Fourth Quarter & Annual Report to CMS Regarding Operation of 1115 Waiver Demonstration Program
– Quarter Ending 12.31.2020
– Year Ending 12.31.2020

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

KanCare
Section 1115 fourth Quarter and Annual Report
Demonstration Year: 8 (1/1/2020-12/31/2020)

Table of Contents

I. Introduction

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

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare and Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017. On December 20, 2017, the State submitted an extension request for its Medicaid 1115 demonstration. On December 18, 2018 the Centers for Medicare and Medicaid Services approved a renewal of the Medicaid Section 1115 demonstration proposal entitled KanCare. The demonstration is effective from January 1, 2019 through December 31, 2023.

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

This five-year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Continue to allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care;
- Extend the Delivery System Reform Incentive Payment program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.
- Provide work opportunities and supports for individuals with specific behavioral health conditions and other disabilities.

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

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

- Further improve the quality of care Kansas Medicaid beneficiaries receive through integrated care coordination and financial incentives paid for performance (quality and outcomes);
- Maintain Medicaid cost control by emphasizing health, wellness, prevention and early detection as well as integration and coordination of care;
- Continue to establish long-lasting reforms that sustain the improvements in quality of health and wellness for Kansas Medicaid beneficiaries and provide a model for other states for Medicaid payment and delivery system reforms as well;
- Help Kansas Medicaid beneficiaries achieve healthier, more independent lives by coordinating services to strengthen social determinants of health and independence and person-centered planning;
- Promote higher levels of member independence through employment programs;
- Drive performance and improve quality of care for Kansas Medicaid beneficiaries by integrating value-based models, purchasing strategies and quality improvement programs; and
- Improve effectiveness and efficiency of the state Medicaid program with increased alignment of MCO operations, data analytic capabilities and expanded beneficiary access to SUD services.

This quarterly report is submitted pursuant to item #64 of the Centers for Medicare & Medicaid Services Special Terms and Conditions (STCs) issued regarding the KanCare 1115(a) Medicaid demonstration program, and in the format outlined in Attachment A of the STCs.

II. Enrollment Information

The following table outlines enrollment activity related to populations included in the demonstration. It does not include enrollment activity for non-Title XIX programs, including the Children's Health Insurance Program (CHIP), nor does it include populations excluded from KanCare, such as Qualified Medicare Beneficiaries (QMB) not otherwise eligible for Medicaid. The table does include members retroactively assigned as of December 31, 2020.

Demonstration Population	Enrollees at Close of Quarter (12/31/2020)	Total Unduplicated Enrollees in Quarter	Disenrolled in Quarter
Population 1: ABD/SD Dual	15,862	17,503	1,641
Population 2: ABD/SD Non-Dual	30,794	31,665	871
Population 3: Adults	54,913	55,620	707
Population 4: Children	225,233	227,567	2,334
Population 5: DD Waiver	9,087	9,139	52
Population 6: LTC	21,059	22,315	1,256
Population 7: MN Dual	2,425	3,298	873
Population 8: MN Non-Dual	1,099	1,332	233
Population 9: Waiver	4,504	4,739	235
Population 10: UC Pool	N/A	N/A	N/A
Population 11: DSRIP Pool	N/A	N/A	N/A
Total	364,976	373,178	8,202

III. Outreach/Innovation

The KanCare website[1] is home to a wealth of information for providers, members, stakeholders, and policy makers. Sections of the website are designed specifically around the needs of members and providers. Information about the 1115 demonstration and its operation is provided in the interest of transparency and engagement.

[1] www.kancare.ks.gov

The KanCare Advisory Council consists of 12 members: 3 legislators representing the House and Senate, 1 representing mental health providers, 1 representing CDDOs, 2 representing physicians and hospitals, 3 representing KanCare members, 1 former Kansas Senator, 1 representing pharmacists. The KanCare Advisory Council occurred December 8, 2020 via Zoom. The agenda was as follows:

- Welcome
- Review and Approval of Minutes from Council Meeting, September 29, 2020
- Old Business
    - Define the capable person policy in regard to the care of our disabled kids and adults in need of care per their personal care plans – Ed Nicholas
    - Regarding new CPT codes related to outpatient care for COVID related concerns, will the new codes 99072 (charge for PPE and additional time/resources spent related to COVID patients) and 87426 (outpatient rapid COVID antigen test including the SOPHIA and BD products) be paid and recognized? The concern that primary care has is amplified due to code 87426 being recognized to KMAP system and assigned payment of $38.45, which does not cover the cost of these tests[2]. - Dr. Rebecca Reddy
    - HCBS staffing for people and COVID PPE and testing. Some of the feedback I have received is that clients are afraid to have help in their home unless people are tested but they can't
    - be tested unless they are symptomatic, and the tests aren't affordable. Also, the agencies aren't providing PPE. – Njeri Shomari
- New Business (No agenda items received)
- KDHE Update – Sarah Fertig, Medicaid Director, Kansas Department of Health and Environment and Chris Swartz, Director of Operations/COO, Deputy Medicaid Director, Kansas Department of Health and Environment
- KDADS Update – Janis DeBoer, Deputy Secretary, Kansas Department for Aging and Disability Services
- KanCare Ombudsman Report – Kerrie Bacon, Ombudsman, KanCare Ombudsman Office
- Updates on KanCare with Q&A
    - Aetna Better Health of Kansas
    - Sunflower State Health Plan
    - UnitedHealthcare Community Plan
- Adjourn

The Tribal Technical Assistance Group met November 3, 2020. The tribal members were consulted on the following items:

- Tribal Federally Qualified Health Clinic (TFQHC) effective
- SPAs for Outpatient cardiac Catherization, Silver Diamide material for the treatment of caries, and EPSDT additional counseling codes for the treatment of maternal depression
- KanCare Open Enrollment – Reminder that tribal members may opt out of managed care
- A new contractor will operate the KanCare Clearinghouse effective 1/1/2021. The new contractor is Conduent.
- The next meeting is scheduled for February 2, 2021.

During the fourth quarter of 2020, Outstationed Eligibility Workers (OEW) staff participated in forty community events (in person and virtual) providing KanCare program outreach, education, and information for the following agencies/events: Washington County Hospital; Community Memorial Healthcare; Wamego Hospital; Clay County Medical Center; Geary Community hospital; Morris County Hospital; Local County Health Departments in Clark; Kiowa; Comanche; Gray; Ford; Riley; Hamilton; Wichita; Finney; Scott; Lane; Russell; Sedgwick; Harper; Sumner; Parents as Teachers; Grace Med; WIC;

[2] https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance

Insight Women's Center; Geary County Community Hospital; Manhattan Area Interagency; Flint Hills Wellness Coalition; Greater Manhattan Area ICC; Community Baby Shower (Pregnancy Support); Delivering Change Coalition Mtg; Be Able-Meet Director; Riley County Perinatal Coalition; Harvey-Marion County CDDO; Advisory Council Virtual Meeting Genesis Family Health; Kearny County Hospital; Greeley County Health Services; Scott County Hospital; LYFTE Prenatal Care education; Embrace Pregnancy Clinic; Better Choice Pregnancy Clinic; USD 259-Nurses; HealthCore Clinic; Tree House; Harper Co K-State Research/Extension; USD 361 Anthony-Harper School District; Crossroads Family Resource Center; USD 511; USD 359; USD 353; Healthy Babies; Pregnancy and Family Resource Center; United Way-El Dorado; Kidz-Fest; Butler Co Extension Office; Cowley County Extension Office; Guest Home Estates; Reno County Community Screening; Prairie Star Health Center.

Support and assistance for KanCare members was provided by 27 OEW by determining eligibility for 752 beneficiaries, assisting in resolving 662 issues involving urgent medical needs, obtaining correct information on applications, addressing gaps or errors in pending applications/reviews with the KanCare Clearinghouse, and assisted with 1183 phone calls and 53 walk-Ins.

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

- PACE Program (quarterly but now as needed during the Public Health Emergency (PHE))
- HCBS Provider Forum teleconferences (quarterly)
- Long-term Care Roundtable with Department of Children & Families (quarterly)
- Presentations, attendance, and information is available as requested by small groups, consumers, stakeholders, providers and associations across Kansas
- Community Mental Health Centers meetings to address billing and other concerns (monthly and quarterly)
- Series of workgroup meetings and committee meetings with the Managed Care Organizations and Community Mental Health Centers
- Regular meetings with the Kansas Hospital Association
- Series of meetings with behavioral health institutions, private psychiatric hospitals, and Psychiatric Treatment Residential Facilities (PRTFs) to address care coordination and improved integration (weekly)
- Medicaid Functional Eligibility Instrument (FE, PD & BI) Advisory Workgroup
- IDD Functional Eligibility Instrument Advisory Workgroup
- Systems Collaboration with Aging & Disability, Behavioral Health and Foster Care Agencies
- PRTF Stakeholder meeting (quarterly)
- Mental Health Coalition meeting (bi-monthly)
- NFMH Directors meeting (monthly)
- CRO Directors meeting (bi-monthly)
- State Interagency Coordinating Council (bi-monthly)
- Kansas Mental Health Coalition meeting (monthly)
- Kansas Association of Addiction Professionals (monthly)
- Behavioral Health Association of Kansas (monthly)
- Heartland RADAC & Substance Abuse Center of Kansas (monthly)
- Complex Case Staffings with MCOs (as needed M-F)
- Bi-monthly Governor's Behavioral Health Services Planning Council meetings; and monthly meetings with the nine subcommittees such as Suicide Prevention, Justice Involved Youth and Adult, and Rural and Frontier
- Monthly Nursing Facility Stakeholder Meetings
- KDADS-CDDO-Stakeholder Meetings (quarterly)

- KDADS-CDDO Eligibility workgroup
- KDADS-Series of meetings with a coalition of advocacy groups including KanCare Advocates Network and Disability Rights Commission to discuss ways KDADS can provide more effective stakeholder engagement opportunities

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

OneCare Kansas Program

A legislative proviso directed KDHE to implement a health homes program. To avoid the confusion caused by the term health homes, a new name was selected for the program – OneCare Kansas (OCK). The program was launched on April 1, 2020. The program has a similar model as the state's previous health homes program. As of December 31, 2020, there were 33 contracted OCK providers across the state. OCK was designed as an opt-in program. As of December 2020, the program has seen 888 members opt-in to the program. This number continues to climb with new members joining each month.

The state continues to use the MCOs as lead entities, who contract with select providers to offer the required six core services. Monthly learning collaboratives are held to assist the providers as they deliver services to OneCare Kansas members.

MCO Outreach Activities

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

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

Marketing Activities

Due to the COVID 19 pandemic, the fourth quarter of 2020 has seen a continued decline in time for outreach and marketing with ABHKS as compared to 2019. Because of social distancing and policies against travel to stop the spread of the virus, the ability to spread the word in person about our work with KanCare members has been dramatically impacted. Staff has been working to communicate with community-based organizations and provider offices virtually since mid-March of 2020 and has seen varying results. By the end of the year, ABHKS saw progress with the number of virtual contacts and hope to continue that movement into 2021. Through virtual efforts with contacts as well as attendance at a virtual State Association Conferences held in November, ABHKS contacted over 520 individuals from provider offices around the State. ABHKS attended the following virtual conferences: InterHab and the Kansas Hospital Association. ABHKS delivered a Community E-newsletter via email to provider offices and community-based organizations each month. The newsletter provides the latest information on our work and the successes we have achieved by providing services to our members. The E-newsletter was sent out to over 1200 individuals during the first week of October and November.

Outreach Activities

ABHKS Community Development and System of Care team staff provided virtual outreach activities to community-based organizations, advocacy groups, and provider offices throughout Kansas. Staff visited virtually with over 720 individuals associated with community-based organizations in Kansas. Examples of the community-based organizations included Olathe Head Start; Lyon County Resource Council; Wichita USD 259; Harvey County Resource Council; Seward County United Way. ABHKS shared our education information with over 330 members or potential members of KanCare through providing mailed information to sites or by participating in virtual member events.

Advocacy Activities
Member Advocates have established a relationship with the KanCare Ombudsman. As a result, advocates receive direct referrals about member issues that require intervention efforts. Staff assisted 7 members referred from the Ombudsman.

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

Marketing Activities
Sunflower Health Plan (SHP) marketing activities included attending and/or sponsoring eleven virtual member and provider events. Due to the COVID-19 pandemic and continued "Stay-at-Home", "No Face to Face Member visits", multiple events were cancelled, postponed, moved to virtual or rescheduled to 2021. SHP sponsored local and statewide member and provider events:

- Arthritis Foundation Annual Jingle Bell Run
- LiveWell AgeWell Conference
- NASUAD 2020 HCBS Conference

Outreach Activities
SHPs outreach activities centered on providing PPE, food and funds support to organizations that serve and support our members and the community at large. Due to the impact of COVID-19, our efforts moved to outreaching to organizations to help sustain their normal work with increased demand on resources and more people to serve. SHP supported events that impacted families and local organizations to ensure food and basic human needs were met.
Examples of notable member outreach activities this quarter:

- Funds to agencies to support food insecure populations and stock community pantries.
- Giving Help & Hope Feminine Protections Drive
- Helping Hands Annual Turkey giveaway

Our quality improvement department continued to make warm calls to members to encourage them to close care gaps.

Advocacy Activities
SHP staff focused monthly on Social Determinants of Health (SDoH) initiatives. Internal teams worked together in addressing programs and outreach to support employment, housing, and food disparities across the state due to COVID-19. This team included SHP Community Relations, Community Health Service Representatives, and the SDoH specialists.
Staff contributed to community workgroups and coalitions advocating for health literacy, persons with disabilities and other topics addressing population health in Kansas.
The community meetings and workgroups included:

- Immunize Kansas Coalition meetings
- Health & Wellness Coalition of Wichita
- Fetal and Infant Mortality Review (FIMR) Community Action Teams
- Social Determinants for Health monthly meeting

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

Marketing Activities
UHC continued to work on virtual member, community organization, and provider education regarding KanCare benefits and COVID-19 resources. Staff continue to complete new member welcome calls and health risk assessments over the phone. UHC continued the incentive program to offer a ten dollar over the counter debit cards to new members to complete a health risk assessment. New members were sent member ID Cards and welcome kits in a timely manner. Due to COVID 19, UHC focused on online activities

and virtual meetings with key health providers, health departments, Federally Qualified Health Centers (FQHCs) and community organizations.

Outreach Activities

UHC outreach focus changed dramatically due to COVID 19. There were few in-person events held during the period since the weather did not allow for outdoor events. The team has continued to work on identifying resources in the community and spreading the word about opportunities for assistance, especially among underserved populations with language or cultural barriers. This quarter UHC also hosted the member advisory meeting via video-conference call.

- Member outreach: UnitedHealthcare outreach staff virtually met with approximately 791 individuals who were members or potential members via online, phone, and video meetings/events.
- Community organizations and provider outreach: UnitedHealthcare outreach staff virtually interacted with approximately 1,257 individuals from community-based organizations and providers. Full list of organizations is listed below.

Advocacy Activities

The focus continued to be around way to support our members through COVID 19, but also pivoted to encourage families to resume activities like getting their wellness checks and immunizations. The outreach team heavily focused on assisting several organizations to spread the word about distribution of resources funded by the CARES Act, expiring at the end of the year, helping with translations and providing feedback to streamline processes. UnitedHealthcare staff also continued to serve in several boards, coalitions, and committees across the state, such as: Ford County Coalition, Garden City Police Department Board, Governor's Mental Health Subcommittee, Health Service Advisory Committee, Healthier Lyon County Coalition, Healthy Food For All Workgroup, Heartland Healthy Neighborhoods Coalition, Kansas Hispanic Latino Affairs Commission, Kansas Nursing Board, Kansas Table, Liberal Families Coalition, LiveWell Douglas County, MidAmerica Assistance Coalition, Pratt Coalition, Seward County Coalition.

Below is a list of the community organizations the Health Plan staff interacted with:

- Barton County Community College
- Boys and Girls Club of SCK
- Catholic Charities of Northeast Kansas
- Catholic Charities of Southwest Kansas Great Bend
- Central Kansas Partnership
- Centro Hispano of Douglas County
- Colby Coalition
- Community Care Network of Kansas
- Derby Recreation Commission
- Dream Center
- El Centro
- Family Crisis Center
- Finney County Coalition
- Finney County Service
- First Call for Help
- Growing Futures (Head Start program)
- Hays Interagency Coordinating Council
- Healthy Dads Healthy Moms
- Kansas Appleseed
- Kansas Children Service League
- Kansas Prevention Collaborative
- KCSL Healthy Families
- Kelly Center Fort Hays State University
- KIDS KS Infant Death & SIDS
- K-State Research & Extension Douglas Ct
- North Oak Community Church
- Options Domestic and Sexual Violence Services
- Parks and Recreation Center of Garden City
- Russell Child Development
- Safe Streets
- Saint Francis Community Services Great Bend
- Salvation Army
- Seward County United Way
- Smoky Hill Foundation for Chem Dep
- Sunflower Early Education
- Treehouse Wichita
- USD 259 Wichita Public Schools
- USD 407
- USD 428
- Wesley Family Medicine
- YMCA Healthy Living program

IV. Operational Developments/Issues

a. Systems and reporting issues, approval and contracting with new plans: Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and such issues are managed either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues.

No KanCare MCO Amendments were approved by CMS in the fourth quarter.

The following amendments were submitted to CMS for approval in the fourth quarter.

Amendment Number	Subject	Submitted Date	Effective Date
11	Capitation Rates and required CMS contract language 7/1/20-12/31/20	12/01/2020	7/01/2020
12	Support Act Language	12/18/2020	10/01/2020

42 CFR 438.6(c) Preprint approved by CMS:

Subject	Submitted Date	Effective Date	Approval Date
Direct the MCOs to pay the minimum fee schedule for services provided to KanCare enrollees for 1/1/21 – 12/31/21.	9/23/2020	1/01/2021	10/14/2020

State Plan Amendments (SPAs) approved:

SPA Number	Subject	Submitted Date	Effective Date	Approval Date
21-0015	Wheelchair Seating Assessments	6/29/2020	7/01/2020	11/04/2020
21-0016	CMA test Rate Increase	7/31/2020	7/01/2020	10/08/2020
20-0017	Dental Rate Increases	7/17/2020	8/25/2020	11/09/2020
20-0018	NF/NFMH Rates	9/10/2020	7/01/2020	11/19/2020

State Plan Amendments (SPA) pending approval:

SPA Number	Subject	Submitted Date	Effective Date
20-0019	Cardiac Catherization Rate Increase	11/17/2020	1/01/2021
20-0020	ER Professional Blended Rates	11/17/2020	1/01/2021
20-0021	EPSDT Additional Counseling Codes	11/17/2020	1/01/2021
20-0022	Maternal Depression Screening	11/17/2020	1/01/2021
20-0023	Silver Diamide Treatment	11/17/2020	1/01/2021

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

b. Benefits: All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value-added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2020, follows:

MCO		Value Added Service Jan-Dec. 2020	Units YTD	Value YTD
Aetna	Top Three VAS	Healthy Rewards Gift Card	37,146	$553,486
		Adult Dental	1,816	$347,147
		Kids Club Program $10 Gift Card	26,849	$268,498
		Total of All Aetna VAS	77,769	$1,627,182
Sunflower	Top Three	My Health Pays	58,419	$625,365
		Comprehensive Medication Review	11,379	$299,645

	VAS	Dental visits for adults	3,983	$122,048
		Total of All Sunflower VAS	107,478	$1,561,127
United	Top Three VAS	Adult Dental & Denture Services	4,561	$496,213
		Debit Card for Completing First Pre-Natal Visit	1,293	$259,036
		Home Helper Catalog Supplies	4,759	$136,214
		Total of All United VAS	18,547	$1,157,571

c. Enrollment issues: for the fourth quarter of calendar year 2020 there were 4 Native Americans who chose to not enroll in KanCare and who are still eligible for KanCare.

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

Enrollment Reason Categories	Total
Newborn Assignment	2,177
KDHE - Administrative Change	748
WEB - Change Assignment	19
KanCare Default - Case Continuity	1,065
KanCare Default – Morbidity	1,089
KanCare Default - 90 Day Retro-reattach	567
KanCare Default - Previous Assignment	298
KanCare Default - Continuity of Plan	112
Retro Assignment	9
AOE – Choice	454
Choice - Enrollment in KanCare MCO via Medicaid Application	6,294
Change - Enrollment Form	214
Change - Choice	248
Change - Access to Care – Good Cause Reason	26
Assignment Adjustment Due to Eligibility	286
Total	13,606

d. Grievances, appeals, and state hearing information:

MCOs' Member Adverse Initial Notice Timeliness Compliance

MCO	ABH	SUN	UHC
% of Notices of Adverse Service Authorization Decisions Sent Within Compliance Standards	99%	99%	100%
% of Notices of Adverse Expedited Service Authorization Decisions Sent Within Compliance Standards	100%	No expedited requests reported.	100%
% of Notices of Adverse Termination, Suspension or Reduction Decisions Sent Within Compliance Standards (10 calendar days only)	100%	100%	100%

MCOs' Provider Adverse Initial Notice Compliance

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

MCOs' Member Grievance Database

MCO	ABH		SUN		UHC		Total
	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	
QOC (non HCBS Providers)	2	5	3	6	10	23	49
QOC – Pain Medication	0	0	1	0	1	4	6

Customer Service	0	5	3	3	12	15	38
Member Rights Dignity	0	0	0	2	0	0	2
Access to Service or Care	0	3	2	11	4	82	102
Non-Covered Services	0	0	1	0	1	1	3
Pharmacy Issues	1	0	0	0	1	6	8
QOC HCBS Provider	0	0	3	0	6	0	9
Billing/Financial Issues (non-Transportation)	3	4	2	4	17	58	88
Transportation – Billing and Reimbursement	0	1	3	5	1	4	14
Transportation - No Show	1	5	4	9	11	13	43
Transportation - Late	1	3	10	7	7	13	41
Transportation - Safety	0	2	1	1	5	2	11
Transportation - No Driver Available	0	0	0	3	3	1	7
Transportation - Other	5	7	7	12	16	17	64
Health Home Services	2	0	0	0	0	0	2
MCO Determined Not Applicable	0	0	0	1	2	3	6
Other	0	1	0	0	4	6	11
TOTAL	15	36	40	64	101	248	504

MCOs' Member Grievance Timeliness Compliance

MCO	ABH	SUN	UHC
% of Member Grievance Resolved and Resolution Notice Issued Within 30 Calendar Days	82%	97%	100%

MCOs' Provider Grievance Database

MCO	ABH	SUN	UHC	Total
Billing/Payment	0	2	0	2
CM	0	1	0	1
Benefits/Eligibility	0	1	0	1
Pharmacy	0	1	0	1
Transportation	0	6	13	19
Services	0	2	0	2
Other – Dissatisfaction with MCO Associate	0	2	0	2
Other (Must provide description in narrative column of Summary Reports)	0	0	2	2
TOTAL	0	15	15	30

MCOs' Provider Grievance Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Grievance Resolved Within 30 Calendar Days	No provider grievances reported	87%	100%
% of Provider Grievance Resolution Notices Sent Within Compliance Standards	No provider grievances reported	100%	100%

MCOs' Appeals Database

Member Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met							

MA – CNM - Durable Medical Equipment	7 32 21	1		3 20 4	2 2 13	1 7	1 2 4
MA – CNM - Inpatient Admissions (Non-Behavioral Health)	7 43	39		3 2	1 2		3
MA – CNM - Medical Procedure (NOS)	22 20 7		1	7 13 4	9 4 3	1	5 2
MA – CNM - Radiology	17 59		3	9 14	6 23	17	2 2
MA – CNM - Pharmacy	78 46 108	1 2 2		38 26 84	30 6 20	6	9 6 2
MA – CNM - PT/OT/ST	15			6	6	3	
MA – CNM - Dental	3 5 11			1 1	1 9	1 1	1 3 1
MA – CNM - Home Health	4 1			1 1	1	1	1
MA – CNM - Out of network provider, specialist or specific provider request	2 1 12		1	1 1 12			
MA – CNM - Inpatient Behavioral Health	4 18			1 12	1 4		2 2
MA – CNM - Behavioral Health Outpatient Services and Testing	1	1					
MA – LOC - LTSS/HCBS	3				1		2
MA – CNM - Mental Health	1						1
MA – CNM - HCBS (change in attendant hours)	1						1
MA – CNM – Ambulance (include Air and Ground)	3						3
MA – CNM - Other	4 14 1			2 8 1	1	3	2 2
NONCOVERED SERVICE							
MA – NCS - Dental	1						1
MA – NCS – Home Health	1			1			
MA – NCS – Out of Network providers	1				1		
MA – NCS - Durable Medical Equipment	1 1				1		1
MA – NCS – Behavioral Health	4			2	1		1
MA – NCS – Other	2 2			2	2		
MA – LCK - Lock In	5		2	2	1		

ADMINISTRATIVE DENIALS							
MA – ADMIN – Denials of Authorization (Unauthorized by Members)	1			1			
TOTAL ABH - Red SUN – Green UHC - Purple	 143 232 215	 1 4 41	 2 3 2	 63 107 113	 50 50 51	 2 39	 25 29 8

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

MCOs' Appeals Database - Member Appeal Summary

Member Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member / Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member / Provider Mistake	MCO Determined not Applicable
Resolved at Appeal Level	 143 232 215	 1 4 41	 2 3 2	 63 107 113	 50 50 51	 2 39	 25 29 8
TOTAL	 143 232 215	 1 4 41	 2 3 2	 63 107 113	 50 50 51	 2 39	 25 29 8
Percentage Per Category		 >1% 2% 19%	 1% 1% 1%	 45% 46% 52%	 35% 22% 24%	 1% 17%	 18% 12% 4%
Range of Days to Reverse Due to MCO Error			 8-38 18-34 8-51				

MCOs' Member Appeal Timeliness Compliance

MCO	ABH	SUN	UHC
% of Member Appeals Resolved and Appeal Resolution Notice Issued in 30 Calendar Days	90%	100%	100%
% of Expedited Appeals Resolved and Appeal Resolution Notice Issued in 72 hours	87%	100%	100%

MCOs' Reconsideration Database - Providers (reconsiderations resolved)

PROVIDER Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn by Provider	MCO Reversed Decision on Reconsideration – MCO Error	MCO Reversed Decision on Reconsideration – Provider Mistake	MCO Upheld Decision on Reconsideration – Correctly Denied / Paid	MCO Upheld Decision on Reconsideration – Provider Mistake	MCO Determined Not Applicable
CLAIM DENIALS							
PR – CPD - Hospital Inpatient (Non-Behavioral Health)	 122 1,902 588		 1 1,008 125	 42 100 65	 73 778 245	 2 153	 4 16

PR – CPD - Hospital Outpatient (Non-Behavioral Health)	96 3,493 3,337	1	 2,131 750	45 24 444	38 1,314 1,043	3 1,100	9 24
PR – CPD - Pharmacy	1				1		
PR – CPD - Dental	3 1 18		 1 10	1 7	2 1		
PR – CPD - Vision	3 56 39		 53 18	 21	3 3 		
PR – CPD - Ambulance (Include Air and Ground)	57 57 107		 32 26	30 7 23	23 13 52	 6	4 5
PR – CPD - Medical (Physical Health not Otherwise Specified)	357 3,297 10,653		 1,737 4,093	76 314 1,644	201 1,209 3,717	22 1,199	58 37
PR – CPD - Nursing Facilities - Total	2 123 383		 84 229	 36	2 37 90	 28	 2
PR – CPD - HCBS	2 587		 469	2 12	 100		 6
PR – CPD - Hospice	8 190 200		 126 68	 13	8 63 103	 16	 1
PR – CPD - Home Health	5 1			3 1	2 		
PR – CPD - Behavioral Health Outpatient and Physician	2 455 1,264		 357 319	 535	 91 321	 89	2 7
PR – CPD - Behavioral Health Inpatient	5 66		 4	4 9	1 44	 9	
PR – CPD - Out of network provider, specialist or specific provider	11 1,595 6,124		 212 2,543	 878	10 1,358 1,764	1 939	 25
PR – CPD - Radiology	39 572 1,072		 264 339	16 91 152	20 212 315	1 266	2 5
PR – CPD - Laboratory	73 1,791 3,611		 1,141 890	8 187 588	51 445 1,296	6 14 837	8 4
PR – CPD - PT/OT/ST	2 3 14		 5		2 3 9		
PR – CPD - Durable Medical Equipment	55 720		1 380	24 3	27 306	1 	2 31
PR – CPD - Other	1 9 689		 7 280	1 101	 1 218	 90	 1
Total Claim Payment Disputes	844 14,851 28,166	1	2 8,002 9,699	252 738 4,517	464 5,933 9,218	36 14 4,732	89 164
BILLING AND FINANCIAL ISSUES							
PR – BFI - Recoupment	1			1			
TOTAL							

ABH - Red	845	1	2	253	464	36	89
SUN – Green	14,851		8,002	738	5,933	14	164
UHC - Purple	28,166		9,699	4,517	9,218	4,732	

MCOs' Provider Reconsiderations Database - Provider Reconsiderations Summary

Provider Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
Resolved at Reconsideration Level	845 14,851 28,166	1	2 8,002 9,699	253 738 4,517	464 5,933 9,218	36 14 4,732	89 164
TOTAL	845 1,4851 28,166	1	2 8,002 9,699	253 738 4,517	464 5,933 9,218	36 14 4,732	89 164
Percentage Per Category		>1%	>1% 54% 34%	30% 5% 16%	55% 40% 33%	4% >1% 17%	11% 1%

MCOs' Provider Reconsiderations Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Reconsideration Resolution Notices Sent Within Compliance Standards	91%/97%	100%	100%

MCOs' Appeals Database - Providers (appeals resolved)

PROVIDER Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn by Provider	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied / Paid	MCO Upheld Decision on Appeal – Provider Mistake	MCO Determined Not Applicable
MEDICAL NECESSITY/LEVEL OF CARE - Criteria Not Met							
PA - CNM - Durable Medical Equipment	11			7	1	2	1
PA - CNM - Inpatient Admissions (Non-Behavioral Health)	8 17			1 14	5 2	1	1 1
PA - CNM - Medical Procedure (NOS)	24 14			3 9	15 1	2 4	4
PA - CNM - Radiology	3 4			2 1	 1	 2	1
PA - CNM - Pharmacy	62	5		34	5	14	4
PA - CNM - PT/OT/ST	1				1		
PA - CNM - Dental	1 9			1 3	 2	 2	 2
PA - CNM - Home Health	1					1	
PA - CNM - Hospice	1			1			
PA - CNM - Inpatient Behavioral Health	7			4	1		2
PA - CNM - Behavioral Health Outpatient Services and Testing	2			2			
PA - CNM - Ambulance (include Air and Ground)	1 6			 3	1 1	 2	
PA - CNM - Other	1			1			
NONCOVERED SERVICE							
PA - NCS - Other	2				1		1

	1			1			
CLAIM DENIAL							
PA – CPD - Hospital Inpatient (Non-Behavioral Health)	33 109 233	 1	1 3 3	9 41 62	22 60 147	 2 	1 3 20
PA – CPD - Hospital Outpatient (Non-Behavioral Health)	6 179 64	 	 6 	3 58 20	1 104 38	 5 	2 6 6
PA – CPD - Pharmacy	1 35	 	 	1 2	 7	 26	
PA – CPD - Dental	4 25 28	 	 9 	2 1 4	1 15 	 24	1
PA – CPD - Vision	7 33	 	5 1	 13	2 12	 7	
PA – CPD - Ambulance (Include Air and Ground)	3 1	 	1 	2 1	 	 	
PA – CPD - Medical (Physical Health not Otherwise Specified)	21 315 159	 	 12 	5 160 57	9 118 74	1 15 	6 10 28
PA – CPD - Nursing Facilities - Total	1 13	 	 	 3	1 6	 	 4
PA – CPD - Hospice	2 6	 	 	2 	 3	 	 3
PA – CPD - Home Health	7 64	 1	1 4	3 29	3 28	 	 2
PA – CPD - Behavioral Health Outpatient and Physician	2 65 39	 	1 1	 24 15	 41 20	 	1 3
PA – CPD - Behavioral Health Inpatient	1 1 9	 	 	 1	 1 4	 	1 4
PA – CPD - Out of network provider, specialist or specific provider	6			1	5		
PA – CPD - Radiology	10		1	6	2		1
PA – CPD - Laboratory	10 142 50	 	 1 	1 12 3	5 126 45	 2 	4 1 2
PA – CPD - PT/OT/ST	1 39 1	 	 	 20 	 19 1	 	1
PA – CPD - Durable Medical Equipment	15 18 6	 	 	3 7 2	2 11 4	 	10
PA – CPD - Other	14 29	 	1 1	8 5	5 15	 	 8
BILLING AND FINANCIAL ISSUES							
PA – BFI - Recoupment	85		1	65	18	1	
TOTAL ABH - Red SUN – Green UHC - Purple	 134 1,164 770	 5 2	 2 41 10	 31 490 217	 63 545 404	 4 52 57	 34 31 80

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

MCOs' Appeals Database - Provider Appeal Summary

Provider Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
Resolved at Appeal Level	134 1,164 770	 5 2	2 41 10	31 490 217	63 545 404	4 52 57	34 31 80
TOTAL	134 1,164 770	 5 2	2 41 10	31 490 217	63 545 404	4 52 57	34 31 80
Percentage Per Category		 >1% >1%	1% 4% 1%	23% 42% 28%	47% 47% 52%	3% 4% 7%	25% 3% 10%
Range of Days to Reverse Due to MCO Error			35-198 3-384 55-203				

MCO's Provider Appeal Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Appeals Resolved in 30 Calendar Days	85%	98%	100%
% of Provider Appeal Resolution Notices Sent Within Compliance Standard	87%/95%	100%	100%

State of Kansas Office of Administrative Fair Hearings - Members

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met															
MH – CNM - Durable Medical Equipment	2 3	1			2 2										
MH – CNM – Inpatient Admissions (Non-Behavioral Health)	2	1			1										
MH – CNM – Pharmacy	2 3				2			2	1						
MH – CNM - Dental	1	1													
MH – CNM – Inpatient Behavioral Health	1			1											
MH – CNM - Other	1							1							
NONCOVERED SERVICE															
MH-NCS - Pharmacy	1			1											
MH-NCS - Durable Medical Equipment	1			1											
ADMINISTRATIVE DENIALS															
MH – ADMIN – Denials of Authorization (Unauthorized by Members)	2	1						1							
TOTAL ABH - Red SUN – Green UHC - Purple	 7 3 9	 1 1 2		3	 3 2 2			 4	 1						
Range of Days to Reverse MCO Decision					165-445 107										

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

State of Kansas Office of Administrative Fair Hearings - Providers

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY / LEVEL OF CARE - Criteria Not Met															
PH - CNM - Durable Medical Equipment	3				3										
PH – CNM – Inpatient Admissions (Non-Behavioral Health)	2	2													
PH - CNM - Pharmacy	1				1										
NONCOVERED SERVICE															
PH – NCS – Durable Medical Equipment	1				1										
CLAIM DENIAL															
PH - CPD - Hospital Inpatient (Non-Behavioral Health)	6 7 8	6 1 5	1		5 3										
PH - CPD - Medical (Physical Health not Otherwise Specified)	3 1	2			1							1			
PH – CPD – Nursing Facilities - Total	1				1										
PH – CPD - HCBS	1				1										
PH – CPD - Hospice	1	1													

PH - CPD - Home Health	2		1		1										
PH - CPD - Behavioral Health Outpatient and Physician	5				5										
PH - CPD - Behavioral Health Inpatient	1			1											
PH – CPD - Radiology	1							1							
PH - CPD – Laboratory	2 1							2 1							
PH - CPD - PT/OT/ST	2				2										
PH – CPD – Durable Medical Equipment	4 2				1								3 2		
PH – CPD - Other	1 1				1 1										
BILLING AND FINANCIAL ISSUES															
PH - BFI - Recoupment	1	1													
TOTAL ABH - Red SUN – Green UHC - Purple	 15 29 15	 10 2 6	 1 1	 1 	 1 21 5			 2 2 1				 1 	 3 2		
Range of Days to Reverse MCO Decision					36-508 132-306										

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

e. Quality of care: Please see Section IX "Quality Assurance/Monitoring Activity" below. The HCBS Quality Review Report for April-June 2020 is attached to this report.

f. Changes in provider qualifications/standards: None.

g. Access: As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason (GCR) pursuant to 42 CFR 438.56 or the KanCare STCs. Most GCR requests were about provider choice, which is not an acceptable reason to switch plans outside of open enrollment. The reduction in GCR requests are due to members changing their managed care plan effective January 1, 2021.

If a GCR is denied by KDHE, the member is given appeal/fair hearing rights. During the fourth quarter of 2020, there was one state fair hearing for a denied GCR, and the decision is pending. A summary of GCR actions this quarter is as follows:

Status	Oct	Nov	DEC
Total GCRs filed	19	13	10
Approved	5	4	2
Denied	8	6	5
Withdrawn (resolved, no need to change)	3	0	1
Dismissed (due to inability to contact the member)	3	3	2
Pending	0	0	0

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

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

KanCare MCO	# of Unique Providers as of 3/31/2020	# of Unique Providers as of 6/30/2020*	# of Unique Providers as of 9/30/2020*	# of Unique Providers as of 12/31/2020*
Aetna	39,097	40,323	39,494	42,617^
Sunflower	33,764	29,286	30,097	39,670^
UHC	42,772	44,634	44,248	46,278^

**Beginning Quarter 1, 2020, the # of unique providers excludes out-of-state providers located more than 50 miles from a Kansas border.*

^Increases in provider counts reflect revisions subsequent to annual audit and other meetings with MCOs that occurred in Quarter 4, 2020.

h. Payment rates: There were no payment rate changes for the quarter ending 12/31/20.

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

j. MLTSS implementation and operation: Kansas placed 34 people on HCBS IDD waiver services, and 106 people on HCBS PD waiver services.

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

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

- The State continues to work with CMS regarding amendments to the seven HCBS waivers, including amendments to performance measures, unbundling Assistive Services, and provisional plans of care.
- The PD and FE waivers were approved by CMS on October 26, 2020, with an effective date of January 1, 2020.

m. Legislative activity: The Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight met December 9 and December 15, 2020. The Committee heard presentations from individuals, providers, and organizations related to KanCare. KDHE presented testimony on the KanCare program in general, the 1115 demonstration, and the new Medicaid eligibility Clearinghouse contractor, Conduent. The efforts to address the COVID-19 pandemic was presented by Secretary Norman and each of the KanCare MCOs.

KDADS presented information on the state hospitals, including lifting the moratorium at Osawatomie State Hospital, updates on Larned State Hospital recruitment and retention of staff. KDADS provided updates on Nursing Homes in Kansas, including COVID 19 updates and visitation guidelines. KDADS did an additional presentation on testing strategies in Nursing Homes. KDADS also provided updates on the HCBS waiting lists, HCBS Final Rule, the PACE Program, PRTF's, antipsychotic drugs in nursing homes, and nursing facility receivership. The Committee also heard from the KanCare Ombudsman and the Medicaid Inspector General. Each MCO also provided information about their operations.

KDHE eligibility workers continue to delay annual reviews in order to not discontinue eligibility during the PHE. The only exceptions for eligibility discontinuation are if the person moves away from the state, dies or voluntarily withdraws from the Medicaid program. This process will remain in place for Kansas to continue to receive the enhanced FMAP of 6.2%. for Medicaid and 4.34% increased federal participation for CHIP through the termination of the Public Health Emergency.

Overview of other changes made to the Medicaid program during the PHE:

- Applicants and beneficiaries have an additional 120 days to request a fair hearing, if the original 33-day deadline falls between March 2020 and the end of the Public Health Emergency
- Remove all cost sharing for testing/treatment of COVID for KanCare members
- Allow for greater flexibility of day service location for HCBS members
- Services can be rendered in home by a family member, with reimbursement to the family member
- Allow for out of state, non-KanCare providers to provide services in Kansas
- Suspend PASRR Level 1 and Level 2 requirements for 30 days
- Temporarily cease all physical visits from MCOs to providers/members

- Allow for early refill of maintenance prescriptions; increase level of pharmacy delivery and mail order availability

KDHE submitted a Disaster Relief SPA for permission to allow Pharmacy Techs and Pharmacy Interns to the effort of administering the vaccine. If approved, this SPA has an effective date of December 2020.

Providers are regularly updated through the Kansas Medical Assistance Program (KMAP) website of changes made to the program. A special page titled "COVID-19 KMAP Providers Information Page[3]" was added to assist providers as a 'one-stop location' for bulletins, phone numbers, and links to online resources.

n. Other Operational Issues: Eligibility workers began alternative work schedules. Staff work from home and work in the office on alternate days and times to control the spread of COVID-19. This effort has resulted in keeping staff safe, and Medicaid applications processed timely.

V. Policy Developments/Issues

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

VI. Financial/Budget Neutrality Development/Issues

Budget neutrality: The State has updated the Budget Neutrality template provided by CMS and has submitted this through the PMDA system. The expenditures contained in the document reconcile to Schedule C from the CMS 64 report for QE 12 31 2020.

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

VII. Member Month Reporting

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

DY MEG	Member Months			
	Oct-20	Nov-20	Dec-2	Total QE 12/31/2020
DY1 CY2013	0	0	0	0
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON DUAL	0	0	0	0
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0

[3] https://www.kmap-state-ks.us/Documents/Content/Provider/COVID%2019%20.pdf

MEG 6 - LTC	0	0	0	0
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY2 CY2014	(6)	(5)	0	(11)
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON DUAL	(6)	(5)	0	(11)
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	0	0
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY3 CY2015	(22)	(63)	(8)	(93)
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON DUAL	(22)	(63)	(8)	(93)
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	0	0
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	0	0
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON DUAL	0	0	0	0
MEG 9 - WAIVER	0	0	0	0
DY4 CY2016	(24)	(119)	(41)	(184)
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON DUAL	(24)	(119)	(23)	(166)
MEG 3 - ADULTS	0	0	0	0
MEG 4 - CHILDREN	0	0	(8)	(8)
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	(9)	(9)
MEG 7 - MN DUAL	0	0	0	0
MEG 8 - MN NON DUAL	0	0	(1)	(1)
MEG 9 - WAIVER	0	0	0	0
DY5 CY2017	(33)	(208)	(94)	(335)
MEG 1 - ABD/SD DUAL	0	0	0	0
MEG 2 - ABD/SD NON DUAL	(33)	(208)	(29)	(270)
MEG 3 - ADULTS	0	0	(21)	(21)
MEG 4 - CHILDREN	0	0	(34)	(34)
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	0	(6)	(6)
MEG 7 - MN DUAL	0	0	(1)	(1)
MEG 8 - MN NON DUAL	0	0	(3)	(3)
MEG 9 - WAIVER	0	0	0	0
DY6 CY2018	(33)	(231)	(100)	(364)
MEG 1 - ABD/SD DUAL	2	5	(9)	(2)
MEG 2 - ABD/SD NON DUAL	(38)	(238)	(30)	(306)
MEG 3 - ADULTS	0	0	(14)	(14)
MEG 4 - CHILDREN	3	2	(35)	(30)
MEG 5 - DD WAIVER	0	0	0	0
MEG 6 - LTC	0	(1)	(2)	(3)
MEG 7 - MN DUAL	0	2	0	2

MEG 8 - MN NON DUAL	0	(1)	(10)	(11)
MEG 9 - WAIVER	0	0	0	0
DY7 CY2019	(37)	(376)	(127)	(540)
MEG 1 - ABD/SD DUAL	45	97	52	194
MEG 2 - ABD/SD NON DUAL	(95)	(489)	(134)	(718)
MEG 3 - ADULTS	0	0	(24)	(24)
MEG 4 - CHILDREN	24	29	11	64
MEG 5 - DD WAIVER	(3)	(5)	0	(8)
MEG 6 - LTC	(4)	(9)	(13)	(26)
MEG 7 - MN DUAL	8	28	15	51
MEG 8 - MN NON DUAL	(6)	(25)	(18)	(49)
MEG 9 - WAIVER	(6)	(2)	(16)	(24)
DY8 CY2020	357,453	363,800	363,651	1,084,904
MEG 1 - ABD/SD DUAL	16,666	16,958	16,615	50,239
MEG 2 - ABD/SD NON DUAL	31,085	31,382	31,062	93,529
MEG 3 - ADULTS	52,171	53,688	54,080	159,939
MEG 4 - CHILDREN	218,520	222,473	223,124	664,117
MEG 5 - DD WAIVER	9,100	9,080	9,088	27,268
MEG 6 - LTC	21,677	21,682	21,433	64,792
MEG 7 - MN DUAL	2,623	2,856	2,707	8,186
MEG 8 - MN NON DUAL	1,270	1,271	1,144	3,685
MEG 9 - WAIVER	4,341	4,410	4,398	13,149
Grand Total	357,298	362,798	363,281	1,083,377

Note: Totals do not include CHIP or MCHIP.

VIII. Consumer Issues

The consumer issues remain the same from previous quarters. A summary of the fourth quarter 2020 consumer issues is below:

Issue	Resolution	Action Taken to Prevent Further Occurrences
Members who were on HCBS and were terminating did not always have notification provided by the MCOs to Medicaid eligibility.	Each MCO has provided updated training for case managers for providing notification to Medicaid eligibility for consumers who are terminating HCBS.	The State has reviewed all trainings for each MCO and ensure updates as needed. This topic was discussed during monthly meetings with the MCOs. In addition, the State has reviewed and confirmed all trainings for case managers.

IX. Quality Assurance/Monitoring Activity

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

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

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

The State participated in the following activities:

- Ongoing automated report management, review, and feedback occurred between the State and the MCOs. Reports from the MCOs consist of a wide range of data reported on standardized templates. The State is preparing to add Provider Satisfaction Survey results to the Report Administration system. This would include MCO submission of survey tools and methodology for State approval prior to survey implementation. These changes are pending contract amendment approval.
- Specific templates were developed for reporting key components of performance for the KanCare program through cross-agency and MCO collaboration. The process of report management, review, and feedback is now automated to ensure efficient access to reported information and maximum utilization/feedback related to the data. The team identified gaps in reporting contract requirements and reports that could improve the quality of data reported.
- Monitored the External Quality Review Organization (EQRO) work plan. Kansas Foundation for Medical Care, the State's EQRO, and the State developed a tool to track EQRO, State, and MCO deliverables due dates. The tool is updated daily by KFMC and distributed to the State and MCOs quarterly. The State uses this mechanism to prepare for upcoming due dates.
- Continued system design with the EQRO to collect reports specific to Performance Improvement Projects (PIPs) and the Health Action Planning for the OneCare Kansas health homes program. Initial reporting of data for the MCOs collaborative HPV and EPSDT PIPs continued. There is a clear pattern of decreasing visits for preventive care emerging because of COVID-19. The State began receiving data from UHC, ABHKS, and SHP related to each MCOs' PIPs.
- Meetings occurred with the EQRO, MCOs, KDADS, and KDHE to discuss EQRO activities and concerns.
- State 2019 KanCare contract audit documentation was delivered to the MCOs.
- The State added a new Program Manager that is dedicated to the annual contract review and added a new data analyst position. The 2020 annual contract review was coordinated with the State EQRO's audit activities. The focus for 2020 was on those contract requirements that scored below Partially Met in 2019. All onsite meetings for 2020 were held virtually through Microsoft

Teams due to COVID-19. All the 2020 desk reviews, onsite meetings and post onsite document reviews were conducted. Review of findings and communication of the results should occur in the first quarter of 2021.

- Medicaid Fraud Control Unit monthly meetings were held with the Attorney General's office to address fraud, waste, abuse cases, referrals to MCOs and State, and collaborate on solutions to identify and prevent fraud, waste, and abuse.
- Continued state staff participation in cross-agency long-term care meetings to report quality assurance and programmatic activities to KDHE for oversight and collaboration.
- Continued participation in weekly calls with each MCO to discuss ongoing provider and member issues, and to troubleshoot operational problems. Progress is monitored through these calls and through issue logs. Leadership from KDADS, KDHE and the three MCOs meet monthly to discuss issues and improvements to KanCare.
- Monitored large, global system issues through a weekly log issued to all MCOs and the State's fiscal agent. The resulting log is posted on the KanCare website for providers and other interested parties. Continued monthly meetings to discuss trends and progress.
- Monitored member or provider specific issues through a tracking database that is shared with MCOs and KDADS for weekly review.
- Attended various provider training and workshops presented by the MCOs. Monitored for accuracy, answer questions as needed.
- With the implementation of KanCare 2.0 each MCO is required to participate in six PIPs. All eighteen PIPs have approved methodologies and have moved to the technical specification and data reporting phase. PIP activities focused on developing strong technical specifications for those interventions that will be reported more than annually. This process went smoothly with KFMC and the State developing and providing a template as well as examples to act as a guide. Once technical specifications are approved, the MCOs begin reporting data on the PIP's interventions. We now have the ability to review the data to assess the success or need for adjustments in the interventions. PIP meetings occur twice per quarter where the State, EQRO and MCO can have in depth discussions related to PIP concerns and enhancements.
- A member-friendly table of all the MCOs' PIPs, with a simplified description of their interventions, has been added to the KanCare website[4]. KDHE developed a table that includes more technical information and highlights the change being piloted with each intervention. This document is being attached to this report (PIP Interventions Technical Summary).
  However, we decided not to post the technical version yet because UHC has decided to change their PPC PIP to AMM PIP and the Collaborative HPV PIP will end, and a COVID-19 Vaccine PIP will be replacing it in the coming quarters. Once these changes are in place, we will post the technical version, as well.
- The State completed improvements to the quality section of the KanCare website. All quality measurement tools and reports are now on one page. The intention is to make this page as member-friendly as possible. This includes a Quality Dashboard which shows how KanCare is doing year to year and compared to other states' health plans on selected measures.
- A Program Manager was hired to focus on revising the KanCare Quality Management Strategy. He began researching our current QMS, other states' QMS, feedback from CMS on our current QMS and the related regulations. The State decided to use the EQRO to complete a review of the effectiveness of the July 2018 QMS. This evaluation will be included in the revised QMS. The State plans to incorporate recommendations from this evaluation in the revised QMS.
- For the programs administered by KDADS: The Quality Assurance (QA) process is designed to give continuous feedback to KDADS, KDHE, and stakeholders regarding the quality of services being provided to KanCare members. KDADS quality assurance staff are integrated in the Aging &

[4] https://www.kancare.ks.gov/policies-and-reports/quality-measurement

Disability Community Services and Programs Commission (A&D CSP) to align staff resources for efficient and timely performance measurement. QA staff review random samples of individual case files to monitor and report compliance with performance measures designated in Attachment J of the MCO contracts. The MCOs contracted with Averifi to serve as a single vendor to conduct HCBS Provider Qualification audits. Status reports are presented at monthly MCO meetings. As of December 1, 2020, Averifi had completed 63 Provider Audits in November and engaged and educated 580 Providers on the HCBS Provider Qualifications.

- Programs administered by KDADS: These measures are monitored and reviewed in collaboration with program staff in the Aging and Disability Community Services and Programs Commission and reported through the Financial and Information Services Commission at KDADS. This oversight is enhanced through collaboration with the Department of Children and Families and the Department of Health and Environment. No HCBS performance measures were reported to CMS via the 372-reporting process due to permissions granted in the Appendix K. A quality assurance protocol and interpretative guidelines are utilized to document this process and have been established with the goal of ensuring consistency in the reviews.
- Below is the timeline that the KDADS Quality Review Team follows regarding the quality review process.

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

X. Managed Care Reporting Requirements

a. A description of network adequacy reporting including GeoAccess mapping:
Each MCO submits a quarterly network adequacy report. The State uses this report to monitor the quality of network data and changes to the networks, drill down into provider types and specialties, and extract data to respond to requests received from various stakeholders. The State's network data and analysis tools were moved from Excel into a dedicated database on a secure server during the second quarter of 2019. This database allows the State to give more robust and timely feedback to the MCOs. This method is less prone to breakdowns and improves business continuity.

KDHE has continued to give MCOs feedback on the accuracy and completeness of their quarterly report. As MCOs improve their reporting, feedback is becoming less about basic errors (duplicates) and more detailed (at provider level). The State used a portion of the annual contract review onsite sessions to present individualized feedback and ask questions of each MCO. Based on these conversations and closing gaps in contract requirements, in 2021, the State plans to

complete another round of meetings with all three MCOs to collaborate and problem solve provider network reporting processes. The State team has been working on improvements to the Access and Availability Report, the NEMT report, the feedback report, mapping formats, Non-Participating Provider Reliance Report, and a HCBS Service Delivery Report. The team continues to match the MCOs' reports against additional data sources to give a clearer picture of the reports' accuracy and completeness. For example, the national NPI database is referenced for matching of NPI types/specialties and taxonomies. The State began collecting the data files for MCO provider directories. The State's plan is to give feedback to the MCOs when differences between the directory and network report are found. This process will give the State insight into information such as office hours, cultural competency, and ADA capabilities. The State has asked the EQRO to perform a comparison analysis of the MCOs' provider directory and the KMAP Provider Network. This comparison will provide the State insight into opportunities for improvement. The results of this analysis are due first quarter of 2021.

There was a lot of progress with mapping in the fourth quarter of 2020. With the addition of a new data analyst and partnership with KDHE Department of Administration we developed an automated procedure, using ArcGIS Pro, to map providers based on the MCOs provider network report submissions. We can then use these maps for multiple purposes. Examples include comparing the GeoAccess map that the MCO submits, finding errors, omissions, or verify gaps in coverage. The team began to implement our exceptions request process. The team chose to focus on OBGYNs. MCOs have begun to close gaps, by adding new providers, and documenting activities to close any remaining gaps. KDHE and KDADS GeoAccess standards are posted on our KanCare website[5].

- MCO Network Access:
  - This report pulls together a summary table from each MCO and provides a side-by-side comparison of the access maps for each plan by specialty.
- HCBS Providers by Waiver Service:
  - Includes a network status table of waiver services for each MCO.

The State also posts the maps that the MCOs submit to this link. The State adds a trending graph to show change between quarters. With changes in the fourth quarter to consistency of map reporting and formatting, the next set of maps the State posts will contain trending graphs which represent count of unique providers and will trend third quarter 2020 with fourth quarter 2020.

b. Customer service reporting, including total calls, average speed of answer, and call abandonment rates, for MCO-based and fiscal agent call centers, October - December 2021:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	14.58	2.35%	151,385
Sunflower	22.62	2.13%	142,500
United	21.79	1.02%	159,061
DXC – Fiscal Agent	9.25	.77%	23,339

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	1.52	.90%	77,181
Sunflower	20.82	1.77%	94,269
United	6.26	.53%	80,172
DXC – Fiscal Agent	22	1.25%	28,176

[5] https://www.kancare.ks.gov/policies-and-reports/network-adequacy

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

MCOs' Grievance Trends Members

Aetna Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	51	
Top 5 Trends		
Trend 1: Transportation – Other	12	24%
Trend 2: Quality of Care (non HCBS Providers)	7	14%
Trend 3: Billing/Financial Issues (non-transportation)	7	14%
Trend 4: Transportation – No Show	6	12%
Trend 5: Customer Service	5	10%

Sunflower Member Grievances:

- There was a decrease of 11 for Transportation – Other from 30 reported third quarter to 19 reported fourth quarter.

Sunflower Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	104	
Top 5 Trends		
Trend 1: Transportation – Other	19	18%
Trend 2: Transportation – Late	17	16%
Trend 3: Access to Service or Care	13	13%
Trend 4: Transportation – No Show	13	13%
Trend 5: Quality of Care (non HCBS Providers)	9	9%

United Member Grievances:

- There was an increase of 18 for Quality of Care (non HCBS Providers) from 15 reported in third quarter to 33 reported in fourth quarter.
- There was an increase of 12 for Customer Service from 15 reported in third quarter to 27 reported in fourth quarter.
- There was an increase of 76 for Access to Service or Care from 10 reported in third quarter to 86 reported in fourth quarter. There was a system error that incorrectly stated multiple members lost their coverage in October but has been corrected.
- There was an increase of 26 for Billing/Financial Issues (non-transportation) from 49 reported in third quarter to 75 reported in fourth quarter.

United Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	349	
Top 5 Trends		
Trend 1: Access to Service or Care	86	25%
Trend 2: Billing/Financial Issues (non-transportation)	75	21%
Trend 3: Quality of Care (non HCBS Providers)	33	9%
Trend 4: Transportation – Other	33	9%
Trend 5: Customer Service	27	8%

MCOs' Grievance Trends Provider

Aetna Fourth Quarter Grievance Trends	
Total # of Resolved Grievances	0

Sunflower Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	15	
Top 5 Trends		
Trend 1: Transportation	6	40%
Trend 2: Billing/Payment	2	13%
Trend 3: Services	2	13%
Trend 4: Other – Dissatisfaction with MCO Associate	2	13%

United Fourth Quarter Grievance Trends		
Total # of Resolved Grievances	15	
Top 5 Trends		
Trend 1: Transportation	13	87%
Trend 2: Other (Must provide description in narrative column of Summary Reports)	2	13%

MCOs' Reconsideration Trends Provider

Aetna Provider Reconsiderations

- There was an increase of 164 provider reconsiderations from 681 reported in third quarter to 845 reported in fourth quarter.
- There was an increase of 23 for PR – CPD – Hospital Inpatient from 99 reported in third quarter to 122 reported in fourth quarter.
- There was an increase of 55 for PR – CPD – Hospital Outpatient from 41 reported in third quarter to 96 reported in fourth quarter.
- There was an increase of 42 for PR – CPD – Ambulance (Include Air and Ground) from 15 reported in third quarter to 57 reported in fourth quarter.
- There was an increase of 83 for PR – CPD – Medical (Physical Health not Otherwise Specified) from 274 reported in third quarter to 357 reported in fourth quarter.

Aetna Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	845	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	357	42%
Trend 2: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	122	14%
Trend 3: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	96	11%
Trend 4: PR – CPD – Laboratory	73	9%
Trend 5: PR – CPD – Ambulance (Include Air and Ground)	57	7%

Sunflower Provider Reconsiderations

- There was an increase of 1,943 provider reconsiderations from 12,908 reported in third quarter to 14,851 reported fourth quarter.
- There was an increase of 499 for PR- CPD – Medical (Physical Health not Otherwise Specified) from 2,798 reported in third quarter to 3,297 reported in fourth quarter.
- There was an increase of 509 for PR – CPD – Laboratory from 1,282 reported in third quarter to 1,791 reported in fourth quarter.

Sunflower Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	14,851	
Top 5 Trends		
Trend 1: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	3,493	24%
Trend 2: PR – CPD – Medical (Physical Health not Otherwise Specified)	3,297	22%
Trend 3: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	1,902	13%
Trend 4: PR – CPD – Laboratory	1,791	12%
Trend 5: PR – CPD – Out of network provider, specialist or specific provider	1,595	11%

United Provider Reconsiderations

- There was a decrease of 729 for PR – CPD – Laboratory from 4,340 reported in third quarter to 3,611 reported in fourth quarter.

