Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program – Year Ending 12.31.13

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

KanCare
Section 1115 Annual Report
Demonstration Year: 1 (1/1/2013-12/31/2013)

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I. Introduction

Pursuant to the KanCare Special Terms and Conditions issued by the Centers for Medicare and Medicaid Services, Number 11-W-00283/7, the State of Kansas, Department of Health and Environment, Division of Health Care Finance, submits this first annual report related to Demonstration Year 2013. 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.

II. STC 78(a) – Summary of Quarterly Report Items

Items from the quarterly reports which are not included in others areas of this annual report and are subject to annualizing are summarized here:

A. Summary of Outreach and Innovation: The KanCare website, www.kancare.ks.gov, is home to a wealth of information for providers, consumers, stakeholders and policy makers. Sections of the website are designed specifically around the needs of consumers and providers, and information about implementation activities, as well as the Section 1115 demonstration itself, is provided in the interest of transparency and engagement. In addition, the KanCare Advisor, the State's electronic implementation newsletter, is distributed to about 300 individual subscribers and various provider and consumer associations. Newsletters were distributed in Demonstration Year on January 3, January 17, January 31, February 14, March 5, May 10, June 17, and December 19. In addition to distribution to subscribers, the Advisor is available on the KanCare website.

Open enrollment for 2014 in the KanCare program was initiated in mid-November, when KDHE started mailing out Open Enrollment Packets for KanCare consumers. This was the first Open Enrollment Period for KanCare (after initial enrollment) and included most everyone that started in the KanCare program in January 2013. All the packets were delivered to the consumers before December 1, and members had until March 4th to change their KanCare MCO plan. Members who did not want to change their plan did not have to take any action and remained in their current MCO. The Open Enrollment Packet can be found on the KanCare website: http://www.kancare.ks.gov/choosing_a_plan.htm.

Through DY2013, Tribal Technical Advisory Group (TTAG) meetings with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations continued on a monthly basis.

Also throughout DY2013, the state's Kancare Advisory Council was active. The Council, first created in 2012, met semimonthly during the first half of 2013. After readiness and initial launch of the program, the Council was revised to reflect additional member perspectives. The first meeting of the newly appointed council was held December 18, 2013, in Topeka at the State

Capitol Building. The current Advisory Council consists of 14 members representing KanCare consumers, KanCare providers, legislators, and tribal governments.

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

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

- Health homes for both target populations – people with serious mental illness (SMI) and people with other chronic conditions (likely diabetes and asthma, although the specific population is still being determined) – will be implemented July 2014
- The model Kansas will implement will be a partnership between the KanCare health plans and community providers, like CMHCs and FQHCs, and together, the partners will provide the six core health home services
- An interagency project team of KDADS and KDHE staff, along with KanCare health plan representatives, university partners, HP staff and actuary staff have been working on the project since Spring 2012
- A Steering Committee of KDADS and KDHE leadership provides direction to the project team
- Completed tasks include:
    - Defining the six health homes services
    - Identifying the first target group, approximately 36,000 adults and children with SMI
    - Determining the goals for health homes and selecting quality measures, including eight required by CMS
    - Defining the provider qualifications and standards
    - Determining that the health plans will be paid a per member per month (PMPM) rate outside of their KanCare PMPM and from this, they will pay their Health Home Partners (HHPs)
    - Obtaining federal planning money ($500,000 matched at the Medicaid service rate to be almost $885,000) to pay university partners at Kansas University Medical Center and Wichita State University (WSU) to analyze claims data to select the target populations and research provider learning collaboratives. Two-thirds of the money will also be used to pay actuaries to create the PMPM and to support stakeholder education, engagement and HIT readiness activities
    - Forming a Focus Group of 80+ stakeholders to provide advice and input. This group has been meeting since April 2012.
    - Consulting with the Substance Abuse and Mental Health Services Administration (SAMHSA) on our approach to health homes for the SMI population
    - Holding bi-weekly calls with the federal technical assistance provider, the Center for Health Care Strategies
    - Participating in monthly calls with CMS to work through issues before official submission of our state plan amendments (SPAs)
    - Holding two forums, attended by almost 400 people, to explain our model and obtain input on service definitions, proposed provider standards, quality goals and measures and other components of the project

- Establishing a web page on the KanCare website to educate and inform stakeholders about the project (http://www.kancare.ks.gov/health_home.htm)
- Publishing a monthly newsletter, the *Health Homes Herald*, to help inform stakeholders about the project and its progress
- Developing consumer education materials, including a brochure, a booklet and a consumer PowerPoint presentation
- Making presentations at various provider association conferences and meetings about the project
- Holding an educational webinar for interested providers
- Identifying the second target population, approximately 38,000 people who have asthma or diabetes and are at risk for a second chronic condition, including hypertension, substance use disorder, coronary artery disease, or depression
- Deploying the Preparedness and Planning Tool to help providers assess their readiness to become HHPs
- Deploying a provider survey through Kansas Foundation for Medical Care to prioritize providers for assistance in planning to implement electronic health records (EHR)
- Transferring responsibility to WSU's Center for Community Support and Research (CCSR) for convening and facilitating the Health Homes Focus Group, now called the Health Homes Stakeholders Meeting
- Scheduling through CCSR twice monthly webinars for providers interested in becoming HHPs
- Developing a HHP network adequacy report format for the health plans to report their progress in establishing networks of Health Homes
- Setting dates for and sending out invitations for the Health Homes consumer tour (March 3-6 and 11-12)
- Creating a referral form for providers and hospitals to use to refer potential Health Homes members to the MCOs
- Creating an informational brochure to help inform consumers about Health Homes
- Securing funding from the Sunflower Foundation and REACH Foundation to support the Health Homes Learning Collaborative beginning July 2014
- Refining the PMPM rate for both target populations

- Tasks still to complete in 2014 include:
  - Developing program manuals for both SMI and chronic conditions (CC) Health Homes
  - Developing the components the State wants the health plans to include in their contracts with HHPs
  - Consulting with SAMHSA for the second, chronic conditions, SPA (March 20)
  - Performing an operational readiness review of the MCOs
  - Developing reporting requirements
  - Final submission of both SPAs

Throughout 2013, Kansas engaged in extensive outreach discussions with KanCare members and providers, with intensive focus on LTSS services and safeguards, and on bringing I/DD waiver

services into the KanCare program during the second year of operation. Specifics related to those activities have been provided to CMS in the quarterly reports submitted by Kansas.

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

- Rapid response calls conducted through the first six months of KanCare, beginning daily and eventually transitioning to weekly.
- Series of workgroup meetings between the Managed Care Organizations and the Community Developmental Disability Organizations (CDDO) to identify and address decision areas related to the integration of long-term supports and services for IDD into KanCare.
- Targeted case manager and community service provider trainings in October.
- IDD KanCare Educational Tour for consumers in eight locations across Kansas.
- Care Coordination Summits with Nursing Facilities and Assisted Living Facilities.
- Series of behavioral health institution meetings to improve admission screening and gatekeeping functions.
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to improve coordination of transitions between inpatient and outpatient care.
- Regular ongoing meetings with KDADS stakeholders such as the Association of Community Mental Health Centers.
- Regular meetings with the Kansas Hospital Association's KanCare implementation technical advisory group
- KanCare's Provider and Operational Issues Workgroup
- KanCare's Consumer and Specialized Issues Workgroup

A summary of the outreach and innovation activities of the three KanCare MCOs follows:

- *Amerigroup:* Over the year, Amerigroup Kansas performed a variety of outreach activities concentrated on general interventions and focused interventions.
    - Community Relations staff provided general interventions on access to information, benefits, and services through building relationships with community and faith based organizations to ensure all stakeholders were aware of the KanCare program and changes associated with the program. Community Relations staff also attended all KanCare educational tours hosted by the state to provide one-on-one support to consumers and families that had questions about the program.
    - New member packet - new members received information in the form of a member handbook that shared information related to covered services, value added benefits, rights and responsibilities, and how to navigate the system. Also included in the packet was information related to our provider network.
    - Health Promotion staff provided more focused interventions through telephonic outreach. Initiatives included:
        - The importance of recommended well-child visits with their PCP, including needed immunizations and education on well-child visits and KAN Be Healthy services.

    - Members with hypertension regarding recommendations for living well with hypertension.
    - In-depth education and outreach for members who experience more complex health conditions.
    - Education and redirection of members to see their PCP or contact Amerigroup Nurse on Call instead of the emergency room for non-emergent issues.
- Health Promotion staff processed health risk assessments (HRAs) that allowed case management or LTSS staff to intervene on a more individualized issues such as:
    - High risk pregnancy
    - Complex mental health needs
    - Diabetes management

- *Sunflower:* Sunflower has developed several marketing activities involving community outreach over 2013. Media inquiries were gathered and regularly reported to KDHE. Social media sites were launched in December 2013 supporting provider activities and encouraging member participation. Sunflower also implemented an email marketing system for providers and members, creating faster communication. This database of addresses has seen growth of 200% since inception. Educational websites supporting member and provider resource and education were created, including a page dedicated to the IDD implementation. Sunflower was able to sponsor and partner with local organizations creating positive relations for KanCare partners. Examples include: Center for Independent Living with media coverage, InterHab Conference, KAMU Conference, KACE Conference, Local Health Fairs.

  Sunflower's calendar of events is submitted monthly to KDHE. They average 10 outreach events and presentations each week throughout the state. Sunflower's team of Member Connections representatives complete regular visits to ADRCs, CDDOs, Nursing Facilities, Independent Living Resource Centers, non-profits, health departments, homeless shelters, etc. to make sure Sunflower is meeting the needs of the specific organization and their members. Sunflower also held 3 Start Smart for Your Baby Showers which provided information on: labor and delivery, post-partum depression, the importance of taking your baby for well-child checkups, and breastfeeding. The Adopt-a-School event included activities and presentations on healthy eating, exercise, and the importance of washing your hands.

  Sunflower is heavily involved with advocacy groups and works with them to educate community members on changes in KanCare and services offered by Sunflower. They are working continuously to find creative and inexpensive ways to share resources and maximize services to Sunflower members. Same activities included:
    - Participated in the KanCare I/DD Pilot Project and also dedicated staff members who attend all rallies and meetings with organizations regarding I/DD

- Initiated partnership with Kansas Head Start Association to join forces in raising awareness on their program at locations across the state
- An outreach plan was developed for ADRCs. The Member Connections staff continues to meet with them and report back any issues
- All CDDOs were visited during the IDD implementation to provide presentations on how Sunflower will provide support to their providers and members
- Ongoing discussions with Johnson County school districts and other school districts to partner in helping to get students healthy for the school year and make sure they have received all vaccinations
- New Mom/Baby shower events were held on August 8, August 22, and December 2.
- Coordinated symposium to feature the benefits of the WORK PROGRAM to employ those with developmental disabilities
- Two Member Advisory Committee meetings held in 2013
- One Community Advisory Committee meeting held in 2013

▪ United: During the initial year of KanCare, United Healthcare Community Plan of Kansas connected with their members and potential KanCare members through numerous avenues. A summary follows:

During 2013, UnitedHealthcare Community Plan of Kansas outreach staff worked to provide personal visits to member, providers and community based organizations educating them on KanCare benefits as well as the benefits of being a member of UnitedHealthcare. The staff also attended community events and conferences targeted at members and potential members of KanCare to provide health and benefit literacy education.

Community Outreach staff are divided by geographic territories covering all areas of Kansas which allowed outreach to occur in each area of the state. The staff also worked with State Staff to ensure outreach efforts were synchronized with and supportive of overall State efforts. Below is a summary of the visits that occurred during 2013.

Target Audience	Total Number of Personal Visits in 2013
Providers	3,283
Community Based Organizations	2,688
Members and Potential Members at Events	47,716
TOTAL	**53,687**

B. Operational Developments/Issues

i. Systems and reporting issues, approval and contracting with new plans: A number of amendments have been submitted to CMS related to the three existing KanCare MCOs. As the State reported to CMS during monthly conference call updates, and in quarterly reports to CMS, there have been a variety of concerns regarding systems and reporting

issues, in line with expectations of a transition of this magnitude. Through a variety of accessible forums and input avenues, the State has been advised of these types of issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues impacting timely and accurate reimbursement; and claims projects to assess and correct systemic issues. Focused reviews of the MCOs as well as comprehensive annual reviews are discussed elsewhere in this report. Kansas is preparing for some additional intensive provider experience improvement activities in early DY2014.

A summary of some of the more common consumer issues addressed during 2013 is as follows:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Electronic systems show only one "responsible person" option, which caused MCO customer service representative to refuse to speak to other responsible persons (e.g., family members, guardians)	MCOs created a field for additional responsible parties to be named once proper documentation is provided.	Ongoing education of related staff and management of the issue. State also worked with stakeholders to address related issues (including protocols regarding who should receive member notices, open enrollment packages and other information).
Member's eligibility cannot be confirmed by pharmacy through MCO's system, so prescriptions cannot be filled (often within a day or two of eligibility being established).	When referred to the State, eligibility was confirmed, the MCO called pharmacy and prescriptions filled.	Providers can confirm eligibility by directly accessing KMAP or calling customer service. Eligibility file load times have been reduced to 24 hours for MCOs and 48 hours for subcontractors.
Prescriptions and other services were delayed or denied for lack of a prior authorization.	• Some PA requirements were relaxed, upon guidance from State Program Managers and Pharmacist. • Providers advised of necessary documentation needed to obtain PA, and allowed to resubmit. • MCO's PA processes were improved to provide more rapid decisions.	For Rx, the State's Pharmacist is monitoring MCOs' PA lists to assure that they aren't incorrectly requiring PAs.

Incorrect information was given to members and providers by customer service representatives.	• Instruction/correction of individual staff when issues were called to MCO's attention. • On occasion, MCO has covered services which were provided on the basis of incorrect information.	Ongoing education of customer service staff to understand the eligibility information available to them, the services which are covered by KanCare, and correct routing of calls.
Incorrect application of spenddown, client obligation, and patient liability	State and MCO dialogue, and input from providers, about protocols to properly apply claims to patient responsibility; focused attention to these issues which especially impact members using LTSS services; collaborating with affected providers to clarify expectations and processes.	Focused management of claims submission, payment and processing protocols related to these unique member status issues.
Services (such as prescription drugs) delayed due to eligibility files incorrectly showing TPL availability	MCOs work with eligibility staff to confirm that insurance is not in effect for the member, and to get file updated.	Ongoing efforts to improve accuracy of eligibility TPL records
Transportation issues: difficult to arrange rides, rude drivers, drivers late for appointments or fail to show up	Transportation vendors provide ongoing education of staff and drivers in response to concerns or grievances.	One MCOs changed transportation vendors to improve customer service; state has worked with MCOs to increase ongoing management, oversight and correction of vendor performance.
Members receive bills from providers for services that member feels should be covered by Medicaid	MCOs work with State and providers to determine whether: • claims are incorrectly being denied as non-covered • bills are being sent while claims are pending payment by the MCOs • member is obligated for payment, due to spenddown • or, provider is balance-billing Action is taken, as appropriate, according to the cause.	Ongoing system corrections by MCOs, to assure coverage is in compliance with State policies. Also, ongoing provider education.

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

MCO	Value Added Service	Units	Value
Amerigroup	Member Incentive Program	10,102	$293,175
	Adult Dental Services	2,780	$262,734
	Mail Order OTC	7,163	$115,724
	Total of all Amerigroup VAS Jan-Dec 2013	*42,959*	*$989,122*

Sunflower	CentAccount debit card	75,060	$1,501,200
	SafeLink®/Connections Plus cell phones	10,923	$522,447
	Adult Dental Services	20,316	$397,721
	Total of all Sunflower VAS Jan-Dec 2013	*1,087,843*	*$3,074,781*
United	Additional Vision Services	26,865	$1,147,095
	Incentive Program for KAN Be Healthy Screening	47,559	$475,590
	Adult Dental Services	4,099	$212,870
	Total of all United VAS Jan-Dec 2013	*94,414*	*$2,206,242*
Combined Totals	**All MCOs - Jan-Dec 2013**	*1,225,216*	$6,270,145

iii. Enrollment issues: A total of 15 American Indian/Alaska Native members chose to not be enrolled in KanCare per the opt-out provision available to AI/AN members, during 2013.The table below represents the enrollment reason categories for all of calendar year 2013. All KanCare eligible members are defaulted to a managed care plan if they do not indicate a preference on their applications.

Start Reasons	2013 – Q1	2013 – Q2	2013 – Q3	2013 – Q4	**2013 - Totals**
Newborn assignment	6	331	7	9	**353**
Administrative change	6	11	10	20	**47**
WEB - Change Assignment	22	31	24	13	**90**
KanCare Default - Case Continuity	791	1285	279	242	**2,597**
KanCare Default – Morbidity	797	1670	531	533	**3,531**
KanCare Default - 90 Day Retro-reattach	n/a	1858	182	254	**2,294**
KanCare Default - Previous Assignment	3907	7027	303	283	**11,520**
KanCare Default - Continuity of Plan	427	3024	2549	3249	**9,249**
Choice - Enrollment into KanCare MCO via Medicaid Application	609	2613	528	662	**4,412**
Change - Enrollment Form	2481	847	407	437	**4,172**
Change – Choice	13,250	7932	754	815	**22,751**
Change - Access to Care - Good Cause Reason	n/a	135	5	27	**167**
Change - Case Continuity - Good Cause Reason	n/a	6	12	2	**20**
Assignment Adjustment Due to Eligibility	n/a	35	11	20	**66**
Total	**22,296**	**26,805**	**5,602**	**6,566**	**61,269**

iv. Grievances and appeals:

For all of 2013, the following member grievances and appeals were received and addressed:

MCO	Total Member Grievances Received in 2013	Total Number of 2013 Member Grievances Resolved	Transportation-Related Grievances Received in 2013
Amerigroup	817	817	323
Sunflower	524	524	326
United	409	409	210
Totals	**1750**	**1750**	**859**

MCO	Total Member Appeals Received in 2013	Total Number of 2013 Appeals Resolved	Total Number of Appeals With Decision Upheld	Total Number of Appeals With Decision Overturned
Amerigroup	88	88	60	28
Sunflower*	336	336	147	121
United	220	220	182	38
Totals	**644**	**644**	**389**	**187**

*Note: 60 appeals were dismissed; 8 were resolved without appeals process completing.

For all of 2013, the following provider appeals were received and addressed, by MCO:

Provider Appeals - Amerigroup Summary Sheet (Includes MCO and Subcontractor Info)				
# of Appeals Received - Reporting Period	3,238			
# of Appeals Received - YTD	28,244*			
# of Appeals Resolved - Reporting Period	2,654			
# of Appeals Resolved - YTD	25,874			
Category	# Resolved Reporting Period	# Resolved YTD		
1. Authorizations	19	95		
2. Claims/Billing Issue	2,614	25,673		
3. Credentialing/Contracting	0	0		
4. Provider Relations	0	0		
5. Formulary	0	0		
6. Customer Service	0	0		
7. Health Plan Administration	0	0		
8. Clinical/Utilization Management	21	106		

9. Quality of Service or Care	0	0		
10. Other	0	0		
Standard	# in Reporting Period	% of Total Reporting Period	# YTD	% of Total YTD
Acknowledgement letters that were sent within 10 business days	2,929	99.46%	15,765	66.49%
Acknowledgement letters that were sent after 10 business days	16	0.54%	7,944	33.51%
Appeals resolved that were resolved within 30 days	2,451	92.35%	22,793	88.09%
Appeals resolved that were resolved within 31 to 60 days	174	6.56%	2,746	10.61%
Appeals resolved that were resolved in greater than 60 days	29	1.09%	335	1.29%
Note on Standards: Provider appeals must be acknowledged within 10 business days and resolved within 60 days.				

*Amerigroup treats and counts every provider initiated claim action request from all sources (verbal, written, email, web-submission, submitted by provider representative or other individual in any form) as an appeal for reporting purposes. Even though there may be commonality of cause across a number of provider contacts, the action itself is counted as a singular event regardless of the number of claims impacted or reported (claim appeals are not aggregated for common cause). Amerigroup's appeal workflow system accounts for each appeal intake as a distinct action. Amerigroup did not develop a uniform methodology with other managed care organizations for reporting claim appeal volume and therefore comparative analysis would be potentially inaccurate

Provider Appeals - Sunflower Summary Sheet (Includes MCO and Subcontractor Info)				
# of Appeals Received - Reporting Period	139			
# of Appeals Received - YTD	925			
# of Appeals Resolved - Reporting Period	118			
# of Appeals Resolved - YTD	903			
Category	# Received Reporting Period	# Received YTD		
1. Authorizations	0	33		
2. Claims/Billing Issue	75	479		
3. Credentialing/Contracting	0	2		
4. Provider Relations	0	0		
5. Formulary	24	95		
6. Customer Service	0	1		
7. Health Plan Administration	3	4		
8. Clinical/Utilization Management	66	339		
9. Quality of Service or Care	0	0		

10. Other	6	29		
Standard	# in Reporting Period	% of Total Reporting Period	# YTD	% of Total YTD
Acknowledgement letters that were sent within 10 business days	140	100.00%	906	99.34%
Acknowledgement letters that were sent after 10 business days	0	0.00%	6	0.66%
Appeals resolved that were resolved within 30 days	118	100.00%	889	98.34%
Appeals resolved that were resolved within 31 to 60 days	0	0.00%	11	1.22%
Appeals resolved that were resolved in greater than 60 days	0	0.00%	4	0.44%
Note on Standards: Provider appeals must be acknowledged within 10 business days and resolved within 60 days.				

Provider Appeals - United Summary Sheet (Includes MCO and Subcontractor Info)				
# of Appeals Received - Reporting Period	186			
# of Appeals Received - YTD	1,683			
# of Appeals Resolved - Reporting Period	147			
# of Appeals Resolved - YTD	1,566			
Category	# Resolved Reporting Period	# Resolved YTD		
1. Authorizations	0	27		
2. Claims/Billing Issue	147	1,538		
3. Credentialing/Contracting	0	0		
4. Provider Relations	0	0		
5. Formulary	0	0		
6. Customer Service	0	1		
7. Health Plan Administration	0	0		
8. Clinical/Utilization Management	0	0		
9. Quality of Service or Care	0	0		
10. Other	0	0		
Standard	# in Reporting Period	% of Total Reporting Period	# YTD	% of Total YTD
Acknowledgement letters that were sent within 10 business days	186	100.00%	1,674	99.47%

Acknowledgement letters that were sent after 10 business days	0	0.00%	9	0.57%
Appeals resolved that were resolved within 30 days	147	100.00%	1,564	99.94%
Appeals resolved that were resolved within 31 to 60 days	0	0.00%	1	100.00%
Appeals resolved that were resolved in greater than 60 days	0	0.00%	0	0.00%
Note on Standards: Provider appeals must be acknowledged within 10 business days and resolved within 60 days.				

C. Customer service reporting:

Member Customer Service Performance Results					
Amerigroup: Member (Voice Portal & Live Agent)	**YTD 2013**	**Sunflower: Beneficiary Calls**	**YTD 2013**	**United: Member Services**	**YTD 2013**
Total # Calls Offered	179,173	Total Offered	188,521	Total Offered	131,507
Total # Handled	178,730	Total Handled	187,082	Total Handled	130,443
Average seconds to answer	0.00006	Average seconds to answer	9	Average seconds to answer	4.49
Average length of call	3:55	Average length of call	5:18	Average length of call	5:24
Abandon Volume	443	Abandon Volume	1963	Abandon Volume	710
Abandon Rate	0.2%	Abandon Rate	1.0%	Abandon Rate	0.4%
Provider Customer Service Performance Results					
Amerigroup: Provider (Voice Portal & Live Agent)	**YTD 2013**	**Sunflower: Provider Calls**	**YTD 2013**	**United: Provider Services**	**YTD 2013**
Total # Calls Offered	102,518	Total Offered	62,478	Total Offered	55,189
Total # Handled	102,080	Total Handled	61,977	Total Handled	55,044
Average seconds to answer	0.00011	Average seconds to answer	9	Average seconds to answer	2.67
Average length of call	0:04:37	Average length of call	06:41	Average length of call	07:50
Abandon Volume	438	Abandon Volume	486	Abandon Volume	150
Abandon Rate	0.41%	Abandon Rate	.8%	Abandon Rate	0.26%

D. Summary of MCO critical incident reporting:

Critical Incidents (All Providers)	1st Qtr			2nd Qtr			3rd Qtr	4th Qtr	YTD
	(AIR)	(KDADS)	Totals	(AIR)	(KDADS)	Totals	AIR Totals	AIR Totals	**TOTALS**
Total # Received	43	300	**343**	122	66	**190**	**131**	**167**	**841**
Total # Reviewed	36	247	**283**	101	66	**167**	**112**	**151**	**630**
Total # Pending	7	53	**60**	21	0	**21**	**8**	**16**	**N/A**
Total # Substantiated	NR	NR	NR	NR	51	**51**	**115**	**145**	**230**

E. Safety Net Care Pool: The Safety Net Care Pool (SNCP) is divided into two pools: the Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The attached report, "Safety Net Care Pool Payment Report – DY1 – 2013" identifies pool payments to participating hospitals, including funding sources, applicable to all of 2013. Disproportionate Share Hospital payments continue, as does support for graduate medical education.

F. Post Award Forum: The Post-Award Forum was conducted June 25 during a meeting of the KanCare Advisory Council. More than 60 stakeholders, in addition to members of the Advisory Council, attended. After listening to a presentation on KanCare implementation, three stakeholders – a consumer, a provider, and a representative of an advocacy organization – offered comments during the forum; additional questions and discussion followed from Advisory Council members on other agenda items related to implementation. Cards were also distributed to attendees indicating that email comments would be accepted for the forum through June 28.

The consumer concern related to a service that was initially authorized but then disallowed by a KanCare MCO because it is not a covered service for adults. By the end of the meeting, the MCO had identified an alternative resource to address the member's need. The provider, a pharmacist, spoke favorably of interaction with State staff but also expressed concerns about delays in receiving confirmation of eligibility for members needing prescriptions filled. The advocate asked for clarification about what the Ombudsman's resolution rate represented.

Among written comments, the focus was on operational issues. One individual, a provider, expressed concern about initial primary care provider assignments, which were affected by the state of each MCO's network development at the time of initial assignment. The provider believed it would be preferable to have one MCO option rather than three, because of contracting complications. A second individual asked for consistency from the MCOs in how to apply the fee-for-service payment floor to services that were manually priced in FFS Medicaid. A provider association reiterated concerns raised during the Advisory Council meeting about each plan's compliance with contractual requirements for maximum allowable cost (MAC) generic drug pricing and administration, including the requirement that each plan have transparent MAC pricing lists.

III. STC 78(b) – Total Annual Expenditures

Total annual expenditures for the demonstration population for Demonstration Year 1 (2013), with administrative costs reported separately, are set out in the attached document entitled "KanCare Budget Neutrality – Demonstration Year 1."

IV. STC 78(c) – Yearly Enrollment Reports

Yearly enrollment reports for demonstration enrollees for Demonstration Year 1 (2013), including all individuals enrolled in the demonstration, that include the member months, as required to evaluate compliance with the budget neutrality agreement, and the total number of unique enrollees within Demonstration year 1, are set out in the attached document entitled "KanCare Budget Neutrality – Demonstration Year 1."

V. STC 78(d) – Quality Strategy

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

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

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

The State values a collaborative, race-to-the-top approach that will allow all KanCare MCOs, providers, policy makers and monitors to maximize the strength of the KanCare program and services. Kansas recognizes that some of the performance measures for this program represent performance that is above the norm in existing programs, or first-of-their-kind measures designed to drive to stronger

ultimate outcomes for members, and will require additional effort by the KanCare MCOs and network providers. Therefore, Kansas continues to work collaboratively with the MCOs and provide ongoing policy guidance and program direction in a good faith effort to ensure that all of the measures are clearly understood; that all measures are consistently and clearly defined for operationalizing; and that the necessary data to evaluate the measures are identified and accessible

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

Kansas has provided quarterly updates to CMS about the activities related to quality monitoring, performance measure development, and about specific activities related to MLTSS services, quality measures, and related HCBS waiver amendment application development and submission. Additional information as to the focused review conducted with each MCO, the annual reviews that have now been completed with related reports being developed, and the KanCare evaluation work with the state's evaluation contractor, is included in later sections of this report.

Consistent with the STCs, the State submitted revisions to the concurrently operating 1915(c) waivers (KS-0476, KS-0304, KS-4165, KS-4164, KS-0320 and KS-0303) to incorporate performance measures that are reflective of services delivered in a managed care delivery system, taking into account a holistic approach to care. The State sought technical assistance from a CMS vendor in the development of the new performance measures. Upon approval of the 1915(c) amendments, the State will revise the Comprehensive Quality Strategy to incorporate the new performance measures.

VI. STC 78(e) – MFP Benchmarks

Pursuant to STC 45, the state must report on the progress of meeting its MFP benchmarks within the MCOs. Summary of 2013 performance on annual transition benchmarks in the Kansas Money Follows the Person grant follows:

			Elderly	DD/ICF	PD	TBI
100% of annual transition benchmarks are achieved.	N	Total number of annual transition benchmarks achieved	**35**	**29**	**110**	**8**
	D	Total number of annual transition benchmarks.	**85**	**40**	**280**	**20**
		Percent Achieved	**41.18%**	**72.50%**	**39.29%**	**40.00%**

Note: This data is reported to CMS on a calendar year.

			Elderly	DD/ICF	PD	TBI
Post transition success - 80% of people who transition will receive adequate services/supports to remain successfully in the community	N	total number of current MFP participants who are re-institutionalized.	3	0	4	0
	D	Total number of current MFP participants	62	51	223	19
		Percentage Reinstitutionalized	**4.84%**	**0.00%**	**1.79%**	**0.00%**
		Percentage of MFP participants maintaining the same level of service after moving to HCBS during the measured time frame.	**95.16%**	**100.00%**	**98.21%**	**100.00%**

Note: This data is reported to CMS on a calendar year.

VII. STC 78(f) – HCBS Waiver Waitlists

Pursuant to STC 47, the state must report on the status of individuals receiving HCBS services. The report must include:

A. Total number of individuals in nursing facilities, and public ICF/IDs

Program	CY 2012	CY 2013
Nursing Facilities	14,913	14,517
Public ICF/IDs	350	344

B. Total number of people on each of the 1915(c) waiting lists
   - Intellectual/Developmental Disabilities waiver program: 3,141 unserved as of December 2013.
   - Physical Disabilities waiver program: 2,000 estimated; list currently undergoing verification.

C. Number of people that have moved off the waiting list and the reason
   - Intellectual/Developmental Disabilities waiver program:

Reason moved off waiting list (compiled data range is from state fiscal year, except where noted)	Number of People
Children coming into custody	54
Transitions from PRTFs	11
TA services were terminated	13
Autism services were terminated	6
Placed on HCBS Services (compiled data range is calendar year)	182
Determined in Crisis	148
Grand Total	**414**

   - Physical Disabilities waiver program:

Reason moved off waiting list (compiled data range is from calendar year)	Number of People
-	14
Deceased	75
Financially Ineligible	4
Moved out of state	1
No longer meets LTC threshold	2
No longer meets program eligibility criteria	59
Permanent nursing facility placement	4
Placed on HCBS Services	858*
Receiving PACE	14
Refused services	14
Unable to locate/contact	46

*Due to the transition to a web based wait list tracking application in CY 2013, and mass clean-up efforts, not all customers who were removed from the wait list and placed on HCBS were tracked appropriately in the system. However, the agency had 858 customers begin their eligibility for the PD Waiver in CY 2013.

D. Number of people that are new to the waiting list: 570 for I/DD waiver (during the calendar year); to be determined for PD waiver.

VIII. STC 78(h) – Ombudsman Program

Pursuant to STC 42, the state must report on the operation, outcomes, data collected, and activities of the Ombudsman program:

Since its creation, the Office of Ombudsman has served an important role as a resource to Kansas Medicaid consumers. The Ombudsman's office has been available to consumers, and has been able to respond to their inquiries and concerns in a timely and flexible manner. Phone calls were answered promptly and phone messages were returned within four hours. Consumer concerns became increasingly complex as the year progressed, requiring the Ombudsman to devote more time to the many calls received.

