and frequency specified in the service plan.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		94%	69%
Sunflower		96%	72%
United		96%	78%
Statewide	85%	95%	72%
FE			
Amerigroup		83%	76%
Sunflower		96%	64%
United		96%	79%
Statewide	87%	92%	72%
IDD			
Amerigroup		78%	84%
Sunflower		97%	62%
United		100%	59%
Statewide	98%	92%	68%
TBI			
Amerigroup		81%	55%
Sunflower		95%	46%
United		85%	71%
Statewide	70%	87%	56%
TA			
Amerigroup		98%	73%
Sunflower		100%	86%
United		96%	58%
Statewide	100%	98%	74%
Autism			
Amerigroup		89%	59%
Sunflower		100%	55%
United		50%	21%
Statewide	50%	86%	49%
SED			
Amerigroup		91%	99%
Sunflower		96%	94%
United		92%	99%
Statewide	13%	93%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source:

Compliance By Waiver	Amerigroup	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:

Data was not collected since customer interviews were not performed during 2015 review period.

Remediation:

KDADS is working to evaluate and develop the structure for this process.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		97%	
Sunflower		92%	
United		93%	
Statewide	Not a measure	94%	
FE			
Amerigroup		85%	
Sunflower		86%	
United		82%	
Statewide	87%	84%	
IDD			
Amerigroup		92%	
Sunflower		96%	
United		93%	
Statewide	Not a measure	94%	
TBI			
Amerigroup		81%	
Sunflower		88%	
United		83%	
Statewide	Not a measure	83%	
TA			
Amerigroup		89%	
Sunflower		84%	
United		85%	
Statewide	Not a measure	87%	
Autism			
Amerigroup		74%	
Sunflower		70%	
United		60%	
Statewide	Not a measure	71%	
SED			
Amerigroup			
Sunflower			
United			
Statewide	Not a measure	No Data	

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**56%**	**69%**	**73%**	**65%**
Numerator	72	83	59	214
Denominator	129	121	81	331
FE	**59%**	**59%**	**75%**	**63%**
Numerator	69	77	60	206
Denominator	117	131	80	328
IDD	**45%**	**42%**	**55%**	**46%**
Numerator	49	69	48	166
Denominator	109	165	88	362
TBI	**50%**	**40%**	**74%**	**52%**
Numerator	58	26	31	115
Denominator	116	65	42	223
TA	**65%**	**80%**	**58%**	**68%**
Numerator	71	53	22	146
Denominator	110	66	38	214
Autism	**67%**	**45%**	**21%**	**49%**
Numerator	18	10	3	31
Denominator	27	22	14	63
SED	**91%**	**72%**	**97%**	**88%**
Numerator	96	66	121	283
Denominator	106	92	125	323

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS has drafted clear guidance to all three MCOs to ensure that all required service plan information and signatures/dates are clearly documented on the participant's POC to render it valid for quality review in terms of indicating a choice of waiver service providers.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		68%	56%
Sunflower		58%	69%
United		69%	73%
Statewide	52%	65%	65%
FE			
Amerigroup		68%	59%
Sunflower		76%	59%
United		77%	75%
Statewide	56%	74%	63%
IDD			
Amerigroup		51%	45%
Sunflower		68%	42%
United		75%	55%
Statewide	99%	64%	46%
TBI			
Amerigroup		54%	50%
Sunflower		75%	40%
United		70%	74%
Statewide	44%	65%	52%
TA			
Amerigroup		87%	65%
Sunflower		84%	80%
United		92%	58%
Statewide	96%	86%	68%
Autism			
Amerigroup		67%	67%
Sunflower		44%	45%
United		88%	21%
Statewide	40%	63%	49%
SED			
Amerigroup		94%	91%
Sunflower		91%	72%
United		84%	97%
Statewide	98%	89%	88%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**53%**	**50%**	**73%**	**57%**
Numerator	68	61	59	188
Denominator	129	121	81	331
FE	**57%**	**47%**	**74%**	**57%**
Numerator	67	62	59	188
Denominator	117	131	80	328
IDD	**46%**	**35%**	**50%**	**42%**
Numerator	50	58	44	152
Denominator	109	165	88	362
TBI	**50%**	**23%**	**67%**	**45%**
Numerator	58	15	28	101
Denominator	116	65	42	223
TA	**65%**	**53%**	**55%**	**60%**
Numerator	72	35	21	128
Denominator	110	66	38	214
Autism	**52%**	**27%**	**14%**	**35%**
Numerator	14	6	2	22
Denominator	27	22	14	63
SED	**92%**	**71%**	**97%**	**88%**
Numerator	103	66	123	292
Denominator	112	93	127	332

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS has drafted clear guidance to all three MCOs to ensure that all required service plan information and signatures/dates are clearly documented on the participant's POC to render it valid for quality review in terms of indicating choice of waiver services.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		68%	53%
Sunflower		72%	50%
United		77%	73%
Statewide	64%	72%	57%
FE			
Amerigroup		67%	57%
Sunflower		86%	47%
United		85%	74%
Statewide	59%	80%	57%
IDD			
Amerigroup		55%	46%
Sunflower		68%	35%
United		77%	50%
Statewide	No Data	66%	42%
TBI			
Amerigroup		56%	50%
Sunflower		80%	23%
United		74%	67%
Statewide	53%	68%	45%
TA			
Amerigroup		86%	65%
Sunflower		97%	53%
United		94%	55%
Statewide	96%	91%	60%
Autism			
Amerigroup		79%	52%
Sunflower		50%	27%
United		88%	14%
Statewide	55%	72%	35%
SED			
Amerigroup		94%	92%
Sunflower		91%	72%
United		84%	97%
Statewide	98%	89%	88%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**57%**	**67%**	**78%**	**66%**
Numerator	74	81	63	218
Denominator	129	121	81	331
FE	**58%**	**56%**	**79%**	**63%**
Numerator	68	74	63	205
Denominator	117	131	80	328
IDD	**47%**	**41%**	**57%**	**46%**
Numerator	51	67	50	168
Denominator	109	165	88	362
TBI	**51%**	**40%**	**74%**	**52%**
Numerator	59	26	31	116
Denominator	116	65	42	223
TA	**65%**	**80%**	**55%**	**68%**
Numerator	71	53	21	145
Denominator	110	66	38	214
Autism	**67%**	**59%**	**43%**	**59%**
Numerator	18	13	6	37
Denominator	27	22	14	63
SED	**92%**	**72%**	**98%**	**89%**
Numerator	105	67	127	299
Denominator	114	93	130	337

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS will draft clear guidance to the MCOs to ensure that all required service plan information and signatures/dates are clearly documented on the participant's POC.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		76%	57%
Sunflower		74%	67%
United		80%	78%
Statewide	Not a measure	76%	66%
FE			
Amerigroup		67%	58%
Sunflower		87%	56%
United		85%	79%
Statewide	65%	80%	63%
IDD			
Amerigroup		47%	47%
Sunflower		69%	41%
United		78%	57%
Statewide	No Data	64%	46%
TBI			
Amerigroup		55%	51%
Sunflower		79%	40%
United		73%	74%
Statewide	No Data	67%	52%
TA			
Amerigroup		87%	65%
Sunflower		98%	80%
United		94%	55%
Statewide	No Data	92%	68%
Autism			
Amerigroup		86%	67%
Sunflower		47%	59%
United		75%	43%
Statewide	No Data	72%	59%
SED			
Amerigroup		94%	92%
Sunflower		91%	72%
United		85%	98%
Statewide	99%	90%	89%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**58%**	**68%**	**78%**	**66%**
Numerator	75	82	63	220
Denominator	129	121	81	331
FE	**59%**	**59%**	**79%**	**64%**
Numerator	69	77	63	209
Denominator	117	131	80	328
IDD	**47%**	**39%**	**57%**	**46%**
Numerator	51	64	50	165
Denominator	109	165	88	362
TBI	**50%**	**43%**	**74%**	**52%**
Numerator	58	28	31	117
Denominator	116	65	42	223
TA	**56%**	**82%**	**58%**	**64%**
Numerator	62	54	22	138
Denominator	110	66	38	214
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
PD			
Amerigroup		64%	58%
Sunflower		73%	68%
United		77%	78%
Statewide	Not a measure	71%	66%
FE			
Amerigroup		64%	59%
Sunflower		84%	59%
United		77%	79%
Statewide	65%	75%	64%
IDD			
Amerigroup		34%	47%
Sunflower		61%	39%
United		77%	57%
Statewide	No Data	53%	46%
TBI			
Amerigroup		50%	50%
Sunflower		85%	43%
United		70%	74%
Statewide	Not a measure	66%	52%
TA			
Amerigroup		82%	56%
Sunflower		98%	82%
United		100%	58%
Statewide	No Data	90%	64%
Autism	**Self-direction is not offered for this waiver**		
Amerigroup			
Sunflower			
United			
Statewide			
SED	**Self-direction is not offered for this waiver**		
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

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 non-preventable causes
Denominator: Number of unexpected deaths
Review Period: 01/01/2015 - 12/31/2015
Data Source:

Compliance By Waiver	Amerigroup	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:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**19%**	**72%**	**80%**	**53%**
Numerator	24	87	64	175
Denominator	127	121	80	328
FE	**16%**	**62%**	**80%**	**50%**
Numerator	19	81	64	164
Denominator	116	131	80	327
IDD	**6%**	**59%**	**56%**	**42%**
Numerator	6	97	49	152
Denominator	109	164	87	360
TBI	**12%**	**45%**	**76%**	**34%**
Numerator	14	29	32	75
Denominator	114	64	42	220
TA	**38%**	**86%**	**61%**	**57%**
Numerator	42	57	23	122
Denominator	110	66	38	214
Autism	**8%**	**29%**	**14%**	**16%**
Numerator	2	6	2	10
Denominator	26	21	14	61
SED	**64%**	**53%**	**63%**	**60%**
Numerator	72	49	82	203
Denominator	113	93	130	336

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		51%	19%
Sunflower		88%	72%
United		90%	80%
Statewide	65%	72%	53%
FE			
Amerigroup		59%	16%
Sunflower		86%	62%
United		92%	80%
Statewide	80%	78%	50%
IDD			
Amerigroup		23%	6%
Sunflower		87%	59%
United		100%	56%
Statewide	99%	68%	42%
TBI			
Amerigroup		30%	12%
Sunflower		94%	45%
United		80%	76%
Statewide	57%	63%	34%
TA			
Amerigroup		61%	38%
Sunflower		99%	86%
United		97%	61%
Statewide	86%	82%	57%
Autism			
Amerigroup		62%	8%
Sunflower		33%	29%
United		43%	14%
Statewide	90%	50%	16%
SED			
Amerigroup		88%	64%
Sunflower		80%	53%
United		78%	63%
Statewide	89%	82%	60%

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

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: 01/01/2015 - 12/31/2015
Data Source:

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

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

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: 01/01/2015 - 12/31/2015
Data Source:

Compliance By Waiver	Amerigroup	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:

The State has realized a more comprehensive system is required to effectively manage the performance measures for Health and Welfare assurances. The lack of data is directly tied to the absence of a comprehensive critical incident system.

Remediation:

The State has implemented a preliminary adverse incident reporting system effective August 2016. In addition, the State is working with Department for Children and Families, Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services to establish a centralized data sharing network via a Memorandum of Understanding (MOU). This MOU will allow enhanced data sharing across three state agencies that will support a centralized collection and reporting of critical incident data.

Compliance Trends	2013	2014	2015
PD			
Amerigroup			
Sunflower			
United			
Statewide			
FE			
Amerigroup			
Sunflower			
United			
Statewide			
IDD			
Amerigroup			
Sunflower			
United			
Statewide			
TBI			
Amerigroup			
Sunflower			
United			
Statewide			
TA			
Amerigroup			
Sunflower			
United			
Statewide			
Autism			
Amerigroup			
Sunflower			
United			
Statewide			
SED			
Amerigroup			
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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	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:

This data was not collected as part of the 2015 MCO reviews that were conducted.

Remediation:

KDADS will add this measure to its internal protocol process.

Compliance Trends	2013	2014	2015
PD			
Amerigroup		78%	
Sunflower		81%	
United		88%	
Statewide	Not a measure	82%	
FE			
Amerigroup		89%	
Sunflower		97%	
United		97%	
Statewide	Not a measure	95%	
IDD			
Amerigroup		91%	
Sunflower		99%	
United		99%	
Statewide	Not a measure	97%	
TBI			
Amerigroup		84%	
Sunflower		94%	
United		93%	
Statewide	Not a measure	90%	
TA			
Amerigroup		100%	
Sunflower		100%	
United		97%	
Statewide	Not a measure	100%	
Autism			
Amerigroup		100%	
Sunflower		92%	
United		100%	
Statewide	Not a measure	98%	
SED			
Amerigroup		54%	
Sunflower		55%	
United		46%	
Statewide	Not a measure	52%	

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: 01/01/2015 - 12/31/2015
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**53%**	**49%**	**80%**	**58%**
Numerator	69	59	65	193
Denominator	129	120	81	330
FE	**62%**	**56%**	**81%**	**65%**
Numerator	73	74	65	212
Denominator	117	131	80	328
IDD	**61%**	**32%**	**58%**	**47%**
Numerator	66	52	51	169
Denominator	109	162	88	359
TBI	**49%**	**42%**	**74%**	**52%**
Numerator	57	27	31	115
Denominator	116	64	42	222
TA	**54%**	**58%**	**63%**	**57%**
Numerator	59	38	24	121
Denominator	110	66	38	214
Autism	**44%**	**27%**	**7%**	**30%**
Numerator	12	6	1	19
Denominator	27	22	14	63
SED	Not a waiver performance measure			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015
PD			
Amerigroup		59%	53%
Sunflower		77%	49%
United		64%	80%
Statewide	Not a measure	67%	58%
FE			
Amerigroup		61%	62%
Sunflower		72%	56%
United		76%	81%
Statewide	59%	70%	65%
IDD			
Amerigroup		67%	61%
Sunflower		58%	32%
United		70%	58%
Statewide	Not a measure	64%	47%
TBI			
Amerigroup		46%	49%
Sunflower		68%	42%
United		56%	74%
Statewide	Not a measure	56%	52%
TA			
Amerigroup		75%	54%
Sunflower		91%	58%
United		86%	63%
Statewide	Not a measure	83%	57%
Autism			
Amerigroup		77%	44%
Sunflower		53%	27%
United		38%	7%
Statewide	Not a measure	64%	30%
SED	Not a measure		
Amerigroup			
Sunflower			
United			
Statewide			

Explanation of Findings:

Non-compliant findings include the following reasons: the case file did not include the service plan document or the document was missing a valid signature/date.

Remediation:

KDADS is in the process of performing a gap analysis on current plans of care, identifying the gaps versus federal rule requirement, and will be developing policy by August 2017 to provide clear direction on the POC development, revision, and updating processes.

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: 01/01/2015 - 12/31/2015
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
HCBS Waivers	**88%**
Numerator	930,036
Denominator	1,059,617

Compliance Trends	2013	2014	2015
All HCBS Waivers			
Statewide	not a measure	90%	88%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

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: 01/01/2015 - 12/31/2015
Data Source: KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	24
Denominator	24
FE	**100%**
Numerator	24
Denominator	24
IDD	**100%**
Numerator	36
Denominator	36
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
PD			
Statewide	not a measure	100%	100%
FE			
Statewide	not a measure	100%	100%
IDD			
Statewide	not a measure	100%	100%
TBI			
Statewide	not a measure	100%	100%
TA			
Statewide	not a measure	100%	100%
Autism			
Statewide	not a measure	100%	100%
SED			
Statewide	not a measure	100%	100%

Explanation of Findings:

Remediation:

Home and Community Based Services Quality Review Report January – June 2016

June 6, 2017

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 Qualtiy Review reports
Review Period: 01/01/2016 - 6/30/2016
Data Source: Quality Review Reports to KDHE

Compliance By Waiver	Statewide
PD	**50%**
Numerator	1
Denominator	2
FE	**50%**
Numerator	1
Denominator	2
IDD	**50%**
Numerator	1
Denominator	2
TBI	**50%**
Numerator	1
Denominator	2
TA	**50%**
Numerator	1
Denominator	2
Autism	**50%**
Numerator	1
Denominator	2
SED	**50%**
Numerator	1
Denominator	2

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	25%	25%	25%	50%
FE				
Statewide	25%	25%	25%	50%
IDD				
Statewide	25%	25%	25%	50%
TBI				
Statewide	25%	25%	25%	50%
TA				
Statewide	25%	25%	25%	50%
Autism				
Statewide	25%	25%	25%	50%
SED				
Statewide	25%	25%	25%	50%

Explanation of Findings:

The quality review for this report was done in a six-month timeframe. There was no quarterly data to report.

Remediation:

KDADS adopted a Quality Review Policy in 2016 and is back on a quarterly review process effective December 2016.

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: 01/01/2016 - 06/30/2016
Data Source: Number of waiver amendments and renewals sent 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	**N/A**
Numerator	0
Denominator	0
SED	**N/A**
Numerator	0
Denominator	0

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

Explanation of Findings:

Remediation:

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: 01/01/2016 - 06/30/2016
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	6
Denominator	6
FE	**100%**
Numerator	6
Denominator	6
IDD	**100%**
Numerator	8
Denominator	8
TBI	**100%**
Numerator	6
Denominator	6
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	Jan-Jun 2016
PD				
Statewide	N/A	N/A	100%	100%
FE				
Statewide	N/A	N/A	100%	100%
IDD				
Statewide	100%	N/A	100%	100%
TBI				
Statewide	100%	N/A	100%	100%
TA				
Statewide	N/A	N/A	N/A	N/A
Autism				
Statewide	N/A	N/A	N/A	N/A
SED				
Statewide	N/A	N/A	N/A	N/A

Explanation of Findings:

Remediation:

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: 01/01/2016 - 06/30/2016
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**75%**
Numerator	3
Denominator	4
FE	**75%**
Numerator	3
Denominator	4
IDD	**75%**
Numerator	3
Denominator	4
TBI	**75%**
Numerator	3
Denominator	4
TA	**75%**
Numerator	3
Denominator	4
Autism	**75%**
Numerator	3
Denominator	4
SED	**75%**
Numerator	3
Denominator	4

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	Not a measure	45%	67%	75%
FE				
Statewide	100%	82%	50%	75%
IDD				
Statewide	Not a measure	91%	Not Available	75%
TBI				
Statewide	Not a measure	73%	Not Available	75%
TA				
Statewide	Not a measure	64%	Not Available	75%
Autism				
Statewide	Not a measure	91%	100%	75%
SED				
Statewide	Not a measure	100%	Not Available	75%

Explanation of Findings:

During the reporting timeframe, the expectations for submission or written or in person reports to the LTC committee were not clear. In addition, the conversion to Office 360 caused some of the documentation submitted to the LTC committee to be lost and thus could not be verified.

Remediation:

Beginning in January 2017, clear expectations have been set for submission of written reports or in person attendance to the LTC meeting. Since this expectation has been set, this performance measure has been met 100%.

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 enrolled waiver participants
Review Period: 01/01/2016 - 06/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**70%**
Numerator	7
Denominator	10
FE	**100%**
Numerator	26
Denominator	26
IDD	**100%**
Numerator	4
Denominator	4
TBI	**89%**
Numerator	8
Denominator	9
TA	**96%**
Numerator	23
Denominator	24
Autism	**100%**
Numerator	11
Denominator	11
SED	**92%**
Numerator	142
Denominator	154

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	64%	83%	96%	70%
FE				
Statewide	81%	91%	93%	100%
IDD				
Statewide	99%	94%	90%	100%
TBI				
Statewide	62%	89%	81%	89%
TA				
Statewide	97%	89%	100%	96%
Autism				
Statewide	82%	No Data	100%	100%
SED				
Statewide	99%	89%	88%	92%

Explanation of Findings:

The initial assessment tool was not completed and/or provided for the review. The person began receiving services prior to being determined eligible for services, functional score did not meet guidelines, score was not correctly calculated, program requirements not met.

Remediation:

Not enough information provided to determine appropriate remediation, only three PD individuals were provided for this performance measure. Of the three, one didn't belong to PD and was an FE participant.

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: 01/01/2016 - 06/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**74%**
Numerator	124
Denominator	168
FE	**80%**
Numerator	117
Denominator	146
IDD	**79%**
Numerator	144
Denominator	183
TBI	**67%**
Numerator	64
Denominator	95
TA	**95%**
Numerator	74
Denominator	78
Autism	**74%**
Numerator	40
Denominator	54
SED	**91%**
Numerator	108
Denominator	119

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	47%	52%	64%	74%
FE				
Statewide	68%	70%	76%	80%
IDD				
Statewide	97%	74%	75%	79%
TBI				
Statewide	39%	50%	62%	67%
TA				
Statewide	94%	90%	86%	95%
Autism				
Statewide	68%	No Data	75%	74%
SED				
Statewide	93%	88%	94%	91%

Explanation of Findings:

Did not complete the reassessment with the required timeline, did not provide an assessment, missing one or more of the assessment required to determine timeliness.

Remediation:

Conclusions: The most prevalent reason this performance measure was not met included:

1. Lack of documentation
2. Re-assessment not complete within 365 days- This in some cases was attributed to the individual being transitioned to one waiver and the coding not catching up.

One issue program noted is the rationale behind some of the quality reviewers determination of non-compliance. In the notes field it states the reviewer could not determine if the individual was on the approved assessor listing. In programs view this is captured in another measure and should not be counted as non-compliant in this measure.

Recommended Remediation:

1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

2. Coding error fix- Ensure all individuals are coded for the right waiver and/or removed based on a 3161.

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: 01/01/2016 - 06/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**79%**
Numerator	141
Denominator	178
FE	**90%**
Numerator	158
Denominator	175
IDD	**99%**
Numerator	186
Denominator	187
TBI	**78%**
Numerator	83
Denominator	106
TA	**100%**
Numerator	102
Denominator	102
Autism	**88%**
Numerator	57
Denominator	65
SED	**89%**
Numerator	137
Denominator	154

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	93%	84%	79%	79%
FE				
Statewide	88%	91%	91%	90%
IDD				
Statewide	97%	95%	99%	99%
TBI				
Statewide	64%	81%	79%	78%
TA				
Statewide	93%	98%	100%	100%
Autism				
Statewide	88%	No Data	90%	88%
SED				
Statewide	77%	79%	83%	89%

Explanation of Findings:

No current assessment provided for review period, wrong assessment tool used, coded for one waiver, assessment completed for another.

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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: 01/01/2016 - 06/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**80%**
Numerator	143
Denominator	178
FE	**90%**
Numerator	158
Denominator	175
IDD	**97%**
Numerator	182
Denominator	187
TBI	**78%**
Numerator	83
Denominator	106
TA	**100%**
Numerator	102
Denominator	102
Autism	**68%**
Numerator	44
Denominator	65
SED	**88%**
Numerator	136
Denominator	154

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Statewide	19%	68%	81%	80%
FE				
Statewide	24%	86%	91%	90%
IDD				
Statewide	92%	85%	96%	97%
TBI				
Statewide	57%	73%	83%	78%
TA				
Statewide	93%	100%	99%	100%
Autism				
Statewide	0%	No Data	57%	68%
SED				
Statewide	99%	71%	88%	88%

Explanation of Findings:

The current/applicable assessment tool was missing, so unable to determine if qualified. The assessors name was not on the approved assessors listing.

Remediation:

Conclusions: In most cases a determination of non-compliance was reached because a current assessment was not provided for review.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will provide all required documentation to quality reviewers.

KDADS HCBS Quality Review Report

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: 01/01/2016 - 06/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**80%**
Numerator	142
Denominator	178
FE	**88%**
Numerator	154
Denominator	175
IDD	**98%**
Numerator	184
Denominator	187
TBI	**76%**
Numerator	81
Denominator	106
TA	**100%**
Numerator	102
Denominator	102
Autism	**88%**
Numerator	57
Denominator	65
SED	**90%**
Numerator	139
Denominator	154

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

Explanation of Findings:

The required timeline was not met, the score did not meet guidelines or was not correctly tabulated.

Remediation:

Conclusions: Not enough information was provided to develop strong conclusions. Considering what was provided, the lack of documentation provided for review was the largest reason for non-compliance.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will provide all required documentation to quality reviewers.