United Fourth Quarter Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	28,166	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	10,653	38%
Trend 2: PR – CPD – Out of network provider, specialist or specific provider	6,124	22%
Trend 3: PR – CPD – Laboratory	3,611	13%
Trend 4: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	3,337	12%
Trend 5: PR – CPD – Behavioral Health Outpatient and Physician	1,264	4%

MCOs' Appeals Trends Member/Provider

Aetna Member Appeals:

- There was a decrease of 20 member appeals for MA – CNM – Pharmacy from 98 reported in third quarter to 78 reported in fourth quarter.

Aetna Provider Appeals:

- There was a decrease of 196 provider appeals from 330 reported in third quarter to 135 reported in fourth quarter.
- There was a decrease of 74 provider appeals for PA – CNM – Medical Procedure (NOS) from 98 reported in third quarter to 24 reported in fourth quarter.
- There was a decrease of 38 provider appeals for PA – CPD – Medical (Physical Health not Otherwise Specified) from 59 reported in third quarter to 21 reported in fourth quarter.
- There was a decrease of 21 provider appeals for PA – CPD – Laboratory from 31 reported in third quarter to 10 reported in fourth quarter.

Aetna Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	143		Total # of Resolved Provider Appeals	134	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	78	55%	Trend 1: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	33	25%
Trend 2: MA – CNM – Medical Procedure (NOS)	22	15%	Trend 2: PA – CNM – Medical Procedure (NOS)	24	18%
Trend 3: MA – CNM - Radiology	17	12%	Trend 3: PA – CPD – Medical (Physical Health not Otherwise Specified)	21	16%
Trend 4: MA – CNM – Durable Medical Equipment	7	5%	Trend 4: PA – CPD - Durable Medical Equipment	15	11%
Trend 5: MA – CNM – Inpatient Behavioral Health / MA – CNM – Other / MA – NCS – Behavioral Health	4	3%	Trend 5: PA – CPD - Laboratory	10	7%

Sunflower Member Appeals:

- There was an increase of 12 member appeals for MA – CNM – Radiology from 47 reported in third quarter to 59 reported in fourth quarter.

Sunflower Provider Appeals:

- There was a decrease of 36 provider appeals for PA – CPD – Hospital Inpatient (Non-Behavioral Health) from 145 reported in third quarter to 109 reported in fourth quarter.
- There was a decrease of 58 provider appeals for PA – BFI – Recoupment from 143 reported in third quarter to 85 reported in fourth quarter.

Sunflower Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	232		Total # of Resolved Provider Appeals	1,164	
Top 5 Trends			Top 5 Trends		

Trend 1: MA – CNM - Radiology	59	25%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	315	27%
Trend 2: MA – CNM – Pharmacy	46	20%	Trend 2: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	179	15%
Trend 3: MA – CNM – Durable Medical Equipment	32	14%	Trend 3: PA – CPD - Laboratory	142	12%
Trend 4: MA – CNM – Medical Procedure (NOS)	20	9%	Trend 4: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	109	9%
Trend 5: MA – CNM – Inpatient Behavioral Health	4	3%	Trend 5: PA – BFI – Recoupment	85	7%

United Provider Appeals:

- There was a decrease of 27 provider appeals for PA – CPD – Hospital Outpatient (Non-Behavioral Health) from 91 reported in third quarter to 64 reported in fourth quarter.
- There was a decrease of 61 provider appeals for PA – CPD – Home Health from 125 reported in third quarter to 64 reported in fourth quarter.
- There was a decrease of 27 provider appeals for PA – CPD – Laboratory from 77 reported in third quarter to 50 reported in fourth quarter.

United Fourth Quarter Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	215		Total # of Resolved Provider Appeals	770	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	108	50%	Trend 1: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	233	30%
Trend 2: MA – CNM – Inpatient Admissions (Non-Behavioral Health)	43	20%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	121	16%
Trend 3: MA – CNM – Durable Medical Equipment	21	10%	Trend 3: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	75	10%
Trend 4: MA – CNM – Out of network provider, specialist or specific provider	12	6%	Trend 4: PA – CPD – Home Health	37	5%
Trend 5: MA – CNM – Dental	11	5%	Trend 5: PA – CPD - Laboratory	33	4%

MCOs' State Fair Hearing Reversed Decisions - Member/Provider

- There were 19 Member State Fair Hearings for all three MCOs. No decisions were reversed by OAH.
- There were 59 Provider State Fair Hearings for all three MCOs. One of Aetna's state fair hearing decisions were reversed by OAH after a hearing.

Aetna Fourth Quarter					
Total # of Member SFH	7		Total # of Provider SFH	15	
OAH reversed MCO decision	0		OAH reversed MCO decision	1	7%

Sunflower Fourth Quarter					
Total # of Member SFH	3		Total # of Provider SFH	29	
OAH reversed MCO decision	0		OAH reversed MCO decision	0	

United Fourth Quarter					
Total # of Member SFH	9		Total # of Provider SFH	15	
OAH reversed MCO decision	0		OAH reversed MCO decision	0	

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

e. Summary of ombudsman activities: The report for the fourth quarter of calendar year 2020 is attached.

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

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

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

AIR is not intended to replace the State reporting system for abuse, neglect and exploitation (ANE) of individuals who are served on the behavioral health and HCBS programs. ANE substantiations are reported separately to KDADS from the Department of Children and Families (DCF) and monitored by the KDADS program integrity team. The program integrity team ensures individuals with reported ANE are receiving adequate supports and protections available through KDADS programs, KanCare, and other community resources. A summary of the 2020 AIR reports through the quarter ending December 31, 2020 follows:

Critical Incidents	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	YTD
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Reviewed	2,896	2,664	3,112	2,988	11,660
Pending Resolution	70	40	49	192	351
Total Received	2,966	2,704	3,161	3,180	12,011
APS Substantiations*	198	182	211	168	759

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

XI. Safety Net Care Pool

The Safety Net Care Pool (SNCP) is divided into two pools: The Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The DY8 fourth quarter HCAIP UCC Pool payments were issued November 12, 2020 and December 17, 2020, the LPTH/BCCH UC Pool payments were issued December 18, 2020.

SNCP and HCAIP reports for the fourth quarter of DY 8, are attached to this report.

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

XII. Demonstration Evaluation

The entity selected by KDHE to conduct KanCare Evaluation reviews and reports is the Kansas Foundation for Medical Care (KFMC). KFMC worked with KDHE to develop a draft evaluation design that was accepted by CMS February 26, 2020.

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

a. Post-award forums
A summary of the December 16, 2020 annual forum is attached to this report.

b. Claims Adjudication Statistics
KDHE's summary of the numerous claims adjudication reports for the KanCare MCOs, covering January-December 2020, is attached.

c. Waiting List Management
PD Waiting List Management
For the quarter ending December 31, 2020:
- Current number of individuals on the PD Waiting List: 2,027
- Number of individuals added to the waiting list: 407
- Number of individuals removed from the waiting list: 196
  - 106 started receiving HCBS-PD waiver services
  - 33 were deceased
  - 57 were removed for other reasons (refused services, voluntary removal, etc.)

I/DD Waiting List Management
For the quarter ending December 31, 2020:
- Current number of individuals on the I/DD Waiting List: 4,464
- Number of individuals added to the waiting list: 121
- Number of individuals removed from the waiting list: 62
  - 34 started receiving HCBS-I/DD waiver services

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

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

XIV. Enclosures/Attachments

Section of Report Where Attachment Noted	Description of Attachment
IV(e)	HCBS Quality Report for April-June 2020
IX	PIP Interventions Technical Summary
X(e)	Summary of KanCare Ombudsman Activities for QE 12.31.2020
XI	Safety Net Care Pool Reports DY8 Q4 and HCAIP Reports DY8 Q4
XIII(b)	KDHE Summary of Claims Adjudication Statistics for January-September 2020

XV. State Contacts

Sarah Fertig, Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3563 (phone)
(785) 296-4813 (fax)
Lee.Norman@ks.gov
Sarah.Fertig@ks.gov

VI. Date Submitted to CMS

March 31, 2021

Kansas
Department for Aging and Disability Services

Home and Community Based Services Long-Term Care Quality Review Report

April - June 2020

January 14, 2020

HCBS Waiver Quality Review Rolling Timeline

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

*Per HCBS Waiver Quality Review policy.

**LTC, MCO, and Assessor data and fallout reports will be compiled.

***MCOs/Assessors will receive the data with explanation of findings following the presentation of data to the LTC meeting. They will be given 15 calendar days to respond. No additional documentation will be accepted.

Revised: 07/05/19

July - September 2019 HCBS Quality Sample			
Waiver	Population Count	Quarterly Sample Size	Completed Reviews
PD	5935	91	89
FE	4766	90	91
IDD	9119	93	92
BI	444	52	51
TA	596	59	57
Autism	49	14	14
SED	3575	87	87

October - December 2019 HCBS Quality Sample			
Waiver	Population Count	Quarterly Sample Size	Completed Reviews
PD	6184	91	90
FE	4942	89	91
IDD	9158	92	92
BI	473	54	54
TA	592	59	59
Autism	52	15	15
SED	3551	87	87

January - March 2020 HCBS Quality Sample			
Waiver	Population Count	Quarterly Sample Size	Completed Reviews
PD	6203	90	90
FE	5046	89	89
IDD	9149	92	91
BI	516	56	55
TA	605	59	58
Autism	49	8	7
SED	3579	87	87

April - June 2020 HCBS Quality Sample			
Waiver	Population Count	Quarterly Sample Size	Completed Reviews
PD	6182	90	91
FE	5271	90	92
IDD	9133	93	97
BI	560	57	60
TA	594	59	60
Autism	56	15	5
SED	3394	86	88

HCBS Quality Review Acronyms

ABA	Applied Behavior Analysis
ANE	Abuse, Neglect, and Exploitation
AU	Autism
BUP	Backup Plan
CAFAS	Child and Adolescent Functional Assessment Scale
CBCL	Child Behavioral Checklist Assessment
CC	Care Coordinator
DPOA	Durable Power of Attorney
FAI	Functional Assessment Instrument
FCAD (SED)	Family Choice Assurance Document
FE	Frail Elderly
HRA	Health Risk Assessment
IDD	Intellectual Developmental Disability
ISP	Integrated Service Plan
KAMIS	Kansas Assessment Management Information System
KBH (SED)	Kan Be Healthy (Annual Physical Exam)
MCO	Managed Care Organization
MMIS	Medicaid Management Information System
PCSP	Person Centered Service Plan
PD	Physical Disability
POC	Plan of Care
R&R	Rights & Responsibilities
SED	Serious Emotional Disturbance
TA	Technology Assistance
TBI/BI	Traumatic Brain Injury/Brain Injury
TLS	Transitional Living Specialist
UAR	Universal Assessment Results
UAT	Universal Assessment Tool

Level of Care Performance Measures 1 & 2

Beginning with the January to March 2018 Quality Review period, KDADS began peforming a data pull to determine compliance for Level of Care Performance Measures 1 & 2. This change applies to each waiver, except Autism, which remains a record review.

Level of Care Performance Measure 1
Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Numerator: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Denominator: Total number of initial enrolled waiver participants

- For Level of Care Performance Measure 1, KDADS will review all waiver participants who became newly eligible during the review period, as determined by MMIS eligibility data. KAMIS assessment data is then pulled for these individuals. Waiver participants are considered "Compliant" if they have had a functional assessment within 365 days prior to their eligibility effective date.

Level of Care Performance Measure 2
Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Denominator: Number of waiver participants who received Level of Care redeterminations

- For Level of Care Performance Measure 2, KDADS will review 100% of waiver participants throughout the four quarters of the year. MMIS eligibility data will be used to determine the denominator, which is the total number of existing waiver participants who had an eligibility effective month within the quarter being reviewed. KAMIS assessment data is then pulled for these individuals. Waiver participants are considered "Compliant" if they received an assessment within 365 days of their previous assessment, and their most current assessment is within 365 days of the review period.

KDADS HCBS Quality Review Report

Administrative Authority
PM 1: Number and percent of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Numerator: Number of Quality Review reports generated by KDADS, the Operating Agency, that were submitted to the State Medicaid Agency
Denominator: Number of Quality Review reports
Review Period: 04/01/2020 – 06/30/2020
Data Source: Quality Review Reports to KDHE

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
FE									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
IDD									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
BI									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
TA									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
Autism									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%
SED									
Statewide	25%	25%	25%	75%	100%	100%	100%	100%	100%

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation necessary

KDADS HCBS Quality Review Report

Administrative Authority
PM 2: Number and percent of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS by the State Medicaid Agency
Numerator: Number of waiver amendments and renewals reviewed and approved by the State Medicaid Agency prior to submission to CMS
Denominator: Total number of waiver amendments and renewals
Review Period: 04/01/2020 – 06/30/2020
Data Source: Number of waiver amendments and renewals sent to KDHE

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	N/A	100%	100%	100%	N/A	N/A	100%	100%	N/A
FE									
Statewide	Not a Measure	100%	100%	100%	N/A	N/A	100%	100%	N/A
IDD									
Statewide	100%	100%	100%	100%	N/A	100%	100%	100%	N/A
BI									
Statewide	100%	100%	100%	100%	N/A	100%	100%	100%	N/A
TA									
Statewide	100%	100%	N/A	100%	N/A	100%	100%	100%	N/A
Autism									
Statewide	100%	100%	N/A	N/A	100%	N/A	100%	100%	N/A
SED									
Statewide	100%	100%	N/A	N/A	100%	N/A	100%	100%	N/A

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation necessary

KDADS HCBS Quality Review Report

Administrative Authority
PM 3: Number and percent of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Numerator: Number of waiver policy changes that were submitted to the State Medicaid Agency prior to implementation by the Operating Agency
Denominator: Number of waiver policy changes implemented by the Operating Agency
Review Period: 04/01/2020 – 06/30/2020
Data Source: Presentation of waiver policy changes to KDHE

Compliance By Waiver	Statewide
PD	**100%**
Numerator	3
Denominator	3
FE	**100%**
Numerator	4
Denominator	4
IDD	**100%**
Numerator	7
Denominator	7
BI	**100%**
Numerator	4
Denominator	4
TA	**100%**
Numerator	3
Denominator	3
Autism	**100%**
Numerator	2
Denominator	2
SED	**100%**
Numerator	2
Denominator	2

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	N/A	N/A	100%	N/A	100%	100%	N/A	100%	100%
FE									
Statewide	N/A	N/A	100%	N/A	100%	100%	N/A	100%	100%
IDD									
Statewide	100%	N/A	100%	100%	100%	100%	N/A	100%	100%
BI									
Statewide	100%	N/A	100%	100%	100%	100%	100%	100%	100%
TA									
Statewide	N/A	N/A	N/A	N/A	100%	100%	N/A	100%	100%
Autism									
Statewide	N/A	N/A	N/A	N/A	100%	100%	N/A	100%	100%
SED									
Statewide	N/A	N/A	N/A	N/A	100%	N/A	N/A	100%	100%

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation necessary

KDADS HCBS Quality Review Report

Administrative Authority
PM 4: Number and percent of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Numerator: Number of Long-Term Care meetings that were represented by the program managers through in-person attendance or written reports
Denominator: Number of Long-Term Care meetings
Review Period: 04/01/2020 – 06/30/2020
Data Source: Meeting Minutes

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	Not a measure	45%	67%	70%	100%	100%	100%	100%	100%
FE									
Statewide	100%	82%	50%	70%	100%	100%	100%	100%	100%
IDD									
Statewide	Not a measure	91%	Not Available	70%	100%	100%	100%	100%	100%
BI									
Statewide	Not a measure	73%	Not Available	70%	100%	100%	100%	100%	100%
TA									
Statewide	Not a measure	64%	Not Available	70%	100%	100%	100%	100%	100%
Autism									
Statewide	Not a measure	91%	100%	70%	100%	100%	100%	100%	100%
SED									
Statewide	Not a measure	100%	Not Available	70%	100%	100%	100%	100%	100%

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation necessary

KDADS HCBS Quality Review Report

Level of Care
PM 1: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Numerator: Number of waiver participants who were determined to meet Level of Care requirements prior to receiving HCBS services
Denominator: Total number of initial enrolled waiver participants
Review Period: 04/01/2020 – 06/30/2020
Data Source: Functional Assessor Record Review/State Data Systems

Compliance By Waiver	Statewide
PD	**91%**
Numerator	250
Denominator	276
FE	**95%**
Numerator	612
Denominator	647
IDD	**97%**
Numerator	108
Denominator	111
BI	**91%**
Numerator	81
Denominator	89
TA	**100%**
Numerator	27
Denominator	27
Autism	**100%**
Numerator	12
Denominator	12
SED	**95%**
Numerator	83
Denominator	87

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	64%	83%	96%	86%	89%	92%	94%	89%	91%
FE									
Statewide	81%	91%	93%	98%	100%	96%	96%	95%	95%
IDD									
Statewide	99%	94%	90%	100%	100%	99%	99%	100%	97%
BI									
Statewide	62%	89%	81%	85%	96%	88%	93%	93%	91%
TA									
Statewide	97%	89%	100%	98%	100%	100%	100%	98%	100%
Autism									
Statewide	82%	No Data	100%	N/A	77%	96%	100%	100%	100%
SED									
Statewide	99%	89%	88%	91%	92%	90%	91%	100%	95%

Explanation of Findings:

For this Performance Measure, KDADS is utilizing KAMIS assessment data and MMIS eligibility data to determine compliance for five of the waivers. The Autism and SED waiver compliance is determined through a record review.

Remediation:

No remediation required . Measures above the 87% threshhold.

KDADS HCBS Quality Review Report

Level of Care
PM 2: Number and percent of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Numerator: Number of waiver participants who receive their annual Level of Care evaluation within 12 months of the previous Level of Care determination
Denominator: Number of waiver participants who received Level of Care redeterminations
Review Period: 04/01/2020 – 06/30/2020
Data Source: Functional Assessor Record Review/State Data Systems

Compliance By Waiver	Statewide
PD	**71%**
Numerator	940
Denominator	1327
FE	**73%**
Numerator	291
Denominator	400
IDD	**97%**
Numerator	2088
Denominator	2146
BI	**66%**
Numerator	60
Denominator	91
TA	**99%**
Numerator	126
Denominator	127
Autism	**100%**
Numerator	12
Denominator	12
SED	Not a waiver performance measure
Numerator	
Denominator	

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	47%	52%	64%	69%	68%	79%	72%	70%	71%
FE									
Statewide	68%	70%	76%	79%	68%	84%	80%	79%	73%
IDD									
Statewide	97%	74%	75%	77%	78%	97%	98%	99%	97%
BI									
Statewide	39%	50%	62%	65%	62%	70%	70%	64%	66%
TA									
Statewide	94%	90%	86%	96%	93%	99%	100%	99%	99%
Autism									
Statewide	68%	No Data	75%	78%	63%	65%	69%	100%	100%
SED									
Statewide	93%	88%	94%	88%	89%	Not a Measure	Not a Measure	Not a Measure	Not a Measure

Explanation of Findings:

For this Performance Measure, KDADS is utilizing KAMIS assessment data and MMIS eligibility data to determine compliance for five of the waivers. The Autism compliance is determined through a record review.

Explanation of Findings for administrative data pull, PD: FE, BI: The individual has not had a functional assessment within the last 365 calendar days or the individual did not have a functional assessment within 365 days of the previous assessment. Re-assessments that fall between 1/27/2020-1/26/2021 have an exception in place through Appendix K Guidance, which could explain some of the cases considered non-compliant utliizing the data pull.

Remediation:

ADRCs and other assessing entities (KVC, CRN, CDDO and CMHC) have indicated conitinued staff training in their remediation plans. Through these trainings we have identied some improvements in their perfrmmance measures pre COVID-19. With COVID-19 there have been some disruption of adequate assesssment due to the inability of assessors to visit with waiver participants.
KDADS will continue to coordinate with ADRCs and other assessing entities to track why an assessment was not conducted within the 12 months by completing data entry into the KAMIS notes OR by maintaining a spreadsheet. ADRCs and other assessing entities are to provide training within 30 days to remind their assessors of this requirement.

KDADS HCBS Quality Review Report

Level of Care
PM 3: Number and percent of waiver participants whose Level of Care (LOC) determinations used the state's approved screening tool
Numerator: Number of waiver participants whose Level of Care determinations used the approved screening tool
Denominator: Number of waiver participants who had a Level of Care determination
Review Period: 04/01/2020 – 06/30/2020
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**97%**
Numerator	86
Denominator	89
FE	**98%**
Numerator	88
Denominator	90
IDD	**99%**
Numerator	94
Denominator	95
BI	**95%**
Numerator	59
Denominator	62
TA	**98%**
Numerator	58
Denominator	59
Autism	**100%**
Numerator	12
Denominator	12
SED	**95%**
Numerator	83
Denominator	87

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	93%	84%	79%	80%	85%	81%	82%	85%	97%
FE									
Statewide	88%	91%	91%	92%	88%	93%	91%	91%	98%
IDD									
Statewide	97%	95%	99%	99%	99%	99%	99%	100%	99%
BI									
Statewide	64%	81%	79%	77%	82%	85%	89%	91%	95%
TA									
Statewide	93%	98%	100%	100%	98%	100%	100%	98%	98%
Autism									
Statewide	88%	No Data	90%	88%	91%	89%	89%	100%	100%
SED									
Statewide	77%	79%	83%	88%	91%	95%	93%	100%	95%

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation required.

KDADS HCBS Quality Review Report

Level of Care
PM 4: Number and percent of initial Level of Care (LOC) determinations made by a qualified assessor
Numerator: Number of initial Level of Care (LOC) determinations made by a qualified assessor
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2020 – 06/30/2020
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**80%**
Numerator	71
Denominator	89
FE	**91%**
Numerator	82
Denominator	90
IDD	**96%**
Numerator	91
Denominator	95
BI	**79%**
Numerator	49
Denominator	62
TA	**100%**
Numerator	59
Denominator	59
Autism	**92%**
Numerator	11
Denominator	12
SED	**95%**
Numerator	83
Denominator	87

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	19%	68%	81%	80%	84%	81%	81%	84%	80%
FE									
Statewide	24%	86%	91%	92%	88%	92%	91%	91%	91%
IDD									
Statewide	92%	85%	96%	97%	96%	98%	97%	95%	96%
BI									
Statewide	57%	73%	83%	77%	82%	85%	88%	89%	79%
TA									
Statewide	93%	100%	99%	100%	94%	100%	100%	98%	100%
Autism									
Statewide	0%	No Data	57%	68%	85%	89%	89%	100%	92%
SED									
Statewide	99%	71%	88%	86%	90%	94%	93%	100%	95%

Explanation of Findings:

PD: No current assessment (and did not fall within Appendix K assessment exception timeframe)

BI: Assessor not on approved list, no current assessment (and did not fall within Appendix K assessment exception timeframe)

Remediation:

ADRCs and other assessing entities (KVC, CRN, CDDO and CMHC) have indicated conitinued staff training in their remediation plans. Through these trainings we have identied some improvements in their performmance measures pre COVID-19. With COVID-19 there have been some disruption of adequate assesssment due to the inability of assessors to visit with waiver participants.
KDADS will continue to coordinate with ADRCs and other assessing entities to track why an assessment was not conducted within the 12 months by completing data entry into the KAMIS notes OR by maintaining a spreadsheet. ADRCs and other assessing entities are to provide training within 30 days to remind their assessors of this requirement. KDADS will continue to work with these entities to ensure any name change is reflected in the approved

KDADS HCBS Quality Review Report

Level of Care
PM 5: Number and percent of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Numerator: Number of initial Level of Care (LOC) determinations made where the LOC criteria was accurately applied
Denominator: Number of initial Level of Care determinations
Review Period: 04/01/2020 – 06/30/2020
Data Source: Functional Assessor Record Review

Compliance By Waiver	Statewide
PD	**80%**
Numerator	71
Denominator	89
FE	**92%**
Numerator	83
Denominator	90
IDD	**100%**
Numerator	95
Denominator	95
BI	**87%**
Numerator	54
Denominator	62
TA	**100%**
Numerator	59
Denominator	59
Autism	**100%**
Numerator	12
Denominator	12
SED	**95%**
Numerator	83
Denominator	87

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	73%	83%	96%	80%	84%	81%	82%	84%	80%
FE									
Statewide	91%	90%	96%	91%	100%	93%	91%	92%	92%
IDD									
Statewide	98%	95%	91%	98%	100%	98%	99%	100%	100%
BI									
Statewide	58%	81%	83%	76%	96%	85%	89%	91%	87%
TA									
Statewide	93%	98%	100%	100%	100%	100%	100%	98%	100%
Autism									
Statewide	89%	No Data	100%	88%	88%	89%	89%	100%	100%
SED									
Statewide	99%	88%	87%	89%	92%	95%	93%	100%	95%

Explanation of Findings:

PD: No current assessment (and did not fall within Appendix K assessment exception timeframe)

Remediation:

ADRCs and other assessing entities (KVC, CRN, CDDO and CMHC) have indicated conitinued staff training in their remediation plans. Through these trainings we have identied some improvements in their performmance measures pre COVID-19. With COVID-19 there have been some disruption of adequate assesssment due to the inability of assessors to visit with waiver participants.
KDADS will continue to coordinate with ADRCs and other assessing entities to track why an assessment was not conducted within the 12 months by completing data entry into the KAMIS notes OR by maintaining a spreadsheet. ADRCs and other assessing entities are to provide training within 30 days to remind their assessors of this requirement.

KDADS HCBS Quality Review Report

Level of Care
PM 6: Number and percent of third party contractor level of care (LOC) determinations found to be valid
Numerator: Number of LOC assessments found valid by a third party contractor
Denominator: Total number of LOC assessments completed by a third party contractor
Review Period: 04/01/2020 – 06/30/2020
Data Source:

Compliance By Waiver	Statewide
PD	Not a Waiver
Numerator	Performance
Denominator	Measure
FE	Not a Waiver
Numerator	Performance
Denominator	Measure
IDD	Not a Waiver
Numerator	Performance
Denominator	Measure
BI	Not a Waiver
Numerator	Performance
Denominator	Measure
TA	Not a Waiver
Numerator	Performance
Denominator	Measure
Autism	Not a Waiver
Numerator	Performance
Denominator	Measure
SED	**100%**
Numerator	23
Denominator	23

Compliance Trends	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD					
	Not a Waiver Performance Measure				
FE					
	Not a Waiver Performance Measure				
IDD					
	Not a Waiver Performance Measure				
BI					
	Not a Waiver Performance Measure				
TA					
	Not a Waiver Performance Measure				
Autism					
	Not a Waiver Performance Measure				
SED					
Statewide	No Data	No Data	91%	100%	100%

Explanation of Findings:

Performance measure achieved. Prior to 2019, the State did not have processes in place to collect data for this performance measure.

Remediation:

No remediation required.

KDADS HCBS Quality Review Report

Qualified Providers
PM 1: Number and percent of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Numerator: Number of new licensed/certified waiver provider applicants that initially met licensure requirements, certification requirements, and other waiver standards prior to furnishing waiver services
Denominator: Number of all new licensed/certified waiver providers
Review Period: 04/01/2020 – 06/30/2020
Data Source:

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

Explanation of Findings:

Coordinated work effort continues to be completed during this time period to develop formalized process for auditing provider qualifications, with assistance from KDHE, KDADS and the MCO's.

Remediation:

Each MCO has a process for credentialing newly enrolled providers. In 2020, MCO's are to launch their process to monitor continued compliance with licensure, certification and training of providers. MCO's have hired a third party to monitor continued compliance with licensure, certification and training of providers.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	100%			N/A					
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	5%	No Data	No Data	No Data	No Data	No Data
Sunflower				30%					
United				N/A					
Statewide	100%			9%					
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	98%			N/A					
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	91%			N/A					
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	93%			N/A					
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	100%			N/A					
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	100%			N/A					

KDADS HCBS Quality Review Report

Qualified Providers
PM 2: Number and percent of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Numerator: Number of enrolled licensed/certified waiver providers that continue to meet licensure requirements, certification requirements, and other waiver standards
Denominator: Number of enrolled licensed/certified waiver providers
Review Period: 04/01/2020 – 06/30/2020
Data Source:

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

Explanation of Findings:

Coordinated work effort continues to be completed during this time period to develop formalized process for auditing provider qualifications, with assistance from KDHE, KDADS and the MCO's.

Remediation:

Each MCO has a process for credentialing newly enrolled providers. In 2020, MCO's are to launch their process to monitor continued compliance with licensure, certification and training of providers. MCO's have hired a third party to monitor continued compliance with licensure, certification and training of providers.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	100%			0%					
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	12%	No Data	No Data	No Data	No Data	No Data
Sunflower				23%					
United				0%					
Statewide	Not a Measure			11%					
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	98%			0%					
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	89%			0%					
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	93%			0%					
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	14%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	100%			4%					
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	100%			0%					

KDADS HCBS Quality Review Report

Qualified Providers
PM 3: Number and percent of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Numerator: Number of new non-licensed/non-certified waiver provider applicants that have met the initial waiver requirements prior to furnishing waiver services
Denominator: Number of all new non-licensed/non-certified providers
Review Period: 04/01/2020 – 06/30/2020
Data Source:

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

Explanation of Findings:

Coordinated work effort continues to be completed during this time period to develop formalized process for auditing provider qualifications, with assistance from KDHE, KDADS and the MCO's.

Remediation:

Each MCO has a process for credentialing newly enrolled providers. In 2020, MCO's are to launch their process to monitor continued compliance with licensure, certification and training of providers. MCO's have hired a third party to monitor continued compliance with licensure, certification and training of providers.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	75%			N/A					
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	100%			N/A					
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	Not a Measure			N/A					
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	88%			N/A					
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	No Data			N/A					
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	82%			N/A					
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	Not a measure			N/A					

KDADS HCBS Quality Review Report

Qualified Providers
PM 4: Number and percent of enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Numerator: Number enrolled non-licensed/non-certified waiver providers that continue to meet waiver requirements
Denominator: Number of enrolled non-licensed/non-certified providers
Review Period: 04/01/2020 – 06/30/2020
Data Source:

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

Explanation of Findings:

Coordinated work effort continues to be completed during this time period to develop formalized process for auditing provider qualifications, with assistance from KDHE, KDADS and the MCO's.

Remediation:

Each MCO has a process for credentialing newly enrolled providers. In 2020, MCO's are to launch their process to monitor continued compliance with licensure, certification and training of providers. MCO's have hired a third party to monitor continued compliance with licensure, certification and training of providers.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	3%	No Data	No Data	No Data	No Data	No Data
Sunflower				1%					
United				0%					
Statewide	75%			1%					
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	Not a Measure			0%					
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
Sunflower				8%					
United				0%					
Statewide	Not a Measure			2%					
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	8%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	88%			3%					
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	13%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	No Data			4%					
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	8%	No Data	No Data	No Data	No Data	No Data
Sunflower				0%					
United				0%					
Statewide	91%			2%					
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		No Data	No Data	N/A	No Data	No Data	No Data	No Data	No Data
Sunflower				N/A					
United				N/A					
Statewide	89%			N/A					

KDADS HCBS Quality Review Report

Qualified Providers
PM 5: Number and percent of active providers that meet training requirements
Numerator: Number of providers that meet training requirements
Denominator: Number of active providers
Review Period: 04/01/2020 – 06/30/2020
Data Source:

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

Explanation of Findings:

Coordinated work effort continues to be completed during this time period to develop formalized process for auditing provider qualifications, with assistance from KDHE, KDADS and the MCO's.

Remediation:

Each MCO has a process for credentialing newly enrolled providers. In 2020, MCO's are to launch their process to monitor continued compliance with licensure, certification and training of providers. MCO's have hired a third party to monitor continued compliance with licensure, certification and training of providers.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	No Data			0%					
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	No Data			0%					
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	99%			0%					
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	No Data			0%					
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	No Data			0%					
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				20%					
Sunflower		No Data	No Data	36%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	No Data			11%					
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup				0%					
Sunflower		No Data	No Data	0%	No Data	No Data	No Data	No Data	No Data
United				0%					
Statewide	88%			0%					

KDADS HCBS Quality Review Report

Service Plan
PM 1: Number and percent of waiver participants whose service plans address participants' goals
Numerator: Number of waiver participants whose service plans address participants' goals
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**58%**	**47%**	**67%**	**57%**
Numerator	15	15	22	52
Denominator	26	32	33	91
FE	**35%**	**64%**	**38%**	**47%**
Numerator	7	21	15	43
Denominator	20	33	39	92
IDD	**81%**	**35%**	**21%**	**38%**
Numerator	13	18	6	37
Denominator	16	52	29	97
BI	**47%**	**35%**	**43%**	**42%**
Numerator	9	7	9	25
Denominator	19	20	21	60
TA	**71%**	**59%**	**38%**	**53%**
Numerator	10	13	9	32
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: No valid signature and/or date, document containing goals not provided or does not cover entire review period

FE: No valid signature and/or date, document containing goals not provided or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, document containing goals not provided or does not cover entire review period, DPOA paperwork not provided for validation

BI:No valid signature and/or date, document containing goals not provided or does not cover entire review period

TA:No valid signature and/or date, document containing goals not provided or does not cover entire review period, DPOA paperwork not provided for validation

AU:Document not provided for review

SED: No valid signature and/or date, document containing goals not provided or does not cover entire review period

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	68%	58%	58%
Amerigroup		55%	33%	63%	79%	86%	N/A	N/A	N/A
Sunflower		57%	64%	59%	81%	78%	86%	84%	47%
United		33%	49%	86%	85%	85%	76%	76%	67%
Statewide	55%	50%	48%	69%	81%	83%	78%	74%	57%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	75%	50%	35%
Amerigroup		50%	42%	54%	70%	75%	N/A	N/A	N/A
Sunflower		56%	51%	75%	79%	73%	86%	69%	64%
United		45%	56%	81%	90%	87%	71%	62%	38%
Statewide	Not a Measure	50%	49%	70%	80%	79%	78%	62%	47%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	60%	42%	81%
Amerigroup		36%	32%	53%	76%	83%	N/A	N/A	N/A
Sunflower		56%	56%	61%	70%	71%	73%	61%	35%
United		52%	41%	73%	85%	85%	58%	32%	21%
Statewide	99%	49%	45%	62%	75%	78%	67%	49%	38%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	43%	42%	47%
Amerigroup		37%	41%	58%	78%	72%	N/A	N/A	N/A
Sunflower		37%	38%	80%	74%	73%	81%	65%	35%
United		22%	55%	78%	79%	87%	75%	48%	43%
Statewide	44%	34%	43%	68%	77%	75%	71%	53%	42%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	78%	69%	71%
Amerigroup		50%	44%	69%	90%	99%	N/A	N/A	N/A
Sunflower		73%	85%	82%	65%	89%	87%	67%	59%
United		64%	32%	70%	95%	70%	87%	63%	38%
Statewide	93%	61%	54%	73%	83%	90%	85%	66%	53%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	50%
Amerigroup		84%	56%	35%	88%	100%	N/A	N/A	N/A
Sunflower		47%	50%	50%	30%	33%	62%	100%	100%
United		63%	36%	17%	13%	41%	65%	25%	50%
Statewide	58%	69%	49%	37%	42%	52%	56%	43%	60%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	96%	95%	13%
Amerigroup		91%	99%	98%	99%	96%	N/A	N/A	N/A
Sunflower		92%	95%	87%	98%	96%	95%	93%	22%
United		89%	100%	98%	88%	97%	98%	100%	27%
Statewide	98%	90%	98%	95%	95%	97%	97%	97%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 2: Number and percent of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Numerator: Number of waiver participants whose service plans address their assessed needs and capabilities as indicated in the assessment
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**63%**	**58%**	**55%**
Numerator	11	20	19	50
Denominator	26	32	33	91
FE	**30%**	**67%**	**59%**	**55%**
Numerator	6	22	23	51
Denominator	20	33	39	92
IDD	**75%**	**60%**	**48%**	**59%**
Numerator	12	31	14	57
Denominator	16	52	29	97
BI	**32%**	**30%**	**33%**	**32%**
Numerator	6	6	7	19
Denominator	19	20	21	60
TA	**57%**	**55%**	**25%**	**43%**
Numerator	8	12	6	26
Denominator	14	22	24	60
Autism	**0%**	**100%**	**0%**	**20%**
Numerator	0	1	0	1
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

FE: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation

IDD: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

BI: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date

TA: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

AU: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date

SED: Assessment documents and/or service plan not provided or does not cover

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	66%	50%	42%
Amerigroup		83%	55%	74%	83%	93%	N/A	N/A	N/A
Sunflower		90%	56%	63%	83%	77%	86%	94%	63%
United		89%	68%	92%	87%	94%	88%	71%	58%
Statewide	86%	87%	59%	76%	84%	88%	83%	73%	55%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	71%	33%	30%
Amerigroup		79%	66%	74%	80%	88%	N/A	N/A	N/A
Sunflower		90%	53%	73%	75%	76%	86%	72%	67%
United		88%	68%	84%	88%	90%	88%	77%	59%
Statewide	87%	86%	61%	77%	81%	84%	84%	66%	55%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	51%	42%	75%
Amerigroup		85%	67%	64%	77%	83%	N/A	N/A	N/A
Sunflower		77%	36%	65%	70%	77%	78%	75%	60%
United		72%	47%	78%	91%	90%	78%	57%	48%
Statewide	99%	78%	48%	68%	77%	82%	75%	65%	59%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	38%	33%	32%
Amerigroup		67%	48%	65%	78%	75%	N/A	N/A	N/A
Sunflower		82%	28%	82%	74%	73%	79%	75%	30%
United		70%	62%	80%	79%	84%	82%	52%	33%
Statewide	72%	73%	45%	72%	77%	76%	71%	56%	32%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	69%	57%
Amerigroup		93%	58%	70%	88%	98%	N/A	N/A	N/A
Sunflower		98%	62%	74%	69%	85%	90%	76%	55%
United		97%	58%	79%	92%	84%	91%	75%	25%
Statewide	96%	96%	59%	73%	83%	91%	89%	74%	43%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		81%	59%	33%	88%	82%	N/A	N/A	N/A
Sunflower		50%	45%	47%	15%	28%	31%	50%	100%
United		63%	21%	22%	13%	24%	62%	0%	0%
Statewide	59%	68%	46%	36%	37%	39%	44%	14%	20%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	56%	86%	13%
Amerigroup		91%	99%	98%	99%	96%	N/A	N/A	N/A
Sunflower		91%	92%	87%	93%	88%	83%	93%	22%
United		89%	98%	96%	84%	76%	77%	100%	27%
Statewide	92%	90%	97%	94%	92%	87%	76%	94%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 3: Number and percent of waiver participants whose service plans address health and safety risk factors
Numerator: Number of waiver participants whose service plans address health and safety risk factors
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**63%**	**58%**	**55%**
Numerator	11	20	19	50
Denominator	26	32	33	91
FE	**30%**	**67%**	**59%**	**55%**
Numerator	6	22	23	51
Denominator	20	33	39	92
IDD	**75%**	**60%**	**48%**	**59%**
Numerator	12	31	14	57
Denominator	16	52	29	97
BI	**32%**	**35%**	**33%**	**33%**
Numerator	6	7	7	20
Denominator	19	20	21	60
TA	**57%**	**55%**	**25%**	**43%**
Numerator	8	12	6	26
Denominator	14	22	24	60
Autism	**0%**	**100%**	**0%**	**20%**
Numerator	0	1	0	1
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

FE: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation

IDD: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

BI: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date

TA: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

AU: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date

SED: Assessment documents and/or service plan not provided or does not cover entire review period, no valid signature and/or date

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship.
Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	66%	50%	42%
Amerigroup		90%	44%	73%	81%	94%	N/A	N/A	N/A
Sunflower		89%	49%	67%	85%	75%	86%	94%	63%
United		96%	67%	90%	88%	95%	86%	71%	58%
Statewide	90%	91%	51%	76%	84%	88%	82%	73%	55%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	33%	30%
Amerigroup		92%	55%	75%	82%	89%	N/A	N/A	N/A
Sunflower		92%	50%	73%	77%	74%	86%	72%	67%
United		95%	70%	82%	88%	91%	88%	74%	59%
Statewide	Not a measure	93%	57%	76%	82%	84%	85%	65%	55%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	51%	42%	75%
Amerigroup		90%	61%	67%	75%	83%	N/A	N/A	N/A
Sunflower		97%	36%	65%	73%	78%	77%	75%	60%
United		89%	45%	78%	92%	90%	77%	61%	48%
Statewide	99%	93%	46%	69%	78%	83%	74%	66%	59%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	40%	42%	32%
Amerigroup		79%	45%	64%	80%	79%	N/A	N/A	N/A
Sunflower		91%	26%	84%	70%	74%	79%	75%	35%
United		83%	64%	80%	79%	89%	82%	52%	33%
Statewide	84%	84%	43%	72%	78%	79%	72%	58%	33%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	69%	57%
Amerigroup		96%	49%	73%	89%	98%	N/A	N/A	N/A
Sunflower		95%	61%	76%	66%	85%	90%	76%	55%
United		94%	58%	79%	92%	84%	91%	75%	25%
Statewide	96%	96%	54%	75%	83%	91%	89%	74%	43%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		79%	59%	30%	88%	91%	N/A	N/A	N/A
Sunflower		61%	45%	47%	15%	28%	31%	100%	100%
United		86%	21%	17%	13%	24%	62%	0%	0%
Statewide	64%	74%	46%	34%	37%	41%	44%	29%	20%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	96%	95%	13%
Amerigroup		90%	99%	97%	99%	96%	N/A	N/A	N/A
Sunflower		89%	95%	87%	98%	97%	95%	93%	22%
United		86%	100%	97%	88%	97%	98%	100%	27%
Statewide	99%	88%	98%	94%	95%	97%	97%	97%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 4: Number and percent of waiver participants whose service plans were developed according to the processes in the approved waiver
Numerator: Number of waiver participants whose service plans were developed according to the processes in the approved waiver
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**44%**	**45%**	**44%**
Numerator	11	14	15	40
Denominator	26	32	33	91
FE	**25%**	**58%**	**49%**	**47%**
Numerator	5	19	19	43
Denominator	20	33	39	92
IDD	**75%**	**44%**	**34%**	**46%**
Numerator	12	23	10	45
Denominator	16	52	29	97
BI	**32%**	**20%**	**33%**	**28%**
Numerator	6	4	7	17
Denominator	19	20	21	60
TA	**50%**	**36%**	**13%**	**30%**
Numerator	7	8	3	18
Denominator	14	22	24	60
Autism	**0%**	**100%**	**0%**	**20%**
Numerator	0	1	0	1
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: No valid signature and/or date, documentation containing goals and/or assessment documents not provided or does not cover entire review period, DPOA paperwork not provided for validation

FE: No valid signature and/or date, documentation containing goals and/or assessment documents not provided or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, documentation containing goals and/or assessment documents not provided or does not cover entire review period, DPOA/Guardianship paperwork not provided for validation

BI: No valid signature and/or date, documentation containing goals not provided or does not cover entire review period

TA: No valid signature and/or date, documentation containing goals and/or assessments not provided or does not cover entire review period

AU: Documentation containing goals and/or assessments not provided or does not cover entire review period, no valid signature and/or date

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	58%	50%	42%
Amerigroup		88%	68%	76%	85%	91%	N/A	N/A	N/A
Sunflower		87%	69%	73%	87%	77%	86%	88%	44%
United		85%	77%	92%	88%	94%	82%	68%	45%
Statewide	80%	87%	70%	80%	86%	87%	78%	70%	44%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	69%	39%	25%
Amerigroup		84%	76%	78%	82%	91%	N/A	N/A	N/A
Sunflower		88%	61%	84%	86%	76%	86%	72%	58%
United		86%	79%	87%	90%	90%	81%	51%	49%
Statewide	Not a Measure	86%	71%	83%	86%	85%	81%	56%	47%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	47%	42%	75%
Amerigroup		80%	80%	73%	77%	94%	N/A	N/A	N/A
Sunflower		80%	59%	74%	80%	79%	77%	63%	44%
United		82%	55%	79%	92%	90%	72%	36%	34%
Statewide	98%	81%	64%	75%	82%	83%	71%	52%	46%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	43%	42%	32%
Amerigroup		76%	53%	64%	79%	79%	N/A	N/A	N/A
Sunflower		86%	43%	86%	80%	73%	77%	70%	20%
United		77%	69%	85%	79%	84%	79%	48%	33%
Statewide	64%	80%	53%	74%	80%	78%	71%	55%	28%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	70%	62%	50%
Amerigroup		84%	68%	71%	90%	96%	N/A	N/A	N/A
Sunflower		97%	86%	85%	68%	89%	88%	67%	36%
United		96%	58%	79%	95%	84%	90%	67%	13%
Statewide	No Data	91%	72%	77%	84%	92%	86%	66%	30%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		74%	59%	35%	88%	91%	N/A	N/A	N/A
Sunflower		51%	50%	47%	20%	39%	31%	50%	100%
United		65%	29%	17%	13%	35%	65%	0%	0%
Statewide	55%	65%	49%	36%	38%	50%	47%	14%	20%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	96%	95%	13%
Amerigroup		92%	99%	98%	99%	96%	N/A	N/A	N/A
Sunflower		90%	94%	86%	98%	97%	95%	93%	22%
United		87%	98%	97%	88%	95%	98%	100%	27%
Statewide	Not a measure	90%	97%	94%	95%	96%	97%	97%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 5: Number and percent of waiver participants (or their representatives) who were present and involved in the development of their service plan
Numerator: Number of waiver participants (or their representatives) who were present and involved in the development of their service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**46%**	**63%**	**61%**	**57%**
Numerator	12	20	20	52
Denominator	26	32	33	91
FE	**30%**	**64%**	**62%**	**55%**
Numerator	6	21	24	51
Denominator	20	33	39	92
IDD	**75%**	**60%**	**48%**	**59%**
Numerator	12	31	14	57
Denominator	16	52	29	97
BI	**32%**	**30%**	**38%**	**33%**
Numerator	6	6	8	20
Denominator	19	20	21	60
TA	**50%**	**50%**	**25%**	**40%**
Numerator	7	11	6	24
Denominator	14	22	24	60
Autism	**0%**	**100%**	**50%**	**40%**
Numerator	0	1	1	2
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period, DPOA paperwork not provided for validation

FE: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period, DPOA/Guardianship paperwork not provided for validation

BI: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period

TA: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period

AU: Service plan not provided or does not cover entire review period, no valid signature and/or date

SED: No valid signature and/or date, service plan not provided, is incomplete or does not cover entire review period

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	68%	58%	46%
Amerigroup		88%	70%	79%	87%	97%	N/A	N/A	N/A
Sunflower		87%	70%	74%	88%	80%	86%	94%	63%
United		84%	79%	89%	88%	95%	87%	74%	61%
Statewide	Not a Measure	87%	72%	81%	88%	91%	83%	77%	57%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	46%	44%	30%
Amerigroup		83%	78%	76%	84%	92%	N/A	N/A	N/A
Sunflower		86%	60%	83%	87%	78%	65%	72%	64%
United		87%	83%	88%	91%	92%	66%	77%	62%
Statewide	90%	85%	72%	83%	88%	87%	63%	69%	55%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	53%	42%	75%
Amerigroup		84%	76%	73%	76%	85%	N/A	N/A	N/A
Sunflower		82%	60%	74%	78%	83%	79%	76%	60%
United		88%	51%	79%	93%	90%	78%	57%	48%
Statewide	Not a Measure	84%	63%	75%	81%	85%	76%	66%	59%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	40%	42%	32%
Amerigroup		73%	51%	65%	80%	82%	N/A	N/A	N/A
Sunflower		84%	45%	86%	80%	79%	77%	75%	30%
United		80%	69%	59%	79%	92%	85%	52%	38%
Statewide	Not a Measure	78%	52%	74%	80%	83%	72%	58%	33%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	78%	69%	50%
Amerigroup		83%	75%	71%	90%	99%	N/A	N/A	N/A
Sunflower		97%	86%	84%	68%	89%	90%	81%	50%
United		97%	58%	79%	95%	86%	91%	79%	25%
Statewide	Not a Measure	91%	76%	76%	84%	93%	89%	78%	40%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	17%	0%	0%
Amerigroup		77%	59%	35%	88%	100%	N/A	N/A	N/A
Sunflower		53%	55%	50%	15%	44%	69%	100%	100%
United		71%	36%	17%	6%	47%	65%	0%	50%
Statewide	Not a Measure	69%	52%	37%	35%	59%	60%	29%	40%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	93%	95%	13%
Amerigroup		92%	98%	97%	97%	97%	N/A	N/A	N/A
Sunflower		90%	95%	86%	98%	96%	95%	93%	22%
United		87%	99%	96%	86%	96%	98%	100%	27%
Statewide	93%	90%	98%	94%	93%	97%	96%	97%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 6: Number and percent of service plans reviewed before the waiver participant's annual redetermination date
Numerator: Number of service plans reviewed before the waiver participant's annual redetermination date
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**35%**	**63%**	**70%**	**57%**
Numerator	9	20	23	52
Denominator	26	32	33	91
FE	**65%**	**67%**	**72%**	**68%**
Numerator	13	22	28	63
Denominator	20	33	39	92
IDD	**63%**	**63%**	**48%**	**59%**
Numerator	10	33	14	57
Denominator	16	52	29	97
BI	**74%**	**65%**	**71%**	**70%**
Numerator	14	13	15	42
Denominator	19	20	21	60
TA	**57%**	**59%**	**38%**	**50%**
Numerator	8	13	9	30
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	**65%**	**44%**	**52%**	**52%**
Numerator	15	14	17	46
Denominator	23	32	33	88

Explanation of Findings:

PD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

FE: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA/Guardianship paperwork not provided for validation

BI: No valid signature and/or date, service plan not provided or does not cover entire review period

TA: No valid signature and/or date, service plan not provided or does not cover entire review period

AU: Service plan not provided or does not cover entire review period, no valid signature and/or date

SED: No valid signature and/or date, service plan not provided or does not cover entire

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	84%	63%	35%
Amerigroup		73%	67%	71%	72%	91%	N/A	N/A	N/A
Sunflower		82%	72%	72%	70%	81%	82%	88%	63%
United		92%	73%	83%	76%	89%	88%	76%	70%
Statewide	82%	82%	70%	75%	72%	87%	85%	77%	57%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	50%	65%
Amerigroup		81%	67%	63%	70%	84%	N/A	N/A	N/A
Sunflower		85%	57%	78%	78%	83%	86%	69%	67%
United		90%	69%	84%	91%	91%	86%	79%	72%
Statewide	81%	85%	64%	76%	81%	86%	85%	70%	68%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	42%	63%
Amerigroup		75%	77%	68%	64%	80%	N/A	N/A	N/A
Sunflower		81%	66%	65%	63%	81%	77%	76%	63%
United		91%	48%	54%	86%	84%	75%	43%	48%
Statewide	97%	82%	66%	63%	70%	81%	76%	62%	59%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	50%	74%
Amerigroup		65%	44%	56%	63%	73%	N/A	N/A	N/A
Sunflower		84%	40%	88%	61%	88%	83%	70%	65%
United		77%	65%	70%	65%	84%	88%	78%	71%
Statewide	60%	76%	47%	68%	63%	80%	83%	69%	70%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	92%	69%	57%
Amerigroup		81%	78%	72%	88%	92%	N/A	N/A	N/A
Sunflower		94%	89%	85%	68%	85%	90%	81%	59%
United		96%	59%	70%	91%	93%	96%	67%	38%
Statewide	92%	89%	79%	76%	83%	90%	93%	72%	50%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	50%	0%	50%
Amerigroup		67%	52%	40%	82%	100%	N/A	N/A	N/A
Sunflower		43%	47%	38%	18%	83%	77%	100%	100%
United		33%	38%	7%	20%	59%	73%	25%	50%
Statewide	64%	57%	48%	31%	41%	78%	71%	43%	60%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	83%	95%	65%
Amerigroup		89%	97%	94%	96%	95%	N/A	N/A	N/A
Sunflower		89%	91%	79%	92%	92%	92%	93%	44%
United		83%	99%	85%	77%	97%	95%	100%	52%
Statewide	80%	87%	96%	86%	88%	95%	92%	97%	52%

KDADS HCBS Quality Review Report

Service Plan
PM 7: Number and percent of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Numerator: Number of waiver participants with documented change in needs whose service plan was revised, as needed, to address the change
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**81%**	**97%**	**85%**	**88%**
Numerator	21	31	28	80
Denominator	26	32	33	91
FE	**75%**	**97%**	**92%**	**90%**
Numerator	15	32	36	83
Denominator	20	33	39	92
IDD	**81%**	**92%**	**79%**	**87%**
Numerator	13	48	23	84
Denominator	16	52	29	97
BI	**95%**	**80%**	**100%**	**92%**
Numerator	18	16	21	55
Denominator	19	20	21	60
TA	**86%**	**82%**	**96%**	**88%**
Numerator	12	18	23	53
Denominator	14	22	24	60
Autism	**100%**	**100%**	**100%**	**100%**
Numerator	2	1	2	5
Denominator	2	1	2	5
SED	**100%**	**59%**	**91%**	**82%**
Numerator	23	19	30	72
Denominator	23	32	33	88

Explanation of Findings:

SED: Service plan not provided even though there were documented changes needed to the plan

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	95%	83%	81%
Amerigroup		20%	36%	67%	68%	98%	N/A	N/A	N/A
Sunflower		53%	58%	50%	54%	94%	95%	100%	97%
United		50%	63%	80%	67%	99%	98%	88%	85%
Statewide	75%	39%	53%	65%	62%	97%	96%	91%	88%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	94%	75%
Amerigroup		24%	71%	42%	70%	96%	N/A	N/A	N/A
Sunflower		39%	51%	63%	59%	92%	97%	94%	97%
United		50%	47%	87%	86%	98%	97%	97%	92%
Statewide	78%	38%	54%	65%	67%	96%	98%	96%	90%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	96%	83%	81%
Amerigroup		7%	60%	27%	67%	95%	N/A	N/A	N/A
Sunflower		38%	16%	25%	47%	97%	96%	98%	92%
United		16%	30%	30%	83%	97%	91%	89%	79%
Statewide	97%	23%	28%	28%	60%	96%	94%	93%	87%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	95%	92%	95%
Amerigroup		24%	42%	61%	67%	88%	N/A	N/A	N/A
Sunflower		54%	27%	75%	44%	86%	92%	95%	80%
United		46%	50%	75%	33%	97%	93%	87%	100%
Statewide	53%	38%	38%	67%	57%	89%	93%	91%	92%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	97%	92%	86%
Amerigroup		32%	73%	56%	94%	96%	N/A	N/A	N/A
Sunflower		54%	89%	63%	57%	92%	95%	86%	82%
United		38%	43%	60%	100%	98%	97%	96%	96%
Statewide	92%	42%	75%	60%	83%	95%	96%	91%	88%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup		10%	0%	17%	75%	100%	N/A	N/A	N/A
Sunflower		17%	25%	50%	14%	94%	85%	100%	100%
United		0%	0%	9%	0%	82%	96%	100%	100%
Statewide	45%	11%	11%	16%	22%	91%	93%	100%	100%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	95%	100%
Amerigroup		90%	90%	97%	97%	96%	N/A	N/A	N/A
Sunflower		83%	79%	68%	88%	91%	92%	93%	59%
United		84%	93%	83%	67%	96%	95%	100%	91%
Statewide	85%	86%	88%	83%	83%	93%	92%	97%	82%

KDADS HCBS Quality Review Report

Service Plan
PM 8: Number and percent of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Numerator: Number of waiver participants who received services in the type, scope, amount, duration, and frequency specified in the service plan
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**42%**	**63%**	**58%**	**55%**
Numerator	11	20	19	50
Denominator	26	32	33	91
FE	**30%**	**64%**	**59%**	**54%**
Numerator	6	21	23	50
Denominator	20	33	39	92
IDD	**69%**	**60%**	**48%**	**58%**
Numerator	11	31	14	56
Denominator	16	52	29	97
BI	**32%**	**25%**	**33%**	**30%**
Numerator	6	5	7	18
Denominator	19	20	21	60
TA	**50%**	**50%**	**25%**	**40%**
Numerator	7	11	6	24
Denominator	14	22	24	60
Autism	**0%**	**0%**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	2	1	2	5
SED	**13%**	**22%**	**27%**	**22%**
Numerator	3	7	9	19
Denominator	23	32	33	88

Explanation of Findings:

PD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

FE: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA/Guardianship paperwork not provided for validation

BI: No valid signature and/or date, service plan not provided or does not cover entire review period

TA: No valid signature and/or date, service plan not provided or does not cover entire review period

AU: Service plan not provided or does not cover entire review period, no valid signature and/or date, individual not recieving services

SED: No valid signature and/or date, service plan not provided or does not cover

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	68%	50%	42%
Amerigroup		94%	69%	79%	83%	93%	N/A	N/A	N/A
Sunflower		96%	72%	76%	88%	80%	86%	94%	63%
United		96%	78%	91%	87%	93%	88%	71%	58%
Statewide	85%	95%	72%	81%	86%	88%	83%	73%	55%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	71%	44%	30%
Amerigroup		83%	76%	75%	81%	86%	N/A	N/A	N/A
Sunflower		96%	64%	86%	87%	77%	88%	72%	64%
United		96%	79%	89%	88%	92%	89%	74%	59%
Statewide	87%	92%	72%	83%	86%	85%	86%	67%	54%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	51%	42%	69%
Amerigroup		78%	84%	73%	75%	82%	N/A	N/A	N/A
Sunflower		97%	62%	77%	80%	82%	79%	76%	60%
United		100%	59%	81%	90%	89%	77%	57%	48%
Statewide	98%	92%	68%	77%	81%	84%	75%	66%	58%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	43%	33%	32%
Amerigroup		81%	55%	63%	77%	73%	N/A	N/A	N/A
Sunflower		95%	46%	84%	76%	76%	74%	70%	25%
United		85%	71%	83%	76%	82%	81%	52%	33%
Statewide	70%	87%	56%	72%	77%	75%	70%	55%	30%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	62%	50%
Amerigroup		98%	73%	79%	88%	98%	N/A	N/A	N/A
Sunflower		100%	86%	82%	68%	87%	89%	81%	50%
United		96%	58%	82%	92%	86%	92%	79%	25%
Statewide	100%	98%	74%	80%	83%	93%	89%	76%	40%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		89%	59%	37%	88%	91%	N/A	N/A	N/A
Sunflower		100%	55%	50%	15%	28%	23%	50%	0%
United		50%	21%	17%	13%	41%	58%	0%	0%
Statewide	50%	86%	49%	38%	37%	48%	40%	14%	0%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	96%	95%	13%
Amerigroup		91%	99%	95%	99%	96%	N/A	N/A	N/A
Sunflower		96%	94%	84%	98%	98%	95%	93%	22%
United		92%	99%	91%	86%	96%	98%	100%	27%
Statewide	13%	93%	98%	90%	94%	97%	97%	97%	22%

KDADS HCBS Quality Review Report

Service Plan
PM 9: Number and percent of survey respondents who reported receiving all services as specified in their service plan
Numerator: Number of survey respondents who reported receiving all services as specified in their service plan
Denominator: Number of waiver participants interviewed by QMS staff
Review Period: 04/01/2020 – 06/30/2020
Data Source: Customer Interview

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
FE	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
IDD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	Not a waiver performance measure			
Numerator				
Denominator				

Explanation of Findings:

During the Public Health Emergency, State staff are working remotely and do not have access to issue survey letters. KDADS anticipates being able to report data on this measure during the October-December 2020 review period.