The work of the new Ombudsman's office for the first five to six months -- in addition to answering the many and varied questions, concerns -- was to create a network of relationships among KanCare's managed care organizations (MCOs), community service providers and state agencies to coordinate assistance for members who contact the Ombudsman's office.

The Ombudsman was deeply involved with various committees and workgroups throughout the year. Among those are:

1. KDADS Friends and Family Advisory Council and Communication/Education Subcommittee
2. I/DD Waiver Pilot Workgroup
3. KDADS Internal I/DD Workgroup
4. KDADS KanCare Weekly Workgroup
5. CMS Implementation Monitoring Meetings
6. HCBS Technical Workgroup

The Ombudsman presented at various forums throughout the year such as:

- Aging and Disability Resource Center
- Kansas Association for Independent Living
- Kansas Mental Health Coalition
- Kansas Council on Disability Concerns
- Families Together
- Kancare Consumer Tours
- KanCare Advisor News Bulletin articles written by Ombudsman
- Training of State Waiver managers and Quality Assurance staff

The Ombudsman actively participated in internal and external forums to enhance the visibility and understanding of KanCare, addressing the collective concerns and experiences of consumers. The Ombudsman has been accessible to Medicaid beneficiaries enrolled in KanCare throughout the year by phone, by presenting at workgroups and forums, via the KanCare Ombudsman website pages and has

distributed the Ombudsman brochure and KanCare QuickStart brochures (specifically for the I/DD stakeholder population).

An Ombudsman assistant was hired in October 2013. This individual assisted with developing the Ombudsman log and the tools created to provide accurate reports. This addition to staff improved response time and concern resolution. The Ombudsman assistant is the liaison for the recently formed Friends and Family Advisory Council, which formed to create opportunities for parents, guardians and self-advocates to contribute their perspective on policies related to I/DD waiver services.

With the addition of the Ombudsman part-time assistant, the Ombudsman has been proactive in reaching out to stakeholder groups to enhance collaboration and facilitate the input of members. The Ombudsman has researched and collaborated with other concern-resolution resources to improve the function of this important member resource.

A web-based Ombudsman Contact Log was created and later refined for monitoring activity and trends throughout the year. It was later enhanced to include a breakdown by MCO, geography and category of Medicaid service.

Ombudsman Contact Log – 2013
(Phone calls only)

Issue/Concern	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr	2013
Access to Providers (usually Medical)	11	11	8	8	38
Appeals, Grievance	3	16	10	7	36
Assessments	0	0	3	4	7
Billing	73	42	35	24	174
Change MCO	65	26	36	14	141
Dental	0	4	5	1	10
Durable Medical Equipment	0	3	7	5	15
Eligibility	42	25	70	33	170
Pharmacy	41	42	15	15	113
Reduction in hours of service	11	16	12	35	74
Transportation	11	9	3	6	29
Reason for call not disclosed	37	100	116	48	301
Returning your call	7	28	21	16	72
Thank you.	2	7	2	3	14
Unspecified	312	127	93	122	654
Total	**615**	**456**	**436**	**341**	**1848**

The focus of Ombudsman contact concerns for the first and third quarters (from the transportation line up) were billing, changing a member's MCO and eligibility determination. In the second quarter, the most frequent inquiries were in regard to pharmacy and billing, which were tied at the top, followed by changing MCOs and eligibility determination. In the 4th quarter reductions in hours of services moved to the top, followed by eligibility determination and billing.

Much of the utility of the Ombudsman's office is a result of the unique perspective gained through daily interactions among consumers, the state, the MCOs and many other stakeholder groups.

In summary, the Ombudsman has been a responsive resource for KanCare members. When members have concerns, they are being heard and addressed. With the addition of a part-time assistant, communication and statistical reporting of interactions and outcomes will be more timely and objectively documented.

IX. STC 78(i) – ID/DD Pilot Project

Pursuant to STC 53, the state must report close out activities following the sunsetting of the pilot on January 31, 2014, on the status of the ID/DD Pilot Project. Please see the document attached, entitled "KanCare I/DD Pilot Project – Pilot Activities through 12/31/13."

X. STC 78(j) – Managed Care Delivery System

A. Project Status, Accomplishments and Administrative Challenges: The initial focus of KanCare implementation was to ensure a successful transition for all populations, with a particular emphasis on populations new to managed care, including the elderly and people with disabilities. Steps taken included:
    - Increased staffing at the enrollment broker during the transition to KanCare
    - Rapid response calls open to providers and consumers during the first six months
    - Regular reporting of key operational data
    - Claims system monitoring
    - Separate and joint critical issues logs
    - Regular meetings involving KDHE, KDADS and all three MCOs
    - Educational and listening tours
    - Complex case staffing meetings with KDADS and MCOs
    - KanCare Advisory Council and external workgroup meetings
    - Provider experience survey
    - Expansion of Ombudsman's office

The initial enrollment of approximately 370,000 people into the program was largely successful, with protections built into the Demonstration playing an important role. For example, primary care physician assignment, which was a responsibility of the MCOs using historical data from the State, led to a number of instances of incorrect pairings of members with PCPs. However, continuity of care protections for all beneficiaries during the first 90 days of KanCare mitigated the effect of such errors by allowing access to previous providers regardless of contracting status. All three MCOs also have open PCP policies, so even after the continuity of care period ended, their members could still see any PCP in their network, not just the PCP on their cards.

Despite some stakeholder concerns that the transition to KanCare might have a negative effect on enrollment, total Medicaid and CHIP KanCare membership increased nearly 4% during the year. While this report details Medicaid enrollment, CHIP enrollment also increased from 51,450 in January to 56,194 by the year's end.

Total managed care enrollment*:

January 2013: 369,866
December 2013: 384,176
*Point in time enrollment, excludes prior month assignments

Among remaining challenges from the initial implementation, ensuring that providers are paid promptly and correctly continued to be marked for improvement. As the first quarterly report for 2014 will note, the State supported legislation, in collaboration with the Kansas Hospital Association, Kansas Medical Society and other provider groups, applying interest penalties on late payments from MCOs to providers. The State also launched a provider experience survey in late 2013 to assist in the development of focused interventions to resolve outstanding issues.

B. Interim Evaluation Findings: The contractor for conducting KanCare Evaluation activities is the Kansas Foundation for Medical Care. KFMC's annual report related to Demonstration Year 1 is attached, entitled "2013 KanCare Evaluation Annual Report – January-December 2013."

C. Utilization Data: Utilization data related to all three KanCare MCOs, separately addressing physical health services, behavioral health, nursing facility, and HCBS services, are collected, with data reported by demonstration quarter. Final adjusted data through the fourth quarter of DY1 will be available in April. The reports are one component of the state's utilization analysis.

D. CAHPS Survey: In 2013, Sunflower State Health Plan (SSHP) was the only KanCare MCO that conducted a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. SSHP conducted CAHPS 5.0 adult and child surveys, July 24 through October 14, 2013. This timeframe is not the normal timeline for CAHPS surveys, which are generally conducted nationally from mid-February through the end of May each year. SSHP needed to complete either an adult or child CAHPS survey prior to January 2014 due to the timeline for their full NCQA accreditation

application. SSHP moved forward with the survey with the expectation that the results would be affected by the implementation of the new KanCare program. For 2014, all three KanCare MCOs will conduct CAHPS 5.0H adult and child with chronic conditions surveys within the normal timeline. The MCOs expect to receive plan level results by mid-July and to have their action plans completed by October 15, 2014.

E. Annual Summary of Network Adequacy: The MCOs continue to recruit and add providers to their networks. Later in the year, efforts were focused on providers of I/DD services in preparation of carving these services into KanCare. The number of contracting providers under each plan is as follows (for this table, providers were de-duplicated by NPI):

KanCare MCO	# of Unique Providers as of 3/26/13	# of Unique Providers as of 6/30/13	# of Unique Providers as of 9/12/13	# of Unique Providers as of 12/20/13
Amerigroup	11,746	16,706	16,891	17,352
Sunflower	10,006	13,016	14,478	15,404
UHC	11,105	14,738	15,893	18,010

Gaps in coverage are reported each month by the MCOs by way of Geo Access Reports. Where gaps exist, the plans report their strategy for closing those gaps. In addition to continuing to recruit pre-KanCare Medicaid providers and any newly identified providers, the plans are committed to working with providers in adjacent cities and counties to provide services to members. Required levels of network coverage for HCBS services are met with the exception of a few specialties in which there is a shortage of providers available. In these instances, the plans are working with and encouraging contracted providers to extend services to areas without providers. An initial assessment of provider network prep and post implementation is included in the attached "2013 KanCare Evaluation Annual Report – January-December 2013" by KFMC.

Regarding MCO compliance with provider 24/7 availability, information as to each of the MCOs' processes, protocols and results on this issue follow:

Amerigroup – Amerigroup's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, provider must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Amerigroup's provider manual, incorporated by reference into provider contracts, also requires that PCPs arrange for coverage of services to assigned members 24 hours a day, 7 days a week in person or by an on-call physician.

In order to properly monitor that this access is available, Amerigroup conducts an annual survey over a broad spectrum of providers (both primary care and specialists) surveying their availability to members. The results of Amerigroup's first annual survey showed 87% of surveyed providers in compliance with the contractual after-hours requirements. Upon receipt

of the results of these surveys, Amerigroup schedules time with providers found not to be in full compliance with the standards to discuss the results. Subsequently, Amerigroup performs "secret shopper" type activities to confirm that providers for whom gaps were previously identified are meeting the access standards. Note also that, in accordance with federal regulations, Amerigroup does not require authorization for emergency services. Providers rendering emergency services are not required to be enrolled in the Amerigroup network to receive payment.

Sunflower – Sunflower's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, provider must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. Sunflower's Provider Manual states that PCPs and specialty physicians are required to maintain sufficient access to needed health care services on an ongoing basis and shall ensure that such services are accessible to members as needed 24 hours a day, 365 days a year as follows. The selected method of 24-hour coverage chosen by the member must connect the caller to someone who can render a clinical decision or reach the PCP or specialist for a clinical decision. Whenever possible, PCP, specialty physician, or covering medical professional must return the call within 30 minutes of the initial contact. After-hours coverage must be accessible using the medical office's daytime telephone number. Sunflower will monitor providers' offices through scheduled and unscheduled visits and audits conducted by Sunflower Provider Relations staff.

Additionally, Sunflower has contracted with NurseWise to provide after-hours services to members and providers. When the Sunflower toll-free number is called after hours, callers have the option of being directed to NurseWise for after hours, weekends and holiday coverage to members and providers. NurseWise reports daily the number of calls received and will escalate any quality of care issues. Sunflower conducts monthly/quarterly Joint Oversight Committee meetings with the vendor to ensure compliance with the contract standards. The oversight meetings are managed by the Sunflower's vendor manager. Members of the Sunflower leadership staff attend the oversight meetings and are responsible for reviewing the reports supplied by the vendor.

United – United's contractual agreements with all its providers mandate that, in accordance with regulatory requirements, providers must ensure that members have access to 24 hour-per-day, 7 day-per-week urgent and emergency services. United's Provider Administrative Guide, which is incorporated by reference into provider contracts, requires that both Primary Care Physicians and Specialists be available to members 24 hours a day, 7 days a week, or have arrangements for live telephone coverage by another UnitedHealthcare provider.

To assess appointment access and availability, United employs a vendor to make calls on their behalf using a script in which the caller identifies themselves as representing the health plan, describes symptoms that represent either an urgent need or a routine need, and requests the

next available appointment with the specific provider named on the list. The script scenarios include both child and adult symptoms/appointments. A random sample of calls is also done after hours to assess whether on-call service is available and how quickly care can be provided. A random sample of 10% of callers employ a "Secret Shopper" method in which they do not identify themselves as representing a plan until after the appointment time has been given. The results of the 2013 information was recently provided to United and for the providers contacted in 2013, results reflected 70% compliance with the 24/7 requirement. Providers who were not in compliance will be contacted and educated regarding the requirements to provide 24/7 coverage.

F. Outcomes of Onsite Reviews – EQRO, Financial, Other: The State of Kansas scheduled two rounds of onsite reviews in DY 1. As the initial launch and the six-month intense monitoring phase of oversight for the KanCare program came to a conclusion, Kansas conducted focused reviews of key infrastructure issues at each of the MCOs, to validate performance and help ensure strong performance as we shifted to the longer term operation of the program. Based on experience in the first two quarters, the areas selected for more intensive desk review and onsite review included: customer service, provider credentialing, grievance/appeal management, prior authorization timeliness and accuracy, and TPL/client obligation/spend down processes. That focused review was conducted during the third quarter, and results of the review were developed and provided to the KanCare MCOs. Overall performance in the focused review met expectations, but also led to action items to enhance performance and compliance. The results of the focused review are summarized in the attached report: "Report on Focused Review of KanCare Managed Care Organizations – July 2013."

   Those focused review items which were noted as areas for improvement or action items were incorporated into the comprehensive annual compliance reviews of the MCOs – which are being done in partnership between Kansas' External Quality Review Organization and the two state agencies (KDHE and KDADS) managing the KanCare program, to maximize leverage and efficiency. Those annual reviews, which address both MCO regulatory requirements and many key state contract requirements, evaluating programmatic, financial and regulatory compliance, began in the fourth quarter of 2013 and were completed in the first quarter of 2014; related reporting will be completed in the second quarter of 2014.

G. Summary of PIPs: Two of the three KanCare MCOs initiated performance improvement projects (PIP) in July 2013, United and Amerigroup. Sunflower's project planning process extended into late 2013; therefore, interventions were not initiated until January 1, 2014. The three MCOs are also working on finalizing the methodology for a collaborative PIP focused on diabetes prevention to be implemented in quarter two of CY2014. Each PIP methodology was reviewed and revised to ensure that clear interventions, outcomes, tracking, and measurement methods were identified. Representatives of each MCO report PIP progress at monthly KanCare

interagency meetings. Written quarterly updates have also been provided post-implementation of each PIP. Following is a brief summary of each MCO's PIP and current standing.

United selected follow-up after hospitalization for mental illness (FUH) for its PIP topic. United estimated that 900 members would participate in the PIP, including 862 Title XIX and 38 Title XXI. United is working to answer the study question, "Does providing timely and appropriate aftercare appointments for members hospitalized for select mental health disorders increase member compliance with follow-up care?" United's interventions include assigning various levels of MCO staff pre-discharge through the follow-up period, and ensuring patients have appropriate medication at time of discharge. Preliminary results for the first six months (July-December 2013) currently indicate that the 30-day ambulatory rate has noticeably increased over baseline.

Amerigroup selected well-child visits in the third, fourth, fifth, and sixth years of life for their PIP topic. Amerigroup estimated that 19,695 members will be eligible for the study, including 17,037 Title XIX and 2,658 Title XXI. Amerigroup is working to answer the study question, "Does the implementation of targeted interventions improve well-child visit rates in the third, fourth, fifth, and sixth years of life?" Amerigroup's interventions include: member education; a rewards program of $25 paid to parents for compliance with well child visits for those aged 5 and 6; birthday postcards; reminder calls; community events; and provider outreach. Monthly data indicate a positive trend; however, initial results appear to be below the goal. Annual data will be compared with pre-KanCare HEDIS data. If the annual rates are not higher than the 2012 rate, the State will work with Amerigroup to adapt the PIP to improve progress.

Sunflower selected initiation and engagement in alcohol and other drugs (AOD) treatment for its PIP topic. Sunflower estimated that 12,467 members will participate in the PIP, including 9,932 Title XIX and 2,537 Title XXI. Sunflower is working to answer the study question, "Will provision of care coordination to members diagnosed needing AOD treatment result in a statistically significant improvement in member initiation and engagement in AOD services?" Sunflower's primary intervention will be the offering of care coordination to the project population. Sunflower will also work to promote partnerships between care coordinators and providers, schedule and promote meetings with providers and care coordinators to generate ideas on how to improve member engagement, and provide specific trainings to providers based on training needs identified during the meetings.

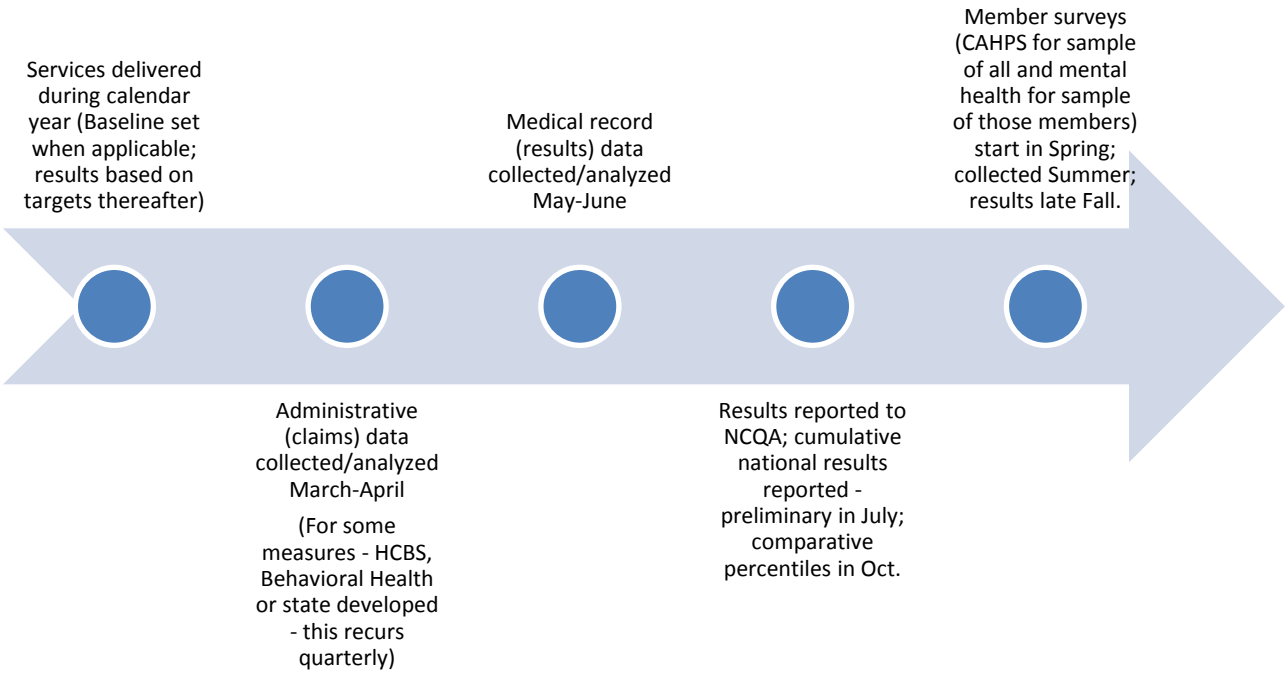
H. Outcomes of Performance Measure Monitoring: The State of Kansas gave special emphasis to real-time process-oriented performance monitoring in the implementation phase of KanCare. Pay for performance measures were regularly reported and were provided to legislative oversight committees and stakeholders. A report reflecting results regarding these performance measures is attached, entitled "KanCare Pay for Performance Measures – Year 1 Summary as of March 2014." Please note the results provided are not yet final, as run out time is required for

certain measures (i.e., claims processing), and validation procedures will be completed in Spring 2014.

As noted earlier in this report, performance measures related to the HCBS waiver programs that are a significant part of the KanCare program and quality strategy have been updated pursuant to STC 46 to reflect services delivered in a managed care system. Kansas will draft revisions to the KanCare Comprehensive Quality Strategy and submit them to CMS for review once the updated waiver performance measures are approved by CMS.

Measures based on standardized HEDIS data analysis will be available in July 2014. Other measures are included V of this report; and in the "2013 KanCare Evaluation Annual Report – January-December 2013" by KFMC, which is attached to this report.

A summary of the cycle related to performance measure outcome data collection, analysis and reporting is as follows:



I. Summary of Plan Financial Performance: The KanCare health plans are required to report specific financial measures to KDHE. The financial data reported to KDHE includes but is not limited to: net income/loss, premium revenue, administrative expenses, medical expenses, and

medical loss ratios (MLRs). In addition, National Association of Insurance Commissioners statutory financial reports are submitted to the Kansas Insurance Department (KID) and the KDHE.

As of December 31, 2013, all three plans are in a sound and solvent financial standing. Although each health plan experienced net operating losses for demonstration year 1, each plan's parent entity contributed adequate capital to ensure each health plan met or exceeded capital requirements as outlined in state of Kansas solvency statutes and requirements. Based on analysis of actual member mix to assumed mix in the blended Long Term Care rate cells and medical cost experience to date, the state completed a planned mid-year rate adjustment for DY1.

As KanCare begins DY 2, filings with the Kansas Insurance Department, as well as analysis completed by KDHE, indicate that each MCO has significantly reduced their medical loss ratios. We anticipate this trend to endure as the MCOs continue their focus on improving the health outcomes of the Medicaid beneficiaries.

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

J. Analysis of Service Reductions: This analysis is included in the document attached entitled "Service Reduction Update – KanCare DY1 (2013)."

XI. Enclosures/Attachments

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

- Safety Net Care Pool Payment Report – DY1 – 2013
- KanCare Budget Neutrality – Demonstration Year 1
- KanCare I/DD Pilot Project – Pilot Activities Through 2013
- Kansas Foundation for Medical Care's 2013 KanCare Evaluation Annual Report – January-December 2013
- Report on Focused Review of KanCare Managed Care Organizations – July 2013
- KanCare Pay For Performance Measures – Year 1 Summary as of March, 2014
- Service Reduction Update – KanCare DY1 (2013)

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Finalized after CMS approval April 25, 2014

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 1 - QE March 2013

Uncompensated Care Pool/Large Public Teaching Hospital-Border City Children's Hospital

*IGT funds are received from the University of Kansas.

COS: 011	PCA: 35008
Reason Code: LPBC	

Sum of Amount Paid Row Labels	Column Labels Q1	Q2	Q3	Q4	Grand Total
Children's Mercy Hospital	2,491,034.38	2,491,034.00	2,491,034.00	2,491,034.00	9,964,136.38
University of Kansas Hospital	7,473,103.00	7,473,103.00	7,473,103.00	7,473,103.00	29,892,412.00
Grand Total	**9,964,137.38**	**9,964,137.00**	**9,964,137.00**	**9,964,137.00**	**39,856,548.38**

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 1 - QE March 2013

COS: 011	PCA: 03264
Reason Code: HCAP	

Health Care Access Improvement Pool

Sum of Amount Paid Row Labels	Column Labels Q1	Q2	Q3	Q4	Grand Total
Bob Wilson Memorial Hospital	30,672	30,672	30,672	30,671	122,687
Children's Mercy Hospital South	132,776	132,776	132,776	132,777	531,105
Coffey County Hospital	22,628	22,628	22,628	22,627	90,511
Coffeyville Regional Medical Center, Inc.	85,288	85,288	85,288	85,286	341,150
Cushing Memorial Hospital	121,789	121,789	121,789	121,790	487,157
Galichia Heart Hospital LLC	36,289	36,289	36,289	36,289	145,156
Geary Community Hospital	108,556	108,556	108,556	108,555	434,223
Hays Medical Center, Inc.	372,362	372,362	372,362	372,360	1,489,446
Hutchinson Hospital Corporation	290,352	290,352	290,352	290,353	1,161,409
Kansas Heart Hospital LLC	30,369	30,369	30,369	30,369	121,476
Kansas Medical Center LLC	46,233	46,233	46,233	46,231	184,930
Kansas Rehabilitation Hospital	6,317	6,317	6,317	6,315	25,266
Kansas Surgery & Recovery Center	4,846	4,846	4,846	4,845	19,383
Labette County Medical Center	90,810	90,810	90,810	90,809	363,239
Lawrence Memorial Hospital	223,486	223,486	223,486	223,485	893,943
Marillac Center, Inc.				94,293	94,293
Memorial Hospital, Inc.	42,456	42,456	42,456	42,455	169,823
Menorah Medical Center	207,646	207,646	207,646	207,647	830,585
Mercy - Independence	47,986	47,986	47,986	47,986	191,944
Mercy Health Center - Ft. Scott	82,850	82,850	82,850	82,851	331,401
Mercy Hospital, Inc.	3,239	3,239	3,239	3,238	12,955
Mercy Reg Health Center	755,583	170,152	170,152	170,151	1,266,038
Miami County Medical Center	57,668	57,668	57,668	57,668	230,672
Mid-America Rehabilitation Hospital	17,575	17,575	17,575	17,574	70,299
Morton County Health System	35,477	35,477	35,477	35,477	141,908
Mt. Carmel Medical Center	207,216	207,216	207,216	207,215	828,863

Newman Memorial County Hospital	127,347	127,347	127,347	127,347	509,388
Newton Medical Center	123,879	123,879	123,879	123,877	495,514
Olathe Medical Center	366,181	366,181	366,181	366,180	1,464,723
Overland Park Regional Medical Center		585,431	585,431	585,432	1,756,294
Prairie View Inc.				104,616	104,616
Pratt Regional Medical Center	57,255	57,255	57,255	57,255	229,020
Providence Medical Center	396,598	396,598	396,598	396,597	1,586,391
Ransom Memorial Hospital	73,654	73,654	73,654	73,654	294,616
Salina Regional Health Center	263,396	263,396	263,396	263,395	1,053,583
Salina Surgical Hospital	654	654	654	654	2,616
Select Specialty Hospital - Kansas City	5,211	5,211	5,211	5,211	20,844
Select Specialty Hospital - Wichita	5,736	5,736	5,736	5,734	22,942
Shawnee Mission Medical Center, Inc.	707,194	707,194	707,194	707,194	2,828,776
South Central KS Reg Medical Center	21,473	21,473	21,473	21,471	85,890
Southwest Medical Center	117,327	117,327	117,327	117,325	469,306
Specialty Hospital of Mid America	376	376	376	374	1,502
St. Catherine Hospital	172,435	172,435	172,435	172,436	689,741
St. Francis Health Center	619,423	619,423	619,423	619,423	2,477,692
St. John Hospital	99,673	99,673	99,673	99,674	398,693
St. Luke's South Hospital, Inc.	121,261	121,261	121,261	121,260	485,043
Stormont Vail Regional Health Center	943,679	943,679	943,679	943,679	3,774,716
Summit Surgical LLC	776	776	776	775	3,103
Sumner Regional Medical Center	27,744	27,744	27,744	27,744	110,976
Susan B. Allen Memorial Hospital	114,299	114,299	114,299	114,300	457,197
Via Christi Hospital St. Teresa	161,584	161,584	161,584	161,582	646,334
Via Christi Regional Medical Center	1,465,595	1,465,595	1,465,595	1,465,595	5,862,380
Via Christi Rehabilitation Center	17,202	17,202	17,202	17,203	68,809
Wesley Medical Center	1,000,423	1,000,423	1,000,423	1,000,422	4,001,691
Western Plains Medical Complex	125,520	125,520	125,520	125,521	502,081
Grand Total	**10,196,364**	**10,196,364**	**10,196,364**	**10,395,247**	**40,984,339**

KanCare Budget Neutrality
Demonstration Year 1

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

	Assistance Total Expenditures	Total Member Months	Administration Total Expenditures
DY1Q1	555,175,207.43	976,512	
DY1Q2	560,306,050.12	988,890	
DY1Q3	615,836,292.23	1,003,208	
DY1Q4	660,816,744.59	1,009,599	
DY1 Total	2,392,134,294.37	3,978,209	122,271,008

UNIQUE ENROLLEES			
Pop 1: ABD/SD Dual	24,656	Pop 6: LTC	27,610
Pop 2: ABD/SD Non Dual	37,878	Pop 7: MN Dual	4,243
Pop 3: Adults	53,068	Pop 8: MN Non Dual	5,775
Pop 4: Children	264,763	Pop 9: Waiver	6,453
Pop 5: DD Waiver	9,269		
		Total:	433,715

OVERALL UNDUPLICATED BENEFICIARIES:	413,372

	Population 1: ABD/SD Dual	Population 2: ABD/SD Non Dual	Population 3: Adults	Population 4: Children	Population 5: DD Waiver	Population 6: LTC	Population 7: MN Dual	Population 8: MN Non Dual	Population 9: Waiver
DY1Q1									
Expenditures	11,820,828.17	83,365,882.52	37,508,648.01	117,749,154.42	98,864,926.01	160,873,260.89	4,005,540.87	5,098,329.12	35,888,637.42
Member-Months	52,544	85,766	92,224	631,785	26,181	66,354	3,580	4,248	13,830
PCP	0	0	0	0	0	0	0	0	0
DY1Q2									
Expenditures	12,021,095.74	87,856,425.67	39,590,922.31	125,151,359.00	101,616,384.21	159,822,442.76	4,089,361.03	4,968,313.42	36,199,688.52
Member-Months	53,895	88,479	98,306	632,145	26,454	66,590	4,036	5,056	13,929
PCP	(65,051.75)	(2,400,217.79)	(698,151.79)	(6,620,191.78)	(232,611.03)	(606,434.10)	(4,575.82)	(120,604.86)	(262,103.62)
DY1Q3									
Expenditures	13,190,367.76	95,539,177.99	43,709,968.63	132,805,882.58	102,862,031.04	183,243,140.15	4,776,346.96	5,996,100.66	39,315,632.80
Member-Months	55,025	90,849	100,335	638,676	26,870	67,756	4,282	5,528	13,887
PCP	(33,309.66)	(1,241,357.82)	(365,445.62)	(3,351,547.66)	(111,565.53)	(303,243.48)	(2,465.11)	(61,965.67)	(131,455.79)
DY1Q4									
Expenditures	13,281,236.97	96,145,932.42	95,278,930.96	134,911,356.99	99,616,378.95	177,720,775.44	4,624,613.17	5,876,627.35	38,985,911.98
Member-Months	55,053	90,276	106,061	641,989	26,652	67,802	4,175	4,156	13,435
PCP	(33,232.87)	(1,276,873.17)	(370,574.65)	(3,335,108.85)	(114,019.70)	(300,862.43)	(2,388.32)	(61,568.26)	(130,391.39)
DY1 Total									
Expenditures	50,181,934.36	357,988,969.82	214,654,297.85	497,310,904.70	402,501,523.95	680,449,079.23	17,486,432.78	21,695,231.76	149,865,919.92
Member-Months	216,517	355,370	396,926	2,544,595	106,157	268,502	16,073	18,988	55,081
DY 1 PMPM	231.77	1,007.37	540.79	195.44	3,791.57	2,534.24	1,087.94	1,142.58	2,720.83

Notes

1) FOR DY1Q4 ONLY - Population 3 Adults- reported expenditures are significantly higher in the quarter due to the inclusion of retroactive delivery payments.

2) Administration costs are allocated to the waiver based on the percentage of Waiver assistance expenditures to the total Medicaid assistance expenditures.

3) Unique Enrollees are individuals who are reported only one time for each population group that they received benefits from being enrolled in. Overall Unduplicated Beneficiaries are the number of beneficiaries only being counted one time regardless of the number of population groups that they received benefits from. The reason for the difference is an individual has the potential to move from one population group to another throughout the year.

4) Member month information has been updated for Q1-Q4 to reflect actual year end enrollment information for DY1.

5) MEG 5 DD - LTSS portion includes all claims paid for DY1 dates of service, including ID/DD pilot expenditures.

6) CHIP and Refugee populations are not included in BN member months or expenditures.

7) Share of Cost is excluded from expenditures.

KanCare I/DD Pilot Project

Pilot Activities through 12/31/13

The Kansas Department for Aging and Disability Services began the rollout of the KanCare Pilot Project for persons with Intellectual and/or Developmental Disabilities (I/DD) during the spring of 2013. Requests to Participate were accepted until June 30, 2013 to allow individuals to volunteer to participate in the pilot after the close of the legislative session. The final I/DD Pilot list was provided to the MCOs for their review and acceptance.