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: 01/01/2016 - 12/31/2016
Data Source: MCO Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
FE	**5%**	**30%**	**N/A**	**9%**
Numerator	3	3	0	6
Denominator	60	10	0	70
IDD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TBI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

United did not provide any documentation for review. Did not have the documentation to support the MCO reviewed the providers qualifications and requirements.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
FE				
Amerigroup				5%
Sunflower				30%
United				N/A
Statewide	100%			9%
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	98%			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	91%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	93%			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
SED				
Amerigroup				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: 01/01/2016 - 12/31/2016
Data Source: MCO Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	77	96	104	277
FE	**12%**	**23%**	**0%**	**11%**
Numerator	40	114	0	154
Denominator	327	499	530	1356
IDD	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	184	232	255	671
TBI	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	55	55	60	170
TA	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	23	26	29	78
Autism	**14%**	**0%**	**0%**	**4%**
Numerator	1	0	0	1
Denominator	7	6	14	27
SED	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	27	27	27	27

Explanation of Findings:

United did not provide any documentation for review. Did not have the documentation to support the MCO reviewed the providers qualifications and requirements.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	100%			0%
FE				
Amerigroup				12%
Sunflower				23%
United				0%
Statewide	Not a measure			11%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	98%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	89%			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	93%			0%
Autism				
Amerigroup				14%
Sunflower				0%
United				0%
Statewide	100%			4%
SED				
Amerigroup				0%
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: 01/01/2016 - 12/31/2016
Data Source: MCO Review

Compliance By Waiver	Amerigroup	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**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TBI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

United did not provide any documentation for review. Did not have the documentation to support the MCO reviewed the providers qualifications and requirements.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	75%			N/A
FE				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	Not a measure			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	88%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	No Data			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	82%			N/A
SED				
Amerigroup				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: 01/01/2016 - 12/31/2016
Data Source: MCO Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**3%**	**1%**	**0%**	**1%**
Numerator	4	2	0	6
Denominator	124	156	163	443
FE	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	7	7	530	544
IDD	**0%**	**8%**	**0%**	**2%**
Numerator	0	5	0	5
Denominator	70	62	69	201
TBI	**8%**	**0%**	**0%**	**3%**
Numerator	6	0	0	6
Denominator	72	77	78	227
TA	**13%**	**0%**	**0%**	**4%**
Numerator	2	0	0	2
Denominator	16	17	19	52
Autism	**8%**	**0%**	**0%**	**2%**
Numerator	1	0	0	1
Denominator	13	9	34	56
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

United did not provide any documentation for review. Did not have the documentation to support the MCO reviewed the providers qualifications and requirements.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				3%
Sunflower				1%
United				0%
Statewide	75%			1%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	Not a measure			0%
IDD				
Amerigroup				0%
Sunflower				8%
United				0%
Statewide	Not a measure			2%
TBI				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	88%			3%
TA				
Amerigroup				13%
Sunflower				0%
United				0%
Statewide	No Data			4%
Autism				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	91%			2%
SED				
Amerigroup				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: 01/01/2016 - 12/31/2016
Data Source: MCO Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	69	75	75	219
FE	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	530	530	530	1590
IDD	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	215	245	267	727
TBI	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	140	140	140	420
TA	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	48	48	48	144
Autism	**20%**	**36%**	**0%**	**11%**
Numerator	4	5	0	9
Denominator	20	14	48	82
SED	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

United did not provide any documentation for review. Did not have the documentation to support the MCO reviewed the providers qualifications and requirements.

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	99%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
Autism				
Amerigroup				20%
Sunflower				36%
United				0%
Statewide	No Data			11%
SED				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	88%			0%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**49%**	**55%**	**75%**	**59%**
Numerator	29	33	40	102
Denominator	59	60	53	172
FE	**45%**	**78%**	**73%**	**66%**
Numerator	24	49	40	113
Denominator	53	63	55	171
IDD	**39%**	**58%**	**60%**	**53%**
Numerator	21	52	25	98
Denominator	54	90	42	186
TBI	**54%**	**92%**	**73%**	**67%**
Numerator	32	22	16	70
Denominator	59	24	22	105
TA	**62%**	**87%**	**65%**	**70%**
Numerator	34	26	11	71
Denominator	55	30	17	102
Autism	**43%**	**46%**	**0%**	**38%**
Numerator	13	12	0	25
Denominator	30	26	10	66
SED	**98%**	**100%**	**96%**	**98%**
Numerator	54	48	49	151
Denominator	55	48	51	154

Explanation of Findings:

The documentation reflecting the goal of the individual was not signed by them/their rep/or guardian. The service plan was missing for the full review period, goals not documented in the file, goals were not addressed in the service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		55%	33%	49%
Sunflower		57%	64%	55%
United		33%	49%	75%
Statewide	55%	50%	48%	59%
FE				
Amerigroup		50%	42%	45%
Sunflower		56%	51%	78%
United		45%	56%	73%
Statewide	Not a measure	50%	49%	66%
IDD				
Amerigroup		36%	32%	39%
Sunflower		56%	56%	58%
United		52%	41%	60%
Statewide	99%	49%	45%	53%
TBI				
Amerigroup		37%	41%	54%
Sunflower		37%	38%	92%
United		22%	55%	73%
Statewide	44%	34%	43%	67%
TA				
Amerigroup		50%	44%	62%
Sunflower		73%	85%	87%
United		64%	32%	65%
Statewide	93%	61%	54%	70%
Autism				
Amerigroup		84%	56%	43%
Sunflower		47%	50%	46%
United		63%	36%	0%
Statewide	58%	69%	49%	38%
SED				
Amerigroup		91%	99%	98%
Sunflower		92%	95%	100%
United		89%	100%	96%
Statewide	98%	90%	98%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**68%**	**57%**	**89%**	**70%**
Numerator	40	34	47	121
Denominator	59	60	53	172
FE	**75%**	**73%**	**78%**	**75%**
Numerator	40	46	43	129
Denominator	53	63	55	171
IDD	**59%**	**61%**	**69%**	**62%**
Numerator	32	55	29	116
Denominator	54	90	42	186
TBI	**58%**	**83%**	**73%**	**67%**
Numerator	34	20	16	70
Denominator	59	24	22	105
TA	**65%**	**80%**	**82%**	**73%**
Numerator	36	24	14	74
Denominator	55	30	17	102
Autism	**43%**	**42%**	**0%**	**36%**
Numerator	13	11	0	24
Denominator	30	26	10	66
SED	**98%**	**100%**	**96%**	**98%**
Numerator	54	48	49	151
Denominator	55	48	51	154

Explanation of Findings:

Missing the service plan or assessment(s) for the full review period, documentation not uploaded for the correct consumer, not able to open the file uploaded, assessed needs and capabilities were not addressed in the service plan, signature was missing, service plan uploaded after deadline to submit documentation.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		83%	55%	68%
Sunflower		90%	56%	57%
United		89%	68%	89%
Statewide	86%	87%	59%	70%
FE				
Amerigroup		79%	66%	75%
Sunflower		90%	53%	73%
United		88%	68%	78%
Statewide	87%	86%	61%	75%
IDD				
Amerigroup		85%	67%	59%
Sunflower		77%	36%	61%
United		72%	47%	69%
Statewide	99%	78%	48%	62%
TBI				
Amerigroup		67%	48%	58%
Sunflower		82%	28%	83%
United		70%	62%	73%
Statewide	72%	73%	45%	67%
TA				
Amerigroup		93%	58%	65%
Sunflower		98%	62%	80%
United		97%	58%	82%
Statewide	96%	96%	59%	73%
Autism				
Amerigroup		81%	59%	43%
Sunflower		50%	45%	42%
United		63%	21%	0%
Statewide	59%	68%	46%	36%
SED				
Amerigroup		91%	99%	98%
Sunflower		91%	92%	100%
United		89%	98%	96%
Statewide	92%	90%	97%	98%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**64%**	**62%**	**85%**	**70%**
Numerator	38	37	45	120
Denominator	59	60	53	172
FE	**77%**	**73%**	**75%**	**75%**
Numerator	41	46	41	128
Denominator	53	63	55	171
IDD	**65%**	**62%**	**69%**	**65%**
Numerator	35	56	29	120
Denominator	54	90	42	186
TBI	**58%**	**92%**	**73%**	**69%**
Numerator	34	22	16	72
Denominator	59	24	22	105
TA	**69%**	**80%**	**82%**	**75%**
Numerator	38	24	14	76
Denominator	55	30	17	102
Autism	**40%**	**42%**	**0%**	**35%**
Numerator	12	11	0	23
Denominator	30	26	10	66
SED	**96%**	**100%**	**94%**	**97%**
Numerator	53	48	48	149
Denominator	55	48	51	154

Explanation of Findings:

Missing the service plan or assessment(s) for the full review period, assessed health and safety risk factors not addressed or listed in the service plan, signature missing, service plan uploaded after deadline to submit documentation.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		90%	44%	64%
Sunflower		89%	49%	62%
United		96%	67%	85%
Statewide	90%	91%	51%	70%
FE				
Amerigroup		92%	55%	77%
Sunflower		92%	50%	73%
United		95%	70%	75%
Statewide	Not a measure	93%	57%	75%
IDD				
Amerigroup		90%	61%	65%
Sunflower		97%	36%	62%
United		89%	45%	69%
Statewide	99%	93%	46%	65%
TBI				
Amerigroup		79%	45%	58%
Sunflower		91%	26%	92%
United		83%	64%	73%
Statewide	84%	84%	43%	69%
TA				
Amerigroup		96%	49%	69%
Sunflower		95%	61%	80%
United		94%	58%	82%
Statewide	96%	96%	54%	75%
Autism				
Amerigroup		79%	59%	40%
Sunflower		61%	45%	42%
United		86%	21%	0%
Statewide	64%	74%	46%	35%
SED				
Amerigroup		90%	99%	96%
Sunflower		89%	95%	100%
United		86%	100%	94%
Statewide	99%	88%	98%	97%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**69%**	**72%**	**87%**	**76%**
Numerator	41	43	46	130
Denominator	59	60	53	172
FE	**79%**	**90%**	**84%**	**85%**
Numerator	42	57	46	145
Denominator	53	63	55	171
IDD	**70%**	**71%**	**69%**	**70%**
Numerator	38	64	29	131
Denominator	54	90	42	186
TBI	**59%**	**96%**	**82%**	**72%**
Numerator	35	23	18	76
Denominator	59	24	22	105
TA	**65%**	**87%**	**82%**	**75%**
Numerator	36	26	14	76
Denominator	55	30	17	102
Autism	**43%**	**42%**	**0%**	**36%**
Numerator	13	11	0	24
Denominator	30	26	10	66
SED	**98%**	**98%**	**94%**	**97%**
Numerator	54	47	48	149
Denominator	55	48	51	154

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review period, the waiver process was not followed, documentation uploaded for the wrong consumer.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		88%	68%	69%
Sunflower		87%	69%	72%
United		85%	77%	87%
Statewide	80%	87%	70%	76%
FE				
Amerigroup		84%	76%	79%
Sunflower		88%	61%	90%
United		86%	79%	84%
Statewide	Not a measure	86%	71%	85%
IDD				
Amerigroup		80%	80%	70%
Sunflower		80%	59%	71%
United		82%	55%	69%
Statewide	98%	81%	64%	70%
TBI				
Amerigroup		76%	53%	59%
Sunflower		86%	43%	96%
United		77%	69%	82%
Statewide	64%	80%	53%	72%
TA				
Amerigroup		84%	68%	65%
Sunflower		97%	86%	87%
United		96%	58%	82%
Statewide	No Data	91%	72%	75%
Autism				
Amerigroup		74%	59%	43%
Sunflower		51%	50%	42%
United		65%	29%	0%
Statewide	55%	65%	49%	36%
SED				
Amerigroup		92%	99%	98%
Sunflower		90%	94%	98%
United		87%	98%	94%
Statewide	Not a measure	90%	97%	97%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**73%**	**72%**	**87%**	**77%**
Numerator	43	43	46	132
Denominator	59	60	53	172
FE	**83%**	**89%**	**84%**	**85%**
Numerator	44	56	46	146
Denominator	53	63	55	171
IDD	**70%**	**70%**	**69%**	**70%**
Numerator	38	63	29	130
Denominator	54	90	42	186
TBI	**64%**	**96%**	**77%**	**74%**
Numerator	38	23	17	78
Denominator	59	24	22	105
TA	**67%**	**90%**	**82%**	**76%**
Numerator	37	27	14	78
Denominator	55	30	17	102
Autism	**40%**	**46%**	**0%**	**36%**
Numerator	12	12	0	24
Denominator	30	26	10	66
SED	**100%**	**98%**	**92%**	**97%**
Numerator	54	47	47	148
Denominator	54	48	51	153

Explanation of Findings:

Service plan was not signed and/or dated by the individual and/or their rep/guardian. Missing service plan for the full review period, documentation uploaded for the wrong consumer.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		88%	70%	73%
Sunflower		87%	70%	72%
United		84%	79%	87%
Statewide	Not a measure	87%	72%	77%
FE				
Amerigroup		83%	78%	83%
Sunflower		86%	60%	89%
United		87%	83%	84%
Statewide	90%	85%	72%	85%
IDD				
Amerigroup		84%	76%	70%
Sunflower		82%	60%	70%
United		88%	51%	69%
Statewide	Not a measure	84%	63%	70%
TBI				
Amerigroup		73%	51%	64%
Sunflower		84%	45%	96%
United		80%	69%	77%
Statewide	Not a measure	78%	52%	74%
TA				
Amerigroup		83%	75%	67%
Sunflower		97%	86%	90%
United		97%	58%	82%
Statewide	Not a measure	91%	76%	76%
Autism				
Amerigroup		77%	59%	40%
Sunflower		53%	55%	46%
United		71%	36%	0%
Statewide	Not a measure	69%	52%	36%
SED				
Amerigroup		92%	98%	100%
Sunflower		90%	95%	98%
United		87%	99%	92%
Statewide	93%	90%	98%	97%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**70%**	**69%**	**86%**	**75%**
Numerator	31	33	38	102
Denominator	44	48	44	136
FE	**66%**	**83%**	**83%**	**78%**
Numerator	21	29	35	85
Denominator	32	35	42	109
IDD	**65%**	**68%**	**50%**	**63%**
Numerator	20	41	15	76
Denominator	31	60	30	121
TBI	**60%**	**100%**	**79%**	**74%**
Numerator	21	16	11	48
Denominator	35	16	14	65
TA	**64%**	**86%**	**67%**	**71%**
Numerator	21	18	6	45
Denominator	33	21	9	63
Autism	**53%**	**31%**	**0%**	**32%**
Numerator	8	4	0	12
Denominator	15	13	10	38
SED	**93%**	**91%**	**88%**	**91%**
Numerator	41	41	36	118
Denominator	44	45	41	130

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review or prior service plan to determine timeliness, service plan not completed within specific waiver timelines.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		73%	67%	70%
Sunflower		82%	72%	69%
United		92%	73%	86%
Statewide	82%	82%	70%	75%
FE				
Amerigroup		81%	67%	66%
Sunflower		85%	57%	83%
United		90%	69%	83%
Statewide	81%	85%	64%	78%
IDD				
Amerigroup		75%	77%	65%
Sunflower		81%	66%	68%
United		91%	48%	50%
Statewide	97%	82%	66%	63%
TBI				
Amerigroup		65%	44%	60%
Sunflower		84%	40%	100%
United		77%	65%	79%
Statewide	60%	76%	47%	74%
TA				
Amerigroup		81%	78%	64%
Sunflower		94%	89%	86%
United		96%	59%	67%
Statewide	92%	89%	79%	71%
Autism				
Amerigroup		67%	52%	53%
Sunflower		43%	47%	31%
United		33%	38%	0%
Statewide	64%	57%	48%	32%
SED				
Amerigroup		89%	97%	93%
Sunflower		89%	91%	91%
United		83%	99%	88%
Statewide	80%	87%	96%	91%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**56%**	**22%**	**78%**	**52%**
Numerator	5	2	7	14
Denominator	9	9	9	27
FE	**50%**	**100%**	**83%**	**82%**
Numerator	2	7	5	14
Denominator	4	7	6	17
IDD	**29%**	**20%**	**25%**	**25%**
Numerator	2	1	1	4
Denominator	7	5	4	16
TBI	**54%**	**100%**	**100%**	**67%**
Numerator	7	3	2	12
Denominator	13	3	2	18
TA	**50%**	**73%**	**75%**	**64%**
Numerator	5	8	3	16
Denominator	10	11	4	25
Autism	**25%**	**100%**	**0%**	**14%**
Numerator	1	1	0	2
Denominator	4	1	9	14
SED	**100%**	**93%**	**77%**	**89%**
Numerator	19	13	17	49
Denominator	19	14	22	55

Explanation of Findings:

no valid signature and/or date, a new service plan should have been completed, no file uploaded or enough documentation to determine.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		20%	36%	56%
Sunflower		53%	58%	22%
United		50%	63%	78%
Statewide	75%	39%	53%	52%
FE				
Amerigroup		24%	71%	50%
Sunflower		39%	51%	100%
United		50%	47%	83%
Statewide	78%	38%	54%	82%
IDD				
Amerigroup		7%	60%	29%
Sunflower		38%	16%	20%
United		16%	30%	25%
Statewide	97%	23%	28%	25%
TBI				
Amerigroup		24%	42%	54%
Sunflower		54%	27%	100%
United		46%	50%	100%
Statewide	53%	38%	38%	67%
TA				
Amerigroup		32%	73%	50%
Sunflower		54%	89%	73%
United		38%	43%	75%
Statewide	92%	42%	75%	64%
Autism				
Amerigroup		10%	0%	25%
Sunflower		17%	25%	100%
United		0%	0%	0%
Statewide	45%	11%	11%	14%
SED				
Amerigroup		90%	90%	100%
Sunflower		83%	79%	93%
United		84%	93%	77%
Statewide	85%	86%	88%	89%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**73%**	**73%**	**89%**	**78%**
Numerator	43	44	47	134
Denominator	59	60	53	172
FE	**77%**	**92%**	**89%**	**87%**
Numerator	41	58	49	148
Denominator	53	63	55	171
IDD	**72%**	**74%**	**74%**	**74%**
Numerator	39	67	31	137
Denominator	54	90	42	186
TBI	**59%**	**96%**	**77%**	**71%**
Numerator	35	23	17	75
Denominator	59	24	22	105
TA	**73%**	**87%**	**82%**	**78%**
Numerator	40	26	14	80
Denominator	55	30	17	102
Autism	**47%**	**46%**	**0%**	**39%**
Numerator	14	12	0	26
Denominator	30	26	10	66
SED	**94%**	**94%**	**90%**	**93%**
Numerator	51	45	46	142
Denominator	54	48	51	153

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review period, missing log notes or documentation to determine, partial year provided, nothing noted in log notes.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		94%	69%	73%
Sunflower		96%	72%	73%
United		96%	78%	89%
Statewide	85%	95%	72%	78%
FE				
Amerigroup		83%	76%	77%
Sunflower		96%	64%	92%
United		96%	79%	89%
Statewide	87%	92%	72%	87%
IDD				
Amerigroup		78%	84%	72%
Sunflower		97%	62%	74%
United		100%	59%	74%
Statewide	98%	92%	68%	74%
TBI				
Amerigroup		81%	55%	59%
Sunflower		95%	46%	96%
United		85%	71%	77%
Statewide	70%	87%	56%	71%
TA				
Amerigroup		98%	73%	73%
Sunflower		100%	86%	87%
United		96%	58%	82%
Statewide	100%	98%	74%	78%
Autism				
Amerigroup		89%	59%	47%
Sunflower		100%	55%	46%
United		50%	21%	0%
Statewide	50%	86%	49%	39%
SED				
Amerigroup		91%	99%	94%
Sunflower		96%	94%	94%
United		92%	99%	90%
Statewide	13%	93%	98%	93%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data was not collected since customer interviews were not performed during this review period.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		97%		
Sunflower		92%		
United		93%		
Statewide	Not a measure	94%		
FE				
Amerigroup		85%		
Sunflower		86%		
United		82%		
Statewide	87%	84%		
IDD				
Amerigroup		92%		
Sunflower		96%		
United		93%		
Statewide	Not a measure	94%		
TBI				
Amerigroup		81%		
Sunflower		88%		
United		83%		
Statewide	Not a measure	83%		
TA				
Amerigroup		89%		
Sunflower		84%		
United		85%		
Statewide	Not a measure	87%		
Autism				
Amerigroup		74%		
Sunflower		70%		
United		60%		
Statewide	Not a measure	71%		
SED				
Amerigroup				
Sunflower				
United				
Statewide	Not a measure	No Data		

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**61%**	**72%**	**85%**	**72%**
Numerator	36	43	45	124
Denominator	59	60	53	172
FE	**70%**	**87%**	**80%**	**80%**
Numerator	37	55	44	136
Denominator	53	63	55	171
IDD	**63%**	**64%**	**67%**	**65%**
Numerator	34	58	28	120
Denominator	54	90	42	186
TBI	**49%**	**96%**	**77%**	**66%**
Numerator	29	23	17	69
Denominator	59	24	22	105
TA	**65%**	**80%**	**82%**	**73%**
Numerator	36	24	14	74
Denominator	55	30	17	102
Autism	**57%**	**46%**	**0%**	**44%**
Numerator	17	12	0	29
Denominator	30	26	10	66
SED	**98%**	**91%**	**85%**	**91%**
Numerator	47	42	39	128
Denominator	48	46	46	140

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		68%	56%	61%
Sunflower		58%	69%	72%
United		69%	73%	85%
Statewide	52%	65%	65%	72%
FE				
Amerigroup		68%	59%	70%
Sunflower		76%	59%	87%
United		77%	75%	80%
Statewide	56%	74%	63%	80%
IDD				
Amerigroup		51%	45%	63%
Sunflower		68%	42%	64%
United		75%	55%	67%
Statewide	99%	64%	46%	65%
TBI				
Amerigroup		54%	50%	49%
Sunflower		75%	40%	96%
United		70%	74%	77%
Statewide	44%	65%	52%	66%
TA				
Amerigroup		87%	65%	65%
Sunflower		84%	80%	80%
United		92%	58%	82%
Statewide	96%	86%	68%	73%
Autism				
Amerigroup		67%	67%	57%
Sunflower		44%	45%	46%
United		88%	21%	0%
Statewide	40%	63%	49%	44%
SED				
Amerigroup		94%	91%	98%
Sunflower		91%	72%	91%
United		84%	97%	85%
Statewide	98%	89%	88%	91%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**54%**	**68%**	**81%**	**67%**
Numerator	32	41	43	116
Denominator	59	60	53	172
FE	**70%**	**87%**	**78%**	**79%**
Numerator	37	55	43	135
Denominator	53	63	55	171
IDD	**65%**	**66%**	**62%**	**65%**
Numerator	35	59	26	120
Denominator	54	90	42	186
TBI	**49%**	**96%**	**77%**	**66%**
Numerator	29	23	17	69
Denominator	59	24	22	105
TA	**65%**	**80%**	**65%**	**70%**
Numerator	36	24	11	71
Denominator	55	30	17	102
Autism	**57%**	**62%**	**0%**	**50%**
Numerator	17	16	0	33
Denominator	30	26	10	66
SED	**98%**	**91%**	**86%**	**92%**
Numerator	51	43	43	137
Denominator	52	47	50	149

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file or partial file uploaded, choice box was not checked/marked on the choice form and/or service plan, documentation uploaded for the wrong consumer.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		68%	53%	54%
Sunflower		72%	50%	68%
United		77%	73%	81%
Statewide	64%	72%	57%	67%
FE				
Amerigroup		67%	57%	70%
Sunflower		86%	47%	87%
United		85%	74%	78%
Statewide	59%	80%	57%	79%
IDD				
Amerigroup		55%	46%	65%
Sunflower		68%	35%	66%
United		77%	50%	62%
Statewide	No Data	66%	42%	65%
TBI				
Amerigroup		56%	50%	49%
Sunflower		80%	23%	96%
United		74%	67%	77%
Statewide	53%	68%	45%	66%
TA				
Amerigroup		86%	65%	65%
Sunflower		97%	53%	80%
United		94%	55%	65%
Statewide	96%	91%	60%	70%
Autism				
Amerigroup		79%	52%	57%
Sunflower		50%	27%	62%
United		88%	14%	0%
Statewide	55%	72%	35%	50%
SED				
Amerigroup		94%	92%	98%
Sunflower		91%	72%	91%
United		84%	97%	86%
Statewide	98%	89%	88%	92%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**61%**	**72%**	**83%**	**72%**
Numerator	36	43	44	123
Denominator	59	60	53	172
FE	**74%**	**87%**	**78%**	**80%**
Numerator	39	55	43	137
Denominator	53	63	55	171
IDD	**65%**	**63%**	**71%**	**66%**
Numerator	35	57	30	122
Denominator	54	90	42	186
TBI	**54%**	**96%**	**77%**	**69%**
Numerator	32	23	17	72
Denominator	59	24	22	105
TA	**64%**	**80%**	**82%**	**72%**
Numerator	35	24	14	73
Denominator	55	30	17	102
Autism	**77%**	**65%**	**20%**	**64%**
Numerator	23	17	2	42
Denominator	30	26	10	66
SED	**98%**	**92%**	**87%**	**92%**
Numerator	54	44	45	143
Denominator	55	48	52	155

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		76%	57%	61%
Sunflower		74%	67%	72%
United		80%	78%	83%
Statewide	Not a measure	76%	66%	72%
FE				
Amerigroup		67%	58%	74%
Sunflower		87%	56%	87%
United		85%	79%	78%
Statewide	65%	80%	63%	80%
IDD				
Amerigroup		47%	47%	65%
Sunflower		69%	41%	63%
United		78%	57%	71%
Statewide	No Data	64%	46%	66%
TBI				
Amerigroup		55%	51%	54%
Sunflower		79%	40%	96%
United		73%	74%	77%
Statewide	No Data	67%	52%	69%
TA				
Amerigroup		87%	65%	64%
Sunflower		98%	80%	80%
United		94%	55%	82%
Statewide	No Data	92%	68%	72%
Autism				
Amerigroup		86%	67%	77%
Sunflower		47%	59%	65%
United		75%	43%	20%
Statewide	No Data	72%	59%	64%
SED				
Amerigroup		94%	92%	98%
Sunflower		91%	72%	92%
United		85%	98%	87%
Statewide	99%	90%	89%	92%

KDADS HCBS Quality Review Report

Plan of Care
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**68%**	**70%**	**83%**	**73%**
Numerator	40	42	44	126
Denominator	59	60	53	172
FE	**75%**	**87%**	**80%**	**81%**
Numerator	40	55	44	139
Denominator	53	63	55	171
IDD	**63%**	**59%**	**64%**	**61%**
Numerator	34	53	27	114
Denominator	54	90	42	186
TBI	**54%**	**96%**	**77%**	**69%**
Numerator	32	23	17	72
Denominator	59	24	22	105
TA	**64%**	**80%**	**82%**	**72%**
Numerator	35	24	14	73
Denominator	55	30	17	102
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	Jan-Jun 2016
PD				
Amerigroup		64%	58%	68%
Sunflower		73%	68%	70%
United		77%	78%	83%
Statewide	Not a measure	71%	66%	73%
FE				
Amerigroup		64%	59%	75%
Sunflower		84%	59%	87%
United		77%	79%	80%
Statewide	65%	75%	64%	81%
IDD				
Amerigroup		34%	47%	63%
Sunflower		61%	39%	59%
United		77%	57%	64%
Statewide	No Data	53%	46%	61%
TBI				
Amerigroup		50%	50%	54%
Sunflower		85%	43%	96%
United		70%	74%	77%
Statewide	No Data	66%	52%	69%
TA				
Amerigroup		82%	56%	64%
Sunflower		98%	82%	80%
United		100%	58%	82%
Statewide	No Data	90%	64%	72%
Autism	**Self-direction is not offered for this waiver**			
Amerigroup				
Sunflower				
United				
Statewide				
SED	**Self-direction is not offered for this waiver**			
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

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 non-preventable causes
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 01/01/2016 - 06/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
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: 01/01/2016 - 06/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 01/01/2016 - 06/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**51%**	**72%**	**79%**	**67%**
Numerator	30	43	42	115
Denominator	59	60	53	172
FE	**51%**	**87%**	**85%**	**75%**
Numerator	27	55	47	129
Denominator	53	63	55	171
IDD	**41%**	**71%**	**71%**	**62%**
Numerator	22	64	30	116
Denominator	54	90	42	186
TBI	**46%**	**88%**	**81%**	**63%**
Numerator	27	21	17	65
Denominator	59	24	21	104
TA	**73%**	**87%**	**82%**	**78%**
Numerator	40	26	14	80
Denominator	55	30	17	102
Autism	**30%**	**35%**	**0%**	**27%**
Numerator	9	9	0	18
Denominator	30	26	10	66
SED	**45%**	**27%**	**29%**	**34%**
Numerator	25	13	15	53
Denominator	55	48	52	155

Explanation of Findings:

The low percentages for this performance measures stems from either the lack of documentation as part of the integrated individuals service plan or a lack of signature on the integrated service plan. The lack of a signature invalidates any integrated service plan and any contents therein.