Remediation:

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	93%	N/A	N/A
Amerigroup		97%			94%	94%	N/A	N/A	N/A
Sunflower		92%			97%	98%	94%	N/A	N/A
United		93%			91%	98%	91%	N/A	N/A
Statewide	Not a Measure	94%	No Data	No Data	94%	97%	93%	N/A	N/A
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A
Amerigroup		85%			97%	96%	N/A	N/A	N/A
Sunflower		86%			93%	95%	96%	N/A	N/A
United		82%			91%	94%	94%	N/A	N/A
Statewide	87%	84%	No Data	No Data	94%	95%	96%	N/A	N/A
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A
Amerigroup		92%			93%	100%	N/A	N/A	N/A
Sunflower		96%			99%	97%	96%	N/A	N/A
United		93%			92%	100%	95%	N/A	N/A
Statewide	Not a Measure	94%	No Data	No Data	96%	98%	96%	N/A	N/A
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	N/A	N/A
Amerigroup		81%			81%	87%	N/A	N/A	N/A
Sunflower		88%			79%	78%	95%	N/A	N/A
United		83%			76%	92%	92%	N/A	N/A
Statewide	Not a Measure	83%	No Data	No Data	80%	85%	95%	N/A	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	60%	N/A	N/A
Amerigroup		89%			96%	98%	N/A	N/A	N/A
Sunflower		84%			94%	95%	100%	N/A	N/A
United		85%			94%	100%	93%	N/A	N/A
Statewide	Not a Measure	87%	No Data	No Data	95%	98%	92%	N/A	N/A
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup		74%			89%	67%	N/A	N/A	N/A
Sunflower		70%			50%	88%	67%	N/A	N/A
United		60%			75%	50%	73%	N/A	N/A
Statewide	Not a Measure	71%	No Data	No Data	68%	68%	71%	N/A	N/A
SED	Not a Waiver Performance Measure								
Aetna									
Amerigroup									
Sunflower									
United									
Statewide									

KDADS HCBS Quality Review Report

Service Plan
PM 10: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver service providers
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver service providers
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**54%**	**66%**	**76%**	**66%**
Numerator	14	21	25	60
Denominator	26	32	33	91
FE	**35%**	**67%**	**74%**	**63%**
Numerator	7	22	29	58
Denominator	20	33	39	92
IDD	**81%**	**60%**	**59%**	**63%**
Numerator	13	31	17	61
Denominator	16	52	29	97
BI	**37%**	**35%**	**43%**	**38%**
Numerator	7	7	9	23
Denominator	19	20	21	60
TA	**71%**	**73%**	**33%**	**57%**
Numerator	10	16	8	34
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	**96%**	**75%**	**97%**	**89%**
Numerator	22	24	32	78
Denominator	23	32	33	88

Explanation of Findings:

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

FE: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation, missing documentation of choice

IDD: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation, missing documentation of choice

BI: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date

TA: Service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans.
Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	64%	58%	54%
Amerigroup		68%	56%	68%	80%	97%	N/A	N/A	N/A
Sunflower		58%	69%	73%	85%	80%	86%	94%	66%
United		69%	73%	89%	87%	94%	88%	74%	76%
Statewide	52%	65%	65%	76%	84%	90%	82%	77%	66%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	44%	35%
Amerigroup		68%	59%	64%	82%	92%	N/A	N/A	N/A
Sunflower		76%	59%	82%	86%	77%	88%	75%	67%
United		77%	75%	85%	91%	93%	88%	79%	74%
Statewide	56%	74%	63%	77%	86%	87%	86%	71%	63%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	51%	42%	81%
Amerigroup		51%	45%	68%	74%	84%	N/A	N/A	N/A
Sunflower		68%	42%	69%	71%	79%	77%	80%	60%
United		75%	55%	76%	91%	89%	80%	64%	59%
Statewide	99%	64%	46%	70%	77%	83%	75%	70%	63%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	38%	42%	37%
Amerigroup		54%	50%	53%	76%	82%	N/A	N/A	N/A
Sunflower		75%	40%	86%	80%	80%	82%	80%	35%
United		70%	74%	83%	79%	92%	84%	52%	43%
Statewide	44%	65%	52%	67%	78%	83%	73%	60%	38%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	76%	77%	71%
Amerigroup		87%	65%	68%	85%	96%	N/A	N/A	N/A
Sunflower		84%	80%	77%	66%	89%	90%	86%	73%
United		92%	58%	79%	95%	86%	91%	88%	33%
Statewide	96%	86%	68%	72%	81%	92%	88%	84%	57%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	17%	0%	50%
Amerigroup		67%	67%	47%	88%	100%	N/A	N/A	N/A
Sunflower		44%	45%	50%	40%	50%	69%	100%	100%
United		88%	21%	17%	19%	29%	65%	0%	50%
Statewide	40%	63%	49%	42%	48%	54%	60%	29%	60%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	91%	95%	96%
Amerigroup		94%	91%	98%	99%	97%	N/A	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	93%	97%	75%
United		84%	97%	88%	88%	97%	95%	100%	97%
Statewide	98%	89%	88%	90%	94%	94%	94%	98%	89%

KDADS HCBS Quality Review Report

Service Plan
PM 11: Number and percent of waiver participants whose record contains documentation indicating a choice of waiver services
Numerator: Number of waiver participants whose record contains documentation indicating a choice of waiver services
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**54%**	**66%**	**76%**	**66%**
Numerator	14	21	25	60
Denominator	26	32	33	91
FE	**35%**	**67%**	**74%**	**63%**
Numerator	7	22	29	58
Denominator	20	33	39	92
IDD	**81%**	**60%**	**59%**	**63%**
Numerator	13	31	17	61
Denominator	16	52	29	97
BI	**37%**	**35%**	**43%**	**38%**
Numerator	7	7	9	23
Denominator	19	20	21	60
TA	**71%**	**73%**	**33%**	**57%**
Numerator	10	16	8	34
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	**96%**	**75%**	**97%**	**89%**
Numerator	22	24	32	78
Denominator	23	32	33	88

Explanation of Findings:

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

FE: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation, missing documentation of choice

IDD: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation, missing documentation of choice

BI: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date

TA: Service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	59%	58%	54%
Amerigroup		68%	53%	62%	79%	96%	N/A	N/A	N/A
Sunflower		72%	50%	71%	36%	74%	86%	94%	66%
United		77%	73%	84%	78%	94%	88%	74%	76%
Statewide	64%	72%	57%	72%	64%	88%	81%	77%	66%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	44%	35%
Amerigroup		67%	57%	67%	80%	92%	N/A	N/A	N/A
Sunflower		86%	47%	82%	35%	74%	88%	75%	67%
United		85%	74%	84%	80%	92%	88%	77%	74%
Statewide	59%	80%	57%	78%	63%	86%	86%	70%	63%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	49%	42%	81%
Amerigroup		55%	46%	70%	71%	85%	N/A	N/A	N/A
Sunflower		68%	35%	69%	34%	79%	78%	80%	60%
United		77%	50%	74%	89%	88%	80%	64%	59%
Statewide	No Data	66%	42%	71%	58%	83%	75%	70%	63%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	38%	42%	37%
Amerigroup		56%	50%	52%	74%	82%	N/A	N/A	N/A
Sunflower		80%	23%	86%	28%	79%	82%	80%	35%
United		74%	67%	80%	76%	92%	85%	52%	43%
Statewide	53%	68%	45%	66%	63%	83%	74%	60%	38%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	73%	77%	71%
Amerigroup		86%	65%	71%	86%	99%	N/A	N/A	N/A
Sunflower		97%	53%	79%	29%	86%	90%	86%	73%
United		94%	55%	64%	82%	86%	91%	88%	33%
Statewide	96%	91%	60%	72%	68%	93%	88%	84%	57%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	17%	0%	50%
Amerigroup		79%	52%	47%	88%	100%	N/A	N/A	N/A
Sunflower		50%	27%	61%	20%	56%	69%	100%	100%
United		88%	14%	17%	13%	41%	65%	0%	50%
Statewide	55%	72%	35%	46%	38%	61%	60%	29%	60%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	91%	95%	96%
Amerigroup		94%	92%	98%	99%	97%	N/A	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	93%	97%	75%
United		84%	97%	88%	87%	97%	95%	100%	97%
Statewide	98%	89%	88%	90%	93%	94%	94%	98%	89%

KDADS HCBS Quality Review Report

Service Plan
PM 12: Number and percent of waiver participants whose record contains documentation indicating a choice of community-based services v. an institutional alternative
Numerator: Number of waiver participants whose record contains documentation indicating a choice of community-based services
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**12%**	**66%**	**76%**	**54%**
Numerator	3	21	25	49
Denominator	26	32	33	91
FE	**15%**	**67%**	**74%**	**59%**
Numerator	3	22	29	54
Denominator	20	33	39	92
IDD	**25%**	**60%**	**59%**	**54%**
Numerator	4	31	17	52
Denominator	16	52	29	97
BI	**11%**	**35%**	**43%**	**30%**
Numerator	2	7	9	18
Denominator	19	20	21	60
TA	**29%**	**73%**	**33%**	**47%**
Numerator	4	16	8	28
Denominator	14	22	24	60
Autism	**0%**	**100%**	**50%**	**40%**
Numerator	0	1	1	2
Denominator	2	1	2	5
SED	**96%**	**75%**	**97%**	**89%**
Numerator	22	24	32	78
Denominator	23	32	33	88

Explanation of Findings:

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

FE: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation, missing documentation of choice

IDD: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation, missing documentation of choice

BI: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date

TA: Service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

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

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	7%	0%	12%
Amerigroup		76%	57%	67%	81%	98%	N/A	N/A	N/A
Sunflower		74%	67%	73%	87%	80%	86%	94%	66%
United		80%	78%	88%	87%	95%	88%	74%	76%
Statewide	Not a Measure	76%	66%	75%	85%	91%	70%	61%	54%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	8%	11%	15%
Amerigroup		67%	58%	72%	81%	92%	N/A	N/A	N/A
Sunflower		87%	56%	82%	86%	77%	88%	75%	67%
United		85%	79%	84%	91%	93%	88%	35%	74%
Statewide	65%	80%	63%	79%	86%	87%	76%	64%	59%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	7%	8%	25%
Amerigroup		47%	47%	66%	73%	87%	N/A	N/A	N/A
Sunflower		69%	41%	68%	74%	80%	78%	80%	60%
United		78%	57%	79%	92%	88%	79%	64%	59%
Statewide	No Data	64%	46%	70%	78%	84%	69%	66%	54%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	11%
Amerigroup		55%	51%	54%	78%	84%	N/A	N/A	N/A
Sunflower		79%	40%	86%	78%	79%	82%	80%	35%
United		73%	74%	83%	79%	92%	84%	52%	43%
Statewide	No Data	67%	52%	68%	78%	84%	65%	51%	30%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	16%	0%	29%
Amerigroup		87%	65%	69%	85%	99%	N/A	N/A	N/A
Sunflower		98%	80%	81%	68%	89%	89%	86%	73%
United		94%	55%	79%	95%	86%	91%	83%	33%
Statewide	No Data	92%	68%	74%	81%	93%	78%	66%	47%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		86%	67%	65%	94%	100%	N/A	N/A	N/A
Sunflower		47%	59%	67%	70%	61%	69%	100%	100%
United		75%	43%	33%	38%	35%	69%	0%	50%
Statewide	No Data	72%	59%	60%	67%	61%	60%	29%	40%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	91%	95%	96%
Amerigroup		94%	92%	98%	99%	97%	N/A	N/A	N/A
Sunflower		91%	72%	84%	94%	87%	93%	97%	75%
United		85%	98%	88%	87%	97%	95%	100%	97%
Statewide	99%	90%	89%	91%	93%	94%	94%	98%	89%

KDADS HCBS Quality Review Report

Service Plan
PM 13: Number and percent of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Numerator: Number of waiver participants whose record contains documentation indicating a choice of either self-directed or agency-directed care
Denominator: Number of waiver participants whose files are reviewed for the documentation
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**15%**	**66%**	**76%**	**55%**
Numerator	4	21	25	50
Denominator	26	32	33	91
FE	**15%**	**67%**	**72%**	**58%**
Numerator	3	22	28	53
Denominator	20	33	39	92
IDD	**25%**	**58%**	**59%**	**53%**
Numerator	4	30	17	51
Denominator	16	52	29	97
BI	**11%**	**35%**	**43%**	**30%**
Numerator	2	7	9	18
Denominator	19	20	21	60
TA	**29%**	**73%**	**33%**	**47%**
Numerator	4	16	8	28
Denominator	14	22	24	60
Autism	Self-Direction is not offered for this Waiver			
Numerator				
Denominator				
SED	Self-Direction is not offered for this Waiver			
Numerator				
Denominator				

Explanation of Findings:

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

FE: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation, missing documentation of choice

IDD: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation, missing documentation of choice

BI: Service plan not provided, is incomplete or does not cover entire review period, no valid signature and/or date

TA: Service plan not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	12%	8%	15%
Amerigroup		64%	58%	72%	81%	92%	N/A	N/A	N/A
Sunflower		73%	68%	72%	87%	79%	84%	94%	66%
United		77%	78%	88%	86%	95%	88%	74%	76%
Statewide	Not a Measure	71%	66%	77%	84%	89%	70%	63%	55%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	10%	0%	15%
Amerigroup		64%	59%	73%	79%	88%	N/A	N/A	N/A
Sunflower		84%	59%	81%	87%	74%	87%	75%	67%
United		77%	79%	85%	88%	93%	88%	79%	72%
Statewide	65%	75%	64%	79%	85%	85%	76%	62%	58%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	7%	8%	25%
Amerigroup		34%	47%	64%	68%	84%	N/A	N/A	N/A
Sunflower		61%	39%	60%	65%	77%	75%	80%	58%
United		77%	57%	73%	93%	89%	79%	64%	59%
Statewide	No Data	53%	46%	64%	73%	82%	68%	66%	53%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	5%	0%	11%
Amerigroup		50%	50%	56%	73%	80%	N/A	N/A	N/A
Sunflower		85%	43%	82%	78%	79%	81%	80%	35%
United		70%	74%	83%	79%	89%	84%	52%	43%
Statewide	No Data	66%	52%	68%	75%	81%	66%	51%	30%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	19%	0%	29%
Amerigroup		82%	56%	66%	84%	99%	N/A	N/A	N/A
Sunflower		98%	82%	79%	68%	89%	89%	86%	73%
United		100%	58%	79%	95%	84%	91%	88%	33%
Statewide	No Data	90%	64%	72%	81%	93%	78%	67%	47%
Autism	Self-Direction is not offered for this Waiver								
Aetna									
Amerigroup									
Sunflower									
United									
Statewide									
SED	Self-Direction is not offered for this Waiver								
Aetna									
Amerigroup									
Sunflower									
United									
Statewide									

KDADS HCBS Quality Review Report

Service Plan
PM 14: Number and percent of service plans reviewed at least every 90 days
Numerator: Number of service plans reviewed at least every 90 days
Denominator: Number of waiver participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	Not a Waiver Performance Measure			
Numerator				
Denominator				
FE	Not a Waiver Performance Measure			
Numerator				
Denominator				
IDD	Not a Waiver Performance Measure			
Numerator				
Denominator				
BI	Not a Waiver Performance Measure			
Numerator				
Denominator				
TA	Not a Waiver Performance Measure			
Numerator				
Denominator				
Autism	Not a Waiver Performance Measure			
Numerator				
Denominator				
SED	**22%**	**31%**	**27%**	**27%**
Numerator	5	10	9	24
Denominator	23	32	33	88

Compliance Trends	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD					
	Not a Waiver Performance Measure				
FE					
	Not a Waiver Performance Measure				
IDD					
	Not a Waiver Performance Measure				
BI					
	Not a Waiver Performance Measure				
TA					
	Not a Waiver Performance Measure				
Autism					
	Not a Waiver Performance Measure				
SED					
Aetna	N/A	N/A	80%	95%	22%
Amerigroup	99%	92%	N/A	N/A	N/A
Sunflower	88%	90%	88%	86%	31%
United	83%	94%	94%	95%	27%
Statewide	91%	92%	89%	92%	27%

Explanation of Findings:

SED: No valid signature and/or date, service plan not provided or does not cover entire review period

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

KDADS HCBS Quality Review Report

Health and Welfare
PM 1: Number and percent of unexpected deaths for which review/investigation resulted in the identification of preventable causes
Numerator: Number of unexpected deaths for which review/investigation resulted in the identification of non-preventable causes
Denominator: Number of unexpected deaths
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**83%**	**67%**	**78%**
Numerator	0	5	2	7
Denominator	0	6	3	9
FE	**N/A**	**100%**	**100%**	**100%**
Numerator	0	5	2	7
Denominator	0	5	2	7
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	3	11	3	17
Denominator	3	11	3	17
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

SUNFLOWER: MCO review and investigation concluded that the death ocurred due to preventable causes. Evidence provided allowed KDADS to verify findings. The individual had recently been hospitlized and left AMA prior to death. The MCO provided sufficient information to confirm findings that lead to the determination of preventable causes.

UHC: MCO review/investigation followed appropriate policies and procedures to identify preventable causes for a reported death that was also determined to be unexpected. Sufficient infromation was provided for KDADS to confirm findings.

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

Remediation:

SUNFLOWER: No remediation required, MCO review/investigation folllowed appropriate policy and procedure, no quality of care concerns identified, no further action necessary.

UHC: Individual was out of state and not receiving HCBS services, no quality of care concerns identified. Provider/staff not involved with incident, no further action necessary.

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							90%	100%	83%
United							100%	100%	67%
Statewide							92%	100%	78%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	N/A	100%
United							75%	N/A	100%
Statewide							96%	N/A	100%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							98%	100%	100%
United							93%	100%	100%
Statewide							97%	100%	100%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	N/A
United							N/A	N/A	N/A
Statewide							100%	100%	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	N/A	N/A
United							N/A	N/A	N/A
Statewide							100%	N/A	N/A
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 2: Number and percent of unexpected deaths for which review/investigation followed the appropriate policies and procedures
Numerator: Number of unexpected deaths for which review/investigation followed the appropriate policies and procedures as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**100%**	**100%**	**100%**
Numerator	0	6	3	9
Denominator	0	6	3	9
FE	**N/A**	**100%**	**100%**	**100%**
Numerator	0	5	2	7
Denominator	0	5	2	7
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	3	11	3	17
Denominator	3	11	3	17
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

All reported incdients of death during this timeframe, particularly those that were concluded as unexpected, it is confirmed that review and investigation followed appropriate policies and procedures. No Corrective Action Plans, or requests for additional information were needed during this timeframe.

Documenation of review and investigation was sufficient to confirm resolution of all reported

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

Remediation:

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							83%	100%	100%
United							100%	100%	100%
Statewide							88%	100%	100%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							89%	N/A	100%
United							75%	N/A	100%
Statewide							87%	N/A	100%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							92%	100%	100%
United							87%	100%	100%
Statewide							92%	100%	100%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	N/A
United							N/A	N/A	N/A
Statewide							100%	100%	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	N/A	N/A
United							N/A	N/A	N/A
Statewide							100%	N/A	N/A
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 3: Number and percent of unexpected deaths for which the appropriate follow-up measures were taken
Numerator: Number of unexpected deaths for which the appropriate follow-up measures were taken as in the approved waiver
Denominator: Number of unexpected deaths
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**100%**	**100%**	**100%**
Numerator	0	6	3	9
Denominator	0	6	3	9
FE	**N/A**	**100%**	**100%**	**100%**
Numerator	0	5	2	7
Denominator	0	5	2	7
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	3	11	3	17
Denominator	3	11	3	17
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

All reported incdients of death during this timeframe, particularly those that were concluded as unexpected review/investigation followed appropriate policies and procedures. No Corrective Action Plans, or requests for additional information were needed during this timeframe.

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

Remediation:

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							100%	100%	100%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	N/A	100%
United							100%	N/A	100%
Statewide							100%	N/A	100%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	86%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							98%	100%	100%
United							100%	100%	100%
Statewide							97%	100%	100%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	N/A
United							N/A	N/A	N/A
Statewide							100%	100%	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	N/A	N/A
United							N/A	N/A	N/A
Statewide							100%	N/A	N/A
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 4: Number and percent of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Numerator: Number of waiver participants who received information on how to report suspected abuse, neglect, or exploitation
Denominator: Number of waiver participants interviewed by QMS staff or whose records are reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**35%**	**75%**	**79%**	**65%**
Numerator	9	24	26	59
Denominator	26	32	33	91
FE	**25%**	**73%**	**74%**	**63%**
Numerator	5	24	29	58
Denominator	20	33	39	92
IDD	**31%**	**62%**	**62%**	**57%**
Numerator	5	32	18	55
Denominator	16	52	29	97
BI	**21%**	**40%**	**57%**	**40%**
Numerator	4	8	12	24
Denominator	19	20	21	60
TA	**43%**	**82%**	**63%**	**65%**
Numerator	6	18	15	39
Denominator	14	22	24	60
Autism	**0%**	**100%**	**50%**	**40%**
Numerator	0	1	1	2
Denominator	2	1	2	5
SED	**13%**	**22%**	**42%**	**27%**
Numerator	3	7	14	24
Denominator	23	32	33	88

Explanation of Findings:

PD: Service plan/documentation of ANE not provided, is incomplete or does not cover entire review period, no valid signature and/or date

FE: Service plan/documentation of ANE not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA document not provided for validation, missing documentation of choice

IDD: Service plan/documentation of ANE not provided, is incomplete or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation, missing documentation of choice

BI: Service plan/documentation of ANE not provided, is incomplete or does not cover entire review period, no valid signature and/or date

TA: Service plan/documentation of ANE not provided or does not cover entire review period, no valid signature and/or date, DPOA/Guardianship document not provided for validation

AU: Service plan/documentation of ANE not provided or does not cover entire review period

SED: No valid signature and/or date, service plan/documentation of ANE not provided or does not cover

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. Through these trainings Service Coordinators are retrained on process for obtaining and documenting validation of DPOA/Guardianship. Service Coordinators are also retrained on pulling the corect documents for entire audit/review period to ensure appropriate documents are included document uploads.
Mco will continue to complete PCSP process by telephone or video and began sending PCSP's to participant via mail with self address envelpe so that participant can sign and return PCSP
With the earlier HCBS Waiver Programs COVID-19 guidance exception now rescinded. KDADS will continue to coordinate with the MCOs to educate their Care Coordinators on how to adequately complete a Person-Centered Service Plan (PCSP)

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	38%	25%	35%
Amerigroup		51%	19%	67%	87%	97%	N/A	N/A	N/A
Sunflower		88%	72%	74%	90%	85%	89%	94%	75%
United		90%	80%	88%	88%	95%	90%	88%	79%
Statewide	65%	72%	53%	76%	88%	93%	78%	73%	65%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	35%	17%	25%
Amerigroup		59%	16%	61%	85%	92%	N/A	N/A	N/A
Sunflower		86%	62%	84%	89%	80%	92%	81%	73%
United		92%	80%	88%	93%	92%	91%	82%	74%
Statewide	80%	78%	50%	78%	89%	88%	83%	69%	63%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	20%	33%	31%
Amerigroup		23%	6%	59%	78%	86%	N/A	N/A	N/A
Sunflower		87%	59%	75%	82%	85%	83%	80%	62%
United		100%	56%	79%	93%	90%	84%	64%	62%
Statewide	99%	68%	42%	71%	83%	86%	75%	69%	57%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	23%	50%	21%
Amerigroup		30%	12%	56%	81%	82%	N/A	N/A	N/A
Sunflower		94%	45%	84%	78%	86%	86%	75%	40%
United		80%	76%	85%	79%	92%	87%	61%	57%
Statewide	57%	63%	34%	69%	80%	85%	73%	64%	40%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	27%	46%	43%
Amerigroup		61%	38%	75%	91%	99%	N/A	N/A	N/A
Sunflower		99%	86%	84%	72%	90%	90%	90%	82%
United		97%	61%	79%	95%	84%	93%	88%	63%
Statewide	86%	82%	57%	78%	86%	93%	81%	79%	65%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	0%	0%	0%
Amerigroup		62%	8%	23%	88%	100%	N/A	N/A	N/A
Sunflower		33%	29%	39%	50%	56%	62%	100%	100%
United		43%	14%	6%	13%	47%	77%	0%	50%
Statewide	90%	50%	16%	26%	50%	63%	62%	29%	40%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	46%	90%	13%
Amerigroup		88%	64%	27%	25%	75%	N/A	N/A	N/A
Sunflower		80%	53%	22%	16%	39%	66%	90%	22%
United		78%	63%	19%	5%	21%	64%	100%	42%
Statewide	89%	82%	60%	23%	15%	45%	62%	94%	27%

KDADS HCBS Quality Review Report

Health and Welfare
PM 5: Number and percent of participants' reported critical incidents that were initiated and reviewed within required time frames
Numerator: Number of participants' reported critical incidents that were initiated and reviewed within required time frames as specified in the approved waiver
Denominator: Number of participants' reported critical incidents
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**97%**	**95%**	**99%**	**97%**
Numerator	38	82	82	202
Denominator	39	86	83	208
FE	**97%**	**96%**	**98%**	**97%**
Numerator	28	65	62	155
Denominator	29	68	63	160
IDD	**92%**	**98%**	**99%**	**98%**
Numerator	235	1132	587	1954
Denominator	255	1152	591	1998
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**100%**	**100%**	**100%**	**100%**
Numerator	3	2	5	10
Denominator	3	2	5	10
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

During this timeframe the MCOs did a great job completing assigned reports within 30 days of receipt. There is documentation and explanations included with reports that did not meet the timeframes, which explain the reason for delay.

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

Remediation:

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	79%	96%	97%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							98%	99%	95%
United							100%	99%	99%
Statewide							96%	98%	97%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	83%	96%	97%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							96%	100%	96%
United							98%	100%	98%
Statewide							95%	99%	97%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	85%	90%	92%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							97%	100%	98%
United							99%	100%	99%
Statewide							96%	99%	98%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	91%	100%	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							99%	100%	N/A
United							99%	100%	N/A
Statewide							98%	100%	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	93%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							98%	100%	100%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	100%	N/A
United							100%	N/A	N/A
Statewide							100%	100%	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 6: Number and percent of reported critical incidents requiring review/investigation where the State adhered to its follow-up measures
Numerator: Number of reported critical incidents requiring review/investigation where the State adhered to the follow-up methods as specified in the approved waiver
Denominator: Number of reported critical incidents
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**100%**	**100%**	**100%**	**100%**
Numerator	39	81	80	200
Denominator	39	81	80	200
FE	**100%**	**100%**	**100%**	**100%**
Numerator	29	63	61	153
Denominator	29	63	61	153
IDD	**100%**	**100%**	**100%**	**100%**
Numerator	254	1147	593	1994
Denominator	254	1147	593	1994
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**100%**	**100%**	**100%**	**100%**
Numerator	3	2	5	10
Denominator	3	2	5	10
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

Program Integrity and Compliance Staff entered all DCF determinations (screened-out, unsubstantiated and substantiated) into AIR for further follow-up and investigation by the corresponding MCO.

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

Remediation:

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							100%	100%	100%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							100%	100%	100%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							100%	100%	100%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	N/A
United							100%	100%	N/A
Statewide							100%	100%	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							100%	100%	100%
Statewide							100%	100%	100%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	100%	N/A
United							100%	N/A	N/A
Statewide							100%	100%	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 7: Number and percent of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Numerator: Number of restraint applications, seclusion or other restrictive interventions that followed procedures as specified in the approved waiver
Denominator: Number of restraint applications, seclusion or other restrictive interventions
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
FE	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
IDD	**100%**	**94%**	**87%**	**93%**
Numerator	8	47	13	68
Denominator	8	50	15	73
BI	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
TA	**N/A**	**N/A**	**0%**	**0%**
Numerator	0	0	0	0
Denominator	0	0	1	1
Autism	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0
SED	**N/A**	**N/A**	**N/A**	**N/A**
Numerator	0	0	0	0
Denominator	0	0	0	0

Explanation of Findings:

The MCOs followed policy and procedure to investigate all reported incidents of restarint, seclusion or other restrictive interventions. MCO review/investigation propoerly identified and remediated, as necesaary for reports that concluded the application did not follow procedures as specified in the approved waiver, or in the individuals behavior support plan.

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

Remediation:

No remediation necessary for the MCOs. Review/Investigation and MCO follow-up confirms that approrpiate action was taken for all reports that identified innapropriate/not approved applications of restraint, seclusion or other restrictive interventions. Documentation was sufficient to verify findings and resolve incidents.

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							0%	N/A	N/A
Statewide							0%	N/A	N/A
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	100%
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							91%	96%	94%
United							58%	78%	87%
Statewide							83%	95%	93%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							0%	N/A	0%
Statewide							0%	N/A	0%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 8: Number and percent of unauthorized uses of restrictive interventions that were appropriately reported
Numerator: Number of unauthorized uses of restrictive interventions that were appropriately reported
Denominator: Number of unauthorized uses of restrictive interventions
Review Period: 04/01/2020 – 06/30/2020
Data Source: Adverse Incident Reporting

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

Explanation of Findings:

MCO review and investigation of all reports confirmed that all unauthorized uses of restraints, seclusions or other restrictive interventions were appropriately reported during this timeframe.

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

Remediation:

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							100%	100%	100%
United							91%	100%	100%
Statewide							94%	100%	100%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							100%	N/A	N/A
Statewide							100%	N/A	N/A
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Amerigroup	No Data						N/A	N/A	N/A
Sunflower							N/A	N/A	N/A
United							N/A	N/A	N/A
Statewide							N/A	N/A	N/A

KDADS HCBS Quality Review Report

Health and Welfare
PM 9: Number and percent of waiver participants who received physical exams in accordance with State policies
Numerator: Number of HCBS participants who received physical exams in accordance with State policies
Denominator: Number of HCBS participants whose service plans were reviewed
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**88%**	**75%**	**79%**	**80%**
Numerator	23	24	26	73
Denominator	26	32	33	91
FE	**75%**	**70%**	**87%**	**78%**
Numerator	15	23	34	72
Denominator	20	33	39	92
IDD	**94%**	**83%**	**66%**	**79%**
Numerator	15	43	19	77
Denominator	16	52	29	97
BI	**95%**	**80%**	**95%**	**90%**
Numerator	18	16	20	54
Denominator	19	20	21	60
TA	**86%**	**64%**	**79%**	**75%**
Numerator	12	14	19	45
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	**87%**	**63%**	**88%**	**78%**
Numerator	20	20	29	69
Denominator	23	32	33	88

Explanation of Findings:

PD: Evidence of physical exam not provided for review and/or did not meet physical exam requirement, physical exam documentation submitted not current for review period

FE: Evidence of physical exam not provided for review and/or did not meet physical exam requirement, physical exam documentation submitted not current for review period

IDD: Evidence of physical exam not provided for review and/or did not meet physical exam requirement, physical exam documentation submitted not current for review period

TA: Evidence of physical exam not provided for review and/or did not meet physical exam requirement, physical exam documentation submitted not current for review period

AU: Evidence of physical exam not provided for review

SED: Evidence of physical exam not provided for review, physical exam documentation submitted not current for review period

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. MCO provided training to Service Coodinators on 4/15/20 and 4/16/20 regarding how to provide education and encourage waiver participants to complete a physical exam. The training also include how to document physical exams in accordance with state policies. MCO also plan to update desktop process to include request for medical records directly from PCP to provide more robust evidence of physical exam. KDADS will continue to work with MCO's and encourage them to obtain a physical exam date from the individual, and it can come from any source.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	76%	67%	88%
Amerigroup		78%			20%	46%	N/A	N/A	N/A
Sunflower		81%			34%	40%	54%	72%	75%
United		88%			34%	23%	77%	71%	79%
Statewide	Not a Measure	82%	No Data	No Data	29%	37%	68%	70%	80%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	56%	56%	75%
Amerigroup		89%			23%	34%	N/A	N/A	N/A
Sunflower		97%			31%	28%	59%	66%	70%
United		97%			31%	18%	71%	56%	87%
Statewide	Not a Measure	95%	No Data	No Data	29%	27%	64%	60%	78%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	88%	83%	94%
Amerigroup		91%			28%	56%	N/A	N/A	N/A
Sunflower		99%			52%	70%	86%	80%	83%
United		99%			26%	29%	72%	86%	66%
Statewide	Not a Measure	97%	No Data	No Data	39%	56%	82%	82%	79%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	60%	67%	95%
Amerigroup		84%			21%	29%	N/A	N/A	N/A
Sunflower		94%			32%	30%	55%	60%	80%
United		93%			19%	35%	78%	74%	95%
Statewide	Not a Measure	90%	No Data	No Data	23%	30%	64%	67%	90%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	81%	92%	86%
Amerigroup		100%			39%	54%	N/A	N/A	N/A
Sunflower		100%			56%	79%	91%	81%	64%
United		97%			68%	62%	87%	92%	79%
Statewide	Not a Measure	100%	No Data	No Data	49%	63%	88%	88%	75%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	40%	100%	50%
Amerigroup		100%			56%	90%	N/A	N/A	N/A
Sunflower		92%			65%	73%	77%	100%	100%
United		100%			19%	42%	60%	50%	50%
Statewide	Not a Measure	98%	No Data	No Data	48%	59%	63%	71%	60%
SED									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	70%	86%	87%
Amerigroup		54%			76%	87%	N/A	N/A	N/A
Sunflower		55%			27%	71%	72%	69%	63%
United		46%			47%	61%	59%	73%	88%
Statewide	Not a Measure	52%	No Data	No Data	52%	67%	66%	75%	78%

KDADS HCBS Quality Review Report

Health and Welfare
PM 10: Number and percent of waiver participants who have a disaster red flag designation with a related disaster backup plan
Numerator: Number of waiver participants who have a disaster red flag designation with a related disaster backup plan
Denominator: Number of waiver participants with a red flag designation
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Record Review

Compliance By Waiver	Aetna	Sunflower	United	Statewide
PD	**62%**	**66%**	**76%**	**68%**
Numerator	16	21	25	62
Denominator	26	32	33	91
FE	**35%**	**70%**	**74%**	**64%**
Numerator	7	23	29	59
Denominator	20	33	39	92
IDD	**88%**	**65%**	**59%**	**67%**
Numerator	14	34	17	65
Denominator	16	52	29	97
BI	**37%**	**35%**	**43%**	**38%**
Numerator	7	7	9	23
Denominator	19	20	21	60
TA	**71%**	**73%**	**33%**	**57%**
Numerator	10	16	8	34
Denominator	14	22	24	60
Autism	**50%**	**100%**	**50%**	**60%**
Numerator	1	1	1	3
Denominator	2	1	2	5
SED	Not a Waiver Performance Measure			
Numerator				
Denominator				

Explanation of Findings:

PD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

FE: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA paperwork not provided for validation

IDD: No valid signature and/or date, service plan not provided or does not cover entire review period, DPOA/Guardianship paperwork not provided for validation

BI: No valid signature and/or date, service plan not provided or does not cover entire review period

TA: No valid signature and/or date, service plan not provided or does not cover entire review period

AU: Service plan not provided or does not cover entire review period, no valid signature and/or date, individual not recieving services

Remediation:

The Managed Care Organizations (MCOs) have indicated conitinued staff training in their remediation plans. MCO provided training to Service Coodinators on 4/15/20 and 4/16/20 regarding how to provide education and encourage waiver participants to complete a physical exam. The training also include how to document physical exams in accordance with state policies. MCO also plan to update desktop process to include request for medical records directly from PCP to provide more robust evidence of physical exam.

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	79%	63%	62%
Amerigroup		59%	53%	73%	86%	96%	N/A	N/A	N/A
Sunflower		77%	49%	66%	79%	85%	86%	91%	66%
United		64%	80%	88%	87%	94%	88%	74%	76%
Statewide	Not a Measure	67%	58%	75%	84%	92%	85%	77%	68%
FE									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	77%	56%	35%
Amerigroup		61%	62%	72%	84%	90%	N/A	N/A	N/A
Sunflower		72%	56%	72%	77%	81%	86%	81%	70%
United		76%	81%	85%	91%	91%	89%	79%	74%
Statewide	59%	70%	65%	76%	84%	87%	86%	75%	64%
IDD									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	64%	50%	88%
Amerigroup		67%	61%	65%	74%	86%	N/A	N/A	N/A
Sunflower		58%	32%	59%	70%	72%	78%	71%	65%
United		70%	58%	73%	90%	86%	80%	64%	59%
Statewide	Not a Measure	64%	47%	64%	76%	79%	77%	66%	67%
BI									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	48%	58%	37%
Amerigroup		46%	49%	62%	80%	82%	N/A	N/A	N/A
Sunflower		68%	42%	80%	84%	88%	85%	75%	35%
United		56%	74%	80%	79%	89%	86%	52%	43%
Statewide	Not a Measure	56%	52%	70%	81%	85%	77%	62%	38%
TA									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	65%	77%	71%
Amerigroup		75%	54%	79%	90%	99%	N/A	N/A	N/A
Sunflower		91%	58%	77%	78%	85%	89%	90%	73%
United		86%	63%	79%	95%	86%	91%	83%	33%
Statewide	Not a Measure	83%	57%	78%	87%	92%	86%	84%	57%
Autism									
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	17%	0%	50%
Amerigroup		77%	44%	32%	88%	100%	N/A	N/A	N/A
Sunflower		53%	27%	67%	80%	72%	77%	100%	100%
United		38%	7%	6%	13%	41%	69%	0%	50%
Statewide	Not a Measure	64%	30%	40%	62%	67%	64%	29%	60%
SED	Not a Waiver Performance Measure								
Aetna									
Amerigroup									
Sunflower									
United									
Statewide									

KDADS HCBS Quality Review Report

Financial Accountability
PM 1: Number and percent of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Numerator: Number of clean claims that are paid by the managed care organization within the timeframes specified in the contract
Denominator: Total number of provider claims
Review Period: 04/01/2020 – 06/30/2020
Data Source: MCO Claims Data

Compliance By Waiver	Statewide
PD	**98%**
Numerator	106,433
Denominator	108,333
FE	**97%**
Numerator	59,281
Denominator	61,125
IDD	**97%**
Numerator	153,060
Denominator	158,256
BI	**96%**
Numerator	15,564
Denominator	16,152
TA	**97%**
Numerator	8,522
Denominator	8,774
Autism	**100%**
Numerator	11
Denominator	11
SED	**91%**
Numerator	15,420
Denominator	16,869
All HCBS Waivers	**97%**
Numerator	358,291
Denominator	369,520

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	Jan-Mar 2020	April-June 2020
PD									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	96%	97%	98%	98%
FE									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	95%	95%	97%	97%
IDD									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	97%	95%	96%	97%
BI									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	90%	94%	96%	96%
TA									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	91%	95%	92%	97%
Autism									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	82%	95%	71%	100%
SED									
Statewide	Not a Measure	N/A	N/A	N/A	N/A	82%	78%	88%	91%
All HCBS Waivers									
Statewide	Not a Measure	90%	88%	95%	95%	95%	95%	96%	97%

Explanation of Findings:

MCO self-reported data. Performance measure achieved.

Remediation:

No remediation necessary

KDADS HCBS Quality Review Report

Financial Accountability
PM 2: Number and percent of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Numerator: Number of payment rates that were certified to be actuarially sound by the State's actuary and approved by CMS
Denominator: Total number of capitation (payment) rates
Review Period: Calendar Year 2020
Data Source: KDHE

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

Compliance Trends	2013	2014	2015	2016	2017	2018	2019	2020
PD								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
FE								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
IDD								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
TBI								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
TA								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
Autism								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%
SED								
Statewide	Not a Measure	100%	100%	100%	100%	100%	100%	100%

Explanation of Findings:

Performance measure achieved

Remediation:

No remediation necessary

PIP Interventions Technical Summary

The Centers for Medicare and Medicaid Services requires Managed Care Organizations (MCOs) to conduct performance improvement projects (PIPs) that focus on both clinical and non-clinical areas each year (42 CFR 438330 and 4571240(b). A PIP is a pilot project designed to improve member health and quality of life. KanCare 2.0 requires each MCO to conduct at least three clinical and two non-clinical State-approved PIPs. The MCOs must conduct one of these PIP collaboratively, and one of the two non-clinical PIPS must be in the area of long-term-care. In addition, the MCOs must conduct a PIP on Early Periodic Screening Diagnostic and Testing (EPSDT) when the MCOs' overall rates drop below 85%.

The following table represents the current KanCare 2.0 PIPs and the interventions the MCOs are using to improve the goals. Each PIP is assessed annually for successes, and changes are made to enhance effectiveness and improve impact.

*Some interventions are being adjusted due to face-to face interaction restrictions during Covid-19

KanCare 2.0 Individual Performance Improvement Projects		
Aetna Better Health (ABH)	Sunflower Health Plan (SHP)	UnitedHealthcare (UHC)
Topic: Reducing food insecurity Initial interventions: • Annual calls to members to identify those with food needs • Quarterly webinars for members with diabetes given by RN/Diabetic Educator. Focus will be on topics such as how to make and access healthy food choices, reading food labels and managing a chronic condition. • Identify members who could benefit from pharmacy consultation. Partner with pharmacists who complete an assessment and send results to ABH. Care Managers then reach out to members to address food needs. • Education and outreach to providers in food desert areas to increase provider use of billing codes that identify members with food needs. This intervention will first be piloted with 1 urban, 1 rural and 1 frontier provider. • Donations to food banks located in food deserts	**Topic: Improving access to mental health services for children in foster care** Initial interventions: • Access to myStrength, a digital behavioral health application used for behavioral health self-management that can be used on a phone, tablet or computer • Evaluation of SED waiver eligibility to enhance services for children in foster care and waiting for placement in a Psychiatric Residential Treatment Facility • Expand Parent Management Training- Oregon Model, an Evidence-Based Practice, to the two new State Foster Care Contractors. Track the number of families who complete most of the modules • Pilot an expedited intake and treatment appointment process with 2 urban and 2 rural/frontier FQHCs • Open the behavioral health portion of the provider portal to allow mental health providers to upload behavioral health documents. This access will allow the provider to guide their sessions and pick up in treatment where a previous provider left off.	**Topic: Provide housing resources for members who are homeless or at-risk of homelessness** Initial interventions: • Provide temporary financial help for eligible members to get and/or keep housing • 10 units of transitional housing to serve medically complex members who are homeless and have high utilization in medical claims • Work with homeless shelters to identify members to connect them with services as needed • Provide financial support to add Community Health Workers at 2 urban and 1 rural health clinics to increase the use of billing codes to identify those who may have housing needs • Train UHC Care Management staff on identifying and assisting members with housing needs

PIP Interventions Technical Summary

KanCare 2.0 Individual Performance Improvement Projects		
Aetna Better Health (ABH)	Sunflower Health Plan (SHP)	UnitedHealthcare (UHC)
Topic: Increasing prenatal care visits and MCO notice of pregnancy Initial interventions: • $20 gift card to member for notifying ABH of pregnancy through interactive text message • $20 gift card to member for notifying ABH of pregnancy through interactive phone message • Direct phone calls to new members who are pregnant to offer enrollment in Promise Pregnancy Program. Calls are made within 3 days of ABH being notified of enrollment • $100 reward to behavioral health and FQHC providers for notifying ABH of member's pregnancy • $25 reward to urgent care providers for notifying ABH of member's pregnancy	**Topic: Increasing cervical cancer screening rates** Initial interventions: • Phone call reminders from case manager to women who are overdue for a screening • Bi-directional and Interactive text message reminders to women who are overdue for a screening • Co-branded letters with providers who have not transitioned to electronic record keeping. SHP will identify the members who are overdue for screenings and mail the reminder. • Reports to providers, who are not participating in SHP's performance incentive, listing assigned/attributed women who are overdue for a screening • Provider webinar focused on overcoming screening concerns of members with an Intellectual or Developmental Disability (I/DD)	**Topic: Increasing rate of prenatal care visits and MCO notice of pregnancy** Initial interventions: • $200 reward for member and $60 reward for provider for notifying UHC of member's pregnancy • Maternity t-shirt for prenatal visit in first trimester • Reward to substance use disorder providers for notifying UHC of member's pregnancy • Reward to Community Mental Health Centers for notifying UHC of member's pregnancy • Addition of billing codes to identify members early in their pregnancy
Topic: Reducing non-emergent use of emergency room (ER) by members in the Home and Community-Based Services (HCBS) program Initial interventions: • Refrigerator magnet with individualized phone numbers for non-ER care resources • Individual meeting with member and caregiver following non-urgent use of ER to discuss non-ER options • Text message reminders with non-ER options including use of Nurse Help Line • Quicker notification to ABH of member's use of the ER through the CareUnify notification system. Case Managers will then contact the member within 3 days to discuss non-ER options when appropriate.	**Topic: Increasing employment for members in the I/DD, Physical Disability and Brain Injury waiver programs** Initial interventions: • Mailers to members with employment-related information and assistance options in the member's community. Mailers will include the Employment Specialist's contact information as well. • Transportation to job interviews and job fairs • Partnering with employers to increase job opportunities for young adults in Project SEARCH • Rewards to day support providers to help members find and maintain competitive employment for members receiving services	**Topic: Increasing number of HCBS members who have Advance Directives** Initial interventions: • Develop an easily understood Advance Directives form and a process to inform, document, store and track the sharing of the form with the member's primary care physician, care providers, family, and interested parties per the member's choice • Mail information about Advance Directives to members on the Frail Elderly waiver in Sedgwick County 3 weeks prior to annual visit. This will allow members an opportunity to prepare for the conversation. • Assist members with completion of Advance Directives for members on the Frail Elderly waiver in Sedgwick County during their annual visit

PIP Interventions Technical Summary

KanCare 2.0 Individual Performance Improvement Projects		
Aetna Better Health (ABH)	Sunflower Health Plan (SHP)	UnitedHealthcare (UHC)
• Study trends of non-emergent ER use by members on the HCBS waivers	• Annual training for case managers on regional employment resources and employment incentive programs. Attendees will complete a pre and post survey to assure the training materials met the case manager's needs.	• Train UHC Community Health Workers and Care Coordinators on the sensitivity of discussing Advance Directives • Collect and store completed Advance Directives in the UHC care management record (Community Care). Assist members with sharing their completed Advance Directives with at least one other person • Inform providers of the Advance Directives project
Topic: Increasing flu vaccination rates for children ages 6 months to 17 years Initial interventions: • $15 gift card to parent/guardian when child gets flu vaccination • Nurse will be available to give flu shots at four community health events • Up to four interactive reminder texts to parents or guardians until reply text is received that child has been vaccinated • Reminders on CVS prescription packages during flu season • Reports to providers of children who have not received a flu vaccination. Providers will then receive a survey to assess if reports were helpful in increasing flu vaccinations.	**Topic: Diabetes monitoring for people with diabetes and schizophrenia** Initial interventions: • Phone call reminders from case managers to members who are overdue for a HbA1c and LDL-C test • Reminder letters to members who are overdue for their HbA1c and LDL-C tests, using both SHP and the physician's letterhead with 5 pilot providers • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test	**Topic: Diabetes monitoring for people with diabetes and schizophrenia** Initial interventions: • Phone call reminders from Care Manager to members identified with complex medical needs and are overdue for a HbA1c and LDL-C test • Phone call reminders from Care Coordinators to members who are receiving waiver services and are overdue for a HbA1c and LDL-C test • Send reports biannually to providers with names of members who are due for their annual HbA1c and LDL-C test
KanCare 2.0 Early Periodic Screening Diagnostic Treatment (EPSDT) KAN Be Healthy PIP		
Topic: Increasing EPSDT rates to 85% Initial interventions: • $25 each year for completing annual well visit - Members ages 13 to 20 years • $10 card and gift pack (including an activity book from Ted E. Bear, M.D.) each year for	**Topic: Increasing EPSDT rates to 85%** Initial interventions: • Interactive text message reminder to parent/guardian or members who are overdue for a visit. System allows members to respond to and ask questions.	**Topic: Increasing EPSDT rates to 85%** Initial interventions: • Phone call reminders to members who are 18-20 years old and overdue for a visit, with the option to warm transfer to schedule an appointment

PIP Interventions Technical Summary

KanCare 2.0 Individual Performance Improvement Projects		
Aetna Better Health (ABH)	Sunflower Health Plan (SHP)	UnitedHealthcare (UHC)
completing annual well visit - Members birth to 12 years • Interactive text message, in the member's language preference, to parents/guardians of children who are overdue for a visit. System will ask for a response and transfer to member services all those who respond that they do not plan to go/make an appointment • Automated phone message to parents/guardians of children who are overdue for a visit. System will allow the member to warm transfer to customer service for assistance • A reminder message attached to prescriptions at all CVS pharmacies in Kansas. Reminder will be included on the first prescription filled during the quarter prior to the member's birthdate • Two provider education webinars. Strategies for adherence and difference between younger and older children will be covered.	• Two community outreach events where KAN Be Healthy visits can be completed onsite • Case Manager phone call reminder of annual visit for members on the SED waiver • Improve and coordinate tracking of EPSDT visits with contracted foster care agencies • In-person provider education visits to 5 large practices to discuss individual goals and barriers for their membership	• Mailing reminders to members without a known phone number. Mailer will include information detailing how members can obtain a phone through the health plan using UHCCP KS's value-added benefits (VAB) • Monetary incentive for providers who have over 50 members needing an EPSDT visit • Notification to contracted foster care agencies of those members who need an EPSDT visit • Reports of members who are due for a visit to providers who are not part of any other UHC EPSDT incentive program

KanCare 2.0 Collaborative PIP (ABH-SHP-UHC: Increase HPV Vaccination Rate)

Topic: Increasing compliance with HPV vaccination administration in adolescents

Initial interventions:

- Telephone reminder calls to parents or guardians for members who are overdue for an HPV vaccine
- Ensuring members residing in a Psychiatric Residential Treatment Facility or Adolescent Substance Use Disorder Residential program are up to date with their HPV immunizations
- Letter to parent or guardian not reached by telephone for members who are overdue for an HPV vaccine
- Mailers with HPV-related information sent to parent/guardian with a child turning 13 in the coming months
- Educational webinars for providers in conjunction with the American Cancer Society and American Academy of Pediatrics
- Monthly Member-Level Reports distributed to providers of members who are due for an HPV vaccine

KanCare Ombudsman Report

Quarter 4, 2020 (based on calendar year)

October 1 – December 31, 2020

Data downloaded 2/4/2021

KanCare Ombudsman Office

Kerrie Bacon, KanCare Ombudsman
Email: KanCare.Ombudsman@ks.gov or Kerrie.Bacon@ks.gov
Phone: (785) 296-6270
Cell: (785) 213-2258
Toll Free: 1-855-643-8180
Relay: 711
Address: 503 S. Kansas Ave., Topeka, KS 66603
Website: www.KanCareOmbudsman.ks.gov
Find Us on Facebook

I. Table of Contents

Contents

II. Highlights/Dashboard

A. KanCare Ombudsman Activities

During fourth quarter:

- The KanCare Ombudsman spent 1-3 days a week in the Kansas City Satellite Office overseeing the volunteers as they returned to service.
- Recruiting/interviewing/hiring a Volunteer Coordinator that will be located at the Kansas City Satellite Office.

These activities are outside the normal weekly activities and thus, some meetings that the KanCare Ombudsman normally attends were temporarily dropped from the schedule.

B. Satellite office back open with partial coverage

Both Kansas City and Wichita offices were open in fourth quarter with two volunteers providing coverage in each office. The Kansas City office had one volunteer in the mentoring stage of volunteering. The Wichita office began training two additional volunteers and a WSU student intern during fourth quarter.

C. Initial Contact continue to increase slowly

In the chart below, the impact of COVID-19 can be seen from first quarter numbers to second quarter, which shows a 47% decrease in contact for the Ombudsman office and a 55% decrease in contacts for the KanCare Clearinghouse. The KanCare Ombudsman numbers are slowly increasing while the KanCare Clearinghouse numbers are increasing, but at a slower rate.

Comparison of KanCare Clearinghouse contacts and KanCare Ombudsman contacts	Q4	Q1	Q2	% +/- Q2 vs Q1, 2020	Q3	Q4	% +/- Q4 vs Q1, 2020
KanCare Ombudsman Contacts	915	903	478	-47%	562	601	-33%
KanCare Clearinghouse contacts	126,682	128,033	57,720	-55%	57,425	59,161	-54%

D. Community Resources by County

By the end of first quarter the KanCare Ombudsman Office will provide county level basic resources on the KanCare Ombudsman webpages. The resources will cover medical, food, shelter, transportation and local and regional general resources.

The volunteers working on this project are college student interns from the University of St. Marys, working toward bachelor's or master's degrees in Social Services or Health Services. The resources will be reviewed and updated on a rotating 18 to 24 month schedule with the continued assistance of college intern volunteers.

III. KanCare Ombudsman Purpose

The KanCare Ombudsman Office helps Kansas Medicaid beneficiaries and applicants, with a priority on individuals participating in long-term supports and services through KanCare. The KanCare Ombudsman Office assists KanCare beneficiaries and applicants with access, service and benefit problems. The KanCare Ombudsman office helps with:

- Answers to questions
- Resolving issues
- Understanding letters from KanCare
- Responding when you disagree with a decision or change
- Completing an application or renewal
- Filing a complaint (grievance)
- Filing an appeal or fair hearing
- Learning about in-home services, also called Home and Community Based Services (HCBS)

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

IV. Accessibility to the Ombudsman's Office

A. Initial Contacts

The KanCare Ombudsman Office was available to members and applicants of KanCare (Medicaid) by phone, email, written communication, social media and the Integrated Referral and Intake System (IRIS) during quarter 4 of 2020.

The KanCare Ombudsman Office has helped KanCare members and applicants since the inception of KanCare in January 2013. Starting in November of 2015, the KanCare Ombudsman office began a volunteer program to assist with answering calls and helping with applications. There are two satellite offices; Wichita and Kansas City.

Quarters 2-4 of 2020 are down in contacts due to COVID-19. Contacts slowly increased during third and fourth quarter.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4
2014	545	474	526	547
2015	510	462	579	524
2016	1,130	846	687	523
2017	825	835	970	1,040
2018	1,214	1,059	1,088	1,124
2019	1,060	1,097	1,071	915
2020	903	478	562	601

The chart below shows one example of other organizations that also had a significant decrease in calls during the COVID-19 pandemic. We have heard of other organizations that have similar decreases in contacts since the beginning of the pandemic. As seen below, there are some increases in the last couple of quarters, but relatively small.

Comparison of KanCare Clearinghouse contacts and KanCare Ombudsman contacts	Q4	Q1	Q2	% +/- Q2 vs Q1, 2020	Q3	Q4	% +/- Q4 vs Q1, 2020
KanCare Ombudsman Contacts	915	903	478	-47%	562	601	-33%
KanCare Clearinghouse contacts	126,682	128,033	57,720	-55%	57,425	59,161	-54%

B. Accessibility through the KanCare Ombudsman Volunteer Program

The KanCare Ombudsman Office has two satellite office for the volunteer program; one in Kansas City metro area and one in Wichita. The volunteers in both satellite offices answer KanCare questions, help with issues and assist with filling out KanCare applications (during COVID-19, by phone only).

During 4th quarter, there have been volunteers assisting in the offices (2 in each office). Both offices have COVID-19 protocol for people in the buildings and the number of people in the buildings have been very limited. Calls are covered by volunteers in the satellite offices, and when there is a gap in coverage, the Topeka staff cover the phones.

Office	Volunteer Hours	# of Volunteers	# of hours covered/wk.	Area Codes covered
Kansas City Office	Mon.: 12:30 - 4 pm Tues. 12:30 - 4 pm	2	7	Northern Kansas Area Codes 785, 913, 816
Wichita Office	Monday 9 - noon Friday 9 - noon	2	6	Southern Kansas Area Codes 316, 620

Information As of December 2020

V. Outreach by KanCare Ombudsman Office

The KanCare Ombudsman Office is responsible to help members, applicants and providers understand the KanCare application process, benefits and services, and provide training and outreach to community organizations. The office does this through resources provided on the KanCare Ombudsman web pages, resources provided with contacts to members, applicants and providers, and outreach through conferences, conference calls, video calls, social media, and in-person contacts.

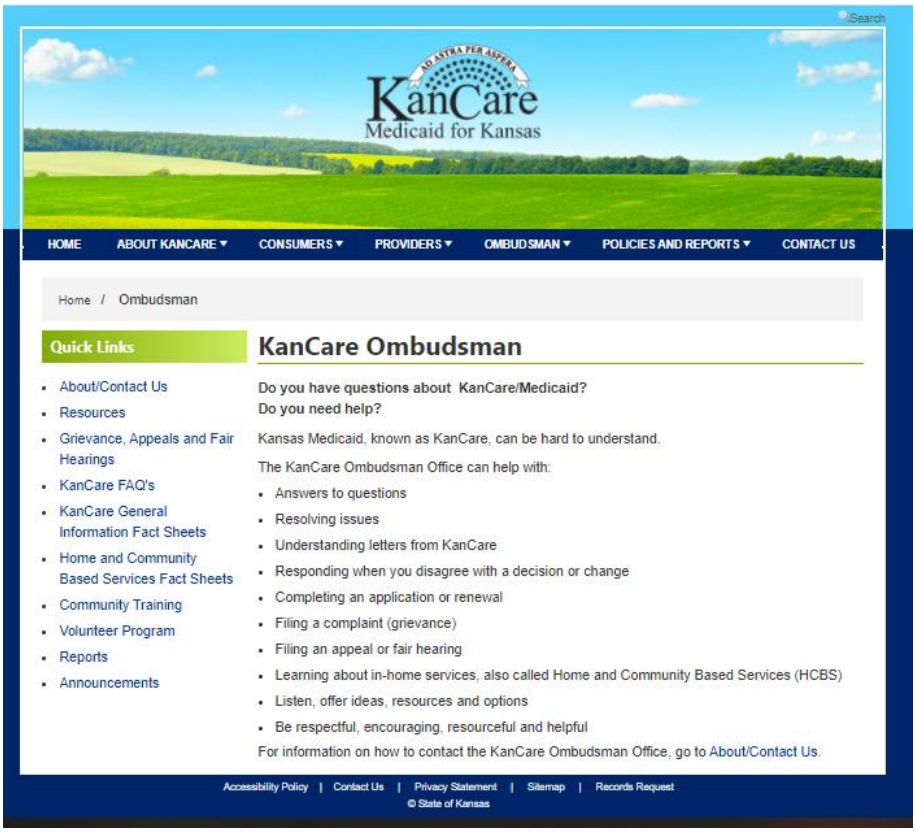
The below chart shows the outreach efforts by the KanCare Ombudsman Office.