Over 500 individuals receiving services through the Home and Community Based Services (HCBS) and approximately 25 service providers enrolled in the KanCare I/DD Pilot Project. The primary objective of the I/DD Pilot Project was to prepare the I/DD population being served by the HCBS I/DD Waiver for full inclusion in KanCare by January 1, 2014.

The three main objectives of the KanCare I/DD Pilot Project, as developed by the blue-ribbon panel of I/DD stakeholders, were as follows:

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

1. Relationship building/shared understanding between MCOs and I/DD system

- With the assistance of Wichita State University, the State and members of the KanCare I/DD Pilot Advisory Committee developed a survey to measure all participant and guardian levels of knowledge of KanCare at different stages of the Pilot process.

- The MCOs participated regularly in the I/DD Pilot Committee biweekly meetings, which included representatives from targeted case managers, community developmental disability organizations (CDDOs), community service providers (CSPs) and KDADS.

- The MCOs answered questions and provided information about billing, person centered planning process, the role of the care coordinator, and communication with providers and CDDOs in the twice weekly Provider Lunch and Learn calls that started in December and will continue through the first quarter of 2014.

- The MCOs answered questions and provided information for consumers, guardians, friends and family members on a weekly call with the KanCare Ombudsman that started in December and will continue through the first quarter of 2014.

- As a part of the effort to increase the knowledge level of Managed Care Organizations (MCOs) regarding the I/DD system, members of the Advisory Committee invited Care Coordinators from the MCO's to meet with several current I/DD system Targeted Case Managers and discuss the roles of both the Care Coordinators and the TCMs.

- Also, members of the Employment First Work Group met with MCOs and the Pilot Advisory Committee to discuss challenges related to increasing the numbers of people with disabilities to obtain employment in integrated/competitive work settings.

- The MCOs and Pilot Advisory Committee also met with members of the Challenging Behaviors Work Group to discuss issues related to supporting persons who demonstrate difficult to manage behaviors.

- During the month of June, State staff, along with staff from the MCOs and representatives from the Advisory Committee held meetings in Garden City, Arkansas City/Winfield, Parsons, and Lawrence and met with more than 100 participants, providers and TCMs to provide information regarding KanCare and the Pilot. Another meeting was held in early July in Great Bend.

- WSU worked with KDADS, the Pilot Workgroup and the Friends and Family Advisory Council to develop information for Consumers related to KanCare. This included a brochure and informational letter that explained what KanCare was, how it worked, and what individuals could expect to change or stay the same after implementation.

- KDADS hosted several educational sessions fostered by recommendations from the IDD Pilot Workgroup and other stakeholders. In September 2013, national advocates spent two days in Kansas educating the State and MCOs about IDD and managed care. They also hosted a listening information session for stakeholders and Pilot Workgroup members to learn more about IDD on the national stage and how the system could be improved in Kansas under KanCare. The information is available on our website at: http://www.kdads.ks.gov/CSP/IDD/KanCare_Imp/HCBS-IDD_Stakeholder_Session_09_2013.pdf

2. Define how services/service delivery will look under KanCare

- At the most fundamental level, the Pilot Committee, the State, and all three MCOs agreed that service delivery and the assessment/tiering for those services should remain in the hands of the CDDOs, CSPs, and TCMs. CDDOs have continued to perform BASIS Assessments to determine eligibility for the I/DD Waiver services. TCMs have developed the plan of care and worked with the MCOs. Several meetings between the CDDOs and MCOs were instrumental in developing detailed workflows and agreements between the MCO and CDDO related to HCBS-IDD access, communication, and program development after implementation.

- Since January 2012, the Administration has maintained its policy decision to allow individuals with I/DD the ability to retain their Targeted Case Manager (TCM). As such, the I/DD Pilot began working on reviewing the role and responsibilities of TCM and aligned the definitions and work of the TCM with CMS regulations in the second and third quarters of 2013.

- I/DD Waiver recipients in the KanCare I/DD Pilot Project were able to take advantage of the Value-Added Services available through the MCO Health Plans. Limited Care Coordinator interaction with Pilot members occurred at the beginning of the third quarter. Pilot members did not experience major service delivery interruptions while in the Pilot Project, and they had access to complex case staffing and opportunities to integrate critical physical and behavioral health services with the long-term supports and services on the HCBS-IDD program.

- Following the close of the legislative session, the I/DD Pilot Committee focused on clearly defining the services and service delivery for the I/DD population that would meet the needs of the consumer while aligning with the managed care delivery system under KanCare.

- During the fourth quarter the I/DD Pilot Committee shifted its focus from developing the claims/billing system to developing the practical aspects of the workflow process including the development and transmission of the plans of care to the MCOs

- An End-to-End Workflow that described the Person Centered Planning process and development of the Integrated Service Plan was developed by the group and reviewed by CMS. It was finalized in December 2013, and has been posted to the KDADS website along with other workflows related to IDD and KanCare. The workflow is available at: http://www.aging.ks.gov/HCBSProvider/IDD_Provider_Index.html.

- The roles of the Care Coordinator and Targeted Case Manager were finalized during the fourth quarter of 2013, and additional training and interaction were expected to occur during the first quarter of 2014, and will be reported in the quarterly report.

3. Develop/Test billing processes for January 1, 2014 inclusion**

- The I/DD Pilot Committee monitored the progress of the technical development of the claims billing system for the I/DD Pilot to test claims prior to the January 1, 2014 implementation.

- Establishing and testing billing processes for I/DD services under KanCare was the focus of the Pilot Committee. However, until the close of the session, many were hesitant to begin detailed discussions about the IT requirements and synchronization between MCO, State, and Provider billing mechanisms. As a result, explicit discussions about how to bill were not had until the beginning of June.

- IT development of the IDD billing structure started in June of 2013. IT staff from the State, MCOs and the State fiscal agent started testing the billing system interfaces in late August and September of 2013. Realistic test scenarios were identified by the KanCare IDD Pilot and utilized in testing the system. The testing was developed to allow pilot service providers to bill and receive payment for services provided to pilot participants in a manner similar to how they would under KanCare during the fourth quarter of 2013. The testing provided valuable insight into areas for improvement in the technical development of pilot billing/claims system, which included continuing to use the KMAP system for front-end billing as well as allowing billing through the MCO web portals. The information learned is available in the "Billing Lessons Learned in the KanCare IDD Pilot" and was used to improve the MCO billing system for all HCBS programs and to accommodate IDD-specific elements to be added the MCO billing system.

- Providers received training regarding the process prior to initial claims billing. Development of the billing pilot for IDD long-term supports and services revealed billing related issues in the fee-for-service system related to partial billing of whole units for Day Supports and Targeted Case Management. Training was conducted with community service providers. The Day Supports unit changed from 1 unit = 1 day to 1 unit = 15 minutes. This change was made to ensure compliance with whole unit billing and continued to allow community service providers the billing flexibility to which they were accustomed. This change was announced on October 15, 2013, and became effective on January 1, 2014.

- On October 1, 2013, providers participating in the pilot began receiving payments for services provided to individuals with I/DD from the appropriate MCOs for persons who were participating in the pilot. The Pilot providers could continue to bill as they had through KMAP or, once they had been trained by the MCO, have the option to bill directly through the MCOs' portals. This activity was a part of our efforts to assure we would be in a position to make timely payments for claims beginning on January 1, 2014. Provider feedback on the process allowed the MCOs to improve their systems. The process revealed critical components of Provider Training for billing, which occurred on October 3rd and October 8th.

- During the last quarter of 2013, IDD Pilot testing of payments and claims occurred. Initial processing of payments for the Pilot Providers revealed several areas for improvement that were corrected and addressed by the MCOs, KDADS, and HP. Attached is a copy of the lessons learned regarding IDD Pilot Billing.

- The Pilot Providers participated in bi-weekly teleconferences with the MCOs to discuss payment and billing related issues and identify potential issues that could be resolved. Each MCO designated one respondent for Pilot Providers who generally responded to inquiries within 48 hours and assisted providers in connecting with MCO billing trainings and provider representatives. To minimize billing issues related to plans of care, all plans of care that were in approved status as of December 27, 2013, were extended until March 31, 2014 to ensure the MCOs had sufficient time to load authorizations into their systems and develop integrated service plans for individuals with January, February and March birthdates.

- Approximately $3.9 million dollars were paid on 4,130 of the 5,135 claims that were billed on or before December 31, 2013. MCOs and Providers worked proactively to address billing and claims issues by highlighting key areas of concern and meeting with the MCOs regularly to discuss their concerns. The MCOs hosted several weekly trainings for billing and worked with providers on completing contracting and credentialing to ensure a smooth transition after the continuity of care period ends.

***On December 27th, the State announced that the integration of long-term care services for persons with intellectual/developmental disabilities into KanCare would be delayed temporarily. The State continued to work with the Centers for Medicare and Medicaid toward a February 1, 2014 agreement that would include a new implementation date. The IDD Delay letter was emailed to providers and CDDOs on Friday, December 27th. A copy of the letter is available on the Provider Page. (Go to www.kdads.ks.gov and click on the "Provider" link). As a result, the IDD Pilot was continued into the first quarter of 2014. The IDD Pilot Evaluation will not be completed and reported until the second quarter of 2014.

Billing Lessons Learned from the KanCare I/DD Pilot Project

Through the KanCare Pilot, there were four common claims and billing issues identified. The state has worked with the Managed Care Organizations (MCOs) to ensure these identified issues did not cause payment disruption when HCBS/IDD long-term supports and services and Targeted Case Management services were implemented into KanCare.

The identified issues and the plans of correction are described below:

Missing Authorizations

- Due to the complexity of the manual Pilot Billing process in coordinating the Fee-for-service system with the MCO systems, there were issues with missing Plans of Care files being transmitted electronically to the MCOs.
- To ensure the plan of care transition did not cause a payment delay, the MCOS will not deny claims for missing HCBS/DD Plan of Care authorizations during the continuity of care pweriod. Instead, there were review processes put in place prior to and after claims were paid that ensured a valid authorization was on file.
- As the authorization systems are validated by the MCOs, the State and the MCOs will work to turn this edit back on during the transition in 2014.

Date Span Billing

- When billing MCOs for unit services that were equal to one day, providers were required to have the number of units billed match the date span.
- Each MCO had training opportunities for providers that needed clarity around date span billing. For implementation, MCOs relaxed their span edit to allow for units billed that did not match billing dates.
- All MCOs provided education to providers and worked with the state to phase this edit back into the process at the appropriate time.

Third Party Liability

- KDHE has been reaching out to insurance carriers in an attempt to secure blanket denials for service codes in order to assist providers in submitting claims with TPL involved. Efforts have been successful in obtaining some blanket denials, but the state has not been able to obtain blanket denials from all carriers.
- KDHE has been asking providers who were able to get a blanket denial from a carrier or service(s), to please share those denials with the state so we could publish them for all providers to use. In order for the state to publish the denials for all providers, they must be blanket denials and not client-specific.

Client Obligation

- Issues around the appropriate deduction of client obligation amounts from payments were identified.
- The MCOs have identified a plan to ensure appropriate process changes to accurately assign client obligation amounts to claims to follow the State's HCBS process. This will continue to be monitored by the State in 2014.
- In addition, MCOs adjusted claims for retroactive client obligation changes made by the state. The process will continue in 2014, and will be monitored by the State to ensure client obligation amounts are properly withheld.

Additional Lessons Learned: MCOs, in conjunction with the State, provided billing education opportunities to providers and added staff to specifically provide outreach and help monitor IDD specific billing issues. Additionally, each MCO has developed a billing guide to address common billing issues and provide basic billing information. Those documents have been shared with providers on the State websites. Open and consistent communication and training opportunities will continue in 2014 to ensure smooth billing.

Both the MCOs and the State will continue monitoring payments compared to fee-for-service trends at a provider level during 2014 to proactively identify any potential cash flow issues that may be on the horizon.

2013 KanCare Evaluation Annual Report
January - December 2013

KFMC Contract Number:	**11231**
Program(s) Reviewed:	**KanCare Demonstration**
Submission Date:	**April 7, 2014**
Review Team:	**Janice Panichello, Ph.D., MPA, AICP, Director of Quality Review and Epidemiologist** **Lynne Valdivia, RN, BSN, MSW, Vice President Quality Improvement and Review**

Prepared for:

KanCare

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April 7, 2014

Background

KanCare is an integrated managed care Medicaid program that is to serve the State of Kansas through a coordinated approach. In 2011, Governor Sam Brownback identified the need to fundamentally reform the Kansas Medicaid program to control costs and improve outcomes. The goal of KanCare is to provide efficient and effective health care services and ensure coordination of care and integration of physical and behavioral health services with each other and with home and community based services (HCBS). On December 27, 2012, the Centers for Medicare and Medicaid Services (CMS) approved the State of Kansas' Medicaid section 1115 demonstration proposal, entitled KanCare. KanCare operates concurrently with the State's section 1915(c) Home and Community-Based Services (HCBS) waivers and together provide the authority necessary for the state to require enrollment of almost all Medicaid beneficiaries (including the aged, people with disabilities, and some individuals who are dually eligible) across the state into a managed care delivery system. This represents an expansion of the State's previous managed care program, which consisted of HealthWave (managed care organization) and HealthConnect Kansas (primary care case management), and provided services to children, pregnant women, and parents in the State's Children's Health Insurance Program (CHIP) and Medicaid programs. 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 will be 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.

GOALS

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 (mental health and substance use disorders) and LTSS;
- **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.

HYPOTHESES

The evaluation will test the following KanCare hypotheses:

- By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs;
- The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired;
- The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, and LTSS; and
- KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

PERFORMANCE OBJECTIVES

Through the extensive public input and stakeholder consultation process, when designing the comprehensive Medicaid reform plan, the State has identified a number of KanCare performance objectives and outcome goals to be reached through the comprehensive managed care contracts. These objectives include the following:

- Measurably improve health care outcomes for Members in the areas including:
  - Diabetes
  - Coronary Artery Disease
  - Prenatal Care
  - Behavioral Health;
- Improve coordination and integration of physical health care with behavioral health care;
- Support Members' desires to live successfully in their communities;

- Promote wellness and healthy lifestyles; and
- Lower the overall cost of health care.

EVALUATION PLAN

Evaluation is required to measure the effectiveness and usefulness of the demonstration as a model to help shape health care delivery and policy. The KanCare evaluation is being completed by the Kansas Foundation for Medical Care, Inc. (KFMC), which will subcontract as needed for targeted review. Evaluation criteria are outlined in the comprehensive KanCare Program Medicaid State Quality Strategy and the Centers for Medicare & Medicaid Services (CMS) Special Terms and Conditions (STCs) document.

In an effort to achieve safe, effective, patient-centered, timely and equitable care the State will assess the quality strategy on at least an annual basis and revise the State Quality Strategy document accordingly. 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, the State Quality Strategy will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use. Revisions in the State Quality Strategy will be reviewed to determine the need for restructuring the specific measurements in the evaluation design and documented and discussed in the evaluation reports.

The KanCare Evaluation Design, approved by CMS on September 11, 2013, includes over 100 performance measures focused on seven major categories:

- Quality of Care
- Coordination of Care (and Integration)
- Cost of Care
- Access to Care
- Ombudsman Program
- Efficiency
- Uncompensated Care Pool
- Delivery System Reform Incentive Program (DSRIP)

These eight categories have 28 subcategories. (See Table 1.) Over the five-year KanCare demonstration, performance measures will be evaluated on either a quarterly basis, an annual basis (beginning in year one), or on an annual basis beginning in year two.

Data for the performance measures are provided by the Kansas Department of Health and Environment – Division of Health Care Finance (KDHE-DHCF) and the Kansas Department for Aging and Disability Services (KDADS). Data sources include state tracking systems and databases, as well as reports from the managed care organizations (MCOs) providing KanCare/Medicaid services. In CY2013, the three

managed care organizations are Amerigroup, Sunflower State Health Plan (Sunflower), UnitedHealthcare Community Plan of Kansas (United). In CY2012, the managed care organizations providing Medicaid services were Coventry Health Care of Kansas, UniCare, Kansas Health Solutions, and Value Options of Kansas.

Table 1 Evaluation Design Categories and Subcategories
Quality of Care
(1) Physical Health
(2) Substance Use Disorder Services
(3) Mental Health Services
(4) Healthy Life Expectancy Measure
(5) Home and Community Based Services (HCBS) Waiver Services
(6) Long Term Care: Nursing Facilities
(7) Member Survey - Quality
(8) Provider Survey
(9) Grievances
(10) Other (Tentative) Studies (specific studies to be determined)
Coordination of Care (and Integration)
(11) Care Management for Nursing Facility (NF) Residents
(12) Care Management for non-NF members
(13) Other (Tentative) Study (specific study to be determined)
(14) Care Management for members with I/DD
(15) Member Survey - CAHPS
(16) Member Survey - Mental Health (MH)
(17) Member Survey - Substance Use Disorder (SUD)
(18) Provider Survey
Cost of Care
(19) Costs
Access to Care
(20) Provider Network - GeoAccess
(21) Member Survey - CAHPS
(22) Member Survey - MH
(23) Member Survey - SUD
(24) Provider Survey
(25) Grievances
Ombudsman Program
(26) Calls and Assistance
Efficiency
(27) Systems
(28) Member Surveys
Uncompensated Care Pool
Delivery System Reform Incentive Program (DSRIP)

Wherever appropriate, and where data is available, performance measures will be analyzed by one or more of the following stratified populations:

- Program - Title XIX (Medicaid) and Title XXI (CHIP)

- Age groups - particularly where stratified in Healthcare Effectiveness Data and Information Set (HEDIS) measures, waivers, and survey populations
- Waiver services
  - Intellectually/Developmentally Disabled (I/DD) and I/DD wait list
  - Physically Disabled (PD) and PD wait list
  - Traumatic Brain Injury (TBI)
  - Technical Assistance (TA)
  - SED (Serious Emotional Disturbance)
  - Frail Elderly (FE)
  - Money Follows the Person (MFP), and
  - Autism
- Providers
- County type (Urban/Semi-Urban, Densely-Settled Rural, Rural/Frontier)
- Those receiving mental health (MH) services
  - Serious and Persistent Mental Illness (SPMI)
  - Serious Mental Illness (SMI)
  - SED (waiver and non-waiver)
- Those receiving treatment for Substance Use Disorder (SUD)
- Those receiving Nursing Facility (NF) services

ANNUAL EVALUATION CALENDAR YEAR (CY) 2013

In this first year of KanCare, baseline data and data criteria have been established and defined. For some of the performance measures, baseline data is available pre-KanCare. Where pre-KanCare data are not available, baseline data are based on CY2013 data.

This first annual KanCare Evaluation includes analysis of performance for several measures that have both pre-KanCare data and CY2013 data available as of March 1, 2014. Data for CY2013 for many of the performance measures are not yet available. The primary reason is that data for the entire year cannot be determined accurately until claims for the year, including fourth quarter CY2013 claims, are more complete (submitted to the MCOs and processed). Several measures are based on standardized HEDIS data analysis, and HEDIS data for 2013 will not be available until July 2014. For measures where pre-KanCare data are available but no CY2013 data are available, this first annual report will provide a summary of the data sources, baseline data sources, populations, and timelines for data availability for comparison in future annual reports. Measures that do not yet have baseline or comparison data available as of March 18, 2014, are described in Appendix A. For a few of the measures in Appendix A, KFMC has provided recommendations on baseline data and reports that were available for preliminary review.

In addition to the measures reviewed annually, there are several measures that are reviewed quarterly. These measures were first reviewed in the KanCare Quarterly Report for CY2013, Quarter 4 (Q4), and are described in Appendix B.

QUALITY OF CARE

Goals, Related Objectives, and Hypotheses for Quality of Care subcategories:

Goal: Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes).

Related Objectives: Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; behavioral health.

- *Improve coordination and integration of physical health care with behavioral health care.*
- *Support members successfully in their communities.*
- *Promote wellness and healthy lifestyles.*

Hypotheses:

- *By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the state will improve health care quality and reduce costs.*
- *The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(See Appendix A for information on additional measures in the following subcategories: (1) Physical Health; (4) Healthy Life Expectancy; (5) HCBS Waiver Services; (6) Long Term Care: Nursing Facilities; (7) Member Survey – Quality; (8) Provider Survey; and (10) Other Tentative Studies. See Appendix B for information on subcategory (9) Grievances.)

(2) Substance Use Disorder (SUD) Services

The following performance measures are based on National Outcome Measures (NOMs) for members who are receiving SUD services, including improvement in living arrangements; reduction in number of arrests; reduction in drug and alcohol use; attendance at self-help meetings; and employment status. Each of these measures will be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare demonstration project.

In the following SUD measures, members may be included in more than one quarter of data (or may be counted more than once in a quarter), as they may be discharged from SUD treatment in one month, but re-enter treatment later in the quarter or year. The denominators in the tables below represent the number of times members were discharged from SUD treatment during the year. The actual number of individual members who received SUD services is not reported.

- Recommendation: KFMC recommends that, where possible, the total number of unduplicated members be reported that received SUD services during the year. Reporting this number would give a clearer picture of the scope and impact of the SUD services provided.

For the SUD performance measures below, fourth quarter rates were compared for CY2012 and CY2013, and rates were compared for Q1 and Q4 of CY2013, to assess statistically significant changes over time. Data were also reviewed for other general trends over time.

- Statistically significant differences
  - Number and percent of members maintaining employment status: In comparing data for Q4 2012 with Q42013, there was a significant increase in the percentage of members discharged from SUD services who maintained employment ($p < 0.03$).
  - Number of members reporting increased attendance of self-help meetings: In comparing data for Q4 2012 with Q4 2013, there was a significant decrease in the percentage of members reporting increased attendance ($p < 0.001$). In Q4 2012, 61.4% of members reported increased attendance compared to 39.1% in Q4 2013.
- General trend comments
  - The number of members discharged from SUD services declined during each subsequent quarter of CY2013, with 264 members discharged in Q1, and 179 discharged by Q4.
    - Recommendation: KFMC recommends that additional information be provided as to the reasons for the decline in the number of members discharged from SUD treatment. If fewer members need treatment (or are not needing additional treatment following discharge), then these declining numbers are a positive result. Alternatively, it is possible that fewer members are being diagnosed as needing SUD treatment that actually need additional treatment. In that case, the results would be a negative trend. Furthermore, the decrease could be a result of less complete data in the system.

- **The number and percent of members receiving SUD services whose employment status was improved or maintained**.
  The denominator for this measure is the number of members, ages 18 and older at admission to SUD services, who were discharged from SUD services during the measurement period, and whose employment status was collected in the Kansas Client Placement Criteria (KCPC) database at both admission and discharge. (See Table 2 below.)

Table 2: Number and percent of members receiving SUD services whose employment status was maintained, CY2012 compared to CY2013

	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members who maintained employment for 30 days prior to discharge	62	74	54	49	78	78	61	63
Denominator: Number of KanCare members discharged from SUD services during reporting period	190	238	180	197	264	254	184	179
Percent of members who maintained employment	**32.6%**	**31.1%**	**30.0%**	**24.9%**	**29.5%**	**30.7%**	**33.2%**	**35.2%**

The numerator is the number of members who reported for the 30 days prior to discharge from SUD services that they maintained employment at both admission and discharge, or that reported that they were employed at discharge.

Analysis: In comparing data for Q4 2012 with Q42013, there was a significant increase in the percentage of members discharged from SUD services that gained or maintained employment ($p < 0.03$). At the end of Q4 2012, 24.9% maintained employment, while at the end of Q4 CY2013, 35.2% maintained employment. Rates for maintaining employment increased during each quarter of CY2013, from 29.5% in Q1 to 35.2% in Q4.

- **The number and percent of members, receiving SUD services, whose attendance of self-help meetings increased**.
The denominator for this measure is the number of members who were discharged from SUD services during the measurement period, and whose attendance at self-help meetings was collected in KCPC at both admission and discharge from SUD treatment services. (See Table 3 below.)

  The numerator is the number of members who reported increased attendance at self-help meetings for the 30 days prior to discharge from SUD services.

Table 3: Number and percent of members receiving SUD services whose attendance of self-help meetings increased, CY2012 compared to CY2013

	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members reporting increased attendance of self-help meetings within 30 days prior to discharge	117	136	108	121	123	98	82	70
Denominator: Number of KanCare members discharged from SUD services during reporting period	190	238	180	197	264	254	184	179
Percent of KanCare members reporting increased attendance of self-help programs	**61.6%**	**57.1%**	**60.0%**	**61.4%**	**46.6%**	**38.6%**	**44.6%**	**39.1%**

Analysis: There was a statistically significant decrease ($p<0.001$) when comparing reported increases in self-help meeting attendance in Q4 CY2012 with reports of attendance in Q4 CY2013. In Q4 CY2012, 61.4% of members receiving SUD services reported increased attendance, while in Q4 CY2013 only 39.1% of members reported increased attendance.

Recommendations:

- KFMC recommends that MCOs work with SUD treatment providers to identify barriers to meeting attendance and to identify any regional differences in attendance rates.
- The SUD survey to be conducted in 2014 is a potential tool to gain information on reasons for poor attendance.
- A major focus of the Sunflower AOD performance improvement project (PIP) is to increase partnerships between providers and care coordinators and generate ideas to increase engagement in treatment. These partnerships can be

opportunities for additional feedback from members and providers on barriers and to generate ideas for improving attendance.

- **The number and percent of members receiving SUD services whose criminal justice involvement improved.**
  The denominator for this measure is the number of members who were discharged from SUD services during the measurement period (quarterly and annually), and whose criminal justice involvements were collected in the KCPC system at both admission and discharge from SUD services. (See Table 4 below.)

  The numerator is the number of episodes of care in which members reported no arrests in the prior 30 days at both admission and discharge, or that reported fewer arrests at discharge than at admission to SUD services.

Table 4: Number and percent of members receiving SUD services whose criminal justice involvement decreased, CY2012 compared to CY2013

	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of clients without arrests	190	235	177	195	261	253	183	178
Denominator: Number of clients discharged during reporting period	190	238	180	197	264	254	184	179
Percent of clients without arrests	**100%**	**98.7%**	**98.3%**	**99.0%**	**98.9%**	**99.6%**	**99.5%**	**99.4%**

Analysis: Data for this measure are tracked and reported quarterly by KDADS. Quarterly rates of those without arrests were over 98% for each quarter of CY2012 and CY2013. In CY2013, quarterly rates were 99.4% or higher for Q2, Q3, and Q4 of CY2013.

- **The number and percent of members receiving SUD services whose living arrangements improved**.
  The denominator for this performance measure is the number of episodes of care for KanCare members who were discharged from SUD services during the measurement period, and whose living arrangement details were collected by KDADS in the KCPC state tracking system. (See Table 5 below.)

  The numerator is the number of episodes of care in which members were living independently at the time of admission and maintained independent living status at the time of discharge, or that reported that their living arrangements improved between admission and discharge, and youth members that were living dependently at the time of admission (at home) and maintained dependent living status at discharge.

  Analysis: Data for this measure are tracked and reported quarterly by KDADS. Rates of improved living arrangements were consistently high throughout CY2012 and CY2013, with Q4 rates at 98.9%.

Table 5: Number and percent of members receiving SUD services whose living arrangements improved, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members discharged from SUD services living independently at discharge	190	234	178	196	262	251	183	177
Denominator: Number of KanCare members discharged from SUD services during the measurement period	190	238	180	197	264	254	184	179
Percent of KanCare members discharged from SUD services living independently at discharge	100%	98.3%	98.9%	99.5%	99.2%	98.8%	99.5%	98.9%

- **The number and percent of members, receiving SUD services, whose drug and/or alcohol use decreased.**
  The denominator for this measure is the number of members who were discharged from SUD services during the measurement period, and whose primary substance use was collected in KCPC at both admission and discharge. (See Table 6 below.)

  The numerator is the number of members who reported at discharge no use of their primary substance for the prior 30 days, or who reported decreased use of their primary substance between admission and discharge from SUD treatment.

Table 6: Number and percent of members receiving SUD services whose drug and/or alcohol use decreased, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare members reporting no use of their primary substance within 30 days prior to discharge	185	221	172	187	244	242	173	170
Denominator: Number of KanCare members discharged from SUD services during reporting period	189	238	180	196	263	254	184	179
Percent reporting no use of their primary substance within 30 days prior to discharge	**97.9%**	**92.9%**	**95.6%**	**95.4%**	**92.8%**	**95.3%**	**94.0%**	**95.0%**

Analysis: Rates of decreased use of members' primary substance were consistently strong in both CY2012 and CY2013. There was a positive trend in high rates of compliance. Rates increased throughout CY2013 from Q1 (92.8%) through Q4 (95.0%).

(3) Mental Health Services

The following performance measures are based on National Outcome Measures (NOMs) for members who are receiving mental health services, including adults with SPMI and youth experiencing SED. Measures focus on increased access to services; improvement in housing status for homeless adults; improvement or maintenance of residential status for youth; gain or maintenance of employment status; improvement in Child Behavior Checklist (CBCL) Competence scores; and reduction in inpatient psychiatric services. Each of these measures will be tracked annually and for trends over time, comparing pre-KanCare (CY2012) with each year of the KanCare

demonstration project. (See Appendix A for Mental Health Services measures that will be analyzed in the second KanCare Evaluation annual report.)

In the following measures, members may be included in more than one quarter of data, as housing and employment status may change throughout the year. Members may also have more than one inpatient admission during the year (or within a quarter).

- **The number and percent of adults with SPMI who were homeless at the initiation of Community Support Services (CSS) and experienced improvement in their housing status**.
  The denominator for this measure is the number of KanCare homeless adults with SPMI at the beginning of each quarterly measurement period. (See Table 7 below.)

  The numerator is the number of KanCare adults with SPMI with improvement in their housing status by the end of the quarterly measurement period.

Table 7: Number and percent of members with SPMI who were homeless at initiation of CSS services and experienced improvement in their housing status, CY2012 compared to CY2013

	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare adults with SPMI with improved housing status at end of measurement period	52	63	78	81	54	60	65	53
Denominator: Number of KanCare homeless adults with SPMI at beginning of measurement period	126	140	164	169	101	100	103	96
Percentage of members with improved housing	**41.3%**	**45.0%**	**47.6%**	**47.9%**	**53.5%**	**60.0%**	**63.1%**	**55.2%**

Analysis: In CY2012, housing status improved for 41.3% of members in Q1, increasing to 47.9% by Q4. In CY2013, housing status improved even more, with quarterly rates ranging from 53.5% (Q1) to a high of 63.1% in Q3. The total number of homeless adults with SPMI dropped from 169 in Q4 CY2012 to only 96 in Q4 CY2013.

- **The number and percent of youth with an SED who experienced improvement in their residential status**
  The denominator for this measure is the number of KanCare SED youth with unstable living arrangements at the beginning of each quarterly measurement period. (See Table 8 below.)

  The numerator for this measure is the number of KanCare SED youth with improved housing status at the end of the quarterly measurement period.

  Analysis: In CY2012, rates of improved housing status dropped each quarter, from 82.9% in Q1 to 80.1% in Q4. In CY2013, rates improved in Q1 to 84%, dropped to 71% in Q2, but were up to 84% by Q4.

Table 8: Number and percent of youth with an SED who experienced improvement in their residential status, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SED youth with improved housing status at end of measurement period	204	218	196	213	205	137	180	184
Denominator: Number of KanCare SED youth with unstable living arrangements at beginning of measurement period	246	264	241	266	244	193	220	219
Percent with improved housing status	**82.9%**	**82.6%**	**81.3%**	**80.1%**	**84.0%**	**71.0%**	**81.8%**	**84.0%**

- **The number and percent of youth with an SED who maintained their residential status.**
  The denominator for this measure is the number of KanCare SED youth with stable living arrangements at the beginning of the measurement period. (See Table 9 below.)

  The numerator is the number of KanCare SED youth who maintained a stable living arrangement at the end of the measurement period.