Remediation:

This performance measure is achieved through documentation on the plan of care. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.

2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

3. Draft integrated service plan. Completed May 2017.

Steps still left to complete remediation:

1. Public comment on integrated support plan policy. Expected completion date: July 2017. Responsible party: KDADS (CSP)

2. Finalize policy and get approval from KDHE AD staff. Expected completion: August 2017. Responsible party: KDADS (CSP), KDHE.

3. Operationalization of policy. Expected completion: November 2017. Responsible party: MCOS and TCMs.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		51%	19%	51%
Sunflower		88%	72%	72%
United		90%	80%	79%
Statewide	65%	72%	53%	67%
FE				
Amerigroup		59%	16%	51%
Sunflower		86%	62%	87%
United		92%	80%	85%
Statewide	80%	78%	50%	75%
IDD				
Amerigroup		23%	6%	41%
Sunflower		87%	59%	71%
United		100%	56%	71%
Statewide	99%	68%	42%	62%
TBI				
Amerigroup		30%	12%	46%
Sunflower		94%	45%	88%
United		80%	76%	81%
Statewide	57%	63%	34%	63%
TA				
Amerigroup		61%	38%	73%
Sunflower		99%	86%	87%
United		97%	61%	82%
Statewide	86%	82%	57%	78%
Autism				
Amerigroup		62%	8%	30%
Sunflower		33%	29%	35%
United		43%	14%	0%
Statewide	90%	50%	16%	27%
SED				
Amerigroup		88%	64%	45%
Sunflower		80%	53%	27%
United		78%	63%	29%
Statewide	89%	82%	60%	34%

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: 01/01/2016 - 06/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 01/01/2016 - 06/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 01/01/2016 - 06/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 01/01/2016 - 06/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup				
Sunflower				
United				
Statewide				
FE				
Amerigroup				
Sunflower				
United				
Statewide				
IDD				
Amerigroup				
Sunflower				
United				
Statewide				
TBI				
Amerigroup				
Sunflower				
United				
Statewide				
TA				
Amerigroup				
Sunflower				
United				
Statewide				
Autism				
Amerigroup				
Sunflower				
United				
Statewide				
SED				
Amerigroup				
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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	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:

This data was not collected as part of the MCO reviews that were conducted.

Remediation:

Physical exams were added to the Quality Review protocol to begin obtaining the needed information following State policy. IT is in the process of adding it to the Quality Review Tracker to ensure reporting for this measure will be available moving forward. The review will begin in 2017 review periods.

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		78%		
Sunflower		81%		
United		88%		
Statewide	Not a measure	82%		
FE				
Amerigroup		89%		
Sunflower		97%		
United		97%		
Statewide	Not a measure	95%		
IDD				
Amerigroup		91%		
Sunflower		99%		
United		99%		
Statewide	Not a measure	97%		
TBI				
Amerigroup		84%		
Sunflower		94%		
United		93%		
Statewide	Not a measure	90%		
TA				
Amerigroup		100%		
Sunflower		100%		
United		97%		
Statewide	Not a measure	100%		
Autism				
Amerigroup		100%		
Sunflower		92%		
United		100%		
Statewide	Not a measure	98%		
SED				
Amerigroup		54%		
Sunflower		55%		
United		46%		
Statewide	Not a measure	52%		

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: 01/01/2016 - 06/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**64%**	**60%**	**81%**	**68%**
Numerator	38	36	43	117
Denominator	59	60	53	172
FE	**74%**	**63%**	**78%**	**71%**
Numerator	39	40	43	122
Denominator	53	63	55	171
IDD	**61%**	**52%**	**60%**	**56%**
Numerator	33	47	25	105
Denominator	54	90	42	186
TBI	**53%**	**75%**	**76%**	**63%**
Numerator	31	18	16	65
Denominator	59	24	21	104
TA	**80%**	**70%**	**82%**	**77%**
Numerator	44	21	14	79
Denominator	55	30	17	102
Autism	**37%**	**54%**	**0%**	**38%**
Numerator	11	14	0	25
Denominator	30	26	10	66
SED	Not a waiver performance measure			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	Jan-Jun 2016
PD				
Amerigroup		59%	53%	64%
Sunflower		77%	49%	60%
United		64%	80%	81%
Statewide	Not a measure	67%	58%	68%
FE				
Amerigroup		61%	62%	74%
Sunflower		72%	56%	63%
United		76%	81%	78%
Statewide	59%	70%	65%	71%
IDD				
Amerigroup		67%	61%	61%
Sunflower		58%	32%	52%
United		70%	58%	60%
Statewide	Not a measure	64%	47%	56%
TBI				
Amerigroup		46%	49%	53%
Sunflower		68%	42%	75%
United		56%	74%	76%
Statewide	Not a measure	56%	52%	63%
TA				
Amerigroup		75%	54%	80%
Sunflower		91%	58%	70%
United		86%	63%	82%
Statewide	Not a measure	83%	57%	77%
Autism				
Amerigroup		77%	44%	37%
Sunflower		53%	27%	54%
United		38%	7%	0%
Statewide	Not a measure	64%	30%	38%
SED	Not a waiver performance measure			
Amerigroup				
Sunflower				
United				
Statewide				

Explanation of Findings:

In the samples reviewed a backup plan was either not present or incomplete.

Remediation:

This performance measure is achieved through the integrated service plan. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.

2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

3. Draft integrated service plan. Completed May 2017.

Steps still left to complete remediation:

1. Public comment on integrated support plan policy. Expected completion date: July 2017. Responsible party: KDADS (CSP)

2. Finalize policy and get approval from KDHE AD staff. Expected completion: August 2017. Responsible party: KDADS (CSP), KDHE.

3. Operationalization of policy. Expected completion: November 2017. Responsible party: MCOS and TCMs.

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: 01/01/2016 - 06/30/2016
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
HCBS Waivers	**94%**
Numerator	520,357
Denominator	551,203

Compliance Trends	2013	2014	2015	Jan-Jun 2016
All HCBS Waivers				
Statewide	not a measure	90%	88%	94%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

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: 01/01/2016 - 06/30/2016
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	Jan-Jun 2016
PD				
Statewide	not a measure	100%	100%	100%
FE				
Statewide	not a measure	100%	100%	100%
IDD				
Statewide	not a measure	100%	100%	100%
TBI				
Statewide	not a measure	100%	100%	100%
TA				
Statewide	not a measure	100%	100%	100%
Autism				
Statewide	not a measure	100%	100%	100%
SED				
Statewide	not a measure	100%	100%	100%

Explanation of Findings:

Remediation:

Home and Community Based Services Quality Review Report July – September 2016

June 6, 2017

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 Qualtiy Review reports
Review Period: 07/01/2016 - 9/30/2016
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	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	25%	25%	25%	50%	100%
FE					
Statewide	25%	25%	25%	50%	100%
IDD					
Statewide	25%	25%	25%	50%	100%
TBI					
Statewide	25%	25%	25%	50%	100%
TA					
Statewide	25%	25%	25%	50%	100%
Autism					
Statewide	25%	25%	25%	50%	100%
SED					
Statewide	25%	25%	25%	50%	100%

Explanation of Findings:

Remediation:

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: 07/01/2016 - 9/30/2016
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	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	N/A	100%	100%	100%	N/A
FE					
Statewide	not a measure	100%	100%	100%	N/A
IDD					
Statewide	100%	100%	100%	100%	N/A
TBI					
Statewide	100%	100%	100%	100%	N/A
TA					
Statewide	100%	100%	N/A	100%	N/A
Autism					
Statewide	100%	100%	N/A	N/A	N/A
SED					
Statewide	100%	100%	N/A	N/A	N/A

Explanation of Findings:

Remediation:

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: 07/01/2016 - 9/30/2016
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	3
Denominator	3
IDD	**100%**
Numerator	5
Denominator	5
TBI	**100%**
Numerator	4
Denominator	4
TA	**100%**
Numerator	3
Denominator	3
Autism	**100%**
Numerator	3
Denominator	3
SED	**100%**
Numerator	3
Denominator	3

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	N/A	N/A	100%	100%	100%
FE					
Statewide	N/A	N/A	100%	100%	100%
IDD					
Statewide	100%	N/A	100%	100%	100%
TBI					
Statewide	100%	N/A	100%	100%	100%
TA					
Statewide	N/A	N/A	N/A	N/A	100%
Autism					
Statewide	N/A	N/A	N/A	N/A	100%
SED					
Statewide	N/A	N/A	N/A	N/A	100%

Explanation of Findings:

Remediation:

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: 07/01/2016 - 9/30/2016
Data Source: Meeting Minutes

Compliance By Waiver	Statewide
PD	**33%**
Numerator	1
Denominator	3
FE	**33%**
Numerator	1
Denominator	3
IDD	**33%**
Numerator	1
Denominator	3
TBI	**33%**
Numerator	1
Denominator	3
TA	**33%**
Numerator	1
Denominator	3
Autism	**33%**
Numerator	1
Denominator	3
SED	**33%**
Numerator	1
Denominator	3

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	Not a measure	45%	67%	75%	33%
FE					
Statewide	100%	82%	50%	75%	33%
IDD					
Statewide	Not a measure	91%	Not Available	75%	33%
TBI					
Statewide	Not a measure	73%	Not Available	75%	33%
TA					
Statewide	Not a measure	64%	Not Available	75%	33%
Autism					
Statewide	Not a measure	91%	100%	75%	33%
SED					
Statewide	Not a measure	100%	Not Available	75%	33%

Explanation of Findings:

During the reporting timeframe, the expectations for submission or written or in person reports to the LTC committee were not clear. In addition, the conversion to Office 360 caused some of the documentation submitted to the LTC committee to be lost and thus could not be verified.

Remediation:

Beginning in January 2017, clear expectations have been set for submission of written reports or in person attendance to the LTC meeting. Since this expectation has been set, this performance measure has been met 100%.

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 enrolled waiver participants
Review Period: 07/01/2016 - 9/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**100%**
Numerator	12
Denominator	12
FE	**94%**
Numerator	16
Denominator	17
IDD	**100%**
Numerator	4
Denominator	4
TBI	**89%**
Numerator	16
Denominator	18
TA	**100%**
Numerator	25
Denominator	25
Autism	**100%**
Numerator	3
Denominator	3
SED	**85%**
Numerator	66
Denominator	78

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	64%	83%	96%	70%	100%
FE					
Statewide	81%	91%	93%	100%	94%
IDD					
Statewide	99%	94%	90%	100%	100%
TBI					
Statewide	62%	89%	81%	89%	89%
TA					
Statewide	97%	89%	100%	96%	100%
Autism					
Statewide	82%	No Data	100%	100%	100%
SED					
Statewide	99%	89%	88%	92%	85%

Explanation of Findings:

The initial assessment tool was not completed and/or provided for the review. The person began receiving services prior to being determined eligible for services, functional score did not meet guidelines, score was not correctly calculated, program requirements not met. SED- no form provided.

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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: 07/01/2016 - 9/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**69%**
Numerator	56
Denominator	81
FE	**78%**
Numerator	62
Denominator	79
IDD	**82%**
Numerator	73
Denominator	89
TBI	**64%**
Numerator	25
Denominator	39
TA	**100%**
Numerator	29
Denominator	29
Autism	**86%**
Numerator	12
Denominator	14
SED	**71%**
Numerator	37
Denominator	52

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	47%	52%	64%	74%	69%
FE					
Statewide	68%	70%	76%	80%	78%
IDD					
Statewide	97%	74%	75%	79%	82%
TBI					
Statewide	39%	50%	62%	67%	64%
TA					
Statewide	94%	90%	86%	95%	100%
Autism					
Statewide	68%	No Data	75%	74%	86%
SED					
Statewide	93%	88%	94%	91%	71%

Explanation of Findings:

Did not complete the reassessment with the required timeline, did not provide an assessment, missing one or more of the assessment required to determine timeliness.SED No form provided

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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: 07/01/2016 - 9/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**82%**
Numerator	76
Denominator	93
FE	**95%**
Numerator	92
Denominator	97
IDD	**98%**
Numerator	91
Denominator	93
TBI	**77%**
Numerator	44
Denominator	57
TA	**100%**
Numerator	54
Denominator	54
Autism	**88%**
Numerator	15
Denominator	17
SED	**79%**
Numerator	62
Denominator	78

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	93%	84%	79%	79%	82%
FE					
Statewide	88%	91%	91%	90%	95%
IDD					
Statewide	97%	95%	99%	99%	98%
TBI					
Statewide	64%	81%	79%	78%	77%
TA					
Statewide	93%	98%	100%	100%	100%
Autism					
Statewide	88%	No Data	90%	88%	88%
SED					
Statewide	77%	79%	83%	89%	79%

Explanation of Findings:

No valid signature and/or date. No current assessment provided for review period, wrong assessment tool used, coded for one waiver, assessment completed for another. SED No form provided

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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: 07/01/2016 - 9/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**82%**
Numerator	76
Denominator	93
FE	**96%**
Numerator	93
Denominator	97
IDD	**96%**
Numerator	89
Denominator	93
TBI	**77%**
Numerator	44
Denominator	57
TA	**100%**
Numerator	54
Denominator	54
Autism	**65%**
Numerator	11
Denominator	17
SED	**78%**
Numerator	61
Denominator	78

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	19%	68%	81%	80%	82%
FE					
Statewide	24%	86%	91%	90%	96%
IDD					
Statewide	92%	85%	96%	97%	96%
TBI					
Statewide	57%	73%	83%	78%	77%
TA					
Statewide	93%	100%	99%	100%	100%
Autism					
Statewide	0%	No Data	57%	68%	65%
SED					
Statewide	99%	71%	88%	88%	78%

Explanation of Findings:

The current/applicable assessment tool was missing, so unable to determine if qualified. The assessors name was not on the approved assessors listing. SED No form provided

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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: 07/01/2016 - 9/30/2016
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**82%**
Numerator	75
Denominator	92
FE	**94%**
Numerator	90
Denominator	96
IDD	**98%**
Numerator	90
Denominator	92
TBI	**77%**
Numerator	43
Denominator	56
TA	**100%**
Numerator	54
Denominator	54
Autism	**88%**
Numerator	15
Denominator	17
SED	**83%**
Numerator	65
Denominator	78

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	73%	83%	96%	80%	82%
FE					
Statewide	91%	90%	96%	88%	94%
IDD					
Statewide	98%	95%	91%	98%	98%
TBI					
Statewide	58%	81%	83%	76%	77%
TA					
Statewide	93%	98%	100%	100%	100%
Autism					
Statewide	89%	No Data	100%	88%	88%
SED					
Statewide	99%	88%	87%	90%	83%

Explanation of Findings:

The required timeline was not met, the score did not meet guidelines or was not correctly tabulated, SED no form provided.

Remediation:

Conclusions: When reviewing this information the most prevalent reason for not meeting this performance measure was lack of documentation.

Recommended Remediation:
1. Corrective action plan : Contractors shall provide a plan detailing how they will meet the 365 re-assessment deadline AND provide all required documentation to quality reviewers.

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:
Data Source:

Compliance By Waiver	Amerigroup	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:

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
FE				
Amerigroup				5%
Sunflower				30%
United				N/A
Statewide	100%			9%
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	98%			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	91%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	93%			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
SED				
Amerigroup				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:
Data Source:

Compliance By Waiver	Amerigroup	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:

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	100%			0%
FE				
Amerigroup				12%
Sunflower				23%
United				0%
Statewide	Not a measure			11%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	98%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	89%			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	93%			0%
Autism				
Amerigroup				14%
Sunflower				0%
United				0%
Statewide	100%			4%
SED				
Amerigroup				0%
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:
Data Source:

Compliance By Waiver	Amerigroup	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:

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	75%			N/A
FE				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	100%			N/A
IDD				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	Not a measure			N/A
TBI				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	88%			N/A
TA				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	No Data			N/A
Autism				
Amerigroup				N/A
Sunflower				N/A
United				N/A
Statewide	82%			N/A
SED				
Amerigroup				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:
Data Source:

Compliance By Waiver	Amerigroup	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:

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				3%
Sunflower				1%
United				0%
Statewide	75%			1%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	Not a measure			0%
IDD				
Amerigroup				0%
Sunflower				8%
United				0%
Statewide	Not a measure			2%
TBI				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	88%			3%
TA				
Amerigroup				13%
Sunflower				0%
United				0%
Statewide	No Data			4%
Autism				
Amerigroup				8%
Sunflower				0%
United				0%
Statewide	91%			2%
SED				
Amerigroup				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:
Data Source:

Compliance By Waiver	Amerigroup	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:

Remediation:

Conclusions: Based on previous on-site assessment from KDADS and KDHE, it was determined that MCOs did not have a system in place to verify initial provider qualifications or verifying provider qualifications on an on-going basis.

Recommended Remediation: Policy. Program will add additional language to the draft integrated Person Centered Service Plan (IPCSP) which will require MCOs to verify provider qualifications upon contracting and on-going thereafter.

Compliance Trends	2013	2014	2015	2016
PD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
FE				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
IDD				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	99%			0%
TBI				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
TA				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	No Data			0%
Autism				
Amerigroup				20%
Sunflower				36%
United				0%
Statewide	No Data			11%
SED				
Amerigroup				0%
Sunflower				0%
United				0%
Statewide	88%			0%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**69%**	**59%**	**96%**	**74%**
Numerator	22	17	27	66
Denominator	32	29	28	89
FE	**57%**	**71%**	**94%**	**74%**
Numerator	17	24	29	70
Denominator	30	34	31	95
IDD	**59%**	**76%**	**81%**	**72%**
Numerator	16	34	17	67
Denominator	27	45	21	93
TBI	**48%**	**73%**	**71%**	**60%**
Numerator	12	11	5	28
Denominator	25	15	7	47
TA	**79%**	**81%**	**75%**	**79%**
Numerator	22	13	6	41
Denominator	28	16	8	52
Autism	**33%**	**67%**	**0%**	**38%**
Numerator	2	4	0	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**100%**	**86%**
Numerator	29	14	24	67
Denominator	30	24	24	78

Explanation of Findings:

The documentation reflecting the goal of the individual was not signed by them/their rep/or guardian. The service plan was missing for the full review period, goals not documented in the file, goals were not addressed in the service plan. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		55%	33%	49%	69%
Sunflower		57%	64%	55%	59%
United		33%	49%	75%	96%
Statewide	55%	50%	48%	59%	74%
FE					
Amerigroup		50%	42%	45%	57%
Sunflower		56%	51%	78%	71%
United		45%	56%	73%	94%
Statewide	Not a measure	50%	49%	66%	74%
IDD					
Amerigroup		36%	32%	39%	59%
Sunflower		56%	56%	58%	76%
United		52%	41%	60%	81%
Statewide	99%	49%	45%	53%	72%
TBI					
Amerigroup		37%	41%	54%	48%
Sunflower		37%	38%	92%	73%
United		22%	55%	73%	71%
Statewide	44%	34%	43%	67%	60%
TA					
Amerigroup		50%	44%	62%	79%
Sunflower		73%	85%	87%	81%
United		64%	32%	65%	75%
Statewide	93%	61%	54%	70%	79%
Autism					
Amerigroup		84%	56%	43%	33%
Sunflower		47%	50%	46%	67%
United		63%	36%	0%	0%
Statewide	58%	69%	49%	38%	38%
SED					
Amerigroup		91%	99%	98%	97%
Sunflower		92%	95%	100%	58%
United		89%	100%	96%	100%
Statewide	98%	90%	98%	98%	86%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**81%**	**69%**	**96%**	**82%**
Numerator	26	20	27	73
Denominator	32	29	28	89
FE	**73%**	**68%**	**90%**	**77%**
Numerator	22	23	28	73
Denominator	30	34	31	95
IDD	**70%**	**69%**	**81%**	**72%**
Numerator	19	31	17	67
Denominator	27	45	21	93
TBI	**64%**	**87%**	**86%**	**74%**
Numerator	16	13	6	35
Denominator	25	15	7	47
TA	**75%**	**69%**	**75%**	**73%**
Numerator	21	11	6	38
Denominator	28	16	8	52
Autism	**17%**	**67%**	**25%**	**38%**
Numerator	1	4	1	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**100%**	**86%**
Numerator	29	14	23	66
Denominator	30	24	23	77

Explanation of Findings:

Missing the service plan or assessment(s) for the full review period, documentation not uploaded for the correct consumer, not able to open the file uploaded, assessed needs and capabilities were not addressed in the service plan, service plan uploaded after deadline to submit documentation. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		83%	55%	68%	81%
Sunflower		90%	56%	57%	69%
United		89%	68%	89%	96%
Statewide	86%	87%	59%	70%	82%
FE					
Amerigroup		79%	66%	75%	73%
Sunflower		90%	53%	73%	68%
United		88%	68%	78%	90%
Statewide	87%	86%	61%	75%	77%
IDD					
Amerigroup		85%	67%	59%	70%
Sunflower		77%	36%	61%	69%
United		72%	47%	69%	81%
Statewide	99%	78%	48%	62%	72%
TBI					
Amerigroup		67%	48%	58%	64%
Sunflower		82%	28%	83%	87%
United		70%	62%	73%	86%
Statewide	72%	73%	45%	67%	74%
TA					
Amerigroup		93%	58%	65%	75%
Sunflower		98%	62%	80%	69%
United		97%	58%	82%	75%
Statewide	96%	96%	59%	73%	73%
Autism					
Amerigroup		81%	59%	43%	17%
Sunflower		50%	45%	42%	67%
United		63%	21%	0%	25%
Statewide	59%	68%	46%	36%	38%
SED					
Amerigroup		91%	99%	98%	97%
Sunflower		91%	92%	100%	58%
United		89%	98%	96%	100%
Statewide	92%	90%	97%	98%	86%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**81%**	**72%**	**96%**	**83%**
Numerator	26	21	27	74
Denominator	32	29	28	89
FE	**73%**	**68%**	**90%**	**77%**
Numerator	22	23	28	73
Denominator	30	34	31	95
IDD	**70%**	**69%**	**81%**	**72%**
Numerator	19	31	17	67
Denominator	27	45	21	93
TBI	**64%**	**80%**	**86%**	**72%**
Numerator	16	12	6	34
Denominator	25	15	7	47
TA	**79%**	**75%**	**75%**	**77%**
Numerator	22	12	6	40
Denominator	28	16	8	52
Autism	**17%**	**67%**	**0%**	**31%**
Numerator	1	4	0	5
Denominator	6	6	4	16
SED	**97%**	**58%**	**100%**	**86%**
Numerator	29	14	24	67
Denominator	30	24	24	78