	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Outreach	49	23	14	8	74	16	96	57

For the full listing of outreach, see Appendix A.

The KanCare Ombudsman Office has a new brochure that is completely different from the brochure in the past. It is a slim, one-page brochure with English on one side and Spanish on the other side. It is targeted to KanCare member and applicants. A copy is available as Appendix B.

There is an addition to the KanCare Ombudsman webpage. Until recently, there has not been a true landing page for this site. A landing page was created, explaining what the KanCare Ombudsman does with Quick Links on the left side for easier access.



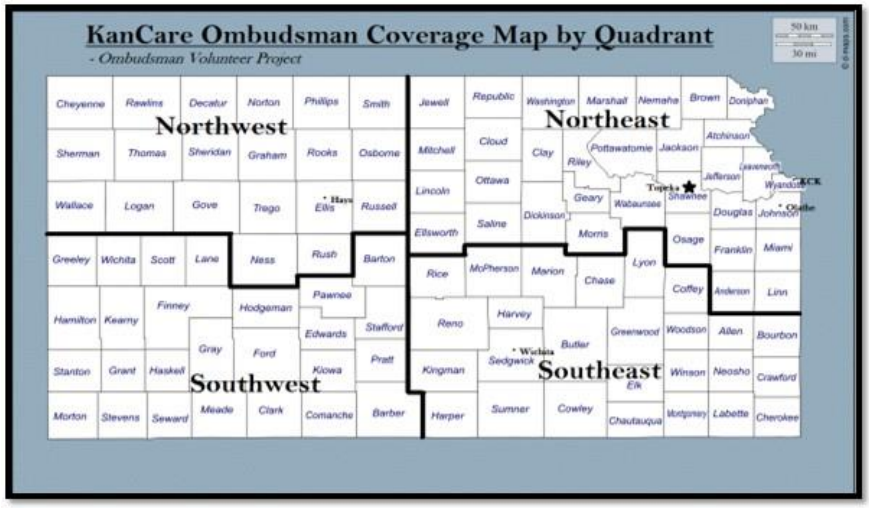
VI. Data by KanCare Ombudsman Office

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

A. Data by Region

1. Initial Contacts to KanCare Ombudsman Office by Region

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



- 785, 913 and 816 area code calls go to the Kansas City Satellite office.
- 316 and 620 area code calls go to the Wichita Satellite office.
- The remaining calls, direct calls and complex calls go to the Topeka (main) office unless people call the direct number for the satellite offices (found on KanCare Ombudsman web pages under Contact Us.
- The chart, by region, shows that most KanCare Ombudsman calls come from the Northeast and Southeast part of Kansas.

REGION	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Northwest	7	20	11	8	15	4	1	5
Northeast	184	210	174	183	158	90	50	69
Southwest	20	24	17	17	16	11	6	8
Southeast	208	129	126	172	171	104	36	84
Unknown	633	706	739	532	544	257	464	435
Out of State	16	8	4	3	2	12	5	0
Total	**1,068**	**1,097**	**1,071**	**915**	**906**	**478**	**562**	**601**

2. KanCare/Medicaid members by Region

This chart shows the **KanCare/Medicaid population** by the KanCare Ombudsman regions. The majority of the Medicaid population is located in the eastern two regions. Most Medicaid members are not being dropped at this time due to COVID-19, so the bottom line number is increasing each quarter.

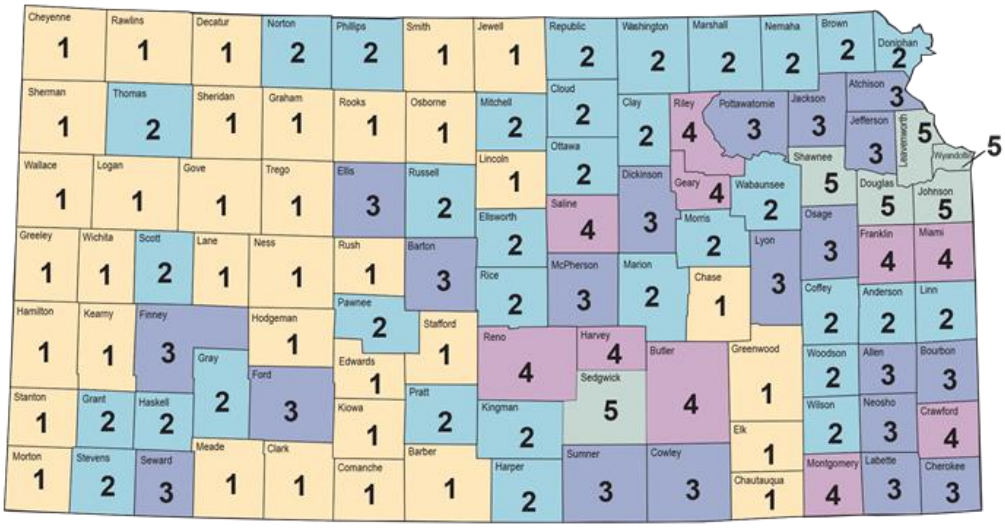
Medicaid

Region	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Northeast	205,267	179,011	188,184	189,133	193,061	199,226	207,371	212,844
Southeast	185,683	160,821	169,598	170,237	174,330	180,611	188,171	193,347
Northwest	13,240	11,575	12,163	12,223	12,550	12,964	13,507	13,928
Southwest	40,073	34,613	36,291	36,472	36,984	38,200	39,667	40,724
Total	**444,263**	**386,020**	**406,236**	**408,065**	**416,925**	**431,001**	**448,716**	**460,843**

3. Kansas Population Density

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

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



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

B. Data by Office Location

Initial phone calls to the KanCare Ombudsman Office toll-free number (1-855-643-8180) are sent directly to one of three KanCare Ombudsman offices based on the area code the call is coming from. The Kansas City office receives 913, 785 and 816 area code calls. The Wichita office receives 620 and 316 area code calls. All other toll-free calls go to the Main office (Topeka) in addition to direct calls to staff.

During fourth quarter, additional calls were handled by volunteers and the Ombudsman Assistant followed up on satellite office calls when there was no volunteer coverage for the day.

Contacts by Office	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Main - Topeka	561	620	733	537	540	362	534	438
Kansas City	166	213	212	182	142	0	1	58
Wichita	333	264	126	196	221	112	26	105
Total	**1,060**	**1,097**	**1,071**	**915**	**903**	**474**	**561**	**601**

C. Data by Contact Method

The contact method most used continues to be telephone and email. The increase in "Other" indicates the use of the Integrated Referral and Intake System (IRIS), a tool designed to encourage warm handoffs among community partners, keeping providers updated along the way.

Contact Method	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Telephone	898	948	956	794	773	356	464	511
Email	152	138	107	109	114	117	90	83
Letter	1	5	2	1	5	4	6	2
Face-to-Face Meeting	12	6	5	8	11	0	0	0
Other	5	0	0	1	0	1	1	5
Social Media	0	0	1	2	3	0	1	0
CONTACT METHOD TOTAL	**1,068**	**1,097**	**1,071**	**915**	**906**	**478**	**562**	**601**

D. Data by Caller Type

Most contacts are consumers which includes beneficiaries, family member, friend, etc.

The “Other type” callers are usually state employees, lawyers, schools, and students/researchers looking for data.

Provider issues are a combination of providers calling to assist a member or applicant having issues, or a provider with billing issues, questions on how to become a provider in Kansas, etc. The provider contacts that are not for an individual member, are forwarded to KDHE.

CALLER TYPE	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Provider	93	69	112	65	70	63	63	58
Consumer	920	939	901	794	773	375	451	497
MCO Employee	8	11	1	7	3	6	5	8
Other Type	47	78	57	49	60	34	43	38
CALLER TYPE TOTAL	**1,068**	**1,097**	**1,071**	**915**	**906**	**478**	**562**	**601**

E. Date by Program Type

The top program types that we received calls for in third quarter were Nursing Facility waiver and the Frail Elderly waiver. Nursing facility calls were an increase over third quarter. The calls, in general, were on the following concerns:

- KanCare application questions/assistance/eligibility
- Nursing facility complaints (referred to KDADS complaint hotline)
- Concerns about persons perceived to need to be in a nursing facility (ask many questions and see if they may need HCBS services, more assistance from MCO, etc.)
- Estate planning questions for preparing to apply for a person to go to a nursing facility (we do not attempt to answer these questions; refer to find an estate planning lawyer)

PROGRAM TYPE	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
PD	40	32	21	29	32	25	35	12
I/DD	30	36	37	20	23	23	16	12
FE	25	20	43	37	34	19	27	16
AUTISM	3	4	1	2	1	1	2	3
SED	5	7	13	10	5	3	2	3
TBI	13	11	7	12	7	4	9	3
TA	5	7	7	10	6	5	2	1
WH	2	5	1	2	0	1	0	0
MFP	0	0	0	1	0	1	0	0
PACE	2	1	2	4	1	0	0	1
MENTAL HEALTH	2	5	2	5	3	8	2	1
SUB USE DIS	1	0	2	1	0	0	0	0
NURSING FACILITY	33	27	27	48	39	29	9	22
FOSTER CARE	0	0	0	0	0	1	0	0
MEDIKAN	0	0	9	3	2	0	0	3
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	1	5	3	2	3	2
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	3	0	1	1	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**161**	**155**	**173**	**192**	**156**	**123**	**108**	**79**

There may be multiple selections for a member/contact.

F. Data by Priorities

This is data collection started in August 2019. The Ombudsman Office is tracking priorities for two purposes:

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

The priorities are defined as follows:

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

PRIORITY	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
HCBS	39	61	66	65	36	30
Long Term Care / MF	12	24	25	27	12	15
Urgent Medical Need	13	33	24	8	9	11
Urgent	23	29	22	12	13	18
Life Threatening	6	8	8	0	1	4
PRIORITIES TOTAL	**93**	**155**	**145**	**112**	**71**	**78**

G. Data by Issue Categories

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

1. Medicaid Issues
2. Home and Community Based Services/Long Term Supports and Services Issues (HCBS/LTSS)
3. Other Issues: Other Issues may be Medicaid related but are tied to a non-Medicaid program or an issue that is worthy of tracking.

1. Medicaid Issues

The top two issues are Medicaid Application assistance and Medicaid General issues with Medicaid Eligibility Issues and Medicaid Info/status also relatively high. Medicare Savings Plan issues tend to be about how to apply and/or providing applications.

MEDICAID ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Access to Providers (usually Medical)	11	14	26	15	11	3	1	9
Appeals/Fair Hearing questions/issues	17	12	10	12	23	8	10	15
Background Checks	2	1	0	1	0	0	0	0
Billing	30	29	54	35	25	16	20	30
Care Coordinator Issues	18	5	15	16	19	3	4	7
Change MCO	12	10	4	6	7	3	8	6
Choice Info on MCO	7	8	3	3	4	2	1	2
Coding Issues	15	11	9	4	8	2	8	3
Consumer said Notice not received	6	7	3	6	3	0	1	2
Cultural Competency	0	0	1	0	0	1	0	0
Data Requests	2	4	0	1	4	4	1	1
Dental	11	6	6	6	4	7	5	3
Division of Assets	8	11	13	12	10	8	7	4
Durable Medical Equipment	4	5	3	2	3	9	2	5
Grievances Questions/Issues	12	19	26	36	33	11	10	22
Help understanding mail (NOA)	0	0	3	6	9	4	7	8
MCO transition	0	0	1	3	2	0	1	0
Medicaid Application Assistance	171	137	130	171	150	114	118	132
Medicaid Eligibility Issues	152	145	147	188	206	63	109	99
Medicaid Fraud	1	4	3	2	1	2	3	3
Medicaid General Issues/questions	273	254	183	199	188	89	103	123
Medicaid info (status) update	124	175	149	188	150	35	107	97
Medicaid Renewal	56	119	84	51	51	3	9	20
Medical Card issues	0	0	1	9	9	6	9	10
Medicare Savings Plan Issues	22	29	62	78	49	22	15	46
MediKan issues	0	0	4	3	3	0	2	8
Moving to / from Kansas	20	17	18	17	19	7	14	14
Medical Services	18	10	13	18	24	19	12	17
Pain management issues	5	1	0	2	0	2	0	1
Pharmacy	18	16	10	11	12	11	4	7
Pregnancy issues	0	0	5	5	5	2	9	22
Prior authorization issues	0	0	1	1	2	2	1	4
Refugee/Immigration/SOBRA issues	0	0	3	10	3	0	1	1

Respite	1	0	0	1	0	0	0	0
Spend Down Issues	29	21	34	33	28	17	23	27
Transportation	11	9	14	9	9	6	0	8
Working Healthy	3	5	5	6	0	1	0	2
MEDICAID ISSUES TOTAL	**1,059**	**1,084**	**1,043**	**1,166**	**1,074**	**482**	**625**	**758**

There may be multiple selections for a member/contact.

2. HCBS/LTSS Issues

The top issues for this group are HCBS General Issues, nursing facility issues, and HCBS eligibility issues.

HCBS/LTSS ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Client Obligation	22	19	27	14	14	10	6	8
Estate Recovery	4	9	10	9	3	3	12	17
HCBS Eligibility issues	35	33	46	61	51	34	54	40
HCBS General Issues	62	47	65	68	60	55	55	48
HCBS Reduction in hours of service	6	3	3	0	5	3	15	4
HCBS Waiting List	6	7	8	6	2	0	12	11
Nursing Facility Issues	36	39	54	49	39	26	29	45
HCBS/LTSS ISSUES TOTAL	**171**	**157**	**213**	**207**	**174**	**131**	**183**	**173**

There may be multiple selections for a member/contact.

3. Other Issues

This section shows issues or concerns that may be *related* to KanCare/Medicaid.

OTHER ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Abuse / neglect complaints	8	6	4	3	8	10	9	7
ADA Concerns	0	0	0	0	0	0	1	0
Adoption issues	0	0	1	2	1	1	0	2
Affordable Care Act Calls	5	5	3	4	3	7	1	4
Community Resources needed	0	0	3	6	8	10	2	4
Domestic Violence concerns	0	0	1	0	0	0	1	2
Foster Care issues	0	0	1	2	6	4	3	1
Guardianship	1	1	2	6	4	5	2	3
Homelessness	0	0	1	3	2	3	4	2
Housing Issues	5	5	7	4	1	7	12	5
Medicare related Issues	18	15	18	23	16	17	11	25
Social Security Issues	16	15	19	7	16	15	18	21
Used Interpreter	0	0	0	6	1	5	4	4
X-Other	134	119	114	85	137	91	181	218
Z Thank you	408	399	350	400	335	218	270	282
Z Unspecified	97	110	137	99	75	47	40	70
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**692**	**675**	**661**	**650**	**613**	**440**	**559**	**650**

There may be multiple selections for a member/contact.

H. Data by Managed Care Organization (MCO) – See Appendix B

VII. Action Taken

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

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

A. Responding to Issues

1. KanCare Ombudsman Office response to members/applicants

The Ombudsman Office goal is to respond to a contact within two business days. During the COVID-19 pandemic, our goal changed to responding within 3-4 business days.

During most of second quarter there were two people answering the contacts rather than three offices, volunteers and staff. In third quarter one volunteer returned to service in the Kansas City office. In fourth quarter, one additional volunteer returned to service in the Kansas City office and two volunteers returned to service in the Wichita office.

Quarter yr.	Nbr Contacts	% Responded 0-2 days	% Responded 3-7 days	% Responded 8 or more days
Q1/2019	1068	88%	11%	1%
Q2/2019	1096	91%	8%	1%
Q3/2019	1071	95%	4%	1%
Q4/2019	915	93%	6%	0%
Q1/2020	905	92%	4%	4%
Q2/2020	476	60%	37%	3%
Q3/2020	562	87%	12%	2%
Q4/2020	601	84%	15%	1%

2. Organizational final response to Ombudsman requests

The KanCare Ombudsman office sends requests for review and assistance to various KanCare/related organizations. The following information provides data on the **resolution rate** for organizations the Ombudsman's office requests assistance from and the amount of time it takes to resolve.

Qtr. 4, 2020

Nbr Referrals	Referred to	% Responded 0-2 Days	% Responded 3-7 days	% Responded 7-30 days	% Responded 31 or more days
46	Clearinghouse	96%	0%	2%	0%
2	DCF	0%	0%	50%	50%
13	KDHE-Eligibility	54%	23%	23%	0%
1	KDHE-Program Staff	100%	0%	0%	0%
8	Aetna	50%	25%	25%	0%
10	Sunflower	10%	40%	40%	10%
10	UnitedHealthcare	50%	0%	40%	10%

3. Action Taken by KanCare Ombudsman Office to resolve requests

90% of initial contacts (which is well above 4 out of 5) were resolved by providing some type of resource. For example, the KanCare Ombudsman office:

- contacted another organization to ask assistance in resolving the issue
- shared information, resources, mailings, etc.
- provided referrals to other organizations

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

Action Taken Resolution Type	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Questions/Issue Resolved (No Resources)	94	85	69	61	70	51	8	16
Used Contact or Resources/Issue Resolved	837	871	909	770	715	361	514	533
Closed (No Contact)	126	123	79	66	55	31	31	37
ACTION TAKEN RESOLUTION TYPE TOTAL	**1,057**	**1,079**	**1,057**	**897**	**840**	**443**	**553**	**586**

There may be multiple selections for a member/contact

This chart shows when information/resources are provided verbally and when resources are mailed or emailed to a member/applicant.

Action Taken Additional Help	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Provided Resources	567	537	682	665	558	339	317	340
Mailed/Email Resources	151	123	152	168	114	73	85	118
ACTION TAKEN ADDITIONAL HELP TOTAL	**718**	**660**	**834**	**833**	**672**	**412**	**402**	**458**

4. Ombudsman Office Resolution of Issues

The average days to close/resolve an issue had a dip in second quarter and is back up to the 70%s in third and fourth quarters.

Quarter yr.	Nbr Contacts	Avg Days To Completion	% Completed 0-2 Days	% Completed in 3-7 Days	% Completed 8 or More Days
Q1/2019	1051	5	71%	17%	13%
Q2/2019	1021	4	75%	13%	12%
Q3/2019	1002	5	75%	10%	15%
Q4/2019	850	5	72%	11%	17%
Q1/2020	804	5	74%	10%	16%
Q2/2020	404	7	46%	31%	23%
Q3/2020	534	4	76%	13%	11%
Q4/2020	570	5	70%	17%	13%

VIII. Enhancements and Future Changes

A. Community Resources by County

By the end of first quarter the KanCare Ombudsman Office will provide county level basic resources on the KanCare Ombudsman webpages. The resources will cover medical, food, shelter, transportation and local and regional general resources.

The volunteers working on this project are college student interns from the University of St. Marys, working toward bachelor's or master's degrees in Social Services or Health Services. The resources will be reviewed and updated on a rotating 18 to 24 month schedule with the continued assistance of college intern volunteers.

B. Changes in the KanCare Ombudsman Office

1. Staff

The KanCare Ombudsman Volunteer Coordinator position has been filled. Josephine Alvey started work for our office on 1/25/21. She is a new graduate of Wichita State University and was a full-time AmeriCorps VISTA volunteer in our Wichita satellite office for a year while attending the university. We are very pleased she has joined our team.

2. Satellite Offices

Both Satellite offices opened the beginning of fourth quarter.

3. Current volunteer coverage

There are two regular volunteers and one volunteer being mentored in the Kansas City Satellite office. There are two regular volunteer and two volunteers in training in the Wichita office. We have two Education Resource Volunteers/Interns in training who are remote and will be assisting with our Community Resources by county project.

IX. Appendix A: Outreach by KanCare Ombudsman Office

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

A. Outreach through Education

- 10/7: WSU CEI staff presented to 68 attendees at the CPAAA monthly networking meeting to promote the work of the Ombudsman Office. Community providers initiated follow up conversations to brainstorm potential networking and education opportunities.
- 10/8: WSU CEI staff attended and presented to 30 attendees at the Healthier Lyon County Coalition meeting via Zoom. Subsequently, staff created an outreach listing on www.emporiastrong.com, a directory of assistance services in the Emporia area. Community providers initiated follow up conversations to brainstorm potential networking and education opportunities.
- 10/15: WSU CEI staff attended and spoke to 9 attendees at the Healthier Greenwood County Coalition meeting via Zoom.
- 10/28: Presentation to TARC (Topeka) staff regarding the KanCare Ombudsman Office.
- Throughout October, WSU CEI staff coordinated with the Executive Director of Children's' Advocacy Centers of Kansas to present to their membership at their quarterly meeting in November via Zoom.
- 12/10: WSU CEI staff & WSU practicum student attended the (virtual) Healthier Lyon County Coalition networking meeting, with 33 other attendees.

B. Outreach through Print Media and Social Media

- In October, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 26 hours on Facebook design & posting plans. These efforts addressed volunteer recruitment/recognition and community/KanCare member outreach
  Wichita Ombudsman VISTA made 9 Facebook posts:
  - 10/7: Volunteer Appreciation: 22 people reached, 0 engagements
  - 10/9: Web Apps Update: 25 people reached; 1 engagement
  - 10/15: Voting Tips for LTC Facilities: 25 people reached, 1 engagement
  - 10/16: Nothing About Us Without Us Celebration: 21 people reached, 1 engagement
  - 10/21: Final Rules Regarding ABLE Accounts: 44 people reached, 1 engagement
  - 10/23: KS LEND Education Series: 13 people reached, 0 engagements
  - 10/28: Legal Needs Survey: 15 people reached; 0 engagements
  - 10/29: Flu Shot Reminder: 12 people reached; 0 engagements
  - 10/30 Waiver Amendments: 13 people reached; 0 engagements
- WSU CEI staff coordinated with Aetna Community Outreach staff to highlight the KanCare Ombudsman Office in an upcoming Aetna newsletter (potentially November).

- In November, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 11 hours on Facebook design & posting plans. These efforts addressed COVID resources for those who are deaf or hard of hearing; COVID eviction prevention; hunger issues; and aging concerns.

  Wichita Ombudsman VISTA made 4 Facebook posts:

  - 11/18: State Plan on Aging: 70 people reached, 7 engagements
  - 11/19: PPE for those who deaf or hard of hearing: 10 people reached, 1 engagement
  - 11/23: Kansas eviction prevention program: 18 people reached, 0 engagements
  - 11/27: Hunger Clearinghouse resources: 21 people reached, 2 engagements
- In November, WSU Ombudsman VISTA continued to address her VISTA Assignment Description (VAD) with tasks that included building and revising an existing Ombudsman Office directory of statewide partners who offer KanCare application assistance in-person. She made 8 contacts with community partners to gather and update information. These partners included:
  - Anderson County Health Department
  - Salina Family Healthcare Center
  - Thrive Allen County
  - Neosho County Health Department
  - Atchison Senior Village
  - Kiowa District Healthcare
  - Butler County Health Department
  - GraceMed statewide
- 11/3: WSU Ombudsman VISTA visited with Wichita-area insurance representative Scott Lee to provide Ombudsman information and resources as he presents himself as a community resource.
- 11/4: WSU CEI staff attended the Central Plains Area Agency on Aging monthly networking meeting.
- WSU LMSW practicum student coordinated with Aetna outreach partners to include Ombudsman information on their resource website, AuntBertha: https://aetna-ks.auntbertha.com/
- WSU LMSW practicum student listed Ombudsman resources on the 1-800-Children online directory: https://1800childrenks.org/
- 11/10: WSU CEI staff was scheduled to present to the quarterly meeting of the State Chapter of Children's Advocacy Centers. The CACKS Executive Director coordinated with WSU CEI staff to cancel and reschedule this meeting due to scheduling conflicts with the CACKS membership. WSU CEI staff provided general outreach resources to pass along to CACKS members.

- 11/18: WSU CEI staff responded to a resource request from the Sedgwick County CDDO and delivered a box of Ombudsman brochures to their Wichita office
- 11/20: WSU CEI staff and VISTA attended virtual Healthier Greenwood County Coalition meeting.
- 11/20: WSU CEI staff met virtually with United Healthcare Outreach staff Laura Canelos to discuss Ombudsman services and reach.
- 11/9-11/20: WSU Ombudsman staff monitored a virtual exhibitor booth at the KCSL Kansas Governor's Conference on the Prevention of Child Abuse & Neglect.
- In December, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 6 hours on Facebook design & posting plans. Anita Martinez was able to schedule several posts before her service ended. Posts addressed COVID resources for those with disabilities, volunteer appreciation/recruitment, Medicaid/CHIP general information, COVID vaccine information, and information on the newly-posted Volunteer Coordinator position in the Johnson County office.

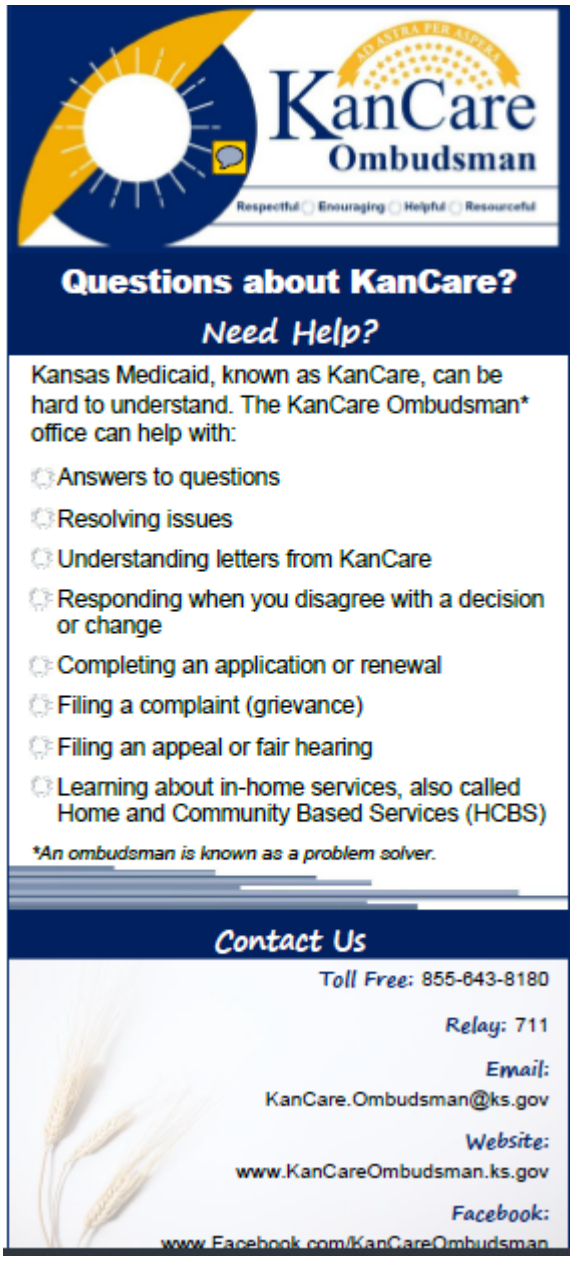
  Wichita Ombudsman personnel made 6 Facebook posts:

  - 12/2: COVID-19 resources for those with disabilities: 24 people reached, 1 engagement
  - 12/4: Volunteer appreciation & recruitment: 26 people reached, 0 engagements
  - 12/7 Medicaid/CHIP general information: 53 people reached, 3 engagements
  - 12/9 Medicaid/CHIP general information, Spanish: 13 people reached, 0 engagements
  - 12/28 Avoiding COVID-19 vaccination scams: 35 people reached, 4 engagements
- In November, WSU CEI staff emailed the editor of the Wichita Riverside neighborhood newsletter to include recruitment & general outreach information in upcoming editions. As a result, our brochure was featured prominently in the December edition.

C. Outreach through Collaboration and Training

- During fourth quarter KanCare Ombudsman Team participated in several Integrated Referral and Intake System (IRIS) informational meetings. When appropriate, information about our organization was shared with other IRIS providers/participants.
  - 10/16: Johnson County IRIS Community Conversation
  - 12/11: Franklin County IRIS meeting
- 11/12: Participation in KanCare Long Term Care meeting. Provided updates on KanCare Ombudsman Office program.
- 12/8: Presentation to the KanCare Advisory Council on 3rd quarter activities and data.
- 12/9: Presentation to the Bethel Joint Committee on Home and Community Based Services and KanCare Oversight on 3rd quarter activities and data.
- 12/10: Participation in KanCare Long Term Care meeting.

X. Appendix B: KanCare Ombudsman Brochure



KanCare Ombudsman

Respectful Encouraging Helpful Resourceful

Questions about KanCare?

Need Help?

Kansas Medicaid, known as KanCare, can be hard to understand. The KanCare Ombudsman* office can help with:

- Answers to questions
- Resolving issues
- Understanding letters from KanCare
- Responding when you disagree with a decision or change
- Completing an application or renewal
- Filing a complaint (grievance)
- Filing an appeal or fair hearing
- Learning about in-home services, also called Home and Community Based Services (HCBS)

**An ombudsman is known as a problem solver.*

Contact Us

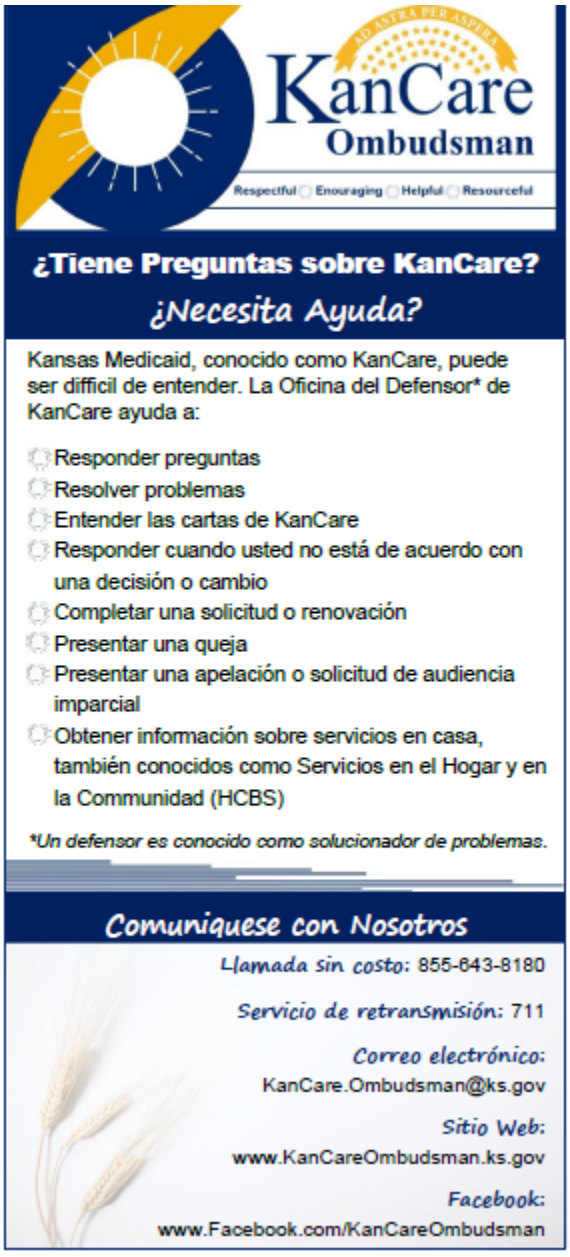
Toll Free: 855-643-8180

Relay: 711

Email: KanCare.Ombudsman@ks.gov

Website: www.KanCareOmbudsman.ks.gov

Facebook: www.Facebook.com/KanCareOmbudsman



KanCare Ombudsman

Respectful Encouraging Helpful Resourceful

¿Tiene Preguntas sobre KanCare?

¿Necesita Ayuda?

Kansas Medicaid, conocido como KanCare, puede ser difícil de entender. La Oficina del Defensor* de KanCare ayuda a:

- Responder preguntas
- Resolver problemas
- Entender las cartas de KanCare
- Responder cuando usted no está de acuerdo con una decisión o cambio
- Completar una solicitud o renovación
- Presentar una queja
- Presentar una apelación o solicitud de audiencia imparcial
- Obtener información sobre servicios en casa, también conocidos como Servicios en el Hogar y en la Comunidad (HCBS)

**Un defensor es conocido como solucionador de problemas.*

Comuníquese con Nosotros

Llamada sin costo: 855-643-8180

Servicio de retransmisión: 711

Correo electrónico: KanCare.Ombudsman@ks.gov

Sitio Web: www.KanCareOmbudsman.ks.gov

Facebook: www.Facebook.com/KanCareOmbudsman

XI. Appendix C: Managed Care Organization (MCO) Data

A. Aetna

MEDICAID ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Access to Providers (usually Medical)	2	2	4	5	0	1	0	3
Appeals/Fair Hearing questions/issues	0	1	1	0	1	1	0	1
Background Checks	0	0	0	0	0	0	0	0
Billing	3	0	5	4	2	2	2	5
Care Coordinator Issues	10	1	4	4	0	0	1	1
Change MCO	4	3	2	2	4	0	1	2
Choice Info on MCO	2	0	2	2	1	0	0	0
Coding Issues	1	0	1	1	0	0	0	0
Consumer said Notice not received	0	1	0	0	0	0	1	0
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0	0
Dental	3	0	2	2	1	0	1	0
Division of Assets	0	0	0	1	0	0	0	0
Durable Medical Equipment	1	2	2	0	1	2	1	2
Grievances Questions/Issues	2	2	4	3	5	3	1	1
Help understanding mail (NOA)	0	0	0	0	0	0	1	0
MCO transition	0	0	1	2	0	0	0	0
Medicaid Application Assistance	2	1	1	2	0	0	0	2
Medicaid Eligibility Issues	5	7	2	5	1	1	1	4
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid General Issues/questions	16	18	5	9	4	2	1	5
Medicaid info (status) update	4	1	4	5	4	4	1	3
Medicaid Renewal	1	12	3	2	3	0	0	1
Medical Card issues	0	0	0	0	0	0	1	0
Medicare Savings Plan Issues	2	1	1	3	3	0	0	1
MediKan issues	0	0	0	0	0	0	0	0
Moving to / from Kansas	0	0	1	1	0	0	0	0
Medical Services	3	4	4	3	2	2	2	3
Pain management issues	0	1	0	0	0	1	0	1
Pharmacy	4	3	1	2	1	0	0	1
Pregnancy issues	0	0	0	0	0	0	0	0
Prior authorization issues	0	0	0	0	0	0	1	1
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Spend Down Issues	1	3	2	3	2	2	2	1
Transportation	4	0	4	5	1	1	0	1
Working Healthy	0	0	0	0	0	0	0	1

MEDICAID ISSUES TOTAL	70	63	56	66	36	22	18	40

HCBS/LTSS ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Client Obligation	2	3	2	2	0	0	0	0
Estate Recovery	0	0	0	0	0	0	0	0
HCBS Eligibility issues	5	3	3	7	0	0	0	0
HCBS General Issues	7	5	7	6	0	5	2	2
HCBS Reduction in hours of service	0	0	1	0	0	1	0	0
HCBS Waiting List	2	0	0	1	0	0	0	0
Nursing Facility Issues	0	1	3	2	3	1	2	0
HCBS/LTSS ISSUES TOTAL	**16**	**12**	**16**	**18**	**3**	**7**	**4**	**2**

OTHER ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Abuse / neglect complaints	0	0	0	0	1	2	1	0
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0	0	0	0
Community Resources needed	0	0	0	0	0	1	0	0
Domestic Violence concerns	0	0	0	0	0	0	0	0
Foster Care issues	0	0	0	0	0	1	0	0
Guardianship	0	0	0	0	0	0	0	0
Homelessness	0	0	0	0	0	0	0	1
Housing Issues	0	0	1	0	0	0	1	1
Medicare related Issues	0	1	4	2	1	0	0	1
Social Security Issues	1	1	1	0	0	0	0	0
Used Interpreter	0	0	0	0	0	0	0	0
X-Other	14	6	6	3	3	6	4	5
Z Thank you	26	32	28	23	9	10	4	15
Z Unspecified	1	1	3	3	0	0	0	1
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**42**	**41**	**43**	**31**	**14**	**20**	**10**	**24**

PROGRAM TYPE	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
PD	3	2	1	2	1	2	1	1
I/DD	1	4	2	1	0	2	0	1
FE	2	1	3	2	0	0	0	0
AUTISM	0	0	0	0	0	0	0	0
SED	0	1	0	2	0	1	0	0
TBI	2	3	2	2	0	0	2	0
TA	2	1	2	1	0	2	0	0
WH	0	0	0	0	0	0	0	0
MFP	0	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	0	0	2	0	0	0	0	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	0	2	1	2	2	2	0	0
FOSTER CARE	0	0	0	0	0	1	0	0
MEDIKAN	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	0	0	1	0
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**10**	**14**	**13**	**12**	**3**	**10**	**4**	**2**

B. Sunflower

MEDICAID ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Access to Providers (usually Medical)	4	3	5	2	2	0	0	2
Appeals/Fair Hearing questions/issues	1	3	0	0	4	2	1	8
Background Checks	0	0	0	0	0	0	0	0
Billing	4	7	6	2	2	1	4	7
Care Coordinator Issues	2	4	5	4	6	1	0	1
Change MCO	2	1	1	0	0	1	3	0
Choice Info on MCO	1	1	0	1	0	1	0	1
Coding Issues	4	3	0	0	0	0	1	1
Consumer said Notice not received	0	0	0	0	0	0	0	1
Cultural Competency	0	0	1	0	0	0	0	0
Data Requests	0	0	0	0	1	1	0	0
Dental	0	2	0	0	1	1	0	0
Division of Assets	0	0	0	0	0	0	0	0
Durable Medical Equipment	0	0	0	0	1	2	1	0
Grievances Questions/Issues	0	6	6	4	6	3	0	4
Help understanding mail (NOA)	0	0	0	0	2	1	0	1
MCO transition	0	0	0	0	0	0	0	0
Medicaid Application Assistance	1	0	1	2	3	0	0	1
Medicaid Eligibility Issues	14	5	3	10	5	1	1	0
Medicaid Fraud	0	0	0	0	0	1	0	0
Medicaid General Issues/questions	18	6	7	9	12	2	0	2
Medicaid info (status) update	4	8	4	9	6	1	2	2
Medicaid Renewal	4	10	6	6	3	0	0	0
Medical Card issues	0	0	1	0	2	1	0	1
Medicare Savings Plan Issues	0	0	2	2	1	0	0	0
MediKan issues	0	0	0	0	0	0	0	0
Moving to / from Kansas	1	0	0	0	2	0	0	0
Medical Services	5	3	2	5	6	2	1	4
Pain management issues	1	0	0	0	0	0	0	0
Pharmacy	6	2	0	2	0	1	0	0
Pregnancy issues	0	0	0	2	0	0	0	1
Prior authorization issues	0	0	0	0	0	1	0	0
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Spend Down Issues	2	0	3	3	3	0	0	1
Transportation	2	1	2	2	3	2	0	0
Working Healthy	1	0	1	0	0	0	0	0
MEDICAID ISSUES TOTAL	77	65	56	65	71	26	14	38

HCBS/LTSS ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Client Obligation	1	0	4	1	2	0	0	1
Estate Recovery	0	0	0	0	0	0	0	0
HCBS Eligibility issues	5	5	6	4	1	0	3	1
HCBS General Issues	7	9	6	8	7	9	7	3
HCBS Reduction in hours of service	2	1	0	0	1	2	2	2
HCBS Waiting List	1	1	1	1	0	0	1	0
Nursing Facility Issues	0	1	1	0	1	0	2	2
HCBS/LTSS ISSUES TOTAL	16	17	18	14	12	11	15	9

OTHER ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Abuse / neglect complaints	0	0	1	0	1	0	0	0
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	1	0	1
Affordable Care Act Calls	0	1	0	0	0	0	0	0
Community Resources needed	0	0	0	0	0	1	0	0
Domestic Violence concerns	0	0	0	0	0	0	0	0
Foster Care issues	0	0	0	0	0	0	0	0
Guardianship	0	0	0	0	1	0	0	0
Homelessness	0	0	0	0	0	1	0	0
Housing Issues	0	0	0	0	0	1	1	1
Medicare related Issues	1	0	0	1	2	1	0	0
Social Security Issues	0	0	0	0	0	1	0	0
Used Interpreter	0	0	0	0	0	0	0	0
X-Other	10	8	5	5	9	6	6	7
Z Thank you	34	29	23	29	24	14	12	14
Z Unspecified	3	4	2	1	0	1	0	1
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**48**	**42**	**31**	**36**	**37**	**27**	**19**	**24**

PROGRAM TYPE	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
PD	2	5	5	4	4	5	5	0
I/DD	5	4	4	2	0	2	2	0
FE	3	2	6	2	1	1	1	3
AUTISM	0	0	1	0	1	0	1	0
SED	0	0	0	1	0	1	0	0
TBI	4	2	0	2	1	1	0	0
TA	1	0	2	1	1	1	0	1
WH	1	1	0	0	0	0	0	0
MFP	0	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	0	0	0	0	0	0	0	1
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	0	1	0	2	1	0	1	1
FOSTER CARE	0	0	0	0	0	0	0	0
MEDIKAN	0	0	0	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	0	0	0	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	1	0	0	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**16**	**15**	**18**	**15**	**9**	**11**	**10**	**7**

C. United Healthcare

MEDICAID ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Access to Providers (usually Medical)	2	2	4	2	1	0	0	3
Appeals/Fair Hearing questions/issues	1	1	1	0	4	2	1	1
Background Checks	0	1	0	0	0	0	0	0
Billing	1	2	4	3	4	2	3	3
Care Coordinator Issues	5	0	1	4	6	0	2	3
Change MCO	2	3	0	3	2	1	1	1
Choice Info on MCO	0	1	0	0	1	1	0	0
Coding Issues	3	1	1	0	1	0	0	0
Consumer said Notice not received	0	0	1	1	0	0	0	0
Cultural Competency	0	0	0	0	0	0	0	0
Data Requests	0	0	0	0	0	0	0	0
Dental	3	1	1	0	0	0	0	0
Division of Assets	0	0	0	0	0	0	0	0
Durable Medical Equipment	2	1	1	1	1	3	0	1
Grievances Questions/Issues	4	0	2	4	6	1	0	3
Help understanding mail (NOA)	0	0	0	0	0	0	0	0
MCO transition	0	0	0	0	1	0	0	0
Medicaid Application Assistance	2	0	0	0	0	1	0	1
Medicaid Eligibility Issues	11	9	4	0	4	2	1	3
Medicaid Fraud	0	0	0	0	0	0	0	0
Medicaid General Issues/questions	20	10	10	4	8	1	1	2
Medicaid info (status) update	9	10	3	3	9	1	0	2
Medicaid Renewal	2	6	3	3	1	0	0	0
Medical Card issues	0	0	0	2	2	1	0	2
Medicare Savings Plan Issues	0	0	1	0	0	0	0	1
MediKan issues	0	0	1	0	0	0	0	0
Moving to / from Kansas	0	0	0	0	0	0	0	0
Medical Services	2	0	1	0	3	3	5	1
Pain management issues	2	0	0	0	0	0	0	0
Pharmacy	2	4	3	0	2	2	2	3
Pregnancy issues	0	0	0	0	0	0	0	0
Prior authorization issues	0	0	1	0	1	0	0	1
Refugee/Immigration/SOBRA issues	0	0	0	0	0	0	0	0
Respite	0	0	0	0	0	0	0	0
Spend Down Issues	4	2	1	2	2	0	1	3
Transportation	1	2	1	1	3	2	0	3

Working Healthy	0	1	0	0	0	0	0	0
MEDICAID ISSUES TOTAL	**78**	**57**	**45**	**33**	**62**	**23**	**17**	**37**

HCBS/LTSS ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Client Obligation	2	1	2	0	0	0	1	1
Estate Recovery	0	0	0	1	0	0	0	0
HCBS Eligibility issues	4	2	1	3	2	0	2	2
HCBS General Issues	12	8	4	4	8	1	5	7
HCBS Reduction in hours of service	3	0	0	0	1	0	5	2
HCBS Waiting List	2	0	2	1	0	0	0	0
Nursing Facility Issues	2	0	3	3	4	0	0	2
HCBS/LTSS ISSUES TOTAL	**25**	**11**	**12**	**12**	**15**	**1**	**13**	**14**

OTHER ISSUES	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Abuse / neglect complaints	0	0	0	0	0	0	0	0
ADA Concerns	0	0	0	0	0	0	0	0
Adoption issues	0	0	0	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0	0	0	0
Community Resources needed	0	0	0	0	0	1	0	0
Domestic Violence concerns	0	0	0	0	0	0	0	0
Foster Care issues	0	0	0	0	0	0	0	0
Guardianship	0	0	0	0	0	0	0	0
Homelessness	0	0	0	0	0	0	1	0
Housing Issues	0	1	0	0	1	0	0	1
Medicare related Issues	2	0	0	1	1	1	0	1
Social Security Issues	0	0	1	0	0	0	1	1
Used Interpreter	0	0	0	0	0	0	0	0
X-Other	11	7	2	2	5	2	8	8
Z Thank you	49	29	22	14	18	8	12	15
Z Unspecified	2	1	2	5	0	1	0	1
Health Homes	0	0	0	0	0	0	0	0
OTHER ISSUES TOTAL	**64**	**38**	**27**	**22**	**25**	**13**	**22**	**27**

PROGRAM TYPE	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
PD	10	5	2	5	3	1	5	4
I/DD	6	10	1	0	1	0	0	1
FE	4	3	3	1	3	0	4	1
AUTISM	1	0	0	0	0	0	0	0
SED	2	1	0	0	0	1	0	0
TBI	2	0	1	0	2	1	1	2
TA	0	1	0	0	1	0	1	0
WH	0	0	0	0	0	0	0	0
MFP	0	0	0	0	0	0	0	0
PACE	0	0	0	0	0	0	0	0
MENTAL HEALTH	0	1	0	0	0	1	0	0
SUB USE DIS	0	0	0	0	0	0	0	0
NURSING FACILITY	2	1	2	5	3	0	0	0
FOSTER CARE	0	0	0	0	0	0	0	0
MEDIKAN	0	0	1	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	1	1	0	1	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	0	1	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0	0	0	0
PROGRAM TYPE TOTAL	**27**	**22**	**10**	**12**	**14**	**5**	**12**	**9**

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 8- QTR 4

DSRIP Payment

Paid dates 11/05/2020

Provider Names	DY8 QTR 4 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	1,781,250	617,025	1,164,225
University of Kansas Hospital	8,240,625	2,854,552*	5,386,073
Total	10,021,875	3,471,578	6,550,298

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 8 - Quarter Four
Health Care Access Improvement Pool
Paid dates 11/12/2020 and 12/17/2020

Provider Name	Program Name	Program ID	Amount	Payment Date	Liability Date	Warrant number	Provider Access Fund 2443	Federal Medicaid Fund 3414
Adventhealth Ottawa	Health Care Access Improvement Program Pool	03264	60,638	12/17/2020	12/31/2020	008576808	20,690	39,948
Ascension Via Christi Hospital St. Teresa Inc	Health Care Access Improvement Program Pool	03264	69,177	12/17/2020	12/31/2020	005367634	23,603	45,574
Ascension Via Christi Rehabilitation Hospital	Health Care Access Improvement Program Pool	03264	18,477	12/17/2020	12/31/2020	008576632	6,304	12,173
Bob Wilson Memorial Grant County Hospital	Health Care Access Improvement Program Pool	03264	23,394	12/17/2020	12/31/2020	008576425	7,982	15,412
Childrens Mercy South	Health Care Access Improvement Program Pool	03264	204,839	12/17/2020	12/31/2020	008576392	69,891	134,948
Coffeyville Regional Medical Center Inc	Health Care Access Improvement Program Pool	03264	64,768	12/17/2020	12/31/2020	008576646	22,099	42,669
Doctors Hospital Llc	Health Care Access Improvement Program Pool	03264	8,385	12/17/2020	12/31/2020	005367483	2,861	5,524
Geary County Hospital	Health Care Access Improvement Program Pool	03264	99,990	12/17/2020	12/31/2020	005367493	34,117	65,873
Hays Medical Center	Health Care Access Improvement Program Pool	03264	272,344	12/17/2020	12/31/2020	008576436	92,924	179,420
Hutchinson Regional Medical Center Inc	Health Care Access Improvement Program Pool	03264	244,073	12/17/2020	12/31/2020	008576568	83,278	160,795
Kansas Heart Hospital Llc	Health Care Access Improvement Program Pool	03264	12,589	12/17/2020	12/31/2020	008576761	4,295	8,294
Kansas Rehabilitation Hospital	Health Care Access Improvement Program Pool	03264	25,202	12/17/2020	12/31/2020	008576719	8,599	16,603
Kansas Surgery And Recovery Center Llc	Health Care Access Improvement Program Pool	03264	2,612	12/17/2020	12/31/2020	008576631	891	1,721
Labette Co Med	Health Care Access Improvement Program Pool	03264	78,448	12/17/2020	12/31/2020	005367640	26,766	51,682
Lawrence Memorial Hospital	Health Care Access Improvement Program Pool	03264	290,612	12/17/2020	12/31/2020	008576691	99,157	191,455
Mcpherson Hospital Inc	Health Care Access Improvement Program Pool	03264	22,013	12/17/2020	12/31/2020	008576576	7,511	14,502
Menorah Medical Center	Health Care Access Improvement Program Pool	03264	192,086	12/17/2020	12/31/2020	008576672	65,540	126,546
Mercy Hospital Inc	Health Care Access Improvement Program Pool	03264	4,583	12/17/2020	12/31/2020	005367577	1,564	3,019
Miami County Medical Center Inc	Health Care Access Improvement Program Pool	03264	59,801	12/17/2020	12/31/2020	005367405	20,404	39,397
Midamerica Rehabilitation Hospital	Health Care Access Improvement Program Pool	03264	21,396	12/17/2020	12/31/2020	008576758	7,300	14,096
Morton County Hospital	Health Care Access Improvement Program Pool	03264	8,759	11/12/2020	9/30/2020	008548675	2,989	5,770
Morton County Hospital	Health Care Access Improvement Program Pool	03264	8,758	12/17/2020	12/31/2020	008576579	2,988	5,770
Nmc Health Medical Center	Health Care Access Improvement Program Pool	03264	145,601	12/17/2020	12/31/2020	008576611	49,679	95,922
Olathe Medical Center Inc	Health Care Access Improvement Program Pool	03264	360,646	12/17/2020	12/31/2020	005367406	123,052	237,594
Overland Park Reg Med Ctr	Health Care Access Improvement Program Pool	03264	718,580	12/17/2020	12/31/2020	008576394	245,179	473,401
Pratt Regional Medical Center Corportation	Health Care Access Improvement Program Pool	03264	37,198	12/17/2020	12/31/2020	008576616	12,692	24,506
Providence Medical Center	Health Care Access Improvement Program Pool	03264	430,055	12/17/2020	12/31/2020	005367434	146,735	283,320

1115 Waiver - Safety Net Care Pool Report
Demonstration Year 8 - Quarter Four
Health Care Access Improvement Pool
Paid dates 11/12/2020 and 12/17/2020

Provider Name	Program Name	Program ID	Amount	Payment Date	Liability Date	Warrant number	Provider Access Fund 2443	Federal Medicaid Fund 3414
Rehabilitation Hospital Of Overland Park	Health Care Access Improvement Program Pool	03264	19,362	12/17/2020	12/31/2020	005373988	6,606	12,756
Saint John Hospital	Health Care Access Improvement Program Pool	03264	75,858	12/17/2020	12/31/2020	005367432	25,883	49,975
Saint Lukes Cushing Hospital	Health Care Access Improvement Program Pool	03264	79,041	12/17/2020	12/31/2020	008576432	26,969	52,072
Saint Lukes South Hospital Inc	Health Care Access Improvement Program Pool	03264	60,327	12/17/2020	12/31/2020	008576659	20,584	39,743
Salina Regional Health Center	Health Care Access Improvement Program Pool	03264	290,522	12/17/2020	12/31/2020	008576639	99,126	191,396
Shawnee Mission Medical Center Inc	Health Care Access Improvement Program Pool	03264	839,299	12/17/2020	12/31/2020	008576450	286,369	552,930
South Central Kansas Regional Medical Center	Health Care Access Improvement Program Pool	03264	31,619	12/17/2020	12/31/2020	008576598	10,788	20,831
Southwest Medical Center	Health Care Access Improvement Program Pool	03264	80,782	12/17/2020	12/31/2020	008576459	27,563	53,219
St Catherine Hospital	Health Care Access Improvement Program Pool	03264	151,209	12/17/2020	12/31/2020	008576423	51,593	99,616
Stormont Vail Health Care Inc	Health Care Access Improvement Program Pool	03264	353,425	12/17/2020	12/31/2020	008576431	120,589	232,836
Susan B Allen Memorial Hospital	Health Care Access Improvement Program Pool	03264	95,272	12/17/2020	12/31/2020	008576445	32,507	62,765
The University Of Kansas Health System Great Bend	Health Care Access Improvement Program Pool	03264	77,263	12/17/2020	12/31/2020	005367672	26,362	50,901
Topeka Hospital Llc D/B/A The University Of Kansas	Health Care Access Improvement Program Pool	03264	284,552	12/17/2020	12/31/2020	008576805	97,089	187,463
Via Christi Hospital Manhattan	Health Care Access Improvement Program Pool	03264	360,254	12/17/2020	12/31/2020	008576650	122,919	237,335
Via Christi Hospital Pittsburg	Health Care Access Improvement Program Pool	03264	255,632	12/17/2020	12/31/2020	008576429	87,222	168,410
Via Christi Hospitals Wichita Inc	Health Care Access Improvement Program Pool	03264	1,503,561	12/17/2020	12/31/2020	008576645	513,015	990,546
Wesley Medical Center	Health Care Access Improvement Program Pool	03264	1,970,770	12/17/2020	12/31/2020	008576724	672,427	1,298,343
Wesley Rehabilitation Hospital, An Affiliate Of En	Health Care Access Improvement Program Pool	03264	26,452	12/17/2020	12/31/2020	008576343	9,025	17,427
Western Plains Medical Complex	Health Care Access Improvement Program Pool	03264	115,883	12/17/2020	12/31/2020	008576341	39,539	76,344
			10,156,107				**3,465,264**	**6,690,843**

1115 Waiver- Safety Net Care Pool Report

Demonstration Year 8 - Quarter Four

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

Paid date 12/18/2020

Hospital Name	Program Name	Program ID	Amount	Payment Date	Liability Date	Warrant number	State General Fund 1000	Federal Medicaid Fund 3414
Childrens Mercy Hospital	Large Public Teaching Border City Children Hosp	04264	616,034	12/18/2020	12/31/2020	008576393	210,191	405,843
University Of Kansas Hospital Authority	Large Public Teaching Border City Children Hosp	04264	1,848,103	12/18/2020	12/31/2020	008576656	630,573*	1,217,530
Total			2,464,137				840,764	1,623,373

*IGT from University of Kansas Hospital Authority

KanCare Summary of Claims Adjudication Statistics per MCO (Jan through Dec 2020)

Aetna YTD Cumulative Claims					
Service Type	Total Count	Total Count Value	Total Denied	Total Denied Value	Percent Claims Denied
Hospital Inpatient	23,324	$1,290,099,245	4,310	$286,019,097	18.5%
Hospital Outpatient	227,876	$844,530,598	41,537	$239,572,775	18.2%
Pharmacy	1,896,813	$151,336,547	540,694	$1,181,416	28.5%
Dental	96,142	$37,353,714	11,931	$4,474,484	12.4%
Vision	8,243	$2,017,382	704	$174,205	8.5%
NEMT	92,603	$3,877,602	2,365	$18,993	2.6%
Medical	1,343,376	$680,314,293	183,705	$122,921,226	13.7%
Nursing Facilities	76,352	$205,794,178	7,340	$25,697,427	9.6%
HCBS	309,427	$147,179,658	7,699	$6,104,009	2.5%
Behavioral Health	222,806	$103,782,712	10,585	$11,859,956	4.8%
Total All Services	4,296,962	$3,466,285,935	810,870	$698,023,591	18.9%

Sunflower YTD Cumulative Claims					
Service Type	Total Count	Total Count Value	Total Denied	Total Denied Value	Percent Claims Denied
Hospital Inpatient	38,633	$2,080,209,813	9,159	$644,143,046	23.7%
Hospital Outpatient	336,066	$1,093,123,081	47,370	$215,979,196	14.1%
Pharmacy	1,871,054	$192,377,040	428,836	$83,046,785	22.9%
Dental	142,005	$52,073,727	17,974	$4,588,694	12.7%
Vision	90,136	$25,230,704	13,176	$4,037,810	14.6%
NEMT	134,713	$3,780,246	1,755	$56,572	1.3%
Medical	1,680,572	$1,123,801,571	234,167	$235,782,577	13.9%
Nursing Facilities	130,207	$321,361,527	11,225	$39,908,653	8.6%
HCBS	660,614	$393,986,154	30,412	$21,890,769	4.6%
Behavioral Health	749,183	$138,498,482	73,144	$17,279,461	9.8%
Total All Services	5,833,183	$5,424,442,347	867,218	$1,266,713,564	14.9%

United YTD Cumulative Claims					
Service Type	Total Count	Total Count Value	Total Denied	Total Denied Value	Percent Claims Denied
Hospital Inpatient	29,722	$1,492,147,740	6,495	$365,014,616	21.9%
Hospital Outpatient	332,412	$1,103,676,179	68,667	$241,552,286	20.7%
Pharmacy	1,828,459	$222,546,532	368,292	$77,921,919	20.1%
Dental	138,710	$55,278,451	27,134	$10,628,167	19.6%
Vision	76,441	$18,401,385	14,210	$3,334,422	18.6%
NEMT	147,774	$4,582,587	1,759	$45,628	1.2%
Medical	1,652,824	$1,129,598,683	292,830	$323,948,575	17.7%
Nursing Facilities	127,422	$366,478,094	18,145	$51,497,045	14.2%
HCBS	538,993	$253,056,096	11,695	$7,139,388	2.2%
Behavioral Health	760,252	$194,465,940	61,729	$35,274,772	8.1%
Total All Services	5,633,009	$4,840,231,692	870,956	$1,116,356,823	15.5%

2020 Annual Report

I. Introduction

Pursuant to the KanCare Special Terms and Conditions issued by the Centers for Medicare and Medicaid Services, Number 11-W-00283/7, the State of Kansas, Department of Health and Environment, Division of Health Care Finance, submits this eighth annual report related to Demonstration Year(DY) 2020. KanCare is a managed care Medicaid program which serves the State of Kansas through a coordinated approach. The State determined that contracting with multiple managed care organizations will result in the provision of efficient and effective health care services to the populations covered by the Medicaid and Children's Health Insurance Program (CHIP) in Kansas and will ensure coordination of care and integration of physical and behavioral health services with each other and with home and community-based services (HCBS).