Table 9: Number and percent of youth with an SED in a Family Home who maintained their residential status, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SED youth who maintained a stable living arrangement at end of measurement period	4,622	5,628	5,475	5,410	4,763	4,558	4,423	4,473
Denominator: Number of KanCare SED youth with stable living arrangements at beginning of measurement period	5,646	5,669	5,511	5,445	4,798	4,703	4,451	4,496
Percent of youth that maintained residential status	**81.9%**	**99.3%**	**99.3%**	**99.4%**	**99.3%**	**96.9%**	**99.4%**	**99.5%**

Analysis: Rates of maintaining stable living arrangements for SED youth were consistently and strongly high in CY2012 through CY2013. At the end of Q4 CY2012, 99.4% of SED youth had maintained a stable living arrangement, and this rate remained steady throughout CY2013. In Q4 CY2013, 99.5% of SED youth were maintaining stable living arrangements.

- **The number and percent of KanCare members, diagnosed with SPMI, who have gained competitive employment**.
  The denominator for this measure is the number of KanCare SPMI adults not employed at the beginning of the quarterly measurement period. (See Table 10 below.)

  The numerator is the number of KanCare SPMI adults employed at the end of each quarter.

Table 10: Number and percent of KanCare adults diagnosed with an SPMI who have gained competitive employment, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SPMI adults employed at the end of the measurement period	125	140	102	87	74	95	94	115
Denominator: Number of KanCare SPMI adults not employed at the start of the measurement period	4,362	3,961	3,604	2,455	3,295	2,963	2,940	3,201
Percent of SPMI adults employed at end of measurement period	**2.9%**	**3.5%**	**2.8%**	**3.5%**	**2.2%**	**3.2%**	**3.2%**	**3.6%**

Analysis: Employment rates for those unemployed at the beginning of the quarter increased significantly in each quarter of CY2013, beginning in Q1 at 2.2% and ending in Q4 at 3.6% ($p < 0.01$). In Q4 of CY2012, 3.5% of the SPMI unemployed at the start of the quarter were employed by the end of the quarter.

- **The number and percent of KanCare members, diagnosed with SPMI, who maintained competitive employment**.
  The denominator for this measure is the number of KanCare adults with SPMI employed at the start of each quarter, and the numerator is the number of adults with SPMI who remain employed at the end of the quarter. (See Table 11 below.)

Table 11: Number and percent of adult members diagnosed with an SPMI who maintained competitive employment, CY2012 compared to CY2013								
	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Numerator: Number of KanCare SPMI adults who remain employed at the end of the measurement period	552	505	499	368	400	379	360	390
Denominator: Number of KanCare SPMI adults employed at the start of the measurement period	706	617	602	434	495	443	436	477
Percent of KanCare SPMI adults who remain employed at the end of the measurement period	**78.2%**	**81.8%**	**82.9%**	**84.8%**	**80.8%**	**85.6%**	**82.6%**	**81.8%**

Analysis: The employment rate in CY2012 increased each quarter; in Q1 78.2% remained employed, and by Q4 the rate increased to 84.8%. In CY2013, 80.8% to 85.6% of the SPMI adults maintained employment.

- **The number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services.**
  The denominator for this measure is the number of KanCare eligible members at the end of each quarter. (See Table 12 below.) The numerator is the number of KanCare members admitted to an inpatient psychiatric facility during each quarter.

  Rates are reported per 10,000.

Analysis: There was a statistically significant decrease in inpatient admissions when comparing the rate in Q4 CY2012 (42.06 per 10,000) with the rate in Q4 CY2013 (32.29 per 10,000), p<0.001.

Table 12: Number and percent of members utilizing inpatient psychiatric services, including state psychiatric facilities and private inpatient mental health services, CY2012 compared to CY2013

	CY2012				CY2013			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Number of KanCare members admitted to an inpatient psychiatric facility during the reporting period	1522	1445	1612	1661	1270	1292	1337	1293
Number of KanCare eligible members at end of measurement period	386,832	390,920	393,121	394,904	421,964	401,627	402,949	400,384
Rate per 10,000	**39.35**	**36.96**	**41.01**	**42.06**	**30.10**	**32.17**	**33.18**	**32.29**

(6) Long Term Care: Nursing Facilities

(See Appendix A for additional NF performance measures that will be reported in the second annual KanCare Evaluation report.)

- **Number of Person Centered Care Homes as recognized by the PEAK program (Promoting Excellent Alternatives in Kansas) in the MCO network.** PEAK program data will be used to identify Person Centered Care Home designated nursing facilities, and MCO provider files will be used to verify inclusion in the network. According to KDADS staff, PEAK program data is reported on a fiscal year basis, based on the State fiscal year, which begins July 1. In FY2013, which began July 1, 2012, there were 8 nursing facilities recognized as PEAK.

(7) Member Survey – Quality

Mental Health Survey

Patient perceptions of mental health provider treatment are based on responses to mental health surveys conducted in CY2012 and CY2013 of a random sample of pre-KanCare and KanCare members who had received one or more mental health services in the prior six month period while a member. The Mental Health Statistics Improvement Program (MHSIP) Youth Services Survey, Youth Services Survey for Families, and Adult Consumer Survey tools, as modified by KFMC over the past four years, were used for this project.

In CY2012 the survey was mailed to 5,238 members. In CY2013 the survey was mailed to 16,302 members due to mental health services being provided by three MCOs compared to the one Pre-Paid Ambulatory Health Plan (Kansas Health Solutions) in CY2012. In CY2013, 1,097 General Adult surveys were completed; 1,009 General Youth surveys; 461 SED Youth surveys; and 31 SED young adult surveys.

Survey results in CY2012 and CY2013 were reported by General Adult, General Youth, and SED Youth and Young Adults receiving mental health services through the SED Waiver. Results were also stratified by whether the member completed the survey or whether a family member completed the survey for a child (age <18) or for an SED waiver young adult.

Response rates to CY2013 survey questions were compared to results from CY2012. Questions were the same in both years, with the exception of a question added in CY2013 on whether medication was available timely. After comparing these results, KFMC compared responses from CY2011 (which included the same questions as CY2012) to better identify trends over time.

Table 13 shows response rates for questions related to quality of care. (See Table 14 for questions related to coordination of care, Table 18 for questions related to access to care, and Table 20 for an efficiency-related question.)

For most of the questions, rates were generally positive and did not change significantly from CY2012 to CY2013, nor from CY2011 to CY2013. (CY2013 rates for each population generally were within the annual confidence intervals of the previous years.) The survey population in CY2013, however, was three times the size of populations surveyed in CY2011 and CY2012. The larger population adds greater strength to the confidence in the rates reported in CY2013.

The quality-related questions in Table 13 focus on the following:

- If given other options, the member would still get services from the mental health provider providing recent care.
  - This question was asked of adults (non-SED, ages 18 and older).
  - From CY2012 to CY2013, there was a statistically significant increase in this rate ($p < 0.05$), increasing from 84.4% to 88.3%. The rate in CY2011 was the same rate as CY2013; however, the survey population size in CY2013 was three times that of the survey population in CY2011, which adds strength to the confidence in the results.
- Comfort in asking questions about treatment, medication, and/or children's problems.
  - Responses were consistently high in the three populations (adult, youth/age 0-17, and in the SED youth and young adults), with rates ranging from 89.1% (SED youth and young adult) to 91.6% (youth/age 0-17).
  - Rates in CY2013 were comparable to the rates in the previous two years for each of these populations.
- Assistance in obtaining information to assist member in managing their health.
  - There was a statistically significant increase in the rate from CY2012 (81.6%) to CY2013 (87.6%), $p<0.01$, in the general adult population. In CY2011 the rate was 89.3%.

Table 13 - Mental Health Survey - Quality-Related Questions

Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
If I had other choices, I would still get services from my mental health providers.	**General Adult (Age 18+)**				
	2013	88.3%	913 / 1,034	86.4% - 90.3%	0.04
	2012	84.4%	232 / 275	79.5% - 88.5%	
	2011	*88.3%*	*263 / 298*	*84.6% - 91.9%*	
I felt comfortable asking questions about my treatment and medication.	**General Adult (Age 18+)**				
	2013	91.1%	959 / 1,052	89.4% - 92.8%	0.05
	2012	87.5%	244 / 279	83.0% - 91.1%	
	2011	*93.6%*	*278 / 297*	*90.8% - 96.4%*	
I have people I am comfortable talking with about my child's problems.	**General Youth (Age <18), Family Responding**				
	2013	91.6%	875 / 955	89.9% - 93.4%	0.43
	2012	93.1%	244 / 262	89.4% - 95.9%	
	2011	*92.6%*	*301 / 325*	*89.8% - 95.5%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2013	89.1%	424 / 476	86.3% - 91.9%	0.50
	2012	87.5%	281 / 321	83.9% - 91.2%	
	2011	*89.4%*	*254 / 284*	*85.9% - 93.0%*	
I, not my mental health providers, decided my treatment goals.	**General Adult (Age 18+)**				
	2013	81.8%	809 / 989	79.4% - 84.2%	0.10
	2012	77.0%	198 / 257	71.4% - 82.0%	
	2011	*83.8%*	*237 / 283*	*79.5% - 88.0%*	
I helped to choose my treatment goals.	**General Youth (Age 12-17), Youth Responding**				
	2013	88.8%	409 / 460	86.0% - 91.7%	0.05
	2012	81.6%	80 / 98	72.5% - 88.7%	
	2011	*86.8%*	*112 / 129*	*81.0% - 92.7%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2013	82.2%	186 / 226	77.2% - 87.2%	0.84
	2012	81.3%	109 / 134	73.7% - 87.6%	
	2011	*83.5%*	*101 / 121*	*76.9% - 90.1%*	
I helped to choose my child's treatment goals.	**General Youth (Age <18), Family Responding**				
	2013	90.5%	846 / 935	88.6% - 92.4%	0.60
	2012	91.6%	229 / 250	87.5% - 94.7%	
	2011	*90.7%*	*294 / 324*	*87.6% - 93.9%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2013	93.1%	450 / 483	90.8% - 95.4%	0.07
	2012	96.2%	303 / 315	94.1% - 98.3%	
	2011	*94.0%*	*264 / 281*	*91.2% - 96.7%*	
As a direct result of services I received, I am better able to do things that I want to do.	**General Adult (Age 18+)**				
	2013	77.7%	787 / 1,012	75.2% - 80.3%	0.05
	2012	70.1%	185 / 264	64.2% - 75.5%	
	2011	*82.4%*	*238 / 289*	*78.0% - 86.8%*	
As a result of the services my child and/or family received, my child is better able to do things he or she wants to do.	**General Youth (Age <18), Family Responding**				
	2013	84.3%	785 / 932	81.9% - 86.6%	0.79
	2012	85.0%	215 / 253	80.0% - 89.2%	
	2011	*84.1%*	*264 / 314*	*80.0% - 88.1%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2013	73.5%	349 / 475	69.6% - 77.5%	0.70
	2012	72.2%	229 / 317	67.3% - 77.2%	
	2011	*76.4%*	*210 / 275*	*71.3% - 81.4%*	

Table 13 - Mental Health Survey - Quality-Related Questions (Continued)					
Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
My mental health providers spoke with me in a way I understood.	**General Adult (Age 18+)**				
	2013	**94.3%**	1,002 / 1,063	92.9% - 95.7%	0.04
	2012	**91.5%**	257/ 281	87.6% - 94.5%	
	2011	*93.4%*	*282 / 302*	*90.6% - 96.2%*	
	General Youth (Age 12-17), Youth Responding				
	2013	**96.3%**	450 / 467	94.6% - 98.0%	0.41
	2012	**98.0%**	97 / 99	92.9% - 99.8%	
	2011	*97.0%*	*131 / 135*	*94.2% - 99.9%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2013	**93.8%**	217 / 231	90.7% - 96.9%	0.51
	2012	**92.0%**	126 / 137	86.1% - 95.9%	
	2011	*92.1%*	*116 / 126*	*87.3% - 96.8%*	
My child's mental health providers spoke with me in a way I understood.	**General Youth (Age <18), Family Responding**				
	2013	**97.3%**	953 / 979	96.3% - 98.3%	0.68
	2012	**97.8%**	262 / 268	95.2% - 99.2%	
	2011	*96.8%*	*327 / 338*	*94.9% - 98.6%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2013	**97.4%**	476 / 488	96.0% - 98.8%	0.71
	2012	**97.8%**	314 / 321	96.2% - 99.4%	
	2011	*97.2%*	*278 / 286*	*95.3% - 99.1%*	
My mental health providers helped me obtain information I needed so that I could take charge of managing my illness.	**General Adult (Age 18+)**				
	2013	**87.6%**	893 / 1,020	85.5% - 89.6%	<0.01
	2012	**81.6%**	213 / 261	76.4% - 86.1%	
	2011	*89.3%*	*258 / 289*	*85.7% - 92.8%*	
As a direct result of services I received, I am better able to control my life.	**General Adult (Age 18+)**				
	2013	**83.0%**	850 / 1,024	80.7% - 85.3%	<0.01
	2012	**76.4%**	204 / 267	70.9% - 81.4%	
	2011	*86.5%*	*250 / 289*	*82.6% - 90.4%*	
As a result of services I received, I am better at handling daily life.	**General Youth (Age 12-17), Youth Responding**				
	2013	**88.6%**	413 / 466	85.7% - 91.5%	0.95
	2012	**88.8%**	87 / 98	80.8% - 94.3%	
	2011	*83.1%*	*108 / 130*	*76.6% - 89.5%*	
As a result of services my child and/or family received, my child is better at handling daily life.	**General Youth (Age <18), Family Responding**				
	2013	**82.1%**	775 / 945	79.6% - 84.5%	0.71
	2012	**81.0%**	205 / 253	75.6% - 85.7%	
	2011	*79.4%*	*258 / 325*	*75.0% - 83.8%*	
	SED Waiver Youth and Young Adult (0-21), Family/Member Responding				
	2013	**74.4%**	355 / 477	70.5% - 78.3%	0.71
	2012	**75.6%**	241 / 319	70.8% - 80.3%	
	2011	*79.4%*	*227 / 286*	*74.7% - 84.1%*	
As a direct result of services I received, I am better able to deal with crisis.	**General Adult (Age 18+)**				
	2013	**79.1%**	780 / 986	76.6% - 81.6%	<0.01
	2012	**71.4%**	182 / 255	65.4% - 76.8%	
	2011	*80.4%*	*221 / 275*	*75.7% - 85.1%*	

- Member choice of treatment goals.
  - Rates were fairly constant over time within each population (adults; youth age 12-17; SED waiver youth age 12-17; youth age 0-18, family responding; and SED youth and young adult, age 0-21, family responding).
  - Rates in CY2013 were highest in SED youth and young adult, family responding (93.1%) and lowest in the general adults (81.8%). The 81.8% rate in the general adults population, however, was an increase from the 77.0% rate in CY2012.
  - The greatest increase from CY2012 to CY2013 was in the general youth (age 12-17), youth responding. Rates increased from 81.6% in CY2012 to 88.8% in CY2013 (p=0.05). The rate in CY2011for this group was 86.8%.
- Better able to do things the member wants to do, as a direct result of services provided.
  - Rates for general youth (family responding) and SED waiver youth/young adult (family responding) were generally consistent year to year. Rates were much higher in the general youth (84.3% in CY2013) than in the SED waiver youth (73.5% in CY2013).
  - In the general adult population, rates increased from 70.1% in CY2012 to 77.7% in CY2013 (p=0.05). The rate in CY2011, however, was 82.4%.
- Understandable communication from provider with member.
  - Rates were consistently high in all of the populations surveyed. Rates in CY2013 ranged from 93.8% to 97.4%. Rates in CY2011 and CY2012 were also above 91%.
  - There was a statistically significant increase from CY2012 (91.5%) to CY2013 (94.3%), $p<0.05$, in the general adult population. In CY2011 the rate was 93.4%.
- Better control of daily life due to services provided.
  - Rates were fairly consistent within populations during CY2011 through CY2013. General youth (age 12-17), youth responding, had the highest satisfaction rate (88.6% in CY2013; 88.8% CY2012; 83.1% in CY2011), and SED waiver youth/young adult (family responding) had the lowest rate (74.4% in CY2013; 75.6% in CY2012; and 79.4% in CY2011).
  - There was a statistically significant increase in the CY2013 rate (83.0%) compared to the CY2012 rate (76.4%), $p<0.01$, for the general adult population. The rate in CY2011 was 86.5%.
- Better ability to deal with crisis, as a direct result of services provided.
  - There was a statistically significant increase in the CY2013 rate (79.1%) compared to the CY2012 rate (71.4%), $p<0.01$, for the general adult population. The rate in CY2011 was 80.4%.

COORDINATION OF CARE (AND INTEGRATION

Goals, Related Objectives, and Hypotheses for Coordination of Care subcategories:

Goal: Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders, and LTSS.

Related Objectives:

- *Improve coordination and integration of physical health care with behavioral health care.*
- *Support members successfully in their communities.*

Hypothesis:

- *The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.*

(See Appendix A for information on additional measures in the following subcategories: (11) Care Management for Nursing Facility (NF) Residents; (12) Care Management for non-NF members; (13) Other Tentative Study; (14) Care Management for members with I/DD; (15) Member Survey – CAHPS; (17) Member Survey – SUD.)

(14) Care Management for members with I/DD

Hypothesis: KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

(See Appendix A for additional performance measures for the I/DD pilot program.)

- **Wichita State University will facilitate the process for determining that members and guardians are aware of service options and how to access services in the KanCare structure. Focus will be members, family members, parents and guardians participating in the pilot. Areas covered will include:**
  - **What is KanCare**
  - **DD services**
  - **TCM role**
  - **Care coordinator role**
  - **Coordination of DD services and other Medicaid services**
  - **Provider network navigation and selecting an MCO**
  - **How can services be accessed to meet new or changing needs**

  In 2013, Wichita State University (WSU) facilitated the development of consumer-friendly information and educational sessions to ensure members, guardians, friends, and family were aware of service option and how to access services in the KanCare structure. Working with KDADS and the I/DD Friends and Family Advisory Council, WSU created a consumer brochure to supplement the

KanCare/IDD Consumer letter that was sent October 15, 2013. The brochure explains what KanCare is, the existing IDD services, the roles of the care coordinator and targeted case manager, and how to contact the MCOs. Additionally, WSU facilitated and evaluated the educational tours held in May, July, September, and December of 2013. WSU continues to work with KDADS on providing information to members, guardians, friends, and family about the roles of targeted case managers and care coordinators, navigating MCOs, and how to access services to meet new or changing needs. This education continues through the WSU-facilitated Consumer Lunch and Learn calls, held every Wednesday starting in December 2013 and continuing through the first quarter of 2014.

(16) Member Survey – Mental Health

The Mental Health Surveys conducted in CY2012 and CY2013 are described above in section 7.

Table 14 - Mental Health Survey - Questions related to Coordination of Care

Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	**General Adult (Age 18+)**				
	2013	**83.4%**	801 / 961	81.0% - 85.7%	0.07
	2012	**76.7%**	191 / 249	71.0% - 81.8%	
	2011	*82.3%*	*214 / 260*	*77.7% - 87.0%*	
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**				
	2013	**86.0%**	916 / 1,065	83.9% - 88.1%	<0.01
	2012	**78.8%**	219 / 278	73.5% - 83.4%	
	2011	*91.3%*	*274 / 300*	*88.2% - 94.5%*	
	General Youth (12-17), Youth Responding				
	2013	**82.8%**	388 / 468	79.4% - 86.2%	0.60
	2012	**85.0%**	85 / 100	76.5% - 91.4%	
	2011	*85.1%*	*114 / 134*	*79.0% - 91.1%*	
	SED Waiver Youth (12-17), Youth Responding				
	2013	**71.8%**	167 / 233	66.0% - 77.6%	0.35
	2012	**76.3%**	103 / 135	68.2% - 83.2%	
	2011	*77.6%*	*97 / 125*	*70.3% - 84.9%*	
My family got as much help as we needed for my child.	**General Youth (0-17), Family Responding**				
	2013	**83.2%**	804 / 966	80.9% - 85.6%	0.90
	2012	**82.9%**	213 / 257	77.7% - 87.3%	
	2011	*84.2%*	*278 / 330*	*80.3% - 88.2%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2013	**75.2%**	363 / 483	71.3% - 79.0%	0.49
	2012	**77.3%**	248 / 321	72.7% - 81.8%	
	2011	*77.5%*	*220 / 284*	*72.6% - 82.3%*	

The following questions in Table 14 (above) are related to the perception of care coordination for members receiving mental health services and focus on the following:

- Encouragement to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).

  - This question was asked of adults (non-SED, ages 18 and older).
  - From CY2011 to CY2012, rates dropped from 82.3% to 76.7%. From CY2012 to CY2013, rates increased to 83.4%.
- Perception that the members were able to access all of the services that they thought they needed.
  - Rates were fairly consistent within the general youth (age 12-17, youth responding), general youth (age 0-17, family responding), and SED waiver youth/young adult (family responding) populations during CY2011 through CY2013.
  - In the general adult population, the rate was 91.3% in CY2011; dropped to 78.8% CY2012; and then increased to 86.0% in CY2013. The increase in rate from CY2012 to CY2013 was statistically significant, $p<0.01$
  - Rates in the SED waiver youth (age 12-17, youth responding) dropped from 77.6% in CY2011 to 76.3% in CY2012 to 71.8% in CY2013. The annual change in rates was not, however, statistically significant.

(18) Provider Survey

In 2013, the questions in the provider surveys distributed by the three MCOs were not consistently worded. The preauthorization questions in the Amerigroup and United surveys were fairly comparable. In the Amerigroup survey, providers were asked about their experience "obtaining pre-certification and/or authorization for Amerigroup members." The Amerigroup survey response options were "Very Satisfied," "Somewhat Satisfied," "Neither Satisfied nor Dissatisfied," "Somewhat Dissatisfied," and "Very Dissatisfied." In the United survey, providers were asked to rate the "ease of the prior authorization process." For the United survey question response options were 0 to 10, with 10 meaning "Excellent" and 0 meaning "Poor." In combining the responses for Amerigroup and United, response selections of "9" or "10" were determined to be comparable to "Very Satisfied"; "7" or "8" were determined to be comparable to "Somewhat Satisfied"; "4" or "5" or "6" were determined to be comparable to "Neither Satisfied nor Dissatisfied"; "0" or "1" were determined to be comparable to "Very Dissatisfied"; and "2" or "3" were determined to be comparable to "Somewhat Dissatisfied."

The combined responses for Amerigroup and United are in Table 15 below. Out of 247 provider responses, 39.3% indicated they were "Satisfied" (8.5% were "Very Satisfied"); 40.1% were "Dissatisfied" (17.4% were "Very Dissatisfied"); and 20.6% indicated they were "Neither Satisfied nor Dissatisfied."

Most of the questions in the Sunflower provider survey, including the question related to satisfaction with the preauthorization process, were framed from the perspective of comparison to other health plans. Providers were asked to rate "timeliness of obtaining pre-certification/referral/authorization information, compared to your experience with other health plans you work with." As reported in Table 15 below, 52.3% of 216 providers considered Sunflower's preauthorization process to be "Average" compared

to the other MCOs; 35.7% considered Sunflower to be “Above Average” (16.7% “Well Above Average”); and 12% considered Sunflower to be “Below Average” (3.2% “Well Below Average”).

Table 15: Provider Satisfaction with Obtaining Precertification and/or Authorization for Members

Amerigroup and United Combined Survey Responses					
Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied nor Dissatisfied	Somewhat Satisfied	Very Satisfied	Total Responses
43	56	51	76	21	247
17.4%	**22.7%**	**20.6%**	**30.8%**	**8.5%**	
	Dissatisfied	Neutral	Satisfied		
	99	51	97		
	40.1%	**20.6%**	**39.3%**		
Sunflower Survey Responses					
"Compared to the other MCOs, Sunflower's preauthorization process is..."					
Well below average	Somewhat below	Average	Somewhat above	Well Above Average	Total
7	19	113	41	36	216
3.2%	**8.8%**	**52.3%**	**19.0%**	**16.7%**	
	Below Average	Average	Above Average		
	26	113	77		
	12.0%	**52.3%**	**35.7%**		

In 2014, provider surveys will be distributed by Amerigroup to be completed in July through September, with survey results by November. Sunflower and United surveys will be completed by providers in August through October, with survey results by December 2014. The question regarding satisfaction with obtaining precertification and/or authorization for members will be reevaluated for more consistent wording and response options amongst the three MCOs, to be included in the 2014 and subsequent annual provider surveys. The responses from the 2014 preauthorization question will be the baseline measure for comparison to responses in subsequent years.

Recommendation: The Provider Survey distributed in 2014 should be revised to ensure that the question(s) on provider satisfaction with obtaining precertification and/or authorization for members have identical wording and consistent response choices.

COST OF CARE

(The Cost of Care measures are measures that are not scheduled to be reported until Demonstration Year (DY) 2. See Appendix A for information on the Cost of Care measures that will be reported beginning in 2015.)

ACCESS TO CARE

Goals, Related Objectives, and Hypotheses for Access to Care subcategories:

Goal: 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.

Related Objectives:

- *Measurably improve health outcomes for members.*
- *Support members successfully in their communities.*
- *Promote wellness and healthy lifestyles.*
- *Improve coordination and integration of physical health care with behavioral health care.*
- *Lower the overall cost of health care.*

Hypothesis: The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.

(See Appendix A for information on additional measures in the following subcategories: (21) Member Survey – CAHPS; and (23) Member Survey - SUD. See Appendix B for information on measures in the following subcategories: (25) Grievances; and (26) Ombudsman Program.)

(20) Provider Network – GeoAccess

- **Percent of counties covered within access standards, by provider type (physicians, hospital, eye care, dental, ancillary [PT, OT, x-ray, lab], pharmacy).**
  KFMC reviewed the GeoAccess reports, maps, and other data to identify the percent of counties where specific provider types are not available from at least one MCO. KFMC also reviewed GeoAccess maps showing provider access by provider type for CY2012. (See Table 16 below.)
  - Urban/Semi-Urban
    - In CY2013 and in CY2012, KanCare members who were residents of any of the 16 Urban/Semi-Urban counties had access to at least one provider in all provider types
  - Densely-Settled Rural/Rural/Frontier
    - In CY2013, KanCare members who were residents of any of the 21 Densely-Settled Rural, 32 Rural, and 36 Frontier counties had access to at least one of the following 10 provider types through at least one MCO: Primary Care Provider (PCP); Cardiology; General Surgery; Hematology/Oncology; Internal Medicine; Neurology; OB/GYN; Ophthalmology; Otolaryngology; and Psychiatrist. Residents of the non-urban counties also had access to Hospitals; Retail Pharmacy, and all of the Ancillary Services (Physical Therapy, Occupational Therapy, X-ray, and Lab).

Table 16	Counties with no providers in any of 3 MCOs in 2013 within access range						Counties with no providers in 2012 within access standard range				
Provider type	# Urban/ Semi-Urban	% of 16 Urban/ Semi-Urban	# non-urban	% of 89 non-urban	Total	% of 105 counties	# Urban/ Semi-Urban	# non-urban	% of 89 non-urban	Total	% of 105 counties
No Change from 2012 to 2013											
Physicians											
Primary Care Provider	0	0%	0	0%	0	0%	0	0	0%	0	0%
Cardiology	0	0%	0	0%	0	0%	0	0	0%	0	0%
General Surgery	0	0%	0	0%	0	0%	0	0	0%	0	0%
Hematology/Oncology	0	0%	0	0%	0	0%	0	0	0%	0	0%
Internal Medicine	0	0%	0	0%	0	0%	0	0	0%	0	0%
Nephrology	0	0%	**3**	**3.4%**	**3**	**2.9%**	0	**3**	**3.4%**	**3**	**2.9%**
Ophthalmology	0	0%	0	0%	0	0%	0	0	0%	0	0%
Urology	0	0%	**3**	**3.4%**	**3**	**2.9%**	0	**3**	**3.4%**	**3**	**2.9%**
Hospitals	0	0%	0	0%	0	0%	0	0	0%	0	0%
Retail Pharmacy	0	0%	0	0%	0	0%	0	0	0%	0	0%
Ancillary Services											
Physical Therapy	0	0%	0	0%	0	0%	0	0	0%	0	0%
X-ray	0	0%	0	0%	0	0%	0	0	0%	0	0%
Lab	0	0%	0	0%	0	0%	0	0	0%	0	0%
Increased Availability from 2012 to 2013											
Physicians											
Dermatology	0	0%	**3**	**3.4%**	**3**	**2.9%**	0	**4**	**4.5%**	**4**	**3.8%**
Neurology	0	0%	0	0%	0	0.0%	0	**20**	**22.5%**	**20**	**19.0%**
Neurosurgery	0	0%	**20**	**22.5%**	**20**	**19.0%**	0	**36**	**40.4%**	**36**	**34.3%**
OB/GYN	0	0%	0	0%	0	0.0%	0	**6**	**6.7%**	**6**	**5.7%**
Otolaryngology	0	0%	0	0%	0	0.0%	0	**3**	**3.4%**	**3**	**2.9%**
Physical Medicine/Rehab	0	0%	**3**	**3.4%**	**3**	**2.9%**	0	**12**	**13.5%**	**12**	**11.4%**
Plastic & Reconstructive Surgery	0	0%	**21**	**23.6%**	**21**	**20.0%**	0	**33**	**37.1%**	**33**	**31.4%**
Podiatry	0	0%	**1**	**1.1%**	**1**	**1.0%**	0	**23**	**25.8%**	**23**	**21.9%**
Psychiatrist	0	0%	0	0%	0	0%	0	**5**	**5.6%**	**5**	**4.8%**
Eye Care - Optometry	0	0%	**4**	**4.5%**	**4**	**4%**	0	**7**	**7.9%**	**7**	**6.7%**
Ancillary Services											
Occupational Therapy	0	0%	0	0%	0	0%	0	**12**	**13.5%**	**12**	**11.4%**
Decreased Availability from 2012 to 2013											
Physicians											
Allergy	0	0%	**9**	**10.1%**	**9**	**8.6%**	0	0	0%	0	0%
Gastroenterology	0	0%	**27**	**30.3%**	**27**	**25.7%**	0	**12**	**13.5%**	**12**	**11.4%**
Neonatology	0	0%	**36**	**40.4%**	**36**	**34.3%**	0	**28**	**31.5%**	**28**	**26.7%**
Orthopedics	0	0%	**2**	**2%**	**2**	**2%**	0	0	0%	0	0%
Pulmonary Disease	0	0%	**3**	**3.4%**	**3**	**2.9%**	0	0	0%	0	0%
Dental Primary Care	0	0%	**6**	**6.7%**	**6**	**5.7%**	0	**2**	**2.2%**	**2**	**1.9%**

- In CY2013, KanCare members who lived in some of the Densely-Settled Rural, Rural, or Frontier counties did not have access to certain provider types in CY2013 from any of the MCOs. These 14 provider types included: Allergy (9 counties); Dermatology (3); Gastroenterology (27); Neonatology (36); Nephrology (3); Neurosurgery (20); Orthopedics (2); Physical Medicine/Rehab (3); Plastic and Reconstructive Surgery (21); Podiatry (1); Pulmonary disease (3); Urology (3); Dental Primary Care (6); and. Eye Care-Optometry (4).

- In CY2012, KanCare members who were residents of any of the 21 Densely-Settled Rural, 32 Rural, and 36 Frontier counties had access to at least one of the following provider types within the access range specified by the State: Primary Care Provider (PCP); Allergy; Cardiology; General Surgery; Hematology/Oncology; Internal Medicine; Ophthalmology; Orthopedics; and Pulmonary disease. Residents of the non-urban counties also had access to Hospitals; Retail Pharmacy, and the following Ancillary Services: Physical Therapy, X-ray, and Lab).
- In CY2012, KanCare members who lived in some of the Densely-Settled Rural, Rural, or Frontier counties did not have access to a provider in CY2012 from any of the MCOs. These provider types included: Dermatology (4); Gastroenterology (12); Neonatology (28); Nephrology (3); Neurology (20); Neurosurgery (36); OB/GYN (6); Otolaryngology (3); Physical Medicine/Rehab (12); Plastic and Reconstructive Surgery (33); Podiatry (23); Psychiatrist (5); Urology (3); Eye Care – Optometry (7); Dental Primary Care (2); and. Occupational Therapy (12).