Explanation of Findings:

Missing the service plan or assessment(s) for the full review period, assessed health and safety risk factors not addressed or listed in the service plan, signature missing, service plan uploaded after deadline to submit documentation. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		90%	44%	64%	81%
Sunflower		89%	49%	62%	72%
United		96%	67%	85%	96%
Statewide	90%	91%	51%	70%	83%
FE					
Amerigroup		92%	55%	77%	73%
Sunflower		92%	50%	73%	68%
United		95%	70%	75%	90%
Statewide	Not a measure	93%	57%	75%	77%
IDD					
Amerigroup		90%	61%	65%	70%
Sunflower		97%	36%	62%	69%
United		89%	45%	69%	81%
Statewide	99%	93%	46%	65%	72%
TBI					
Amerigroup		79%	45%	58%	64%
Sunflower		91%	26%	92%	80%
United		83%	64%	73%	86%
Statewide	84%	84%	43%	69%	72%
TA					
Amerigroup		96%	49%	69%	79%
Sunflower		95%	61%	80%	75%
United		94%	58%	82%	75%
Statewide	96%	96%	54%	75%	77%
Autism					
Amerigroup		79%	59%	40%	17%
Sunflower		61%	45%	42%	67%
United		86%	21%	0%	0%
Statewide	64%	74%	46%	35%	31%
SED					
Amerigroup		90%	99%	96%	97%
Sunflower		89%	95%	100%	58%
United		86%	100%	94%	100%
Statewide	99%	88%	98%	97%	86%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**81%**	**69%**	**96%**	**82%**
Numerator	26	20	27	73
Denominator	32	29	28	89
FE	**80%**	**76%**	**94%**	**83%**
Numerator	24	26	29	79
Denominator	30	34	31	95
IDD	**74%**	**80%**	**86%**	**80%**
Numerator	20	36	18	74
Denominator	27	45	21	93
TBI	**60%**	**80%**	**86%**	**70%**
Numerator	15	12	6	33
Denominator	25	15	7	47
TA	**79%**	**88%**	**75%**	**81%**
Numerator	22	14	6	42
Denominator	28	16	8	52
Autism	**33%**	**67%**	**0%**	**38%**
Numerator	2	4	0	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**100%**	**86%**
Numerator	29	14	24	67
Denominator	30	24	24	78

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review period, the waiver process was not followed, documentation uploaded for the wrong consumer. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		88%	68%	69%	81%
Sunflower		87%	69%	72%	69%
United		85%	77%	87%	96%
Statewide	80%	87%	70%	76%	82%
FE					
Amerigroup		84%	76%	79%	80%
Sunflower		88%	61%	90%	76%
United		86%	79%	84%	94%
Statewide	Not a measure	86%	71%	85%	83%
IDD					
Amerigroup		80%	80%	70%	74%
Sunflower		80%	59%	71%	80%
United		82%	55%	69%	86%
Statewide	98%	81%	64%	70%	80%
TBI					
Amerigroup		76%	53%	59%	60%
Sunflower		86%	43%	96%	80%
United		77%	69%	82%	86%
Statewide	64%	80%	53%	72%	70%
TA					
Amerigroup		84%	68%	65%	79%
Sunflower		97%	86%	87%	88%
United		96%	58%	82%	75%
Statewide	No Data	91%	72%	75%	81%
Autism					
Amerigroup		74%	59%	43%	33%
Sunflower		51%	50%	42%	67%
United		65%	29%	0%	0%
Statewide	55%	65%	49%	36%	38%
SED					
Amerigroup		92%	99%	98%	97%
Sunflower		90%	94%	98%	58%
United		87%	98%	94%	100%
Statewide	Not a measure	90%	97%	97%	86%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**84%**	**72%**	**86%**	**81%**
Numerator	27	21	24	72
Denominator	32	29	28	89
FE	**70%**	**76%**	**94%**	**80%**
Numerator	21	26	29	76
Denominator	30	34	31	95
IDD	**74%**	**80%**	**86%**	**80%**
Numerator	20	36	18	74
Denominator	27	45	21	93
TBI	**60%**	**80%**	**86%**	**70%**
Numerator	15	12	6	33
Denominator	25	15	7	47
TA	**79%**	**75%**	**75%**	**77%**
Numerator	22	12	6	40
Denominator	28	16	8	52
Autism	**33%**	**67%**	**0%**	**38%**
Numerator	2	4	0	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**100%**	**86%**
Numerator	29	14	24	67
Denominator	30	24	24	78

Explanation of Findings:

Service plan was not signed and/or dated by the individual and/or their rep/guardian. Missing service plan for the full review period, documentation uploaded for the wrong consumer. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		88%	70%	73%	84%
Sunflower		87%	70%	72%	72%
United		84%	79%	87%	86%
Statewide	Not a measure	87%	72%	77%	81%
FE					
Amerigroup		83%	78%	83%	70%
Sunflower		86%	60%	89%	76%
United		87%	83%	84%	94%
Statewide	90%	85%	72%	85%	80%
IDD					
Amerigroup		84%	76%	70%	74%
Sunflower		82%	60%	70%	80%
United		88%	51%	69%	86%
Statewide	Not a measure	84%	63%	70%	80%
TBI					
Amerigroup		73%	51%	64%	60%
Sunflower		84%	45%	96%	80%
United		80%	69%	77%	86%
Statewide	Not a measure	78%	52%	74%	70%
TA					
Amerigroup		83%	75%	67%	79%
Sunflower		97%	86%	90%	75%
United		97%	58%	82%	75%
Statewide	Not a measure	91%	76%	76%	77%
Autism					
Amerigroup		77%	59%	40%	33%
Sunflower		53%	55%	46%	67%
United		71%	36%	0%	0%
Statewide	Not a measure	69%	52%	36%	38%
SED					
Amerigroup		92%	98%	100%	97%
Sunflower		90%	95%	98%	58%
United		87%	99%	92%	100%
Statewide	93%	90%	98%	97%	86%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**63%**	**73%**	**92%**	**74%**
Numerator	12	16	11	39
Denominator	19	22	12	53
FE	**67%**	**75%**	**89%**	**77%**
Numerator	12	12	17	41
Denominator	18	16	19	53
IDD	**65%**	**75%**	**58%**	**68%**
Numerator	11	21	7	39
Denominator	17	28	12	57
TBI	**64%**	**88%**	**75%**	**74%**
Numerator	7	7	3	17
Denominator	11	8	4	23
TA	**91%**	**100%**	**80%**	**91%**
Numerator	10	6	4	20
Denominator	11	6	5	22
Autism	**0%**	**50%**	**0%**	**25%**
Numerator	0	2	0	2
Denominator	2	4	2	8
SED	**96%**	**42%**	**83%**	**76%**
Numerator	25	8	15	48
Denominator	26	19	18	63

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review or prior service plan to determine timeliness, service plan not completed within specific waiver timelines. SED No form provided.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		73%	67%	70%	63%
Sunflower		82%	72%	69%	73%
United		92%	73%	86%	92%
Statewide	82%	82%	70%	75%	74%
FE					
Amerigroup		81%	67%	66%	67%
Sunflower		85%	57%	83%	75%
United		90%	69%	83%	89%
Statewide	81%	85%	64%	78%	77%
IDD					
Amerigroup		75%	77%	65%	65%
Sunflower		81%	66%	68%	75%
United		91%	48%	50%	58%
Statewide	97%	82%	66%	63%	68%
TBI					
Amerigroup		65%	44%	60%	64%
Sunflower		84%	40%	100%	88%
United		77%	65%	79%	75%
Statewide	60%	76%	47%	74%	74%
TA					
Amerigroup		81%	78%	64%	91%
Sunflower		94%	89%	86%	100%
United		96%	59%	67%	80%
Statewide	92%	89%	79%	71%	91%
Autism					
Amerigroup		67%	52%	53%	0%
Sunflower		43%	47%	31%	50%
United		33%	38%	0%	0%
Statewide	64%	57%	48%	32%	25%
SED					
Amerigroup		89%	97%	93%	96%
Sunflower		89%	91%	91%	42%
United		83%	99%	88%	83%
Statewide	80%	87%	96%	91%	76%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**67%**	**67%**	**100%**	**80%**
Numerator	2	2	4	8
Denominator	3	3	4	10
FE	**25%**	**40%**	**75%**	**46%**
Numerator	1	2	3	6
Denominator	4	5	4	13
IDD	**0%**	**100%**	**33%**	**33%**
Numerator	0	1	1	2
Denominator	2	1	3	6
TBI	**50%**	**80%**	**N/A**	**67%**
Numerator	2	4	0	6
Denominator	4	5	0	9
TA	**100%**	**50%**	**N/A**	**60%**
Numerator	1	2	0	3
Denominator	1	4	0	5
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**92%**	**36%**	**88%**	**68%**
Numerator	11	5	7	23
Denominator	12	14	8	34

Explanation of Findings:

no valid signature and/or date, a new service plan should have been completed, no file uploaded or enough documentation to determine, incorrect person file uploaded. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		20%	36%	56%	67%
Sunflower		53%	58%	22%	67%
United		50%	63%	78%	100%
Statewide	75%	39%	53%	52%	80%
FE					
Amerigroup		24%	71%	50%	25%
Sunflower		39%	51%	100%	40%
United		50%	47%	83%	75%
Statewide	78%	38%	54%	82%	46%
IDD					
Amerigroup		7%	60%	29%	0%
Sunflower		38%	16%	20%	100%
United		16%	30%	25%	33%
Statewide	97%	23%	28%	25%	33%
TBI					
Amerigroup		24%	42%	54%	50%
Sunflower		54%	27%	100%	80%
United		46%	50%	100%	N/A
Statewide	53%	38%	38%	67%	67%
TA					
Amerigroup		32%	73%	50%	100%
Sunflower		54%	89%	73%	50%
United		38%	43%	75%	N/A
Statewide	92%	42%	75%	64%	60%
Autism					
Amerigroup		10%	0%	25%	N/A
Sunflower		17%	25%	100%	N/A
United		0%	0%	0%	N/A
Statewide	45%	11%	11%	14%	N/A
SED					
Amerigroup		90%	90%	100%	92%
Sunflower		83%	79%	93%	36%
United		84%	93%	77%	88%
Statewide	85%	86%	88%	89%	68%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**84%**	**72%**	**93%**	**83%**
Numerator	27	21	26	74
Denominator	32	29	28	89
FE	**80%**	**76%**	**87%**	**81%**
Numerator	24	26	27	77
Denominator	30	34	31	95
IDD	**74%**	**82%**	**86%**	**81%**
Numerator	20	37	18	75
Denominator	27	45	21	93
TBI	**60%**	**73%**	**86%**	**68%**
Numerator	15	11	6	32
Denominator	25	15	7	47
TA	**86%**	**81%**	**75%**	**83%**
Numerator	24	13	6	43
Denominator	28	16	8	52
Autism	**33%**	**67%**	**0%**	**38%**
Numerator	2	4	0	6
Denominator	6	6	4	16
SED	**93%**	**58%**	**96%**	**83%**
Numerator	28	14	23	65
Denominator	30	24	24	78

Explanation of Findings:

No valid signature and/or date, missing service plan for the full review period, missing log notes or documentation to determine, partial year provided, nothing noted in log notes. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		94%	69%	73%	84%
Sunflower		96%	72%	73%	72%
United		96%	78%	89%	93%
Statewide	85%	95%	72%	78%	83%
FE					
Amerigroup		83%	76%	77%	80%
Sunflower		96%	64%	92%	76%
United		96%	79%	89%	87%
Statewide	87%	92%	72%	87%	81%
IDD					
Amerigroup		78%	84%	72%	74%
Sunflower		97%	62%	74%	82%
United		100%	59%	74%	86%
Statewide	98%	92%	68%	74%	81%
TBI					
Amerigroup		81%	55%	59%	60%
Sunflower		95%	46%	96%	73%
United		85%	71%	77%	86%
Statewide	70%	87%	56%	71%	68%
TA					
Amerigroup		98%	73%	73%	86%
Sunflower		100%	86%	87%	81%
United		96%	58%	82%	75%
Statewide	100%	98%	74%	78%	83%
Autism					
Amerigroup		89%	59%	47%	33%
Sunflower		100%	55%	46%	67%
United		50%	21%	0%	0%
Statewide	50%	86%	49%	39%	38%
SED					
Amerigroup		91%	99%	94%	93%
Sunflower		96%	94%	94%	58%
United		92%	99%	90%	96%
Statewide	13%	93%	98%	93%	83%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data was not collected since customer interviews were not performed during this review period.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		97%			
Sunflower		92%			
United		93%			
Statewide	Not a measure	94%			
FE					
Amerigroup		85%			
Sunflower		86%			
United		82%			
Statewide	87%	84%			
IDD					
Amerigroup		92%			
Sunflower		96%			
United		93%			
Statewide	Not a measure	94%			
TBI					
Amerigroup		81%			
Sunflower		88%			
United		83%			
Statewide	Not a measure	83%			
TA					
Amerigroup		89%			
Sunflower		84%			
United		85%			
Statewide	Not a measure	87%			
Autism					
Amerigroup		74%			
Sunflower		70%			
United		60%			
Statewide	Not a measure	71%			
SED					
Amerigroup					
Sunflower					
United					
Statewide	Not a measure	No Data			

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**75%**	**69%**	**89%**	**78%**
Numerator	24	20	25	69
Denominator	32	29	28	89
FE	**60%**	**79%**	**94%**	**78%**
Numerator	18	27	29	74
Denominator	30	34	31	95
IDD	**70%**	**73%**	**86%**	**75%**
Numerator	19	33	18	70
Denominator	27	45	21	93
TBI	**44%**	**80%**	**86%**	**62%**
Numerator	11	12	6	29
Denominator	25	15	7	47
TA	**71%**	**75%**	**75%**	**73%**
Numerator	20	12	6	38
Denominator	28	16	8	52
Autism	**50%**	**50%**	**0%**	**38%**
Numerator	3	3	0	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**88%**	**82%**
Numerator	29	14	21	64
Denominator	30	24	24	78

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		68%	56%	61%	75%
Sunflower		58%	69%	72%	69%
United		69%	73%	85%	89%
Statewide	52%	65%	65%	72%	78%
FE					
Amerigroup		68%	59%	70%	60%
Sunflower		76%	59%	87%	79%
United		77%	75%	80%	94%
Statewide	56%	74%	63%	80%	78%
IDD					
Amerigroup		51%	45%	63%	70%
Sunflower		68%	42%	64%	73%
United		75%	55%	67%	86%
Statewide	99%	64%	46%	65%	75%
TBI					
Amerigroup		54%	50%	49%	44%
Sunflower		75%	40%	96%	80%
United		70%	74%	77%	86%
Statewide	44%	65%	52%	66%	62%
TA					
Amerigroup		87%	65%	65%	71%
Sunflower		84%	80%	80%	75%
United		92%	58%	82%	75%
Statewide	96%	86%	68%	73%	73%
Autism					
Amerigroup		67%	67%	57%	50%
Sunflower		44%	45%	46%	50%
United		88%	21%	0%	0%
Statewide	40%	63%	49%	44%	38%
SED					
Amerigroup		94%	91%	98%	97%
Sunflower		91%	72%	91%	58%
United		84%	97%	85%	88%
Statewide	98%	89%	88%	91%	82%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**72%**	**69%**	**89%**	**76%**
Numerator	23	20	25	68
Denominator	32	29	28	89
FE	**67%**	**79%**	**94%**	**80%**
Numerator	20	27	29	76
Denominator	30	34	31	95
IDD	**78%**	**73%**	**86%**	**77%**
Numerator	21	33	18	72
Denominator	27	45	21	93
TBI	**52%**	**80%**	**86%**	**66%**
Numerator	13	12	6	31
Denominator	25	15	7	47
TA	**79%**	**75%**	**75%**	**77%**
Numerator	22	12	6	40
Denominator	28	16	8	52
Autism	**50%**	**50%**	**0%**	**38%**
Numerator	3	3	0	6
Denominator	6	6	4	16
SED	**97%**	**58%**	**88%**	**82%**
Numerator	29	14	21	64
Denominator	30	24	24	78

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file or partial file uploaded, choice box was not checked/marked on the choice form and/or service plan, documentation uploaded for the wrong consumer. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		68%	53%	54%	72%
Sunflower		72%	50%	68%	69%
United		77%	73%	81%	89%
Statewide	64%	72%	57%	67%	76%
FE					
Amerigroup		67%	57%	70%	67%
Sunflower		86%	47%	87%	79%
United		85%	74%	78%	94%
Statewide	59%	80%	57%	79%	80%
IDD					
Amerigroup		55%	46%	65%	78%
Sunflower		68%	35%	66%	73%
United		77%	50%	62%	86%
Statewide	No Data	66%	42%	65%	77%
TBI					
Amerigroup		56%	50%	49%	52%
Sunflower		80%	23%	96%	80%
United		74%	67%	77%	86%
Statewide	53%	68%	45%	66%	66%
TA					
Amerigroup		86%	65%	65%	79%
Sunflower		97%	53%	80%	75%
United		94%	55%	65%	75%
Statewide	96%	91%	60%	70%	77%
Autism					
Amerigroup		79%	52%	57%	50%
Sunflower		50%	27%	62%	50%
United		88%	14%	0%	0%
Statewide	55%	72%	35%	50%	38%
SED					
Amerigroup		94%	92%	98%	97%
Sunflower		91%	72%	91%	58%
United		84%	97%	86%	88%
Statewide	98%	89%	88%	92%	82%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**66%**	**69%**	**89%**	**74%**
Numerator	21	20	25	66
Denominator	32	29	28	89
FE	**77%**	**79%**	**94%**	**83%**
Numerator	23	27	29	79
Denominator	30	34	31	95
IDD	**63%**	**73%**	**86%**	**73%**
Numerator	17	33	18	68
Denominator	27	45	21	93
TBI	**40%**	**80%**	**86%**	**60%**
Numerator	10	12	6	28
Denominator	25	15	7	47
TA	**75%**	**81%**	**75%**	**77%**
Numerator	21	13	6	40
Denominator	28	16	8	52
Autism	**50%**	**67%**	**25%**	**50%**
Numerator	3	4	1	8
Denominator	6	6	4	16
SED	**97%**	**58%**	**88%**	**82%**
Numerator	29	14	21	64
Denominator	30	24	24	78

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan. SED No form provided

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		76%	57%	61%	66%
Sunflower		74%	67%	72%	69%
United		80%	78%	83%	89%
Statewide	Not a measure	76%	66%	72%	74%
FE					
Amerigroup		67%	58%	74%	77%
Sunflower		87%	56%	87%	79%
United		85%	79%	78%	94%
Statewide	65%	80%	63%	80%	83%
IDD					
Amerigroup		47%	47%	65%	63%
Sunflower		69%	41%	63%	73%
United		78%	57%	71%	86%
Statewide	No Data	64%	46%	66%	73%
TBI					
Amerigroup		55%	51%	54%	40%
Sunflower		79%	40%	96%	80%
United		73%	74%	77%	86%
Statewide	No Data	67%	52%	69%	60%
TA					
Amerigroup		87%	65%	64%	75%
Sunflower		98%	80%	80%	81%
United		94%	55%	82%	75%
Statewide	No Data	92%	68%	72%	77%
Autism					
Amerigroup		86%	67%	77%	50%
Sunflower		47%	59%	65%	67%
United		75%	43%	20%	25%
Statewide	No Data	72%	59%	64%	50%
SED					
Amerigroup		94%	92%	98%	97%
Sunflower		91%	72%	92%	58%
United		85%	98%	87%	88%
Statewide	99%	90%	89%	92%	82%

KDADS HCBS Quality Review Report

Plan of Care
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**78%**	**69%**	**89%**	**79%**
Numerator	25	20	25	70
Denominator	32	29	28	89
FE	**77%**	**76%**	**94%**	**82%**
Numerator	23	26	29	78
Denominator	30	34	31	95
IDD	**63%**	**64%**	**76%**	**67%**
Numerator	17	29	16	62
Denominator	27	45	21	93
TBI	**56%**	**73%**	**86%**	**66%**
Numerator	14	11	6	31
Denominator	25	15	7	47
TA	**64%**	**75%**	**75%**	**69%**
Numerator	18	12	6	36
Denominator	28	16	8	52
Autism	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				
SED	**Self-direction is not offered for this waiver**			
Numerator				
Denominator				

Explanation of Findings:

No valid signature and/or date, not an original signature, not signed by the guardian/rep, partial year provided, no file uploaded, choice box was not checked/marked on the choice form and/or service plan.

Remediation:

Conclusions: As part of an existing corrective action plan to CMS, KDADS has acknowledged the need for additional policy to clarify the plan of care expectations and provided direction. When reviewing this data this need is confirmed. Additionally, in many cases the most common reason for not meeting plan of care performance measures is a lack of documentation.

Recommended Remediation:
1. Policy development: Complete the integrated person centered service plan policy and implement.

2. Corrective action plan : MCOs shall provide a plan detailing how they will provide all required documentation to quality reviewers.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		64%	58%	68%	78%
Sunflower		73%	68%	70%	69%
United		77%	78%	83%	89%
Statewide	Not a measure	71%	66%	73%	79%
FE					
Amerigroup		64%	59%	75%	77%
Sunflower		84%	59%	87%	76%
United		77%	79%	80%	94%
Statewide	65%	75%	64%	81%	82%
IDD					
Amerigroup		34%	47%	63%	63%
Sunflower		61%	39%	59%	64%
United		77%	57%	64%	76%
Statewide	No Data	53%	46%	61%	67%
TBI					
Amerigroup		50%	50%	54%	56%
Sunflower		85%	43%	96%	73%
United		70%	74%	77%	86%
Statewide	No Data	66%	52%	69%	66%
TA					
Amerigroup		82%	56%	64%	64%
Sunflower		98%	82%	80%	75%
United		100%	58%	82%	75%
Statewide	No Data	90%	64%	72%	69%
Autism	**Self-direction is not offered for this waiver**				
Amerigroup					
Sunflower					
United					
Statewide					
SED	**Self-direction is not offered for this waiver**				
Amerigroup					
Sunflower					
United					
Statewide					

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 non-preventable causes
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 07/01/2016 - 9/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
Sunflower					
United					
Statewide					

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 07/01/2016 - 9/30/2016
Data Source:

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

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
Sunflower					
United					
Statewide					

Explanation of Findings:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**81%**	**72%**	**96%**	**83%**
Numerator	26	21	27	74
Denominator	32	29	28	89
FE	**70%**	**79%**	**94%**	**81%**
Numerator	21	27	29	77
Denominator	30	34	31	95
IDD	**70%**	**80%**	**86%**	**78%**
Numerator	19	36	18	73
Denominator	27	45	21	93
TBI	**56%**	**87%**	**86%**	**70%**
Numerator	14	13	6	33
Denominator	25	15	7	47
TA	**79%**	**81%**	**75%**	**79%**
Numerator	22	13	6	41
Denominator	28	16	8	52
Autism	**14%**	**50%**	**0%**	**24%**
Numerator	1	3	0	4
Denominator	7	6	4	17
SED	**10%**	**29%**	**13%**	**17%**
Numerator	3	7	3	13
Denominator	30	24	24	78

Explanation of Findings:

The low percentages for this performance measures stems from either the lack of documentation as part of the integrated individuals service plan or a lack of signature on the integrated service plan. The lack of a signature invalidates any integrated service plan and any contents therein.

Remediation:

This performance measure is achieved through the integrated service plan. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.

2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

3. Draft integrated service plan. Completed May 2017.

Steps still left to complete remediation:

1. Public comment on integrated support plan policy. Expected completion date: July 2017. Responsible party: KDADS (CSP)

2. Finalize policy and get approval from KDHE AD staff. Expected completion: August 2017. Responsible party: KDADS (CSP), KDHE.

3. Operationalization of policy. Expected completion: November 2017. Responsible party: MCOS and TCMs.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		51%	19%	51%	81%
Sunflower		88%	72%	72%	72%
United		90%	80%	79%	96%
Statewide	65%	72%	53%	67%	83%
FE					
Amerigroup		59%	16%	51%	70%
Sunflower		86%	62%	87%	79%
United		92%	80%	85%	94%
Statewide	80%	78%	50%	75%	81%
IDD					
Amerigroup		23%	6%	41%	70%
Sunflower		87%	59%	71%	80%
United		100%	56%	71%	86%
Statewide	99%	68%	42%	62%	78%
TBI					
Amerigroup		30%	12%	46%	56%
Sunflower		94%	45%	88%	87%
United		80%	76%	81%	86%
Statewide	57%	63%	34%	63%	70%
TA					
Amerigroup		61%	38%	73%	79%
Sunflower		99%	86%	87%	81%
United		97%	61%	82%	75%
Statewide	86%	82%	57%	78%	79%
Autism					
Amerigroup		62%	8%	30%	14%
Sunflower		33%	29%	35%	50%
United		43%	14%	0%	0%
Statewide	90%	50%	16%	27%	24%
SED					
Amerigroup		88%	64%	45%	10%
Sunflower		80%	53%	27%	29%
United		78%	63%	29%	13%
Statewide	89%	82%	60%	34%	17%

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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
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: 07/01/2016 - 9/30/2016
Data Source:

Compliance By Waiver	Amerigroup	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:

Data not available.