On August 6, 2012, the State of Kansas submitted a Medicaid Section 1115 demonstration proposal, entitled KanCare. That request was approved by the Centers for Medicare and Medicaid Services on December 27, 2012, effective from January 1, 2013, through December 31, 2017. The State submitted a one-year temporary extension request of this demonstration to CMS on July 31, 2017. The temporary extension was approved on October 13, 2017. On December 20, 2017, the State submitted an extension request for its Medicaid 1115 demonstration. On December 18, 2018 the Centers for Medicare and Medicaid Services approved a renewal of the Medicaid Section 1115 demonstration proposal entitled KanCare. The demonstration is effective from January 1, 2019 through December 31, 2023.

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

This five-year demonstration will:

- Maintain Medicaid state plan eligibility;
- Maintain Medicaid state plan benefits;
- Continue to allow the state to require eligible individuals to enroll in managed care organizations (MCOs) to receive covered benefits through such MCOs, including individuals on HCBS waivers, except:
    - American Indian/Alaska Natives are presumptively enrolled in KanCare but will have the option of affirmatively opting-out of managed care.
- Provide benefits, including long-term services and supports (LTSS) and HCBS, via managed care;
- Extend the Delivery System Reform Incentive Payment program; and
- Design and implement an alternative payment model (APM) program to replace the DSRIP program
- Maintain the Safety Net Care Pool to support hospitals that provide uncompensated care to Medicaid beneficiaries and the uninsured.
- Increase beneficiary access to substance use disorder (SUD) treatment services.
- Provide work opportunities and supports for individuals with specific behavioral health conditions and other disabilities.

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

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

II. STC 64(a) – Operational Updates

Items from the 2020 quarterly reports which are not included in other areas of this annual report, have not already been provided in cumulative annual form, and/or are subject to annualizing are summarized here:

A. Operational Developments/Issues:
   i. Systems and reporting issues, approval and contracting with new plans:
   No new plans have been contracted. Through a variety of accessible forums and input avenues, the State is kept advised of any systems or reporting issues on an ongoing basis and worked either internally, with our MMIS Fiscal Agent, with the operating state agency and/or with the MCOs and other contractors to address and resolve the issues. Examples of this include ongoing external work groups with consumer focus and provider focus; technical work groups with key provider associations to resolve outstanding issues; and provider surveys or focused projects to assess and address systemic issues. Annual reviews of the MCOs are discussed elsewhere in this report. Each quarter, the State reports then-current consumer issues, resolutions, and actions taken to prevent further occurrences. Summaries of those issues are included in the state's quarterly STC reports submitted to CMS and posted on the KanCare website[6].

B. KanCare Ombudsman Annual Report:
   i. A summary of the KanCare Ombudsman program activities for demonstration year 2020 is attached.

C. Legislative Activity:
   i. KDHE and KDADS conducted robust legislative activity and engagement throughout the 2020 demonstration year. Updates legislative activity are provided in each quarterly 1115 Waiver Report. For the most recent update please see section IV(m.) of the 2020 fourth quarter report.

[6] https://kancare.ks.gov/policies-and-reports/annual-and-quarterly-reports

D. Annual Public Forum Update:

i. The KanCare annual public forum, pursuant to STC 71, was conducted on December 16, 2020. A summary of the forum, including comments and issues raised at the forum, is attached.

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

A. Benefits:

All pre-KanCare benefits continue, and the program includes value-added benefits from each of the three KanCare MCOs at no cost to the State. A summary of value-added services utilization, per each of the KanCare MCOs, by top three value-added services and total for January-December 2020, follows:

MCO		Value Added Service Jan-Dec. 2020	Units YTD	Value YTD
Aetna	Top Three VAS	Healthy Rewards Gift Card	37,146	$553,486
		Adult Dental	1,816	$347,147
		Kids Club Program $10 Gift Card	26,849	$268,498
		Total of All Aetna VAS	77,769	$1,627,182
Sunflower	Top Three VAS	My Health Pays	58,419	$625,365
		Comprehensive Medication Review	11,379	$299,645
		Dental visits for adults	3,983	$122,048
		Total of All Sunflower VAS	107,478	$1,561,127
United	Top Three VAS	Adult Dental & Denture Services	4,561	$496,213
		Debit Card for Completing First Pre-Natal Visit	1,293	$259,036
		Home Helper Catalog Supplies	4,759	$136,214
		Total of All United VAS	18,547	$1,157,571

B. Enrollment issues: for the calendar year 2020 there were 16 Native Americans who chose to not enroll in Kancare.

The table below represents the enrollment reason categories for calendar year 2020. All KanCare eligible members were defaulted to a managed care plan.

Enrollment Reason Categories	Total
Newborn Assignment	9,163
KDHE - Administrative Change	3,008
WEB - Change Assignment	46
KanCare Default - Case Continuity	3,850
KanCare Default – Morbidity	3,836
KanCare Default - 90 Day Retro-reattach	9,442
KanCare Default - Previous Assignment	2,420
KanCare Default - Continuity of Plan	1,785
Retro Assignment	153
AOE – Choice	5,574
Choice - Enrollment in KanCare MCO via Medicaid Application	32,919
Change - Enrollment Form	961
Change - Choice	1,121
Change - Access to Care – Good Cause Reason	77
Change - Case Continuity – Good Cause Reason	4
Assignment Adjustment Due to Eligibility	1,527
Total	75,886

C. Grievances and appeals:

The following grievance, appeal and state fair hearing data reports activity for all of 2020.

MCOs' Member Adverse Initial Notice Timeliness Compliance

MCO	ABH	SUN	UHC
% of Notices of Adverse Service Authorization Decisions Sent Within Compliance Standards	99%/100%	100%	100%
% of Notices of Adverse Expedited Service Authorization Decisions Sent Within Compliance Standards	100%	93%	97%
% of Notices of Adverse Termination, Suspension or Reduction Decisions Sent Within Compliance Standards (10 calendar days only)	100%	100%	100%

MCOs' Provider Adverse Initial Notice Compliance

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

MCOs' Member Grievance Database

MCO	ABH		SUN		UHC		Total
	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	HCBS Member	Non HCBS Member	
QOC (non HCBS Providers)	4	12	29	40	21	50	156
QOC – Pain Medication	0	4	3	10	1	8	26
Customer Service	5	19	11	18	27	35	115
Member Rights Dignity	1	4	4	3	0	1	13
Access to Service or Care	1	8	27	35	6	97	174
Non-Covered Services	1	6	3	0	4	6	20
Pharmacy Issues	4	1	2	3	3	17	30
QOC HCBS Provider	1	0	15	0	8	0	24
Billing/Financial Issues (non-Transportation)	5	21	8	18	31	165	248
Transportation – Billing and Reimbursement	1	10	9	20	8	24	72
Transportation - No Show	4	13	42	41	34	64	198
Transportation - Late	7	15	29	45	44	57	197
Transportation - Safety	6	7	9	8	28	20	78
Transportation - No Driver Available	1	3	4	12	6	4	30
Transportation - Other	21	22	62	39	53	76	273
Health Home Services	2	2					4
MCO Determined Not Applicable			2	4	2	14	22
Other		1	1	1	8	15	26
TOTAL	64	148	260	297	284	653	1,706

MCO's Member Grievance Timeliness Compliance

MCO	ABH	SUN	UHC
% of Member Grievance Resolved and Resolution Notice Issued Within 30 Calendar Days	89%	90%	100%

MCOs' Provider Grievance Database

MCO	ABH	SUN	UHC	Total
Billing/Payment	2	22	1	25
Wrong Information		1		1
Network – MCO		1		1
UM		5		5
CM		2		2
Benefits/Eligibility		1		1
Pharmacy		2		2
Transportation		34	40	74
Services		2		2
Health Plan – Technology		2		2
Other – Dissatisfaction with MCO Associate		4		4
Other (Must provide description in narrative column of Summary Reports)			22	22
TOTAL	2	76	63	141

MCO's Provider Grievance Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Grievance Resolved Within 30 Calendar Days	100%	95%	97%
% of Provider Grievance Resolution Notices Sent Within Compliance Standards	100%	100%	100%

MCOs' Appeals Database

Member Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met							
MA – CNM - Durable Medical Equipment	13 126 75	 2 	1 1 	4 75 22	4 11 46	2 27 	2 10 7
MA – CNM - Inpatient Admissions (Non-Behavioral Health)	2 19 121	 97	 	 4 6	 3 17	 3 	2 9 1
MA – CNM - Medical Procedure (NOS)	69 56 37	2 	2 1 	20 33 16	29 9 19	1 8 	15 5 2
MA – CNM - Radiology	36 165	 	 6	19 41	9 96	1 19	7 3
MA – CNM - Pharmacy	285 176 409	6 14 8	3 2 	113 99 330	111 24 64	 15 	52 22 7
MA – CNM - PT/OT/ST	28 1	 	2 	8 	12 	6 	 1
MA – CNM - Dental	10 23 33	 1	 	 2 3	7 5 26	2 10 	1 6 3
MA – CNM - Home Health	5 23 1	2 	 	1 14 1	2 4 	 2 	 3
MA – CNM - Out of network provider,	3 2	 	1 	1 1	1 	 	 1

specialist or specific provider request	22			13	9		
MA – CNM - Inpatient Behavioral Health	18 45 13	 1 1	1	5 29 3	9 13 8		3 2 1
MA – CNM - Behavioral Health Outpatient Services and Testing	1 2 2	 1			1 2		 1
MA – LOC - LTSS/HCBS	4 12 2	 1		2 1	2 5 1	3	 3
MA – CNM - Mental Health	5 2		1	1 1	3		 1
MA – CNM - HCBS (change in attendant hours)	11 1		4	1	4		2 1
MA – CNM – Ambulance (include Air and Ground)	3						3
MA – CNM - Other	6 48 10	 1	1 4	2 21 5	1 4 4	 11	2 7 1
NONCOVERED SERVICE							
MA – NCS - Dental	2 6 4				1 4 4		1 2
MA – NCS – Home Health	1 1			 1	1		
MA – NCS - Pharmacy	11 2 2	 1 1		6 1 1	3		2
MA – NCS – Out of Network providers	2				2		
MA – NCS - Durable Medical Equipment	2 6 1			1 1	 3 1		1 2
MA – NCS – Behavioral Health	6 1	 1		3	2		1
MA – NCS – Other	27 3	 1	1	18	4 2	2	2
MA – LCK - Lock In	18		3	9	5		1
MA – BFI – BILLING AND FINANCIAL ISSUES	1						1
ADMINISTRATIVE DENIALS							
MA – ADMIN – Denials of Authorization (Unauthorized by Members)	2 3			 1	 2		2
TOTAL ABH - Red SUN – Green UHC - Purple	 479 783 764	 10 20 111	 10 21 3	 178 349 412	 186 201 212	 6 106	 89 86 26

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

MCO's Appeals Database - Member Appeal Summary

Member Appeal Reasons ABH - Red	Number Resolved	Withdrawn	MCO Reversed Decision on	MCO Reversed Decision on Appeal –	MCO Upheld Decision on Appeal –	MCO Upheld Decision on	MCO Determined not Applicable

SUN – Green UHC - Purple			Appeal – MCO Error	Member/ Provider Mistake	Correctly Denied	Appeal – Member/ Provider Mistake	
Resolved at Appeal Level	479 783 764	10 20 111	10 21 3	178 349 412	186 201 212	6 106	89 86 26
TOTAL	479 783 764	10 20 111	10 21 3	178 349 412	186 201 212	6 106	89 86 26
Percentage Per Category		2% 3% 15%	2% 3% >1%	37% 45% 54%	39% 26% 28%	1% 13%	19% 10% 3%
Range of Days to Reverse Due to MCO Error			8-148 4-60 8-51				

MCO's Member Appeal Timeliness Compliance

MCO	ABH	SUN	UHC
% of Member Appeals Resolved and Appeal Resolution Notice Issued in 30 Calendar Days	85%	99%	100%
% of Expedited Appeals Resolved and Appeal Resolution Notice Issued in 72 hours	90%	97%	98%

MCOs' Reconsideration Database - Providers - (reconsiderations resolved)

PROVIDER Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn by Provider	MCO Reversed Decision on Reconsideration – MCO Error	MCO Reversed Decision on Reconsideration – Provider Mistake	MCO Upheld Decision on Reconsideration – Correctly Denied / Paid	MCO Upheld Decision on Reconsideration – Provider Mistake	MCO Determined Not Applicable
CLAIM DENIALS							
PR – CPD - Hospital Inpatient (Non-Behavioral Health)	618 7,107 2,408	2	7 3,273 512	270 437 289	264 3,353 1,216	4 391	71 44
PR – CPD - Hospital Outpatient (Non-Behavioral Health)	427 12,366 15,224	1	12 7,255 3,496	188 311 2,534	161 4,655 6,257	8 2,937	57 145
PR – CPD - Pharmacy	14		1	8	5		
PR – CPD - Dental	30 45 24		3 22 10	15 13 11	12 9 3		 1
PR – CPD - Vision	20 115 153		 77 90	1 57	16 38 2		3 4
PR – CPD - Ambulance (Include Air and Ground)	118 144 361		4 81 110	65 13 88	36 39 126	 37	13 11
PR – CPD - Medical (Physical Health not Otherwise Specified)	1,412 11,120 48,174	2	44 5,795 16,587	409 1,160 9,637	627 3,846 15,359	83 6,591	247 319
PR – CPD - Nursing Facilities - Total	8 406 1,666		1 275 738	1 352	3 120 455	1 121	2 11
PR – CPD - HCBS	32 2,463	2	 1,862	17 33	6 475		7 93
PR – CPD - Hospice	25		1	8	13		3

	764 996		504 342	111	224 461	82	36
PR – CPD - Home Health	39 19		2 3	22 3	8 9	4	7
PR – CPD - Behavioral Health Outpatient and Physician	30 1,207 5,837		2 695 1,161	15 1 2,543	5 406 1,588	545	8 105
PR – CPD - Behavioral Health Inpatient	30 418		60	18 96	10 203	59	2
PR – CPD - Out of network provider, specialist or specific provider	15 5,900 30,596		471 12,729	1 4,597	12 5,083 9,390	1 3,880	1 346
PR – CPD - Radiology	127 1,879 5,524		1 803 1,347	56 382 897	57 654 1,897	3 1,383	10 40
PR – CPD - Laboratory	220 5,769 17,486	1	1 3,276 3,876	31 706 3,975	151 1,700 6,286	16 14 3,349	20 73
PR – CPD - PT/OT/ST	36 100 94		4 58 23	16 10 15	9 31 39	4 17	3 1
PR – CPD - Durable Medical Equipment	265 2,253		15 1,273	125 15	98 898	3	24 67
PR – CPD - Other	3 56 2,855		24 839	2 534	1 27 1,087	395	5
Total Claim Payment Disputes	3,469 51,694 131,835	8	98 25,744 41,923	1,268 3,081 25,739	1,494 21,558 44,378	123 14 19,791	478 1,297 4
BILLING AND FINANCIAL ISSUES							
PR – BFI - Recoupment	14		1	4	7		2
ADMINISTRATIVE DENIAL							
PR – ADMIN - Denials of Authorization (Unauthorized by Members)	12			9	2		1
TOTAL ABH - Red SUN – Green UHC - Purple	3,495 51,694 131,835	8	99 25,744 41,923	1,281 3,081 25,739	1,503 21,558 44,378	123 14 19,791	481 1,297 4

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

MCOs' Provider Reconsiderations Database - Provider Reconsiderations Summary

Provider Reconsideration Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
Resolved at Reconsideration Level	3,495 51,694 131,835	8	99 25,744 41,923	1,281 3,081 25,739	1,503 21,558 44,378	123 14 19,791	481 1,297 4
TOTAL	3,495 51,694 131,835	8	99 25,744 41,923	1,281 3,081 25,739	1,503 21,558 44,378	123 14 19,791	481 1,297 4
Percentage Per Category		>1%	3% 50% 32%	37% 6% 20%	43% 42% 33%	3% 15%	14% 2% >1%

MCOs' Provider Reconsiderations Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Reconsideration Resolution Notices Sent Within Compliance Standards	93%	100%	100%

MCOs' Appeals Database - Providers - (appeals resolved)

PROVIDER Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn by Provider	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied / Paid	MCO Upheld Decision on Appeal – Provider Mistake	MCO Determined Not Applicable
MEDICAL NECESSITY/LEVEL OF CARE - Criteria Not Met							
PA - CNM - Durable Medical Equipment	32 54	1		10 25	10 13	 11	11 5
PA - CNM - Inpatient Admissions (Non-Behavioral Health)	114 82	 1	1 5	49 44	48 12	3 10	13 10
PA - CNM - Medical Procedure (NOS)	256 48	2	6 1	67 29	109 6	7 12	65
PA - CNM - Radiology	11 8			6 4	4 1	 3	1
PA - CNM - Pharmacy	1 242	 17	 2	1 148	 25	 27	 23
PA - CNM - PT/OT/ST	8 5			4 1	3 3	 1	1
PA - CNM - Dental	8 24 22		1	6 6 2	1 7 20	 6	 5
PA - CNM - Home Health	8 12	 1		5 6	 2	 2	3 1
PA - CNM - Hospice	3 1		1	2 1			
PA - CNM - Out of network provider, specialist or specific provider request	3			1	1		1
PA - CNM - Inpatient Behavioral Health	12			6	2		4
PA - CNM - Behavioral Health Outpatient Services and Testing	1 10	 1		 6	 2		1 1
PA - LOC - LTSS/HCBS	4 1		1	1	2 1		
PA - LOC - Mental Health	2				2		
PA - CNM - Ambulance (include Air and Ground)	3 23		 1	2 9	1 4	 7	 2
PA - CNM - Other	12			7		4	1
NONCOVERED SERVICE							
PA - NCS - Dental	3 1 19			1 1 8	 11		2
PA - NCS - Pharmacy	4			2	1		1
PA - NCS - Durable Medical Equipment	5			3	2		
PA - NCS - Behavioral Health	1				1		
PA - NCS - Other	2 1			 1	1		1
CLAIM DENIAL							

PA – CPD - Hospital Inpatient (Non-Behavioral Health)	134 493 1,021	 1	4 25 9	46 221 254	58 213 659	1 17 	25 17 98
PA – CPD - Hospital Outpatient (Non-Behavioral Health)	103 628 323	 	2 29 3	29 250 69	43 290 178	6 21 	23 38 73
PA – CPD - Pharmacy	1 36	 	 	1 2	 8	 26	
PA – CPD - Dental	5 66 90	 	 20 	2 2 21	1 44 45	 24	2
PA – CPD - Vision	7 33 106	 	 10 12	1 1 21	3 22 44	 29	3
PA – CPD - Ambulance (Include Air and Ground)	4 12 22	 	 3 	3 5 11	 4 7	 	1 4
PA – CPD - Medical (Physical Health not Otherwise Specified)	138 1,140 536	3 	1 73 4	32 542 142	52 428 256	2 49 	48 48 134
PA – CPD - Nursing Facilities - Total	27 46	 	1 	7 7	16 21	2 	1 18
PA – CPD - HCBS	8 16	 	 1	5 7	1 8	 	2
PA – CPD - Hospice	4 10 10	 	 2 1	3 4 	1 2 5	 2 	 4
PA – CPD - Home Health	2 198 372	 2	 18 6	1 137 97	1 29 224	 12 	 2 43
PA – CPD - Behavioral Health Outpatient and Physician	11 206 165	 	1 1	1 92 63	6 108 75	 3 	3 3 26
PA – CPD - Behavioral Health Inpatient	8 1 49	 	 	6 22	 1 18	 	2 9
PA – CPD - Out of network provider, specialist or specific provider	102 8	 	6 	24 1	54 6	17 	1 1
PA – CPD - Radiology	3 101 10	 	 10 1	1 52 2	1 36 3	 2 	1 1 4
PA – CPD - Laboratory	73 517 222	 	1 7 	13 41 8	49 400 180	4 67 	6 2 34
PA – CPD - PT/OT/ST	4 111 4	 	 	 55 	2 52 2	 2 	2 2 2
PA – CPD - Durable Medical Equipment	43 299 9	 	2 15 	16 111 3	6 138 6	3 30 	16 5
PA – CPD - Other	1 29 46	 	 1 1	 13 15	1 12 20	 	 3 10
BILLING AND FINANCIAL ISSUES							

PA – BFI - Recoupment	2 366 14	1	26	251 1	1 61 12	7	1 20 1
ADMINISTRATIVE DENIAL							
PA – ADMIN - Denials of Authorization (Unauthorized by Members)	7			3		2	2
TOTAL ABH - Red SUN – Green UHC - Purple	 1,016 4,902 3,130	 6 21 3	 21 256 38	 318 2,114 749	 411 1,997 1,800	 26 316 79	 234 198 461

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

MCOs' Appeals Database - Provider Appeal Summary

Provider Appeal Reasons ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrawn	MCO Reversed Decision on Appeal – MCO Error	MCO Reversed Decision on Appeal – Member/ Provider Mistake	MCO Upheld Decision on Appeal – Correctly Denied	MCO Upheld Decision on Appeal – Member/ Provider Mistake	MCO Determined not Applicable
Resolved at Appeal Level	1,016 4,902 3,130	6 21 3	21 256 38	318 2,114 749	411 1,997 1,800	26 316 79	234 198 461
TOTAL	1,016 4,902 3,130	6 21 3	21 256 38	318 2,114 749	411 1,997 1,800	26 316 79	234 198 461
Percentage Per Category		1% 1% >1%	2% 5% 1%	31% 43% 24%	40% 41% 58%	3% 6% 3%	23% 4% 15%
Range of Days to Reverse Due to MCO Error			35-199 1-430 12-334				

MCOs' Provider Appeal Timeliness Compliance

MCO	ABH	SUN	UHC
% of Provider Appeals Resolved in 30 Calendar Days	92%	96%	100%
% of Provider Appeal Resolution Notices Sent Within Compliance Standard	90%	100%	99%

State of Kansas Office of Administrative Fair Hearings - Members

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY/LEVEL OF CARE – Criteria Not Met															
MH – CNM - Durable Medical Equipment	5 5	 2			5 3										
MH – CNM - Inpatient Admissions (Non-Behavioral Health)	2 1	1			1			 1							
MH – CNM - Medical Procedure (NOS)	1							1							
MH – CNM - Radiology	1							1							
MH – CNM – Pharmacy	3 2 16	 1	1	2	 1 2			 1 11	 2						
MH – CNM – PT/OT/ST	3	1			2										
MH – CNM - Dental	1	1													
MH – CNM – Home Health	1 1 1		1		 1			 1							
MH – CNM – Hospice	1							1							
MH – CNM - Out of network provider, specialist or specific provider request	1									1					
MH – CNM - Inpatient Behavioral Health	1 2 2	 1 1		1	 1			 1							
MH – CNM – Behavioral Health Outpatient Services and Testing	1 1			1				 1							
MH – CNM – Health Home Services	1							1							
MH – LOC – LTSS/HCBS	6	2			4										

MH – CNM - Other	5	2	1		1			1							
NONCOVERED SERVICE															
MH-NCS - Dental	1												1		
MH-NCS - Pharmacy	1			1											
MH-NCS - Durable Medical Equipment	1 2	2		1											
ADMINISTRATIVE DENIALS															
MH – ADMIN – Denials of Authorization (Unauthorized by Members)	2	1						1							
TOTAL ABH - Red SUN – Green UHC - Purple	 9 23 39	 1 5 10	 1 	 4 	 4 13 8	 	 	 4 17	 2	 1	 	 	 1 	 	

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

State of Kansas Office of Administrative Fair Hearings - Providers

ABH - Red SUN – Green UHC - Purple	Number Resolved	Withdrew	OAH Affirmed MCO Decision	OAH Reversed MCO Decision	Dismiss Moot MCO Reversed	Dismiss Moot Duplicate	Dismiss Untimely	Dismiss Not Ripe/ No MCO Appeal	Dismiss No Adverse Action	Dismiss No Auth.	Dismiss Appellant Verbally Withdrew	Dismiss Failure to State a Claim	Default Appellant Failed to Appear	Default Respondent Failed to Appear	Default Respondent Failed to File Agency Summary
MEDICAL NECESSITY / LEVEL OF CARE - Criteria Not Met															
PH - CNM - Durable Medical Equipment	2 3	1	1		 3										
PH - CNM - Inpatient Admissions (Non-Behavioral Health)	7 5	4 3 1		1	 4										2
PH - CNM - Medical Procedure (NOS)	5	1			4										
PH - CNM - Radiology	1							1							
PH - CNM - Pharmacy	1 1		1		 1										
PH – CNM – Home Health	1		1												
PH - LOC - LTSS/HCBS	3	3													

PH - NCS - Durable Medical Equipment	1 1				1			1							
PH - CPD - Hospital Inpatient (Non-Behavioral Health)	14 15 37	8 1 29	1		5 10 7		1	1 3							
PH - CPD - Hospital Outpatient (Non-Behavioral Health)	5				4										1
PH - CPD - Pharmacy	1 10	2			1		2	3					3		
PH – CPD - Dental	2 2	2			2										
PH - CPD - Medical (Physical Health not Otherwise Specified)	9 3	5			3			3				1			
PH – CPD – Nursing Facilities - Total	4				4										
PH – CPD - HCBS	11	6			5										
PH – CPD - Hospice	2 1	1					1	1							
PH - CPD - Home Health	1 3 18	10	1		1 3 1			5	1						
PH - CPD - Behavioral Health Outpatient and Physician	12				12										
PH - CPD - Behavioral Health Inpatient	3 1	2		1	1										
PH – CPD - Radiology	1 8 1							1 8	1						
PH - CPD – Laboratory	2 22 1							2 22 1							
PH - CPD - PT/OT/ST	2				2										
PH – CPD – Durable Medical Equipment	6 11		1		2 1		1	3					3 6		
PH – CPD - Other	3 5				3 1		1	2					1		
BILLING AND FINANCIAL ISSUES															

PH - BFI - Recoupment	1 5	4			1		1								
ADMINISTRATIVE DENIALS															
PH – ADMIN – Denials of Authorization (Unauthorized by Members)	1 1	1			1										
TOTAL ABH - Red SUN – Green UHC - Purple	 54 109 92	 23 12 46	 3 2 1	 2	 15 55 13		 2 5	 7 35 15	 2			 1	 3 10		 3

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

MCOs' Grievance Trends - Members

Aetna Member Grievances:

- There was a decrease of 150 member grievances from 362 reported in CY2019 and 212 reported in CY2020.
- There was an increase of 10 member grievances for Billing/Financial Issues (non-transportation) from 16 reported in CY2019 to 26 reported in CY2020.
- There was a decrease of 14 member grievances for Customer Service from 38 reported in CY2019 to 24 reported in CY2020.
- There was a decrease of 13 member grievances for Transportation – No Show from 30 reported in CY2019 to 17 reported in CY2020.
- There was a decrease of 14 member grievances for Transportation - Late from 36 reported in CY2019 to 22 reported in CY2020.
- There was a decrease of 17 member grievances for Transportation - Other from 60 reported in CY2019 to 43 reported in CY2020.

Aetna Annual Grievance Trends		
Total # of Resolved Grievances	212	
Top 5 Trends		
Trend 1: Transportation – Other	43	20%
Trend 2: Billing/Financial Issues (non-transportation)	26	12%
Trend 3: Customer Service	24	11%
Trend 4: Transportation – Late	22	10%
Trend 5: Transportation – No Show	17	8%

Sunflower Member Grievances:

- There was a decrease of 364 member grievances from 921 reported in CY2019 and 557 reported in CY2020.
- There was a decrease of 74 member grievances for Quality of Care (non HCBS Providers) from 143 reported in CY2019 to 69 reported in CY2020.
- There was a decrease of 80 member grievances for Transportation - Late from 154 reported in CY2019 to 74 reported in CY2020.
- There was a decrease of 55 member grievances for Transportation - Other from 156 reported in CY2019 to 101 reported in CY2020.

Sunflower Annual Grievance Trends		
Total # of Resolved Grievances	557	
Top 5 Trends		
Trend 1: Transportation – Other	91	16%
Trend 2: Transportation – No Show	83	15%
Trend 3: Transportation – Late	74	13%
Trend 4: Quality of Care (non HCBS Providers)	69	12%
Trend 5: Access to Service or Care	61	11%

United Member Grievances:

- There was an increase of 67 member grievances for Access to Service or Care from 36 reported in CY2019 to 103 reported in CY2020. There was a system error that incorrectly stated multiple members lost their coverage in October but has been corrected.
- There was an increase of 40 member grievances for Transportation – No Show from 60 reported in CY2019 to 100 reported in CY2020.
- There was a decrease of 35 member grievances for Billing/Financial Issues (non-transportation) from 231 reported in CY2019 to 196 reported in CY2020.

- There was a decrease of 45 member grievances for Transportation - Other from 174 reported in CY2019 to 129 reported in CY2020.

United Annual Grievance Trends		
Total # of Resolved Grievances	937	
Top 5 Trends		
Trend 1: Billing/Financial Issues (non-transportation)	196	21%
Trend 2: Transportation – Other	129	14%
Trend 3: Access to Service or Care	103	11%
Trend 4: Transportation – Late	101	11%
Trend 5: Transportation – No Show	100	11%

MCOs' Grievance Trends - Provider

Aetna Provider Grievances:

- There was a decrease of 5 provider grievances from 7 reported in CY2019 and 2 reported in CY2020.

Aetna Annual Grievance Trends		
Total # of Resolved Grievances	2	
Top 5 Trends		
Trend 1: Billing/Payment	2	100%

Sunflower Provider Grievances:

- There was a decrease of 42 provider grievances from 118 reported in CY2019 and 76 reported in CY2020.

Sunflower Annual Grievance Trends		
Total # of Resolved Grievances	76	
Top 5 Trends		
Trend 1: Transportation	34	45%
Trend 2: Billing/Payment	22	29%
Trend 3: UM	5	7%
Trend 4: Other – Dissatisfaction with MCO Associate	4	5%

United Provider Grievances:

- There was an increase of 20 provider grievances from 43 reported in CY2019 and 63 reported in CY2020.

United Annual Grievance Trends		
Total # of Resolved Grievances	63	
Top 5 Trends		
Trend 1: Transportation	40	63%
Trend 2: Other (Must provide description in narrative column of Summary Reports)	22	35%

MCOs' Reconsideration Trends - Provider

Aetna Provider Reconsiderations

- There was an increase of 2,225 provider reconsiderations from 1,270 reported in CY2019 and 3,495 reported in CY2020.
- There was an increase of 418 provider reconsiderations for PR – CPD – Hospital Inpatient (Non-Behavioral Health) from 200 reported in CY2019 and 618 reported in CY2020.
- There was an increase of 204 provider reconsiderations for PR – CPD – Hospital Outpatient (Non-Behavioral Health) from 223 reported in CY2019 and 427 reported in CY2020.

- There was an increase of 1,040 provider reconsiderations for PR – CPD – Medical (Physical Health not Otherwise Specified) from 372 reported in CY2019 and 1,412 reported in CY2020.
- There was an increase of 147 provider reconsiderations for PR – CPD – Laboratory from 73 reported in CY2019 and 220 reported in CY2020.
- There was an increase of 183 provider reconsiderations for PR – CPD – Durable Medical Equipment from 82 reported in CY2019 and 265 reported in CY2020.

Aetna Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	3,495	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	1,412	40%
Trend 2: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	618	18%
Trend 3: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	427	12%
Trend 4: PR – CPD – Durable Medical Equipment	265	8%
Trend 5: PR – CPD – Laboratory	220	6%

Sunflower Provider Reconsiderations

- There was an increase of 22,826 provider reconsiderations from 28,868 reported in CY2019 and 51,694 reported in CY2020.
- There was an increase of 1,410 provider reconsiderations for PR – CPD – Hospital Inpatient (Non-Behavioral Health) from 5,697 reported in CY2019 and 7,107 reported in CY2020.
- There was an increase of 7,818 provider reconsiderations for PR – CPD – Hospital Outpatient (Non-Behavioral Health) from 4,548 reported in CY2019 and 12,366 reported in CY2020.
- There was an increase of 6,385 provider reconsiderations for PR – CPD – Medical (Physical Health not Otherwise Specified) from 4,735 reported in CY2019 and 11,120 reported in CY2020.
- There was an increase of 3,021 provider reconsiderations for PR – CPD – Out of network provider, specialist or specific provider from 2,879 reported in CY2019 and 5,900 reported in CY2020.
- There was an increase of 2,853 provider reconsiderations for PR – CPD – Laboratory from 2,916 reported in CY2019 and 5,769 reported in CY2020.

Sunflower Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	51,694	
Top 5 Trends		
Trend 1: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	12,366	24%
Trend 2: PR – CPD – Medical (Physical Health not Otherwise Specified)	11,120	22%
Trend 3: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	7,107	14%
Trend 4: PR – CPD – Out of network provider, specialist or specific provider	5,900	11%
Trend 5: PR – CPD – Laboratory	5,769	11%

United Provider Reconsiderations

- There was a decrease of 21,138 provider reconsiderations from 152,973 reported in CY2019 and 131,835 reported in CY2020.
- There was a decrease of 2,433 provider reconsiderations for PR – CPD – Medical (Physical Health not Otherwise Specified) from 50,607 reported in CY2019 and 48,174 reported in CY2020.
- There was a decrease of 974 provider reconsiderations for PR – CPD – Behavioral Health Outpatient and Physician from 6,811 reported in CY2019 and 5,837 reported in CY2020.
- There was a decrease of 4,690 provider reconsiderations for PR – CPD – Out of network provider, specialist or specific provider from 35,286 reported in CY2019 and 30,596 reported in CY2020.
- There was a decrease of 6,858 provider reconsiderations for PR – CPD – Laboratory from 24,344 reported in CY2019 and 17,486 reported in CY2020.

United Annual Provider Reconsideration Trends		
Total # of Resolved Reconsiderations	131,835	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	48,174	37%
Trend 2: PR – CPD – Out of network provider, specialist or specific provider	30,596	23%
Trend 3: PR – CPD – Laboratory	17,486	13%
Trend 4: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	15,224	12%
Trend 5: PR – CPD – Behavioral Health Outpatient and Physician	5,837	4%

MCOs' Appeals Trends - Member/Provider

Aetna Member Appeals:

- There was an increase of 60 member appeals for MA – CNM – Pharmacy from 225 reported in CY2019 and 285 reported in CY2020.
- There was a decrease of 20 member appeals for MA – CNM – Durable Medical Equipment from 33 reported in CY2019 and 13 reported in CY2020.
- There was a decrease of 27 member appeals for MA – CNM – Radiology from 63 reported in CY2019 and 36 reported in CY2020.

Aetna Provider Appeals:

- There was an increase of 720 provider appeals from 296 reported in CY2019 and 1,016 reported in CY2020.
- There was an increase of 114 provider appeals for PA – CNM – Inpatient Admissions (Non-Behavioral Health) from 0 reported in CY2019 and 114 reported in CY2020.
- There was an increase of 256 provider appeals for PA – CNM – Medical Procedure (NOS) from 0 reported in CY2019 and 256 reported in CY2020.
- There was an increase of 82 provider appeals for PA – CPD – Hospital Inpatient (Non-Behavioral Health) from 52 reported in CY2019 and 134 reported in CY2020.
- There was an increase of 74 provider appeals for PA – CPD – Hospital Outpatient (Non-Behavioral Health) from 29 reported in CY2019 and 103 reported in CY2020.
- There was an increase of 56 provider appeals for PA – CPD – Medical (Physical Health not Otherwise Specified) from 82 reported in CY2019 and 138 reported in CY2020.

Aetna Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	479		Total # of Resolved Provider Appeals	1,016	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	285	59%	Trend 1: PA – CNM – Medical Procedure (NOS)	256	25%
Trend 2: MA – CNM – Medical Procedure (NOS)	69	14%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	138	14%
Trend 3: MA – CNM – Radiology	36	8%	Trend 3: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	134	13%
Trend 4: MA – CNM -Inpatient Behavioral Health	18	4%	Trend 4: PA – CNM – Inpatient Admissions (Non-Behavioral Health)	114	11%
Trend 5: MA – CNM – Durable Medical Equipment	13	3%	Trend 5: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	103	10%

Sunflower Member Appeals:

- There was a decrease of 220 member appeals from 1,003 reported in CY2019 and 783 reported in CY2020.
- There was an increase of 72 member appeals for MA – CNM – Radiology from 93 reported in CY2019 and 165 reported in CY2020.
- There was a decrease of 182 member appeals for MA – CNM – Pharmacy from 358 reported in CY2019 and 176 reported in CY2020.

- There was a decrease of 39 member appeals for MA – CNM – Other from 87 reported in CY2019 and 48 reported in CY2020.

Sunflower Provider Appeals:

- There was an increase of 286 provider appeals for PA – CPD – Medical (Physical Health not Otherwise Specified) from 854 reported in CY2019 and 1,140 reported in CY2020.
- There was an increase of 316 provider appeals for PA – CPD – Laboratory from 201 reported in CY2019 and 517 reported in CY2020.
- There was a decrease of 77 provider appeals for PA – CPD – Hospital Inpatient (Non-Behavioral Health) from 570 reported in CY2019 and 493 reported in CY2020.
- There was a decrease of 381 provider appeals for PA – CPD – Hospital Outpatient (Non-Behavioral Health) from 1,009 reported in CY2019 and 628 reported in CY2020.

Sunflower Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	783		Total # of Resolved Provider Appeals	4,902	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	176	22%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	1,140	23%
Trend 2: MA – CNM – Radiology	165	21%	Trend 2: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	628	13%
Trend 3: MA – CNM – Durable Medical Equipment	126	16%	Trend 3: PA – CPD – Laboratory	517	11%
Trend 4: MA – CNM – Medical Procedure (NOS)	56	7%	Trend 4: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	493	10%
Trend 5: MA – CNM – Other	48	6%	Trend 5: PA – BFI - Recoupment	366	7%

United Member Appeals:

- There was a decrease of 274 member appeals from 1,038 reported in CY2019 and 764 reported in CY2020.
- There was a decrease of 40 member appeals for MA – CNM – Durable Medical Equipment from 115 reported in CY2019 and 75 reported in CY2020.
- There was a decrease of 145 member appeals for MA – CNM – Pharmacy from 554 reported in CY2019 and 409 reported in CY2020.

United Provider Appeals:

- There was an increase of 39 provider appeals for PA – CPD – Laboratory from 183 reported in CY2019 and 222 reported in CY2020.
- There was an increase of 166 provider appeals for PA – CPD – Home Health from 206 reported in CY2019 and 372 reported in CY2020.

United Annual Member/Provider Appeal Trends					
Total # of Resolved Member Appeals	764		Total # of Resolved Provider Appeals	3,130	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	409	54%	Trend 1: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	1,021	33%
Trend 2: MA – CNM – Inpatient Admissions (Non-Behavioral Health)	121	16%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	536	17%
Trend 3: MA – CNM – Durable Medical Equipment	75	10%	Trend 3: PA – CPD – Home Health	372	12%
Trend 4: MA – CNM – Medical Procedure (NOS)	37	5%	Trend 4: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	323	10%
Trend 5: MA – CNM – Dental	33	4%	Trend 5: PA – CPD – Laboratory	222	7%

MCOs' State Fair Hearing Reversed Decisions - Member/Provider

- There were 71 Member State Fair Hearings for all three MCOs. No decisions were reversed by OAH.
- There were 106 Provider State Fair Hearings for all three MCOs. Five of Aetna's state fair hearing decisions were reversed by OAH. Two were reversed after a hearing and three were reversed due to Default – Respondent Failed to File Agency Summary.

Aetna Annual					
Total # of Member SFH	9		Total # of Provider SFH	54	
OAH reversed MCO decision	0		OAH reversed MCO decision	5	6%

Sunflower Annual					
Total # of Member SFH	23		Total # of Provider SFH	15	
OAH reversed MCO decision	0		OAH reversed MCO decision	0	

United Annual					
Total # of Member SFH	39		Total # of Provider SFH	37	
OAH reversed MCO decision	0		OAH reversed MCO decision	0	

D. Customer Service: Reporting, including total calls, average speed of answer and call abandonment rates, for MCO-based and fiscal agent call centers January- December 2020:

KanCare Customer Service Report – Member

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	14.58	2.35%	151,385
Sunflower	22.62	2.13%	142,500
United	21.79	1.02%	159,061
DXC – Fiscal Agent	9.25	.77%	23,339

KanCare Customer Service Report - Provider

MCO/Fiscal Agent	Average Speed of Answer (Seconds)	Call Abandonment Rate	Total Calls
Aetna	1.52	.90%	77,181
Sunflower	20.82	1.77%	94,269
United	6.26	.53%	80,172
DXC – Fiscal Agent	22	1.25%	28,176

E. Critical Incident Summary of Reporting:

Critical Incidents January-December 2020	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	2020
	AIR Totals	AIR Totals	AIR Totals	AIR Totals	TOTALS
Reviewed	2,896	2,664	3,112	2,988	11,660
Pending Resolution	70	40	49	192	351
Total Received	2,966	2,704	3,161	3,180	12,011
APS Substantiations*	198	182	211	168	759

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

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

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

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

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

F. Access to Care:

As noted in previous reports, members who are not in their open enrollment period are unable to change plans without a good cause reason pursuant to 42 CFR 438.56 or the KanCare STCs. GCRs (member "Good Cause Requests" for change in MCO assignment) after the choice period are denied as not reflective of good cause if the request is based solely on the member's preference, when other participating providers with that MCO are available within access standards. In 2020, 40% of the approved requests were due to a single dental provider in rural Kansas who was unwilling to renew their contract with two of the MCOs. The remaining requests were due largely to members mistakenly believing that they can file good cause requests because they prefer a provider outside of their assigned MCO's network. In these cases, the MCOs are tasked with offering to assist the member in scheduling an appointment with one of their participating providers.

There were three state fair hearings for denied GCRs. Two GCRs were upheld, and one is still pending a decision. A summary of GCR actions for 2020 is as follows:

Status	2020 Totals
Total GCRs filed	228
Approved	71
Denied	97
Withdrawn (resolved, no need to change)	25
Dismissed (due to inability to contact the member)	35
Pending	0

Access to Dental Care: KanCare and partner agencies continue to emphasize the importance of regular dental care for our members and are committed to maintaining an increased utilization of these important services. Results indicate dental services have been consistently provided in the 75th percentile each year since 2015.

Annual Dental Visit – Ages 2 to 20		
Year	Percentage	National Ranking (Quality Compass percentile)

2019	66.7%	>75th
2018	65.4%	>75th
2017	64.8%	>75th
2016	63.7%	>75th
2015	60.9%	>75th
2014	60.0%	>66.67th
2013	60.3%	>50th

G. HCBS Waiver Updates:

i. FE: The Frail Elderly waiver renewal was approved by CMS on October 26, 2020, with an effective date of January 1, 2020. The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

ii. IDD: The State continues to work on waiver amendments to the IDD waiver as agreed upon with CMS. The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

iii. PD: The Physical Disability waiver renewal was approved by CMS on October 26, 2020, with an effective date of January 1, 2020. The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

iv. TA: The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

v. SED: KDADS worked with stakeholders to update the SED waiver manual for providers. The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

vi. Autism: The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

vii. BI: KDADS worked with stakeholders to discuss potential waiver amendments to enhance the waiver program management. Work continues on this topic. The State requested, and CMS approved, the implementation of Appendix K measures during the COVID-19 pandemic to promote social distancing and support individuals and families care needs.

H. Beneficiary CAHPS Survey:

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

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

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

provide information regarding the access, timeliness and quality of health care services provided to health care consumers.

The following members were identified for participation in the survey:

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

CAHPS surveys were conducted in 2020 by all three MCOs for Adults, Title 19-General Child, Title 21-General Child, Title 19-children with chronic conditions and Title 21-children with chronic conditions populations. The initial review shows continued positive results. The validated results are due from the EQRO in May 2021 and will be discussed in next year's annual report. Below is a table of CAHPS care coordination survey question results for the past three years.

Care Coordination CAHPS Survey Questions	2020	2019	2018
In the last 6 months, did you/your child get care from a doctor or other health provider besides his or her personal doctor?			
Adults	61.3%	61.7%	60.9%
General Child - Title XIX & Title XXI (CHIP)	44.3%	45.4%	45.8%
Children with Chronic Conditions - Title XIX & Title XXI (CHIP)	60.9%	61.7%	63.3%
How often did your/your child's personal doctor seem informed and up-to-date about the care you/your child got from these doctors or other health providers?			
Adults	87.9%↑	83.0%	84.2%
	>66.67th	<50th	≥50th
General Child - Title XIX & Title XXI (CHIP)	84.2%	83.2%	81.4%
	<33.33rd	<50th	<33.33rd
Children with Chronic Conditions - Title XIX & Title XXI (CHIP)	83.5%	81.1%	82.9%
	<25th	<25th	<50th

The above table shows that of the 61.3% of adults who responded that they had received care outside their personal doctor in the last six months, 87.9% felt their personal doctor was informed about the care they received from the other provider. Of the 44.3% general child population who responded that they had received care outside their personal doctor in the last six months, 84.2% felt their personal doctor was informed about the care they received from the other provider. Additionally, 60.9% of the children with chronic conditions population reported that they had received care outside their personal doctor in the last six months, and of those, 83.5% felt their personal doctor was informed about the care they received from the other provider. While there is always room for improvement, the State is encouraged by these results.

KanCare implemented a care coordination initiative in April of 2020 called OneCare Kansas (OCK). OCK provides coordination of physical and behavioral health care with long term services and supports for people with chronic conditions. OCK expands upon medical home models to include links to community and social supports. OCK focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in a OCK member's health communicate with one another so that all of a patient's needs are addressed in a comprehensive manner. The additional services include comprehensive care management, care coordination, comprehensive transitional care (including appropriate follow-up from inpatient to other settings), patient and family support, referral to community and social support services (when relevant), and health promotion.

I. Annual Summary of Network Adequacy:

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

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

KanCare MCO	# of Unique Providers as of 3/31/2020	# of Unique Providers as of 6/30/2020*	# of Unique Providers as of 9/30/2020*	# of Unique Providers as of 12/31/2020*
Aetna	39,097	40,323	39,494	42,617^
Sunflower	33,764	29,286	30,097	39,670^
UHC	42,772	44,634	44,248	46,278^

*Beginning Quarter 1, 2020, the # of unique providers excludes out-of-state providers located more than 50 miles from a Kansas border.

^Increases in provider counts reflect revisions subsequent to annual audit and other meetings with MCOs that occurred in Quarter 4, 2020.

KDHE continues to provide feedback and analysis of data trends in the Network Adequacy Report through the KDHE-built monitoring tool. KDHE performed MCO training sessions with the MCO credentialing and data staff to show how the report should be completed and how to understand the scorecards issued each quarter through the monitoring tool. The network adequacy reporting from the MCOs remains problematic to analyze due to repetitive and extensive errors with duplication, incorrect types and specialties, incorrect addresses, and inconsistency in reporting between MCOs. Each MCO has struggled with correcting their data. While the reports are much improved since previous years, errors remain. Additional meetings are being planned for 2021.

The State participated in the following Provider Network activities:

- Ongoing automated report management, review and feedback between the State and the MCOs. Reports from the MCOs consist of a wide range of network data reported on standardized templates. Every quarter, the MCOs submit to the State provider network reports with data of providers within their network. Within these reports are unique provider counts that show how many providers are serving KanCare members.
- The MCOs also submit GeoAccess reports quarterly with maps showing state coverage of their service providers. GeoAccess reports include ADA compliant mapping format, NEMT report, Specialty Care Report, and the Access and Availability Analysis Report.
- The network adequacy team met frequently with each MCO to review policies, and to examine issues of network reporting within the MCOs' quarterly reports. Issues discussed included inconsistent unique provider counts, gaps in provider coverage, and compliance with State report submission protocol.
- The network adequacy team began to implement a new exceptions request process, with the team focusing first on OBGYNs. As a result, MCOs have begun to close service gaps by adding new providers, and documenting activities to close any remaining gaps.
- KDHE and KDADS GeoAccess standards are posted on our KanCare website[7]. The State also posts the MCOs' submitted maps to this link.

[7] https://www.kancare.ks.gov/policies-and-reports/network-adequacy

- The State applies a trending graph to show changes of provider counts between quarters. With the increase in consistency of map reporting and formatting, the next set of maps the State posts will contain trending graphs which represent count of unique providers and will trend third quarter 2020 with fourth quarter 2020.
- Progress was made with geo-mapping with the addition of a new data analyst and a partnership with KDHE Department of Administration, the network adequacy team developed an automated mapping procedure, using ArcGIS Pro, to map providers based on the MCOs provider network report submissions. The team can then use these maps to compare with the MCOs' submitted GeoAccess maps to find errors or omissions and verify gaps in coverage. The team has also begun to map HCBS providers and member county locations. Because most HCBS services do not have distance or number of provider standards these maps will be used for internal analysis purposes only.
- The State used a portion of the annual contract review onsite sessions to present individualized feedback and ask questions of each MCO. Based on these conversations and closing gaps in contract requirements, in 2021 the State plans to complete another round of meetings with all three MCOs to collaborate and problem solve provider network reporting processes.
- The State team has been working on improvements to the Access and Availability Report, the NEMT report, the feedback report and mapping formats. The network adequacy team has been working on two additional reports: Non-Participating Provider Reliance Report, and a HCBS Service Delivery Report.

The team continues to match the MCO's reports against additional data sources to give a clearer picture of the report's accuracy and completeness. The State continued to collect the data files for MCO provider directories in 2020.

As the new Managed Care rules have removed enrollment responsibility from MCOs, the State of Kansas added complete provider enrollment duties into the contract with their Fiscal Agent to build a new MMIS system. In that new system, we are building a provider enrollment portal that all Kansas Medicaid providers must use to enroll. The Fiscal Agent will assign specialties and provider types per the enrollment and taxonomy information provided by the provider. Phase one of this system was operational in 2017. This new system will be a solution to one long-standing problem with network adequacy analysis – inaccurate provider data from the MCO reports. With the new system, this will provide standardized provider types, specialties, and address information, thus eliminating some of the current errors with the network adequacy reports. Issues remain with a system, which puts the responsibility for accurateness on the provider and a one-way (State to MCO) communication channel.
Regarding MCO compliance with provider 24/7 availability, here are the processes, protocols and results from each of the MCOs (Due dates for results from 2021 surveys for all MCOs have been aligned and are due October 29, 2021):

Aetna Annual Assessment of Network Appointment Accessibility
Methodology:

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

Aetna Better Health of Kansas defines practitioner types as follows:

Practitioner Types for Appointment Access Analysis

Category	Practitioner Type
Primary Care	General Pediatrician, Family Practitioner, General Internist, General Practitioner
Specialty Care: High-Volume/High-Impact	Oncology: Oncologist OB/Gyn: Certified Nurse Midwife, Maternal Fetal Medicine, Obstetrician/Gynecologist
Behavioral Health	Prescribers: Psychiatrist, Psychiatric Nurse Practitioner Non-Prescribers: Psychologist, Licensed Clinical Mental Health Professional, Licensed Clinical Psychotherapist, Licensed Mental Health Professional, Positive Behavioral Support

Practitioner Appointment Accessibility Study:

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

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

Audit Population Determination:

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

Universe of Providers by Specialty (n=6466):

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

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

Representative Sample of Provider Specialty (n=260):

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

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

Study Period:

February 20, 2020 through March 9, 2020

Indicators:

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

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

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

Provider Accessibility Survey Indicators/Goals

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

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

Quantitative Analysis:

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

2020 Provider Appointment Accessibility Results

Appointment Type	Numerator/Denominator*	Goal	Rate*	Goal Met/Not Met
Primary Care Physician/Family Practice/Pediatrics General Pediatrician, Family Practitioner, General Internist, General Practitioner				
Routine	107/115	80%	93.0%	Met
Non-Urgent	41/115	80%	35.7%	Not Met
Urgent	86/115	80%	74.8%	Not Met
After Hours	101/115	80%	87.8%	Met

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

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

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

PCP:

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

Oncology

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

would contact the member with a provider. Given the number of oncologist responses is less than 30, caution should be taken in interpretation of results.

Obstetrics and Gynecology:

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

Behavioral Health (Prescriber):

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

Behavioral Health (Non-Prescriber):

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

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

Qualitative Analysis:

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

Sampling Methodology:

Goals were not consistently met by provider type nor appointment type. The sampling methodology used was appropriate for identifying the providers from the universe and selecting the sample based on the proportion of providers within the universe. However, given the number of failures for each provider type, this survey should be expanded to include a valid sample

(confidence interval 90 percent =/- 5 percent) for each provider type. This expanded survey would allow for a more comprehensive understanding of the goals that are not met.

Obstetrics and Gynecology:

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

Behavioral Health:

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

After Hours:

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

Additional Reports:

Aetna Better Health of Kansas identifies and analyzes multiple sources of data to understand the member experience with appointment availability. One key analysis is member grievances. In 2019 there were 11 member grievances related to access to appointments or providers. There were no trends identified for 2020. Network Management continues evaluates the network for adequacy of providers. On a quarterly basis, assessment is completed on providers locations and specialties.

Barriers

The following barriers were noted:

- Low denominators do not allow for adequate assessment of key drivers to the failure
- Inconsistent awareness of providers as to appointment availability standards
- Large provider groups have complex processes to manage appointment, e.g. urgent requests are forwarded to office nurse for triage and scheduling
- Front office staff/appointment coordinators are unaware of appointment standards
- Provider capacity to meet the appointment standards may be limited

Sunflower Health Plan (SHP) Appointment and After-Hours Access to Care Report

Procedure:

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

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

Methodology:

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

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

Office Surveys – Primary Care Routine and Urgent Care Appointment Access

Medicaid	Access Standard	Appointment Results
Urgent Care	Primary care urgent appointments within 48 hours	New Patients - 67%
		Established Patients – 80%
Routine Care - New Patients	Primary care routine appointments not to exceed 3 weeks	1st Available - 74%
		2nd Available - 71%
		3rd Available - 67%
Routine Care - Established Patients	Primary care routine appointments not to exceed 3 weeks	1st Available - 89%
		2nd Available - 85%
		3rd Available - 82%
Wait Time	Primary care wait time not to exceed 45 minutes	91%

Survey of After-Hours Care

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

Results:

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

Office Surveys – Specialists Routine and Urgent Care Appointment Access

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

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

Behavioral Health Routine and Urgent Care Appointment Access

Medicaid	Access Standard	Appointment Results
Urgent Care (Behavioral Health Prescribers)	Behavioral Health care for urgent appointments within 48 hours	New Patients – 49%
		Established Patients – 72%
		1st Available - 40%

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

UnitedHealthcare Appointment Waiting Times/After Hours Access Results:

Table 1: Sample

	PCP		Specialist		BH		Total	
	2019	2020	2019	2020	2019	2020	2019	2020
	% (n)		% (n)		% (n)		% (n)	
Sample Size	103	123	106	133	67	172	276 (Urgent & Routine) 209 (Emergent) 103 (EPSDT & After Hours	428 (Urgent & Routine) 256 (Emergency) 123 (EPSDT & After Hours)
Emergency Care	100%	100%	100%	100%	NA	NA	100%	100%
(number)	103	123	106	133	NA	NA	209	256
Urgent Care	100%	100%	100%	100%	100%	100%	100%	100%
(number)	103	123	106	133	67	172	276	428
Routine Care	100%	100%	100%	100%	100%	100%	100%	100%
(number)	103	123	106	133	67	172	276	428
*(subset) EPSDT/Well Child	100%	100%	NA	NA	NA	NA	100%	100%
(number)	103	123	NA	NA	NA	NA	103	123
After-Hours Coverage	73.8%	95.93%	NA	NA	NA	NA	73.8%	95.93%
(number)	76	118	NA	NA	NA	NA	76	118

Table 1 : Description of Sample:
Specialists and BH providers are not included in after-hours calls; after-hours calls are placed to all other providers who participate in survey.

Table 1: UHC Analysis:
Secret Shopper calls were made in following time period: October 2020 (recalls January 2021 for validation). How many attempts will be made to reach someone at the provider's office? When will attempts be made? Three call attempts at different times during operating hours. As well as three call

attempts for after-hours calls. Once results from vendor are reviewed all failed providers will receive the same process and call script from the health plan to validate results.

A. Sample Selection

1. 24/7 Accessibility Physician Coverage: Primary Care Physicians (PCPs) must provide coverage to members 24 hours/seven (7) days a week. Offices must have a phone message or answering service available to members after office hours that instruct the member how to contact the physician for urgent or emergency conditions (there may be circumstances identified by the health plan where a practitioner in a service area with limited back-up may be given latitude with these requirements). Annually, where required by the state requirement, and/or when the member survey data do not meet goal, surveys to assess after-hours care will be conducted as prescribed by the state or to identify the root cause of dissatisfaction.
    - A list of plan PCPs is obtained from a designated data source. The list should include the practitioner name, group name, office location, and total number of member encounters for the past year.
    - Practitioners may be randomly selected for review based upon the size of the network (see Table 1), based upon the percentage of overall encounters that the practitioner/group represents, or another statistically valid methodology.
    - If the sample is based upon total encounters, the practitioner groups called should represent a majority of encounters (e.g., 20% of the practitioner locations called will make up 80% of the encounters).
    - Calls will be conducted by plan Quality Improvement (QI) staff, Network staff or a designated vendor, after normal business hours. Calls may be made on an annual basis or more frequently if required by state regulations.
    - Any location that has multiple PCPs may be called once and the survey results applied to all practitioners at the location.
    - Callers will identify themselves and state the purpose of their call.

B. Permissible after-hours call responses are as follows:
    - The call is picked up by an answering service who verifies they have the ability to contact the practitioner or their designee for a non-life-threatening emergency.
    - The call is picked up by a triage nurse who will evaluate the nature of the call, and/or contact the physician on-call, and/or direct the member to a hospital emergency room.
    - The physician answers the call directly.
    - The office answering machine directs the member to call a specific telephone number in order to reach the practitioner or an answering service who will then reach the practitioner on-call for a non-life-threatening emergency.
    - The office answering machine directs the member to call a specific telephone number in order to reach a hospital switchboard and/or hospital emergency room who will reach the practitioner on-call for non-life-threatening emergencies.

C. Unacceptable call responses are as follows:
    - The answering machine states the office is closed and directs the member to proceed to the nearest hospital emergency room. No alternative mode is provided to contact a live person in the event of a non-life-threatening emergency.
    - The office telephone number rings continuously without an answer.

D. Appointment Availability:

1. Primary Care Practitioners: Telephonic phone surveys to assess PCP appointment availability will be conducted as prescribed by each individual state and when member survey / CAHPS® data indicate dissatisfaction with current routine and or urgent care appointment availability.