- **Average distance to a behavioral health provider**
  The following data are based on reports submitted to the State by the three MCOs, summarizing the provider access as of March CY2014. No data were available for comparison from CY2012.

  Of the 105 counties in Kansas, 16 are "Urban" or "Semi-Urban," 21 are "Densely-Settled Rural," and 68 counties are "Rural" or "Frontier."
  - Urban/Semi-Urban
    - Amerigroup– The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.8 miles; to two providers was 1.6 miles; and to one provider was 1.3 miles.
    - Sunflower – The average distance to a choice of five providers was 1.9 miles; to four providers was 1.8 miles; to three providers was 1.7 miles; to two providers was 1.6 miles; and to one provider was 1.3 miles.
    - United– The average distance to a choice of five providers was 2.0 miles; to four providers was 1.9 miles; to three providers was 1.9 miles; to two providers was 1.7 miles; and to one provider was 1.5 miles.
  - Densely-Settled Rural
    - Amerigroup – The average distance to a choice of five providers was reported as 4.7 miles; to four providers was 4.7 miles; to three providers was 4.4 miles; to two providers was 4.0 miles; and to one provider was 2.9 miles.
      - Amerigroup misclassified Jackson County as Rural/Frontier. Including Jackson County, the average distance to one provider was changed by only 0.1 miles (from 2.9 to 3.0 miles).
    - Sunflower – The average distance to a choice of five providers was 5.2 miles; to four providers was 4.9miles; to three providers was 4.8 miles; to two providers was 4.0 miles; and to one provider was 3.4 miles.

        - United – The average distance to a choice of five providers was 4.4 miles; to four providers was 4.4 miles; to three providers was 4.4 miles; to two providers was 4.3 miles; and to one provider was 3.7 miles.
    - Rural/Frontier
        - Amerigroup – The average distance to a choice of five providers was reported as 18.7 miles; to four providers was 16.3 miles; to three providers was 14.5 miles; to two providers was 10.8 miles; and to one provider was 8.0 miles.
        - The March 2014 GeoAccess report submitted by Amerigroup omitted Wallace County, one of the Frontier counties, and mistakenly classified Jackson County as a Rural/Frontier county (instead of Densely-Settled Rural). The January 2014 report indicated that the average distance to at least one behavioral health provider was 31.9 miles for the 48 Amerigroup members who live in Wallace County. With these corrections, the average distance to a behavioral health provider in rural/Frontier counties was 8.2 miles (instead of 8.0 as reported). Sunflower – The average distance to a choice of five providers was 17.3 miles; to four providers was 15.9 miles; to three providers was 15.4 miles; to two providers was 13.7 miles; and to one provider was 11.0 miles.
        - United – The average distance to a choice of five providers was 11.1 miles; to four providers was 11.1 miles; to three providers was 10.6 miles; to two providers was 10.3 miles; and to one provider was 9.6 miles.

  Recommendation: Amerigroup GeoAccess reports should be corrected to ensure accurate reporting for average distance and access standards.

- **Percent of counties covered within access standards for behavioral health**
  Behavioral health providers were available to members of all three MCOs within the State access standards for each county type.
    - Urban/Semi-Urban
        - The access standard for Urban and Semi-Urban counties is a distance of 30 miles.
        - The access standard was met in CY2013 for 100% of the 16 Urban and Semi-Urban counties in Kansas, as reported by the three MCOs.
        - Based on the GeoAccess map reports, the access standard was also met in CY2012.
    - Densely-Settled Rural
        - The access standard for Densely-Settled Rural counties is a distance of 45 miles.
        - The access standard was met in CY2013 for 100% of the 21 Densely-Settled Rural counties in Kansas, as reported by the three MCOs.
        - Based on the GeoAccess map reports, the access standard was also met in CY2012.
    - Rural/Frontier
        - The access standard for Rural and Frontier counties is a distance of 60 miles.

  - The access standard was met in CY2013 for 100% of the 32 Rural counties and the 36 Frontier counties in Kansas, as reported by Amerigroup, Sunflower, and United.
  - Based on the GeoAccess map reports, the access standard was also met in CY2012.

- **Home and Community Based Services (HCBS) Counties with access to at least two providers by provider type and services.**
  Table 17 below provides information reported by the three MCOs indicating the number of counties that have at least two service providers, and the number of counties that have at least one service provider, for each HCBS provider type. The baseline for this measure will be CY2013 since no comparable pre-KanCare reports of HCBS provider type by county were identified for review.

  As indicated in Table 17, 17 of the 27 HCBS services are available from at least two service providers in all 105 counties for members of all three MCOs.

  Of the remaining 10 Home and Community Based Services:
  - **Speech Therapy (Autism Waiver)** services from at least two providers are only available in three counties through Amerigroup and in only two counties through United. In the Sunflower network, there are at least two service providers in 13 counties, and at least one service provider in 27 counties.
  - **Adult Day Care** - Services are available from at least two providers in 74 counties through Amerigroup, with at least one service provider in 103 of the 105 counties. Services are available from at least two providers in 87 counties through United, with at least one service provider in all 105 counties. In the Sunflower system, however, services are available from at least two providers in only 47 counties, with at least one service provider available in 73 counties.
  - **Health Maintenance Monitoring** – At least two service providers are available through Sunflower and United in all 105 counties. In Amerigroup, only 70 counties have at least two service providers, and 103 counties have at least one service provider.
  - **Home Modification** - At least two service providers are available through Sunflower and United in all 105 counties. In Amerigroup, only 23 counties have at least two service providers, and 105 counties have at least one service provider.
  - **Intermittent Intensive Medical Care-** At least two service providers are available through United in all 105 counties. In Amerigroup, only 84 counties have at least two service providers, and 104 counties have at least one service provider. Through Sunflower, only 78 counties have at least two service providers, and all 105 counties have at least one service provider.

  Amerigroup and Sunflower report that at least two service providers are available in all 105 counties for five HCBS services that are specifically related to the TBI waiver (Behavior Therapy – TBI waiver; Cognitive Therapy – TBI waiver; Occupational Therapy – TBI waiver; Physical Therapy – TBI waiver; and Speech Therapy – TBI waiver). United reports that for these TBI waiver specific services, at

least two service providers are available for Behavior Therapy and Cognitive Therapy in only one county (with at least one provider in 4 counties); at least two service providers for Occupational Therapy in 11 counties (with at least one provider in 32 counties); at least two service providers for Physical Therapy in 14 counties (with at least one provider in 36 counties); and at least two service providers for Speech Therapy in seven counties (with at least one provider in 21 counties). The wide gap in reporting of availability of the TBI-related services indicates potential discrepancies in reporting by the MCOs, and a need for additional follow-up clarification.

Table 17: Home and Community Based Services (HCBS) - Counties with access to at least 2 providers, by provider type and services

	Amerigroup		Sunflower		United	
Provider type	**2 or more**	**at least 1**	**2 or more**	**at least 1**	**2 or more**	**at least 1**
Speech therapy - Autism Waiver	**3**	**3**	**13**	**27**	**2**	**2**
Adult day care	**74**	**103**	**47**	**73**	**87**	105
Health maintenance monitoring	**70**	**103**	105	105	105	105
Home modification	**23**	105	105	105	105	105
Intermittent intensive medical care	**84**	**104**	**78**	105	105	105
Behavior therapy - TBI waiver	105	105	105	105	**1**	**4**
Cognitive therapy - TBI waiver	105	105	105	105	**1**	**4**
Occupational therapy - TBI waiver	105	105	105	105	**11**	**32**
Physical therapy - TBI waiver	105	105	105	105	**14**	**36**
Speech therapy - TBI waiver	105	105	105	105	**7**	**21**
Assistive services	105	105	105	105	105	105
Assistive technology	105	105	105	105	105	105
Attendant care services (Direct)	105	105	105	105	105	105
Comprehensive support (Direct)	105	105	105	105	105	105
Financial management services (FMS)	105	105	105	105	105	105
Home telehealth	105	105	105	105	105	105
Home-delivered meals (HDM)	105	105	105	105	105	105
Long-term community care attendant	105	105	105	105	105	105
Medication reminder	105	105	105	105	105	105
Nursing evaluation visit	105	105	105	105	105	105
Personal emergency response (installation)	105	105	105	105	105	105
Personal emergency response (rental)	105	105	105	105	105	105
Personal services	105	105	105	105	105	105
Sleep cycle support	105	105	105	105	105	105
Specialized medical care/medical respite	105	105	105	105	105	105
Transitional living skills	105	105	105	105	105	105
Wellness monitoring	105	105	105	105	105	105

There is no indication on the report as to which counties do not have at least two services available. The provider network adequacy reports indicate specific providers, but do not separately provide a list of counties with no providers (or less than two providers).

Population – The HCBS reports do not indicate whether members needing these services are residents of the counties where there are no providers or less than two providers. If this information was provided by each MCO, members, program managers, and reviewers could more easily identify counties where services may be provided by one of the other MCOs, and alternatively whether none of the MCOs have providers in the particular county (and in neighboring counties). The MCO GeoAccess reports provide information on the total number of members in each county; however, the reports do not indicate whether members in sparsely populated counties are in need of services that are not commonly needed or available.

Recommendations:

- KFMC recommends that reporting be revised to require MCOs to report the specific counties where there are no providers contracted for specific services, and specific counties where only one provider is contracted for specific services.
- KFMC recommends that the State follow up with the MCOs to clarify the availability of the TBI-related HCBS service providers.
- For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county (or through arrangement by the MCO in a neighboring state). It is also possible, particularly in low-population Frontier counties, for there to be no members in need of a particular service.

- **Provider Open/Closed Panel Report**
  The MCOs submit monthly Network Adequacy reports that include a data field for indicating whether the provider panel is open, closed, or accepting only existing patients. KFMC reviewed the Network Adequacy reports of each of the MCOs and found the data to be extremely limited as to whether the panel is open or closed. Most of the entries in this field are blank. There are also a high frequency of duplicate entries (including exact duplicates, address variations for the same address, P.O. Box address and street address in a small town, etc.). Some entries indicate the provider is not accepting patients, while others for the same provider at the same address give either no indication or conflicting information. State program managers routinely de-duplicate the entries to better identify available providers on this report that has tens of thousands of entries.

  Recommendations:
  - KFMC recommends that the State request that the MCOs update the Network Adequacy report to include more complete data as to whether panels are open or closed. If this data is not available or not known, KFMC recommends that additional reporting and tracking be required to better identify whether providers are accepting patients.
  - As providers may practice at more than one location in a community, and as there could be differences in panel sizes and availability by location, KFMC recommends that the State require the MCOs to

complete quality reviews of the Network Adequacy reports, including de-duplicating entries.

- **Provider After Hour Access (24 hours per day/7 days per week)**
  The MCOs are required by the State to ensure that the 24/7 requirement is met. No tracking report templates, however, are required of the MCOs by the State for tracking this. This is due in part to differing methods and systems used by the MCOs for monitoring provider adherence to these standards.
  - Amerigroup conducts an annual survey of providers. Their first annual survey found that 87% of the providers surveyed were in compliance with after-hours requirements. Amerigroup staff meet with providers not in compliance, and then follow up with "secret shopper" type activities to confirm that changes have been put in place.
  - Sunflower assesses provider accessibility through surveys asking about after-hours access and "secret shopper" calls.
  - United contracts with a vendor (Dial America) that calls a random sample of providers after hours to ensure on-call service is available.

- **Annual Provider Appointment Standards Access (In-office wait times; Emergent, urgent and routine appointments; Prenatal care – first second, third trimester and high risk)**
  The MCOs are required by the State to ensure that in-office wait time requirements are met. No tracking report templates, however, (as per the 24/7 access above) are required of the MCOs by the State for tracking these measures.
  - The MCOs use surveys, "secret shopper" calls, and follow-up provider education to monitor access to appointments.
  - Calls from members with concerns about access prompt follow-up contact by provider representatives through the grievance processes.
  - United's vendor (Dial America) also contacts providers, identifies themselves as representing United, describes symptoms that represent either an urgent or routine need, and ask when the next available appointment would be. Dial America contacts a random sample of 10% of the callers, using a "secret shopper" approach where they do not identify themselves as representing United. United then follows up with providers who are identified as not being in compliance.

<u>Recommendations for the 24/7 and Appointment Access Requirements</u>:

- If no common reporting system or template can reasonably be developed for tracking these measures in CY2014, KFMC recommends that the State review the methods and systems used by each MCO to track provider adherence to these standards, and require routine reporting by each MCO that provides evidence that these access standards are consistently met.
- KFMC recommends that provider after hour access be confirmed through after hours phone calls to the providers.

- Reporting compliance rates and appointment availability based on calls to provider offices from "secret shoppers" separately from callers who first identify that they are representatives of an MCO is recommended.

(22) Member survey – Mental Health

The Mental Health Surveys conducted in CY2012 and CY2013 are described above in section 7.

Questions related to member perceptions of access to mental health services are listed in Table 18 below. The access-related questions in Table 18 focus on the following:

- Provider availability as often as member felt it was necessary
  - Annual rates for this measure in the general adults population have been consistent, with rates ranging from 85.4% to 88.8%.
- Provider return of calls within 24 hours
  - Rates dropped from 88.1% in CY2011 to 80.8% in CY2012. Rates then increased in CY2013 to 84.4% in the general adults population.
- Services were available at times that were good for the member
  - There was a statistically significant increase in the general adult population from CY2012 (87.7%) to CY2013 (92.1%), $p<0.01$. The CY2013 rate is comparable to the CY2011 rate (92.3%).
  - Annual rates within the youth population groups were consistent throughout the time period. In CY2013, rates ranged from 82.6% (SED waiver youth, age 12-17, youth responding) to 88.7% (in both general youth populations).
- Ability to get all the services the members thought they needed
  - There was a statistically significant increase in the general adult population from CY2012 (78.8%) to CY2013 (86.0%), $p<0.01$. The rate in CY2012 had dropped from the CY2011 rate of 91.3%.
  - Annual rates were consistent from CY2011 to CY2013 in the general youth (age <18, family responding) and SED youth/young adult (family responding) populations.
  - Annual rates dropped slightly (not statistically significantly) from CY2011 to CY2012 to CY2013 in the general youth (age 12-17, youth responding) and SED waiver youth (age 12-17, youth responding) populations. In the general youth, the rates dropped from 85.1% (CY2011) to 85.0% (CY2012) to 82.8% (CY2013). In the SED youth, the rates dropped from 77.6% (CY2011) to 76.3% (CY2012) to 71.8% (CY2013).
- Ability to see a psychiatrist when the member wanted to
  - There was a statistically significant increase in the rate in general adults from CY2012 (70.8%) to CY2013 (82.3%), $p <0.001$. The rate in CY2012 had dropped from 82.1% in CY2011.

Table 18 - Mental Health Survey - Access-Related Questions

Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
My mental health providers were willing to see me as often as I felt it was necessary.	**General Adult (Age 18+)**				
	2013	**88.2%**	928 / 1051	86.3% - 90.2%	0.63
	2012	**85.4%**	233 / 273	80.6% - 89.3%	
	2011	*88.8%*	*233 / 273*	*80.6% - 89.3%*	
My mental health providers returned my calls in 24 hours.	**General Adult (Age 18+)**				
	2013	**84.4%**	840 / 996	82.1% - 86.6%	0.15
	2012	**80.8%**	202 / 250	75.4% - 85.5%	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	
Services were available at times that were good for me.	**General Adult (Age 18+)**				
	2013	**92.1%**	986 / 1070	90.5% - 93.8%	**0.01**
	2012	**87.7%**	242 / 276	83.2% - 91.3%	
	2011	*92.3%*	*277/300*	*89.3% - 95.3%*	
	General Youth (Age <18), Family Responding				
	2013	**88.7%**	871 / 983	86.7% - 90.6%	0.77
	2012	**88.0%**	235 / 267	83.5% - 91.7%	
	2011	*85.9%*	*287 / 334*	*82.2% - 89.7%*	
	General Youth (Age 12-17), Youth Responding				
	2013	**88.7%**	411 / 464	85.8% - 91.6%	0.12
	2012	**83.0%**	83 / 100	74.2% - 89.8%	
	2011	*89.5%*	*119 / 133*	*84.3% - 94.7%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2013	**85.1%**	415 / 487	81.9% - 88.3%	0.15
	2012	**88.6%**	287 / 324	85.1% - 92.0%	
	2011	*85.3%*	*243 / 285*	*81.2% - 89.4%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2013	**82.6%**	190 / 230	77.7% - 87.5%	0.92
	2012	**82.2%**	111 / 135	74.7% - 88.3%	
	2011	*83.7%*	*103 / 123*	*77.2% - 90.3%*	
I was able to get all the services I thought I needed.	**General Adult (Age 18+)**				
	2013	**86.0%**	916 / 1065	83.9% - 88.1%	**<0.01**
	2012	**78.8%**	219 / 278	73.5% - 83.4%	
	2011	*91.3%*	*274 / 300*	*88.2% - 94.5%*	
	General Youth (Age 12-17), Youth Responding				
	2013	**82.8%**	388 / 468	79.4% - 86.2%	0.60
	2012	**85.0%**	85 / 100	76.5% - 91.4%	
	2011	*85.1%*	*114 / 134*	*79.0% - 91.1%*	
	SED Waiver Youth (Age 12-17), Youth Responding				
	2013	**71.8%**	167 / 233	66.0% - 77.6%	0.35
	2012	**76.3%**	103 / 135	68.2% - 83.2%	
	2011	*77.6%*	*97 / 125*	*70.3% - 84.9%*	

Table 18 - Mental Health Survey - Access-Related Questions (continued)					
Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
My family got as much help as we needed for my child.	**General Youth (Age <18), Family Responding**				
	2013	**83.2%**	804 / 966	80.9% - 85.6%	0.90
	2012	**82.9%**	213 / 257	77.7% - 87.3%	
	2011	*84.2%*	*278 / 330*	*80.3% - 88.2%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2013	**75.2%**	363 / 483	71.3% - 79.0%	0.49
	2012	**77.3%**	248 / 321	72.7% - 81.8%	
	2011	*77.5%*	*220 / 284*	*72.6% - 82.3%*	
I was able to see a psychiatrist when I wanted to.	**General Adult (Age 18+)**				
	2013	**82.3%**	808 / 982	79.9% - 84.7%	**<0.001**
	2012	**70.8%**	187 / 264	65.0% - 76.2%	
	2011	*82.1%*	*225 / 274*	*77.6% - 86.7%*	
During a crisis, I was able to get the services I needed.	**General Adult (Age 18+)**				
	2013	**85.4%**	744 / 872	83.0% - 87.7%	0.10
	2012	**79.2%**	183 / 231	73.4% - 84.3%	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	
During a crisis, my family was able to get the services we needed.	**General Youth (Age <18), Family Responding**				
	2013	**86.2%**	607 / 704	83.7% - 88.8%	0.68
	2012	**87.4%**	173 / 198	81.9% - 91.7%	
	2011	*89.5%*	*204 / 228*	*85.5% - 93.5%*	
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2013	**76.4%**	298/ 390	72.2% - 80.6%	0.42
	2012	**79.1%**	197 / 249	74.1% - 84.2%	
	2011	*80.1%*	*173 / 216*	*74.8% - 85.4%*	
Medication available timely	**General Adult (Age 18+)**				
	2013	**92.0%**	833 / 907	90.0% - 93.6%	*NA
	General Youth (age <18)				
	2013	**86.1%**	530 / 616	83.3% - 88.8%	*NA
	SED Waiver Youth and Young Adult (0-21), Family Responding				
	2013	**90.9%**	380 / 418	88.2% - 93.7%	*NA
(*Not asked in 2012 and 2011)					

- Timely availability of medication
  - CY2013 was the first year that this question was added to the mental health survey.
  - Rates were high and generally consistent, ranging from 86.1% (general youth, age <18) to 90.9% in SED waiver youth/young adults (family responding) to 92.0% in the general adult population.

- Ability to get services during a crisis
  - Within the youth population groups surveyed, the changes in annual rates did not significantly differ and were generally consistent over time.
    - SED waiver youth/young adults (ages 0-21, family responding) had the lowest annual rates – 80.1% in CY2011, 79.1% in CY2012, dropping slightly to 76.4% in CY2013.
    - In the general youth (age <18, family responding), rates ranged from 89.5% in CY2011, dropping slightly in CY2013 to 86.2%.
  - Rates in the general adult population increased from 79.2% in CY2012 to 85.4% in CY2013. In CY2011, the rate was 88.1%.

(24) Provider Survey

In 2013, the questions in the provider surveys distributed by the three MCOs were not consistently worded. The questions in the Amerigroup and United surveys on the availability of specialists were fairly comparable. In the Amerigroup survey, the question asked, "How satisfied are you with the availability of specialists?" Response options in the Amerigroup survey were "Very Satisfied," "Somewhat Satisfied," "Neither Satisfied nor Dissatisfied," "Somewhat Dissatisfied," and "Very Dissatisfied." In the United survey, providers were asked to rate "the availability of specialists in the referral network. For the United survey question response options were 0 through 10, with 10 meaning "Excellent" and 0 meaning "poor." In combining the responses for Amerigroup and United, response selections of "9" or "10" were determined to be comparable to "Very Satisfied"; "7" or "8" were determined to be comparable to "Somewhat Satisfied"; "4" or "5" or "6" were determined to be comparable to "Neither Satisfied nor Dissatisfied"; "0" or "1" were determined to be comparable to "Very Dissatisfied"; and "2" or "3" were determined to be comparable to "Somewhat Dissatisfied."

The combined responses for Amerigroup and United are in Table 19 below.

Out of 151 provider responses, 49.7% indicated they were "Satisfied" (10.6% were "Very Satisfied"); 17.2% were "Dissatisfied" (4.0% were "Very Dissatisfied"); and 33.1% were "Neither Satisfied nor Dissatisfied."

Most of the questions in the Sunflower provider survey, including the question related to satisfaction with the availability of specialists, were framed from the perspective of comparison to other health plans. Providers were asked to rate the number of specialists in Sunflower's provider network "compared to your experience with other health plans you work with." As reported in Table 19 below, 63.1% of 195 providers considered the number of specialists available in the network to be "Average" compared to the other MCOs; 11.8% considered Sunflower to be "Above Average" (2.1% "Well Above Average"); and 25.1% considered Sunflower to be "Below Average" (8.7% "Well Below Average").

Table 19: Provider Satisfaction with Availability of Specialists					
Amerigroup and United Combined Survey Responses					
Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied nor Dissatisfied	Somewhat Satisfied	Very Satisfied	Total Responses
6	20	50	59	16	151
4.0%	13.2%	33.1%	39.1%	10.6%	
	Dissatisfied	Neutral	Satisfied		
	26	50	75		
	17.2%	**33.1%**	**49.7%**		
Sunflower					
"Compared to other health plans, the number of specialist in the Sunflower network is..."					
Well below average	Somewhat below average	Average	Somewhat above average	Well Above Average	Total
17	32	123	19	4	195
8.7%	16.4%	63.1%	9.7%	2.1%	
	Below Average	Average	Above Average		
	49	123	23		
	25.1%	**63.1%**	**11.8%**		

Provider surveys will be distributed in 2014 by Amerigroup to be completed in July through September, with survey results by November. Sunflower and United surveys will be completed by providers in August through October, with survey results by December 2014. The question regarding satisfaction with the availability of specialists is being evaluated for consistent wording and response options amongst the three MCOs, to be included in the 2014 and subsequent annual provider surveys. The responses from the 2014 specialist question will be the baseline measure for comparison to responses in subsequent years.

Recommendation: The Provider Survey distributed in 2014 should be revised to ensure that the question(s) on provider satisfaction with availability of specialists have identical wording and consistent response choices.

EFFICIENCY

(See Appendix A for information on additional measures in the following subcategories of Efficiency: (27) Systems; and (28) Member Surveys. See Appendix B for information on measures in the following subcategory: (27) Systems.)

(28) Member Surveys

The Mental Health Surveys conducted in CY2012 and CY2013 are described above in section 7.

The question related to efficiency of mental health services was: "My mental health providers returned my calls in 24 hours."

As shown in Table 20, over 84% of the 996 adults surveyed in 2013 indicated that providers returned their calls within 24 hours. This is an increase over the 2012 response rate of 80.8%, and less than the rate in 2011 (88.1%).

Table 20 - Mental Health Survey - Efficiency-Related Questions

Question	Year	%	N/D	95% Confidence	p-value (compare 2013 to 2012)
	General Adult (Age 18+)				
My mental health providers returned my calls in 24 hours.	**2013**	**84.4%**	840 / 996	82.1% - 86.6%	0.15
	2012	**80.8%**	202 / 250	75.4% - 85.5%	
	2011	*88.1%*	*251 / 285*	*84.3% - 91.8%*	

Comments: Rates are higher in 2013 than in 2012; however, MCOs should continue to stress to providers and CMHCs the importance of returning calls within 24 hours.

UNCOMPENSATED CARE POOL AND DELIVERY SYSTEM REFORM INCENTIVE PROGRAM

(See Appendix A.)

CONCLUSIONS

This first KanCare Evaluation annual report generally focused on measures where data were available for comparison of performance pre-KanCare with performance in the first year of KanCare implementation. Due to claims lag times and standard reporting tools and surveys (such as HEDIS and CAHPS), complete annual data for several performance measures were not available for review in this report. For measures where no comparable pre-KanCare data are available, CY2013 data will be used as baseline for comparison with data in subsequent years. Measures that were not yet available for analysis of performance are summarized in Appendix A. Measures reported quarterly are summarized in Appendix B.

KFMC found that performance outcomes reviewed in this first annual report were generally positive.

QUALITY OF CARE

SUD Services

- There was a significant increase in the percentage of members discharged from SUD services that gained or maintained employment.
- There was a significant decrease in the percentage of members reporting increased attendance of self-help meetings.

- The number of members discharged from SUD services declined during each subsequent quarter of CY2013. If fewer members needed treatment, or fewer members had multiple discharges from treatment, then this is a positive result. Alternatively, it is possible that fewer members were diagnosed as needing SUD treatment that actually needed treatment. The decrease could also be a result of less complete data in the system.
- The success rate of the following measures remained consistently high in both CY2012 and CY2013:
  - Decreased criminal justice involvement (99.0% in Q4 CY2012; 99.4% in Q4 CY2013)
  - Improved living arrangements (99.5% in Q4 CY2012; 98.9% in Q4 CY2013)
  - Decreased drug and/or alcohol use (95.4% in Q4 CY2012; 95.0% in Q4 CY2013).

Mental Health Services

- There was a statistically significant decrease in inpatient psychiatric admissions, comparing Q4 CY2012 (42.06 per 10,000) with Q4 CY2013 (32.29 per 10,000).
- The housing status of KanCare adults with SPMI improved in CY2013. In Q4 CY2012, 47.9% of those homeless at the beginning of the quarter had improved housing; in Q4 CY2013, 55.2% had improved housing.
- The percent of KanCare members with SPMI who gained or maintained competitive employment did not change significantly in CY2013.
- The percent of SED youth who had improved housing at the end of Q4 CY2013 (84.0%) was higher than the percentage in Q4 CY2012 (80.1%).
- The percentage of SED youth that maintained a stable living arrangement remained high in both years (99.4% at the end of Q4 CY2012; 99.5% at the end of Q4 CY2013).

Long-Term Care: Nursing Facilities

- There were eight nursing facilities in 2013 that were recognized as PEAK.

Member Survey

- Mental Health survey responses in CY2013 were generally positive and did not change significantly from CY2012 to CY2013, nor from CY2011 to CY2013. The survey population in CY2013, however, was three times the size of the survey populations in the two prior years, which adds strength to the confidence in the positive rates reported.

COORDINATION OF CARE (AND INTEGRATION)

Care Management for Members with I/DD

- WSU developed and distributed informational materials and facilitated educational tours and Consumer Lunch and Learn calls in CY2013.

Provider Survey

- Out of 247 provider responses to Amerigroup and United survey questions on satisfaction with obtaining pre-certification and/or preauthorization, 39.3% indicated they were "Satisfied" (8.5% were "Very Satisfied"); 40.1% were "Dissatisfied" (17.4% were "Very Dissatisfied"); and 20.6% were "Neither Satisfied nor Dissatisfied."
- Sunflower's provider survey responses were reviewed separately, as Sunflower framed their questions from the perspective of comparison to other health plans. Compared to providers' "experience with other plans" they worked with, 52.3% of 216 providers considered Sunflower's preauthorization process to be "Average"; 35.7% "Above Average"; and 12% "Below Average."

Mental Health Survey

- Responses to questions related to coordination of care were consistently positive in CY2012 and CY2013.

ACCESS TO CARE

Provider Network – GeoAccess

- KFMC reviewed GeoAccess reports and maps to identify the number and percent of counties that have no services provided by any of the three MCOs in CY2013, and that had no services provided in CY2012 pre-KanCare, within the access standards for each service type.
  - Services provided in all Kansas counties in CY2012 and CY2013 within State-specified access standards included the following: Hospitals, Primary Care Provider, Cardiology, General Surgery, Hematology/Oncology, Internal Medicine, Ophthalmology, Physical Therapy, X-ray, Lab, and Retail Pharmacy.
  - Services that were not provided in all Kansas counties, but that did not increase or decrease in number of counties with access, between CY2012 and CY2013, included Nephrology and Urology.
  - Services that were offered in more counties in CY2013 than in CY2012 included: Dermatology, Neurology, Neurosurgery, OB/GYN, Optometry, Otolaryngology, Physical Medicine/Rehab, Plastic & Reconstructive Surgery, Podiatry, Psychiatrist, and Occupational Therapy.
  - Services that were offered in fewer counties in CY2013 than in CY2012 included Allergy, Gastroenterology, Neonatology, Orthopedics, Pulmonary Disease, and Dental Primary Care.
- **Behavioral health** - Behavioral health services were provided in all counties within the access standards required by the State.
- **HCBS** - Regarding HCBS access to at least two providers by provider service type:
  - Of the 27 HCBS services, 17 are available from at least two service providers in all Kansas counties from all three MCOs.
  - Of the 10 remaining HCBS services**:**
    - Speech Therapy (Autism Waiver) – Services are available from at least two providers in only three counties through Amerigroup, and in only

two counties through United. In the Sunflower network, there are at least two providers in 13 counties, and at least one service provider in 27 counties.

- Adult Day Care – Services are available from at least two providers in 74 counties through Amerigroup, with at least one service provider in 103 of the 105 counties. Services are available from at least two providers in 87 counties through United, with at least one service provider in all 105 counties. In the Sunflower system, services are available from at least two providers in 47 counties, with at least one service provider in available in only 73 counties.
- Health Maintenance Monitoring - At least two service providers are available through Sunflower and United in all 105 counties. In Amerigroup, only 70 counties have at least two service providers, and 103 counties have at least one service provider.
- Home Modification - At least two service providers are available through Sunflower and United in all 105 counties. In Amerigroup, only 23 counties have at least two service providers, and 105 counties have at least one service provider.
- Intermittent Intensive Medical Care- At least two service providers are available through United in all 105 counties. In Amerigroup, only 84 counties have at least two service providers, and 104 counties have at least one service provider. Through Sunflower, only 78 counties have at least two service providers, and all 105 counties have at least one service provider.
- TBI Waiver services: Behavior Therapy, Cognitive Therapy, Occupational Therapy, Physical Therapy, and Speech Therapy
  - Amerigroup and Sunflower indicate that there are at least two service providers in all 105 counties for each of the TBI Waiver-related services. United reports having very few counties with access to these services.

  - There is no indication in the HCBS report as to which counties do not have at least two services available.
  - The HCBS report does not indicate whether members needing services are residents of the counties where there are no providers or where there are less than two providers. In a “Frontier” county, in particular, it is possible that there are no members in the county that are in need of one of the more specialized HCBS services.