Remediation:

KDADS has continued to move forward with the corrective action plan submitted to CMS on January 31, 2017. Concerning this health and welfare performance measure the following remediation steps have taken place:

1. Established a reporting system to capture all adverse/critical incidents. This was completed on 8/1/2016 and to date the "Adverse Incident Reporting" system has received 4,418 reports from August 1, 2016 to May 2, 2017. This represents a 189.7% increase in reports from the previous total summing 1,525 reports.

2. Developed and provided an on-line AIR system training. Completed 2/1/2017 and ongoing.

3. Finalizing the adverse incident policy with clearly defines investigation and follow up responsibilities, time frames, and associated workflows. Expected completion August 15, 2017. Responsible party: Community Services and Programs Commission, KDADS.

4. Define system revisions based on adverse incident policy and workflows. Complete and to IT: April 2017.

5. Complete AIR system modifications to operationalize AIR policy. Expected completion 7/1/2017. Responsible Party: KDADS FISC Commission.

6.Complete connection of the Dept. of Children and Families' Abuse Neglect and Exploitation system to the KDADS AIR system. Responsible Party: KDADS FISC Commission and DCF IT.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup					
Sunflower					
United					
Statewide					
FE					
Amerigroup					
Sunflower					
United					
Statewide					
IDD					
Amerigroup					
Sunflower					
United					
Statewide					
TBI					
Amerigroup					
Sunflower					
United					
Statewide					
TA					
Amerigroup					
Sunflower					
United					
Statewide					
Autism					
Amerigroup					
Sunflower					
United					
Statewide					
SED					
Amerigroup					
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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	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:

This data was not collected as part of the MCO reviews that were conducted.

Remediation:

Physical exams were added to the Quality Review protocol to begin obtaining the needed information following State policy. IT is in the process of adding it to the Quality Review Tracker to ensure reporting for this measure will be available moving forward. The review will begin in 2017 review periods.

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		78%			
Sunflower		81%			
United		88%			
Statewide	Not a measure	82%			
FE					
Amerigroup		89%			
Sunflower		97%			
United		97%			
Statewide	Not a measure	95%			
IDD					
Amerigroup		91%			
Sunflower		99%			
United		99%			
Statewide	Not a measure	97%			
TBI					
Amerigroup		84%			
Sunflower		94%			
United		93%			
Statewide	Not a measure	90%			
TA					
Amerigroup		100%			
Sunflower		100%			
United		97%			
Statewide	Not a measure	100%			
Autism					
Amerigroup		100%			
Sunflower		92%			
United		100%			
Statewide	Not a measure	98%			
SED					
Amerigroup		54%			
Sunflower		55%			
United		46%			
Statewide	Not a measure	52%			

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: 07/01/2016 - 9/30/2016
Data Source: MCO Record Review

Compliance By Waiver	Amerigroup	Sunflower	United	Statewide
PD	**78%**	**72%**	**93%**	**81%**
Numerator	25	21	26	72
Denominator	32	29	28	89
FE	**77%**	**82%**	**94%**	**84%**
Numerator	23	28	29	80
Denominator	30	34	31	95
IDD	**63%**	**67%**	**81%**	**69%**
Numerator	17	30	17	64
Denominator	27	45	21	93
TBI	**64%**	**93%**	**71%**	**74%**
Numerator	16	14	5	35
Denominator	25	15	7	47
TA	**79%**	**94%**	**75%**	**83%**
Numerator	22	15	6	43
Denominator	28	16	8	52
Autism	**43%**	**100%**	**0%**	**53%**
Numerator	3	6	0	9
Denominator	7	6	4	17
SED	Not a waiver performance measure			
Numerator				
Denominator				

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
PD					
Amerigroup		59%	53%	64%	78%
Sunflower		77%	49%	60%	72%
United		64%	80%	81%	93%
Statewide	Not a measure	67%	58%	68%	81%
FE					
Amerigroup		61%	62%	74%	77%
Sunflower		72%	56%	63%	82%
United		76%	81%	78%	94%
Statewide	59%	70%	65%	71%	84%
IDD					
Amerigroup		67%	61%	61%	63%
Sunflower		58%	32%	52%	67%
United		70%	58%	60%	81%
Statewide	Not a measure	64%	47%	56%	69%
TBI					
Amerigroup		46%	49%	53%	64%
Sunflower		68%	42%	75%	93%
United		56%	74%	76%	71%
Statewide	Not a measure	56%	52%	63%	74%
TA					
Amerigroup		75%	54%	80%	79%
Sunflower		91%	58%	70%	94%
United		86%	63%	82%	75%
Statewide	Not a measure	83%	57%	77%	83%
Autism					
Amerigroup		77%	44%	37%	43%
Sunflower		53%	27%	54%	100%
United		38%	7%	0%	0%
Statewide	Not a measure	64%	30%	38%	53%
SED	Not a waiver performance measure				
Amerigroup					
Sunflower					
United					
Statewide					

Explanation of Findings:

In the samples reviewed a backup plan was either not present or incomplete.

Remediation:

This performance measure is achieved through the integrated service plan. KDADS is in the process of creating an updated integrated service plan policy that addresses both new federal requirements and waiver performance measures.

To date the following has been completed:

1. MCO integrated service plan self assessment to KDADS. Completed. March 2017.

2. KDADS gap analysis against federal requirements and waiver performance measures. Completed. March 2017.

3. Draft integrated service plan. Completed May 2017.

Steps still left to complete remediation:

1. Public comment on integrated support plan policy. Expected completion date: July 2017. Responsible party: KDADS (CSP)

2. Finalize policy and get approval from KDHE AD staff. Expected completion: August 2017. Responsible party: KDADS (CSP), KDHE.

3. Operationalization of policy. Expected completion: November 2017. Responsible party: MCOS and TCMs.

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: 07/01/2016 - 9/30/2016
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
HCBS Waivers	**95%**
Numerator	284,897
Denominator	300,560

Compliance Trends	2013	2014	2015	Jan-Jun 2016	July-Sept 2016
All HCBS Waivers					
Statewide	not a measure	90%	88%	94%	95%

Explanation of Findings:

Remediation:

KDADS HCBS Quality Review Report

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: 07/01/2016 - 9/30/2016
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	Jan-Jun 2016	July-Sept 2016
PD					
Statewide	not a measure	100%	100%	100%	100%
FE					
Statewide	not a measure	100%	100%	100%	100%
IDD					
Statewide	not a measure	100%	100%	100%	100%
TBI					
Statewide	not a measure	100%	100%	100%	100%
TA					
Statewide	not a measure	100%	100%	100%	100%
Autism					
Statewide	not a measure	100%	100%	100%	100%
SED					
Statewide	not a measure	100%	100%	100%	100%

Explanation of Findings:

Remediation:

KanCare Ombudsman KDHE Quarterly Report

Kerrie J. Bacon, KanCare Ombudsman
2nd Quarter 2017 Report

Executive Summary Dashboard

Contacts by Office	Q1/17	Q2/17
Main	648	639
Johnson County	28	81
Wichita	149	115
Total	**825**	**835**

Contact Method	Q1/17	Q2/17
Email	125	127
Face-to-Face Meeting	11	5
Letter	2	0
ONLINE	0	0
Other	0	2
Telephone	687	701
Total	**825**	**835**

	Q1/17	Q2/17
Avg. Days to Resolve Issue	11	9
% files resolved in one day or less	34%	44%
% files closed	88%	92%

Top four issues for second quarter:

Issues	Q2/17
Medicaid Eligibility Issues	*177*
Medicaid Application Assistance	*54*
HCBS Eligibility issues	48
Medicaid Renewal	*43*

Accessibility by Ombudsman's Office

The KanCare Ombudsman was available to members and potential members of KanCare (Medicaid) by phone, email, written communication and in person during the second quarter of 2017. Second quarter is an increase over first quarter of 2017 and only a slight decrease of from last year, second quarter.

Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Comments
2013	615	456	436	341	this year does not include emails
2014	545	474	526	547	
2015	510	462	579	524	
2016	1,130	846	687	523	
2017	825	835			
2017 Comparison to 2016	-27%	-1%			

The KanCare Ombudsman webpage is *located at (www.kancare.ks.gov/kancare-ombudsman-office)*. The Resources page was updated on a regular basis to reflect the information that is used by the volunteers and staff; it is also now being provided on the website to the Ombudsman Liaison Volunteers. Much of this information is mailed or emailed to KanCare members on an as needed basis.

Outreach by Ombudsman's office

Presentations: (educational, networking, referrals)

- Provided quarterly information on the Ombudsman's office at the Robert Bethell HCBS and KanCare Oversight Committee Meeting, April 19, 2017
- Outreach for Ombudsman's office at Franklin County Health Fair, April 26, 2017
- Outreach for Ombudsman's office at Mercy and Truth Medical Missions, April 28, 2017
- Attended Severe Emotional Disturbance Listening Session as outreach; Andover; Monday, May 1, 2017.
- Outreach for Ombudsman's office at Community Connections Celebration event in Osage City, May 5, 2017
- Outreach for Ombudsman's office (six county regional event) at Active Aging Expo; May 3, 2017

- Provided Liaison Training (Community Collaboration/Outreach)
    - Wyandotte Center, April 21, 2017

- Johnson County CDDO, May 17, 2017
- Developmental Services of Northwest Kansas (CDDO), Hays, KS, June 21, 2017.
- Community Health Council of Wyandotte County, Kansas City, KS, June 29, 2017

- Provided testimony on the Ombudsman's office for the KanCare Advisory Council; June 13, 2017
- Attended the KanCare Renewal Listening Session in Topeka, Pittsburg and Wichita as outreach; June 2017.
- Attended the KanCare Consumer Specialized Issues Workgroup and provided several topics for review/discussion; June 20, 2017.
- Presentation on the Ombudsman's office for the Sunflower Advisory Committee; June 26, 2017.
- Mailing by Wichita VISTA volunteer to 38 county local organizations on the Ombudsman's office.

Publications: Outreach, posts and/or articles about the KanCare Ombudsman office services.

- May newsletter for Volunteer Commission in Wichita on recruitment
- Wichita State Facebook page Recruitment blurb; May, 2017
- ComCare Staff Bulletin; May 2017
- Shepherd's Voice E-Newsletter (June 2017)
- Senior Bluebook Magazine (Kansas City, KS and Kansas City, MO) (April, May, June 2017)
- Livable Neighborhoods Neighborhood E-News (Wyandotte Co. newsletter) (April 2017)

Outreach through the KanCare Ombudsman Volunteer Program Update.

- The ***KanCare Ombudsman Johnson County Satellite Office*** has been providing assistance to KanCare members for over a year. Johnson County Satellite office is answering the phone and meeting with individuals on Wednesdays (10-1), Thursdays (10-4), and soon Fridays (10-1).
- The ***KanCare Ombudsman Southern Kansas Satellite Office (Wichita)*** has been open over a year and a half, providing assistance to KanCare members. The Southern Kansas Satellite Office is answering the phone and meeting with individuals Monday through Friday 10:00am to 5:00pm with the assistance of the part-time supervisor.
- Both Satellite offices are assisting consumers with filling out applications on the phone and by appointment, in person.
- Volunteer Applications are available on the KanCare Ombudsman webpage. www.KanCare.ks.gov/kancare-ombudsman-office.

Data by Ombudsman's Office

The Ombudsman on-line tracker has been updated to include the main Ombudsman office and Ombudsman satellite offices covered by volunteers.

Starting with the fourth quarter report, we are able to provide the number of contacts made to the main office and the Ombudsman's satellite offices across Kansas.

Contacts by Office	**Q4/16**	**Q1/17**	**Q2/17**
Main	432	648	639
Johnson County	21	28	81
Wichita	70	149	115
Total	**523**	**825**	**835**

Contact Method	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**
phone	862	644	507	394	687	701
email	265	191	174	125	125	127
letter	2	3	1	0	2	0
in person	0	8	3	3	11	5
online	1	0	2	1	0	0
other	0	0	0	0	0	2
Total	**1,130**	**846**	**687**	**523**	**825**	**835**

Caller Type	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**
Provider	179	110	100	71	117	112
Consumer	866	601	544	352	630	661
MCO employee	7	4	10	8	18	9
Other	78	131	33	92	60	53
Total	**1,130**	**846**	**687**	**523**	**825**	**835**

Contact Information. The average number of days it took to resolve an issue during second quarter was nine.

Q1/16	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**

Avg. Days to Resolve Issue	7	5	6	4	11	9
% files resolved in one day or less	49.6%	56%	54%	52%	34%	44%
% files closed	77%	88%	87%	80%	88%	92%

The most frequent calls regarding home and community-based services (HCBS) waivers during the second quarter of 2017 was in regard to the physical disability waiver and then the intellectual/developmental disability and frail elderly waiver.

Occasionally more than one option can be chosen; for example when mental health or substance abuse might be included in addition to a waiver or a nursing facility.

Waiver	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**
PD	48	22	13	9	40	37
I/DD	48	27	21	11	43	27
FE	23	19	10	7	30	27
Autism	1	2	2	1	3	2
SED	4	0	1	3	4	4
TBI	10	3	7	5	6	8
TA	10	9	4	4	8	10
MFP	8	5	3	0	2	1
PACE	0	0	0	0	0	0
Mental Health	8	6	3	2	5	5
Substance Use Disorder	0	0	0	0	0	0
Nursing Facility	47	27	16	27	65	45
Other	941	739	612	456	628	677
Total	**1,148**	**859**	**692**	**525**	**834**	**843**

The Issue Categories listed below reflect the last six quarters in alphabetical order. The top five issues for each quarter are highlighted. The issues that carry across several quarters are Medicaid Eligibility Issues and Other (besides Thank You).

The issues with n/a starting Q1/16 through Q1/17 were added during Q1/17 and do not have history available during that timeframe. There may be multiple issues for a member/contact.

Issues	**Q1/16**	**Q2/16**	**Q3/16**	**Q4/16**	**Q1/17**	**Q2/17**
Access to Providers	7	6	9	13	14	14
Affordable Care Act	n/a	n/a	n/a	n/a	3	6
Appeals, Grievances	49	42	36	16	36	33
Billing	43	39	37	26	21	33
Care Coordinator Issues	7	3	6	4	5	11
Change MCO	15	3	0	6	3	1
Client Obligation	n/a	n/a	n/a	n/a	17	35
Dental	4	5	5	5	7	9
Division of Assets	n/a	n/a	n/a	n/a	2	2
Durable Medical Equipment	7	7	2	4	2	9
Estate Recovery	n/a	n/a	n/a	n/a	5	5
Guardianship Issues	0	1	2	2	3	1
HCBS Eligibility issues	45	33	21	9	46	48
HCBS General Issues	69	32	16	15	33	34
HCBS Reduction in hours of service	12	4	3	3	7	2
HCBS Waiting List issues	18	2	2	4	6	9
Housing issues	8	2	2	3	4	6
Medicaid Application Assistance	*n/a*	n/a	n/a	n/a	*n/a*	*54*
Medicaid Eligibility Issues	512	244	173	174	*236*	*177*
Medicaid Renewal	n/a	n/a	n/a	n/a	*29*	*43*
Medical Services	29	20	10	12	20	23
Moving to/from Kansas	n/a	n/a	n/a	n/a	5	7
Nursing Facility Issues	40	25	22	22	38	25
Pharmacy	24	13	11	8	10	9
Questions for Conf Calls	0	0	1	2	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	18	32
Transportation	6	8	6	1	8	9
z-Other	332	377	381	224	274	323
z-Thank you	72	85	114	100	235	318
z-Unspecified	79	38	21	17	45	39
Total	**1,378**	**989**	**880**	**670**	**1,132**	**1,317**

Action Taken to Resolve Issues by Ombudsman's Office

The Resource Category below shows what action was taken and what contacts were made on behalf of a member, potential member, provider or other caller to resolve an issue and what resources where provided. A few new categories were created during first quarter of 2017. History is not available before then. Often multiple resources are provided to a member/contact.

Action Taken	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17
Question/Issue Resolved	122	239	233	214	160	78
Used Contacts or Resources/Issues Resolved	463	394	313	166	494	601
Closed	198	313	111	17	65	69
Provided Resources to Member	361	239	115	88	203	305
Mailed/Email Resources	n/a	n/a	n/a	n/a	43	123
KDHE Contacts	214	97	97	111	134	76
DCF Contacts	6	2	1	4	1	4
MCO Contacts	48	43	44	31	33	29
MCO Referral	n/a	n/a	n/a	n/a	19	34
Clearinghouse Contact	n/a	n/a	n/a	n/a	73	129
Clearinghouse Referral	n/a	n/a	n/a	n/a	25	104
HCBS Team Contacts	28	21	12	5	29	23
HCBS Team Referral	n/a	n/a	n/a	n/a	7	12
CSP Mental Health Contacts	1	1	0	0	2	0
Other KDADS Contacts/Referral	53	16	44	38	49	41
State/Community Agency Referral	111	40	53	14	46	78
Disability Rights and/or KLS Referral	13	7	4	3	8	3
Total	**1,618**	**1,412**	**1,027**	**691**	**1,391**	**1,709**

Next Steps for Ombudsman's Office

KanCare Ombudsman Volunteer Program

The Ombudsman Volunteer Coordinator, Lisa Churchill, and Ombudsman Project Coordinator, Percy Turner, continue training community based organizations regarding Medicaid. Trainings are two - one and a half hours with topics such as: How to assist with Medicaid applications, and KanCare programs and Home and Community Based Services overview. We are planning to also offer this as a webinar for those who may have difficulty getting away from the office to attend. This is another way the Ombudsman's office is adding capacity to the Kansas Community for KanCare/Medicaid assistance.

Four plus trainings are on the Ombudsman website for the fall/winter timeframe all across Kansas. (www.kancare.ks.gov/kancare-ombudsman-office/liaison-training)

Data by Managed Care Organization

The following charts provide the issue categories for the last six quarters by MCO. The top four issues are shaded (more may be shaded if there was a tie for the last number). There may be multiple issues for a member/contact.

Amerigroup

Issue Category - Amerigroup	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17
Access to Providers (usually Medical)	1	1	2	2	3	7
Affordable Care Act	n/a	n/a	n/a	n/a	0	0
Appeals / Grievances	9	5	1	0	10	4
Billing	11	6	7	2	1	5
Care Coordinator Issues	4	1	3	1	1	4
Change MCO	1	1	0	0	1	0
Client Obligation	n/a	n/a	n/a	n/a	1	7
Dental	0	0	1	1	0	0
Division of Assets	n/a	n/a	n/a	n/a	0	0
Durable Medical Equipment	2	2	1	1	0	1
Estate Recovery	n/a	n/a	n/a	n/a	0	1
Guardianship	0	0	0	0	1	0
HCBS Eligibility issues	8	5	4	0	6	7
HCBS General Issues	13	3	3	3	11	10
HCBS Reduction in hours of service	6	1	1	1	2	0
HCBS Waiting List	0	0	0	1	1	2
Housing Issues	1	1	0	1	0	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0	0
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0	0
Medicaid Eligibility Issues	28	8	5	6	8	5
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	4	7
Medical Services	7	2	3	1	5	7
Moving to/from Kansas	n/a	n/a	n/a	n/a	1	0
Nursing Facility Issues	2	1	0	1	1	3
Other	19	16	20	10	14	21
Pharmacy	3	1	0	2	1	2
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	2	5
Thank you.	6	4	9	5	23	31
Transportation	2	1	1	0	1	1
Unspecified	2	0	0	1	1	1
Total	**125**	**59**	**61**	**39**	**99**	**132**

Sunflower

Issue Category - Sunflower	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17
Access to Providers (usually Medical)	1	1	2	0	4	3
Affordable Care Act	n/a	n/a	n/a	n/a	0	1
Appeals / Grievances	14	11	8	2	5	8
Billing	6	7	9	7	3	6
Care Coordinator Issues	2	1	1	2	1	2
Change MCO	3	1	0	1	0	0
Client Obligation	n/a	n/a	n/a	n/a	3	4
Dental	1	2	0	0	0	1
Division of Assets	n/a	n/a	n/a	n/a	0	0
Durable Medical Equipment	5	2	0	2	0	2
Estate Recovery	n/a	n/a	n/a	n/a	0	0
Guardianship	0	0	0	0	0	0
HCBS Eligibility issues	3	7	3	2	3	10
HCBS General Issues	15	9	1	5	5	6
HCBS Reduction in hours of service	0	3	1	0	1	1
HCBS Waiting List	1	0	0	0	1	1
Housing Issues	0	0	0	0	1	1
Medicaid Application Assistance	n/a	n/a	n/a	n/a	1	0
Medicaid Coding Issues	n/a	n/a	n/a	n/a	2	0
Medicaid Eligibility Issues	26	7	10	9	14	8
Medicaid Renewal Issues	n/a	n/a	n/a	n/a	6	5
Medical Services	4	8	0	3	5	3
Moving to/from Kansas	n/a	n/a	n/a	n/a	0	1
Nursing Facility Issues	3	3	2	1	2	1
Other	23	12	24	16	18	19
Pharmacy	4	1	4	4	4	3
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	2	4
Thank you.	7	6	8	11	20	25
Transportation	1	2	4	1	4	3
Unspecified	1	0	0	0	1	0
Total	**120**	**83**	**77**	**66**	**106**	**118**

United Healthcare

Issue Category - UnitedHealthcare	Q1/16	Q2/16	Q3/16	Q4/16	Q1/17	Q2/17
Access to Providers (usually Medical)	2	1	0	2	4	2
Affordable Care Act	n/a	n/a	n/a	n/a	0	0
Appeals / Grievances	6	4	5	1	3	3
Billing	3	5	2	3	3	7
Care Coordinator Issues	0	0	2	1	3	1
Change MCO	3	0	0	4	2	1
Client Obligation	n/a	n/a	n/a	n/a	2	2
Dental	1	3	2	0	1	3
Division of Assets	n/a	n/a	n/a	n/a	0	0
Durable Medical Equipment	0	1	0	0	2	2
Estate Recovery	n/a	n/a	n/a	n/a	0	1
Guardianship	0	0	0	1	0	0
HCBS Eligibility issues	6	3	2	0	9	6
HCBS General Issues	11	5	2	3	2	4
HCBS Reduction in hours of service	2	0	0	2	2	0
HCBS Waiting List	2	1	1	0	0	0
Housing Issues	0	0	0	0	0	0
Medicaid Application Assistance	n/a	n/a	n/a	n/a	0	1
Medicaid Coding Issues	n/a	n/a	n/a	n/a	0	0
Medicaid Eligibility Issues	18	4	5	5	7	7
Medicaid Renewal	n/a	n/a	n/a	n/a	1	1
Medical Services	4	1	4	0	3	3
Moving to/from Kansas	n/a	n/a	n/a	n/a	0	0
Nursing Facility Issues	2	1	2	2	2	2
Other	14	20	20	12	15	17
Pharmacy	7	2	4	0	0	1
Questions for Conference Calls/Sessions	0	0	0	0	0	0
Spenddown Issues	n/a	n/a	n/a	n/a	0	1
Thank you.	5	8	6	9	11	22
Transportation	1	0	0	0	2	2
Unspecified	2	0	0	0	2	0
Total	**89**	**59**	**57**	**45**	**76**	**89**

Kansas Foundation for Medical Care, Inc

800 SW Jackson St., Suite 700
Topeka, Kansas 66612-1265
Phone 785-273-2552
kfmc.org

August 25, 2017

Becky Ross
Medicaid Initiatives Coordinator
Kansas Department of Health & Environment
Division of Health Care Finance
900 SW Jackson St.
Topeka, KS 66612

RE: 2017 KanCare Evaluation Quarterly Report
Year 5, Quarter 2, April - June

Dear Ms. Ross:

Enclosed is the 2017 Quarter 2 KanCare Evaluation Quarterly Report. If you have questions or corrections regarding this information, please contact me, jpanichello@kfmc.org or (785) 271-4138.

Sincerely,

Janice D. Panichello, PhD, MPA
Director of Quality Review & Epidemiologist

Electronic Version: Shirley Norris, Senior Manager, MCO Operations, KDHE

Enclosures

Kansas Foundation for Medical Care, Inc.

URAC ACCREDITED Independent Review Organization: Comprehensive Expires 07/01/2018

2017 KanCare Evaluation

Quarterly Report

Year 5, Quarter 2, April - June

Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**August 25, 2017**
Review Team:	**Janice Panichello, PhD, MPA, Director of Quality Review & Epidemiologist**

Prepared for:

AD ASTRA PER ASPERA KanCare

Table of Contents

2017 KanCare Evaluation Quarterly Report

Year 5, Quarter 2, April - June

List of Tables

KanCare Evaluation Quarterly Report
Year 5, Quarter 2, April – June 2017
August 25, 2017

Background/Objectives

The Kansas Department of Health and Environment (KDHE), Division of Health Care Finance (DHCF), submitted the KanCare Evaluation Design to the Centers for Medicare & Medicaid Services (CMS) in August 2013; it was approved by CMS in September 2013 and updated in March 2015. The Kansas Foundation for Medical Care, Inc. (KFMC) is conducting the evaluation. KFMC also serves as the External Quality Review Organization (EQRO) for Kansas Medicaid managed care.