- A list of plan PCPs is obtained from a designated data source. The list should include the practitioner name, group name, office location, and total number of member encounters for the past year.
- Practitioners may be randomly selected for review based upon the size of the network (see Table 1), based upon the percentage of overall encounters that the practitioner/group represents, or another statistically valid methodology.
- If the sample is based upon total encounters, the practitioner groups called should represent a majority of encounters (e.g., 20% of the practitioner locations called will make up 80% of the encounters).
- Calls will be conducted by plan QI staff, Network staff or a designated vendor. Calls may be made on an annual basis or more frequently if required by state regulations.
- Any location that has multiple PCPs may be called once and the survey results applied to all practitioners at the location.
- If a group has multiple office locations, the health plan should call the additional sites to determine if appointment access differs by location, depending on the sampling methodology (i.e., if the assessment is being conducted by site or by practitioner).
- Callers will identify themselves and state the purpose of their call.
- Appointment availability calls for PCPs should include the date of the call and ask, "If I were a UHCCP member":
    - When is the next available appointment for a routine visit – not a physical? Please provide the date and time.
    - When is the next available appointment for an urgent visit? Please provide the date and time.
    - Any state required questions.

2. High Volume and High Impact Specialists: Telephonic phone surveys to assess specialty care appointment availability will be conducted as prescribed by each individual state. In addition, high volume and high impact specialist calls will be made at least annually to assess the availability of routine appointments for new and existing patients.
    - Refer to the list of state required practitioner types and/or the annual list of high volume/high impact specialty types identified via claims and cdc.gov data.
    - A list of the associated specialty practitioners is obtained from a designated data source. The list should include the practitioner name, specialty, group name, office location, and total number of encounters for the past year.
    - Practitioners may be randomly selected for review based upon the size of the network (see Table 1), based upon the percentage of overall encounters that the practitioner/group represents, or another statistically valid methodology.
    - If the sample is based upon total encounters, the practitioner groups called should represent a majority of encounters (in an ideal scenario 20% of the practitioner locations called will make up 80% of the encounters).
    - Calls will be conducted by plan QI staff, Network staff or a designated vendor. Calls may be made on an annual basis or more frequently if required by state regulations.
    - Any location that has multiple practitioners with the same specialty may be called once and the survey results applied to all practitioners at the location.
    - If a group has multiple office locations, the health plan may consider calling additional sites to determine if appointment access differs by location.
    - The caller will verify appointment availability according to UnitedHealthcare (UHC)/state specific standards.
    - Appointment availability calls for specialists should include asking, "If I were a UHCCP member":

- When is the next available appointment for a routine new patient visit? Please provide the date and time.
- When is the next available appointment for a routine existing patient follow-up visit? Please provide the date and time.
- Any state required questions

E. Follow-up Process for Phone Calls

1. 24/7 and appointment availability call results are recorded in health plan specific spreadsheets and can be accessed by Network QI staff.
2. The following actions will be taken when a non-compliant practitioner is identified:
   - Network/QI staff re-educates non-compliant practitioners within 30 days of identifying non-compliance. Re-education may be provided via verbal or written contact.
   - Network/QI staff follow-up with non-compliant practitioners within 90 days to determine if the issue has been resolved.
   - If a practitioner remains non-compliant after the initial follow-up, Network/QI staff will again re-educate the practitioner.
   - If the practitioner remains non-compliant after the second follow-up the practitioner and issue will be referred to Provider Advisory Committee (PAC). The PAC may recommend a formal corrective action plan, practitioner termination may allow for continued non-compliance due to extenuating circumstances (i.e., solo practitioner in a rural area with limited physicians).

F. Did you oversample?

No.

G. Selection and exclusion criteria, including reasons for exclusions:

There are no exclusion criteria. If a provider is unreachable, we will notate why, for example phone number changed or provider moved and report that into our provider advocates, our network team, or our Medical Director or CMO.

H. How did you determine your sample size was valid?

Sample sizes were determined using Open Epi Open Source Epidemiologic Statistics Software for Public Health. OpenEpi development was supported in part by a grant from the Bill and Melinda Gates Foundation to Emory University, Rollins School of Public Health. Based on previous years' survey data, an anticipated frequency of 85% was used to estimate the sample size. Confidence limits of +- five% were estimated to allow for reasonably precise results while keeping sample sizes manageable.

I. How many providers total and by specialty did you determine were needed for your sample?

Based on the above we follow the grid on the Dial America Guide submitted to the state.

J. What did the plan do with providers in the sample who were not able to be reached? (Be specific)

Once all efforts, Dial America and re-calls for validation, are made we will look at the reasons and discuss outcomes at our QMC committee meeting. At that time, we will forward all out of compliance providers to the appropriate department for follow up. Once we have follow-up, we will assess the outcomes and take appropriate action.

K. Please describe your plan for those found not in compliance last year.

For providers that are not in compliance we review the results and individual providers at our QMC committee meeting and have our provider advocates, our network teams, and/or our Medical Director or CMO do outreach the providers in question. We also confirm these providers through follow-up after outreach to make sure providers are following the availability standards or take appropriate action.

L. Did your sample include those providers who were out of compliance last year?

Our sample is random. Some may or may not fall into the next years sample.

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

	PCP	Specialist	OB	BH	Total

	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	160	171	151	152	127	132	183	186	621	641
Refused to Participate	0.63%	4.09%	0.66%	3.29%	0.00%	2.27%	0.55%	3.23%	0.48%	3.28%
(number)	1	7	1	5	0	3	1	6	3	21
Unable to Contact in 3 Attempts	6.25%	0.00%	10.60%	1.32%	4.72%	0.00%	15.30%	0.00%	9.66%	0.31%
(number)	10	0	16	2	6	0	28	0	60	2
Technical Problems	2.50%	0.00%	0.66%	1.97%	0.00%	0.00%	0.55%	0.00%	0.97%	0.47%
(number)	4	0	1	3	0	0	1	0	6	3
Moved, No Updated Information	3.75%	12.87%	0.00%	3.29%	1.57%	2.27%	1.64%	1.61%	1.77%	5.15%
(number)	6	22	0	5	2	3	3	3	11	33
Total Not Surveyed	35.63%	28.07%	29.80%	12.50%	37.01%	14.39%	63.39%	7.53%	42.67%	15.6%
(number)	57	48	45	19	47	19	116	14	265	100

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

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

	SUD
	2020
Sample Size	1317
No outpatient services	1.75%
(number)	23
Limited services offered (member would be referred elsewhere)	4.10%
(number)	54
Refused to Participate	0.53%
(number)	7
Unable to Contact in 3 Attempts	0.53%
(number)	7

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

Table 2a & b UHC Analysis:

PCP Other reasons	Specialist Other reasons	OB other reasons	BH Other reasons
IO - Not a PCP: 15	IO - Does not see patients: 4	IP- Does not Handle Pregnancies: 12	IN - Not a UHC Provider: 1
IR- Retired: 4	*Technical reasons - unable to see appt availability without entering member information	IR - Retired: 1	IO - Does not see patients: 4
			*Refusal reasons: Not seeing new patients, provider schedules own appointments and unable to reach

The sample includes only providers eligible to be interviewed. Those who had retired, gone out of business, dropped out as a UHC provider or were otherwise ineligible were eliminated before the sample was calculated.

Table 3a-3c. Average Days Wait for Schedule Appointment

Table 3a: Average Days Wait for Schedule Appointments: PCP, Specialist, BH

	PCP		Specialist**		BH	
	2019	2020	2019	2020	2019	2020
Sample Size	103	123	106	133	67	172
	Number of Days					
Emergency Care	5.6	0	11	0.33	NA	NA
Urgent Care	4.8	0.24	10.8	0.59	7.6	0.7
	Number of Days					
Routine Care	1.5	5.53	NA	11.38	10.5	5.08
*(subset) EPSDT/Well Child	12.2	5.23	NA	NA	NA	NA

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

Table 3b: Average Days Wait for Schedule Appointment: OB

	OB	
	2019	2020
Sample Size	80	113
	Number of Days	
OB 1st Trimester	10.3	7.57
OB 2nd Trimester	11.9	5.72
OB 3rd Trimester	11.4	3.7

Table 3c: Average Days Wait for Schedule Appointment: SUD

	SUD
	2020
Sample Size	1227
	Number of Days
Substance Use Disorder	2.3
IV Drug User	2.3
Pregnant IV Drug User	0.98

Table 3a-c UHC Analysis

Tables 3a-c, shown above, reflect timeliness of appointment access using those standards specified in the State contract. Appointment timeliness is calculated in whole days as the date of the appointment minus the date the practice was called. Therefore, immediate access can only be evaluated if a same-day appointment is offered, and calls made later in the day with next-day access will appear noncompliant even though they fall within 24 hours. OB access is determined according to trimester of pregnancy rather than emergent, urgent, or routine need. Behavioral Health is stratified into BH and SUD since their standards are different.

Methodology and Additional UHC Analysis

The process for assessing access is as follows: operators at a third-party vendor, Dial America, call offices on a list provided by the MCO using a pre-arranged script. The script explains the purpose and asks whether this is a good time for the call; if not, a call-back time is arranged (three attempts are made). The scripts ask for the first available appointment date for a United member (Medicaid is not specified) for an emergency, urgent, or routine need. For PCPs, the scripts also ask for a

date for an adult physical and EPSDT exam. The operator then asks whether these appointment dates apply to all providers on the list or only certain ones. Dates are adjusted as needed for providers with different availability, though in most cases the appointment times given apply to all providers on the list. It should be noted that not all providers in the practice are assessed in any given call because random sampling means that only certain providers may be in the sample. Pregnancy access is asked according to trimester of pregnancy, with longer compliance times allowed for earlier stages (three weeks for first trimester, two for second trimester, and one for third trimester).

Table 4: After Hours Compliance

	PCP		OB		Specialists		BH*		Total	
	2019	2020	2019	2020	2019	2020	2019	2020	2019	2020
	% (n)		% (n)		% (n)		% (n)		% (n)	
Sample Size	103	123	127	113	NA	133	NA	NA	287	369
Answering Service, Nurse, Physician, or Message (with number to contact)	73.79 %	95.93%	56.69%	98.23%	NA	96.99%	NA	NA	51.57%	97.02%
(number)	76	118	72	111	NA	129	NA	NA	148	358
Answering Machine Instructing Member to Go to Nearest Hospital	25.00 %	0.00%	8.33%	0.00%	NA	0.00%	NA	NA	16.89%	0.00%
(number)	19	0	6	0	NA	0	NA	NA	25	0
Phone Rings Continuously with No Answer	2.91 %	1.63%	0.79%	0.88%	NA	1.50%	NA	NA	1.39%	1.36%
(number)	3	2	1	1	NA	2	NA	NA	4	5
Other Unacceptable (typically message instructing member to dial 911)	3.88 %	2.44%	0.00%	0.88%	NA	1.50%	NA	NA	1.39%	1.63%
(number)	4	3	0	1	NA	2	NA	NA	4	6

**BH did not receive after-hours compliance calls in 2019 or 2020.*

Table 4 UHC Analysis

After hours calls were placed to all provider types except behavioral health. Across all provider types, 97.02% had an adequate process in place, such as an answering service, nurse, physician, or number to contact. This represents an increase from the previous year. The state contract requirements regarding after-hours access are as follows: "2.2.5.10 "The CONTRACTOR(S) shall have procedures in place to ensure medically necessary services are available to Members on a 24 hours-per-day, seven (7) days per week basis." Medically necessary services can be carried out by an Emergency Room or Hospital, if needed, after hours. UHC has just completed their 2020 follow-up calls (initial calls were made in October/November 2020).

Table 5:a-c Percent Offices Surveyed in Compliance with State Contractual Appointment Standards

Table 5a: Percent Offices Surveyed in Compliance with State Contractual Appointment Standards-PCP, Specialists and BH

	PCP		Specialist		BH		Total	
	2019	2020	2019	2020	2019	2020	2019	2020

	% (n)		% (n)		% (n)		% (n)	
Sample Size	103	123	106	133	67	172	276 (Urgent & Routine) 209 (Emergent) 103 (EPSDT & After Hours	428 (Urgent & Routine) 256 (Emergency) 123 (EPSDT & After Hours)
Emergency Care	100%	100%	100%	100%	NA	NA	100%	100%
(number)	103	123	106	133	NA	NA	209	256
Urgent Care	100%	100%	100%	100%	100%	100.00%	100%	100.00%
(number)	103	123	106	133	67	172	276	428
Routine Care	100%	100%	100%	100%	100%	100%	100%	100%
(number)	103	123	106	133	67	172	276	428
*(subset) EPSDT/Well Child	100%	100%	NA	NA	NA	NA	100%	100%
(number)	103	123	NA	NA	NA	NA	103	123
After Hours Coverage	73.80%	95.93%	NA	NA	NA	NA	73.80%	95.93%
(number)	76	118	NA	NA	NA	NA	76	118

Table 5b: Percent Offices Surveyed in Compliance with State Contractual Appointment Standards-OB

	OB	
	2019	2020
	% (n)	
Sample Size	80	113
After Hours Coverage	90%	98.23%
(number)	72	111
OB 1st Trimester	100%	99.12%
(number)	80	112
OB 2nd Trimester	100%	99.12%
(number)	80	112
OB 3rd Trimester	100%	99.12%
(number)	80	112

Table 5c: Percent Offices Surveyed in Compliance with State Contractual Appointment Standards-SUD

	SUD
	2020
Sample Size	1227
Substance Use Disorder	100.00%
(number)	1227
IV Drug User	100.00%
(number)	1227
Pregnant IV Drug User	92.09%
(number)	1130

State Review of Appointment and After-Hours Access to Care Reports

The State network team reviews MCO surveys of appointment and after-hours surveys during each annual contract review. State findings on compliance with the contract requirements can be found in the annual review reports sent to the MCOs. State staff also use the onsite meetings,

during the contract reviews, to discuss concerns or ask questions about the MCOs survey methodology and results. State staff and the MCO staff collaborated and designed a template for submitting Appointment and After-Hours survey results in a consistent format and agreed upon an annual due date for submission. The first submission of this new template is October 29, 2021 for 2021 survey results. The State contracted with KFMC (EQRO) to conduct an after-hours survey to assess the KanCare provider compliance with the requirement that primary care providers (PCPs) contracted by MCOs must be accessible after hours for members' non-emergent needs and respond to those member needs in a timely manner. The results of this study will be included in the EQRO Annual Technical Report.

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

Total annual expenditures for the demonstration population for Demonstration Year 8 (CY2020), with administrative costs reported separately, are set out in the attached document entitled "KanCare Expenditure & Enrollment Data DY8 CY2020." Yearly enrollment reports for demonstration enrollees for Demonstration Year 8 (CY2020), 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 8, are also set out in the attached document entitled "KanCare Expenditure & Enrollment Data DY8 CY2020."

The State has updated the quarterly Budget Neutrality template provided by CMS and has submitted this through the PDMA system. Please see Section VI of the fourth quarter report. The expenditures contained in the document reconcile to Schedule C from the CMS 64 report for QE 12 31 2020.

Safety Net Care Pool: The Safety Net Care Pool (SNCP) is divided into two pools: The Health Care Access Improvement Program (HCAIP) Pool and the Large Public Teaching Hospital/Border City Children's Hospital (LPTH/BCCH) Pool. The attached Safety Net Care Pool Reports identify pool payments to participating hospitals, including funding sources, applicable to 2019/DY7.

Disproportionate Share Hospital payments continue, as does support for graduate medical education.
Delivery System Reform Incentive Payment (DSRIP) Pool: Currently there are two hospitals participating in the DSRIP activities. They are Children's Mercy Hospital (CMH) and Kansas University Medical Center (KU). CMH has chosen to do the following projects: Complex Care for Children, and Patient Centered Medical Homes. KU will be completing STOP Sepsis, and Self-Management and Care Resiliency for their projects. Kansas Foundation for Medical Care (KFMC) is working with the State on improving healthcare quality in KanCare. The hospitals continue identifying community partners, creating training for community partners, and working toward reaching the project milestones for DY6. The CMS approved DSRIP annual and semi-annual payments were made on June 11, 2020, August 6, 2020, and November 5, 2020 respectively. A summary of 2020/DY8 DSRIP payments is attached.

Summary of Plan Financial Performance: As of December 31, 2020, all three plans are in a sound and solvent financial standing.

Statutory filings for the KanCare health plans can be found on the National Association of Insurance Commissioners' (NAIC) "Company Search for Compliant and Financial Information" website[8].

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

A. The State Quality Strategy:

[8] https://eapps.naic.org/cis/

The KanCare Quality Management Strategy, along with the Quality Assurance and Performance Improvement (QAPI) plans of the KanCare MCOs, are dynamic and responsive tools to support strong, high quality performance of the program. As such, they will be regularly reviewed and operational details will be continually evaluated, adjusted and put into use. This approach is guided by information collected from KanCare managed care organization (MCO) and state reporting, quality monitoring, onsite reviews and other KanCare contract monitoring results; external quality review findings and reports; feedback from State and Federal agencies, the KanCare MCOs, Medicaid providers, Medicaid members, and public health advocates. This combined information assists KDHE, KDADS and the MCOs to identify and recommend quality initiatives to monitor and implement the State's KanCare Quality Management Strategy (QMS). The QMS is consistent with the managed care contract and approved terms and conditions of the KanCare 1115 Medicaid demonstration.

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

An example of this process occurred when the MCOs expressed concern regarding not receiving phone numbers for approximately 42% of their members from the State. (When the primary applicant is not eligible, no phone number is included in the file sent to the MCO.) The State, along with relevant partners, researched the issue, brainstormed, and collaborated to discuss options and has implemented a solution. The project resulted in a weekly file being sent to MCOs which contain the phone number for all head of households along with any email addresses supplied with the Medicaid application. Further, performance improvement project activities have been demonstrating improved health outcomes and increasing HEDIS rates when the MCO reaches out, by phone, to the member. UHC chose to change one of their PIP topics because outcomes showed further improvement was not needed (above 95 percentile). The State and UHC collaborated to find a new topic, Antidepressant Medication Management (AMM), where rates need improvement and, experts say, during the COVID pandemic, need attention. Discussions have begun to end the HPV Collaborative PIP in favor of a COVID Vaccine PIP which targets those who are resistant to the vaccine.

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

Kansas has provided quarterly updates to CMS about the various activities related to HEDIS measurements, CAHPS surveys, Mental Health surveys, Pay for Performance measures, and about specific activities related to MLTSS services, quality measures, and related HCBS waiver amendment application

development and submission. Performance measures continue to evolve, and change based upon analysis of Healthcare Effectiveness Data and Information Set (HEDIS) data and claim encounter data.
KDHE received notice of CMS approval of the KanCare Evaluation Design on February 19, 2020. KFMC continued discussions with the MCOs, during the 2020 State/MCO/EQRO contract meetings (1/23, 4/23, 7/23 & 10/22) regarding data needed for the evaluation. The State has also been gathering information regarding the MCO Value-Based Purchasing projects and beginning conversations around which projects will be used for the Evaluation. Several other meetings occurred in 2020 to discuss the exact extraction location for each needed data point. More meetings are scheduled for 2021. State is attempting to pull as much data as possible from existing reports and systems. Data needed from the MCOs primarily includes member-level data for eleven HEDIS measures, CAHPS survey data, Substance Use Disorder member surveys, completed Health Screening Tools and completed Health Risk Assessments. Other data needed for evaluation will be obtained by KFMC from encounter data (from MCOs' claims); Medicaid enrollment and eligibility data; OneCare Kansas (OCK) Health Action Plan (HAP) documents.

KFMC attended OneCare Kansas Planning Council meetings and developed the web-based HAP portal in collaboration with KDHE for an April 1, 2020 effective date. KFMC attended OCK Learning Collaborative meetings after program implementation. KFMC is participating in the Behavioral Health and Disability Employment Support Pilot Advisory Group, to learn and to provide input regarding evaluation measures since employment services are a component in the KanCare 2.0 evaluation.

KanCare 2.0 evaluation activities and deliverables going forward include:

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

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

B. Utilization Data:

One component of the state's analysis of our Medicaid program is a comparison of the previous KanCare demonstration period (ending CY 2018) with the current demonstration (beginning CY 2019). Each annual report will add utilization data for the previous calendar year throughout the KanCare 2.0 demonstration period. This comparison provides information on shifts and trends in general and specific service areas, including services for both physical and behavioral health care needs, nursing facility and HCBS services, as well as inpatient and outpatient service settings. Refinement of our processes for compiling utilization data has allowed the state to compare utilization across a spectrum of 21 service types thus allowing us to monitor specific service areas as well as general service types across the entire array of Managed Care services.

During the first five years of our demonstration program, KanCare is maintaining an upward trend in utilization of community based, local, outpatient office visits and ancillary services by members. By

providing the MCOs with financial incentives based on outcomes that are tied to meaningful and reliable performance measures, the state is improving health care quality for our members.

		Claims/1000 member-months		Days/1000 member-months		Unduplicated prescriptions/1000	
		2018	2019	2018	2019	2018	2019
Outpatient ER	Claims	1,043	1,053				
Outpatient ER ANCILLARY	Claims	3,970	4,107				
Outpatient Non-ER	Claims	3,326	3,779				
Inpatient	Days			680	825		
Medical-Specialty	Claims	5,758	5,127				
Medical-General Practice	Claims	1,781	2,816				
Medical-Other	Claims	1,129	1,010				
Dental	Claims	4,024	4,078				
Vision	Claims	1,367	1,394				
FQHCs/RHCs	Claims	987	1,161				
Transportation - AMB	Claims	233	230				
Transportation - NEMT	Claims	1,186	1,406				
Pharmacy	Prescriptions					5,700	5,673
DME	Claims	746	706				
Hospice	Claims	326	315				
Independent Laboratory	Claims	1,682	1,695				
Renal Dialysis Center	Claims	290	334				
Targeted Case Management	Claims	499	591				
HCBS	Units	9,307	9,724				
Behavioral Health	Claims	5,493	5,349	124.2	132.1		
Long Term Care	Days			8,984	9,896		

C. Summary of Performance Improvement Projects (PIPs):

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

i. Monthly PIP team meetings-these went virtual in March of 2020
ii. Approval of all PIP Methodology worksheets
iii. Continuation of HPV collaborative PIP and improvements to the technical specifications of data reporting.
iv. Implementation of newly designed tools and processes to focus on complying with protocols, ensuring interventions are measurable, ease of use, consistency and improve documentation of outcomes
v. Pre-approval of interventions
vi. Designed tool for MCOs to report major adjustment to an intervention
vii. Define and document technical specifications for each measure

viii. Transition from a stagnant data recounting mechanism to a web-based, robust reporting system. A PIP Activity Report (PAR) is produced monthly for each PIP showing impacts of the interventions or changes to the overall outcome rates.

The EQRO reviews and validates the reports for each PIP annually.

D. Outcomes of Performance Measure Monitoring:

A summary of statewide results (all three KanCare MCOs aggregated) for calendar years 2014-2019 (measurements conducted in 2020) validated by Kansas Foundation for Medical Care. These numbers show the Kansas performance compared to the national 50th percentile on each of the measures. This information is detailed in a chart "HEDIS Comparison Measures-Physical Health & 2019 Performance Measure Validation" attached to this report.

E. Pay for Performance Measures:

The interim results of the KanCare MCOs' performance for the 2019 pay for performance measures (measured in 2020) are detailed in the "2019 Pay for Performance Summary" document attached to this report. The results are not yet complete for Aetna. The new quality staff at Aetna are still learning how to review and rebut encounter errors. All other measurements are completed.

F. Outcomes of Onsite Reviews:

The State of Kansas collaborated with its contracted External Quality Review Organization (EQRO), Kansas Foundation for Medical Care (KFMC), to conduct the 2020 Annual Contract Review. The audit included assessment of the level to which each Managed Care Organization (MCO) performs the duties of the KanCare 2.0 contract through operationalization of MCO policies and procedures and the quality of services delivered to providers and members. The contract areas were chosen as an outcome of results found in the 2019 audit that were only Partially Met (PM) or less. This change was designed to examine areas where the MCO's service delivery model previously showed a serious need for improvement.

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

Interviews with MCO staff were conducted by State team leads and accompanying SMEs. Principal topics included:

- Member and provider grievances and appeals demonstrating adherence to KanCare 2.0 Attachment D contract requirements including systems for tracking notices, acknowledgement letters, routing, monitoring, reporting, and readiness for future legislation involving provider appeal turnaround time and EQR independent reviews.
- Network adequacy standards and network management; contract compliance with Standards, reporting, recruitment, and retention; HCBS network growth. Accurate accounting of unique providers, unique locations, adult and pediatric PCPs and specialists, HCBS providers, accurate Geo Access maps
- Customer Service policies, desk procedures, call-center tracking system, inquiry type disbursement, and review of each MCO's member handbook.
- Validation of current sub-contractor contracts, vendor contract compliance, and performance monitoring tools.
- Utilization Management to include post-desk review discussion of members' physical health, behavior health, LTSS, SHCN, dental, vision, and pharmacy cases, UM policies, desk procedures, workflow, and PH/BH service integration. Considerable time was taken to hear MCO staff describe the service coordination process designed and utilized to ensure members receive timely and appropriate initial health screenings, Health Risk Assessments, needs assessments, and person-centered service planning, as needed.

- Cultural Competency in the delivery of services, provider office policies and practices, and MCO written materials requirements.

The findings for the audits are currently in the final draft stage and MCOs should receive their final findings report in first quarter 2021.

VI. STC 64(e) – SUD Health IT

Kansas had two primary SUD Health IT systems functioning at a statewide level, the Kansas Substance Use Reporting Solution (KSURS) and K-TRACS. KSURS was primarily used by SUD service providers to collect client level data to submit to the state. K-TRACS is the state's prescription drug monitoring program.

KSURS serves a basic function of collecting & monitoring client level data but does not fully replace the more robust electronic health record which would include additional provider-oriented tools like ASAM assessments and treatment plans. Kansas continues to support KSURS with periodic updates and continuous quality improvement on data submissions. Kansas is currently working to develop an RFP for a state hospital EHR solution which will help modernize and combine numerous mental health and SUD health IT solutions in a single system. It is anticipated that this modernization effort will take between 18 and 24 months to be fully realized statewide and be available to providers

Kansas submitted a SUD Health IT Plan as part of the SUD Demonstration Implementation Protocol that was approved by CMS in 2019. The Kansas Board of Pharmacy is responsible for the oversight and implementation of K-TRACS. The Kansas SUD Health IT Plan focuses on improving the functionality and utilization of K-TRACS to monitor the prescription and usage of controlled substances and other drugs of concern in Kansas. At the end of 2020, K-TRACS was connected to 34 other states, Washington DC, and Puerto Rico through APPRIS. The Board of Pharmacy continues to work on integration within the region. Other efforts and progress in 2020, Board of Pharmacy received a BJA Harrold Rodgers Prescription Drug Monitoring Program Grant. Finally, Kansas has continued efforts to improve Planned K-TRACS enhancements built into the grant funding include the development of a software tool to identify outlier prescribing and dispensing patterns, one-on-one peer review with pharmacists and prescribers through the evidence-based practice of academic detailing and verifying pharmacy compliance with program reporting requirements.

Kansas' progress on the submitted SUD Health IT Plan is evident in the outcomes below demonstrating increased provider use and growth of the PDMP program. K-TRACS continues to see increases in utilization and user enrollment quarterly.

Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020
Aggregate Registered Users	14,033	14,331	14,717	14,970
Prescribers	10,456	10,684	10,930	11,098
Pharmacists	3,340	3,405	3,537	3,615
Others (investigators, administrators, agencies)	237	242	250	257

Measure	Q1 2020	Q2 2020	Q3 2020	Q4 2020
New Users				
Prescribers	261	228	246	168
Pharmacists	53	65	132	78
Others (investigators, administrators, agencies)	5	5	8	7

2020	January	February	March	April	May	June
Total Patient Queries	215,691	199,086	193,419	195,288	203,823	239,506

	July	August	September	October	November	December
	249,590	240,859	241,390	239,993	221,169	248,640

Kansas has begun submitting SUD Health IT metrics in the SUD Demonstration Monitoring Plan which fulfills the STC requirements, along with ongoing reports and updates related to Attachment R: SUD Health IT Plan.

VII. Enclosures/Attachments

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

Section of Report Where Attachment Noted	Description of Attachment
STC 64(b)	KanCare Ombudsman Report Annual 2020
STC 64(c)	KanCare Expenditure & Enrollment Data DY8 CY2020
STC 64(c)	KanCare Safety Net Care Pool Reports (including DSRIP payments)
STC 64(d)	KanCare 2020 Public Forum Summary
STC 64(d)	HEDIS Comparison Measures-Physical Health & 2019 Performance Measure Validation
STC 64(e)	2019 Pay for Performance Summary

VIII. State Contacts(s)

Dr. Lee A. Norman, M.D., Secretary
Sarah Fertig, Medicaid Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building – 9th Floor
900 SW Jackson Street
Topeka, Kansas 66612
(785) 296-3563 (phone)
(785) 296-4813 (fax)
Lee.norman@ks.gov
Sarah.Fertig@ks.gov

IX. Date Submitted to CMS

March 31, 2021

ANNUAL REPORT 2020

KANCARE OMBUDSMAN OFFICE

Kerrie Bacon, KanCare Ombudsman
Email: KanCare.Ombudsman@ks.gov or Kerrie.Bacon@ks.gov
Phone: (785) 296-6270
Cell: (785) 213-2258
Toll Free: 1-855-643-8180
Relay: 711
Address: 503 S. Kansas Ave., Topeka, KS 66603
Website: www.KanCareOmbudsman.ks.gov
Like us on Facebook

I. Table of Contents

Contents

II. Highlights/Dashboard

A. Contacts are down for 2020

The number of contacts to the KanCare Ombudsman Office significantly decreased during the pandemic, starting in March of 2020. The satellite offices closed, and staff worked remotely. We have heard from other service organizations that contacts were and continue to be down for them as well.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
2016	1,130	846	687	523	3,186
2017	825	835	970	1,040	3,670
2018	1,214	1,059	1,088	1,124	4,485
2019	1,060	1,097	1,071	915	4,143
2020	903	478	562	601	2,544

B. Significant increase in outreach efforts

The KanCare Ombudsman office had a significant increase in outreach during 2020. Highlights include:

1. Liaison Training on-line
2. Outreach to members and community partners increased
3. New KanCare Ombudsman brochure (see Appendix B)
4. New landing page for KanCare Ombudsman website
   (see page 7 for more detail)

C. Nursing facility concerns in 2020 second highest in 5 years

Although nursing facility issues were down in 2020 from the prior year, they were the second highest in the last 5 years and during a year when calls were significantly down. In general, the calls were about:

- KanCare application questions/assistance/eligibility
- Nursing facility complaints (referred to KDADS complaint hotline)
- Concerns about persons perceived to need to be in a nursing facility (ask many questions and see if they may need HCBS services, assistance from MCO, etc.)
- Estate planning questions for preparing to apply for a person to go to a nursing facility (we do not attempt to answer these questions; refer to find an estate planning lawyer)

	2016	2017	2018	2019	2020
Nursing Facility Issues	112	110	86	178	139

III. KanCare Ombudsman Purpose

The KanCare Ombudsman Office helps Kansas Medicaid beneficiaries and applicants, with a priority on individuals participating in long-term supports and services through KanCare. The KanCare Ombudsman Office assists KanCare beneficiaries and applicants with access, service and benefit problems. The KanCare Ombudsman office helps with:

- Answers to questions
- Resolving issues
- Understanding letters from KanCare
- Responding when you disagree with a decision or change
- Completing an application or renewal
- Filing a complaint (grievance)
- Filing an appeal or fair hearing
- Learning about in-home services, also called Home and Community Based Services (HCBS)

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

IV. Accessibility to the Ombudsman's Office

A. Initial Contacts

Activity: The KanCare Ombudsman Office was available to members and applicants of KanCare (Medicaid) by phone, email, written communication, social media and the Integrated Referral and Intake System (IRIS) during quarter 4 of 2020.

The KanCare Ombudsman Office has helped KanCare members and applicants since the inception of KanCare in January 2013. Starting in November of 2015, the KanCare Ombudsman office began a volunteer program to assist with answering calls and helping with applications. There are two satellite offices; Wichita and Kansas City.

Outcome: The KanCare Ombudsman Office has helped an increasing number of KanCare members and applicants over the last several years, starting in November 2015 with the beginning of trained volunteer help in the two satellite offices (Olathe and Wichita). For the years 2018 and 2019 total quarterly contacts have averaged around 1,000.

The decrease in 2020 is due to the pandemic. Although satellite offices were closed during second and third quarter, the Topeka staff continued to assist those requesting help.

Initial Contacts	Qtr. 1	Qtr. 2	Qtr. 3	Qtr. 4	Total
2014	545	474	526	547	2,092
2015	510	462	579	524	2,075
2016	1,130	846	687	523	3,186
2017	825	835	970	1,040	3,670
2018	1,214	1,059	1,088	1,124	4,485
2019	1,060	1,097	1,071	915	4,143
2020	903	478	562	601	2,544

B. Accessibility through the KanCare Ombudsman Volunteer Program

Activity: The KanCare Ombudsman Office has two satellite offices for the volunteer program; one in Kansas City metro area and one in Wichita. The volunteers in both satellite offices answer KanCare questions, help with issues and assist with filling out KanCare applications (during the pandemic, by phone only).

Outcome: In March 2020, all volunteers were told the satellite office were closed due to the pandemic. Volunteers started back in 4th quarter, 2020. There were two volunteers in each office. Both office sites had staff working remotely, so there were very limited people in the office. We set up a cleaning protocol for the offices to follow when volunteers came in. Members and applicants were assisted, but it took longer to respond due to less people handling calls. See response rate chart on page 16.

V. Outreach by KanCare Ombudsman Office

Activity: The KanCare Ombudsman Office is responsible to help members, applicants and providers understand the KanCare application process, benefits and services, and provide training and outreach to community organizations. The office does outreach through resources provided on the KanCare Ombudsman web pages, resources provided with contacts to members, applicants and providers, and outreach through conferences, conference calls, video calls, social media, and in-person contacts.

Outcome 1: The below chart shows the outreach efforts by the KanCare Ombudsman Office. The increase for 2020 is due to an outreach plan for first quarter by the new Project Coordinator in the Wichita office and an outreach plan to introduce our office to the significant number of IRIS (Integrated Resource and Intake System) partners across Kansas through email and mail.

	2016	2017	2018	2019	2020
Outreach	86	92	136	82	243

For the full listing of 2020 outreach, see Appendix A.

Outcome 2: Liaison Training available online

The Volunteer Coordinator completed the project of putting the KanCare Ombudsman Liaison Trainings on YouTube with voice and open captioning. This was a major project that took well over 100 hours. This is community organization training on Medicaid 101 and a Line by Line explanation of how to complete an application.

Outcome 3: **New Brochure**

The KanCare Ombudsman Office created a new brochure that is completely different from the brochure in the past. It is a slim, one-page brochure with English on one side and Spanish on the other side. It is targeted to KanCare members and applicants. A copy is available as Appendix B.

Outcome 4: Website update

There is an addition to the KanCare Ombudsman webpage. Until recently, there has not been a true landing page for this site. A landing page was created, explaining what the KanCare Ombudsman does with Quick Links on the left side for easier access.

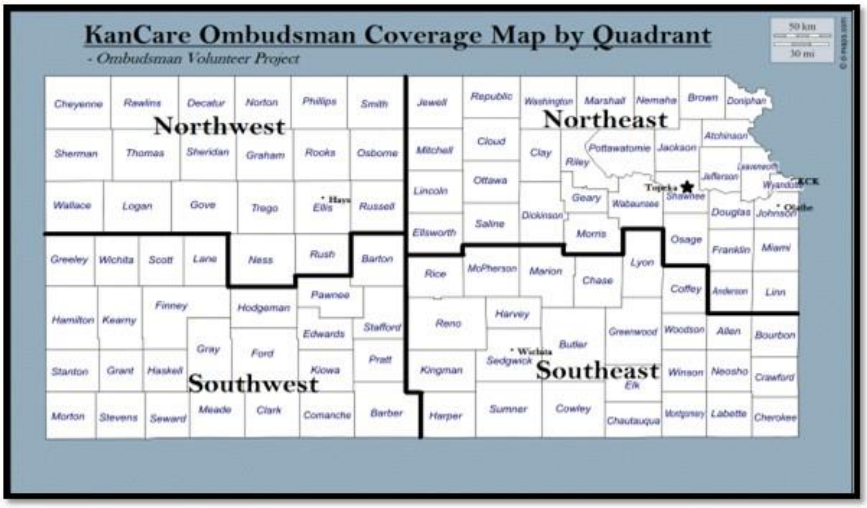
VI. Data by KanCare Ombudsman Office

Activity: The data for the KanCare Ombudsman Office reflects the work done by the KanCare Ombudsman office, showing **Outcomes** by region, office location, contact method, caller type, program type, issue category, action taken, and priority.

A. Data by Region

1. Initial Contacts to KanCare Ombudsman Office by Region

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



- 785, 913 and 816 area code calls go to the Kansas City Satellite office.
- 316 and 620 area code calls go to the Wichita Satellite office.
- The remaining calls, direct calls and complex calls go to the Topeka (main) office unless people call the direct number for the satellite offices (found on KanCare Ombudsman web pages under Contact Us.
- The chart, by region, shows that most KanCare Ombudsman calls come from the Northeast and Southeast part of Kansas.

REGION	2018	2019	2020
Northwest	54	46	25
Northeast	805	751	367
Southwest	76	78	41
Southeast	605	635	395
Unknown	2875	2610	1700
Out of State	69	31	1
Total	**4,484**	**4,151**	**2,529**

2. KanCare/Medicaid members by Region

This chart shows the **KanCare/Medicaid population** by the KanCare Ombudsman regions. The majority of the Medicaid population is located in the eastern two regions. Most Medicaid members are not being dropped at this time due to the pandemic, so the bottom line number is increasing each quarter.

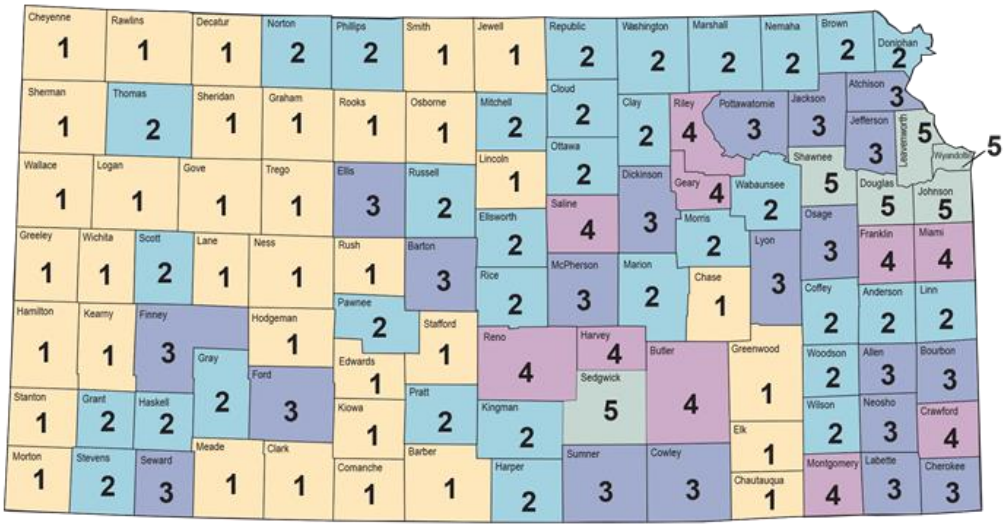
Medicaid

Region	Q1/2019	Q2/2019	Q3/2019	Q4/2019	Q1/2020	Q2/2020	Q3/2020	Q4/2020
Northeast	205,267	179,011	188,184	189,133	193,061	199,226	207,371	212,844
Southeast	185,683	160,821	169,598	170,237	174,330	180,611	188,171	193,347
Northwest	13,240	11,575	12,163	12,223	12,550	12,964	13,507	13,928
Southwest	40,073	34,613	36,291	36,472	36,984	38,200	39,667	40,724
Total	**444,263**	**386,020**	**406,236**	**408,065**	**416,925**	**431,001**	**448,716**	**460,843**

3. Kansas Population Density

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

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



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

B. Data by Office Location

Initial phone calls to the KanCare Ombudsman Office toll-free number (1-855-643-8180) are sent directly to one of three KanCare Ombudsman offices based on the area code the call is coming from. The Kansas City office receives 913, 785 and 816 area code calls. The Wichita office receives 620 and 316 area code calls. All other toll-free calls go to the Main office (Topeka) in addition to direct calls to staff.

As can be seen by the chart below, in 2020, the Topeka office handled most of the calls due to the closure of the Satellite offices for over seven months.

Contacts by Office	2018	2019	2020
Main - Topeka	2,428	2,451	1,876
Kansas City	549	773	201
Wichita	1,505	919	470
Total	4,482	4,143	2,547

C. Data by Contact Method

The contact method most used continues to be telephone and email. The "Other" category includes the use of the Integrated Referral and Intake System (IRIS), a tool designed to encourage warm handoffs among community partners, keeping providers updated along the way. We started participating in IRIS in 2020.

Contact Method	2016	2017	2018	2019	2020
Telephone	2,413	3,112	3,868	3,596	2,104
Email	783	517	545	506	404
Letter	6	2	8	9	17
Face-to-Face Meeting	14	30	58	31	11
Other	6	11	5	6	7
Social Media	0	0	0	3	4
CONTACT METHOD TOTAL	**3,222**	**3,672**	**4,484**	**4,151**	**2,547**

D. Data by Caller Type

Most contacts are consumers which includes members, applicants, family members, friends, etc.

The “Other type” callers are usually state employees, lawyers, social workers at schools and hospitals, and students/researchers looking for data.

Provider issues are a combination of providers calling to assist a member or applicant having issues, or a provider with billing issues, questions on how to become a provider in Kansas, etc. The provider contacts that are not for an individual member, are forwarded to KDHE.

CALLER TYPE	2,016	2,017	2,018	2,019	2,020
Provider	468	492	369	339	254
Consumer	2,372	2,927	3,884	3,554	2,096
MCO Employee	31	44	19	27	22
Other Type	351	209	212	231	175
CALLER TYPE TOTAL	**3,222**	**3,672**	**4,484**	**4,151**	**2,547**

E. Data by Program Type

The top program types that we received calls for in 2020 were the Physical Disability waiver, Nursing Facility issues and the Frail Elderly waiver. Nursing facility calls were, in general, on the following concerns:

- KanCare application questions/assistance/eligibility
- Nursing facility complaints (referred to KDADS complaint hotline)
- Concerns about persons perceived to need to be in a nursing facility (we ask many questions and see if they may need HCBS services, more assistance from MCO, etc.)
- Estate planning questions for preparing to apply for a person to go to a nursing facility (we do not attempt to answer these questions; refer to find an estate planning lawyer)

PROGRAM TYPE	2016	2017	2018	2019	2020
PD	92	154	143	122	104
I/DD	108	200	124	123	74
FE	59	128	110	125	96
AUTISM	6	7	8	10	7
SED	8	18	26	35	13
TBI	26	27	32	43	23
TA	31	27	18	29	14
WH	0	4	20	10	1
MFP	16	3	1	1	1
PACE	0	2	0	9	2
MENTAL HEALTH	23	17	8	14	14
SUB USE DIS	0	0	0	4	0
NURSING FACILITY	121	251	155	135	99
FOSTER CARE	0	0	0	0	1
MEDIKAN	0	0	0	12	5
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	6	10
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	3	2
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0
PROGRAM TYPE TOTAL	**490**	**838**	**645**	**681**	**466**

There may be multiple selections for a member/contact.

F. Data by Priorities

This is data collection started in August 2019. The Ombudsman Office is tracking priorities for two purposes:

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

The priorities are defined as follows:

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

PRIORITY	2019	2020
HCBS	100	197
Long Term Care / MF	36	79
Urgent Medical Need	46	52
Urgent	52	65
Life Threatening	14	13
PRIORITIES TOTAL	**248**	**406**

G. Data by Issue Categories

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

1. Medicaid Issues
2. Home and Community Based Services/Long Term Supports and Services Issues (HCBS/LTSS)
3. Other Issues: Other Issues may be Medicaid related but are tied to a non-Medicaid program or an issue that is worthy of tracking.

1. Medicaid Issues

The top two issues are Medicaid Application assistance and Medicaid General issues with Medicaid Eligibility Issues and Medicaid Info/status also relatively high.

MEDICAID ISSUES	2016	2017	2018	2019	2020
Access to Providers (usually Medical)	35	51	24	66	24
Appeals/Fair Hearing questions/issues	0	44	126	51	56
Background Checks	0	2	5	4	0
Billing	147	90	118	148	91
Care Coordinator Issues	21	34	42	54	33
Change MCO	24	12	61	32	24
Choice Info on MCO	0	0	29	21	9
Coding Issues	0	29	73	39	21
Consumer said Notice not received	0	2	50	22	6
Cultural Competency	0	0	0	1	1
Data Requests	0	8	9	7	10
Dental	19	29	32	29	19
Division of Assets	0	14	29	44	29
Durable Medical Equipment	20	18	27	14	19
Grievances Questions/Issues	147	107	98	93	76
Help understanding mail (NOA)	0	0	0	9	28
MCO transition	0	0	0	4	3
Medicaid Application Assistance	0	441	638	609	514
Medicaid Eligibility Issues	1,122	951	798	632	477
Medicaid Fraud	0	0	12	10	9
Medicaid General Issues/questions	0	0	705	909	503
Medicaid info (status) update	0	4	810	636	389
Medicaid Renewal	0	171	224	310	83
Medical Card issues	0	0	0	10	34
Medicare Savings Plan Issues	0	30	81	191	132
MediKan issues	0	0	0	7	13
Moving to / from Kansas	0	27	70	72	54
Medical Services	72	60	74	59	72
Pain management issues	0	0	1	8	3
Pharmacy	59	43	30	55	34
Pregnancy issues	0	0	0	10	38
Prior authorization issues	0	0	0	2	9
Refugee/Immigration/SOBRA issues	0	0	0	13	5
Respite	0	0	2	2	0
Spend Down Issues	71	108	112	117	95
Transportation	21	34	47	43	23
Working Healthy	0	5	26	19	3
MEDICAID ISSUES TOTAL	**1,758**	**2,314**	**4,353**	**4,352**	**2,939**

There may be multiple selections for a member/contact.

2. HCBS/LTSS Issues

The top issues for this group are HCBS General Issues and HCBS eligibility issues. Nursing facility issues were down from 2019, but second highest in the last five years. Nursing facility calls were, in general, on the following concerns:

- KanCare application questions/assistance/eligibility
- Nursing facility complaints (referred to KDADS complaint hotline)
- Concerns about persons perceived to need to be in a nursing facility (ask many questions and see if they may need HCBS services, assistance from MCO, etc.)
- Estate planning questions for preparing to apply for a person to go to a nursing facility (we do not attempt to answer these questions; refer to find an estate planning lawyer)

HCBS/LTSS ISSUES	2016	2017	2018	2019	2020
Client Obligation	0	123	139	82	38
Estate Recovery	0	21	32	32	35
HCBS Eligibility issues	109	216	145	175	179
HCBS General Issues	133	137	180	242	218
HCBS Reduction in hours of service	23	19	14	12	27
HCBS Waiting List	26	27	22	27	25
Nursing Facility Issues	112	110	86	178	139
HCBS/LTSS ISSUES TOTAL	**403**	**653**	**618**	**748**	**661**

There may be multiple selections for a member/contact.

3. Other Issues

This section shows issues or concerns that may be *related* to KanCare/Medicaid.

OTHER ISSUES	2016	2017	2018	2019	2020
Abuse / neglect complaints	0	2	29	21	34
ADA Concerns	0	0	0	0	1
Adoption issues	0	0	0	3	4
Affordable Care Act Calls	0	19	44	17	15
Community Resources needed	0	0	0	9	24
Domestic Violence concerns	0	0	0	1	3
Foster Care issues	0	0	0	3	14
Guardianship	5	11	19	10	14
Homelessness	0	0	0	4	11
Housing Issues	15	17	26	21	25
Medicare related Issues	0	37	97	74	69
Social Security Issues	0	5	58	57	70
Used Interpreter	0	0	0	6	14
X-Other	1,342	1,018	594	452	627
Z Thank you	389	1,407	2,048	1,557	1,105
Z Unspecified	110	216	298	443	232
OTHER ISSUES TOTAL	**1,873**	**2,735**	**3,213**	**2,678**	**2,262**

There may be multiple selections for a member/contact.

H. Data by Managed Care Organization (MCO) – See Appendix C

VII. Action Taken

Activity: This section reflects the action taken by the KanCare Ombudsman Office in responding to people who contact the office and the related organizations assisting the KanCare Ombudsman Office.
This data shows **Outcomes** on:

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

A. Responding to Issues

1. KanCare Ombudsman Office response to members/applicants

The Ombudsman Office goal is to respond to a contact within two business days. During the COVID-19 pandemic, our goal changed to responding within 3-4 business days.

This is a good example of why it is important to have data. When we first started using this report, during 2016, it provided the information that this was an area we needed to concentrate on and the numbers improved dramatically. Then in 2017, when the numbers were getting higher again, I had a conversation with staff and volunteers about the goal of responding within 2 business days, and the numbers improved again.

Quarter yr.	Nbr Contacts	% Responded 0-2 Days	% Responded 3-7 Days	% Responded 8 or More Days
Q1/2016	1160	75%	10%	15%
Q2/2016	850	63%	19%	18%
Q3/2016	688	78%	17%	5%
Q4/2016	522	82%	18%	0%
Q1/2017	827	77%	21%	2%
Q2/2017	835	80%	19%	1%
Q3/2017	970	65%	31%	4%
Q4/2017	1040	69%	22%	9%
Q1/2018	1213	82%	17%	1%
Q2/2018	1059	90%	10%	0%
Q3/2018	1088	87%	12%	1%
Q4/2018	1124	86%	14%	0%
Q1/2019	1068	88%	11%	1%
Q2/2019	1096	91%	8%	1%
Q3/2019	1071	95%	4%	1%
Q4/2019	915	93%	7%	0%
Q1/2020	905	92%	4%	4%
Q2/2020	476	60%	37%	3%
Q3/2020	562	86%	12%	2%
Q4/2020	601	84%	15%	1%

2. Organizational final response to Ombudsman requests

The KanCare Ombudsman office sends requests for review and assistance to various KanCare/related organizations. The following information provides data on the **resolution rate** for organizations the Ombudsman's office requests assistance from and the amount of time it takes to resolve. For this annual report, this is a comparison of two quarters; fourth quarter for 2019 and 2020.

Q4/2019

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

Q4/2020

Nbr Referrals	Referred to	% Responded 0-2 Days	% Responded 3-7 Days	% Responded 7-30 Days	% Responded 31 or More Days
46	Clearinghouse	98%	0%	2%	0%
4	KDADS-Behavior Health	25%	25%	50%	0%
9	KDADS-HCBS	22%	33%	44%	0%
13	KDHE-Eligibility	54%	23%	23%	0%
1	KDHE-Program Staff	100%	0%	0%	0%
5	KDHE-Provider Contact	40%	0%	40%	20%
8	Aetna	50%	25%	25%	0%
10	Sunflower	10%	40%	40%	10%
10	UnitedHealthcare	50%	0%	40%	10%

3. Action Taken by KanCare Ombudsman Office to resolve requests

88% of initial contacts (which is better than 4 out of 5) were resolved by providing some type of resource. For example, the KanCare Ombudsman office:

- contacted other organization(s) to ask assistance in resolving the issue
- shared information, resources, mailings, etc.
- provided referrals to other organizations

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

Action Taken Resolution Type	2016	2017	2018	2019	2020
Questions/Issue Resolved (No Resources)	928	417	356	309	145
Used Contact or Resources/Issue Resolved	1,357	2,505	3,091	3,387	2,124
Closed (No Contact)	841	367	483	394	154
ACTION TAKEN RESOLUTION TYPE TOTAL	**3,126**	**3,289**	**3,930**	**4,090**	**2,423**

There may be multiple selections for a member/contact

This chart shows when information/resources are provided verbally, mailed or emailed to a member/applicant.

Action Taken Additional Help	2016	2017	2018	2019	2020
Provided Resources	816	1,340	3,004	2,451	1,555
Mailed/Email Resources	2	409	679	594	390
ACTION TAKEN ADDITIONAL HELP TOTAL	**818**	**1,749**	**3,683**	**3,045**	**1,945**

4. Ombudsman Office Resolution of Issues

The average days to close/resolve an issue had a dip in second quarter,2020 and is back up to the 70%s in third and fourth quarters of 2020.

Quarter yr.	Nbr Contacts	Avg Days To Completion	% Completed 0-2 Days	% Completed in 3-7 Days	% Completed 8 or More Days
Q1/2019	1051	5	71%	17%	13%
Q2/2019	1021	4	75%	13%	12%
Q3/2019	1002	5	75%	10%	15%
Q4/2019	850	5	72%	11%	17%
Q1/2020	804	5	74%	10%	16%
Q2/2020	404	7	46%	31%	23%
Q3/2020	534	4	76%	13%	11%
Q4/2020	570	5	70%	17%	13%

VIII. Changes from the past year and Future Changes

A. Updates on Outreach

1. Liaison Training available online

The Volunteer Coordinator completed the project of putting the KanCare Ombudsman Liaison Trainings on YouTube with voice and open captioning. This was a major project that took well over 100 hours. This is community organization training on Medicaid 101 and a Line by Line explanation of how to complete an application.

2. New Brochure

A new brochure was developed for the KanCare Ombudsman office that is simpler, a single page document, with English and Spanish on the same document. See Appendix B.

3. Updated On-line presence

- **Website:** Until recently, there has not been a true landing page for the KanCare Ombudsman webpages. The Contact/About Us page was used as the landing page. A new landing page was created, explaining what the KanCare Ombudsman does with Quick Links on the left side for easier access.
- **Facebook:** Until recently there has not been a strong Facebook page for the KanCare Ombudsman Office. AmeriCorps VISTA and Interns redesigned and began actively created content and a regular posting schedule with three targeted areas: educational, recruitment and policy changes for Medicaid and related topics. Facebook engagements increased dramatically during 2020.

4. New Partnership with Integrated Referral and Intake System (IRIS)

The IRIS system provides not only a new avenue for referrals, it provides an opportunity to connect with a significant number of new partners across Kansas on a regular basis.

B. Changes in the KanCare Ombudsman Office

1. Staff

The KanCare Ombudsman Volunteer Coordinator position was vacated in March 2020. The staff member found a new opportunity. The position was posted, and interviews completed in December 2020. The delay in filling the position was due to a hiring freeze in March due to the pandemic. Josephine Alvey started work for our office on 1/25/21. She is a new graduate of Wichita State University and was a full-time AmeriCorps VISTA volunteer in our Wichita satellite office for a year while attending the university. We are very pleased she has joined our team.

2. Satellite Offices

Both Satellite offices closed March 2020 and opened the beginning of fourth quarter.

3. Current volunteer coverage

There are two regular volunteers and one volunteer being mentored in the Kansas City Satellite office. There are two regular volunteer and two volunteers in training in the Wichita office. We have two Education Resource Volunteers/Interns in training who are remote and will be assisting with our Community Resources by county project.

C. Future: Community Resources by County

By the end of first quarter the KanCare Ombudsman Office will provide county level basic resources on the KanCare Ombudsman webpages. The resources will cover medical, food, shelter, transportation and local and regional general resources.

The volunteers working on this project are college student interns from the University of St. Marys, working toward bachelor's or master's degrees in Social Services or Health Services. The resources will be reviewed and updated on a rotating 18 to 24 month schedule with the continued assistance of college intern volunteers.

D. Future: Updating Training Manual and Resources

The new volunteer coordinator has a quarterly schedule to completely update the training manual and tests within the next year. Adding Trauma Informed Systems of Care (TISC) and Cultural Awareness to the training manual. Resources will be updated annually using a quarterly update schedule.