- **Open/Closed Panels** (Network Adequacy Report) – Data on open and closed panels is very limited in the Network Adequacy report. Most of the entries are blank, and there is a high frequency of duplicate entries of providers. These duplicates could over-inflate the number of available providers.
- **Provider After Hour Access and Provider Appointment Standards Access**
  - MCOs are required to meet specific access standards for these measures. No standard tracking reports were required of the MCOs in CY2013. This was due in part to differing methods and systems used by the MCOs to monitor provider adherence to these standards.

Mental Health Survey

- Responses to questions related to access to care were consistently positive in CY2012 and CY2013.

Provider Survey

- Out of 151 provider responses to Amerigroup and United survey questions on satisfaction with the availability of specialists, 49.7% indicated they were "Satisfied" (10.6% were "Very Satisfied"); 17.2% were "Dissatisfied" (4.0% were "Very Dissatisfied"); and 33.1% were "Neither Satisfied nor Dissatisfied."
- Sunflower's provider survey responses were reviewed separately, as Sunflower framed their questions from the perspective of comparison to other health plans. Compared to providers' "experience with other plans" they worked with, 63.1% of 195 providers considered Sunflower's availability of specialists to be "Average"; 11.8% "Above Average"; and 25.1% "Below Average."

EFFICIENCY

Mental Health Survey

- Members indicated in CY2013 and the previous two years consistently positive responses as to mental health providers returning calls within 24 hours.

RECOMMENDATIONS

(Recommendations made for several performance measures described in Appendix A for improving survey methodology and reporting are included in the summary below.)

QUALITY OF CARE

SUD Services

- KFMC recommends that, where possible, the total number of unduplicated members be reported that received SUD services during the year. Reporting this number would give a clearer picture of the scope and impact of the SUD services provided.
- KFMC recommends that additional information be provided as to the reasons for the decline in the number of members discharged from SUD treatment.
- Self-help meeting attendance
  - KFMC recommends that MCOs work with SUD treatment providers and self-help groups to identify barriers to meeting attendance and to identify any regional differences in attendance rates.
  - The SUD survey to be conducted in 2014 is a potential tool to gain information on reasons for poor attendance.
  - A major focus of the Sunflower AOD performance improvement project (PIP) is to increase partnerships between providers and care coordinators and generate ideas to increase engagement in treatment. These partnerships

can be opportunities for additional feedback from members and providers on barriers and to generate ideas for improving attendance.

Healthy Life Expectancy Measures (See Appendix A.)

- KFMC recommends that the survey questions regarding flu shots, pneumococcal vaccination, hepatitis A vaccination, and hepatitis B vaccination be modified to add a response option of "I don't know."
- Flu Shots: As this is an annual measure, the survey results could potentially be strengthened by reviewing claims data for flu shot administration.
- Hepatitis A and B Vaccinations: One to two lifetime doses are recommended for the Hepatitis A vaccination, and a series of two to three lifetime doses are recommended for the Hepatitis B vaccination. These vaccines are now routinely given in childhood (and are included in the HEDIS Childhood Immunization Status measure), but were not available or routinely recommended until recent years. Because these immunizations could have been administered at any age, and because members may have been vaccinated prior to MCO membership, surveys were used to determine past vaccination. In addition to vaccination, the HEDIS measure compliance criteria include a documented history of the illness or a seropositive test result. KFMC recommends that the survey to be administered in 2014 be modified to provide members the option to report a history of Hepatitis A or Hepatitis B (that can be verified in medical records) to be considered compliant with these performance measures.

COORDINATION OF CARE (AND INTEGRATION)

Continue learning from providers regarding ways to improve preauthorization processes and implement improvement efforts as appropriate.

Provider Survey

- The provider survey distributed in 2014 should be revised to ensure that the question(s) on provider satisfaction with obtaining precertification and/or authorization for members have identical wording and consistent response choices.

ACCESS TO CARE

GeoAccess Reports

- Amerigroup GeoAccess reports should be corrected to ensure accurate reporting for average distance and access standards.
- HCBS
  - KFMC recommends that reporting be revised to require MCOs to report the specific counties where there are no providers contracted for specific services and specific counties where only one provider is contracted for specific services.
  - KFMC recommends that Amerigroup and Sunflower review the requirements for the TBI waiver-related services and verify to the State the number of counties where there are at least two service providers who meet the TBI-

related qualifications and specialized training for Behavior therapy, Cognitive therapy, Occupational therapy, Physical therapy, and Speech therapy.
    - For those counties with no providers, it would be important to know the number of members needing these services that reside in that county and their average distance to a provider. It is possible members needing these services are able to obtain them in a nearby county, or that there are no members needing one or more of the services (particularly in low-population Frontier counties).
- **Open/Closed Panels** (Network Adequacy Report)
    - KFMC recommends that the State request that the MCOs update the Network Adequacy report to include more complete data as to whether panels are open or closed. If this data is not available or not known, KFMC recommends that additional reporting and tracking be required to better identify whether providers are accepting patients.
    - KFMC recommends that the State require the MCOs to complete quality reviews of the Network Adequacy reports, including de-duplicating entries.
- **After hour access and appointment access standards**
    - If no common reporting system or template can reasonably be developed for tracking provider after hour access (24 hours per day/7 days per week) and provider appointment access standards (in-office wait times; emergent, urgent, and routine appointments; prenatal care) in CY2014, KFMC recommends that the State review the methods and systems used by each MCO to track provider adherence to these standards, and require routine reporting by each MCO that provides evidence that these access standards are consistently met.
    - KFMC recommends that MCOs continue to monitor provider after hour access through after hours phone calls to the providers.

Provider Survey

- The provider survey distributed in 2014 should be revised to ensure that the question(s) on provider satisfaction with availability of specialists have identical wording and consistent response choices.

Appendix A

Performance Measures with Comparison or Baseline Data Not Yet Available for Review

Kansas Foundation for Medical Care, Inc.

Appendix A - Performance Measures with Comparison or Baseline Data not yet Available for Review

The following performance measures will be reported and analyzed in subsequent annual reports. Some of these measures have CY2013 baseline data and will be reviewed when comparison data for CY2014 are available. Measures that will be comparing pre-KanCare data with KanCare data that are in Appendix A are those that do not yet have CY2013 data due primarily to claims lag and standardized data analyses (e.g., Healthcare Effectiveness Data and Information Set [HEDIS]) that will be completed in CY2014.

QUALITY OF CARE

Goals, Related Objectives, and Hypotheses for Quality of Care subcategories:

Goal: Improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes).

Related Objectives: Measurably improve health care outcomes for members in areas including: diabetes; coronary artery disease; prenatal care; behavioral health.

- *Improve coordination and integration of physical health care with behavioral health care.*
- *Support members successfully in their communities.*
- *Promote wellness and healthy lifestyles.*

Hypotheses:

- *By holding MCOs to outcomes and performance measures, and tying measures to meaningful financial incentives, the State will improve health care quality and reduce costs.*
- *The State will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.*

(1) Physical Health

Most of the Physical Health performance measures for CY2013 will be assessed using HEDIS data. As indicated above, HEDIS 2014 (based on care provided in CY2013) will not be available until July or August 2014. Annual comparisons of performance will be made in the 2014 KanCare Evaluation report for measures comparing pre-KanCare with KanCare data. However, annual comparisons of performance for measures with baseline data based on 2013 claims and HEDIS data will be made in the 2015 KanCare Evaluation annual report.

Pre-KanCare data for the following measures will be based on HEDIS data for CY2012 from MCOs (Coventry and UniCare) that provided services to Medicaid

members in 2012. In the second annual KanCare evaluation report, HEDIS 2014 rates (reflecting 2013 care) will be compared with pre-KanCare HEDIS 2013 rates (reflecting 2012):

- **Comprehensive Diabetes Care**
  - This measure is a composite HEDIS measure composed of 10 rates.
  - Population: Ages 18-75; Medicaid; CHIP
  - Analyses: Pre-KanCare compared to KanCare and trending over time
- **Hemoglobin A1c (HbA1c) testing for pediatric patients ages 5-17**
  - Population**:** Ages 5-17; Medicaid; CHIP
  - Analyses: Pre-KanCare compared to KanCare and trending over time
- **Well-Child Visits in the First 15 Months of Life.**
  - Population: Age through 15 months; Medicaid; CHIP
  - Analysis: Pre-KanCare compared to KanCare and trending over time
- **Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life**.
  - Population: Ages 3-6; Medicaid; CHIP
  - Analyses: Pre-KanCare compared to KanCare and trending over time
- **Prenatal Care**
  - Population: Medicaid; CHIP
  - Analyses: Pre-KanCare compared to KanCare and trending over time

The baselines for the following performance measures are HEDIS data for CY2013. Comparison analyses will be completed in the third annual KanCare evaluation report since CY2014 data will not be available until August 2015.

- **Adolescent Well Care Visit.**
  - Population: Ages 12-21; Medicaid; CHIP
  - Analyses: Pre-KanCare compared to KanCare and trending over time
- **Adults Access to Preventive/Ambulatory Health Services.**
  - Population: Ages 20-44; 45-65; 65 and older; Medicaid
  - Comparison: Annual comparison to 2013 baseline, trending over time
- **Annual Monitoring for Patients on Persistent Medications.**
  - Population: Medicaid; CHIP
  - Analyses: Annual comparison to 2013 baseline, trending over time
- **Medication Management for People with Asthma, for members 5-64 years of age.**
  - Population: Ages 5-11, 12-18, 19-50, 51-65; Medicaid; CHIP
  - Analyses: Annual comparison to 2013 baseline, trending over time
- **Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication, for ages 6-12 yrs**.
  - Population: Ages 6-12; Medicaid; CHIP
  - Analyses: Annual comparison to 2013 baseline, trending over time
- **Follow-up after Hospitalization for Mental Illness, within seven days of discharge**.
  - Population: Medicaid; CHIP
  - Analyses: Annual comparison to 2013 baseline, trending over time

The baseline data for the following performance measure are Kansas Vital Records data for CY2012 for births to Medicaid members. Data for CY2013 will also be based on Vital Records data for births to KanCare members in 2013. Comparison analyses will be completed in the third annual KanCare evaluation report.

- **Preterm Births**.
  - Population: Medicaid; CHIP
  - Pre-KanCare compared to KanCare and trending over time

(3) Mental Health Services

The following performance measures will be reported in the second annual KanCare Evaluation report. Due to differing methods of reporting in CY2012, KDADS staff are applying methods used in CY2013 to allow comparisons to be made with pre-KanCare data.

- **The number and percent of adults with SPMI who had increased access to services.**
- **The number and percent of youth experiencing SED who had increased access to services.**
- **The number and percent of KanCare youth receiving MH services with improvement in their Child Behavior Checklist (CBCL Competence T-scores).**

(4) Healthy Life Expectancy Measure

Population: The Healthy Life Expectancy (HLE) performance measures focus on persons with Intellectual or Developmental Disabilities (I/DD) (and those on the I/DD wait list); persons with Physical Disabilities (PD) (and those on the PD wait list); and persons with Serious Mental Illness (SMI).

Baseline data for all of the HLE measures, with the exception of Mortality, are for CY2013, with annual comparisons and analyses of trends over time. Data sources for these measures include HEDIS data (limited to the I/DD, PD, and SMI populations); surveys conducted by MCOs, with the assistance of Community Mental Health Centers (CMHCs); and Vital Records Data.

HEDIS-like Measures

The following measures are described as “HEDIS-like” in that HEDIS criteria will be used for each performance measures, but the HEDIS programming will be adapted to include only those populations that meet eligibility criteria and are also I/DD, PD, or SMI. HEDIS results for CY2013 are projected to be available by August 2014. Comparison HEDIS results for CY2014 measures will subsequently be available by August 2015. Performance for these measures will be compared and analyzed in the third annual KanCare Evaluation report.

- **Breast Cancer Screening**
- **Cervical Cancer Screening**
- **Chlamydia Screening in Women**
- **Adults’ Access to Preventive/Ambulatory Health Services**
- **Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**
- **Comprehensive Diabetes Care**

- **Cholesterol Management for Patients with Cardiovascular Conditions**
- **Persistence of Beta-Blocker Treatment after a Heart Attack**
- **Controlling High Blood Pressure**
- **Adult BMI Assessment**

Survey Data

The baseline data for the questions below are from surveys conducted by the MCOs by phone and in person in 2013, with the assistance of CMHCs. These surveys will be repeated annually and include members who are in the I/DD, I/DD wait list, PD, PD wait list, and SMI populations. Results from the surveys completed in CY2013 and CY2014 will be reported in the 2014 KanCare Evaluation Annual Report.

- **Health Literacy**
  Members who responded "Yes" to the question, "Have you seen a provider in the last six months?" were asked the questions below. Response options included: "Never," "Sometimes," "Usually," and "Always."
  - "How often did your providers give you all the information you wanted about your health?"
  - "How often did your providers encourage you to talk about all your health questions or concerns?"
  - "How often did your providers ask you to describe how you were going to follow instructions?"
  - "How often were instructions about your medicines easy to understand?"
- **Flu Shots for adults**
  - Annual flu shots for adults ages 18 and older.
  - Members were asked, "Have you received a flu shot in the last year?"
  - Recommendations**:**
    - As this is an annual measure, the survey results could potentially be strengthened by reviewing claims data for flu shot administration. Flu shots, however, are available through many sources, including places of employment or the local pharmacy. Because of this, and because this is an annual vaccination, a survey question was determined to be adequate for this measure. (The CAHPS survey includes a question on annual flu vaccination. The CAHPS survey, however, is sent to a random sample of the MCO membership, and the focus for this measure is the PD, DD, or SMI populations.)
    - KFMC recommends that the survey administered in 2014 be modified to add an option of "I don't know."
- **Pneumococcal Vaccination**
  - Members age 65 and older
  - According to CDC guidelines, one dose is needed at age 65 and older.
  - Members were asked, "Have you ever been vaccinated for Pneumonia?"
  - Recommendation**:**
    - As per above, KFMC recommends that the survey administered in 2014 be modified to add an option of "I don't know."

- **Hepatitis A Vaccination & Hepatitis B Vaccination**
  - Members were asked, "Have you ever been vaccinated for Hepatitis A?" and "Have you ever been vaccinated for Hepatitis B?"
  - Recommendations**:**
    - As per above, KFMC recommends that the survey administered in 2014 be modified to add an option of "I don't know" for each of these questions.
    - One to two lifetime doses are recommended for the Hepatitis A vaccination, and a series of two to three lifetime doses are recommended for the Hepatitis B vaccination. These vaccines are now routinely given in childhood (and are included in the HEDIS Childhood Immunization Status measure), but were not available or routinely recommended until recent years. Because these immunizations could have been administered at any age, and because members may have been vaccinated prior to MCO membership, surveys were used to determine past vaccination. In addition to vaccination, the HEDIS measure compliance criteria include a documented history of the illness or a seropositive test result. KFMC recommends that the survey to be administered in 2014 be modified to provide members the option to report a history of Hepatitis A or Hepatitis B (that can be verified in medical records) to be considered compliant with these performance measures.
- **Smoking Cessation**
  Survey questions for this performance measure are based on questions included in the CAHPS survey. Because the CAHPS survey is a random sample of all members in an MCO, and because the focus of this performance measure was on specific subpopulations (I/DD, PD, and SMI), a separate survey was used to assess the responses to the questions below.

  Members who responded "every day" or "some days" to the question, "Do you now smoke cigarettes or use tobacco: every day, some days, or not at all?" were asked the following questions:
  - **"How often were you advised to quit smoking or using tobacco by a doctor or other health provider?"**
  - **"How often was medication recommended or discussed by a provider to assist you in quitting smoking or using tobacco?"**
  - **"How often did your doctor discuss methods other than medication to assist you with quitting smoking or using tobacco?"**

Vital Records Data

- **Mortality Rate**
  Because of concern that mortality rates are higher at younger ages, particularly for those who are SMI, one of the goals of KanCare is to reduce the age-adjusted mortality rate of members who are SMI, PD, and I/DD. Mortality rates will be

analyzed at the end of five years, and interim rates will be reviewed annually beginning in 2015.

(5) Home and Community Based Services (HCBS) Waiver Services

The following performance measures will be tracking the number and percent of KanCare members, who are receiving HCBS I/DD, PD, or Traumatic Brain Injury (TBI) waiver services, who have gained competitive employment and the number and percent who maintained competitive employment. The baseline data for these measures are 2013 employment data by waiver.

- **The number and percent of KanCare members, receiving HCBS I/DD, PD, or TBI waiver services who have gained competitive employment.**
- **The number and percent of KanCare members, receiving HCBS I/DD, PD or TBI waiver services who maintained competitive employment.**

The following performance measures will be tracking provision of services to ensure that members are receiving services identified in individualized service plans. Pre-KanCare data will annually be compared with KanCare data, and will be reported by individual waiver population: I/DD, PD, TBI, Technical Assistance (TA), SED, Autism, Money Follows the Person (MFP), and Frail Elderly (FE). Data for Quarter four (Q4) of CY2014 was not yet available; therefore, the following measures will be reported in the second annual KanCare Evaluation report.

- **Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment.**
- **Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan.**

(6) Long Term Care: Nursing Facilities (NF)

The following NF performance measures, that each compare pre-KanCare data with KanCare annual data, will be reported in the second KanCare Evaluation report. Each of these measures include claim and encounter data that will not be available for review until April 2014.

- **Percentage of Medicaid Nursing Facility (NF) claims denied by the MCO.**
- **The percentage of NF members who had a fall with a major injury.**
- **Nursing Facility Days of Care: The number of nursing facility days used by eligible beneficiaries.**
- **The percentage of members discharged from a NF who had a hospital admission within 30 days.**
    - Criteria for this measure are in process. Performance for this measure will be assessed when criteria are defined and comparison data is available.

(7) Member Survey – Quality

CAHPS Survey

The CAHPS Survey is being distributed in 2014 to KanCare members by Amerigroup and United from mid-February through May, and by Sunflower from March through June. The MCOs will receive survey results in July 2014. These survey results will be compared with pre-KanCare survey results in the second annual KanCare Evaluation. Survey results will be reported by program type Title XIX (Medicaid) and Title XXI (CHIP). Medicaid survey results will be stratified by Adult, Child-general, and Child-chronic conditions; CHIP results will be stratified by Child-general and by Child-chronic conditions.

CAHPS questions related to quality of care will include the following questions focused on patient perceptions of provider treatment:

- **Rating of personal doctor**
- **Rating of health care**
- **Rating of health plan**
- **Rating of specialist seen most often**
- **Doctor spent enough time with the client.**
- **Doctor explained things in a way easy to understand.**
- **Doctor respected client comments.**
- **Doctor discussed pros and cons of treatment choices.**
- **Doctor asked which treatment choice the client thought best.**

Substance Use Disorder (SUD) Consumer Survey

In January through April 2012, Value Options-Kansas (VO) conducted a member satisfaction survey of 629 members who accessed substance use disorder treatment services during fiscal year (FY) 2012 (which began July 2011). The survey consisted of 30 questions that were administered by mail and through face-to-face interviews at provider locations.

Kansas Department for Aging and Disability Services (KDADS) staff are reviewing the VO survey instrument to identify any modifications or additions that may be indicated. The three MCOs will be conducting surveys in 2014 of members who have accessed SUD services. Results from the 2014 survey will be compared with the results from the 2012 VO survey in the second annual KanCare Evaluation report.

Questions related to patient perceptions of SUD services that will be included in the 2014 SUD survey include:

- **How would you rate your counselor on involving you in decisions about Your care?**
- **Since beginning treatment, in general are you feeling much better, better, about the same, or worse?**

(8) Provider Survey

Provider surveys will be distributed in 2014 by Amerigroup to be completed in July through September, with survey results by November. Sunflower and United surveys will be completed by providers in August through October, with survey results by December 2014. One or more questions on provider perceptions of beneficiary quality of care, with consistent wording and response options for all three MCOs, will be developed by May 2014 for inclusion in the provider surveys in 2014 and subsequent annual provider surveys during the KanCare demonstration project. The responses from the 2014 quality of care question will be the baseline measure for comparison to responses in subsequent years.

(10) Other (Tentative) Studies (Specific studies to be determined)

The focus and topics for "other studies" will be determined based on review of the various program outcomes, planned preventive health projects, and value-added benefits provided by the MCOs . Potential examples of studies include the impact of new moms and babies programs on prenatal care, preterm births, and well baby/well child visits; and the impact of smoking cessation programs on number of members who smoke.

COORDINATION OF CARE (AND INTEGRATION)

Goals, Related Objectives, and Hypotheses for Coordination of Care subcategories:

Goal: Provide integration and coordination of care across the whole spectrum of health to include physical health, behavioral health, mental health, substance use disorders, and LTSS.

Related Objectives:

- *Improve coordination and integration of physical health care with behavioral health care.*
- *Support members successfully in their communities.*

Hypothesis: The KanCare model will reduce the percentage of beneficiaries in institutional settings by providing additional HCBS and supports to beneficiaries that allow them to move out of an institutional setting when appropriate and desired.

(11) Care Management for Nursing Facility Residents

The population for the following performance measures is members who are nursing facility residents. Specific criteria for the following measures are currently being delineated and revised to better capture the quality of care management for nursing facility residents.

- **The number and percent of KanCare members, who are nursing facility residents and in care management, with a POC that addresses identified member needs, as identified by comparing the resident health risk assessment results against the plan of care.**

- **The number and percent of KanCare members, who are nursing facility residents and in care management, with evidence that POC services were provided.**
- **The number and percent of KanCare members, who are nursing facility residents and in care management, indicating satisfaction with integration of their services.**

(12) Care Management for non-NF members

The population for the following performance measures is members who are not nursing facility residents who are in care management with needs in two or more of the following areas: mental health; substance use disorder, or physical health disease management. Specific criteria for the following measures are currently being delineated and revised to better capture the quality of care management for non-nursing facility residents.

- **The number and percent of KanCare members, who are not nursing facility residents and are in care management, with a POC that addresses identified member needs**.
- **The number and percent of KanCare members, who are not nursing facility residents and are in care management, with evidence that POC services were provided.**
- **The number and percent of KanCare members, who are not nursing facility residents and are in care management, indicating satisfaction with integration of their services.**

(13) Other (Tentative) Study (Specific study to be determined)

This measure will be reported when a specific study and study criteria are determined and defined, and will be based on areas of special focus on care coordination and integration of care.

(14) Care Management for members with I/DD

Hypothesis: KanCare will provide integrated care coordination to individuals with developmental disabilities, which will improve access to health services and improve the health of those individuals.

The following measures refer to the I/DD pilot project conducted in CY2013 through January 2014.

- **Number of I/DD providers submitting a credentialing application to an MCO, who completed the credentialing application to an MCO, who completed the credentialing process within 45 days.**
  KDADS has been monitoring the contracting and credentialing process for pilot and non-pilot members. MCOs have provided KDADS a detailed report about the contracting and credentialing process, and final numbers will be available in the next few weeks. Analysis of these reports will be included in the second annual KanCare Evaluation report.

- **MCOs have demonstrated an understanding of the Kansas DD service system. MCOs demonstrate a knowledge and understanding of:**
  - **The statutes and regulations that govern the I/DD service delivery system.**
  - **The person-centered planning process and regulations related to the process.**
  - **The various types of providers and the roles they play in the I/DD service system.**
  - **Tools/strategies used by CDDO/Stakeholder processes.**
  - **The tools used by CDDOs to implement various local processes (local quality assurance, funding committees, crisis determinations, public school system collaboration, etc.)**

  KDADS provided technical assistance and training to MCOs regarding the Kansas I/DD service system, including a Targeted Case Manager and Care Coordinator Summit to educate care coordinators. In the readiness reviews, the MCOs have provided information about comprehensive training for care coordinators who were in the process of being hired for I/DD integration into KanCare. KDADS will be reviewing data and responses to the MCO proficiency and competency results within the first 60 days of IDD long-term supports and services into KanCare and due by April 30, 2014. KFMC will review this measure in the next annual KanCare Evaluation.

I/DD pilot project provider surveys are the data source for the following three performance measures. KDADS will be reviewing responses to these provider surveys that are due March 31, 2014. Analysis of these performance measures will be included in the second annual KanCare Evaluation report.

- **The number of I/DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to enter their provider network.**
- **Number of I/DD providers who, having requested it, report receiving helpful information and assistance from MCOs about how to submit claims for services provided.**
- **Number of providers who, having participated in the DD pilot project, report understanding how to help the members they support understand the services available in the KanCare program and how to access those services.**

The data source for the following performance measure is a survey of targeted case managers. Responses to this survey are due to KDADS by May 31, 2014. This performance measure will be analyzed in the second annual KanCare Evaluation report.

- **Improved access to services including physical health, behavioral health, specialists, prevention. Targeted Case Managers participating in the pilot will be the focus of this measurement.**

(15) Member Survey – CAHPS

Amerigroup and United are distributing the CAHPS Survey to KanCare members from mid-February through May (2014), and Sunflower is surveying members from March through June. The MCOs will receive survey results in July 2014. These survey results will be compared with pre-KanCare survey results in the second annual KanCare Evaluation. Survey results will be reported by program type Title XIX (Medicaid) and Title XXI (CHIP). Medicaid survey results will be stratified by Adult, Child (general), and Child (chronic conditions); CHIP results will be stratified by Child (general) and by Child (chronic conditions).

CAHPS questions related to coordination of care will include the following questions focused on perception of care and treatment in the Medicaid and CHIP populations:

- **In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from these doctors or other health providers?**
- **In the last 6 months, when there was more than one choice for your treatment or health care, did a doctor or other health provider ask which choice you thought was best for you?**
- **In the last 6 months, did a doctor or other health provider talk with you about the pros and cons of each choice for your treatment or health care?**
- **Does your personal doctor understand how any health problems you have affect your day-to-day life?**

CAHPS questions related to coordination of care will include the following questions focused on perception of care and treatment from the Children with Chronic Conditions (CCC) Module:

- **In the last 6 months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?**
- **Does your child's personal doctor understand how these medical behavioral or other health conditions affect your child's day-to-day life?**
- **Does your child's personal doctor understand how your child's medical, behavioral or other health conditions affect your family's day-to-day life?**
- **In the last 6 months, how often was it easy to get appointments for your child with specialists?**
- **In the last 6 months, how often was it easy to get the care, tests, or treatment you thought your child needed through his or her health plan?**
- **In the last 6 months, was it easy to get prescription medicines for your child through his or her health plan?**
- **Did anyone from your child's health plan, doctor's office, or clinic help you get your child's prescription medicines?**
- **In the last 6 months, did you get the help you needed form your child's doctors or other health providers in contacting your child's school or daycare?**

(17) Member Survey – SUD

In January through April 2012, Value Options-Kansas (VO) conducted a member satisfaction survey of 629 members who accessed substance use disorder treatment services during fiscal year (FY) 2012 (which began July 2011). The survey consisted of 30 questions that were administered by mail and through face-to-face interviews at provider locations.

The three MCOs will be conducting surveys in 2014 of members who have accessed SUD services. Results from the 2014 survey will be compared with the results from the 2012 VO survey in the second annual KanCare Evaluation report. Questions related to perceptions of care coordination for members receiving SUD services that will be in the 2014 SUD survey include:

- **Has your counselor requested a release of information for this other substance abuse counselor who you saw?**
- **Has your counselor requested a release of information for and discussed your treatment with your medical doctor?**

COST OF CARE

Goals, Related Objectives, and Hypotheses for Costs subcategories:

Goal: Control Medicaid costs by emphasizing health, wellness, prevention and early detection, as well as integration and coordination of care

Related Objectives:

- *Promote wellness and healthy lifestyles*
- *Lower the overall cost of health care.*

Hypothesis: By holding MCOs to outcomes and performance measures, and typing measures to meaningful financial incentives, the state will improve health care quality and reduce costs.

(19) Costs

The Costs performance measures below are scheduled to be assessed in Demonstration Years (DY) 2-5, and will be reported in subsequent KanCare Evaluation annual reports.

- **Total dollars spent on HCBS budget compared to institutional costs**.
  - Population: Members receiving HCBS
  - Analyses: Pre-KanCare compared to KanCare and trending over time beginning in DY2.
- **Per member per month (PMPM) costs**
  - **Compare pre-KanCare PMPM costs to post-KanCare PMPM costs by MEG.**
    - Population: ABD/SD Dual, ABD/SD Non-Dual, Adults, Children, I/DD Waiver, Long Term Care (LTC), Medically Needy (MN) Dual, MN Non-Dual, Waiver
    - Analyses: Pre-KanCare compared to KanCare and trending over time.

  - **Compare pre-KanCare and post-KanCare costs for members in care management, comparing costs prior to enrollment in care management to costs after enrollment in care management.**
    - Population: Members in Care Management
    - Analyses: Compare baseline to subsequent years
  - **Compare KanCare PMPM costs before and after targeted value-added services, such as newborn and perinatal costs before and after implementation of prenatal care/new moms and babies programs.**
    - Population: Population will be determined based on value-added services and health outcomes that may be associated with these services.
    - Compare baseline to subsequent years
- **Assess budget neutrality reports completed by KDHE**.
  - Analyses: Pre-KanCare compared to post-KanCare and trending over time

ACCESS TO CARE

Goals, Related Objectives, and Hypotheses for Access to Care subcategories:

Goal: 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.

Related Objectives:

- *Measurably improve health outcomes for members.*
- *Support members successfully in their communities.*
- *Promote wellness and healthy lifestyles.*
- *Improve coordination and integration of physical health care with behavioral health care.*
- *Lower the overall cost of health care.*

Hypothesis: The state will improve quality in Medicaid services by integrating and coordinating services and eliminating the current silos between physical health, behavioral health, mental health, substance use disorder, and LTSS.

(21) Member survey – CAHPS

The CAHPS Survey is being distributed in 2014 to KanCare members by Amerigroup and United from mid-February through May, and by Sunflower from March through June. The MCOs will receive survey results in July 2014. These survey results will be compared with pre-KanCare survey results in the second annual KanCare Evaluation. Survey results will be reported by program type Title XIX (Medicaid) and Title XXI (CHIP). Medicaid survey results will be stratified by Adult, Child (general), and Child (chronic conditions); CHIP results will be stratified by Child (general) and by Child (chronic conditions).

CAHPS questions related to access of care will include the following questions:

- **In the last 6 months, how often was it easy to get appointments with specialists?**
- **In the last 6 months, how often was it easy to get the care, tests, or treatment you thought you needed through your health plan?**
- **In the last 6 months, not counting the times you needed care right away, how often did you get an appointment for your health care as soon as you thought you needed?**
- **In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?**

(23) Member Survey – SUD

In January through April 2012, Value Options-Kansas (VO) conducted a member satisfaction survey of 629 members who accessed substance use disorder treatment services during fiscal year (FY) 2012 (which began July 2011). The survey consisted of 30 questions that were administered by mail and through face-to-face interviews at provider locations.

The three MCOs will be conducting surveys in 2014 of members who have accessed SUD services. Results from the 2014 survey will be compared with the results from the 2012 VO survey in the second annual KanCare Evaluation report. Questions related to perceptions of access to care for members receiving SUD services that will be in the 2014 SUD survey include:

- **Did you get an appointment as soon as you wanted?**
- **For urgent problems, how satisfied are you with the time it took you to see someone?**
- **For urgent problems, were you seen within 24 hours, 24 to 48 hours, or did you wait longer than 48 hours?**
- **Is the distance you travel to your counselor a problem or not a problem?**
- **Were you placed on a waiting list?**
- **If you were placed on a waiting list, how long was the wait?**

EFFICIENCY

(27) Systems

Baseline data for 2013, stratified by SUD, I/DD, PD, TBI, Frail Elderly (FE), and Mental Health (MH) for the following measures will be compared to CY2014 data when data are available for both years. Due to claims lag, these measures will likely be reviewed in the third KanCare Evaluation annual report.