The KanCare Evaluation Design includes over 100 annual performance measures developed to measure the effectiveness of the KanCare demonstration managed care Medicaid program. A subset of the annual performance measures was selected to be assessed and reported quarterly. The quarterly measures for the first quarter (Q1) Calendar Year (CY) 2017 report include the following:

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

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

Quarterly and annual KanCare Evaluation topics and recommendations are discussed with MCO staff at quarterly KanCare interagency meetings that include participants from the State, the MCOs, and the EQRO and also at project-specific site visits at the MCO offices in Lenexa and Overland Park, Kansas.

Timely Resolution of Customer Service Inquiries

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

Data Sources

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

Current Quarter and Trend over Time

In Q2 CY2017, 99.5% of the 88,548 member customer service inquiries received by the MCOs and 99.98% of the 41,038 provider customer service inquiries were resolved within two business days (see Table 1). In each quarter to date prior to Q2 CY2017, the two-day resolution rate exceeded 99.5%. (Of the 471 member customer service inquiries not resolved within two business days in Q2, 439 were reported by UnitedHealthcare.)

Table 1. Timeliness of Resolution of Member and Provider Customer Service Inquiries - Quarter 2, CY2015 to CY2017

	Quarter 2					
	Member Inquiries			Provider Inquiries		
	CY2015	CY2016	CY2017	CY2015	CY2016	CY2017
Number of Inquiries Received	97,594	96,632	88,548	46,742	43,315	41,038
Number Resolved within 2 Business Days	97,587	96,441	88,078	46,742	43,312	41,028
Number Not Resolved within 2 Business Days	7	191	471	0	3	10
% Resolved Within 2 Business Days	99.99%	99.80%	99.47%	100%	99.99%	99.98%
Number Resolved within 5 Business Days	97,594	96,502	88,274	46,742	43,315	41,031
Number Not Resolved within 5 Business Days	0	130	274	0	0	7
% Resolved within 5 Business Days	100%	99.87%	99.69%	100%	100%	99.98%
Number Resolved within 15 Business Days	97,594	96,593	88,504	46,742	43,315	41,037
Number Not Resolved within 15 Business Days	0	39	44	0	0	1
% Resolved within 15 Business Days	100%	99.96%	99.95%	100%	100%	99.998%

In Q2 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days. Two of the three MCOs met the contractual requirements to resolve 100% of inquiries within 15 business days: Amerigroup and Sunflower reported 100% of their member and provider inquiries were resolved within five business days. UnitedHealthcare reported 99.95% of member inquiries and 99.998% of provider inquiries were resolved within 15 days; 44 member inquiries and one provider inquiry in Q2 CY2017 were reported as not resolved within 15 business days. All of the member inquiries not resolved within five business days in Q2 CY2017 (274) and in Q2 CY2016 (130) were reported by UnitedHealthcare.

Member Customer Service Inquiries

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

Table 2. Customer Service Inquiries from Members, Q1 CY2016 to Q2 CY2017

Member Inquiries	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
1. Benefit Inquiry – regular or VAS	21,924	22,319	21,652	18,152	17,675	**17,216**
2. Concern with access to service or care; or concern with service or care disruption	1,934	1,716	1,681	2,484	1,889	**1,978**
3. Care management or health plan program	1,597	1,584	1,363	1,177	1,010	**1,001**
4. Claim or billing question	6,416	6,381	5,557	4,838	5,764	**5,398**
5. Coordination of benefits	3,280	2,964	3,467	2,724	3,075	**3,280**
6. Disenrollment request	606	600	635	458	463	**524**
7. Eligibility inquiry	18,002	13,478	12,555	13,006	15,475	**14,420**
8. Enrollment information	3,203	2,396	2,558	2,632	3,900	**3,234**
9. Find/change PCP	12,893	12,488	12,906	8,586	10,519	**9,554**
10. Find a specialist	3,512	3,375	3,320	2,787	2,794	**3,043**
11. Assistance with scheduling an appointment	30	47	74	40	58	**88**
12. Need transportation	1,326	1,200	1,214	1,232	1,353	**1,594**
13. Order ID card	6,958	6,453	7,263	5,318	6,894	**6,190**
14. Question about letter or outbound call	1,322	1,961	1,338	1,143	1,134	**2,253**
15. Request member materials	1,083	1,119	976	920	732	**751**
16. Update demographic information	12,944	13,343	14,985	11,356	13,821	**12,568**
17. Member emergent or crisis call	699	687	597	676	655	**371**
18. Other	5,018	4,491	4,918	6,052	5,162	**5,085**
Total	**102,742**	**96,632**	**97,059**	**83,581**	**92,373**	**88,548**

- Benefit inquiries in Q2, as in previous quarters, had the highest percentage (19%) of member inquiries
- Of the 88,548 member customer service inquiries in Q2 CY2017, 46% were received by Sunflower, 33% by UnitedHealthcare, and 20% by Amerigroup.
- As in previous quarters, there are categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:
  - *Update demographic information*: 81% of 12,568 inquiries in Q2 CY2017 were reported by Sunflower (71% to 82% for last 11 quarters);
  - *Enrollment information*: 76% of 3,234 inquiries were reported in Q2 CY2017 by Amerigroup (69% to 81% for the last 11 quarters);
  - *Concern with access to service or care; or concern with service or care disruption*: 70% of 1,978 inquiries were reported in Q2 CY2017 by Sunflower (70% to 80% for last five quarters);
  - *Care management or health plan program*: 74% of 1,001 inquiries in Q2 CY2017 were reported by Amerigroup (74% to 86% in last five quarters);

  - *Member emergent or crisis call*: 99% of 371 inquiries in Q2 CY2017 were reported by Sunflower (99% to 99.8% in the last 11 quarters); and
  - *Need transportation*: 66% of 1,594 inquiries were reported in Q2 CY2017 by Amerigroup (66% to 77% in last three quarters).
- Sunflower continued to add a category for Health Homes (which were discontinued as of July 1, 2016); the 52 customer service inquiries reported in Q2 CY2017 as related to "Health Homes" were added to the "*Other*" category for consistency in reporting aggregated counts and percentages for the three MCOs.

The member customer service inquiry category "*Concern with access to service or care; or concern with service or care disruption*" seems to potentially describe contacts tracked as grievances or appeals in the State's quarterly GAR reports. In the last six quarters, the number of access-related inquiries reported as "customer service inquiries" ranged from 1,681 to 2,484; the number of *Access to Service or Care* grievances reported in grievance reports for the same time period ranged from 15 to 44. In response to the EQRO recommendation that "*the State should provide clear criteria to the MCOs for this category to ensure grievance and appeals contacts are not underestimated and misclassified as customer service inquiries*," KDHE staff met with KFMC and indicated they plan to include clarification of criteria for this metric in upcoming training of MCO staff in grievance reporting criteria. KDHE staff plan to closely monitor reporting of this metric to ensure member contacts that meet grievance or appeal criteria are not instead reported only as customer service inquiries.

Provider Customer Service Inquiries

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

- Of the 41,038 provider inquiries received by MCOs in Q2 CY2017, Amerigroup received 40%, Sunflower 48%, and UnitedHealthcare 13%.
- For providers, claim status inquiries were again the highest percentage (49.5%) of the 41,038 provider inquiries.
- Sunflower again added a category for provider inquiries related to Health Homes; the four provider inquiries reported in Q2 CY2017 as related "*Health Homes*" were added to the "*Other*" category for consistency in reporting aggregated counts and percentages for the three MCOs.

As noted in previous quarterly reports, there are a number of categories where aggregated data primarily reflect one MCO rather than all three over time. Categories where two thirds or more of the provider inquiries in Q2 were reported by one MCO included:

- *Authorization—New*: 99% of 1,561 inquiries in Q2 CY2017 were reported by Amerigroup (98% to 99% for last 11 quarters);
- *Authorization—Status*: 74% of 2,351 inquiries in Q2 CY2017 were reported by Amerigroup (73% in previous quarter);
- *Update demographic information*: 97% of 655 inquiries were reported in Q2 CY2017 by Sunflower (91% to 99.5% in last 11 quarters);
- *Web support*: 82% of 101 inquiries were reported in Q2 CY2017 by Sunflower (78% to 86% in last seven quarters); and
- *Recoupment or negative balance*: 98% of 40 inquiries in Q2 CY2017 were reported by Sunflower (68% to 98% in last four quarters).

Table 3. Customer Service Inquiries from Providers, Q1 CY2016 to Q2 CY2017

Provider Inquiries	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
1. Authorization – New	1,942	1,812	1,870	1,735	**1,707**	**1,561**
2. Authorization – Status	2,773	2,373	2,599	2,610	**2,497**	**2,351**
3. Benefits inquiry	3,259	3,121	3,273	2,215	**2,811**	**2,730**
4. Claim denial inquiry	5,605	4,423	5,540	3,920	**5,127**	**5,245**
5. Claim status inquiry	23,613	21,685	20,682	17,442	**17,519**	**20,320**
6. Claim payment question/dispute	4,575	4,142	3,725	3,948	**3,537**	**3,910**
7. Billing inquiry	596	389	407	317	**367**	**337**
8. Coordination of benefits	373	396	429	332	**348**	**283**
9. Member eligibility inquiry	2,030	1,646	1,754	1,389	**1,695**	**1,634**
10. Recoupment or negative balance	66	85	75	41	**83**	**40**
11. Pharmacy/prescription inquiry	598	529	583	475	**535**	**499**
12. Request provider materials	71	40	34	35	**52**	**42**
13. Update demographic information	744	710	549	554	**684**	**655**
14. Verify/change participation status	345	258	249	243	**293**	**243**
15. Web support	182	103	99	122	**139**	**101**
16. Credentialing issues	231	162	157	119	**160**	**147**
17. Other	1,918	1,441	1,784	1,781	**974**	**940**
Total	**48,921**	**43,315**	**43,809**	**37,278**	**38,528**	**41,038**

Of the 17 provider customer service inquiry categories, seven are claims-related: *Authorization—New*, *Authorization—Status*, *Benefit Inquiry*, *Claim Denial Inquiry*, *Claim Status Inquiry*, *Claim Payment Question/Dispute*, and *Billing Inquiry*. As shown in Table 4, the range of inquiries for these seven claims-related categories varied greatly, but consistently, by MCO. For the last 10 quarters, for example, Amerigroup has reported over 98% of the provider inquiries categorized as *Authorization—New,* and Sunflower has reported 0% of the *Claim Denial* provider inquiries.

Table 4. Maximum and Minimum Numbers of Claim-Related Provider Inquiries by MCO - Q3 CY2016 to Q2 CY2017

	CY2016				CY2017			
	Q3		Q4		Q1		Q2	
	Max	Min	Max	Min	Max	Min	Max	Min
Authorization - New	1,839	7	1,725	0	1,695	0	1,546	1
Authorization - Status	1,661	126	1,879	48	1,816	134	1,741	172
Benefits Inquiry	1,519	582	1,364	359	1,550	431	1,762	441
Claim Denial Inquiry	3,798	0	2,234	0	3,070	0	3,646	0
Claim Status Inquiry	11,845	2,911	10,047	1,367	10,011	1	12,903	670
Claim Payment Question/Dispute	1,745	346	2,275	148	1,971	127	2,688	74
Billing Inquiry	247	2	170	0	241	1	217	0

Amerigroup UnitedHealthcare
Sunflower

Combining the seven claims-related inquiries may allow a better comparison over time overall and by MCO. As shown in Table 5, the number of claims-related provider inquiries reported by the MCOs since January 2016:

- UnitedHealthcare reported 42% to 70% fewer provider inquiries than Amerigroup and Sunflower, with inquiries ranging from 4,289 (Q4 CY2016) to 8,362 (Q3 CY2016).
- The overall number of claims-related provider inquiries increased 9% from Q1 to Q2 CY2017; however, compared to Q2 CY2016, there was a 4% decrease in Q2 CY2017.
- Sunflower provider inquiries decreased each quarter from 18,706 in Q1 CY2016 to 13,213 in Q1 CY2017, and then increased to 16,787 in Q2 CY2017;
- Amerigroup provider inquiries in Q2 CY2017 decreased slightly (2%) compared to Q1 CY2017 and compared to Q2 CY2016.

Table 5. Combined Totals of the Seven Claims-Related Provider Inquiry Categories by MCO, Q1 CY2016 to Q2 CY2017

	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
Amerigroup	16,373	14,967	14,479	14,354	15,015	14,663
Sunflower	18,706	16,182	15,255	13,544	13,213	16,787
UnitedHealthcare	7,284	6,796	8,362	4,289	5,337	5,004
Total	42,363	37,945	38,096	32,187	33,565	36,454

Follow-up on Previous Recommendations (Timely Resolution of Customer Service Inquiries)

- *The State should provide clear criteria to the MCOs for the member customer service category "Concern with access to service or care; or concern with service or care disruption" to ensure grievance and appeals contacts are not underestimated and misclassified as customer service inquiries.*

  Follow-up response: KDHE staff indicated they plan to provide additional direction to MCO staff in upcoming trainings as to when a customer service inquiry related to "*concern with access to service or care; or concern with service or care disruption*" should instead be categorized as a grievance or appeal.

Recommendations (Timely Resolution of Customer Service Inquiries)

1. The MCOs should ensure all staff responding to customer service inquiries are categorizing the inquiries based on State-specified criteria.
2. After additional MCO training is completed, the State should consider reviewing a sample of customer service inquiries categorized as "*concern with access to service or care; or concern with service or care disruption*" to ensure contacts that should be categorized as grievances and appeals are not instead reported as customer service inquiries.
3. MCOs should include the State-specified member and provider customer service inquiries in the drop-down menu options available to customer service staff responding to member inquiries.

Timeliness of Claims Processing

Claims, including those of MCO vendors, are to be processed within 30 days if "clean" and within 60 days if "non-clean"; all claims, except those meeting specific exclusion criteria, are to be processed within 90 days. Claims excluded from the measures include "*claims submitted by providers placed on prepayment review or any other type of payment suspension or delay for potential enforcement issues*" and "*any claim which cannot be processed due to outstanding questions submitted to KDHE*."

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; claims from a providers under investigation for fraud or abuse; and/or claims under review for medical necessity.

Claims received in the middle or end of a month may be processed in that month or the following month(s). Since a non-clean claim may take up to 60 days to process, a claim received in mid-March, for example, may be processed in March or may not be processed until early May and still meet contractual requirements. To allow for claims lag, the KanCare Evaluation Report for Q2 CY2017 assesses timeliness of processing clean, non-clean, and all claims reports received through Q1 CY2017 (see Table 6).

Data Sources

In monthly Claims Overview reports, MCOs report the monthly number of claims received and processed, including whether or not these claims were processed in a timely manner as defined by the type of claim and State-specified timelines. The report also includes average turnaround time (TAT) for processing clean claims. Due to claims lag, claims processed in one month may be from that month or from a month or two prior to that month.

Beginning in 2015, timeliness of claims processing metrics were added to the State's pay-for-performance incentive program. Metrics in 2015 through 2017 include incentives for the MCOs to process 99.5% of clean claims within 20 days (instead of the contractually required 30 days) and to process 99% of all claims within 60 days (instead of the contractually-required 90 days).

Timeliness of Claims Processing by Claim Type and Date Received

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

For claims received in Q1 CY2017:

- **Clean claims**:
  - None of the MCOs met the contractual requirement to process 100% of clean claims within 30 days.
  - 99.96% of 4,331,720 clean claims received in Q1 CY2017 were reported by the MCOs as processed within 30 days.
  - Of the 1,770 clean claims not processed within 30 days – 1,391 (79%) were claims received by UnitedHealthcare; 185 (11%) were claims received by Amerigroup; and 185 (11%) were claims received by Sunflower.

Table 6. Timeliness of Claims Processing, Q1 CY2016 to Q1 CY2017					
	CY2016				CY2017
	Q1	Q2	Q3	Q4	Q1
Clean Claims					
Clean claims received in quarter	4,380,378	4,248,060	4,052,640	4,242,248	4,332,165
Number of claims excluded	263	88	61	709	445
Number of clean claims not excluded	4,380,115	4,247,972	4,052,579	4,241,539	4,331,720
Clean claims received within quarter processed within 30 days	4,378,159	4,246,507	4,050,603	4,239,788	4,329,950
Clean claims received within quarter not processed within 30 days	1,956	1,465	1,976	1,751	1,770
Percent of clean claims processed within 30 days	99.96%	99.97%	99.95%	99.96%	99.96%
Non-Clean Claims					
Non-clean claims received in quarter	198,558	157,210	182,401	217,957	238,370
Number of claims excluded	2,974	1,434	1,344	1,372	1,617
Number of non-clean claims not excluded	195,584	155,776	181,057	216,585	236,753
Non-clean claims received within quarter processed within 60 days	195,335	155,608	180,909	211,621	235,719
Non-clean claims received within quarter not processed within 60 days	249	168	148	4,964	1,034
Percent of non-clean claims processed within 60 days	99.87%	99.89%	99.92%	97.71%	99.56%
All Claims					
All claims received in quarter	4,578,936	4,405,270	4,235,041	4,460,205	4,570,535
Number of claims excluded	3,237	1,522	1,405	2,081	2,062
Number of claims not excluded	4,575,699	4,403,748	4,233,636	4,458,124	4,568,473
Number of all claims received within quarter processed within 90 days	4,575,552	4,403,630	4,233,492	4,457,945	4,568,285
Number of all claims received within quarter not processed within 90 days	147	118	144	179	188
Percent of all claims processed within 90 days	99.997%	99.997%	99.997%	99.996%	99.996%

- **Non-clean claims**:
  - In Q1 CY2017, all three MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
  - 99.6% of 236,753 non-clean claims received in Q1 CY2017 were reported by the MCOs as processed within 60 days.
  - Of the 1,034 non-clean claims not processed within 60 days – 208 were claims received by Amerigroup; 563 were claims received by Sunflower; and 263 were claims received by Sunflower.
- **All claims**:
  - 99.996% of 4,568,473 "all claims" received in Q1 CY2017 were reported by the MCOs as processed within 90 days.
  - None of the MCOs met the requirement of processing 100% of claims within 90 days.
  - Of the 188 claims not processed within 90 days – 170 were claims received by Amerigroup; 13 were claims received by Sunflower; and five were claims received by UnitedHealthcare.

During the annual performance measure validation process for the claims-related P4P claims metrics, KFMC found some differences by each of the MCOs in interpretation of reporting criteria for claims processing timeliness. MCOs each made corrections in their reporting processes that will now allow more accurate aggregation of the three MCOs' quarterly claims data. The P4P claims metrics, however, differ from the contractual timeliness criteria summarized in the KanCare Quarterly Evaluation Reports. The P4P standard for processing of all claims, for example, is 98.75% within 40 days, compared to the contractual standard of 100% within 90 days. The claims data reported in Table 6 for 2017 have not yet been updated to reflect the criteria revisions, as additional coding is required based on the contractual time period differences. It is anticipated these corrections will be reflected in the Quarter 3 KanCare Quarterly Evaluation report.

Average Turnaround Time for Processing Clean Claims

As indicated in Table 7, the MCOs reported 4,439,117 clean claims processed in Q2 CY2017 (includes claims received prior to Q2). Excluding 1,722,540 pharmacy claims (which are processed same day), there were 2,716,577 clean claims processed.

Table 7. Average Monthly Turnaround Time Ranges for Processing Clean Claims, by Service Category - Comparison of Current and Previous Quarter and Annual Monthly Ranges

Service Category	Current and Previous Quarter		Annual Monthly Ranges		
	Q1 CY2017	Q2 CY2017	CY2014	CY2015	CY2016
Hospital Inpatient	7.5 to 14.7	**6.0 to 15.6**	5.0 to 19.2	6.4 to 15.9	7.1 to 18.4
Hospital Outpatient	4.5 to 10.1	**4.7 to 9.8**	3.6 to 12.8	3.5 to 10.8	4.0 to 12.9
Pharmacy	same day	**same day**	same day	same day	same day
Dental	6.0 to 13.0	**6.0 to 13.0**	2.0 to 21.0	4.0 to 13.1	6.0 to 13.0
Vision	6.0 to 12.8	**6.0 to 12.0**	7.0 to 12.5	9.0 to 12.5	7.0 to 12.7
Non-Emergency Transportation	11.4 to 14.0	**11.0 to 13.0**	10.9 to 18	10.4 to 16	9.0 to 14.4
Medical (Physical health not otherwise specified)	4.7 to 9.4	**5.0 to 9.8**	3.3 to 10.6	3.4 to 10.5	4.2 to 10.7
Nursing Facilities	5.0 to 10.5	**4.3 to 9.6**	4.3 to 11.5	4.1 to 9.7	4.6 to 9.0
HCBS	5.7 to 9.3	**6.4 to 9.1**	3.2 to 15.6	4.1 to 10.2	5.7 to 10.8
Behavioral Health	4.2 to 9.9	**3.8 to 9.6**	3.4 to 8.6	2.7 to 10.5	4.1 to 11.7
Total Claims (Including Pharmacy)	4,645,537	**4,439,117**	16,763,501	17,820,402	17,820,402
Total Claims (Excluding Pharmacy)	2,854,942	**2,716,577**	10,370,998	10,999,807	10,999,807
Average TAT (Excluding Pharmacy)	**5.3 to 9.7**	**5.5 to 9.9**	**4.3 to 11.5**	**4.3 to 10.3**	**5.0 to 10.6**

The average TAT for Total Services (excluding pharmacy claims) was 5.5 to 9.9 days in Q2 CY2017, compared with 5.3 to 9.7 in Q1 and 5.0 to 9.9 days in Q4 (CY2016). Amerigroup had the shortest total TAT (5.5 to 6.5), compared to Sunflower (8.5 to 8.8) and UnitedHealthcare (9.1 to 9.9).

It should be noted that the average TAT monthly ranges reported in Table 7 only include clean claims processed by the MCOs and do not include clean claims received but not yet processed. Also, the average TATs reported for *Total Claims* are weighted averages calculated after excluding pharmacy claims.

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

- **Hospital Inpatient** – Hospital Inpatient claims had TATs in Q2 CY2017 ranging from 6.0 to 15.6 days. Amerigroup had the shortest TAT in Q2 (6.0 to 10.5), compared to Sunflower (10.9 to 11.9) and UnitedHealthcare (14.5 to 15.6).
- **Medical** – Medical claims had monthly TATs in Q2 ranging from 5.0 to 9.8 days. Amerigroup had the shortest TATs (5.0 to 6.0), and UnitedHealthcare had the highest (9.0 to 9.8). Sunflower's TATs ranged from 8.1 to 8.6 days in Q2.
- **Nursing Facilities** – Nursing Facility claims had TATs ranging from 4.3 to 9.6 days in Q2. Amerigroup had the shortest TATs (4.3 to 6.0), and Sunflower had the longest TATs (9.1 to 9.6) in Q2. UnitedHealthcare's TATs ranged from 7.1 to 8.3 days in Q2.
- **Dental** - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q2 CY2017. Sunflower had the shortest TATs (6.0 to 8.0); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q2 CY2016 and the previous six quarters.
- **Behavioral Health** – Behavioral Health claims TATs ranged from 3.8 to 9.6 days in Q2 CY2017. Amerigroup had the shortest TATs (3.8 to 4.8), compared to Sunflower (8.3 to 8.5) and UnitedHealthcare (7.9 to 9.6).
- **Vision** – The average monthly TATs for Vision in Q2 ranged from 6.0 to 12.8 days. Amerigroup had the shortest monthly TATs (6.0 to 7.0), compared to Sunflower (11.0 to 12.0) and UnitedHealthcare (11.9).

Follow-up on Previous Recommendations (Timeliness of Claims Processing)

- *Top promote consistency in reporting by MCOs, the State should consider revising the criteria for the Claims Overview quarterly reports to better correspond to the criteria used in the P4P reporting for the claims metrics.*
  Follow-up response: Staff from KDHE and the MCOs are in agreement with revising the criteria for the Claims Overview monthly reports to better correspond to the criteria used by the MCOs when reporting claims processing data for the validated P4P claims-related metrics. The time periods for revising past monthly Claims Overview reports to reflect the updated criteria are under review. This recommendation is in process; an update will be provided in the Q3 CY2017 KanCare Evaluation Report.
- *The State should provide guidance to the MCOs as to whether corrections should be made in any of the data for prior months where vendors' claims processing reporting did not follow State reporting criteria.*
  Follow-up response: KDHE staff agree that criteria for tracking and reporting of timeliness of claims processing does not differ for vendors. The time period for correcting monthly Claims Overview reports is under review. This recommendation is in process; an update will be provided in the Q3 CY2017 KanCare Evaluation Report.
- *The State should provide additional direction to the MCOs as to appropriate processing times newborn claims. If newborn claims are not to be excluded from the 90-day processing requirement for "all claims," additional direction should be provided as to whether previous quarterly reports should be updated to include processing of newborn claims within the 90-day time period.*
  Follow-up response: KDHE staff are considering revisions to the Claims Overview monthly report that will ensure appropriately tracking and reporting of timeliness in processing of newborn claims. This recommendation is still in process.