IX. Appendix A: Outreach by KanCare Ombudsman Office

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

A. Outreach through Education

- Bethell KanCare Oversight Committee meeting, Topeka, Feb. 28, 2020; provided annual report (1)
- KanCare Advisory Council Meeting, Topeka, 3/3/2020; provided annual report (1)
- January – WSU CEI Staff made in-person contacts/presentations with the following organizations (28):
    - Central Plains Area Agency on Aging (SG Co)
    - Butler County Child Family Development Task Force, including
    - Thrive! Butler
    - Department of Commerce
    - El Dorado USD 490 schools
    - Big Brothers Big Sisters
    - Butler County Health Department
    - South Central Community Mental Health Center
    - Child Care Aware of Kansas
    - Salvation Army
    - Rainbows United
    - Sunlight Child Advocacy Center
    - South Central Kansas Aging Disability Resource Center (serves 10 Central KS counties)
    - Healthier Greenwood County Coalition, including
    - Crosswinds Counseling Center
    - KansasWorks
    - Healthier Lyon County
    - KDHE
    - Resource Center for Independent Living LY/GW/BU Co
    - Sunlight Child Advocacy Center & Sunshine Children's Home
    - Greenwood County Health Department
    - Greenwood County Hospital
    - Hope Unlimited (Iola: AL/AN/NO/WO Co)
    - Neosho County Health Department
    - Montgomery County Health Department
    - Kansas Consumer-Run Organization networking meeting
    - Choices Medical Clinic (Wichita)
    - Women's Health Network meeting (Wichita)

- April - WSU CEI staff and Ombudsman VISTA maintained contact with program staff at community partners RSVP and SHICK.
- 5/5 – WSU CEI staff responded to emailed questions from staff at South Central Kansas Area Agency on Aging regarding Medicaid application processes
- 5/6 – WSU CEI staff attended CPAAA networking meeting (via WebEx)
- 5/11 – WSU Ombudsman VISTA emailed with RSVP program staff
- 7/1 – WSU CEI staff and VISTA attended CPAAA networking meeting (via WebEx); WSU CEI staff are on the CPAAA schedule to present information about the Ombudsman Office and volunteer opportunities at the October CPAAA meeting.
- 7/29 – WSU CEI staff emailed with the United Way of the Plains Emergency Assistance Provider coordinator with a program update and general greeting.
- Throughout July, KanCare Ombudsman Team worked with Lindsay Galindo of KU's Center for Public Partnerships and Research to implement engagement with the Integrated Referral and Intake System (IRIS). This software enables communities in over 20 Kansas counties to make connections and referrals for Kansas residents. In July, the Ombudsman Office staff signed user agreements and began communicating with IRIS "community champions" in each IRIS community. As a result, WSU CEI staff made direct connection with the director of Child Care Aware of Eastern Kansas, located in Topeka. WSU CEI staff compiled introductory emails as IRIS/KU staff sent them throughout July. By the end of the month, WSU CEI staff made plans to target each community champion with outreach information. These efforts were set to begin in August.
- 8/5: WSU CEI staff and VISTA attended CPAAA networking meeting (via WebEx); WSU CEI staff are on the CPAAA schedule to present information about the Ombudsman Office and volunteer opportunities at the October CPAAA meeting.
- 8/14: WSU CEI staff responded to NE KS DCF staff request for resources via email.
- Throughout August, KanCare Ombudsman Team worked to establish engagement with the Integrated Referral and Intake System (IRIS). Letters of introduction and KanCare Ombudsman brochures were mailed to about half of the IRIS communities and email connections made with several others. As a result, the KanCare Ombudsman team connected with the following community agencies:
    - Barton County Health Department (email & USPS)
    - Sedgwick County Health Department
    - Wichita KU Medical School
    - Spring River Mental Health (SE Kansas)
    - Hays Area Children's Center
    - Johnson County Dept of Health and Environment
    - Mitchell County Regional Medical Foundation
    - Riley County Health Department
    - Saline County Health Department (email & USPS)
    - Child Care Aware of Eastern Kansas
    - Wyandotte County-area KU Medical School

    - Franklin County Health Department
    - Harvey County Health Department
    - Hutchinson Community Foundation
    - Reno County Health Department
    - Geary County-area KU Center for Public Policy and Research
    - 20th Judicial Court Services
    - 20th Judicial Court Services Juvenile
    - Barton County Community College
    - Central KS Community Corrections
    - Journey to Resolve Poverty (Barton County)
    - Kansas Children's Service League
    - Stafford County Health Department
    - Sunflower Early Education Services
    - The Center for Counseling and Consultation
    - USD 428
    - USD 440
    - USD 373 - Chisolm Middle School
    - Cooper Early Education Center
    - Halstead Public Library
    - Healthy Families (Newton)
    - Kansas Big Brothers Big Sisters (Harvey County)
    - Peace Connections
    - Baby Talk ICT
    - Free State Healthcare
    - Healthy Babies
    - Holy Family Medical
    - Human Kind
    - KS KIDS
    - The Treehouse
    - The Village ICT

- 9/2: WSU CEI staff mailed updated brochures to community partners with previous relationships or special requests. These included personnel at South Central KS Area Agency on Aging and Disability Resource Center, Derby Senior Services Center, and Plainview Senior Services Center.
- 9/24: WSU CEI staff, practicum student, and VISTA attended Sedgwick County CDDO quarterly networking/education meeting via Zoom.
- WSU CEI staff emailed with coordinators of Healthier Lyon County Community Coalition, Butler County Early Childhood Coalition, and Greenwood County Community Coalition. Staff has been included in invitations to future meetings.
- Continuing from August, KanCare Ombudsman Team worked to establish engagement

with the Integrated Referral and Intake System (IRIS). This software enables communities in over 20 Kansas counties to make connections and referrals for Kansas residents. As a result, connections were made with the following 43 community agencies:

- Chanute KANSASWORKS
- Cherokee County Health Dept
- Child Care Link
- Community Access Center SEK
- Crawford County Health Dept
- Greenbush Education
- Holy Cross Hutchinson
- Horizons Mental Health Center
- Human Kind Wichita
- Independence KANSASWORKS
- Interfaith Ministries Hutchinson
- KCSL
- KS Kids SG Co
- K-State Research & Extension SEK
- Labette County Health Dept
- Mother to Mother Ministry
- My Family – SEK
- Neosho County Health Dept
- New Beginnings
- Parents as Teachers Greenbush
- Pittsburg KANSASWORKS
- Prairie Independent Living Resource Center
- Reno County Government departments, including Health Dept and Juvenile Corrections
- Safe Families for Children
- SEK CAP Early Childhood
- St Francis Ministries
- TECH Inc
- The Salvation Army Pittsburg
- The Treehouse Wichita
- Topeka Head Start
- USD 308
- USD 309
- USD 445 Parents as Teachers
- Vie Medical Clinic
- Wilson County Health Dept

- KanCare Ombudsman Team attended the following IRIS community meetings:
  - 9/14: Shawnee County Early Childhood Coalition IRIS meeting (presented)

    - 9/22: SEK funding network & brainstorming meeting
    - 9/24: Sedgwick County IRIS quarterly network meeting
- WSU CEI staff coordinated with Aetna Community Outreach staff to highlight the KanCare Ombudsman Office in an upcoming Aetna newsletter (i.e. November).
- 10/7: WSU CEI staff presented to 68 attendees at the CPAAA monthly networking meeting to promote the work of the Ombudsman Office. Community providers initiated follow up conversations to brainstorm potential networking and education opportunities.
- 10/8: WSU CEI staff attended and presented to 30 attendees at the Healthier Lyon County Coalition meeting via Zoom. Subsequently, staff created an outreach listing on www.emporiastrong.com, a directory of assistance services in the Emporia area. Community providers initiated follow up conversations to brainstorm potential networking and education opportunities.
- 10/15: WSU CEI staff attended and spoke to 9 attendees at the Healthier Greenwood County Coalition meeting via Zoom.
- 10/28: Presentation to TARC (Topeka) staff regarding the KanCare Ombudsman Office.
- Throughout October, WSU CEI staff coordinated with the Executive Director of Children's' Advocacy Centers of Kansas to present to their membership at their quarterly meeting in November via Zoom.
- 12/10: WSU CEI staff & WSU practicum student attended the (virtual) Healthier Lyon County Coalition networking meeting, with 33 other attendees.

B. Outreach through Print Media and Social Media

- In total, the WSU VISTA spent approximately 33 hours creating Facebook content and redesign. This included 26 posts this quarter.
- January – WSU CEI Staff emailed contacts at the following organizations (10):
    - Butler County Health Department
    - Kansas Alliance for Drug Endangered Children
    - Treehouse, Inc. (Wichita)
    - Woodlake Senior Residences (Wichita)
    - Sunlight Child Advocacy Center (El Dorado: BU/EK/GW Co's)
    - Neosho County Health Department
    - Hope Unlimited (Iola: AL/AN/NO/WO co.'s)
    - Kansas Association of Community Access Programs
    - Montgomery County Health Department
    - Sedgwick County Developmental Disability Organization Community Council
- April – Wichita Ombudsman VISTA made 4 Facebook posts or updates
- WSU CEI Communications staff highlighted Ombudsman work and VISTA engagement with the following Facebook post, dated April 29: https://www.facebook.com/wsucei/photos/a.10151031618448819/10157986812823819/?type=3&theater
- Wichita Ombudsman VISTA made 3 Facebook posts during this transition to a new VISTA volunteer.

- July 2020 - Wichita Ombudsman VISTA and WSU CEI staff focused approximately 12 hours on Facebook design & posting plans. These efforts addressed volunteer recruitment/recognition and community outreach. **Please refer to Addendum of Outreach – below) for details; note that the boosted post concerned general community outreach promoting KanCare Ombudsman services.**
- August 2020 - Wichita Ombudsman VISTA and WSU CEI staff focused approximately 26 hours on Facebook design & posting plans. These efforts addressed volunteer recruitment/recognition and community/KanCare member outreach.
    - Wichita Ombudsman VISTA made 6 Facebook posts:
    - 8/6: 2020 Prosperity Tour: 31 people reached, 3 engagements
    - 8/7: Title V Grant: 29 people reached, 2 engagements
    - 8/13: Brain Injury Waiver Age Update: 486 people reached, 47 engagements
    - 8/19: 2020 Census reminder: 71 people reached, 4 engagements
    - 8/25: MCO changes & selections: 24 people reached, 4 engagements
    - 8/27: Volunteer Appreciation/Recruitment: 24 people reached, 1 engagement
- September 2020 - Wichita Ombudsman VISTA and WSU CEI staff focused approximately 26 hours on Facebook design & posting plans. These efforts addressed volunteer recruitment/recognition and community outreach.
- WSU CEI staff emailed staff at Wichita/Sedgwick County area newsletter "The Active Age," to be included in that publication's annual directory of services affecting the 55 years and older population.

- In October, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 26 hours on Facebook design & posting plans. These efforts addressed volunteer recruitment/recognition and community/KanCare member outreach
  Wichita Ombudsman VISTA made 9 Facebook posts:
    - 10/7: Volunteer Appreciation: 22 people reached, 0 engagements
    - 10/9: Web Apps Update: 25 people reached; 1 engagement
    - 10/15: Voting Tips for LTC Facilities: 25 people reached, 1 engagement
    - 10/16: Nothing About Us Without Us Celebration: 21 people reached, 1 engagement
    - 10/21: Final Rules Regarding ABLE Accounts: 44 people reached, 1 engagement
    - 10/23: KS LEND Education Series: 13 people reached, 0 engagements
    - 10/28: Legal Needs Survey: 15 people reached; 0 engagements
    - 10/29: Flu Shot Reminder: 12 people reached; 0 engagements
    - 10/30 Waiver Amendments: 13 people reached; 0 engagements
- WSU CEI staff coordinated with Aetna Community Outreach staff to highlight the KanCare Ombudsman Office in an upcoming Aetna newsletter (potentially November).
- In November, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 11 hours on Facebook design & posting plans. These efforts addressed COVID resources for those who are deaf or hard of hearing; COVID eviction prevention; hunger issues; and aging concerns.

Wichita Ombudsman VISTA made 4 Facebook posts:

  - 11/18: State Plan on Aging: 70 people reached, 7 engagements
  - 11/19: PPE for those who deaf or hard of hearing: 10 people reached, 1 engagement
  - 11/23: Kansas eviction prevention program: 18 people reached, 0 engagements
  - 11/27: Hunger Clearinghouse resources: 21 people reached, 2 engagements
- In November, WSU Ombudsman VISTA continued to address her VISTA Assignment Description (VAD) with tasks that included building and revising an existing Ombudsman Office directory of statewide partners who offer KanCare application assistance in-person. She made 8 contacts with community partners to gather and update information. These partners included:
  - Anderson County Health Department
  - Salina Family Healthcare Center
  - Thrive Allen County
  - Neosho County Health Department
  - Atchison Senior Village
  - Kiowa District Healthcare
  - Butler County Health Department
  - GraceMed statewide
- 11/3: WSU Ombudsman VISTA visited with Wichita-area insurance representative Scott Lee to provide Ombudsman information and resources as he presents himself as a community resource.
- 11/4: WSU CEI staff attended the Central Plains Area Agency on Aging monthly networking meeting.
- WSU LMSW practicum student coordinated with Aetna outreach partners to include Ombudsman information on their resource website, AuntBertha: https://aetna-ks.auntbertha.com/
- WSU LMSW practicum student listed Ombudsman resources on the 1-800-Children online directory: https://1800childrenks.org/
- 11/10: WSU CEI staff was scheduled to present to the quarterly meeting of the State Chapter of Children's Advocacy Centers. The CACKS Executive Director coordinated with WSU CEI staff to cancel and reschedule this meeting due to scheduling conflicts with the CACKS membership. WSU CEI staff provided general outreach resources to pass along to CACKS members.

- 11/18: WSU CEI staff responded to a resource request from the Sedgwick County CDDO and delivered a box of Ombudsman brochures to their Wichita office
- 11/20: WSU CEI staff and VISTA attended virtual Healthier Greenwood County Coalition meeting.
- 11/20: WSU CEI staff met virtually with United Healthcare Outreach staff Laura Canelos to discuss Ombudsman services and reach.

- 11/9-11/20: WSU Ombudsman staff monitored a virtual exhibitor booth at the KCSL Kansas Governor's Conference on the Prevention of Child Abuse & Neglect.
- In December, Wichita Ombudsman VISTA and WSU CEI staff focused approximately 6 hours on Facebook design & posting plans. Anita Martinez was able to schedule several posts before her service ended. Posts addressed COVID resources for those with disabilities, volunteer appreciation/recruitment, Medicaid/CHIP general information, COVID vaccine information, and information on the newly-posted Volunteer Coordinator position in the Johnson County office.

  Wichita Ombudsman personnel made 6 Facebook posts:

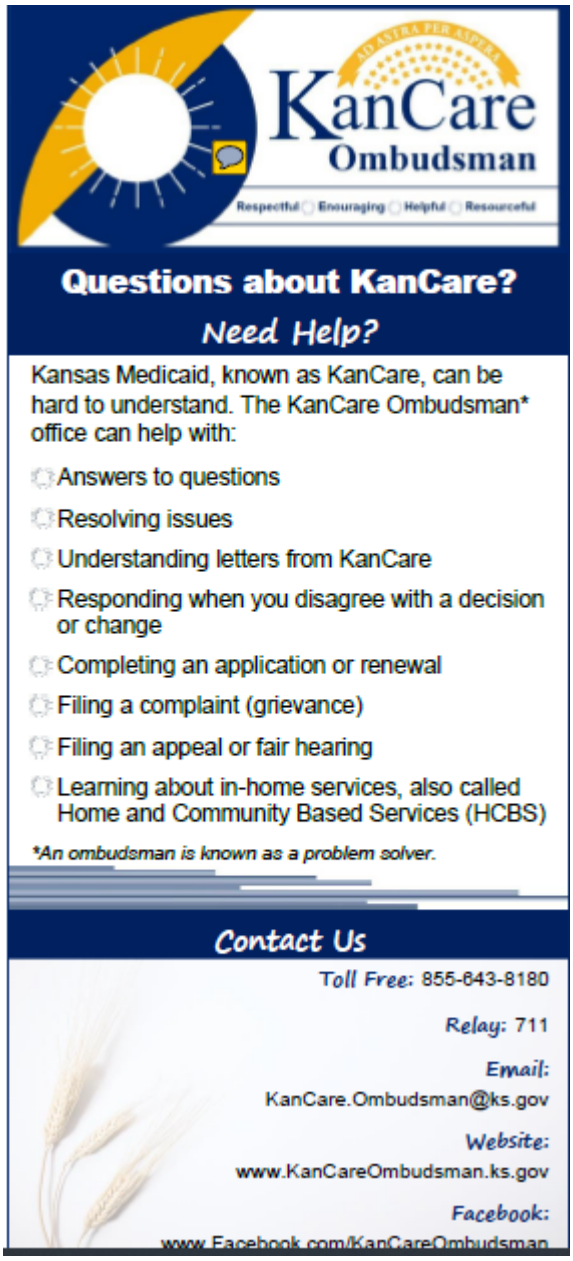
  - 12/2: COVID-19 resources for those with disabilities: 24 people reached, 1 engagement
  - 12/4: Volunteer appreciation & recruitment: 26 people reached, 0 engagements
  - 12/7 Medicaid/CHIP general information: 53 people reached, 3 engagements
  - 12/9 Medicaid/CHIP general information, Spanish: 13 people reached, 0 engagements
  - 12/28 Avoiding COVID-19 vaccination scams: 35 people reached, 4 engagements
- In November, WSU CEI staff emailed the editor of the Wichita Riverside neighborhood newsletter to include recruitment & general outreach information in upcoming editions. As a result, our brochure was featured prominently in the December edition.

C. Outreach through Collaboration and Training

- February– WSU CEI Staff made in-person contacts/presentations with the following organizations (8):
  - CPAAA networking meeting
  - Cairn Health (SG Co)
  - GraceMed (statewide)
  - Native American All-Indian Center (SG Co area)
  - United Way Emergency Assistance Providers networking meeting
  - Central Kansas regional Knights of Columbus insurance agents networking meeting
  - March – WSU CEI Staff made in-person contacts/presentations with the following organizations:
  - OneCare KS/Medicaid partners
  - CPAAA networking meeting
- The Volunteer Coordinator completed the project of putting the KanCare Ombudsman Liaison Trainings on YouTube with voice and open captioning. This was a major project that took well over 100 hours. This is community organization training on Medicaid 101 and Line by Line explanation of completing an application.
- This on-line training allows our office to continue to provide the Liaison training with reduced staff and also during this period of reduced face-to-face contact.

- 4/13 – WSU CEI staff provided KanCare resources to social worker at Wichita VA Hospital
- WSU Ombudsman VISTA continued daily, in-depth training with WSU CEI staff throughout June. With training, the VISTA began seriously addressing work tasks outlined in her VISTA Assignment Description (VAD). Tasks included building and revising an existing Ombudsman Office directory of statewide partners who offer KanCare application assistance in-person. The WSU CEI staff and VISTA together spent approximately 4 hours addressing this very long-term task.
- 6/3 – WSU CEI staff attended CPAAA networking meeting (via WebEx)
- 6/16 – WSU CEI staff and VISTA met with Lindsay Galindo of KU's Center for Public Partnerships and Research to discuss the Integrated Referral and Intake System (IRIS). This software enables communities in over 20 Kansas counties to make connections and referrals for Kansas residents. In June, the Ombudsman team discussed becoming this referral system and decided to pursue involvement. WSU CEI staff continued communication with Ms. Galindo accordingly.
- August 13, KanCare Long Term Care agency meeting; reported on activities.
- September 10, KanCare Long Term Care agency meeting; reported on activities.
- September 28, Provided Quarter 2 KanCare Ombudsman report to Bethell Joint Committee on HCBS and KanCare Oversight.
- KanCare Liaison Training continues to be available through video presentation (YouTube) through the KanCare Ombudsman Community Training web page. The various videos have had anywhere from 39 to 177 views since their posting in March 2020.
- During fourth quarter KanCare Ombudsman Team participated in several Integrated Referral and Intake System (IRIS) informational meetings. When appropriate, information about our organization was shared with other IRIS providers/participants.
    - 10/16: Johnson County IRIS Community Conversation
    - 12/11: Franklin County IRIS meeting
- 11/12: Participation in KanCare Long Term Care meeting. Provided updates on KanCare Ombudsman Office program.
- 12/8: Presentation to the KanCare Advisory Council on 3rd quarter activities and data.
- 12/9: Presentation to the Bethel Joint Committee on Home and Community Based Services and KanCare Oversight on 3rd quarter activities and data.
- 12/10: Participation in KanCare Long Term Care meeting.

X. Appendix B: KanCare Ombudsman Brochure



KanCare Ombudsman

Respectful Encouraging Helpful Resourceful

Questions about KanCare?

Need Help?

Kansas Medicaid, known as KanCare, can be hard to understand. The KanCare Ombudsman* office can help with:

- Answers to questions
- Resolving issues
- Understanding letters from KanCare
- Responding when you disagree with a decision or change
- Completing an application or renewal
- Filing a complaint (grievance)
- Filing an appeal or fair hearing
- Learning about in-home services, also called Home and Community Based Services (HCBS)

**An ombudsman is known as a problem solver.*

Contact Us

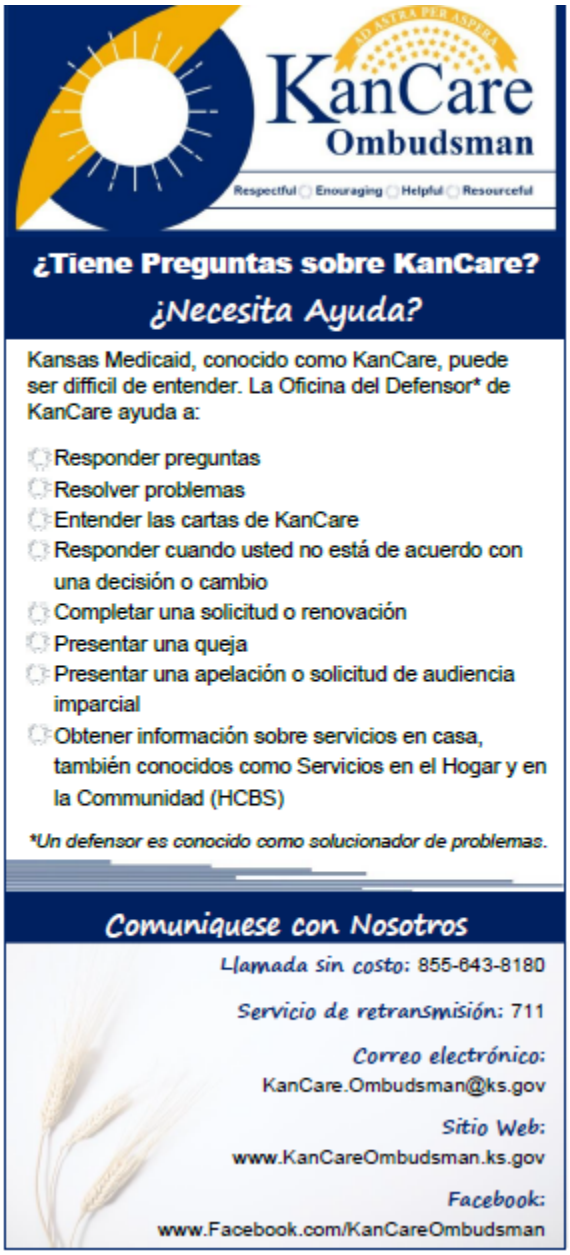
Toll Free: 855-643-8180

Relay: 711

Email:
KanCare.Ombudsman@ks.gov

Website:
www.KanCareOmbudsman.ks.gov

Facebook:
www.Facebook.com/KanCareOmbudsman



KanCare Ombudsman

Respectful Encouraging Helpful Resourceful

¿Tiene Preguntas sobre KanCare?

¿Necesita Ayuda?

Kansas Medicaid, conocido como KanCare, puede ser difícil de entender. La Oficina del Defensor* de KanCare ayuda a:

- Responder preguntas
- Resolver problemas
- Entender las cartas de KanCare
- Responder cuando usted no está de acuerdo con una decisión o cambio
- Completar una solicitud o renovación
- Presentar una queja
- Presentar una apelación o solicitud de audiencia imparcial
- Obtener información sobre servicios en casa, también conocidos como Servicios en el Hogar y en la Comunidad (HCBS)

**Un defensor es conocido como solucionador de problemas.*

Comuniquese con Nosotros

Llamada sin costo: 855-643-8180

Servicio de retransmisión: 711

Correo electrónico:
KanCare.Ombudsman@ks.gov

Sitio Web:
www.KanCareOmbudsman.ks.gov

Facebook:
www.Facebook.com/KanCareOmbudsman

XI. Appendix C: Managed Care Organization (MCO) Data

A. Aetna

MEDICAID ISSUES - Aetna	2019	2020
Access to Providers (usually Medical)	13	4
Appeals/Fair Hearing questions/issues	2	3
Background Checks	0	0
Billing	12	11
Care Coordinator Issues	19	2
Change MCO	11	7
Choice Info on MCO	6	1
Coding Issues	3	0
Consumer said Notice not received	1	1
Cultural Competency	0	0
Data Requests	0	0
Dental	7	2
Division of Assets	1	0
Durable Medical Equipment	5	6
Grievances Questions/Issues	11	10
Help understanding mail (NOA)	0	1
MCO transition	3	0
Medicaid Application Assistance	6	2
Medicaid Eligibility Issues	19	7
Medicaid Fraud	0	0
Medicaid General Issues/questions	48	12
Medicaid info (status) update	14	12
Medicaid Renewal	18	4
Medical Card issues	0	1
Medicare Savings Plan Issues	7	4
MediKan issues	0	0
Moving to / from Kansas	2	0
Medical Services	14	9
Pain management issues	1	2
Pharmacy	10	2
Pregnancy issues	0	0
Prior authorization issues	0	2
Refugee/Immigration/SOBRA issues	0	0
Respite	0	0
Spend Down Issues	9	7
Transportation	13	3
Working Healthy	0	1
MEDICAID ISSUES TOTAL	**255**	**116**

HCBS/LTSS ISSUES – Aetna	2019	2020
Client Obligation	9	0
Estate Recovery	0	0
HCBS Eligibility issues	18	0
HCBS General Issues	25	9
HCBS Reduction in hours of service	1	1
HCBS Waiting List	3	0
Nursing Facility Issues	6	6
HCBS/LTSS ISSUES TOTAL	**62**	**16**

OTHER ISSUES - Aetna	2019	2020
Abuse / neglect complaints	0	4
Community Resources needed	0	1
Domestic Violence concerns	0	0
Foster Care issues	0	1
Guardianship	0	0
Homelessness	0	1
Housing Issues	1	2
Medicare related Issues	7	2
Social Security Issues	3	0
Used Interpreter	0	0
X-Other	29	18
Z Thank you	109	38
Z Unspecified	8	1
Health Homes	0	0
OTHER ISSUES TOTAL	**157**	**68**

PROGRAM TYPE- Aetna	2019	2020
PD	8	5
I/DD	8	3
FE	8	0
AUTISM	0	0
SED	3	1
TBI	9	2
TA	6	2
WH	0	0
MFP	0	0
PACE	0	0
MENTAL HEALTH	2	0
SUB USE DIS	0	0
NURSING FACILITY	5	4
FOSTER CARE	0	1
MEDIKAN	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0
PROGRAM TYPE TOTAL	**49**	**19**

B. Sunflower

MEDICAID ISSUES - Sunflower	2016	2017	2018	2019	2020
Access to Providers (usually Medical)	4	12	13	14	4
Appeals/Fair Hearing questions/issues	0	2	9	4	15
Background Checks	0	0	1	0	0
Billing	30	23	22	19	14
Care Coordinator Issues	6	10	6	15	8
Change MCO	5	3	9	4	4
Choice Info on MCO	0	0	1	3	2
Coding Issues	0	6	15	7	2
Consumer said Notice not received	0	0	10	0	1
Cultural Competency	0	0	0	1	0
Data Requests	0	0	0	0	2
Dental	3	3	8	2	2
Division of Assets	0	0	1	0	0
Durable Medical Equipment	9	5	4	0	4
Grievances Questions/Issues	35	17	16	16	13
Help understanding mail (NOA)	0	0	0	0	4
MCO transition	0	0	0	0	0
Medicaid Application Assistance	0	6	5	4	4
Medicaid Eligibility Issues	52	49	42	32	7
Medicaid Fraud	0	0	2	0	1
Medicaid General Issues/questions	0	0	46	40	16
Medicaid info (status) update	0	0	26	25	11
Medicaid Renewal	0	25	17	26	3
Medical Card issues	0	0	0	1	4
Medicare Savings Plan Issues	0	1	7	4	1
MediKan issues	0	0	0	0	0
Moving to / from Kansas	0	1	1	1	2
Medical Services	15	14	11	15	13
Pain management issues	0	0	0	1	0
Pharmacy	13	8	7	10	1
Pregnancy issues	0	0	0	2	1
Prior authorization issues	0	0	0	0	1
Refugee/Immigration/SOBRA issues	0	0	0	0	0
Respite	0	0	0	0	0
Spend Down Issues	8	13	7	8	4
Transportation	8	9	6	7	5
Working Healthy	0	0	3	2	0
MEDICAID ISSUES TOTAL	**188**	**207**	**295**	**263**	**149**

HCBS/LTSS ISSUES - Sunflower	2016	2017	2018	2019	2020
Client Obligation	0	17	13	6	3
Estate Recovery	0	1	0	0	0
HCBS Eligibility issues	15	29	24	20	5
HCBS General Issues	30	23	32	30	26
HCBS Reduction in hours of service	4	3	2	3	7
HCBS Waiting List	1	3	1	4	1
Nursing Facility Issues	10	4	4	2	5
HCBS/LTSS ISSUES TOTAL	**60**	**80**	**76**	**65**	**47**

OTHER ISSUES - Sunflower	2016	2017	2018	2019	2020
Abuse / neglect complaints	0	0	3	1	1
Adoption issues	0	0	0	0	2
Affordable Care Act Calls	0	1	1	1	0
Community Resources needed	0	0	0	0	1
Guardianship	0	1	3	0	1
Homelessness	0	0	0	0	1
Housing Issues	0	3	3	0	3
Medicare related Issues	0	2	8	2	3
Social Security Issues	0	1	2	0	1
Used Interpreter	0	0	0	0	0
X-Other	75	63	40	28	28
Z Thank you	32	109	166	115	64
Z Unspecified	1	4	7	10	2
Health Homes	2	0	0	0	0
OTHER ISSUES TOTAL	**110**	**184**	**233**	**157**	**107**

PROGRAM TYPE - Sunflower	2016	2017	2018	2019	2020
PD	27	31	31	16	14
I/DD	22	34	15	15	4
FE	9	18	9	13	6
AUTISM	1	2	1	1	2
SED	2	1	2	1	1
TBI	6	4	7	8	2
TA	9	5	2	4	3
WH	0	1	3	2	0
MFP	4	1	1	0	0
MENTAL HEALTH	6	2	0	0	1
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	15	16	8	3	3
FOSTER CARE	0	0	0	0	0
MEDIKAN	0	0	0	0	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	0	1
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	1	0
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0
PROGRAM TYPE TOTAL	**101**	**115**	**79**	**64**	**37**

C. United Healthcare

MEDICAID ISSUES	2016	2017	2018	2019	2020
Access to Providers (usually Medical)	5	8	0	10	4
Appeals/Fair Hearing questions/issues	0	5	13	3	8
Background Checks	0	0	0	1	0
Billing	13	13	20	10	12
Care Coordinator Issues	3	9	15	10	11
Change MCO	7	6	6	8	5
Choice Info on MCO	0	0	2	1	2
Coding Issues	0	3	6	5	1
Consumer said Notice not received	0	0	3	2	0
Cultural Competency	0	0	0	0	0
Data Requests	0	0	1	0	0
Dental	6	6	3	5	0
Division of Assets	0	1	1	0	0
Durable Medical Equipment	1	5	1	5	5
Grievances Questions/Issues	16	10	10	10	10
Help understanding mail (NOA)	0	0	0	0	0
MCO transition	0	0	0	0	1
Medicaid Application Assistance	0	4	15	2	2
Medicaid Eligibility Issues	32	42	44	24	10
Medicaid Fraud	0	0	1	0	0
Medicaid General Issues/questions	0	0	39	44	12
Medicaid info (status) update	0	0	19	25	12
Medicaid Renewal	0	14	19	14	1
Medical Card issues	0	0	0	2	5
Medicare Savings Plan Issues	0	1	7	1	1
MediKan issues	0	0	0	1	0
Moving to / from Kansas	0	0	2	0	0
Medical Services	9	8	18	3	12
Pain management issues	0	0	1	2	0
Pharmacy	14	4	8	9	9
Pregnancy issues	0	0	0	0	0
Prior authorization issues	0	0	0	1	2
Refugee/Immigration/SOBRA issues	0	0	0	0	0
Respite	0	0	1	0	0
Spend Down Issues	3	9	20	9	6
Transportation	1	7	10	5	8
Working Healthy	0	0	2	1	0
MEDICAID ISSUES TOTAL	**110**	**155**	**287**	**213**	**139**

HCBS/LTSS ISSUES	2016	2017	2018	2019	2020
Client Obligation	0	12	23	5	2
Estate Recovery	0	1	0	1	0
HCBS Eligibility issues	12	25	17	10	6
HCBS General Issues	21	16	34	28	21
HCBS Reduction in hours of service	4	4	1	3	8
HCBS Waiting List	4	0	3	5	0
Nursing Facility Issues	7	7	9	8	6
HCBS/LTSS ISSUES TOTAL	**48**	**65**	**87**	**60**	**43**

OTHER ISSUES	2016	2017	2018	2019	2020
Abuse / neglect complaints	0	1	3	0	0
Adoption issues	0	0	0	0	0
Affordable Care Act Calls	0	0	0	0	0
Community Resources needed	0	0	0	0	1
Guardianship	1	1	1	0	0
Homelessness	0	0	0	0	1
Housing Issues	0	1	1	1	2
Medicare related Issues	0	3	2	3	3
Social Security Issues	0	0	2	1	2
Used Interpreter	0	0	0	0	0
X-Other	67	57	25	22	23
Z Thank you	31	96	175	114	53
Z Unspecified	2	10	3	10	2
Health Homes	1	0	0	0	0
OTHER ISSUES TOTAL	**102**	**169**	**212**	**151**	**87**

PROGRAM TYPE	2016	2017	2018	2019	2020
PD	13	20	24	22	13
I/DD	14	22	13	17	2
FE	14	21	13	11	8
AUTISM	1	1	0	1	0
SED	1	1	6	3	1
TBI	3	5	5	3	6
TA	2	3	3	1	2
WH	0	0	4	0	0
MFP	6	0	0	0	0
PACE	0	0	0	0	0
MENTAL HEALTH	2	3	2	1	1
SUB USE DIS	0	0	0	0	0
NURSING FACILITY	7	16	12	10	3
FOSTER CARE	0	0	0	0	0
MEDIKAN	0	0	0	1	0
INSTITUTIONAL TRANSITION FROM LTC/NF	0	0	0	1	3
INSTITUTIONAL TRANSITION FROM MH/BH	0	0	0	0	1
INSTITUTIONAL TRANSITION FROM PRISON/JAIL	0	0	0	0	0
PROGRAM TYPE TOTAL	**63**	**92**	**82**	**71**	**40**

State of Kansas
Kansas Department of Health & Environment
Division of Health Care Finance
KanCare Annual Report
Demonstration Year 8
Calendar Year 2020

Population	Unduplicated Beneficiaries by Population	Member Months	Expenditures
Pop 1: ABD/SD Dual	21,856	194,316	$47,491,386
Pop 2: ABD/SD Non Dual	37,467	366,334	$485,574,095
Pop 3: Adults	62,295	591,608	$343,460,322
Pop 4: Children	249,083	2,537,637	$739,312,351
Pop 5: DD Waiver	9,397	109,206	$531,023,550
Pop 6: LTC	26,515	256,818	$1,131,713,241
Pop 7: MN Dual	6,401	25,618	$23,011,081
Pop 8: MN Non Dual	2,204	12,897	$24,726,913
Pop 9: Waiver	5,940	51,261	$171,741,614
Total	421,158	4,145,695	$3,498,054,553
Administration			$210,204,021
Overall Unduplicated Beneficiaries	403,405		

Notes:
1. CHIP and MCHIP are excluded.
2. Enrollment data is updated through Mar 2021 capitation data.
3. Member months data is updated through Mar 2021 capitation data.
4. Expenditure data is updated through QE 12 31 2020

1115 Waiver - Safety Net Care Pool Report

Demonstration Year 8- YE 2020

DSRIP Payment

Paid dates 1/1/2020 through 12/31/2020

Provider Names	YE 2020 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Children's Mercy Hospital	6,590,625	2,282,993	4,307,633
University of Kansas Hospital	19,279,688	6,678,484*	12,601,204
Total	25,870,313	8,961,476	16,908,837

*IGT funds are received from the University of Kansas Hospital

1115 Waiver - Safety Net Care Pool Report

Demonstration Year Eight- YE 2020

Health Care Access Improvement Pool

Paid dates 1/1/2020 through 12/31/2020

Provider Names	YE 2020 Amt Paid	Provider Access Fund 2443	Federal Medicaid Fund 3414
Adventhealth Ottawa	242,555	92,789	149,766
Ascension Via Christi Hospital St. Teresa Inc	276,708	105,855	170,853
Ascension Via Christi Rehabilitation Hospital	73,905	28,272	45,633
Bob Wilson Memorial Grant County Hospital	93,573	35,796	57,777
Childrens Mercy South	819,359	313,446	505,913
Coffeyville Regional Medical Center Inc	259,075	99,109	159,966
Doctors Hospital Llc	33,543	12,832	20,711
Geary County Hospital	399,963	153,006	246,957
Hays Medical Center	1,089,373	416,740	672,633
Hutchinson Regional Medical Center Inc	976,295	373,482	602,813
Kansas Heart Hospital Llc	50,356	19,264	31,092
Kansas Rehabilitation Hospital	100,805	38,563	62,242
Kansas Surgery And Recovery Center Llc	10,445	3,996	6,449
Kvc Prairie Ridge Psychiatric Hospital	83,690	32,016	51,674
Labette Co Med	313,795	120,042	193,753
Lawrence Memorial Hospital	1,162,448	444,694	717,754
Mcpherson Hospital Inc	88,049	33,683	54,366
Menorah Medical Center	768,344	293,930	474,414
Mercy Hospital Inc	18,332	7,013	11,319
Miami County Medical Center Inc	239,204	91,507	147,697
Midamerica Rehabilitation Hospital	85,584	32,740	52,844
Morton County Hospital	35,035	13,403	21,632
Nmc Health Medical Center	582,407	222,800	359,607
Olathe Medical Center Inc	1,442,581	551,859	890,722
Overland Park Reg Med Ctr	2,874,320	1,099,571	1,774,749
Prairie View Hospital	2,522	965	1,557
Pratt Regional Medical Center Corportation	148,795	56,922	91,873
Providence Medical Center	1,720,217	658,069	1,062,148
Rehabilitation Hospital Of Overland Park	77,448	29,628	47,820
Saint John Hospital	303,432	116,078	187,354
Saint Lukes Cushing Hospital	316,164	120,949	195,215
Saint Lukes South Hospital Inc	241,305	92,311	148,994
Salina Regional Health Center	1,162,088	444,557	717,531
Shawnee Mission Medical Center Inc	3,357,196	1,284,295	2,072,901
South Central Kansas Regional Medical Center	126,473	48,382	78,091
Southwest Medical Center	323,128	123,613	199,515
St Catherine Hospital	604,836	231,380	373,456
Stormont Vail Health Care Inc	1,413,700	540,811	872,889
Sumner Community Hospital	50,274	19,232	31,042
Sumner Community Hospital*	45,120	17,261	27,859
Susan B Allen Memorial Hospital	381,091	145,786	235,305
The University Of Kansas Health System Great Bend	309,052	118,228	190,824
Topeka Hospital Llc D/B/A The University Of Kansas	1,138,211	435,423	702,788
Via Christi Hospital Manhattan	1,441,016	551,261	889,755
Via Christi Hospital Pittsburg	1,022,528	391,168	631,360
Via Christi Hospitals Wichita Inc	6,014,244	2,300,749	3,713,495
Wesley Medical Center	7,883,080	3,015,672	4,867,408
Wesley Rehabilitation Hospital, An Affiliate Of En	105,808	40,477	65,331
Western Plains Medical Complex	463,529	177,323	286,206
Grand Total	**40,771,001**	**15,596,946**	**25,174,055**

* DY 7 Q3 & Q4 Amount Paid

1115 Waiver - Safety Net Care Pool Report

Demonstration Year Eight- YE 2020

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

Paid dates 1/1/2020 through 12/31/2020

Hospital Name	YE 2020 Amt Paid	State General Fund 1000	Federal Medicaid Fund 3414
Childrens Mercy Hospital	$ 3,080,170	$ 1,178,319	$ 1,901,851
University Of Kansas Hospital Authority*	$ 9,240,515	$ 3,534,959	$ 5,705,556
Total	**$ 12,320,685**	**$ 4,713,278**	**$ 7,607,407**
*IGT funds are received from the University of Kansas Hospital			

Amount Paid includes DY Seven Quarter Four payments.

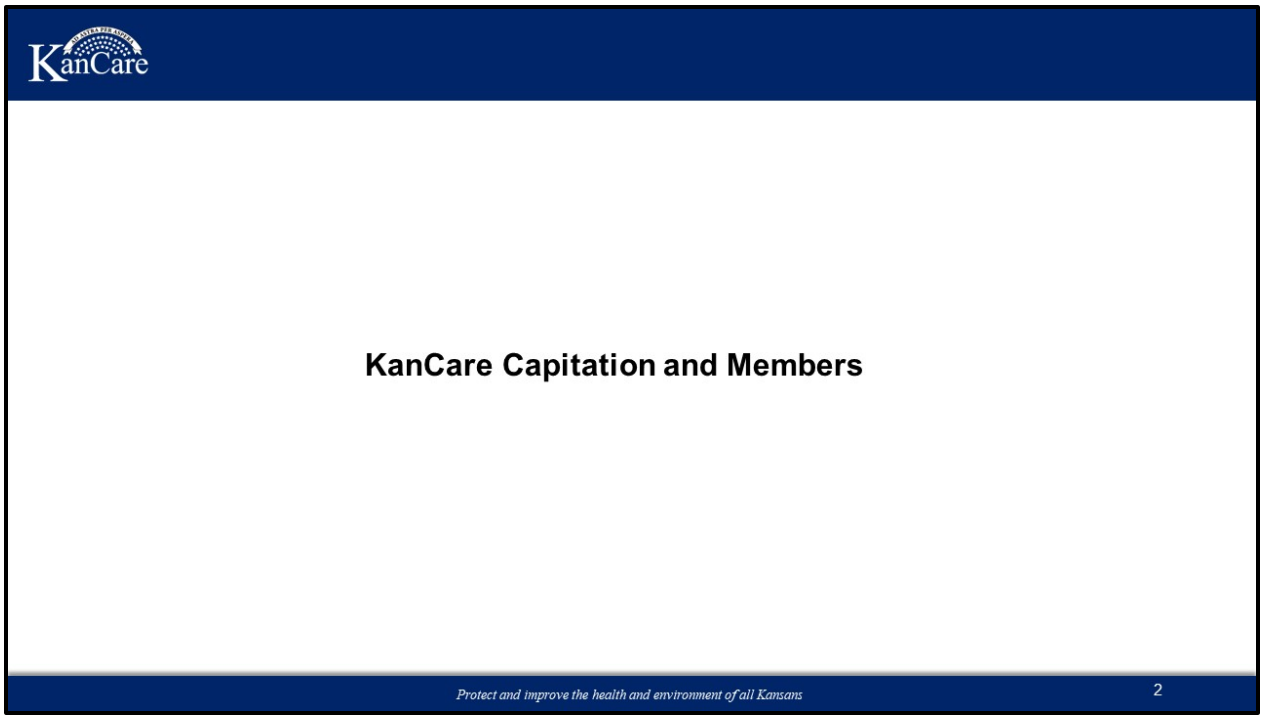
Summary of Annual KanCare Post Award Forum Held 12.16.2020

The KanCare Special Terms and Conditions, at item #71, provide that annually "the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in STC64a, associated with the quarter in which the forum was held. The state must also include the summary of its annual report.

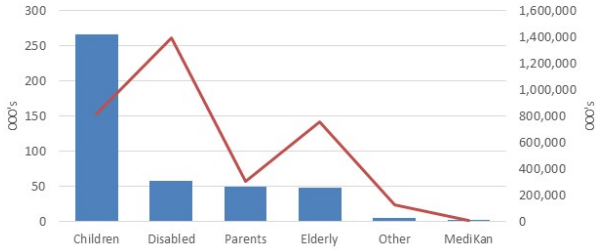
Consistent with this provision, Kansas held its 2020 KanCare Public Forum, providing updates and opportunity for input, on Wednesday, December 16, 2020, from 3:00-4:00 pm via Zoom virtual meeting. The forum was published on the home page of the www.KanCare.ks.gov website, starting in November 2020. A screen shot of the notice from the KanCare website face page is as follows:

At the public forum, less than 20 KanCare program stakeholders (providers, members, and families) attended, as well staff from the Kansas Department of Health and Environment; staff from the Kansas Department of Aging and Disability Services; staff from the KanCare managed care organizations; and CMS. A summary of the information presented by state staff is included in the following PowerPoint documents:

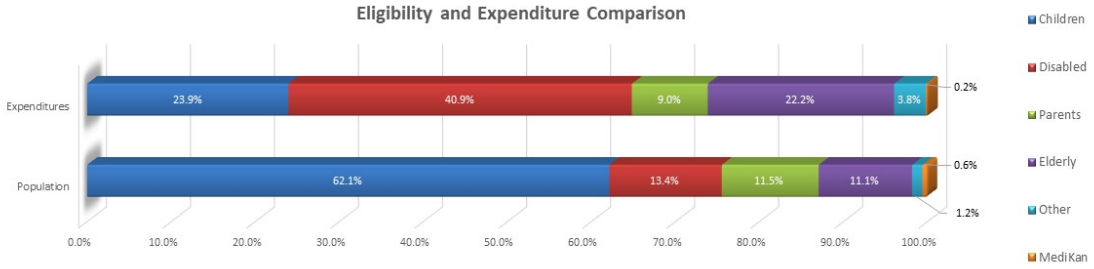
KDHE:



Medicaid/CHIP Member Eligibility and Expenditures
Calendar Year 2020 (Jan – Oct)



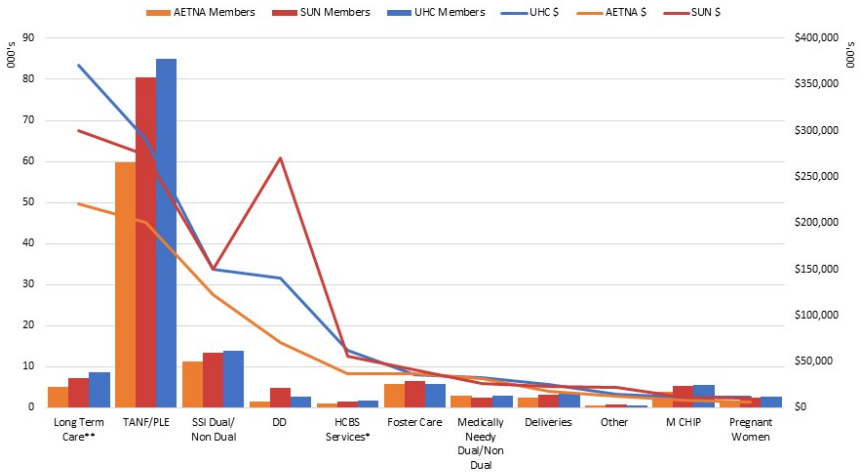
	% Total	
	Population	Expenditures
Children	62.1%	23.9%
Disabled	13.4%	40.9%
Parents	11.5%	9.0%
Elderly	11.1%	22.2%
Other	1.2%	3.8%
MediKan	0.6%	0.2%



Protect and improve the health and environment of all Kansans

3

Capitation Comparison with Members YTD CY 2020 (Jan - Oct)

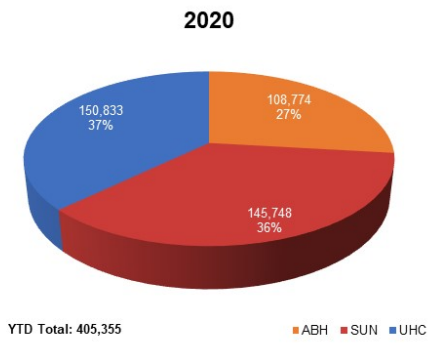


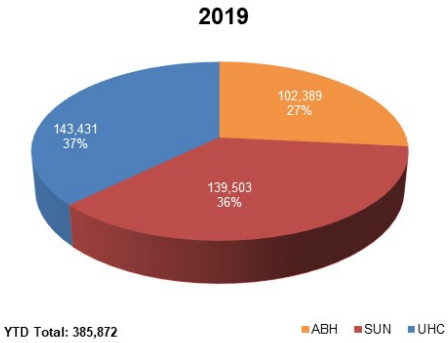
*HCBS Services includes Autism, Severe Emotional Disturbance, Technology Assisted, and Traumatic Brain Injury
**Long Term Care includes Nursing Facilities, and the Physically Disabled and Frail Elderly Waivers

Protect and improve the health and environment of all Kansans

4

Average Members by MCO YTD





Protect and improve the health and environment of all Kansans

5

KanCare Provider Network

Protect and improve the health and environment of all Kansans

6

Provider Network

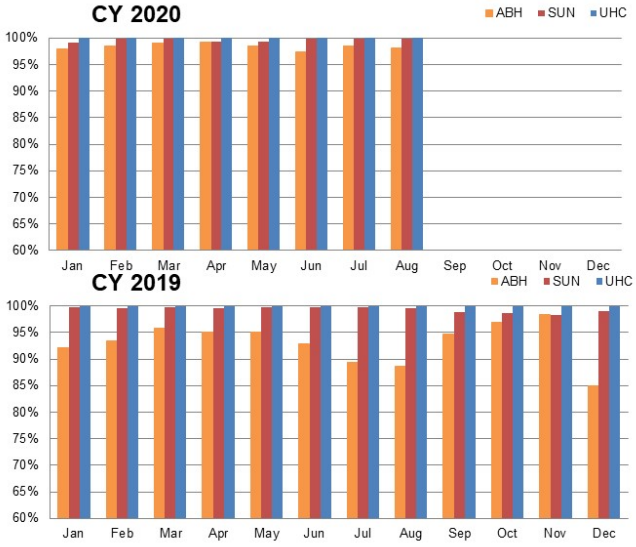
2019-2020	# of Unique Provider/ Locations			
KanCare MCO	# of Unique Providers as of 12/31/2019	# of Unique Providers as of 3/31/2020	# of Unique Providers as of 6/30/2020	# of Unique Providers as of 9/30/2020*
Aetna	34,229	39,097	40,323	39,494
Sunflower	31,888	33,764	29,286	30,097
United	46,946	42,772	44,634	44,248

.
Note: *Beginning Quarter 1, 2020, the # of unique providers excludes out-of-state providers located more than 50 miles from a Kansas border.

The counts below represent the unique number of NPIs—or, where NPI is not available—provider name and service locations (based on the KanCare county designation identified in the KanCare Code Guide). This results in counts for the following:
Providers with a service location in a Kansas county are counted once for each county.
Providers with a service location in a border area are counted once for each state in which they have a service location that is within 50 miles of the KS border.
Out of state providers (>50 miles from KS border) are counted once.
Providers for services provided in the home are counted once for each county in which they are contracted to provide services.

KanCare Claims Overview

Claims Data-% Clean Claims Processed Within 30 days



Claims Processed 2020 YTD (Jan-Sep)

	Total Claim Count			Total claim %		
Service Type	**ABH**	**SUN**	**UHC**	**ABH**	**SUN**	**UHC**
Pharmacy	1,418,507	1,425,382	1,376,749	44%	33%	33%
Medical Other	1,001,848	1,232,385	1,215,627	31%	28%	29%
Behavioral Health	170,065	568,848	566,915	5%	13%	14%
HCBS	231,525	498,567	400,055	7%	11%	10%
Outpatient Hospital	168,342	245,835	243,322	5%	6%	6%
Dental	69,704	103,698	98,547	2%	2%	2%
NEMT	61,178	102,830	112,640	2%	2%	3%
Nursing Facilities	58,134	98,489	96,995	2%	2%	2%
Vision	5,779	64,137	53,433	0%	1%	1%
Inpatient Hospital	17,474	29,227	22,405	1%	1%	1%
Total All Services	**3,202,556**	**4,369,398**	**4,186,688**	**100%**	**100%**	**100%**

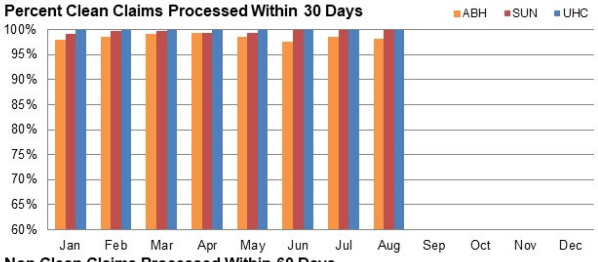
Contract Standard: 100% of Clean Claims Processed within 30 days

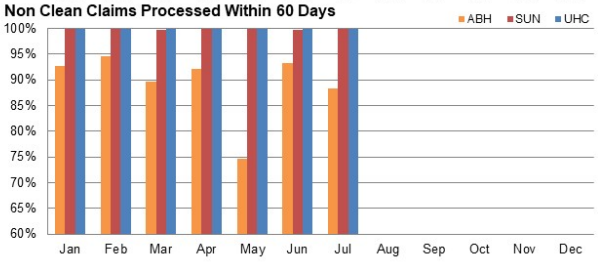
A clean claim is a claim that can be paid or denied with no additional intervention required and does **not** include: Adjusted or corrected claims, claims that require documentation (i.e., consent forms, medical records) for processing, claims from out-of-network providers that require research and setup of that provider in the system, claims from providers where the updated rates, benefits or policy changes were not provided by the State 30 days or more before the effective date (these claims may be pended until rates are loaded so the appropriate amounts can be paid)

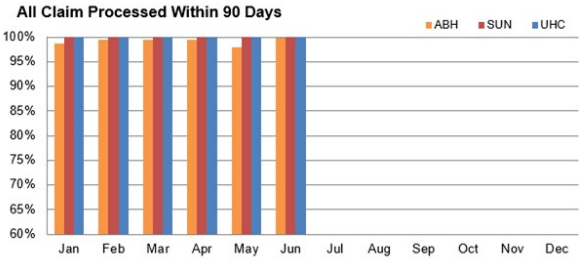
Percent = Number of clean claims processed within 30 days divided by Number of claims received.

Processed = adjudication decision of a claim to approved to paid or denied status.

Claims Data-% Clean Claims Processed Within 30/60/90 days

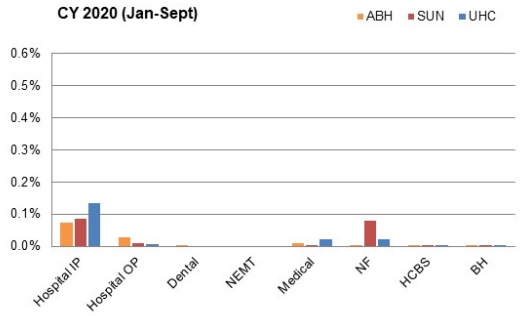


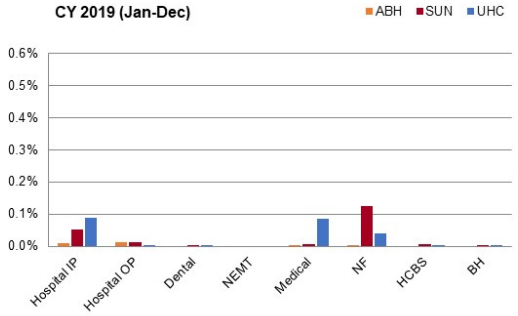




Timely Claims Processing Standard- 100% of clean claims are processed within 30 calendar days; 99% of all non clean claims are processed within 60 calendar days; 100% of all claims are processed within 90 calendar days

Claims Data-Percent of Claims Adjusted more than 3 times

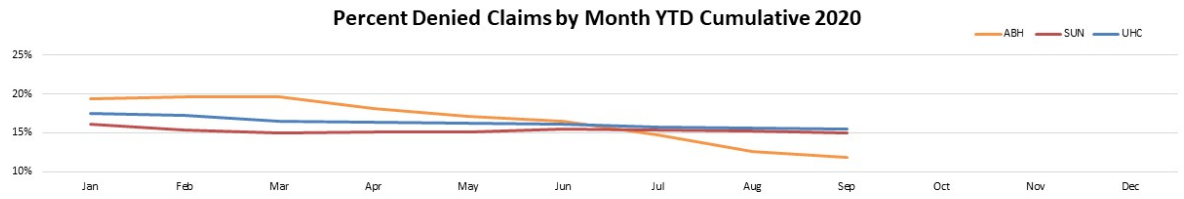


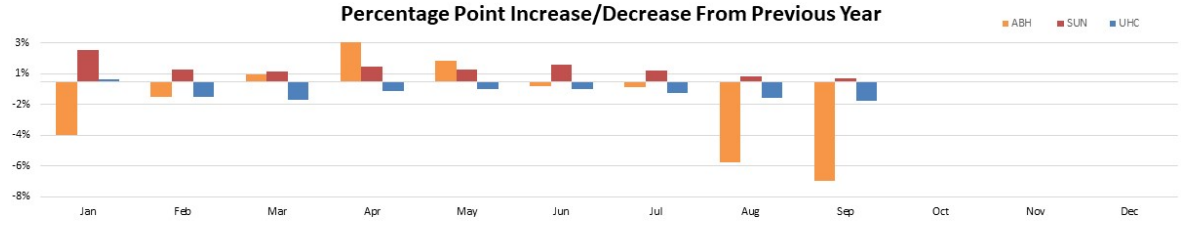


YTD Claim Requiring Adjustments Greater than 3 Times Represents Accuracy
Purpose: The purpose is to review payment accuracy
Methodology: Monitoring the frequency of the claims adjustments by MCO in each category utilizing the total claims adjusted/claims processed *(category provider type: Hospital Inpatient, Hospital Outpatient, Dental, Medical, Nursing Facilities, HCBS, BH). Pharmacy, Vision and NEMT Have had 0% adjustments over 3 times for over one year so have been dropped from this report.* Pharmacy is point of sale processing so will not have adjustments

Total YTD claims adjusted 4 or more times divided by the YTD total number of claims processed by service type.