- **Emergency Department Visits**
  - Population: KanCare (all members), and stratified by SUD, I/DD, PD, TBI, FE and ME
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time. Baseline CY2013 data will be compared to CY2014 data when emergency department visit data are available for both years.

- **Inpatient Hospitalizations**
  - Population: KanCare (all members), and stratified by SUD, I/DD, PD, TBI, FE, and MH
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time. Baseline CY2013 data will be compared to CY2014 data when inpatient hospitalization data are available for both years. Due to claims lag, this measure may be reviewed in the third KanCare Evaluation annual report.
- **Inpatient Readmissions within 30 days of inpatient discharge**
  - Population: KanCare (all members), and stratified by SUD, I/DD, PD, TBI, FE, and MH.
  - Analysis: Comparison of baseline CY2013 to annual measurement and trending over time. The criteria for this measure and reporting template are still in process. Due to claims lag, this measure may be reviewed in the third KanCare Evaluation annual report.

(28) Member Surveys

CAHPS Survey
The CAHPS Survey is being distributed in 2014 to KanCare members by Amerigroup and United from mid-February through May, and by Sunflower from March through June. The MCOs will receive survey results in July 2014. These survey results will be compared with pre-KanCare survey results in the second annual KanCare Evaluation.

Survey results will be reported by program type Title XIX (Medicaid) and Title XXI (CHIP). Medicaid survey results will be stratified by Adult, Child (general), and Child (chronic conditions); CHIP results will be stratified by Child (general) and by Child (chronic conditions).

CAHPS questions related to efficiency will include the following questions:

- **How often did you have a hard time speaking with or understanding your personal doctor because you spoke different languages?**
- **Customer service gave necessary information/help.**

SUD Survey
The three MCOs will be conducting surveys in 2014 of members who have accessed SUD services. Results from the 2014 survey will be compared with the results from the 2012 VO survey in the second annual KanCare Evaluation report. One of the questions related to efficiency for members receiving SUD services that will be in the 2014 SUD survey includes:

- **How would you rate your counselor on communicating clearly with you?**

UNCOMPENSATED CARE POOL AND DELIVERY SYSTEM REFORM INCENTIVE PROGRAM

(29) Uncompensated Care (UC) Pool

- **Number of Medicaid Days for UC Pool hospitals compared to UC Pool Payments**
  The UC Pool funding for CY2013 is based on costs of care during FY2011, and funding for CY2014 is based on costs of care during FY2012. To better assess the impact of KanCare and projects undertaken as part of the Delivery System Reform Incentive (to be implemented in CY2015), this measure will be analyzed in subsequent KanCare Evaluation annual reports.

(30) Delivery System Reform Incentive Program (DSRIP)

KDHE proposed an amendment August 19, 2013, to delay the implementation of the DSRIP Pool for one year, from DY2 (2014) to DY3 (2015) to allow the State and CMS to focus on other critical activities related to the KanCare demonstration. Consequently, receipt of CMS feedback on the DSRIP protocols is delayed. KDHE will complete the DSRIP section of the KanCare Evaluation Design when the DSRIP projects are defined in 2014.

Appendix B

Performance Measures Reported on a Quarterly Basis

Kansas Foundation for Medical Care, Inc.

Appendix B - Performance Measures Reported on a Quarterly Basis

The following measures are analyzed and reported on a quarterly basis. These measures were first reviewed in the KanCare Evaluation Quarterly Report for CY2013, Quarter 4.

QUALITY OF CARE

(9) Grievances

- **Compare/track number of grievances related to quality over time, by population type**.

ACCESS TO CARE

(25) Grievances

- **Compare/track the number of access-related grievances over time, by population categories.**

OMBUDSMAN PROGRAM

(26) Calls and Assistance

- **Evaluate for trends regarding types of questions and grievances submitted to Ombudsman's Office.**
- **Track number and type of assistance provided by the Ombudsman's Office.**

EFFICIENCY

(27) Systems

- **Quantify system design innovations implemented by KanCare such as:**
  - Patient-Centered Medical Homes
  - Electronic Health Record use
  - Use of Telehealth
  - Electronic Referral Systems
- **Timely resolution of grievances**
- **Timely resolution of customer service inquiries**
- **Timeliness of claims processing**

Report on Focused Review of KanCare Managed Care Organizations – July 2013

State of Kansas

Kansas Department of Health and Environment

Division of Health Care Finance

Focused Review Visits Conducted
July 23, 2013 – UnitedHealthcare Community Plan
July 24, 2013 – Amerigroup Kansas
July 25, 2013 – Sunflower State Health Plan

Contents

Background and Summary

The Kansas Department of Health and Environment (KDHE), in partnership with Kansas Department on Aging and Disability Services (KDADS), conducted a focused review of the KanCare Managed Care Organizations (MCOs) in July 2013. The review focused on core operational areas of the KanCare MCOs, to validate performance reports and to help ensure strong performance as the program shifted from the launch/initial implementation phase to the long-term/operational phase. Program management, contract monitoring and fiscal oversight staff from KDHE and KDADS obtained and assessed extensive documentation samples reflecting MCO performance and conducted related onsite reviews of these KanCare operational areas:

- Customer Service – for both members and providers
- Provider Credentialing – including timing and accuracy of related processes
- Grievances and Appeals – for both members and providers
- Prior Authorizations – including timing and accuracy of MCO and subcontractor decisions
- Third Party Liability, Spend Down and Client Obligation – evaluating program integrity

The KanCare MCOs were promptly responsive to the documentation requests, and made available relevant staff and information during the onsite portion of the reviews. The focused reviews identified substantive areas of strong performance for each MCO, and also some limited areas where processes needed to be strengthened or expanded to ensure long-term success. Operational considerations were also highlighted for both the state and the MCOs as to effective ways to obtain and present review information in ways that demonstrate compliance and communicate the actual performance of both the MCOs and the subcontractors for which they are responsible. This report summarizes key findings related to the KanCare focused review and related improvements and action items that will be addressed in ongoing business meetings and annual onsite reviews of the KanCare MCOs.

I. Customer Service

AMERIGROUP

Our overall impression of Amerigroup's customer service activities is of a well planned approach that focuses national and local resources into the hands of the customer service representatives. Beneficiary customer service representatives are carefully screened, given several weeks of training and continuously reviewed. Meaningful evaluations focus on resolution and people skills rather than call times. Evaluation results impact the employee's compensation and future opportunities. Provider representatives receive training on their systems and meet weekly to review urgent and systemic issues. The customer service teams are supported by responsive systems that give them efficient access to benefits and beneficiary information allowing them to solve many issues without the need for research and follow up.

Desk Review

Policy & Procedure Manuals

Amerigroup was able to provide the requested policy and procedure manuals and no material concerns were noted during a brief review. While Amerigroup's material is well developed the subcontractors Ocular Benefits and SCION have the same customer care manual and training curriculum. There are instances where find and replace were not effective.

Selected Call Review

Several calls could not be provided; technology errors were cited for the omission. In one call from a Spanish speaking beneficiary the coordination between translator, call representative and care specialists was poor resulting in three frustrating transfers. In most of the provider calls reviewed the customer service representatives did not verify the provider's ID or call back number. In some of the provider calls reviewed the customer service representative did not verify the beneficiary's ID. SCION calls had several instances of poor customer service, long hold times and multiple transfers.

Onsite Review

Call Center Resources

- Training

The candidate selection process, extensive training curriculum and monitoring programs were all exceptional for the beneficiary customer service representatives. The provider process funnels problems to a national resolution center out of state. The national center is responsible for researching issues and return resolutions to the provider representative. Field representatives receive two weeks training on systems, policy and customer service.

- Systems

ATLAS - A very impressive knowledge base with national and Kansas benefits and policy data. The Kansas data is reviewed and updated locally resulting in quick updates. Entries are reviewed for in use clarity as well as accuracy.

Sales Force – Tracks calls, emails and visits for Provider Representatives. Data entry is narrative and the notes are reviewed for systemic issues and representative productivity. The system is open to the Internal Resolution Unit.

COMPASS – Issue tracking system that contains individual level benefits coverage and manages workbaskets for timely resolution. The system prompts customer service representatives to obtain outstanding information during the call.

Customer Service Processes

- Provider Processes

Provider calls are logged directly into the Sales Force database. The information is available to the Internal Resolution Unit (IRU) that supports the provider representatives. The Kansas provider field representatives work only on KanCare. Currently there are five field agents with mention of adding a sixth. The field representatives receive support from an in-office provider representative position. Difficult issues are sent to the IRU for research and returned for follow up. Every provider is to receive some form of contact each quarter. Field representatives meet weekly with the provider relations manager.

- Beneficiary Processes

Beneficiary customer service team receives extensive training and support with the focus on compliance, people skills and resolution. Regular call monitoring by independent groups and tangible rewards for quality service contribute to high standards. Each customer service rep receives a monthly scorecard with the expectation of 95% accuracy. Reps below this standard are subject to retraining. Floor walkers/coaches provide assistance for de-escalation and resolution. The customer service reps can use their Amerigroup data systems to handle overflow calls from other states.

Customer Service Interviews and Call Monitoring

Provider – Provider Reps reported returning calls within 24 hours. Reports from providers do not substantiate this. The reps are expected conduct 20 face to face meetings with providers each week. Provider Reps report receiving about two weeks training on their systems. Overall they feel the training and systems provided are adequate.

Beneficiary – customer service reps feel they received adequate training and are well supported. They demonstrated effective use of call center systems to research and respond accurately to caller inquires. Where additional input was needed the systems and training allowed for efficient collaboration with other internal groups. The level of quality and respect for the beneficiary were very high.

Issues of Concern

Subcontractor Oversight

This review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Amerigroup. The dental and optical customer care manuals are poorly edited copies of the same document which points to an undeveloped customer service plan. Poor customer service was evident in recorded

calls from Access2Care and SCION. Transportation complaints were common with failure to appear, rude driver, inappropriate vehicle and companion not allowed topping the list.

Provider Representative Responsiveness

While expectations are high and include a 24 hour turnaround on contacts, the current provider relations network cannot keep pace with provider calls. The suggested sixth field representative is unlikely to mitigate provider concerns. The State's experience during this time period suggests claims issues are much of this volume and substantial progress in this area will reduce the load on provider representatives to a more manageable level.

SUNFLOWER

Call center operations are straightforward with information system support and escalation processes in place. The center is dominated by a tally board that displays the representatives' availability and call metrics. These metrics play an important role in the representative's evaluations. Representative performance covered the spectrum from highly capable and respectful to disengaged and offensive. The State is concerned that customer service quality assurance allows unacceptable performance to exist in this department.

The CentAccount reward card was a common call topic in sampled calls with a lot of confusion surrounding its use. In some cases minors have received the card in their own name. The letter sent with the card is not providing sufficient explanation and call center representatives struggle to answer specific questions.

Desk Review

Policy & Procedure Manuals

Sunflower was able to provide the requested manuals with the exception of value added services policies. No issues of substance were noted in a short review. Opticare references an adopted customer service program titled MAGIC but did not include the information or training details.

Selected Call Review

A number of requested calls could not be provided or were only partially available, particularly for Cenpatico who provided one and a fraction of the four calls requested. Of the nine calls recorded by the Sunflower customer service center five did not meet courtesy standards and four did not offer clear resolution. Six of the calls requested additional information on the CentAccount rewards card and customer service representatives did not have precise information to convey.

Onsite Review

Call Center Resources

- Training

Provider and beneficiary representatives each receive four weeks training on the KanCare program. Provider reps receive additional training on provider-centric topics such as claims and credentialing. Representatives are surveyed for refresher training topics. Pop quizzes are part of the training plan. Each call center agent receives a monthly report card consisting of ten calls that are graded for duration, documentation, and accuracy as well as the results of their pop quizzes. Each agent must listen to a minimum of one of their own calls per month as chosen by the supervisor. The call center staff includes a member trained in crisis intervention.

- Systems

The Customer Relationship Management (CRM) system provides metrics and trends for provider and beneficiary calls. The CRM also tracks issues and resolutions. A live chat system facilitates collaboration and escalation. Provider manuals are available on SharePoint. Policy updates are communicated via email and IM. The call center systems do not capture incoming phone numbers. Dropped calls are lost and cannot be returned. The center monitoring system has voice and screen activity capture capability.

Customer Service Processes

- Provider Processes

Sunflower has seven provider field reps backed by assistance at the call center. The call center has one provider lead for escalation. An escalation log is maintained by the provider representative manager. Providers are placed in a tiered system for resource management. Call duration expectations are between five and a half and seven minutes to achieve a meets or exceeds expectations. Duration metrics are used to grade the provider representative.

- Beneficiary Processes

Ten beneficiary representatives were in the local call center which only handles Kansas calls. They have one floor lead that monitors activity and handles escalations. Formal oversight includes a weekly staff meeting and daily huddles. The call center currently has bi-lingual representatives that take Spanish, Thai and Russian language calls directly. Call duration expectations are between five and a half and seven minutes to achieve a meets or exceeds expectations. Duration metrics are used in the member services grading process. After hours calls are recorded and returned as the first item of business the following day.

Customer Service Interviews and Call Monitoring

Provider - While provider representatives enter contact details into the CRM system they report using MS Excel to assist in management of their individual schedules and follow ups. A central escalation log is maintained by the senior provider representative. When asked about response times the replies ranged from immediate to 24 hours. Provider feedback does not substantiate this.

Formal training was described as high level and focused on benefits and services with the details of relationship management coming from the experience of the representative. One representative suggested additional training on the provider portal would be beneficial but did not know how their schedule could accommodate it. All representatives report their time is spent only on the KanCare account.

Beneficiary – Monitored calls ranged from excellent to unacceptable. Representatives only work on the KanCare program. Google is used to find addresses and phone numbers for providers. Some representatives put callers on hold and leave them unengaged during research time. A representative was observed taking a caller off hold before the hold time reached one minute to avoid a negative metric. The caller was not engaged during this metric manipulation. Call center representatives would like additional training on the specific benefits of Kansas waivers.

Issues of Concern

Subcontractor Oversight

The review found examples of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Sunflower. The Cenpatico sample was incomplete and included a partial recording that did not include verifying member identification before discussing personal health information.

Beneficiary Customer Service Call Center

Some acute examples of poor customer service were evident in the recorded calls and directly observed during the on site visit. Quality oversight and follow up are not in place. An unwillingness to accept State feedback or responsibility for their own or subcontractor inadequacies was apparent in some members of management.

The phone numbers of incoming calls are not captured resulting in lost communication if the call is dropped. Rather than access a network directory with important information like panel availability, Google is used to find contact information for Sunflower medical providers. In some instances the representative did not confirm the beneficiary's identification before discussing personal health information.

Provider Representative Responsiveness

Provider representatives report an expectation of 24 hours turnaround on contacts. Ongoing provider commentary describes difficulty meeting this expectation. Provider reps report they are 'hammered by claims and credentialing inquiries' and 'just so swamped' they struggle to meet expectations. Recorded customer service calls included provider claims inquiries that the customer service representatives cannot resolve. One representative told the provider their claims department should be handling these calls but they are too busy. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.

UNITED

Beneficiary call center is well developed with multiple quality assurance reviews and oversight. The systems in place support the Customer Service representatives with beneficiary specific information. Member calls considered to have a negative or inaccurate component are returned the following business day with corrections. Escalation processes are in place and Spanish speaking representatives are part of the local team. While provider services calls are routed to a centralized unit in Arizona the representatives there were observed to accurately answer Kansas specific questions about benefits and authorizations.

Desk Review

Policy & Procedure Manuals

The requested manuals were provided and no material concerns were noted in United's submissions during the brief review. Pages in the SCION provider manual refer to Ocular Benefits and list the same customer service number.

Selected Call Review

A number of requested calls could not be provided, technology issues were cited for the omission. United had particular difficulty identifying behavioral health and substance use disorder calls and the State received an incomplete sample. Many calls requested additional information about value added services. Most inquiries were handled accurately and with respect for the caller. In one case inaccurate information was given regarding child eyewear benefits. In another basic courtesy was lacking.

Onsite Review

Call Center Resources

- Training

Both provider and beneficiary representatives receive training on the Behavioral Analytics Program. Beneficiary call center reps receive 8-9 weeks of training. Provider reps receive training on claims processing, credentialing and program specific information.

- Systems

The Behavior Analytics Program allows the CS representative to analyze caller types including ad hoc reports of caller behavior to assist with de-escalation and resolution.

My Coach gives the representatives access to benefits summaries and policy and procedures.

A caller satisfaction tool, the United Experience Survey, is available after each call. Only a small percentage of calls opt to respond. If a negative survey is received a supervisor is alerted for remediation.

Qfiniti is used for call recording and monitoring.

Customer Service Processes

- Provider

Provider call center is located in AZ. There are 20 Provider Reps on the ground in KS. They are divided by specialty rather than geographic area. These representatives service other United lines of business.

The unit contains a Provider Escalation Team (PET) of seven people to assist with difficult calls. PET and SMEs are contacted via through an IM system. A reporting analyst reviews all calls. Providers are limited to inquiries on only 20 claims per call and must hang up and call back to continue claims reconciliation. The provider call center serves as backup to Washington with Kansas calls having priority in the queue.

- Beneficiary

New CS reps receive 8-9 weeks of training. Supervisors monitor 8-10 calls per rep per month and the Quality staff monitor an additional five to seven calls. Evaluation methods include Quality Survey Score which consists of 5 to 10 calls per rep per month that are monitored by the Quality Behavioral Analytics team and their supervisors. Daily feedback is given by two floor supervisors. Two Gatekeepers provide a second line of review and listen to all the previous day's dropped calls. If the oversight process determines a representative needs additional training on specific subjects they will be scheduled for continued education. Customer Service reps handle mostly Kansas calls and are a backup for the New Jersey Plan.

Customer Service Interviews and Call Monitoring

Provider – We found no dedicated tracking system available to provider representatives. A variety of outlook features, paper files and spreadsheets were employed by representatives to track and follow up with providers. Some representatives also service MCR Medical Supply, United commercial business and Tricare. One rough estimate was that 70% of a representative's time was spent on KanCare. Provider representatives have a goal of returning calls within 24 hours but as yet providers report call response times are still a concern. Sample interviews showed approximately 80% of provider contact was accomplished by email leaving face to face meetings and phone calls with only 10% each. Representatives mentioned they would like additional training on Front End Billing (FEB) and FEB claims adjustment as well as I/DD when available.

Although a few exceptions were noted, overall the call center representatives were polite and helpful. Representatives have limited ability to reconcile claims issues often transfer calls to lines that are not recorded limiting our review of final resolution.

Beneficiary – Call center staff displayed proficiency with their systems by quickly and accurately retrieving beneficiary information from a variety of caller starting points. The representatives were prompted to obtain and complete missing information and even health assessments by the software. They report their training has adequately prepared them for their duties. Calls that are transferred to a supervisor or other departments do not get recorded unless the representative stays on the line. New policies and amendments are sent out via newsletter and email blasts.

Issues of Concern

Subcontractor Oversight

The review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by United. The dental subcontractor is using a copied and poorly edited customer service manual that indicative of an incomplete customer service plan. United receives monthly and quarterly reports from subs including claims turnaround, customer service call metrics and utilization management. Joint operating meetings are held monthly.

Provider Representative Responsiveness

With provider reps spread across multiple lines of business KanCare must compete with other priorities for provider issue resolution. Complaints from providers during the review period describe frustration with long turnaround times from field representatives. The lack of a central contact tracking system complicates management and reporting of representative effectiveness. The 20 claim inquiry limit at the call center is reasonable but suggests a volume of claims issues that exceed planned capacity. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.

Summary of findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	• Beneficiary call center is well developed with multiple quality assurance reviews and oversight. • The systems in place support the Customer Service representatives with beneficiary specific information. • Member calls considered to have a negative or inaccurate component are returned the following business day with corrections. • Escalation processes are in place and Spanish speaking representatives are part of the local team. • While provider services calls are routed to a centralized unit in Arizona the representatives there were observed to accurately answer Kansas specific questions about benefits and authorizations.	• The review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by United. The dental subcontractor is using a copied and poorly edited customer service manual that indicative of an incomplete customer service plan. United receives monthly and quarterly reports from subs including claims turnaround, customer service call metrics and utilization management. Joint operating meetings are held monthly. • With provider reps spread across multiple lines of business KanCare must compete with other priorities for provider issue resolution. Complaints from providers during the review period describe frustration with long turnaround times from field representatives. The lack of a central contact tracking system complicates management and reporting of representative effectiveness. The 20 claim inquiry limit at the call center is reasonable but suggests a volume of claims issues that exceed planned capacity. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.

Amerigroup	• Our overall impression of Amerigroup's customer service activities is of a well planned approach that focuses national and local resources into the hands of the customer service representatives. • Beneficiary customer service representatives are carefully screened, given several weeks of training and continuously reviewed. • Meaningful evaluations focus on resolution and people skills rather than call times. Evaluation results impact the employee's compensation and future opportunities. • Provider representatives receive training on their systems and meet weekly to review urgent and systemic issues. • The customer service teams are supported by responsive systems that give them efficient access to benefits and beneficiary information allowing them to solve many issues without the need for research and follow up.	• This review found instances of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Amerigroup. The dental and optical customer care manuals are poorly edited copies of the same document which points to an undeveloped customer service plan. Poor customer service was evident in recorded calls from Access2Care and SCION. Transportation complaints were common with failure to appear, rude driver, inappropriate vehicle and companion not allowed topping the list. • While expectations are high and include a 24 hour turnaround on contacts, the current provider relations network cannot keep pace with provider calls. The suggested sixth field representative is unlikely to mitigate provider concerns. The State's experience during this time period suggests claims issues are much of this volume and substantial progress in this area will reduce the load on provider representatives to a more manageable level.

Sunflower	• Call center operations are straightforward with information system support and escalation processes in place. • The center is dominated by a tally board that displays the representatives' availability and call metrics. These metrics play an important role in the representative's evaluations. • Representative performance covered the spectrum from highly capable and respectful to disengaged and offensive. • The State is concerned that customer service quality assurance allows unacceptable performance to exist in this department.	• The review found examples of poor customer service from subcontractors. The State is concerned that subcontractor calls are not being sampled and policy and procedure manuals are not being reviewed by Sunflower. The Cenpatico sample was incomplete and included a partial recording that did not include verifying member identification before discussing personal health information. • Some acute examples of poor customer service were evident in the recorded calls and directly observed during the on site visit. Quality oversight and follow up are not in place. An unwillingness to accept State feedback or responsibility for their own or subcontractor inadequacies was apparent in some members of management. • The phone numbers of incoming calls are not captured resulting in lost communication if the call is dropped. Rather than access a network directory with important information like panel availability, Google is used to find contact information for Sunflower medical providers. In some instances the representative did not confirm the beneficiary's identification before discussing personal health information. • Provider representatives report an expectation of 24 hours turnaround on contacts. Ongoing provider commentary describes difficulty meeting this expectation. Provider reps report they are 'hammered by claims and credentialing inquiries' and 'just so swamped' they struggle to meet expectations. • Recorded customer service calls included provider claims inquiries that the customer service representatives cannot resolve. One representative told the provider their claims department should be handling these calls but they are too busy. Progress on claims payment deficiencies would free provider representatives to address other network opportunities.

II. Provider Credentialing

For each of the MCOs, a sample of credentialing files was requested – across all provider types and including vendor/subcontractors that conduct provider credentialing. For each file, during desk reviews by state staff, the issues evaluated were whether the MCO credentialing review had been accurately and timely conducted, using the timing criteria of the KanCare contract (both as to standard contract timing of 30 days and enhanced pay-for-performance [P4P] timing of 20 days). In addition, each file was evaluated as to the required program integrity checks required by both federal law and the KanCare contract.

During onsite review discussions, standardized questions were asked of each MCO, to further explore their policies, procedures and practices related to provider credentialing issues. Those questions were:

1. MCO please provide a brief overview as to how provider credentialing applications are received and processed, from the staff who conduct that work, and related questions from state staff which will include:
    a. How do you identify and record when an application is received; whether it is complete (and specifically what would cause it to be categorized as not complete); when it is excluded from the credentialing P4P measure (and what would cause it to be excluded); and when it is decided?
    b. How do you ensure and document that required provider exclusion screening checks are conducted prior to making the decision that a provider is credentialed for your network. Specifically speak to how each of these checks are conducted prior to the decision: Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the General Services Administration's Excluded Parties List System (EPLS), the Medicare Exclusion Database (the MED) **plus** appropriate licensing confirmation?
    c. How do you ensure and document that required provider exclusion screening checks are done monthly?
2. State staff conduct follow up with specific questions from state staff related to review of the materials (policies, procedures, manuals) and samples you produced, as well as questions from the overview.
3. MCO provide responsive information related to the supplemental provider letter, section labeled "1. Access," including:
    a. How do you ensure that providers in your network are categorized and published accurately as to all of their practice areas?
    b. How do you ensure that members are assigned to PCPs who meet their needs, by area of practice, by distance, or by member choice?
    c. How do you identify which providers are willing to take additional members; and how do you ensure that providers to whom members are assigned are actually taking additional patients?
    d. How do you notify providers that they have been designated as a member of your network, and how you intend to publish them in your network?

Summary of findings:

For all MCOs, the policies and practices demonstrated overall compliance with the provider credentialing processing and timing standards (some limited documentation gaps were identified and communicated). Similarly, state requirements related to network categorizing, PCP assignment and publication were met (with some best practices regarding PCP assignment and providers with multiple specialties identified).

Additional specific findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	• Most core requirements related to credentialing are addressed in United's policies and procedures. • HCBS providers are credentialed locally with a dedicated provider representative responsible for this group of providers. The provider representative reaches out to the provider if the credentialing documents are incomplete. • Logisticare provider representatives make daily and weekly contact with providers when credentialing documents are incomplete.	• Ensure that SSA death master file and the National Plan and Provider Enumeration System checks are conducted by both United and subcontractors, with results recorded prior to credentialing decision. • Ensure that subcontractors are aware of the contractual requirements regarding program integrity checks for the KanCare program. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. • Get engaged in effective ways to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient
Amerigroup	• Amerigroup demonstrated overall sound policies, procedures and practices related to provider credentialing. Local plan program is well supported by national credentialing resources and that resource allows leveraging best practices and efficiencies. • Participating in a pilot program with CMS to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient. Amerigoup has been proactive about pursuing this option.	• Ensure that SSA death master file checks are consistently conducted by both Amerigroup and subcontractors, with results recorded prior to credentialing decision. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. Storing electronically is fine, but when sample demonstration is requested those materials should be provided by screen shot or otherwise so that you definitively demonstrate compliance.

Sunflower	• Most core requirements related to credentialing are addressed in Sunflower's policies and procedures. • Strong practices regarding outreach to and engagement of providers around credentialing issues; good communication.	• Ensure that SSA death master file checks are conducted by both Sunflower and subcontractors, with results recorded prior to credentialing decision. • Ensure that subcontractors are aware of the contractual requirements regarding program integrity checks for the KanCare program. • Ensure that all records related to a provider credentialing application are available and provided when the state requests information regarding credentialing processes and decisions. • Get engaged in effective ways to access the Medicare Exclusion Database (the MED), which will make screening checks more efficient. • Explore ways to capture and publish areas of practice for providers, when the provider has more than one specialty.

Action Items – Necessary for All Three MCOs
• Work with KDADS staff to ensure provider licensing/compliance issues for the behavioral health, HCBS and LTSS services they administer are known and considered at time of credentialing and recredentialing decisions. Build processes to ensure full understanding of provider requirements, current and over-time provider performance on licensing standards, and shared attention on compliance concerns. • Continue to work with KDHE's program integrity staff to fully operationalize monthly provider exclusion screening checks, reviews related to provider entity owners/partners/covering partners, and full compliance with all contractually-required screenings. • Conduct more real-time monitoring of subcontractors to ensure understanding of and compliance with contractual requirements.

III. Grievances and Appeals

The grievance and appeals team approached the overall review as three components; 1) policy and procedure review, 2) selected sample review and 3) onsite review. Findings are compiled and summarized according to these three components.

AMERIGROUP

Overall, the team found there are some very positive things happening in the area of grievances and appeals at Amerigroup. The team struggled at the front end of the review as requested materials were incomplete and not as well organized as they could have been. However, the onsite review went well and we appreciated their preparedness when we arrived onsite.

Policy and Procedure Review

All policy and procedure documents provided were reviewed for compliance with State requirements and then compared to practices discussed at the onsite review. Some concerns have been noted below. Other notes or suggestions made by the reviewers have been forwarded to the MCO manager for possible future revisions.

Noted concerns:

- Member Appeal - Core Process: incorrectly states members have 90 days to file an appeal. This also contradicts the information in the Member Appeal Process - KS document which states 30 + 3 days from notice of action.
- Provider Claims Appeals – KS: no mention of MCO acknowledging the receipt of an appeal in writing.
- Amerigroup Kansas Grievances and Appeals Training – the following points in the training slides contradict Amerigroup policy:
    - Each grievance is acknowledged in writing within 7 calendar day of receipt (corporate policy says 5 calendar days)
    - Complaint is reviewed within 30 days of receipt (corporate policy says they are disposed of within 30 calendar days)
    - Notice of disposition of grievances are given within 5 business days of determination (unclear if this is within the 30 day review period, or if over and above the 30 day period)
- Access2Care Claims Department Policies and Procedures – Claims Denials and Appeals Policy – no mention of acknowledging receipt of the appeal in writing.
- Scion UM Policies and Procedures – Delegated Dental Appeals – Member and Provider – does not state timeframe for issuing a decision.

Selected Sample Review

As previously mentioned, sections of the records initially sent were incomplete. Amerigroup was asked to complete the files requested. There were still samples that were incomplete.

Member Grievance Samples – of note by the reviewers:

- Screen prints from the system did not show a specific category of grievance. The system has this capability, but the plan did not include those screen shots.
- Vision complaint was sent to Scion Dental for research and follow-up. When the reviewer questioned the grievance specialist, the response did not make sense.

Member Appeal Samples – no noted concerns.

Provider Appeal Samples – of note by the reviewers:

- Reviewers consistently noted that documentation did not indicate when the appeal was received other than the receipt date was stated in the resolution letter. (Amerigroup and Scion)
- Multiple cases where the member in the documentation submitted did not match the member on the appeal requested.
- Several samples could not be thoroughly reviewed due to lack of documentation
- Review of one sample indicated that incorrect information was given to the provider.
- On one sample, the initial decision was overturned without requiring the MedWatch form for brand. This is Amerigroup's decision, but the plan still should have required that the provider submit the MedWatch form to the FDA for their adverse event reporting program.

Onsite Review

The Amerigroup team was well prepared. Their team appeared to have a collaborative approach in their work. The review team appreciated the inclusion of the customer service director, as customer service is the primary conduit for grievances.

The following positive observations were noted by the team in regard to the onsite visit:

- Although timeframes are important, they focus on service and making sure the grievance is addressed.
- Use of daily 'huddles' to communicate trends, changes, etc.
- Grievance specialists are quality reviewed every day. All letters are reviewed before sending.
- Atlas alert system is an effective tool for communicating through management.
- Grievance staff dedicated to KanCare.

A few points were noted as weaknesses:

- Only one staff member assigned to 'process' grievances.
- Lack of verbal contact with the member who has filed a grievance. Verbal contact ensures that Amerigroup fully understands the nature of the complaint and gives the member a sense that their grievance is taken seriously. Thorough research cannot be done if not all the

details are initially communicated.

- Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. It's not necessary that the details of the resolution be captured, but the fact that the case has been resolved and closed by the local quality team would seem to close the loop. Appears there could be a potential for issues to fall through the cracks.
- No formalized process for trending grievances.
- Reports are created by corporate office – local staff has not run reports from either the grievance or appeals systems. Concerns about keeping a grasp on trends and patterns without the ability to run reports as needed.
- Although their audit/review process seems to be adequate, one selected sample resolution letter contained several typos. This raises questions regarding QA review.