Grievances

Data Sources

Grievances are reported and tracked on a quarterly basis by MCOs in the Grievance and Appeal (GAR) report. The report tracks the number of grievances received in the quarter, the number of grievances closed in the quarter, the number of grievances resolved within 30 business days, and the number of grievances resolved within 60 business days. The GAR report also provides detailed descriptions of each of grievance resolved, including narratives of grievance descriptions and resolution, category type, date received, Medicaid ID, waiver type, and number of business days to resolve.

Track Timely Resolution of Grievances

Quarterly tracking and reporting of timely resolution of grievances in the KanCare Evaluation are based on the MCOs' contractual requirements to resolve 98% of all grievances within 30 business days and 100% of all grievances within 60 business days (via an extension request). The number of grievances reported as resolved in a quarter includes some grievances from the previous quarter. As a result, the number of grievances reported as "received" each quarter does not (and is not expected to) equal the number of grievances "resolved" during the quarter (see Table 8).

Table 8. Timeliness of Resolution of Grievances - Q3 CY2016 to Q2 CY2017

	CY2016		CY2017	
	Q3	Q4	Q1	Q2
Grievances received in quarter	452	406	412	458
Grievances resolved in quarter*	446	395	412	447
Grievances resolved within 30 business days*	387	395	410	441
Percent resolved within 30 business days	86.8%	100%	99.5%	98.7%
Grievances not resolved within 30 business days	59	0	2	6
Grievances resolved within 60 business days*	446	395	412	446
Percent resolved within 60 business days*	100%	100%	100%	99.8%
Grievances closed in quarter not resolved in 60 business days*	0	0	0	1

*Grievances resolved in the quarter include grievances received in the previous quarter.

In Q2 CY2017, 98.7% (441) of the 447 grievances reported by the MCOs as resolved in Q2 were reported as resolved within 30 business days, and 99.8% were reported to be resolved within 60 business days. Of the 447 grievances resolved in Q2 CY2017, 137 (27%) were reported by Amerigroup, 152 (34%) by Sunflower, and 174 (39%) by UnitedHealthcare.

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

All Grievances

In Q2 CY2016, grievances and appeals categories were updated, and KDHE staff provided training to MCO staff to clarify criteria for each category, and provided more detailed grievance and appeal criteria definitions and examples in the reporting template to promote more accurate and consistent reporting. In reviewing of the grievance descriptions and resolution details each quarter, however, many grievances each quarter continue to appear to be misclassified. In response, KDHE is planning to provide

additional training to MCO staff and has increased staff review and response to MCOs related to apparent misclassifications. Based on the grievance descriptions and resolution details in the Q2 CY2017 GAR report, up to 30% of the grievances may be misclassified (see Table 9).

Table 9. Comparison of Grievances as Categorized by MCOs and Based on Grievance Descriptions Q2 CY2017*

	As categorized by MCOs		Based on Grievance Descriptions	
	# grievances	# members	# grievances	# members
Billing and Financial Issues	77	72	82	76
Access to Service or Care	20	20	13	13
Quality of Care (non-HCBS)	8	8	33	32
Quality of Care^	45	43	-	-
Quality of Care - HCBS	9	8	14	12
Customer Services	42	38	30	30
Pharmacy Issues	21	20	12	11
Member's Rights/Dignity	15	13	11	11
Value-Added Benefit	3	3	11	11
Transportation Issue	83	79	66	64
Transportation Safety	16	16	22	22
Transportation No Show	44	44	58	54
Transportation Late	53	49	53	50
Other	11	11	10	10
Appeal-related	-	-	*40*	*39*
Total	447	424	455	435

*Includes grievances received in Quarter 1 CY2017 resolved in Quarter 2 CY2017.
^UnitedHealthcare categorized 1 of 46 grievances as HCBS-related. All others were categorized only as "Quality of Care."

There are a number of difficulties MCOs may encounter when categorizing grievances. Examples of potential misclassifications and barriers in Q2 include:

- Appeals - KFMC identified 40 “grievances” that may potentially meet “appeals” criteria. As the appeal process steps differ from those of grievances, accurate categorization of appeals is critical; whenever there is doubt as to whether the grievance should be processed as an appeal, MCOs should seek assistance from KDHE staff. Categories with grievances that are potential appeals this quarter included *Pharmacy Issues*, *Quality of Care*, *Access to Service or Care*, *Billing or Financial Issues*, *Customer Service*, *Member Rights/Dignity*, and *Transportation Issues*. Examples include calls related to reduction of care giver hours, removal of respite care, appeal of lock-in, and denial of services and supplies.
- More than one grievance category – When member contacts include more than one grievance in a call, each grievance should be separately reported to ensure each is appropriately addressed. As indicated in Table 9, instead of 447 grievances from 424 members, there may instead have been 455 grievances from 435 members (also assuming 40 grievances were not actually appeals).

- Duplicates – A few grievances had duplicate information in all fields. As the summary data totals match the number of grievances resolved (that includes the duplicates), it raises questions as to whether the error was including the duplicates in the counts or whether an error occurred that resulted in excluding another grievance.
- Not using State-specified categories – UnitedHealthcare again this quarter did not categorize quality of care grievances using the State-specified category (*Quality of Care – non-HCBS, non-Transportation*). For several of these grievances, not enough details were provided to be able to determine whether or not the quality of care grievances were HCBS-related.
- No hierarchy in prioritizing grievances – Some grievances could arguably meet more than one grievance (or appeal) category. For example, *Access to Service or Care* criteria includes "*complaints about non-covered services,*" which in some instances may be more appropriately categorized and processed as an appeal. *Quality of Care (non-HCBS, non-Transportation)* includes grievances where "*it is determined necessary to forward to the QOC department for investigation*"; several grievances this quarter that were categorized as *Access to Service or Care* included resolution details indicating the grievances were forwarded to the QOC staff for investigation.
- MCO drop down menu options – MCOs should make sure that the State-defined categories for grievances (and for customer service inquiries) are available in drop-down menus for MCO staff categorizing grievances (and appeals) as they are received from the members.
- Errors and omissions – One member with three grievances was listed as "Frail Elderly" for a quality of care grievance, "SED" for a second quality of care grievance, and as no waiver for a transportation-related grievance. All three had the same member identification number. Since the transportation-related grievance was from a member concerned about exposure to second-hand smoke while she is pregnant, it seemed highly unlikely that the member was "frail elderly."

Grievance categories with the highest number of potential misclassifications this quarter included:

- 30 grievances categorized as *Quality of Care* that may be better categorized as *Customer Service, Billing and Financial Issues, Value-Added Benefits*, *Access to Service or Care*, *Member Rights/Dignity*, *Other*, or as appeals;
- 24 grievances categorized as *Customer Service*, but, based on their descriptions, could be *Billing and Financial Issues, Quality of Care (non-HCBS, non-Transportation), Quality of Care - HCBS, Value-Added Benefits*, *Access to Service or Care*, *Member Rights/Dignity*, *Transportation Issues*, *Other*, or as appeals; and
- 20 grievances categorized as general *Transportation Issues* that, based on their descriptions, should more appropriately be categorized as *Transportation Late, Transportation No Show, Transportation Safety, Quality of Care – HCBS, Billing and Financial Issues,* or as appeals.

Transportation-related grievances continued to be the most frequently reported grievances; MCOs reported resolution of 199 transportation-related grievances, up from 182 and 164 in the previous two quarters. Of the 199 transportation-related grievances, 58 (29%) were reported by Amerigroup, 82 (41%) were reported by Sunflower, and 59 (30%) were reported by UnitedHealthcare. The number of "No Show" and "Late" transportation grievances continued to be high, with 58 "No Show" grievances and 53 "Late" grievances in Q2 (based on grievance descriptions). Of concern is the number of *Transportation – Safety* grievances (22 in Q2, up from 13 in Q1).

Also of concern again in Q2 is the number of Amerigroup grievances (categorized as *Transportation Issues*) indicating the transportation vendor was unable to provide the member with transportation, despite the member contacting ahead of time appropriately. Based on grievance details, there were at

least 13 occasions reported where the member was told no driver was available. In response to this issue, KDHE is adding a *No Driver Available* category to future GAR reports to improve tracking. Also of note this quarter were grievances where members reported transportation providers arriving early. A primary concern is where the driver arrives early and then does not wait until the arrival time requested by the member. In one grievance, the driver showed up "*90 minutes early*" for the appointment. The resolution details advised, "*Drivers can only wait 5-10 mins for mbrs (sic) before having to leave*."

Of 455 grievances in Q2 (based on grievance descriptions), 164 (36%) were from 148 members receiving waiver services, up from 139 grievances reported by 136 members in Q1. Table 10 shows the number of grievances by category and by waiver group.

Table 10. Grievances Reported by Waiver Members Resolved in Q2 CY2017*

	Number of Grievances by Waiver Type						
	FE	I/DD	PD	SED	TA	Autism	TBI
Billing and Financial Issues	2	5	8	2			
Access to Service or Care		3	1	1			
Quality of Care (non-HCBS)		3	3	2			
Quality of Care - HCBS	4	1	6	1			1
Customer Service	2	1	6				
Pharmacy Issues		2	1				
Member's Rights/Dignity	1	2	2				
Value-Added Benefit			1				
Transportation Issue	3	2	15	1	1		2
Transportation Safety	1	1	7				1
Transportation No Show	5	2	14				
Transportation Late	5	2	15		1		1
Other	3	2	3				
Appeal-related	*1*	*2*	*8*	*2*	*0*	*1*	*1*
Total	27	28	90	9	2	1	6

*Counts are based on grievances as described by MCOs.

As shown in Table 11, the percentage of transportation-related grievances was higher among waiver members (48% in Q2) compared to members not receiving waiver services (41% in Q2). The number of transportation-related grievances received from waiver members was higher in Q2 CY2017 than the six previous quarters. Of 164 grievances received from 148 waiver members in Q2, 79 (48%) were transportation-related.

- Physical Disability (PD) Waiver members had the most grievances in Q2, with 82 members reporting 90 grievances, 51 (57%) transportation-related. In Q1, 69 PD waiver members reported 71 grievances, 41 transportation-related.
- Intellectual/Developmental Disability (I/DD) Waiver members (27) in Q2 reported 28 grievances, up from 11 grievances in Q1; 7 (25%) of the 27 grievances were transportation-related.
- Frail Elderly (FE) Waiver members (25) reported 27 grievances in Q2, down from 31 grievances the previous quarter; 14 (52%) of the 27 grievances were transportation-related.

- Traumatic Brain Injury (TBI) Waiver members (6) reported six grievances (down from 13 grievances in Q1); four (67%) of the six grievances were transportation-related.
- Technology Assistance (TA) Waiver members (3) reported three grievances in Q2, two (67%) transportation-related.
- Serious Emotional Disturbance (SED) Waiver members (9) reported nine grievances in Q2, one (11%) transportation-related.
- Autism Waiver members reported one grievance in Q2 that was not transportation-related.

Table 11. Transportation-Related Grievances Resolved in Q1 to Q2 CY2017, by Waiver

	# Grievances		# Transportation Related		% Transportation Related	
	Q1	Q2	Q1	Q2	Q1	Q2
Physical Disability (PD)	71	90	41	51	58%	57%
Frail Elderly (FE)	31	27	17	14	55%	52%
Intellectual/Developmental Disability (I/DD)	11	28	4	7	36%	25%
Traumatic Brain Injury (TBI)	13	6	5	4	38%	67%
Serious Emotional Disturbance (SED)	8	9	2	1	25%	11%
Technology Assisted (TA)	5	3	1	2	20%	67%
Autism	0	1	NA	0	NA	0%
Waiver Member Grievances	139	164	70	79	50%	48%
Non- Waiver Member Grievances	265	291	112	120	42%	41%
All Member Grievances	404	455	182	199	45%	49%

Access-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Access to Service or Care* criteria are those where "*Appointment availability, no providers available within distance standards, timeliness to get appointment, complaints about non-covered services (other than pharmacy), MCO system issue error – (eligibility not updated, TPL not current, processing error) difficulty finding HCBS provider*."

Of 447 grievances as categorized by MCOs in the Q2 GAR report, 20 (4.5%) were categorized as *Access to Service or Care.* Based on grievance descriptions, however, there may have been only 13 in Q2 that met the criteria for the *Access to Service or Care* category.

- Based on the GAR report criteria, up to 16 of the 20 grievances categorized as *Access to Service or Care* may more appropriately be categorized as *Quality of Care (non HCBS, non-Transportation)* (6), *Quality of Care – HCBS* (1), *Value-Added Benefit* (1), *Billing or Financial Issues* (1), *Other* (1), and six that may meet appeals criteria.
- Based on grievance descriptions, nine grievances categorized as *Customer Services* (4), *Member Rights/Dignity* (1), *Other* (1), *Quality of Care* (2), and *Quality of Care (non-HCB, non-Transportation)* (1) may be better categorized as *Access to Service or Care*.

Quality-Related Grievances

Definitions and examples in the GAR report of grievances meeting *Quality of Care (non-HCBS, non-Transportation)* criteria are those where "*Provider/Staff error or neglect in delivery of any health care services, e.g., someone is hurt, or it is determined necessary to forward to the QOC department for investigation. Additional examples: someone is dropped during transfer, doctor operates on wrong site, wrong medication administered, neglect*."

Definitions and examples in the GAR report of grievances meeting *Quality of Care - HCBS* criteria are those where "*Provider/Staff error or neglect in delivery of any HCBS services, e.g., mistreatment of member, not providing service as specified in support plan or plan of care.*"

Of 447 grievances categorized in the Q2 GAR report, 8 were categorized by the MCOs as *Quality of Care (non-HCBS, non-Transportation)*, 9 were categorized as *Quality of Care – HCBS*, and 45 were categorized by UnitedHealthcare as *Quality of Care*.

- Based on the GAR report criteria:
  - 2 of the 8 grievances categorized as *Quality of Care (non-HCBS, non-Transportation)* may more appropriately be categorized as *Access to Service or Care* and *Customer Services*;
  - 1 of the 9 grievances categorized as *Quality of Care – HCBS* may more appropriately be categorized as *Quality of Care (non-HCBS, non-Transportation);* and
  - Of the 45 grievances categorized by UnitedHealthcare as *Quality of Care*:
    - 14 should be categorized as *Quality of Care (non-HCBS, non-Transportation);*
    - 1 should be categorized as *Quality of Care – HCBS;*
    - 9 may be better categorized as *Customer Services*;
    - 4 may be better categorized as *Billing or Financial Issues*;
    - 3 may be better categorized as *Value-Added Benefit*;
    - 2 may be better categorized as *Access to Service or Care*;
    - 1 may be better categorized as *Member Rights/Dignity*;
    - 4 may be better categorized as *Other*; and
    - 7 may meet criteria as appeals.
- Based on grievance descriptions:
  - 12 grievances categorized as *Access to Service or Care* (7), *Customer Services* (3), *Member Rights/Dignity* (1), and *Billing or Financial Issues*1) may be better categorized as *Quality of Care (non-HCBS, non-Transportation)*.
  - 2 grievances categorized as *Transportation Issues* may be better categorized *as Quality of Care – HCBS.*

Follow-up on Previous Recommendations (Grievances)

- *The State should work with the MCOs to identify corrective actions to address the high number of transportation grievances related to safety, "no show," late," errors in scheduling, and lack of vendor availability of transportation.*
  Follow-up response: KDHE has revised their processes to closely track and monitor transportation grievances, particularly those related to safety, no show, lateness, and lack of transportation availability. KDHE is also adding a transportation category "*No Driver Available*" to the quarterly GAR report to track the number of grievances where members are told no transportation providers are available.
- *MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.*
  Follow-up response: KDHE has assigned staff to specifically review the grievance and appeals descriptions and resolution details and provided feedback on to the MCOs on errors made in grievance and appeal categorization in the Q2 CY2017 GAR reports.
- *The State should review the grievances KFMC has identified as potentially misclassified to evaluate whether additional examples, grievance and appeal descriptions, and follow-up training should be provided to MCO staff routinely categorizing grievances.*
  Follow-up response: KDHE staff reviewed the grievance and appeals descriptions and resolution

details in Q2 CY2017 and provided feedback to MCOs on specific misclassifications of grievances and appeals. KDHE indicated to KFMC that additional follow-up training will be scheduled for MCO staff.

- *Due to the addition of the "Transportation Late" category, the State should update the Grievance definition of the "Transportation Issues" category to include "late" as an exclusion, i.e. "(other than no show, safety, or late)."*
  Follow-up response: KDHE has revised the GAR report to include "*Transportation – Late*" in the Grievance Definitions and added wording clarifying "*Late*" is an exclusion from the "*Transportation Issues*" category.
- *UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter. Resolution details should not be limited to verification that a letter of resolution was sent.*
  Follow-up response: As directed by the State, UnitedHealthcare provided more detailed descriptions in the GAR report of most of the grievances resolved in Q2 CY2017.
- *MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.*
  Follow-up response: KDHE has revised the STC report to focus instead on summary of outreach and advocacy activities conducted during the quarter. This recommendation is no longer applicable.
- *The State should consider using the same grievance and appeals categories in the STC and GAR reports to promote consistency and allow more complete assessment of grievances over time. The STC report categories should be reviewed to assess whether any of the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.*
  Follow-up response: KDHE has revised the STC report. Grievances and appeals will continue to be tracked and reported in detail in the GAR report. This recommendation is no longer applicable.

Recommendations (Grievances)

1. MCOs should ensure their staff categorize grievances using the revised categories and criteria.
   - Before submitting the GAR report to the State, MCOs should review the grievance detailed descriptions to identify those that may instead meet the criteria for appeals. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.
   - MCOs should review transportation-related grievances to ensure those related to no-show, lateness, safety issues, and lack of provider availability are categorized appropriately.
   - Each grievance should be categorized separately, even if the grievances are reported during one contact by phone or mail.
2. Drop-down menus used by MCO staff categorizing grievances should be reviewed and updated to include the State-specified categories for classifying grievances and appeals.
3. The State should consider developing a hierarchy of grievance categories to provide additional guidance where individual grievances may reasonably meet criteria in more than one grievance category.
4. UnitedHealthcare should identify whether QOC grievances are or are not HCBS-related.

Ombudsman's Office

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

Data Sources

The primary data source in Q2 CY2017 is the quarterly KanCare Ombudsman Update report.

Current Quarter and Trend over Time

Ombudsman Office assistance is provided by the Ombudsman (Kerrie Bacon), a Volunteer Coordinator, a Project Coordinator, and trained volunteers at satellite offices, including (as of March) one VISTA volunteer. Information (as well as volunteer applications) is also available on the Ombudsman's Office website, www.KanCare.ks.gov/kancare-ombudsman-office, and is provided to members by mail and email on an as-needed basis.

The Ombudsman's Office is located in Topeka, with satellite offices in Wichita and Olathe (Johnson County). Assistance is provided by phone and in person, by appointment, including assistance completing Medicaid applications.

- The Wichita satellite office provides onsite assistance from 10 a.m. to 5 p.m. Monday through Friday.
- The Johnson County satellite office in Olathe provides onsite assistance on Wednesdays (10 a.m. to 1 p.m.) and Thursdays (10 a.m. to 4 p.m.), with plans to provide assistance on Fridays (10 a.m. to 1 p.m.).

In Q2, liaison trainings focused on how to assist with Medicaid applications and an overview of KanCare programs and HCBS were provided by Ombudsman Office staff to four community service organizations in Wyandotte County, Johnson County, and Hays.

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

The Ombudsman's office tracks contacts by contact method, caller type, by specific issues, by location (main office or satellite office), and whether the contacts are MCO-related (see Table 12). In Q2 CY2017, 189 of 835 contacts were MCO-related.

Table 12. Ombudsman's Office Contacts - All and MCO-Related, CY2016 to Q2 CY2017

	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
All Contacts	**1,130**	**846**	**687**	**523**	**825**	**835**
*Main office**				*432*	*648*	*639*
*Olathe satellite office**				*21*	*28*	*81*
*Wichita satellite office**				*70*	*149*	*115*
MCO-Related Contacts	**250**	**150**	**141**	**108**	**178**	**189**
% MCO-Related Contacts	**22.1%**	**17.7%**	**20.5%**	**20.7%**	**21.6%**	**22.6%**

* Contacts by location began to be tracked and reported beginning in Q4 CY2016.

The Ombudsman's Office is also required to track contacts by geographic area; trends by geography, however, are not included in the Ombudsman's quarterly reports. According to Kerrie Bacon,

Ombudsman, callers' cities are often tracked, but many of the calls to the office are too short to gather additional demographic data and/or the callers prefer to not provide identifying information.

Since some contacts include more than one issue, the Ombudsman's Office tracks the number of certain issues addressed during contacts, including the number of issues that are MCO-related (see Table 13The most frequently reported issues quarterly to date have been *Medicaid Eligibility Issues* and HCBS-related issues. Beginning in Q1 CY2017, additional issue categories were added, including *Client Obligation*, *Medicaid Renewal*, *Medicaid Application Assistance*, *Medicaid Coding*, *Moving to/from Kansas*, and *Spenddown Issues*. In Q2, 261 (26%) of 996 issues addressed in 835 contacts were MCO-related.

Table 13. Issues tracked by Ombudsman's Office - All and MCO-Related, CY2016 to Q2 CY2017

	CY2016								CY2017			
	Q1		Q2		Q3		Q4		Q1		Q2	
	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related	All	MCO Related
Medicaid Eligibility Issues	**512**	**72**	**244**	**19**	**173**	**20**	**174**	**20**	**236**	**29**	**177**	**20**
Appeals, Grievances	**49**	**29**	**42**	**20**	**36**	**14**	**16**	**3**	**36**	**18**	**33**	**15**
Medical Services	**29**	**15**	**20**	**11**	**10**	**7**	**12**	**4**	**20**	**13**	**23**	**13**
Billing	**43**	**20**	**39**	**18**	**37**	**18**	**26**	**12**	**21**	**7**	**33**	**18**
Durable Medical Equipment	**7**	**7**	**7**	**5**	**2**	**1**	**4**	**3**	**2**	**2**	**9**	**5**
Pharmacy	**24**	**14**	**13**	**4**	**11**	**8**	**8**	**6**	**10**	**5**	**9**	**6**
HCBS - Total	**144**	**67**	**71**	**37**	**42**	**18**	**31**	**17**	**92**	**43**	**93**	**47**
HCBS General Issues	*69*	*39*	*32*	*17*	*16*	*6*	*15*	*11*	*33*	*18*	*34*	*20*
HCBS Eligibility Issues	*45*	*17*	*33*	*15*	*21*	*9*	*9*	*2*	*46*	*18*	*48*	*23*
HCBS Reduction in Hours of Service	*12*	*8*	*4*	*4*	*3*	*2*	*3*	*3*	*7*	*5*	*2*	*1*
HCBS Waiting List	*18*	*3*	*2*	*1*	*2*	*1*	*4*	*1*	*6*	*2*	*9*	*3*
Care Coordinator Issues	**7**	**6**	**3**	**2**	**6**	**6**	**4**	**4**	**5**	**5**	**11**	**7**
Transportation	**6**	**4**	**8**	**3**	**6**	**5**	**1**	**1**	**8**	**7**	**9**	**6**
Nursing Facility Issues	**40**	**7**	**7**	**5**	**22**	**4**	**22**	**4**	**38**	**5**	**25**	**6**
Housing Issues	**8**	**1**	**2**	**1**	**2**	**0**	**3**	**1**	**4**	**1**	**6**	**2**
Access to Providers	**7**	**4**	**6**	**3**	**9**	**4**	**13**	**4**	**14**	**11**	**14**	**12**
Change MCO	**15**	**7**	**3**	**2**	**0**	**0**	**6**	**5**	**3**	**3**	**1**	**1**
Dental	**4**	**2**	**5**	**5**	**5**	**3**	**5**	**1**	**7**	**1**	**9**	**4**
Client Obligation*									**17**	**6**	**35**	**13**
Medicaid Renewal*									**29**	**11**	**43**	**13**
Spenddown Issues*									**18**	**4**	**32**	**10**
Medicaid application assistance*									**46**	**1**	**54**	**1**
Medicaid Coding*									**3**	**2**	**0**	**0**
Moving to/from Kansas*									**5**	**1**	**7**	**1**
Other^	411	61	415	48	402	64	241	39	**319**	**51**	**373**	**61**
Total Issues - All & MCO-Related	**1,450**	**383**	**957**	**220**	**807**	**190**	**599**	**141**	**1,028**	**270**	**996**	**261**

* Categories added in Q1 CY2017

^Includes issues categorized as "Other," "Affordable Care Act," Estate Recovery," and "Unspecified"

The Ombudsman's Office also reports contact issues by waiver-related type. As shown in Table 14, there were 116 waiver-related contacts in Q2, The most frequent waiver-related issues in Q2 were related to the PD Waiver (37), I/DD Waiver (27), and FE Waiver (27).