Claims Denial Data CY 2019-20



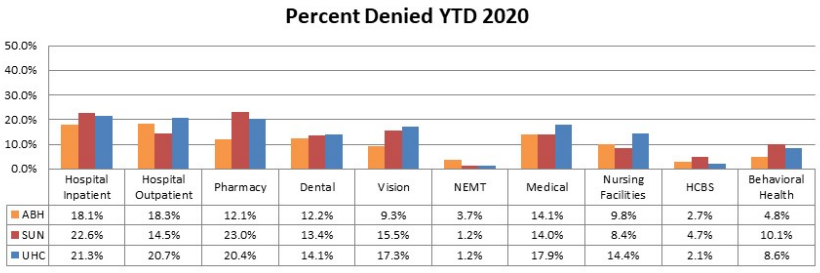


Claims Denial Data

Claims Processed 2020 YTD (Jan-Sep)	Total Claim Count			Total Claim %		
Service Type	ABH	SUN	UHC	ABH	SUN	UHC
Pharmacy	1,418,507	1,425,382	1,376,749	44%	33%	33%
Medical Other	1,001,848	1,232,385	1,215,627	31%	28%	29%
Behavioral Health	170,065	568,848	566,915	5%	13%	14%
HCBS	231,525	498,567	400,055	7%	11%	10%
Outpatient Hospital	168,342	245,835	243,322	5%	6%	6%
Dental	69,704	103,698	98,547	2%	2%	2%
NEMT	61,178	102,830	112,640	2%	2%	3%
Nursing Facilities	58,134	98,489	96,995	2%	2%	2%
Vision	5,779	64,137	53,433	0%	1%	1%
Inpatient Hospital	17,474	29,227	22,405	1%	1%	1%
Total All Services	**3,202,556**	**4,369,398**	**4,186,688**	**100%**	**100%**	**100%**

Claims Processed 2020 YTD (Jan-Sep)	Total Claim Count			Total Claim Denied			Total Claim Denied %		
Service Type	ABH	SUN	UHC	ABH	SUN	UHC	ABH	SUN	UHC
Pharmacy	1,418,507	1,425,382	1,376,749	172,129	328,037	281,206	45%	50%	43%
Medical Other	1,001,848	1,232,385	1,215,627	140,920	172,949	218,053	37%	26%	34%
Behavioral Health	170,065	568,848	566,915	8,185	57,205	48,514	2%	9%	7%
Outpatient Hospital	168,342	245,835	243,322	30,865	35,579	50,336	8%	5%	8%
HCBS	231,525	498,567	400,055	6,236	23,339	8,489	2%	4%	1%
Dental	69,704	103,698	98,547	8,520	13,941	13,927	2%	2%	2%
Vision	5,779	64,137	53,433	540	9,926	9,218	0%	2%	1%
Nursing Facilities	58,134	98,489	96,995	5,725	8,302	13,937	2%	1%	2%
Inpatient Hospital	17,474	29,227	22,405	3,163	6,593	4,780	1%	1%	1%
NEMT	61,178	102,830	112,640	2,294	1,253	1,334	1%	0%	0%
Total All Services	**3,202,556**	**4,369,398**	**4,186,688**	**378,577**	**657,124**	**649,794**	**100%**	**100%**	**100%**

Claims Denial Data (Jan-Sept)



	Hospital Inpatient	Hospital Outpatient	Pharmacy	Dental	Vision	NEMT	Medical	Nursing Facilities	HCBS	Behavioral Health
ABH	18.1%	18.3%	12.1%	12.2%	9.3%	3.7%	14.1%	9.8%	2.7%	4.8%
SUN	22.6%	14.5%	23.0%	13.4%	15.5%	1.2%	14.0%	8.4%	4.7%	10.1%
UHC	21.3%	20.7%	20.4%	14.1%	17.3%	1.2%	17.9%	14.4%	2.1%	8.6%

KanCare Member Benefits

Protect and improve the health and environment of all Kansans 15

Value Added Services - January-September 2020

Aetna	Members YTD	Total Units YTD	Total Value YTD
Healthy Rewards Gift Card	29,808	29,808	$577,315
PROMISE Pregnancy Program Gift Card	4,275	4,275	$319,355
Ted E. Bear, M.D. Kids Club Program $10 Gift Card	19,622	19,622	$295,840
Adult Dental	855	1,284	$240,898
Healthy Teens Gift Card	4,571	4,571	$114,275
Transportation Services	181	912	$72,870
Dentures	21	25	$33,472
Podiatry Visits	175	459	$25,222
OTC Medications and Supplies	570	570	$14,250
Healthy Teens Membership	138	138	$6,900
Weight Management	28	28	$3,724
Pest Control Services	5	5	$1,250
Home-delivered meals	46	46	$782
GED Support	8	8	$264
Respite Services	21	21	$137
Adult Vision	3	3	$25
TOTAL	**60,327**	**61,775**	**$1,706,579**
KanCare Grand Total	**165,086**	**186,382**	**$4,190,378**

Sunflower	Members YTD	Total Units YTD	Total Value YTD
My Health Pays	58,419	58,419	$625,365
Comprehensive Medication Review	8,161	11,379	$299,645
Dental visits for adults	2,291	3,983	$122,048
Farmers Market Vouchers	1,621	12,202	$122,020
In-home telemonitoring: Service	452	452	$113,000
Caregiving Collaborations - Assessment Assistance	747	2,658	$94,177
Start Smart for Your Baby	1,845	1,845	$51,935
Caregiving Collaborations - Journals	681	681	$24,312
Dentures	24	44	$21,007
Healthy Solutions for Life - Disease Management	9,875	9,875	$19,750
In-home telemonitoring: Install	96	96	$16,800
Sunny's Kids Club	4,529	4,529	$16,526
NF-Community Transition Meals	70	116	$15,229
Community Health Services Home Visiting Program	367	367	$9,593
NF-Community Transition	8	8	$4,859
Boys & Girls Clubs	111	111	$3,250
Healthy Solutions for Life - Weight Management Program	682	682	$1,364
Employment - GED Test Vouchers	4	4	$144
Peer Support Program	20	20	$50
Employment - GED Prep Test	6	6	$36
Internet Service	1	1	$16
TOTAL	**92,067**	**109,535**	**$1,561,127**

United	Members YTD	Total Units YTD	Total Value YTD
Adult Dental Services	2,467	2,911	$276,275
Debit Card for Completing First Pre-Natal Visit	906	906	$181,636
Adult Dentures	112	165	$129,436
Home Helper Catalog Supplies	2,508	4,310	$113,301
Healthy First Steps	727	727	$87,240
Happy and Healthy at Home	103	103	$50,390
UHC Health Rewards Program	2,608	2,608	$31,486
Internet Access	211	211	$15,379
On My Way (OMW) Program	0	0	$8,500
Membership to Youth Organizations*	206	206	$7,305
Wellness Calendar	2,250	2,250	$4,944
Pest Control	21	21	$4,750
Seeking Safety Training Events	0	0	$4,025
Mental Health First Aid Program	15	15	$2,875
Sesame Street - Food For Thought	45	45	$1,575
Community Baby Showers	200	200	$1,200
12 round trip rides, 10 miles each way max, for all adult members	47	125	$1,170
Respite Care Services**	13	8	$701
12 Additional Rides to Support Group Meetings	4	12	$360
A is for Asthma	249	249	$125
TOTAL	**12,692**	**15,072**	**$922,672**

Protect and improve the health and environment of all Kansans 16

In Lieu of Services January- September 2020

	Aetna			Sunflower			United		
	Unduplicated Members	Value of Service Provided	Value of Services Avoided	Unduplicated Members	Value of Service Provided	Value of Services Avoided	Unduplicated Members	Value of Service Provided	Value of Services Avoided
Additional Medicaid covered services, beyond existing limitations, including personal care services beyond existing waiver limitations, sleep cycle support, home modifications, equipment and assisted services … in lieu of members needing to be admitted to an acute care hospital or nursing facility	53	$491,481	$1,161,410	53	$276,749	$947,403	345	$1,012,784	$1,652,000
Non-Covered services including private nurse, PET scans, CPAP equipment and sleep cycle support in lieu of members needing to access ICU, acute hospital, home health, or more intensive physical or behavioral health services or nursing facility services	242	$242,105	$8,464,270	120	$94,130	$4,841,855	147	$1,084,426	$3,600,000
Totals	**295**	**$733,586**	**$9,625,680**	**173**	**$370,879**	**$5,789,258**	**492**	**2,097,210**	**$5,252,000**

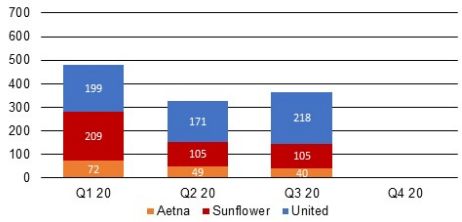
KanCare YTD Total

Unduplicated Members	Value of Service Provided	Value of Services Avoided
960	$6,356,465	$20,666,938

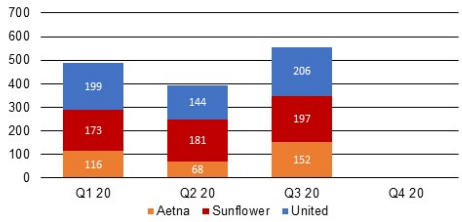
KanCare Grievance, Appeal and State Fair Hearing

Member Grievance and Appeals Comparison

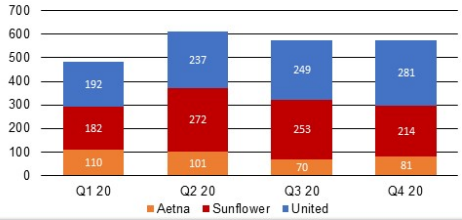
Resolved Member Grievances 2020



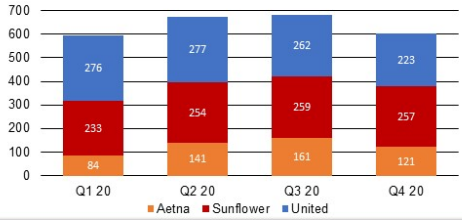
Resolved Member Appeals 2020



Resolved Member Grievances 2019

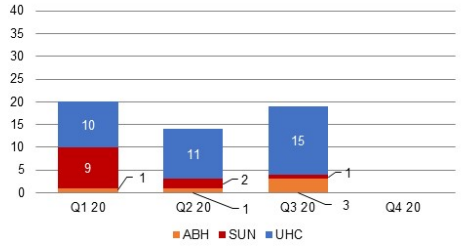


Resolved Member Appeals 2019

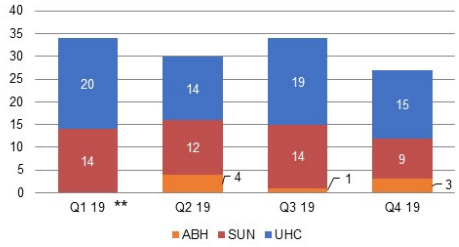


Member State Fair Hearing Comparison

Received Member State Fair Hearings 2020



Received Member State Fair Hearings 2019

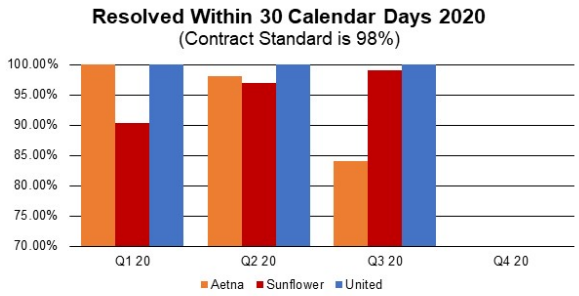


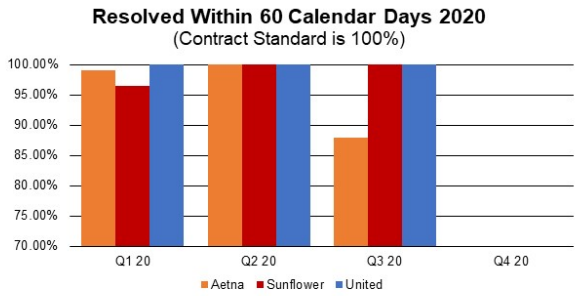
*These totals reflect the number of member state fair hearings received. This includes requests withdrawn, decisions is reversed by the MCO, Overturned and Upheld.
** Aetna did not have any State Fair Hearing requests in the first quarter of their 2019.

Provider Appeal Compliance

Provider Appeals

Contract Standard is: 98% Resolved Within 30 Calendar Days, 100% Resolved Within 60 Calendar Days





KanCare Update: KanCare Advisory Council Public Forum
December 16, 2020

Agenda

Sarah Fertig, State Medicaid Director

- KanCare Program
  - Status of Protected Income Limit Regulation Amendments
  - OneCare Kansas
  - Disability and Behavioral Health Employment Support Pilot Program
  - KanCare COVID-19 Update
  - KanCare Executive Summary

Christiane Swartz, Director of Medicaid Operations

- Eligibility Update
  - Medicaid Eligibility Applications Update
  - Federally Facilitated Marketplace Enrollment Update
  - Clearinghouse Contract

KanCare Update December 2020

Update on Regulations: Protected Income Limit

Background:

- Effective September 1, 2019, the HCBS Protected Income Limit (PIL) increased from $747/month to $1,177/month.
- With new PIL, 92% of HCBS members have no client obligation, and an additional 2% have a client obligation <$100.
- Provisos authorized the change, but KDHE regulations needed to catch up.

Since September:

- The public hearing on the proposed amendments to K.A.R. 129-6-103(c) was held on December 3, 2020.
- No changes were made following the public hearing, so the regulation will take effect 15 days after publication in the Kansas Register. Anticipated publication date: December 17, 2020.
- Anticipated effective date: January 1, 2021 (15 days after publication).

OneCare Kansas

- Program launched on April 1, 2020.
  - To date, 37 providers have applied to be OneCare providers. Of these applicants, 34 have met the standards and are fully contracted.
  - 581 members enrolled in Asthma population as of December 1, 2020.
  - 304 members enrolled in SMI population as of December 1, 2020.
- The 6 month audits of OneCare partners are currently underway. No systemic issues have been reported to the state. The audit tool is publicly posted on the KanCare website.
- KDHE staff are conducting monthly provider Implementation Calls to answer OCK partner questions and facilitate program operation.
- The Learning Collaborative continues to be well-received. This is a monthly virtual gathering of OCK partners where success strategies and lessons learned can be shared.
- State staff continue to engage OCK partners and stakeholders in an effort to explore options for increasing program participation.

What is OneCare Kansas?

The term "OneCare Kansas" refers to a new Medicaid option to provide coordination of physical and behavioral health care with long term services and supports for people with chronic conditions. OneCare Kansas expands upon medical home models to include links to community and social supports. OneCare Kansas focuses on the whole person and all his or her needs to manage his or her conditions and be as healthy as possible. All the caregivers involved in a OneCare Kansas member's health communicate with one another so that all of a patient's needs are addressed in a comprehensive manner.

OneCare Kansas is intended for people with certain chronic conditions, like diabetes, asthma, or mental illness. These people must be KanCare members. They can be members who also receive Medicare along with Medicaid.

OneCare Kansas
a program of KanCare, Kansas Medicaid

Disability and Behavioral Health Employment Support Pilot Program

- Background:
  - KDHE will operate a voluntary pilot program for up to 500 eligible KanCare members through an 1115 demonstration.
  - This pilot will operate during the KanCare waiver period (2019-2023), with a possibility of renewal.
  - Pilot participants will have access to Benefits Specialists who will provide program guidance to potential participants so that they are aware of any impact participation in the pilot may have on benefits.
- KDHE continues to work with and receive guidance from an advisory board.

Disability and Behavioral Health Employment Support Pilot Program

- Update since September:
  - KDHE has begun the process of recruiting two additional Benefits Specialists and a Program Manager to support the pilot.
  - KDHE executed a contract with a subject matter expert to provide technical assistance on implementation and write a program manual. The contractor began work in November.
  - The Advisory Board met on October 22, 2020. Breakout groups of board members will work on an assessment tool, outreach strategies, and designing an effective referral process.
- Target go-live date remains July 2021.

KanCare Update December 2020

KanCare COVID-19 Update - Recent Highlights

- KDHE received approval to use SPARK funding to continue providing coverage for CHIP and M-CHIP beneficiaries who aged out of the program (turned 19) during the pandemic.
- COVID-19 testing is covered by Medicaid with an order from a qualified provider. *See* KMAP Bulletin 20041.
- COVID-19 vaccines will be covered by Medicaid. The typical vaccine reimbursement structure is the cost of the vaccine + an administration fee.
- U.S. Department of Health & Human Services Secretary Alex Azar renewed the public health emergency (PHE) through January 21, 2021. Kansas will continue to receive 6.2% increased federal participation for Medicaid and 4.34% increased federal participation for CHIP through March 31, 2021, if the PHE is not further extended.
- KDHE and KDADS continue to have discussions with the MCOs, providers, and advocates about telehealth.

Overview of Changes to Program (Not Complete List)

- Delay annual eligibility reviews; will not remove anyone from program during the PHE except if the person moves away from the state or voluntarily withdraws from the program (required for enhanced FMAP)
- Applicants and beneficiaries have an additional 120 days to request a fair hearing, if the original 33 day deadline falls between March 2020 and the end of the Public Health Emergency
- Remove all cost sharing for testing/treatment of COVID for KanCare members
- Allow for greater flexibility of day service location for HCBS members
  - Services can be rendered in home by family member, with reimbursement to family member
- Suspend provider revalidation, allowing for continuity of care
- Allow for out of state, non-KanCare providers to provide services in KS
- Suspend PASRR Level 1 and Level 2 requirements for 30 days
- Temporarily cease all physical visits from MCOs to providers/members
- Allow for early refill of maintenance prescriptions; increase level of pharmacy delivery and mail order availability

KanCare Update December 2020

Eligibility Update

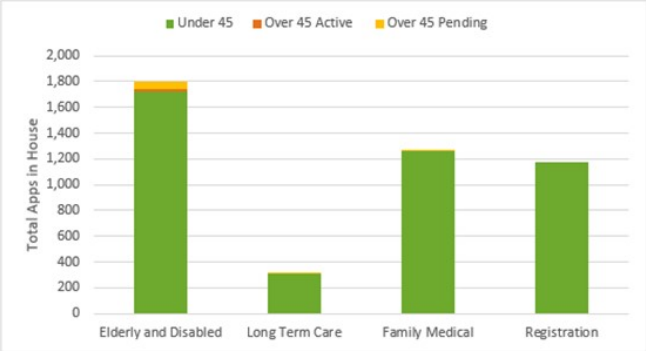
Christiane Swartz, Director of Medicaid Operations

- Medicaid Eligibility Applications Update
- Federally Facilitated Marketplace Open Enrollment Update
- Status of Clearinghouse RFP

Medicaid Eligibility Application Status

4,546 total applications in house

- 89 applications over 45 days, 2% of total applications 31 applications (1% of total) over 45 days in active status – ready to be processed
- 58 applications (1% of total) over 45 days in pending status – waiting for more information from applicant/provider/financial institution



	Under 45	Over 45 Active	Over 45 Pending	Total
Elderly and Disabled	1,722	24	50	1,796
Long Term Care	304	3	6	313
Family Medical	1,261	4	2	1,267
Registration	1,170	0	0	1,170
Total	4,457	31	58	4,546

	Under 45	Over 45 Active	Over 45 Pending	Total
Elderly and Disabled	95.9%	1.3%	2.8%	100.0%
Long Term Care	97.1%	1.0%	1.9%	100.0%
Family Medical	99.5%	0.3%	0.2%	100.0%
Registration	100.0%	0.0%	0.0%	100.0%
Total	98.0%	0.7%	1.3%	100.0%

KanCare Update December 2020

Federally Facilitated Marketplace Open Enrollment Status

- The Federally Facilitated Marketplace open enrollment started 11/01 and ends 12/15
- As of 12/14/20, we have received 12,636 applications from the marketplace:
  - 7,259 Family Medical
  - 3,925 Elderly and Disabled
  - 253 Long Term Care
  - 1,199 in Registration

Clearinghouse Contract Update

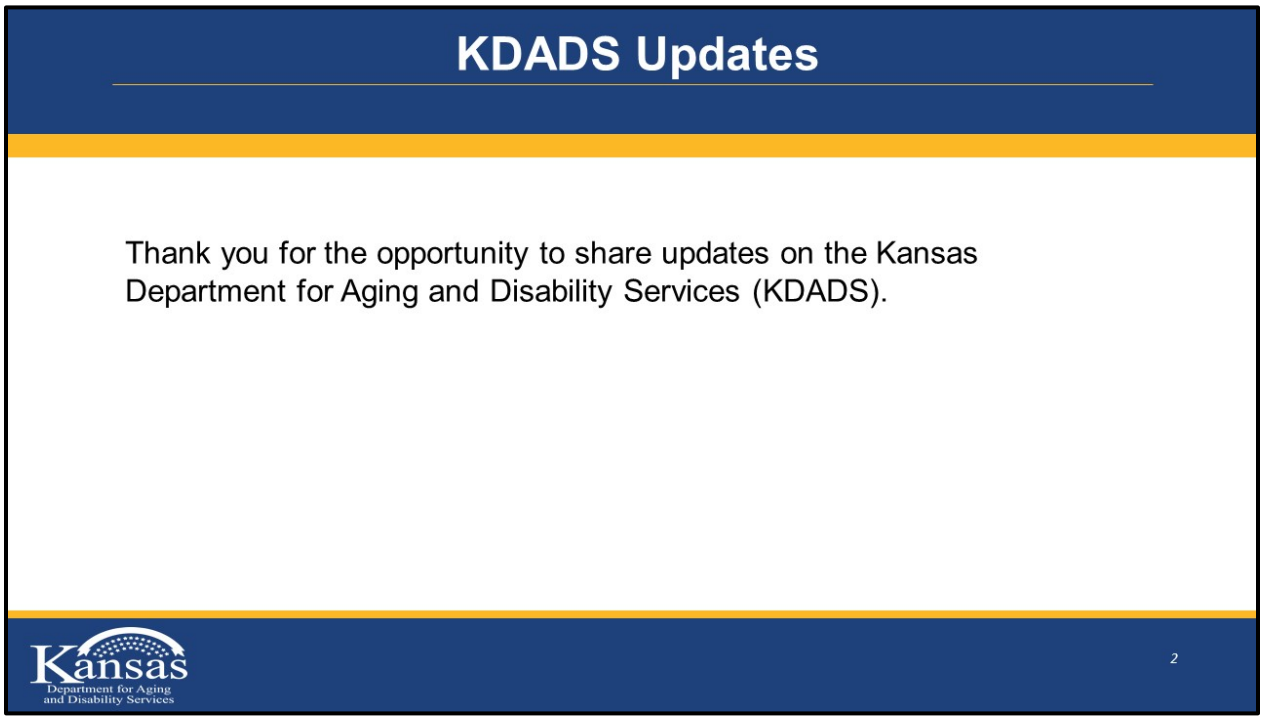
- MAXIMUS to continue processing Family Medical applications through the end of the contract period (12/31/20)
- Procurement of a new Clearinghouse contract is complete and in August 2020 the contract was awarded to a new contractor: CONDUENT
- CONDUENT will begin processing Family Medical applications at the start of the new contract period 01/01/21
  - Delays in contract award caused by the COVID-19 pandemic are resulting in an extremely aggressive implementation timeline
  - KDHE and CONDUENT are engaged in multiple planning and implementation activities
  - KDHE and MAXIMUS are engaged in multiple end of contract and transition activities

KanCare Update December 2020

Thank You/Questions

KDADS:


KDADS Updates
Presentation - KanCare Public Forum
December 16, 2020
Department for Aging and Disability Services
Laura Howard, Secretary
Kansas
Department for Aging and Disability Services
12/16/2020


KDADS Updates
Thank you for the opportunity to share updates on the Kansas Department for Aging and Disability Services (KDADS).
Kansas
Department for Aging and Disability Services
2

KDADS Updates

KDADS Update
Laura Howard, Secretary

Kansas Department for Aging and Disability Services

KDADS's Organizational Structure

▪ Office of the Secretary	Laura Howard, Secretary
▪ Two Deputy Secretaries	Janis DeBoer, Programs Scott Brunner, State Hospitals and Facilities
▪ Five Commissions	Andy Brown, Behavioral Health Commissioner Amy Penrod, Aging & Disability Community Services and Programs Commissioner Vacant (new Commission), Long Term Care Commissioner Lacey Hunter, Survey, Certification and Credentialing Commissioner Mike Dixon, State Hospital Commissioner

Kansas Department for Aging and Disability Services

LTC Receiverships

LTC RECEIVERSHIPS
Deputy Secretary Janis DeBoer

Kansas Department for Aging and Disability Services

Update
Nursing Facility Receiverships

- KDADS took 22 adult care homes into receivership due to insolvency or because life-threatening or endangering conditions existed at the facilities.
- The Receivership Statute was updated during the 2019 legislative session: K.S.A. 39-954.
- Of the twenty two nursing facilities in receivership:
  - One facility closed in 2018, one sold in early 2019.
  - The fifteen Skyline facilities sold effective October 1, 2019.
  - One of the three Pinnacle Receivership facilities sold November 1, 2019.
  - One facility sold in June 1, 2020.
  - One facility sold in August, 2020.
  - A closing is scheduled in late December, 2020.
  - One facility remains on the market for sale.

Kansas Department for Aging and Disability Services

Home and Community Based Services

HOME AND COMMUNITY BASED SERVICES (HCBS)

Commissioner Amy Penrod

Kansas Department for Aging and Disability Services

HCBS Waiver Enrollment—October 2020

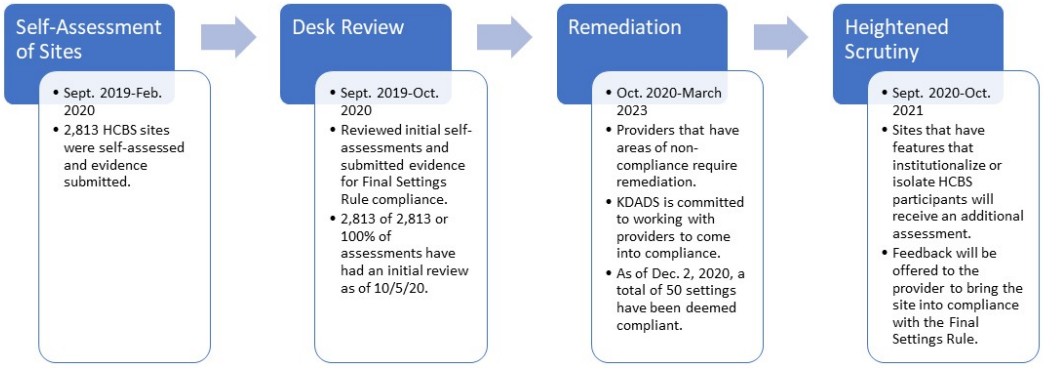
HCBS Program	Number of People Eligible to Receive HCBS Services	Number of People on Wait List	Number of Proposed Recipients
Autism	60		329 (as of 10/31/2020)
Serious Emotional Disturbance (SED)	3,287		
Technology Assisted (TA)	598		
Frail Elderly (FE)	5,550		
Brain Injury (BI)*	628		
Intellectual and Developmental Disabilities (I/DD)	9,102	4,394	
Physical Disability (PD)	6,107	1,872	

Notes:

- Data as of November 18, 2020
- The HCBS Monthly Summary is posted under Monthly Waiver Program Participation Reports at http://kdads.ks.gov/commissions/home-community-based-services-(hcbs)

Kansas Department for Aging and Disability Services

HCBS Final Rule



Kansas Department for Aging and Disability Services

9

Administrative Case Management

Administrative Case Management provides eligibility and enrollment assistance to individuals who have been found functionally eligible for the Brain Injury, Physical Disability, and Frail Elderly waivers, as well as PACE.

- Administrative Case Management services launched statewide on May 1, 2020.

Administrative Case Management

Month	# Unduplicated Served	# Units	# Hours
May	108	595	148.75
June	288	1,636	409.00
July	316	1,879	469.75
August	305	1,682	420.50
September	410	1,976	494.00
October	481	2,298	574.50
Total	1,908	10,066	2,516.50

Kansas Department for Aging and Disability Services

10

Program of All-Inclusive Care for the Elderly (PACE)

Via Christi Hope	Midland Care	Bluestem Communities
• Sedgwick	• Douglas • Jackson • Jefferson • Leavenworth • Lyon • Marshall • Nemaha • Osage • Shawnee • Pottawatomie • Wabaunsee • Wyandotte	• McPherson • Ottawa* • Saline • Rice* • Marion • Reno* • Harvey

*PACE is available in limited zip codes within these counties.

Kansas Department for Aging and Disability Services

Aging – State Unit on Aging State Plan

- Every four years, KDADS must update its State Unit on Aging State Plan. Comments and feedback are being received through March 31.

Kansas Department for Aging and Disability Services

Behavioral Health Services

BEHAVIORAL HEALTH SERVICES
Commissioner Andrew Brown

Kansas Department for Aging and Disability Services

Psychiatric Residential Treatment Facilities

- KDADS has decreased PRTF MCO wait lists again in 2020, for the second year in a row.
  - As of 12/7/20 there were 107 individuals on the lists, down from 160 a year ago.
  - Of the 107 individuals; 15 were in foster care, down from 40 a year ago.
- KDADS has increased the current number of PRTF licensed beds.
  - As of 12/7/20 is 386 in the system of care, up from 298 a year ago.
- KDADS has updated PRTF Regulations which will be available for public comment after legal review is completed.
- KDADS meets with MCOs and DCF weekly to review individual cases on the wait list.
- KDADS is working with MCO Care Coordination to facilitate community-based services.
- PRTFs received access to the CARES/SPARK web portal for ordering PPE supplies.

Kansas Department for Aging and Disability Services

State Institution Alternatives

- In 2020, KDADS introduced new State Plan Amendment and KanCare policies for State Institution Alternatives (SIAs).
- SIA allows Private Hospitals to enroll in KanCare for the care and treatment of patients as if they were a State Hospital.
- These policies allow for members to be admitted to local regional hospitals as an alternative to hospitalization at a State Hospital.
- As the network of SIA hospitals is built up around the state, this will help reduce admissions to state hospitals and provide communities with greater access to care.
- The policy allows SIAs to bill KanCare MCOs using per diem rates, as though they were a State Hospital.
- This policy will also help reduce member wait times in local Emergency Departments.

Kansas Department for Aging and Disability Services

Peer Support Expansion

- In 2020, KDADS expanded Peer Support in KanCare through a number of efforts.
- KDADS added a MCO performance measure requiring a 10% increase in Peer Support as a financial incentive for expansion.
- KDADS increased access to Peer Support provider training and certification to increase the workforce.
- KDADS increased the KanCare provider reimbursement rates for Peer Support by 10%.
- KDADS is currently working to add additional Peer Support categories for certification and specialization.
- KDADS included peer support in the expansion of telehealth under the national Public Health Emergency in 2020.

Kansas Department for Aging and Disability Services

Substance Use Disorder Services

IMD Exclusion Waiver

- KDADS completed the implementation and evaluation plans for the SUD IMD exclusion wavier and began reporting on initial progress to CMS in 2020.
- KDHE & KDADS worked together to add MAT services for OUD to KanCare.
- KDADS included SUD providers in Peer Support expansion efforts.
- KDADS is working with KDHE to explore opportunities for improving integration of SUD screening and services in KanCare.
- KDADS increased access to housing supports for KanCare members with SUD or in recovery.
- KDADS expanded options for SUD treatment through telehealth during the national Public Health Emergency in 2020.

Kansas Department for Aging and Disability Services

LTC Survey, Certification and Credentialing

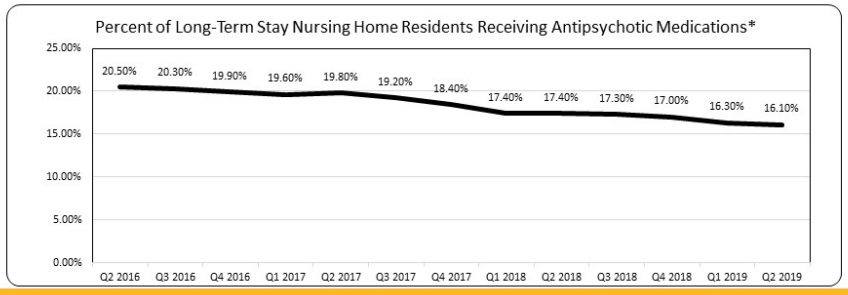
LONG TERM CARE SCC

Deputy Secretary Scott Brunner

Kansas Department for Aging and Disability Services

Kansas is Making Progress in Reducing the Use of Antipsychotic Drugs in Nursing Homes

- In 2011, Kansas ranked 51st in the nation (42nd in 2018), in the use of anti-psychotic drugs in nursing facilities.
- Kansas now ranks 37th in the nation and expects to continue to show improvement based on the activities undertaken.
- The national quarterly prevalence is 14.3%.



Kansas Department for Aging and Disability Services

*Excludes residents diagnosed with schizophrenia, Huntington's Disease, or Tourette's Syndrome
Source: National Partnership to Improve Dementia Care in Nursing Homes: Antipsychotic Medication Use Data Report (April 2019) https://qioprogram.org/sites/default/files/Overall%20Data%20Report%20FINAL.pdf

Priorities and Issues
COVID-19 and Adult Care Homes

Status of Required Adult Care Home Infection Control Surveys

- As of September 23, 2020 all Adult Care Homes have been surveyed for infection control policies, procedures and practices.

Plan to return to regular survey activity

- Nursing Facilities

  At this time survey activity for certified nursing facilities includes:

  - Federal Infection Control Surveys as outlined in QSO Memo 20-31 All
  - Complaint investigations that are triaged as Immediate Jeopardy, Non-Immediate Jeopardy-High or Non-Immediate Jeopardy Medium
  - Special Focus Facility and Special Focus Facility Candidate recertification surveys; and
  - Recertification surveys in facilities where it has been over 15 months since the last standard survey
  - Onsite revisits for surveys with end dates on, or after June 1, 2020

Kansas Department for Aging and Disability Services

Priorities and Issues
COVID-19 and Adult Care Homes

Plan to return to regular survey activity (continued)

- State Licensed Only Adult Care Homes
  - Annual Licensure Surveys
  - Complaint investigations that are triaged as Immediate Jeopardy, Non-Immediate Jeopardy-High or Non Immediate Jeopardy Medium
  - On-site Revisits
  - Initial Licensure Surveys

Kansas Department for Aging and Disability Services

State Hospitals

STATE HOSPITALS
Deputy Secretary Scott Brunner

Kansas Department for Aging and Disability Services

Lifting the Moratorium
Osawatomie State Hospital

A1 & A2 – AAC unit (certified) At the beginning of the pandemic, capacity was reduced to 30 (patients having private rooms) to provide adequate space for social distancing in case of COVID 19. After an increase in patients on the moratorium list, OSH Leadership increased AAC's capacity from 30 to 44 patients.

KDADS has begun interviewing contractors to begin the construction projects at OSH related to the approved budget.

OSH Leadership are working on recruiting and retaining staff needed to fill positions in the new and opened units needed to lift a moratorium.

Kansas Department for Aging and Disability Services

COVID Related Updates

COVID 19

Deputy Secretaries Janis DeBoer and Scott Brunner

Kansas Department for Aging and Disability Services

COVID-19 Response
Funding

In June, KDADS began working closely with Governor Kelly's SPARK Recovery Office to receive dollars available from the CARES Act.

As of December, 2020, over $81 million in SPARK/CARES dollars will have been distributed to KDADS and its stakeholders.

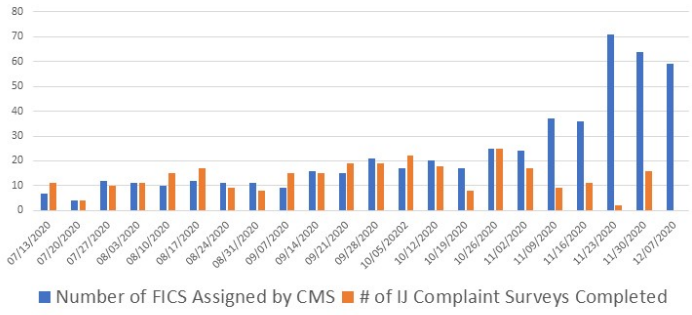
$33.7	million to Nursing Facilities
$9.7	million to Community Based providers
$19.2	million to Behavioral Health providers
$18	million to multiple stakeholders for Personal Protective Equipment, communications devices, visitation equipment
$0.4	million for administrative equipment

Kansas Department for Aging and Disability Services

25

Priorities and Issues
COVID-19 and Adult Care Homes

Per QSO Memo 20-31-All KDADS is required to perform on-site surveys (within three to five days of identification) of any nursing home with 3 or more new COVID-19 suspected and confirmed cases in its last NHSN COVID-19 report, or 1 confirmed resident case in a facility that was previously COVID-free. State Survey Agencies are encouraged to communicate with their State Healthcare Associated Infection coordinators prior to initiating these surveys.



Kansas Department for Aging and Disability Services

26

Testing Machines to Nursing Facilities

Health and Human Services sent point of care testing machine (BD Veritor System and Quidel Sofia2) with associated tests to all nursing homes with a current CLIA Certificate of Waiver across the country.

There were three waves of delivery: July 20-August 14, August 17-September 30, and November 2-6

These instruments and tests were sent to nursing homes from HHS free of charge.

- 319 Kansas nursing facilities received a point of care testing machine as of November 19, 2020

Kansas Department for Aging and Disability Services

27

CMS Visitation Guidance

On September 17, CMS replaced earlier restrictions on visitors in Nursing Facilities. CMS acknowledged the importance of visitation on Nursing Facility resident well being and health. The guidance generally allows visitation considering the person-centered needs of residents to support their quality of life and strongly encourages outside visitation whenever possible.

Nursing facilities should allow visitors as long as the community spread of COVID-19 is low, adequate infection control practices and social distancing practices are in place, facilities are conducting testing as required and visitors follow facility guidelines about visitation.

The guidance authorizes states to provide $3,000 grants from Civil Monetary Penalty funds for facilities to purchase equipment to facilitate visitation such as tents or plexiglass screens. KDADS also used CARES Act funding to purchase telecommunication devices

Kansas Department for Aging and Disability Services

28

KDADS Visitation Guidance

On October 19th, KDADS issued visitation guidance for long term care settings.

KDADS recognizes the prolonged separation of long-term care residents from their loved ones has taken a significant toll on the health of everyone involved; as well as the need to continue to protect this vulnerable population. The guidance outlines that visitation is a right for residents in adult care homes and facilities should make best efforts to facilitate visitation for residents and their loved ones or preferred visitors taking a person-centered approach.

Adult Care Homes should allow visitors as long as the community spread of COVID-19 is low, adequate infection control practices and social distancing practices are in place and visitors follow facility guidelines about visitation.

Kansas Department for Aging and Disability Services

29

HCBS COVID-19 Response

Appendix K for HCBS Waivers

Appendix K is a standalone appendix that may be utilized by states during emergency situations to request amendment to approved 1915(c) waivers. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency.

CMS-approved Appendix K flexibilities include:

- Suspend Settings Rules to Allow Services to be Provided in Homes or Temporary Settings
- Permit Payment to Family Caregivers to Provide Personal Care Services
- Expansion of Telehealth Opportunities
- Home-delivered Meals
- Permit Provisional Employment Pending Background Checks
- Provider Retainer Payments for Habilitation Services and Personal Care Services

KDADS-issued COVID-19 guidance can be found at https://www.kdads.ks.gov/covid-19

Kansas Department for Aging and Disability Services

30

Behavioral Health COVID-19 Response

Kansas Department of Aging and Disability Services (KDADS) has been working closely with KDHE to respond to COVID-19 in Behavioral Health Services.

KDADS quickly issued guidance to providers that allowed for the expansion of telehealth and verbal consent to facilitate social distancing during treatment service delivery in outpatient settings. KDADS also provided flexibility to providers to provide continuity of essential services allowing for additional infection control measures to be taken in residential treatment facilities.

KDADS worked with KDHE to establish new telehealth policies for KanCare providers and MCOs that helped mitigate some of the negative financial impact on providers and allowed for continuity of essential services during the pandemic.

KDADS has been working at the federal level to advocate for continued flexibility in CMS regulations for the telehealth delivery of behavioral health services in Medicaid and Medicare.

Kansas Department for Aging and Disability Services

31

COVID 19
State Hospitals

All four of the State Hospitals have experienced COVID 19 cases and have responded, as needed:

Larned State Hospital
Osawatomie State Hospital
Parsons State Hospital
Kansas Neurological Institute (KNI)

Kansas Department for Aging and Disability Services

32

After the presentations from both KDHE and KDADS, participants were offered the opportunity to present questions or comments for discussion. No public comment or questions were brought forward. Director Sarah Fertig thanked all participants for joining the Public Forum.

Physical Health Measures, MY2015–2019										
Measure	**HEDIS Aggregated Results**					**Quality Compass ≥50th Percentile**				
	2015	**2016**	**2017**	**2018**	**2019**	**2015**	**2016**	**2017**	**2018**	**2019**
Adults' Access to Preventive/Ambulatory Health Services (AAP)										
Ages 20–44	83.7%	82.6%	83.6%	^ 83.1%	**84.2%**	↑	↑	↑	↑	↑
Ages 45–64	92.3%	91.3%	90.7%	^ 90.4%	**91.4%**	↑	↑	↑	↑	↑
Ages 65 and older	89.7%	90.1%	90.9%	^ 91.3%	**91.3%**	↑	↑	↑	↑	↑
Total – Ages 20 and older	87.1%	86.1%	86.7%	^ 86.6%	**87.7%**	↑	↑	↑	↑	↑
Annual Dental Visit (ADV)										
Ages 2–3	42.8%	45.8%	46.6%	45.8%	**47.7%**	↑	↑	↑	↑	↑
Ages 4–6	66.2%	69.2%	70.7%	71.2%	**72.1%**	↑	↑	↑	↑	↑
Ages 7–10	70.3%	72.7%	73.7%	74.9%	**75.8%**	↑	↑	↑	↑	↑
Ages 11–14	63.2%	66.4%	67.7%	68.6%	**70.1%**	↑	↑	↑	↑	↑
Ages 15–18	54.1%	57.2%	58.7%	59.5%	**60.7%**	↑	↑	↑	↑	↑
Ages 19–20 *(19–21 for 2015)*	34.7%	33.1%	33.9%	35.5%	**37.0%**	↑	↓	↓	↓	↓
Total – Ages 2–20 *(2–21 for 2015)*	60.9%	63.7%	64.8%	65.4%	**66.7%**	↑	↑	↑	↑	↑
Initiation in Treatment for Alcohol or other Drug Dependence (IET)* *(CMS Core Quality Measure)*										
Ages 13–17	46.4%	50.2%	* 43.6%	43.4%	**47.9%**	↑	↑	↑	↑	↑
Ages 18 and older	37.7%	40.1%	* 34.7%	35.3%	**40.2%**	↓	↓	↓	↓	↓
Total – Ages 13 and older	38.9%	41.4%	* 35.8%	36.2%	**41.2%**	↑	↑	↓	↓	↓
Engagement in Treatment for Alcohol or other Drug Dependence (IET)* *(CMC Core Quality Measure)*										
Ages 13–17	26.8%	27.5%	* 23.6%	21.5%	**25.5%**	↑	↑	↑	↑	↑
Ages 18 and older	10.7%	12.4%	* 10.4%	10.3%	**11.9%**	↑	↑	↓	↓	↓
Total – Ages 13 and older	12.9%	14.3%	* 12.0%	11.6%	**13.6%**	↑	↑	↓	↓	↓
Prenatal and Postpartum Care (PPC) *(CMS Core Quality Measure)*										
Timeliness of Prenatal Care	67.4%	68.4%	69.3%	* 75.5%	* **84.3%**	↓	↓	↓	↓	↓
Postpartum Care	57.5%	58.0%	61.1%	58.2%‡	* **67.0%**	↓	↓	↓	↓	↓
Chlamydia Screening in Women (CHL) *(CMS Core Quality Measure)*										
Ages 16–20	41.3%	41.0%	39.6%	37.5%	**40.3%**	↓	↓	↓	↓	↓
Ages 21–24	53.5%	52.8%	54.5%	54.9%	**55.9%**	↓	↓	↓	↓	↓
Total – Ages 16–24	45.8%	45.3%	45.1%	43.5%	**45.3%**	↓	↓	↓	↓	↓
Adult BMI Assessment (ABA) *(CMS Core Quality Measure)*										
	77.6%	80.9%	86.5%	90.4%‡	**88.8%‡**	↓	↓	↓	↑	↓
Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents *(CMS Core Quality Measure)*										
Weight Assessment/BMI for Children and Adolescents (WCC)										
Ages 3–11	48.9%	55.5%	64.3%	^ 66.3%‡	**60.3%**	↓	↓	↓	↓	↓
Ages 12–17	48.1%	56.9%	65.6%	^ 59.3%‡	**60.4%**	↓	↓	↓	↓	↓
Total – Ages 3–17	48.6%	56.0%	64.7%	^ 63.8%‡	**60.3%**	↓	↓	↓	↓	↓
Counseling for Nutrition for Children and Adolescents (WCC)										
Ages 3–11	50.6%	55.4%	60.6%	59.5%	**58.8%**	↓	↓	↓	↓	↓
Ages 12–17	45.7%	53.1%	56.7%	53.2%	**60.9%**	↓	↓	↓	↓	↓
Total – Ages 3–17	49.1%	54.7%	59.2%	57.2%	**59.6%**	↓	↓	↓	↓	↓
Counseling for Physical Activity for Children and Adolescents (WCC)										
Ages 3–11	43.3%	47.9%	51.9%	53.8%	**50.6%**	↓	↓	↓	↓	↓
Ages 12–17	48.3%	58.6%	57.8%	57.3%	**62.2%**	↓	↓	↓	↓	↓
Total – Ages 3–17	44.9%	51.5%	53.9%	55.0%	**54.9%**	↓	↓	↓	↓	↓

↑ Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile. Due to the COVID-19 pandemic having unequal impact on HEDIS rates across the nation, use caution when comparing 2019 percentiles to prior years' percentiles.

* Quality Compass identified "Break in Trending" due to specification changes from prior year

^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

† HEDIS rates greater than 50th percentile that indicate poor performance

‡ KanCare rates for measures are aggregation of only Sunflower Health Plan and United HealthCare

Physical Health Measures, MY2015–2019 (Continued)										
Measure	**HEDIS Aggregated Results**					**Quality Compass ≥50th Percentile**				
	2015	**2016**	**2017**	**2018**	**2019**	**2015**	**2016**	**2017**	**2018**	**2019**
Follow-Up after Hospitalization for Mental Illness (FUH)* (CMS Core Quality Measure)										
Within 7 days of discharge	62.8%	64.4%	* 59.0%	^ 55.3%	**54.4%**	↑	↑	↑	↑	↑
Within 30 days of discharge			76.5%	* 74.6%	**73.5%**				↑	↑
Follow-Up Care for Children Prescribed ADHD Medication (ADD)^ (CMS Core Quality Measure)										
Initiation Phase	50.7%	52.1%	49.5%	^ 48.7%	**52.8%‡**	↑	↑	↑	↑	↑
Continuation & Maintenance Phase	61.2%	61.4%	57.5%	^ 56.1%	**59.9%‡**	↑	↑	↑	↑	↑
Adolescent Well Care Visits (AWC) *(CMS Core Quality Measure)*										
	46.8%	47.7%	53.3%	50.7%	**56.5%**	↓	↓	↓	↓	↓
Well-Child Visits in the First 15 Months of Life (W15) *(CMS Core Quality Measure)*										
0 visits	3.0%	3.4%	2.9%	3.9%	**2.7%‡**	↑†	↑†	↑†	↑†	↑†
1 visit	3.3%	3.5%	3.4%	3.6%	**3.2%‡**	↑†	↑†	↑†	↑†	↑†
2 visits	4.8%	4.8%	4.1%	5.0%	**5.2%‡**	↑†	↑†	↑†	↑†	↑†
3 visits	6.5%	5.5%	6.5%	6.9%	**5.0%‡**	↑†	↑†	↑†	↑†	↑†
4 visits	9.1%	8.6%	8.0%	9.9%	**8.6%‡**	↓	↓	↓	↑	↑
5 visits	14.5%	15.5%	14.4%	15.9%	**12.4%‡**	↓	↓	↓	↑	↓
6 or more visits	58.7%	58.6%	60.7%	54.8%	**63.0%‡**	↓	↓	↓	↓	↓
Controlling High Blood Pressure (CBP) *(CMS Core Qualilty Measure)*										
	48.2%	52.1%	53.6%	* 58.6%‡	**54.4%**	↓	↓	↓	↓	↓
Comprehensive Diabetes Care (CDC)										
HbA1c Testing *(CMS Core Quality Measure)*	84.9%	85.8%	86.2%	^ 87.7%	**85.8%**	↓	↓	↓	↓	↓
Eye Exam (Retinal)	62.5%	64.4%	62.4%	^ 64.8%	**62.9%**	↑	↑	↑	↑	↑
Medical Attention for Nephropathy	89.2%	87.2%	88.8%	^ 86.7%	**86.7%**	↓	↓	↓	↓	↓
HbA1c Control (<8.0%)	46.6%	51.0%	55.0%	^ 54.9%	**53.2%**	↓	↑	↑	↑	↑
HbA1c Poor Control (>9.0%) *(CMS Core Quality Measure)*	45.4%	41.1%	35.3%	^ 36.8%	**39.0%**	↓	↓	↑	↑	↓
Blood Pressure Control (<140/90)	58.8%	57.9%	61.1%	^ 43.3%	**58.5%**	↓	↓	↓	↓	↓
Appropriate Testing for Pharyngitis (CWP)										
Ages 3–17	55.0%	61.2%	68.6%	73.3%	**73.8%**	↓	↓	↓	↓	↓
Ages 18–64					**63.6%**					↓
Ages 65 and older					**66.7%**					↑
Total					**72.3%**					↓
Medication Management for People with Asthma (MMA) *(CMS Core Quality Measure in 2013-2017)*										
5–11 years of age	29.1%	31.7%	37.9%	^ 38.5%	**37.4%‡**	↑	↑	↑	↑	↑
12–18 years of age	26.6%	31.9%	36.3%	^ 37.8%	**38.3%‡**	↑	↑	↑	↑	↑
19–50 years of age	38.3%	41.4%	46.5%	^ 47.3%	**47.8%‡**	↑	↑	↑	↑	↑
51–64 years of age	55.1%	60.1%	60.2%	^ 62.9%	**52.5%‡**	↑	↑	↑	↑	↓
Total – Ages 5–64	29.9%	33.7%	39.2%	^ 40.4%	**39.9%‡**	↓	↑	↑	↑	↑
Appropriate Treatment for Upper Respiratory Infection (URI)										
Ages 3 months–17 years	76.3%	79.2%	81.9%	86.6%	**88.1%**	↓	↓	↓	↓	↓
Ages 18–64					**77.2%**					↑
Ages 65 and older					**83.4%**					↑
Total					**86.5%**					↓

↑ Signifies Quality Compass ranking ≥50th percentile; ↓Signifies Quality Compass ranking <50th percentile. Due to the COVID-19 pandemic having unequal impact on HEDIS rates across the nation, use caution when comparing 2019 percentiles to prior years' percentiles.

* Quality Compass identified "Break in Trending" due to specification changes from prior year

^ Quality Compass identified "Trend with Caution" due to specification changes from prior year

† HEDIS rates greater than 50th percentile that indicate poor performance

‡ KanCare rates for measures are aggregation of only Sunflower Health Plan and United HealthCare

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Aetna*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2019 Target Thresholds	2019 results	Met/Not Met
Comprehensive Diabetes Care (CDC): *HbA1c Control (< 8.0%)*	Percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).	Healthcare Effectiveness Data and Information Set [HEDIS] (Hybrid)	7.79%	Unless otherwise noted, KDHE will set Performance Targets as follows: • *>= 50th %-ile benchmark:* 100% of incentive payment for measure OR • *>= 5 percentage point improvement:* 100% OR • *>= 3 percentage point improvement:* 50% *If MCO meets more than one criteria, it shall receive 100% of incentive payment for measure.*	Rate ≥ 50th QC = 100%; Valid Rate = 50%	52.55%	100% Met
Childhood Immunization Status: *Combination 10*	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday [HEDIS measure Combination 10]	HEDIS (Hybrid)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	35.61%	50% Met
Immunizations for Adolescents: *Combination 2*	Percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday (Meningococcal; tetanus, diphtheria toxoids and acellular pertussis [Tdap]; human papillomavirus [HPV])	HEDIS (Hybrid)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	35.04%	50% Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Aetna*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2019 Target Thresholds	2019 results	Met/Not Met
Timeliness of Prenatal Care	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	HEDIS (Hybrid)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	82.24%	50% Met
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.	HEDIS (Hybrid)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	68.61%	50% Met
Cervical Cancer Screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	HEDIS (Hybrid)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	44.28%	50% Met
Annual Dental Visit: *Total*	Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	HEDIS (Admin)	7.79%		Rate ≥ 50th QC = 100%; Valid Rate = 50%	66.46%	100% Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Aetna*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2019 Target Thresholds	2019 results	Met/Not Met
Residents of a NF or nursing facility for mental health (NFMH), receiving antipsychotic medication ***Lower rate indicates better performance.**	Percentage of long-term stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome.	Minimum Data Set (MDS)	7.79%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	Rate ≤ 12% = 100%	12.93%	Not Met
Nursing Home residents discharged to the community who are admitted to a hospital within 30 days of discharge ***Lower rate indicates better performance.**	Percentage of NF discharges who are admitted to a hospital within 30 days of discharge from the NF.	MDS/ Encounter Data	14.28%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	Rate ≤ 12% = 100%	12.39%	Not Met
Residents of a NF or NFMH discharged to a community setting	Percentage of NF and NFMH residents indicating a desire to return to the community who are discharged to a community setting during the year.	MDS	7.79%	• *Rate >= 55%:* 100% OR • *Rate < 55% and >= 50%:* 50%	Rate ≥ 50% = 100%	56.73%	100% Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Aetna*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2019 Target Thresholds	2019 results	Met/Not Met
Covered service accurately submitted via Encounter data	Percent of covered service accurately submitted via encounter data within 30 days of claim paid date. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Rate ≥ 98.00% = 100%*	*Q1* *Q2* *Q3* *Q4*	*Q1 Deemed Met by the State* *Q2 Deemed Met by the State* *Q3 Under Review* *Q4 Under Review*
Service payments matched to / validated by encounter record	Percent of reported financials reflecting service payments that are matched to/validated by an encounter record submitted by the MCO. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Rate ≥ 98.00% = 100%*	*Q1* *Q2* *Q3* *Q4*	*Q1 Deemed Met by the State* *Q2 Deemed Met by the State* *Q3 Under Review* *Q4 Under Review*

For Aetna CY2019 HEDIS measure performance, Aetna can earn only one of the below (whichever is more):

- *Meet objective performance target (e.g., >= 50th %-ile benchmark for HEDIS measure):* Earn incentive payment for measure
- *Report valid measure:* Earn 50% of incentive payment for measure *(i.e., pay-for-reporting)*

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Sunflower*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Comprehensive Diabetes Care (CDC): *HbA1c Control (< 8.0%)*	Percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).	Healthcare Effectiveness Data and Information Set [HEDIS] (Hybrid)	7.79%	Unless otherwise noted, KDHE will set Performance Targets as follows: • *>= 50th %-ile benchmark:* 100% of incentive payment for measure OR • *>= 5 percentage point improvement:* 100% OR • *>= 3 percentage point improvement:* 50% *If MCO meets more than one criteria, it shall receive 100% of incentive payment for measure.*	48.18%	45.99%	Not Met
Childhood Immunization Status: *Combination 10*	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday [HEDIS measure Combination 10]	HEDIS (Hybrid)	7.79%		34.79%	38.69%	100% Met
Immunizations for Adolescents: *Combination 2*	Percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday (Meningococcal; tetanus, diphtheria toxoids and acellular pertussis [Tdap]; human papillomavirus [HPV])	HEDIS (Hybrid)	7.79%		35.77%	35.52%	Not Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Sunflower*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Timeliness of Prenatal Care	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	HEDIS (Hybrid)	7.79%		69.83%	77.13%	100% Met
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.	HEDIS (Hybrid)	7.79%		68.13%	68.13%	Not Met
Cervical Cancer Screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	HEDIS (Hybrid)	7.79%		54.50%	59.61%	100% Met
Annual Dental Visit: *Total*	Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	HEDIS (Admin)	7.79%		66.13%	67.24%	100% Met
Residents of a NF or nursing facility for mental health (NFMH), receiving antipsychotic medication ***Lower rate indicates better performance.**	Percentage of long-term stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome.	Minimum Data Set (MDS)	7.79%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	12.50%	11.84%	100% Met
Nursing Home residents discharged to the community who are admitted to a hospital within 30 days of discharge ***Lower rate indicates better performance.**	Percentage of NF discharges who are admitted to a hospital within 30 days of discharge from the NF.	MDS/ Encounter Data	14.28%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	12.63%	12.50%	Not Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *Sunflower*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Residents of a NF or NFMH discharged to a community setting	Percentage of NF and NFMH residents indicating a desire to return to the community who are discharged to a community setting during the year.	MDS	7.79%	• *Rate >= 55%:* 100% OR • *Rate < 55% and >= 50%:* 50%	57.02%	60.51%	100% Met
Covered service accurately submitted via Encounter data	Percent of covered service accurately submitted via encounter data within 30 days of claim paid date. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Q1 96.58%* *Q2 95.41%* *Q3 97.60%* *Q4 98.56%*	*Q1 98.63%* *Q2 98.14%* *Q3 99.39%* *Q4 99.71%*	*100% Met* *100% Met* *100% Met* *100% Met*
Service payments matched to / validated by encounter record	Percent of reported financials reflecting service payments that are matched to/validated by an encounter record submitted by the MCO. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Q1 99.50%* *Q2 99.31%* *Q3 99.54%* *Q4 98.87%*	*Q1 98.75%* *Q2 98.67%* *Q3 100.75%* *Q4 99.55%*	*100% Met* *100% Met* *100% Met* *100% Met*

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *UnitedHealthcare*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Comprehensive Diabetes Care (CDC): *HbA1c Control (< 8.0%)*	Percentage of patients 18–75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).	Healthcare Effectiveness Data and Information Set [HEDIS] (Hybrid)	7.79%	Unless otherwise noted, KDHE will set Performance Targets as follows: • *>= 50th %-ile benchmark:* 100% of incentive payment for measure OR • *>= 5 percentage point improvement:* 100% OR • *>= 3 percentage point improvement:* 50% *If MCO meets more than one criteria, it shall receive 100% of incentive payment for measure.*	58.26%	61.31%	100% Met
Childhood Immunization Status: *Combination 10*	Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DtaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday [HEDIS measure Combination 10]	HEDIS (Hybrid)	7.79%		33.09%	35.77%	Not Met
Immunizations for Adolescents: *Combination 2*	Percentage of adolescents 13 years of age who had recommended immunizations by their 13th birthday (Meningococcal; tetanus, diphtheria toxoids and acellular pertussis [Tdap]; human papillomavirus [HPV])	HEDIS (Hybrid)	7.79%		33.58%	36.01%	Not Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *UnitedHealthcare*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Timeliness of Prenatal Care	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.	HEDIS (Hybrid)	7.79%		82.45%	91.73%	100% Met
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	Percentage of members 3–6 years of age who had one or more well-child visits with a primary care provider (PCP) during the measurement year.	HEDIS (Hybrid)	7.79%		72.59%	74.94%	100% Met
Cervical Cancer Screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	HEDIS (Hybrid)	7.79%		54.50%	59.61%	100% Met
Annual Dental Visit: *Total*	Percentage of members 2–20 years of age who had at least one dental visit during the measurement year.	HEDIS (Admin)	7.79%		65.00%	66.28%	100% Met
Residents of a NF or nursing facility for mental health (NFMH), receiving antipsychotic medication ***Lower rate indicates better performance.**	Percentage of long-term stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's Disease or Tourette's Syndrome.	Minimum Data Set (MDS)	7.79%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	12.76%	11.37%	100% Met
Nursing Home residents discharged to the community who are admitted to a hospital within 30 days of discharge ***Lower rate indicates better performance.**	Percentage of NF discharges who are admitted to a hospital within 30 days of discharge from the NF.	MDS/ Encounter Data	14.28%	• *Rate <= 12%:* 100% OR • *>= 1 percentage point improvement:* 50% *If MCO meets both criteria, it shall receive 100% of incentive payment for measure.*	13.16%%	13.80%	Not Met

Calendar Year (CY) 2019 KanCare Pay for Performance (P4P) Measures: *UnitedHealthcare*

Measure	Description	Data Source	Measure Weight	2019 Performance Target	2018 Results	2019 results	Met/Not Met
Residents of a NF or NFMH discharged to a community setting	Percentage of NF and NFMH residents indicating a desire to return to the community who are discharged to a community setting during the year.	MDS	7.79%	• *Rate >= 55%:* 100% OR • *Rate < 55% and >= 50%:* 50%	58.15%	56.20%	100% Met
Covered service accurately submitted via Encounter data	Percent of covered service accurately submitted via encounter data within 30 days of claim paid date. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Q1 97.47%* *Q2 97.72%* *Q3 94.39%* *Q4 99.71%*	*Q1 99.71%* *Q2 99.96%* *Q3 99.76%* *Q4 99.16%*	*100% Met* *100% Met* *100% Met* *100% Met*
Service payments matched to / validated by encounter record	Percent of reported financials reflecting service payments that are matched to/validated by an encounter record submitted by the MCO. Please note that there will be no rounding on this measure.	Encounter Data	7.79%	• *Rate >= 98%:* 100% • *Rate < 98% and >= 95%:* 50% KDHE will assess measure each quarter. Measure value will be 1.785% per quarter (7.14% / 4 quarters) *For Aetna Only:* • KDHE will deem Aetna as having met Q1 and Q2 2019 performance targets. • KDHE will hold Aetna to performance targets for Q3 and Q4 2019	*Q1 100.93%* *Q2 100.57%* *Q3 100.33%* *Q4 98.45%*	*Q1 99.32%* *Q2 99.18%* *Q3 98.64%* *Q4 99.92%*	*100% Met* *100% Met* *100% Met* *100% Met*