SUNFLOWER

Sunflower struggled to make the requested documents available. When we did receive them, the files were not organized in a manner that was easy for the team to locate the specific files they needed. At the onsite visit, however, Sunflower shared a very helpful overview of the grievance and appeals processes that included flowcharts of the processes. The involvement of their subcontractors was also well documented in this presentation.

Policy and Procedure Review

All policy and procedure documents provided were reviewed for compliance with State requirements and then compared to practices discussed at the onsite review. Some concerns have been noted below. Other notes or suggestions made by the reviewers have been forwarded to the MCO manager for possible future revisions.

Of note by the reviewers:

- Sunflower Drug Denial & Appeals Process Flow – the document should include timeframe requirements
- Cenpatico Grievance System – Right to State Fair Hearing – "…both providers and members may access the State Fair Hearing process at any time….". Incorrect - Providers must complete the MCO grievance and appeal process before they can file for SFH.
- Cenpatico Appeals – Timeframes for Appeal Resolution Process, D. Resolution of Appeal – "Kansas members must complete the Cenpatico process before filing a State Fair Hearing." Incorrect – members can access SFH simultaneous to filing an appeal with the MCO.
- Cenpatico Grievance Process - Right to State Fair Hearing – "…both providers and members may access the State Fair Hearing process at any time….". Incorrect - Providers must complete the MCO grievance and appeal process before they can file for SFH.
- OptiCare Member Complaints: NC and Other States – 6.: Does not address that appeals must be file within 30 days. Also does not

reference State Fair Hearing.

- OptiCare Provider Concerns/Complaints: All Plans – 6. "This process should take no longer than 30 calendar days (once all the necessary information is collected with which to make a decision)." The requirement should be that resolution should be within 30 days or 60 days with an extension request to DHCF. Also, this document does not reference SFH.
- DentaQuest 200.009 Complaints and Non-Clinical Appeals – Providers – 3.00 "An appeal refers to a verbal or written statement by….." This contradicts 3.02 which states, "The Appeal must be in writing and concisely state." Also, the document does not address 1) timeframe for submitting the appeal, 2) acknowledgment of the grievance or appeal and 3) State Fair Hearing.
- DentaQuest 200.008 Complaints and Grievances – Secondary Delegation – appeal is defined differently than in DentaQuest 200.009 Complaints and Non-Clinical Appeals – Providers

Selected Sample Review:

Sunflower had a difficult time transferring the requested files. Incomplete material was received prior to the onsite visit, however, Sunflower supplied the missing documents as follow-up to the onsite. The team noted the following during their review of the selected samples.

Member Grievance Samples

- Early resolution letters gave no insight as to how the grievance was resolved. Sunflower improved their letters as time went on to include information and steps taken to resolve the issue.
- Only acknowledgement and resolution letters were received. There are no screen prints to confirm category or if letters were sent timely.
- Some resolution letters address only part of the complaint. (i.e. letter addresses the issue of missing appointments due to driver getting lost, but does not address the rudeness of the driver.)

Member Appeals Samples – no noted concerns

Provider Appeals Samples

- Dr. appealed on behalf of member. Appeal was denied but before the resolution letter went out, the member called to appeal. The Dr. appeal was resolved within 30 days but the member appeal was initiated 3/4/13 and overturned on 4/8/13. Not clear what triggered the overturn when the appeal was initially denied and why it took more than 30 days.

Onsite Review

The Sunflower team prepared a very helpful presentation that provided a visual of their processes; however, the review team came away with some concerns regarding training, systems and organization.

A positive observation noted by the team in regard to the Onsite visit was that customer services records are routinely reviewed to ensure all calls that were grievances were identified as such. Letters are generated and mailed in-house. This is also viewed as favorable to being generated out of state.

Concerns noted are as follows:

- Cenpatico and NIA grievances and appeals are delegated to the subcontractor and tracked in the respective subcontractor systems.
- No formal training for grievance and appeal staff.
- Lack of requested records creates a concern about their ability to coordinate information between all of their systems.
- Lack of verbal contact with the member who has filed a grievance. Verbal contact ensures that UHC fully understands the nature of the complaint and gives the member a sense that their grievance is taken seriously. Thorough research cannot be done if not all the details are initially communicated.
- Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. It's not necessary that the details of the resolution be captured, but the fact that the case has been resolved and closed by the quality team would seem to close the loop. Appears there could be a potential for issues to fall through the cracks.
- Difficult to see pharmacy from end to end due to their systems. This creates fragmentation that leads to poor communication and difficulty with providers and members.
- They claim to have oversight of all grievances and appeals, including those processed by their subcontractors, however, it's unclear how they assure trends with subcontractors and providers are adequately addressed.
- Although all state fair hearing cases are reviewed, audits of grievances and appeals processed is looser than would be expected. A minimum of only five cases per month per coordinator are reviewed.
- During the interview, it was stated that all HP escalated issues, as well as those from State staff, are recorded in their grievance system. However, during the demonstration, it was clear that only those clearly identified as being from someone wanting to file a grievance are recorded in the database. We do not expect inquiries be tracked as grievances, but we do expect that staff are consistent and aware of the process.

UNITED

Overall, United did a very nice job of providing all grievance and appeals materials requested. Their submission was complete, on time and very organized. Their onsite team was prepared and, in spite of a late change in the organization of the interview upon arrival, they had the right people in the right place at the right time. The review team very much appreciated their flexibility.

Policy and Procedure Review

All policy and procedure documents provided were reviewed for compliance with State requirements and then compared to practices discussed at the onsite review. Some concerns have been noted below. Other notes or suggestions made by the reviewers have been forwarded to the MCO manager for possible future revisions.

Of note by the reviewers:

- Provider Grievances and Appeals System – B.1. states UHC will acknowledge receipt of grievances within 10 days, but does not specify 'in writing'. Same for C.1. (appeals) – 'in writing' not specified.
- Kansas OptumHealth Behavioral Solutions Member Appeals, Complaints and Grievances – although UHC states they do not delegate G&A, this policy describes procedures for OptumHealth to "acknowledge, review and resolve" these issues. This is confusing.
- Several documents contain the following language, "if written consent is not received from the member within 10 days, withdraw the grievance and send letter to the member/provider advising case has been withdrawn due to no consent from the member." The term 'withdraw' indicates something is being taken back by the one who initiated it. 'Dismissed' would be a more appropriate description of the action. The following documents refer to this 'withdrawal' procedure.
    - Kansas QoC and QoS
    - Kansas Admin Clinical Appeals
    - Kansas Dental Appeals
    - Kansas LogistiCare Transportation
    - Kansas Pharmacy Appeals
    - Kansas Vision Appeals

Selected Sample Review

United's selected sample submission was complete, on time and in a very organized format. The team noted the following during their review of the selected samples.

<u>Member Grievance Samples</u>

- Grievance was shown as 'withdrawn', but there is no documentation to support that; seems incorrectly coded.
- Case was referred to QM director as a QOC issue, but the member indicated this issue was not QOC. It was referred back to the correct staff and was resolved. In reference to the recording, the reviewer indicated, "CS rep was courteous and asked appropriate questions."
- Reason in resolution letter to member not the same as what was found when investigated.
- No resolution letter to member found.
- Case was referred to QoC, then what? No evidence of resolution.

- Resolution letter contained misspelled words.
- Spanish speaking member was sent letters in English.

Member Appeals Samples

- Appeals are labeled as 'Withdrawn', but the resolution letter indicates the reason for closure was because the AOR form was not returned or they were unable to contact the member. Only the one who initiates the appeal can withdraw.

Provider Appeals Samples

- Several appeals were referred or redirected to other departments for review and response. No evidence of resolution.

Onsite Review:

As previously mentioned, we made a late decision to visit with the management team first and swap out for the member advocates later in the interview session. We also requested to shadow member advocates working on Good Cause Requests. These requests were made the day prior but the review coordinator at United had overlooked the request and had not picked up the voicemail, so the requests were handled upon our arrival. The United team was very accommodating with these last minute changes.

The following positive observations were noted by the team in regard to the onsite visit:

- Staff is well trained with ample opportunities for continued or refresher training
- Daily 'huddles' presented as a very functional approach to communicating workload, policy/process changes, brief education/training, etc. and seems to be effective
- ETS (Escalated Tracking System) for G&A appears to have great capabilities for tracking and trending
- Nice check and balance system to make sure all grievances/appeals are captured. Gatekeepers in Customer Service review all calls at the end of the day to make sure calls were routed appropriately and member advocate supervisor reviews the following morning to capture any others that may have been missed.
- Every case is reviewed and audited

A few points were noted as weaknesses:

- G&A system did not capture issues received from HP or State staff. These are captured using spreadsheets. The team would like to see issues that are truly grievances tracked through the grievance system, regardless of the source.
- Focus seems to be on contractual or pay for performance metrics with little mention of the customer. Supervisors analyze Volume per Hour data, both to evaluate workers' output and to manager workload and stay within required timelines. This is needed and good, but we hope they are not sacrificing quality for quantity.

- Lack of verbal contact with the member who has filed a grievance. Verbal contact ensures that UHC fully understands the nature of the complaint and gives the member a sense that their grievance is taken seriously. Thorough research cannot be done if not all the details are initially communicated.
- Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. It's not necessary that the details of the resolution be captured, but the fact that the case has been resolved and closed by the local quality team would seem to close the loop. Appears there could be a potential for issues to fall through the cracks.
- Noted the advocate working on provider grievances has the KanCare account as primary responsibility, but serves as backup to Maryland as well. Is there a potential here for confusion of policies and procedures?

Summary of findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	• All documentation requests were honored with complete, on time and organized information provided. Responsive to onsite requests and adjustments. • Staff managing grievances and appeals are well trained with ample opportunities for continued or refresher training. • Daily 'huddles' presented as a very functional approach to communicating workload, policy/process changes, brief education/training, etc. and seems to be effective. • ETS (Escalated Tracking System) for G&A appears to have great capabilities for tracking and trending. • Nice check and balance system to make sure all grievances/appeals are captured. Gatekeepers in Customer Service review all calls at the end of the day to make sure calls were routed appropriately and member advocate supervisor reviews the following morning to capture any others that may have been missed. • Every case is reviewed and audited.	• Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. • G&A system did not capture issues received from HP or State staff. • Focus seems to be on contractual or pay for performance metrics with little mention of the customer. • Lack of verbal contact with the member who has filed a grievance. • Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. It's not necessary that the details of the resolution be captured, but the fact that the case has been resolved and closed by the local quality team would seem to close the loop. Appears there could be a potential for issues to fall through the cracks. • Noted the advocate working on provider grievances has the KanCare account as primary responsibility, but serves as backup to Maryland as well. Is there a potential here for confusion of policies and procedures?

Amerigroup	• Amerigroup has overall strong performance in the areas of grievances and appeals. • Staff managing grievances and appeals work as a collaborative team and connect with customer service staff effectively. • Although timeframes are important, they focus on service and making sure the grievance is addressed. • Use of daily 'huddles' to communicate trends, changes, etc. • Grievance specialists are QA'd every day. All letters are reviewed before sending. • Atlas alert system is an effective tool for communicating through management. • Grievance staff dedicated to KanCare.	• Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. • Only one staff member assigned to 'process' grievances • Lack of verbal contact with the member who has filed a grievance. • Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured. No formalized process for trending grievances. • Reports are created by corporate office – local staff has not run reports from either the grievance or appeals systems. Concerns about keeping a grasp on trends and patterns without the ability to run reports as needed. • Although their audit/review process seems to be adequate, one selected sample resolution letter contained several typos.
Sunflower	• Strong onsite responsiveness, and helpful overview of processes for managing grievances and appeals, helped plug gaps in documentation. • Customer service records are routinely reviewed to ensure all calls that were grievances were identified as such. • Communication regarding grievances and appeals are generated and mailed in-house.	• Struggled to make requested documents available, and once received, the materials were disorganized and inaccessible to reviewers. • Specific errors or omissions in policies and procedures, or in documentation practices, were identified and need to be addressed. • Cenpatico and NIA grievances and appeals are delegated to the subcontractor and tracked in the respective subcontractor systems. • No formal training for grievance and appeal staff. • Lack of requested records creates a concern about ability to coordinate information between all of their systems. • Lack of verbal contact with the member who has filed a grievance. • Concern about quality of care issues being redirected to the national quality department with lack of final resolution being captured, creating fragmentation that leads to poor communication and difficulty with providers and members. • Lack of clarity in how they assure trends with subcontractors and providers are adequately addressed. • Although all state fair hearing cases are reviewed, audits of grievances and appeals processed is looser than would be expected. A minimum of only five cases per month per coordinator are reviewed. • During the interview, it was stated that all HP escalated issues, as well as those from State staff, are recorded in their grievance system. However, during the demonstration, it was clear that only those clearly identified as being from someone wanting to file a grievance are recorded in the database.

IV. Prior Authorizations

For this portion of the KanCare focused review, the review team utilized this focus and approach:

1. Policies and procedures related to prior authorization practices/standards of both MCO and subcontractors were requested and assessed.
2. Business practice manuals (of whatever name) that guide the staff of the MCO and subcontractors in management of prior authorizations were requested and assessed.
3. A sample of prior authorization requests received during April 14-20, 2013 and May 19-25, 2013, were requested and assessed for each of the following categories, as relevant for each MCO:
   Physical Health (MCO)
   Physical Health (Subcontractor)
   Behavioral Health (MCO)
   Behavioral Health (Subcontractor)
   Nursing Facility (MCO)
   Nursing Facility (Subcontractor)
   Dental Services (MCO)
   Dental Services (Subcontractor)
   Vision (MCO)
   Vision (Subcontractor)
4. A sample of prior authorization requests received on April 12, April 23 and May 18, 2013, were requested and assessed for the following two categories:
   Pharmacy (MCO)
   Pharmacy (Subcontractor)
   For items 3 and 4, the following issues were assessed: Whether the information reported to the state and internally tracked was accurate, based upon prior authorization standards for the service involved; and, whether providers in the service area had 24/7 access to all identified receipt modes (phone, portal, fax, and any other).
5. Provider Representative and Provider Advocate staff at each MCO, engaging providers in the PA request process for the specified dates, were identified, and a sample of those staff were selected for interview during the onsite portion of the focused review.

During onsite review discussions, standardized questions were asked of each MCO, to further explore their policies, procedures and practices related to provider credentialing issues. Those questions were:

1. Brief overview as to how PA requests are received and processed, from the identified staff who conduct that work, and related questions from state staff which will include:
   a. Employee Interview: Training received regarding KanCare program.
   b. Employee Interview: Desk aids and other materials received to conduct the KanCare program work.

2. Follow up with specific questions resulting from state staff related to review of the materials (policies, procedures, manuals) and samples you produced, in these categories: Physical health; behavioral health; nursing facilities; vision; dental; pharmacy. Some specific questions related to pharmacy:
   - What process do you have in place to resolve member grievance/appeals related to physicians not requesting a prior authorization for a prescription thereby resulting in a prescription denial?
   - Which health plan employees can request a prior authorization be initiated for PBM on the behalf of members?
   - How do you manage PA requests for people being discharged from an inpatient/facility setting who have physician orders for DME, home health or other home-based services/supports?
   - How do you ensure that timely access to those services is made available, and how do you communicate the authorization for those services (including inviting providers to seek retroactive authorization with no trouble, for PA requests not deemed urgent by your policies/practices)?

3. MCO provide responsive information related to the supplemental provider letter, section labeled "3) Preauthorization Process," including:
   a. Specific explanation as to prescription prior authorizations.
   b. Specific explanation as to imaging and diagnostic procedures authorizations.
   c. Specific explanation as to what mental health services require preauthorization, and what limits are applied to those services.
   d. How do you assure that members receive authorizations in time sensitive situations?
   e. How do you communicate these standards and findings to providers?

Summary of findings:
For all MCOs, the policies and practices demonstrated overall compliance with the state's prior authorization standards for the service involved (some limited exceptions related to Pharmacy standards were identified and communicated); PA decisions were timely and accurately made; and providers in the service area had 24/7 access to all identified receipt modes when applicable. Additional specific findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	• Documentation presented reflects that processes are being followed. • Layered approach to training whereby all staff get the national PA training then additional specialized training total 4-5 months. • Open to additional state training related LTSS transitions and state workgroup opportunities.	• Recommend that UCSMM. 06.16 INITIAL REVIEW TIMEFRAMES – include the requirement that members have access to emergency services without prior authorization. • Language regarding the below RFP requirement is not found in UCSMM.06.16 Initial Review Timeframes but is found in UCSMM.04.11 Consumer Safety. Suggest it be in this P&P as well. 2.2.40.3 Members shall have access to emergency services without PA, even if the emergency services provider does not have a subcontract with the CONTRACTOR. • Should provide all documentation utilized to make decisions (i.e. KCPC, Lucidity) • Provide all the resources United uses for training during the annual review.
Amerigroup	• Strong policy, clearly addressing urgent and routine requests. • Numerous resources for staff to utilize desk aids, SharePoint, etc. • Documentation presented reflects that processes are being followed.	• Amerigroup did not provide the clinical information needed (only provided screen shots of authorization database). In future reviews, need to provide complete records. • Herceptin and Neulasta are not in the pharmacy regulation and cannot be on PA. • Lidoderm reviewed using unapproved criteria step for Kansas (gabapentin failure).
Sunflower	• Policies are clear. • Received KCPC training from a RADAC and stated they continue to learn about this system and feel comfortable with Lucidity as well. • Documentation presented reflects that processes are being followed. • Will have a web-based system up and running, soon.	• Sunflower did not make all randomly selected PA staff available during the onsite. • The Sample included 10 employees were chosen from the list provided and titled, 'Employees Handling PA' and 10 employees were chosen from the 'BH – Staff Created Auths' list. The only employees available were from US Script but not all employees from that sample were available, either. • PA authorizations only submitted, need all documentation in the file to make determinations in the future. • Several questions and recommendations related to pharmacy prior authorizations were identified and communicated during the review.

Action Items – Necessary for All Three MCOs
• Effort to maintain robust training should continue and specialized training, including LTSS, should be a strong focus area for all plans. • Continue to work with KDHE's pharmacy staff to ensure the appropriate prior authorization criteria are applied correctly and consistently. • For future reviews, provide all clinical information and supporting documentation to support determinations.

V. Third Party Liability, Spend Down and Client Obligation

For this portion of the KanCare focused review, the review team utilized this focus and approach:

1. Policies and procedures related to third party liability (TPL), spend down and client obligation management were requested and assessed.
2. Business practice manuals (of whatever name) that guide the staff of the MCO and subcontractors in management of TPL, spend down and client obligation practices were requested and assessed.
3. A sample of TPL proprietary file information and HCBS waiver claims, for specified dates in May and June, 2013, with follow up documentation as to client obligation management for selected records, were requested and assessed.

Summary of findings:
For all MCOs, the policies and practices, including business practice materials, demonstrated overall compliance with spend down and client obligation management standards for the service involved. Also for all MCOs, additional work is necessary (under the ongoing guidance of and consultation with the state's TPL manager) regarding TPL policies and practices. Additional specific findings:

KanCare MCO	Areas of Strength	Areas for Improvement
United	• Very good letters/notifications to providers and members regarding client obligation (CO), and willing to add CO amount to member letter. • Provider notification contains necessary information. Sample clearly showed how United is applying CO correctly.	• Included only claims payment instructions, no policies or procedures for CO process or notification to members/providers. Only have informal workflows at this point as this has been a process under development with the state. More complete procedures should be available for review at annual onsite review.

Amerigroup	• LTSS HCBS Claims document contains a detailed set of instructions for a manual claims process, with process underway to automate.	• Initial policies are fine; however, guidance sent to MCO's in February 2013 regarding need to notify members/providers of CO assignments, and this appears to have not happened until 7.1.13. Amerigroup states they will have more complete procedures for CO by the time of the annual onsite review as these processes have been under development with the state. • 8 of 30 (27%) CO records did not withhold CO appropriately. Amerigroup is remedying this by developing an automation process to minimize opportunity for human error. In the 3rd quarter will do look back and recoup.
Sunflower	• Sunflower has the CO process built into an automated system which makes their process efficient and accurate (other than SED waiver being erroneously excluded).	• Included only claims payment instructions, no policies or procedures for CO process or notification to members/providers. We recommend they develop procedures that incorporate the medical management process involved with CO as well as their automated claims process. • Sunflower/Cenpatico is not taking CO out of SED waiver members' claims. This will have to be fixed by Sunflower and a process undertaken to recoup these amounts from any affected providers.

Action Items – Necessary for All Three MCOs
• All plans have the rudimentary pieces in place for client obligation procedures, mostly documented in the claims processes. Recommend they develop a more formal procedure, including all areas impacted (i.e. claims, waiver services, medical management, etc.) and have available to demonstrate both implementation and results during onsite review. • Continue to work with KDHE's TPL manager to ensure TPL requirements are applied correctly and consistently. In addition to guidance and consultation, the TPL manager will request periodic record samples to evaluate effectiveness of MCO performance on TPL issues.

Pay for Performance Measures – Year One

Summary of 2013 Performance Per MCO (January-December 2013; as of March 2014)

Reporting Protocol and Summary-Amerigroup

Subject	P4P Metric	Measurement Period	Measures Achieved During Reporting Period																					
Monthly			Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec	
			Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Claims Processing-AMG	- 100% of clean claims are processed within 20 days	Monthly w/reset	284417	99.762%	308294	99.501%	317273	99.798%	385231	99.948%	372619	99.658%	371942	100.000%	392913	99.999%	389889	99.971%	381078	99.932%	435054	99.950%	408095	99.314%		
Claims Processing-AMG	- 99% of all non-clean claims are processed within 45 days	Monthly w/reset	11744	100.000%	10158	98.900%	11982	99.825%	4439	100.000%	3347	100.000%	2890	100.000%	3053	100.000%	2520	100%	2718	100%	2873	100.000%	2609	100.000%		
Claims Processing-AMG	- 100% of all claims are processed within 60 days	Monthly w/reset	296839	100.000%	320000	99.965%	329918	100.000%	389872	100.000%	375966	99.661%	374832	100.000%	395968	100.000%	392409	99.971%	383944	99.971%	438139	99.999%	413559	100.008%		
Credentialing-AMG	90% providers completed in 20 days	Monthly w/reset	111	47%	319	96%	240	96%	528	98%	215	95%	184	97%	137	100%	120	100%	100	100%	203	100%	224	100%	102	100%
Credentialing-AMG	100% providers completed in 30 days	Monthly w/reset	194	82%	334	100%	250	100%	540	100%	226	100%	190	100%	137	100%	120	100%	100	100%	203	100%	224	100%	102	100%
Customer Service-AMG	- 98% of all inquiries are resolved within 2 business days from receipt date - 100% of all inquiries are resolved within 8 business days from receipt date	Monthly w/reset	41201	99.985%	23271	99.991%	23926	99.996%	23158	100%	22289	99.996%	20566	100.0%	22296	99.991%	19560	99.959%	17303	99.983%	19354	99.995%	16083	100%	15906	100%
Quarterly			1Q		2Q		3Q		4Q																	
Grievances-AMG	- 98% of grievances are resolved within 20 days	Quarterly w/reset	220	100%	206	100%	190	100%	190	100%																
Grievances-AMG	- 100% of grievances are resolved within 40 days	Quarterly w/reset	0	100%	0	100%	190	100%	190	100%																
Appeals-AMG	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request	Quarterly w/reset	6	100%	17	100%	33	97.1%	31	100%																

Reporting Protocol and Summary-Sunflower

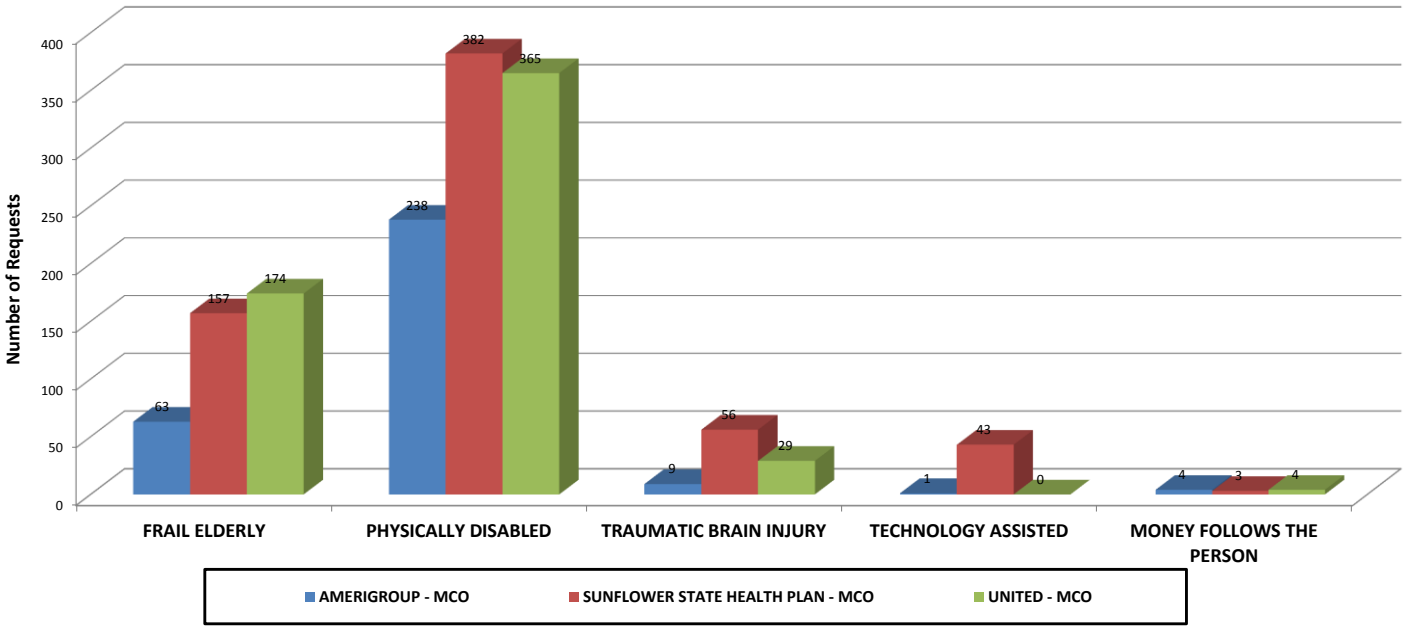
Subject	P4P Metric	Measurement Period	Measures Achieved During Reporting Period																					
Monthly			Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec	
			Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Claims Processing-SHP	- 100% of clean claims are processed within 20 days	Monthly w/reset	184,435	100%	324,946	99%	375,424	98%	414,508	98%	407,742	97%	379,320	98%	404,306	97%	425,604	98%	384,431	99%	454,318	99%	541,664	99%		
Claims Processing-SHP	- 99% of all non-clean claims are processed within 45 days	Monthly w/reset	5,795	100%	24,501	100%	21,970	91%	12,892	87%	15,461	95%	14,658	97%	12,051	94%	14,828	93%	8,518	76%	12,805	78%	4,904	92%		
Claims Processing-SHP	- 100% of all claims are processed within 60 days	Monthly w/reset	64,611	100%	236,097	100%	281,968	100%	297,541	99%	276,479	99%	281,676	100%	293,169	100%	447,545	100%	387,199	99%	472,700	99%	549,324	99%		
Credentialing-SHP	90% providers completed in 20 days	Monthly w/reset	95	94%	75	96%	65	97%	102	100%	144	37%	90	67%	139	99%	98	97%	65	100%	141	94%	179	99%	180	97%
Credentialing-SHP	100% providers completed in 30 days	Monthly w/reset	101	100%	78	100%	67	100%	102	100%	231	59%	100	75%	139	99%	88	87%	65	100%	150	100%	180	100%	183	99%
Customer Service-SHP	- 98% of all inquiries are resolved within 2 business days from receipt date - 100% of all inquiries are resolved within 8 business days from receipt date	Monthly w/reset	42,664	100%	31,527	100%	28,325	100%	30,096	100%	22,807	100%	21,358	100%	20,596	100%	20,761	100%	18,750	100%	21,865	100%	20,217	100%	19659	100%
Quarterly			1Q		2Q		3Q		4Q																	
Grievances-SHP	- 98% of grievances are resolved within 20 days	Quarterly w/reset	170	100%	170	100%	112	100%	112	100%																
Grievances-SHP	- 100% of grievances are resolved within 40 days	Quarterly w/reset	161	100%	161	100%	112	100%	112	100%																
Appeals-SHP	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request	Quarterly w/reset	9	100%	31	100%	171	100%	118	100%																

Reporting Protocol and Summary- United Health Community Plan

Subject	P4P Metric	Measurement Period	Measures Achieved During Reporting Period																							
Monthly			**Jan**		**Feb**		**Mar**		**Apr**		**May**		**Jun**		**Jul**		**Aug**		**Sep**		**Oct**		**Nov**		**Dec**	
			Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Claims Processing-UHC	- 100% of clean claims are processed within 20 days	Monthly w/reset	330,461	92.26%	243,951	96.39%	315,844	91.87%	319,201	92.01%	354,002	99.23%	325,313	99.86%	313,315	99.64%	345355	100%	301184	100%	390,647	99.99%	388,792	99.998%		
Claims Processing-UHC	- 99% of all non-clean claims are processed within 45 days	Monthly w/reset	16,857	99.09%	18,234	100.00%	16,882	99.02%	16,641	99.08%	14,119	96.49%	17,553	99.97%	11,210	100%	13398	100%	9166	100%	16,155	99.89%	11,259	99.98%		
Claims Processing-UHC	- 100% of all claims are processed within 60 days	Monthly w/reset	375,060	99.96%	276,106	100.00%	360,694	99.96%	363,584	99.96%	369,714	99.56%	343,324	100.00%	325,659	100%	358755	100%	310351	100%	406,819	99.99%	400,114	99.9998%		
Credentialing-UHC	90% providers completed in 20 days	Monthly w/reset	312	98%	217	99%	137	97%	215	98%	134	99%	93	97%	110	100%	135	100%	92	99%	111	97%	113	100%	89	100%
Credentialing-UHC	100% providers completed in 30 days	Monthly w/reset	317	100%	220	100%	141	100%	219	100%	135	100%	96	100%	110	100%	135	100%	93	100%	113	98%	113	100%	89	100%
Customer Service-UHC	- 98% of all inquiries are resolved within 2 business days from receipt date - 100% of all inquiries are resolved within 8 business days from receipt date	Monthly w/reset	36,554	99.78%	16,197	99.17%	17,194	98.84%	16,205	99.04%	13,037	99.03%	11,387	97.95%	12,808	97.61%	12,867	99.89%	12,244	99.82%	13,725	100%	11,460	100%	10960	100%
Quarterly			**1Q**		**2Q**		**3Q**		**4Q**																	
Grievances-UHC	- 98% of grievances are resolved within 20 days	Quarterly w/reset	110	100%	110	100%	94	100%	94	100%																
Grievances-UHC	- 100% of grievances are resolved within 40 days	Quarterly w/reset	140	100%	140	100%	94	100%	94	100%																
Appeals-UHC	Contractor sends an acknowledgement letter within 3 business days of receipt of the appeal request	Quarterly w/reset	8	100%	39	100%	78	98%	104	100%																

POC Reduction Requests By Program - 4/1/13 to 12/31/13

HCBS PROGRAM	AMERIGROUP - MCO	SUNFLOWER STATE HEALTH PLAN - MCO	UNITED - MCO	TOTAL
FRAIL ELDERLY	63	157	174	394
PHYSICALLY DISABLED	238	382	365	985
TRAUMATIC BRAIN INJURY	9	56	29	94
TECHNOLOGY ASSISTED	1	43	0	44
MONEY FOLLOWS THE PERSON	4	3	4	11
TOTAL	315	641	572	1528



POC Reduction Requests By Status 4/1/13 to 12/31/13

REQUEST STATUS	AMERIGROUP - MCO	SUNFLOWER STATE HEALTH PLAN - MCO	UNITED - MCO	TOTAL
APPROVED	271	535	540	1346
REQUEST DENIED	23	62	19	104
UNDER REVIEW	10	5	11	26
RETURNED FOR MORE INFO	11	39	2	52
TOTAL	315	641	572	1528