Table 14. Waiver-Related Inquiries to Ombudsman, Q1 CY2016 to Q2 CY2017

Waiver	CY2016				CY2017	
	Q1	Q2	Q3	Q4	Q1	Q2
Intellectual/Developmental Disability (I/DD)	48	27	21	11	43	27
Physical Disability (PD)	48	22	13	9	40	37
Technology Assisted (TA)	10	9	4	4	8	10
Frail Elderly (FE)	23	19	10	7	30	27
Traumatic Brain Injury (TBI)	10	3	7	5	6	8
Serious Emotional Disturbance (SED)	4	0	1	3	4	4
Autism	1	2	2	1	3	2
Money Follows the Person (MFP)	8	5	3	0	2	1
Total	**152**	**87**	**61**	**40**	**136**	**116**

The GAR report, which included details of grievances and appeals and resolution details and dates, is submitted to KDHE, but not to the Ombudsman's Office. Tracking of resolutions of issues from KanCare members who contact the Ombudsman's Office could potentially be enhanced by review by the Ombudsman of the grievance details provided by the MCOs to the State in the quarterly GAR reports.

Recommendations (Ombudsman's Office)

1. Copies of the quarterly GAR reports should be made available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports, where applicable.

Conclusions Summary

Timely Resolution of Customer Service Inquiries

- In Q2 CY2017, 99.5% of the 88,548 member customer service inquiries and 99.98% of the 41,038 provider customer service inquiries received by the MCOs were resolved within two business days.
- In Q2 CY2017, all three MCOs met contractual requirements for resolving at least 98% of customer service inquiries within five business days.
- Two of the three MCOs met the contractual requirements to resolve 100% of inquiries within 15 business days: Amerigroup and Sunflower reported 100% of their member and provider inquiries were resolved within five business days. UnitedHealthcare reported 99.95% of member and provider inquiries were resolved within 15 days; 44 member inquiries and five provider inquiries in Q2 CY2017 were reported as not resolved within 15 business days.

- The criteria used by the MCOs to categorize member and provider inquiries continue to vary by MCO. As a result, aggregated data for certain categories are more representative of only one of the MCOs rather than all three.
- Member customer service inquiries
  - The member customer service inquiry category "*Concern with access to service or care; or concern with service or care disruption"* seems to potentially describe contacts tracked as "grievances" or "appeals" in the State's quarterly "GAR" grievance reports. In Q3 CY2017, the MCOs received 1,978 contacts in this category that were in addition to the grievances and appeals reported by members. In upcoming training for MCO staff, KDHE plans to include direction as to criteria that indicate the "inquiry" should instead be categorized as a grievance or appeal.
  - Of the 88,548 member customer service inquiries in Q2 CY2017, 46% were received by Sunflower, 33% by UnitedHealthcare, and 20% by Amerigroup.
  - Benefit inquiries were the highest percentage (19%) of member inquiries in Q2.
  - As in previous quarters, there were categories where two thirds or more of the inquiries in the quarter were reported by one MCO. This seems likely to be due to differing interpretations of the criteria for several of the categories in the reporting template. The categories where over two thirds of the reported inquiries were from one MCO include:
    - *Care management or health plan program*,
    - *Concern with access to service or care; or concern with service or care disruption*,
    - *Member emergent or crisis call,*
    - *Update demographic information*,
    - *Enrollment information*, and
    - *Need transportation*."
- Provider customer service inquiries
  - Of the 41,038 provider inquiries received by MCOs in Q2 CY2017, Amerigroup received 40%, Sunflower 48%, and UnitedHealthcare 13%.
  - For providers, claim status inquiries were again the highest percentage (49.5%) of provider inquiries.
  - Categories where two-thirds or more of the provider inquiries in Q2 were reported by only one MCO included:
    - *Authorization – New*,
    - *Authorization – Status*,
    - *Update demographic information*,
    - *Web support*, and
    - *Recoupment or negative balance*.
  - Of the 17 provider inquiry categories, seven are focused on claims; the range of inquiries for each of the seven varied greatly by MCO. The combined total number of inquiries for these seven categories may allow better comparison of overall claims-related inquiries. In the last three quarters, for example, UnitedHealthcare reported 60-70% fewer overall claims-related provider inquiries than Amerigroup and Sunflower during the same time period.

Timeliness of Claims Processing

- **Timeliness of meeting contractual requirements for processing clean claims within 30 days, non-clean claims within 60 days, and all claims within 90 days**
  - In Q1 CY2017, none of the MCOs met the contractual requirement to process 100% of clean claims within 30 days. Of 4,331,720 clean claims received in Q1 CY2017, however, 99.96% were processed within 30 days. Of the 1,770 clean claims not processed within 30 days, 1,391 (79%)

were claims received by UnitedHealthcare; 185 (11%) were claims received by Amerigroup; and 185 (11%) were claims received by Sunflower.

- In Q1 CY2017, all three MCOs met the contractual requirement of processing at least 99% of the non-clean claims within 60 days.
- Of 4,568,473 "all claims" received in Q1 CY2017, 99.996% were processed within 90 days. None of the MCOs met the requirement of processing 100% of claims within 90 days. Of the 188 claims not processed within 90 days – 170 were claims received by Amerigroup; 13 were claims received by Sunflower; and five were claims received by UnitedHealthcare.
- During the annual performance measure validation process for the claims-related P4P claims metrics, KFMC found some differences by each of the MCOs in interpretation of reporting criteria for claims processing timeliness. MCOs each made corrections in their reporting processes that will now allow more accurate aggregation of the three MCOs' quarterly claims data. The P4P claims metrics, however, differ from the contractual timeliness criteria summarized in the KanCare Quarterly Evaluation Reports. The P4P standard for processing of all claims, for example, is 98.75% within 40 days, compared to the contractual standard of 100% within 90 days. The claims data reported in Table 6 for 2017 have not yet been updated, as additional coding is required based on the contractual time period differences. It is anticipated these corrections will be reflected in the Q3 KanCare Quarterly Evaluation report.

- **Turnaround time (TAT) ranges for processing clean claims**
  - In Q2 CY2017, the MCOs reported processing of 4,439,117 clean claims (including 1,722,540 pharmacy claims).
  - The average TAT for Total Services (excluding pharmacy claims) was 5.5 to 9.9 days in Q2 CY2017, compared with 5.3 to 9.7 in Q1 and 5.0 to 9.9 days in Q4 (CY2016). Amerigroup had the shortest TAT for Total Services (5.5 to 6.5), compared to Sunflower (8.5 to 8.8) and UnitedHealthcare (9.1 to 9.9).
  - The average TAT for processing clean claims for individual service types again varied by service type and by MCO.
    - Hospital Inpatient – Hospital Inpatient claims had TATs in Q2 CY2017 ranging from 6.0 to 15.6 days. Amerigroup had the shortest TAT in Q2 (6.0 to 10.5), compared to Sunflower (10.9 to 11.9) and UnitedHealthcare (14.5 to 15.6).
    - Medical – Medical claims had monthly TATs in Q2 ranging from 5.0 to 9.8 days. Amerigroup had the shortest TATs (5.0 to 6.0), and UnitedHealthcare had the highest (9.0 to 9.8). Sunflower's TATs ranged from 8.1 to 8.6 days in Q2.
    - Nursing Facilities – Nursing Facility claims had TATs ranging from 4.3 to 9.6 days in Q2. Amerigroup had the shortest TATs (4.3 to 6.0), and Sunflower had the longest TATs (9.1 to 9.6) in Q2. UnitedHealthcare's TATs ranged from 7.1 to 8.3 days in Q2.
    - Dental - Dental claims TATs, which were processed in several months of previous quarters in as few as two to four days, ranged from 6.0 to 13.0 days in Q2 CY2017. Sunflower had the shortest TATs (6.0 to 8.0); Amerigroup and UnitedHealthcare had TATs of 13.0 days in Q2 CY2016 and the previous six quarters.
    - Behavioral Health – Behavioral Health claims TATs ranged from 3.8 to 9.6 days in Q2 CY2017. Amerigroup had the shortest TATs (3.8 to 4.8), compared to Sunflower (8.3 to 8.5) and UnitedHealthcare (7.9 to 9.6).
    - Vision – The average monthly TATs for Vision in Q2 ranged from 6.0 to 12.8 days. Amerigroup had the shortest monthly TATs (6.0 to 7.0), compared to Sunflower (11.0 to 12.0) and UnitedHealthcare (11.9).

Grievances

- In Q2 CY2017, 98.7% (441) of the 447 grievances reported by the MCOs as resolved in Q2 CY2017 were reported as resolved within 30 business days, and 99.8% were reported to be resolved within 60 business days.
- KDHE has increased staff review and response to MCOs related to apparent misclassification of grievances and appeals and is planning to provide MCO staff with additional training.
- Of the 447 grievances reported by MCOs as resolved in Q2:
  - 137 (27%) were reported by Amerigroup, 152 (34%) by Sunflower, and 174 (39%) by UnitedHealthcare.
  - 20 grievances were categorized in the GAR report as *Access to service or care*. Based on grievance descriptions, however, there may have been only 13 in Q2 that met the criteria for the *Access to Service or Care* category.
  - 62 grievances were categorized by MCOs as being related to quality of care: 8 as *Quality of Care (non-HCBS, non-Transportation),* 9 *Quality of Care – HCBS*, and 45 as *Quality of Care.* (UnitedHealthcare did not report whether or not the 45 quality of care grievances were or were not HCBS-related, as had been directed by the State.) Based on grievance descriptions, however, there were 47 grievances related to quality of care: 33 *Quality of Care (non-HCBS, non-Transportation)* and 14 *Quality of Care – HCBS.*
- Transportation-related grievances continued to be the most frequently reported grievances.
  - MCOs reported resolution of 199 transportation-related grievances, up from 182 and 164 the previous quarters.
  - The number of *Transportation No Show, Transportation - Late,* and *Transportation – Safety* grievances continued to be high, with 59 *Transportation – No Show* grievances, 53 *Transportation – Late* grievances, and 22 *Transportation – Safety* grievances in Q2.
  - In response to the continued number of instances where the transportation vendors reported they were unable to provide members with transportation, KDHE is adding a transportation tracking category *No Driver Available* to the quarterly GAR report.
- In Q2, 164 (36%) grievances were from 148 members receiving waiver services, up from 139 grievances reported by 136 members in Q1; 48% of the grievances were transportation-related.
- Based on grievance descriptions, KFMC estimated up to 30% of the grievances reported in Q2 may be categorized incorrectly, including 40 grievances that may be more appropriately categorized as "appeals."

Ombudsman's Office

- Ombudsman's Office assistance is available at the main office in Topeka, two satellite offices (Wichita and Olathe), and on the Ombudsman's Office website. In Q2, assistance was available at the Wichita satellite office from 10 a.m. to 5 p.m. Monday through Friday, and at the Johnson County satellite office in Olathe on Wednesdays and Thursdays from 10 a.m. to 1 p.m.
- The Ombudsman's Office provided trainings focused on how to assist with Medicaid applications and on overviews of KanCare programs and HCBS to four community service organizations in Wyandotte County, Johnson County, and in Hays.
- In Q2, 261 (26%) of 996 issues addressed in 835 contacts were MCO-related.
- The most frequently reported issues continue to be those related to Medicaid eligibility and HCBS.
- The most frequent waiver-related issues were related to the PD Waiver (37 in Q2), PD Waiver (27 in Q2), and FE Waiver (27 in Q2).

Follow-up on Previous Recommendations Summary

Timely Resolution of Customer Service Inquiries

- *The State should provide clear criteria to the MCOs for the member customer service category "Concern with access to service or care; or concern with service or care disruption" to ensure grievance and appeals contacts are not underestimated and misclassified as customer service inquiries.*
  Follow-up response: KDHE staff indicated they plan to provide additional direction to MCO staff in upcoming trainings as to when a customer service inquiry related to "*concern with access to service or care; or concern with service or care disruption*" should instead be categorized as a grievance or appeal.

Timeliness of Claims Processing

- *To promote consistency in reporting by MCOs, the State should consider revising the criteria for the Claims Overview quarterly reports to better correspond to the criteria used in the P4P reporting for the claims metrics.*
  Follow-up response: Staff from KDHE and the MCOs are in agreement with revising the criteria for the Claims Overview monthly reports to better correspond to the criteria used by the MCOs when reporting claims processing as identified during validation of the P4P claims-related metrics. The time periods for revising past monthly Claims Overview reports to reflect the updated criteria are under review. This recommendation is in process; an update will be provided in the Q3 CY2017 KanCare Evaluation Report.
- *The State should provide guidance to the MCOs as to whether corrections should be made in any of the data for prior months where vendors' claims processing reporting did not follow State reporting criteria.*
  Follow-up response: KDHE staff indicated agreement that criteria for tracking and reporting of timeliness of claims processing does not differ for vendors. The time period for correcting monthly Claims Overview reports is under review. This recommendation is in process; an update will be provided in the Q3 CY2017 KanCare Evaluation Report.
- *The State should provide additional direction to the MCOs as to appropriate processing times newborn claims. If newborn claims are not to be excluded from the 90-day processing requirement for "all claims," additional direction should be provided as to whether previous quarterly reports should be updated to include processing of newborn claims within the 90-day time period.*
  Follow-up response: KDHE staff are considering revisions to the Claims Overview monthly report that will ensure timeliness in processing of newborn claims is appropriately tracked and reported. This recommendation is still in process.

Grievances

- *UnitedHealthcare should provide more detailed descriptions of the grievances resolved each quarter. Resolution details should not be limited to verification that a letter of resolution was sent.*
  Follow-up response: As directed by the State, UnitedHealthcare provided more detailed descriptions in the GAR report of most of the grievances resolved in Q2 CY2017.
- *MCOs should ensure details on resolution of grievances in the GAR report are provided for each grievance. State staff should review the GAR report and request additional details be provided where resolution details are blank or do not include enough detail to determine grievance resolution.*

Follow-up response: KDHE has assigned staff to specifically review the grievance and appeals descriptions and resolution details and provided feedback on to the MCOs on errors made in grievance and appeal categorization in the Q2 CY2017 GAR reports.

- *The State should review the grievances KFMC has identified as potentially misclassified to evaluate whether additional examples, grievance and appeal descriptions, and follow-up training should be provided to MCO staff routinely categorizing grievances.*
  Follow-up response: KDHE staff reviewed the grievance and appeals descriptions and resolution details in Q2 CY2017 and provided feedback to MCOs on specific misclassifications of grievances and appeals. KDHE indicated to KFMC that additional follow-up training will be scheduled for MCO staff.
- *MCOs should, as directed by the instructions for the STC reports, "insert a brief summary of trends and any actions taken to prevent recurrence" for specific grievances and trends rather than repeating standard language each quarter.*
  Follow-up response: KDHE has revised the STC report to focus instead on summary of outreach and advocacy activities conducted during the quarter. This recommendation is no longer applicable.
- *The State should consider using the same grievance and appeals categories in the STC and GAR reports to promote consistency and allow more complete assessment of grievances over time. The STC report categories should be reviewed to assess whether any of the categories (such as "Benefit Denial or Limitation" or "Service or Care Disruption") may be appeals rather than grievances.*
  Follow-up response: KDHE has revised the STC report. Grievances and appeals will continue to be tracked and reported in detail in the GAR report. This recommendation is no longer applicable.
- *Due to the addition of the Transportation Late category, the State should update the Grievance definition of the Transportation Issues category to include "late" as an exclusion, i.e. "(other than no show, safety, or late)."*
  Follow-up response: KDHE has revised the GAR report to include *Transportation – Late* in the Grievance Definitions.
- *The State should work with the MCOs to identify corrective actions to address the high number of transportation grievances related to safety, "no show," late," errors in scheduling, and lack of vendor availability of transportation.*
  Follow-up response: KDHE has revised their processes to closely track and monitor transportation grievances, particularly those related to safety, no show, lateness, and lack of transportation availability. KDHE also added a transportation category in the GAR report to track the number of grievances where members are told no transportation providers are available.

Recommendations Summary

Timely Resolution of Customer Service Inquiries

1. The MCOs should ensure all staff responding to customer service inquiries are categorizing the inquiries based on State-specified criteria.
2. After additional MCO training is completed, the State should consider reviewing a sample of customer service inquiries categorized as "*concern with access to service or care; or concern with service or care disruption*" to identify any contacts reported as customer service inquiries that should instead be categorized as grievances and appeals.
3. MCOs should include the State-specified member and provider customer service inquiries in the drop-down menu options available to customer service staff responding to member inquiries.

Timeliness of Claims Processing

1. MCOs should update their monthly claims processing reports for 2017 and annual totals for 2016 to reflect the criteria used by all three MCOs (and their vendors) as revised during the validation of P4P claims metrics, adapted to meet contractual timeliness standards for clean claims (30 days), non-clean claims (60 days), and all claims (90 days).
2. (See *Follow-up on Previous Recommendations* above for recommendations where follow-up is in process.)

Grievances

1. MCOs should ensure their staff categorize grievances using the revised categories and criteria.
   - Before submitting the GAR report to the State, MCOs should review the grievance detailed descriptions to identify those that may instead meet the criteria for appeals. MCOs should contact KDHE staff to request clarification for any grievance or appeals categories where criteria are not clearly understood.
   - MCOs should review transportation-related grievances to ensure those related to no-show, lateness, safety issues, and lack of provider availability are categorized appropriately.
   - Each grievance should be categorized separately, even if the grievances are reported during one contact by phone or mail.
2. Drop-down menus used by MCO staff categorizing grievances should be reviewed and updated to include the State-specified categories for classifying grievances and appeals.
3. The State should consider developing a hierarchy of grievance categories to provide additional guidance where individual grievances may reasonably meet criteria in more than one grievance category.
4. UnitedHealthcare should identify whether QOC grievances are or are not HCBS-related.

Ombudsman's Office

1. The State should consider making the quarterly GAR reports available to the Ombudsman to allow more complete review of grievance resolutions, particularly for members who have contacted the Ombudsman's office related to these grievances.
2. As the STCs include a requirement to track geographic residences of those who contact the Ombudsman's Office, regional trends in contacts (for example, by general area of the State, by county type, etc.) are recommended for inclusion in the Ombudsman's Office quarterly reports, where applicable.

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 5 - Quarter 2
Health Care Access Improvement Pool
Paid date 6/29/2017

Provider Name	HCAIP DY/QTR: 2017/2	Provider Access Fund 2443	Federal Medicaid Fund 3414
Bob Wilson Memorial Hospital	69,082	30,251	38,831
Children's Mercy Hospital South	472,084	206,726	265,358
Coffey County Hospital	43,796	19,178	24,618
Coffeyville Regional Medical Center, Inc.	163,874	71,760	92,114
Cushing Memorial Hospital	196,760	86,161	110,599
Doctors Hospital	4,870	2,133	2,737
Geary Community Hospital	146,410	64,113	82,297
Great Bend Regional Hospital	162,426	71,126	91,300
Hutchinson Hospital Corporation	278,680	122,034	156,646
Kansas Heart Hospital LLC	64,582	28,280	36,302
Kansas Medical Center LLC	94,448	41,359	53,089
Kansas Rehabilitation Hospital	13,096	5,735	7,361
Kansas Surgery & Recovery Center	5,708	2,500	3,208
Labette County Medical Center	111,120	48,659	62,461
Lawrence Memorial Hospital	448,840	196,547	252,293
Memorial Hospital, Inc.	73,346	32,118	41,228
Menorah Medical Center	370,490	162,238	208,252
Mercy Health Center - Ft. Scott	99,682	43,651	56,031
Mercy Hospital, Inc.	13,576	5,945	7,631
Mercy Reg Health Ctr	425,266	186,224	239,042
Miami County Medical Center	89,744	39,299	50,445
Mid-America Rehabilitation Hospital	38,094	16,681	21,413
Morton County Health System	31,318	13,714	17,604
Newton Medical Center	253,966	111,212	142,754
Olathe Medical Center	463,240	202,853	260,387
Overland Park Regional Medical Ctr.	1,376,928	602,957	773,971
Prairie Ridge (formerly KVC)	6,614	2,896	3,718
Prairie View Inc.	24,510	10,733	13,777
Pratt Regional Medical Center	82,394	36,080	46,314
Providence Medical Center	764,740	334,880	429,860
Ransom Memorial Hospital	137,406	60,170	77,236
Saint Luke's South Hospital, Inc.	109,616	48,001	61,615
Salina Regional Health Center	369,888	161,974	207,914
Salina Surgical Hospital	13,296	5,822	7,474
Shawnee Mission Medical Center, Inc.	1,905,548	834,439	1,071,109
South Central KS Reg Medical Ctr	83,862	36,723	47,139
Southwest Medical Center	175,674	76,928	98,746
St. Catherine Hospital	511,614	224,036	287,578
St. Francis Health Center	978,238	428,370	549,868
St. John Hospital	153,814	67,355	86,459
Stormont Vail Regional Health Center	2,072,744	907,655	1,165,089
Sumner Regional Medical Center	58,584	25,654	32,930
Susan B. Allen Memorial Hospital	250,104	109,521	140,583
Via Christi Hospital - Pittsburg	349,000	152,827	196,173
Via Christi Hospital St Teresa	124,552	54,541	70,011
Via Christi Regional Medical Center	3,645,238	1,596,250	2,048,988
Via Christi Rehabilitation Center	75,034	32,857	42,177
Wesley Medical Center	2,378,124	1,041,380	1,336,744
Wesley Rehabilitation Hospital	25,672	11,242	14,430
Western Plains Medical Complex	260,832	114,218	146,614
Total	20,068,524	8,788,007	11,280,517

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 5 - Quarter 2

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

Paid May 19, 2017

Hospital Name	DY5/Q2	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	$ 1,232,068.00	$ 539,522.58	$ 692,545.42
University of Kansas Hospital	$ 3,696,206.00	1,618,568.60*	$ 2,077,637.39
Total	**$ 4,928,274.00**	**$ 2,158,091.19**	**$ 2,770,182.81**

*IGT funds are received from the University of Kansas Hospital

KDHE Summary of Claims Adjudication Statistics – January through December 2016 – KanCare MCOs

AMERIGROUP 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	18,090	$773,273,251.49	2,653	$143,488,279.93	14.67%
Hospital Outpatient	167,448	$436,720,665.60	20,226	$48,793,682.58	12.08%
Pharmacy	989,938	$76,513,237.39	275,069	Not Applicable	27.79%
Dental	65,465	$17,682,366.70	4,382	$1,201,812.26	6.69%
Vision	39,296	$10,571,517.49	6,861	$2,124,532.69	17.46%
NEMT	55,293	$2,095,063.26	286	$13,404.20	0.56%
Medical (physical health not otherwise specified)	963,613	$585,590,625.12	120,188	$77,707,046.87	12.47%
Nursing Facilities-Total	44,739	$108,973,146.86	5,391	$10,393,861.31	12.05%
HCBS	96,365	$58,093,768.09	5,542	$3,536,100.27	5.75%
Behavioral Health	329,966	$43,877,896.08	31,354	$4,039,545.15	9.50%
Total All Services	2,770,213	$2,113,391,538.08	471,952	$291,298,265.26	17.04%

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	$798,556,794	4,816	$209,308,508	23.19%	$798,556,794
Hospital Outpatient	$444,339,650	27,449	$66,287,613	15.52%	$444,339,650
Pharmacy	$161,159,969.97	539,104	$96,686,682.52	33.37%	$161,159,969.97
Dental	$19,452,114.58	7,474	$1,480,208.43	9.79%	$19,452,114.58
Vision	$10,968,260.31	5,653	$1,375,363.02	12.11%	$10,968,260.31

KDHE Summary of Claims Adjudication Statistics – January through December 2016 – KanCare MCOs

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
NEMT	$2,193,510.66	954	$31,854.86	1.17%	$2,193,510.66
Medical (physical health not otherwise specified)	$485,737,069	109,500	$69,546,719	11.64%	$485,737,069
Nursing Facilities-Total	$153,021,166	6,475	$19,182,638	9.35%	$153,021,166
HCBS	$124,993,979	14,162	$5,374,744	4.55%	$124,993,979
Behavioral Health	$51,989,946	28,621	$4,815,498	8.55%	$51,989,946
Total All Services	$2,252,412,460	744,208	$474,089,829	20.26%	$2,252,412,460

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	14,323	$530,674,372.69	3,263	$142,757,416.15	22.78%
Hospital Outpatient	161,955	$433,773,741.98	30,366	$88,629,030.02	18.75%
Pharmacy	907,790	$63,224,718.00	208,712	$53,463,019.64	22.91%
Dental	69,500	$18,757,869.83	5,324	$1,452,884.42	7.66%
Vision	40,507	$8,110,049.56	3,742	$753,478.93	9.24%
NEMT	90,965	$2,370,823.39	1,179	$35,244.35	1.29%
Medical (physical health not otherwise specified)	960,378	$416,762,358.14	131,059	$88,452,251.96	13.65%
Nursing Facilities-Total	47,623	$126,266,798.25	7,275	$22,196,929.65	28.54%
HCBS	216,468	$73,881,152.33	12,083	$3,955,586.47	5.58%

KDHE Summary of Claims Adjudication Statistics – January through December 2016 – KanCare MCOs

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
Behavioral Health	164,420	$55,588,320.21	10,227	$7,320,788.37	6.22%
Total All Services	2,673,929	$1,729,410,204	413,230	$409,016,630	15.45%